TRUTH WILL PREVAIL

1200 Studies that refute vaccine claims

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The nearly 400 pages added to this version have concentrated on the COVID-19 shots, as they represent a dangerous changepoint in history. See that section in the Table of Contents for a deep dive into the most controversial "vaccines" in history.

PREFACE

STOP! If you have looked at the size of this document and are ready to jump ship, DON'T do it! The reason you should stay is that as you will see over these first few pages, this is a UNIQUE resource with shortcuts and easy ways to access exactly what you want to check out, with minimal time and effort. It now contains excerpts and summaries from over 1,400 studies. **I promise you it will be WELL WORTH IT!**

Secondly, because this document has amazing tools that can allow you quick access to just the information you want to see, you will want to read pages **"labeled"** 6-10 for an overview and pages 20-22 which are the instructions of those shortcuts and features. I would recommend printing those 3 pages initially, as a reference for you. (print pgs 21-23, as the PDF recognizes the cover as pg 1).

Three important things before the introduction

It is such a blessing that my free *1200 Studies- Truth Will Prevail* eBook has been downloaded over 100,000 times and probably shared tens or hhundreds of thousands of times more than that. My goal has been to provide a research and reference tool for people that are looking to see the evidence that contradicts what the public is being told about the safety and effectiveness of vaccines. As of the release of the version prior to this one on November 1st, 2020 and due to the continued work I am doing on this living document, I have made the decision to charge a nominal fee of $6.95 for it or $12.95 which will include 3 future updates. With the ever-evolving COVID-19 vaccines situation and the precident pharma hopes to set for rollouts of future vaccines, I'm sure there will be no shortage of research, data and stories I will have to report on. I hope that the information this document will continue to provide will contribute to challenging and eventually changing the vaccine paradigm for the safety of all people, including our children now and all children in the future.

Over the last many months, I have had numerous requests for information and recommendations about three things…

1) Viral prevention and treatment, 2) requests for the latest information and 3) Evidence and science-based information on all the aspects of the COVID-19 pandemic including how things have been manipulated as well as the Unscientific and damaging public health responses…. So, in response here goes!

One…Viral Prevention and Treatment

***Due to the health concerns related to the COVID-19 pandemic, I have been inundated with requests for nutritional recommendations for viral prevention and treatment. Visit this page for detailed information…**

https://www.wellnessdoc.com/nutritional-viral-prevention-and-treatment-products/

Two…Stay connected and up to date

***You can stay up to date with my monthly *1200 Studies Update Newsletter*.**
I will do the leg work for you, finding "alternative" information that isn't front page news (but should be), and bring it to you in concise, easy to digest bites in a monthly newsletter. And, I will provide you with the data sources, so you can click and investigate them further if that is your desire! Subscribe here…

https://www.wellnessdoc.com/science-and-news-monthly-newsletter/

Three…Reports exposing truths about the various aspects of the pandemic and pandemic responses

*** Whether it is the ineffectiveness or harms from lockdowns to the mask mandates, the origins of the virus, the PCR testing debacle, the suppression of safe and effective medications, nutritional alternatives and a host of other topics, I have produced special investigative reports on them all available at: https://www.wellnessdoc.com/ebooks-and-publications/**

And now on to the introduction!

INTRODUCTION

IS THE SCIENCE SETTLED?

WE ARE CONSISTENTLY TOLD BY THE MEDIA AND THE MEDICAL SPOKESPERSONS ON TELEVISION, RADIO AND THE INTERNET, THAT "THE SCIENCE IS SETTLED" ON THE ISSUE OF VACCINES. BUT IS IT REALLY?

THIS DOCUMENT WILL ANSWER THAT QUESTION WITH EMPHASIS!

The contents of this e-Book are evidence based and substantiated by extensive research published in medical and scientific journals. It contains **SEVERAL HUNDRED LINKS** that you can click on, giving you instant access to the actual studies, corroborating everything reported in this document. In addition, the references contained in the excerpts from these studies **consist of thousands of additional studies** that also corroborate that evidence.

To the best of my knowledge, this is the most extensive exposé on vaccines to date and the first presented in this easy to search and share electronic format. If you have looked at the number of pages this contains and have concluded that you could never have the time to read it, sit tight because over the next few pages, I will describe the many shortcuts to get you to exactly the information you are most interested in. **For those that don't even want to attempt to read this, I at least want you to see what it contains. Read the whole introduction and then go to page 28 and scroll through the Table of Contents. The take-away you will get, is that there is such a massive amount of credible science that contradicts what we have been told and the current vaccine mania, that we have to open an honest and unbiased investigation into the entire matter**.

And, with this update you will find an extensive amount of information on the COVID-19 vaccines. The link to that section can be found near the back of the Table of Contents.

For those currently supporting the vaccine agenda, I challenge you to read this with an open mind and contrast it with what you currently know and believe. Then let the evidence fall where it may. And as you will clearly see, THIS IS AN EVIDENCE BASED REPORT.

We face a crisis of unprecedented proportions

We are facing an unprecedented crisis in our nation and the Western world. There has been a meteoric rise in the rates of autism, developmental delays, learning disabilities, allergy, asthma, autoimmune diseases and more in the way of chronic and debilitating diseases. And tragically, we are losing a large portion of the next generation of children to neurological, neurodevelopmental, behavioral and learning disabilities. According to statistics released by the CDC **in 2008, 1 in 6** children suffered from either autism or some form of developmental problem! (https://www.cdc.gov/ncbddd/developmentaldisabilities/about.html) Now 13 years later, given the increasing prevalence and current estimates, that number may be as high as **1 child in 4**! And those statistics show that these developmental delays including behavioral and learning disabilities are continuing to increase at alarming rates. And all of the learning and behavioral conditions have a prevalence much higher in boys. In addition, all across the spectrum, the rates of allergy, asthma and autoimmunity are nearing epidemic proportions.

Autism Spectrum Disorder (Autism), is just one of those many conditions that are affecting our children. But it is the condition that get most of the press. The incidence of autism is rising sharply and unabated. The **2014** CDC estimates were that **1 in 45 children were autistic (NHIS data*)**, up from **1 in 150 in 2002 (ADDM Network **)**, just 12 years prior**. Compare that to rates of autism estimated at 1 in 10,000 in the 1950s and 1960s, 1 in 5,000 in the 1970s and increasing to 1 in 300 in the 1990s.**

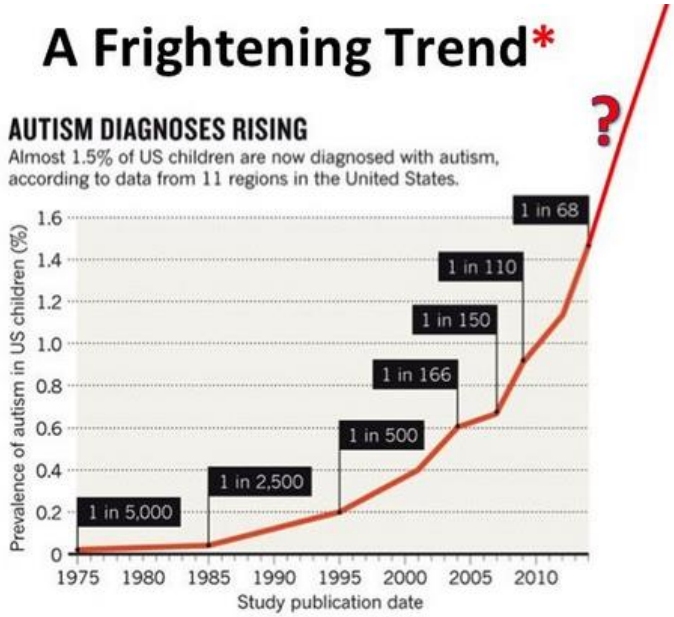
* https://www.cdc.gov/nchs/data/nhsr/nhsr087.pdf

** https://www.cdc.gov/ncbddd/autism/data.html

There is no doubt that there has been a steady increase in the prevalence of autism each time new stats come out, with approximately 4.3 times as many boys than girls being affected. Currently, it is estimated that approximately 1 in 25 boys are autistic in New Jersey. Some experts believe at the current trajectory, by the year **2032**, **1 in 2 boys will be autistic!!** And

that is not even considering the crippling rates of other intellectual disabilities just mentioned. **THIS IS COMPLETELY UNACCEPTABLE!**

This chart published in ***Nature- the International Weekly Journal of Science***, shows the rate increases up to 2011, when the rates were 1 in 68. As just mentioned, the rates as of 2014 were 1 in 45 and the projections for when the 2022 rates come out may be as high as 1 in 25.



*K. Weintraub, Nature 479, Nov. 3 2011, 22-24.

What would this mean for our society? It is estimated that it takes between two and three million dollars to raise an autistic child. Think about the current cost economically. And as the proportions of autistic children continue to increase, the cost over the next thirty years of raising millions of young people on the spectrum will be astronomical! We cannot sustain it. Just doing some simple math let's take just boys, since the prediction of 1 in 2 becoming autistic is only for boys. There were approximately 2-million boys born in the U.S. in 2017*. If we reach a point (heaven forbid), where 1 in 2 boys are autistic, conservatively using today's birth numbers of 1 million boys, and the current cost of an estimated of $60,000 annually to raise an autistic child to age 40, that amounts to an annual expenditure of 60 billion dollars at today's cost! Add girls in to the equation and that expenditure climbs to around 80 billion dollars (since autism is 3-4 times more prevalent in boys, fewer girls are affected). Over 40 years (**without** inflation factored in), **that amounts to 3 trillion, 200 billion dollars (3,200,000,000,000)! That is very close to the nearly 3 trillion 400 billion dollars in TOTAL health care expenditure FOR ALL U.S. health care spending in 2017*****. This will be an economic disaster! It gets worse. In addition, consider that as the years elapse, most likely many more boys and girls will be born annually than at the current birth rates. And, when the increased costs of caring for an autistic child, (i.e. medical and educational/vocational costs) increase, which we know they will, all of a

sudden that huge spending number we just considered could be twice as high. And, to make matters even worse, this calculation doesn't even take into effect the added costs involved for children with other neurodevelopmental delays, learning or behavioral problems, chronically ill with allergies, asthma and autoimmune disorders.

In addition, can you imagine the impact on us socially, on militarily readiness and on the affected children and families themselves? What about our intellectual capacity to churn out scientists, inventors and business innovators for the years to come? The clock is ticking. Left unchecked, it is truly a doom and gloom scenario. We must get to the bottom of it and we must do it now! And by sharing this document, you can be a part of the driving force to make this happen.

* https://www.cdc.gov/nchs/data/vsrr/report004.pdf
** https://www.ncbi.nlm.nih.gov/pubmed/24911948
*** https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf

It is my hope that this document will be the clarion call, that will create urgency and a groundswell of public insistence that action be taken in identifying the causative factors and changing them before it is too late. And you can help be a difference maker. In a few pages, you will find links to the download page for this e-Book and social media links to share it throughout your sphere of influence.

How to get the most out of this document

This document is interactive

First, a bit of housekeeping before I launch into the meat of this, and there is **A LOT** of meat in here!

To make it easy for you, I have copied quotes and summaries directly from the articles themselves for you to easily read. That allows you to get a snapshot of the conclusions the researchers have come to, without spending hours reading often very technical information and data.

This manuscript is designed to be read on a computer, as **it is an interactive document**. **It has hundreds of active links in the Table of Contents that will connect you directly to the page in the document where that topic is found. That way there is no tedious and time-consuming scrolling necessary. Beyond that, there are also links in each topic, that take you directly online to the article.** The vast majority of the references are peer reviewed medical and

scientific journal articles, that are found on the ***National Institutes of Health*** database called ***PubMed***, which we all have free access to. Other sources are reports from government agencies, articles, books and public interest watchdog groups. I have been careful to only use referenced and evidence-based information that has substantiation. I have even traced references from the independent web site and public watchdog groups articles contained in here. This easy-access, interactive capability, will give you the instant ability to see the evidence for yourself right from the scientists and researchers, rather than simply taking my word for it.

You are about to have **direct access to hundreds of studies and indirect access to thousands of studies** through the references that dispute, and in many cases widely dispute what we are currently being told about the safety and efficacy of vaccines. If you take into consideration the references just from the sections of the articles I have quoted in this eBook, **it actually represents thousands of studies,** not just the **1200 plus** studies and sources covered in this document. The beautiful thing is, that these are all **free** direct public access research that every American (actually every person in the world), has direct access to 24/7. Some of the information is from the abstracts or summaries of the full articles. Some of the articles are free in their entirety and some are available for purchase. When you click on the full text link, if there is a fee to purchase the article you will be directed to the option to do so. But don't worry, all of the abstracts I have cited can be accessed free, and almost all of the full studies are also free should you choose to read the entire article.

When you are directed to those articles, **some are merely summaries of the research**. **Some will have a free full text link on that first page**, whereby you can view or download the entire article and read it if you have the interest and the time. **If you want to cut to the chase, you can read the results and conclusion part of the abstract or summary of the article.** If you open the **full article, you can also read the conclusion or discussion at the very end of the article which typically has additional details than the abstract on the first page**. With a few of the links, a box may open warning to be sure it is a trustworthy source. That is because you are opening a PDF file directly. I have tested all those types of links and at the time I tested them they all worked perfectly without resulting in any problems with my computer.

What I don't want anyone to lose sight of, is **that this body of evidence represents hundreds of thousands of hours of hard work and discovery, put in by dedicated doctors, scientists and researchers seeking the truth, wherever that may lead them**. This project is as much a testament to them and their contribution to the evidence and data. For the first time at least at this level, the harmony of the full complement of information all of them have provided is on display. This, so that you and everyone you are willing to share this with, will have unfettered access to this untold story. In fact, this is a story that many do not want told.

Charts, graphs and tables-

I have only included a few charts, tables and graphs in the body of this document, because it would have made the file size of the document too large to email. However, there are links directly to many of these visual graphics either directly or accessing them from the articles that you can connect to. And, when you see them it will emphasize the points, findings and conclusions of the research. A picture can truly be worth a thousand words!

One more thing to be aware of, is that some of the words contained may be difficult to recognize or understand if you don't have a science background. That is because **you are actually looking at direct quotes from the research findings itself. Don't let that discourage you. By reading through the quotes and the conclusions, you will get a VERY good idea of what it is saying and the implications that are being made. In addition, as I will explain in a moment, I have underlined, bolded and even made some text red to give you the main takeaways.** This is all designed to help you make reading and understanding the key points very quick and easy.

Italicized **comments within parentheses and statements not contained in quotation marks in this document <u>are my comments and opinions</u>.**

This document is searchable.

Here is a quick encapsulation of those features, with a detailed description of how to use them in a few pages.

With the document open, click on the edit tab in the upper left. Then select find. Then a search box will open in the upper right. Type the word or phrase you want to search for and click on next. It will take you the next place in the document that the word or phrase is used. For example, you can type the word measles, or you can type in the phrase adverse reactions, and as you click the next (or previous) button, you will be taken to every place in the document forward or backward sequentially where measles or adverse reactions is found.

Because every study or article presented has active links directly to the article itself, I have not included a table of references. Tables of reference can be helpful, but very tedious to use. You have to look each one up manually in order to access it. That can take an unreasonable amount of time. With this document you have **instant access** to each reference and directly to the information that is referenced simply by clicking on the link.

Often, numbered footnotes to the references are placed within the text of a document with the actual references listed at the end of the study or article after the conclusion. I have omitted those numbered footnotes in the excerpts quoted. This is to facilitate ease of reading and because all the footnotes would not be included within *1200 Studies* itself. When you click on

the blue link to the abstract or article within each section, you can easily find the original footnotes and references for review in the source document.

This document is extensively researched and referenced

Each article you have access to, may have dozens or even hundreds of references to other scientific articles that the authors used to support, validate and verify the quotes, statistics, points and findings of the other studies that they are referencing. This is how you can have access to literally many thousands of studies that support the positions that this document is validating. In fact, when you consider the sources of the information I am presenting here, it represents tens of thousands of articles from peer reviewed scientific journals! These are not "fringe" studies. Many of the journals are considered some of the most prestigious ones in the world, journals like the Journal of the American Medical Association (JAMA), JAMA Pediatrics, The Lancet, The British Medical Journal, The New England Journal of Medicine, the Cochrane Database Systematic Review and the Journal of American Physicians and Surgeons just to name a few.

There are over 45 different medical and scientific disciplines represented by the studies in this eBook, representing a vast array of scientific perspectives

Hundreds of these studies you will see are from highly respected and reputable journals in the fields of biology, molecular neurobiology, toxicology, molecular medicine, biochemistry, inorganic biochemistry, immunity, immunology, immunotherapy, immunotoxicology, autoimmunity, virology, infectious diseases, neurology, neuroscience, neurodegeneration, brain injury, laboratory medicine, vaccines, prenatal medicine, perinatal medicine, pediatrics, child psychology, child neurology, developmental disabilities, family medicine, psychiatry, environmental health, environmental chemistry, environmental medicine, epidemiology, hospital epidemiology, molecular science, pharmacology, drug safety, public health, nephrology, nutrition, autism, medical research, genetics and epigenomics, infection control, rheumatology and investigative medicine.

In addition, I have drawn from Reports to Congress, information from the CDC, the FDA, HHS, the Institute of Medicine, National Academy of Sciences and other government agencies.

This eBook is meant to be distributed as widely as possible.

I have attempted to remove any objection to accessing this. That's why I am making it **free of charge**. The majority of people that have known I was working on this, have told me to charge something for it, even $5 or $10. Despite that encouragement, my heart told me to allow

everyone the opportunity to see this without any financial expenditure. So please share it far and wide! I would also strongly encourage you to share this with your doctors, as most of them have no idea that this information exists. And doctors once educated, can be a driving force for reform and change. Near the end of the book, I have tools that will also allow you to easily share this with your state and federal elected representatives.

There are several ways you can help to get this message out.

1. Share this through email **with everyone in your e-mail address book**. It is a small enough file size to send as an attachment.

2. Share it **on all of your social media** sites by clicking on the links to those platforms in a couple of pages.

3. Share it to everyone you know **by copying and sending them the link to the direct download**. The link you will see in a couple pages can be copied and pasted into an email. Once they click on it in the email you send them, they can read and/or download it to their computer.

4. Tell everyone you can to **go to 1200studies.com** and download this eBook for themselves. If for some reason that link does not work, they can go to **wellnessdoc.com/1200studies** or **chiropractic.org/1200studies**, where backup links are available.

5. You have my permission to host a download link of this eBook on your website and share it with your visitors if you have the capability to do so. There are only two things I ask. Do not change or alter anything and do not charge anything for it.

This is very important. You have my permission to share this information with everyone that you can, but please **DO NOT** charge anyone for it and **DO NOT** use it or any of the information that it contains for commercial purposes.

Why is this e-Book so long?

This document started as a response to social media posts, grew to an article, then to a book and now into arguably the most thorough, detailed and easily utilized resource that has ever been created on this topic. The real reason that it is so long and has now taken me 22 months,

is that once I dove into the research, it just kept coming and coming and coming with no end in sight. My explorations opened up "rabbit trails" that led me to new and compelling data I had to include. These regular "detours" have produced a continual stream of new and relevant information. I literally could have kept adding and adding, but my strong desire to get this out has finally overcome my wish to be even more thorough. In fact, there are many new articles coming out every week on this subject. **As much data as this eBook contains, it is still literally just the tip of the iceberg!**

Even though the information is very science based, I really believe that if you have a curious mind, or like drama, intrigue, suspense or a good cliffhanger like a good novel that keeps you on the edge of your seat, you will love this and will not be able to "metaphorically" put this eBook down. The great thing about it is, whenever you here a controversial debate, argument or claim about vaccines, now you have a resource to check out the facts. You can quickly access information that is organized, summarized and referenced.

These are the reasons I wrote this and how you can get the most from it

DEDICATION:

This eBook is dedicated to the hundreds of thousands of children that have been lost to vaccine injury AND their families who have suffered unimaginable hardships on so many levels. As you will see in this document, those shocking numbers are no exaggeration. In addition to those conditions developing in close proximity to the delivery of vaccines, this document will demonstrate that there is very good reason to believe that the meteoric rise in the incidence of autoimmune diseases, chronic neurological, immunological, reproductive problems and chronic illness is also associated with the tremendous increase in the number of vaccine doses that have been added to the schedule over the last 50 years.

There is a blatantly false and dishonest public narrative that vaccines do not cause serious injury and death. Rarely, a spokesperson will acknowledge and then minimize those facts, but then will rationalize and justify those cases as unfortunate casualties necessary "for the greater good of humanity". This eBook will challenge both of those erroneous positions.

My prayer is that this resource will be instrumental in demonstrating through a massive amount of credible scientific evidence, that there are indisputable reasons to warrant complete and independent investigational oversight of all facets of the vaccine industry and their products. In doing so, the truth will come out and if the necessary changes are made, it

will spare countless numbers of people from developing these life-altering acute and chronic conditions in the future.

Important to the genesis of this eBook:

As mentioned previously, this e-book started as a response to social media posts I was seeing. It has taken on a life of its own, as the more I researched, the more I found. Every time I thought I was near completion, more essential to share information popped up on the radar screen and I couldn't leave it out. **The evidence you will see, is so compelling that I promise you, that you will be blown away.** This e-book could have been well over a thousand pages long. That being said, 732 pages is a lot of information. **DON'T LET THAT INTIMIDATE YOU.** I have a several ways to help you shortcut the process. If it is more that you want to read, **PLEASE AT LEAST read the Table of Contents!** If that peaks you interest, but you still don't want to tackle over 700 pages, **skim the table of contents and find topics that interest you**. Then you can click on each topic you want to explore, and you will be taken instantly to that page. You can even search by key word or phrase (more on how to do all that in a bit). Even before the interactive Table of Contents, you will see **a list of the major categories discussed in the order that they appear in the document.** This will give you a broad perspective of what is in here. The Table of Contents will give you a really good idea of the extent of the massive amount of information that YOU NEED TO SEE in this eBook.

In addition, to create another time saving shortcut I have underlined, **bolded** and even typed in **red bold** font some of the most important key points. The underlined are very important. The bolded are the emphasized points. And, the red bolded are the main take-aways. Be aware that those are my edits and not those of the authors, study or article. So, if you really want to get the cliff notes, just read those. I highly recommend reading it all, but rather than lose some of you that don't have the time to do that, I wanted to give you an alternative that will prove to you that **THE SCIENCE ON VACCINES IS FAR FROM SETTLED!** In spending just a little bit of time, you will see that I have amassed an **OVERWHELMING** amount of evidence that contradicts what you are being told by the media, many doctors and the pharmaceutical industry. That is the reason I went to the extreme effort and extent to write such an exhaustive document. I didn't want anyone with even the slightest amount of intellectual honesty to be able to deny that statement. You will see what I mean **if** you read it.

In fact, those that say that the science is settled and have planted their flag firmly on the side that vaccines are completely safe and effective, have either never heard the scientific basis for questioning that premise, or they have a personal, professional or financial agenda. If and when they read this with an open mind, I believe that they will have their perspective flipped 180 degrees by the time they are done!

My Mission and Purpose:

I am not a scientist. I am not a researcher. Scientists and researchers are much smarter people than me. In fact, the contents of this document are credited to brilliant people like that. I am a physician that has worked in health care for over 30 years. My "gift" to contribute to this project, is that I have a very inquisitive and investigational mind. And, I have a voracious appetite for pulling back the curtain on a particular subject and looking behind it to see if what was being displayed on the façade (or false front) is true and accurate. Many things we are told in science and medicine are not exactly as they appear. If we are told something repetitively and long enough, we tend to believe it as fact.

In this fact-finding mission, I am committed to do what I can to change the trajectory of chronic childhood illness, including the epidemic of neurological and immune related diseases and disabilities that we are seeing in the western world. You will see when you read this, that the illnesses I am referring to are not the typically self-limiting infectious diseases like measles, mumps, chicken pox or the flu. It is a litany of much more serious, debilitating and costly long-term chronic illnesses plaguing our society, that are threatening to exhaust our health care system and bankrupt our economy. You will see the evidence of that in this document.

One more thing. I have dedicated nearly two years to this project. As you will see, it has been a huge undertaking! This is the first time that all of this information has been made available to the public and especially in a format that allows rapid search and discovery features. To do so, I have had to put my Wellnessdoc health and lifestyle coaching practice on the shelf to devote the time required for this project. I want it to reach every person that is willing to take an objective look at this subject. I want to encourage YOU to send it to all of your friends, family and contact lists via email and ask them to do the same. Post the link to download on your social media and in your post ask everyone to do the same. If anything ever needed to go viral (pun intended), this is it! The time for this conversation and open public debate is long overdue. You can be a catalyst for creating a public discussion, that will shine the spotlight on the mountain of suppressed evidence that contradicts what we are told by the media, governmental agencies and the medical establishment. You will see it all in this document.

We need to question the status quo and kickstart this conversation using real science. Social media will be the perfect way to do that and you can help. I would like to encourage you to use these links and share this article with everyone you know on your social media outlets.

The most important question before we start

Before you start to read this, I would like to ask you one simple question. **What is your level of confidence in what you are told regarding vaccines by the pharmaceutical industry, the government, the media and most medical doctors?** Give me a percentage between zero and 100% with 100% being you believe everything they are telling the public and 0% being that you believe nothing that they are telling you. Write that number down. When you're done reading this document, I'm going to ask you the same question, simply to see if the case I make is persuasive or not, one way or the other. Please be objective and open-minded.

The challenge is intellectual honesty

I realize that what I am presenting in this document is controversial. Probably the biggest reason it will face fierce opposition is because vaccination is the "holy grail" of medicine. It has been touted as medicine's greatest achievement and the reason for the decline of infectious disease. This will all be challenged by the evidence I am presenting here.

No matter what your opinion on vaccines, I challenge you to take the time to read this document through to the finish, **including looking at the links to the references showing you the proof of what I'm saying and what the articles reveal**. **If you feel strongly about this issue one way or the other, isn't it worth investing that small amount of time to investigate the evidence?** After doing so, then decide for yourself based on the merits of the **EVIDENCE**, NOT based on your pre-existing bias, what you hear from the media, the pharmaceutical industry, doctors or the government OR even by what you hear from the people that dare question the safety and efficacy of vaccination, sometimes referred to as "anti-vaxxers". I prefer to use the term vaccine skeptics.

Are you willing to follow the evidence, wherever it leads?

I started "neutral" in the vaccine debate**. I am strictly an evidence-based person. I research, study and base my opinion on the preponderance of the evidence.** If you are an "all-in" pro-vaccine advocate, **I have a challenge for you**. If you believe everything you hear about how safe and effective vaccines are, because doctors, politicians, the government and the media says so, I want to challenge your assumptions. Yes, I said assumptions. Because, if you've made up your mind without looking at the evidence, you are no better than someone sitting on a jury convicting somebody of a crime after listening to the prosecuting attorney's make their case,

without the defense attorney even being allowed to present his or her case to you. How intellectually honest is that? Could you in good conscience, convict somebody and sentence them to life in prison based on hearsay testimony, without evidence to corroborate those claims and without considering the evidence that the defense has to offer? If you are willing to parrot what people tell you about the vaccine issue without taking the time to investigate it yourself, then you are no better than that. Sure, everybody has a right to their own opinion, but unless you investigate the facts on both sides of the issue in order to determine what you believe and base your belief on the evidence, then you have no right to assert your opinion on others that disagree with you. You may be surprised to learn that a large number of people who have serious concerns about vaccines, have done a good amount of homework to base their conclusions on. If you are a person that questions the safety and efficacy of vaccines, I am asking you to do the same. Not everything that you hear from the people on the far end of that spectrum is accurate either.

Looking for Civil Discourse

What do people do when they don't know enough about something to have an intellectual argument? They get angry, they mock, they criticize, they denigrate, they call names, they curse, and they belittle. That is exactly what Jimmy Kimmel did in his condescending monolog and angry medical doctor tirade. We also see this graphically in today's political climate.

This is exactly what is also happening today in the debate over vaccination. The vaccine skeptics assert their right to decide what goes in to the bodies of themselves and their children. They have been educated to certain facts and seen and heard the evidence from doctors, scientists, former pharmaceutical researchers and organizations that have assembled valid information and data that warrants questioning and a serious debate. They really just want to have the freedom to choose what they allow to be put into their bodies and the bodies of their children.

The vaccine proponents state their opinion very loudly and militantly, opining that the people who question the safety and efficacy of vaccines, are lunatics and idiots that don't know nearly as much as their own child's pediatrician. They say, if it's good enough for the government to approve, and good enough for most doctors and the media to approve, then it's good enough for my child! They feel based on what they have been told, that those who do not vaccinate are putting themselves and their children at risk. I get that concern, based on the power and reach of the public information campaigns. Had I never been exposed to the steady stream of data I have over the last 30 years that contradicts those positions, I would likely feel the same way myself.

Be a "healthy skeptic"

I am a huge proponent of healthy skepticism. This is what I do on virtually every topic of importance that I'm faced with. I am skeptical. But my skepticism is also combined with an open mind and a desire to seek the truth. That is healthy. Yes, there are times when I spend an inordinate amount of time researching to find the preponderance of the evidence. But once I have made a decision, my conscience can rest knowing that I've done my very best to come to an accurate, valid and truthful conclusion. That is all I am asking you to do.

Follow and test the facts

If after you devote time to a serious fact-finding investigation and you come away with the resultant opinion, then you can rest in knowing that you have looked at the evidence with an open mind and can speak confidently about what you believe. If you are intrigued by what I'm presenting, you could run down dozens of additional articles from peer-reviewed medical and scientific journals referenced in the topics I have included here. If you did that, it would further reinforce and support the conclusions of the already extensive list of references that I have placed within this e-book. Keep in mind, that for every article I cite, the authors often cite anywhere from 100-200 references from other peer reviewed articles that support the data they present and the conclusions they make. The evidence is truly overwhelming. The quotes from the articles also have reference identifiers in the original text you will see if you follow the link to the source. I have removed them in this document, because adding all of those additional references would be such a massive undertaking. By following the link to the original document, you can see where those statements that are referenced are credited to.

It's true, that to dig deep into this topic you would need to spend many hours looking at all the data. But I am convinced that if you did, there is only one conclusion that you could be left with and that is this. That there needs to be serious and exhaustive **independent** investigation regarding the safety and effectiveness of vaccines, including the corruption within the pharmaceutical industry, the Food and Drug Administration (FDA) and the Centers for Disease Control (CDC). Yes imagine that, corruption at the highest levels of industry and government. Have you ever heard that assertion before? It certainly isn't anything new. According to Lord Actin, a British Historian from the late 19th and early 20th century, **"Power corrupts and absolute power corrupts absolutely."** His observation was that as a person's power increases, their sense of morality decreases. In the vaccine world, there is a revolving door that allows people to go back and forth between the CDC and big pharma, gaining lucrative positions in the process. Yes, the CDC and vaccine manufacturers have an incestuous relationship (which you will learn about in this document), for far too long. This is exactly why we cannot allow either the CDC or the pharmaceutical industry to be in charge of the **neutral and unbiased** research that needs to be done on vaccines. The fox has been watching the henhouse long enough.

Personally, I have always remained neutral when asked by my patients, if I think they should vaccinate their child. I have provided them with information consisting of books and studies on the subject and asked them to request the same from their child's pediatrician. I would tell them to gather those professional opinions, read the research and study the evidence on both sides of the subject. After all of that, make a decision as to what they believe is in the best interest of their child. In the end, I am going to assert that right for every parent. In fact, if you decide that you want to vaccinate your child but are concerned about some of the red flag issues that are presented from the science in this document, I am going to recommend you get guidance from one of hundreds of pediatricians that are willing to work with parents to support legitimate and appropriate exemptions, or to modify the vaccine schedule as warranted. These are recommendations that more and more pediatricians who have taken the time to study this topic are currently making for their patients. And many of them are taking heat for it. But kudos to them for standing up to the bullying.

If you choose not to vaccinate, I believe that you have the right to choose what goes into your body or the body of your child. I respect each person's right to choose, especially in the light of what I am about to present here. If you are wholeheartedly supportive of vaccines, before you have a knee jerk reaction and navigate away from this eBook, I challenge you to stay put and look at the evidence I am presenting here. If you suspend your bias and what you know up to this point and simply look at what thousands of scientists and researchers have to say about the subject, you will if nothing else, gain a different appreciation as to why so many people have their reservations.

Is there a ONE CAUSE of anything?

You may be surprised to learn that I do not believe vaccines are THE cause of autism. When I say THE, I mean THE ONLY cause. I cannot think of one condition or disease known to man that has only one cause. In addition to genetic influences, there are always epigenetic influences. Epigenetics describes the way our genes interact with our environment. Everything in our environment, physical, chemical and emotional interact with our genes. As you will learn from this document, autism and its full spectrum of neurobehavioral conditions display a pattern of certain antecedents, triggers and genetic components that predispose an individual to damage. Once you complete reading this document, you will be hard-pressed to deny that vaccines given to susceptible individuals can be a powerful triggering mechanism.

I am so excited that you are making the decision to seek the truth. Because in the end, the **TRUTH WILL PREVAIL!**

To Your Better Health,

Dr. Alan Palmer *(Author Bio at the end of this document)*

Consider supporting this effort

If you find this project helpful, educational, or even life changing for you or someone you love, please consider making a donation. There is a donation button here and at the end of this e-book. Even the amount that you would spend on a regular book would be greatly appreciated.

Donate securely here

Thank you in advance to all of you that will consider supporting this cause. But for those that need to be convinced first, I understand. And I intend to earn your support with the content of this manuscript. I am sure that by the time you finish, you will be astounded and inspired to share this information with the world. For full disclosure, this is NOT a non-profit donation, so it would not be tax deductible. And it is not payment for the information, but simply a voluntary donation in appreciation for the work involved.

COVID-19, AKA SARS-CoV-2

Nothing has ever captured the attention of the whole world like the latest pandemic of SARS-CoV-2.

And, with the inaccuracies of the catastrophic mortality projections, the exaggerated fear-provoking reporting, the inflated death rates setting the whole world into a panic, people are asking what is the truth? As the data has rolled out and I have looked RATIONALLY at the facts, a different picture emerged. I am in no way trying to downplay the severity of becoming infected with COVID-19 if you are in the subset of individuals at highest risk. Because for those people the infction can be deadly. Fortunately for the vast majority of people, the symptoms are mild or even non-existent. But, as we have learned more about the virus throughout the last 15 months, we can create lifestyle and nutritional strategies to protect ourselves and our loved ones going forward. There are articles and documents on my website to help you do just that. Visit https://wellnessdoc.com to learn more.

Would you like to receive monthly updates on the research, news stories, insider information and more as it relates to COVID-19 and the wide spectrum of issues relating to vaccines?

For just $6 a month, you will also learn more about the stories behind the stories and will be able to shed the fear by arming yourself with facts and a game plan of prevention and early treatment if you do become infected.

Subscribe to my monthly newsletter

Share 1200 Studies with your friends

Instructions for using the searchable and instant access features of this document

You may want to print these next three pages, to have on hand as a reference tool until you get the hang of the rapid navigation tools this document provides you.

1. The first thing to mention is that when you click on a link to look at a study **Adobe may open a window titled "Security Warning**", asking if you trust this site. It says, "This document is trying to connect to, and will list the site it is trying to access, so that you can see where it is taking you. **To prevent the security window from popping open every time you try to access an article from that site, simply check the check box in**

that window that says, "Remember this action for this site for all PDF documents". The vast majority of the articles are from PubMed or the CDC. Therefore, if you check the "Remember this action… box the first time you try to access an article on PubMed, you shouldn't have to do that again for any other PubMed based article. You may choose to do that with any of the others as well. Most of the non-PubMed articles are accessed from the sites where that journal article is hosted.

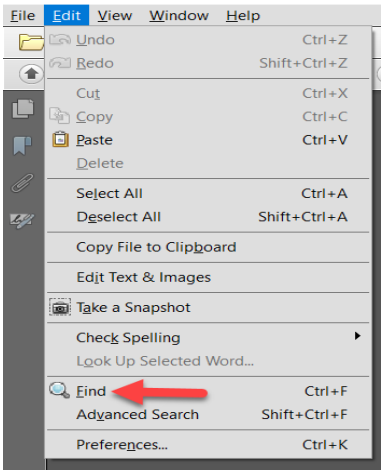
2. Next, the page numbers you see in the window of the PDF reader may be 1 page off from what the page number on the page itself says. I tried several corrections for that without success. However, the instant access link on each topic of the Table of Contents should take you directly to the correct page number.

3. Next, depending on the program or web browser your computer uses to open this document, the first part of these directions on key word searching may or may not apply to you. These are specific for Adobe Acrobat Professional, however Adobe Acrobat and some of the others may have similar features for searching. You can also change the **file associations** on your computer to have a PDF opened with other programs.

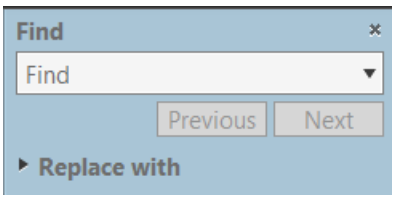
Key Word Search-

In the upper left of the window, click on the **Edit** tab….Then this window will pop up.

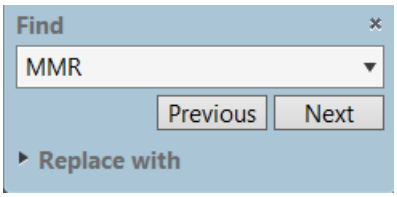
- Click on the word **Find** (where the red arrow is)



A new small window will pop-up in the upper right of the document toolbar area.



Type in a key word or phrase you want to find in the document. For example, you can search MMR, adverse effects, mercury, autism, hepatitis B, prenatal exposure, etc.



Then you can navigate continually to the next place that MMR (or whatever key word or phrase you use), is used by clicking on the **Next** button. Or, you can go back to the previous place it was found by clicking on the **Previous** button.

Jump instantly to a topic on any page in the document-

As mentioned previously, in an effort to cut to the chase and save you lots of time, **the document allows you to jump directly to that topic**. This way, you can selectively peruse the topics you are most interested in.

In the Table of Contents, you will find topic titles. Find one that you want to read about.

- Hover your cursor (which may look like a hand), over the title.
- Click your mouse or the lower left of your touchpad on a notebook computer. You will be transported directly to that page in the document. No tedious scrolling!

Return to last visited place in the Table of Contents-

- **If you go to that page and then decide you want to return to that same place in the Table of Contents, just hold the alt key down and push the left arrow once**. As long as you haven't clicked on another link in the article, it should return you to the same place in the Table of Contents. It will only go back there if you haven't navigated away from where that originally took you. **If you have tabbed up or down from that position, you can sequentially push the left arrow as you hold the alt key down. Each push of the left arrow will have you back one previously visited position in the document.**

Go to source article or study-

Within each topic, you will find the source abstract, article or story that the topic was derived from. To go directly to that source, simply hover your cursor over blue colored link in the topic

content and click your mouse or lower left corner of your mouse touch pad. It should open a browser window directly to that source. If the source is a PDF document, you may have a window pop up asking if you trust that source. I have tested all of the PDF links and they have all worked perfectly for me with no issues.

To go directly to a specific page

Select the View tab

Click- Choose page navigation
Click- -Page
-and the open page window will appear
-type the desired page number in

Another way to open the open page window is by holding Shift + Ctrl + N

To enable scrolling if the scrolling bar is not visible on the right side of the page

If your scrolling bar is not visible on the right of the window you may try the fix found here.
https://www.solveyourtech.com/how-to-enable-scrolling-by-default-in-adobe-reader-xi/

If you have touch screen computer- it is possible that touch screen mode is enabled by default. You can toggle it off and the **scroll bars** will be shown. Open Preferences by clicking Edit and select Preferences. Next, select General on the left menu and change Touch mode to Never.

A "bird's eye view" OVERVIEW of the major Categories

The following list does not have the instant access links taking you directly to the page. It is merely a broad overview of major categories of topics in the document. It is by no means a comprehensive list of all that this e-book contains but should give you a general overview of just a few of the topics covered and the order of which they are presented.

A DETAILED table of contents providing instant access through active links with page numbers, follows this general overview on page 27.

GENERAL OVERVIEW-

Preface

-Introduction

- Is the science settled?
- The Looming Crisis we face
- The unique search, easy access and source study access of 1200 Studies
- My Mission and Purpose behind this project
- Are you a truth seeker? Follow the evidence
- Sharing and Instruction pages for getting the most out of the interactive features

-Arguments and Assumptions

-Vaccine Ingredients

- Mercury- (see additional under autism link)
- Aluminum- (Link this to the long section on aluminum on 162-186)
- Why are mercury and aluminum used? (put Adjuvants & Preservatives here)
- Other Ingredients & toxicity profiles
- More on Human DNA from aborted fetuses in vaccines
- Contaminants in vaccines

-Autism

- Facts and Statistics
- Epidemic Proportions- A crushing wave of damaged children is coming
- Vaccine coverage & autism
- The role of fever
- Mercury's role in autism, autoimmune conditions and more
    - How much is in vaccines?
    - Why autism has continued to climb as mercury was reduced
- Human DNA fragment contamination
- Large increases in aluminum

-Vaccine risks to the fetus during pregnancy

-The Lynchpin- Too many shots too early

-Acetaminophen (Paracetamol) connection with autism

-One-way vaccines cause brain damage: Immune activation resulting in inflammation

-The epidemic of Autoimmune Diseases and the vaccine connection

-Other adverse health conditions linked to vaccines

- Gulf War Syndrome
- Obesity
- Type 1 Diabetes
- Emotional and Psychiatric disturbances
- Seizures
- Allergies and Asthma
- Immune overload
- Alzheimer's Disease

-Chronic diseases produce a demand for other medications- The vicious cycle

-Bias, conflicts of interest and scientific deception

- Many studies commonly used to support vaccines riddled with issues
- Become your own conflicts of interest researcher
- Conflicts of interest at the CDC

-Vaccine safety and the prevalence of vaccine injury

- Informed consent sorely lacking
- The National Vaccine Injury Compensation Program (NVIC)
- Low reporting of vaccine adverse reactions
- Vaccine safety testing far less rigorous than other drugs
- Long term safety testing before release is very rare
- Register on Pubmed to receive updates on vaccine studies
- The 1986 National Childhood Vaccine Injury Act bailed out the vaccine manufacturers
- Semantics are used in the hearings- Autism is not compensated for, but brain damage is
- As vaccine doses increase, the number of hospitalizations rise

-Mitochondrial injury- One of the consequences of vaccine injury

-World stats on countries infant and child mortality (death) correlates directly to the number of vaccine doses given

-Institute of Medicine Report expresses concern over how different vaccines may be interacting with each other

-Central Nervous System Demyelinating Diseases and vaccines

-Transmission of the vaccine virus to others and mutant strains caused by vaccines

-The Sudden Infant Death connection with vaccines

-Vaccines may cause an increased risk of contracting other infections

-Factors that can increase the risk of vaccine injury

-Vaccines are suspected to cause DNA damage that is passed down multiple generations

-Endocrine (hormone) disrupting chemicals found in vaccines cause numerous health problems

-The Science is NOT Settled

-Institute of Medicine says more safety studies are needed

-Vaccines.gov a U.S. Government website is misinforming the public- See my rebuttals

-Persecution of doctors that don't "Tow-the-Line"

- The Andrew Wakefield Witch Hunt- lies and deception
- Daniel Neides MD

-Culpability for the spread of pro-vaccine misinformation- Let's place the blame where it belongs

-True cost of mass vaccination campaigns

-Infectious Disease- Separating fact from fiction

- The facts about the decline of measles and other infectious diseases
- Death rates from infectious disease plummeted to nearly zero BEFORE vaccine for those diseases
- Manipulation of statistics
- Measles cases are significantly over diagnosed
- The real reasons for the precipitous drop of deaths from infectious disease in the west
- The real cause of infectious diseases
- Vaccine proponents are acting as if our modern societies are third-world countries and doing their best to sell everyone on the need for their vaccines to "save" them
- The germ or the terrain- Pasteur vs. Bechamp
- A parent's role in their children's immune competency
- Some newly discovered benefits of viruses

-Misinformation and marketing- A prevalent tandem in the vaccine world

-Common myths continue to be perpetuated

- Herd Immunity
- Non-immunized children are putting all the others at risk

-The ineffectiveness, dangers, misrepresentation and scandalous history of common vaccines

- The Influenza (Flu) Vaccine
- The Hepatitis B Vaccine
- The Varicella (Chickenpox) Vaccine
- The Shingles Vaccine
- The MMR (Measles, Mumps and Rubella) Vaccine- Problems with all
- The Pertussis (Whooping Cough) Vaccine
- The HPV Vaccine
- The BCG (Tuberculosis) Vaccine
- Tetanus and Diphtheria
- The Smallpox Vaccine

- The Polio Vaccine
    - AFM- (Acute Flacid Myelitis)- A recent polio like illness

-The benefits of contracting childhood infectious diseases and how vaccines are stealing our future health

-The Health of Vaccinated vs. Unvaccinated Children- The long-awaited study that vaccine proponents have never wanted to do

-Children in Third-World Countries get our vaccine leftovers and failures

-Doctors Bonused for Vaccine Compliance

-Two important questions to ask when considering what you are told about vaccines

-The "End Game" of the pharmaceutical industry and their vaccine subsidiaries

-The attempt to silence the vaccine backlash

-Vaccine company profits

-The COVID-19 Vaccines Introduction

- What are the risks for serious outcomes or death for various groups?
- Are children at risk?
- Are children spreaders of the virus?
- What about natural immunity? Does it last?

-The COVID Vaccines- A comprehensive Review

-Conclusion

-The Bottom-Line Problems and Solutions (Pages 699-703 for a sneak peak)

-For those that choose to vaccinate- What can be done to prevent adverse reactions?

-Strategies for detoxification and prevention/treatment for infectious diseases

(Pages 704-716 for the positive take-aways)

- Recommended quality nutritional support
- Detoxification strategies
- Specific nutrients and their benefits
- Diet and Lifestyle Recommendations

-If vaccines are going to stay, what needs to be done to fix the problems?

-Current Vaccine Exemptions in Various States

-Questions to ask if you intend to receive or give your child a vaccine

-Please consider donating to support this effort

-Help in contacting your federal and state representatives

-Closing thoughts and remarks

-Dr. Palmer's Bio

-Additional Resources:

- **Appendix A-** Websites of organizations that provide educational materials and information on vaccine risks and efficacy
- **Appendix B-** Lists of references from letters to the Department of Health and Human Services from prominent scientists
- **Appendix C-** Resources as quick reference guides for vaccine information

Instant access Table of Contents

The Three Main Pro-Vaccine Arguments

Let's look at the pro-vaccine position. There are three primary arguments, based on assertions that pro-vaccine proponents use and most consumers accept as gospel. I will address these arguments, one at a time.

1. **Doctors are the experts and we can trust them, as they are always right.** Their opinions must be true because they have years of medical education and have typically spent years in the medical field. If the concerns over vaccines were legitimate, doctors wouldn't be so confident that they are safe and effective.

   You may be surprised to find out that medicine has a long history of making very grave mistakes and have been slow and stubborn to change the official dogma *(a principle or set of principles laid down by an authority as incontrovertibly true),* even once the facts are well known. I will cover some powerful examples on pages 71-76.

2. **Vaccines are "proven" to be Safe.**

   In the current pro-vaccine ideology regarding safety, there are two primary assertions:

   a. **Vaccines are proven to be safe**. Along with that, the ingredients in vaccines are harmless. This could not be farther from the truth, as you will see.
   b. **There is no connection between the MMR vaccine, mercury or aluminum and autism** (or any other type of neurological, learning or behavioral condition affecting children for that matter). As you will see, hundreds of scientific articles beg to differ with this brazen talking point. The huge amount of evidence cannot be denied, and I will share it with you.

3. **Vaccines are "proven" to be effective.** Vaccines have been the sole reason all the "horrible" diseases we vaccinate against have diminished so dramatically. That narrative will be challenged with evidence directly from our government's own records and much more. And the record of effectiveness for most vaccines does not hold up to scrutiny when published statistics and studies that I will show you are revealed.

So here we go!

Assumption / Assertion #1- Doctors are the experts and we can trust them, as they are always right

Their opinions must be true because they have years of medical education and have spent years in the medical field.

Jimmy Kimmel is an agent of change. He in fact is one of the primary reasons for this e-book. Thank you Jimmy Kimmel, for spearheading this movement that will shine a light in some very dark places. Thank you for being the catalyst that will reveal the truth and science, that has been suppressed for far too long.

On February 27, 2015, Jimmy did a monologue criticizing those individuals who would question the safety and efficacy of vaccines for their children. It was scathing. It was nasty. It was rude. It was arrogant. It was insensitive. He parroted many pro-vaccine talking points that I will destroy in this e-book. They even videoed several medical doctors who took below the belt shots at parents who question anything about vaccination, even using cursing and indignant disgust in their description of the "idiocy" of parents would question such a sacred thing as vaccines and worse yet, their credentials superior knowledge as "DOCTORS". Kimmel's point, was how can these parents who question vaccines, possibly know more than medical doctors who have undergone eight years of postgraduate study? In fact, he makes a comment that would equate the stupidity of not vaccinating to letting your children smoke cigarettes. His point was that doctors tell you not to smoke and we think it wise to follow their advice on that, so it's ridiculous to not follow their advice to vaccinate. In two pages, on point number five you will see the irony in his example!

Watch this video now and then watch it after you read this document. I promise you, you will have a profoundly different reaction about the doctors and their glib comments after knowing the truth.
https://www.youtube.com/watch?v=QgpfNScEd3M

You will see after reading this e-book, that all these arrogant and pompous doctors did, was prove their naivety and ignorance. And you will agree, that all Jimmy did was demonstrate what an uninformed bully he is. He is someone with a bully pulpit, that condemns a whole group of people without taking the time to his homework. Shame on him. In fact, I would argue that most parents that choose not to vaccinate, or choose a less aggressive vaccine schedule, have done their research and probably know way more about the issue and the science than Jimmy Kimmel.

So, what about trusting doctors unquestionably?

Sometimes doctors get it wrong… Epic historical examples

So, are doctors always on the right side of history? Well let me take you briefly through a history of just a few of the things that medicine has fully supported with fervor, only later to be proven wrong. And it started over 170 years ago.

Historical Examples of Medical Errors

1. **In 1847, Ignaz Semmelweis** an Austrian medical doctor, proposed that the incidence of childbed fever could be drastically cut by the use of hand disinfection in obstetrics clinics. **He proposed the practice of washing hands with chlorinated lime solution to prevent infections in patients.** Later he recommended washing surgical instruments to disinfect them. **His experiments showed that mortality due to infection could be reduced by 90% with the simple procedure.** He was first ridiculed and then ostracized from practicing medicine. For many years he fought the medical establishment in an effort to persuade them to adopt these procedures. **He was ridiculed and driven from practice. Unfortunately, his efforts fell on deaf ears for nearly 20 years, which frustrated him to the point of becoming mentally unstable. He was tormented because his common-sense idea was vehemently opposed. As a result, it cost thousands of people their lives.** Fortunately for mankind, the medical profession finally realized the importance of proper sanitary procedures in obstetric and surgical procedures. The medical profession was dead wrong about the stand they took.

2. A more recent example is that of **the drug Diethylstilbestrol (DES).** From 1940 to 1971 DES was given to women with the belief that it would reduce the risk of complications in pregnancy. In 1971, **DES was shown to cause Clear Cell Carcinoma, a vaginal tumor in girls and women who had been exposed to the drug in utero. Subsequent studies have shown an approximately 40 times increased risk of this type of cancer.** Women who were exposed to DES have also been shown to have **an increased risk of breast cancer and breast cancer mortality**. (Prenatal diethylstilbestrol exposure and risk of breast cancer. Cancer, biomarkers and prevention. August 2006. Lead author Palmer, Jr.). **Prior to the discovery of these horrible complications of exposure to DES, it was commonly thought that toxins were not able to cross the placental barrier into the fetus**. Unfortunately for so many affected by DES, again the medical profession was dead wrong.

3. **Another example is the common practice of x-raying babies in utero**. This was a popular practice until 1955 when **David Hewitt**, a statistician at England's Oxford University noticed that in the preceding few years there had been **more than a 50% increase in the number of British children dying of leukemia**. That prompted **Dr. Alice Stewart** of Oxford to search for a reason. Trained as both a pediatrician and epidemiologist, she did an extensive review of children in Great Britain who had died of cancer during the previous two years. She found that **twice as many cancer deaths occurred before the age of 10 among children whose mothers received pelvic x-rays while pregnant**. **As a result of her findings, she found herself facing a firestorm of criticism from the medical profession. She even lost her funding for her research.** She continued to persist and in 1958 with an expanded database she determined that **a fetus exposed in the first three months of development was 10 times more likely to develop cancer**. Finally, in 1962 **Dr. Brian McMahon** of the Harvard School of Public Health did a study of 700,000 children born between 1947 in 1964. He found that **cancer mortality was 40% higher in children who were x-rayed in utero.** (Source: https://www.ratical.org/radiation/KillingOurOwn/KOO6.html)

4. **Thalidomide** was first marketed in 1957 in West Germany under the trade-name **Contergan**. The German drug company Chemie Grünenthal developed and sold the drug. **Primarily prescribed as a sedative or hypnotic, thalidomide also claimed to cure "anxiety, insomnia, gastritis, and tension". Afterwards, it was used against nausea and to alleviate morning sickness in pregnant women**. Thalidomide became an over-the-counter drug in West Germany on October 1, 1957. **Shortly after the drug was sold in West Germany, between 5,000 and 7,000 infants were born with phocomelia (malformation of the limbs). Only 40% of these children survived**. Throughout the world, about 10,000 cases were reported of infants with phocomelia due to thalidomide; **only 50% of the 10,000 survived. Those subjected to thalidomide while in the womb experienced limb deficiencies in a way that the long limbs either were not developed or presented themselves as stumps. Other effects included deformed eyes and hearts, deformed alimentary and urinary tracts, blindness and deafness.** (Source: https://en.wikipedia.org/wiki/Thalidomide)

5. **In February of 2006, the American Journal of Public health published an article titled, "The Doctor's Choice is America's Choice". This article chronicled the history of the cigarette industry's relationship with medical doctors. Medical doctors took center stage between 1930 to 1953 as the face of authority recommending cigarette smoking in tobacco company advertising.** One advertisement by Lucky Strikes Tobacco bragged "20,679 physicians say, 'Lucky's are less irritating'" and featured a white coated doctor with a reassuring smile. In the mid-1930s Phillip Morris, designed a campaign that referred directly to research conducted by physicians. The premise of their claim was based on studies showing that diethylene-glycol added to cigarettes made them "moister and less irritating" than other brands. This "benefit", then appeared in various medical journals. **This advertising touting medical doctors recommending various brands of cigarettes ran in those journals and became a steady source of income for well-respected medical journals including, the New England Journal of Medicine and the Journal of the American Medical Association**. (Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470496/ The Doctor's Choice is America's Choice").

Contemporary Examples of Medical Errors

Medical doctors have created a problem that many scientists and health experts consider the number one thing threatening the survival of the human species on this planet. That is bacterial resistance due to **the over-prescribing of antibiotics. As a result of this practice, many bacteria have mutated now so that even the most powerful antibiotics that we have are ineffective against them**. And these mutations are fast outpacing our best efforts to develop new antibiotics. **Over the last several decades, doctors have written millions of prescriptions annually for antibiotics to treat viral conditions including the common cold, something that antibiotics are useless for.** This is the caveat that all doctors are supposed to know. That antibiotics are completely ineffective against viruses. This practice of over prescribing, despite warnings from scientists in the medical journals that doctors are supposed to be reading, has been completely irresponsible.

According to the CDC, bacterial resistant infections affect 2 million people annually and 23,000 die from them in the U.S. https://www.cdc.gov/drugresistance/index.html This is physician caused, due to the overuse and inappropriate use of antibiotics.

> **This is an excellent article addressing this issue:** https://sciencebasedmedicine.org/overprescribing-antibiotics/ This **2017 article** in the ***JAMA Network***, underscores the importance of only prescribing antibiotics when absolutely necessary. It looked at ambulatory visits (those where the person walked into the doctor's office or hospital) during the years 2010-2011. **It found that 30% of the time antibiotics were prescribed were INAPPROPRIATE.** This is the major reason that "superbugs", as they are often called have developed and threaten our very existence.
>
> **30% of salmonella bacteria are now resistant to multi-drug intervention…** http://www.cidrap.umn.edu/news-perspective/2017/02/eu-nations-report-high-drug-resistance-humans-animals-food , **with one common strain in humans being as much as 81% resistant**…http://ecdc.europa.eu/en/press/news/_layouts/forms/News_DispForm.aspx?ID=1546&List=8db7286c-fe2d-476c-9133-18ff4cb1b568&Source=http%3A%2F%2Fecdc%2Eeuropa%2Eeu%2Fen%2FPages%2Fhome%2Easpx
>
> **According to the CDC, in 2011 hospital acquired infection occurs in 1 of every 25 people that visit the hospital equating to 722,000 patients. Of those 722,000 patients, more than 10% (75,000) died**. CDC.gov Health Care Associated Infections
>
> **Agricultural overuse of antibiotics in animals is another serious practice that contributes significantly to the problem and needs to change.**

The overuse of antibiotics without consideration of the downstream problems that it may cause is a striking parallel to what we are now seeing with the overuse of vaccines. While vaccine do cause a reduction in the incidence of the infectious disease, that temporary "benefit" is now being eclipsed with the ever-increasing rates of chronic neurological disorders including, neurodevelopmental delays and disabilities, learning and behavioral problems, allergies, asthma, autoimmune and reproductive disorders. Many of these are becoming epidemic, increasing proportionally over time to the number of doses of vaccines with no indication of slowing down. Are vaccines the sole cause of that? I am not saying that has been proven, but as you will see in this eBook, there are hundreds of studies (currently over 1,300), that cast much doubt and, in many cases overtly refute what we are being told about the safety and effectiveness of vaccines. Stay tuned as you read on!

These are but six examples of very serious, even disturbing mistakes that have been made throughout the history of the medical profession. Unfortunately, we have learned from history that some of the most staunch and confident positions taken by medicine, have later been proven to be deadly mistakes for millions of people, (as you will see on the next page). **As if these six are not enough, I have two more examples, because I don't think they should be ignored.**

The first, is that **medical care in the United States is FAR FROM SAFE**. Over the last 20 years, medical researchers have continued to downgrade the safety of the medical profession. An example is the **number of people that die due to medical error in hospitals annually**. In 1999, the prestigious ***Institute of Medicine***, published a report titled, **To Err is Human**. Dr Lucian Leape MD, a Harvard pediatrician who is referred to as "the Father of Patient Safety" was on the committee that wrote the report. The report was published in the ***Journal of the American Medical Association*** (JAMA), and shocked the medical world. **It stated that 98,000 people die annually due to medical mistakes in hospitals**.

Unfortunately, the news has continued to get worse since then. An article published in the ***Journal of Public Safety*** **September 2013 titled, A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care**, found that **a minimum of 210,000 preventable deaths per year occur in the U.S. and that the number may actually exceed 400,000 because of the limitations of the search tools they used. Incredibly, they also determined that serious harm to patients in hospitals may be 10-20 times greater than that horrific lethal number of 400,000! That means between 4 million and 8 million people are seriously harmed in hospitals annually in the U.S!**

On pages 321-322, you will see statistics on excessive medication and medication related errors, injuries and deaths that will shock you.

Let's bring my reasons to question medical opinions and authority to a close, (even though there are many more I could cite), with an example that relates directly to children's issues. **That is how the U.S. rates compared to the other countries of the world in infant mortality?** Where would you guess we would rate? Top 3? Top 10? Top 20? Top 30? Top 40? Top 50? If you said yes to any of those, you are wrong. **We rate 56th in the world in infant mortality according to the CIA factbook 2017**. **According to the World Health Organization (2015), the United States ranks fifth from the bottom of the Organization for Economic Cooperation and Development (OECD) countries in under-five mortality rate per 1000 live births**.
(Source: https://en.wikipedia.org/wiki/List_of_countries_by_infant_mortality_rate).

How can this be? Well stay tuned. There are some incredible and almost unbelievable links that I will share with you later in this document, that relate to the number of vaccine doses and infant mortality rates around the world.

Drug companies accused of abandoning the primary goal of patient well-being for profit driven motives and a marketing/pay-for-play strategy to co-opt all institutions

According to ***Dr. Marcia Angell, the former Editor in Chief*** of the prestigious ***New England Journal of Medicine***, "The combined profits for the ten drug companies in the Fortune 500 ($35.9 billion) were more than the profits for all the other 490 businesses put together ($33.7 billion) [in 2002]. Over the past two decades the pharmaceutical industry has moved very far from its original high purpose of discovering and producing useful new drugs. **Now primarily a marketing machine to sell drugs of dubious benefit, this industry uses its wealth and power to co-opt every institution that might stand in its way, including the US Congress, the FDA, academic medical centers, and the medical profession itself**." Angell M (2005) The truth about drug companies: How they deceive us and what to do about it. New York: Random House.

That quote was from 2004. Now 15 years later, the problem has gone from bad to worse.

Therein lies a HUGE part of the problem with what we are seeing in the vaccine issue. The pharmaceutical industry has its tentacles into every facet of educational, political, medical and media conglomerates. Their money and thus influence, has infiltrated all aspects of society, including the policy and decision makers in health care and politics and therefore the resultant public messaging. Despite an overwhelming amount of evidence that contradicts just about everything the public hears about the safety and effectiveness of vaccines (which you will see in 1200 Studies), that evidence is stifled as "vaccine misinformation" by a well-financed campaign of vaccine industry talking points. Money = power. Power = influence. And, influence = control. And they are controlling the narrative.

Despite the facts that I am presenting here, **I am not anti-medical**. Medicine has accomplished and continues to accomplish many incredible advancements. Life-saving methods and critical care procedures are some of the most amazing examples of this. I have many friends that are MDs. They can repair broken bodies, save lives in times of peril and stabilize serious life-threatening situations. Unfortunately however, the facts speak for themselves. There are many areas of medicine that need radical changes and improvements. The vaccine issue happens to be just one of those. Just like I would bet you were unaware of most of the facts that I just cited, there is even far more about the vaccine issue that you will learn from this exposé.

Assumption / Assertion #2a- Vaccines are proven to be safe and the ingredients are harmless.

A recent search with the words "vaccine adverse effects" on ***Pubmed***, the ***National Institutes of Health*** Database of scientific and medical literature returned 32,930 studies addressing the topic. Over 26,000 of those studies were published since 1990. If vaccines were proven to be safe, why would there be such a tremendous number of studies addressing their adverse effects?
https://www.ncbi.nlm.nih.gov/pubmed/?term=vaccine+adverse+effects

Mocking parents that choose not to vaccinate their children

In early 2017, there had been a cartoon circulating around the internet which features a school bus with some people on board that they are portraying as "anti-vaxxers" and a woman that "educates" them on the virtues of vaccinations and the idiocy of the anti-vaxxer viewpoints.
https://www.youtube.com/watch?v=nDjz5qHIzsc .

This is once again an example of mocking, demeaning and lying in order to shame anyone that would dare question vaccines and to "validate" the blind opinions of those that parrot the party line of the vaccine industry. Here are just two of the lies in the little school bus parody. The first one said this…. "decades ago vaccines contained a **non-toxic** version of mercury…." **NON-TOXIC?**

There are hundreds of studies in this document that take major exception to that statement!!!

But before we get to that, there is one question that needs to be asked. Are the number of parents that question the safety and effectiveness of vaccines as low as the media would lead you to believe? Maybe not, at least according to this survey.

Parents that have legitimate questions and concerns regarding vaccines are not a "fringe" group. Nationwide polling shows a large percentage have a variety of concerns

Parents that express concerns over the safety of vaccines are **not** "fringe" radicals. In fact, a 2011 National Public Radio (NPR), nationwide poll of 3,000 parents found that a large percentage of parents have concerns over vaccines. The article was published on NPR's web site: https://www.npr.org/sections/health-shots/2011/09/29/140928470/worries-about-autism-link-still-hang-over-vaccines?ps=sh_sthdl

From the article:
"During the first half of August, we asked people across the country for their views on vaccines in the latest NPR-Thomson Reuters Health Poll."

"**Autism remains a top worry, with 21 percent of respondents saying they believe autism is linked to vaccines**. About 7 percent believe in a link between vaccines and diabetes."

"**Overall, a little more than a quarter of households had concerns about the safety or value of vaccines. Among households with kids younger than 18, 30 percent had one of those concerns**."

"The more common issues for those with concerns were a **fear of side effects (46 percent of the group) or uncertainty about long-term health effects (47 percent)**."

"We wondered if people's opinions about vaccines had changed in the last five years. Nearly a quarter said they had. **In that group, 59 percent said their opinions had become less favorable**. A little more than a third said their opinions had gotten better."

The truth is as the article states, that the numbers of parents questioning everything we are being told about vaccines continues to increase and the level of trust in what they are being told and the people doing the messaging, is decreasing.

Vaccine adjuvants and preservatives are at the center of the controversy over the safety of vaccines

Vaccine adjuvants are implicated in the rise of serious health problems

Vaccine adjuvants are implicated as a major cause of the thousands of vaccine adverse reactions that occur yearly. In addition, they are also implicated in the epidemic like increase in the rates of neurological, neurodevelopmental, learning disabilities and emotional problems in the youth of today. And yes, even in the various forms of Autism Spectrum Disorder (ASD). You will see hundreds of published studies through this document, drawing a strong conclusion about the connection with these disorders. In addition, you will see dozens of published studies linking vaccines to many other chronic diseases that have risen steadily in the last 30 years, closely paralleling the continual increase in vaccine dose exposure to both children and adults.

What are vaccine adjuvants and why are they used in vaccines?

An adjuvant is an ingredient put in the vaccine, to stimulate a stronger immune response. Without some type of adjuvant, the vaccine would not be effective at all. Unfortunately, as you will see in this document, this becomes a double-edged sword. This hyper-reaction is exactly how the body's immune cells engulf and distribute the adjuvant material into the brain and other organs (which is not good) and leads to many different types of immediate and delayed adverse reactions. You will learn about all of that throughout this document.

Aluminum is the most common adjuvant used in vaccines today. Some vaccines even have two different forms of aluminum in them. Then there are other agents such as formaldehyde, mercury and antibiotics which are used to kill microorganisms in the vaccines. There are even multiple antibiotics in some vaccines, that medical prescribing sites say should never be used together as that can cause adverse reactions. Much more on all of this over the next several pages.

Here is more detail from the ***National Institutes of Health Institute of Allergy and Infectious Diseases (NIAID)*** website, listing vaccine adjuvants and their accessory components found in vaccines.
https://www.niaid.nih.gov/research/vaccine-adjuvants-types

Note: This content was last reviewed on October 01, 2015.

"Types of Vaccine Adjuvants
Only two adjuvants—alum and AS04—are used in commercially available vaccines in the United States. In 2013, the Food and Drug Administration approved the inclusion of another adjuvant, AS03, in the pandemic H5N1 influenza vaccine. Currently, this vaccine is included in the U.S. vaccine stockpile but is

not commercially available. Additional adjuvants have been approved for use in Europe, and many others are being tested in clinical trials.

Some types of compounds being used or tested as adjuvants are highlighted below.
*(*note it does say **being used**)*

Pathogen Components
Naturally occurring parts of pathogens used as adjuvants can help trigger early non-specific, or innate, immune responses to vaccines. These adjuvants target various receptors inside or on the surface of innate immune cells. The innate immune system influences adaptive immune responses, which provide long-lasting protection against the pathogen that the vaccine targets.

Examples of pathogen components tested and used as adjuvants include the following:

- **Monophosphoryl Lipid A**
  Monophosphoryl lipid A (MPL) is an immune-stimulating lipid (fat). It has been combined with alum to produce the AS04 adjuvant used in the human papillomavirus vaccine Cervarix.
- **Poly(I:C)**
  Poly(I:C) is synthetic double-stranded RNA that mimics a molecular pattern associated with viral infection. In rhesus monkeys, poly(I:C)-containing vaccines against SIV—a close relative of HIV that causes an AIDS-like disease in monkeys—have elicited protective immune responses.
- **CpG DNA Adjuvants**
  CpG DNA adjuvants are short segments of DNA that include sequence motifs, or patterns, commonly found in bacterial DNA. Hepatitis B vaccines containing CpG-based adjuvants are being tested in clinical trials, and initial results suggest that the CpG-adjuvanted vaccines are safe and effective.
- **Emulsions**
  An emulsion is a blend of two liquids that are normally unmixable, such as water and oil. An oil-in-water emulsion called MF59 is used as an adjuvant in Fluad, an influenza vaccine available in Europe. MF59 helps recruit immune cells from the blood to the vaccine injection site. MF59 contains similar ingredients as AS03, which is part of the pandemic influenza vaccine in the U.S. vaccine stockpile.

Particulate Adjuvants
Particulate adjuvants form very small particles that can stimulate the immune system and also may enhance delivery of antigen to immune cells.

Examples of particulate adjuvants include the following:

- **Alum**
  Alum, the most commonly used vaccine adjuvant, consists of aluminum salts that are not soluble in water. Alum is included in numerous vaccines, including those that prevent hepatitis B and human papillomavirus. Scientists are beginning to understand how alum stimulates vaccine-induced immunity. Gaining information about the mechanisms that alum uses to activate the

immune system will help increase understanding of adjuvant function and facilitate the design of new vaccine adjuvants.

- **Virosomes**
  Virosomes, particles that resemble viruses but are noninfectious, are included as adjuvants in the flu vaccine Inflexal and the hepatitis A vaccine Epaxal, both licensed in Europe. The virosomes incorporated into these vaccines have antigens and other viral proteins on their surfaces, but they cannot cause infection because they do not contain any viral genetic material. Certain immune cells recognize these virus-like particles and engulf them. These cells then present the antigen to adaptive immune cells, which mount a protective response.
- **Cytokines**
  Cytokines are small proteins that serve as chemical messengers of the immune system. Because of their role in coordinating immune responses, some cytokines have been evaluated as vaccine adjuvants. For example, scientists have conducted animal studies to evaluate interleukin 12 (IL-12) as an adjuvant in vaccines against various bacterial and viral infections. Results from these studies suggest that IL-12 may increase protective immunity to some respiratory pathogens.

Combination Adjuvants
Combinations of adjuvants, such as AS04, are of interest because of their ability to elicit multiple protective immune responses. Adjuvants that have a modest effect when used alone may induce a more potent immune response when used together.

Combination adjuvant research is in the early stages. Scientists must work to identify how adjuvants can be combined to elicit immune responses that are useful for a given antigen. NIAID is supporting research to identify and determine the function of novel adjuvant combinations. A long-range goal of this line of research is to develop a toolbox of adjuvants that can be combined in different ways to elicit a certain type of immune response.

Evidence that adjuvants can be dangerous

Sjögren's syndrome, an autoimmune/inflammatory syndrome caused by adjuvants

This article titled, **Sjögren's syndrome: another facet of the autoimmune/inflammatory syndrome induced by adjuvants (ASIA)** is from the ***Journal of Autoimmunity*** and published in 2014.
https://www.ncbi.nlm.nih.gov/pubmed/24774584

Symptoms associated with ASIA include:

- **Myalgia**, myositis, or muscle weakness.
- **Arthralgia** and/or arthritis.
- **Chronic fatigue**, unrefreshing sleep, or sleep disturbances.
- **Neurological** manifestations (especially associated with demyelination)
- **Cognitive impairment**, memory loss.
- **Pyrexia**, **dry mouth**.

Quotes from the article:
"Recently, **a new syndrome, namely the "Autoimmune/inflammatory syndrome induced by adjuvants" (ASIA)** has been defined. In this syndrome, different conditions characterized by common signs and symptoms and induced by the presence of an adjuvant are included. The adjuvant is a substance capable of boosting the immune response and of acting as a trigger in the development of autoimmune diseases. Post-vaccination autoimmune phenomena represent a major issue of ASIA."

"Own to the straight association between infectious agent's exposure (mainly viruses) and sicca syndrome development, the possible link between vaccine and Sjogren's Syndrome is not surprising."

The Journal Autoimmunity links aluminum in vaccines with numerous serious disorders

This article from the Journal ***Autoimmunity*** published in 2013 titled, **Autoimmune/inflammatory syndrome induced by adjuvants (ASIA) 2013: unveiling the pathogenic, clinical and diagnostic aspects**, warns that aluminum adjuvants in vaccines can be dangerous and cause autoimmunity in some people. https://www.ncbi.nlm.nih.gov/pubmed/24238833

From the article:
"**This article acknowledges that aluminum adjuvants in vaccines have also been linked to several different conditions including macrophagic myofasciitis, allergic reactions, chronic fatigue syndrome, arthritis, multiple sclerosis, systemic lupus erythematosus, granulomas and various neurological disorders**."

"**Clinical manifestations of some of these reactions can take months or years to develop, which is much longer than the time intervals utilized in vaccine safety studies.**"

Because genetic differences cause people to react differently to vaccines, these authors make a very important recommendation. They recommend that vaccines and vaccine schedules should be personalized to the individual based on their genetic profile and risk for reactivity. The science on perfecting this capability still has a long way to go, but it must be developed as soon as possible.

2017 study from the journal Metabolic Brain Disease calls for the phase out of aluminum adjuvants ASAP

An October 2017 study published in the journal ***Metabolic Brain Disease*** titled, **The putative role of environmental aluminium in the development of chronic neuropathology in adults and children. How strong is the evidence and what could be the mechanisms involved?**, finds serious problems with the continued use of aluminum adjuvants in vaccines and the risk it exposes to pregnant women, women planning on becoming pregnant and children.

This section is technical, but I felt it important to include it due to its excellent summation of and agreement with, so many contemporary scholarly articles and studies. It is really zeroing in on the

mechanisms by which adjuvants like aluminum, preservatives like mercury and other toxic/noxious chemicals that are found in vaccines can cause damage.

Systemic immune activation primed microglia and chronic neuro-inflammation
(All references can be accessed online)

"There is ample evidence demonstrating that chronic immune system activation and systemic inflammation can lead to the development of chronic neuro-inflammation. **Communication of inflammatory signals to the brain is mediated by PICs via a number of routes, including innervation of the vagus nerve, carrier-enabled transport across the blood-brain barrier (BBB), activation of endothelial cells within the BBB and perivascular macrophages, and finally via transport through circumventricular organs devoid of a functional BBB. The transduced inflammatory signals may lead to the development of chronic neuro-inflammation via the activation of microglia if of sufficient intensity and/or duration or lead to the development of B primed ^ microglia**. Microglial priming involves the upregulation of a range of surface receptors such as MHC class II, CD11b and CD11c integrins, co-stimulatory molecule CD86 and TLR-4." *(PICs stands for Pro-inflammatory Cytokines)*

"Following the upregulation of these receptors, such microglia become exquisitely sensitive to subsequent inflammatory stimuli, leading to an exaggerated production of neurotoxic molecules that may exacerbate the pre-existing pathology and may even accelerate the progression of existing neuro-inflammatory or neurodegenerative diseases. **Activated microglia exert their neurotoxic effects by releasing PICs, such as TNF-α ,IL-1β, IL-6, and IFN-γ, and free radicals including superoxide, NO and peroxynitrite, as well as inflammatory molecules such as prostaglandin E2. Moreover, TNF-α ,IL-1β and IFN-γ can act as secondary sources of RNS and other inflammatory molecules by acting as potent inducers of iNOS and via their capacity to upregulate cyclooxygenase-2 (COX-2) with the resultant production of prostaglandin E2**. **The concept of microglial priming could change the frame of reference from a consideration of a single inoculation containing aluminium adjuvant to a cumulative effect caused by a vaccination schedule in which successive immune insults over a short period could provoke chronic pathology either directly, by provoking microglial activity, or more indirectly by provoking macromolecular damage which could eventually reach a threshold capable of provoking chronic pathology. It should be noted that there is an accumulating body of evidence, albeit from animal studies, that successive and frequent postnatal immune and inflammatory insults play a pivotal role in the advent of microglial priming and the genesis of neurodevelopmental disorders. There is also emerging data implicating the development of microglial priming as a major factor in the development of several if not all neurodegenerative diseases**." *(RNS stands for Reactive Nitrogen Species, powerful free-radicals. iNOS stands for Cytokine inducible Nitric Oxide Synthase)*

From the conclusions:
"**Aluminium has no known beneficial physiological action in the human body and some genetic polymorphisms predispose to a greater susceptibility to its adverse effects. Therefore, a strong case can be made for avoiding unnecessary exposure to environmental sources of aluminium salts, especially on the part of children, pregnant mothers and women of child- bearing age who may become pregnant.**"

"The use of aluminium salts in medical products is a more contentious issue. While antacids are available which do not contain aluminium salts, the avoidance of immunisations which do not contain aluminium salts as adjuvants has wider political and financial implications. **It would seem prudent to try to find an alternative to aluminium adjuvants as soon as possible and phase out their use.**"

This diagram from the study shows the various damaging effects of aluminum on the astrocytes (brain nerve cells) and the microglia (brain immune cells) of the brain.

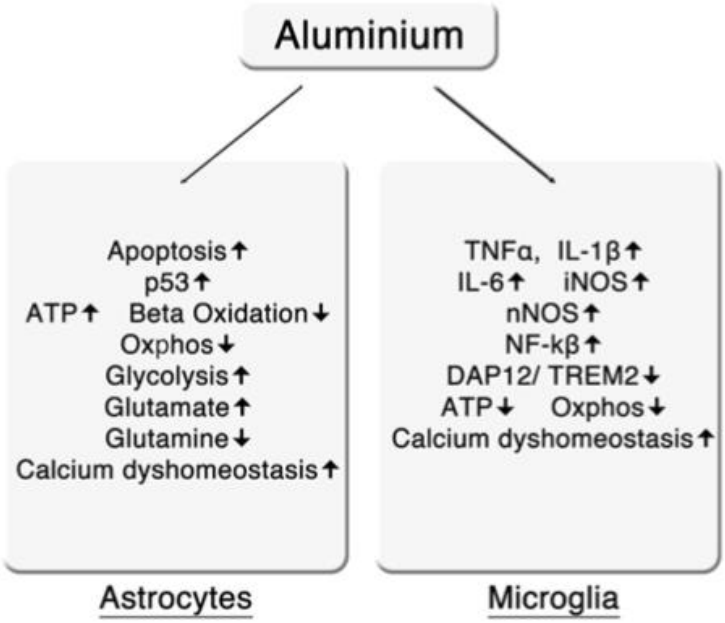


Fig. 2 Effects of aluminium on astrocytes and microglia

Some attempts are being made to develop safer adjuvants. The question is, will they be?

An August 12, 2018 study from the ***Journal of Controlled Release*** titled, **Cationic lipids as one-component vaccine adjuvants: A promising alternative to alum**, expresses some promising results in an alternative vaccine adjuvant to replace aluminum. It found that it boosted both humoral and cellular immunity in mice. https://www.ncbi.nlm.nih.gov/pubmed/?term=30110615

From the Abstract:
"The TLR and inflammasome stimulations, together with the antigen carrier properties of lipopolyamines, resulted in both humoral and cellular immunity in mice vaccinated against OVA and make lipopolyamines promising one-component vaccine adjuvants."

The hope is that researchers would continue to search for safe and effective alternatives to the current use of heavy metals and other adjuvant components that have demonstrated potential for increasing risk.

Stay tuned for much more on aluminum and other dangerous adjuvants

I will go much further into detail about the massive amount of research implicating adjuvants like aluminum and human DNA found in many vaccines, with many serious health conditions. I will also cover details about what else is in vaccines. Stay tuned, much of what you read will shock you!

Mercury – An initial intro, with much more later

Robert F. Kennedy's organization ***World Mercury Project*** released a 248-page eBook titled **Peer-Reviewed, Published Research on the Adverse Effects of Mercury (From Any Source)**. **It is a compilation of over 240 studies detailing the toxicology and health damaging effects of mercury.** It can be accessed here… https://worldmercuryproject.org/wp-content/uploads/mercury-all%20sources-research-combined.pdf

Dozens of studies find that Thimerosal the mercury preservative used in vaccines, is extremely toxic and damaging

Study finds that even at minute levels, thimerosal is a POISON and causes brain damage at the levels found in vaccines

A 2009 article ***from the Journal Toxicological and Environmental Chemistry*** titled, **Mitochondrial dysfunction, impaired oxidative-reduction activity, degeneration, and death in human neuronal and fetal cells induced by low-level exposure to thimerosal and other metal compounds.**
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3924342/

If you simply read page one about the high-level of toxicity of Thimerosal, you will see how untrue that is. This study found that **even in very small quantities, Thimerosal damaged brain cells**.

From the article:
"Of particular recent concern, routine administering of Thimerosal-containing biologics/childhood vaccines have become significant sources of Hg exposure for some fetuses/infants."

"Thimerosal at low nanomolar (nM) concentrations induced significant cellular toxicity in human neuronal and fetal cells. Thimerosal-induced cytoxicity *(cell toxicity)* is similar to that observed in AD *(Alzheimer's Disease),* pathophysiologic studies. Thimerosal was found to be significantly more toxic than the other metal compounds examined."

Another 2015 article finds "thimerosal is a poison at minute levels with a plethora of deleterious consequences even at the levels currently administered in vaccines"

This 2015 article is from ***the International Journal of Clinical Chemistry*** titled, **Thimerosal: clinical, epidemiologic and biochemical studies.** You only need to read page one, although the full text is available to download free. https://www.ncbi.nlm.nih.gov/pubmed/?term=25708367

The article conclusion: "The culmination of the research that examines the effects of Thimerosal in humans indicates that **it is a poison at minute levels with a plethora of deleterious consequences, even at the levels currently administered in vaccines.**"

Thimerosal destroys the mitochondria of brain cells

Mitochondria are the cellular organelles that make energy in the form of ATP for the cell. There are hundreds of mitochondria in each cell in our bodies. Their health and proper function is ESSENTIAL for the cell to survive.

This article from the ***Journal of toxicology*** 2012 titled, **Thimerosal derived ethylmercury is a mitochondrial toxin in human astrocytes: possible role of Fenton chemistry in the oxidation and breakage of mtDNA**, clearly shows the mechanism by which thimerosal damages the DNA of mitochondria in brain cells. And how this leads to cell damage and even cellular death. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3395253/

From the article:
"The results of this study suggest that **ethylmercury is a mitochondrial toxin in human astrocytes**. We believe that this finding is important, particularly since the number of diseases in which mitochondrial dysfunction has been implicated are rapidly increasing." *Ethylmercury is the form found in vaccines, in the form of thimerosal)*

This study shows that Thimerosal changes the membrane potential of the mitochondria in the brain cells (astrocytes), **allowing the mercury to flow into the mitochondria by a factor of 1000-fold.**
"…ethlymercury **will partition into the mitochondria by a factor of 1,000 fold**, its accumulation driven by the approximate 180mV mitochondrial membrane potential [25], Figure 7(a)."

The ethylmercury in thimerosal damages the mitochondrial DNA which is abbreviated as mtDNA. "In Figure 4 we demonstrated that while **the levels of damaged nuclear DNA and mtDNA are very low in untreated cells, ethylmercury induces a large increase in oxidized mtDNA lesions**." *This damage to the mitochondrial DNA* ***causes a loss of cellular energy and a large increase in free radical production in the form of superoxide radicals resulting in damage to the brain cell and potentially cellular death***.

Thimerosal has been linked to neurological disorders

This 2017 article from the ***Journal of Environmental Research***, titled **Low-dose Thimerosal in pediatric vaccines: Adverse effects in perspective**, confirms the harmful neurological effects of thimerosal in vaccines. In addition, the authors reveal that while efforts have been made to reduce mercury from vaccines in industrialized countries, children in underdeveloped countries are still subjected to the full gamut of mercury containing shots. https://www.ncbi.nlm.nih.gov/pubmed/?term=27816865

From the article:
"Young children (before the age of six months) are the demographic group most exposed to recommended/mandatory vaccines preserved with Thimerosal and its metabolite ethylmercury (EtHg). Particularly in the less-developed countries, newborns, neonates, and young children are exposed to EtHg because it is still in several of their pediatric vaccines and mothers are often immunized with Thimerosal-containing vaccines (TCVs) during pregnancy." *(Unfortunately, that still happens in the U.S. also).*

"Thimerosal, known to have **neurotoxic effects even at low doses**, has not been scrutinized for the limit of tolerance alone or in combination with adjuvant-Al during immaturity or developmental periods (pregnant women, newborns, infants, and young children). Scientific evidence has shown the potential hazards of Thimerosal in experiments that modeled vaccine-EtHg concentrations."

"However, **consistently, they showed a link of EtHg with risk of certain neurodevelopment disorders,** such as tic disorder, while clearly revealing the benefits of removing Thimerosal from children's vaccines (associated with immunological reactions) in developed countries. So far, only rich countries have benefited from withdrawing the risk of exposing young children to EtHg. Regarding Thimerosal administered to the very young, we have sufficient studies that characterize a state of uncertainty: the collective evidence strongly suggests that **Thimerosal exposure is associated with adverse neurodevelopmental outcomes.** It is claimed that the continued use of Thimerosal in the less-developed countries is due to the cost to change to another preservative, such as 2-phenoxyethanol. However, the estimated cost increase per child in the first year of life is lower than estimated lifetime cost of caring for a child with a neurodevelopmental disorder, such tic disorder. The evidence indicates that Thimerosal-free vaccine options should be made available in developing countries."

NEW - Thimerosal causes severe reproductive issues in male rats and is linked to multiple systemic health problems

A study published in the ***Saudi Journal of Biological Sciences*** titled **A study on the potential reprotoxic effects of thimerosal in male albino rats**, had many damning things to say about Thimerosal and it's use in vaccines.

Abstract:

"Thimerosal is ethyl mercury-based compound which is being used as a preservative in vaccines since decades. Pharmaceutical products and vaccines that contain thimerosal are among the potential source of mercury exposure. Current research was intended to ascertain the reprotoxic effects of thimerosal on rat testes. Twenty-four adult male albino rats were sorted into four groups (n = 6). The first group was a control group. Rats of experimental Group 2, 3 and 4 were treated with various dosages of thimerosal (0.5, 10, 50 mg/kg) respectively. Rats were decapitated after thirty days of trial and different parameters were analyzed. Thimerosal exposure resulted in a significant decrease in antioxidant enzyme activities including catalase (CAT), peroxidase (POD), superoxide dismutase (SOD), glutathione reductase (GSR)and increased levels of thiobarbituric acid reactive substances (TBARS). **Different doses of thimerosal significantly decreased ($p < 0.05$) the concentration of plasma testosterone, luteinizing hormone (LH) and follicle stimulating hormone (FSH). Additionally, Daily sperm production (DSP) and efficiency of daily sperm production were significantly reduced followed by thimerosal exposure. Moreover, thimerosal significantly ($p < 0.05$) decreased the primary spermatocytes, secondary spermatocytes, number of spermatogonia along with spermatids. Thimerosal induced adverse histopathological and morphological changes in testicular tissues such as decreased Leydig cells, diameter of seminiferous tubules, tunica albuginea height and epithelial height. On the other hand, the increase in tubular lumen and interstitial spaces was observed due to thimerosal. These outcomes indicated that thimerosal has potential repro-toxic effects in male albino rats."**

From the study:
"Mercury is one of the most damaging sources of the reproductive system in animals and humans (Boujbiha et al., 2009). By disturbing the thyroid, pituitary, pancreas and adrenal glands, mercury can affect the endocrine systems of humans and animals even at very low concentration (Rice et al., 2014)."
"Thimerosal is used in vaccines, which breaks down into ethylmercury (Et-Hg) and thiosalycilic acid and readily accumulates in the tissues (Magos, 2003). Et-Hg, which is released from thimerosal is more lethal as compared to the parent compound (Clarksonet al., 2003). Due to lack of knowledge, the risk assessments forEt-Hg was made on the basis of toxicity caused by Me-Hg. Nonetheless, recent data have displayed that Me-Hg is not a proper reference for risk assessment for mercury released from thimerosal as there is a large difference between the kinetics of metabolism of both methyl and ethyl mercury (Magos, 2003; Burbacher et al.,2005)."

"The harmful impacts of thimerosal are abnormal pain sensitivity (Olczak et al., 2009), neuro-degradation of hippocampus(Olczak et al., 2010) and modification in dopaminergic pathways with successive behavioral disorganization (Olczak et al., 2011).Likewise, it is reported that **neonatal administration of thimerosal may cause poor regulation of neurodevelopment, endocrine sys-tem and synaptic activity, which could be incidentally linked with mice autistic behavior (Li et al., 2014). Despite the harmful effects, thimerosal is still being used in antiseptics and vaccines (Sykeset al., 2014)."**

Conclusion:
"**In conclusion, our findings show that exposure to thimerosal results in increased oxidative stress and decreased activities of antioxidant enzymes, which ultimately lead to impairment in reproductive hormones and eventually decreased daily sperm pro-duction in testicular tissues of treated rats.** Our findings provided information about the safe use of low concentrations of thimerosal in vaccines. **Thus, the use of thimerosal as animal and human vac-cine preservative should be of great concern, specifically till the efficient risk evaluation."** https://pubmed.ncbi.nlm.nih.gov/32994739/

What does the Material Safety Data Sheet (MSDS) say about the toxicity of mercury?

What is incredible, is that the material safety data sheet for thimerosal says, "pregnant women should not be exposed to the product". That is found on page 3 of the **Material Safety Data Sheet (MSDS)** http://www.gihonlab.com/farmo1.php (Gihon Lab's web site) and click on the PDF symbol for the MSDS in English. By the way, why is the skull and crossbones shown on the product label and the shipping packaging for Thimerosal if it is "non-toxic", as the little school bus video claimed? You can see that on Gihon's home page at that link.

In addition, the material data safety sheet warns of ***Mutagenic Effects (DNA damage):*** "mutagenic for mammalian somatic cells. May cause damage to the following organs: kidneys, liver, spleen, bone marrow, central nervous system (CNS)". On the ***Special Remarks on Chronic Effects on Humans*** section it states "**may cause cancer based on animal data**. No human data found. May cause **adverse reproductive effects** (female fertility – post implantation mortality, fetal toxicity) and birth defects. **May affect genetic material.**"

That warning clearly states that thimerosal is toxic to a fetus!

Additionally, in 2010 the **US Advisory Committee on Immunization Practices** began recommending flu vaccination for all healthy children older than six months. If given from multi-dose vials, this again introduces thimerosal into the brains of these children. In 2012, the ***Cochrane Collaboration Systemic* Review** concluded that **for children under the age of two, the currently licensed flu vaccines "are not significantly more efficacious than placebo**."

There is "Widespread manipulation of conclusions…of the studies" on the flu vaccine

They also said, "The review showed that reliable evidence on influenza vaccines is thin but there is **evidence of widespread manipulation of conclusions and spurious notoriety of the studies**." https://www.ncbi.nlm.nih.gov/pubmed/22895945

Despite this finding, pediatricians are commonly recommending flu shots for these very young children. Remember the blood brain barrier does not begin to protect the brains of children under after the age of 2 at the very earliest according to most experts. Many studies show that full maturation and thus maximal protection does not occur until much later.

Thimerosal administered at levels equal to those in vaccines cause pathological damage and cell death to brain cells

A 2010 article from the journal ***Folia Neuropathologica*** titled, **Lasting neuropathological changes in rat brain after intermittent neonatal administration of thimerosal**, found that doses of Thimerosal given to rat pups equivalent to those given to human infants caused significant neuropathological damage and cell death. https://www.termedia.pl/Original-paper-Lasting-neuropathological-changes-in-rat-brain-after-intermittent-neonatal-administration-of-thimerosal,20,15811,1,1.html

From the Introduction:
"Thimerosal (THIM; sodium ethylmercurithiosalicylate), containing approximately 49% mercury (Hg) by weight, has been used as a vaccine preservative since the 1930s. However, during the past decade **serious concerns have emerged regarding its safety in infants, young children, and pregnant women**. In the body THIM is metabolized to ethylmercury and subsequently to inorganic Hg forms, which **accumulate in different organs/tissues including the brain, where they can remain for months or years. Hundreds of years of human experience and thousands of scientific publications provide evidence of toxicity of mercurials, particularly severe for developing organisms. With growing numbers of paediatric vaccines, many of which contained or still contain THIM in some countries, administered at ever younger age (e.g. Hep B vaccine is given during the first 24 h after birth in Poland, the U.S. and many other countries), infants have been exposed to increasing amounts of Hg, with potentially negative effects on their health. In fact, the years of the late 1980s and 1990s, when infants were exposed to the largest ever doses of Hg in vaccines, coincide with the emergence of epidemics of paediatric neurodevelopmental disorders, including autism."**

"In conclusion, the present study documents that administration of THIM to suckling rats in a vaccination-like manner and at doses analogous to those used in paediatric vaccines or higher injures neurons and astroglia in several brain regions. These findings may be extrapolated (with caution) to certain clinical conditions, **since THIM and other mercurials are suspected pathogenic factors in the aetiology of several neurodevelopmental disorders, including autism [12,13,15,25,29,41,51]. Some**

neuropathologies, such as morphological and neuroanatomical changes in the prefrontal and temporal cortex, or loss of Purkinje cells, seem common for THIM's neurotoxic actions and these disorders. While this study has obvious limitations, **it provides clear evidence of neurotoxicity of pharmacologically relevant doses of THIM in developing organisms, lending further support to the hypothesis implicating mercurials in paediatric neurodevelopmental disorders. On the whole, the results of this study argue for urgent removal of THIM from all vaccines for children and pregnant women, as well as from other medicinal products and cosmetics**."

Study finds it plausible that low-dose thimerosal is linked to autism

A 2010 article from ***Cellular Biology and Toxicology*** titled, **Induction of metallothionein in mouse cerebellum and cerebrum with low-dose thimerosal injection**, finds that even low-dose thimerosal causes activity in the cerebellum of the brain and supports the plausibility of the mercury/autism connection. https://www.ncbi.nlm.nih.gov/pubmed/19357975

From the Abstract:
"It is thought that the cerebellum is a sensitive organ against thimerosal. **As a result of the present findings, in combination with the brain pathology observed in patients diagnosed with autism, the present study helps to support the possible biological plausibility for how low-dose exposure to mercury from thimerosal-containing vaccines may be associated with autism**."

Mercury from vaccines causes a 40-fold increase in premature puberty

A 2010 study from the ***Indian Journal of Medical Research*** titled, **Thimerosal exposure & increasing trends of premature puberty in the vaccine safety datalink**, **used the Vaccine Safety Datalink (VSD), a reliable source of vaccine statistics to expose a 40-fold increase in premature puberty from the National Institutes of Health (NIH) historical incidence of premature puberty at 1 in 10,000 people**. Premature puberty is characterized by sexual development before the age of eight in girls, and age 10 in boys. **The study looked at 278,624 children born between 1990-1996 and compared the subjects that developed premature puberty to their extent of exposure to Thimerosal Containing Vaccines (TCVs)**. Exposures to Hg from TCVs were calculated by birth cohort for specific exposure windows from birth-7 months and birth-13 months of age.
http://www.ijmr.org.in/temp/IndianJMedRes1314500-6779162_184951.pdf

From the study:
"The ***US Agency for Toxic Substances and Disease Registry (ATSDR)*** reports that mercury (Hg) **is a known endocrine disruptor and it adversely affects the steroid synthesis pathway in animals and humans, and may interact to enhance the risk for a child developing premature puberty**. An

association between premature puberty and exposure to Hg from thimerosal-containing vaccines (TCVs) was evaluated in computerized medical records within the Vaccine Safety Datalink (VSD)."

"**The overall results of the present study showed a significant association between Hg exposure from thimerosal-containing vaccines and premature puberty**. There were **significantly increased rate ratios for premature puberty** following increasing Hg exposure from thimerosal-containing vaccines administered in the first 7 and 13 months of life. Further, it was observed that the overall median age of **puberty among those diagnosed with premature puberty in the present study (4.5 yr) was significantly reduced in comparison to the lower end of the normal reference ranges for puberty in girls (≥ 8 yr) and boys (≥ 10 yr) in the US**[2]. The present study found an adjusted overall prevalence rate of premature puberty occurring in about one in 250 children. **This represents a significant (about 40-fold) increase in the diagnosed rate of premature puberty of about one in 10,000 children from previous NIH estimates**."

Several strengths of the study were noted. Here are just three of them:
"**First**, the VSD contains medical records for patients that were collected on a prospective basis, as part of the routine treatment course of physician care. **The VSD requires no reporting of adverse events or having a physician associate an outcome with an exposure**."

Second, "The birth cohort years examined from 1990 through 1996 occurred many years prior to the raising of concern about potential problems with thimerosal in childhood vaccines by the ***American Academy of Pediatrics*** and the ***US Public Health Service***, so that their announcement to remove thimerosal from childhood vaccines in July of 1999 should have had virtually no impact on physicians' thoughts about thimerosal in childhood vaccines.

"Finally, another significant strength of the present study stems from the **trends in birth cohort Hg exposure and outcomes**. It was observed there were increasing/decreasing trends in exposures and outcomes across the birth cohort years examined, and that **for premature puberty there were significant associations between birth cohort mean Hg exposure and disease prevalence rates**. It is important to note that the increasing/decreasing trends in Hg exposure were not simply the result of random yearly fluctuations in vaccine uptake rates or even simply the result of increasing exposure to vaccine antigens, but **instead reflect known changes in the Hg content of the US childhood vaccine schedule**. **Namely, in the late 1980s/early 1990s the Hg dose from vaccines increased with the addition of hepatitis B (12.5 µg Hg/dose) and Hib (25 µg Hg/dose) vaccines to the routine childhood schedule during the first year of life.** Subsequently, starting from 1992, the Hg dose from vaccines decreased with the addition of combination whole-cell DTP-Hib (25 µg Hg/dose) vaccine, instead of the 50 µg Hg per joint administration of whole-cell DTP and Hib vaccines (each contained 25 µg Hg/dose) in separate immunizations. This was finally followed by in the mid-1990s the replacement of whole-cell DTP vaccines with acellular DTaP vaccines (25 µg Hg/dose). For the most part these vaccines were not made in combination with Hib vaccine."

"**The observed effects were consistent with the known human endocrine disrupting effects of Hg exposure**." The study concludes with a discussion of other studies that have shown that mercury disrupts the levels of sex steroid hormones and by binding to receptor sites on ovarian cellular membranes. It also confirmed that many studies have found that mercury has endocrine disrupting effects and that exposure can lead to hormonal problems.

The CDC pushes mercury and aluminum containing vaccines for pregnant women putting a vulnerable fetus at risk

Keeping that in mind, incredibly a Fox News report posted May 01, 2017, quoted Dr. Anne Schucat, the acting director for the CDC saying that the first vaccine she would recommend for pregnant women is a flu shot. She went on to say that the changes in a woman's body makes it harder to fight the flu. "And infants, who are also at risk for serious flu complications cannot be vaccinated until they are at least six months old." The article also states, "vaccination can protect mom but also have antibodies cross over the placenta to protect the baby, and keep the baby protected before they'll get the vaccine as an infant kick in". In addition, she says "Another vaccine expectant mothers should be getting is the Tdap (tetanus – diphtheria – acellular pertussis) vaccine, which includes a booster for whooping cough." She goes on to say, "you need to get several doses in your life and it's not 100% effective". To make people feel more comfortable, the article states that both the flu and Tdap vaccines are made with inactive ingredients, like killed viruses or dead bacteria.

Unfortunately, as they mention in the article, the antibodies can cross through the placenta into the baby, but that is not the only thing that will enter the into the baby. There will be several components from the vaccines including thimerosal (mercury), aluminum, formaldehyde, polysorbate-80, fetal cellular DNA, two-phenoxyethanol and dog kidney cell proteins among many other ingredients. Unfortunately, and very importantly, a fetus is at significant risk for absorbing these toxins directly into their brain, because the brain has not even begun to form the blood brain barrier (which I will talk more about later in this article). http://www.fox10phoenix.com/health/252243608-story

Was thimerosal removed from most childhood vaccines simply as a precaution, or was there a smoking gun?

One common claim you hear from the "talking heads" is that the Thimerosal was removed as a precaution only and there was no evidence of health concerns with its use……Really? This next section should put all those lies to rest!

A Congressional Report released in 2003 refutes the claim that thimerosal was removed purely as a precaution. The scathing report points the finger for the rise in autism directly at thimerosal, our government agencies and the drug industry

Federal hearings were held that prompted the drug manufacturers to reduce the amount of mercury in vaccines… These are excerpts from those hearings:
After a three-year investigation, a Congressional report released May 2003 by the staff of the Subcommittee on Human Rights and Wellness, Committee on Government Reform, "Mercury in Medicine" Hearings of the United States House of Representatives stated:
"Thimerosal used as a preservative in vaccines is likely related to the autism epidemic. This epidemic in all probability may have been prevented or curtailed had the FDA not been asleep at the switch regarding the lack of safety data regarding injected thimerosal and the sharp rise of infant exposure to this known neurotoxin. Our public health agencies' failure to act is indicative of institutional malfeasance for self-protection and misplaced protectionism of the pharmaceutical industry."
https://www.gpo.gov/fdsys/pkg/CREC-2003-05-21/html/CREC-2003-05-21-pt1-PgE1011-3.htm

From the report:
"In July 2000, it was estimated that 8,000 children a day were being exposed to mercury in excess of Federal guidelines through their mandatory vaccines."

"One leading researcher made the following statement to the Committee in July 2000:
``There's no question that mercury does not belong in vaccines.
``There are other compounds that could be used as preservatives. And everything we know about childhood susceptibility, neurotoxicity of mercury at the fetus and at the infant level, points out that we should not have these fetuses and infants exposed to mercury. There's no need of it in the vaccines.''

II. Findings and Recommendations of the report:
Italics and bold sections are added by me for emphasis)

A. Findings
Through this investigation of pediatric vaccine safety, the following findings are made:

1. **Mercury is hazardous to humans**. Its use in medicinal products is undesirable, unnecessary and **should be minimized or eliminated entirely.**

2. **For decades, ethylmercury was used extensively in medical products** ranging from vaccines to topical ointments as preservative and an anti-bacteriological agent.

3. **Manufacturers of vaccines and thimerosal, (an ethylmercury compound used in vaccines), have never conducted adequate testing on the safety of thimerosal. The FDA has never required manufacturers to conduct adequate safety testing on thimerosal and ethylmercury compounds.**

4. **Studies and papers documenting the hyperallergenicity and toxicity of thimerosal (ethylmercury) have existed for decades**.

5. **Autism in the United States has grown at epidemic proportions during the last decade**. **By some estimates the number of autistic children in the United States is growing between 10 and 17 percent per year. The medical community has been unable to determine the underlying cause(s) of this explosive growth.** *(And still hasn't fifteen years later)*

6. At the same time that the incidence of autism was growing, **the number of childhood vaccines containing thimerosal was growing, increasing the amount of ethylmercury to which infants were exposed threefold**. *(Imagine what it is today from the combination of maternal prenatal vaccines, those given to newborns and the high aluminum exposure from additional vaccines! See about the shockingly excessive amounts on pages 196-202).*

7. **A growing number of scientists and researchers believe that a relationship between the increase in neurodevelopmental disorders of autism, attention deficit hyperactive disorder, and speech or language delay, and the increased use of thimerosal in vaccines is plausible and deserves more scrutiny**. In 2001, the Institute of Medicine determined that such a relationship **is biologically plausible**, but that not enough evidence exists to support or reject this hypothesis.

8. **The FDA acted too slowly to remove ethylmercury** from over-the-counter products like topical ointments and skin creams. Although an advisory committee determined that ethylmercury was unsafe in these products in 1980, a rule requiring its removal was not finalized until 1998.

9. **The FDA and the CDC failed in their duty to be vigilant** as new vaccines containing thimerosal were approved and added to the immunization schedule. When the Hepatitis B and Haemophilus Influenzae Type b vaccines were added to the recommended schedule of childhood immunizations, the cumulative amount of ethylmercury to which children were exposed **nearly tripled**.

10. **The amount of ethylmercury to which children were exposed through vaccines prior to the 1999 announcement exceeded two safety thresholds** established by the Federal government for a closely related substance--methylmercury. **While the Federal Government has established no safety threshold for ethylmercury, experts agree that the methylmercury guidelines are a good substitute**. Federal health officials have conceded that the amount of thimerosal in vaccines exceeded the EPA threshold of 0.1 micrograms per kilogram of bodyweight. In fact, the amount of mercury in one dose of DTaP or Hepatitis B vaccines (25 micrograms each) **exceeded this threshold many times over**. Federal health officials have not conceded that this amount of

thimerosal in vaccines exceeded the FDA's more relaxed threshold of 0.4 micrograms per kilogram of body weight. In most cases, however, **it clearly did**.

11. **The actions taken by the HHS to remove thimerosal from vaccines in 1999 were not sufficiently aggressive.** As a result, thimerosal remained in some vaccines for an additional two years.

12. **The CDC's failure to state a preference for thimerosal-free vaccines in 2000 and again in 2001 was an abdication of their responsibility**. As a result, many children received vaccines containing thimerosal when thimerosal-free alternatives were available.

13. **The Influenza vaccine appears to be the sole remaining vaccine given to children in the United States on a regular basis that contains thimerosal**. Two formulations recommended for children six months of age or older continue to contain trace amounts of thimerosal. **Thimerosal should be removed from these vaccines. No amount of mercury is appropriate in any childhood vaccine.** *(an as you will see in this e-book, the term "trace" is a misnomer)*

14. **The CDC in general and the National Immunization Program in particular are conflicted in their duties to monitor the safety of vaccines**, while also charged with the responsibility of purchasing vaccines for resale as well as promoting increased immunization rates.

15. **There is inadequate research regarding ethylmercury neurotoxicity and nephrotoxicity.**

16. **There is inadequate research regarding the relationship between autism and the use of mercury-containing vaccines**.

17. **To date, studies conducted or funded by the CDC that purportedly dispute any correlation between autism and vaccine injury have been of poor design, under-powered, and fatally flawed.** The CDC's rush to support and promote such research is reflective of a philosophical conflict in looking fairly at emerging theories and clinical data related to adverse reactions from vaccinations.

On page 8 of the report, Dr. H. Vasken Aposhian, Professor of Molecular and Cellular Biology and Pharmacology, University of Arizona discussed thimerosal's history during Congressional testimony:

``In the early thirties, in fact the 1940's and up until the mid-1950's, mercurials were used in medicine . . . The medical community . . . had nothing better to use. They had nothing better to use as a preservative at that time than thimerosal. And I would venture the opinion that it has just been going on because no one has objected to it. And there's no need for it any longer. And I don't know any medical community or scientific community that would agree to the need for having thimerosal in any vaccine.''

Vaccine proponents often say that ethylmercury (thimerosal) is not as toxic as methymercury. What does the report say about that?

From the report: "While there is frequent reference to the paucity of science in understanding the harm that ethylmercury can do**,** there is more understanding in the scientific community than government officials have shared with the Committee. The following dialogue between Congressman Dave Weldon (R-FL) and Dr. David Baskin during the Committee's December 10, 2002 hearing sheds a great deal of light onto the true nature of ethyl versus methylmercury.

Dr. Weldon: ``I have a couple of questions for Dr. Baskin about ethylmercury versus methylmercury. I have had some people say that data on methylmercury is fairly good, but we don't have good data on ethylmercury. I take it from your testimony there is actually quite a bit of data on ethylmercury and it's as toxic as methylmercury.''

Dr. Baskin: ``There is more data, more and more data on ethylmercury. The cells that I showed you dying in cell culture are dying from ethylmercury. Those are human frontal brain cells. You know, there has been a debate about . . . ethyl versus methyl. But from a chemical point of view, most chemical **compounds that are ethyl penetrate into cells better than methyl. Cells have a membrane on them, and the membrane is made of lipids, fats. And ethyl as a chemical compound pierces fat and penetrates fat much better than methyl.** And so, you know, when I began to work with some of the Ph.D.s in my laboratory and discuss this **everyone said, `oh gosh, you know, we've got to adjust for ethyl because it's going to be worse; the levels are going to be much higher in the cells**.' So . . . I think at best they're equal, but it's probably highly likely that they are worse. And some of the results that we are seeing in cell culture would support that.''

Dr. Baskin explained that according to scientific research in humans and animals, brain tissue absorbs five times more mercury than other tissues in the body.

Safe limits of mercury ingested orally is often inappropriately compared to injected levels

The vaccine industry plays games suggesting that 10 times the EPA, FDA and WHO maximum ingestion of mercury is safe. That is not only untrue, but deceptive as oral exposure is very poorly absorbed, whereas injected exposure is 100% absorbed

From the report:
"The Committee repeatedly heard from government officials that merely exceeding the guideline was not cause for concern. One Merck official, in teaching a Grand Rounds session to staff in November of 1999, postulated that the minimum risk level would need to be multiplied by ten to reach a level at which harm would be expected through exposure. Dr. Roberta McKee of Merck wrote:

``A number of environmental and public health agencies have set a **Minimum Risk Level (MRL)** for toxic substances. An MRL for **ingestion** is conceptually equivalent to the Reference Dose of the US Environmental Protection Agency, the Acceptable Daily Intake of the US FDA, and the Tolerable Daily Intake of the WHO. Any exposure to the substance below the MRL is assured to be safe, while exposure to ten times the MRL is assumed to place one at risk of overdose. Exposure at or near the MRL is assumed to be safe but should trigger deliberate and careful review.'' *One must consider that they are talking about ingestion, which means by mouth. As you will see in this document, less than 1% of orally ingested mercury is actually absorbed. It is not a valid comparison to injected mercury with regard to minimum risk level (MRL).*

"**Based on Dr. McKee's explanation, many babies were exposed to levels of mercury that ``placed one at risk of overdose,'' and were exposed to amounts well over ten times the EPA's scientifically validated reference dose.** For example, at a recent Committee hearing, Chairman Dan Burton (R-IN) discussed his own family's experience with vaccine injuries: ``My grandson received vaccines for nine different diseases in one day. **He may have been exposed to 62.5 micrograms of mercury in one day through his vaccines**. According to his weight, the maximum safe level of mercury he should have been exposed to in one day is 1.5 micrograms, **so that is 41 times the amount at which harm can be caused.''**

"According to the analysis of Dr. McKee, based on the methylmercury ingestion guidelines, the Chairman's grandson would have exceeded the ``ten times the MRL'' and therefore was placed ``at risk of overdose.'' In fact, with a 62.5 microgram exposure alone, the EPA, ATSDR, and FDA levels would have been exceeded by 10 times. **Because the FDA chose not to recall thimerosal-containing vaccines in 1999, in addition to all of those already injured, 8,000 children a day continued to be placed ``at risk for overdose'' for at least an additional two years**."

When you read about the **shell game** played **with oral absorption safe limits being used to compare to amounts of aluminum and mercury in vaccines**, you will begin to understand the massive amounts of these toxic metals that our children are being exposed to. More on this on pages 161-164 and 174-181 (mercury) and 196-202 (aluminum).

A 2004 report by the *U.S. Office of Special Counsel* finds sufficient evidence of danger to public health

On May 22, 2004, after hundreds of disclosures from citizens to the ***Office of Special Counsel***, U.S. Special Counsel Scott Bloch issued these statements:

"I have recently received hundreds of disclosures from private citizens alleging a widespread danger to the public health, specifically to infants and toddlers, caused by childhood vaccines which include thimerosal, a mercury-containing preservative. As you know, the vaccine program is administered by the U.S. Department of Health and Human Services (HHS), over which you have oversight jurisdiction.

Because none of the individuals making the disclosures are federal employees, former federal employees or applicants for federal employment, OSC lacks jurisdiction over these cases and can legally take no action on the allegations. 5 U.S.C. § 1213(a)(1). I hasten to add, however, that based on the publicly available information, as discussed briefly below, it appears there may be sufficient evidence to find a substantial likelihood of a substantial and specific danger to public health caused by the use of thimerosal/mercury in vaccines because of its inherent toxicity."

"Due to the gravity of the allegations, I am forwarding a copy of the information disclosed to you in your capacity as Chairmen of the Senate Committee and House Committee with oversight authority for HHS. I hope that you will review these important issues and press HHS for a response to this very serious public health danger."

"The disclosures allege that thimerosal/mercury is still present in childhood vaccines, contrary to statements made by HHS agencies, HHS Office of Investigations and the American Academy of Pediatrics. According to the information provided, vaccines containing 25 mcg of mercury and carrying expiration dates of 2005, continue to be produced and administered. In addition, the disclosures allege, among other things, that some datasets showing a relationship between thimerosal/mercury and neurological disorders **no longer exist**, that independent researchers **have been arbitrarily denied access to Centers for Disease Control and Prevention (CDC) databases**, and that government-sponsored studies have not assessed the genetic vulnerabilities of subpopulations. Due to their heightened concern that additional datasets may be destroyed, these citizens urge the immediate safeguarding of the Vaccine Safety Datalink database, and other relevant CDC information, so that critical data are not lost."

The disclosures also allege that the CDC and the Food and Drug Administration colluded with pharmaceutical companies at a conference in Norcross, Georgia, in June 2000, to prevent the release of "a study which showed a statistical correlation between thimerosal/mercury exposure through pediatric vaccines and neurological disorders, including autism, Attention-Deficit/Hyperactivity Disorder, stuttering, tics and speech and language delays. Instead of releasing the data presented at the conference, the author of the study, Dr. Thomas Verstraeten, later published a different version of the study in the November 2003 issue of Pediatrics, which did not show a statistical correlation. No explanation has been provided for this discrepancy. Finally, the disclosures allege that **there is an increasing body of clinical evidence on the connection of thimerosal/mercury exposure to neurological disorders which is being ignored by government public health agencies."**

***Segway from this current story to clarify this last paragraph and to fill in the gaps of the story….**

The infamous Simpsonwood conference:

The meeting took place in June of 2000, whereby the CDC convened a scientific review panel at the Simpsonwood Retreat Center near Atlanta. At the gathering (which was intended to be secret), were over 50 experts—representing the CDC and FDA, state and international public health agencies and vaccine companies. The attendees met to discuss what they described as "theoretical concerns" about the risks of thimerosal-containing vaccines.

The following is an excerpt from the ***Children's Health Defense*** eBook, **Conflicts of Interest- Undermine Children's Health.** It is an excellent resource for gaining a more complete understanding of the convoluted conflicts of interest and industry protecting mechanisms in place. *(As always, references can be found in the original document).*

"The lead Simpsonwood speaker, ***Thomas ("Tom") Verstraeten, MD***, was a junior physician-biostatistician working in the CDC's Epidemic Intelligence Service (EIS). Verstraeten had been conducting analyses designed to assess the impact of thimerosal-containing vaccines on neurodevelopmental disorders in children. His earliest tables—never reported on or published but obtained through a Freedom of Information Act request by the autism advocacy organization ***SafeMinds***—demonstrated "striking" and statistically significant effects "supportive of a causal relationship between vaccine mercury exposure and childhood developmental disorders (especially autism)." These initial analyses, dubbed "Generation Zero" by SafeMinds, found consistently elevated risks (2-11 times higher) in the high-exposure groups compared to the zero-exposure group, with the strongest effects "for the highest levels of mercury exposure at the earliest time of exposure."

Between February 2000 and November 2003, Verstraeten and his CDC supervisors produced four further rounds of analyses that—with each round or "generation"—reduced or eliminated the elevated and statistically significant risks apparent in the Generation Zero data. This reflected, according to SafeMinds, "deliberate" methodological choices that took the findings in a direction "towards insignificance." When going over the "Generation One" analysis at Simpsonwood, Verstraeten made it clear that he was caught in the middle. On the one hand, he described a safety signal that would "never go away"—showing that thimerosal exposure in infancy displayed a statistically significant dose-related association with subsequent neurological damage—but he also hinted at the pressure that he was under to "turn everything around" and "make it go away" (see "Undeniable Safety Signal").Meanwhile, other Simpsonwood attendees cautioned that "we have to be very, very careful that we got it right when we decide to make a policy call on this." By the close of the meeting, all but one Simpsonwood attendee had agreed to rate the association between thimerosal and neurodevelopmental disorders as "weak."

In a post-Simpsonwood email in July, 2000 to Harvard researcher ***Philippe Grandjean***—a leading mercury and neurotoxicology expert—Verstraeten apologized for dragging Grandjean into a "nitty-gritty discussion" about thimerosal and neurodevelopment. Verstraeten stated, "I do not wish to be the advocate of the anti-vaccine lobby and sound like being convinced that thimerosal is or was harmful, but at least I feel we should use sound scientific argumentation and not let our standards be dictated by our desire to disprove an unpleasant theory."

Despite Verstraeten's scruples, others at the CDC—with Julie Gerberding at the helm—proceeded to hastily publish a handful of poorly designed epidemiological studies intended to shore up the Simpsonwood consensus. Authored by industry-funded scientists, the studies examined a single neurodevelopmental outcome (autism) and seemingly absolved thimerosal of any responsibility for causing it. A study of the data presented at Simpsonwood was published in *Pediatrics* in 2003, with Verstraeten (now working at GlaxoSmithKline) as lead author. Although the publication used the later generations of analyses—featuring reworked exclusion criteria, exposure measures and statistical models—Verstraeten contested the notion that he or the CDC had "watered down" the original results. In a letter to the editor of *Pediatrics* in 2004, he described the study's results as "neutral," stating, "The bottom line is and has always been the same: an association between thimerosal and neurological outcomes could neither be confirmed nor refuted, and therefore, more study is required."

Back to the 2004 report by the Office of Special Council…

"I recognize that Congressman Dan Burton, Chairman of the House Committee on Government Reform, held hearings on CDC Activities Related to Autism most recently in April 2002 as well as from 1999-2001. During those hearings Dr. David Baskin, a Baylor School of Medicine neurologist, testified about his research and the **serious consequences of exposure to mercury**. Dr. Baskin concluded that even if the link to autism has not yet been conclusively proven, based on what is known to date about **mercury as a deadly neurotoxin** and because thimerosal is not an essential component to the vaccine, **there is no reason to continue to purposefully inject it into the bloodstream of infants**."

"I believe these allegations **raise serious continuing concerns** about the administration of the nation's vaccine program **and the government's possibly inadequate response to the growing body of scientific research on the public health danger of mercury in vaccines**. The allegations also present troubling information regarding children's cumulative exposure to mercury and the connection of that exposure to the increase in neurological disorders such as autism and autism-related conditions among children in the U.S."

https://worldmercuryproject.org/wp-content/uploads/2016/11/Scott_Bloch_letter_to_Congress.pdf

Even the Institute of Medicine found it plausible that thimerosal containing vaccines could be associated with neurodevelopmental disorders

This is a statement downloaded from the FDA's website
https://www.fda.gov/biologicsbloodvaccines/vaccines/questionsaboutvaccines/ucm070430.htm :

"In its report of October 1, 2001, the Institute of Medicine (IOM's) Immunization Safety Review Committee concluded that **the evidence is inadequate to either accept or reject a causal relationship between thimerosal exposure from childhood vaccines and the neurodevelopmental disorders of autism, attention deficit hyperactivity disorder (ADHD), and speech or language delay**. At that time, the committee's conclusion was based on the fact that there were no published epidemiological studies examining the potential association between thimerosal-containing vaccines and neurodevelopmental disorders. **The Committee did conclude that the hypothesis that exposure to thimerosal-containing vaccines could be associated with neurodevelopmental disorders was biologically plausible.** However, additional studies were needed to establish or reject a causal relationship. The Committee stated that the effort to remove thimerosal from vaccines was "a prudent measure in support of the public health goal to reduce mercury exposure of infants and children as much as possible."

Thimerosal is the neurotoxic heavy metal that is always brought up in these discussions, it was removed from most of the vaccines between 15 to 20 years ago as the FDA statement just stated… The removal came when it was concluded by a panel of scientific experts that it could not be proven safe. **In a few pages, you will be introduced to the toxic metal that has significantly increased in the vaccine dosing**

schedule, even as mercury was being reduced. That metal is aluminum and it's every bit as harmful if not more, as you will see. First, more on the mercury in vaccines.

The preservatives including thimerosal are extremely toxic to nerve cells, yet amounts found in vaccines are very ineffective in killing bacteria

A 2010 article in the journal ***Medical Science Monitor: International medical journal of experimental and clinical research*** titled, **The relative toxicity of compounds used as preservatives in vaccines and biologics** found that **thimerosal is by far the most toxic (aluminum wasn't studied).** It also found that even thimerosal which was most toxic to nerve cells was not very effective as a preservative. https://www.ncbi.nlm.nih.gov/pubmed/20424565

From the study: "**Using human neuroblastoma *(nerve)* cells, the relative cytotoxicity *(toxicity to cells),*** of the levels of the compounds commonly used as preservative in US licensed vaccines was found to be ***(least to most toxic to cells)*…phenol <2-phenoxyethanol < benzethonium chloride < Thimerosal. The observed relative toxicity indices (human neuroblastoma cells/bacterial cells) were 2-phenoxyethanol (4.6-fold) < phenol (12.2-fold) < Thimerosal (>330-fold!!). In addition, for the compounds tested, except for 2-phenoxyethanol, the concentrations necessary to induce significant killing of bacterial cells were significantly higher than those routinely present in US licensed vaccine/biological preparations**."

The Conclusion: "None of the compounds commonly used as preservatives in US licensed vaccine/biological preparations can be considered an ideal preservative, and their ability to fully comply with the requirements of the US Code of Federal Regulations (CFR) for preservatives **is in doubt**. **Future formulations of US licensed vaccines/biologics should be produced in aseptic manufacturing plants as single dose preparations, eliminating the need for preservatives and an unnecessary risk to patients."**

"Overall, none of the compounds commonly used as preservatives can be considered ideal preservatives. They were all found to be significantly toxic to human neurons, **and worse they were all found to be significantly more toxic to human neurons than bacterial cells.**"

Interestingly: In the study, the researchers tested **thimerosal at a concentration of 10 times the strength used in vaccines** and it **was ineffective** at killing the bacteria**. Phenol on the other hand, was tested at a strength 5 times weaker** than found in vaccines **and was effective at killing the bacteria**. This suggests that thimerosal, as toxic as it is to human beings, is not an effective preservative for vaccines. On the other hand, phenol concentrations could conceivably be reduced to one fifth the concentration used in vaccines and be somewhat safer to the vaccine recipients. Phenol if you recall from the vaccine ingredients section of this manuscript is very toxic to humans.

Controversy in claims about mercury

It is often said that vaccines with mercury only carry "trace" amounts. Is that true?

This is a statement that is frequently bandied about by vaccine advocates. According to the FDA's own website, the definition of a trace amount is given in reference 1. Note that the symbol for microgram is µg:

Thimerosal is approximately 50% mercury (Hg) by weight. A 0.01% solution (1 part per 10,000) of thimerosal **contains 50 µg (micrograms) of Hg per 1 mL dose or 25 µg of Hg per 0.5 mL dose.

[1] The term "trace" has been taken in this context to mean 1 microgram of mercury per dose or less

[2] Individuals 6 months of age and older receive a full-dose of vaccine, i.e., 0.5 mL

[3] Children 6 months of age to less than 3 years of age receive a half-dose of vaccine, i.e., 0.25 mL; children 3 years of age and older receive 0.5 mL dose

View it here:
https://www.fda.gov/biologicsbloodvaccines/safetyavailability/vaccinesafety/ucm096228.htm#bib

SUMMARY: This text from the CDC states that **a trace amount is considered 1 microgram (µg) or less,** yet it also says that **individuals 6 months of age receive a 0.5 mL dose which is 25 µg of mercury or 25X what would be considered a trace amount!**

How much mercury is in current vaccines?

This table from ***Johns Hopkins Bloomberg School of Public Health*** lists the current tally in "some" of the mercury containing vaccines. http://www.vaccinesafety.edu/thi-table.htm Most of the vaccines listed have about 25 mcg/0.5 mL of Thimerosal. **The ones with an asterisk have the following statement….**
***** This product should be considered equivalent to thimerosal-free products. This vaccine may contain trace amounts (<0.3 mcg) of mercury left after postproduction thimerosal removal; these amounts have no biological effect. JAMA 1999;282(18) and JAMA 2000;283(16).

That statement from 1999 has been disproven today. In fact, this article has several studies that refute that claim. **So in essence, even "thimerosal-free" vaccines can contain thimerosal**.

The Director from the *Institute of Vaccine Safety* at *Johns Hopkins University* calls for the reduction or elimination of thimerosal from vaccines. He states that the ethylmercury in thimerosal is neurotoxic

This is a very interesting caveat to that article. The title is **Limiting Infant Exposure to Thimerosal in Vaccines and Other Sources of Mercury**. This is Dr. Neal Halsey's editorial on ways to cut down on infant exposure to mercury.

In reading this article (actually it is a slide presentation), it appears to be a thoughtful expose on way to reduce mercury exposure by taking into account the weight of the baby, etc.
http://www.whale.to/vaccines/thimerosal3.html

So, who is Dr. Halsey and what are his qualifications as an expert in this arena? **Dr. Neal Halsey, is the *Director of the Institute of Vaccine Safety at Johns Hopkins University***.

Quotes from Dr. Halsey's presentation:

"**Exposure to a fixed dose (e.g. 62.5 ug) of mercury at 2 months of age poses a greater potential risk than the same dose administered at 6 months of age because a child weighs more at 6 months and the target organ, the brain, is more vulnerable early in life**."

"The recent ***American Academy of Pediatrics***/Public Health Service recommendation to defer the first dose of hepatitis B vaccine for infants born to HBsAg negative mothers until 2-6 months of age has addressed the problem of exposure at birth, **but the exposure to mercury at 2 months of age is much greater and we need to do more to reduce this potential exposure**."

He calls for looking for alternatives for mercury. "*The last point is that we need to have good science used for decision making in the review of alternatives to thimerosal and the effects on the final product from **reducing or removing thimerosal from vaccines**.*"

So, when they say, "these amounts have no biological effect", this article that they cite to support their argument**, is actually completely NON-supportive**. **It ACTUALLY SAYS that mercury at any level is not acceptable.**

I find this a lot in the pro-vaccine research references. Often the referenced article or statement actually **disproves** what they say it proves. I guess they feel that no one will take the time to read it or dive deeper than the surface. And, the vast majority of the time they get away with it.

In response to Dr Halsey's report, **a series of three letters debating the issue commenced and an argument ensued in *JAMA Letters*. One is by Paul Offit MD, a CDC scientist and spokesperson for the vaccine industry. Another physician critical of Dr. Halsey was Dr. Plotkin. They were both critical of Dr. Halsey's position. Dr. Halsey unloaded on them in a 2000 JAMA response:**

Preventing Harm from Thimerosal in Vaccines—Reply

Neal A. Halsey, MD JAMA Letters, April 26, 2000;283(16):2104-2105. doi:10.1001/jama.283.16.2101

In Reply:

Dr Offit and Dr Plotkin criticize policy changes in the absence of data indicating harm from thimerosal in vaccines. There is no surveillance system in place to detect the effects of low to moderate doses of organomercurials on the developing nervous system, and special studies of children who received the highest doses will take several years to complete. Given the availability of alternative products, it was

inappropriate to continue exposing infants to amounts of mercury that exceed Environmental Protection Agency guidelines, which are based on careful scientific studies and established principles for toxic exposures. Infants in less than the fifth percentile in weight for age who received all thimerosal-containing vaccines would be exposed to cumulative amounts of mercury exceeding those in the Agency for Toxic Substances and Disease Registry guidelines, and larger infants who received mercury from their mothers or other sources also would exceed these limits. Safety margins should be respected because of individual variability in susceptibility and limitations in our ability to measure subtle toxic effects. **The ethylmercury in thimerosal is neurotoxic** and in the absence of data to the contrary, experts agree that the potential toxicity from ethylmercury should be considered equivalent to that from methylmercury.

Dr Offit estimates that an infant should have the theoretical capacity to respond to about 10,000 vaccines at any one time

"A more practical way to determine the diversity of the immune response would be to estimate the number of vaccines to which a child could respond at one time...**then each infant would have the theoretical capacity to respond to about 10,000 vaccines at any one time**." *Huh? What a ridiculous and bizarre statement!* https://www.ncbi.nlm.nih.gov/pubmed/11773551

The following two quotes attributed to Dr. Offit and links on his voting pattern are from www.fourteenstudies.org

Regarding Thimerosal in vaccines:
"In some instances, I think full disclosure can be harmful. Is it safe to say there is zero risk with thimerosal, when it is remotely possible that one child would get sick? Well, since we say that mercury is a neurotoxin, we have to do everything we can to get rid of it. But I would argue that removing thimerosal didn't make vaccines safer -- it only made them perceptibly safer."

On potential conflicts of interest as a vaccine patent-holder:
"I am a co-holder of a patent for a (rotavirus) vaccine. If this vaccine were to become a routinely recommended vaccine, I would make money off of that. When I review safety data, am I biased? That answer is really easy: absolutely not."

Read about his erratic voting pattern on the rotavirus vaccine when he sat on the ACIP committee here. Also check out www.pauloffit.com.

The fix is in:
In fact, as one of the patent holders Offit along with Stanley Plotkin M.D. on the first failed Rotavirus Vaccine, Offit sat on the Advisory Committee on Immunization Practices (ACIP), that voted whether the Rotavirus Vaccine should be approved and added to the schedule. As the patent holder for the vaccine, how he can even have a seat in the room, much less vote on approving it for the vaccine schedule it is incomprehensible!

An article posted February 05, 2019 on the ***Children's Health Defense*** web site titled, **The Rotavirus Vaccine: A Case Study in Government Corruption and Malfeasance** summarized the conflicts of interest

nicely. https://childrenshealthdefense.org/news/the-rotavirus-vaccine-a-case-study-in-government-corruption-and-malfeasance/

"Among the Congressional investigation's findings were that three out of five members of the FDA's Vaccines and Related Biological Products Advisory Committee (VRBPAC) "who voted to approve the rotavirus vaccine in December 1997 had financial ties to pharmaceutical companies that were developing different versions of the vaccine", while four out of eight members of the CDC's Advisory Committee on Immunization Practices (ACIP) "who voted to approve guidelines for the rotavirus vaccine in June 1998 had financial ties to pharmaceutical companies that were developing different versions of the vaccine".

The Rotavirus debacle and the numerous improprieties involved in the approval process, triggered a congressional investigation and report titled, **Conflicts of Interest in Vaccine Policy Making** by the ***Committee on Government Reform, U.S. House of Representatives*** dated August 21, 2000. There were several recommendations made designed to correct the blatant lack of oversight in preventing conflict of interest and financial interest bias from members of these committees who have ties to the pharmaceutical companies that manufacture the very vaccines that they are deciding whether to approve or not. The real question is, have those safeguards been put in place and followed?

The Children's Health Defense article cites another bizarre quote by Offit:
"Offit also happens to be a routinely cited go-to "expert" on vaccines for the mainstream media. He once penned an op-ed for the *New York Times* accusing parents who choose not to vaccinate their children of *child abuse* on the grounds that Jesus, were he with us in the flesh today, would advocate forcibly vaccinating children against their parents' will."

Not only that, but the vaccine was pulled off the market less than a year after it was released due to increased rates of intussusception (bowel obstruction), which led to hospitalizations, surgeries and even one death. It was revealed later that the clinical trials found this same problem, but it was not considered "significant enough" by the vaccine manufacturer to withhold its release. The pre-licensure clinical trials 5 children out of 10,054 children developed intussusception. That is a rate of .05 %, which the package insert called "insignificant" ("RotaShield" Package Insert, Wyeth-Ayerst, pg. 13). Once on the market, a clear and present danger associated intussusception with the vaccine. The "RotaShield" rotavirus vaccine was removed from the U.S. market in October 1999.

So, what did Dr. Offit the original patent holder do? Over the next few years, he proceeded to develop a second patent on a new second-generation Rotavirus Vaccine, the RotaTeq Vaccine. That vaccine was eventually approved for release in 2006. It has been reported that Offit personally made approximately $30 million dollars selling the rights to the vaccine. Recently, and ironically, there has been a higher incidence of intussusception associated with the latest generation Rotavirus vaccine. As a result, there have been calls for the removal of that vaccine due to the same issues with intussusception that the first-generation Rotavirus vaccine Dr. Offit patented caused. You would think that they would have determined the reason for the problem and fixed it the second time around.

Other adverse effects from the Rotavirus Vaccine:

A CDC document on Rotavirus which is supposed to prevent diarrhea from Rotavirus, lists the percentage of recipients that experience the following side effects for the RV5: Diarrhea 18.1% and Vomiting 11.6%. So, nearly 1 in 5 children develop diarrhea from the vaccine and 1 in 9 develop vomiting. That's 30% of recipients that have a significant adverse reaction from the vaccine! https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/rota.pdf

Later in this document you will see another section discussing more about the problems being associated with the 2 second generation Rotavirus Vaccines Rotarix and RotaTeq. As a teaser, one of the issues is contamination with pig circoviruses. You can do a key word search for Circovirus and it will take you right to it.

It is often quoted that ethylmercury is not as dangerous as methylmercury. This is completely false

The ethylmercury found in vaccines is as toxic as the methylmercury found in fish and other creatures contaminated from mercury in their environment. The 2002 study often cited as refuting that claim is was published in the British medical journal ***Lancet***. It was titled, **Mercury concentrations and metabolism in infants receiving vaccines containing thiomersal: a descriptive study.** This study had numerous design flaws and has since been proven false (see more below). https://www.ncbi.nlm.nih.gov/pubmed/12480426

A 2017 study looks at multiple comparatives between methyl and ethyl mercury and their toxic effects

Case in point, a new CDC study titled **Alkyl Mercury-Induced Toxicity: Multiple Mechanisms of Action** and published in the ***Reviews of Environmental Contamination and Toxicology*** warns of the extreme danger of the ethylmercury in vaccines. https://www.ncbi.nlm.nih.gov/pubmed/27161558

CDC study finds that Thimerosal in extremely toxic even in minute amounts

The following is an excerpt from an excellent article written by Robert F. Kennedy Jr. and Lyn Redwood, RN, MSN on the EcoWatch web site, dated February 01, 2017. The article is titled, **New CDC Research Debunks Agency's Assertion That Mercury in Vaccines Is Safe** (https://www.ecowatch.com/cdc-mercury-vaccines-kennedy-2226257805.html)

The CDC has long answered that nettlesome question with the controversial claim that ethylmercury in vaccines is not toxic to humans. Now, two CDC scientists have published research decisively debunking that assertion. As it turns out, there is no "good mercury" and "bad mercury." Both forms are equally poisonous to the brain.

The 45-page meta-review of relevant science examines the various ways that mercury harms the human body. Its authors, John F. Risher, PhD, and Pamela Tucker, MD, are researchers in the CDC's Division of Toxicology and Human Health Sciences, Agency for Toxic Substances and Disease Registry.

"This scientific paper is the one of most important pieces of research to come out of the CDC in a decade," Paul Thomas, M.D., a Dartmouth-trained pediatrician who has been practicing medicine for 30 years, said. **"It confirms what so many already suspected: that public health officials have been making a terrible mistake in recommending that we expose babies and pregnant women to this neurotoxin**. I regret to say that I gave these shots to children. The CDC led us all to believe that it was perfectly safe."

Among the findings of the CDC's new study:

- Methylmercury, the highly-regulated neurotoxin found in fish, and ethylmercury (found in medical products, including influenza and tetanus vaccines, ear drops and nasal sprays) are **similarly toxic to humans**. Methylmercury and ethylmercury share common chemical properties, and **both significantly disrupt central nervous system development and function**.

- Thimerosal **is extremely toxic at very low exposures** and is more damaging than methylmercury in some studies. For example, **ethylmercury is even more destructive to the mitochondria in cells than methylmercury**.

- **The ethylmercury in thimerosal does not leave the body quickly as the CDC once claimed, but is metabolized into highly neurotoxic forms**.

"**This study is a nuclear bomb detonating over the CDC," Boyd Haley, chairman emeritus of the University of Kentucky Chemistry Department, said. "It should be getting international, front page headlines**."

The study meticulously details identical toxicity pathways shared by both forms of mercury: There were numerous pathways of damage listed. Refer to the above article for those details.

Wow!

In the earlier cited study that concluded that ethylmercury is "cleared" from the body faster than methylmercury, therefore it isn't as dangerous. **What actually happens is that a large percentage of ethylmercury is absorbed and taken up into the organs and bones and stored causing all kinds of metabolic problems. They made the assumption that the mercury was being excreted because the blood levels were dropping.** https://www.ncbi.nlm.nih.gov/pubmed/12480426

So, how credible this study? The author of the study claimed that he had no conflicts of interests. A comment by Mark R. Geier and David A. Geier published in 2004 in ***The Lancet***, the British medical journal that published the article, stated the following:

"In their 2002 Article on mercury concentrations and metabolism in infants receiving vaccines containing thiomersal,[1] Michael Pichichero and colleagues' conflict of interest statement read: "None declared."

Despite such a claim, Pichichero published in the journal **American Family Physician**[2] in 2000 the statement: "The author has received research grants and/or honoraria from the following pharmaceutical companies: Abbott Laboratories, Inc.; Bristol-Myers Squibb Company; Eli Lilly & Company; Merck & Co.; Pasteur Merieux Connaught; Pfizer Labs; Roche Laboratories; Roussel-Uclaf; Schering Corporation; Smith Kline Beecham Pharmaceuticals; Upjohn Company; and Wyeth-Lederle."

On the basis of this disclosure by Pichichero of 12 different pharmaceutical conflicts he had previously disclosed in another study, **he clearly did have a conflict of interest that he did not disclose to the readers of *The Lancet***.

Mark R. Geier has been an expert witness and a consultant in cases involving vaccine adverse reactions before the no-fault National Vaccine Injury Compensation Program (NVICP) and in civil litigation.

According to ***VaccineImpact.com***, "Dr. Geier is NOT anti-vaccine. He is an M.D. and has a Ph.D. in genetics. He spent 10 years working at the National Institute of Health, and was a professor at Johns Hopkins University as a geneticist. He is also the author of over 150 peer-reviewed publications. He worked on vaccine safety and efficacy for more than 30 years. He was one of four scientists that worked to replace the DTP vaccine, a vaccine that caused every child to become sick with a high fever at the time of vaccination, with the DTaP vaccine, which is a more purified vaccine and causes illness due to fever in only 3% of those vaccinated." https://vaccineimpact.com/2018/get-your-flu-shot-doj-report-from-vaccine-court-reveals-flu-shot-is-most-dangerous-vaccine-in-u-s/

David A. Geier has been a consultant in cases involving vaccine adverse reactions before the no-fault National Vaccine Injury Compensation Program (NVICP) and in civil litigation.

"Mr. Geier's extensive research experience has involved cellular molecular-biology studies, large population observational epidemiological studies, and human placebo-controlled randomized clinical trials. Mr. David A. Geier has published more than 100 peer-reviewed scientific/medical studies in academic journals and medical textbook chapters. Mr. Geier's research has repeatedly been published in such prestigious academic journals as ***Experimental Biology and Medicine***, *Expert Opinion on Drug Safety*, *Expert Opinion on Pharmacotherapy*, and *Expert Review of Molecular Diagnostics*." https://mercuryfreebaby.org/david-a-geier/

Another study echoes the dangers of ethylmercury found in vaccines

A 2005 study titled **Effects of Thimerosal on NGF Signal Transduction and Cell Death in Neuroblastoma Cells** and published in the ***Journal of Toxicological Sciences*** refutes claims that the ethylmercury found in thimerosal is not as toxic as methylmercury. https://www.ncbi.nlm.nih.gov/pubmed/15843506

From the article: Ethylmercury and its decomposition product, Hg2þ, rapidly accumulate in the tissues, preferentially in the kidneys and brain. Following in vivo administration, **ethylmercury passes through cellular membranes and concentrates in cells of vital organs, including the brain, where it releases inorganic mercury, raising its concentrations higher than equimolar doses of its close and highly toxic relative methylmercury.**

How does the amount in vaccines compare to the "safe" limits determined by the EPA?

- 2 parts per billion (ppb) of mercury is the mandated limit in drinking water (considering that < 1% of orally ingested mercury is even absorbed through the gut into the blood stream, **the absorbed amount** would be approximately .02 ppb and is the EPA's maximum allowable amount).
- 0.5 parts per billion (ppb) mercury = Kills human neuroblastoma cells (Parran et al., ***Toxicological Sciences*** 2005; 86: 132-140) https://academic.oup.com/toxsci/article/86/1/132/1654176)
- 20 ppb mercury = Neurite membrane structure destroyed (Leong et al., Neuroreport 2001; 12: 733-37).
- **200 ppb mercury in liquid waste renders it a toxic hazard**
- **25,000 ppb is found in the hepatitis B shot** given at birth (and this goes directly into the blood stream and is **1,250,000 times the maximum safe (absorbed) EPA limit**
- **50,000 ppb is found in regular flu shots** — recommended for children, pregnant women, the elderly…**2,500,000 times the EPA absorbed maximum safe limit!**
- **50,000 ppb Mercury** = Concentration of mercury in **multi-dose DTaP and Haemophilus B vaccine vials**, administered 4 times each in the 1990's to children at 2, 4, 6, 12 and 18 months of age.
- **50,000 ppb Mercury** = Current "preservative" level mercury **in multi-dose flu** (94% of supply), **meningococcal and tetanus** (7 and older) **vaccines.** This can be confirmed by simply analyzing the multi-dose vials.

https://www.nvic.org/faqs/mercury-thimerosal.aspx
https://www.naturalnews.com/045418_flu_shots_influenza_vaccines_mercury.html
https://healthfreedomidaho.org/flu-vaccine-is-not-mercury-free

As bad or worse than mercury, levels of aluminum exposure in vaccines has steadily risen- Much, much more on this later in this document

A major factor in the escalating incidence of immune and neurological conditions, is that as mercury exposure has gone down, aluminum has gone up!

Unfortunately, as vaccine manufacturers have reduced the use of mercury, they have increased the use of aluminum, **which many scientists believe may be up to seven times more neurotoxic than Mercury**. I will first present a recent study that describes this assertion and then numerous studies later that will remove any doubt about aluminum's role in the continued escalation of autism rates.

A viable explanation for the fact that autism rates continued to climb after mercury was removed from most childhood vaccines

An article published in the journal ***Environmental Health*** titled, **A comparison of temporal trends in United States autism prevalence to trends in suspected environmental factors**, explains the continuing rise of autism after thimerosal was phased out of most childhood vaccines. They cite the increase in pre-natal shots to pregnant mothers with mercury containing vaccines and the replacement of mercury with aluminum in most childhood vaccines including the hepatitis B vaccine infants get at birth. https://www.ncbi.nlm.nih.gov/pubmed/?term=25189402

From the article:
"Figure S6 shows that the expansion of thimerosal exposure in the late 1980s and early 1990s coincides closely with the rise in autism around that time. However, as noted by others, the temporal trends in autism and thimerosal following the childhood vaccine thimerosal phaseout are incompatible."

"**A possible confounding factor in the postnatal thimerosal analysis is the administration of flu shots to pregnant women, which increased in the late 1990s/early 2000s around the same time that thimerosal was being phased out of children's vaccines. Many flu shots still contain 25µg Hg and thus may be leading to increased prenatal exposure**."

"**Other vaccine indices, including cumulative aluminum adjuvants and cumulative total number of immunizations, continue to correlate strongly with autism trends** (See page 7- Figure 5, Additional file 1: Figure S7-S8). **Aluminum is a demonstrated neurotoxin that can induce neuroimmune disorders and cellular oxidative stress. Several recent studies have described biological mechanisms by which aluminum could contribute to autism** and have emphasized the need to consider the interaction of aluminum and vaccines with other pharmaceuticals, including antibiotics and the antipyretic acetaminophen. **The upward trend in aluminum adjuvant exposure is also notable in that very young infants have experienced the largest relative increases from the early 1980s to 2005. Newborns have seen essentially an infinite increase due to the hepatitis B birth dose, the receipt of which has been linked epidemiologically to increased autism risk, while 2 month-olds have seen about a 3-fold increase in aluminum adjuvant exposure."**

Environmental influences including aluminum vaccine adjuvants are triggers for the development of autism

A 2016 study from ***Environment International*** titled, **Environmental factors in the development of autism spectrum disorders**, looks at the full spectrum of environmental factors that can be contributing factors in the genesis of autism. But the last sentence seems to put an exclamation point on the aluminum from adjuvants. https://www.ncbi.nlm.nih.gov/pubmed/26826339

From the Abstract:
"In developed countries, it is now reported that 1%-1.5% of children have ASD, and **in the US 2015 CDC reports that approximately one in 45 children suffer from ASD**. *(2014 statistics)* Despite the intense research focus on ASD in the last decade, the underlying etiology remains unknown. Genetic research

involving twins and family studies strongly supports a significant contribution of environmental factors in addition to genetic factors in ASD etiology. **A comprehensive literature search has implicated several environmental factors associated with the development of ASD. These include pesticides, phthalates, polychlorinated biphenyls, solvents, air pollutants, fragrances, glyphosate and heavy metals, especially aluminum used in vaccines as adjuvant."**

As I stated previously, there is MUCH, MUCH more on the dangers of aluminum to come in this document!

VACCINE INGREDIENTS

What exactly is in vaccines? And, are the ingredients toxic?

If you want to be shocked, read this. It is a link the to the CDC's vaccine ingredients contained in all of the approved vaccines. You can read it for yourself. If you want to be REALLY shocked, first read this section over the next several pages on the ingredients and the health risks presented by those ingredients, then go back and read which ones are in the different vaccines.

https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/b/excipient-table-2.pdf

Some of the things that you will see in this list are:

Formaldehyde, AKA Formalin (the trade name often used in vaccines) is a proven carcinogen, MSG (by itself and including several other forms of neuroexcitatory chemicals in these vaccines appearing as hydrolyzed, modified, autolyzed), the neurotoxic heavy metals aluminum and thimerosal (Mercury), human-diploid fibroblast cell cultures from aborted babies, fetal cow serum, 2-phenoxyethanol which the FDA has linked to depression of the central nervous system, WI-38 and MRC-5 human cells from aborted babies, monkey kidney cells, antibiotics (neomycin, neomycin sulfate, kanamycin, streptomycin, tetracycline and gentamicin sulfate), polysorbate 80 (Tween 80), polysorbate 20, nonylphenol ethoxylate, acetone, unique animal derived retroviruses that have been found in human tumors and tissues, human serum albumin, human and animal DNA (even DNA fragments from the aborted human fetuses mentioned above), Human, cow and pig serum proteins, glutaraldehyde (a strong biocide disinfectant and sanitizer for industrial purposes), squalene, cetyltrimethlyammonium bromide, β-propiolactone plus many other chemicals with names that are difficult, if not impossible to pronounce.

UPDATE: As of January 2019, the CDC has changed the way they are reporting the vaccine ingredients on their vaccine excipient and media table. They have removed the word media from the title and have added the following statement…." Note: Substances used in the manufacture of a vaccine but not listed as contained in the final product (e.g., culture media) can be found in each PI, but are not shown on this table." *(P.I. stands for Product Insert)*. This is very problematic because it appears as though they don't want to be fully forthcoming with the public who want to know what is in the vaccines. It is possible for an individual to go to each vaccine's product insert online and find the ingredient section and read it there, but that is very tedious and time consuming.

It also looks as though they have removed one of the most controversial ingredients from the table, the WI-38 Human Diploid Lung Fibroblasts Cell line that the virus for the Rubella portion of the MMR and MMRV vaccines are cultured in. Those human lung fibroblasts came from an aborted baby in 1962. In fact, the baby used was the 32nd aborted baby they used before settling on these cells. The cells containing that baby's own DNA have been used since that time. This is problematic on many levels, including moral, ethical, religious and potential for causing health problems in humans including the possibility that this DNA could contaminate the DNA of the person getting the vaccines. You will read more about this in the next couple pages and more about the various cell lines from other aborted babies and the ramifications on pages 125-130 and more later in this eBook.

Mercury and aluminum have grabbed most of the headlines as toxic ingredients in vaccines, but there is so much more!

The heavy metal aluminum **stimulates the immune system to react more vigorously to the vaccine**. Both mercury and aluminum have been shown to cause serious neurotoxicity. Much, much more on this later.

Details and concerns regarding the other vaccine ingredients than mercury and aluminum

The abbreviation **MSDS** that you will see in the excerpts from with many of these chemicals, stands for **Material Safety Data Sheet**. It is the sheet produced for all chemicals that detail their properties, precautions, warnings, reactivity and possible health hazards.

Some of the following information is provided by http://vaxtruth.org/2011/08/vaccine-ingredients/ (and various other sources as indicated).

- Aborted fetal tissue cell lines

This raises serious religious, personal, ethical and moral issues. Abortion is a contentious issue because unborn babies are killed, plain and simple. The injection of DNA from aborted fetal cell lines into a person's body in unconscionable to many based on their personally held beliefs. **For many of you reading this, you had no idea that you were allowing these DNA particulates from aborted babies to be injected into the bodies of yourselves and your children.** Therein lies a big part of the problem. **There is often no true informed consent with vaccines**. **And if one is presented, it is usually sorely inadequate. People should be told EVERYTHING about what is in the vaccine, ALL the risks and what the ACCURATE effectiveness is. Lots more on all of this later!**

Question my claim about aborted baby tissue used to make vaccines? Read this…..
Development of Vaccines from Aborted Babies by Jessica Farnsworth, M.D., May 2011. http://www.epm.org/static/uploads/downloads/Vaccines_Using_Tissue_from_Aborted_Babies.pdf. This paper discusses the history of using aborted babies to produce the cell lines that are still used in many of the vaccines today.

Examples of fetal cell lines containing human DNA that are used in vaccines include:

WI-38, MRC-5, HEK-293, walvax-2, etc. More detail on these and the controversies surrounding them at the end of the vaccine ingredients summaries.

- 2- phenoxyethanol-
  In 2008, the FDA has warned consumers not use nipple creams for breastfeeding mothers because the phenoxyethanol in it **"can depress the central nervous system and may cause vomiting and diarrhea, which can lead to dehydration in infants."**
  http://scienceblogs.com/terrasig/2008/05/25/nipple-cream-warning-harmful-t/

- Polysorbate-80-
  This is from an article from the ***Annals of Allergy, Asthma & Immunology*** titled, **Polysorbate 80 in medical products and nonimmunologic anaphylactoid reactions,** showing that Polysorbate 80 which is one of the common ingredients in vaccines can cause **anaphylactic reactions.**
  Volume 95, Issue 6**,** December 2005, Pages 593-599.
  https://www.ncbi.nlm.nih.gov/pubmed/16400901

  Quotes from the article:
  "Polysorbate 80 was identified as the causative agent for the anaphylactoid reaction of nonimmunologic origin." **Conclusions:** "Polysorbate 80 is a ubiquitously used solubilizing agent that can cause **severe** nonimmunologic anaphylactoid reactions."

  It is ironic that Polysorbate 80 is being studied and used in recent years to help transport nanoparticles and drugs that would normally be prevented from entering the brain by the blood brain barrier (BBB) into the brain. "It's special property of actively crossing from the blood stream into the brain has made it a novel transport mechanism for drug delivery of compounds that normally would not be able to cross the BBB". **In fact, many of the articles**

demonstrated that it transported neurotoxic substances into the brain. One way it does this is by disrupting (damaging) the Blood-Brain Barrier.

A current search of PubMed using the key words Polysorbate 80 AND Blood Brain Barrier resulted in 77 studies. This is just one example…A study published in the Journal ***NeuroRX: The Journal of the American Society for Experimental NeuroTherapeutics*** *titled,* **The blood-brain barrier: bottleneck in brain drug development.**
https://www.ncbi.nlm.nih.gov/pubmed/15717053

From the article: Solvent/adjuvant-mediated Blood Brain Barrier (BBB) disruption

"The BBB, like cell membranes in general, is subject to solvent-mediated disruption with chemicals such as ethanol, dimethylsulfoxide (DMSO), or detergents such as SDS, or **Tween 80 also known as polysorbate-80."** ***This is really bad news, especially because a fetus, infants and young children already have an immature/incomplete BBB. These solvents will further disrupt that already "leaky" membrane allowing larger particles to shoot through into the brain!***

"Tween 80, also known as polysorbate-80, is frequently administered in CNS drug formulations. A dose of polysorbate-80 of 3-30 mg/kg **will cause BBB disruption in mice**. Analgesia with kyotorphin, a oligopeptide that normally does not cross the BBB, is possible following the peripheral administration of the peptide, **providing Tween 80 is co-administered**."

What does that have to do with the fact that it is found in vaccines? I thought you would never ask. **Currently 15 vaccines contain Polysorbate 80 (AKA Tween 80) and 3 contain Tween 20**, which has the same effect. **The Tween 80 and Tween 20 transport nanoparticles and larger particles into the brain. Aluminum, mercury and other components in vaccines are in various sizes including nanoparticle size**. **A current search on PubMed with the key words aluminum hydroxide and nanoparticles revealed 216 articles**.

So, essentially the neurotoxic metals in the vaccines have a convenient delivery system in the vaccine itself (polysorbate or Tween 80), that assist these heavy metals into the brain where they can do their damage. I wonder how many doctors or scientists even realize this? Have I seen studies that have shown this transport of aluminum and mercury specifically? No, but it was shown to carry iron oxide another metal into the brain.
https://www.ncbi.nlm.nih.gov/pubmed/?term=27092793

So, it makes perfect sense that the properties of the Tween 80 and 20 to transport numerous substances readily into the brain creates a high probability that it will do the same with the metals and many other chemicals fund in vaccines. This needs to be investigated further.

These are the vaccines currently on the schedule containing Polysorbate 80 (Tween 80) and aluminum or Thimerosal (mercury)

*some that do not have the metals are listed with some of the other potentially harmful ingredients found in those vaccines

- DTaP (Infanrix) + aluminum
- DTaP-IPV (Kinrix) + aluminum
- DTaP-IPV (Quadracel) + aluminum
- DTaP-HepB-IPV (Pediarix) + aluminum
- DTaP-IPV/Hib (Pentacel) + aluminum
- Hep B (Heplisav-B)
- Human Papillomavirus (HPV) (Gardasil 9) + aluminum
- Influenza (Fluad) + Squalene, neomycin, kanamycin
- Influenza (Fluarix) Trivalent & Quadrivalent + gentamicin sulfate
- Influenza (Flucelvax) Trivalent & Quadrivalent + β-propiolactone
- Influenza (Flulaval) Trivalent & Quadrivalent + thimerosal (multi-dose)
- Meningococcal (MenB – Trumenba) + aluminum
- Pneumococcal (PCV13 – Prevnar 13) + aluminum
- Rotavirus (RotaTeq)
- Tdap (Boostrix) + aluminum
- Zoster (Shingles) (Shingrix)

Polysorbate 20 (Tween 20)

- Hep A (Havrix) + aluminum
- Hep A / Hep B (Twinrix) + aluminum (2 types)
- Influenza (Flublok) Trivalent & Quadrivalent

Interestingly, Polysorbate 80 is also being studied to deliver natural substances into the brain. A 2016 study in the ***Journal of Microencapsulation***, titled **Polysorbate-80-coated, polymeric curcumin nanoparticles for in vivo anti-depressant activity across BBB and envisaged biomolecular mechanism of action through a proposed pharmacophore model**, successfully tests the transport of curcumin to affect an anti-inflammatory action in the brain. https://www.ncbi.nlm.nih.gov/pubmed/?term=27682805

From the abstract:
"Depression is a modern world epidemic. Its main causative factor is oxidative stress, as reported in study subjects."

Another 2008 article from the ***Bulletin of Experimental Biology and Medicine*** titled, **Antiparkinsonian effect of nerve growth factor adsorbed on polybutylcyanoacrylate nanoparticles coated with polysorbate-80**, describes great success with using the Polysorbate 80 coated drug. https://www.ncbi.nlm.nih.gov/pubmed/?term=19023984

From the Abstract:
"These data attest to the possibility of using nanoparticles prepared from amphiphilic polymers and coated with polysorbate-80 for the delivery of nerve growth factor into the brain during systemic treatment."

As you will see on page 600-601, 605-606, 607-611 and 626-628, Polysorbate 80 was used along with aluminum as the "placebo" in the clinical trials for the HPV vaccine Gardasil. That breaks every scientific precedent for what a true placebo is (typically a saline or mildly salty solution, like normal body fluids which will not create a reaction of any kind).

- Polysorbate 20 (Tween 20)
  Polysorbate 20 has a relatively clean toxicity report based on the Material Safety Data Sheet. The Environmental Working Group states, that the chemical in and of itself has a relatively safe track record https://www.ewg.org/skindeep/ingredient/705137/POLYSORBATE-20/ , although it cites concerns over **possible contamination by Ethylene Oxide, a known human carcinogen** https://www.ewg.org/skindeep/ingredient/726229/ETHYLENE_OXIDE/ **and 1,4-Dioxane a possible human carcinogen**. https://www.ewg.org/skindeep/ingredient/726331/1%2C4-DIOXANE/

- Formalin, AKA Formaldehyde-

  (Source: vaxtruth.org)- Formalin is an aqueous, form of Formaldehyde. **Formaldehyde is toxic and is known to cause cancer**. The International Agency for Research on Cancer (IARC) **classifies formaldehyde as a human carcinogen,** [International Agency for Research on Cancer (June 2004). *IARC Monographs on the Evaluation of Carcinogenic Risks to Humans Volume 88 (2006): Formaldehyde, 2-Butoxyethanol and 1-tert-Butoxypropan-2-ol*. Retrieved June 10, 2011, from:http://monographs.iarc.fr/ENG/Monographs/vol88/index.php].

  In 2011, the ***National Toxicology Program***, an interagency program of the Department of Health and Human Services, named formaldehyde as a known **human carcinogen** in its **12th Report on Carcinogens [National Toxicology Program** (June 2011). **Report on Carcinogens, Twelfth Edition**. ***Department of Health and Human Services, Public Health Service, National Toxicology Program***. Retrieved June 10, 2011, from: http://ntp.niehs.nih.gov/go/roc12].

  Also, in a bulletin dated August 08, 2014, the ***National Academy of Sciences and Institute of Medicine*** classified formaldehyde **as a known human carcinogen**.
  http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=18948

  Formaldehyde at body temperature is oxidized into formic acid which leads to acidosis and nerve damage. Acidosis can be described as a condition in which the acidity of the body tissues and fluids is abnormally high. The liver and the kidneys may also be damaged. Interestingly, formic acid is the same chemical that fire ants secrete when they bite. If you've ever been bitten by a fire ant, I'm sure that you will remember the pain and swelling that it can cause.

Many people experience an allergic reaction to formaldehyde. According to the ***National Research Council:*** Fewer than 20%, but perhaps more than 10% of the general population may be susceptible to formaldehyde allergies ***and may react acutely at any exposure level***. Therefore, if 15% of individuals will suffer an allergic reaction to it, it makes no sense to keep it in vaccines.

Other known side effects from exposure to formaldehyde:

- Alters tissue proteins
- anemia
- antibodies formation
- apathy
- blood in urine
- body aches
- cardiac impairment
- palpitations and arrhythmias
- central nervous system depression
- changes in higher cognitive functions
- chest pains and tightness
- colds
- coma
- constipation
- convulsions
- death
- destruction of red blood cells
- depression
- diarrhea
- difficulty concentrating
- disorientation
- dizziness
- ear aches
- eczema
- emotional upsets
- fatigue
- fetal asphyxiation [SIDS, perhaps?]
- flu-like or cold like illness
- UTI
- gastritis
- gastrointestinal inflammation
- headaches
- hyperactivity
- hypo-menstrual syndrome
- immune system sensitizer
- impaired (short) attention span
- inability to recall words and names

- inconsistent IQ profiles
- asthma
- irritability
- jaundice
- retarded speech pattern
- schizophrenic-type symptoms
- sensitivity to sound

Vaccine proponents will claim that the amount of formaldehyde (formalin), in vaccines is so small that it has no adverse health effects. Most studies on the toxicity of formalin have been done on inhaled and ingested exposure. Most toxicity comes from environmental sources like particle board, plywood and other building materials, cigarette smoke, e-cigarettes, automobile exhaust, some synthetic fabrics (i.e. polyester), permanent press fabrics including bedsheets, flame retardant chemicals and some personal care products.

The issue is that while even very small levels are a bi-product of some biochemical reactions in the body, in processes that are corrected by the body, there have been no studies on injecting it into a newborn or passed through the placenta to the fetus. **Both the flu and Tdap Vaccines recommended and given to pregnant women contain formaldehyde**, as do many other vaccines given to both children and adults.

- Benzethonium Chloride-
  (Source: vaxtruth.org)- (referred to as "BC") is an anti-microbial agent used as a preservative in some vaccines. There has been no testing done on humans to find out information regarding the injection of BC into the blood stream. I have been searching for over a year with no luck in finding any such information. What has been documented about BC under the MSDS (Material Safety Data Sheet) under section 11 is that it is **toxic when inhaled or ingested and is also hazardous to human skin**. Based on animal testing, it may **cause mutations in genetic information** and also be **carcinogenic** (cause cancer).

  The known side effects of ingesting BC are (according to its Material Safety Data Sheet):

  - Seizures
  - Coma
  - Respiratory depression
  - Central Nervous System Depression
  - Convulsions
  - Coma
  - Urinary system reaction

- Beta-Propiolactone-
  According to ***Wikipedia***, Beta-Propiolactone is made industrially by the reaction of formaldehyde and ketene. Beta-Propiolactone is an excellent sterilizing and sporicidal agent, but **its carcinogenicity** precludes that use. β-Propiolactone is "reasonably anticipated to be a human carcinogen" (*International Agency for Research on Cancer…*IARC, 1999). **It is one of 13 "OSHA-**

regulated carcinogens," chemicals regarded occupational carcinogens by the Occupational Safety and Health Administration *(OSHA)*, despite not having an established permissible exposure limit. https://en.wikipedia.org/wiki/Beta-Propiolactone

Classified as a potential human carcinogen on the ***Occupational Safety and Health Guideline*** found on the CDC's website https://www.cdc.gov/niosh/docs/81-123/pdfs/0528.pdf . **Summary of toxicology:** *Effects on animals:* In rats, acute oral administration or intraperitoneal injection of beta-propiolactone caused muscular spasms, respiratory difficulty, convulsions, and death. Acute intravenous injection caused kidney tubule and liver damage.

According to the ***National Toxicology Program, Department of Health and Human Services*** Subcutaneous injection of β-propiolactone caused cancer at the injection site in mice of unspecified sex (fibrosarcoma, adenocarcinoma, and squamous-cell carcinoma) and in rats of both sexes (sarcoma), (IARC 1974). In nursing mice, **a single intraperitoneal injection** of β-propiolactone **caused lymphoma in both sexes and liver tumors** (hepatocellular tumors) **in males**.

Beta Propiolactone is a "polyester" and highly carcinogenic according to *Stanislaw Penczek, Stanislaw Slomkowski, in* **Comprehensive Polymer Science and Supplements***, 1989, chapter 50 titled,* **Some Properties of Polyesters,** "**β-Propiolactone has been found to be highly carcinogenic, and is banned from any practical use**, although its polymer might have been an interesting product for the plastic and fiber industry." In other words, if it wasn't for its highly carcinogenic properties, it may have been useful as a polyester fiber in the textile industry.

Amazingly, beta-propiolactone is still found in the Afluria Influenza Vaccine (Trivalent and Quadrivalent versions).
https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/b/excipient-table-2.pdf

- Glutaraldehyde-
(source: vaxtruth.org)- is an organic compound that is used to disinfect medical and dental equipment. In vaccines, it is used as a chemical preservative. Vaxtruth.org

There have been several studies done on Glutaraldehyde and it has been found that exposure to it can cause:

- Asthma
- Allergic reactions (up to 10% of up people can be allergic to Glutaraldehyde.)
- Induced respiratory issues
- diarrhea

Sources: "Glutaraldehyde-induced and formaldehyde-induced allergic contact dermatitis" SCOTT M. RAVIS, M.D., MATTHEW P. SHAFFER, M.D., CHRISTY L. SHAFFER, M.D., SEENA DEHKHAGHANI, M.D. and DONALD V. BELSITO, M.D.**;** "Glutaraldehyde-induced asthma." Quirce S, Gómez M, Bombín C, Sastre J. 1999 Oct;54(10):1121-2.; Genetic toxicity and carcinogenicity studies of glutaraldehyde–a review. Zeiger E, Gollapudi B, Spencer P. Mutat Res. 2005 Mar;589(2):136-

51; Divergent immunological responses following glutaraldehyde exposure. Azadi S, Klink KJ, Meade BJ. Toxicol Appl Pharmacol. 2004 May 15;197(1):1-8.

- Phenol- AKA Carbolic Acid. This one is a BOMB shell-
  It is a known mutagen, (meaning it causes cells to mutate), a teratogen (meaning causes birth defects), and fetotoxic (or toxic to the fetus). According to the Material Safety Data Sheet (MSDS) on Phenol, "Special Remarks on Chronic Effects on Humans: Animal: **passes through the placental barrier**. **May cause adverse reproductive effects and birth defects (teratogenic). Embryotoxic and/or foetotoxic in animal (The definition of foetotoxic or fetotoxic is "Poisonous to the fetus"). May affect genetic material (mutagenic)….The substance may be toxic to kidneys, liver, central nervous system (CNS). Repeated or prolonged exposure to the substance can produce target organs damage**".

  In addition to all that, according to the EPA cited in a CDC document: "Phenol is also considered to be an **extremely** hazardous substance (EPA 2006i)…."Designated as a **toxic pollutant** in accordance with Section 307(a)(1) of the Federal Water Pollution Control Act" https://www.atsdr.cdc.gov/toxprofiles/tp115-c8.pdf

  Yet, with all that damning evidence on phenol, the CDC recommends vaccines containing Phenol for pregnant women.

  I'm going to take some literary license on this and take extra time to make a very important point, because it has to do with careless exposure of unborn babies to this very toxic chemical. Most of these other compounds are discussed in more detail in other sections of this manuscript, but I felt compelled to linger here on this one a little longer.

  This list of recommended vaccines during pregnancy comes from the CDC website at https://www.cdc.gov/vaccines/pregnancy/hcp/guidelines.html

  Routine Vaccines:

  - Hepatitis A
  - Hepatitis B
  - ~~Human Papillomavirus (HPV)~~
  - Influenza (inactivated)
  - ~~Influenza (LAIV)~~
  - ~~Measles, Mumps, Rubella (MMR)~~
  - Meningococcal (MenACWY or MPSV4)
  - Meningococcal (MenB)
  - Pneumococcal Conjugate (PCV13)
  - Pneumococcal Polysaccharide (PPSV23)
  - Polio (IPV)
  - Tetanus, Diphtheria, and Pertussis (Tdap); & Tetanus and Diphtheria (Td)
  - ~~Varicella~~
  - ~~Zoster~~

  The only ones that are specifically contraindicated (NOT recommended) in the list above, are the HPV, Live Influenza Nasal (LAIV), MMR, Varicella (Chickenpox) and Zoster (Shingles)- (The red strikethroughs I have added)

The pneumococcal Polysaccharide (PPSV23) listed above contains phenol according to page 3 of the latest Vaccine Excipient list…
https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf

Yes, phenol is an ingredient in the PPSV23 Pneumococcal vaccine allowed for pregnant women. The CDC website says that there is inadequate data for specific recommendation. In other words, it isn't outright recommended, yet not contraindicated. This leaves doctors the latitude to make the decision whether to give it or not. This is a very precarious position for doctors that don't know what's in it (probably 99% of them). **Phenol which the Material Safety Data Sheet (MSDS) says crosses the placental barrier into the fetus. The same phenol that the MSDS says is "poisonous" to the fetus and has the capacity to cause birth defects!** When concocting these vaccines, don't they ever consider looking into this stuff? Because if they know this, the vaccine manufacturer should red flag this vaccine as contraindicated during pregnancy, or certainly the FDA or the CDC should have if they haven't. Where is the governmental oversight designed to protect the consumer?

This is by no means an exhaustive review of all of the potential interactions that could occur between ingredients co-mingling in the human body from a variety of combinations of vaccines.

Well, it's long overdue! I am calling on the scientific community to an exhaustive review of just that.

Not only that, but **the Pneumovax PPSV23 package insert states the following:**

"Tell your doctor if:
- you are pregnant or intend to become pregnant. It is **not known** whether the vaccine is harmful to an unborn baby when given to a pregnant woman. *(What?)* Your doctor will give you PNEUMOVAX 23 only if it is clearly needed.
- you are breast-feeding. It is **not known** whether PNEUMOVAX 23 passes into breast milk. Your doctor will discuss the possible risks and benefits of you being given PNEUMOVAX 23 while breast-feeding."

Women are often given multiple vaccines during pregnancy. Some of those vaccines contain ingredients that are incompatible or cross-react with ingredients in the other vaccines.

The MSDS also states that **phenol "is incompatible" with formaldehyde**. **Pregnant women are also recommended to receive the Tdap (see above), both versions which contains formaldehyde. The Fluarix, Fluzone Quadrivalent and High Dose, and Flulaval vaccines contains formaldehyde. If a woman is given the PPSV23 vaccine along with any of these others a cross reaction between phenol and formaldehyde could occur. Another vaccine contains both phenol and formaldehyde in the same shot, is the Typhoid vaccine given to people all over the world. (CDC chart says inadequate data regarding pregnancy).**

The MSDS also says that phenol is incompatible with metals and metal alloys. As stated earlier, the flu shot is recommended to pregnant women. The multi-dose version of Fluzone

Quadrivalent flu vaccine contains Thimerosal, (mercury, a heavy metal). The Tdap, which is recommended during pregnancy contains aluminum.

The various versions of the Meningococcal and Hepatitis A & B vaccines contain formaldehyde, aluminum and mercury.

There needs to be more scrutiny of the possible cross-reactions and interactions of the various vaccine components contained in vaccines that are given together.

Endocrine Disrupting Chemicals (NPEs and OPEs)- Also see section on page 444

- Nonylphenol Ethoxylate (NPEs)-
  According to the EPA' s website, NPEs are nonionic surfactants that are used in a wide variety of industrial applications and consumer products. Many of these, such as laundry detergents, are "down-the-drain" applications. Some others, such as dust-control agents and deicers, lead to direct release to the environment. NPEs, though less toxic and persistent than NP, are also **highly toxic to aquatic organisms**, and, in the environment, degrade into NP. NP has also been shown to **exhibit estrogenic properties** in in vitro and in vivo assays. **Nonylphenol is also neurotoxic**. https://www.ncbi.nlm.nih.gov/pubmed/23334477

- Octylphenol ethoxylate (OPEs) and Octoxynol-10; AKA Triton X-100-
  Closely related to Nonylphenol Ethoxylate. OPEs act as a detergent and are widely used in cleaning agents. They are also added to paints, coatings, treatments for textiles and chemicals used in paper manufacture. According to Wikipedia, Triton X-100 is widely used to lyse cells to extract protein or organelles, or to permeabilize the membranes of living cells.

- Cetyltrimethylammonium bromide-
  According to the Material Safety Data Sheet at http://datasheets.scbt.com/sc-278833.pdf , "there is some evidence that human exposure to the material **may result in developmental toxicity**…."

  Toxic Effects on Humans:
  "May cause adverse reproductive effects and birth defects (teratogenic) based on animal test data." http://www.sciencelab.com/msds.php?msdsId=9923367

  "The substance may be toxic to liver, cardiovascular system, central nervous system (CNS)".

  "CONSIDERED A HAZARDOUS SUBSTANCE ACCORDING TO OSHA 29 CFR 1910. This material and its container must be disposed of as hazardous waste".

  The Fluad Influenza vaccine contains this compound, which as we just read may result in developmental toxicity, adverse reproductive effects and birth defects. In addition, Fluad contains to 2 antibiotics that are not supposed to be given with pregnancy (Neomycin and Kanamycin *see next section), formaldehyde and polysorbate 80. Flu vaccines are recommended for all pregnant women. Frightening isn't it?

The following four antibiotics are found in several flu vaccines and are contraindicated (not recommended), for pregnant women or nursing mothers. Yet, the CDC recommends the flu vaccine for all pregnant women. They are also not established to be safe in children under the age of 18. More details on these on pages 267-270, along with the references.

- Neomycin sulfate-
  Same family of antibiotics as Gentamycin Sulfate and Kanamycin called **aminoglycosides**

  According to the warning label, **"Aminoglycosides can cause fetal harm when administered to pregnant women. Aminoglycoside antibiotics cross the placenta and there have been several reports of total, irreversible, bilateral congenital deafness in children whose mothers received streptomycin during pregnancy**."

  Neomycin Sulfate is found in the following vaccines:
  - **Influenza (Afluria)Trivalent & Quadrivalent**
  - **Influenza (Fluad)**
  - **Influenza (Fluvirin)**

- Gentamicin Sulfate-
  Same family of antibiotics as Neomycin and Kanamycin called **aminoglycosides**. It is found in the **Influenza (Fluarix) Trivalent & Quadrivalent vaccine**. **The warning label states "This medication is not recommended for use during pregnancy."**

- Kanamycin-
  Same family of antibiotics as Neomycin and Gentamicin Sulfate called **aminoglycosides.** The **Influenza (Fluad) vaccine contains both Kanamycin and Neomycin Sulfate**. Again, like in the case of the other aminoglycosides, they are **contraindicated for pregnant and nursing mothers or children**.

- Polymyxin B-
  An antibiotic. The warning label on PubMed Health says it can cause kidney and nerve problems and diarrhea. **This same document**, https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011783/?report=details#side_effects **states that this antibiotic should not be taken with neomycin, one of the other antibiotics just discussed. Yet, the Fluvirin brand of influenza (Flu) vaccine has BOTH of these antibiotics in it!**
  Refer to the CDC's Vaccine Excipient and Media Summary and look under Influenza (Fluvirin).
  https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf

  WARNING LABEL:
  "**THE CONCURRENT OR SEQUENTIAL USE OF OTHER NEUROTOXIC AND/OR NEPHROTOXIC DRUGS** WITH POLYMYXIN B (polymyxin b sulfate) SULFATE, PARTICULARLY BACITRACIN, STREPTOMYCIN, **NEOMYCIN, KANAMYCIN, GENTAMICIN**, TOBRAMYCIN, AMIKACIN, CEPHALORI-DINE, PAROMOMYCIN, VIOMYCIN, AND COLISTIN **SHOULD BE AVOIDED**."

Note that it calls Neomycin, Kanamycin and Gentamicin neurotoxic (nerve damaging) and nephrotoxic (kidney damaging)!!!

"WARNING

CAUTION: WHEN THIS DRUG IS GIVEN **INTRAMUSCULARLY** AND/OR INTRATHECALLY, IT SHOULD BE GIVEN **ONLY TO HOSPITALIZED PATIENTS, SO AS TO PROVIDE CONSTANT SUPERVISION BY A PHYSICIAN.**" (when it is injected as part of a vaccine, **that is intramuscular injection**). If that doesn't make your skin crawl, I don't know what would!

- Monosodium Glutamate or MSG-
  MSG is a neuroexcitatory agent that upregulates the NMDA receptors in the brain. This **can lead to damage of the brain cells**. MSG and other neuroexcitatory agents are the topic of one of the best books I have read on the subject by the prominent Neurosurgeon Russell Blaylock M.D., ***Excitotoxins- The Taste That Kills…*** https://www.amazon.com/Excitotoxins-Taste-Russell-L-Blaylock/dp/0929173147

- Squalene-
  Squalene is **an oil-based adjuvant** used in certain vaccines. It has been implicated as a possible causative factor in ***Gulf War Syndrome*** **and in batches of the H1N1 flu vaccine that has been linked to the autoimmune condition narcolepsy**. **Much more on both of those later.**

  Squalene is found in the human body and manufactured in the liver. It is a precursor to cholesterol and thus to sex steroid hormones. It has been reported to have numerous health benefits similar to omega-3 fatty acids. Just like with other fats, these essential fats make up the cell membranes of our body's tissues. The richest source of squalene is in shark liver oil. Vegetarian sources include olive, amaranth, palm, wheat germ and rice bran oils. It is used in many cosmetics aa a prized ingredient for healthy skin. **Squalene in and of itself is not dangerous, BUT when it is injected, the body's immune system over-reacts (which is why they put it in the vaccine in the first place), and produces antibodies that attack all the other squalene in the body, including in places where it can be beneficial like your nervous system and other organs and tissues.**

  In a 2000 study published in the ***American Journal of Pathology***, titled, **The Endogenous Adjuvant Squalene Can Induce a Chronic T-Cell-Mediated Arthritis in Rats,** they injected squalene into arthritis prone rats caused them to develop rheumatoid arthritis. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1850095/ .

  A similar issue was also identified in this 1999 study, published in the **Scandinavian Journal of Immunology** titled, **Identification of Arthritogenic Adjuvants of Self and Foreign Origin.** https://onlinelibrary.wiley.com/doi/epdf/10.1046/j.1365-3083.1999.00463.x

One has to wonder why it has been continued to be used for the past 20 years, after the ability of **injected squalene to trigger inflammatory and autoimmune reactions in the body has been well known?** It also begs the question, where else in the body can this compound when injected, trigger other autoimmune diseases in persons that may be genetically susceptible to that particular disease? As you will see in this eBook, just because you have the genes for something, it doesn't mean you are doomed to develop it. This is the concept of **epigenetics**, which we will explore more later.

- Acetone-

  Acetone is a solvent. The MSDS contains the following warnings: "**Causes damage to the following organs: central nervous system (CNS) characterized by depression, fatigue, excitement, stupor, coma, headache, altered sleep time, ataxia, tremors**.

  May cause damage to the following organs: kidneys, the reproductive system, liver, skin. May contain trace amounts of benzene and formaldehyde which may cancer and birth defects. Human: passes the placental barrier."

  Acetone is found in the Adenovirus vaccine, which is currently only available to the military.

- Sodium Borate (Borax)-

  Found in the following vaccines:
  - Hep A (Vaqta)
  - Hib/Hep B (Comvax)- *also contains aluminum - Comvax was discontinued in 2014
  - HPV (Gardasil)
  - HPV (Gardasil 9)

  Sodium Borate is a common **ingredient found in rat poison, pesticides, and various commercial applications** such as flame retardants, enamel glazes, and laundry detergent. **The FDA has outlawed Sodium Borate from use as a food preservative in the U.S.**
  http://www.rightinginjustice.com/news/2012/03/28/is-borax-responsible-for-gardasils-adverse-side-effects/

  According to one source, the ***U.S. National Library of Medicine*** states in an article that boric acid is "no longer commonly used in medical preparations." It's a good thing, too, considering that the U.S. National Library of Medicine also reports that this substance used to be used to disinfect and treat wounds and that individuals "who received such treatment over and over again got sick, and some died." In fact, the U.S. National Library of Medicine provides the number for Poison Control for people exposed to this chemical and notes that treatment for those exposed to it may include gastric lavage (stomach pumping), dialysis, and liquids by mouth or IV. http://www.offtheradar.co.nz/vaccines/104-rat-poison-chemical-in-gardasil.html

  Because of reproductive and developmental toxicity concerns, borax was added to the European Union's (EU) **Substance of Very High Concern** (SVHC) candidate list in December 2010. The SVHC candidate list is part of the EU Regulations on the Registration, Evaluation, Authorization and

Restriction of Chemicals 2006, and the addition was based on the revised classification of borax **as toxic for reproduction** category 1B under the Classification, Labeling and Packaging Regulations. **Substances and mixtures imported into the EU which contain borax are now required to be labeled with the warnings 'May damage fertility' and 'May damage the unborn child'**. Riederer A, Caravanos J. Borax–Summary of Health Human Risks Associated with Borax in Artisanal and Small-Scale Gold Mining. *Global Alliance on Health and Pollution* Apr. 1, 2013.

Based on that information, vaccines with sodium borate should never be given to pregnant women, yet one of the Hepatitis A vaccines (Vaqta) has it in it. Hepatitis A is recommended to women under certain circumstances during pregnancy. Another vaccine containing sodium borate, is the HPV vaccine Gardasil 9.

Yet, according to the ***Immunization Action Coalition*** an organization funded in part by the CDC as published in their vaccinations for Prgnant Women flier…."You need this vaccine if you have a specific risk factor for hepatitis A virus infection* or simply want to be protected from this disease. The vaccine is usually given in 2 doses, 6–12 months apart. If you need to get or continue the HepA vaccine series, it's safe to do so during pregnancy." "Technical content reviewed by the Centers for Disease Control and Prevention" http://www.immunize.org/catg.d/p4040.pdf

- VERO Cells-
  These are cell lines from the African Green Monkey kidney cultures. Vaccines such as the Smallpox vaccine using live Smallpox virus grown in the VERO cells have a laundry list of serious potential side effects. ***The following is from the Smallpox Vaccine package insert*** and can be found on the FDA's web site at https://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM142572.pdf :

  "Suspected cases of myocarditis and/or pericarditis have been observed in healthy adult primary vaccinees (**at an approximate rate of 5.7 per 1000**, 95% CI: 1.9-13.3) receiving ACAM2000 [see Warnings and Precautions (5.1)]. Encephalitis, encephalomyelitis, encephalopathy, progressive vaccinia, generalized vaccinia, severe vaccinial skin infections, erythema multiforme major (including STEVENS-JOHNSON SYNDROME), eczema vaccinatum resulting in permanent sequelae or death, ocular complications, blindness, and fetal death have occurred following either primary vaccination or revaccination with live vaccinia virus smallpox vaccines [see Warnings and Precautions (5)]. These risks are increased in vaccinees with the following conditions and may result in severe disability, permanent neurological sequelae and/or death: Cardiac disease or a history of cardiac disease Eye disease treated with topical steroids, Congenital or acquired immune deficiency disorders, including those taking immunosuppressive medications Eczema and persons with a history of eczema or other acute or chronic exfoliative skin conditions Infants less than 12 months of age Pregnancy

  ACAM2000 is a live vaccinia virus that can be transmitted to persons who have close contact with the vaccinee and the risks in contacts are the same as those for the vaccinee. The risk for

experiencing serious vaccination complications must be weighed against the risks for experiencing a potentially fatal smallpox infection."

This 2018 study also verifies this danger of myocarditis following smallpox vaccination. The study published in the ***British Medical Journal Case reports*** titled, **Myocarditis secondary to smallpox vaccination** confirms the associated risk with the smallpox vaccine. https://www.ncbi.nlm.nih.gov/pubmed/29572367

From the Abstract:
"…vaccines are not without risk; reactions can range from injection site reactions to life-threatening anaphylaxis. Among the more serious vaccine-related sequela is myocarditis. Although myocarditis has been reported following many different vaccines, the smallpox vaccine has the strongest association."

"Vaccine-associated myocarditis should always be on the differential for patients that exhibit cardiopulmonary symptoms after recent vaccinations."

More on the use of aborted fetal cell lines and the DNA fragments from those cells found in vaccines

First of all, why is this important? It boils down to religious, moral, ethical and personal beliefs about abortion, sale of aborted baby parts for profit, freedom to choose what I put in my or my child's body and the question of **what happens when the DNA of one human being is inserted into the DNA of another human being**. The short answer to that last question is, **WE DON'T KNOW!** Are any of those concerns important to you? That is why I will now devote a larger section to this topic.

The WI-38 cell line was developed by Dr. Leonard Hayflick in 1962, by taking lung tissue from an aborted baby. The WI comes from Wistar Institute and the 38 is the number of aborted babies used until they found the "perfect" cell line for their purposes.

The MRC-5 cell line was developed for the Medical Research Council in England by J.P. Jacobs in 1966 from lung tissue of an aborted baby. These are vaccines that contain human DNA and aborted fetal tissue from these cell lines: Adenovirus, DTaP, hepatitis A, hepatitis B, MMR, MMRV, rabies, varicella (Chickenpox) and zoster (Shingles).

The HEK-293 is used for research *(and vaccines)*. This cell line originated from a legally aborted fetus in the Netherlands in 1973. The tissue came from the baby's kidneys, hence Human Embryonic Kidney (HEK). The lab culturing the cells was Alex van der Eb's laboratory. Frank Graham was the scientist running the experiments refining the cell culture process. The 293 was incorporated in the name because it was produced from his 293rd experiment. https://en.wikipedia.org/wiki/HEK_293_cells

Current vaccines that contain DNA from this cell line are for Cystic Fibrosis, Ebola, Heart (Abciximab-Repro), Hemophilia, Infection prevention (G-CSF). It is also used in other products. According to Creative Biolabs, at least five therapeutic agents produced in HEK293 cells have been approved by the FDA or the European Medicines Agency (EMA) for therapeutic use.

The PER.C6 cell line is a line that is not only being used in vaccine production, but in many other medicines and more in production. http://www.gmp-creativebiolabs.com/per-c6-cell-lines_74.htm It was developed in 1995. These are quotes from GMP-Creative Biolabs web site…

"The PER.C6 cell line is derived from human embryonic retinal cells, originally from the retinal tissue of an 18 week old fetus aborted in 1985 and further developed and prepared as cell line by transfection with defined E1 region of the adenovirus type 5 followed by selection for transfectants with an immortal phenotype. At the beginning, this cell line was mainly applied for the production of human adenovirus vectors for use in vaccine development and gene therapy, and further optimization makes PER.C6 become a superexcellent host cell line for large-scale industrial production of therapeutic proteins, especially the human IgG."

"The PER.C6 cell line is a superduper and commercial available manufacturing system that can be used to produce a variety of biopharmaceutical products, including vaccines, gene therapy products, antibodies and other therapeutic proteins. Up to now, more than fourteen biopharmaceutical products utilizing the PER.C6 cell line are in Phase I/II clinical trials, for example, the MOR103 mAb, a human IgG antibody against granulocyte macrophage colony-stimulating factor in clinical development for the treatment of rheumatoid arthritis and multiple sclerosis; another example is CL184, a combination of two monoclonal antibodies (mAbs) against the rabies virus, which has been granted FDA fast-track approval status. Furthermore, mostly PER.C6-based vaccines against tuberculosis, malaria and HIV are also currently in clinical trials."

According to LifeCanada.org, "It is being used in the development of numerous new vaccines against "influenza A, influenza B, 'avian flu', tuberculosis, respiratory syncytial virus, HIV, anthrax and various encephalopathic viruses." (34) In 2002, PER.C6 was also "launched into commercial production of fully human monoclonal antibodies" (Mabs), totally unrelated to vaccine production. Mabs are currently used in a broad array of cancer therapies, chronic autoimmune inflammatory diseases such as rheumatoid arthritis and ulcerative colitis, and have potential for use in treating infectious diseases, SARS, rabies and others. While Mabs currently in use were not developed using human cell strains, and animal strains have worked well, various biotech companies are aggressively pursuing Mab development using human strains such as PER.C6. In addition, gene therapy is being developed using PER.C6."

The walvax-2 cell line is the most recent development of human fetal cell lines from an aborted baby. In a 2015 article titled Characteristics and viral propagation properties of a new human diploid cell line, walvax-2, and its suitability as a candidate cell substrate for vaccine production. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4526020/#cit0007 It is thought that the walvax-2 cell line will eventually take the place of the MRC-5 and the WI-38 lines as they lose the ability to self-replicate.

There were 9 aborted fetuses "vying" for the one that produced the best cell line to make vaccines from. The cells eventually used, came from lung tissue of a 3-month-old female aborted baby in China. **The method they used to deliver the fetus was the "water bag" method which was done so as to deliver the baby intact, so as to provide the freshest and most viable tissue samples possible**. "The tissues from the freshly aborted fetuses were immediately sent to the laboratory for the preparation of the cells."

According to ethicalresearch.net, there was "**Questionable complicity between the doctors who performed the abortion and vaccine researchers who benefited from obtaining freshly aborted fetal lung fibroblast tissue.** Ethicists have universally insisted that, in the development of viral vaccines from aborted fetal tissue, there should be no collusion between the woman who has decided to abort her baby (and, by extension, the doctors doing the abortion) and the researchers. The mother must have made her decision to abort before she is asked whether she wants to donate fetal tissue for research purposes. It appears this was done in the Walvax-2 research."

"By extension, the involved physicians performing the abortion should not deviate from the normal method of aborting the fetus (in the case of a three-month fetus, a D&C) just so they might provide "optimal fetal tissue" for the vaccine researchers. But this is what the doctors did in aborting the 3-month old female fetus whose tissue eventually proved to produce the best diploid cell strain out of the batch of 9 aborted fetuses for the Walvax-2 cell substrate. They employed a special means of induction (the water bag method) so they or someone they delegated, could deliver to Bo Ma et al intact fetal cadavers with fresh organs which would facilitate, in turn, the ready harvest of the needed fetal fibroblast lung tissue from which they developed the human diploid cell strain conducive to the growth of the respective viruses (rabies, hepatitis-A and varicella [chicken-pox])." . http://ethicalresearch.net/positions/the-ethics-of-the-walvax-2-cell-strain/

The question of whether a fetus is a human life or not has created polarizing battles in our nation. To take it to the next level, this methodology brings into question a whole other moral and ethical dilemma as to whether a fetus should be terminated (killed) inside or outside the womb. Does it suffer more if killed before being delivered alive or not. A very morbid thought, but a real world one that I'm sure many reading this have never considered. Personally, I can't imagine being the person performing that "procedure". To witness and experience the pain, suffering and aftermath of the baby that you are killing, without conscious or self-remorse is beyond me.

Other aborted fetal cell lines are used for vaccines and medical/scientific purposes

From http://www.lifecanada.org/vaccines/vaccines-fetal-tissue-qa - "Numerous other cell strains have been made as back-ups for the current strains, and for research. Two of the most commonly known stains are:

MRC-9 (Medical Research Council cell strain 9) was derived from the lungs of a female fetus aborted in 1974 and developed by Jacobs and colleagues for research and as a back-up for vaccine manufacture.

IMR-90 (Institute for Medical Research cell strain 90) was derived from the lungs of a sixteen-week old female fetus aborted in July 1975. IMR-90 is designated for "research and related activities."

How can fetal cells from as far back as 1962 still be available for use today?

To answer that let's take a look at LifeCanada.org's website- Vaccines and Fetal Tissue Q&As discussing the WI-38 cell line. http://www.lifecanada.org/vaccines/vaccines-fetal-tissue-qa

"Tissue was taken from the lungs, kidneys, skin, muscles, heart, liver, thymus, and thyroid of 19 electively-aborted fetuses. Batches of cells taken from these tissues were incubated in a labratory setting. After a cell batch had multiplied sufficiently to form a mass big enough to harvest, the mass was divided up into smaller batches, and incubated again. After about 50 'cell population doublings,' the cells divided more slowly and deteriorated. Although cell strains have a finite life-span, by freezing excess cells at each sub-cultivation, one could have cells available at any given time in almost limitless numbers. The frozen cells can be thawed, sub-cultivated repeatedly, and the excess from each of these sub-cultivations can, in turn, be frozen and later thawed for use. **This pattern can be repeated until the total potential yield of about 20 million metric tons of cells (wet weight) is reached**." ***WOW!***

More on MRC-5, DNA, MRC-5 Cellular Protein, Human Serum Albumin-

All of these derive from either human tissue or human blood. (Source for the following is vaxtruth.org)

MRC-5, MRC-5 Cellular Protein**-** In the 1970's, a second human cell line was created from an infant boy at 14 weeks gestation and became known as MRC-5. To explain MRC-5, let's look at a brief history before MRC-5 came about. In 1964, during an outbreak of Rubella, some doctors urged women who had been exposed to the Rubella virus to abort their pregnancy. (Why? Rubella is an extremely mild virus [see: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0002541/]. Most people don't show any symptoms, especially children, some may get a rash all over their body. Rubella becomes dangerous when a pregnant woman is exposed to the virus because it has the potential to cause severe abnormalities in the child.) From one of these aborted children that had been exposed to Rubella Virus, doctors developed a virus strain that became known as RA/27/3 — Rubella; Abortus; 27th aborted fetus; 3rd tissue explant. **In other words, it took 26 aborted infants to get the right strain. The virus was then cultivated on the lung tissue of another aborted child, and this child became known as WI-38 — Winster Institute 38)**. WI -38 was an infant girl at 3 months gestation. What makes this seem somewhat ridiculous is that the Japanese, years before the first aborted infant was used to extract the Rubella virus, proved that the virus can be taken from a *living* child simply by swabbing their throat.

WI-38 and MRC-5 have become the most used cell lines to make vaccinations. Labs currently use these 2 cell lines, as well as new sources *(i.e. Walvax-2)* to create new vaccines.

The use of tissue from aborted infants has caused heated debate because **it is ethically questionable.** Pro-life groups, which include many churches and parents whose morals condemn profiting from aborted infants, continue to fight the pharmaceutical companies to produce vaccines that do not contain this tissue. And the thing is, it's possible. Vaccines *can* be made from other sources.

Investigative videos released in 2015 by ***the Center for Medical Progress*** exposed Planned Parenthood and their practice of harvesting body parts from aborted babies for profit. Even though the aborted

fetuses, whose cell line is still used to produce vaccines are from decades ago, the videos exposing Planned Parenthood's marketing of aborted baby organs and tissue brings the whole ethical question front and center. http://www.centerformedicalprogress.org/cmp/investigative-footage/

DNA- DNA is harvested from the aborted fetuses cell lines. It is used as adjuvant in vaccines. In vaccines, **100,000,000 bits and strands of human DNA are allowed per dose**. Again, we encounter the issue of the ethical dilemma. Not only that, but **many scientists believe that these DNA strands and the genetic code that they carry, can be incorporated to the person's own DNA**. More about those concerns later in this document.

Human Serum Albumin**-** Human Serum Albumin is a stabilizing protein made from human blood donated by screened donors. We already discussed above why injecting a protein directly into the body is dangerous.

With that aside, let's look at the points we reach regarding these 4 different ingredients:
We have human DNA, human cell lines from aborted infants, and protein from human blood in 23 of our vaccines. **When we need a blood transfusion, or a blood donation of some kind, what is absolutely required? A match, correct? For example, if a person with type O blood receives type A+ blood, the outcome is fatal. There are rules of science that cannot be crossed regarding DNA and blood**. It is imperative to be tested when receiving any type of tissue or blood to ensure that a fatal blood or tissue type isn't put into your body. So, may I ask: **How many of you or your children were given a blood test before receiving vaccinations?** We all know the answer to that. It doesn't happen. The outcome to mixing and NOT matching human blood and tissue with other humans can be virtually disastrous. **Remember that every one of those 4 ingredients have human DNA in them. Even after the protein is extracted from human blood, DNA remains.**

As MMR vaccine compliance rates dropped, so did rates of autism. As MMR compliance rates increased again, so did rates of autism- a natural experiment

A 2015 article published in ***Issues in Law and Medicine*** titled, **Epidemiologic and Molecular Relationship Between Vaccine Manufacture and Autism Spectrum Disorder Prevalence**, reveals that when Dr. Andrew Wakefield identified gastrointestinal pathological changes in children that reacted to the MMR vaccine and **many parents pulled back from having their children vaccinated with MMR, there was a corresponding temporary drop in rates of diagnosed Autism Spectrum Disorder for those children that fell within those birth years. And as interestingly, when the rates of MMR compliance once again recovered, the rates of Autism increased proportionately**. The article also reveals the contribution to and risk of foreign human fetal DNA contamination into DNA of vaccine recipients, the relationship with Autism and the associated health risks involved.
https://www.ncbi.nlm.nih.gov/pubmed/26103708

You can read the truth about the underserved vilification of Dr. Wakefield in the section titled,* ***Persecution of Doctors That Don't Toe the Line* *later in this document*

I feel that the full abstract warrants inclusion here due to the relevant information contained:

OBJECTIVES:
To assess the public health consequences of fetal cell line manufactured vaccines that contain residual human fetal DNA fragments **utilizing laboratory and ecological approaches including statistics, molecular biology and genomics.**

METHOD:
MMR coverage and autism disorder or autism spectrum disorder prevalence data for Norway, Sweden and the UK were obtained from public and government websites as well as peer reviewed published articles. Biologically, the size and quantity of the contaminating fetal DNA in Meruvax II and Havrix as well as the propensity of various cell lines for cellular and nuclear uptake of primitive human DNA fragments were measured and quantified using gel electrophoresis, fluorescence microscopy and fluorometry. Lastly, genomic analysis identified the specific sites where fetal DNA fragment integration into a child's genome is most likely to occur.

RESULTS:
The average MMR coverage for the three countries fell below 90% after Dr. Wakefield's infamous 1998 publication but started to recover slowly after 2001 until reaching over 90% coverage again by 2004. During the same time period, the average autism spectrum disorder prevalence in the United Kingdom, Norway and Sweden dropped substantially after birth year 1998 and gradually increased again after birth year 2000. Average single stranded DNA and double stranded DNA in Meruvax II were 142.05 ng/vial and 35.00 ng/vial, respectively, and 276.00 ng/vial and 35.74 ng/vial in Havrix respectively. **The size of the fetal DNA fragments in Meruvax II was approximately 215 base pairs. There was spontaneous cellular and nuclear DNA uptake in HFF1 and NCCIT cells. Genes that have been linked to autism (autism associated genes; AAGs) have a more concentrated susceptibility for insults to genomic stability in comparison to the group of all genes contained within the human genome.** Of the X chromosome AAGs, 15 of 19 have double strand break motifs less than 100 kilobases away from the center of a meiotic recombination hotspot located within an exon.

CONCLUSION:
Vaccines manufactured in human fetal cell lines contain unacceptably high levels of fetal DNA fragment contaminants. The human genome naturally contains regions that are susceptible to double strand break formation and DNA insertional mutagenesis. The "Wakefield Scare" created a natural experiment that may demonstrate a causal relationship between fetal cell-line manufactured vaccines and ASD prevalence.

Read more on fetal cell lines and their probable involvement in the continuing rise in the percentage of children with autism, after the autism statistics section.

When the vaccine inserts don't list all of the ingredients that the CDC lists, how do you know who to believe?

From the package insert found on the FDA's website dated December 26, 2017:

"What are the ingredients in Fluzone Quadrivalent Southern Hemisphere vaccine? Fluzone Quadrivalent Southern Hemisphere vaccine contains 4 killed flu virus strains."

"Inactive ingredients include formaldehyde and octylphenol ethoxylate. The preservative thimerosal is only in the multi-dose vial of Fluzone Quadrivalent Southern Hemisphere vaccine."
https://www.fda.gov/BiologicsBloodVaccines/Vaccines/ApprovedProducts/ucm112854.htm

The CDC website lists the following ingredients *(bolded items are not disclosed on the package insert):* formaldehyde, **egg protein**, octylphenol ethoxylate (Triton X-100), **sodium phosphate-buffered isotonic sodium chloride solution**, thimerosal (multi-dose vials), **sucrose**

It's what is in vaccines that aren't even supposed to be there that is another huge cause for concern

A 2017 study using sophisticated technology, finds toxic compounds not listed in the ingredients lists of 44 different vaccines

A 2017 article published in the ***International Journal of Vaccines and Vaccination*** titled, **New Quality-Control Investigations on Vaccines: Micro- and Nanocontamination**, **reveals a shocking conglomeration of NON-biocompatable particulates and foreign bodies in randomly selected batches of 43 different human vaccines** and one veterinary vaccine. Ironically, the veterinarian vaccine checked out to be cleaner than all of the human vaccines. **This essentially means that all of the human vaccines are "dirty", containing unintended particulates and aggregates of metals and foreign matter, most likely from the manufacturing process**. http://medcraveonline.com/IJVV/IJVV-04-00072.php

The researchers used Field Emission Gun Environmental Electron Scanning Microscope, equipped with an X-ray microprobe. The study highlights pictures of the particulates and substances found.

"**all samples checked vaccines contain non biocompatible and bio-persistent foreign bodies** which are not declared by the Producers, against which the body reacts in any case."

In addition to aluminum, which is disclosed in some vaccines, **they found aluminum in some vaccines that don't list in in the ingredients list. Also discovered was lead, stainless steel, tungsten, silicon, gold, silver, nickel, iron, chromium, copper, zirconium, Hafnium, Strontium, Antimony, Platinum,**

Bismuth, Cerium, and aggregates of combinations of these metals and biological compounds the researchers called nano-bio-interactions, some with what they describe as having a "protein corona".

"Figure 5a-5f show examples of these nano-bio-interactions. Aggregates can be seen (stable composite entities) containing particles of Lead in Meningitec, (Figure 5a & 5b) of stainless steel (Iron, Chromium and Nickel, Figure 5c & 5d) and of Copper, Zinc and Lead in Cervarix (Figure 5e & 5f). Similar aggregates, though in different situations (patients suffering from leukemia or cryoglobulinemia), have already been described in literature. **The link between these two entities generates an unfolding of the proteins that can induce an autoimmune effect once those proteins are injected into humans**."

"The investigations revealed that some particles are embedded in a biological substrate, probably proteins, endo-toxins and residues of bacteria. As soon as a particle comes in contact with proteic fluids, a nano-bio-interaction [6] occurs and a "protein corona" is formed. **The nano-bio-interaction generates a bigger-sized compound that is not biodegradable and can induce adverse effects, since it is not recognized as self by the body.**"

"(Figure 7a & 7b) present an area of Repevax **where the morphology of red cells - we cannot tell whether they are human or animal- is clearly visible**." ***What? Wow!***

Ok, you have got to read this! It is the discussion by the researchers at the send of the study. It is worthy to print nearly the entire section.

Discussion:

"The quantity of foreign bodies detected and, in some cases, their unusual chemical compositions baffled us. The inorganic particles identified **are neither biocompatible nor biodegradable**, that means that they are **biopersistent and can induce effects** that can become evident either immediately close to injection time or after a certain time from administration. It is important to remember that particles (crystals and not molecules) **are bodies foreign to the organism and they behave as such**. More in particular, their toxicity is in some respects different from that of the chemical elements composing them, **adding to that toxicity** which, in any case, is still there, that typical of foreign bodies. For that reason, **they induce an inflammatory reaction**."

"After being injected, those microparticles, nanoparticles and aggregates can stay around the injection site forming swellings and granulomas. But **they can also be carried by the blood circulation, escaping any attempt to guess what will be their final destination.** We believe that in many cases they get distributed throughout the body without causing any visible reaction, but **it is also likely that, in some circumstances, they reach some organ, none excluded and including the microbiota, in a fair quantity**. As happens with all foreign bodies, particularly that small, **they induce an inflammatory reaction that is chronic** because most of those particles cannot be degraded. Furthermore, the protein-corona effect (due to a nano-bio-interaction) can produce organic/inorganic composite particles **capable of stimulating the immune system in an undesirable way**. **It is impossible not to add that particles the size often observed in vaccines can enter cell nuclei and interact with the DNA**." **WOW!**

"In some cases, e.g. as occurs with Iron and some Iron alloys, **they can corrode and the corrosion products exert a toxicity affecting the tissues**."

"The detection of presence of Aluminum and NaCl salts is obvious as they are substances used by the Producers and declared as components, but other materials are not supposed to be in the vaccine or in any other injectable drug, at that, and, in any case, **Aluminum has already been linked with neurological diseases**."

"Given the contaminations we observed **in all samples of human-use vaccines, adverse effects after the injection of those vaccines are possible and credible and have the character of randomness, since they depend on where the contaminants are carried by the blood circulation. It is only obvious that similar quantities of these foreign bodies can have a more serious impact on very small organisms like those of children.** Their presence in the muscles, due an extravasation from the blood, **could heavily impair the muscle functionality**."

"In any case, whatever their origin**, they should not be present in any injectable medicament, let alone in vaccines, more in particular those meant for infants**."

"Other forms of so-far unknown contaminations have recently been observed and, in any case, **vaccines contain components that could themselves be the cause of adverse effects**. **It is a well-known fact in toxicology that contaminants exert a mutual, synergic effect, and as the number of contaminants increases, the effects grow less and less predictable. The more so when some substances are unknown.**"

All of that should frighten anyone reading this!

The introduction of the article also has much to say **about the known side effects of vaccines**. Here is part of that discussion:

"**Side effects** have always been reported but in the latest years it seems that they **have increased in number and seriousness, particularly in children** as the ***American Academy of pediatrics*** reports [1,2]. "For instance, the diphtheria-tetanus-pertussis **(DTaP)** vaccine was linked to cases of **sudden infant death syndrome (SIDS**) [3]; ***(MMR)*** measles-mumps-rubella vaccine **with autism** [4,5]; **multiple immunizations** with **immune disorders** [6]; **hepatitis B** vaccines with **multiple sclerosis**, etc."

"**The notice of Tripedia DTaP by Sanofi Pasteur reports "Adverse events reported** during post-approval use of Tripedia vaccine **include idiopathic thrombocytopenic purpura, SIDS, anaphylactic reaction, cellulitis, autism, convulsion/grand mal convulsion, encephalopathia, hypotonia, neuropathy, somnolence and apnea**". The epidemiological studies carried out did not show a clear evidence of those associations, even if in 2011 **the National Academy of Medicine (formerly, IOM) admitted: "Vaccines are not free from side effects, or adverse effects**" [7]."

"Specific researches on components of the vaccines like **adjuvants (in most instances, Aluminum salts**) are already indicated as possible responsible of **neurological symptoms** [8-10] and in some cases, in-vivo

tests and epidemiological studies demonstrated a possible correlation with **neurological diseases** [10,11]. **Neurological damages** induced in patients under hemodialysis treated with water containing **Aluminum** are reported in literature [12]."

"Recently, with the worldwide-adopted vaccines against **Human Papillomavirus (HPV),** the debate was reawakened due to some adverse effects reported by some young subjects. Specific studies communicated the existence of **symptoms related to never-described-before syndromes developed after the vaccine was administered**. **For instance, Complex Regional Pain Syndrome (CRPS), Postural Orthostatic Tachycardia Syndrome (POTS), and Chronic Fatigue Syndrome (CFS) [13]. The side-effects that can arise within a relatively short time can be local or systemic**."

New research finds that vaccines contain unknown contaminants AND may not have the very components that would generate virus specific antibodies as claimed

An Italian scientific research firm Corvelva, finds shocking evidence of widespread contamination and false labeling of vaccine ingredients

Released in November of 2018, a report on the analysis of 7 vaccines finds that 5 of the 7 are "not compliant".

According to the report:

"The results are alarming, on 7 types of vaccines, as many as 5 do not conform to the guidelines for the quantity of biological material, DNA or foreign RNA of human or animal origin, or for the presence of genetic mutations of the antigens!!!"

1. *Priorix Tetra, GlaxoSmithKline - NOT CONFORMING*
2*. Infanrix hexa, GlaxoSmithKline - NOT CONFORMING*
3. *Measles live vaccine B.P., Poonawalla Group - NOT CONFORMING*
4. *PolioInfanrix, GlaxoSmithKline - NOT CONFORMING*
5*. Vivotif, PaxVax - NOT CONFORMING*

These results throw a shadow on the quality of the checks carried out by the controller's bodies.

"We can not yet release the original documentation and communicate the names of the laboratories, that are internationally certified, because we are completing further investigations to understand other aspects that are decisive for safety and effectiveness. Vaccines such as Infanrix hexa and PolioInfanrix have the viral DNA of the poliovirus in quantities below the limits of detection of both standard instruments and the sensitivity of deep sequencing, this raises the following questions: is the antigen really present? those vaccines immunize? These questions and many others will be answered in the second line of our research."

"In Italy already in the coming days will be presented complaints to the competent authorities and we will keep you updated."

https://www.corvelva.it/it/speciali-corvelva/analisi/vaccingate-5-of-7-vaccines-analyzed-are-not-compliant.html

Another analysis of the 6 in 1 vaccine Infanrix Hexa finds serious contaminants AND that it lacks the antigens it claims to have

Infanrix Hexa

A December 2018 release of the results of analysis of GalaxoSmithKline's Infanrix Hexa was truly a bombshell. This six in one vaccine is supposed to contain the following antigens: tetanus, diphtheria and pertussis toxoids; inactivated poliomyelitis viral strains 1-2-3; and hepatitis B surface antigen. Shockingly, Corvelva found NONE of these antigens in the vaccine, meaning, that NO antibodies to the intended antigens will be created.

And it gets worse. In addition to no vaccine antigens, they found the following:

- traces of 65 chemical cross-contaminants from other manufacturing lines;
- chemical toxins;
- unrecognizable macromolecules;
- various free bacterial peptides that are potential allergens and are capable of inducing autoimmune reactions.

Some comments from their report:

"We were expecting to find the three toxoids and the other antigens not modified by treatment with formaldehyde and glutaraldehyde, to separate the antigens from each other and to be digestible by the enzyme specific for proteins (trypsin). **We have found instead a real polymer, insoluble and indigestible, that we supposed to be the set of antigens chemically bound together (has to be defined if this is present as an aggregate of the individual antigens or a single macromolecule), on which we can find in literature partial information regarding the single antigens. This macromolecule could not be recognized in any way by the protein databases, and in fact it turned out to be a solid compound of an unknown chemical structure.**

Proteins solubility and their digestion (i.e. the capacity to divide them into small peptide fragments) are two typical proteins characteristics that not only makes it possible to study them through some specific analysis methods **but are also fundamental for the interaction with the immune system to create protective antibodies**, **because if the protein structure is heavily altered from the original one, the new antibodies result completely different from those that are able to attack the original antibodies causing illnesses.**

Since this polymer we have encountered, derived from the antigenic mix, is not only different for its spatial conformation but it's chemically different, so **we can state that we are not facing antigens similar to the original ones but in the form of a compound with an unknown and unpredictable toxicity and efficacy.**

Not only vaccine antigens have been not detected, there were also 65 signs of chemical contaminants of which only 35% is known, there are among these various processing residues and cross-contaminations from other manufacturing lines, and their identification will be checked during the second level of the analytical study (i.e. with standard controls).

7 chemical toxins among these signals have also been identified, probably deriving from chemical contaminants of the manufacturing process or other manufacturing lines at the vaccine manufacturing site; these toxins have a structure that could probably be partially derived from the formaldehyde, glutaraldehyde and cyanogen bromide reaction with other chemical contaminants in the vaccine. We'd like to point out that **the toxicity of many of these toxins have been confirmed and published in Pubchem or Toxnet** and **this poses important safety problems, issues and concerns.**
From the protein and peptide fraction study, various free peptides of bacterial origin have been obtained probably coming from the bacterial culture cells used for the antigen extraction. **Literature reports bacterial peptides as potential allergens 5 and also as capable of inducing autoimmune reactions 6 and these too put a safety issue that needs to be further clarified with the regulatory bodies.**

Coming back to the two basic principles that have been our topic on this analysis path, we reaffirm what we have said in the recent interview on the scientific journal Nature: we are inquiring the vaccines efficacy and safety and we can't quite understand how it is possible to claim that this vaccine is even able to generate the 6 protective antibodies - reason why it is designed for - and furthermore to understand how this cluster made of 6 neurotoxic antigens bound together can be claimed as not toxic for newborns.

Infanrix Hexa hexavalent, as for the method we have commissioned, casts major doubts on both its effectiveness and on its safety…

One thing is for sure: we will not stop to proceed."

https://www.corvelva.it/speciali-corvelva/analisi/vaccingate-initial-results-on-infanrix-hexa-chemical-composition.html

Other vaccines tested including Gardasil, Merck's HPV vaccine were found to have similar shocking results

The next vaccines they tested yielded similar results. Another 6-in-1 vaccine Hexyon manufactured in a partnership between Sanofi Pasteur and Merck (MSD) and Gardasil 9 made by Merck.

The following quotes are from an article found on the web site ***Vaxxter*** titled, **Exposing Vaccine Contamination – More Results from Corvelva**

Hexyon-

"Hexyon is a six-in-one shot to vaccinate against diphtheria, tetanus and pertussis (DTaP), polio, hepatitis B and Haemophilus influenza b (Hib). It is called a six-in-one vaccine; however, 8 vaccine antigens are actually present because the polio vaccine has three antigens (three separate viruses). The vaccine, manufactured by a partnership between Sanofi Pasteur and MSD (Merck), was approved for use in 2013 in Western European Countries; simultaneously, it was approved for use in Eastern European countries under the brand name Hexacima. Here is the package insert."

Gardasil 9-

"Even though Gardasil is not mandatory in Italy, the vaccine has been associated with a large number of serious injuries and even death in countries around the world, including the US. Gardasil, the vaccine promoted to prevent cervical cancer and venereal warts associated with human papillomaviruses (HPV), was approved for use in girls in 2006 and then approved for boys in 2009. The vaccine contained four antigens: HPV subtypes 6, 11, 16 and 18."

"In 2014, the FDA approved Gardasil 9 for use in girls. The following year, it was approved for boys and in 2018, approval was granted to give Gardasil 9 to individuals up to 45 years of age. The new formulation added five HPV subtypes to the mix – 31, 33, 45, 52 and 58 – and increased the amount of aluminum in each injection from 250mcg to 500mcg."

https://vaxxter.com/exposing-vaccine-contamination-more-results-from-corvelva/

Corvelva's analysis of Gardasil 9 found:

- Only 7 of 9 HPV antigens were present; subtypes 11 and 58 **were not detected.**
- **338 signals** of chemical contaminants were detected, of which **78% were unknown.**
- **10 chemical toxins**, thought to be cross-contaminants from manufacturing of other vaccine production lines.

Results of Corvelva's analysis:

"Presence of adventitious genetic material in residual quantities. The following essential points can be summarized:

Presence of adventitious genetic material as DNA:

- **Bacteria: The percentage is significant: 54% of the total DNA**, the contamination can derive mainly from yeast culture, but also from contaminants in the laboratory; more blanks have been made to minimize the error due to environmental contamination, but we will have more accurate data when we make replicates with other laboratories. **The bacterial DNA could**

interact with the adjuvant aluminum and cause allergies, inflammation and autoimmunity. Data to be confirmed.

- **Human and Mouse DNA: their origin is not known!** It may be that human DNA could instead be a cross-contamination from other cell lines used for the production of vaccines (it is a hypothesis). **These DNA could interact with the adjuvant aluminum and cause inflammatory and autoimmune reactions.**
- **Adventitious viruses:** fragment L1 of the HPV virus double strain DNA – comes from the antigen manufacturing process; **it is a contaminant because it poses safety problems as it is not degraded and remains in the macrophages linked to the adjuvant aluminum for a long time; its biological effect is not fully known but it can probably be integrated into the host DNA, stimulate inflammation through the production of proinflammatory cytokines and autoimmune reactions (see research by Prof. Lee).**
- **Phages:** they derive from the manufacturing process, **they are adventitious contaminants of unknown hazards. Can antibodies against phages interact with bacteria in the intestinal bacterial flora? Can they integrate into the bacterial flora?**
- **Molluscum contagiosum virus: it belongs to the family Poxviridae, subfamily Chordopoxvirinae, genus Molluscipoxvirus. The term pox contained in the name of these viruses comes from the vesicles (poxes) produced be the smallpox virus.**
- **Retrovirus: potentially integrated into DNA; they can cause neoplastic transformation and mutations of the host genome; they derive from the contamination of human and mouse DNA, such as possible cross-contamination with other cell lines.**
    - **Mouse leukemia virus.**
    - **Human endogenous retrovirus K.**

Adventitious genetic material present as RNA:

- **Bacteria**: the transcripts indicate that the bacteria are present and active during the manufacturing process.
- **Synthetic constructs (artificial sequences):** they may derive from the antigen production process by genetic recombination with the plasmid; **they are potentially able to recombine with human DNA; the link with the adjuvant aluminum can extend and enhance the biological effect (inflammation and autoimmunity).**
- **Yeast and its viruses** (L-BC virus and narnavirus): **yeast RNA can give rise to allergenic proteins** (which can bind to adjuvant aluminum), while viruses are not known for effects on human cells and microbiota.
- **Infectious equine anemia virus and mouse leukemia virus: (the latter) is present both as DNA and RNA and therefore it's a complete virus). These viruses derive from the contamination of raw materials and must not be present."**

On one hand this news is shocking, but on the other hand, it isn't. With zero accountability or oversight for the production, quality or damage caused by vaccines, the manufacturers have no motivation to produce safer and more effective products. They are making HUGE amounts of money with no liability.

Assumption #2b- There is no connection between the MMR vaccine, mercury or aluminum and autism (or any other type of neurological or behavioral condition affecting children for that matter)

Although this assumption addresses the MMR vaccine specifically, this eBook will refute that claim and not just for the MMR vaccine's contribution, but also with the ever-expanding vaccine schedule and the dangerous levels of aluminum and other suspects being injected into our children.

The school bus parody video mentioned earlier also made this untrue statement … "there is zero evidence that vaccines cause autism or mental disorders of any kind."

THAT IS DEAD WRONG!!! Read on and see for the EVIDENCE for yourself….

The sad truth is, that this is the same message that is conveyed through the media, doctors and the pharmaceutical industry.

So let's take a detailed look at what we have come to know as Autism, or Autism Spectrum Disorder (ASD)

AUTISM

Here is a wide range of autism facts and statistics

Bear in mind that the autism spectrum disorders are not the only conditions that are implicated. Numerous other neurological, immunological, learning and behavioral conditions will be covered later in this document. Autism gets the most press, so we will start there.

Before we even discuss the relationship of vaccination and autism, I think it **is vital to present some statistics about autism spectrum disorder (ASD).** Aside from the obvious suffering and tragedy that autistic individuals and families experience, I think it is important to establish the extreme gravity of what is happening and the rate that it is accelerating.

When was autism first recognized?

According to the testimony of Mark Blaxill, Board Member of ***SafeMinds*** before the ***Committee on Oversight and Government Reform, US House of Representatives*** on November 29, 2012, the childhood behavioral spectrum we now call autism was non-existent prior to 1935.
https://oversight.house.gov/wp-content/uploads/2012/11/Blaxill-Testimony-Bio-TnT.pdf

From his testimony:
"In 1935, John Hopkins professor named Leo Kanner wrote the world's first textbook on Child Psychiatry *(actually called **Child Psychiatry** and was the first English language textbook for child psychiatry)*. In 527 pages and 43 chapters, Kanner described every psychiatric condition in children know to medicine at the time. There was no condition remotely resembling autism."

According to the Wikipedia article on him, **Kanner is known as the "father of child psychiatry.**" Kanner was the first physician in the United States to be identified as a child psychiatrist.
https://en.wikipedia.org/wiki/Leo_Kanner

"In 1938, Oliver and Mary Triplett left Mississippi with their five year old son Donald to visit Kanner, by then considered the world's leading authority on children's development. When Kanner met Donald he was fascinated. He had never seen a child like him."

"In 1943, Kanner wrote a paper *(titled **Autistic Disturbances of Affective Contact**)*, inspired by Donald. "Since 1938," he wrote, "there have come to our attention a number of children *(eleven to be exact),* whose condition differs so markedly and uniquely from anything reported so far, that each case merits-and, I hope, will eventually receive-a detailed consideration of its fascinating peculiarities.""

"The oldest child of the eleven described was born in 1931. Kanner subsequently diagnosed hundreds of children with autism, but never found a case born before 1930. The historical record is clear: before 1930, the rate of autism was effectively zero."

Even as the recognition of autism grew over the years, many believe that **the rate of autism before 1960 was in the neighborhood of one in ten-thousand (1:10,000).**

Fast forward to today…

These facts are from the Autism Society's website http://www.autism-society.org/what-is/facts-and-statistics/ **.**

- About 1 percent of the world population has autism spectrum disorder. (CDC, 2014)
- More than 3.5 million Americans live with an autism spectrum disorder. (Buescher et al., 2014)
- **Prevalence of autism in U.S. children increased well over 100 percent from the year 2000 (1 in 150) to 1 in 59 according to CDC's 2014 ADDM statistics).** https://www.cdc.gov/ncbddd/autism/data.html **The CDC's NHIS Report November 2015 cited a 1 in 45 autism rate for the year 2014).**
- Autism is the fastest-growing developmental disability. (CDC, 2008)
- **Prevalence has increased by 6-15 percent each year from 2002 to 2010.** (Based on biennial numbers from the CDC)
- **Autism services cost U.S. citizens $236-262 billion annually**. (Buescher et al., 2014)
- A majority of costs in the U.S. are in adult services – $175-196 billion, compared to $61-66 billion for children. (Buescher et al., 2014)

- Cost of lifelong care can be reduced by 2/3 with early diagnosis and intervention. (Autism. 2007 Sep;11(5):453-63; The economic consequences of autistic spectrum disorder among children in a Swedish municipality. Järbrink K1.)
- 1 percent of the adult population of the United Kingdom has autism spectrum disorder. (Brugha T.S. et al., 2011)
- **Children and adolescents with ASD had average medical expenditures that exceeded those without ASD by $4,110–$6,200 per year. On average, medical expenditures for children and adolescents with ASD were 4.1–6.2 times greater than for those without ASD.** https://www.cdc.gov/ncbddd/autism/data.html
- **In 2005, the average annual medical costs for Medicaid-enrolled children with ASD were $10,709 per child, which was about six times higher than costs for children without ASD** ($1,812). https://www.cdc.gov/ncbddd/autism/data.html
- Over and above medical costs, the cost of intensive behavioral interventions for children with ASD **cost $40,000 to $60,000 per child per year**. https://www.cdc.gov/ncbddd/autism/data.html
- **The U.S. cost of autism over the lifespan is about $2.4 million for a person with an intellectual disability, or $1.4 million for a person without intellectual disability**. (Buescher et al., 2014)
- 35 percent of young adults (ages 19-23) with autism have not had a job or received postgraduate education after leaving high school. (Shattuck et al., 2012)
- It costs more than $8,600 extra per year to educate a student with autism. (Lavelle et al., 2014) (The average cost of educating a student is about $12,000 – NCES, 2014)
- **It is estimated that the lifetime cost of raising a child with autism is somewhere between $3 and $5 million**. https://tacanowblog.com/2015/07/30/the-annual-cost-of-autism-continues-to-soar/

Diagnosis (from CDC https://www.cdc.gov/ncbddd/autism/data.html)

- Research has shown that a diagnosis of autism at age 2 can be reliable, valid, and stable.
- Even though ASD can be diagnosed as early as age 2 years, most children are not diagnosed with ASD until after age 4 years. The median age of first diagnosis by subtype is as follows.
    - Autistic disorder: 3 years, 10 months
    - ASD/pervasive developmental disorder (PDD): 4 years, 8 months
    - Asperger disorder: 5 years, 7 months
- Studies have shown that parents of children with ASD notice a developmental problem before their child's first birthday. Concerns about vision and hearing were more often reported in the first year, and differences in social, communication, and fine motor skills were evident from 6 months of age.

Autism Statistics from various reporting agencies show the growth of autism is reaching epidemic proportions

The CDC is involved with 3 different monitoring systems which use different methods for gathering data

The consensus is that looking at all three statistical methods will give a more complete overview of the prevalence and demographics of autism. Keep this is mind as you look at the different findings of studies and reports in this document. This is one reason why you may see a discrepancy in the prevalence of autism in the same or nearly the same year reported by the different monitoring systems. Despite that variance, the sad reality is that all three are showing a steady and dramatic increase over the last 30 years that continues today.

The 3 systems are:

The Autism and Developmental Disabilities Monitoring Network (ADDM) –

According to the CDC, "The Autism and Developmental Disabilities Monitoring (ADDM) Network is the only collaborative network to track the number and characteristics of children with autism spectrum disorder (ASD) in multiple communities in the United States." The report evaluates the prevalence of ASD in 8-year-olds and is released every 2 years. The most recent report from 2014 received data from 11 different sites in various parts of the country.

The National Health Interview Survey (NHIS) –

Since 1997, this parent answered survey has included questions as to whether a child has ever been diagnosed with Autism Spectrum Disorder (ASD), Intellectual Disability (ID) and Developmental Delays (DD).

National Survey of Children's Health (NSCH) –

This is a survey covering all 5o states and the District of Columbia. It is taken via telephone and covers- Physical and emotional health; factors that may relate to well-being of children, including medical home, family interactions, parental health, school experiences, and safe neighborhoods. It was taken in 2003, 2007, 2011-12 and annually since 2016. Apparently, according to the ChildHealthData.org website, the method of sampling, data collection and wording of questions changed in 2016, therefore comparisons to previous years will not yield an accurate trend analysis.
http://childhealthdata.org/browse/compare-data-across-states/multiple-indicators

View the 2016 "Hot-Spotting" table of all 50 states for the National Outcome Measures for different health related categories including Autism and ADD/ADHD here:
http://childhealthdata.org/browse/compare-data-across-states/multiple-indicators/title-v-national-outcome-measures-nsch-2016

A fourth method of data collection on autism is operated by the U.S. Department of Education. It comes under the Individuals with Disabilities Education Act (IDEA)

In this tracking system, children utilizing special needs are categorized by age, birth to age 2, children ages 3-5, students and children from 6-21 years of age.

According to the most recent report, the **39th Annual Report to Congress on the Implementation of the *Individuals with Disabilities Education Act*, 2017**, (citing up to 2015 data), there has been a steady increase in the number of children with autism served under these programs over the last 11 years.

- From 2004 to 2015, the percentage of the total U.S. population of children and young adults ages 6 to 21 served with autism, has risen from .2 percent to .7 percent.
- For 2015, the percentages of children ages 3-5 served within the IDEA system by disability category are as follows:
    - Speech or language impairment- 43.3%
    - Developmental delay- 37.4%
    - Other disabilities combined- 9.8%
    - Autism- 9.5%

https://www2.ed.gov/about/reports/annual/osep/2017/parts-b-c/39th-arc-for-idea.pdf

Historical prevalence and growth of autism rates with tables showing 2006 data on number of vaccine doses compared to infant mortality of 34 countries

According to a paper published by ***Generation Rescue*** in 2009, titled **AUTISM AND VACCINES AROUND THE WORLD: Vaccine Schedules, Autism Rates, and Under 5 Mortality**, **AUTISM PREVALENCE** in the United States has soared. In 1970, Treffert et. al. published the first known autism prevalence study in the United States, **Epidemiology of Infantile Autism**, with an autism prevalence rate of **less than 1 per 10,000**. In 1987, Burd et. al. published a study, **A prevalence study of pervasive developmental disorders in North Dakota**, showing an autism rate of **3.3 per 10,000**. In 2007, the ***Centers for Disease Control's Autism and Developmental Disabilities Monitoring Network*** released data showing that prevalence of autism had grown to **66 per 10,000 or 1 in 150, an increase of more than 6,000% from the 1970 study.** http://www.rescuepost.com/files/gr-autism_and_vaccines_world_special_report1.pdf

Two different reporting systems come up with slightly different data. Both are alarming!

As you will see from the CDC's 2014 ADDM Network statistics, the prevalence has increased to 1 in 59 births! https://www.cdc.gov/ncbddd/autism/data.html

While this report was released in 2018, it covers data from 2014. That on the surface seems an obvious observation, but what one needs to consider is that **with 4-year-old data and the rate of autism increasing by 10-20 percent per year, if the 2018 numbers could be released now, they would be much worse than the 2014 data.** With the 4 year report cycle, by the time we know today's 2018 autism prevalence, it will be 2022 and we will still be underappreciating the severe gravity of the current situation. My concern in bringing attention to this, is that **by giving the false impression that things aren't currently as bad as they really are, we may be complacent and not push as hard as we need to for answers and actions that will change the trajectory of this looming crisis.**

As you will read in a couple pages, in the CDC's December 18, 2009 issue of the MMWR Report, there was a report released by the CDC titled, **Prevalence of Autism Spectrum Disorders --- Autism and Developmental Disabilities Monitoring Network, United States, 2006**.
https://www.cdc.gov/mmwr/preview/mmwrhtml/ss5810a1.htm

In the report it stated, "The average prevalence of ASDs identified among children aged 8 years **increased 57% in 10 sites from the 2002 to the 2006** ADDM surveillance year. **That represents an average of a 14.25 percent increase annually.**

Another chart from CDC data shows just how much **rates of autism have increased from 2000-2014**. The chart **shows an increase of 1 in 150 to 1 in 59 over that period of time, a 254 percent increase. That works out to an annual average of 18 percent**. https://www.cdc.gov/ncbddd/autism/data.html

If we take the more conservative estimation at 14.25 percent, that means **the increase in the prevalence of autism in these 4-year-old reports may be nearly 60 percent under-reported! At that rate, the 2018 stats may be closer to 1 in 25 or 30 children! And remember, that was the more conservative rate percentage increase. When are people going to demand a halt to everything that could be a possible cause and take a few steps back to re-evaluate EVERYTHING!!!!**

According to CDCs National Health Statistics (NHIS) Report. November 13, 2015 for year ending 2014, 1 in 45 children born in the U.S. will develop autism
https://www.cdc.gov/nchs/data/nhsr/nhsr087.pdf

WOW! This is yet a slightly different estimation from one of those 3 CDC autism reporting systems showing an even more ominous result. Again, this **data was from 2014 and it is now 2018. I'm afraid to even ask, but If 1 in 45 was the number four years ago, what is the current number?!**

As if that is not frightening enough, the CDC latest release, November 2017 of the prevalence of autism shows a shocking increase from 2014 to 2016!

This is critical information to understand!

In what can only be described as shocking, because even though the trends in the increased prevalence of autism and developmental disability were trending upwards sharply for the last 3 decades, this last estimation even exceeds that devastating trajectory. This report compares the percent with these neurodevelopmental delays to the entire U.S. population between the ages of 6 and 21 years of age.

From the NCHS Data Brief Report:
From 2014 to 2016, the prevalence of children aged 3 to 17 with the following categories increased:

- Autism Spectrum Disorder changed from 2.24 to 2.76 percent ***(just over one half a percent)***
- Diagnosed with a developmental disability increased from 5.7 to 6.99 percent.
- Diagnosed with "Other developmental delay" increased from 3.57 to 4.55 percent.

Source: https://www.cdc.gov/nchs/data/databriefs/db291_table.pdf#1

Keep in mind that **this is only over a two-year period**, which represents a very significant increase in all categories. **The report tries to downplay the INCREASE in autism by saying that the rate "did not change significantly". If a half a percent is not significant, then let's extrapolate it out over 10 years. That would be a 5 percent increase. This represents hundreds of thousands of additional cases. In 20 years, it would represent a 10 percent increase, representing millions of new cases.**

What are the real numbers in lives impacted?

The statisticians love to downplay small numbers because it trivializes the threat and "makes sense" to the average non-mathematics/statistics-oriented person. To put things into perspective, according to the last U.S. Census of 2010, the number of children in the U.S. between the ages of 3-17 was approximately 64 million (that's 64,000,000). One percent of 64,000,000 is 640,000. One half of one percent is therefore 320,000. Now let's look at that "non-significant" number in the increase of autism and the ramifications of that over that two-year period from 2014 to 2016. The increase was *just over* one half of one percent in that 2-year period. The real cost in human lives devastated by autism, is somewhere in the neighborhood of 330,000 additional cases! Not to mention, typically each child has two parents. That's another 660,000 individual's lives, that were deeply impacted by having a child develop ASD. To drive home the point, that is 990,000 (nearly a million) people in just a two-year period whose lives have been changed forever! This is NOT trivial!

Now back to the 20-year 10 percent increase in the numbers, based on that "non-significant amount". If one percent of that 68,000,000 is 680,000, then 10 percent is 6,800,000! Yes, that is 6.8 MILLION NEW CASES OF AUTISM! And that is not even accounting for population growth!

To make matters even worse, the numbers I am citing are year 2010 population statistics, https://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf **. In the 8 years since 2010, the 3 to 17-year-old population has increased. How much exactly we don't know for sure, but the 2020 census will tell us more accurately. And with the rate of autism steadily increasing, the 2020 numbers promise to shake any person with an intellect and a conscious to the core.**

To put an exclamation point on these shocking numbers, we are only dealing with the INCREASE in the two-year period. The 2016 estimated percentage of the age 3-17 population with autism was 2.76 percent. That means that ONE MILLION SEVEN HUNDRED THOUSAND, FOUR HUNDRED (1,700,400), CHILDREN BETWEEN THE AGES OF 3 AND 17 HAD EVER BEEN DIAGNOSED WITH AUTISM IN 2016! That was 330,000 more cases than in 2014. Some estimates put the current percentage of children in the U.S. with autism at 3 percent. With a modest increase in the population of 3 to 17-year-olds by 2018 from the 2010 number to 66,000,000, 3 percent represents approximately 2 MILLION CASES of AUTISM in 3 to 17-year-olds!

Now go ahead and consider the even larger percentage increases of "other" developmental delays of nearly 1 percent up to 4.55 percent and developmental disabilities increased 1.3 percent up to 7 percent. The number of developmental disabilities in the 3 to 17-year-old population is 4,480,000. The number of 3 to 17-year-olds classified with other developmental delays numbers approximately 2,912,000.

Absolutely staggering statistics on autism and developmental problems

So, what are the 2016 totals of just those 3 categories of neurobehavioral disorders in 3 to 17-year-olds?

- **Autism- 1,700,400**
- **Developmental Disabilities- 4,480,000**
- **Other Developmental Delays- 2,912,000**

The Total = 9,092,400 or 14.2 percent of the total number of 3 to 17-year-olds!

That is 1 in 7 children!

Let that sink in a minute…

UPDATE: The updated total number of individuals diagnosed with ASD in the U.S. as of the end of 2017 is 1,725,297 according to the ***Title V National Outcome Measure #17.3: Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder.*** Look at the increase from 2016 to 2017. It represents an additional 24,897 children added!

We MUST demand that the government and independent academic and scientific groups undergo extensive INDEPENDENT AND UNBIASED research to find out what is happening to our children!

At the currently increasing rates of prevalence the outcome by 2032 will be devastating, with an estimated 1 in 2 children being autistic!

According to the National Health Statistics Reports, (Number 87, November 13, 2015), **1 in 45 children ages 3-17 have autism…** https://www.cdc.gov/nchs/data/nhsr/nhsr087.pdf **Consider that approximately 4 times as many boys as girls have autism, the number of boys diagnosed is much higher than that**. These rates are up from 1 in 150 in the year 2000. This information was gathered in the form of a survey called the **2014 National Health Interview Survey**. **The survey also looked at Developmental Delays and Intellectual Disability. It found the prevalence of autism was 2.24% which was a significant increase from the 2011-2013 data of a 1.25% prevalence.** The researchers believe that a portion of that increase was due to the fact that in previous years, "some parents of children diagnosed with ASD reported this developmental disability as other Developmental Delay (DD) instead of, or in addition to, ASD."

According to government statistics, in 2015, close to 4 million children were born in the U.S. That means that approximately 89,000 of those children will develop an Autism Spectrum Disorder. Due to the trajectory of the steepening curve, **some estimates are that by the year 2032, 1 in 2 boys born in the U.S. will suffer from ASD.** Therefore, these already frightening numbers stand to increase exponentially! **If that bears out and 5 million children are born in 2032, and 51 percent of live births are boys** (http://www.pnas.org/content/112/16/E2102), **that would mean that of 2,550,000 boys born, 1,275,000 will develop autism! That is 14X more boys developing autism annually than are currently suffering this life-long disability.** Add the girls that will develop autism and you would add around 283,000 more, bringing **the total number to 1,558,000 children.** The **current** annual costs at $250 billion, will grow to massive proportions! **This is catastrophic!!**

Also, it is important to consider that these statistics do not cover many other developmental, neurological (like ADHD) and immunological effects (like allergies, asthma and autoimmune disorders) that are now being associated with vaccine injury in the scientific literature. Just think about the cumulative effect personally and economically of the dramatic rise in prevalence of all of these conditions!

The increased rates of autism may be in part due to changing diagnostic criteria and a recognition of milder versions of ASD, but **the data between 2007 and 2012 shows a 72% increase** which cannot be solely attributed to those factors. **That's an annual increase of 14.4 percent**. It's clear that the incidence of autism continues to increase. https://www.cdc.gov/nchs/data/nhsr/nhsr065.pdf

2019 study from JAMA Pediatrics acknowledges the rising rates of autism and identifies significant variations between different states

A 2019 study from JAMA Pediatrics titled, **Prevalence and Treatment Patterns of Autism Spectrum Disorder in the United States, 2016**, identifies various trends in rates of autism and treatment prevalence. **It considered 43,032 children ages 3-17**. https://www.ncbi.nlm.nih.gov/pubmed/30508021

From the abstract:
"Autism spectrum disorder (ASD) is a complex neurodevelopmental disorder. Previous surveys have reported a steady increase in ASD prevalence in US children over the past decades."

"This study showed that the prevalence of ASD in the United States was relatively high, and it varied substantially across US states."

Let's do some math….

The state-level prevalence of **ever-diagnosed ASD** varied from 1.54% in Texas to 4.88% in Florida. What strikes me about that, is the Florida rates at 4.88% (call it 5%) means that nearly 1 in 20 children have been diagnosed with autism! Since boys are diagnosed at a rate that is approximately 4 times that of girls, that would suggest that as many as 1 in 12.5 boys have been diagnosed as on the spectrum!

Here's how I got there so you can check my math…

- 1 in 20 diagnosed (DX), with ASD, is **equal to 5 in 100** (total boys and girls, so assuming 50 boys + 50 girls).
- Rates of autism are typically **4X greater in boys** than girls. So, **of those 5 out of a hundred, 4 would be boys.** (That is why I want to focus on the boy's numbers)
- If 50 of those 100 children are boys and 50 are girls, then **4 out of the 50 boys are DX with ASD** and 1 out of 50 girls are DX with ASD.
- **4 out of every 50 boys is equal to 1 out of every 12.5 boys! That is catastrophic!**

So according to the statements in the article, the acknowledgement apparently exists by JAMA Pediatrics, that there has been a precipitous rise in the rate of autism over the past decades. They even report that 1 in 13 boys in Florida are autistic. Then one has to ask the question. Why is no one at JAMA Pediatrics asking the question….WHY? I would think there would be a desperate search for answers! The quest to find the source would-be front-page news! But all we hear is crickets. So, then I must ask the question. Is it because they really don't want to know?

See a map comparing the prevalence of autism from all 50 states compared to the US average based on the National Survey of Children's Health (NSCH)

The numbers on the map represent the percentage of those children whose parents answered the question as to whether their child had EVER been diagnosed with autism.

http://childhealthdata.org/browse/rankings/maps?s=152

***One note of caution.** When looking at the results of these surveys, they often ask two different questions. One is, has your child EVER been diagnosed with autism? The other is, is your child currently diagnosed as having autism? The "ever" question garnishes a higher percentage of affirmative response. So, when looking at data representing a percentage of children with autism, that should be taken into consideration. Polling can skew results one way or the other depending on what the organization doing the polling wants the outcome to be, or who they want it to favor.

Aside from autism, developmental disabilities of various forms are epidemic

According to the CDC, "Recent estimates in the United States show that about one in six, or about 15%, of children aged 3 through 17 years have one or more developmental disabilities."
(Trends in the Prevalence of Developmental Disabilities in US Children, 1997–2008. Pediatrics. 2011; 27: 1034-1042). https://www.cdc.gov/ncbddd/developmentaldisabilities/about.html

Not only that, but their statement suggests the scope of the problem and that they usually suffer from them the rest of their life. "Developmental disabilities are a group of conditions due to an impairment in physical, learning, language, or behavior areas. These conditions **begin during the developmental period**, may impact day-to-day functioning, **and usually last throughout a person's lifetime**."

This statement from the CDC corroborates the section above in which I laid out the numbers of children ages 3 to 17 with autism and the 2 major categories of the developmental delays and disabilities **at 14.2 percent.**

The CDC's report released in November 2017 titled, **Estimated Prevalence of Children With Diagnosed Developmental Disabilities in the United States, 2014–2016** states, "During 2014–2016, the prevalence of children ever diagnosed with any developmental disability significantly increased, from 5.76% in 2014 to 6.99% in 2016." Now on the surface, that would appear like the stats are better 6.99%) than reported above in the 2011 report (approximately 15%), but consider this statement from the 2017 CDC report… "The prevalence of developmental disabilities described in this report is lower than findings described in previous reports using NHIS data (1). **This report uses a more restrictive definition for a developmental disability that does not include conditions such as attention-deficit/hyperactivity disorder or learning disabilities, which may account for differences in estimates**."
https://www.cdc.gov/nchs/products/databriefs/db291.htm

Well there you go. **One has to be very careful when looking at statistics on the surface. Changing diagnostic criteria or definitions can give the appearance that things are getting better or even getting worse.** Even where the samples are taken from can manipulate the data. For instance, **if the government sampled rates of autism from certain states where the prevalence is lower, it would not be representative of the average incidence nationally. It could be made to look as though the rates are not climbing as rapidly as they really are. Stay tuned. You will see more on this in this document.**

Rates of autism keep going up and are being diagnosed at earlier ages

In the CDC's December 18, 2009 issue of the MMWR Report, there was an article titled, **Prevalence of Autism Spectrum Disorders --- Autism and Developmental Disabilities Monitoring Network, United States, 2006**. https://www.cdc.gov/mmwr/preview/mmwrhtml/ss5810a1.htm

In that article they looked at 8-year-olds and considered the median age in months for which children were first diagnosed with ASD. The first study had data collected in 2002 and compared the results with those in a second study in 2006. It compared 10 sites in different states where this data was collected. **On average, the age at which ASD was initially diagnosed was 4.4 months earlier in 2006 than in 2002. That begs the question, is this due to the fact that ASD is being recognized at an earlier age, or are children developing it earlier in life.** The beginning of the 2009 MMWR Report says, "Autism spectrum disorders (ASDs) are a group of developmental disabilities characterized by atypical development in socialization, communication, and behavior. ASDs typically are apparent before age 3 years, with associated impairments affecting multiple areas of a person's life."

"**The average prevalence of ASDs identified among children aged 8 years increased 57% in 10 sites from the 2002 to the 2006 ADDM surveillance year**. Although improved ascertainment accounts for some of the prevalence increases documented in the ADDM sites, a true increase in the risk for children to develop ASD symptoms cannot be ruled out. On average, although delays in identification persisted, ASDs were being diagnosed by community professionals at earlier ages in 2006 than in 2002."

"These results indicate an increased prevalence of identified ASDs among U.S. children aged 8 years and underscore the need to regard ASDs as an urgent public health concern." Do you think? That was 2009, nearly 9 years ago. If the concern was URGENT nine years ago, don't you think more would have been done by now?

ADDM statistics called into question by the Editor-at-Large of Age of Autism

As bad as the autism statistics are, they may actually be much worse. **Mark Blaxill** is the Editor-at-Large at ***www.ageofautism.com*** . He wrote a scathing critique of the way he feels that the CDC manipulates statistics to make the autism epidemic look less catastrophic. He goes into great detail in his criticisms.

Here are four of the things he questions:

1. **They (the CDC), "officially" started tracking autism statistics in 1992 for comparison sakes, rather than a few years earlier**. The statistics from the example he uses from New Jersey, showed "that among children born 1988 or 1989, there were exactly ZERO cases of full syndrome autism; yet by the 1993 birth year the full syndrome rate had soared to 1 in 128." By comparing current statistics to 1992, they don't seem as dramatic as if they compared to the mid 1980's which some sources put at 1 in 5,000.

2. **They hide behind diagnostic criteria changes and don't control for their effect.** The criteria for diagnosing autism keeps changing. This could lead to the false appearance that the rates of autism are climbing at a slower rate than they really are.
3. The Autism Developmental Disabilities Monitoring (ADDM) system, a project of the CDC reports on the prevalence of autism in specified states every two years. **They keep including and eliminating certain states that they draw their statistics from. This leaves the appearance of a shell game, which could be a way of hiding data from the final outcome**. Essentially, they would cherry pick the states they want rather than staying with the same ones, which would give a more reliable comparison to previous years. See pages 5-8 of the report below for specific details.
4. **They suppress the evidence supporting the upward changes in autism rates.**

http://www.ageofautism.com/2010/01/mark-blaxill-lies-damned-lies-and-cdc-autism-statistics.html

Another government agency, the *Office of Special Education and Rehabilitative Services U.S. Department of Education*, report statistics on autism growing at an alarming rate

In an online blog called ***autismpolicyblog.com***, John J. Pitney summarizes **the 37th Annual Report to Congress on the Implementation of the *Individuals with Disabilities Education Act (IDEA)*, 2015** as it pertains to the statistics on the increased rates of children throughout the country, including the District of Columbia and Puerto Rico, who were served under IDEA with autism between the 5-year period from 2008-2013. **Remarkably, 39 of 50 states had a greater than 50 percent increase and 2 states, Mississippi and Florida rates well-exceeded 100 percent, at 149.3 and 117.3 percent respectively.**
http://www.autismpolicyblog.com/2016/02/idea-stats-huge-percentage-increases-in.html

This chart shows that the rates of autism are growing at an increasing rate

This chart from ***CDC*** data shows just how much rates of autism have increased from 2000-2014. The chart **shows an increase of 1 in 150 to 1 in 59 over that period of time, a 254 percent increase**. That works out to an annual average of 18 percent. https://www.cdc.gov/ncbddd/autism/data.html
Other data from CDC: https://www.cdc.gov/ncbddd/developmentaldisabilities/features/birthdefects-dd-keyfindings.html#

While the diagnostic criteria have changed over the years, as has the awareness of autism and developmental delays, these alone do not come close to explaining why the incidence has skyrocketed to this extent in the last 50 years.

The rate of autism for kindergarteners in California public schools jumped a whopping 17 percent in 2016

According to a report in the ***Sacramento Bee*** dated July 18, 2016, the state experienced an increase of 7 percent in the number of autistic children in the public schools, with the kindergarten level increasing by 17 percent. According to the writer Phillip Reese, the rates of autism in California Public Schools has risen 700 percent since 2001. https://www.sacbee.com/site-services/databases/article90300877.html

So how does the rate of vaccination in California compare to the rest of the country?

According to the CDC's report titled, **Health, United States 2016**, the 2015 **national average** of vaccine coverage for the Combined 7 Vaccine Series* for 19-35 month-olds is 72.2%.
https://www.cdc.gov/nchs/data/hus/hus16.pdf#066

The 7 Vaccine Series consists of:

- 4 or more doses of the combination Diphtheria, Pertussis, Tetanus vaccines
- 3 or more doses of any Poliovirus vaccine
- 1 or more doses of a measles containing vaccine
- 3-4 or more doses of the HiB vaccine
- 3 or more doses of the Hep B vaccine
- 1 or more doses of the Varicella vaccine
- 4 or more doses of the Pneumococcal conjugate vaccine

According to a Washington Post article April 13, 2017, titled, **California vaccination rate hits new high after tougher immunization law**. According to the article, "State public health officials released data this week that showed that **nearly 96 percent of this year's kindergartners have received all the required vaccines.** That's a nearly three-point increase over last year, health officials said."

The article indicates that the rate of immunization for children starting kindergarten for the prior school year of 2015-2016 school year, was 92.8 percent.

https://www.washingtonpost.com/news/to-your-health/wp/2017/04/13/california-vaccination-rate-hits-new-high-after-tougher-immunization-law/?utm_term=.431ce3ad7a64

Comparing that 92.8 percent vaccination coverage in California to the national average of 72.2 percent, makes one wonder if there is a correlation to the 17 percent rise in kindergarteners with autism reported on the previous page? I'm not saying it is the case, but it sure makes you wonder.
California has one of the toughest mandatory vaccine laws in the country (SB277). The law was approved June 30, 2015 and enacted in 2016. The law mandates that children entering public school be fully up to date on all of their vaccinations. The law removes personal belief exemptions.

List of states that the rate of autistic children being served in the IDEA system has exceeded 100% increase from 2008-2015

As reported in the **39th Annual Report to Congress on the Implementation of the *Individuals with Disabilities Education Act*, 2017**, the rates of children with autism in some states far exceeds others.

On page 137-138 0f the report, there is a list of states in alphabetical order showing the percentage of children served in the IDEA System in 2008 and 2015, the change **between 2008 and 2015 and the percentage of change. The average percentage increase across the country was 83 percent.**

Here is a list of states with greater than a 100 percent increase from lowest to highest:

Alaska- 102.8%
Nevada- 104.6%
Alabama- 106.8%
Texas- 107.9%
Oklahoma- 108.5%
New Hampshire- 109.3%
Virginia- 112.1%
Colorado- 113.3%
Kentucky- 115.9%
D.C.- 128.4%
New Mexico- 131.6%
South Carolina- 144.1%
Florida- 158.4%
Puerto Rico- 162.9%
Mississippi- 185.6%
BIE Schools- 203.7% (Bureau of Indian Education Schools)

The S.E.E.D. project is an ongoing research effort by the CDC, to identify trends and factors that may be contributing to the epidemic of autism and developmental delays in our children

S.E.E.D. stands for, Study to Explore Early Development and is an ongoing effort to identify trends and factors in the increasing incidence of autism and developmental delays in children. Currently there are 6 states involved in the research, Colorado, Wisconsin, Missouri, Maryland, North Carolina and Georgia.

Since approximately 1 in 6 children suffer from developmental delays of various types and 1 in 45 develop autism, **this is a national crisis.** This is a complicated issue and much work needs to be done to understand all of the contributing factors, so that critical action steps can be taken to abort the disastrous consequences. **It is estimated that in the mid 70's only 1 child in 30 suffered from developmental delays and 1 child in 5,000 developed autism*** (*Source: Autism Speaks).
For more information on S.E.E.D.: https://www.cdc.gov/ncbddd/autism/seed.html

U.S. and Canadian government statistics show rates of autism compared to vaccine coverage in 8-year-olds show strong correlation

CDC MMWR Vaccination Coverage Among Children in Kindergarten — United States, 2011–12 School Year https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6133a2.htm

Vaccines monitored were MMR, DTaP/DT, Polio, Hep B, Varicella (1 or 2 doses)

https://www.cdc.gov/mmwr/volumes/67/ss/ss6706a1.htm

https://www.cdc.gov/mmwr/volumes/67/ss/pdfs/ss6706a1-H.pdf

Social services will be overwhelmed at the current rate of increases

Report from the U.K. shows a dramatic increase in the numbers of individuals waiting for acceptance into special programs

Special education services are becoming increasingly strained and the budgets to support them will not be able to keep up in the future.

An article about parents suing the government over Special Educational Needs Funding (SEND), titled **'High Court told of 'genuine crisis' in special educational needs funding'**, contained the following:

"Jenni Richards QC, for the families, told the court during a hearing on Wednesday that there was "clear and incontrovertible evidence" of a "substantial national shortfall" in funding...**She said the figures showed there were 25,540 young people aged 16-25 in January 2015 with a statement or Education, Health and Care (EHC) plan, which had increased to 84,260 by January 2018**...Government lawyers said the increase in demand was recognised by the ministers and that Mr Hinds had "made it clear" that High Needs would be one of his priorities ahead of the 2019 Spending Review."
https://www.thecanary.co/uk/news/2019/06/26/high-court-told-of-genuine-c...

As reported June 26, 2019 in ***the Independent***, a British online news service, in an article by Elanor Busby titled, **Education is a right': Parents of children with special needs launch legal fight to get government to fund school places**

"Analysis from the National Education Union this week revealed that **more than 8,000 young people with SEND are awaiting provision for a school place**."
https://www.independent.co.uk/news/education/education-news/special-educational-needs-funding-cuts-high-court-government-children-parents-a8974876.html

To contrast that 8,000 plus number with the numbers of those waiting over the last 3 years, **John Stone the U.K. Editor for Age of Autism wrote the following in an editorial:**

"**Just two years ago I wrote in these columns about a rise of "1,710 in 2016 to 4,050 this year**." *(This year being 2017)*
'**The Writing is on the Wall'**, 19 July 2017, https://www.bmj.com/content/357/bmj.j2449/rr-16

My fear is that the rapid increases in funding needs for special education, social services and care for these aging autistic individuals, will eventually eclipse the growing numbers of the elderly with dementia and Alzheimer's Disease, conditions that by themselves are posed to put an unbearable strain economically on society in the next 30 years. What happens when the numbers of autistic children reach 1 in 4 or worse? What will happen as this tidal wave of individuals that can not care for themselves, exceed the lifespan of their parents? Who will take care of them? And, at what cost? Will we need to build large institutional hospitals to care for them as they live out the rest of their days? There will literally be millions to care for, so those hospitals had better be very large and very plentiful. These are real questions that we had better be asking ourselves if we are not going to first identify and then address the root causes of the problem. There needs to be an immediate and urgent effort to investigate the most probable causes for this catastrophic epidemic. And vaccines as suspect number one, should be the first place to start. **Because waiting, is literally NOT an option!**

Who will take care of the ever-increasing numbers of autistic individuals that are unable to care for themselves, as their parents become elderly and pass away?

Imagine if our worst fears are realized and we do not get a grip on this run-away train of an epidemic that is speeding into the station. Are we destined to build hundreds of care facilities and hospitals to "store" these casualties of the autism epidemic where they can live out their lives? How will we pay for that? These are very real and valid questions that no one seems to be asking! This is why it is so urgent to investigate ALL factors that could be associated with this tragedy.

A foreshadowing of an example of the future challenges we will be facing-

In an op-ed written to the British Medical Journal by John Stone, the U.K. Editor for ***The Age of Autism*** in response to and article written by Anthony Harwood titled, **Whorlton Hall: Advisers quit government review in protest at CQC's handling of abuse scandal** (365:doi **10.1136/bmj.l4368).**

"Sadly, Anthony Harwood's reportdoes not surprise me at all: supporting complex autism cases well and appropriately takes immense amounts of time, space and - above all - empathy. Ian Birrell wrote in the Mail on Sunday last October:

"Ministers have failed to meet pledges made after the 2011 Winterbourne View care abuse scandal to empty assessment and treatment units (ATUs) of people with learning disabilities by returning them to families and communities;

"Latest figures show that 2,375 people with learning disabilities are still stuck in these supposedly short-stay units;

"One man has been held an astonishing 18 years. His elderly parents say the experience has been a nightmare and that their son is very depressed, crying when their weekly visits end;

"The number of children in ATUs doubled over the past three years – yet powerless parents are routinely gagged by courts and some have been threatened with having homes seized if they speak out;"

"The NHS spends up to £13,000 a week per person kept in ATUs..."

“It remains a question how we are going to humanely cope as a nation as the autism rate heads beyond 3% in our schools, without Matthew Hancock's Department of Health and Social Care apparently showing the remotest curiosity about why this is happening. Apart from anything else if the correct resources are not made available in the first place you are likely to end up with even more costly and unsuitable answers.”

Fever, one of the most common adverse reactions to vaccines is a hallmark of regression into autism

There are numerous articles in this document that regard fever as one of the most common symptoms a child will experience post vaccination. In light of that, this next article should be cause for concern.

This article, published in the ***Journal of Child Neurology*** in 2010 and titled, **Fever plus mitochondrial disease could be risk factors for autistic regression**, describes fever as a risk factor for autistic regression in individuals who have a genetic mitochondrial defect or disease.
https://www.ncbi.nlm.nih.gov/pubmed/19773461

From the article:
“Because a variety of metabolic disorders, including mitochondrial disease show regression with fever, a retrospective chart review was performed and identified 28 patients who met diagnostic criteria for autistic spectrum disorders and mitochondrial disease. Autistic regression occurred in 60.7% (17 of 28), a statistically significant increase over the general autistic spectrum disorder population ($P < .0001$). Of the 17 individuals with autistic regression, **70.6% (12 of 17) regressed with fever** and 29.4% (5 of 17) regressed without identifiable linkage to fever or vaccinations. **None showed regression with vaccination unless a febrile response was present.”**

These conclusions lead one to draw a very strong correlation with fever post vaccination and autistic regression in susceptible children. These concerns have led many experts to recommend fever control with medication when children are vaccinated. A very serious consideration however, is that as you will see in many of the articles I published in this document, the use of acetaminophen (i.e. as with Tylenol), is also strongly linked to autistic spectrum disorder (ASD). Acetaminophen blocks the body’s production of glutathione, often called the master antioxidant and most potent detoxifier of the body. This obstruction of the body’s ability to clear toxins and heavy metals, will put the child at greater risk of neurological damage. As you can see, all of these different variables can lead to a virtual minefield for genetically susceptible individuals. The more we understand and learn however, about these intricate interactions between genetics, medications and environmental toxicity, the closer we will come to solving this tragic loss of human potential.

The MMRV vaccine has precautions not to give children the first dose under 4 years of age, because of the higher risk of fever and seizure than with the MMR and Varicella vaccines given separately, yet the Vaccine Information Statement form contradicts that

From the CDC's Combination Vaccines parent flyer:

Recommendations for the MMRV Vaccine

"The MMRV vaccine combines the MMR (for measles, mumps, and rubella) vaccine with the chickenpox vaccine."

"Some children who get the first MMRV shot at 12 through 23 months of age may have a higher chance of a seizure **caused by fever after the shot**. But, this is not common. These "febrile" seizures are scary for parents, but they are not harmful to children."

"Because of this slightly higher risk of seizures, The Centers for Disease Control and Prevention recommend that children under 4 years old get the first dose of MMR and chickenpox vaccines separately." Considering the concern that **fever** could be a trigger into regressive autism as discussed in the previous article, that is probably a very good idea.
https://www.cdc.gov/vaccines/hcp/patient-ed/conversations/downloads/fs-combo-vac.pdf

So, get this. The CDC page https://www.cdc.gov/vaccines/hcp/vis/vis-statements/mmrv.html , **showing the Vaccine Information Statement for the MMRV (02-12-18) states the following:**

MMRV Vaccine

"MMRV vaccine **may be given** to children 12 months through 12 years of age. **Two doses are usually recommended:**

- First dose: 12 through 15 months of age
- Second dose: 4 through 6 years of age

A third dose of MMR might be recommended in certain mumps outbreak situations.
There are no known risks to getting MMRV vaccine at the same time as other vaccines.
Instead of MMRV, some children 12 months through 12 years of age might get 2 separate shots: **MMR** (measles, mumps and rubella) and **chickenpox** (varicella). MMRV is not licensed for people 13 years of age or older. There are separate Vaccine Information Statements for MMR and chickenpox vaccines. Your health care provider can give you more information."

So the first CDC page cited says not to give MMR and V together, but then the Vaccine Information Statement makes it sound perfectly OK to do that. Confused yet? Well so am I.

A 2018 report in JAMA Pediatrics finds that parents that have children with autism, refuse some vaccines for their autistic child and their younger siblings

To me, this headline falls into the category of DUH! If you as a parent had a child develop, or regress into autism immediately or shortly after receiving a series of vaccines, wouldn't you be more than a little gun shy about taking them or your other children back in for more doses?

The report, **Vaccination Patterns in Children After Autism Spectrum Disorder Diagnosis and in Their Younger Siblings** published in ***JAMA Pediatrics***, looked at 3729 children with autism spectrum disorder and 592 907 children without autism spectrum disorder to identify trends in continued vaccine compliance after diagnosis with Autism Spectrum Disorder.
https://jamanetwork.com/journals/jamapediatrics/article-abstract/2676070

From the article: "Parents who had a child with ASD were more likely to refuse at least 1 recommended vaccine for that child's younger sibling and to limit the number of vaccines administered during the younger sibling's first year of life."

The "conclusion and relevance" from the article: "Children with ASD and their younger siblings were under-vaccinated compared with the general population. The results of this study suggest that children with ASD and their younger siblings are at increased risk of vaccine-preventable diseases."

At risk? Addressing that their children are "at risk" for vaccine-preventable diseases, when at least one of their children has, at least in the parent's minds already lost the purported odds risk against vaccine injury is kind of like saying, "I know that you have been struck by lightning once, but I still want you to go out on the golf course in the middle of a thunderstorm carrying a 10-foot lighting rod." It shows a tone deafness that, is quite frankly hard to understand or even imagine.

Comparing autism rates from different countries is difficult due to inconsistent diagnostic criteria, erroneous reporting and stigmas toward vaccine reactions and neurologically damaged children

The is a wide disparity between countries as it relates to diagnosing, tracking, managing and reporting statistics on vaccine adverse reactions, rates of neurological, immunological, developmental disabilities, behavioral and learning problems in children. Therefore, one must consider this when looking at these statistics from a 35,000-foot view.

An example is in Poland. Their statistics say that the rate of autism is 3 in 10,000 or approximately 1 in 3,333. https://www.focusforhealth.org/autism-rates-across-the-developed-world/

As compared to the U.S. rate of approximately 1 in 35, that is about 100 times lower. However, according to the European Forum for Vaccine Vigilance, "Poland considerably differs from the majority of European countries and Russia in such an important aspect of life as human rights. Human rights concern vaccination, too. Poland never ratified the European Bioethics Convention. There takes place a permeation of pharmaceutical business and public institutions and decisions about public health are taken by "cronies" – that's what sociologists say (Polish). In Poland there is no *Vaccine Injury Compensation Program* and *Adverse Events Following Immunisation (AEFI, vaccine Adverse Events)* are neither recognized nor reported as it happens in other European countries…. Censorship about the reality of vaccination is very hard and authoritarian here too."

In addition, with the full autism spectrum recognized in most countries, the milder forms are not identified and/or included in the statistical registries.

MERCURY

Scientific Evidence Supporting a Causal Relationship of mercury to autism

Former Director of the *National Institutes of Health* expresses concerns over the vaccine and autism link in susceptible children

In this May 12th, 2008 ***CBS News*** interview of Bernadine Healy M.D., **the Former Director of the *National Institutes of Health (N.I.H.)***, Dr. Healy expresses the concern about **the lack of safety studies** and her belief that **more work needs to be done to identify susceptible children** that would be at a greater risk of vaccine damage. She states that the question has **not** been answered and when she looks at all of the evidence**, it is plausible that vaccines or some components in vaccines may be linked with autism**. She also questions the motives behind the hesitation of doing these studies.
https://www.youtube.com/watch?v=UZFPpHBNp2M

In an April 10, 2008 article written by Dr. Healy for *U.S. News and World Report*, Dr. Healy questions the motives and of the resistance by medicine to doing more safety studies on vaccines.
https://health.usnews.com/health-news/managing-your-healthcare/brain-and-behavior/articles/2008/04/10/fighting-the-autism-vaccine-war

"The debate roils on—even about research. The Institute of Medicine in its last report on vaccines and autism in 2004 said that more research on the vaccine question is **counterproductive**: Finding a susceptibility to this risk in some infants would **call into question** the universal vaccination strategy that is a bedrock of immunization programs **and could lead to widespread rejection of vaccines**. The IOM concluded that efforts to find a link between vaccines and autism "must be balanced against the broader benefit of the current vaccine program for all children." *My comment: In other words, sacrifice the few for the greater good…that sounds like Nazi Germany to me.*

Thimerosal (mercury) and aluminum, are strongly associated with autism, mental, neurological, immunological (including autoimmune disease) and a variety of other disorders

These first 15 studies are just the tip of the iceberg. You will see many more as you read through this document.

The Journal of Developmental Disabilities sounds the alarm about mercury and other immune-toxic exposures in the womb and shortly after birth

A 2012 article, published in the ***Journal of Developmental Disabilities*** titled, **Commentary: A Link Between Mercury Exposure, Autism Spectrum Disorder, and Other Neurodevelopmental Disorders? Implications for Thimerosal-Containing Vaccines** reveals some very disturbing facts.
http://oadd.org/wp-content/uploads/2012/01/41011_JoDD_18-1_34-42_Tomljenovic_et_al.pdf

Abstract: "Autism is a multisystem developmental disorder characterized by dysfunctional immunity and impaired brain function. Although autism is partly determined by genetic susceptibility factors, reported dramatic increases in the prevalence of autism in developed countries have intensified scientific focus on environmental exposures. Pre- and perinatal immunotoxic insults are now strongly suspected as contributors to this increase. Mercury (Hg) is both a neuro- and an immunotoxin and continues to be used in some pediatric vaccines in the form of the preservative thimerosal. Although currently there are no direct human studies on the risks of Hg exposure from thimerosal-containing vaccines (TCVs), animal studies show that doses relevant to human TCV exposure can result in adverse neurodevelopmental outcomes. To date, TCVs continue to be administered on a regular basis to potentially the most vulnerable populations: pregnant women and children. **In light of existing experimental evidence, the rationale for using this known immunotoxic and neurotoxic substance in human vaccines should be reconsidered."**

The article makes another important statement.

People with disabilities: "There is no data on safety of TCVs in people with autism or developmental

disabilities. Historically, vaccine trials have routinely excluded individuals with a variety of pre-existing conditions. These include personal or family history of developmental delays or neurological disorders." "This lack of relevant safety data should be of concern, since cases of deaths following vaccination in children with developmental disabilities (i.e., psychomotor retardation) have been established in the scientific literature."

The *North American Journal of Medical Sciences* say that there is "compelling" evidence supporting a "significant" relationship between mercury exposure from vaccines and neurodevelopmental delay

This article is from ***the North American Journal of Medical Sciences*** and is titled, **Thimerosal -Containing Hepatitis B Vaccination and the Risk for Diagnosed Specific Delays in Development in the United States: a case-control study in the vaccine safety datalink.**
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4215490/

Conclusion:
"The present study provides compelling new epidemiological evidence supporting a significant relationship between increasing organic-Hg exposure from Thimerosal-containing childhood vaccines and the subsequent risk of a diagnosis for specific delays in development among both males and females. Many recent studies support the biologically plausible role of organic-Hg exposure from Thimerosal-containing vaccines in the pathogenesis of specific delays in development. The specific ICD-9 code examined in the current study included specific delays in development involving speech/language, coordination, hearing, and reading disorders. **Hg *(mercury)* is a known developmental and neurotoxin,** and its specificity in targeting long-range axons, as the evidence here would suggest, possibly contributes to the abnormal long-range tracts that are found in children diagnosed with specific delays in development, such as reading, hearing, coordination and speech/language."

"**In summary, using a hypothesis-testing, epidemiological analytical methodology in the VSD database, organic-Hg exposure from Thimerosal-containing childhood vaccines was determined to be a significant risk factor for the subsequent diagnosis of specific delays in development among males and females.**"

Using data from U.S. Government records, a 2004 study finds a strong correlation with levels of mercury from vaccines and rates of autism.

In a study published in the ***Medical Science Monitor*** titled, **A comparative evaluation of the effects of MMR immunization and mercury doses from thimerosal-containing childhood vaccines on the population prevalence of autism**, researchers cross referenced the ***Biological Surveillance Summaries of the Centers for Disease Control and Prevention (CDC)***, ***the U.S. Department of Education datasets, and the CDC's yearly live birth estimates*** and found "biological plausibility and epidemiological evidence **showing a direct relationship between increasing doses of mercury from thimerosal-containing**

vaccines and neurodevelopmental disorders, and measles-containing vaccines and serious neurological disorders." https://www.ncbi.nlm.nih.gov/pubmed/?term=14976450

The following are excerpts from Dr. Dan Murphy's web site where he reviewed this article and included several quotes from the study's authors:
http://www.danmurphydc.com/wordpress/wp-content/uploads/archive/2003/Article_41-03.geier.pdf

Results: It was determined that there was **a close correlation** between mercury doses from thimerosal-containing childhood vaccines and the prevalence of autism from the late 1980s through the mid-1990s.

In contrast, there was a potential correlation between the number of primary pediatric measles-containing vaccines administered and the prevalence of autism during the 1980s. In addition, it was found that there were **statistically significant odds ratios for the development of autism following increasing doses of mercury from thimerosal- containing vaccines** (birth cohorts: 1985 and 1990–1995) in comparison to a baseline measurement (birth cohort: 1984).

The contribution of thimerosal from childhood vaccines (>50% effect) was greater than MMR vaccine on the prevalence of autism observed in this study.

Conclusions: The results of this study agree with a number of previously published studies.

The amount of mercury that each child was administered was based upon the number of doses of thimerosal-containing vaccines distributed administered. **The thimerosal-containing vaccines analyzed in this study included:**

1) Four variations of the Diphtheria-Tetanus-Pertussis (DPT).

2) Haemophilus influenza Type b (Hib).

3) Pediatric hepatitis B.

We determined the amount of mercury in each respective vaccine based upon the 2001 report of the ***Institute of Medicine*** (IOM) of the ***U.S. National Academy of Sciences.*** **The mercury doses per vaccine that we calculated were as follows:**

- **DTP and Hib all had 25 micrograms per dose. [WOW]**
- **Pediatric hepatitis B had 12.5 micrograms per dose**.

RESULTS: Between 1981 to 1996, the "prevalence of autism increased approximately 6- fold, from approximately 50 cases per 100,000 children (i.e. 1 in 2,000 children) to approximately 300 cases per 100,000 children (i.e. 1 in 333 children)." [WOW]

"As the prevalence of autism increased from the birth cohorts from the late 1980s through the early 1990s **a corresponding increase in the average mercury dose per child occurred.**"

"A maximum occurred in the birth cohort of 1993 in both the average mercury dose per child and the prevalence of autism." [IMPORTANT]

"A decrease in both the prevalence of autism and the average mercury dose per child occurred from 1993 through 1996." [IMPORTANT]

"There was a potential correlation between increasing doses of primary pediatric measles-containing vaccine and an increasing prevalence of autism during the 1980s".

"In 2001, the IOM published a report stating that **it was biologically plausible for mercury from thimerosal-containing childhood vaccines to cause childhood neurodevelopmental disorders**." [***Institute of Medicine*** (US). Immunization safety review: ***Thimerosal-containing vaccines and neurodevelopmental disorders***. Washington, DC: National Academy Press; 2001].

Authors have reported **distinct similarities "between autism and mercury exposure in their effects upon biochemistry, the immune system, the central nervous system structure, neuro-chemistry, and neurophysiology."**

"**Children with autistic spectrum disorders have a decreased ability to excrete mercury** in comparison to normal controls."

Studies show that thimerosal induced membrane and DNA damage, initiated apoptosis in human neurons and fibroblasts, **and that thimerosal toxicity may occur at even lower doses with longer times of exposure.**

The results of this study are supported by both previous epidemiological and biological plausibility data.

"**The prevalence of autism has risen from one in about 2,500 children in the mid- 1980s to as common as about one in 250 by the mid-1990s**."

The "rise in the prevalence in autism reflects genuine phenomena, and is **not the result of population migration, differences in autism diagnoses, or other potential confounders**."

"The strength of this study regarding mercury from thimerosal-containing childhood vaccines stems from the fact that **it provides a large overall picture of the effects of administration of tens of millions of doses of thimerosal-containing childhood vaccines to millions of children**. In addition, the children in the birth cohorts examined in this study were all **at least six years of age**, allowing for sufficient elapse of time so that a diagnosis of autism could be made, and **all diagnoses of autism were all made by the same organization, namely the *U.S. Department of Education*, minimizing any potential differential diagnoses of autism**."

"**This indicates that mercury from thimerosal-containing childhood vaccines has a very significant relationship with autism**."

In a previous study the authors determined that the odds ratio of autism increased by 3% per microgram of mercury. In this study, the odds ratio of autism increased by 2.3% per microgram of mercury.

They conclude, "there is truly an association between mercury from thimerosal containing childhood vaccines and the childhood neurodevelopmental disorder of autism."

These author's "own epidemiological analyses showed that there was an increased risk for serious neurological disorders including autism, permanent brain damage, ataxia and mental retardation following pediatric MMR immunization."

As a consequence of MMR Immunization, other researchers have identified"

1) Chronic intestinal colitis, ulcerative colitis and other gastrointestinal disease. *(Interestingly, this is what Dr. Andrew Wakefield found and was excoriated for. More on this later)*

2) Onset of behavioral symptoms.

3) A strong association between MMR and central nervous system autoimmunity.

4) Encephalopathy

5) Serious neurological disorders These findings appear within 14 days following measles vaccination. It is recommended that thimerosal be removed from all vaccines, and additional research be undertaken to produce an MMR vaccine with an improved safety profile.

The Journal of Translational Neurodegeneration discusses new epidemiological evidence connecting mercury containing vaccines and Autism Spectrum Disorder conditions

From *the Journal Translational Neurodegeneration*, 2013, 2:25 titled A two-phase study evaluating the relationship between Thimerosal-containing vaccine administration and the risk for an autism spectrum disorder diagnosis in the United States.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3878266/

Conclusions: "Routine childhood vaccination is an important public health tool to reduce the morbidity and mortality associated with infectious diseases, but **the present study provides new epidemiological evidence supporting an association between increasing organic Hg (Mercury) exposure from Thimerosal-containing childhood vaccines and the subsequent risk of an Autism Spectrum Disorder diagnosis**."

Mercury caused brain damage linked to symptoms of autism spectrum disorders

A 2008 study from the ***Indian Journal of Medical Research*** titled, **A comprehensive review of mercury provoked autism**, outlines the serious neurological consequences of mercury exposure and relates that damage to the symptoms of autism. https://www.ncbi.nlm.nih.gov/pubmed/?term=19106436

From the article:
"Emerging evidence supports the theory that some autism spectrum disorders (ASDs) may result from a combination of genetic/biochemical susceptibility, specifically a reduced ability to excrete mercury (Hg), and exposure to Hg at critical developmental periods."

"**Hg *(mercury),* has been found to cause immune, sensory, neurological, motor, and behavioural dysfunctions similar to traits defining/associated with ASDs, and that these similarities extend to neuroanatomy, neurotransmitters, and biochemistry. Furthermore, a review of molecular mechanisms indicates that Hg exposure can induce death, disorganization and/or damage to selected neurons in the brain similar to that seen in recent ASD brain pathology studies, and this alteration**

may likely produce the symptoms by which ASDs are diagnosed. Finally, a review of treatments suggests that ASD **patients who undergo protocols to reduce Hg and/or its effects show significant clinical improvements in some cases**. **In conclusion, the overwhelming preponderance of the evidence favours acceptance that Hg exposure is capable of causing some ASDs**."

Vaccinated children have a 41% greater incidence of autism than unvaccinated children

From the same article:
"**one can compute a 41% increased relative frequency of autism diagnosis in the vaccinated versus the unvaccinated population in this age range**, a number that might well have been statistically significant had it been singled out. **Finally, it is likely that other vaccines in addition to MMR play a role in autism, particularly since, unlike many vaccines, MMR contains neither thimerosal nor aluminum. MMR is often administered simultaneously with Diphtheria, Tetanus and Pertussis (DTaP), an aluminum-containing vaccine. The synergistic and cumulative effects of multiple vaccines would likely lead to nonlinear enhancement of adverse events**."

The Journal Toxicological and Environmental Chemistry finds that even low-level exposure to thimerosal and other metals induces "significant cellular toxicity" in human neuronal and fetal cells

http://www.tandfonline.com/doi/abs/10.1080/02772240802246458 This article from the ***Journal Toxicological and Environmental Chemistry*** titled, **Mitochondrial dysfunction, impaired oxidative-reduction activity, degeneration, and death in human neuronal and fetal cells induced by low-level exposure to thimerosal and other metal compounds** clearly cites the toxicity of Thimerosal.

From the article:

"Thimerosal (ethylmercurithiosalicylic acid), an ethylmercury (EtHg)-releasing compound (49.55% mercury (Hg)), was used in a range of medical products for more than 70 years. Of particular recent concern, **routine administering of Thimerosal-containing biologics/childhood vaccines have become significant sources of Hg exposure for some fetuses/infants.**

"**Thimerosal at low nanomolar (nM) concentrations induced significant cellular toxicity in human neuronal and fetal cells**. Thimerosal-induced cytoxicity is similar to that observed in AD pathophysiologic studies. **Thimerosal was found to be significantly more toxic than the other metal compounds examined.**"

The Biochemical Journal finds compelling evidence that there is a "significant" and dose dependent relationship of mercury exposure and developmental delays

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4199012/ This article published in the ***Biochemical Journal*** titled, **A Dose-Response Relationship between Organic Mercury Exposure from Thimerosal-Containing Vaccines and Neurodevelopmental Disorders**, shows a clear connection between thimerosal exposure in a dose related way and neurodevelopmental disorders.

Some excerpts:
"On a per microgram of organic-Hg basis, **Pervasive developmental disorder (PDD), specific developmental delay, tic disorder and hyperkinetic syndrome of childhood cases were significantly more likely than controls to receive increased organic-Hg (mercury) exposure.** By contrast, none of the non-thimerosal related outcomes were significantly more likely than the controls to have received increased organic-Hg exposure. Routine childhood vaccination may be an important public health tool to reduce infectious disease-associated morbidity/mortality, but **the present study significantly associates organic-Hg exposure from T-HBV with an increased risk of a Neurodevelopmental Disorder diagnosis**".

Conclusions: "This study provides new epidemiological evidence supporting a significant relationship between increasing organic-mercury exposure from Thimerosal Containing Vaccines and the subsequent risk of a Neurodevelopmental Disorder diagnosis."

A study involving nearly 300,000 children, found "consistent significantly increased" rates of autism, ADD and emotional disturbances linked to Thimerosal Containing Vaccines (TCVs)

A 2008 article in the ***Journal of the Neurological Sciences*** titled, **Thimerosal exposure in infants and neurodevelopmental disorders: an assessment of computerized medical records in the Vaccine Safety Datalink**, find a significant connection between thimerosal exposure in vaccines and neurodevelopmental conditions. https://www.ncbi.nlm.nih.gov/pubmed/18482737

From the Abstract:
"The study evaluated possible associations between neurodevelopmental disorders (NDs) and exposure to mercury (Hg) from Thimerosal-containing vaccines (TCVs) by examining the automated Vaccine Safety Datalink (VSD). **A total of 278,624 subjects** were identified in birth cohorts from 1990-1996 that had received their first oral polio vaccination by 3 months of age in the VSD. The birth cohort prevalence rate of medically diagnosed International Classification of Disease, 9th revision (ICD-9) specific NDs and control outcomes were calculated. Exposures to Hg from TCVs were calculated by birth cohort for specific exposure windows from birth-7 months and birth-13 months of age. Poisson regression analysis was used to model the association between the prevalence of outcomes and Hg doses from TCVs. **Consistent significantly increased rate ratios were observed for autism, autism spectrum disorders, tics, attention deficit disorder, and emotional disturbances with Hg exposure from Thimerosal Containing Vaccines**." …"**efforts should be undertaken to remove Hg from vaccines**."

From the Study:
"Burbacher et al. evaluated infant monkeys following injection of doses of Thimerosal **comparable to the dosing schedule (weight- and age-adjusted) US children received during the 1990s. They determined that the maximum ethylmercury content in the brains of the Thimerosal-treated infant monkeys ranged from about 40 to 50 parts-per-billion (ppb). In addition, post-dosing-schedule testing found the concentration of inorganic mercury (formed from the ethylmercury entering the brain) averaged 16 ppb in the brains of the Thimerosal-treated infant monkeys. Moreover, the half-life of this inorganic mercury in the monkeys' brains was too long to estimate a value from the available data (no significant measurable decline was detectable by 120 days)."**

The Environmental Working Group reports on a metabolic biomarker in autistic children that makes them more susceptible to exposure to mercury and other toxins

Overloaded? New science, new insights about mercury and autism in children. This article is published by the ***Environmental Working Group*** www.ewg.org

Summary: "Scientists have identified a signature metabolic impairment or biomarker in autistic children that **strongly** suggests that these children would be susceptible to the harmful effects of mercury and other toxic chemical exposures."

"**Finally, these findings raise serious concerns about the studies that have allegedly proven the safety of mercury in vaccines.** The epidemiologic studies used to dismiss a causal relationship between autism and thimerosal **have assumed that all children have the same resistance to chemical exposure**. To properly investigate potential harm from mercury -containing shots researchers would have to compare autism rates in children with the same type of vulnerability."

The Journal of Immunotoxicology says that in addition to mercury, which it finds harmful, the human DNA and retroviruses found in vaccines put children at risk of damage to central nervous system development, and mitochondrial function

This is from the previously mentioned article in ***the Journal Immunotoxicology*** published in 2011 titled, **Theoretical Aspects of Autism. The article clearly shows that It's not just the mercury that puts children at risk from vaccines. There is human DNA and retroviruses found in childhood vaccines. This article discusses many plausible explanations for the rise in autism as a result of various vaccine** related factors. http://www.tandfonline.com/doi/full/10.3109/1547691X.2010.545086

Here are some quotes from the article:
"Data from a worldwide composite of studies show that an increase in cumulative incidence began about 1988–1990 (McDonald and Paul, 2010). The new version of the measles, mumps, rubella vaccine (i.e., MMR II) that did not contain Thimerosal was introduced in 1979. By 1983, only the new version

was available. Autism in the United States spiked dramatically between 1983 and 1990 from 4–5/10,000 to 1/500. In 1988, **two doses of MMR II were recommended to immunize those individuals who did not respond to the first injection. A spike of incidence of autism accompanied the addition of the second dose of MMR II.** Also, in 1988, MMR II was used in the United Kingdom, which reported a dramatic increase in prevalence of autism to 1/64 (noted above). Canada, Denmark, and Japan also reported dramatic increases in prevalence of autism. **It is important to note that unlike the former MMR, the rubella component of MMR II was propagated in a human cell line derived from embryonic lung tissue** (Merck and Co., Inc., 2010). **The MMR II vaccine is contaminated with human DNA from the cell line. This human DNA could be the cause of the spikes in incidence. An additional increased spike in incidence of autism occurred in 1995 when the chicken pox vaccine was grown in human fetal tissue (Merck and Co., Inc., 2001; Breuer, 2003).** The current incidence of autism in the United States, noted above, is approximately 1/100."

Study finds the thimerosal containing Hepatitis B vaccine series was increasing developmental disabilities in boys by 900%

A 2008 study published in the ***Journal of Translational and Environmental Chemistry*** titled, **Hepatitis B triple series vaccine and developmental disability in US children aged 1–9 years**, found boys ages 1-9 that were given **3 doses of the thimerosal containing Hepatitis B vaccine were 9 times more likely to require special needs education or behavioral and learning assistance.**
https://www.tandfonline.com/doi/abs/10.1080/02772240701806501#

National Health and Nutrition Examination Survey 1999–2000 data was analyzed to determine the percentage of children having the 3 shot series that needed early intervention or special education services (EIS).

"The odds of receiving EIS were approximately nine times as great for vaccinated boys (*n* = 46) as for unvaccinated boys (*n* = 7), after adjustment for confounders."

"This study found statistically significant evidence to suggest that boys in United States who were vaccinated with the triple series Hepatitis B vaccine, during the time period in which vaccines were manufactured with thimerosal, were more susceptible to developmental disability than were unvaccinated boys."

One explanation as to why boys are affected with autism implicates human DNA found in vaccines

This paragraph was mentioned in the previous section on fetal DNA...

"The human DNA from the vaccine can be randomly inserted into the recipient's genes by homologous recombination, a process that occurs spontaneously only within a species. Hot spots for DNA insertion are found on the X chromosome in eight autism-associated genes involved in nerve cell synapse formation, central nervous system development, and mitochondrial function (Deisher, 2010). This could provide some explanation of why autism is predominantly a disease of boys. Taken together, these data support the hypothesis that residual human DNA in some vaccines might cause autism."

"**There is evidence that Thimerosal (which is 49% ethyl mercury) is indeed harmful.** Since the 1930s, Thimerosal has been extensively used as an antibacterial agent in vaccines (Geier et al., 2007). Thimerosal has been implicated as a cause of autism. **Not only is every major symptom of autism documented in cases of mercury poisoning but also biological abnormalities in autism are very similar to the side effects of mercury poisoning itself (Bernard et al., 2001): these include psychiatric disturbances (e.g., impairments in sociality, stereotypic behaviors, depression, anxiety disorder, and neuroses), increased incidences of allergies and asthma, increases in the presence of IgG autoantibodies against brain and myelin basic proteins, reductions in natural killer cell function, and increases in neopterin levels (indicative of immune activation). Autistic brains show neurotransmitter irregularities that are virtually identical to those arising from mercury exposure."**

On vaccine causation: "The incidence and prevalence data indicate the timing of introduction of vaccines and changes in the type and increasing number of vaccines given at one time implicate vaccines as a cause of autism."

New study finds an association with early mercury exposure and rates of autistic behavior at 5 years old

In a 2017 article published in the Journal ***Science of the Total Environment***, titled, **Associations of prenatal and early childhood mercury exposure with autistic behaviors at 5 years of age: The Mothers and Children's Environmental Health (MOCEH) study**, authors made the following associations:

- We explored the associations between blood mercury levels and autistic behaviors.
- This study involved an ongoing multi-center prospective birth cohort.
- Blood mercury levels were repeatedly measured from early pregnancy to 3 years.
- Autistic behaviors were assessed at 5 years with the Social Responsiveness Scale.
- **Prenatal and early childhood mercury levels were associated with autistic behaviors.**

http://www.sciencedirect.com/science/article/pii/S0048969717316479

The Journal Laboratory Medicine finds that thimerosal, may cause direct neurotoxic, immuno-depressive, and autoimmune injury and contribute to early onset and regressed autism

In a 2002 article titled, **Vaccines and Autism** and published in ***Laboratory Medicine,*** the authors make the following connections between autism, Thimerosal and the MMR vaccine.

"It is clear that the proportion of autistic children who enjoyed normal neurobehavioral development and then regressed, usually in the second year of life, has been on the rise for about 2 decades. New vaccines, including combined MMR, hepatitis B, and Haemophilus influenza are new environmental factors that were introduced during this period of changing onset."

"**Vaccinations may be one of the triggers for autism.** Substantial data demonstrate immune abnormality in many autistic children consistent with impaired resistance to infection, activation of inflammatory response, and autoimmunity. Impaired resistance may predispose to vaccine injury in autism."

"**A mercurial preservative in childhood vaccines, thimerosal, may cause direct neurotoxic, immunodepressive, and autoimmune injury and contribute to early onset and regressed autism. Live viruses in measles, mumps, and rubella (MMR) may result in chronic infection of the gut and trigger regressed autism. Thimerosal injection may potentiate MMR injury.**"

"We postulate that **thimerosal in vaccines may cause direct** neurotoxic, immune-depressive, and autoimmune injury resulting in either **early-onset or regressed autism**. Further, we submit that MMR (usually at 15 months) may result in chronic infection of the gut by vaccinial measles, and trigger regressed autism. Thimerosal injections in series prior to or at the time of MMR may potentiate injury by MMR."

"**Chronic measles infection from MMR is suggested by studies that demonstrate: 1) chronic vaccinial measles infection of the peripheral monocytes of autistic children with enterocolitis; 2) genomic material consistent with chronic measles infection in intestinal biopsies of regressed autistic children with enterocolitis; and 3) presence in the majority of autistic children of a unique anti-MMR antibody highly correlated with a marker for nervous system autoimmunity. Autoimmune injury to both gut and brain is suggested in autism."**

"They also cite the importance of **screening children that may have compromised immune systems, therefore putting them at increased risk for adverse reactions to vaccines. "Development of screening tests to identify children with higher risks of any negative effects of MMR should be a high priority. Such screening might include skin-testing for allergy, dietary; family questionnaires to identify possible low vitamin A levels; tetanus titers for allergy; or immunoglobulin and T-cell counts in special cases."**

I hate to be cynical, but I don't have much hope for the advancement of effective screening of newborns to identify genetic predispositions to vaccine injury. One main reason is that we already know that screening pregnant women for Hepatitis B, would identify mothers that don't have Hep B and spare the

child from having to be subjected to that vaccine on day-one that is completely useless and unnecessary for them. But do we even do that one simple thing? NO. See pages 533-545 for more on the Hep B vaccine.

NEWS ALERT! The journal Editor in Chief Roger L. Bertholf PhD recently retracted this study. On October 18, 2018, he made the decision to retract the article based on the fact that the study was being prominently displayed in search engine results and that he was concerned that it would further advance an anti-vaccine agenda. He also said that he didn't want his journal which he says is a leader in promoting global health to be viewed as endorsing a paper that has a false and potentially dangerous premise. Do him, this was enough to pull a paper 16 years after its publication.

In this article, Dr. Bertholf was quoted as saying the following:

- "…aware of the paper's existence when I took over as Editor in Chief in 2012 but didn't give any thought to retraction until I saw Dr. Ghezzi's study, which revealed that the Rimland and McGinnis paper was prominently displayed in search engine result pages."
- "This caused me some concern that the paper would be used to advance an anti-vaccine agenda."
- "And I did not want the American Society for Clinical Pathology, which publishes *Lab Medicine* and is a leader in promoting global health, to be viewed as endorsing a paper on vaccination that has a false and potentially dangerous premise based on the flawed paper retracted by *The Lancet." (**my comment:** when you read the truth about what happened with that "flawed" paper in the Lancet, its mischaracterization and the character assassination of Dr. Wakefield later in this document, you will see that this premise has no merit)*

https://www.precisionvaccinations.com/mmr-vaccine-does-not-cause-autism-says-cdc

I cannot emphasize how dangerous this practice of article retraction is. There seems to be a trend in this country of censoring speech and opinions that don't agree with a certain group, party or industry. And I have seen this with other vaccine related scientific papers that don't agree with the status quo. It is similar to the censorship that the communist and totalitarian regimes employ to suppress free expression/speech and opinions. If something doesn't agree with the party line, you don't refute it with credible evidence and a scientific rebuke, you simply shut it down or take it off-line. You will see another example of this on pages 348-349.

This article also states the following: "On August 21, 2018, the Centers for Disease Control and Prevention (CDC), said the following, "The evidence is clear: thimerosal is not a toxin in vaccines, but merely a preservative, preventing contamination, that has been used in vaccines for decades.'"
If true, this statement simply proves how ignorant and blinded the CDC really is. As you have read and will continue to see in this document, there is a huge amount of scientific evidence that emphatically disagrees with that assertion.

This short slide presentation to the *Institute of Medicine* shows compelling graphs demonstrating the parallel rise in the prevalence of autism and the amount of mercury in childhood vaccines

http://www.nationalacademies.org/hmd/~/media/D2CB3EDCAE414143BC588F1970849FA8.ashx

When did the CDC first know about the association between Thimerosal and an increased (760%), risk of autism?

The CDC was aware of the connection in 1999 as shown by this study

Increased risk of developmental neurologic impairment after high exposure to thimerosal-containing vaccine in first month of life. Two of the four study authors were well-known researchers (Thomas M. Verstraeten and Frank DeStefano), and **this study was one of the first to show a strong connection between Thimerosal containing vaccines given the first month of life and autism (a 760% increase).** Interestingly, the researchers that did this article were CDC researchers and it was conducted by the CDC's Division of Epidemiology and Surveillance, Vaccine Safety and Development Branch, National Immunization Program in 1999. This proves that the CDC knew of this connection nearly two decades ago. The link to the article PDF can be found here https://homeopathicassociates.com/portfolio-item/100-research-papers-supporting-vaccineautism-causation-1-10 It is the first article listed.

A 2016 review of 91 studies examining the relationship between mercury and autism, found 67 (74%) that suggest mercury is a risk factor for autism

A 2016 article published in the ***Journal of Trace Elements in Medicine and Biology*** titled, **The relationship between mercury and autism: A comprehensive review and discussion** found that mercury is causal and/or contributory to autism.

"In the studies that examine blood (whole blood and red blood cells) and nails, results show that the higher the mercury levels, the worse the autism symptoms."

"No studies were found during our literature search that examined tissue mercury levels and autism severity that did not find a correlation." *(all studies found a correlation)*

Conclusion:

"In this evaluation, it was found that **74% of studies support a link between mercury exposure and ASD, which corroborates a previous evaluation of the same issue conducted in 2010. In that study, Desoto and Hitlan also found that 74% of studies support a link between mercury exposure and ASD. This agreement in science six years later is compelling and supports the validity of the finding."**

"With the increase in neurodevelopmental disorders in general, and especially ASD, the evidence suggests that **governmental/public policy changes are urgently needed."**

130 studies linking vaccines to neuro and autoimmune issues common to autism

https://go.thetruthaboutvaccines.com/wp-content/uploads/130-STUDIES-LINKING-VACCINES-TO-NEUROLOGICAL-AND-AUTOIMMUNE-ISSUES-COMMON-TO-AUTISM.pdf **This link will take you to a PDF with 130 different studies that link vaccines to neurological and autoimmune issues common to autism. I have cited many of those studies in this document, but there are many more in that PDF that just add to the mountain of evidence presented in this eBook.**

Thimerosal, toxic even at minute levels, is still in vaccines given to pregnant women and children and is considered dangerous by many in the scientific community

While it is true that thimerosal has been removed from most childhood vaccines, the industry is still pushing the flu and Tdap vaccines on pregnant women, when the baby in-utero is most susceptible. The multi-dose flu vaccine still contains thimerosal. If we learned anything from the DES travesty, we learned that toxins can cross through the placenta into the fetal bloodstream. So not only are babies in utero being exposed to mercury from adult shots that still contain it, they are also exposed to aluminum and other metabolic and neurological toxins contained in adult vaccines.

This 2015 article from the Journal ***Clinica Chi Chimica Acta*** titled**, Thimerosal: clinical, epidemiologic and biochemical studies**, presents damning evidence on the use of thimerosal in vaccines, even in minute levels. https://www.ncbi.nlm.nih.gov/pubmed/?term=25708367

"Despite all of the aforementioned concerns and the fact that there are other approved and effective preservatives available, Thimerosal continues to be used as a preservative in several vaccines to date and is a considerable source of Hg *(mercury)* exposure for children. About 50% of the Hg exposure in infants comes from the recurring bolus doses of Thimerosal from Thimerosal-containing vaccines administered in the first 2 years of life (**cumulative doses of Hg exposure from Thimerosal containing vaccines can be as high as 187.5 µg Hg in the first six months of life**. Although this degree of exposure in the first six months of life has been reduced in the US in recent years, it remains unchanged in developing countries. **There is considerable body of scientific and medical evidence supporting a role from Hg exposure causing harmful consequences. To date, there are at least 180 studies that show harm from Thimerosal."**

The study then cites several different scientific studies showing the cumulative dose of thimerosal significantly exceeding the EPA's safe level for toxicity. It then goes on to say, "Overall, these investigators observed that doses of **Hg exposure from administration of a single Thimerosal-preserved**

influenza vaccine during pregnancy resulted in a developing fetus receiving a dose of Hg in excess of the US EPA Hg safety limit from between 1,000,000 times to 10,000 times that safety limit at 1 week of development to 7.6 times to 0.1 times that limit at 38 weeks of development. It is interesting to note, from the Brown and Austin modeling data, that, **even assuming 99% elimination of the Hg dose by the placenta, a developing fetus even at 16 weeks-old would still receive a dose of Hg greater than 2.5 times the EPA Hg limit for safety**. **Overall, both Brown and Austin and Goldman concluded their toxicokinetic studies by suggesting that, given the magnitude in excess of the EPA Hg safety limits presented by exposure to a dose of Thimerosal-preserved vaccine during pregnancy, it is biologically plausible for such exposures to result in fetal/infant death and developmental disability."**

Their concluding statement:

"**However, the culmination of the research that examines the effects of Thimerosal in humans indicates that it is a poison at minute levels with a plethora of deleterious consequences, and there is a clear cause for concern.**"

Now, hold that thought and take this into consideration:

Massive amounts of mercury (EPA standards) are found in vaccines

The flu vaccine contains 25,000 X more mercury that the EPA allows in drinking water!

In 2014, Natural News publisher Mike Adams, revealed results of the analysis done on the Flulaval flu vaccine. http://www.naturalnews.com/045418_flu_shots_influenza_vaccines_mercury.html

"(***NaturalNews***) Mercury tests conducted on vaccines at the Natural News Forensic Food Lab have revealed a shockingly high level of toxic mercury in an influenza vaccine (flu shot) made by GlaxoSmithKline (lot #9H2GX). **Tests conducted via ICP-MS document mercury in the *Flulaval* vaccine at a shocking 51 parts per million, or over 25,000 times higher than the maximum contaminant level of inorganic mercury in drinking water set by the EPA.(**1)"

The tests were conducted via ICP-MS using a 4-point mercury calibration curve for accuracy. Even then, the extremely high level of mercury found in this flu shot was higher than anything we've ever tested, including tuna and ocean fish which are known for high mercury contamination.

In fact, the concentration of mercury found in this GSK flu shot was **100 times higher than the highest**

level of mercury we've ever tested in contaminated fish. **And yet vaccines are *injected* directly into the body, making them many times more toxic than anything ingested orally**."

One question I have is this. How can the EPA tell pregnant mothers not to eat fish more than once per month, for fear that the baby would suffer harm from the mercury, yet the CDC and the FDA promotes injecting it straight into a pregnant woman and consequently into a newborn's blood stream? In answering this question, you also have to consider that absorption of mercury ingested (as in eating fish), is miniscule compared to injecting it into the blood stream, making the scenario asked in this question all the more bizarre.

Timeline of increases of thimerosal (mercury) in childhood vaccines and how it correlates with the rapid rise in autism- according to a 2003 report from congressional hearings

According to the **Mercury in Medicine Report** 2003, released by the ***Congressional Subcommittee on Human Rights and Wellness*** mentioned earlier, the significant increase in exposure to mercury as more vaccines with thimerosal were added correlates directly with the meteoric rise in the rates of autism from the mid-1980s and continuing today. **While thimerosal is the main focus of the congressional hearing, aluminum levels from vaccines has risen dramatically and is one of the key components that is continuing to trigger neurodevelopmental challenges in our children.**
https://www.gpo.gov/fdsys/pkg/CREC-2003-05-21/html/CREC-2003-05-21-pt1-PgE1011-3.htm

From the Report:

"Through most of the twentieth century, individuals were required to receive very few vaccines. However, with **the licensing of the Hepatitis B (Hep B) vaccine and the Haemophilus Influenzae Type b (Hib) vaccine starting in the mid-to-late 1980's, and their subsequent recommendation for universal use in 1991, the amount of mercury to which infants were exposed rose dramatically. It was during this period of increased exposure to thimerosal and its ethylmercury component that the growing wave of late-onset autism became apparent.** This confluence of events led many to suspect a correlation between the two and call for more research into the relationship between ethylmercury in vaccines and autism spectrum disorders."

"A number of vaccines never contained thimerosal. These classes of vaccines are generally live-virus vaccines. The ethylmercury in thimerosal would kill the living virus, making it unsuitable for such vaccines. **These shots include the Measles-Mumps-Rubella (MMR) vaccine, the oral polio vaccines (which are no longer recommended for use in the United States), and the chicken pox (varicella zoster) vaccines."**

"Prior to the approval of the recombinant Hepatitis B vaccine in 1986, the only vaccine containing thimerosal routinely given to infants was the DTP vaccine. DTP contained 25 micrograms of ethylmercury and was given 3 times in the first six months of life (75 micrograms of ethylmercury) and a total of four times in two years (100 micrograms of ethylmercury)."

"The polysaccaride Haemophulus Influenzae B (Hib) vaccine was first licensed in 1985. It had 25 micrograms of ethylmercury and was given 3 times in the first six months of life (75 micrograms of ethylmercury) and a total of four times in the first two years of life."

"The approval of the Hep B vaccine in 1986 added another thimerosal-containing shot to the recommended schedule. This vaccine contained 12.5 micrograms of ethylmercury and was given within hours of birth and a total of 3 times in the first six months of life (37.5 micrograms of ethylmercury)."

"After 1986, some children went from getting 25 micrograms in one day or 75 micrograms in the first six months of life to getting 62.5 micrograms of ethylmercury in a day or 187.5 micrograms in the first six months of life. This would be in addition to any fetal exposure to mercury from the mother. In 1991, the CDC recommended that both Hib and Hep B be added to the universal recommendations for childhood immunization."

"As was noted previously, the effects of ethylmercury have not been studied as carefully as methylmercury, and the Federal Government has not established safety thresholds for ethylmercury exposure. Because of the obvious similarities between the two, however, when the FDA reviewed the amount of injected ethylmercury in vaccines in 1999, they compared it to the Federal limits for **(ingested)** methylmercury exposure. **They were compelled to admit at that point that the cumulative amount of ethylmercury in vaccines exceeded the EPA's threshold for exposure to methylmercury. This led the FDA to recommend the removal of thimerosal from most pediatric vaccines in 1999**, more than a decade after the Hepatitis B vaccine was added to the schedule."

"In point of fact, the potential problem was worse than the FDA suggested. **Not only did the cumulative amount of ethylmercury on the routine schedule exceed the EPA's limit, the amount of ethylmercury in each individual shot of DTP (or DTaP) and Hepatitis B exceeded the limit.** Young children were getting three boosters of each shot. The EPA's threshold is 0.1 micrograms of methylmercury for each kilogram of body weight. This does not mean that injury would definitely occur above this level because a significant safety margin is built in. However, the chances of injury increase as the exposure rises above this level. **For an 11-pound baby (five kilograms), the threshold would be roughly 0.5 micrograms. For a 22-pound baby (ten kilograms), the threshold would be 1 microgram. The DTP (and DTaP) vaccine contained 25 micrograms of thimerosal per dose, as does the Hepatitis B vaccine. The Hib vaccine contained 12.5 micrograms per dose. In addition, it is clear that for many, many children, the amount of thimerosal they received in vaccines in the 1990's also exceeded the FDA's higher threshold of 0.4 micrograms per kilogram of body weight."**

"Of particular concern to many parents are those instances in which children received several vaccines in one visit to their pediatrician. This practice has become commonplace **with the new vaccine schedules recommending 26 doses of vaccines before school attendance."** ***(Bear in mind that this was in 2003.***

The 2018 CDC immunization schedule calls for 43 doses (including flu shots) by the time a child enters school!

https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

Bear in mind as you add them up, that the DTaP and MMR are really three-in-one vaccines and count as 3 doses each time administered.

"Chairman Burton spoke about one such incident at a recent hearing: ``The FDA recently acknowledged that in the first 6 months of life children get more mercury than is considered safe by the EPA. The truth is that sometimes kids go to their doctor's office and get four or five vaccines at the same time. **My grandson received vaccines for nine different diseases in 1 day. He may have been exposed to 62.5 micrograms of mercury in 1 day through his vaccines. According to his weight, the maximum safe level of mercury he should have been exposed to in 1 day is 1.5 micrograms, so that is 41 times the amount at which harm can be caused."**

"When testifying before the Committee, Mrs. Lynn Redwood made the following observation regarding her son's bolus exposure to mercury through vaccinations: **``According to the EPA criteria, his allowable dose was only 0.5 micrograms based on his weight. He had received 125 times his allowable exposure on that day. The large injected bolus exposures continued at two months, four months, 12 months, and 18 months to a total mercury exposure of 237.5 micrograms. I also discovered that the injections that I received during my pregnancy, the first and third trimesters, and hours after the delivery of my son to prevent RH blood incompatibility disease also contained mercury.''**

The testimony of this medical doctor makes some very important key points including

Continued from the Report:
"***Dr. Stephanie Cave***, who provided testimony to the Committee, is a doctor in Baton Rouge, Louisiana whose medical practice is focused on treating children with the symptoms of autism. She concurs with other experts from whom the Committee received testimony that there appears to be a correlation between increased use of vaccines containing thimerosal and a rise in autism:

- ``I believe that **the introduction of the hepatitis B vaccine in 1991** has sparked this recent epidemic because of thimerosal. **When added to the mercury imparted through the DTP and HIB, the exposure to mercury exceeds EPA safe limits** for the metal if you consider a bolus dose on a single day.
- ``The EPA limits are usually related to **ingested** mercury, which is partially cleared by the liver. *(More importantly, it is estimated that less than 1% of orally ingested mercury is even absorbed).* Injecting boluses of ethylmercury presents an entirely different, another scenario. The 2-month dose of mercury is at least **30 times higher** than the recommended daily maximum exposure set by the EPA. **During the 1990's, infants received 12.5 micrograms of mercury at birth, followed by 12.5 micrograms at 1 month, 62.5 micrograms at 2 months, 50 micrograms at 4 months, 50 micrograms at 6 months, 50 micrograms at 15 to 18 months; a total of 237.5 micrograms for a child who at best weighs 10 kilograms. This far exceeds the safety limits if you consider bolus dosing. Safety limits would be more like 1 to 1.5 micrograms."**

(That means that the 237.5 micrograms is 190 times (19,000%) greater than the safety limit!)

- ``The **bile production is minimal in infancy**, making it more difficult for metals to be cleared from the body. When added to a vaccine, the metals are even more dangerous because the vaccines **trigger immune reactions that increase the permeability of the GI tract and the blood/brain barrier.**
- ``The injection of mercury appears to affect only certain children, but **I fear that we've underestimated the devastation by concentrating only on the autistic children. We're measuring elevated levels of mercury in other children with milder difficulties like learning disabilities, ADHD, Asperger's Syndrome and many others.** We do not have any idea what the scope of this problem is at this point. And there are no safety standards for infants getting bolus doses of ethylmercury.''

The FDA's own paid consultant finds levels of mercury exceeding all agencies safe limits in 1999, yet the FDA "slow rolls" the actions to remove it from childhood vaccines

A report by Robert F. Kennedy Jr. and Lyn Redwood on the web site ***EcoWatch*** revels some disturbing information about the way our government handled to realization that childhood vaccines were exposing infants and young children to dangerous levels of mercury.
https://www.ecowatch.com/cdc-mercury-vaccines-kennedy-2199157054.html

From the article:
"Uncovered documents show that the ***U.S. Food and Drug Administration (FDA)*** and the ***Centers for Disease Control and Prevention*** (CDC) **knew that infant vaccines were exposing American children to mercury far in excess of all federal safety guidelines since 1999**. The documents, created by a FDA consulting toxicologist, show how federal regulators **concealed the dangerous impacts and lied to the public."**

"In 1997, Congress passed the FDA Modernization Act. A provision of that statute required the FDA to "compile a list of drugs that contain intentionally introduced mercury compounds, and provide a quantitative and qualitative analysis of the mercury compounds on the list." In response, manufacturers reported the use of the mercury-based preservative, thimerosal, in more than 30 licensed vaccines."
https://www.fda.gov/RegulatoryInformation/LawsEnforcedbyFDA/SignificantAmendmentstotheFDCAct/FDAMA/ucm100218.htm

"**FDA's Center for Biologics Evaluation and Research (CBER) was responsible for adding up the cumulative exposure to mercury from infant vaccines, a simple calculation that, astonishingly, had never been performed by either the FDA or the CDC. When the agency finally performed that basic calculation, the regulators realized that a six-month-old infant who received thimerosal-preserved vaccines following the recommended CDC vaccine schedule would have received a jaw dropping 187.5 micrograms of mercury.** "

"Instead of immediately ordering the removal of thimerosal, FDA officials circled the wagons treating the public health emergency as a public relations problem. Peter Patriarca, then director of the FDA Division of Viral Products, warned his fellow bureaucrats that hasty removal of thimerosal from vaccines **would: "… raise questions about FDA being 'asleep at the switch' for decades by allowing a potentially hazardous compound to remain in many childhood vaccines, and not forcing manufacturers to exclude it from new products**. It will also raise questions about various advisory bodies regarding aggressive recommendations for use. We must keep in mind that the dose of ethylmercury was not generated by "rocket science." Conversion of the percentage thimerosal to actual micrograms of mercury involves ninth grade algebra. **What took the FDA so long to do the calculations? Why didn't CDC and the advisory bodies do these calculations when they rapidly expanded the childhood immunization schedule?"**

The FDA's consultant who shed the light on the overexposure from mercury and the fallout that followed

Dr. Barry Rumack was hired by the FDA as a consultant in 1999 and tasked to determine the amount of ethylmercury that infants were being exposed to and how that compared to the safe limits. The following information comes from a report titled, **Mercury in Medicine**, ***A Report Prepared by the Staff of the Subcommittee on Human Rights and Wellness Committee on Government Reform United States House of Representatives***, under the Honorable Chairman, Representative Dan Burton from Indiana. The report was the result of a three-year investigation, initiated in the ***Committee on Government Reform***. According to the report (on page 66), Dr. Rumack, discovered that the safe levels were being exceeded by the recommended vaccine schedule. As a result, several other highly esteemed researchers and physicians called for the removal of mercury from these childhood vaccines. **Even though experts urged the government to take rapid action, the move was slow rolled leaving millions of children continuing to be exposed.** https://vaccines.procon.org/sourcefiles/Burton_Report.pdf

From the report:
"The task of analyzing the amount of mercury in vaccines and its ramifications was assigned to Dr. Leslie Ball, a pediatrician employed at the FDA and her husband and colleague Dr Robert Ball, a medical officer at FDA's CBER. Despite the general lack of scientific research on the toxicity of ethylmercury, their review of the available literature led to two working conclusions:"

1. "The recommended guidelines for exposure to methylmercury were a good starting point for reviewing exposure to ethylmercury; and

2. "The amount of ethylmercury in children's vaccines exceeded the EPA's guidelines for exposure to methylmercury."

Dr. Ball became a proponent for the removal of mercury from the vaccines.

"An important part of the FDA's review was a comparison of the amount of ethylmercury in vaccines to the recommended safe levels for exposure to methylmercury established by the EPA and the FDA. In 1999, a consultant to the FDA, Dr. Barry Rumack, developed a

pharmacokinetic model to analyze the amount of mercury to which infants were being exposed. The FDA produced to the Committee two charts developed from that model dated June 28, 1999. Both charts demonstrate what has now become widely acknowledged, that most children in the 1990s received doses of ethylmercury in their vaccines that exceeded the EPA's limits for exposure to methylmercury (0.1 micrograms per kilogram) for at least the first six months of their lives. Even more significantly, the charts also indicate that most children received doses of ethylmercury that exceeded the FDA's less-restrictive limits (0.4 micrograms per kilogram) for at least the first two months of their lives."

"Federal officials have never publicly acknowledged this second fact. In public statements and Congressional testimony, they have acknowledged only that the EPA's lower limit was exceeded, even though simple math makes clear that most infants also breached the FDA's higher limit of 0.4 micrograms per kilogram."

"**Dr. Neal Halsey, Director of the Institute of Vaccine Safety at Johns Hopkins University, acknowledged this important fact, however. As previously mentioned, Dr. Halsey became convinced that thimerosal should be removed from vaccines.** On June 22, 1999, Dr. Ball presented the results of her research to the Medical Policy Coordinating Committee of the FDA's Center for Biologics Evaluation and Review (CBER).171 Dr. Halsey attended that meeting. **The next day, on June 23, 1999, Dr. Halsey wrote a letter to the members of the American Academy of Pediatricians' Committee on Infectious Diseases, which he chaired. He stated: *"In the past few days, I have become aware that the amount of thimerosal in most hepatitis B, DTaP and Hib vaccines that we administer to infants results in a total dose of mercury that exceeds the maximum exposure recommended by the EPA, the FDA, CDC and WHO..."***

"Dr. Halsey's admission that more than just the EPA's more conservative guideline was exceeded is a significant departure from the public statements of most Federal officials. Dr. Halsey acknowledges that the guidelines of the EPA, the CDC, the FDA and the World Health Organization were all exceeded."

"Another noteworthy fact is that the charts produced by Dr. Rumack, and the FDA's analysis in general, failed to take into consideration the background levels of mercury to which children are exposed from other sources." Dr. Ball made that very important point in follow-up documentation.

Regarding the findings of Dr. Rumack, a report by Robert F. Kennedy Jr. and Lyn Redwood on ***EcoWatch*** cites the following: "The models *(graphs of mercury loads)* predicted sharp peaks of mercury concentrations in both blood and tissue, in a stair-step sequence following each of the new thimerosal-containing vaccines given during the first six months of life. **Based on these models, Rumack predicted exposure to thimerosal-containing vaccines was dosing American children with mercury levels far exceeding all three federal safety guidelines established by the U.S. Environmental Protection Agency (EPA), FDA, and Agency for Toxic Substances and Disease Registry (ATSDR). There was no point in time from birth to approximately 16-18 months of age that infants were below the EPA guidelines for allowable mercury exposure. In fact, according to the models, blood and body burden levels of**

mercury peaked at six months of age at a shockingly high level of 120ng/liter. To put this in perspective, the CDC classifies mercury poisoning as blood levels of mercury greater than 10 ng/L."

"After receiving this alarming news from its toxicological consultant, the FDA chose to conceal these acute exposures using a deceptive statistical trick. Instead of honestly reporting the dangerous spikes in pediatric blood levels, FDA's public documents averaged the exposures over a six month period despite the fact that the exposures only occurred on four days during that six month period: at birth, and at two, four and six months of age."

"An analogy would be to compare taking two Tylenol tablets a day for a month to taking 60 Tylenol tablets in one day; the first exposure is acceptable, while the other is lethal. Using this misleading gimmick, regulators were able to report that mercury exposure levels were below FDA and ATSDR guidelines. Even after employing this deception, the levels were still above EPA guidelines which were the most stringent of the three. Numerous toxicologists have reported that the FDA's calculation, averaging these high bolus dose exposures, was not appropriate."

Despite the "phasing out" of mercury in childhood vaccines, the CDC still recommends vaccines with mercury be given prenatally. We know that those vaccines expose the fetus to the mercury in those vaccines, so what are we doing? We are playing a shell game with the lives of millions of children. When the shell is lifted and the nut is not there, that doesn't mean it doesn't exist. It's just hiding under another shell.

So, what has been done in light of all of this overwhelming amount of evidence? As we are witness to in today's political arena, inappropriate, unethical or even illegal activities that are uncovered through congressional hearing rarely if ever go anywhere. Nothing becomes of the recommendations. No one is ever prosecuted or held accountable. No changes are made to the status quo. If private citizens behaved that way, they would lock us up and throw away the key. It is sad to see that the same thing was happening 15 years ago, to the detriment of our nation's most precious asset, our children. But, just as sadly we are seeing the same dangerous games being played today with the lives of our children.

Blood levels of mercury related to higher rates of autism

A 2007 article published in the ***Journal of Child Neurology*** titled, **Blood levels of mercury are related to diagnosis of autism: a reanalysis of an important data set**, reanalyzed data from a previous study after finding a mistake. That re-analysis found a "significant" relationship existed between blood mercury levels and autism. https://www.ncbi.nlm.nih.gov/pubmed/?term=18006963

From the Abstract:
"The question of what is leading to the apparent increase in autism is of great importance. Like the link between aspirin and heart attack, even a small effect can have major health implications. If there is any link between autism and mercury, it is absolutely crucial that the first reports of the question are not falsely stating that no link occurs. We have reanalyzed the data set originally reported by Ip et al. in 2004 and have found that the original p value was in error and that a **significant relation does exist between the blood levels of mercury and diagnosis of an autism spectrum disorder**. **Moreover, the hair sample**

analysis results offer some support for the idea that persons with autism may be less efficient and more variable at eliminating mercury from the blood."

Why have autism rates continued to climb despite removal of the mercury from most childhood vaccines?

There are three main plausible explanations

1. Aluminum content has increased as mercury has decreased
2. Many vaccines contain foreign human DNA
3. The dramatic increase in vaccine doses & combined exposure to the chemicals & metals they contain

And don't let any of the vaccine lobby tell you that mercury was taken out of the vaccines and autism is still going up, so that PROVES that mercury was not the cause. What about prenatal exposure? And, as mentioned earlier and time and again, this document will show indisputably, **the substitution of aluminum for mercury and the addition of human DNA, retroviruses, and the many toxic chemicals of various types that have been added in increasing doses is having the same net effect…immunological and neurological damage to a large percentage of our children**. Considering the epidemic rates of developmental, emotional, immune and other chronic health problems we see today, one must consider that the escalating rates of all of those conditions also parallel the increases in the dose schedules of vaccines over the last 30 years. This document will show strong evidence to that effect.

HUMAN DNA FROM ABORTED FETAL CELLS

Where does the human DNA come from and what problems can it cause?

Once again, referring to the 2011 study done by Dr. Helen Ratajczak called **Theoretical aspects of autism: Causes–A review**. It was published in the ***Journal of Immunotoxicology***. In this study, Dr.

Ratajczak studied the problems associated with injecting human tissue into another person. Please see the CBS report on this study. **In this CBS report it says:** Ratajczak also looks at a factor that hasn't been widely discussed: human DNA contained in vaccines. That's right, human DNA. Ratajczak reports that about the same time vaccine makers took most thimerosal out of most vaccines (with the exception of *multi-dose* flu shots (Hep B and which still widely contain thimerosal), they began making some vaccines using human tissue. Ratajczak says **human tissue is currently used in 23 vaccines**. **She discusses the increase in autism incidences corresponding with the introduction of human DNA to MMR vaccine, and suggests the two could be linked. Ratajczak also says an additional increased spike in autism occurred in 1995 when chicken pox vaccine was grown in human fetal tissue.**
http://www.tandfonline.com/doi/full/10.3109/1547691X.2010.545086

Why could human DNA potentially cause brain damage? The way Ratajczak explained it to me: "Because it's human DNA and recipients are humans, there's homologous recombination. That DNA is incorporated into the host DNA. Where is this most expressed? The neurons of the brain. Now you have body killing the brain cells and it's an ongoing inflammation. It doesn't stop, it continues through the life of that individual."

IMPORTANTLY from the article in the *Journal of Immunotoxicology*: "The human DNA from the vaccine can be randomly inserted into the recipient's genes by homologous recombination, a process that occurs spontaneously only within a species. Hot spots for DNA insertion are found on the X chromosome in eight autism-associated genes involved in nerve cell synapse formation, central nervous system development, and mitochondrial function (Deisher, 2010**). This could provide some explanation of why autism is predominantly a disease of boys. Taken together, these data support the hypothesis that residual human DNA in some vaccines might cause autism."**

Who is Dr. Ratajczak and why is she so qualified in this area? Throughout her illustrious career, she focused on immunology and toxicology with an emphasis on hypersensitivity.

According to Catherine J. Frompovich, in an excellent and telling interview with Dr, Ratajczak posted on Vactruth.org. Dr. Ratajczak worked at the IIT Research Institute in Chicago and was the leader of the Immunology Group. Research there included designing and performing hypersensitivity testing, studying the chronobiology of immunologic endpoints in the mouse and directing the research of graduate students. She also taught applied immunology to graduate students at IIT.

Former positions that Dr. Ratajczak occupied in her long career included working at medical schools where she studied a mouse model of breast cancer, immunology of the eye, and hypersensitivity pneumonitis in the rabbit model of farmers' lung disease. Her PhD research was on respiratory syncytial virus in a golden Syrian hamster model. The research for her MS degree was on rheumatoid arthritis in the human. Her BS degree was in chemistry with a mathematics and physics minor.

With such impeccable credentials, Dr. Ratajczak is more than qualified to discuss immunological and hypersensitivity issues currently surrounding mandatory vaccinations for infants, toddlers, and teens in the United States. Her work in recent years has been in the autism field. You can read an excellent three part 2011 interview by Catherine J. Frompovich, posted on vactruth.org's web site here....
https://vactruth.com/2011/06/06/part-1-of-3-an-interview-about-vaccines-with-helen-v-ratajczak-phd/

How the increased rates of autism correlate with the inclusion of aborted human fetal cell lines and retroviruses into vaccines?

A landmark study published in 2014 in the prestigious ***Journal of Public Health and Epidemiology*** titled, **Impact of Environmental Factors on the Prevalence of Autistic Disorder after 1979** was the first to **show significant data point increases in the prevalence of autism corresponding with introduction of fetal cell line tissues and retroviruses into vaccines in the U.S. The same correlation was also found in the U.K., Western Australia and Denmark when those elements were introduced. The vaccines that added these fetal tissues were the MMR, the Hepatitis A and B, and the Varicella (chickenpox) vaccine.** http://www.academicjournals.org/journal/JPHE/article-full-text/C98151247042

From the summary:
"Autistic disorder change points years are coincident with introduction of vaccines manufactured using human fetal cell lines, containing fetal and retroviral contaminants, into childhood vaccine regimens. This pattern was repeated in the US, UK, Western Australia and Denmark. Thus, rising autistic disorder prevalence is directly related to vaccines manufactured utilizing human fetal cells."

The infamous "hockey stick" shape in the rise of autism when human fetal cell lines were introduced

A 2014 article published in the **Journal of Public Health and Epidemiology** titled, **Impact of environmental factors on the prevalence of autistic disorder after 1979**, produces convincing evidence of the effects of human fetal cell lines on the "change point" where the incidence of autism rose sharply in the late 1980s. https://academicjournals.org/journal/JPHE/article-full-text-pdf/C98151247042

The spikes in autism produced what is called a hockey stick appearance with a steep increase starting at the time of introduction of these cells. You can see the graphs on pages 4 & 5 of the article.

These findings are quite alarming as many of today's vaccines have several different fetal cell lines. As mentioned previously, to see which vaccines contain them you simply need to go to the CDC's website and type in vaccine ingredients, or go here >
https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/b/excipient-table-2.pdf

More from the study…
"**In 1979, coincident with the first autism disorder change point, vaccine manufacturing changes introduced human fetal DNA fragments and retroviral contaminants into childhood vaccines** (Victoria et al., 2010). While we do not know the causal mechanism behind these new vaccine contaminants and autistic disorder, **human fetal DNA fragments are inducers of autoimmune reactions, while both DNA fragments and retroviruses are known to potentiate genomic insertions and mutations** (Yolken et al., 2000; Kurth 1998; U S Food and Drug Administration 2011). **Infants and children are almost universally exposed to these additional vaccine components/contaminants, and these converging events are associated with rising autistic disorder in a dose-de-pendent fashion due to the increasing numbers of**

human fetal manufactured vaccines which have been added to the US immunization guidelines, including Pentacel®, which since 2008, contains inactivated polioviruses grown on the MRC-5 human fetal cell line. Pentacel® is recommended for children at 2, 4 and 6 months of age, and may account for the recent idea that scientists have become more adept at diagnosing autism at younger age. Diagnosis at younger age may more likely be the result of introducing human fetal cell vaccine contaminates to younger children."

**** In addition, let's not forget that shortly after 1999 when mercury was being phased out, aluminum exposure was increasing.***

A pioneering effort in doing research and demanding more scientific scrutiny be done on potential dangers of using vaccines with fetal DNA

Dr. Deisher, founder of *Sound Choice Pharmaceutical Institute* is at the forefront of pushing for scientific scrutiny and accountability in the area of the use of human DNA and retroviruses in vaccines, drugs and cosmetics. https://www.soundchoice.org/

From her Bio… Dr. Theresa Deisher's career has focused on discovering and developing new therapies for grievous human illness. **Dr. Deisher obtained her PhD in Molecular and Cellular Physiology from Stanford University and has spent over 20 years in commercial biotechnology**, working with companies such as Genentech, Repligen, ZymoGenetics, Immunex and Amgen, prior to founding AVM Biotechnology and Sound Choice Pharmaceutical Institute (SCPI). AVM Biotechnology is the marquee prolife biotech company worldwide, certifying that it does not use morally illicit material in any process. SCPI's mission is to end human trafficking in biomedical research.

Dr. Deisher is an inventor on 23 issued US patents, and her discoveries have led to clinical trials of FGF18 for osteoarthritis and cartilage repair, and for Factor XIII for surgical bleeding. Dr. Deisher was the first person to discover adult cardiac derived stem cells and has been a champion of adult stem cell research, both professionally and privately, for two decades. **Dr. Deisher was a plaintiff in the US federal lawsuit to prohibit use of federal taxpayer dollars for embryo destructive research, which was instrumental in steering science towards adult stem cell research, which has led to 14 US FDA approved adult stem cell products and the Washington Post Dec 2013 headline "Scientists go ethical in 2013".**

Pointed and serious questions about human DNA fragments in vaccines are being levied at the pharmaceutical industry by scientists

Dr. Theresa Deisher has called into question several serious issues that the pharmaceutical industry has no answers for.

The article posted on July 28, 2017 on Sound Choices web site titled, **SOUND CHOICE SCIENTISTS SPEAK UP ON VACCINE OUTRAGE**, points to the tone deafness of big pharma and the government on matters of grave health and bioethics concerns. http://soundchoice.org/newsletter-march-2017/

One-point Dr. Deisher argues, is that the studies looking at mercury and the MMR vaccines have missed the forest for the trees. The research done by her and her group of scientists has determined that it is the human fetal DNA fragments from the aborted babies used to culture several of the vaccines, including the MMR vaccine that are triggering autoimmune reactions in susceptible individuals given these vaccines.

This link from that article to a letter Dr. Deisher submitted Testimony on ***Conscience Rights related to biologic drug disclosure and alternative drugs***.
https://bioethicsarchive.georgetown.edu/pcbe/transcripts/sept08/deisher_statement.pdf

I've dedicated a couple of pages to this document, because of the highly important nature of the questions and issues that she raises. **Every person, no matter what your position on vaccines should be very concerned about the "trojan horse" implications of what is being put into our vaccines, biologics, medicines and even food additives.**

Moral and ethical questions

In her opening statement she outlines the informed consent aspect of the issue:
"I would like to discuss Fair Labeling and Informed Consent for our medicines, and to ask for your support for studies to examine the health consequences of having contaminating aborted fetal human DNA in our medicines and vaccines. It is a matter of conscience, whether for moral reasons or safety concerns, that a consumer should be informed of the source of contaminants in our medicines, and of alternative medicines that may be available that would not be morally or philosophically objectionable to them."

She does a fantastic job of articulating serious questions that as of yet the pharmaceutical industry, the CDC, FDA and other governmental agencies have yet to address:

"When pharmaceutical companies switched from using animal cell lines to using aborted human fetal cells lines to produce these vaccines, in the mid to late 1970s, they assumed, without any evidence, that using aborted fetal cells would result in a more efficient production system. Brief discussions about potential adverse health consequences of using aborted human cell lines for vaccine production were captured in minutes from FDA advisory meetings about this switch. **However, no studies have been done to actually measure the extent of those potential adverse consequences.**"

"Vaccines and biologics (engineered proteins as drugs) are too large to make in a test tube, so companies harness the normal machinery used to make these, cells. No final drug is ever completely 'pure' and **you will find contaminating DNA and cellular debris from the production cell in your final product. When we switch from using animal cells to using human cells we now have human DNA in our vaccines and our drugs."**

"Shouldn't parents and grandparents know that when they immunize their children with a particular vaccine they are also injecting their children with **DNA from an aborted fetus**? Yet there are no laws

that require drug manufacturers to inform the public of this. The package insert for the MMR II vaccine (mumps, measles, rubella) states : "MERUVAX* II (Rubella Virus Vaccine Live), the Wistar RA 27/3 strain of live attenuated rubella virus propagated in WI-38 human diploid lung Fibroblasts", **but doesn't tell you that contaminating DNA from the WI-38 propagation strain is found in the final product.** The package insert for Varivax, a chickenpox vaccine, states that the vaccine contains "residual components of MRC-5 cells including DNA and protein", but how many parents or grandparents, let alone pediatricians and pharmacists, would know that MRC-5, or WI-38, is a cell line derived from an aborted fetus, and that **the contaminating DNA and protein listed on the package insert is the DNA and protein of an aborted fetus? If we have the legal right to know what is in our Big Macs, don't we have the right to know what is in our vaccines and medicines?"**

The dangers of contaminating human DNA in our medicines and food

"**Contaminating human DNA in these vaccines has the potential to trigger auto-immune responses and also the potential to become incorporated into our own genes, a process called homologous recombination**."

"How might the human DNA contaminated vaccines contribute to human disease? First, there is the potential for the contaminating DNA to be mixed with our own genes by a process called homologous recombination. **Homologous recombination is an established biologic phenomenon in which a segment of a cell's DNA is substituted by another segment of DNA that is similar.** This can occur during cell division or DNA repair. Homologous recombination occurs naturally to create genetic diversity in our offspring and is also conveniently harnessed by scientists to introduce experimental DNA into cells or animals. We do not yet know if this occurs with the contaminating human DNA found in some of our vaccines, and if so, to what extent**. Imagine the potential consequences of human DNA from a vaccine, a vaccine that is given to children at an average age of 15 months, being incorporated into a child's developing brain. One does not need to be a rocket scientist to know that this potential has to be studied.**"

"In addition to the potential for homologous recombination, **DNA is known to be a powerful immune stimulant**. **Diseases like graft versus host, juvenile (type I) diabetes, multiple sclerosis, lupus and some forms of arthritis are what are called auto-immune diseases. What these are diseases driven by immune attack from our own immune system on our own organs, a system normally responsible to attack invading bacteria and pathogens. Targeted self-destruction, if you will. Science does not yet know, except for graft versus host disease, what triggers the auto-immune attack. We certainly lack studies that have examined the relationship between immune responses to human DNA containing vaccines and auto-immune diseases."**

"I would ask all of you to **support FLICA legislation, Fair Labeling and Informed Consent**, to insure that consumers, whether for moral, philosophical or safety reasons, KNOW what they are giving their children in vaccines. The FLICA legislation would require not only informed consent, but education of each parent about alternative vaccines. With the approval of the creation of HUMAN-ANIMAL hybrids by

the UK this past spring, this legislation is now gaining bipartisan and pro-choice support. Wouldn't you want to know if your medicine contained DNA from a human-animal hybrid?"

"Aborted human DNA in our vaccines is not the end, it is only the beginning, as the creation of human-animal hybrids demonstrates. A new aborted fetal cell line has been developed, called PerC6, and licenses have been taken by over 50 partners, including the NIH and the Walter Reed Army Institute, to use this cell line for new vaccine and biologics production. The goal of the company that created the PerC6 is to become the production cell line for ALL vaccines, therapeutics antibodies, biologic drugs and gene therapy. **We must know the consequences of contaminating human DNA before we wake up and discover that all newly approved recombinant drugs are produced by aborted fetal cells."**

"**Aborted fetal cells are also now used to discover new food additives and flavor enhancers.** Imagine that; the cells from an aborted fetus used to make your candy sweeter. Isn't that disgusting? And furthermore, as the company that performs this research states, **one may never know these additives will someday be in our food products due to the current labeling guidelines which would allow these new additives to be captured under the generic label of 'artificial flavors'."**

*As a point of clarification, according to Debi Vinnedge the Director of COGforlife, there is no residual DNA in the end-product of the flavorings. The cell lines are used in the testing process.

Highly qualified scientist makes the strong case for the dangers of using human fetal tissue to grow viruses for vaccines

The years 2018 and 2019 have seen an unprecedented attack on rights of citizens to make their own free choices when it comes to the drugs and biologicals that the government wishes to force on them and their children. One of those battlefronts is the rights to religious freedom regarding vaccines and the removal of vaccine exemptions for religious beliefs. One such moral and ethical argument is that several vaccines contain human DNA from aborted babies. When those vaccines are administered, that DNA enters the body of the recipient and can combine with the recipient's DNA. The thought of injecting the DNA from a baby that was aborted into one's body or that of their children is entirely reprehensible to many people of faith, including myself. As if that isn't bad enough, the fact that the child was aborted and then used for commercial purposes for financial gain by the pharmaceutical industry makes it that much worse. That is the moral and ethical dilemma that so many people face today. In addition, there is an ominous and dangerous health dilemma that people also need to be aware of. That is, how does the body react to this foreign human DNA? Well, it so happens that it reacts very differently than it would to bovine (cow), porcine (pig) or the DNA of other non-human species.

In an open letter to legislators dated April 08, 2019, Dr. Theresa Deisher explains the dangers of fetal human DNA in vaccines and its connection to autoimmune disease and autism. And she backs it up with the references to the science supporting her assertions. It is an excellent prosecution of the health ramifications. Dr. Deisher is a brilliant woman. **You may recall that Dr. Deisher obtained her PhD in Molecular and Cellular Physiology from Stanford University, has spent over 23 years in the biotechnology field and is an inventor on 23 U.S. Patents**.

Rather than including selected excerpts here, I highly recommend that anyone that doubts the extreme gravity of the threat this practice poses, follow this link and read this compelling letter for themselves. https://www.soundchoice.org/open-letter-to-legislators/

In some cases, ethical alternatives to vaccines tainted by aborted fetal DNA are available

For individuals willing to consent to vaccines and the other ingredients, except for their religious or ethical beliefs regarding the use of aborted fetal cell line DNA, there are alternative vaccines in some cases. This document produced (and updated as of November 2017), by ***Children of God for Life*** shows all of the vaccines that contain DNA from aborted babies and which do and do not offer ethical alternatives. https://cogforlife.org/wp-content/uploads/vaccineListOrigFormat.pdf

Another option is to allow for the separation of the Measles, Mumps and Rubella Vaccine into individual vaccines like they used to be here and are still available in various countries around the world- Why not the U.S.?

According to the ***W.H.O.*** report titled, **Observed Rate of Vaccine Reactions –MMR Vaccines** – 2014:

Monovalent vaccines:
Measles: "Numerous live attenuated measles vaccines, most derived from the Edmonston strain, are currently produced worldwide….."

Mumps: "More than ten live attenuated mumps vaccine strains (Jeryl Lynn, Urabe, Hoshino, Leningrad-3, L-Zagreb, Miyahara, Torii, NK M-46, S-12 and RIT 4385) have been used throughout the world. The Jeryl Lynn strain is used in many countries. Most vaccines contain 25 μg of neomycin per dose. Several manufacturers in Japan and Europe produce a mumps vaccine containing the Urabe Am9 virus strain. However, concerns about vaccine-associated meningitis prompted several countries to stop using Urabe vaccine strain (WER 1992). Other vaccines have more limited distribution. "

Rubella: "Most live attenuated rubella vaccines used throughout the world contain the RA 27/3 virus strain (Plotkin, 1965). Exceptions are vaccines produced in China (BRD2 virus strain) and Japan (Matsuba, Takahashi, and TO-336), produced on rabbit kidney cells, and the Matsuura strain, produced on quail embryo fibroblasts.
https://www.who.int/vaccine_safety/initiative/tools/MMR_vaccine_rates_information_sheet.pdf

2019 study demonstrates that using aborted fetal tissue to produce the Rubella Vaccine is unnecessary

This 2019 study from the journal ***Human Vaccines and Immunotherapeutics*** titled, **Immunogenicity and safety of the new MMR vaccine containing measles AIK-C, rubella Takahashi, and mumps RIT4385 strains in Japanese children: a randomized phase I/II clinical trial**, showed that the alternative strains cultured on quail eggs and rabbit kidney cells, can be as effective and could solve the moral, ethical and religious dilemma that so many people have with the Rubella portion of the MMR vaccine using aborted fetal tissue marketed in the U.S.. https://www.ncbi.nlm.nih.gov/pubmed/30724658

From the Abstract:
"Domestic measles, mumps, and rubella combined (MMR) vaccines were discontinued in 1993 in Japan because of the unexpected high incidence of aseptic meningitis. The introduction of an effective MMR vaccine with lower reactogenicity has been expected. A new MMR vaccine (JVC-001) was developed, using mumps RIT4385 strain in combination with Japanese measles AIK-C strain and rubella Takahashi strain (MR) vaccine."

"Seroconversion rates of measles and rubella were both 100%."

As this study mentioned, the MMR vaccine was introduced in Japan in 1989 and was withdrawn in 1993 due to unexpectedly high rates of aseptic meningitis associated with the mumps Urabe AM 9 strain. One in 900 children developed serious adverse reactions, a rate 2,000 times higher than expected. The fact that countries like Japan, who abandoned that version of the MMR Vaccine due to serious adverse reactions associated with it, have gone to monovalent vaccines **and have developed alternatives to the Rubella portion grown on rabbit or quail tissues, shows that it can be done successfully**. Instead we are still using a Rubella Vaccine containing human DNA. **Again I have to ask, if Japan can offer an alternative Rubella vaccine to the WI-38 cell line, which is propagated on the tissue of the aborted fetus, why can't that be offered in the U.S.?**

The success of the Japanese version of the MMR was known nearly 30 years ago

One of the original studies showing the effectiveness and promise of the replacement MMR Vaccine was published in ***The American Journal of Diseases of Children*** in 1990. The study is titled, **A new combined trivalent live measles (AIK-C strain), mumps (Hoshino strain), and rubella (Takahashi strain) vaccine. Findings in clinical and laboratory studies**.
https://www.ncbi.nlm.nih.gov/pubmed/?term=2198807

From the Abstract:
"Trivalent virus vaccine, containing measles AIK-C strain, mumps Hoshino strain, and rubella Takahashi strain, was administered to a total of 1369 healthy children, 8 months to 18 years of age."

"Inoculation induced sufficient serological responses: 99.7% for measles and rubella viruses and 96.3% for mumps virus. The incidence of febrile reaction (greater than or equal to 37.5 degrees C axillary

temperature) was low, 15.9%, and a temperature of 39.0 degrees C or higher occurred in only 1.3% of the subjects."…. "The seroconversion rate, magnitude of antibody titers, and incidence of clinical reactions following the trivalent vaccination were similar to those occurring after the monovalent measles vaccination."

A third reason is that statistics show a strong correlation to the ever-increasing number of doses and an increasing incidence of autism

A 2018 article on World Mercury Project's web site, highlights that Canadian Government records of autism rates in various provinces and territories correlate with number of doses of vaccines given

On April 26, 2018, Robert F. Kennedy Jr.'s organization World Mercury Project published an article titled, **Official Canadian Data Show That There Is More Autism in Regions Where Vaccine Coverage Is Highest**. The article points to some very interesting correlations related to vaccine coverage and rates of immunization. Interestingly, both documents referenced were released from the ***Public Health Agency of Canada***. The 2013 data regarding the statistics about the percent of children receiving 11 different vaccinations and the compliance with the vaccine schedule, comes from the May 2016 release by the ***Public Health Agency of Canada*** of the report titled, **VACCINE COVERAGE IN CANADIAN CHILDREN RESULTS FROM THE 2013 CHILDHOOD NATIONAL IMMUNIZATION COVERAGE SURVEY (CNICS)**.
http://healthycanadians.gc.ca/publications/healthy-living-vie-saine/immunization-coverage-children-2013-couverture-vaccinale-enfants/alt/icc-2013-cve-eng.pdf

The 2015 data regarding the rates of autism comes from the March 2018 release by the ***Public Health Agency of Canada*** of a report titled, **AUTISM SPECTRUM DISORDER AMONG CHILDREN AND YOUTH IN CANADA 2018- A REPORT OF THE NATIONAL AUTISM SPECTRUM DISORDER SURVEILLANCE SYSTEM**
https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/diseases-conditions/autism-spectrum-disorder-children-youth-canada-2018/autism-spectrum-disorder-children-youth-canada-2018.pdf

From the World Mercury Project article:
"The Canadian public had been expecting the ***Public Health Agency of Canada*** to release these first-ever nationally representative ASD numbers since 2016. The data come from the National ASD Surveillance System (NASS), which, according to the Public Health Agency, is intended to pinpoint the number of young people diagnosed with ASD "both across regions and over time." The Agency's report provides answers on both fronts—showing steady increases in ASD prevalence since 2003 and notable differences across regions—but the document declines to speculate on factors that might account for the regional differences."

"NASS compiles administrative data from the health, education and social services sectors for children and youth (aged 5-17 years) who have a confirmed ASD diagnosis. Seven of Canada's 13 provinces and territories provided information for 2015, including six provinces (British Columbia, New Brunswick, Newfoundland and Labrador, Nova Scotia, Prince Edward Island and Quebec) and one territory (Yukon). As the figure below *(figures are located in the article at **the World Mercury Project** link below)* **shows, ASD prevalence in 2015 varied among the seven regions, with the highest prevalence noted in the three provinces of Newfoundland and Labrador (1 in 57), Prince Edward Island (1 in 59) and Quebec (1 in 65). In comparison, prevalence was substantially lower in the Yukon territory (1 in 125).**"

The report shows between a 227% and a 349% increase in autism rates of the most highly vaccinated provinces over the 6 to 12-year periods studied!

"The three high-prevalence provinces also provided retrospective data that allowed for an assessment of temporal trends. For the slightly narrower age group of 5-14 year olds, the historical data showed sizeable increases in ASD prevalence from 2003 to 2015 (Prince Edward Island and Quebec) and from 2003 to 2009 (Newfoundland and Labrador):

- Newfoundland and Labrador: from 6 to 19.6 per 1,000 **(a 227% increase)**
- Prince Edward Island: from 5 to 17.7 per 1,000 **(a 254% increase)**
- Quebec: from 3.5 to 15.7 per 1,000 **(a 349% increase)"**

When the Data from the Autism statistics report was cross referenced with the report released earlier (the vaccination compliance report), the correlation was quite striking! There are 2 graphs in the **World Mercury Project Report** that show this visually. The first shows the rates of autism ad the second shows the rates of vaccination coverage in 2-year olds living in the different geographic regions, for 11 different vaccines. The highest rates of vaccine coverage were in Newfoundland and Labrador. The lowest rates of vaccine coverage were in the Yukon Territory. **As mentioned above, Newfoundland and Labrador had an autism rate of 17.5 per 1,000 children (1 in 57). The Yukon had a rate of 8 per 1,000 (1 in 126), nearly half the rate of Newfoundland and Labrador. The Province of New Brunswick with the second lowest vaccination coverage had the second lowest rate of autism at 12.6 per 1,000 (1 in 79)**. As the article states, correlation does not always mean causation, but it does warrant further NON-BIASED investigation, especially since the differences are so dramatic and linear.
https://worldmercuryproject.org/news/official-canadian-data-show-that-there-is-more-autism-in-regions-where-vaccine-coverage-is-highest/

Number of vaccine doses correlates with rates of autism and speech and language impairment in the U.S.

A 2011 study published in the ***Journal of Toxicology and Environmental Health*** titled, **A positive association found between autism prevalence and childhood vaccination uptake across the U.S. population**, make the strong assertion that the number of vaccines directly correlates to the rates of autism. https://www.ncbi.nlm.nih.gov/pubmed/21623535

The Abstract:
"The reason for the rapid rise of autism in the United States that began in the 1990s is a mystery. Although individuals probably have a genetic predisposition to develop autism, researchers suspect that one or more environmental triggers are also needed. **One of those triggers might be the battery of vaccinations that young children receive.** Using regression analysis and controlling for family income and ethnicity, the relationship between the proportion of children who received the recommended vaccines by age 2 years and the prevalence of autism (AUT) or speech or language impairment (SLI) in each U.S. state from 2001 and 2007 was determined. **A positive and statistically significant relationship was found: The higher the proportion of children receiving recommended vaccinations, the higher was the prevalence of AUT or SLI. A 1% increase in vaccination was associated with an additional 680 children having AUT or SLI.** Neither parental behavior nor access to care affected the results, since vaccination proportions were not significantly related (statistically) to any other disability or to the number of pediatricians in a U.S. state. **The results suggest that although mercury has been removed from many vaccines, other culprits may link vaccines to autism. Further study into the relationship between vaccines and autism is warranted.**"

The authors of this study could not have been more clear and direct than that!

ALUMINUM

Another reason beyond mercury and human fetal DNA that autism rates continue to rise, is the Increasing use of aluminum as an adjuvant in vaccines is a MAJOR issue

Aluminum is a toxic metal like mercury. Is it Safer? Scientists say a resounding NO!

One thing I hear repeatedly in the media is "mercury has been removed from vaccines". This statement is designed to reassure the public that a toxic metal no longer resides in their vaccines. This false sense of security is based on a half-truth. Yes, mercury has been removed

from many vaccines, but the use of aluminum as a vaccine adjuvant has far exceeded the maximum threshold of exposure mercury had ever achieved. And in fact, aluminum has been shown to be significantly more neurotoxic (up to 7X more!).

Before diving into the mountain of evidence proving aluminum's toxicity, how prevalent is the evidence linking aluminum and toxicity?

An August 9th, 2018 PubMed search of the key words Aluminum and toxicity revealed 5,262 articles!

Just the sheer number of scientific articles dedicated to the toxicity of aluminum, doesn't shout safe to me. In fact, as one scrolls through the titles and samples some of the abstracts that come up, you would be shocked as to the level of insistence by scientists of the significant toxicity of aluminum in the human body. If you do that search, you will see the results by year graphic on the right. By running your cursor over the columns in the graphic, you can see how many articles have been posted annually. As you will see, most of these articles have been produced since 2005 **with 298 produced in 2016 alone. With the growing body of evidence linking aluminum to neurological and immunological damage in the human body over the last decade, there is NO excuse for vaccine manufacturers continued use in vaccines. You will see plenty of evidence of what I am talking about in the remainder of this document. You will hear from numerous researchers and scientists, as they call for a ban of mercury and aluminum from ALL vaccines!**

Aluminum produces 7 times more Reactive Oxygen Species (dangerous free radicals), than mercury

What are Reactive Oxygen Species, why are they so dangerous and how does that relate to vaccine damage?

Definition of Reactive Oxygen Species (ROS) = A very unstable and reactive molecule that contains oxygen and easily reacts with other molecules in a cell by robbing electrons and destabilizing those molecules. A build-up of reactive oxygen species in cells may cause damage to DNA, RNA, and proteins, and may cause cell death. Reactive oxygen species are also referred to as free radicals. They are also called oxygen radicals. Examples include hydroxyl radicals, superoxide radicals, peroxides and singlet oxygen. The damaging effects of oxygen free radicals on molecules and thus on cells, is called oxidative stress.

In this next study, **they tested the production of ROS in human nerve cells by different metals. ROS produced by vaccine adjuvants have been implicated in the development of neurological and**

immunological impairments in children seen after administration of vaccines. They have also been implicated in progressive, long-term neurodegenerative diseases such as Alzheimer's, Dementia, Parkinson's and ALS (Lou Gehrig's Disease).

The 2012 study published in the ***International Journal of Molecular Sciences*** titled, **Metal-Sulfate Induced Generation of ROS in Human Brain Cells: Detection Using an Isomeric Mixture of 5- and 6-Carboxy-2',7'-Dichlorofluorescein Diacetate (Carboxy-DCFDA) as a Cell Permeant Tracer** *(that sounds way above my pay grade-ha).* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3431818

From that abstract:
"We introduced pathological stress using the sulfates of 12 environmentally-, industrially- and agriculturally-relevant divalent and trivalent metals including **Aluminum**, Cadmium, Copper, Iron, **mercury**, Gallium, Magnesium, Manganese, Nickel, Lead, Tin and Zinc. In this experimental test system, of all the metal sulfates analyzed, **aluminum sulfate showed by far the greatest ability to induce intracellular ROS."**

"…and aluminum was determined to stand out among all the ions studied for its remarkable ability to induce ROS, even compared with mercury and lead. Aluminum induced a response that was a factor of seven higher than that of mercury and a factor of three higher than that of lead."

The same study identifies Aluminum as toxic to genes (DNA and RNA)

Genotoxicity is defined as a destructive effect on a cell's genetic material (DNA, RNA) affecting its integrity. Genotoxins are mutagens; they can cause mutations.

"**Besides being toxic to the human reproductive system, mucous membranes, skin, eyes, and urinary s, aluminum sulfate is intensely genotoxic**."

The article also states the combination of these metals (such as aluminum and mercury found in many vaccines) can be "additive or synergistic", meaning it can multiply the effects of the ROS. This is addressed in this document on pages 236-237.

Aluminum exposure including from vaccines, causes a wide array of neurological and autoimmune disorders

A 2013 study published in the Journal ***Immunologic Research*** titled, **Aluminum in the central nervous system (CNS): toxicity in humans and animals, vaccine adjuvants, and autoimmunity**, clearly demonstrated the negative neurological and autoimmune generating impacts of aluminum across all ages, including the number of aluminum containing vaccines and the rate of autism spectrum disorders. https://www.ncbi.nlm.nih.gov/pubmed/?term=23609067

From the abstract:
"We have examined the neurotoxicity of aluminum in humans and animals under various conditions, following different routes of administration, and provide an overview of the various associated disease states. **The literature demonstrates clearly negative impacts of aluminum on the nervous system across the age span. In adults, aluminum exposure can lead to apparently age-related neurological deficits resembling Alzheimer's and has been linked to this disease and to the Guamanian variant, ALS-PDC. Similar outcomes have been found in animal models. In addition, injection of aluminum adjuvants in an attempt to model Gulf War syndrome and associated neurological deficits leads to an ALS *(Lou Gehrig's Disease),* phenotype *(expression)* in young male mice. In young children, a highly significant correlation exists between the number of pediatric aluminum-adjuvanted vaccines administered and the rate of autism spectrum disorders. Many of the features of aluminum-induced neurotoxicity may arise, in part, from autoimmune reactions, as part of the ASIA syndrome**."

There are massive amounts of aluminum in childhood vaccines!

The amount of aluminum in the Hepatitis B vaccine is 14 X what the FDA approves

At birth, most children are given **the hepatitis B vaccination which contains 250 mcg. of aluminum**. The amount of aluminum in the Hepatitis B vaccine alone, is almost **14 TIMES THE AMOUNT OF ALUMINUM THAT IS FDA-APPROVED. But, as you will read in this next section, IT GETS MUCH WORSE AS MULTIPLE VACCINES CONTAINING HIGH LEVELS OF ALUMINUM ARE PILED ON!**

So, we learn from those FDA documents that if a premature baby receives more than 10 mcg of aluminum in an IV, it can accumulate in their bones and brain, and can be toxic.

The FDA maximum restrictions for aluminum received in an IV **is 25 mcg**. The suggested aluminum per kg (2.2 pounds), of weight to give to a person is up to 5mcg/day. **(so, a 5-pound baby *should* get no more than 11 mcg of aluminum.)**

All I.V. products given for parenteral nutrition are required to contain less than 25 mcg of aluminum. In addition, all products are to have a warning on the label that reads:

WARNING: *This product contains aluminum that may be toxic.* ***Aluminum may reach toxic levels with prolonged parenteral administration if kidney function is impaired. Premature neonates are particularly at risk because their kidneys are immature****, and they require large amounts of calcium and phosphate solutions, which contain aluminum.*

Research indicates that patients with impaired kidney function, ***including premature neonates, who receive parenteral levels of aluminum at greater than 4 to 5 [micro]g/kg/day accumulate aluminum at***

levels associated with central nervous system and bone toxicity. Tissue loading may occur at even lower rates of administration. (My comment: Tissue loading is exactly what happens when multiple vaccines containing aluminum are given over a period of time).
[http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?fr=201.323]
The FDA page containing this information was last updated April 01, 2017.

— Vaccines, for some reason, are not required to have this label and also are not required to follow the maximum dosage of 25 mcg.

Parenteral nutrition formulas exceed aluminum exposure to infants by 12-fold

This study was published in the ***Journal of Parenteral and Enteral Nutrition*** and titled, **Aluminum exposure from pediatric parenteral nutrition: meeting the new FDA regulation**, found that aluminum levels of exposure to infants were being far exceeded, even in products containing the lowest aluminum concentrations. https://www.ncbi.nlm.nih.gov/pubmed/18443135

The following quote came from a 2011 study published in the Journal of Pediatric Pharmacology and Therapeutics titled, **Aluminum in Pediatric Parenteral Nutrition Products: Measured Versus Labeled Content.**

"A 2006 study by Poole et al., calculated the expected daily aluminum exposure from pediatric PN solutions based on the manufacturer-stated aluminum concentration. Even when selecting products allegedly containing the lowest aluminum concentration, expected average aluminum exposure in infants was 59.9 mcg/kg/day, exceeding the FDA recommended limit by a 12-fold measure. The FDA's recommended limit of 5 mcg/kg/day was only feasible in patients weighing over 50 kg." ***(For reference 50 kg is 110 pounds!)***
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3208446/#i1551-6776-16-2-92-b15

Let's do the math. How much aluminum is in childhood vaccines?

So, doing some math — the following are examples of weight with their corresponding **maximum** levels of aluminum, **per the FDA**:

- **8-pound**, healthy baby: **18.16 mcg of aluminum**
- **15-pound**, healthy baby: **34.05 mcg of aluminum**
- **30-pound**, healthy toddler: **68.1 mcg of aluminum**
- **50-pound**, healthy child: **113 mcg of aluminum**
- **150-pound** adult: **340.5 mcg of aluminum**

- **350-pound** adult: **794.5 mcg of aluminum**

How much aluminum is in the vaccines that are routinely given to children and what do those amounts total?

- **Hib** (PedVaxHib brand only) – 225 mcg per shot **(and up to 4 doses are recommended by 18 months, equivalent to 775-900 mcg!)**
- **Hepatitis B** – 250 mcg **(and 3 doses are recommended by 12 months, equivalent to 750 mcg!)**
- **DTaP** – depending on the manufacturer, ranges from 170 to 625 mcg **(and 3 doses are recommended by age 1 and a 4th by age 15 months, equivalent to up to 2,500 mcg!)**
- **Pneumococcus** – 125 mcg **(and 4 doses are recommended by age 1, equivalent to 500 mcg!)**
- **Hepatitis A** – 250 mcg **(and 1 dose is recommended at age 1 and another 6 months later, equivalent to 500 mcg!)**
- **HPV** – 225 mcg (1st dose recommended at age 11-12, but says can start as early as age 9- **up to 3 doses total equivalent up to 675 mcg)**
- **Pentacel** (DTaP, HIB and Polio combo vaccine- 5 different vaccines in one shot) – **330 mcg**
- **Pediarix** (DTaP, Hep B and Polio combo vaccine- 5 different vaccines in one shot) – **850 mcg**

Remember what I just said? The amount of aluminum in the Hepatitis B vaccine alone is almost 14 TIMES THE AMOUNT OF ALUMINUM THAT IS FDA-APPROVED. In addition to that, consider this!

At well-child check-ups, it's common for 2-month, 4-month, 6 month etc., appointments to include up to 8 vaccinations that add up to more than 1,000 mcg of aluminum in one sitting. In fact, the Pediarix Vaccine can be given as early as 6 weeks according to the package insert- "**Immunization** with **PEDIARIX** consists of 3 doses of 0.5 mL each by intramuscular injection at 2, 4, and 6 months of age (at intervals of 6 to 8 weeks, preferably 8 weeks). The first dose may be **given** as early as 6 weeks of age."
If a 6-week-old baby receiving the Pediarix Vaccine weighs 12 pounds or 5.5 kg., that means that the 850 mcg of aluminum they receive is 34 TIMES more than the FDA allows in I.V. nutrition in a 24-hour period! Look at the chart above and notice that that amount isn't even safe for a 350-pound adult!

In total, the CDC's 2018 schedule calls for up to 35 doses of 10 different vaccines in the first 18 months of life with a potential total of up to 5,825 mcg of aluminum!
Now consider that the average 18-month-old weighs 23-pounds. The FDA's maximum amount of aluminum given intravenously would be only 52.15 mcg for a 23-pound (10.43 kg) baby. Again, taking

the example above of a 23-pound child receiving as much as 1,000 mcg of aluminum in one doctor's visit, that is 19X what the FDA allows for parenteral I.Vs.
See the CDC vaccine schedule here: https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html#f6

One of the changes in the 2018 vaccine schedule was the addition of+ 2 more doses by 15 months. One of those vaccines happens to be the 4th dose of DTaP, which depending on the manufacturer and version contains aluminum, two antibiotics that are not supposed to be used together (Neomyxin and Polymyxin B Sulfate), formaldehyde, polysorbate 80, 2-phenoxyethanol, glutaraldehyde, foreign DNA, VERO cells from monkey kidney cells, MRC-5 human diploid cells from aborted babies and many other questionable ingredients. So, by 15 months babies have had 4 doses of this toxic soup. The other one they most likely will have by 15 months is the Hepatitis A, which contains many of these same ingredients.
https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf

A recent article from the International Journal of Vaccines and Vaccination sounds the alarm of the amount of aluminum in childhood vaccines.

A 2017 article from the ***International Journal of Vaccines and Vaccinations*** titled, **Short Review of Aluminum Hydroxide Related Lesions in Preclinical Studies and their Relevance**, discusses several complications of the aluminum adjuvants found in vaccines.
https://pdfs.semanticscholar.org/2018/02108484552f4bf614e80fbf5d029e3576c2.pdf

From the Abstract:
"Aluminum is currently the most commonly used vaccine adjuvant. Toxicity and safety in regards to the use of aluminum adjuvants is highly controversial and also confused by conflicting study results."

"Nevertheless, aluminum is a well demonstrated toxin in biological systems and its specific impacts on the nervous system have been widely documented."

"The EMA restricted the aluminum content to **1.25 mg per human dose**. **An aluminum-containing placebo is often used while evaluating safety and efficacy of vaccine clinical trials, either containing equal or greater amount of aluminum as to the test vaccine. Without exception, these trials shown a comparable rate of adverse reactions between the placebo and the test group. According to the FDA, a placebo is "an inactive pill, liquid, or powder that has no treatment value". The established neurotoxic properties of aluminum therefore suggest that aluminum-containing formulations cannot serve as a valid placebo.**"

"…**studies with various animal models have reported aluminum hydroxide to induce motor deficits, motor degeneration and neuroinflammation**. A recent technology, taking advantage of fluorescent nano diamonds, that allows aluminum hydroxide particles to be traced in tissue have shown the

progressive shrinkage of the local granuloma **and the translocation of aluminum from the injection site to draining lymph nodes, spleen and brain tissue**."

"Despite the longstanding and widespread use of aluminum adjuvants their precise mechanism of action **remains poorly understood**. The physiochemical mechanism can be described by aluminum hydroxide stimulation of the immune system by **inducing the release of uric acid, an immunological danger signal**, which strongly attracts certain types of monocytes who differentiate into dendritic cells. The antigen is carried by the dendrite cells to the lymph nodes where it stimulates T cells and B cells. Aluminum adjuvant is potent stimulators of the immune system and specially shift the immune response towards a Th2 profile." *A Th2 profile means that the immune system Is shifted towards an allergy/autoimmune propensity.*

The article calls out pro-vaccine studies for falsely comparing orally ingested aluminum to injected aluminum

The way aluminum is administered makes a huge difference. The article addresses it in the following manner: "It must also be recognized that aluminum compounds may vary in their toxic potential depending on the specific route of administration. Mice fed with aluminum hydroxide at 66.5, 133 and 266 mg Al/kg body weight /day did not reveal neuro developmental damage, **while parenteral *(Intravenous or injected)* administration of aluminum chloride in rats at 40 mg/kg bw/day caused maternal deaths, embryo lethality, growth retardation and fetal abnormalities. It has been concluded that dietary aluminum is very poorly absorbed, ~0.25 %, is absorbed into systemic circulation, and aluminum from vaccines may be absorbed at nearly 100%**

What does the FDA say are "safe" levels for aluminum intravenously and how does that compare to what a child gets with their vaccinations?

One of the most important considerations when reading this part, is that the comparison of aluminum given intravenously through I.V.s correlated closely with vaccines, which are injected directly into the body. Vaccine proponents will often falsely argue that there is more aluminum in breast milk or food than in the vaccines. Even if this were true as I explain in detail in a few pages, the comparison is like comparing apples to oranges and calling them exactly the same thing. **Aluminum ingested orally is very poorly absorbed into the bloodstream (1% or less), compared to 100% with injected aluminum.**

According to the *FDA Code of Federal Regulations Title 21, Volume 4*:

"Aluminum may reach toxic levels with prolonged parenteral administration [this means injected into the body] if kidney function is impaired . . . Research indicates that patients with impaired kidney function, including premature neonates [babies], who received parenteral levels of aluminum at greater than 4 to 5 micrograms *(mcg)*, per kilogram of body weight per day, accumulate aluminum at levels associated with central nervous system and bone toxicity ***(for a tiny newborn, this toxic dose would be 10 to 20 micrograms, and for an adult it would be about 350 micrograms)***. Tissue loading may occur at even lower rates of administration." **[Department of Health and Human Services, Food and Drug**

Administration, Document NDA 19-626/S-019, Federal Food, Drug and Cosmetic Act for Dextrose Injections.]"

A 2016 article discussing the most commonly used aluminum adjuvant and the threat of it migrating to the brain in what researchers call a "Trojan Horse" effect. Researchers calling for "a serious re-evaluation" of the long-term effects

A 2016 study released in the journal ***Morphologie*** titled, **Aluminum adjuvants of vaccines injected into the muscle: Normal fate, pathology and associated disease**, raises serious concerns over the mechanism by which aluminum from the most commonly used aluminum adjuvant in vaccines **can migrate to lymphoid organs and the brain leading to autoimmune and neurological damage**. Incredibly, it also admits that we do not even have a good handle on the mechanisms by which it affects the immune system response. https://www.ncbi.nlm.nih.gov/pubmed/26948677

From the Abstract:
"Aluminum oxyhydroxide (Alhydrogel(®)) is a nano-crystalline compound forming aggregates that has been introduced in vaccine for its immunologic adjuvant effect in 1926. It is **the most commonly used adjuvant in human and veterinary vaccines but mechanisms by which it stimulates immune responses remain ill-defined**. Although generally well tolerated on the short term, it has been suspected to **occasionally cause delayed neurologic problems in susceptible individuals. In particular, the long-term persistence of aluminic granuloma also termed macrophagic myofasciitis is associated with chronic arthromyalgias and fatigue and cognitive dysfunction**. Safety concerns largely depend on the **long biopersistence** time inherent to this adjuvant, which may be related to its quick withdrawal from the interstitial fluid by avid cellular uptake; **and the capacity of adjuvant particles to migrate and slowly accumulate in lymphoid organs and the brain**, a phenomenon documented in animal models and resulting from MCP1/CCL2-dependant translocation of adjuvant-loaded monocyte-lineage cells (**Trojan horse phenomenon**). **These novel insights strongly suggest that serious re-evaluation of long-term aluminum adjuvant phamacokinetics and safety should be carried out**."

Currently, there are 26 vaccines on the U.S. Market that contain aluminum. Some contain two forms of aluminum.

https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/b/excipient-table-2.pdf

Aluminum can compromise brain development and cause permanent neurological impairments

A section from the book ***A Comprehensive Guide to Autism*** titled, **Autism Spectrum Disorders and Aluminum Vaccine Adjuvants**, points the finger at aluminum as a significant contributing factor to the epidemic rates of autism.

https://link.springer.com/referenceworkentry/10.1007%2F978-1-4614-4788-7_89

The Abstract:
"**Impaired brain function, excessive inflammation, and autoimmune manifestations are common in autism. Aluminum (Al), the most commonly used vaccine adjuvant, is a demonstrated neurotoxin and a strong immune stimulator. Hence, adjuvant Al has the necessary properties to induce neuroimmune disorders. Because peripheral immune stimuli in the postnatal period can compromise brain development and cause permanent neurological impairments, the possibility that such outcomes could also occur with administration of Al vaccine adjuvants needs to be considered.** In regard to the risk of adjuvant toxicity in children, the following should be noted: **(i) children should not be viewed as "small adults" as their unique physiology makes them more vulnerable to toxic insults; (ii) in adult humans Al adjuvants can cause a variety of serious autoimmune and inflammatory conditions including those affecting the brain, yet children are routinely exposed to much higher amounts of Al from vaccines than adults; (iii) compelling evidence has underscored the tight connection between the development of the immune system and that of the brain. Thus, it appears plausible that disruptions of critical events in immune development may also play a role in the establishment of neurobehavioral disorders; (iv) the same immune system components that play key roles in brain development appear to be targeted for impairment by Al adjuvants. In summary, research data suggests that vaccines containing Al may be a contributing etiological factor in the increasing incidence of autism.**"

THE MASSIVE INCREASE IN VACCINE DOSES & CUMMULATIVE EXPOSURE TO ALUMINUM

Intravenous aluminum deemed dangerous- Why not in vaccines?

Intravenous feeding solutions containing aluminum recognized as dangerous for infants in 1996

This article titled **Aluminum Toxicity in Infants and Children** published in in 1996, in the ***Journal Pediatrics*** **(which is the official journal for the American Academy of Pediatrics),** sounded the alarm on aluminum exposure to infants from common fluids given intravenously in the hospital.
http://pediatrics.aappublications.org/content/97/3/413

The article stated the following:
"A number of substances commonly administered intravenously, including calcium and phosphorus salts and albumin, have high levels of aluminum. Premature infants receiving intravenous fluid therapy may accumulate aluminum and show evidence of aluminum toxicity. Efforts are being made to reduce the levels of aluminum in products added to intravenous solutions; these efforts must continue."

Isn't it strange that the American Academy of Pediatrics would be so concerned about aluminum exposure to infants in 1996, but has had nothing to say about the high levels of aluminum from multiple vaccines as new vaccines containing aluminum have been added to the schedule?

According to the CDC's schedule as of 2009 and the product inserts from those vaccines, the average child was receiving nearly 5,000 mcg (or 5 mg) of aluminum by 18 months of age, The FDA says that anything over .85 mg of aluminum can be dangerous. Do the math yourself. The average child receives approximately 600% more aluminum from vaccines alone than the FDA deems safe.

Intravenous (I.V.) aluminum impacts mental development scores

This is yet another article discussing the neurotoxicity of aluminum in infants. It was published in the ***New England Journal of Medicine*** 1997 and titled, **Aluminum Neurotoxicity and Preterm Infants Receiving Intravenous Feeding Solutions**.
http://www.nejm.org/doi/full/10.1056/NEJM199705293362203#t=article

From the article:
"The former (the group with standard levels of 25 mcg/dl aluminum in the feeding solution), were significantly more likely (39 percent, vs. 17 percent of the latter group) to have a Mental Development Index of less than 85, increasing their risk of subsequent educational problems. For all 157 infants without neuromotor impairment, increasing aluminum exposure was associated with a reduction in the Mental Development Index, with an adjusted loss of one point per day of intravenous feeding for infants receiving the standard solutions."

"In infants fed intravenously for 10 or more days, those receiving the standard solutions had a major (10 point) deficit in their Mental Development Index and were twice as likely to have a Mental Development Index below 85. **These results provide support for our hypothesis that intravenous aluminum may have neurotoxic effects, longer-term consequences for neurologic development**."

"However, a substantial number of infants received little or no intravenous feeding after randomization, and explanatory **analysis showed that the effect of aluminum exposure was dose-related**."

Conclusions: In preterm infants, prolonged intravenous feeding with solutions containing aluminum is associated with impaired neurologic development.

To be clear, vaccines are delivered by injection and there is no reason to believe that the results would be any different than in this study. As many studies in this document reveal, metals travel from the injection site to distant parts of the body, including the organs and brain.

A 2014 study cites the dangers of using aluminum in pharmaceutical products

A 2014 study in the journal of ***Critical Reviews in Toxicology*** titled, **Systematic review of potential health risks posed by pharmaceutical, occupational and consumer exposures to metallic and nanoscale aluminum, aluminum oxides, aluminum hydroxide and its soluble salts**, exposes the dangers of aluminum in pharmaceutical products, cites the dangers prenatally and postnatally and calls for the change in its use. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4997813/

From the study:
"Aluminum exposures during neonatal and pediatric parenteral nutrition (PN) can impair bone mineralization and delay neurological development. Adverse effects to vaccines with Al adjuvants have occurred; however, **recent controlled trials found that the immunologic response to certain vaccines with Al adjuvants was no greater, and in some cases less than, that after identical vaccination without Al adjuvants**." *(Cases in point, the articles cited five pages prior)*

"**The scientific literature on the adverse health effects of Al is extensive**. Health risk assessments for Al must take into account individual co-factors (e.g., age, renal function, diet, gastric pH). **Conclusions from the current review point to the need for refinement of** the PTWI, reduction of Al contamination in PN solutions, **justification for routine addition of Al to vaccines**, and harmonization of OELs *(Occupational Exposure Limits)* for Al substances."

"Given the absence of standardized quantitative measures designed to calculate the therapeutic ratio, the comparative safety and/or efficacy of Al adjuvants in these vaccines, especially in children and pregnant women (Wijnans et al. 2011), remains unknown."

"Based on results with the relatively few published controlled trials with Al adjuvants it is not clear whether routine use of Al adjuvants represents best clinical practice."

"**Of the vaccines currently registered in the United States, 12 contain Al(OH)3 and 23 contain other Al compounds**. Standard adjuvants in diphtheria, tetanus, and pertussis (DTP) and other vaccines include alum (AlK(SO4)2, Al2(SO4)3, Adju-Phos (Al(PO4)3) Imject Alum (Al(OH)3 + MgOH) and alhydrogel (Al(OH)3). The United States FDA limits the elemental Al content of a single vaccine injection to 0.85 mg a value equivalent to 2.45 mg Al(OH)3 per dose."

Unfortunately, as we have already established that single injection limit is often far exceeded due to multiple vaccines given at a time. The other factor is that the metals continue to "seep" from the injection site for months or years after injection. This exposes the recipient to an accumulative effect into the end organ storage depots.

In an opinion editorial, a retired nurse astutely asks, why we aren't looking at aluminum in medical products as a way to PREVENT Alzheimer's. She also implicates vaccines.

The original opinion piece was published in the Pittsburgh Post- Gazette July 29, 2019 by ***Kenneth I. Moch*** and titled **Scientists can beat Alzheimer's**. https://www.post-gazette.com/opinion/Op-Ed/2019/07/29/Kenneth-I-Moch-Alzheimers-dementia-neurodegenerative-scientists-politicians/stories/201907290009?cid=search .

The retired nurse, ***Pat Sassano's*** response was posted August 10, 2019….. "In response to the op-ed "Scientists Can Beat Alzheimer's" by Kenneth Moch: **There was no mention made regarding finding the cause of Alzheimer's. We know that finding the cause of a disease is far more beneficial and cost effective than finding a cure.**

Scientists and nephrologists in the 1970s were well aware that dialysis treatments were causing an irreversible dialysis dementia, an encephalopathy, from aluminum toxicity in the dialysate and oral binders required in treatment of renal failure. We removed the source of aluminum toxicity and solved the dialysis dementia problem.

Aluminum has long been thought to play a role in the cause of Alzheimer's disease, which is the most common form of dementia. Aluminum has no known beneficial function in the human body, **and we know that it causes inflammation in the tissues in which it is deposited.**

One of the leading scientists in aluminum toxicity found large deposits of aluminum in the donated brains of many Alzheimer's patients. One of the largest sources of aluminum is the adjuvants of many of the vaccines on the schedule of the Centers for Disease Control and Prevention. When injected, it is transported and deposited in the brain the same way it found its way into the brains of our dialysis dementia patients.

Shouldn't we be looking at the accumulation of aluminum in the products and medications we use as a cause of the Alzheimer's problem as well as developing effective treatments to cure it?"

This is exactly what more medical professionals need to be doing. That is questioning the status quo and asking for action on this critically important issue. If you are a medical professional reading this, it is your ethical responsibility to speak up. Millions of lives are depending on it.

NEW - Was amorphous aluminium hydroxyphosphate sulfate adequately evaluated before authorisation in Europe?

This article reveals more of the shenanigans that vaccine makers use to cook the books in their vaccine trails. The HPV vaccine Gardasil is arguable the most notorious vaccine currently on the market with regard to a high level of serious adverse reactions. The aluminum used as the adjuvant is accused of being the main culprit along with Polysorbate 80. This article sheds light on the apparent sleight of hand

regarding the type of aluminum (one with a higher risk safety profile) used in the vaccine compared to what was approved.

Abstract

The Merck Sharp & Dohme Corp aluminium adjuvant 'amorphous aluminium hydroxyphosphate sulfate' (AAHS), primarily used in the Gardasil vaccines against human papilloma virus, has been criticised for lack of evidence for its safety. Documentation from Danish authorities and answers from the European Medicines Agency (EMA) suggest that AAHS may not have been sufficiently evaluated. Documentation from the Danish Medicines Agency shows discrepancies in the trial documents of two prelicensure clinical trials with Gardasil in 2002 and 2003. **For both trials, the Agency seems to have authorised potassium aluminium sulfate as the adjuvant and not AAHS**. In addition, the participants in the trial launched in 2002 **were informed that the comparator was saline, even though the comparator was AAHS** in an expedient consisting of L-histidine, **polysorbate-80**, sodium borate and sodium chloride. According to the EMA, AAHS was first introduced in Europe in 2004 as the adjuvant in Procomvax, a vaccine against the hepatitis B virus and *Haemophilus influenza* type b. The EMA reports that AAHS was introduced without any prelicensure safety evaluation. The adjuvant is described by the company to be both physically and functionally distinct from all other previously used aluminium adjuvants. There is a need for rigorous evaluation of benefits and harms of the adjuvant AAHS.
https://ebm.bmj.com/content/early/2020/08/05/bmjebm-2020-111419.long

Children have experienced a huge increase in the number of aluminum containing vaccines

Aluminum containing vaccines have gone from four in the 1970's to seventeen today

This is an excellent 2015 article by **Dr. Joseph Mercola** titled, **The Case Against Aluminum in Vaccines**

http://articles.mercola.com/sites/articles/archive/2015/03/31/aluminum-vaccines.aspx

The article discusses that the first vaccine children receive in the USA is the hepatitis B, which contains 225 mcg of aluminum and is often given within the baby's first 48 hours of life. "This is five times the total exposure of orally absorbed aluminum through the next six months. Premature babies have to deal with this load with even lower kidney function and lots more aluminum that comes from the medications (such as I.V. feeding solutions), given in the newborns intensive care unit (NICU)."

"While mercury preservative has been mostly removed from vaccines because of its known neurotoxicity, **the levels of adjuvant aluminum have virtually no upper limit in the vaccine program**. **The number of aluminum-containing vaccines children receive today[6] has quadrupled over the past 30**

years. In the 1970s, children got only four aluminum-containing vaccines in their first 18 months of life, but now they typically receive 17."

In this article are two excellent videos. One is by ***Dr. Suzanne Humphries*** author of ***Dissolving Illusions*** explaining about the toxicity of aluminum in vaccines and ***Dr. Stephanie Seneff*** who is a brilliant researcher from ***M.I.T.*** who has published numerous articles on vaccines. Dr. Seneff does an outstanding job of explaining the vaccine autism connection.

Simultaneous vaccines can lead to permanent alterations of brain and immune function

This is such a stunning article, from the ***Journal Lupus 2012,*** that I thought it necessary to include the whole abstract summary of the article. It is titled, **Mechanisms of aluminum adjuvant toxicity and autoimmunity in pediatric populations.** I have bolded some text for emphasis….
https://www.ncbi.nlm.nih.gov/pubmed/?term=22235057

Abstract: "Immune challenges during early development, including those vaccine-induced, can lead to **permanent** detrimental alterations of the brain and immune function. Experimental evidence also shows that **simultaneous administration of as little as two to three immune adjuvants** can overcome genetic resistance to autoimmunity. In some developed countries, by the time children are 4 to 6 years old, they will have received a total of **126** antigenic compounds along **with high amounts** of aluminum (Al) adjuvants through routine vaccinations. According to the US Food and Drug Administration, safety assessments for vaccines **have often not** included appropriate toxicity studies because vaccines have not been viewed as inherently toxic. **Taken together, these observations raise plausible concerns about the overall safety of current childhood vaccination programs**. When assessing adjuvant toxicity in children, several key points ought to be considered: **(i) infants and children should not be viewed as "small adults" with regard to toxicological risk** as their unique physiology makes them much more vulnerable to toxic insults **(Incomplete Blood Brain Barrier); (ii) in adult humans Al vaccine adjuvants have been linked to a variety of serious autoimmune and inflammatory conditions** (i.e., "ASIA" **Autoimmune Syndrome Induced by vaccine Adjuvants)**), **yet children are regularly exposed to much higher amounts of Al from vaccines** than adults; **(iii) it is often assumed that peripheral immune responses do not affect brain function. However, it is now clearly established that there is a bidirectional neuro-immune cross-talk that plays crucial roles in immunoregulation as well as brain function**. In turn, perturbations of the neuro-immune axis have been demonstrated in many autoimmune diseases encompassed in "ASIA" and are **thought to be driven by a hyperactive immune response; and (iv) the same components of the neuro-immune axis that play key roles in brain development and immune function are heavily targeted by Al adjuvants.**

In summary, research evidence shows that increasing concerns about current vaccination practices may indeed be warranted. Because children may be most at risk of vaccine-induced complications, a rigorous evaluation of the vaccine-related adverse health impacts in the pediatric population is urgently needed."

Inappropriate comparisons of orally ingested to injected aluminum

Ingested aluminum deemed toxic at levels much less than vaccines contain, even though vaccines go directly into the bloodstream (Ingested 0.25% absorbed vs. vaccines nearly 100%)

This article from ***Current Medicinal Chemistry*** is titled, **Aluminum vaccine adjuvants: are they safe?** https://www.ncbi.nlm.nih.gov/pubmed/21568886

Here is the Abstract (Summary) of their findings:

"**Aluminum is an experimentally demonstrated neurotoxin and the most commonly used vaccine adjuvant**. Despite almost 90 years of widespread use of aluminum adjuvants, medical science's understanding about their mechanisms of action **is still remarkably poor**. **There is also a concerning scarcity of data on toxicology and pharmacokinetics of these compounds**. In spite of this, the notion that aluminum in vaccines is safe appears to be widely accepted. **Experimental research, however, clearly shows that aluminum adjuvants have a potential to induce serious immunological disorders in humans. In particular, aluminum in adjuvant form carries a risk for autoimmunity, long-term brain inflammation and associated neurological complications and may thus have profound and widespread adverse health consequences. In our opinion, the possibility that vaccine benefits may have been overrated and the risk of potential adverse effects underestimated, has not been rigorously evaluated in the medical and scientific community. We hope that the present paper will provide a framework for a much needed and long overdue assessment of this highly contentious medical issue**."

"Bishop et al. have shown that, parenteral exposure *(through ingestion, not injection)*, to as little as 20 µg/kg bw (*body weight),* of aluminum for >10 days may result in long-term detrimental outcomes in neurologic development in preterm infants. In 2004, the U.S. Food and Drug Administration (FDA) set a limit for aluminum from parenteral sources for individuals with impaired kidney function and premature neonates at no greater than 4 to 5 µg/kg bw/day, stating that levels above those have been associated with CNS and bone toxicity. In addition, according to the FDA, tissue loading may occur at even lower levels of administration**. What the upper limit for "safe" aluminum exposure might be for healthy neonates is not known.**"

"**In spite of these above data, newborns, infants and children up to 6 months of age in the U.S. and other developed countries receive 14.7 to 49 times more than the FDA safety limits for aluminum from parenteral sources from vaccines through mandatory immunization programs** (Table 2). **Specifically, 2-month old children in U.K., U.S., Canada and Australia routinely receive as much as 220 to 245 µg/kg bw of aluminum per vaccination session** (Table 2), **a burden equivalent to 34 standard adult-dose injections of hepatitis B vaccine** (Table 3). **Similarly, newborns at birth receive 73.5 µg Al/kg bw/day from a single hepatitis B vaccine, which is a dose equivalent to 10 standard adult-dose injections of hepatitis B vaccine in a single day** (Table 3). **Whether such doses of aluminum are safe even for adults is not known."**

Since the levels of aluminum found to be toxic at small levels listed in the research cited above, was aluminum that had been given parenterally, meaning ingested through the mouth. Since only a minute amount of aluminum ingested in this way is actually absorbed into the bloodstream through the digestive tract, it is especially concerning given the fact that aluminum injected directly into the bloodstream is nearly hundred percent absorbed. The article goes on to state this very important distinction. This is extremely concerning indeed.

"Finally, it should be fairly obvious that parenterally administered aluminum bears more relevance to vaccine exposure than dietary aluminum. In this context, it is worth noting that unlike dietary aluminum of which only ~0.25 % is absorbed into systemic circulation, aluminum from vaccines may be absorbed at nearly 100% efficiency." *That means that only ¼ of 1 mg out of 100 mg aluminum ingested, is actually absorbed verses 100 mg out of 100 mg absorbed, (or 400 times more via the injectable route).*

This is absolutely inexcusable! It has to stop, until an exhaustive scientific inquiry by non-biased, non-partisan and objective minded scientists is completed. If vaccine programs are going to be continued, safe alternatives to these neurotoxic ingredients must be incorporated (if they even exist). It could take years to create new safer alternatives and evaluate them for several years in large scale INDEPENDENT trials to know if they will be safe. Until then, I am calling for adjuvant free vaccines (the studies in this document suggest they don't work as advertised anyway). It's either that or scrap the vaccines with adjuvants altogether!

Aluminum impacts central nervous system at every level, even by changing gene expression

This is from a 2014 article from the ***Journal immunotherapy*** titled, **Are there negative CNS impacts of aluminum adjuvants used in vaccines and immunotherapy?**
https://www.ncbi.nlm.nih.gov/pubmed/25428645

This is the Abstract:
"In spite of a common view that aluminum (Al) salts are inert and therefore harmless as vaccine adjuvants or in immunotherapy, the reality is quite different. In the following article we briefly review the literature on Al neurotoxicity and the use of Al salts as vaccine adjuvants and consider not only direct toxic actions on the nervous system, but also the potential impact for triggering autoimmunity. Autoimmune and inflammatory responses affecting the CNS appear to underlie some forms of neurological disease, including developmental disorders. **Al has been demonstrated to impact the CNS at every level, including by changing gene expression**. These outcomes should raise concerns about the increasing use of Al salts as vaccine adjuvants and for the application as more general immune stimulants."

"**As a result of cellular damage caused by an Al compound, injured and dying cells will release proteases, excitatory amino acids, and ions (e.g., potassium, calcium), disrupting biosemiosis at many levels. Toxic effects of Al and its compounds thus tend to proliferate**. Interactive results involving immune functions, for instance, make the impact worse than if only one system were involved. Of course, the dose-response of Al and its compounds must be considered, **but even at low doses,**

especially with repeated exposures, Al can have cumulative deleterious effects that can be extreme and even fatal. For that reason, a repeated low dose exposure may prove more damaging than a single larger dose. Al and its compounds can cross biosemiotic levels, damaging genetic systems, proteins, cells, and all systems up through the CNS (CNS = the Central Nervous System). While higher doses may rapidly affect multiple levels, as in dialysis-associated encephalopathy (DAE), **low doses over time, for example, from vaccines, can degrade metabolism and disrupt repair and defense systems and can spiral out of control as in ASIA. Aluminum adjuvants in vaccines may hyperdrive the immune functions of the body but they also directly disrupt biosemiotic systems. Sound theory, empirical research, and reasonable inferences from sources cited here show that Al and its compounds damage biological systems. Such conclusions warrant considerations at a policy level to limit human exposure to Al and its compounds.**"

Footnote: Biosemiotic systems or levels are from the Greek "bio" = life and semeion = signs. An example of how aluminum affects the different levels in life systems is that is affects all of these levels: Molecular (molecules) > Genomic (Genes) > Proteins > Cells > Circuits > Systems > Central Nervous System, Reproductive System, Endocrine System, Immune System, etc.

Exposure to aluminum and mercury maternally and early in life, can have dire and lifelong consequences

This article published in ***the International Journal of Environmental Research and Public Health*** 2015, titled, **Exposure to mercury and aluminum in early life: developmental vulnerability as a modifying factor in neurological and immunologic effects**, is a bombshell that raises serious questions about aluminum adjuvants in vaccines. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4344667/#__sec7title

Here are some quotes from the article:
"thimerosal (used in multi-dose vials as an anti-microbial agent) was reduced in some pediatric vaccines in the USA, but **it still remains in the majority of influenza vaccines and with the influenza vaccine been added to the vaccine schedule, it continues to be given to pregnant women, infants, and children in the USA**." "The continuing use of thimerosal -containing vaccines (TCV's) in pediatrics (mostly during infancy) is still a matter of concern".

"May *et al.* Reported that **vaccines contain the highest concentrations of aluminum and mercury among all biological products tested. In the last 30 years, not only has the number of pediatric TCV's increased, but also the AL: Hg ratio, rising from around 10-12 fold, to 50 fold in some current vaccines that use thimerosal at 0.01%." (Hg stands for Mercury).**

"**Although children are more susceptible than adults to toxic effects of heavy metal exposure, fetuses and neonates are even more vulnerable and the least protected by existing regulatory bodies**. **Therefore, environmental and iatrogenic exposures to neurotoxic chemicals during critical periods of her early life – in utero, neonatal and during infancy – are of particular concern. The proper function of the brain depends on the integrity of the whole central nervous system (CNS). Any developmental toxicity capable of affecting optimal development can have lifelong consequences**."

"Mercury and aluminum share the ability to affect the neurological, renal, and immunological systems. Concentrations relevant to thimerosal containing vaccines affect the developing nervous system as demonstrated by in vitro and in the vivo studies. However, **during the developmental stages of early life, the first (iatrogenic) encounter with xenobiotics (chemicals), such as thimerosal and aluminum adjuvants is a current feature of routine pediatric immunization practices that need to be addressed**."

"…in this animal model, males are more susceptible to thimerosal toxicity than females." ***(this correlates with humans, with regard to autism)***

Studies showing aluminum to be less harmful have major flaws

A 2017 study published in the journal ***Annales Pharmaceutiques Francaises*** (published in French), and titled, **[Critical analysis of reference studies on aluminium-based adjuvants toxicokinetics]**, reveals serious flaws in studies the pharmaceutical industry relies on to downplay the harmful effects of aluminum. https://www.ncbi.nlm.nih.gov/pubmed/?term=28576261

The Abstract:
"We reviewed the three reference toxicokinetic studies commonly used to suggest innocuity of aluminum (Al)-based adjuvants.

A single experimental study was carried out using isotopic ^{26}Al (**Flarend et al., 1997**). **This study ignored adjuvant cell capture**. **It was conducted over a short period of time (28 days) and used only two rabbits per adjuvant**. At the endpoint, Al retention was 78% for aluminum phosphate and 94% for aluminum hydroxide, **both results being incompatible with quick elimination of vaccine-derived Al** in urines. Tissue distribution analysis **omitted three important retention sites: the injected muscle, the draining lymph node and bone**.

Two theoretical studies have evaluated the potential risk of vaccine Al in infants, by reference to the oral **Minimal Risk Level (MRL) extrapolated from animal studies**. **Keith et al., 2002 used a too high MRL (2mg/kg/d), an erroneous model of 100% immediate absorption of vaccine Al, and did not consider renal and blood-brain barrier immaturity**. **Mitkus et al. (2011) only considered absorbed Al, with erroneous calculations of absorption duration**. **They ignored particulate Al captured by immune cells, which play a role in systemic diffusion and the neuro-inflammatory potential of the adjuvant**. MRL they used **was both inappropriate (oral Al vs injected adjuvant) and far too high (1mg/kg/d)** with regard to experimental studies of Al-induced memory and behavioral changes. **Both paucity and serious weaknesses of these studies** strongly suggest that novel experimental studies of Al adjuvants toxicokinetics **should be performed on the long-term, including post-natal and adult exposures**, to ensure innocuity and restore population confidence in Al-containing vaccines."

The misconception that infants get more exposure to metals from breastmilk

Another belief that is circulating out there is that "infants will get more aluminum and mercury from breast milk than from the vaccines." This is completely false.

There are various reasons for that:

- While some aluminum can be transferred from mother to child from breastmilk, oral absorption of aluminum is estimated to be well below 1%. So, for every 100 mcg ingested orally, only 0.2-1.5 mcg will be absorbed. If 100 mcg of aluminum is injected into a child, they get the full 100 mcg into their blood stream. That's 100 times more into the blood stream than with oral ingestion. (see below)
- Infants and young children still have inefficient kidney function which is one of the main ways toxic metals are eliminated from the body. Therefore, it remains circulating in the blood stream much longer allowing it to accumulate in the body's tissues.

Here's another quote from this article above demonstrating that…*(and my added comments are in italics)*

"During breast-feeding, the exposure to mercury and aluminum is proportional to the amount of colostrum or breast milk consumed; different from a bolus dose in thimerosal containing vaccines, breastmilk is taken in proportion to infant size through various feeding periods throughout the entire lactation…..The first exposure to neonates is the hepatitis B vaccine (HBV). In this specific vaccine, depending on the manufacturer, the aluminum to mercury ratio is 25 to 1, whereas the 0.5 ml dose for newborns will deliver a weight adjusted dose of over a 20-fold variation among extremes of birth weight. *(low birth weight preemies are also given this shot)* In either case, mercury or aluminum so absorbed from colostrum by neonates can be far less than the loads inoculated through HBV; **estimated loads of mercury and aluminum in thimerosal containing vaccines could attain a level corresponding to that absorbed from breastmilk taken during the entire six months of lactation. *(so that is one hepatitis B shot compared to 6 months of breast feeding)*** Indeed, the aluminum body burden from feeding (human milk and formulas) during the first year (0.1 mg) was estimated as much less than that (4 mg) attributed to vaccines ***(Therefore 40 times higher).*** **Actually, this figure could increase, if we knew how much of mercury and aluminum is transferred from thimerosal containing vaccines during pregnancy." (As in flu shots).**

This destroys the claims that breast milk contains more mercury than the vaccines. In addition, the new 2017 CDC schedule https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html shows that the CDC **now recommends flu shots for infants starting at six months. In fact, it is recommended that they receive two shots initially to boost their levels**. Then children are recommended to have one flu shot annually. If these flu vaccines happen to come **from the multi-dose vials, they do contain thimerosal.**

Aluminum and Mercury Accumulate

Where does the mercury go when blood levels drop after exposure?

I've often heard it said, "mercury does not stay in the system very long, because blood levels drop within 24 hours of exposure".

The truth is that mercury like other heavy metals become stored in the body's tissues. The reason blood levels drop is twofold. Partly due to elimination, but primarily due to the fact that these toxins become stored in organs, including and especially the brain. Toxins tend to accumulate in fatty tissue. Since the brain is approximately 70% fat, it is a ripe target for accumulation of heavy metals such as aluminum and mercury.

Another quote from the study I was just referencing that puts that myth to bed:

"Human studies indicate that, once de-alkylated, the brain retrained mercury species has ½ life of several years to decades following exposure. These long residences in the brain clearly involve a long-lasting toxic effect."

Studies confirm the mechanism that transports aluminum or mercury to the brain and other organs

These next several studies shed light on a previous mystery, as to how heavy metals and toxins in the vaccines travel from the injection site to what they call "target" organs and tissues. With this information being available now in dozens of studies, there is **NO EXCUSE** for the people in charge of our vaccine programs to keep their heads in the sand. They simply cannot hide from it anymore!

Toxic metals accumulate in various tissues in the body. Aluminum accumulates in the brain.

A 2015 article published in the ***Scientific Reports*** at ***nature.com***, titled, **The preferential accumulation of heavy metals in different tissues following frequent respiratory exposure to $PM_{2.5}$ in rats**, shows the different organs and glands that different metals preferentially accumulate in. Aluminum was found to accumulate preferentially in the cerebral cortex (brain), compared to other organs.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4652264/

From the Abstract:
"Besides, arsenic was prominently enriched both in cerebral cortex and in blood, and so did the **aluminum in the cerebral cortex** and the copper in the liver."

"**The main toxic effect of aluminum is exerted on the nervous system**. Aluminum can combine with the phospholipids by complexation and affect the function of nerve cell membrane. Aluminum can also bind the phosphate group in the nuclear chromatin of neurons and disturb DNA transcription and replication to result in abnormal metabolism and protein synthesis. In addition, it can interfere with cellular energy status and bring about changes in cholinergic neurotransmitter and destruction of BBB function to cause dementia or other degenerative diseases. Related studies have shown that long-term exposure of aluminum increases the susceptibility to Alzheimer's disease. In this study, high dose exposure to $PM_{2.5}$ significantly increased the content of aluminum in cerebral cortex, **which confirmed that aluminum can pass the BBB and tend to accumulate in the brain**." ***(BBB stands for the Blood Brain Barrier. This has always been the concern with mercury, aluminum and other toxins. The BBB is especially "porous" for lack of a better term in the fetus, infants and young children. This study found that even in adult rats, the aluminum was able to pass through into the brain.)***

Journal Vaccine shows that aluminum accumulates in tissues

http://www.sciencedirect.com/science/article/pii/S0264410X97000418 This 1997 article published in the Journal ***Vaccine*** and titled, **In vivo absorption of aluminum-containing vaccine adjuvants using 26Al** clearly shows that aluminum accumulates in tissues after injection and that 3 times more aluminum phosphate was absorbed than aluminum hydroxide. This fact was known before the reduction of mercury (Thimerosal) and subsequent increase of aluminum adjuvants in childhood vaccines. From the article:

"The area under the blood level curve for 28 days indicates that three times more aluminum was absorbed from AP *(aluminum phosphate)* adjuvant than AH *(aluminum hydroxide)* adjuvant. The distribution profile of aluminum to tissues was the same for both adjuvants (kidney > spleen > liver > heart > lymph node > brain)."

Where does that excess aluminum go in the body?

According to the FDA and the AAP (American Academy of Pediatrics), what happens if a child receives more than the maximum required dose of aluminum?

- Aluminum builds up in the bones and brain and can be toxic.
- Aluminum can cause neurological harm.
- Aluminum overdose can be fatal in patients with weak kidney's, kidney disorders or in premature babies. (*How many children are tested to see if their kidneys are functioning properly before they are vaccinated? Could this also be why the Hepatitis B shot, given to infants at birth, has been linked to SIDS? See the section in this document on vaccine associations with SIDS in various places, as well as pages 422-429)*

How does the aluminum and mercury get to the brain and other organs?

A 2016 study published in the Journal ***Scientific Reports*** titled, **Insight into the cellular fate and toxicity of aluminium adjuvants used in clinically approved human vaccinations**, **describes how aluminum migrates away from the injection site and is transported to the brain**. Furthermore, Alhydrogel (Aluminum Hydroxide), which is the most commonly used form is also the one that is the most predisposed to migrate away from the injection site, including access to the brain.
https://www.ncbi.nlm.nih.gov/pubmed/27515230

"We demonstrate that **not all aluminium adjuvants are equal neither in terms of their physical properties nor their biological reactivity and potential toxicities both at the injection site and beyond**. High loading of aluminium oxyhydroxide in the cytoplasm of THP-1 cells without immediate cytotoxicity might **predispose this form of aluminium adjuvant to its subsequent transport throughout the body including access to the brain**."

"As such, Alhydrogel® continues to predominate as the clinically relevant adjuvant of choice in these studies."

"**Our results continue to raise concern over use of the experimental and chemically different, aluminium hydroxycarbonate and magnesium hydroxide based Imject™ Alum formulation, as the model adjuvant of choice in the study of clinical vaccination**. Furthermore Imject™ Alum has been shown to elicit weaker humoral TH2 immune responses via diminished IgG antibody production and reduced pro-inflammatory cytokine release versus Alhydrogel®…"

"Taken collectively **our results thereby support that the release of extracellular DNA and the cytotoxicity of Adju-Phos®** may be additionally governed by **the release of Al3+ (aq) at the injection site**." *(Al3+ is aluminum)*

"In conclusion, our results demonstrate through minimal cytotoxicity and high cytoplasmic loading that Alhydrogel® as the most commonly used ABA in clinically approved vaccinations is most pre-disposed to migration away from the injection site through migratory phagocytic cell lineages. It is known that monocytes are capable of differentiating into either macrophagic or dendritic cell types and both have subsequently been linked to the presence of increased MHCII-positive DCs at the injection site, seven days following vaccination. **As such, migratory APCs including monocytes containing the internalised antigen may enter lymph nodes via draining through high endothelial venules (HEVs)**."
(APCs are Antigen Presenting Cells and ABA refers to Aluminum Based Adjuvants)
"Through *in vitro* cellular modelling, our results further shed light on **the capacity of ABA to deposit at sites distant to the injection site as has been suggested in macrophagic myofasciitis (MMF), whereby aluminium is proposed to translocate through draining lymph nodes to distant organs**."

Small doses of Aluminum Hydroxide, the most common adjuvant causes accumulation in the brain and neurotoxic effects

A 2017 study published in the journal Toxicology titled, **Non-linear dose-response of aluminium hydroxide adjuvant particles: Selective low dose neurotoxicity**, demonstrates the dangers presented by the aluminum hydroxide adjuvant. https://www.ncbi.nlm.nih.gov/pubmed/27908630

From the abstract:
"Aluminium (Al) oxyhydroxide (Alhydrogel®), the main adjuvant licensed for human and animal vaccines, consists of primary nanoparticles that spontaneously agglomerate. **Concerns about its safety emerged following recognition of its unexpectedly long-lasting biopersistence within immune cells in some individuals, and reports of chronic fatigue syndrome, cognitive dysfunction, myalgia, dysautonomia and autoimmune/inflammatory features temporally linked to multiple Al-containing vaccine administrations.**" (*Agglomerate means to clump together)*

"We conclude that Alhydrogel® injected at low dose in mouse muscle may selectively induce long-term Al cerebral accumulation and neurotoxic effects."

More confirmation as to how aluminum travels through the body to the brain and other organs

A 2012 article from The Journal ***Lupus*** titled, **Macrophagic myofasciitis: characterization and pathophysiology** explains how a toxic metal like aluminum can migrate from the injection site to distant organs including the brain. https://www.ncbi.nlm.nih.gov/pubmed/22235051

From the summary:
"Alum is the most commonly used adjuvant in human and veterinary vaccines but mechanisms by which it stimulates immune responses remains incompletely understood. Although generally well tolerated, alum may occasionally cause disabling health problems in presumably susceptible individuals. A small proportion of vaccinated people present with delayed onset of diffuse myalgia, chronic fatigue and cognitive dysfunction, and exhibit very long-term persistence of alum-loaded macrophages at site of previous intra-muscular (i.m.) immunization, forming a granulomatous lesion called macrophagic myofasciitis (MMF**). Clinical symptoms associated with MMF are paradigmatic of the recently delineated "autoimmune/inflammatory syndrome induced by adjuvants" (ASIA). The stereotyped cognitive *(brain)* dysfunction is reminiscent of cognitive deficits described in foundry workers exposed to inhaled Al particles."**

From the article:
"Preliminary results have substantiated this view. We observed that fluorescent surrogates of alum particles injected into mouse muscle were rapidly taken up by macrophages to form a MMF-like granuloma. **An important proportion of particles escaped the injected muscle, mainly within immune cells, gaining access to the regional lymph nodes. Then particle-loaded cells exited the lymphatic**

system to reach the blood stream (presumably through the thoracic duct, a terminal lymphatic vessel plugged to the subclavian vein), **allowing them to gain access to distant organs such as spleen, liver and, eventually, the brain**."

"Thus, immune cells loaded with alum-like particles circulate after the i.m. injection **and can reach distant tissues such as brain, especially if they produce attracting signals for inflammatory cells or exhibit weak blood brain barrier (BBB)**. This may also apply to other poorly degradable nanomaterials such as silicone, another compound suspected to cause ASIA. Of course, lot remains to be done to determine if, in what conditions, and to what extent alum and other mineral particles **gaining access to the brain by a Trojan horse mechanism**, as HIV and HCV particles do, **can cause significant inflammatory and neurotoxic damage.**"

"In conclusion, Macrophagic Myofasciitis revealed an almost complete lack of knowledge on the fate, systemic diffusion, and long-term safety of alum particles. On the grounds of our clinical and experimental data, we believe that increased attention should be paid to possible long-term neurologic effects of continuously escalating doses of alum-containing vaccines administered to the general population. Special emphasis should be put on individuals with immature/altered Blood Brain Barrier or inflammatory states."

Mercury also accumulates in the brain and other organs- This study shows astronomical levels in heart tissue of young athletes with a particular type of cardiomyopathy

A 2005 article written by ***Boyd E. Haley PhD***., the ***Chair of the Department of Chemistry at the University of Kentucky*** and titled, **Mercury toxicity: Genetic susceptibility and synergistic effects**, expresses sharp criticism at our government agencies for ignoring the dangers of mercury in medical interests (vaccines) and dental practices.

"Our government agencies, the FDA, CDC and NIH **routinely ignore** the possible involvement of mercury in the cause or ex-acerbation of any disease. It is my opinion this shunning of mercury based toxicity studies is influenced by organized dentistry and medical interests (**vaccine manufacturers**) who routinely use mercury in the treatment of patients. An outrageous claim one would rationally think."

"But look at the facts. In 1999 a highly respected Journal of ***the American College of Cardiology*** that stated that **individuals who die of Idiopathic Dilated Cardiomyopathy (IDCM) had 178,400 nanograms of mercury per gram of heart tissue, an amazing amount** (Table 1). Measuring mercury is not rocket science, it is easy to accomplish if you have the proper instrument, which most research universities do. **This level was 22,000 times higher than the rest of the tissues in the body, and in the heart tissue of subjects who died of other forms of cardiovascular disease** (Table 1). **IDCM is the named disease that young athletes unexpectedly die of and is one of the major reasons for heart transplants in many adults. Yet, with this data obviously available, neither the NIH nor the FDA has made any requests for grants to study the possible involvement of, or source of, mercury in IDCM. They have essentially ignored this just as they have ignored the obvious emission of mercury vapors from dental amalgams and the elevated mercury levels found in autistic children.**" *The researchers found that the heart tissue*

of these subjects had 178,400 nanograms/gram of heart tissue compared to controls without this disorder, who had 8 ng/g in their heart tissue.
https://1796web.com/pdfs/haley.pdf

Here is a presentation of Dr. Haley's findings published by National Academies Press
http://nationalacademies.org/hmd/~/media/Files/Activity%20Files/PublicHealth/ImmunizationSafety/Haleyslides.pdf

The article from the *American Journal of Cardiology*, referenced in this article by Dr. Haley stated:

"No cases of occupational exposure to TE were observed, not did any patients or control subjects come from heavily polluted geographic areas."

"The increased concentration of TE *(Trace Elements, like mercury)* **in pts with IDCM may adversely affect mitochondrial activity and myocardial metabolism and worsen cellular function."**
(Here they note mitochondrial activity, which is fast becoming a prevalent observation in many studies looking at the effects of mercury and aluminum on the brain)

"This abnormality is limited to the myocardium and correlates with the severity of both heart failure and electrical instability."

The title of the article is **Marked Elevation of Myocardial Trace Elements in Idiopathic Dilated Cardiomyopathy Compared with Secondary Cardiac Dysfunction**
http://www.onlinejacc.org/content/accj/33/6/1578.full.pdf

Particles of aluminum continue to accumulate in organs for months after being injected into the body

The ***Journal of Inorganic Biochemistry*** published an article in late 2015 titled, **Highly delayed systemic translocation of aluminum-based adjuvant in CD1 mice following intramuscular injections.** In this article researchers found that the microscopic particles of aluminum drain slowly from the injection site and accumulate in distant organs. https://www.ncbi.nlm.nih.gov/pubmed/26384437

From the Abstract:
"Concerns regarding vaccine safety have emerged following reports of potential adverse events in both humans and animals. In the present study, alum, alum-containing vaccine and alum adjuvant tagged with fluorescent nanodiamonds were used to evaluate i) the persistence time at the injection site, ii) the translocation of alum from the injection site to lymphoid organs, and iii) the behavior of adult CD1 mice following intramuscular injection of alum (400 μg Al/kg). **Results showed for the first time a strikingly delayed systemic translocation of adjuvant particles.** Alum-induced granuloma remained for a very long time in the injected muscle despite progressive shrinkage from day 45 to day 270. Concomitantly, a markedly delayed translocation of alum to the draining lymph nodes, major at day 270 endpoint, was

observed. Translocation to the spleen was similarly delayed **(highest number of particles at day 270)**. In contrast to C57BL/6J mice, no brain translocation of alum was observed by day 270 in CD1 mice."

"On the basis of **previous reports showing alum neurotoxic effects in CD1 mice**, an additional experiment was done, and showed early brain translocation at day 45 of alum injected subcutaneously at 200 µg Al/kg. **This study confirms the striking biopersistence of alum**. **It points out an unexpectedly delayed diffusion of the adjuvant in lymph nodes and spleen** of CD1 mice, and suggests the importance of mouse strain, route of administration, and doses, for future studies focusing on the potential toxic effects of aluminum-based adjuvants."

Another article describes the way these metals like aluminum "bioaccumulate" into the brain and other organs for long periods of time

A 2013 article published on ***Open Access by Bio Med Central*** titled, **Slow CCL2-dependent translocation of biopersistent particles from muscle to brain**, **discusses the method and delivery system for small particles of aluminum transported to organs and the brain by the body's immune cells**. Unborn fetuses and young children are particularly at risk to this accumulation of heavy metals in the brain, due to the immature blood-brain-barrier. **CCL2 is a small chemokine or signaling protein, that helps attract monocytes and other immune cells to a site of infection**.
https://bmcmedicine.biomedcentral.com/articles/10.1186/1741-7015-11-99

Results:
"Intramuscular injection of alum-containing vaccine was associated with the appearance of aluminum deposits in distant organs, such as spleen and brain where they were still detected one year after injection. Both fluorescent materials injected into muscle translocated to draining lymph nodes (DLNs) and thereafter were detected associated with phagocytes in blood and spleen. **Particles linearly accumulated in the brain up to the six-month endpoint *(when the study ended)***; they were first found in perivascular CD11b+ cells and **then in microglia and other neural cells**. DLN ablation dramatically reduced the biodistribution. Cerebral translocation was not observed after direct intravenous injection, but **significantly increased in mice with chronically altered blood-brain-barrier**. Loss/gain-of-function experiments consistently implicated CCL2 in systemic diffusion of Al-Rho particles captured by monocyte-lineage cells and in their subsequent neurodelivery. Stereotactic particle injection pointed out brain retention as a factor of progressive particle accumulation."

Conclusions:
"Nanomaterials can be transported by monocyte-lineage cells to DLNs, blood and spleen, and, similarly to HIV, **may use CCL2-dependent mechanisms to penetrate the brain.** This occurs at a very low rate in normal conditions explaining good overall tolerance of alum despite **its strong neurotoxic potential**. **However, continuously escalating doses of this poorly biodegradable adjuvant in the population may become insidiously unsafe, especially in the case of overimmunization or immature/altered blood brain barrier or high constitutive CCL-2 production**."

"On the other hand, **alum has high neurotoxic potential**, and planning administration of continuously escalating doses of this poorly biodegradable adjuvant in the population **should be carefully evaluated by regulatory agencies since the compound may be insidiously unsafe**. It is likely that good tolerance to alum **may be challenged by a variety of factors including overimmunization, BBB immaturity, individual susceptibility factors, and aging that may be associated with both subtle BBB alterations and a progressive increase of CCL2 production**."

Researchers find a "highly significant" correlation between the number of pediatric aluminum-adjuvanted vaccines given and autism

A 2013 study in the journal ***Immunological Research*** titled, **Aluminum in the central nervous system (CNS): toxicity in humans and animals, vaccine adjuvants, and autoimmunity**, **found damning evidence of the number of aluminum containing vaccines given to children and the rate of autism spectrum disorders**. https://www.ncbi.nlm.nih.gov/pubmed/23609067

In the same study, researchers discuss the relationship with aluminum exposure in adults and the development of Alzheimer's and similar to ALS/PDC

ALS Parkinsonism Dementia Complex (ALS/PDC) is a neurodegenerative, invariably fatal, disorder found in certain native populations, including on the islands of Guam. **An environmental toxin has been implicated in that condition**. The toxin causes development of neurofibrillary tangles and beta-amyloid plaques in the brain.

The study abstract:
"We have examined the neurotoxicity of aluminum in humans and animals under various conditions, following different routes of administration, and provide an overview of the various associated disease states. The literature demonstrates **clearly negative impacts of aluminum on the nervous system** across the age span. **In adults, aluminum exposure can lead to apparently age-related neurological deficits resembling Alzheimer's and has been linked to this disease and to the Guamanian variant, ALS-PDC.** Similar outcomes have been found in animal models. In addition, **injection of aluminum adjuvants in an attempt to model Gulf War syndrome and associated neurological deficits leads to an ALS phenotype in young male mice**. **In young children, *a highly significant* correlation exists between the number of pediatric aluminum-adjuvanted vaccines administered and the rate of autism spectrum disorders**. **Many of the features of aluminum-induced neurotoxicity may arise, in part, from autoimmune reactions, as part of the ASIA syndrome**."

A 2018 study finds "extraordinarily high" levels of aluminum stored in the brains of autistic individuals

A 2018 article published in the in ***Journal of Trace Elements in Medicine and Biology*** titled, **Aluminium in brain tissue in autism** claims to be the first study using these methods to identify and quantify the amount of aluminum in the brains of autistic individuals.
https://www.sciencedirect.com/science/article/pii/S0946672X17308763

From the study: "Human exposure to aluminium *(British spelling of aluminum),* has been implicated in Autism Spectrum Disorder with conclusions being equivocal. To-date the majority of studies have used hair as their indicator of human exposure to aluminium while aluminium in blood and urine have also been used to a much more limited extent. **Paediatric vaccines that include an aluminium adjuvant are an indirect measure of infant exposure to aluminium and their burgeoning use has been directly correlated with increasing prevalence of ASD. Animal models of ASD continue to support a connection with aluminium and to aluminium adjuvants used in human vaccinations in particular**. Hitherto there are no previous reports of aluminium in brain tissue from donors who died with a diagnosis of ASD. We have measured aluminium in brain tissue in autism and identified the location of aluminium in these tissues."

Conclusion: "**We have made the first measurements of aluminium in brain tissue in Autism Spectrum Disorder and we have shown that the brain aluminium content is extraordinarily high**. We have identified aluminium in brain tissue as both extracellular and intracellular with the latter involving both neurones and non-neuronal cells. **The presence of aluminium in inflammatory cells in the meninges, vasculature, grey and white matter is a standout observation and could implicate aluminium in the aetiology of ASD**."

Again, massive amounts of aluminum are implicated

"In addition to these questionable actions **during this highly publicized "phase-out" of mercury, four doses of a new vaccine with high aluminum content were added to the childhood immunization schedule in February 2000 (for pneumococcus) and two doses of another aluminum-containing vaccine (for hepatitis A) were added in 2005**. These changes to the vaccine schedule **resulted in a substantial increase of aluminum-containing vaccine doses—from 10 to 16 injections—that babies are still mandated to receive by 18 months of age**."

"Each of these vaccines contains aluminum, and multiple doses (booster shots) are required (Table 1). **Babies are injected with 1,225 mcg of aluminum instantaneously at age 2 months, and 4,925 mcg of accumulated aluminum by age 18 months** (Figure 2)." Table 1 shows all the schedule, the number of shots and the amount of aluminum in each.

According to the ***American Academy of Pediatrics*** (AAP), "**Aluminum is now being implicated as interfering with a variety of cellular and metabolic processes in the nervous system and in other tissues**." Bishop et al. published data showing that "**aluminum accumulates in the body when**

protective gastrointestinal mechanisms are bypassed, renal function is impaired, and exposure is high." For example, in premature infants, "prolonged intravenous feeding with solutions containing aluminum is associated with impaired neurologic development" by 18 months of age. More recently, Kawahara et al. published research confirming that "**aluminum can cause severe health problems in particular populations, including infants.**" The authors of this paper also declared that "whilst being environmentally abundant, aluminum is not essential for life. **On the contrary, aluminum is a widely recognized neurotoxin that inhibits more than 200 biologically important functions and causes various adverse effects in plants, animals, and humans.**"

"**Dr. Vito Caserta, chief medical officer for the *Vaccine Injury Compensation Program***, had this to say: "**One of the things I learned at the aluminum conference in Puerto Rico...that I never really understood before, is the interactive effect of different metals when they are together in the same organism. It is not the same as when they are alone, and I think it would be foolish for us not to include aluminum as part of our thinking with this." This next study corroborates those concerns:**

Exposure to toxins during critical brain development increases risk of autism

Another study published in 2016, in the ***CNS & Neurological Drug Targets Journal*** titled, **Neuro-Inflammatory Mechanisms in Developmental Disorders Associated with Intellectual Disability and Autism Spectrum Disorder: A Neuro- Immune Perspective**, implicates the detrimental effects of an abnormal immune response during critical periods of development and the role that can play in the development of forms of autism. https://www.ncbi.nlm.nih.gov/pubmed/26996174

From the study: "While most evidence indicates that a genetic component plays an important role in the aetiology of both autism and ID, a number of studies suggest that immunological dysfunctions may participate in the pathophysiology of these disorders. Brain-specific autoantibodies have been detected in the sera of many autistic children and autoimmune disorders are increased in families of children with autism. Furthermore, cytokine imbalance has been reported in children with autism. These results may reflect an inappropriate immune response to environmental factors, such as infectious **or toxic exposure**. The role of microglia as sensors of pre- and post-natal environmental stimuli and its involvement in the regulation of synaptic connectivity, maturation of brain circuitry and neurogenesis has recently emerged. **An abnormal immune response during critical windows of development and consequent abnormal production of neuro-inflammatory mediators may have an impact on the function and structure of brain and can play a role in the pathogenesis of non syndromic autism. Recent evidence suggests an involvement of neuro-inflammation also in syndromic forms of autism and ID**. The present review summarizes the current literature suggesting that neuro-inflammatory mechanisms may contribute to the pathogenesis of different ID- and autism-associated disorders."

This is key, because the statement just made "during critical windows of development" parallels the concerns of numerous scientists that children are getting too many vaccines, too early in life during these critical windows of development. The microglia mentioned are the immune related nerve cells in the brain and have been implicated as being activated when toxins such as mercury, aluminum or other neuroexcitatory agent cross the blood-brain barrier into the brain.

Three letters written in June of 2017 to The Department of Health and Human Services, from prominent scientists, urging immediate action on the dangers of aluminum in vaccines

The following are three letters from very prominent and distinguished scientists declaring the extreme damage that aluminum from vaccines can cause and stressing a dire urgency in the re-evaluation of and research into the effects of aluminum adjuvants of vaccine recipients.

Dear Directors:

I am writing to you in regard to aluminum adjuvants in vaccines. This subject is one my laboratory works on intensively and therefore one where I feel that I have some expertise. In particular, we have studied the impact of aluminum adjuvants in animal models of neurological disease, including autism spectrum disorder (ASD). Our relevant studies on the general topic of aluminum neurotoxicity in general and specifically in regard to adjuvants are cited below.

These studies and the broader existing literature regarding aluminum toxicity, lead almost invariably to the conclusion that aluminum in any chemical form is always neurotoxic when administered to humans. Further, I am convinced that aluminum adjuvants in vaccines may contribute to neurological disorders across the lifespan. In adults, such adjuvant may induce macrophagic myofasciitis, a disease with neuropathological aspects. In children, there is growing evidence that aluminum adjuvants may disrupt developmental processes in the central nervous system and therefore contribute to ASD in susceptible children.

Despite the foregoing, the safety of aluminum adjuvants in vaccines has not been properly studied in humans even though, pursuant to the recommended vaccine schedule published by the Centers for Disease Control (CDC), a baby may be injected with up to 3,67 5 micrograms of aluminum adjuvant by six months of age.

In regard to the above, it is my belief that the CDC's claim on its website that "Vaccines Do Not Cause Autism" is wholly unsupported. Given this, I remain convinced that much more research on the role of aluminum adjuvant in vaccines and neurological disorders, including ASD, is warranted and should be a research priority for the NIH and other funding bodies.

Yours sincerely,

Christopher A. Shaw, Ph.D, Professor- Dept. of Ophthalmology and Visual Sciences, University of British Columbia

You can view the 14 references in Appendix B

Dear Directors:

I am an expert in the field of aluminum adjuvants toxicity in humans and animal models. I have been working in this field since the initial description of the Al vaccine-induced macrophagic myofasciitis in 1998. Since that time I have written 40 peer-reviewed scientific publications and one book on this subject.

I strongly support the contention that aluminum adjuvants in vaccines may have a role in the etiology of autism spectrum disorder (ASD). My view is founded on a significant and burgeoning body of peer reviewed scientific evidence which makes the link between ASD and exposure to aluminum through vaccinations and other sources. Examples of this literature from my own group are detailed below and I urge the HHS to take them into consideration in forming any future opinion on the safety of aluminum adjuvants in vaccines.

The Center for Disease Control's claim on its website that "Vaccines Do Not Cause Autism" is unsupported with respect to aluminum adjuvants and this claim stifles the important research to determine the safety of aluminum adjuvants used in vaccines. As an expert in the field of aluminum adjuvants and aluminum toxicity I solemnly declare that more research on the role of aluminum adjuvant in vaccines and neurological disorders, including ASD, is essential and urgently required.

Yours very sincerely

Romain K. Gherardi

Professor, Neuromuscular Pathology Expert Centre, University Paris-Est

You can view the 15 references in Appendix B

Dear Directors:

I am an expert in the field of aluminum adjuvants and aluminum toxicity. I have been working in this field for more than 30 years during which time I have written in excess of 150 peer-reviewed scientific publications on this subject.

I strongly support the contention that aluminum adjuvants in vaccines may have a role in the etiology of autism spectrum disorder (ASD). My view is founded on a significant and burgeoning body of peer-reviewed scientific evidence which makes the link between ASD and exposure to aluminum through vaccinations and other sources. Examples of this literature from my own group are detailed below and I urge the HHS to take them into consideration in forming any future opinion on the safety of aluminum adjuvants in vaccines.

The Center for Disease Control's claim on its website that "Vaccines Do Not Cause Autism" is unsupported with respect to aluminum adjuvants and this claim stifles the important research to determine the safety of aluminum adjuvants used in vaccines. As an expert in the field of aluminum adjuvants and aluminum toxicity I solemnly declare that more research on the role of aluminum adjuvant in vaccines and neurological disorders, including ASD, is essential and urgently required.

Yours faithfully

Christopher Exley PhD, Professor in Bioinorganic Chemistry, Keele University, United Kingdom

You can view the 23 references in Appendix B

W.H.O. official admits, because the public is naive about the danger of aluminum, it's better to defend its presence in vaccines than incur the costs of finding an alternative!

Listen to the callousness and complete lack of understanding of the difference between right and wrong by this official with the World Health Organization and reported on page 49 of the transcripts from the following workshop…. ***Department of Health and Human Services, National Vaccine Program Office, and Task Force for Child Survival and Development***. Transcript of presentations at: **Workshop on Aluminum in Vaccines**; San Juan, Puerto Rico; May 11, 2000:1-263.

"Some health authorities seemed to admit that even if aluminum is dangerous, it would be burdensome to remove it. For example, according to **Dr. John Clements with the World Health Organization's Expanded Programme on Immunization**, "There are not easy and obvious substitutes to aluminum adjuvants…. **The existing vaccines, if they change the adjuvant for any reason, would need to be resubmitted for clinical trials for safety and efficacy and it would take a great deal of time to do that." Furthermore, "Aluminum is not perceived, I believe, by the public as a dangerous metal. Therefore, we are in a much more comfortable wicket in terms of defending its presence in vaccines*." Can you believe that quote?!**

*Department of Health and Human Services, National Vaccine Program Office, and Task Force for Child Survival and Development). Transcript of presentations at: Workshop on Aluminum in Vaccines; San Juan, Puerto Rico; May 11, 2000:1-263.

Even vaccine industry experts cite "pervasive uncertainty" about the safety of aluminum for humans.

From that same workshop (https://archive.hhs.gov/nvpo/nvac/documents/Aluminumws.pdf), comes the following quote, "From the ***Metal Ions in Biology and Medicine International Symposium*** held immediately prior to the aluminum workshop, we learned about **"pervasive uncertainty", a phrase used in this workshop to denote missing data on pharmocokinetics and toxicities of aluminum injected into humans." That clearly indicates, that even in such a high-level scientific symposium attended by scientists, researchers and doctors, that there is a pervasive (widespread) uncertainty about injecting aluminum into humans. Yet, not only has that practice continued since then (the year 2000), it had expanded greatly, even without adequate safety studies!!!!**

Vaccines containing aluminum, deposit 33 times more aluminum in tissues than injecting a solution containing aluminum alone

Just in case you are not yet convinced, let me give you a brand-new October 31, 2018 study from the veterinary journal of the ***American College of Veterinary Pathologists*** called ***Veterinary Pathology.*** This study titled, **Granulomas Following Subcutaneous Injection with Aluminum Adjuvant-Containing Products in Sheep**, confirms what the other studies we just looked at found. **Granulomas containing aluminum form at the injection sites and the aluminum travels to the lymph nodes and beyond.**
https://www.ncbi.nlm.nih.gov/pubmed/?term=30381018

http://journals.sagepub.com/doi/abs/10.1177/0300985818809142?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed

From the Study:

1. Those granulomas contain large amounts of aluminum
2. Immune cells work to break down the granulomas
3. They then transport the aluminum particles into the local lymph nodes
4. From there the aluminum is distributed to distant "target organs and tissues", including the brain, kidneys, bones and other organs and tissues.

Interestingly, the vaccine containing the aluminum adjuvant deposited 33 TIMES more aluminum into the lymph nodes than the shots containing aluminum alone.

The aluminum adjuvant used was **Alhydrogel**, the same one referenced elsewhere in this document used in human vaccines. The placebo group was injected with simple saline solution.

- **100% of the vaccine group developed nodules that were larger and "round and conspicuous"**
- **92% of the aluminum adjuvant only group developed nodules that were flat and "plaque like"**
- **0% of the placebo group developed nodules**

The tissue in the granulomas of the vaccine group was dead, described as **"massive central sterile caseous necrosis".**

"Vaccine-induced nodules were round and conspicuous (Fig. 4), whereas adjuvant-only–induced nodules tended to be plaque-like or at least not as round (Fig. 5). In both groups, nodule size was generally within a range of 0.5 and 2cm. However, especially in the adjuvant-only group, some nodules were difficult to locate because of their small size."

Part of the stated reason for doing this study is because sheep are experiencing the same type of autoimmune complex symptoms called ASIA following vaccination as some humans! As discussed previously, ASIA stands for Autoimmune/Inflammatory Syndrome Induced by Adjuvants.

"To date, ovine *(Sheep)* ASIA syndrome is **consistently** observed in field conditions, and **there is an urgent need to understand its pathogenesis to control its effects.**"

Seven childhood vaccines containing aluminum, some given together in multiple dose vaccines called out as a high risk for toxicity

A 2013 study from the Journal of ***Biomolecular Concepts*** titled, **The meaning of aluminium exposure on human health and aluminium-related diseases**, takes a critical look at vaccine aluminum adjuvants and their association with neurological and immunological disorders, as well as their role in Gulf War Syndrome." https://www.ncbi.nlm.nih.gov/pubmed/?term=25436567

From the study:
"**Aluminium is unquestionably neurotoxic**, as has been well demonstrated in multiple experimental animals and in clinical practice."

"In recent years, humans have probably experienced a burgeoning exposure to biologically reactive aluminium, with possible relevant consequences for human health and disease."

"Some concerns have been raised in recent years **regarding the possible adverse effects of aluminium in childhood vaccines on the maturation of the immune system. In fact, aluminium is used as an adjuvant in multiple childhood vaccines, including DtaP, Pediatrix (DtaP, hepatitis B, polio combination), Pentacel (DtaP, HIB, polio combination), hepatitis A, hepatitis B, *Haemophilus* influentiza B (HIB), human papilloma virus (HPV) and pneumococcal vaccines. *(Bear in mind that this does not even take into account the mercury and aluminum in the vaccines recommended to pregnant women!).***

"Taken all together, these data clearly indicate that aluminium represents a significant component of exposure of humans to xenobiotics and contaminants and that newborns are at risk of aluminium-related toxicity not only in the perinatal period, but also in childhood and in adulthood. To alert the medical community about the risk humans are experiencing from aluminium exposure represents an ambitious but measured plan that could be initiated, extending with caution information to pregnant women and to mothers about the vulnerability of infants to early exposure to this contaminant. Moreover, food manufacturers should be forced to indicate on labels the level of aluminium contained in every food product, with particular care for neonatal products, to reduce aluminium-related human pathologies, with the hope of halting the epidemic increase of neurodegenerative diseases in elderly people."

Gulf War Syndrome

"Recently, adjuvant aluminium hydroxide has been also associated with Gulf War syndrome, which has been hypothesized to be linked to the multiple vaccines that soldiers underwent during their participation in the Persian Gulf War."

"Previously described as chronic fatigue syndrome, Gulf War syndrome (GWS) is a multisymptom condition described **in a significant percentage** of USA veterans of the 1991 conflict known as the Gulf

War who, months after their return home, experienced muscle fatigue associated with impaired cognition, ataxia, diarrhoea, bladder dysfunction, headache, arthralgia, skin rashes and sleep disturbances. **A subset of veterans of the 1991 Persian Gulf War developed a severe motor neuron disease, virtually indistinguishable from classical amyotrophic lateral sclerosis (ALS), except for the age of onset.** Whereas numerous environmental factors have been linked to the origin of GWS**, the role of the adjuvant aluminium hydroxide associated to the multiple vaccines that Western army soldiers underwent during the months before their departure to the Persian Gulf War has come under increasing scrutiny**. **Recently, GWS, together with other syndromes linked to previous exposure to an adjuvant, including macrophagic myofascitis syndrome (MMS), siliconosis and other post-vaccination adverse effects, have been included in the autoimmune/inflammatory syndrome induced by adjuvants, the ASIA syndrome**."

Researchers cite "strong" evidence of an aluminum/autism connection

A 2012 article from the Journal ***Entropy*** titled, **Empirical Data Confirm Autism Symptoms Related to Aluminum and Acetaminophen Exposure**, contains large amounts of data implicating vaccines, especially aluminum containing vaccines and autism. **It also cites acetaminophen as a co-conspirator.** You can download the full article from the link on the left side of the page.
http://www.mdpi.com/1099-4300/14/11/2227

Abstract:
"Autism is a condition characterized by impaired cognitive and social skills, associated with compromised immune function. The incidence is alarmingly on the rise, and environmental factors are increasingly suspected to play a role. This paper investigates word frequency patterns in the U.S. CDC Vaccine Adverse Events Reporting System (VAERS) database. **Our results provide strong evidence supporting a link between autism and the aluminum in vaccines**. A literature review showing toxicity of aluminum in human physiology offers further support. Mentions of autism in VAERS increased steadily at the end of the last century, **during a period when mercury was being phased out, while aluminum adjuvant burden was being increased.** Using standard log-likelihood ratio techniques, we identify several signs and symptoms that are significantly more prevalent in vaccine reports after 2000, **including cellulitis, seizure, depression, fatigue, pain and death, which are also significantly associated with aluminum-containing vaccines.** We propose that children with the autism diagnosis are especially vulnerable to toxic metals such as aluminum and mercury **due to insufficient serum sulfate and glutathione**. **A strong correlation between autism and the MMR (Measles, Mumps, Rubella) vaccine is also observed, which may be partially explained via an increased sensitivity to acetaminophen administered to control fever."**

"**But, most interesting for our purposes were the association of fever** (p = 0.024) **and autism** (p = 0.0067) **with MMR.** There were a total of 1840 adverse reactions mentioning fever in the MMR set. This suggests to us that the acetaminophen connection may be correct—**that the fever associated with MMR exposure is treated with acetaminophen, which then becomes toxic to the brain of the child predisposed toward autism, because of their inability to dispose of it. Acetaminophen would also**

deplete sulfate needed to detoxify aluminum in any concurrent aluminum-containing vaccine such as DTaP."

From the article:
"The ASD community has maintained a long-standing conviction that vaccination plays a causative role in ASD, an idea that has been vehemently denied by the vaccine industry, but nonetheless is still hotly debated. A study published in 2011 has confirmed a positive correlation between the proportion of children who received vaccinations in each state over the interval from 2001 to 2007 and the incidence of autism or speech and language impairment. **For each 1% increase in vaccination rate, 680 additional children were diagnosed with autism or speech delay.**"

"The Food and Drug Administration (FDA) has set an upper limit of 5 micrograms Al/kg/day for neonates and individuals with impaired kidney function. A highly informative recent review of a possible relationship between aluminum toxicity and Alzheimer's disease also discussed issues related to the aluminum burden in children's vaccines. There, it was pointed out that **children today receive a cumulative aluminum burden from vaccines that may exceed the FDA limit by a factor of 50**."

"**Since aluminum is a known neurotoxin, there is no safe level. The central nervous system is particularly susceptible to the deleterious effects of aluminum. Exposure of human neuronal cells to a low concentration (100 nM) of aluminum sulfate induces a response that emulates the gene expression changes associated with Alzheimer's disease."**

"All of the significant symptoms in the table—macule, cellulitis, blister, seizure, abscess, death, and low appetite—are also significant symptoms associated with the vaccines containing aluminum. **This result further supports the possibility that the aluminum in these vaccines administered to young children may be even more toxic than the mercury**."

"This strong association does not however exclude mercury as a contributor to autism, given that Hep B has both mercury and aluminum. In fact, mercury and aluminum together may be synergistically toxic."

"A highly significant correlation is found between "autism" and "Hep-B" (p = 0.0014), confirming the results reported in Gallagher CM, Goodman MS. **Hepatitis B vaccination of male neonates and autism diagnosis, NHIS 1997–2002**. ***J Toxicol Environ Health*** A 2010;73(24):1665–1677. https://www.ncbi.nlm.nih.gov/pubmed/?term=21058170

From the article:
"Findings suggest that U.S. male neonates vaccinated with the hepatitis B vaccine prior to 1999 (from vaccination record) had a threefold higher risk for parental report of autism diagnosis compared to boys not vaccinated as neonates during that same time period."

All of the vaccines and direct access to their package inserts containing all the ingredients including aluminum levels can be found here > http://www.immunize.org/fda/

Keep in mind, when the amount is listed as milligrams (mg), you have to multiply by 10 to convert it to micrograms (mcg or sometimes noted as µg). For example, 85 mg is equivalent to 850 mcg.

1 gram (g) = 100 milligrams (mg) = 1,000 micrograms (mcg or µg)

Children get 112 times the FDA daily safe level of aluminum by the FDA, by 18 months of age!

The total amount of aluminum given to children in routine vaccines by age 18 months, is approximately 112 times (11,200 percent), greater than the daily amount deemed safe intravenously by the FDA for an average size baby at 23 pounds.

While it is true that the aluminum is given in "batches" throughout that 18 months as reported above, sometimes those batches include up to 1,000 mcg at a time. And all the while, more and more is being stored in the brain and other organs.

More information on allowable levels and effects of aluminum toxicity in infants and children can be found here:
[**Aluminum Toxicity in Infants and Children, Committee on Nutrition,** American Academy of Pediatrics, ***Pediatrics*** Volume 97, Number 3, March 1996, pp. 413-416.
http://pediatrics.aappublications.org/content/pediatrics/97/3/413.full.pdf

Aluminum causes a release of neurotoxins from the brain's immune cells

Another article titled **Aluminum Induced Immuno-excitotoxicity in Neurodevelopmental and Neurodegenerative Disorders** implicates aluminum. It is from ***Current Inorganic Chemistry*** 2012, 2, 46-53, by ***Russell Blaylock MD*** a prominent neurosurgeon.
http://www.geoengineeringwatch.org/documents/Aluminum-Blaylock.pdf

Abstract:
"A great deal has been learned about the neurotoxicity of aluminum over the past two decades in terms of its ability to disrupt cellular function. Newer evidence suggests that a more central pathophysiological mechanism may be responsible for much of the toxicity of aluminum and aluminofluoride compounds on the brain. **This mechanism involves activation of the brain's innate immune system, primarily the microglia, with a release of neurotoxic concentrations of excitotoxins and pro-inflammatory cytokines, chemokines and immune mediators**. A large number of studies suggest that excitotoxicity

plays a significant role in the neurotoxic action of a number of metals, **including aluminum**. Recently, researchers have found that **while most of the chronic neurodegenerative effects of these metals are secondary to prolonged inflammation, it is the enhancement of excitotoxicity by the immune mediators that is responsible for most of the metal's toxicity.** This enhancement occurs *via* a crosstalk between cytokine receptors and glutamate receptors. The author coined the name immune-excitotoxicity to describe this process. **This paper reviews the evidence linking immune-excitotoxicity to aluminum's neurotoxic effects.**

Another study implicates aluminum and fluoride as triggering co-conspirators in autism, based on a brain immune-excitotoxicity mechanism

A 2018 study from the journal of ***Surgical Neurology International*** titled, **Immunoexcitotoxicity as the central mechanism of etiopathology and treatment of autism spectrum disorders: A possible role of fluoride and aluminum**, points to brain immune overactivation/excitation from aluminum and fluoride as the central players in the development of neurodevelopmental, neurodegenerative conditions and ASD. This study is extensive with 297 references.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5909100/?report=printable

The Abstract:
"**Our review suggests that most autism spectrum disorder (ASD) risk factors are connected, either directly or indirectly, to immunoexcitotoxicity**. Chronic brain inflammation is known to enhance the sensitivity of glutamate receptors and interfere with glutamate removal from the extraneuronal space, where it can trigger excitotoxicity over a prolonged period. Neuroscience studies have clearly shown that sequential systemic immune stimulation can activate the brain's immune system, microglia, and astrocytes, and that with initial immune stimulation, there occurs CNS microglial priming. **Children are exposed to such sequential immune stimulation via a growing number of environmental excitotoxins, vaccines, and persistent viral infections. We demonstrate that fluoride and aluminum (Al^{3+}) can exacerbate the pathological problems by worsening excitotoxicity and inflammation. While Al^{3+} appears among the key suspicious factors of ASD, fluoride is rarely recognized as a causative culprit**. A long-term burden of these ubiquitous toxins has several health effects with a striking resemblance to the symptoms of ASD. **In addition, their synergistic action in molecules of aluminofluoride complexes can affect cell signaling, neurodevelopment, and CNS functions at several times lower concentrations than either Al^{3+} or fluoride acting alone. Our review opens the door to a number of new treatment modes that naturally reduce excitotoxicity and microglial priming**."

One rationale for the predominance of male associated ASD-

"**Population of the developing brain with microglia varies with sex, with males having a significantly greater number of microglia early after birth (P4–postnatal day) than females in brain regions concerned with cognition, learning, and memory (hippocampus, parietal lobe, and amygdala). The onset of the dramatic increase in brain microglia in males coincides with the rise in their testosterone**

levels, somewhere around E18 (embryonic day 18). As a result, males are more likely to be diagnosed with early onset neurological disorders, such as ASD, dyslexia, and ADHD."

"Females were shown to have a greater number of microglia than males, but this appeared later in development (P30–60)…. In humans, females increase the number of their microglia with increasing age."

Microglia concentration in cerebellum and autism spectrum disorder

"**Several studies have shown the cerebellum to be the most involved area of the brain in ASDs**. **Vargas *et al*. found extensive damage to the cerebellum in both younger and older autistic cases**. As with the cortical areas of the brain, microglia also play a critical role in cerebellar development, which includes neurite outgrowth, synaptic pruning, debris clearance, apoptosis, and axon and dendritic development. Likewise, microglia during cerebellar development undergo morphologic alterations, changing from amoeboid to ramified as development proceeds. **It is now appreciated that the cerebellum has nonmotor functions that include control of attention, working memory, language, emotional elaboration, reward, and other higher functions. The human cerebellum matures postnatally with the greatest acceleration of growth and neural organization during the first two years after birth.**

What activates the microglia?

"Microglia can be activated by peripheral autoantibodies, as are frequently seen in autistic patients. Elevations in peripheral cytokines and chemokines by other mechanisms, **such as exposure to neurotoxic metals, certain pesticides/herbicides, stress, trauma, ischemia/hypoxia, and autoimmune disorders, can also activate brain microglia**, principally involving IL-1b and tumor necrosis factor-alpha (TNF-α)."

ALUMINUM AS A NERUOTOXIN

"There are a number of Al^{3+} sources, such as the drinking water, dietary substances, cosmetics, and the **widespread use of Al^{3+} in medicine, namely in vaccines. Many investigations show that Al^{3+} can elicit impairment of development and immunity; that it acts as a hormonal disruptor, a neurotoxin, and elicits intense and prolonged activation of brain inflammation. Al^{3+} toxicity in humans, especially as regards the CNS, has been studied and discussed by several authors [e.g. 23,171,256,271. It is not surprising that Al^{3+} appears among the environmental toxins, which can participate in the etio-pathology of ASD.**"

ALUMINUM AND FLUORIDE EXPOSURE INDUCES MICROGLIA ACTIVATION, INCREASES GLUTAMATE BLOOD AND BRAIN LEVELS AND ABNORMALITY IN THE DEVELOPING BRAIN AND NEURODEGENERATION

"**Recent studies have also shown that both fluoride and Al^{3+}, as well as AlF_x can induced microglial, astrocyte and B-cell activation, with resulting increases in blood and brain ROS, RNS, and LPP. Because both Al^{3+} and fluoride accumulate in the brain with chronic exposure, even low dose exposure of**

these two elements can eventually result in neurotoxic concentrations. There is compelling evidence from a multitude of studies indicating that fluoride and micromolar Al^{3+}. acting synergistically, can elevate blood and brain glutamate to levels known to cause alterations in the developing brain, as well as initiate brain inflammation, and neurodegeneration. We suggest that both of these ubiquitous environmental toxins have a substantial role in the immunoexcitotoxicity and the etiopathology of ASD."

From the Conclusion:

"It also explains why ASD has not disappeared despite the removal of mercury from most childhood vaccines, since excessive immune activation is the initiating and sustaining event in ASD. Evidence is presented that the abundance of fluoride added to the water worldwide and the widespread availability of aluminum particularly to infants and young children through aluminum containing vaccinations, singly or together as aluminofluoride can be potent factors in producing the condition of immunoexcitotoxicity that leads to the pathological changes seen in ASD. The vaccination program should be evaluated to reduce the excessive stimulation of immature immune system and to replace Al^{3+}-adjuvants."

Study finds a strong association between the measles component of the MMR and antibody reaction resulting in central nervous system autoimmunity and autism

This study published in the ***Journal of Biomedical Sciences*** in 2002 titled, **Abnormal measles-mumps-rubella antibodies and CNS autoimmunity in children with autism**, describes a statistically significant correlation between laboratory findings of an unusual MMR antibody specific only to the measles component of the vaccine in 60% of autistic children and none of the controls (non-autistic children). https://www.ncbi.nlm.nih.gov/pubmed/12145534

The abstract:

"**Autoimmunity to the central nervous system (CNS), especially to myelin basic protein (MBP), may play a causal role in autism**, a neurodevelopmental disorder. Because many autistic children harbor elevated levels of measles antibodies, we conducted a serological study of measles-mumps-rubella (MMR) and MBP autoantibodies. Using serum samples of 125 autistic children and 92 control children, antibodies were assayed by ELISA or immunoblotting methods. ELISA analysis **showed a significant increase in the level of MMR antibodies in autistic children**. Immunoblotting analysis revealed the presence of an unusual MMR antibody in 75 of 125 (60%) autistic sera but not in control sera. This antibody specifically detected a protein of 73-75 kD of MMR. This protein band, as analyzed with monoclonal antibodies, was immunopositive for measles hemagglutinin (HA) protein but not for measles nucleoprotein and rubella or mumps viral proteins. **Thus the MMR antibody in autistic sera detected measles HA protein, which is unique to the measles subunit of the vaccine**. **Furthermore, over 90% of MMR antibody-positive autistic sera were also positive for MBP autoantibodies, suggesting a strong association between MMR and CNS autoimmunity in autism. Stemming from this evidence, we**

suggest that an inappropriate antibody response to MMR, specifically the measles component thereof, might be related to pathogenesis of autism."

Parental autoimmune disease as a risk factor for having an autistic child

A family history of autoimmune disease is a risk factor for autism

A 2015 article published in the journal of ***Neuroscience and Behavioral Reviews*** titled, **Family history of autoimmune diseases is associated with an increased risk of autism in children: A systematic review and meta-analysis**, implicates family history of autoimmune disease and autism.
https://www.ncbi.nlm.nih.gov/pubmed/?term=25981892

From the article: "A total of 11 articles were included in the meta-analysis, including 3 cohort studies, 6 case-control studies, and 2 cross-sectional studies. **The meta-analysis showed that family history of all ADs combined was associated with a 28% (95% CI: 12-48%) higher risk of autism in children.**"

Aluminum even has damaging effects on heart tissue

A 2018 study in the Journal ***Environmental Pollution*** titled, **Aluminum: A potentially toxic metal with dose-dependent effects on cardiac bioaccumulation, mineral distribution, DNA oxidation and microstructural remodeling**, demonstrated **the mitochondrial and DNA oxidative damage affects other organs than the brain and nervous system, in this case the heart**.
https://www.ncbi.nlm.nih.gov/pubmed/30032078

From the Abstract:
"**Our findings indicated that the heart was sensitive to Al-mediated toxicity**, especially in animals treated with the three highest doses of Al. In response to Al-induced loss of the parenchyma, heart stroma exhibited a reactive and compensatory expansion, which, in combination with the increased distribution of thick myofibrils and degenerated mitochondria in cardiomyocytes, provides morphological evidence that cardiac tissue adaptations are not enough to adjust the relationships between the parenchyma and stroma until a steady state is reached, **resulting in continuous pathological remodeling potentially associated with Al-induced proinflammatory and pro-oxidant events.**

All aluminum is brain damaging, but the nanoparticle size is even more harmful

A 2018 article from the Journal ***Biological Trace Element Research*** titled, **Size-Dependent Neurotoxicity of Aluminum Oxide Particles: a Comparison Between Nano- and Micrometer Size on the Basis of Mitochondrial Oxidative Damage** found that all forms of aluminum caused severe oxidative stress, mitochondrial damage and that nanoparticles were even more toxic, even penetrating further into the brain. https://www.ncbi.nlm.nih.gov/pubmed/28856594

Note: *AlNPs = Aluminum Nanoparticles and AlMPs = Aluminum Microparticles. Nanoparticles are smaller than microparticles.*

From the Abstract:
"**Aluminum nanoparticles (AlNPs)** are among the most abundantly produced nanosized particles in the market. There is limited information about the potential harmful effects of aluminum oxide due to its particle size on human health. **Considering the toxic effects of Al on brain as its target tissue, in this study, the toxicity of nanoparticles, microparticles, and ionic forms of Al on rat brain and isolated mitochondria was evaluated.**"

"The results showed that **all forms of Al particles induced ROS formation, lipid peroxidation, protein oxidation, glutathione depletion, mitochondrial dysfunction, and gait abnormalities in a dose-dependent manner. In addition, Al particles decreased mitochondrial membrane potential. These data indicated that oxidative stress might contribute to the toxicity effects of Al.** Comparison of oxidative stress markers between all forms of Al revealed that **the toxic effect of AlNP on brain tissue was substantially more than that caused by AlMP and bulk form. This study showed more neurotoxicity of AlNPs compared to other forms on brain oxidative damage that probably is due to more penetration into the brain**."

Vaccine researchers like the smaller nanoparticle aluminum hydroxide because it has a stronger adjuvant effect, BUT as the last study cited, it also causes more brain damage!

Now, as you read this article summary, take the last statement of the last article into consideration relative to the evidence showing that the smaller nanoparticle aluminum penetrates deeper into the brain and does more damage.

A 2014 study published in the ***Journal of Controlled Release*** titled, **Aluminum hydroxide nanoparticles show a stronger vaccine adjuvant activity than traditional aluminum hydroxide microparticles**, looks at the enhanced adjuvant response of the smaller nanoparticle size aluminum, but at what cost to the health of the individual being injected with it?
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3918952/

The Abstract:
"Aluminum hydroxide is used as a vaccine adjuvant in various human vaccines. Unfortunately, despite its favorable safety profile, aluminum hydroxide can only weakly or moderately potentiate antigen-specific

antibody responses. When dispersed in an aqueous solution, aluminum hydroxide forms particulates of 1–20 μm. **There is increasing evidence that nanoparticles around or less than 200 nm as vaccine or antigen carriers have a more potent adjuvant activity than large microparticles.** In the present study, we synthesized aluminum hydroxide nanoparticles of 112 nm. Using ovalbumin and *Bacillus anthracis* protective antigen protein as model antigens, we showed that protein antigens adsorbed on **the aluminum hydroxide nanoparticles induced a stronger antigen-specific antibody response than the same protein antigens adsorbed on the traditional aluminum hydroxide microparticles of around 9.3 μm**. The potent adjuvant activity of the aluminum hydroxide nanoparticles was likely related to their ability to more effectively facilitate the uptake of the antigens adsorbed on them by antigen-presenting cells. Finally, the local inflammation induced by aluminum hydroxide nanoparticles in the injection sites was milder than that induced by microparticles. Simply reducing the particle size of the traditional aluminum hydroxide adjuvant into nanometers represents a novel and effective approach to improve its adjuvanticity." ***Vaccine manufacturers love the idea of an improved adjuvant effect by the smaller particle size. Unfortunately, as the previous study indicated, the smaller the particle size, the more neurotoxic they are.***

COMBINATIONS OF ALUMINUM & MERCURY CONTAINING VACCINES POSE SERIOUS RISK

Aluminum when mixed with mercury is especially toxic!

Mercury combined with aluminum- A volatile combination

Prior to learning of this study and as I was doing research for this article I thought to myself, I wonder what would happen if mercury and aluminum came in contact with one another? This is what I found…

In looking at the **Material Safety Data Sheet for Thimerosal**, I noticed on page 3, in section 10 titled Stability and Reactivity, (http://www.gihonlab.com/farmo1.php), **that it will react with aluminum and reducing agents and that they should be avoided**. So that got me to thinking. I wonder if the vaccines containing thimerosal past and present were ever given in combination with vaccines that contain aluminum. I checked the CDC Vaccine Ingredient List and cross referenced it to their recommended shot schedule and found out that they frequently are!

So, I wondered…how does mercury react with aluminum? So, I Googled it and found these two short videos. **These reactions are MASSIVE**. Obviously, these videos show it on a large scale/direct contact fashion, but what about on a microscopic level in the body? We know that metals can react with minerals in the body and that metals can react with metals in the body. Regardless, these videos are a very graphic and visible look at this very real chemical reaction. (**remember the Material Safety Data Sheet (MSDS) on aluminum I referred to earlier, that warned about mercury reacting with aluminum?**)

https://www.youtube.com/watch?v=Z7Ilxsu-JlY

https://www.youtube.com/watch?v=NauUM5ySWYQ

These dramatic examples make the graphic I just showed about the increased neurotoxicity of combining mercury and aluminum much more understandable.

Aluminum and mercury combined cause much greater percentage of brain cell death

In many cases, thimerosal and aluminum containing vaccines are given at the same time. In this study titled, **Mercury toxicity: Genetic susceptibility and synergistic effects**, **Dr. Boyd Haley**, former professor of medicinal chemistry and ***chairman of the chemistry department at the University of Kentucky***, published a study in which he investigated the effect of combining aluminum hydroxide with thimerosal. In this study, cultured neurons showed no significant cell death six hours after they were exposed to just aluminum; more than 90% survived. Thimerosal alone also caused few neurons to die after six hours of exposure. Again, more than 90% survived. **However, when cultured neurons were exposed to aluminum and thimerosal, only about 40% survived after six hours, clearly demonstrating synergistic toxicity** (Figure 3). http://www.1796kotok.com/pdfs/haley.pdf

This is one of the most telling graphics I have seen to show how dangerous mixing Thimerosal (mercury) and aluminum is.

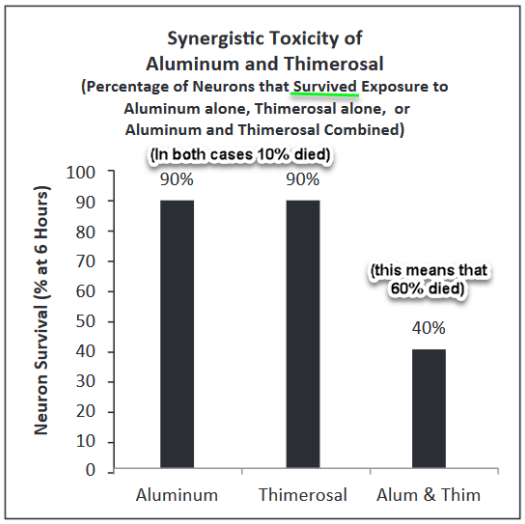


Figure 3. Survival of Neurons Exposed to Aluminum, Thimerosal, or Both

"**In summary, mercury build up in the brain tissue has the ability to cause the equivalent of a biochemical train wreck. Most importantly, the axon, which contains tubulin, is rapidly and effectively disrupted by Hg2+. Many pathways and many supramolecular structures are injured by mercury similar to the aberrancies observed in AD brain pathology and biochemistry**." *(AD stands for Alzheimer's Disease)*

Another interesting aspect of the experiments was that they added neomycin an antibiotic that is common in vaccines (along with others from the same antibiotic family). They found that the neomycin combined with either the aluminum or the mercury caused an even greater loss of brain cells AND that the antibiotic prevents excretion of the heavy metals, thus allowing additional accumulation in the brain and other organs.

From the article:
"It is also known that certain antibiotics greatly enhance the toxicity of thimerosal in ocular solutions and that antibiotics prevent test animals from effectively excreting mercury."

It is a fact that metals react and bind with other metals even essential minerals in the body.

Here is an article describing some of those interactions from the ***Annual Review of Nutrition***
https://www.ncbi.nlm.nih.gov/pubmed/?term=9240918

From the article:
"Cadmium, lead, mercury, and aluminum are toxic metals that may interact metabolically with nutritionally essential metals. Iron deficiency increases absorption of cadmium, lead, and aluminum. Lead interacts with calcium in the nervous system to impair cognitive development. Cadmium and aluminum interact with calcium in the skeletal system to produce osteodystrophies *(bone diseases)*. Lead replaces zinc on heme enzymes and cadmium replaces zinc on metallothionein. **Selenium protects from mercury and methylmercury toxicity**. **Aluminum interacts with calcium in bone and kidneys, resulting in aluminum osteodystrophy. Calcium deficiency along with low dietary magnesium may contribute to aluminum-induced degenerative nervous disease**."

A 2017 study calls for the elimination of metal adjuvants from vaccines

A 2017 article from the ***International Journal of Environmental Research and Public Health*** titled, **The Metal Neurotoxins: An Important Role in Current Human Neural Epidemics?**, sheds light on the dangerous effects of metals in the development of neurological diseases. **It reports on the significant increases of miscarriages in the 2009-2010 influenza campaign. In that same year, two flu shots were recommended to pregnant women**. It discusses genetic susceptibility. **It also calls for the immediate removal of metals from vaccines**. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5750929/

"**Now, global neurological illnesses that are widespread and cover general populations are becoming increasingly evident in epidemic numbers especially in young children and in the aged, and appear to result from anthropogenic environmental causes undoubtedly coupled to genetic susceptibilities. Autism in children affects male/female babies in a ratio of roughly four to one, possibly indicating an additional role of hormones**. **Overall, its rate of occurrence has increased in the recent period of 30 years by several orders of magnitude**." ***It is ironic that the last 30 years have seen a huge uptick of vaccines containing mercury and more recently aluminum.***

"However, it emphasized the realization that **a fetus in pregnancy had to be considered differently from adults and that toxic substances could be far more life changing to fetal brains and bodies in development**. **The question of damaging the brain is very different with children, whose brains are still small and forming, whereas adults have fully-developed brains that may be damaged, but in different ways.**"

"Mercury is **highly neurotoxic** in organic forms, such as the methylmercury in fish, **and thimerosal still used in some vaccines.**"

"Mercury, another **potent neurotoxicant** documented through the centuries has also come to the forefront in recent decades. This is mainly through **concerns due to its presence as the organometallic thimerosal in vaccines**."

"**It's toxicology is well documented**. Additionally, monkey blood and brain studies have clearly **confirmed organic mercury's ability to enter the brain**. For ethylmercury, from thimerosal, about one-third becomes inorganic and **two-thirds remains organic**."

"One report noted the enhanced rate of miscarriages in the US during the 2009/2010 influenza vaccine period. For the first and last time, pregnant women were given two different influenza vaccines instead of the normal one during any trimester. They both contained thimerosal. The analysis showed that miscarriages that year increased by more than an order of magnitude compared to earlier or later years."

"To be prudent, one important step would be **to initiate testing to establish the baseline values of these neurotoxicant metals in all women of child-bearing ages**. In some cases waiting until pregnancy may be too late and **this might also reduce the high rates of miscarriages that now are reported**."

"Additionally, **governmental changes and directives are clearly needed concerning vaccines and any neurotoxic content**. Canada is one country that already has taken action, **particularly with regard to safer vaccines for pregnancy.**"

"Consequently, the recent introduction of aluminum hydroxide as the dominant adjuvant in many US vaccines has now modified the situation and requires renewed studies. Consequences of such inoculations have been analyzed far less, but **one very extensive review now accepts that the levels of absorption by the body will be much higher**. **Additional studies have suggested that this alone is a high medical risk for neurological complications**. In addition although the documentation

concerning the known ingress/egress transport across the blood-brain barrier (BBB) remains hazy for Al, it has been shown to occur."

"**Interestingly, aluminum also has recently been blamed as a risk factor in male infertility**."

"As a result, the main elemental inorganic neurotoxicants of concern to the general public center on Al, As, Hg, Pb, Mn, and Se chemistries and merit in depth examination. The first four of these are non-essential to the body **and serve no bodily purpose**." *(As = Arnenic, Hg = Mercury, Pb = Lead, Mn = Manganese and Se = Selenium).*

"Additionally, such observations are **also reported for fetal brain autopsies reflecting similar metals and confirming the mother/baby close inter-connection. Studies have clearly identified the presence of mercury, for example, that correlates directly to the maternal hair level**." ***(This clearly reflects that the metals from the mother pass through to the baby. Prenatal vaccines containing metals should not be given to the mother. In fact, as this study will suggest, any young woman planning on conceiving in the nest few years should avoid all sources of toxic metal exposure. A significant portion of those those metals remain stored in the body and are gradually released over time. Thus, a body burden of stored metals can impact the developing fetus).***

"…the present scientific examination of the numerous global blood monitoring databases for adults that include the concentrations of the neurotoxic elements, aluminum (Al), arsenic (As), lead (Pb), manganese (Mn), mercury (Hg), and selenium (Se) clearly indicate that, when considered in combination, for some, **the human body may become easily over-burdened**. This can be explained by changes in modern lifestyles. Similar data, solely for pregnant women, have been examined confirming this. All these elements are seen to be present in the human body and at **not** insignificant magnitudes."

"One observation is that many distributions for pregnant women are not too dissimilar from those of general populations. Women obviously have their individual baseline of neurotoxin values before pregnancy and any efforts to modify this to any significant degree is not yet clearly apparent."

"There are a certain fraction of people that lie well above the MRL values **and may be at risk, especially if genetically susceptible**. Additionally, **synergistic effects between neurotoxins and with other trace metals are now also being reported**. It appears prudent for women of child-bearing age to establish their baseline values well before pregnancy. Those at risk then can be better identified. Adequate instrumental testing now is commercially available for this. **In addition, directives are necessary for vaccination programs to use only non-neurotoxic adjuvants, especially for young children and all women of child-bearing ages.** Additionally, clearer directives concerning fish consumption must now be reappraised."

"**Additionally, the medical profession has to reassess its current general vaccination program. Although there is no denying this has been a tremendous success, it has now grown three- to four-fold in size in the last 30 years and has become excessive**. **It is twice as large as any other country**."

"It can no longer be denied that this is contributing to body-burden, especially if administered in multiple doses at the same time. Such a practice has to be considered dangerous, irresponsible, and certainly should be ended. Furthermore, development and use of alternate adjuvants for neurotoxicant-free vaccines is critically needed."

My comment:
As of the 2018 CDC schedule, by six years old, a child in the US can have up to 44 inoculations that increase to a total, twelve years later of about 74." (In 2018, the CDC added a forth dose of DTap and a Hepatitis A shot, both by age 15 months. Both of those also contain aluminum and the DTaP contains 2 antibiotics that are not supposed to be used together).

Study identifies how oxidative stress from metals form very toxic and damaging by-products in the brain

A 2010 study published in the ***Journal of Molecular and Cellular Biochemistry*** titled, **Metals, oxidative stress and neurodegenerative disorders**, describes the way that oxidative stress wreaks havoc on the brain. The italicized sections are my explanation of the technical jargon from the study. https://www.ncbi.nlm.nih.gov/pubmed/20730621

From the abstract:
"The increased level of oxidative stress in Alzheimer's Disease brain is reflected by the increased brain content of iron (Fe) and copper (Cu) both capable of stimulating free radical formation (e.g. hydroxyl radicals via Fenton reaction), ***(This is the same way mercury and aluminum do damage),*** increased protein and DNA **oxidation** in the Alzheimer's Diseased brain, enhanced lipid peroxidation, decreased level of cytochrome c oxidase and advanced glycation end products (AGEs), carbonyls, malondialdehyde (MDA), peroxynitrite, and heme oxygenase-1 (HO-1). AGEs *(Advanced Glycation End Products, which are damaged proteins)*, mainly through their interaction with receptors for advanced glycation end products (RAGEs), further activate signaling pathways, inducing formation of **proinflammatory cytokines such as interleukin-6 (IL-6).** ***The main takeaway of this very complex discussion is that oxidative stress from metals, toxins or other free radical initiating compounds are extremely destructive to the brain!***

"…the cause of neuronal death in neurological disorders appears to be multifactorial. However, it is **clear, that the underlying factor in the neurological disorders is increased oxidative stress** substantiated by the findings that the protein side-chains are modified **either directly by reactive oxygen species (ROS) or reactive nitrogen species (RNS), or indirectly, by the products of lipid peroxidation**." ***(These are free radicals, highly reactive molecules that rob electrons from others damaging them. This causes oxidative stress to the cells, including the lipids in the brain, i.e.lipid peroxidation. The brain is estimated to be nearly 60% fat, so fat damaging free radicals can be particularly destructive.***

This study titled **Essential fatty acids and human brain** published in 2009, emphasizes the critical role that fatty acids have in brain health, function and neuroprotection. https://www.ncbi.nlm.nih.gov/pubmed/20329590).

From the Abstract:

"The human brain is **nearly 60 percent fat**. We've learned in recent years that **fatty acids are among the most crucial molecules that determine your brain's integrity and ability to perform**. Essential fatty acids (EFAs) are required for maintenance of optimal health but they cannot be synthesized by the body and must be obtained from dietary sources. Clinical observation studies has related imbalance dietary intake of fatty acids to impaired brain performance and diseases. **Most of the brain growth is completed by 5-6 years of age. The EFAs, particularly the omega-3 fatty acids, are important for brain development during both the fetal and postnatal period. Dietary decosahexaenoic acid (DHA) is needed for the optimum functional maturation of the retina and visual cortex, with visual acuity and mental development seemingly improved by extra DHA. Beyond their important role in building the brain structure, EFAs, as messengers, are involved in the synthesis and functions of brain neurotransmitters, and in the molecules of the immune system. Neuronal membranes contain phospholipid pools that are the reservoirs for the synthesis of specific lipid messengers on neuronal stimulation or injury**. These messengers in turn participate in signaling cascades that can either promote neuronal injury or neuroprotection. The goal of this review is to give a new understanding of how EFAs determine our brain's integrity and performance, and to recall the neuropsychiatric disorders that may be influenced by them. As we further unlock the mystery of how fatty acids affect the brain and better understand the brain's critical dependence on specific EFAs, correct intake of the appropriate diet or supplements becomes one of the tasks we undertake in pursuit of optimal wellness.

How does that relate to the discussion we just read about the damage caused by oxygen free radicals created by metals and toxins in the brain? When fat damaging free radicals like described above damage mitochondria and brain cells, a downward spiral of diminishing function and pathology ensues in the brain. Short term effects in the developing brain of an infant or child manifest as neurodevelopmental, learning or behavioral problems. And Lord knows, those are at an all-time high right now and increasing every year. In the long term especially under continued exposure, these changes and subsequent dysfunction can lead to cognitive decline, neurodegeneration and diseases like dementia, Parkinson's and Alzheimer's. And Lord knows, those are at an all-time high and increasing every year too. One thing is for sure. If we continue to do what we are currently doing and don't change anything, we are destined for destruction economically, societally and relationally. All the experts agree, diseases like autism, dementia, Parkinson's and Alzheimer's are difficult if not impossible to treat once established. Virtually all of them agree that PREVENTION IS THE KEY. We must work on investigating and making changes to the most probable suspects. In my opinion that MUST START WITH VACCINES. Still don't think so. Continue through the rest of this eBook and I believe you will change your mind.

The medical establishment shows no signs of coming to their senses on this issue-

On August 28, 2017, the American Academy of Pediatrics (AAP) recommended that newborns who weigh at least 2,000 grams (4.4 pounds) should receive their first dose of hepatitis B vaccine within 24 hours of birth. **This is absurd!** In addition to the evidence produced in this document, this next article on Dr. Mercola's site presents additional and compelling evidence showing the lunacy of this policy.

In fact, you may recall earlier in this eBook, I discussed a presentation in which Dr. Neal Halsey the ***Director of the Institute of Vaccine Safety at Johns Hopkins University*** stated the following:

"The recent ***American Academy of Pediatrics***/Public Health Service recommendation **to defer the first dose of hepatitis B vaccine for infants born to HBsAg negative mothers until 2-6 months of age has addressed the problem of exposure at birth, but the exposure to mercury at 2 months of age is much greater and we need to do more to reduce this potential exposure.**" Dr. Halsey was discussing mercury, but the same logic would need to be followed with aluminum which is as or more neurotoxic than mercury.

As stated, the ***American Academy of Pediatrics*** **was quoted as recommending that the Hep B vaccine be delayed until between 2 and 6 months of age. That presentation was given in 1999. In that presentation, Dr. Halsey also states that 6 months would be better than 2 months, because the baby is larger at 6 months and their "target organ" (brains), are less vulnerable as a result. "Exposure to a fixed dose (e.g. 62.5 ug) of mercury at 2 months of age poses a greater potential risk than the same dose administered at 6 months of age because a child weighs more at 6 months and the target organ, the brain, is more vulnerable early in life." I find it curious that he calls the brain the "target organ". This sounds like a clear admission that the brain accumulates mercury and aluminum.**

Why the turn around with recommending the Hep B Vaccine at birth by the ***American Academy of Pediatrics (AAP)***? One would hope that Big Pharma hasn't gotten to them, but as Sheryl Attkisson an investigative reporter working for CBS News reported in 2009, there is a lot of drug company money going to the ***AAP.*** I will cover more on this later in this document, but her article titled, **How independent ARE Vaccine Defenders?** Cites the following:

"The vaccine industry gives millions to the Academy of Pediatrics for conferences, grants, medical education classes and even helped build their headquarters. The totals are kept secret, but public documents reveal bits and pieces."

- A $342,000 payment from Wyeth, maker of the pneumococcal vaccine - which makes $2 billion a year in sales.
- A $433,000 contribution from Merck, the same year the academy endorsed Merck's HPV vaccine - which made $1.5 billion a year in sales.
- Another top donor: Sanofi Aventis, maker of 17 vaccines and a new five-in-one combo shot just added to the childhood vaccine schedule last month.

https://www.cbsnews.com/news/how-independent-are-vaccine-defenders/

An in-depth look at the science behind the dangers of vaccines given during brain development

http://articles.mercola.com/sites/articles/archive/2008/03/14/the-danger-of-excessive-vaccination-during-brain-development.aspx This article titled, **The Danger of Excessive Vaccination During Brain Development**, was also **written by Dr. Blaylock** and is an extremely comprehensive look at the science connecting the problems associated with the overload on the developing immune system from the onslaught of vaccinations that children face today. And, if the pharmaceutical industry has their way, the list will just continue to grow. **This article has 172 references!**

A 2017 study cites the need for and lack of an accurate way to track the full extent of where the aluminum goes and is stored post-vaccination

A 2017 article published in the ***Journal of Regulatory Toxicology and Pharmacology*** titled, **Towards toxicokinetic modelling of aluminium exposure from adjuvants in medicinal products**, expresses concerns that sufficient data is not available as to what happens to the aluminum after being injected into the human body, especially with repetitive doses.
https://www.ncbi.nlm.nih.gov/pubmed/?term=28237896

From the study:
"As **a potentially toxic agent on nervous system and bone**, the safety of aluminium exposure from adjuvants in vaccines and subcutaneous immune therapy (SCIT) products has to be continuously re-evaluated, especially regarding concomitant administrations. For this purpose, **knowledge on absorption and disposition of aluminium in plasma and tissues is essential**. Pharmacokinetic data after vaccination in humans, however, **are not available**, and for methodological and ethical reasons difficult to obtain." They then go on to propose a model that they feel would provide a better method of evaluation of what happens to the aluminum once it is injected into the body.

Studies show the metal adjuvants in vaccines may not even do what they're promoted to do, and higher levels relate to increasing adverse reactions

A 2009 study in ***The New England Journal of Medicine*** titled, **A Novel Influenza A (H1N1) Vaccine in Various Age Groups**, found that the vaccine **without** the aluminum adjuvant created a greater immune response and the local reactions were fewer.
https://www.ncbi.nlm.nih.gov/pubmed/?term=19846844

From the article;
"**Vaccine without adjuvant was associated with fewer local reactions and greater immune responses than was vaccine with adjuvant.**"

"The vaccines formulated without alum adjuvant were more effective in inducing an immune reaction in subjects than were vaccines with adjuvant. This lack of enhancement by the use of alum adjuvant was consistent with data from previous studies of other influenza vaccines. There were no significant differences in the immunogenicity of the 15-µg and 30-µg doses of nonadjuvant vaccine (Tables 2 and 3), in line with the results reported by Greenberg et al." This also demonstrates that the weaker dose vaccines resulted in equivalent immunogenicity.

The conclusion stated:
"These data suggest that a single dose of 15 µg of hemagglutinin antigen without alum adjuvant induces a typically protective immune response in the majority of subjects between 12 and 60 years of age."

Adjuvants do not work as advertised anyway. So why increase risk with them then?

Another ***New England Journal of Medicine*** article, published in 2008 and titled, **A clinical trial of a whole-virus H5N1 vaccine derived from cell culture**, also finds that adjuvants did not improve the antibody response and in fact the maximum responses were obtained with the non-adjuvanted vaccines. https://www.ncbi.nlm.nih.gov/pubmed/18550874

From the abstract:

"**The use of adjuvants did not improve the antibody response.** Maximum responses to the vaccine strain were obtained with formulations containing 7.5 microg and 15 microg of hemagglutinin antigen without adjuvant. Mild pain at the injection site (in 9 to 27% of subjects) and headache (in 6 to 31% of subjects) were the most common adverse events identified for all vaccine formulations."

Another article finds the adjuvant in the influenza vaccine ineffective

A 2006 article from the British medical journal ***Lancet*** titled, **Safety and immunogenicity of an inactivated split-virion influenza A/Vietnam/1194/2004 (H5N1) vaccine: phase I randomised trial** found similar results to the previous study. https://www.ncbi.nlm.nih.gov/pubmed/?term=16714186

From the study abstract:
"**Adjuvant did not improve the response to the lower doses.**"

Increasing aluminum adjuvant increases risk of adverse reactions, but doesn't improve immune reactivity

A 2005 article published in the journal ***Vaccine*** titled, **Effects of lowering the aluminium content of a dTp vaccine on its immunogenicity and reactogenicity when given as a booster to adolescents**, comparing three different levels of aluminum adjuvant revealed some interesting results. Not only that, **but the greater levels of aluminum corresponded with increased adverse effects**. (Aluminium is the British way to spell aluminum.) https://www.ncbi.nlm.nih.gov/pubmed/15670888

The study took 647 subjects that had previously been vaccinated and compared three different levels of aluminum in the dTpa booster vaccine, 0.5 mg, 0.3 mg and 0.133 mg.

From the results:
"In terms of the immune response to diphtheria and tetanus, no significant difference was for 10d between the 0.5 mg group and each of the low aluminium content groups." *(They also provide 3 additional references to other studies that found the same result.)*

"Concerning anti-pertussis antibody responses, there was no significant difference in post-vaccination booster response rates between the 0.5 mg group and each of the low aluminium content groups for each antigen."

"**Approximately 65% of subjects in each group reported at least one systemic symptom following vaccination** (see Table 3). The incidence of fever (>37.5 degrees C *or 99.5 degrees F)*), headache, fatigue, and gastrointestinal symptoms within 2 days of follow up were similar between groups. For gastro-intestinal symptoms within 14 days after vaccination, a significant difference between study groups was found, with **a higher incidence observed in the 0.5 mg group**."

"Grade 3 (see Table 3) solicited general symptoms considered related to the vaccine by the investigator were rare, but **tended to increase with increasing aluminium concentration**. Only for fatigue, a significant difference between study groups was found. **The percentage of subjects who used antipyretic medication *(medication to reduce fever),* within 2 days after vaccination also tended to increase with increasing aluminium content: 6.5%** (95% CJ: 3.6-10.7), **8.6%** (95% Cl: 5.2-13.3) and **10.3%** (95% CJ: 6.6-15.0) **in the 0.133, 0.3 and 0.5 mg groups, respectively**."

"The difference in total aluminium content reflects mostly a difference in excess aluminium content. Combined DTP-containing vaccines **contain more aluminium than required for full adsorption of antigen, aiming at enhancing the immune response through excess aluminium; however, a decline in adjuvant effect was demonstrated when increasing the aluminium content above an "optimum" concentration which has been postulated to be due to immuno-suppressive effects of excessive aluminium**." *So in essence, they put in too much aluminum, to stimulate an enhanced immune response, but that causes a decline in the effect of the aluminum, because excess aluminum has an immune-suppressive effect. What? That is self-defeating! Adding what looks like an unnecessary toxic metal, to sabotage the desired benefit of the vaccine itself makes less than no sense.*

"In combined toxoid vaccines, even when toxoids are well purified, the relative contribution of aluminium to reactogenicity seems to be minimal."

These and other studies like this raise serious questions as to why more than a decade later, are toxic heavy metals still being used in so many vaccines?

One mechanism in which vaccines can cause neurological damage: Activation of the brain's immune system and the inflammatory cascade that follows

Inflammatory proteins trigger inflammation of the brain's immune cells (microglia) and increase the risk of autism

Activation of the brain's immune system by vaccines cause brain inflammation, a hallmark of autism

In a 2006 article by Paul H. Patterson and published in ***Engineering and Science*** titled, **Pregnancy, Immunity, Schizophrenia and Autism**, the author identifies a very plausible connection with individuals with autism and a perpetual upregulation of the brain's immune system, thus increasing inflammatory cytokines (proteins). http://www.cco.caltech.edu/~phplab/images/whatwedo/EngSci31006.pdf

From the article:
"There is also very striking evidence of immune dysregulation in the brain itself. Just last year, a group led by Carlos Pardo at Johns Hopkins found what they're calling a "neural inflammation" in postmortem examination of brains of patients with autism who died between the ages of eight and 44 years. But these people weren't infected—they died of such things as drowning or heart attacks. The study found that **the microglial cells, which act as the brain's own immune system, were activated.** The study also found amazing increases of certain cytokines in the brain, and of others in the cerebrospinal fluid. This is a landmark paper, in my opinion. It presents the first evidence that **there's an ongoing, permanent immune-system activation in the brains of autistic people**."

And asks some very compelling questions….

"Finally, I want to ask a question that's come up in the literature in the last few years—should we really be promoting universal maternal vaccination? The flu vaccine has been recommended routinely

to pregnant women in the United States since 1957. The official policy of the Centers for Disease Control states that "administration of vaccines to women seeking prenatal care is an opportunity for preventative intervention that should not be wasted." Now you might say, "Well, of course, you don't want to get the flu if you're pregnant!" But remember that double-stranded RNA experiment—we activated the immune system, and it caused all these downstream effects on the fetus. And what does a vaccination do? It activates the immune system. That's the point of vaccination. In practice, not all pregnant women receive flu shots, and I think that universal vaccination of pregnant women could get us into a whole new set of problems."

Inflammatory cytokines produced by vaccine components can cause a cascade of events in a child's brain leading to autism and other neurodevelopmental problems

An article titled, **Role of Microglia in Autism: Recent Advances** published in ***Developmental Neurosciences*** in 2015, **emphasizes how inflammation triggers microglial activation and can lead to the development of autism**. https://www.ncbi.nlm.nih.gov/pubmed/25998072

From the study:

"**Mounting evidence indicates that microglial activation or dysfunction can profoundly affect neural development, resulting in neurodevelopmental disorders, including autism**. These mechanisms in autism have been investigated using neuropathological studies of human autopsy brains, a large number of murine experimental models and in vivo neuroimaging studies of the human brain. The purpose of this review is to discuss microglial activation or dysfunction and to highlight the detrimental role that microglia play in the development of autism."

"**…any factors that alter the number or activation state of microglia either in utero or during the early postnatal period can profoundly affect neural development, thus resulting in neurodevelopmental disorders, including autism.**"

This next paragraph has some "deep" scientific terms. Unless you have a certain level of medical or scientific background, you may want to concentrate on the underlined portion and the summary at the end…

Maternal Inflammatory Activation- "Polyriboinosinic-polyribocytidilic acid (poly I:C), a synthetic double-stranded RNA shown to bind to Tolllike receptor 3, leads to the activation of NF-κB (nuclear factor κ-light-chain-enhancer of activated B cells) and the production of proinflammatory cytokines such as TNF-α, IL-6 and IL-12. Poly I:C is often referred to as a viral mimetic as it activates the immune system and produces dose-dependent cytokine responses comparable to those occurring during naturally occurring or opportunistic viral infections. In spiny mouse experiments, a single subcutaneous injection of a low dose of poly I:C at midgestation induces subclinical infections such as the common cold during pregnancies. However, the offspring showed significant impairments in nonspatial memory and learning tasks and demonstrated motor activity similar to autistic behaviors. A brain histological examination revealed a significantly decreased expression of reelin, an increased expression of glial fibrillary acidic

protein and an increased number of activated microglia, specifically in the hippocampus. These investigations imply that the prenatal subclinical infection and resultant activation of the maternal immune system could be risk factors for neurodevelopmental disorders such as autism."

Summary: ***A compound was given to the pregnant female which mimics a virus to activate the immune system (which is what a vaccine does, except with a much stronger stimulus), and in turn it caused the activation and stimulation of inflammatory chemicals which resulted in a neurotoxic effect, and caused brain damage and behavioral changes in the offspring like is seen in autistic individuals.*** **(This is shown clearly in a beautiful graphic on page 3 of this article).**

Inflammatory cytokines are elevated in tissues of autistic individuals

A 2015 article published in the journal ***Mediators of Inflammation*** titled, **Inflammatory Cytokines: Potential Biomarkers of Immunologic Dysfunction in Autism Spectrum Disorders** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4333561/

From the article: "A number of studies have shown that the cytokine levels in the blood, brain, and cerebrospinal fluid (CSF) of autistic subjects differ from that of healthy individuals; for example, a series of studies suggests that interleukin-6 (IL-6), tumor necrosis factor-α (TNF-α), and interferon-γ (IFN-γ) are significantly elevated in different tissues in autistic subjects."

"In addition, abnormalities in the cellular immune response have also been reported in children with autism; in particular, reduced cytotoxic activity and elevated levels of selected proinflammatory cytokines produced by peripheral blood mononuclear cells, such as tumor necrosis factor (TNF-α) and IL1β, have been shown to disrupt neurodevelopment."

Decreased emotional recognition, one of the hallmarks of autism demonstrated in this 2018 study

A 2018 article published in the journal ***Brain, Behavior and Immunity*** titled, **Low-grade inflammation decreases emotion recognition - Evidence from the vaccination model of inflammation**, shows how systemic inflammation ensues after vaccination and how that inflammation impairs social-cognitive functioning. https://www.ncbi.nlm.nih.gov/pubmed/?term=29742460

From the Abstract:
"The ability to adequately interpret the mental state of another person is key to complex human social interaction. **Recent evidence suggests that this ability, considered a hallmark of 'theory of mind' (ToM), becomes impaired by inflammation.** However, extant supportive empirical evidence is based on experiments that induce not only inflammation but also induce discomfort and sickness, factors that could also account for temporary social impairment. Hence, an experimental inflammation manipulation was applied that avoided this confound, isolating effects of inflammation and social interaction. Forty healthy male participants (mean age = 25, SD = 5 years) participated in this double-blind placebo-

controlled crossover trial. Inflammation was induced using Salmonella Typhi vaccination (0.025 mg; Typhim Vi, Sanofi Pasteur, UK); saline-injection was used as a control. About 6 h 30 m after injection in each condition, participants completed the Reading the Mind in the Eyes Test (RMET), a validated test for assessing how well the mental states of others can be inferred through observation of the eyes region of the face. **Vaccination induced systemic inflammation, elevating IL-6** by +419% ($p < .001$), without fever, sickness symptoms (e.g., nausea, light-headedness), or mood changes (all p's > .21). Importantly, compared to placebo, vaccination significantly reduced RMET accuracy ($p < .05$). RMET stimuli selected on valence (positive, negative, neutral) provided no evidence of a selective impact of treatment. **By utilizing an inflammation-induction procedure that avoided concurrent sicknesses or symptoms in a double-blinded design, the present study provides further support for the hypothesis that immune activation impairs ToM. Such impairment may provide a mechanistic link explaining social-cognitive deficits in psychopathologies that exhibit low-grade inflammation, such as major depression."**

While the study mentions the connection with social-cognitive deficits and depression, this study gives insight into the correlation with neurological inflammation induced by vaccines. As the other studies we have just looked at have concluded, the upregulation of the microglia or brain immune system by inflammation and the subsequent vicious cycle of inflammation is one of the ways that vaccine have the potential to trigger neurological damage.

Cerebral Palsy as a possible result of an adverse vaccine reaction

Seizures and developmental delays are widely recognized as possible adverse reactions to vaccines, but how can Cerebral Palsy be connected with vaccines?

To be clear, there are several causes of C.P., other than from vaccine damage. But that does not exclude the potential risk of C.P. as a result of a vaccine reaction.

While cerebral palsy was originally thought to be cause by a lack of blood flow (oxygen) to the brain in utero or during childbirth, scientists now think that only a small percentage of C.P. case are caused by that. See this article on the CDC's web site https://www.cdc.gov/ncbddd/cp/causes.html

The article states that congenital C.P. (damage that occurs before or during birth), can be caused by… "Infections during pregnancy—Infections can lead to increases in certain proteins called *cytokines* that circulate in the brain and blood of the baby during pregnancy. **Cytokines cause inflammation, which can lead to brain damage in the baby. Fever in the mother during pregnancy or delivery also can cause this problem**. Some types of infection that have been linked with CP include viruses such as chickenpox, rubella (german measles), and cytomegalovirus (CMV), and bacterial infections such as infections of the placenta or fetal membranes, or maternal pelvic infections." As you will learn, fever is one of the most common side effects of a vaccine. Mothers given vaccine during pregnancy often spike a fever, AND babies are now given a Hepatitis B Vaccine immediately after birth which commonly causes a fever in that newborn infant.

The interesting thing about that description of causation is, that the **increase in inflammatory cytokines** described as the reason for the damage leading to C.P. from infection **is also well documented from**

vaccination as evidenced in numerous articles that you will see included in **1200 Studies**. One interesting recommendation from that same CDC article states: "Get vaccinated for certain diseases (such as chickenpox and rubella) that could harm a developing baby. It is important to have many of these vaccinations *before* becoming pregnant." **BEFORE** becoming pregnant, would imply that getting the vaccines during pregnancy could cause problems. That's something that this eBook will document exceedingly well. Stay tuned!

In addition, the CDC article discusses "Acquired" C.P., which is C.P. that develops more than 28 days AFTER birth. One of the causes it cites is Infection- "Infections of the brain, for example, meningitis or encephalitis during infancy." Encephalitis is one of the severe adverse reactions from vaccines that has been well documented and even compensated for numerous times in vaccine court. Babies now get 35 doses of vaccines in the first 18 months with 26 of those given in the first 12 months. This can cause a tremendous increase in the production of pro-inflammatory cytokines, that this eBook will show is being implicated as one of the main factors for neurological damage from vaccines.

Production of inflammatory cytokines common from vaccines, but highest from HPV vaccine

An article published in the journal ***Vaccine*** in 2014 titled, Inflammatory **responses following intramuscular and subcutaneous immunization with aluminum-adjuvanted or non-adjuvanted vaccines** confirms that inflammatory cytokines are increased in serum from aluminum adjuvant vaccines. https://www.ncbi.nlm.nih.gov/pubmed/24768634 Note: AS04 is the aluminum adjuvant used in the vaccine.

"Cytokine production was examined in the injected muscular tissues and **AS04 adjuvanted HPV induced higher IL-1β, IL-6, KC, MIP-1, and G-CSF levels in muscle tissues than any other vaccine,** but similar serum cytokine profiles were observed to those induced by the other vaccines."

The journal *Vaccine* describes how aluminum is carried throughout the body

In a 2011 article published in ***Vaccine*** and titled, **Updated aluminum pharmacokinetics following infant exposures through diet and vaccination**, the authors accurately explain **how the aluminum adjuvant causes the protein or polysaccharide antigens to stick to its surface, which are then eaten (phagocytized) by the macrophages (a type of immune cell of the body), which leads to a stimulation of the Th-2 immune system response, amplifying the reaction to the antigen. This is the basic way that the adjuvant ramps up the immune system against the protein antigens to give immunity to the individual. This also leads to the mechanism of how the aluminum is carried throughout the body. These macrophages carry the aluminum particles to distant parts of the body (i.e. organs and brain).** https://www.ncbi.nlm.nih.gov/pubmed/?term=22001122

Notice a couple things from that statement. **First, they describe how the macrophages engulf the aluminum particles with the antigen (which is a protein). The macrophages circulate throughout the body. This means the aluminum particles are now being carried to distant parts of the body**. Secondly, the immune response triggered by the proteins stuck to the aluminum particles is what causes the body's innate immune system to attack that same virus when exposed to it from the environment. Pretty amazing right? I think so too. **But wait until you continue to read about the unforeseen consequences of this master plan.**

The way an immune response to the viral antigen occurs, could be the exact reason why vaccines trigger unwanted immune reactions to other components of the vaccine

In light of the explanation from that last section, of the way the aluminum picks up proteins and triggers a strong immune reaction against those proteins, consider this statement from a December 2017 op-ed by Vinu Arumugham, an independent researcher titled, **Safety studies of aluminum in vaccines lack immunotoxicity analysis of this immunological adjuvant: Ignorance or deception?**
https://www.researchgate.net/publication/325393007_Safety_studies_of_aluminum_in_vaccines_lack_immunotoxicity_analysis_of_this_immunological_adjuvant_Ignorance_or_deception

From his paper:
"The quoted paragraph above assumes that the only proteins in the vaccine are viral/bacterial target proteins required for immunoprotection. In that case, as they state, the stimulation by aluminum plays a vital role in generating immunoprotection. **But obviously, vaccines contain numerous other proteins including food proteins (ovalbumin, milk, soy, yeast, oils from sesame, peanut, fish etc.), culture medium cell proteins (Vero monkey kidney cell proteins, calf serum proteins, WI38/MRC5 fibroblast cell proteins, chick embryo cell culture proteins etc.), non-target viral/bacterial proteins, that are also adsorbed on to the surface of insoluble aluminum particles. As they state then, aluminum adjuvants stimulate the immune system to respond more effectively to ALL these proteins as well. The result is off-target immune responses that includes synthesis of antibodies against any and all of these proteins as well as cell mediated immune responses. The result of such a response of course includes food allergy, asthma, autism and autoimmune diseases."**

"How can they perform a safety assessment of aluminum in vaccines while **completely ignoring** this immunological effect?"

GREAT point! With the epidemic of allergies, asthma, atopic disorders like eczema and psoriasis as well as autoimmune disorders, why aren't researchers looking at the way that the adjuvants are also stimulating the immune system to react to all of the other proteins, polysaccharides and toxins in the vaccine soup? Could this be one of the main causes? As the immune system is strongly induces to react to various proteins, the likelihood that it accidentally and mistakenly begins to target the body's own tissues increases. The result? Allergies and autoimmune diseases.

Activation of brain microglia is implicated in many forms of neurodegenerative diseases

More than a decade ago, this mechanism for brain injury was recognized as a major factor. This 2007 article published in ***Current Medicinal Chemistry*** and titled, **Microglial activation and its implications in the brain diseases** had some very strong comments on this process.
https://www.ncbi.nlm.nih.gov/pubmed/?term=17504139

From the article summary:

"An inflammatory process in the central nervous system (CNS) is believed to play an important role in the pathway leading to neuronal cell death in a number of neurodegenerative diseases including Parkinson's disease, Alzheimer's disease, prion diseases, multiple sclerosis and HIV-dementia. The inflammatory response is mediated by the activated microglia, the resident immune cells of the CNS, which normally respond to neuronal damage and remove the damaged cells by phagocytosis. **Activation of microglia is a hallmark of brain pathology."**

"**The chronic activation of microglia may in turn cause neuronal damage through the release of potentially cytotoxic molecules such as proinflammatory cytokines, reactive oxygen intermediates, proteinases and complement proteins.** Therefore, suppression of microglia-mediated inflammation has been considered as an important strategy in neurodegenerative disease therapy."

NEW - Mercury exposure, oxidative stress and brain tumors

A study published on November 24th, 2020 in the ***Current Medicinal Chemistry*** titled, **Mercury Exposure, Epigenetic Alterations and Brain Tumorigenesis: A Possible Relationship?**, raises very serious questions about the connection between mercury and brain tumors. It also outlines the mechanisms by which mercury causes severe oxidative stress and inflammation of the brain.

Abstract

The risk assessment of mercury (Hg), in both wildlife and humans, represents an increasing challenge. Increased production of Reactive Oxygen Species (ROS) is a known Hg-induced toxic effect, which can be accentuated by other environmental pollutants and by complex interactions between environmental and genetic factors. Some epidemiological and experimental studies have investigated a possible correlation between brain tumors and heavy metals. Epigenetic modifications in brain tumors include aberrant activation of genes, hypomethylation of specific genes, changes in various histones, and CpG hypermethylation. Also, Hg can decrease the bioavailability of selenium and induce the generation of reactive oxygen that plays important roles in different pathological processes. Modification of of metals can induce excess ROS and cause lipid peroxidation, alteration of proteins, and DNA damage. In this review, we highlight the possible relationship between Hg exposure, epigenetic alterations, and brain tumors. https://pubmed.ncbi.nlm.nih.gov/31566127/

VACCINE RISKS TO THE FETUS DURING PREGNANCY

Safety of vaccines for pregnant women and their unborn babies receive harsh scrutiny from hundreds of scientists

February 2019- A freedom of Information Act inquiry reveals that there were never any safety studies done using the 2 vaccines recommended in pregnancy…the Tdap and Influenza Vaccines

Robert F. Kennedy Jr. filed a Freedom of Information Act (FOIA) request with the FDA to find out if there had ever been any safety studies done with the 2 vaccines that the CDC is recommending every pregnant woman receive. The request was filed on behalf of the Informed Consent Action Network and its founder Del Bigtree.

The following is a summary from the court documents:

WHEREAS, plaintiff Informed Consent Action Network ("ICAN") requested the following records from defendant United States Food & Drug Administration ("FDA") pursuant to the Freedom of Information Act ("FOIA"): "A copy of the report for each clinical trial relied upon by the FDA when approving for use by pregnant women any influenza vaccine currently approved by the FDA."

WHEREAS, after ICAN appealed, the FDA responded, in relevant part, as follows:

"These requests sought the clinical trials relied upon by the FDA prior to approving any currently licensed influenza or Tdap vaccine for use in pregnant women as an indicated use. … We have no records responsive to your requests."

How about that? It appears that all the women who have ever been given these vaccines or are currently given these 2 vaccines are serving as unknowing subjects in a huge human experimental "safety" study! When you read the following section on these vaccines given during pregnancy, you will see how damaging this practice has been and continues to be.

Shocking revelations from the flu vaccine package insert regarding pregnant women, nursing mothers and young children- NEVER been tested in pregnant women

Flu vaccine recommended for pregnant women has not been tested in pregnant women or children less than 6 months of age for safety or effectiveness

https://www.fda.gov/downloads/biologicsbloodvaccines/vaccines/approvedproducts/ucm182404.pdf

The Influenza A (H1N1) 2009 Monovalent Vaccine manufactured by Sanofi Pasteur Inc. vaccine package insert provides an amazing admission… "Safety and effectiveness of influenza A (H1N1) 2009 monovalent vaccine **have not been established in pregnant women or nursing mothers or children less than six months of age."** That is found on page 1 and also expounded upon in section 8.1, 8.3, and 8.4.

There are two shocking revelations that the insert reveals:

1. They **have not** established the safety and efficacy of the flu vaccine **when given to pregnant women, nursing mothers and children less than six months of age.**
2. The insert **only cited one study** that tested the vaccine in children and it was from 2003 – 2004. And **the sample size was extremely low testing only 19 children 6 to 23 months of age, and only 12 children 24 to 36 months of age**.

The drug manufacturer of the flu vaccine holding their study results "on file" rather than publishing it

With regard to the second point from the flu vaccine insert made above, any good incredible researcher will tell you that a sample size that small is virtually worthless (19 children and 12 children). Not only that, but the citation given for the reference to that study on the package insert, simply says: *Sanofi Pasteur Inc. Data on file, 071107*. Sanofi Pasteur Inc. is the drug manufacturer. Apparently, that was **an in-house study and was never published in a peer-reviewed journal**. It would appear that the data from that study is on file with the drug company, which make it difficult if not impossible to review further. Why wouldn't they just publish it for all the world to see? It sure makes me wonder.

Despite these admissions & shortfalls, CDC still recommends these shots for those groups

Yet, the CDC's Advisory Committee was, and is still recommending giving pregnant women these shots.

Use of Influenza A (H1N1) 2009 Monovalent Vaccine, Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2009.
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5810a1.htm

From the report:

"Highlights of these recommendations include the identification of five initial target groups for vaccination efforts (**pregnant women**, persons who live with or provide care for infants aged <6 months, health-care and emergency medical services personnel, children and young adults aged 6 months--24 years, and persons aged 25--64 years who have medical conditions that put them at higher risk for influenza-related complications)."

So how can our government's committee designated to oversee the safety and efficacy of vaccines, recommend a vaccine to pregnant women that the manufacturer itself clearly states that there has been no safety and effectiveness studies done with pregnant women or nursing mothers?

More on the dangers of heavy metal exposure during pregnancy-

This study published in the Journal ***Contributions to Science*** and titled, **Risks of aluminum exposure during pregnancy**, discusses the dangers of maternal exposure to the fetus as well as the toxicity in infants. http://publicacions.iec.cat/repository/pdf/00000022/00000054.pdf

From the study:

"…there is unequivocal evidence that Al is a potent neurotoxic agent inducing neurofibrillary degeneration in animal brains after intracerebral Al injections and systemic Al exposure."

"A recent review by Borak and Wise attempts to minimize the potential toxicity of Al during pregnancy by stating that environmental and dietary Al exposures are unlikely to pose risks of Al accumulation to pregnant animals or their fetuses, **but the weight of evidence would seem not to support this statement**. In relation to this, the current review shows a lot of evidence on Al-induced maternal and developmental toxicity in rats and mice."

"On the other hand, recent attention has also focused on Aluminum toxicity in infants. Moreno et al. reported that both, preterm and full-term neonates are susceptible to Al accumulation in tissues while receiving parenteral nutrition. In turn, Bishop et al. showed that, in preterm infants, prolonged **intravenous feeding with solutions containing Al is associated with impaired neurologic development.** Bishop et al. had previously shown **increased concentrations of Al in the brain of a parenterally fed premature infant."**

Journal of Pediatrics study shows increases of systemic inflammation, cardiorespiratory complications and brain inflammation after vaccine administration

A 2007 study from the ***Journal of Pediatrics*** found some concerning cardio and respiratory effects after administration of one and multiple vaccines administered to 239 pre-term infants. The study titled, **Primary immunization of premature infants with gestational age <35 weeks: cardiorespiratory complications and C-reactive protein responses associated with administration of single and multiple separate vaccines simultaneously.** https://www.ncbi.nlm.nih.gov/pubmed/?term=17643770

*** CRP levels referred to are a blood marker for inflammation. CRP stands for C Reactive Protein.**

RESULTS: "Abnormal elevation of CRP level occurred in **85%** of infants **administered multiple vaccines** and up to **70%** of those **given a single vaccine**. **Overall, 16% of infants had vaccine-associated cardiorespiratory events within 48 hours postimmunization**. ***In logistic regression analysis, abnormal CRP values were associated with multiple vaccines…15.77 X increase).... and severe intraventricular hemorrhage (IVH)…. (2.28 X increase)….. Cardiorespiratory events were associated marginally with receipt of multiple injections... (3.62 X increase)… and significantly with gastroesophageal reflux (GER) …(4.76 X increase)…***

CONCLUSION:
"CRP level is expected to be elevated in the 48 hours following immunization. In a minority of infants immunized, cardiorespiratory events were associated with presumed need for intervention. Underlying medical conditions **and possibly multiple injections are associated with cardiorespiratory events. Precautionary monitoring following immunizations is warranted.**"

According to Helen V. Ratajczak, PhD, "The data provide evidence for a unified theory of adverse vaccine reactions: Brain inflammation, as indicated by elevations of CRP; brain swelling (edema), as one of the cardinal manifestations of inflammation; potentially lethal cardio-respiratory events (bradycardia and apnea); and intraventricular brain hemorrhages."

A 2017 study published in the prestigious JAMA Pediatrics, finds a significant correlation with the flu vaccine given first trimester and autism. They then unsuccessfully try to explain it away

In a recent (2017) article published in ***JAMA Pediatrics*** titled, **Association Between Influenza Infection and Vaccination During Pregnancy and Risk of Autism Spectrum Disorder**, **researchers found a 20 percent increase in rates of autism with women who were vaccinated against the flu in their first trimester of pregnancy**. https://jamanetwork.com/journals/jamapediatrics/fullarticle/2587559

This study has recently been hailed in the media by those pushing the vaccine agenda as "proof" that the flu shot is not connected with autism. I say, **NOT SO FAST! A critical look at the study finds the association and an attempt to sweep the findings under the rug**.

The study looked at **196,929 children born over a ten-year period from 2000-2010**. They compared children born of mothers that were vaccinated for influenza at first, second and third trimesters of pregnancy. **In the first year of the study, only 6% of the women were vaccinated. In the last year (2010) that number was 56%. This most likely represents that change in policy recommendations for pregnant women to get the flu shot by the CDC.** According to ***Kelly Brogan M.D.***: **"Since 1997, the ACIP has recommended the trivalent inactivated flu vaccine to pregnant women after the first trimester. Then, in 2004, this recommendation, inexplicably changed and grew, as is the way with vaccine recommendations, to encompass all pregnant women (and every human over 6 months of age), regardless of personal risk factors, immune determinants, diet, regional exposures, and timing of injection**." http://kellybroganmd.com/rejecting-flu-vaccine-in-pregnancy/ Another factor was that the H1N1 flu scare was in 2009-2010.

From the JAMA article: "After adjustment for covariates, first trimester influenza vaccination was associated with an increased risk of Autism Spectrum Disorder (AHR, **1.20** [95% CI, 1.04-1.39], ***P* = .01**); **however**, adjusting for the multiplicity of hypotheses tested (n = 8) **using the Bonferroni correction** suggests that this association could be due to chance (***P* = .10**)." Essentially, they found that a flu shot during the first trimester resulted in a 1.2 X increased risk of Autism Spectrum Disorder. It seems that when researchers don't like the outcome of something, they try to explain it away. This explanation, however may not be the most credible way to do that. A criticism of the Bonferroni correction according to ***Wikipedia*** states: "**Criticism**: **The correction comes at the cost of increasing the probability of producing false negatives *(meaning making something look like a negative finding that isn't)*, i.e., reducing statistical power**. There is not a definitive consensus on how to define a family in all cases, and adjusted test results may vary depending on the number of tests included in the family of hypotheses. Note that these criticisms apply to Family Wise Error Rate control in general, and are not specific to the Bonferroni correction."
Essentially that means that using the FWER method, which is prone to making a finding look less significant, may be misleading. But then again, maybe making the finding look less significant was the point.

What does this mean from a practical sense? One of the statistical measures often looked at is called "P Value" or "P" (P stands for probability and relates to the statistical significance). So essentially, by using the Bonferroni correction they reduced the probability that the findings that the flu shot given during the first trimester correlated with a higher rate of autism was by chance (and not a real correlation), from only 1% to 10% (P = 0.01 to P = 0.1). Another way to put it, is P = .01 means there is only one in a hundred probability, that the findings are due to chance (or a 99% probability that the findings are NOT due to chance and is statistically significant). P = 0.1 means that there is only a one in ten probability of the findings being due to chance, (or a 90% probability the findings are NOT due to chance). (See the red numbers above)

In fact, many distinguished experts have cried foul, as a result of the attempt to "erase" the correlation with autism. In an article on the web site EcoWatch at https://www.ecowatch.com/pregnancy-flu-shot-autism-kennedy-2159830326.html , ***Robert F. Kennedy Jr. and Lyn Redwood RN, MSN*** stated the following: "When applied to the first trimester flu vaccine dataset, the Bonferroni Correction reduced the significance of the association from 99 percent to 90 percent. Despite the fact that the adjusted result was still considered marginally statistically significant, the authors then made a second dodgy judgment, by declaring that, "this association could be due to chance."

"Dr. James Lyons-Weiler, PhD, the CEO and director of the ***Institute for Pure and Applied Knowledge***, and data manager of more than 100 biomedical research studies, told me that the author's "incorrect" and "unorthodox" application of the Bonferroni Correction in this circumstance risked the appearance that they were using improper methodologies to, "**make an unwanted but statistically significant finding vanish in a sea of statistical wizardry**."

"Sander Greenland, professor of Statistics and Epidemiology at ***UCLA's School of Public Health and College of Letters and Science***, agreed that the use of the Bonferroni Adjustment was inappropriate in this context. Greenland is among America's preeminent statisticians with more than 300 peer reviewed publications—two of which have been cited more than 500 times. **He is editor of the Dictionary of Epidemiology**. Greenland said the research team's use of Bonferroni makes no sense "where there are finely correlated outcomes" and where the cost of a false negative is high—the possibly erroneous conclusion that first trimester flu shots are safe. *(See at the end of the post Dr. Greenland's detailed explanation of the Bonferroni and why it was inappropriate.)"*

"Greenland observes that "in a context like this, it's something that's usually called up, after the fact, when they get some significance like this, where they don't like it and they want to see if they can get rid of it that way. It's obvious why they used it. It makes the so-called significance go away and, of course, that's the goal. **They're trying to make things go away…that's sort of a standard strategy now—by a large segment of the pharmaceutical experts that try to get rid of things**. **They didn't like the results and they jumped on it with the Bonferroni. It's not appropriate here."**

Other comments in the JAMA Pediatrics article make additional associations:

"Compared with unvaccinated pregnant women, vaccinated pregnant women were more likely to be older and have a college education. **Asthma, autoimmune disease, and hypertension were more likely to be diagnosed in vaccinated women before conception, and gestational diabetes was more likely to be diagnosed during the study pregnancy** (Table 1). In the 0.7% (1400) of cases in which influenza was diagnosed in pregnant women, they were more likely to be younger than the women who did not have influenza. These women were also more likely to have the same health conditions as vaccinated pregnant women (eTable 1 in the Supplement). A small proportion of women were exposed to both influenza infection and influenza vaccination during pregnancy (0.2%)." Why would the women who are

more likely to be vaccinated (and were), have higher rates of those diseases that this eBook and the research presented show to be highly correlated with vaccines? Just a question.

"If influenza vaccination during the first trimester of pregnancy causes ASD, our results suggest that it would amount to 4 additional ASD cases for every 1000 women vaccinated. Our finding of a possible association between maternal influenza vaccination in the first trimester and increased ASD risk parallels previous studies reporting an association between maternal viral infection or fever and increased ASD risk in the first trimester."

Wow! I certainly think that their confession of 4 additional cases of autism per 1,000 women vaccinated against the flu, IS hugely significant!

Yet, it comes off as if they mention it as matter of fact, no big deal. It is a big deal! That is 4 families whose lives are changed forever, who will never see their child reach what should have been his or her potential. Who may never be able to be a productive member of society, get married, have a family and enjoy their independence.

When you extrapolate that 4 per 1,000 number out to a million pregnant women vaccinated during flu season (which wouldn't be a stretch), that's 4,000 children who now have autism that would not have otherwise!

"**Like infection, influenza vaccination during pregnancy has been reported to induce a transient increase in the levels of a number of proinflammatory cytokines, including interleukin 6, tumor necrosis factor α, and C-reactive protein. Studies on mice found an association between high interleukin-6 levels during pregnancy and abnormal behavior and brain structure.** However, in epidemiological studies, associations between maternal cytokine levels and ASD have been mixed. While an earlier study found an association between elevated levels of C-reactive protein in the second trimester and increased ASD risk, a recent study did not find an association between maternal C-reactive protein and increased risk of ASD after controlling for maternal BMI. Elevated levels of interleukin 6 during pregnancy have been associated with increased risk of developmental delays but not ASD in one study and with increased ASD risk with intellectual disability in another."

Also, from the article: "Compared with children without ASD, children with ASD were more likely to be male and born at less than 37weeks gestation. Mothers of children with ASD were more likely to be older at delivery and have a college or postgraduate education."

Pregnant women told to get vaccines containing toxic metals, despite evidence showing they cross the placenta into the fetus

This article published in the ***Journal of American Physicians and Surgeons***, Winter 2016 also pokes major holes in the previous article. The name of the article is **Aluminum in Childhood Vaccines is Unsafe**. http://www.jpands.org/vol21no4/miller.pdf

From the article:
"Prior to the mercury phase-out (pre-2000), babies received 3,925 micrograms (µg or mcg) of aluminum in their first year-and-a-half of life. After pneumococcal and hepatitis vaccines were added to the immunization schedule, babies began receiving 4,925 mcg of aluminum during the same age period—a 25% increase (Figure 1). In 2011, CDC recommended that pregnant women receive a pertussis vaccine (Tdap), which also contains aluminum. (Depending on the manufacturer, the Tdap vaccine contains between 170 and 625 micrograms of aluminum. If the woman receives the brand with 625 mcg of aluminum, the baby will absorb an additional and significant percentage of that dose). Studies show that aluminum crosses the placenta and accumulates in fetal tissue."

"**From 1999 through 2002, several vaccines containing mercury were phased out of the childhood immunization schedule. Manufacturing of childhood vaccines with thimerosal ceased in 2001, but those that were not past their expiration date remained on the market for sale until January 2003. They were replaced with low-mercury or "thimerosal-free" vaccines. In the years that followed, autism rates continued to rise, prompting health authorities to assert that autism is not linked to mercury in vaccines and that vaccination policies are safe and appropriate. (If mercury in vaccines contributed to autism, then rates should have dropped after mercury was removed.) However, in 2002, during this so-called phase-out period, the Centers for Disease Control and Prevention (CDC) actually added two doses of mercury-containing influenza vaccines to the list of inoculations urged for all babies 6 to 23 months of age. Two years later, the CDC also added pregnant women in their first trimester to the list of people officially recommended and actively encouraged to receive influenza vaccines, even though a majority of available doses contained mercury."**

Antacids containing aluminum taken prenatally can damage the fetus, studies show. With ingested aluminum absorbed at 1%, why do we think it's safe to inject in into pregnant women?

A 2003 study in the Journal ***Drug Safety*** titled, **Aluminium in over-the-counter drugs: risks outweigh benefits?, warns about ingestion of antacids that contain aluminum during pregnancy. Even though aluminum ingested orally is only absorbed at around 1%, warnings about using antacids during pregnancy have been issued 15-20 years ago. So why is the CDC increasing the number of doses of aluminum (and even mercury) containing vaccines for pregnant women?**
https://www.ncbi.nlm.nih.gov/pubmed/14583063

From the study:

"In the early 1970s, aluminium toxicity was first implicated in the pathogenesis of clinical disorders in patients with chronic renal failure involving bone (renal osteomalacia) or brain tissue (dialysis encephalopathy)."

"It is now commonly acknowledged that aluminium toxicity can be induced by infusion of aluminium-contaminated dialysis fluids, by parenteral nutrition solutions, and by oral exposure as a result of aluminium-containing pharmaceutical products such as aluminium-based phosphate binders or antacid intake. **Over-the-counter antacids are the most important source for human aluminium exposure from a quantitative point of view**. However, **aluminium can act as a powerful neurological toxicant and provoke embryonic and fetal toxic effects in animals and humans after gestational exposure**. Despite these facts, the patient information leaflets from European antacids that are available OTC show substantial differences regarding warnings from aluminium toxicity. It seems advisable that all patients should receive the same information on aluminium toxicity from patient information leaflets, in particular with regard to the increased absorption through concomitant administration with citrate-containing beverages **and the use of such antacids during pregnancy**."

2014 study finds a linear relationship between the level of mercury exposure and lowered I.Q. levels

A study in the ***Journal of Perinatal Medicine*** titled, **Mercury exposure in pregnancy: a review**, found that there is a linear correlation between levels of mercury exposure and I.Q. levels. They also say that mercury should be avoided during pregnancy and a safe limit cannot be calculated.
https://www.ncbi.nlm.nih.gov/pubmed/24698820

From the article: "Mercury exposure in pregnancy **has been associated with both pregnancy complications and developmental problems in infants**. Apart from industrial accidents and contaminated food, mercury exposure is likely to arise from predatory fish consumption, environmental contamination and dental amalgam restorations placed before or during pregnancy. **It would be prudent to recommend that pregnant women avoid these potential problems and minimize any risk. The available literature indicates a linear relationship with mercury levels and IQ deficit, and therefore a safe limit of mercury cannot be calculated."**

Giving pregnant women vaccines triggers immune activation of her baby's brain cells causing neurological abnormalities- 3 Studies

An article published in the ***Journal Neuroscience*** in 2007 titled, **Maternal immune activation alters fetal brain development through interleukin-6,** supports the concern over giving pregnant women vaccines with adjuvants that activate the immune system. The fear is that in doing so, genetically susceptible

babies exposed to a permanent inflammatory brain condition.
https://www.ncbi.nlm.nih.gov/pubmed/17913903

From the article:
"Schizophrenia and autism are thought to result from the interaction between a susceptibility genotype and environmental risk factors. The offspring of women who experience infection while pregnant have an increased risk for these disorders. Maternal immune activation (MIA) in pregnant rodents produces offspring with abnormalities in behavior, histology, and gene expression that are reminiscent of schizophrenia and autism, making MIA a useful model of the disorders."

"Here we show that the cytokine interleukin-6 (IL-6) is critical for mediating the behavioral and transcriptional changes in the offspring."

My editorial: *IL-6 is a pro-inflammatory cytokine which can activate inflammation systemically, including in the brain cells of the fetus. This is definitely not a good thing during fetal development! Reducing Il-6 is also a key to decreasing the chances of the mother and child from developing autoimmunity.* ***Increasing*** *maternal intake of fish Oil, curcumin and resveratrol block IL-6. Some studies caution against the use of curcumin during pregnancy as it is thought that it may stimulate the uterus. Other studies refute that. The majority of studies on resveratrol show positive benefits. As always, check with your doctor before taking any herbs or nutraceuticals while pregnant and with regard to dosing.* ***Decreasing*** *inflammatory oils like high omega 6 vegetable oils during pregnancy can also reduce IL-6 and thus systemic inflammation.*

New research implicates vaccines or other toxins given to pregnant women as triggers for autism in genetically susceptible offspring

A 2018 article titled, **Beyond infection - Maternal immune activation by environmental factors, microglial development, and relevance for autism spectrum disorders** and published in ***Experimental Neurology***, does a great job of connecting the dots between how maternal infection or exposure to viral stimulation (such as mimicked in vaccines), can trigger increased microglial activity in the baby during important neurological development. This can then lead to an increased risk of neurodevelopmental disorders including Autism Spectrum Disorders (ASD).
https://www.ncbi.nlm.nih.gov/pubmed/28698032

***Note that these authors are from Harvard Medical School, Duke University, Massachusetts General Hospital for Children, Boston and U.C. Irvine.**

From the article:
"Immune molecules such as cytokines and chemokines and the cells that produce them within the brain, notably microglia, are critical for normal brain development. This recognition has in recent years led to the working hypothesis that inflammatory events during pregnancy, e.g. in response to infection, may

disrupt the normal expression of immune molecules during critical stages of neural development and thereby contribute to the risk for neurodevelopmental disorders such as autism spectrum disorder (ASD). This hypothesis has in large part been shepherded by the work of Dr. Paul Patterson and colleagues, which has elegantly demonstrated that a single viral infection **or injection of a viral mimetic to pregnant mice significantly and persistently impacts offspring immune and nervous system function, changes that underlie ASD-like behavioral dysfunction including social and communication deficits**. **Subsequent studies by many labs - in humans** and in non-human animal models - **have supported the hypothesis that ongoing disrupted immune molecule expression and/or neuroinflammation contributes to at least a significant subset of ASD**."

"The heterogeneous clinical and biological phenotypes observed in ASD **strongly suggest that in genetically susceptible individuals, environmental risk factors combine or synergize to create a tipping or threshold point for dysfunction**. **Importantly, animal studies showing a link between maternal immune activation (MIA) and ASD-like outcomes in offspring involve different species and diverse environmental factors associated with ASD in humans, beyond infection, including toxin exposures, maternal stress, and maternal obesity, all of which impact inflammatory or immune pathways**."

Information such as this demands a critical look at the policy of recommending flu shots to pregnant women.

Certain women if vaccinated when pregnant, may run a greater risk of having a behaviorally challenged child

Another 2014 study titled, **The risk for behavioural deficits is determined by the maternal immune response to prenatal immune challenge in a neurodevelopmental model**, and published in the Journal ***Brain, Behavior and Immunity,*** measured an inflammatory blood marker levels called tumor necrosis factor alpha (TNF-α) after maternal immune activation. Researchers found that the pregnant females that lost weight after immune activation had higher levels of TNF-α and their offspring had significant behavioral challenges including the inability to experience pleasure.
https://www.ncbi.nlm.nih.gov/pubmed/24973728

This **is simply additional reinforcement that giving pregnant women injections that stimulate and activate their immune systems in such a way is not good for the fetus.**

One more 2014 study from the Journal ***Behavioral Brain Research*** titled, **Hypolocomotive behaviour associated with increased microglia in a prenatal immune activation model with relevance to schizophrenia**, showed that the rats from offspring treated with a chemical that stimulated (activated) the mother's immune system showed delayed locomotion or development in walking and an absent or diminished startle response. The article also references similar characteristics with autism.

One hallmark of regressive autism, is that children who are progressing normally with their locomotion skills, coordination and movement, suddenly and significantly regress into a state of difficult locomotion, coordination and movement, as well as a diminished startle response/reaction to external stimulus. The timing of this regression often correlates directly or shortly after they are given a routine vaccination or vaccinations. https://www.ncbi.nlm.nih.gov/pubmed/24129217

Pediatrician leading the movement to a safer vaccine schedule comments on mercury and aluminum given to pregnant women

According to his web site, ***Paul Thomas M.D.*** is an Oregon based pediatrician that founded Integrative Pediatrics LLC, where he has over 11,000 patients who largely are attracted to the safer gentler vaccine schedule and his integrative medicine approaches that embraces the best from all disciplines of medicine. He is an avid blogger and presence on You Tube and now is about to publish a major book: **The Vaccine-Friendly Plan *(which is now available)***.

From his site: https://www.drpaulapproved.com/
"**While the thimerosal that used to be in most vaccines as a preservative, was quietly and quickly removed in 2001, the aluminum in vaccines remains at very high levels. When the thimerosal (mercury) was removed in 2001, the CDC and AAP made the tragic decision to move the Hep B vaccine from giving it to teens to giving it to all newborns, 2 month, and 6 month olds. This added an additional 250 micrograms of aluminum being injected at birth, 2 months and 6 month olds. Remember, the maximum aluminum allowed by the FDA for premies in IV feedings is 4-5 micrograms/ Kg / day. Could this explain why there was no decrease in autism when the thimerosal was removed?"**

"Now imagine this: The ACIP (our governments CDC division that makes vaccine recommendations) has just **added the Dtap to be given to all pregnant moms. That is injecting 170 – 650 micrograms of aluminum (depending on brand used) into a pregnant mom whose fetus has zero protection against the aluminum toxin. Remember the uterus has the job of shunting nutrients to the developing baby. I'm quite certain there is no safe amount of aluminum to inject into pregnant moms. Since when do we allow research like this on our unborn children?"**

"Please PLEASE **share** this aluminum story with all you care about."

"If you are pregnant and your doctor is ordering the Dtap, ask them if they know how much aluminum is in that vaccine?
ANSWER: 250 micrograms." *(mcg)*

"Ask them if they know how much aluminum is safe for a newborn premie?

ANSWER: 4-5 micrograms/Kg." *A 5-pound premie is 2.27 kg. Therefore, "safe" amount for a 5-pound premie is between 9.08 to11.35 micrograms (mcg).* ***As you can see that is approximately 25 times the safe limit.***

"If they didn't know the answer to these two questions – don't take their advice if they are still recommending you get the vaccine."

The flu vaccine given to pregnant mothers implicated in increased rates of fetal deaths

Not only that, but there are serious concerns about the escalation of stillborn babies since this recommendation has gone into effect. The following excerpts are from this website http://kellybroganmd.com/rejecting-flu-vaccine-in-pregnancy/ . She cites a breathtaking 2013 study in which the authors took a look at the differences between fetal deaths prior to and subsequent to the inclusion of the flu vaccine to pregnant mothers.

The 2013 study was published in the Journal of ***Human and Experimental Toxicology*** titled, **Comparison of VAERS fetal-loss reports during three consecutive influenza seasons. Was there a synergistic fetal toxicity associated with the two vaccine 2009/2010 season?**
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3888271/

Dr. Kelly Brogan's article states the following from that study:

"**Goldman does what we would hope our impartial governing medical bodies might have. He assesses the shortcomings of our passive reporting system – the Vaccine Adverse Event Reporting System (VAERS) – and uses validated statistical methodology to confirm the danger associated with multiple vaccines in pregnancy."**

"Clearly, as a perinatal practitioner, I have concerns with even one vaccine administration in pregnancy; however, that women in 2009 were subject to a completely and entirely unstudied combo pack of interventions, the package insert of which clearly states,

"**It is also not known whether these vaccines can cause fetal harm when administered to pregnant women or can affect reproduction capacity""**

"Goldman, the researcher and author of the aforementioned study, determined the following:

- **Spontaneous abortion (miscarriage) and still birth rates determined to be proximally associated to vaccine delivery were analyzed by Moro et al for the flu seasons of 1990-2009 finding 1.9/million or an average incidence of 1.2 per year.**

- **From this average to the first 5 months of the 2009/10 season in which women were recommended to receive both the typical flu vaccine and the H1N1, there were 57/million fetal losses reported.**
- **Using a capture-recapture statistical tool that allows for researchers to control for the inherent limitations of a reporting system, 174 cases from VAERS and 67 cases from NCOW were pooled to identify an ascertainment-corrected rate of 1/1695 (590/million). This adjustment reflects the fact that VAERS is a gross underestimation of the actual incidence of adverse events – in this case representing only 13% of the vaccine-related fetal losses.**

Goldman then discusses how initial *underreporting* can influence further *underreporting*:

"Because both patient and health care professionals relied on a historical profile that was incomplete with respect to assessing fetal-demise reporting, a possible link to fetal demise following administration of influenza vaccine/vaccines during 2009/2010 was rarely contemplated or was considered highly unlikely and thus, more often than not, not reported."

"**This 4250% increase in fetal deaths was known to the CDC and did not trigger any reparative action.** We have a committee comprised of pharmaceutically-invested "experts" telling doctors what to do with their patients. The transparency of the no-citizen-left-behind agenda is never more apparent than in the fact that you can engage this potentially lethal medical intervention (yes, death is a known and documented potential side effect) at your local CVS. Long gone are the days of informed consent."

The flu vaccine given during pregnancy increases inflammation, a hallmark for activation of microglial brain cells in the fetus

A 2011 study published in the ***Journal Vaccine*** titled, **Inflammatory Responses to Trivalent Influenza Virus Vaccine Among Pregnant Women**, finds that women who received the flu shot had significantly higher C Reactive Protein (CRP) levels, which are a blood marker for systemic inflammation. Tumor Necrosis Factor Alpha (TNF- α), and Interleukin-6 (IL-6) are two other markers for inflammation which were measured. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3204610/

Results: "Significant increases in CRP were seen at one and two days post-vaccination (*p*s <.05). A similar effect was seen for TNF-α, for which an increase at two days post-vaccination approached statistical significance (*p* = .06). There was considerable variability in magnitude of response; coefficients of variation for change at two days post-vaccination ranged from 122% to 728%, with the greatest variability in IL-6 responses at this timepoint."

Conclusion: "Trivalent influenza virus vaccination elicits a measurable inflammatory response among pregnant women. There is sufficient variability in response for testing associations with clinical outcomes. As adverse perinatal health outcomes including preeclampsia and preterm birth have an inflammatory component, a tendency toward greater inflammatory responding to immune triggers may predict risk of adverse outcomes, providing insight into biological mechanisms underlying risk."…

Also noted in the study was a reference to a earlier study… Characterization of type 1 and type 2 cytokine production profile in physiologic and pathologic human pregnancy. Clin Exp Immunol. 1996 Oct;106(1):127–33. [PMC free article] [PubMed], which stated:

"…among pregnancies that subsequently ended in miscarriage or small for gestational age babies, Peripheral Blood Mononuclear Cells exhibited *greater* proinflammatory cytokine production and *reduced* anti-inflammatory cytokine production as compared to cells from both nonpregnant women and healthy pregnancies." This relationship between increased inflammation may tie into the previously mentioned article by Dr. Kelly Brogan regarding a vaccination/miscarriage link. Also see the next study mentioned.

Various flu vaccines contain four different antibiotics that are not supposed to be given during pregnancy. Some vaccines contain more than one of these which combining them is also contraindicated by safety warnings.

In looking at the ingredients in the various flu and TdAP vaccines the CDC recommends for pregnant women, you will find formaldehyde, MSG, polysorbate 20 & 80, aluminum, mercury (multi-dose flu vaccines), glutaraldehyde, 2-phenoxyethanol, squalene, barium, cellular DNA, cetyltrimethlyammonium bromide, antibiotics and other chemicals. I thought I would check out the antibiotics that they add to the vaccines to prevent growth of bacteria to see if they were safe to take during pregnancy. What I found shocked me. Check this out….

There are 4 antibiotics in vaccines recommended to pregnant women that are contraindicated during pregnancy according to the drug labels.

Antibiotic #1- Neomycin sulfate-

An ingredient in the following flu vaccines:

- **Influenza (Afluria)Trivalent & Quadrivalent**
- **Influenza (Fluad)**
- **Influenza (Fluvirin)**

Warning against use in pregnancy**-** "Aminoglycosides can cause fetal harm when administered to a pregnant woman. Aminoglycoside antibiotics cross the placenta and there have been several reports of total irreversible bilateral congenital deafness in children whose mothers received streptomycin during pregnancy. Although serious side effects to fetus or newborn have not been reported in the treatment of pregnant women with other aminoglycosides, the potential for harm exists. Animal reproduction studies of neomycin have not been conducted. If neomycin is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus."

Nursing Mothers- "It is not known whether neomycin is excreted in human milk, but it has been shown to be excreted in cow milk following a single intramuscular injection. Other aminoglycosides have been shown to be excreted in human milk. Because of the potential for serious adverse reactions from the aminoglycosides in nursing infants, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother."

Pediatric Use

"The safety and efficacy of oral neomycin sulfate in patients less than 18 years of age have not been established."

Source: https://medlibrary.org/lib/rx/meds/neomycin-sulfate/

Antibiotic #2- Gentamicin Sulfate- **(**Same family of antibiotics as Neomycin and **Kanamycin** called aminoglycosides)

An ingredient in the following flu vaccine:

- **Influenza (Fluarix) Trivalent & Quadrivalent**

Warning against use in pregnancy- "This medication is not recommended for use during pregnancy."

Source: https://www.webmd.com/drugs/2/drug-94473/gentamicin-sulfate-pf-intravenous/details

Antibiotic #3- Kanamycin- **(**Same family of antibiotics as Neomycin and Gentamicin Sulfate called aminoglycosides)

An ingredient in the following flu vaccine:

- **Influenza (Fluad)**- In fact, Fluad contains both Kanamycin and Neomycin Sulfate

Warning against use in pregnancy- **"**Aminoglycosides can cause fetal harm when administered to pregnant women. Aminoglycoside antibiotics cross the placenta and there have been several reports of total, irreversible, bilateral congenital deafness in children whose mothers received streptomycin during pregnancy."

Source: https://www.rxlist.com/kantrex-drug.htm#warnings_precautions

Antibiotic #4- Polymyxin B-

Warning against use in pregnancy- **"USAGE IN PREGNANCY**: THE SAFETY OF THIS DRUG IN HUMAN PREGNANCY HAS NOT BEEN ESTABLISHED."

"**THE CONCURRENT OR SEQUENTIAL USE OF OTHER NEUROTOXIC AND/OR NEPHROTOXIC DRUGS** WITH POLYMYXIN B (polymyxin b sulfate) SULFATE, PARTICULARLY BACITRACIN, STREPTOMYCIN,

NEOMYCIN, **KANAMYCIN**, **GENTAMICIN**, TOBRAMYCIN, AMIKACIN, CEPHALORI-DINE, PAROMOMYCIN, VIOMYCIN, AND COLISTIN **SHOULD BE AVOIDED**."

"WARNING

CAUTION: WHEN THIS DRUG IS GIVEN **INTRAMUSCULARLY** AND/OR INTRATHECALLY, IT SHOULD BE GIVEN ONLY TO HOSPITALIZED PATIENTS, SO AS TO PROVIDE CONSTANT SUPERVISION BY A PHYSICIAN." (when it is injected as part of a vaccine, that is intramuscular injection).

Source: https://www.rxlist.com/polymyxin-b-drug.htm#description

"**Polymyxin B is an FDA pregnancy category C medication. This medication may be harmful to an unborn baby**. Tell your doctor if you are pregnant or plan to become pregnant during treatment."

Source: https://www.everydayhealth.com/drugs/polymyxin-b-trimethoprim-ophthalmic

Now, considering all of that, these versions of the flu vaccine which are regularly recommended for pregnant women contain this antibiotic

- Influenza (Afluria) Trivalent & Quadrivalent
- Influenza (Fluvirin)

*** Both of these flu vaccines also contain Neomycin Sulfate and Thimerosal in the multi-dose vials, BOTH big red flags during pregnancy).** If you decide to get the flu shot during pregnancy, insist on the single dose vials without the Thimerosal and brands without the aminoglycoside antibiotics.

What vaccines are appropriate during pregnancy according to the Mayo Clinic…
https://www.mayoclinic.org/healthy-lifestyle/pregnancy-week-by-week/expert-answers/vaccines-during-pregnancy/faq-20057799

From the article:
"Two vaccines are routinely recommended during pregnancy:

- Flu (influenza) shot. The flu shot is recommended for women who are pregnant during flu season — typically November through March. ...
- Tetanus toxoid, reduced diphtheria toxoid and acellular pertussis (Tdap) vaccine."

(Even though the Tdap doesn't contain these antibiotics, it does contain aluminum, which as we have seen poses serious risk to the fetus).

Again, as just mentioned the previous page, the Fluad flu vaccine contains both neomycin and kanamycin which should not be used together and never during pregnancy.

Honestly, if you are a woman that has taken these vaccines when you were pregnant or told that you need them when you decide to get pregnant, how does this make you feel? If I were you, I would feel violated. **Most likely, the doctors that are giving these shots have no idea that they contain antibiotics. And even if they do, I doubt that they know that the antibiotics they are injecting into your body are contraindicated during pregnancy based on the drug manufacturer's own information. But, don't you**

think it is their responsibility to know these things? After all, they are the ones that went to school for 8-12 years to learn how to do their job "safely" and "effectively. In fact, patient safety is supposed to be the highest priority above all else. First, Do No HARM.

There are other vaccines that are recommended for pregnant women under certain circumstances. http://www.immunize.org/catg.d/p4040.pdf

In addition, these vaccines also contain Polymyxin B (and some along with.

- DTaP-HepB-IPV (Pediarix)
- DTaP-IPV (Quadracel)
- DTaP-IPV (Kinrix)
- DTaP-IPV/Hib (Pentacel)
- Smallpox (Vaccinia) (ACAM2000)

Even though the DTaP Vaccines listed are not recommended for during pregnancy, children are given them at 2, 4, 6 and 15 months. These all contain mixes of Neomycin Sulfate and Polymyxin B antibiotics and aluminum. The Pediarix contains Neomycin Sulfate, Polymyxin B AND 3 DIFFERENT FORMS OF ALUMINUM!

If absolutely contraindicated because of the fear for the safety of the fetus during pregnancy, when the mother's body absorbs some of it and the baby has partial exposure, how safe can it be to give injections directly into a 60-day old baby where they have to deal with ALL of it? Then again at 4, 6 and 15 months?

And this is just the tip of the iceberg. With the ever-growing number of doses of various vaccines given during the first 2 years of life and most of them containing aluminum, fetal DNA, Polysorbate 80, mixes of antibiotics and other chemicals, the total body burden of children of today is far in excess of what it was when I was a child. And the ability of individual children to detoxify and eliminate these chemicals and metals varies greatly. With no reliable tests yet to identify children that have genetic flaws that make them vulnerable to becoming overloaded and damaged, we are literally playing Russian Roulette with our children.

2018 CDC Immunization Schedule:
https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

Vaccine Ingredients:
https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf

Flu shots to pregnant women increase miscarriage nearly eightfold

A study released September 25, 2017 in the journal ***Vaccine*** titled, **Association of spontaneous abortion with receipt of inactivated influenza vaccine containing H1N1pdm09 in 2010-11 and 2011-12**, show a powerful correlation between pregnant women receiving the H1N1 flu shot and spontaneous abortion (miscarriage) within the next 28 days. https://www.ncbi.nlm.nih.gov/pubmed/28917295

The study showed a 7.7 times greater risk of miscarriage than the control group. According to the study, **"Among women who received pH1N1-containing vaccine in the previous influenza season, the aOR in the 1-28 days was 7.7."** (aOR stands for Adjusted Odds Ratio. The Odds Ratio represents the odds that an outcome will occur given a particular exposure, compared to the odds of the outcome occurring in the absence of that exposure).

This policy is still being pushed on pregnant mothers to be, even though there is no basis science showing the benefit of vaccines in pregnancy. In addition, even according to the package inserts for the flu vaccine, they were never tested in pregnant women.

Flu vaccine package inserts reveal the safety gap when used during pregnancy

The following quotes are from the different flu vaccine package inserts:

Afluria- "**There are, however, no adequate and well-controlled studies in pregnant women**. Because animal reproduction studies are not always predictive of human response, **AFLURIA should be given to a pregnant woman only if clearly needed."**

Fluzone- **"Available data with Fluzone Quadrivalent use in pregnant women are insufficient to inform vaccine-associated risk of adverse developmental outcomes."**
"There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, **Fluzone Quadrivalent should be given to a pregnant woman only if clearly needed."**

Fluarix- **"There are insufficient data on FLUARIX QUADRIVALENT in pregnant women to inform vaccine-associated risks."**
"There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, **FLUARIX should be given to a pregnant woman only if clearly needed."**

Fluvirin- **"Safety and effectiveness of FLUVIRIN® have not been established in pregnant women, nursing mothers or children less than 4 years of age. (8.1, 8.3, 8.4)"**

"There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, **this vaccine should be used during pregnancy only if clearly needed."**

Flublok- "Safety and effectiveness of Flublok have not been established in pregnant women, nursing mothers, children, or adults 50 years of age and older. (8.1, 8.3, 8.4, 8.6)"
"There are, however, no adequate and well-controlled studies in pregnant women.
Because animal reproduction studies are not always predictive of human response, **this vaccine should be used during pregnancy only if clearly needed."**

Fluad- "There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, **this vaccine should be used during pregnancy only if clearly needed."**

Flucelvax- "Safety and effectiveness of FLUCELVAX have not been established in pregnant women or nursing mothers. (8.1)"
"There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, **this vaccine should be used during pregnancy only if clearly needed."**

Flulaval- "There are insufficient data on FLULAVAL QUADRIVALENT in pregnant women to inform vaccine-associated risks."

Flumist-
"Who may not be able to get FluMist Quadrivalent?

- **are pregnant or nursing"**

"FluMist Quadrivalent is not absorbed systemically following intranasal administration and maternal use is not expected to result in fetal exposure to the drug." *My obvious question would be, if it is not absorbed into the system, then how can it stimulate an immune response and provide the promised "protection"?*

The FDA admits that safety testing was never done on the flu vaccines or the Tdap in pregnancy, yet both are recommended for pregnant women

Despite the package warnings you just read about, the CDC recommends that all pregnant women get the flu and Tdap shots. ***Children's Health Defense*** recently published an excellent article on this use of untested flu and Tdap vaccines on pregnant women. It reveals that the FDA has no records showing that these vaccines have been safety tested.

Filing a Freedom of Information Act Request, Robert F. Kennedy Jr., on behalf of The Informed Consent Action Network (ICAN) **asked the FDA for the following: "A copy of the report for each clinical trial relied upon by the FDA when approving for use by pregnant women any influenza vaccine currently approved by the FDA."**

In response, they received the following response from the FDA: "These requests sought the clinical trials relied upon by the FDA prior to approving any currently licensed influenza or Tdap vaccine for use in pregnant women as an indicated use. ... We have no records responsive to your requests."

https://childrenshealthdefense.org/news/fda-admits-that-government-is-recommending-untested-unlicensed-vaccines-for-pregnant-women/

If all of that damning evidence regarding the insanity of giving pregnant women vaccines loaded with toxic compounds isn't enough, there are more on the way!

A 2018 article in the journal ***Expert Reviews of Vaccines*** titled, **Immunization During Pregnancy** discusses the development of group B streptococcus and respiratory syncytial virus vaccines to be given during pregnancy.

"…presents available data on group B streptococcus and respiratory syncytial virus **that are in development for administration during pregnancy.**" https://www.ncbi.nlm.nih.gov/pubmed/29715051

Imagine doubling the load of toxins on the unborn fetus. And if you think they are done there, think again! There is tremendous profitability and dozens of other viruses and bacteria left to try to vaccinate into oblivion, all at the expense of an unsuspecting and trusting public.

Despite all of this evidence and more, groups like the *American College of Obstetricians and Gynecologists* make false position statements

These statements that completely absolve vaccination from any potential for risk are irresponsible. These are the kinds of misleading statements that give people a false sense of security and safety, when what is really needed from these groups is truth and honesty. Groups that represent an entire profession should endeavor to provide accurate information.

Here are a couple examples from the page on their website giving advice on the flu vaccine and pregnancy. https://www.acog.org/Patients/FAQs/The-Flu-Vaccine-and-Pregnancy

***The red words are those from their statement that I am challenging, and the black italicized words are my response.**

Are vaccines safe?

Vaccines are developed with the highest safety standards. The U.S. Food and Drug Administration approves all vaccines. The CDC continues to monitor all vaccines after they are approved. They have been used for many years in millions of pregnant women and **are not known to cause pregnancy problems or birth defects.** ***(In addition to the evidence already presented, you will see a mountain of additional evidence throughout the remainder of this document. In fact, they may not consider miscarriage a birth defect, but a strong connection exists as just presented a few pages ago).***

Can vaccines made with thimerosal cause autism?

There is **no scientific evidence that vaccines made with *thimerosal*, a mercury-containing preservative, can cause *autism* or other health problems in babies**. ***(No scientific evidence? Really? Numerous studies, many presented in this document disagree, as well as the Subcommittee on Human Rights and Wellness, Committee on Government Reform quoted previously. That is exactly why the decision was made to remove it from many of the vaccines).*** **Thimerosal-containing vaccines do not cause autism in children born to women who received these vaccines. There is a flu vaccine made without thimerosal, but experts have not said that the thimerosal-free version is better for any particular group—including children and pregnant women.** ***(That's what happens when you are unwilling to look beyond the studies that support your position. Also, "many experts" have said that the thimerosal version is better as presented in this document. They instead should have said, "The experts we agree with…" The mantra that the rates of autism have continued to climb after the removal of thimerosal is because of the substitution of aluminum and other adjuvants, fetal DNA and other components that have increased in vaccines, not to mention the ever-increasing number of vaccine doses being added to the schedule).***

The CDC's position statements are very similar. This is from their website:

A Long Record of Safety for Flu Shots in Pregnant Women

Flu shots have been given to millions of pregnant women over many years with a good safety record. There is **a lot of evidence that flu vaccines can be given safely during pregnancy**; though these data are limited for the first trimester. **CDC and ACIP recommend that pregnant women get vaccinated during any trimester of their pregnancy. It is very important for pregnant women to get the flu shot.**
https://www.cdc.gov/flu/protect/vaccine/pregnant.htm

Not only do medical groups work so hard to make vaccines appear safe and without blemish, but the reality is that they are trying to prop up something that has a miserable track record of safety and effectiveness, as you are about to find out.

*If you jumped to this section because of an interest in finding out about the dangers of vaccines during pregnancy, but missed the discussion on phenol in the vaccine ingredients section, you may want to check that out as well.

Scant evidence of the safety and efficacy of the flu vaccine for young children

This 2012 article published in the ***Journal of Human Vaccines and Immunotherapeutics*** titled, **effectiveness and harms of seasonal pandemic influenza vaccines in children adults and elderly – a review and reanalysis of 15 meta-analyses** looked at the **15 meta-analyses that had been published between 1995 and 2011** to evaluate the efficacy/effectiveness and harms of diverse influenza vaccines. http://www.tandfonline.com/doi/abs/10.4161/hv.19917

After this exhaustive analysis, the following statement was issued regarding the flu vaccine for young children:

"However, **Live Attenuated Virus (LAV) is not recommended for children aged < 2 y, while Parenteral Inactivated Vaccine (PIV) is recommended in several countries. In addition, very limited data are available on the safety profile of both vaccines.**"

Based on such strong evidence, it is dangerous and irresponsible that the CDC has not changed their recommendations that were made in the previously mentioned **2010 US advisory committee on immunization practices** to start vaccinating children at six months old. Once again this shows a callous disregard for the health of children and in favor of big Pharma. As you continue to read this article, you will see why this is such a big deal.

Package insert warnings from the flu vaccines warn against giving them to young children

As you will see from the warnings from these flu vaccines package inserts, these vaccines are often given to infants and young children against the recommendations of the manufacturers. Since many doctors are not educated on this, parents must take the lead and bring this vital information to their attention.

Afluria

"AFLURIA is not approved for use in children less than 5 years of age because of increased rates of fever and febrile seizures. One comparator-controlled trial demonstrated higher rates of fever in recipients of AFLURIA as compared to a trivalent inactivated influenza vaccine control."

Fluarix

"The immune response to FLUARIX has been evaluated in children aged 6 months through 4 years. In a randomized, controlled trial, serum hemagglutination-inhibition (HI) antibody titers were lower in

children aged 6 months through 35 months compared with a US-licensed vaccine. Based on these data, FLUARIX is not approved for use in children younger than 3 years."

Fluvirin
"The safety and immunogenicity of FLUVIRIN® have not been established in children under 4 years of age."

Flublok
"Data from a randomized, controlled study demonstrated that children 6 months to less than 3 years of age had diminished hemagglutinin inhibition (HAI) responses to Flublok as compared to a U.S.-licensed influenza vaccine approved for use in this population, strongly suggesting that Flublok would not be effective in children younger than 3 years of age. Safety and effectiveness of Flublok in children 3 years to less than 18 years of age have not been established."

Fluad
"The safety and effectiveness of FLUAD in the pediatric population have not been established. In clinical trials, in children 6 through 23months of age, FluMist was associated with an increased risk of hospitalization and wheezing. (8.4)"

Despite convincing evidence to the contrary, the CDC is still on board with infants as young as 6 months getting the thimerosal containing flu vaccine

Here are screen captures from the CDC's 2016-2017 Influenza Vaccine recommendations, still showing that the CDC is comfortable with infants as young as 6 months old to receive the thimerosal containing flu vaccine.

TABLE 1. Influenza vaccines — United States, 2016–17 influenza season

Print-friendly version PDF [128KB, 1 page]

Trade name	Manufacturer	Presentation	Age indication	Mercury (from thimerosal) µg/0.5 mL	Latex	Route
Inactivated influenza vaccine, quadrivalent (IIV4), standard dose†						
Fluarix Quadrivalent	GlaxoSmithKline	0.5 mL single-dose prefilled syringe	≥3 yrs	NR	No	IM§
Flulaval Quadrivalent	ID Biomedical Corp. of Quebec (distributed by GlaxoSmithKline)	0.5 mL single-dose prefilled syringe	≥6 mos	NR	No	IM
		5.0 mL multi-dose vial	≥6 mos	<25	No	IM
Fluzone Quadrivalent - Sanofi Pasteur		5.0 mL multidose vial	≥6 mos	25	No	IM

Source: https://www.cdc.gov/flu/protect/vaccine/vaccines.htm

***In addition to the previous section on vaccines in pregnancy, you should re-visit pages 108-124 covering vaccine ingredients, many of which have specific warnings against exposure during pregnancy. You should also review the section on pages 440-446 on the germ layer DNA damage caused to a fetus from various toxins in vaccines. This has been shown to cause multi-generational DNA damage in the offspring of the fetus and their offspring up to several generations. As you will see, this damage is also linked to common diseases in adulthood. Be sure to read my red-letter commentaries on page 441 and 443-447.**

Women who are breastfeeding must also be aware of the warnings.

One flu vaccine manufacturer admits that that they don't know the ramifications of taking their vaccine while breastfeeding.

"It is not known whether FLULAVAL QUADRIVALENT is excreted in human milk. Data are not available to assess the effects of FLULAVAL QUADRIVALENT on the breastfed infant or on milk production/excretion."

THE LYNCHPIN – TOO MANY SHOTS, TOO EARLY

All medical students are taught that the Blood Brain Barrier is still porous early in life

I know it's a radical idea for the average person to question the safety of these ingredients (kidding of course), but I don't think it is at all radical for someone like myself who is a medical professional. All doctors (M.D.s, D.O.s, D.C.s, NMDs) all study **Guyton's Physiology** and have learned that the blood brain barrier (BBB), isn't completely closed at least until age 2 and some doctors feel that it may not completely close until adolescence. In the adult brain, there are what are called "tight junctions". Those very small spaces only allow a select number of things to pass into the brain. Just like growth plates in bones are not fully close until late in a child's teens, these tight junctions are actually loose junctions early in life. This means that larger molecular weight molecules like toxins, chemicals and heavy metals are able to pass freely into the brain. When those immature loose junctions finally mature and close, it keeps most toxins and metals from passing through into the brain. Even as an adult, certain conditions including brain trauma alcohol and drug abuse, and even obesity can weaken this selective barrier effect of the brain's blood vessels.

This is a quote from **Guyton's physiology**: "The neurons of the brain require a very exactly controlled environment, or else their function becomes abnormal and so also does the function of the entire brain. The blood brain barrier protects the cerebral tissue from detrimental substances in the blood." (Guyton, 6th Edition, pg. 386)

To date, PubMed lists nearly 41,000 articles that discuss the blood brain barrier. Type blood brain barrier in the search bar at www.pubmed.org and you will see for yourself that It is a very important topic in medicine, but possibly the one thing that is most important to consider when talking about vaccinating babies and young children.

This 2012 article titled **Blood–brain barrier dysfunction–induced inflammatory signaling in brain pathology and epileptogenesis,** is from the ***Journal Epilepsia***. It goes in-depth about the problems of a faulty or immature blood brain barrier as a major causative factor for neurological and neurodegenerative diseases. This is a summary from the article:

"The protection of the brain from blood-borne toxins, proteins, and cells is critical to the brain's normal function. Accordingly, a compromise in the blood–brain barrier (BBB) function accompanies many neurologic disorders and is tightly associated with brain inflammatory processes initiated by both infiltrating leukocytes from the blood, and activation of glial cells. Those inflammatory processes contribute to determining the severity and prognosis of numerous neurologic disorders, and can both cause, and result from BBB dysfunction."
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3703535/

Multiple doses of vaccines in a single doctor visit increases risk exponentially

2016 paper written by ***Neil Z. Miller*** and published in the ***Journal of American Physicians and Surgeons*** titled, **Combining Childhood Vaccines at One Visit is Not Safe** questions this common practice. The findings of the research discussed in this paper are so powerful, shocking and important, that I felt it necessary to include a good portion of the paper here. As you read this. Bear in mind when the numbers of adverse vaccine reactions reported in VAERS are just a very small percentage (as low as 1-2%), of all adverse reactions that occur. The numbers reported here based on just the adverse events reported to VAERS are shocking themselves. If you add two zeros to each of those numbers as a possibility of what the actual numbers really are, that would truly be catastrophic.
https://www.jpands.org/vol21no2/miller.pdf

From the paper:
"Although CDC recommends polio, hepatitis B, diphtheria, tetanus, pertussis, rotavirus, *Haemophilus influenzae* type B, and pneumococcal vaccines for two-, four-, and six-month-old infants, **this combination of eight vaccines administered during a single physician visit was never tested for safety in clinical trials. This is at odds with a CDC report that found that mixed exposures to chemical substances and other stress factors, including prescribed pharmaceuticals, may produce "increased or unexpected deleterious health effects." This CDC report also noted that "exposures to mixed stressors can produce health consequences that are additive, synergistic, antagonistic, or can potentiate the**

response expected from individual component exposures." **Thus, CDC is well aware that mixing several pharmaceutical products increases the likelihood of synergistic toxicity and unexpected adverse reactions. Nonetheless, CDC urges infants to receive multiple vaccines concurrently without scientific evidence to confirm the safety of this practice.** Administering six, seven, or eight vaccine doses to an infant during a single physician visit is certainly more convenient for parents, as opposed to making additional trips to the doctor's office, and increases the likelihood that the infant will receive all the vaccines, but vaccine safety must remain the highest priority."

Hospitalizations and deaths following vaccine administration increases proportionally with the number of doses given

"We started by downloading the complete VAERS database from 1990 through 2010. There were more than 325,000 VAERS reports. We then eliminated all case reports that were not associated with infants (babies aged up to one year). This left us with 38,801 VAERS reports in which infants had adverse events after receiving one or more vaccine doses."

"**Next, we determined how many vaccine doses each infant received prior to the adverse event**. (A computer program was written to make these calculations.) For example, if an infant received a hepatitis B vaccine and a rotavirus vaccine prior to the adverse event, it was recorded as two vaccine doses. **DTaP is administered with one injection but contains three separate vaccine doses, for diphtheria, tetanus, and acellular pertussis. Thus, if an infant received a polio vaccine, a pneumococcal vaccine, and DTaP prior to the adverse event, it was recorded as five vaccine doses.** Some babies received six, seven, or eight doses prior to an adverse event. This was not unusual because of the CDC recommendations noted above, plus its recommendation for two doses of an influenza vaccine during infancy."

"**Finally, we isolated the "serious" adverse events—hospitalizations and death—from non-serious events, such as fever and local reactions. About 13% of all adverse events reported to VAERS are classified as serious, involving life-threatening conditions, hospitalization, permanent disability, or death.** We sought to determine whether there were any trends or patterns associated with the number of vaccine doses an infant received and the likelihood that the adverse event reported to VAERS would require hospitalization or result in death."

Vaccine Doses and Hospitalizations

"**Of the 38,801 VAERS reports that we analyzed, 969 infants received two vaccine doses prior to the adverse event and 107 of those infants were hospitalized: a hospitalization rate of 11%. Of 1,959 infants who received three vaccine doses prior to the adverse event, 243 of them required hospitalization: 12.4%. For four doses, 561 of 3,909 infants were hospitalized: 14.4%. Notice the emerging pattern: Infants who had an adverse event reported to VAERS were more likely to require hospitalization when they received three vaccine doses instead of two, or four vaccine doses instead of three**."

"**The pattern continues: Of 10,114 infants who received five vaccine doses prior to the adverse event, 1,463 of them required hospitalization: 14.5%. For six doses, 1,365 of 8,454 infants were hospitalized:**

16.1%. For seven doses, 1,051 of 5,489 infants were hospitalized: 19.1%. And for eight doses, 661 of 2,817 infants were hospitalized: 23.5%. The hospitalization rate increased linearly from 11.0% for two doses to 23.5% for eight doses. Linear regression analysis of hospitalization rates as a function of the number of reported vaccine doses yielded a linear relationship, with an ***R2*** of 0.91."

"Note: The hospitalization rate of infants who received just one vaccine dose was disproportionately high (16.3%) due to the hepatitis B vaccine administered at birth. As such, the hospitalization rate corresponding to one dose is an outlier and was excluded from the linear regression analysis."

Vaccine Doses and Mortality

"**Our study also calculated the case fatality ratio (mortality rate) among vaccinated infants, stratified by the number of vaccine doses they received. Of the 38,801 VAERS reports that we analyzed, 11,927 infants received one, two, three, or four vaccine doses prior to having an adverse event, and 423 of those infants died: a mortality rate of 3.6%. The remaining 26,874 infants received five, six, seven, or eight vaccine doses prior to the adverse event and 1,458 of them died: 5.4%. The mortality rate for infants who received five to eight vaccine doses (5.4%) is significantly higher than the mortality rate for infants who received one to four vaccine doses (3.6%), with a rate ratio (RR) of 1.5 (95% CI, 1.4-1.7). Of infants reported to VAERS, those who had received more vaccines had a statistically significant 50% higher mortality rate compared with those who had received fewer**."

The Age Effect on Hospitalizations and Death

"Our study also analyzed whether the age at which an infant received vaccines had an effect on hospitalizations and death. Of the 38,801 VAERS reports that we analyzed, 765 concerned **infants six-weeks-old or younger who received one or more vaccine doses prior to the adverse event**, and 154 of those infants **were hospitalized: a hospitalization rate of 20.1%.** Of 5,572 **infants aged six months at vaccination**, 858 were hospitalized: **15.4%.** Of 801 **infants who were nearly a year old when they were vaccinated,** 86 were hospitalized: **10.7%. The hospitalization rate decreased linearly from 20.1% for neonates to 10.7% for older infants.** Linear regression analysis of hospitalization rates as a function of patient age yielded an ***R2*** of 0.95."

"In the 38,801 VAERS reports we analyzed, 26,408 **infants were younger than six months**. After receiving one or more vaccine doses, 1,623 of those infants died: **a mortality rate of 6.1%.** The remaining 12,393 **infants were between six months and one year of age.** After receiving one or more vaccine doses, 258 of them died: **2.1%.** The mortality rate for vaccinated **infants younger than six months was significantly higher** than the mortality rate for vaccinated infants aged between six months and one year, with an RR = 3.0 (95% CI, 2.6-3.4). **Infants who had an adverse event reported to VAERS were significantly more likely to be hospitalized or die if they were younger rather than older at the time of vaccination**."

Summary of Results and Media Response

"**Our study showed that infants who receive several vaccines concurrently, as recommended by CDC, are significantly more likely to be hospitalized or die when compared with infants who receive fewer vaccines simultaneously. It also showed that reported adverse effects were more likely to lead to hospitalization or death in younger infants**."

"**These findings are so troubling that we expected major media outlets in America to sound an alarm, calling for an immediate reevaluation of current preventive health care practices. But 4 years after publication of our study, this has not happened. Could it be because, according to Robert Kennedy, Jr., about 70% of advertising revenue on network news comes from drug companies?**

He went on to say…. "Debate on vaccine safety is a Kafkaesque taboo on network news channels, which accept upwards of $5.4 billion annually from pharma, or on the editorial pages of America's newspaper conglomerates, many of which have financial ties to drug companies. … Instead of fact-based discourse, the debate… has devolved into 'argument by credential' and its corollary, 'argument by insult.' By reducing the issue to a binary choice—you're either pro-vaccine or anti-vaccine—journalists marginalize safety advocates…, vilify the parents of vaccine-injured children and silence debate on a complex issue. …The American public is entitled to an honest, probing and robust discussion about this critical public health issue—a debate based on facts, not rooted in fear, nor on blind faith in regulators and the pharmaceutical industry."
—Robert F. Kennedy, Jr. SOURCE: https://childrenshealthdefense. org/news/why-im-not-anti-vaccine-and-why-we-should-all-want-to-study-vaccine-safety/

In fact, the president of a network news division admitted that he would fire a host who brought on a guest that led to loss of a pharmaceutical account. That may be why the mainstream media won't give equal time to stories about problems with vaccine safety."

Conclusion

"**The safety of CDC's childhood vaccination schedule was never affirmed in clinical studies**. Vaccines are administered to millions of infants every year, yet health authorities have **no scientific data from synergistic toxicity studies on all combinations of vaccines that infants are likely to receive.** National vaccination campaigns must be supported by scientific evidence. No child should be subjected to a health policy that is not based on sound scientific principles and, in fact, has been shown to be potentially dangerous."

"Undesirable outcomes associated with childhood vaccination can be reduced by requiring national vaccination policies to be supported by scientific evidence, holding vaccine manufacturers accountable when their products harm consumers, and urging major news outlets that rely on pharmaceutical advertising revenue to change their business models so that crucial scientific research, regardless of how controversial it may be, is widely disseminated into the public domain. **Meanwhile, the evidence presented in this study shows that multiple vaccines administered during one visit, and vaccinating young infants, significantly increase morbidity and mortality. Parents and physicians should consider health options associated with a lower risk of hospitalization or death."**

The dramatic increase of vaccine doses since 1983

The National Vaccine Information Center has a couple of excellent infographics showing the increase in doses of the respective vaccines on the CDC Schedule.

1983- 22 doses of 7 vaccines by age 6 >>> 2017- 50 doses of 14 vaccines by age 6

1983- 24 doses of 7 vaccines by age 18 >>> 2017- 69 doses of 16 vaccines by age 18

View them here,,,

https://www.nvic.org/cmstemplates/nvic/pdf/downloads/1983-2017-vaccine-schedules.pdf

https://www.nvic.org/downloads/49-doses-posterb.aspx

The acetaminophen (paracetamol) connection with autism

Tylenol is the most recognized name brand of this drug

Compounding the genetic predisposition to increased sensitivity in some individuals, a growing body of evidence over the last 5-7 years suggests that the use of acetaminophen (i.e. Tylenol), blocks the body's ability to produce glutathione, which is considered the body's "Master Antioxidant". This also happens to a greater degree in genetically susceptible children. That further prevents their bodies from eliminating toxins like mercury, aluminum, formaldehyde, MSG and other toxic substances found in vaccines. It's not the acetaminophen that causes autism, rather its use in proximity to vaccination that appears to handcuff the body's ability to clear the metals and toxins. While it is true that many children that regress into autism do so without having been given this drug, it now appears that the drug may significantly increase that risk.

This article does a fantastic job of explaining how this happens

This article written by William Shaw Ph.D., who is the ***Clinical Laboratory Director of Great Plains Laboratories***, is a very detailed accounting of the mechanisms by which acetaminophen does this. Much of the article is very technical, but a quick look will give you an idea of the content and the quality of his review. It also has 84 references. The title of the article is **Evidence that Increased Acetaminophen use in Genetically Vulnerable Children Appears to be a Major Cause of the Epidemics of Autism, Attention Deficit with Hyperactivity, and Asthma.** https://www.greatplainslaboratory.com/articles-1/2015/11/13/evidence-that-increased-acetaminophen-use-in-genetically-vulnerable-children-appears-to-be-a-major-cause-of-the-epidemics-of-autism-attention-deficit-with-hyperactivity-and-asthma

Oh, and by the way the graph in the article is fascinating**. It shows a timeline demonstrating the rise in rates of autism and asthma strongly correlating with the increased use of acetaminophen**. In 1986, the FDA recommended that parents do not give their children aspirin because of the increased risk of Reye's Syndrome. Reye's Syndrome often caused severe brain damage and even death in around 30% of those contracting it. It also had an apparent 90% correlation with aspirin use. As an alternative to

aspirin, pediatricians began to recommend acetaminophen. Because of those recommendations by the FDA, doctors and pediatrician's groups, parents began to give acetaminophen to their babies for fever, after circumcision and for fever and local injection site discomfort following vaccination. **The toxins in vaccines, including mercury, aluminum, MSG and others are expelled from the body, primarily by the body's master antioxidant glutathione. Acetaminophen essentially handcuffs the body's ability to eliminate those toxins by blocking production of glutathione, essentially poisoning genetically susceptible children. Studies have shown that autistic children have decreased capacities to eliminate these metals and toxins from their bodies.**

A couple quotes from the article:

Acetaminophen has a long history of serious side effects. "**A PubMed search of the scientific literature indicated the presence of 2685 articles regarding acetaminophen toxicity**.":

- Neurotoxic effects on brain neurons
- "Maternal use during pregnancy is associated with teratogenic defects in testicular function and gastrointestinal tract."
- Oxidative damage to proteins, nucleic acids, amino acids, and lipids
- Causes increased mitochondrial and cellular damage and death
- Severe immune abnormalities and immune response depression
- Depletion of glutathione by acetaminophen causes severe metabolic acidosis
- "The leading cause of liver failure in the United States."
- 56,000 emergency room visits in the US per year
- Increased rates of certain blood cancers
- Prenatally or postnatally increased incidence of asthma

"As of 2012, there were 170 articles that indicated an association between toxic chemical exposure and autism."

A 2018 study that vaccinated rat pups with MMR and DPT and gave them acetaminophen for fever, produced autistic characteristics

A 2018 article from the journal ***Inflammopharmacology*** titled, **Effect of early natal supplementation of paracetamol on attenuation of exotoxin/endotoxin induced pyrexia and precipitation of autistic like features in albino rats**, strongly associated the connection with the development of autistic characteristics in rats that were vaccinated with MMR and DPT vaccines and given acetaminophen (Paracetamol-PCM), as is often done in human infants and children to control the fever from the vaccines. https://www.ncbi.nlm.nih.gov/pubmed/29327281

From the Abstract:
"The present study was aimed to test the hypothesis that paracetamol (PCM) can precipitate autistic like features when used to counteract vaccine-induced fever using experimental rat pups. The pups were treated with **measles mumps rubella (MMR) vaccine, diphtheria tetanus and pertussis (DPT) vaccines and lipopolysaccharide (LPS) with subsequent PCM treatment**. The pups were evaluated for postnatal growth (weight gain, eye opening) and behavior alterations (swimming performance, olfactory discrimination, negative geotaxis, nociception, and locomotor activity) by performing battery of neurobehavioral test. **Significant correlation was observed between social behavioral domains (nociception, anxiety and motor coordination) and pro-inflammatory load in the pups when treated with MMR/LPS along with PCM. A significant change in pro and anti-inflammatory (IL-4, IL-6, IL-10) markers were observed in rats treated with PCM, MMR, LPS, DPS alone or in combination with MMR, LPS and DPT.**" *(LPS stands for lipopolysaccharide, which is a vaccine adjuvant…Note that significant changes were created in the IL cytokines that regulate inflammation with the vaccines alone and in combination with the PCM)*

"Pups were also scrutinized for the markers of oxidative stress, inflammation and histopathologically. **All the treatment groups showed significant alteration in the behavioral changes, oxidative markers and inflammatory markers** without following any specific treatment. **These observation could be accorded to variable phenotypes *(expressions)* of autistic spectrum disorders (ASDs)**." ***(These markers of oxidative stress and inflammation were greater with the MMR + PCM, than the MMR alone and greater with DPT + PCM, than with DPT alone. This correlates with other similar studies and hypotheses that acetaminophen [or PCM] interfere with the body's natural antioxidant and anti-inflammatory protective mechanisms. This is harmful to 100% of individuals that are vaccinated, but especially harmful to those persons that have genetic defects in their ability to handle toxins already. Those are the ones at greatest risk of manifesting an autism spectrum disorder or a neurodevelopmental disability. This underscores the need TO DEVELOP GENETIC SCREENING TOOLS THAT WOULD IDENTIFY BABIES BORN WITH THESE GENETIC POLYMORPHISMS OR DEFECTS).***

Acetaminophen interferes with glutathione production, reducing the ability to detoxify metals and toxins

This brand new 2017 article from the ***Journal of International Medical Research*** titled, **the Role of Oxidative Stress, Inflammation and Acetaminophen Exposure from Birth to Early Childhood in the Induction of Autism.** These authors are from Duke University Medical Center, Harvard Medical School and the University of Colorado, Boulder. http's s://www.ncbi.nlm.nih.gov/pubmed/28415925

This study emphasizes the fact that **the bodies of babies and young children have difficulty in the metabolic breakdown of pharmaceuticals and toxins**. One of the mechanisms that has repeatedly been shown is the fact that **acetaminophen interferes with the body's production of glutathione**, the most powerful detoxifying agent our bodies produce. Couple that with a genetic predisposition towards impaired detoxification ability, it's a recipe for disaster.

From the article:
"The wide range of factors associated with the induction of autism is invariably linked with either inflammation or oxidative stress, and sometimes both. The use of acetaminophen in babies and young children may be much more strongly associated with autism than its use during pregnancy, perhaps because of well-known deficiencies in the metabolic breakdown of pharmaceuticals during early development. Thus, one explanation for the increased prevalence of autism is that increased exposure to acetaminophen, exacerbated by inflammation and oxidative stress, is neurotoxic in babies and small children." **This leads to a decreased ability to eliminate toxins and heavy metals such as mercury and aluminum found in vaccines. This is most likely one of the most important missing links in the autism discussion of causation. Couple a genetic susceptibility, with a drug that depletes glutathione given to relieve fever and pain caused by vaccine injection and it's a recipe for disaster. On top of that, males that are circumcised are given heavy doses of acetaminophen for the pain of the procedure. Could that be one of the reasons that the rate of autism is so much higher in males?**

"**This view mandates extreme urgency** in probing the long-term effects of acetaminophen use in babies and the possibility that many cases of infantile autism may actually be induced by acetaminophen exposure shortly after birth."

The significance of this correlation is underscored by this statement from the study. "The long-term, steady increase in the prevalence of autism was punctuated by short-term decreases coinciding with widely publicized cases of acetaminophen poisoning that temporarily deterred the public from using the drug." *Wow! The definition of punctuation that this author used, is defined by Dictionary.com as "to interrupt at intervals". Essentially, the statement means that when there were scares about safety of the acetaminophen supply and its usage dropped, there were also short term corresponding decreases in the autism rates.*

"Acetaminophen use is currently ubiquitous and thought to be the only humane approach to pain and fever reduction for children from the time of birth to 6 months." "**Almost one-quarter of all infants are given acetaminophen in any given week when in the hospital, making it the number one medication used in infants**." **Ironically**, the study also said, Acetaminophen is **not that effective** for pain relief for children and infants. "Thus, it seems unwise to risk potentially permanent neurological injury for apparently ineffective pain relief." Physical, non-pharmacological approaches to pain relief are promising and "have few side effects."

The study also said, "At present, half of all parents of children with autism suspect vaccines as an underlying cause of their child's condition."

Once again, this reiterates that in genetically susceptible children, the inability for them to make enough glutathione, coupled with being given Tylenol makes them at risk for adverse reactions to the onslaught of metals and toxins they are exposed to from the excessive number of vaccines given before the blood brain barrier can protect them.

Another explanation as to the mechanism of how acetaminophen can contribute to autism

A 2009 article published in ***Alternative Medicine Review*** titled, **Did Acetaminophen Provoke the Autism Epidemic?** makes a strong connection with the role the popular drug acetaminophen may play in the expression of autism. http://archive.foundationalmedicinereview.com/publications/14/4/364.pdf

In 1980, after studies showed an association between aspirin and Reye's Syndrome in children, the market share shifted from the common use of aspirin to acetaminophen. According to a 1987 study published in the Journal ***Pediatrics*** titled, **National patterns of aspirin use and Reye syndrome reporting, United States, 1980 to 1985**, use of aspirin declined sharply and acetaminophen increased sharply. For nearly the last 40 years, it has been recommended by doctors and commonly given to children by parents, for pain and fever after vaccination.
https://www.ncbi.nlm.nih.gov/pubmed/3588140

The Alternative Medicine Review article goes on to explain how acetaminophen impairs the body's ability to detoxify metals and chemicals:

"Because infant's Tylenol is three times more concentrated than children's Tylenol, and parents may not realize children's cold remedies often contain acetaminophen, acetaminophen overdose in young children is not uncommon. Schultz et al noted that sulfation by the liver is the primary pathway to detoxify and excrete acetaminophen in children younger than 10."

"**When sulfation is impaired, acetaminophen oxidizes to the toxic metabolite N-acetyl-p-benzoquinone imine, which is then detoxified by glutathione. Acetaminophen overdose depletes the liver's supplies of sulfate and glutathione, impairing its ability to detoxify and excrete harmful substances**."

How is circumcision possibly related to the increased incidence of autism in boys?

A 2013 article from the Journal of ***Environmental Health*** titled, **Prenatal and perinatal analgesic exposure and autism: an ecological link** found interesting correlations between acetaminophen (paracetamol) use for fever, pain and circumcision around the time of vaccination and autism. Most doctors recommend it for pain and fever management following vaccination.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3673819/pdf/1476-069X-12-41.pdf

Using the U.S. Centers for Disease Control and Prevention Summary of Autism/ASD Prevalence Studies database and all available country-level data (n = 8 *countries*) for the period 1984 to 2005, these authors analyzed correlations between autism prevalence and exposure to acetaminophen *in utero*, and in early life, and as related to circumcision rates.

In the US, "usage of paracetamol [acetaminophen] by pregnant women mirrors the population demographics of women whose children develop autism spectrum disorder, by race, age and education."

"In 1983 the average U.S. child received 8 immunizations before age 2. In 2011, the average was 25, a 313% increase." This does not tell the whole story however. As discussed in other parts of this document, **the levels of toxic metals, human fetal DNA, animal proteins and DNA, chemicals and antibiotics found in vaccine today has increased by many multiples and is unprecedented.**

Conclusions:
"In this hypothesis generating exploratory analysis, **several lines of evidence support the plausibility of a relationship between prenatal and early life exposure to paracetamol and autism spectrum disorder**. It is proposed that the use of paracetamol in pregnancy and/or early childhood **may alter immune processes increasing the risk of autism spectrum disorder in susceptible individuals**. In an ecologic analysis, with all the previously discussed limitations, **a correlation was found between maternal prenatal use of paracetamol and autism spectrum disorder**. **Additionally, a correlation was identified for the first time between neonatal circumcision with a probable paracetamol exposure and autism spectrum disorder.** These relationships along with the synchronous rise in use of paracetamol and ASD, the convergence of the potential biologic mechanisms and the identification of plausible causes of increased male susceptibility provide consistent evidence of an association. Large scale population based epidemiologic studies are needed to confirm or disprove this association."

Even if this association is accurate, it does not absolve vaccines as a major player in the autism/neurodevelopmental/behavioral/immunological challenges epidemic. Without the introduction of the toxic metals, fetal DNA and other chemicals like formaldehyde, Polysorbate 80, etc., etc., the use of acetaminophen would not cause autism. The acetaminophen (paracetamol), simply sabotages the body's ability to clear those toxins efficiently. The genetically or environmentally susceptible, or maternally predisposed children would still be at very high risk of developing autism. The additional compromise of the body's detoxification mechanisms by the drug, is in many cases the proverbial straw that breaks the camel's back.

A 2008 study found a significant association with acetaminophen use but not with ibuprofen. And, the MMR Vaccine is strongly associated with autism

A 2008 study published in the Journal ***Autism*** titled, **Acetaminophen (paracetamol) use, measles-mumps-rubella vaccination, and autistic disorder: the results of a parent survey** found a significant (600-800%) association with acetaminophen use after vaccination and autism.
https://www.ncbi.nlm.nih.gov/pubmed/18445737

From the study:
"This preliminary study found that acetaminophen use after measles-mumps-rubella vaccination **was associated with autistic disorder**."

Compared to controls, children ages 1-5 years with autism were **eight times more likely to have gotten sick after the MMR vaccine**, and were **six times more likely to have taken acetaminophen**. Children with autism who regressed in development were **four times** more likely to have taken acetaminophen after the vaccine.

Illnesses concurrent with the **MMR** vaccine were **nine times** **more likely in autistic children** when all cases were considered, **and seventeen times** **more likely after limiting cases to children who regressed**.

This is important, because acetaminophen (ie. Tylenol or other brands), is often used to control fever after vaccination. Parents need to be aware of this serious risk and doctors need to stop recommending it.

Children with autism are genetically more susceptible to the adverse effects on the liver of acetaminophen and therefore reducing glutathione production and protection

A 2010 study published in the Journal ***Acta Neurobiologiae Experimentalis*** titled, **Can autism be triggered by acetaminophen activation of the endocannabinoid system?**, makes a strong case for the autism acetaminophen connection. https://www.ncbi.nlm.nih.gov/pubmed/?term=20628445

The Abstract:
"**Acetaminophen use in children has been associated with increased autism risk**. Recent evidence suggests that acetaminophen's analgesic actions result from activation of the endocannabinoid system, and activation of this system can have neuromodulatory consequences during development. This investigation was performed to determine if there is evidence to support the hypothesis that acetaminophen use can trigger autism by activation of the endocannabinoid system."

Excerpt from Dan Murphy D.C.'s article review 16-14: ***(Dan Murphy D.C. is a professor at Life West University and is a highly sought after speaker and consultant on wide ranging health topics. He offers an article review subscription service covering many different and sometimes controversial health related topics).*** **His web site is** https://danmurphydc.com/). **He offers an excellent article review service where he sends out article reviews on studies in the areas of drugs, nutrition, neurology, and science trends in health.**

"Acetaminophen is **available in more than 200 OTC and prescription drugs. It has more than 50 brand names, the best known is Tylenol in the US**. Tylenol, a pain/fever drug, is often given to children; parents rarely give children aspirin because of the increased risk of Reye's syndrome. **Acetaminophen is the primary cause of liver toxicity in the US.**"

"An internet search of the Tylenol WebPage finds this information: "Jr. TYLENOL® Meltaways® Chewable Tablets comes in an easy-to-use form that kids love—Jr. TYLENOL® Meltaways® Chewable Tablets. Fast relief —in yummy Grape Punch and Bubblegum Burst. Meltaways® are easy to give—no spoon and no water needed. And easy to take."

"Liver warning: This product contains acetaminophen. Severe liver damage may occur if your child takes more than 5 doses in 24 hours, which is the maximum daily amount." **Importantly, the liver is the primary producer of the detoxifying antioxidant glutathione. Glutathione depends upon the availability of sulfate**."

"Children with autism appear to be poor metabolizers of acetaminophen, leading to higher than normal therapeutic levels. "Children who are poor metabolizers of acetaminophen may be at higher [autism] risk since normal therapeutic doses may lead to higher blood levels in these children." *This in turn will decrease their body's ability to detoxify from the metals and chemicals they are exposed to including vaccines.*

What's the bottom line with autism and what are the main triggers?

Personally, I believe (and the science shows) that autism is caused by a variety of factors including all of these:

- **Family history of autoimmune disease**.
- **Maternal obesity which is associated with increased systemic inflammation**.
- **Maternal infection during the pregnancy**.
- **Maternal pre-natal and child post-natal exposure to toxins from the vaccines** (mercury, aluminum and the other components listed above).
- **Maternal pre-natal and child post-natal exposure to environmental toxins and inflammatory dietary and lifestyle triggers that increase inflammation** and inflammatory cytokines (proteins) that can trigger microglial/neurological reactions in the baby. **Remember at the beginning of this document, I stated that there is no ONE cause of anything?** The increased use of environmental toxins like glyphosate, the active ingredient in herbicides like Roundup by Monsanto have also shown strong correlation with the rise of autism. The use of pesticides and other toxic chemicals have also increased over the last three decades. http://www.anh-usa.org/half-of-all-children-will-be-autistic-by-2025-warns-senior-research-scientist-at-mit/
- **Genetic predisposition of reduced detoxification ability and immune competency conditions**. Genetic testing is available that can help to identify those individuals that may be at risk. If you would like to receive information about that kind of testing, click this link.

GENETIC TESTING INFORMATION

- **Too many vaccines too early in life**, especially before the blood brain barrier is closed and can protect the brain from the mercury, aluminum, polysorbate 80, formaldehyde, MSG, etc., which all have deleterious effects on the brain.
- **Doses of acetaminophen** (i.e. Tylenol, etc.), which has been proven to significantly reduce the body's ability to make glutathione. Glutathione is necessary to detoxify the mercury, aluminum and other toxins that are found in the vaccines. Several doses of Tylenol over 3-5 days of is often given for the pain of circumcision (it may one factor why boys are more affected by autism). It is

also given to reduce pain and fever after children are given their shots, effectively rendering them incapable of eliminating many of the toxins in the shots.

- **Antibiotics given concurrently or shortly before being vaccinated**.

This table from this study does a nice job of summarizing the various "triggers" of autism based on the relative severity of the risk associated with that trigger.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5536672/table/table1-0300060517693423/

It summarizes the findings of the study, which cites that the things that cause inflammation and oxidative stress are major risk factors of autism. The list contains several things including acetaminophen, genetic variants including decreased glutathione production (also made worse by acetaminophen), parental autoimmune disorders, environmental toxins (pesticides, air pollution, heavy metals like mercury and aluminum), infection during pregnancy, maternal obesity, etc.

AUTOIMMUNE DISEASES ARE NEARING EPIDEMIC PROPORTIONS – THE VACCINE CONNECTION

Autoimmunity is when the body develops antibodies (auto antibodies), that cause the immune system to mistakenly attack a target organ or tissue. I am **not saying that vaccines are the "sole" cause of autoimmunity** (remember at the beginning I said that there is no ONE cause of any disease?). What I am suggesting (and it's based on the dozens of references throughout this document), is that **scientists and researchers are finding a strong connection.** Just **do a key word search of autoimmune and one of autoimmunity and you will see how the articles throughout this eBook are riddled with that conclusion.**

Autoimmune diseases are **nearing epidemic proportions**. **According to *the American Autoimmune Related Diseases Association*, 50 million Americans suffer from one or more autoimmune conditions. *(Incredibly, that means nearly 1 person in 6 suffers from an autoimmune related illness)***

From their web site:
https://www.aarda.org/news-information/statistics/#1488234386508-a9560084-9b69

- The ***National Institutes of Health*** (NIH estimates up to 23.5* million Americans suffer from autoimmune disease and that the prevalence is rising. **We at AARDA say that 50 million* Americans suffer from autoimmune disease. Why the difference? The NIH numbers only include 24 diseases for which good epidemiology studies were available**.

- **Researchers have identified 80-100 different autoimmune diseases and suspect at least 40 additional diseases of having an autoimmune basis**. These diseases are chronic and can be life-threatening.

- NIH estimates up to 23.5 million Americans* have an AD. **In comparison, cancer affects up to 9 million and heart disease up to 22 million.**

- **NIH estimates annual direct health care costs for AD to be in the range of $100 billion** (source: NIH presentation by Dr. Fauci, NIAID). In comparison, cancers costs are $57 billion (source: NIH, ACS), and heart and stroke costs are $200 billion (source: NIH, AHA).

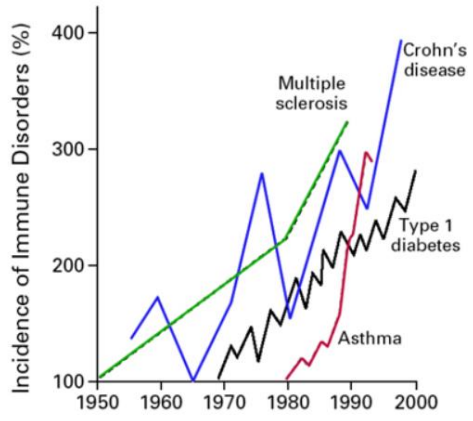
- NIH research **funding for AD in 2003 came to $591 million**. In comparison, cancer funding came to **$6.1 billion**; and heart and stroke, to **$2.4 billion** (source: NIH).

Autoimmune diseases have been rising consistently over the last 3 decades. A December 2015 article published in the ***International Journal of Celiac Disease*** titled, **The World Incidence and Prevalence of Autoimmune Diseases is Increasing**, did a systematic review of 30 long-term studies over the last 30 years. The results are really quite remarkable and frightening.
https://www.researchgate.net/publication/294419057_The_World_Incidence_and_Prevalence_of_Autoimmune_Diseases_is_Increasing

From the Abstract:
The world-wide average increase in incidence (new cases) per year was 19.1% and the average prevalence (% of population with autoimmune disease) per year was 12.5%.

This graph published in the Townsend Newsletter in 2012, shows about 4 decades of trending. Since then (over the last 20 years), the numbers have continued to climb unabated. In fact, the Mayo Clinic reports that U.S. Lupus rates have tripled in the last 40 years.

Figure 1: Rising Incidence of Autoimmune Disorders



The main takeaway from all of the research I have seen on this topic, is that **the common conclusion is that it is NOT genetic, but that it is environmental causes** that is triggering this run-away freight train.

The increased use of vaccines and the increased number of doses over the past 40 years seems to parallel the increase in autoimmune diseases shown in the chart above. I'd say reducing the vaccine dosing schedules would be a very good place to start!

Aluminum causes numerous malfunctions in various systems in the body

A 2013 article published in the Journal ***Immunome Research*** titled, **Aluminum's Role in CNS-immune System Interactions leading to Neurological Disorders**, describes the damaging effects aluminum has on various body systems and the mechanisms by which that can occur.
https://www.omicsonline.org/open-access/aluminums-role-in-cnsimmune-systeminteractionsleading-to-neurological-disorders-14822-1745-7580-9-069.php?aid=20403

The Abstract: (Al refers to aluminum)
"Multisystem interactions are well established in neurological disorders, in spite of conventional views that only the central nervous system (CNS) is impacted. **We review evidence for mutual interactions between the immune and nervous systems and show how these seem to be implicated in the origin and progression of nervous system disorders.** Well-established immune system triggers leading to autoimmune reactions are considered. Of these, **aluminum, a known neurotoxicant, may be of particular importance. We have demonstrated elsewhere that aluminum has the potential to induce damage at a range of levels in the CNS leading to neuronal death, circuit malfunction and ultimately, system failure. Aluminum is widely used as an adjuvant in various vaccine formulations and has been implicated in a multisystem disorder termed "autoimmune/inflammatory syndrome induced by adjuvants" (ASIA).** The implications of aluminum-induced ASIA in some disorders of the CNS are considered. **We propose a unified theory capturing a progression from a local response to a systemic response initiated by disruption of water-based interfaces of exposed cells**."

"Aluminum has been used in vaccine formulations since 1926 after the discovery that it potentiates the immune response to the target pathogen. Perceptions of Al safety that abound in the medical literature are largely based upon a lack of recognized adverse events over the past 70 years, rather than randomized, true-placebo-controlled clinical trials, or the now abundant experimental animal literature. **A meaningful conclusion that unlimited use of Al is safe in vaccines cannot be made. Adverse events are significantly under-reported, and physician bias often influences the reporting process**. Quite often, the requisite inquiry as to whether a vaccination preceded an acute illness is not asked. Autoimmune reactions to aluminum in vaccines are not of sufficient frequency to facilitate prospective randomized control trials. Causation is difficult to establish in general, when so many factors could be in play, although the use of the Hill criteria certainly helps the process of sifting causality from coincidence. Some researchers have opined that the latency period of autoimmune disease makes it difficult to infer causation retrospectively, but this may not be a valid critique, since there is still a clear sequence of events from presumed causal factor to disease outcome."

"**Al adjuvants are used in childhood vaccines against diphtheria, tetanus, pertussis, hepatitis B, anthrax, *Haemophilus influenza* and human papilloma virus, amongst others**. **A child may be injected with as much as 4.225 mg of elemental Al by the age of 12 months**. **Our review of currently licensed vaccine package inserts in the United States is consistent with this figure**. Mitkus et al. reported that

this dosage is within the U.S. Agency for Toxic Substances and Disease Registry's minimum risk levels for infants, **extrapolating data from a volunteer study of adults using radioactive aluminum tracer, and a toxic autokinetic study performed on rabbits**. *(REALLY?)* Mitkus et al. used the creatinine clearance differential between children and adults to estimate total Al body burden of infants following vaccination. **The estimation is based upon an assumption that Al excretion parallels creatinine clearance, an assumption that is unlikely to be correct either on theoretical or experimental grounds. In the first instance, rapid excretion of Al would nullify the very basis of having it as an adjuvant in the first place. Experimentally, the notion that Al adjuvants are rapidly excreted is challenged by the recent work of Khan et al."**

A summary of the researchers explaining their proposed flow of aluminum in the body. Other downstream effects of health that may not be manifest for years is explained afterwards.

"In the remainder of this paper, we will develop what we believe to be a novel proposal for an inflammation cascade subsequent to exposure of tissues to Al and other neurotoxicants.

Briefly, the cascade can be outlined as follows:

(a) Aluminum disrupts water-based cellular homeostasis and causes a crisis for the exposed cell.
(b) The cell sends out "death alarm" messages, which draw in macrophages and other immune cells, initiating an inflammatory cascade.
(c) The highly stressed cell dies *via* necrosis rather than a "programmed cell death," and releases its DNA into the interstitial tissues.
(d) This extracellular DNA is picked up as an antigenic signal by immune cells and leads directly to autoimmune disease.
(e) In parallel, sulfate synthesis and sulfate transport are disrupted due in part to Al contamination of the pineal gland and other sensitive nuclei in the midbrain.
(f) The entire biological system switches from a sulfate-based to a phosphate-based management strategy for maintaining water interfaces, leading to hyperparathyroidism."

"The capacity to produce vitamin D3 in the skin decreases with aging, and we believe this can be attributed in part to the impaired ability to produce sulfate because of an increasing Al burden. Sulfate is needed for efficient transport of vitamin D3 and of cholesterol, which is also produced in the skin. We have argued that Al disrupts this function by its biophysical effects on water. The overuse of Al-containing high-sun protection factor (SPF) sunscreens contributes to the problem both by blocking the UV light and by Al's role in disrupting eNOS' sulfate synthesis. Correlations between reduced sun availability and autism rates in the 50 states of the US are consistent with this hypothesis. **Impaired sulfate synthesis leads to systemic dysfunction manifested not only as neurological impairment, but also as diverse somatic conditions such as eczema, asthma, impaired gut function, diabetes, kidney disease and heart disease, due to deficiencies in cholesterol sulfate and other sulfated biomolecules. This provides a direct link between somatic and neurological aspects of autoimmune diseases."**

"Depending on a combination of genetic predisposition and the cumulative burden of environmental toxic exposures, the brain may or may not be spared when sulfate supplies become deficient. Even

within the brain, it depends on which parts of the brain are most affected as to which neurological disease will emerge. Parkinson's disease defects are mostly concentrated in the *Substantia nigra* (the source of dopamine), whereas Alzheimer's affects mainly the cortex, at least initially, and ALS may focus on the motor neurons in the spinal cord, brain stem and motor cortex. However, all of these conditions have somatic complications that are explained by deficiencies in sulfate and by excessive activation of calcium phosphate pathways through an overactive parathyroid gland."

"As discussed in Section 5, an increase in bone fragility and parathyroid function follows directly from vitamin D3 insufficiency."

"In addition, sulfate depletion then leads to glucose intolerance due to the important role sulfate plays in the storage of glucose in the extracellular matrix."

"**In this article, we have demonstrated the multiple deleterious roles that Al plays across all levels of organization, beginning at a molecular level and culminating in systems-wide dysfunctions. Of particular relevance for the etiology of CNS disorders, Al acts directly to alter neural cell function. As well, Al disturbs immune function, and thus indirectly attacks the nervous system through autoimmune actions. The combined weight of these two actions may explain the diverse forms of many developmental and age-related neurological diseases. These observations may provide more than sufficient reasons to consider how we can limit human exposure to this element from whatever source. Of particular concern in this regard is to limit the exposure to the most vulnerable populations: the very young and the very old.**"

Mercury and aluminum can trigger autoimmunity

In addition to the many articles sprinkled throughout this document implicating mercury and aluminum in the development of autoimmune conditions, here are just a few more.

Mercury and aluminum in vaccines causing autoimmunity

This article titled **Vaccines, Adjuvants and Autoimmunity** is from the ***Journal Pharmacological Research*** 2015. https://www.ncbi.nlm.nih.gov/pubmed/26275795

Quotes from the article:

"**In this review of the literature, there is evidence of vaccine-induced autoimmunity and adjuvant-induced autoimmunity in both experimental models as well as human patients**."

"These mechanisms are shared by different conditions triggered by adjuvants leading to the autoimmune/inflammatory syndrome induced by adjuvants (ASIA syndrome)."

Background and vaccine connection to the syndrome known as ASIA

A 2014 study published in ***Immunologic Research*** titled**, Autoimmune/inflammatory syndrome induced by adjuvants (ASIA): clues and pitfalls in the pediatric background**, goes into some of the background of the ASIA Syndrome and discusses the relationship between vaccine adjuvants and this constellation of disorders. https://www.ncbi.nlm.nih.gov/pubmed/25395340

From the Abstract:
"The development and increasing diffusion of new vaccinations and global immunization protocols have aroused burning debates about safety of adjuvants and their immunogenicity-enhancing effect in vaccines. Shoenfeld and Agmon-Levin have grouped under the term "autoimmune/inflammatory syndrome induced by adjuvants" (ASIA) a complex of variable signs and symptoms that may occur after a previous exposure to different adjuvants and also external environmental triggers, even eliciting specific overt immune-mediated disorders. This entity subsumes five medical conditions: post-vaccination phenomena, gulf war syndrome, macrophagic myofasciitis syndrome, siliconosis, and sick building syndrome, but the relevance and magnitude of the syndrome in the pediatric age is fundamentally limited to post-vaccination autoimmune or inflammatory disorders."

Aluminum in vaccines not only triggers neurotoxicity and autoimmunity, but it also changes gene expression in the nervous system

This article from the Journal ***Immunotherapy*** in 2014 titled, **Are there negative CNS impacts of aluminum adjuvants used in vaccines and immunotherapy?** raises serious concerns about the use of aluminum in vaccines. https://www.ncbi.nlm.nih.gov/pubmed/?term=25428645

"**In spite of a common view that aluminum (Al) salts are inert and therefore harmless as vaccine adjuvants or in immunotherapy, the reality is quite different**. In the following article, we briefly review the literature on **Al neurotoxicity and the use of Al salts as vaccine adjuvants and consider not only direct toxic actions on the nervous system, but also the potential impact for triggering autoimmunity. Autoimmune and inflammatory responses affecting the CNS appear to underlie some forms of neurological disease, including developmental disorders. Al has been demonstrated to impact the CNS at every level, including by changing gene expression. These outcomes should raise concerns about the increasing use of Al salts as vaccine adjuvants and for the application as more general immune stimulants."**

The Epidemic of Autoimmune Disease and the Aluminum Connection

I work as a health and lifestyle coach, utilizing functional medicine, clinical nutrition and lifestyle management with my clients. One of things I have noticed over the past few years is a dramatic increase in diagnosed autoimmune conditions. This is something that in my opinion has many causes, but the

more I research the connection with vaccine adjuvants **AND** considering the huge increase in exposure to these toxins our children (and adults) have experienced **AND** as more vaccines are introduced **AND** the dosing schedules have increased, the more I am convinced that **these toxins are playing an increasingly significant role.**

Aluminum and even newer adjuvants implicated in the creation of autoimmune diseases

A 2015 article published in the Journal of ***Autoimmunity Reviews*** titled, **On vaccine's adjuvants and autoimmunity: Current evidence and future perspectives**, cites that "**Recent studies implicate a web of mechanisms in the development of vaccine adjuvant-induced autoimmune diseases, in particular, in those associated with aluminium-based compounds**."
https://www.ncbi.nlm.nih.gov/pubmed/26031899

From the Abstract:
Adjuvants are compounds incorporated into vaccines to enhance immunogenicity and the development of these molecules has become an expanding field of research in the last decades. Several of these molecules have been approved, including aluminium salts, oil-in-water emulsions (MF59, AS03 and AF03), virosomes and AS04. **Adjuvants have recently been implicated in the new syndrome named "ASIA-Autoimmune/inflammatory Syndrome Induced by Adjuvants", which describes an umbrella of clinical conditions including post-vaccination adverse reactions. Recent studies implicate a web of mechanisms in the development of vaccine adjuvant-induced autoimmune diseases, in particular, in those associated with aluminium-based compounds. Fewer and unsystematised data are instead available about other adjuvants, despite recent evidence indicating that vaccines with different adjuvants may also cause specific autoimmune adverse reactions possible towards different pathogenic mechanisms. This topic is of importance as the specific mechanism of action of each single adjuvant may have different effects on the course of different diseases**. Herein, we review the current evidence about the mechanism of action of currently employed adjuvants and discuss the mechanisms by which such components may trigger autoimmunity.

Squalene and aluminum are the top two adjuvants associated with the autoimmune syndrome known as A.S.I.A.

A 2013 article from the journal ***Expert Review Clinical Immunology*** titled, **Autoimmune/inflammatory syndrome induced by adjuvants (Shoenfeld's syndrome): clinical and immunological spectrum**, looks at the vaccine adjuvant connection with the spectrum of autoimmune conditions syndrome now known as Autoimmune Inflammatory Induced by Adjuvants (A.S.I.A.).
https://www.ncbi.nlm.nih.gov/pubmed/23557271

From the abstract:
"An adjuvant is a substance that enhances the antigen-specific immune response, induces the release of inflammatory cytokines, and interacts with Toll-like receptors and the NALP3 inflammasome. The immunological consequence of these actions is to **stimulate the innate and adaptive immune response.** The activation of the immune system by adjuvants, a desirable effect, **could trigger manifestations of**

autoimmunity or autoimmune disease. Recently, a new syndrome was introduced, autoimmune/inflammatory syndrome induced by adjuvants (ASIA), **that includes postvaccination phenomena**, macrophagic myofasciitis, Gulf War syndrome and siliconosis. This syndrome is characterized by nonspecific and specific manifestations of autoimmune disease. **The main substances associated with ASIA are squalene (Gulf War syndrome), aluminum hydroxide (postvaccination phenomena, macrophagic myofasciitis) and silicone with siliconosis. Mineral oil, guaiacol and iodine gadital are also associated with ASIA**."

Aluminum is by far the most commonly used adjuvant in vaccines. As discussed frequently in this document, the cumulative amounts of aluminum contained in the vaccine schedule is off the charts.

Additional articles demonstrating connections with vaccines containing aluminum (which most do), and autoimmune diseases:

This article from ***Journal of Inorganic Biochemistry*** titled, **Do aluminum vaccine adjuvants contribute to the rising prevalence of autism?**, clearly states that the **immunological effects from vaccines, can lead to permanent alterations in the brain and immune system including autoimmunity**.
https://www.ncbi.nlm.nih.gov/pubmed/?term=22099159

From the article…. ''Immune challenges during early development, including those vaccine-induced, can lead to permanent detrimental alterations of the brain and immune function. Experimental evidence also shows that simultaneous administration of as little as two to three immune adjuvants can overcome genetic resistance to autoimmunity. **In some developed countries, by the time children are 4 to 6 years old, they will have received a total of 126 antigenic compounds along with high amounts of aluminum (Al) adjuvants through routine vaccinations.".** In summary, research evidence shows that increasing concerns about current vaccination practices may indeed be warranted. Because children may be most at risk of vaccine-induced complications, **a rigorous evaluation of the vaccine-related adverse health impacts in the pediatric population is urgently needed**.

Association of specific autoimmune diseases and specific vaccines

A 2010 article from ***Discovery Medicine*** titled, **Vaccines and Autoimmune Diseases of the Adult** looks at the proven associations of certain vaccines and specific autoimmune diseases.
https://www.ncbi.nlm.nih.gov/pubmed/20193633

Abstract: "Infectious agents contribute to the environmental factors involved in the development of autoimmune diseases possibly through molecular mimicry mechanisms. **Hence, it is feasible that vaccinations may also contribute to the mosaic of autoimmunity**. Evidence for the association of vaccinations and the development of these diseases is presented in this review. Infrequently reported post-vaccination autoimmune diseases include systemic lupus erythematosus, rheumatoid arthritis, inflammatory myopathies, multiple sclerosis, Guillain-Barré syndrome, and vasculitis. In addition, we will

discuss macrophagic myofasciitis, aluminum containing vaccines, and the recent evidence for autoimmunity following human papilloma virus vaccine."

From the Article:
"Vaccines are a prototypic source for natural immune stimulation, **but may be involved in pathogenic disease in the setting of aberrant immune system function. Possibly, the burden on the immune system resulting from simultaneous multiple vaccines and even the different types of vaccines may also be an overwhelming challenge in the autoimmune prone individual** (Shoenfeld et al., 2008). In this review, we discuss the evidence for the development of autoimmune diseases following infections and vaccinations."

"Reported post-vaccination autoimmune diseases in the adult include SLE, rheumatoid arthritis (RA), inflammatory myopathies, multiple sclerosis (MS), Guillain-Barré syndrome (GBS), and vasculitis. Evidence for the association of vaccinations and the development of these diseases is presented in this review. In addition, we will discuss macrophagic myofasciitis, post aluminum containing vaccines and the recent support for autoimmunity following human papilloma virus vaccine."

Here are a couple of examples reported in the study:

Hepatitis B vaccine-
"A summary of the serious autoimmune adverse events following vaccination with hepatitis B vaccination reported to the vaccine adverse events reporting system (VAERS) include **in descending order by odds ratio:** RA (OR-18), optic neuritis (OR-14), SLE (OR-9.1), alopecia (OR-7.2), MS (OR-5.2), and vasculitis (OR-2.6). Many of the adverse events associated with hepatitis B vaccination were extra-hepatic and are manifestations of infection with HBV. **In addition to the potential epitopes in the HBsAg (HBV surface antigen) vaccine, adjuvants containing aluminum and mercury may provide potential antigenic stimulation** (Geier et al., 2005)."

Multiple Sclerosis-
"**Neurological manifestations are common following vaccinations (Huynh et al., 2008). In a case-control epidemiological study for serious adverse events reported in the hepatitis B vaccination exposed group compared to those that received tetanus vaccine, MS was prominent with an odds ratio of 5.2 (P<0.0003). Optic neuritis was also very commonly encountered (OR-14, p<0.0002) (Geier et al., 2005)."**

These comments by the authors are very astute….

"A comprehensive strategy is required to develop a new vaccine that will not induce autoimmune manifestations as previously proposed."

"Perhaps, the assessment of autoantibody and HLA status prior to immunization will serve as a marker for individuals at risk. More research is required to identify those individuals who may develop autoimmune diseases following immunizations. It is not clear if genomics or proteomics will reveal the individuals with an increased risk to develop autoimmune phenomena."

One important consideration when considering results of studies on the association of vaccines and autoimmunity, is the amount of time subjects are followed. Autoimmune manifestations may take months and in many cases years to develop. Studies that do not follow the subjects for several years can erroneously report a negative association.

Attempting to connect patterns related to various vaccine adjuvants and the autoimmune conditions they trigger

A 2018 study from the journal ***Clinical Rheumatology*** titled, **The autoimmune/inflammatory syndrome induced by adjuvants (ASIA)/Shoenfeld's syndrome: descriptive analysis of 300 patients from the international ASIA syndrome registry**, looks at 300 cases of A.S.I.A. up to December 2016. The study looked at similarities and differences between the various manifestations of symptoms, time from vaccination until onset of disease as well as clinical and laboratory features variables with the type of adjuvant used. https://www.ncbi.nlm.nih.gov/pubmed/28741088

From the Abstract:
"The autoimmune/inflammatory syndrome induced by adjuvants (ASIA) is a recently identified condition in which **the exposure to an adjuvant leads to an aberrant autoimmune response**. We aimed to summarize the results obtained from the ASIA syndrome registry up to December 2016, in a descriptive analysis of 300 cases of ASIA syndrome, with a focus on the adjuvants, the clinical manifestations, and the relationship with other autoimmune diseases."

"The mean age at disease onset was 37 years, and **the mean duration of time latency between adjuvant stimuli and development of autoimmune conditions was 16.8 months, ranging between 3 days to 5 years**. Arthralgia, myalgia, and chronic fatigue were the most frequently reported symptoms. **Eighty-nine percent of patients were also diagnosed with another defined rheumatic/autoimmune condition.** The most frequent autoimmune disease related to ASIA syndrome was undifferentiated connective tissue disease (UCTD). ASIA syndrome is associated with a high incidence of UCTD and positive anti-nuclear antibodies (ANA) test. **Clinical and laboratory features differ from the type of adjuvant used. These findings may contribute to an increased awareness of ASIA syndrome and help physicians to identify patients at a greater risk of autoimmune diseases following the exposure to vaccines and other adjuvants**."

The real questions are, when they learn which individuals are at greater risk, what are they going to do about it? Will they implement protocols to test everyone, identify those at risk and allow those persons to opt out? Or, will they continue to push the one-size-fits-all approach, and crucify doctors and parents that attempt to get legitimate medical exemptions for vulnerable and at-risk individuals?

Many different flaws in vaccine technology exposed leading to numerous autoimmune and neurological disorders

https://www.ncbi.nlm.nih.gov/pubmed/22652881 This 2012 article published in the ***Frontiers of Bioscience*** Journal titled, **Peptide cross – reactivity: the original sin of vaccines**, does a wonderful job of explaining the cause and effect of adverse events to vaccination. It discusses **many different flaws within the vaccine technology**. It also **verifies that the adjuvants in vaccines do cause autoimmune reaction in the body** including reactivity to myelin which is the sheath that covers nerves in the spinal cord. **Demyelinating diseases such as multiple sclerosis and Lou Gehrig's disease or ALS have been on the rise over the last three decades. Because adjuvants stimulate hyperreactivity of the immune system, this hyperreactivity of the immune system is the fundamental definition of autoimmune disease**.

A 2015 article identifies how to predict who may be at risk for post-vaccination autoimmunity

A 2015 article published in the journal ***Pharmacological Research*** titled, **Predicting post-vaccination autoimmunity: who might be at risk?** identifies 4 groups of individuals that are at higher risk for developing a vaccine induced autoimmune disorder. https://www.ncbi.nlm.nih.gov/pubmed/25277820

From the article:
"Vaccinations have been used as an essential tool in the fight against infectious diseases, and succeeded in improving public health. However, **adverse effects, including autoimmune conditions may occur following vaccinations (autoimmune/inflammatory syndrome induced by adjuvants--ASIA syndrome**)."

"**In this perspective we defined four groups of individuals who might be susceptible to develop vaccination-induced ASIA: patients with prior post-vaccination autoimmune phenomena, patients with a medical history of autoimmunity, patients with a history of allergic reactions, and individuals who are prone to develop autoimmunity (having a family history of autoimmune diseases; asymptomatic carriers of autoantibodies; carrying certain genetic profiles, etc**.)."

A 2017 study looks at cases of autoimmune reactions caused by vaccines and attempts to identify risk factors underlying that correlation

A 2017 article published in the ***Journal of Predictive, Preventive and Personalized Medicine*** (PPPM), titled, **Vaccination and autoimmune diseases: is prevention of adverse health effects on the horizon?**, looks at evidence and mechanisms, by which vaccines can trigger autoimmune reaction and predictive ways to prevent the tragic outcome many individuals and families have experienced.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5607155/

From the article:
"In the last decade, reports have accumulated on various autoimmune disorders, such as idiopathic thrombocytopenia purpura, myopericarditis, primary ovarian failure, and systemic lupus erythematosus (SLE), **following vaccination**. In this review, we discuss the possible underlying mechanisms of autoimmune reactions following vaccinations and review cases of autoimmune diseases that have been correlated with vaccination. **Molecular mimicry and bystander activation** are reported as possible mechanisms by which vaccines can cause autoimmune reactions. The individuals who might be susceptible to develop these reactions could be especially not only those with previous post-vaccination phenomena and those with allergies but also in individuals who are prone to develop autoimmune diseases, **such as those with a family history of autoimmunity or with known autoantibodies, and the genetic predisposed individuals**."

"**Further research is encouraged into the direct associations between vaccines and autoimmune conditions, and the biological mechanisms behind them**."

Here are just a couple of the examples given by the article regarding the correlation between vaccines and specific autoimmune conditions. One important thing to remember is that if vaccines have been proven to trigger certain autoimmune disease in certain individuals, the potential exists that is may be a primary causative factor in **ANY** autoimmune condition. **The list of autoimmune conditions continues to grow** as science is discovering the underlying mechanisms for new and even rare syndromes.

"**Systemic lupus erythematosus (SLE)** is a chronic, multisystemic autoimmune inflammatory disease. **Several studies reported the relationship between SLE and HBV vaccine, with statistically significant temporal/causal association, probably due to the low prevalence of post- vaccination autoimmunity, low rate of reporting post- vaccination adverse events, and various latency periods between vaccination and the onset of disease, as well as atypical presentation of autoimmunity following vaccine**. The cause-and-effect interaction between HBV vaccine and SLE is unclear, although the post-HBV vaccination auto- immunity might be related to an increase in the number of immune complexes as well as to the molecular mimicry between some components of the vaccine (e.g., aluminum, yeast, thimerosal) and self-antigens. **This theory is supported by the study of Kowal et al. that proved cross-reactivity, at the molecular level, between pneumococcal anti-bacterial antibodies and generation of anti-DNA antibodies, in SLE patients**."

"Another confirmed autoimmune adverse effect associated with vaccination is the induction of **Idiopathic Thrombocytopenia (ITP)**, also known as immune thrombocytopenia, **following the measles mumps rubella (MMR) vaccine**, in particular within 6 weeks of immunization. ITP is an autoimmune condition, clinically characterized by low platelet count (less than 100,000 platelets per microliter) due to increased destruction and impaired platelet production, and by the presence of autoantibodies (IgG) directed toward platelet membrane antigens (glycoproteins IIb-IIIa). The main clinical manifestations include various degrees of cutaneous and/or mucosal purpura; life-threatening hemorrhages occur in less than 5% of adult patients. **ITP risk following the MMR vaccine is seen highest in children, aged 12–19 months, which is the estimated age when children would normally be receiving the MMR vaccine.**"

MMR and Rheumatoid Arthritis (RA), is another. "Another study evaluated the incidence of joint manifestations within 6 weeks after MMR immunization: **it included 2658 vaccinated and 2359 non-vaccinated children, confirming an increased risk of joint symptoms (arthralgia or arthritis) in the**

immunized children." *(Benjamin CM, Chew CG, Silman AJ. Joint and limb symptoms in children after immunization with measles, mumps and rubella vaccine. BMJ. 1992;304:1075-7)."* The study then goes into more detail.

HPV Vaccine and transverse myelitis. "Transverse myelitis (TM) is the paradigm of inflammatory myelopathy, in which **an immune-mediated process causes neural injury to the spinal cord, resulting in varying degrees of weakness, sensory alterations, and autonomic dysfunction**. TM may exist as part of a multifocal central nervous system disease (e.g., multiple sclerosis), multisystemic disease (e.g., SLE), or as an isolated idiopathic entity." The study then goes into more detail.

HPV vaccine and ASIA syndrome. "Recently, several reports have suggested grouping different autoimmune conditions that are **triggered by external stimuli (e.g., exposure to vaccine)** as a single syndrome called auto-immune syndrome induced by adjuvants (ASIA). This syndrome is characterized by the appearance of myalgia, myositis, muscle weakness, arthralgia, arthritis, chronic fatigue, sleep disturbances, cognitive impairment, and memory loss."

HPV vaccine and primary ovarian failure. "The HPV vaccines (such as Gardasil® and Cervarix®) were introduced to fight the cervical cancer; however, **several cases of onset or exacerbations of autoimmune diseases following vaccination have been reported.**"

"**The authors suggested that the use of adjuvants in the HPV vaccine could be a risk factor for eliciting an autoimmune reaction to the vaccination: the DNA fragments detected in 16 different Gardasil® vaccines appeared to be bound to the aluminum used in the vaccine formulation**."

Finally, a conclusion that makes perfect sense to me. Until an alternative to vaccines, or at least safer vaccines can be created, this seems to be an important next step.

The authors conclude with this: "Finally, we believe that our commitment should be to plan genetic investigations on the post-vaccination auto-immune-affected patients in order to clarify the pathogenic background and the physiopathology of vaccine-related autoimmune response. Hopefully, this approach might lead to outline a screen-test (patch test?) for this risk and, eventually, to prevention of adverse reactions by vaccination. It could represent a "personalized medicine" that could potentially improve preventive methods and therapeutic options, accordingly with the recommendations of the "European Association for Predictive, Preventive and Personalised Medicine." I say Amen to that!

New H. Pylori Vaccine alters immune cells and their adaptive immune response towards an inflammatory reaction and possible autoimmune direction

A 2018 study published in the journal ***Helicobacter*** titled, **Toxic adjuvants alter the function and phenotype of dendritic cells to initiate adaptive immune responses induced by oral Helicobacter pylori vaccines**, presents findings the vaccine produces, that could be very concerning. Right from the start, they tell you that a **toxic adjuvant** is necessary in the vaccine.

From the Abstract:
"**Toxic adjuvant is considered as an indispensable constituent** for oral Helicobacter pylori (H. pylori) vaccines. However, the elaborate role of toxic adjuvant in the initiation of adaptive immune response is largely undescribed."

"Gastric inflammatory and Th1/Th17 responses were analyzed by flow cytometry. Expressions of inflammatory cytokines were measured by quantitative real-time PCR."

"In a prophylactic vaccination model, mice immunized with NPs + adjuvants significantly reduced the gastric colonization of H. pylori, **induced antigen-specific antibody responses and Th1/Th17 cell responses**."

My comments are italicized:
*While a **Th1 response** can help mount an attack against bacteria and viruses, **it is proinflammatory and can lead to autoimmune disease.*** This quote is from a scientific commentary published in the ***British Medical Journal*** titled, **Th1 and Th2 responses: what are they?** "Th1-type cytokines tend **to produce the proinflammatory responses** responsible for killing intracellular parasites **and for perpetuating autoimmune responses**. Interferon gamma is the main Th1 cytokine. **Excessive proinflammatory responses can lead to uncontrolled tissue damage**, so there needs to be a mechanism to counteract this." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC27457/

***Th17 cell responses** have been associated with triggering autoimmune responses. Inflammation in the gut drives the Th17 response and that causes more inflammation. It becomes a vicious cycle.* A 2015 article titled, **The Role of IL-17 and Th17 Lymphocytes in Autoimmune Diseases**, describes these concerns. "The end of twentieth century has introduced some changes into T helper (Th) cells division. The identification of the new subpopulation of T helper cells producing IL-17 modified model of Th1–Th2 paradigm and **it was named Th17. High abilities to stimulate acute and chronic inflammation made these cells ideal candidate for crucial player in development of autoimmune disorders. Numerous publications based on animal and human models confirmed their pivotal role in pathogenesis of human systemic and organ-specific autoimmune diseases.**"
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4633446/

Back to the Abstract:
"Our study indicated that **toxic adjuvants** within oral H.pylori vaccines **altered the function and phenotype of dendritic cells and facilitated the establishment of proinflammatory microenvironment** to initiate adaptive immune responses." *Dendritic cells are part of the immune system that act as messengers between the innate and adaptive part of the immune system. They show antigens on their surface to other cells like T cells (lymphocytes) that then respond to those antigens. My concern is that when you "alter the function and phenotype" of these immune cells (which means the behavior or way those cells interact with their environment), you may create a situation that gets out of control and leads to a chronic or lasting shift towards an inflammatory and autoimmune dominance.*

One of the adjuvants they used in this study raises major concerns. It is called LPS or lipopolysaccharide. The following quote is from **VIOLIN "a web-based vaccine database and analysis system"**
http://www.violinet.org/index.php

"Bacterial lipopolysaccharide (LPS) has T-helper 1 (Th1) immunostimulatory activities **but because of toxicity and pyrogenicity cannot be used as an adjuvant.**" (Jamalan *et al.*, 2011). **Pyrogenicity means that it stimulates fever**. As we have seen in this document, **spiking fever after administration of vaccines is one of the triggering mechanisms for adverse reactions, including autism**. **Why in 2018, are they developing vaccines with adjuvants in them that have been proven to be toxic and spike fever? This seems like another large scale, unsupervised and non-controlled human trial, for which we will not know the outcome and damage done for another decade or two. Well, what else is new? This seems to be the status quo and should be no surprise.**
http://www.violinet.org/vaxjo/vaxjo_detail.php?c_vaxjo_id=27

Incidentally, H. Pylori infections can be safely treated with natural herbal formulations that are made and distributed by various manufacturers.

Other Adverse Health Conditions Being Linked to Vaccination

Gulf War Syndrome linked to vaccines

Gulf War Syndrome may be linked to the aluminum and squalene adjuvants in vaccines given to service personnel

A 2009 article in the ***Journal of Inorganic Biochemistry*** titled, **Aluminum hydroxide injections lead to motor deficits and motor neuron degeneration**, suggests that Gulf War Syndrome may be linked to the vaccines adjuvants aluminum and squalene contained in the vaccinations given to service men and women who were deployed into the Gulf War theater.
https://www.ncbi.nlm.nih.gov/pubmed/19740540

The Abstract:

"Gulf War Syndrome is a multi-system disorder afflicting many veterans of Western armies in the 1990-1991 Gulf War. A number of those afflicted may **show neurological deficits including various cognitive dysfunctions and motor neuron disease, the latter expression virtually indistinguishable from classical amyotrophic lateral sclerosis (ALS) except for the age of onset**. This ALS "cluster" represents the second such ALS cluster described in the literature to date. **Possible causes of GWS include several of the adjuvants in the anthrax vaccine and others. The most likely culprit appears to be aluminum hydroxide. In an initial series of experiments, we examined the potential toxicity of aluminum hydroxide in male, outbred CD-1 mice injected subcutaneously in two equivalent-to-human doses.**

After sacrifice, spinal cord and motor cortex samples were examined by immunohistochemistry. Aluminum-treated mice showed significantly increased apoptosis *(death)* of motor neurons and increases in reactive astrocytes and microglial proliferation within the spinal cord and cortex. Morin stain detected the presence of aluminum in the cytoplasm of motor neurons with some neurons also testing positive for the presence of hyper-phosphorylated tau protein, a pathological hallmark of various neurological diseases, including Alzheimer's disease and frontotemporal dementia. A second series of experiments was conducted on mice injected with six doses of aluminum hydroxide. Behavioural analyses in these mice revealed significant impairments in a number of motor functions as well as diminished spatial memory capacity. The demonstrated neurotoxicity of aluminum hydroxide and its relative ubiquity as an adjuvant suggest that greater scrutiny by the scientific community is warranted."

Another study incriminates the aluminum and squalene adjuvants found in the Anthrax Vaccine given to service personnel that developed in Gulf War Syndrome

A 2007 article published in ***Neuromolecular Medicine*** titled, **Aluminum adjuvant linked to Gulf War illness induces motor neuron death in mice**, makes a strong case for the neurological deficits experienced by some men and women deployed in the Gulf War, relating to the aluminum and squalene in the heavy doses of vaccines they were given. https://www.ncbi.nlm.nih.gov/pubmed/17114826

The Abstract:

Gulf War illness (GWI) affects a significant percentage of veterans of the 1991 conflict, but its origin remains unknown. Associated with some cases of GWI are increased incidences of amyotrophic lateral sclerosis and other neurological disorders. Whereas many environmental factors have been linked to GWI, **the role of the anthrax vaccine has come under increasing scrutiny. Among the vaccine's potentially toxic components are the adjuvants aluminum hydroxide and squalene.** To examine whether these compounds might contribute to neuronal deficits associated with GWI, an animal model for examining the potential neurological impact of aluminum hydroxide, squalene, or aluminum hydroxide combined with squalene was developed. Young, male colony CD-1 mice were injected with the adjuvants at doses equivalent to those given to US military service personnel. All mice were subjected to a battery of motor and cognitive-behavioral tests over 6-mo period post injections. **Following sacrifice, central nervous system tissues were examined using immunohistochemistry for evidence of inflammation and cell death. Behavioral testing showed motor deficits in the aluminum treatment group that expressed as a progressive decrease in strength measured by the wire-mesh hang test (final deficit at 24 wk; about 50%). Significant cognitive deficits in water-maze learning were observed in the combined aluminum and squalene group (4.3 errors per trial) compared with the controls (0.2 errors per trial) after 20 wk. Apoptotic neurons were identified in aluminum-injected animals that showed significantly increased activated caspase-3 labeling in lumbar spinal cord (255%) and primary motor cortex (192%) compared with the controls. Aluminum-treated groups also showed significant motor neuron loss (35%) and increased numbers of astrocytes* (350%) in the lumbar spinal cord. The findings suggest a possible role for the aluminum adjuvant in some neurological features associated with GWI and possibly an additional role for the combination of adjuvants**.

* (The body uses astrocytes in a protective role in stress, injury or toxic conditions. The increased number of astrocytes is a protective response by the body trying to deal with inflammatory reaction or damage to the nerve cells).

Nearly 100% of service personnel whether deployed to the Middle East or not, who developed Gulf War Syndrome had high levels of antibodies nearly 10 years later

An article published in the year 2000 in the ***Journal of Experimental and Molecular Pathology*** titled, **Antibodies to squalene in Gulf War Syndrome**, found that 95-100% of the service personnel that developed Gulf War Syndrome symptoms had antibodies to squalene.
https://www.ncbi.nlm.nih.gov/pubmed/10640454

The Abstract:
"Gulf War Syndrome (GWS) is a multisystemic illness afflicting many Gulf War-era veterans. The molecular pathological basis for GWS has not been established. We sought **to determine whether the presence of antibodies to squalene correlates with the presence of signs and symptoms of GWS**. Participants in this blinded cohort study were individuals immunized for service in Desert Shield/Desert Storm during 1990-1991. They included 144 Gulf War-era veterans or military employees (58 in the blinded study), 48 blood donors, 40 systemic lupus erythematosus patients, 34 silicone breast implant recipients, and 30 chronic fatigue syndrome patients. Serum antibodies to squalene were measured. In our small cohort, the substantial majority **(95%) of overtly ill deployed GWS patients had antibodies to squalene. All (100%) GWS patients** immunized for service in Desert Shield/Desert Storm **who did not deploy, but had the same signs and symptoms as those who did deploy, had antibodies to squalene**. **In contrast, none (0%) of the deployed Persian Gulf veterans not showing signs and symptoms of GWS have antibodies to squalene. Neither patients with idiopathic autoimmune disease nor healthy controls had detectable serum antibodies to squalene. The majority of symptomatic GWS patients had serum antibodies to squalene."**

One thing that I found very interesting in this article, was that both deployed and non-deployed service personnel that had symptoms of Gulf War Syndrome, also had elevated antibodies to squalene. **The fact that service personnel who never deployed to the Middle East had high levels of squalene antibodies plus full-blown Gulf War Syndrome, tells me that the condition was not caused by anything else in the environment or on the battlefield in the theater. And it makes the squalene adjuvant that much more suspect.**

One would expect that person's injected with an adjuvant would develop some immune reaction and antibodies to that adjuvant, but **this study was done more than 9 years after those injections were given**. Adjuvants are supposed to give a short powerful reaction by the immune system so that the virus or virus components in the vaccines are recognized by the body's immune system and antibodies are produced to that virus. Then whenever the person is exposed to that virus, the immune system is supposed to mount an attack on that particular virus. Remember from the vaccine ingredients section on squalene that squalene is a compound that is naturally found in the body and in certain dietary

sources and that it has beneficial properties in the body? Having antibodies attacking all the squalene in the body for years and years can have harmful consequences.

Thimerosal and obesity

https://www.ncbi.nlm.nih.gov/pubmed/27583238 ***From the North American Journal of Medical Sciences,*** July 08, 2016 **Thimerosal-containing Hepatitis B Vaccine Exposure is Highly Associated with Childhood Obesity: A Case-control Study Using the Vaccine Safety Datalink.**

CONCLUSIONS: "In a dose-response manner, the present study associates an increased organic mercury exposure from Thimerosal-containing hepatitis B vaccines with an increased risk of obesity diagnosis and **suggests that Thimerosal is an obesogen." (causes obesity)**

Thimerosal, aluminum, immunization and Type 1 diabetes

Vaccines shown to cause "large number" of cases of type 1 diabetes

https://www.omicsonline.org/scientific-reports/2155-9899-SR-679.pdf ***Open Access Scientific Reports***, Vol. 2, Issue 3, 2013 titled **Prevalence of Autism is Positively Associated with the Incidence of Type 1 Diabetes, but Negatively Associated with the Incidence of Type 2 Diabetes, Implication for the Etiology of the Autism Epidemic**

Conclusion: …"**Vaccines have shown to cause a large number of cases of type 1 diabetes in both a prospective clinical trial as well as in animal toxicity studies.** The pathophysiology is believed to involve vaccine induced macrophage activation, especially by aluminum adjuvants and complex polysaccharides, and resulting interleukin 1, interleukin 6, and TNF production. It is the belief of the author, based in part on the data present in this manuscript **that the epidemics of type 1 diabetes and autoimmune autism are more likely than not to share the same etiological cause.**"

Family history of type 1 diabetes increases risk of diabetes in offspring with vaccination

Risk of Vaccine Induced Diabetes in Children with a Family History of Type 1 Diabetes by John Barthelow Classen, MD. Published in ***The Open Pediatric Medicine Journal***, 2008, 2, 7-10 http://www.vaccines.net/7TOPEDJ.pdf

Abstract:
"Cohort data from Denmark in all children born from January 1, 1990 to December 31, 2000 was analyzed to assess the association between immunization and type 1 diabetes in all Danish children and

in a subgroup where children had a sibling with type 1 diabetes. **Pediatric vaccines were associated with a statistically significant increased risk of type 1 diabetes in 12 of 21 endpoints in the general population.** The rate ratios in children who received at least one dose of a specific vaccine were also elevated in the subgroup and were statistically the same as in the general population. Three doses of the hemophilus vaccine were associated with a rate ratio of 1.23 (1.02<<RR<<1.48) and an absolute risk in the general population of three cases/100,000 per year compared to 1.58 (0.60<<RR<<4.15) **and an absolute risk of 2885 cases/100,000 per year in the subgroup with a sibling with type 1 diabetes. The hemophilus immunization is associated with a cumulative attributable risk of 2.3/100 (2.3%) in the subgroup."**

HIB (Hemophilus Influenza B) Vaccination increases antibodies that can trigger diabetes

Vaccinations may induce diabetes-related autoantibodies in one-year-old children. Published in the ***Annals of the New York Academy of Sciences***, 2003.
https://www.ncbi.nlm.nih.gov/pubmed/?term=14679101

Abstract:
"**Vaccinations have been discussed as one among many environmental candidates contributing to the immune process that later may lead to type 1 diabetes**. ABIS (All Babies in Southeast Sweden) is a prospective cohort study following a nonselected birth cohort of general population. In a randomly selected sample collection from 4400 children, GADA and IA-2A have been determined at the age of 1 year. The information on vaccinations was collected from questionnaires answered by the parents and was related to beta cell autoantibodies. When studying the induction of autoantibodies using the autoantibody level of 90th percentile as cutoff level, hemophilus influenza B (HIB) vaccination appeared to be a risk factor for IA-2A…*(5.9X)*….and for GADA…*(3.4X)*…. in logistic regression analyses. Furthermore, the titers of IA-2A were significantly higher ($p < 0.01$ in Mann-Whitney test) in those children who had got HIB vaccination. **We conclude that HIB vaccination may have an unspecific stimulatory polyclonal effect increasing the production of GADA and IA-2A. This might be of importance under circumstances when the beta cell-related immune response is activated by other mechanisms**."

2017 study links Thimerosal and emotional disturbances

https://www.ncbi.nlm.nih.gov/pubmed/28102704 From the ***Journal Brain Injury*** 2017. **Thimerosal exposure and disturbance of emotions specific to childhood and adolescence: A case-control study in the Vaccine Safety Datalink (VSD) database.**

CONCLUSIONS: "**The results show a significant relationship between Hg exposure from Thimerosal-containing childhood vaccines and the subsequent risk of an ED diagnosis.**"

Vaccines linked to pediatric psychiatric disorders

A 2017 article from the Journal *Frontiers in Psychiatry*, finds that vaccines may well have a relationship to pediatric psychiatric disorders

A 2017 article from the Journal ***Frontiers in Psychiatry*** titled, **Temporal Association of Certain Neuropsychiatric Disorders Following Vaccination of Children and Adolescents: A Pilot Case–Control Study**, looked at the following diagnoses and found a relationship with a greater probability of the development of certain disorders with certain vaccines. The departments involved in the research were from the Department of Public Health Sciences, Pennsylvania State University College of Medicine, Hershey, PA, USA and Yale Child Study Center, Yale University School of Medicine, New Haven, CT, USA. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5244035/

The psychiatric conditions and the specific vaccines most correlated with onset within either 3, 6 or 12 months:

- Obsessive compulsive disorder (OCD) - Influenza and Hepatitis A vaccines
- Anorexia nervosa (AN) - Influenza or Tetanus and Diphtheria vaccines
- Anxiety disorder - Influenza
- Tic disorder (TD) - Influenza or Meningococcal
- Attention Deficit Hyperactivity Disorder (ADHD) - any vaccine
- Major depression - less likely correlated
- Bipolar disorder - less likely correlated

*Keep in mind this **only followed the 6-15 year olds for 12 months, so it is possible that additional correlations may occur beyond one year.**

From the study:
"Some disorders were predominantly female (AN), and some predominantly male (ADHD and TD). Receipt of any vaccine in the previous 6 months was highest for children with AN (21.4%), followed by OCD (15.9%) and tic disorder (15.8%)."

"Children with OCD, AN, anxiety disorder, or ADHD were more likely to have had a vaccination in each of the preceding periods than their matched controls, and children with tic disorder were more likely to have had a vaccination in the preceding 6- and 12-month periods than their matched controls. Hazard Ratios (HRs), associated with receipt of any vaccine were highest for children with AN, ranging from 1.47 for the 12-month preceding period to 1.80 for the 3-month preceding period, followed by OCD, which ranged from 1.23 for both the 12-month and 3-month preceding periods to 1.27 for the 6-month preceding period." *(An HR of 1.0 would be zero correlation…An HR of 1.27 is a 27% increased incidence…An HR of 2 would be a 100% increase incidence)*

"Children with OCD were more likely to have received the influenza vaccine in each of the preceding periods, or the hepatitis A vaccine in the previous 6 or 12 months. Children with AN were also more likely to have received the influenza vaccine in the preceding 3 or 6 months, or the TD vaccine in the previous 12 months. Children with anxiety disorder were more likely to have received the influenza vaccine in the previous 12 months. Children with tic disorder were more likely to have received an influenza or a meningococcal vaccine in the previous 6 or 12 months."

"Our findings showing that children with AN, OCD, or a tic disorder were more likely to have received the influenza vaccine in the preceding periods were noteworthy given the findings of increased incidence of narcolepsy in Finland, Sweden, Ireland, Norway, England, and France after vaccination with AS03-adjuvanted H1N1 vaccine. Studies also show a threefold increase in the incidence of narcolepsy after following the 2009 H1N1 pandemic in China. Although the strong association between HLA class II and narcolepsy suggests that narcolepsy may be an autoimmune disorder, the exact mechanism leading to immune-related narcolepsy is not completely understood and other host factors are likely to play an important role."

"**It is also of note that the observed association between the antecedent administration of the influenza vaccine and the new onset of AN and OCD may suggest that aberrant immune functioning may be a common pathogenetic pathway for OCD and AN**. The high comorbidity rates between OCD and AN, common cortico-striatal abnormalities in neuroimaging studies, and anti-putamen antibodies both in OCD and AN cases are some of the shared features of these two disorders worth considering. **In addition, the increased risk for autoimmune disorders (such as type 1 diabetes mellitus, Crohn's disease, and celiac disease) in eating disorders and the documented comorbidity of OCD and autoimmune diseases (such as systemic lupus erythematosus, thyroid dysfunction, and multiple sclerosis) indicate the possible shared host factors and the role of immune-mediated mechanisms in the development of AN and OCD**. We also note the findings of Zastrow and colleagues that vaccination to prevent H1N1 influenza is recommendable even in extremely underweight AN patients." *(Obviously not a good idea).*

Clinical Significance

"These findings provide preliminary epidemiologic evidence that the onset of some pediatric-onset neuropsychiatric disorders, including AN, OCD, anxiety disorders, and tic disorders, may be temporally related to prior vaccinations. Each of these conditions is etiologically heterogeneous *(diverse in character)*, and host factors *(i.e. Genetic factors, immune competency, nutritional status, etc.),* likely play an important role in a small subset of vulnerable individuals."

Again and importantly, they only followed these 6-15 year olds for 12 months. And they only tracked influenza, tetanus and diphtheria (TD), hepatitis A, hepatitis B, meningitis, and varicella. They did not test pertussis, measles, mumps, rubella, HPV or polio vaccines, which are also all on the schedule.

Isn't it amazing that all of those psychological disorders have now been linked to various vaccines? This may explain in part the tremendous rise in pediatric emotional and psychological problems. Once again, as you will see in other places in this document the pharmaceutical industry stands ready to "treat" these manufactured conditions with a wide array of psychological and behavioral drugs. And

incredibly, Yale University and their medical system continues to recommend the whole host of vaccines to their students and medical personnel, including the ones that they found these results in.

Notice, once again we see that the term "vulnerable individuals". As you will see in various sections in the rest of this document, the consensus in the scientific community is that there is a subset of individuals that are vulnerable to adverse reactions due to numerous biological variants within their makeup. Where the problem lies, is the fact that screening tests to identify these various abnormalities have yet to be invented or are not yet available for testing in an accurate, efficient and cost-effective manner.

Rates of seizures from specific vaccines

Speaking of seizures following vaccination, the VAERS reporting System allows us to identify trends in type of vaccine given cross referenced with age to see which vaccines are the greatest seizure generators. **This link** http://www.medalerts.org/analysis/archives/468 **shows a very interesting correlation across the spectrum correlating seizures from the different vaccine by age group.**

2018 article demonstrates that children with epilepsy have higher rates of seizures after vaccinations than those with epilepsy that were not vaccinated

The article published in BMC Pediatrics titled, **Risk of seizures after immunization in children with epilepsy: a risk interval analysis**, finds a significant increase in seizures after immunization, although the risk of "medically attended" seizure was not increased (meaning needed medical intervention). https://bmcpediatr.biomedcentral.com/track/pdf/10.1186/s12887-018-1112-0

From the study:
"**Children with immunizations had more seizures than either those with no immunizations or those with no records(mean 2.5 *(vaccinated)* versus 0.7 *(non-vaccinated)* versus 0.9 *(no records)*…" *(That means that the vaccinated children had 3 ½ times the rates of seizures than the non-vaccinated children)***

Children with that were diagnosed with epilepsy at an earlier age (mean age of 2.1 years), had more post immunization events than older children.

"In contrast, a study of 17 children with severe myoclonic epilepsy of infancy whose parents completed seizure diaries after MMR immunization reported an incidence rate ratio of parent-reported seizure of 2.3… in the 5–12 days after the first MMR dose versus the control periods of 0–4 days and 13– 42 days post-immunization. Children with severe myoclonic epilepsy of infancy are particularly susceptible to fever-induced seizure, which may explain the increased risk of seizures after MMR vaccine during the period when MMR-associated febrile seizures are observed."

"In addition, in 16% to 21% of children with severe myoclonic epilepsy of infancy, their first seizure

occurred after immunization. Only 15 children central immunization registries for evaluating vaccine safety. Children with immunization events experienced more seizure events than those without immunization events or whose records were not available, which would be expected to lead to an overestimation of the risk of post-immunization seizure."

"**In addition, if parents were warned that seizures could occur after immunization, they may have been less likely to report post-immunization seizures. This could have led to an underestimation of the risk of post-immunization seizure.** The precision of the results was limited by the small sample size and there were no healthcare encounters during the risk period after a live vaccine, which precluded determination of the relative risk. Nonetheless, we demonstrated that the upper limit of the attributable risk of seizure during the 0–14 day and 0–2 day risk intervals was only 1 seizure per 25 immunizations and 1 per 75 inactivated immunizations, respectively, with two-thirds of events being mild enough to be managed by telephone."

Vaccine association with allergies and asthma

This article from the Journal ***Epidemiology*** published in 1997 and titled, **Is infant immunization a risk factor for childhood asthma or allergies?**, was one of the earlier studies to show the potential relationship between infant immunization with subsequent development of asthma and allergy. https://www.ncbi.nlm.nih.gov/pubmed/9345669

This study done in New Zealand evaluated 1,265 children up to the age of 16 who had been vaccinated as an infant with the diphtheria/pertussis/tetanus (DPT) shot. **As of age 10, of those immunized infants, 22% had gone for asthma consultations and 23% had experienced asthma episodes. Of those same vaccinated children, 30% of those had doctor consultations for other allergic illness. They compared those results to 23 non-immunized children. Of those 23 non-immunized children, none of them had experienced any asthma or allergy episodes, or had any doctor visits. Six years later, they did a follow-up and as of age 16 the results were essentially the same. To be sure that the results were not influenced by genetics or environment, factors such as ethnicity, socioeconomic status, parental allergies or asthma, parental smoking or pet ownership were taken into consideration. To put into real numbers, if the DPT shots were not the causative factor, one would expect that six of the 23 nonimmunized children would have developed asthma and seven of those 23 would have developed allergies. This is statistically significant and is a stark contrast between the two groups.**

These authors propose and present evidence that immunizations can increase the immunoglobulin E (IgE) response, which enhances histamine release, increasing the incidence of allergy and asthma.

While I don't have exact numbers to share, anecdotally in over 30 years of private practice my experience has been very similar. And, with colleagues of mine who were chiropractors and had seen much of the science indicating potential problems with vaccination, it was rare that any of their children were vaccinated and extremely rare that any of them had developed asthma, allergies, eczema or chronic otitis media (middle ear infections).

Allergies more prevalent in young adults that were vaccinated for measles as a child, than unvaccinated individuals

A 1996 study published in the British medical journal ***Lancet*** titled, **Measles and atopy in Guinea-Bissau**, tested the hypothesis that natural measles infection protected against allergic sensitivity later in life. The results did confirm that hypothesis. Guinea-Bissau is in West Africa. Atopy is defined as the tendency to develop allergic diseases such as allergic rhinitis, asthma and atopic dermatitis (eczema). Atopy is typically associated with heightened immune responses to common allergens, especially inhaled allergens and food allergens. https://www.ncbi.nlm.nih.gov/pubmed/?term=8667923

From the study:
"**17 (12.8 percent) of 133 participants who had had measles infection were atopic compared with 33 (25.6 percent) of 129 of those who had been vaccinated and not had measles** (odds ratio, adjusted for potential confounding variables…)." That is approximately a 200 percent greater incidence of atopy in the vaccinated group.

Interestingly…"Participants who had been breastfed for more than a year were less likely to have a positive skin test to housedust mite. **After adjustment for breastfeeding and other variables, measles infection was associated with a large reduction in the risk of skin-prick test positivity to housedust mite**…"

Increased rates of vaccine doses correlate with epidemic of immune overload diseases in children

An article published in the ***Journal of Molecular Genetics*** in 2014, titled, **Review of Vaccine Induced Immune Overload and the Resulting Epidemics of Type 1 Diabetes and Metabolic Syndrome, Emphasis on Explaining the Recent Accelerations in the Risk of Prediabetes and other Immune Mediated Diseases** and authored by Barthelow Classen J, MD, provides convincing evidence of the link between the rise of immune mediated childhood disease corresponding with the increased number of vaccines in the immunization schedule. https://www.omicsonline.org/open-access/vaccine-induced-immune-overload-and-the-resulting-epidemics-of-type-diabetes-and-metabolic-syndrome-1747-0862.S1-025.php?aid=24058

Abstract
"**There has been an epidemic of inflammatory diseases that has paralleled the epidemic on iatrogenic immune stimulation with vaccines. Extensive evidence links vaccine induced immune over load with the epidemic of type 1 diabetes. More recent data indicates that obesity, type 2 diabetes and other components of metabolic syndrome are highly associated with immunization and may be manifestations of the negative feedback loop of the immune system reacting to the immune overload**. The epidemic of diabetes/prediabetes appears to be accelerating at a time when the prevalence of obesity has stabilized, indicating that the negative feedback system of the immune system has been

over whelmed. The theory of vaccine induced immune overload can explain the key observations that have confounded many competing hypothesis. **The current paper reviews the evidence that vaccine induced immune overload explains the disconnect between the increase in prediabetes and nonalcoholic fatty liver at a time when the obesity epidemic is waning in children**."

"**Since 1999 the routine pediatric immunization schedule increased by 80 vaccines.** This number is derived by the fact that multivalent vaccines contain specific vaccines to each separate strain. The following have been added, pneumococcus (13 valent), meningococcus (4 valent), human papilloma virus (4 valent), hepatitis A (1 valent), rotavirus (4 additional valent), influenza (3 valent per year x 18 years=54)."

"Twenty years ago it was predicted that a massive increase in immunization would result in a massive increase in people with chronic immune related diseases like type 1 diabetes, autoimmune diseases, and asthma. A massive increase in immunization has occurred. **In the United States for example since just 1999 children are scheduled to routinely receive over 80 additional vaccines over their childhood as explained below. The increase in immunization has been followed by a huge increase in inflammation associated disorders. Diseases like autism, type 1 diabetes, asthma, food allergies, many autoimmune diseases, obesity, type 2 diabetes, NASH and metabolic syndrome have increased many fold in children**. The rate of change of several closely followed diseases appear to be accelerating while others have decelerated. This paper describes how the theory of vaccine induced immune overload can explain many observations about the changes in the epidemics."

Aluminum has toxic effects on the immune system

A 2013 study from the ***Journal of Environmental Toxicology and Pharmacology*** titled, **Impact of aluminum exposure on the immune system: a mini review**, implicates aluminum as a major toxicant affecting the immune system in many ways. https://www.ncbi.nlm.nih.gov/pubmed/?term=23274174

From the Abstract:
"Aluminum (Al) is widely used in daily life and will lead to environmental release and exposure. **The toxicity of Al had been documented, and which attracted a growing concern on human and animal health. The immune system appears to be sensitive to Al exposure**. But few studies focused on the potential immunological responses induced by Al. It is imperative to study the effects of Al on the immune function and **this review discusses the effects of Al on autoimmunity, oral tolerance, expression of the immune cells, hypersensitivity and erythrocyte immune function**. It will provide evidence to study the association between Al and immune function."

The Vaccine / Alzheimer's Connection

The possibility exists that the metals like aluminum and mercury migrating to and stored in the brain can lead to Alzheimer's Disease later in Life

In a 2011 article in the ***Journal of Molecular Neuroscience*** titled, **Unraveling the role of metal ions and low catalytic activity of cytochrome C oxidase in Alzheimer's disease**, scientists confirm the damage that metal ions can cause in the mitochondria of the brain and link this process to an increased potential for the development of Alzheimer's. https://www.ncbi.nlm.nih.gov/pubmed/?term=20725867

From the article abstract:
"Alzheimer's disease (AD) is a neurodegenerative disorder **characterized by high levels of aluminum** and certain other metal ions in the brain: The disease is **also characterized by low activity of brain cytochrome c oxidase (COX)…"** ***The Cytochrome C Oxidase enzyme is critical in the production of ATP for energy by the mitochondria and is essential for normal brain health and function.***

"The results suggest a sequence of events in vivo in which **oxygen radical damage to mitochondria and COX leads to low ATP production and excess heme establishing conditions thought to be ideal for neurodegeneration.**"

Study of brains of Alzheimer's victims finds extremely high levels of aluminum

A 2017 study published in the ***Journal of Trace Elements in Medicine and Biology*** titled, **Aluminum in Brain Tissue in Familial Disease**, looked at the diseased brains people that suffered from Alzheimer's Disease. https://www.sciencedirect.com/science/article/pii/S0946672X16303777?via%3Dihub

From the study:
"The genetic predispositions which describe a diagnosis of familial Alzheimer's disease can be considered as cornerstones of the amyloid cascade hypothesis. Essentially they place the expression and metabolism of the amyloid precursor protein as the main tenet of disease aetiology. However, we do not know the cause of Alzheimer's disease and environmental factors may yet be shown to contribute towards its onset and progression. One such environmental factor is human exposure to aluminium and aluminium has been shown to be present in brain tissue in sporadic Alzheimer's disease. **We have made the first ever measurements of aluminium in brain tissue from 12 donors** diagnosed with familial Alzheimer's disease. **The concentrations of aluminium were extremely high, for example, there were values in excess of 10μg/g tissue dry wt. in 5 of the 12 individuals. Overall, the concentrations were higher than all previous measurements of brain aluminium except cases of known aluminium-induced encephalopathy.** We have supported our quantitative analyses using a novel method of aluminium-selective fluorescence microscopy to visualise aluminium in all lobes of every brain investigated. **The unique quantitative data and the stunning images of aluminium in familial Alzheimer's disease brain tissue raise the spectre of aluminium's role in this devastating disease**."

Conclusions:
"**Aluminium is neurotoxic and the concentrations of aluminium found in these familial AD brains are unlikely to be benign and indeed are highly likely to have contributed to both the onset and the aggressive nature of any ongoing AD in these individuals. These data lend support to the recent conclusion that brain aluminium will contribute towards all forms of AD under certain conditions**."

This study did not mention vaccines, so what does this have to do with vaccines? Heavy metals like aluminum, mercury and lead accumulate it tissue. All exposures over time must be considered. Many childhood vaccines contain aluminum. Many adult vaccines contain aluminum. These are environmental neurotoxins and can have devastating consequences, especially in people that are poor excretors or who have a genetic defect in biochemical processes that assist the body in purging toxins such as these.

Current research implicates long term, low level aluminum exposure as one of the main causes of early brain aging and age-related neurological diseases

A 2014 study in the Journal ***Toxicology*** titled, **Prolonged exposure to low levels of aluminum leads to changes associated with brain aging and neurodegeneration**, correlated long term low level exposure of aluminum, which is what we are exposed to with vaccines to brain aging and neurodegeneration. Currently there are 26 vaccines marketed in the U.S. that contain aluminum. https://www.ncbi.nlm.nih.gov/pubmed/24189189

From the article:
"Epidemiological studies suggest that **aluminum may not be as innocuous as was previously thought and that aluminum may actively promote the onset and progression of Alzheimer's disease**. Epidemiological data is strengthened by experimental evidence of **aluminum exposure leading to excess inflammatory activity within the brain**. Such apparently irrelevant immune activity unprovoked by an exogenous infectious agent **characterizes the aging brain and is even more pronounced in several neurodegenerative diseases**. The causation of most of these age-related neurological disorders is not understood but since they are generally not genetic, one must assume that their development is underlain by unknown **environmental factors**. **There is an increasing and coherent body of evidence that implicates aluminum as being one such significant factor. Evidence is outlined supporting the concept of aluminum's involvement in hastening brain aging. This acceleration would then inevitably lead to increased incidence of specific age-related neurological diseases**."

Brain cells exposed to aluminum trigger inflammation and changes in genes similar to those seen in Alzheimer's. Cells even expressed gene changes programing them for early cell death.

The ***Journal of Inorganic Biochemistry*** published an article titled, **Nanomolar aluminum induces pro-inflammatory and pro-apoptotic gene expression in human brain cells in primary culture.** In that article, researchers found that when brain cells were exposed to aluminum, it triggered gene expression in 87.5 percent of aluminum-induced genes to exhibit patterns similar to those observed in Alzheimer's Disease. https://www.ncbi.nlm.nih.gov/pubmed/?term=15961160

From the article:
"Aluminum, the most abundant neurotoxic metal in our biosphere, **has been implicated in the etiology of several neurodegenerative disorders including Alzheimer's disease (AD).** To further understand

aluminum's influence on gene expression, we examined total messenger RNA levels in untransformed human neural cells exposed to 100 nanomolar aluminum sulfate using high density DNA microarrays that interrogate the expression of every human gene. Preliminary data indicate that of **the most altered gene expression levels, 17/24 (70.8%) of aluminum-affected genes, and 7/8 (87.5%) of aluminum-induced genes exhibit expression patterns similar to those observed in AD.** The seven genes found to be **significantly up-regulated by aluminum encode pro-inflammatory or pro-apoptotic *(= pro-cell death, a process of programmed cell death)* signaling elements**, including NF-kappaB subunits, interleukin-1beta precursor, cytosolic phospholipase A2, cyclooxygenase-2, beta-amyloid precursor protein and DAXX, a regulatory protein known to induce apoptosis and repress transcription. The promoters of genes up-regulated by aluminum are enriched in binding sites for the stress-inducible transcription factors HIF-1 and NF-kappaB, suggesting a role for aluminum, HIF-1 and NF-kappaB in **driving atypical, pro-inflammatory and pro-apoptotic gene expression. The effect of aluminum on specific stress-related gene expression patterns in human brain cells clearly warrant further investigation.**"

The Journal of Alzheimer's Disease confirms that damage to the mitochondria and dysfunction in the Cytochrome C Oxidase enzyme contributes to the development of Alzheimer's Disease

In a 2006 article published in the ***Journal of Alzheimer's Disease*** titled, **Dysfunction of mitochondria and oxidative stress in the pathogenesis of Alzheimer's disease: on defects in the cytochrome c oxidase complex and aldehyde detoxification**, researchers identified mechanisms within the mitochondrial energy production system that tie into the damage and dysfunction caused by metal ions in the brain as discussed in the previous article. These are just a small sample of an extensive number of scientific articles over the last fifteen years that support the concept of brain mitochondrial damage from toxins and metals as a precursor to neurodevelopmental and neurodegenerative disorders. This article also suggests that certain individuals may have a genetic predisposition to developing these mechanisms. This has been well established and **further supports the need to develop appropriate screening for infants before initiation of any vaccine protocols**.
https://www.ncbi.nlm.nih.gov/pubmed/16873963

From the abstract:
"The mitochondrion is an organelle that plays a central role in energy production. It, at the same time, generates reactive oxygen species as by-products."

"Since amyloid beta peptide has been recently shown to be present in neuronal mitochondria to decline energy production and enhance ROS production, it has become possible to link AD more closely with roles of mitochondria in the pathogenesis *(cause)*."

A recent article in Molecular Neurobiology underscores the emerging role of mitochondrial dysfunction in the development of Alzheimer's Disease

A 2016 article published in ***Molecular Neurobiology*** titled, **Mechanisms of Mitochondrial Dysfunction in Alzheimer's Disease**, confirms that mitochondrial dysfunction is a hot topic in the research into the cause of Alzheimer's Disease. https://www.ncbi.nlm.nih.gov/pubmed/26537901

From the abstract:
"Mitochondria are the primary source for energy generation in the cell, which manifests itself in the form of the adenosine triphosphate (ATP)."

"In this review, we describe mainly the bioenergetic properties of mitochondria, such as those found in the ETC that may be altered in Alzheimer's disease (AD). Increasing evidence points to several mitochondrial functions that are affected in AD. Furthermore, it is becoming apparent that mitochondria are a potential target for treatment in early-stage AD. With growing interest in the mitochondria as a target for AD, it has been hypothesized that deficit in this organelle may be at the heart of the progression of AD itself. **The role of mitochondria in AD may be significant and is emerging as a main area of AD research.**"

Special new technology measures the highest levels of aluminum ever in Alzheimer's diseased brains, strongly linking this heavy metal to the disease

A 2017 study published in the ***Journal of Trace Elements in Medicine*** and Biology titled, **Aluminium in brain tissue in familial Alzheimer's disease**, used a special aluminum-selective fluorescence microscopy to clearly visualize the levels of aluminum in all areas of the brain.
https://www.sciencedirect.com/science/article/pii/S0946672X16303777?via%3Dihub

From the Abstract:
"We have made the first ever measurements of aluminium in brain tissue from 12 donors diagnosed with familial Alzheimer's disease. **The concentrations of aluminium were extremely high**, for example, there were values in excess of 10 μg/g tissue dry wt. in 5 of the 12 individuals. Overall, the concentrations were **higher than all previous measurements of brain aluminium** except cases of known aluminium-induced encephalopathy. We have supported our quantitative analyses using a novel method of aluminium-selective fluorescence microscopy to visualise aluminium in all lobes of every brain investigated. **The unique quantitative data and the stunning images of aluminium in familial Alzheimer's disease brain tissue raise the spectre of aluminium's role in this devastating disease**."

Conclusion:
"**Aluminium is neurotoxic and the concentrations of aluminium found in these familial AD brains are unlikely to be benign and indeed are highly likely to have contributed to both the onset and the aggressive nature of any ongoing AD in these individuals. These data lend support to the recent conclusion that brain aluminium will contribute towards all forms of AD under certain conditions."**

A subset of autistic persons have mitochondrial disorders and display a different set of symptoms and disabilities than typical autistic individuals

This 2008 study published with ***PLOS ONE*** of 25 children with autism and suspected mitochondrial disorders found that people with mitochondrial disorders have additional symptom complexes that differentiate them from "typical" autistic individuals, which is often referred to as idiopathic *(of unknown cause)* autism. **Mitochondrial Disease in Autism Spectrum Disorder Patients: A Cohort Analysis** http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0003815

From the study: "Our results indicate diverse and complex developmental, neurological, and medical phenotypes of persons with mitochondrial autism, nearly all of which differ from those of patients with idiopathic ASD."

The study listed other organ system dysfunctions such as cardiac, hematological, growth retardation, fatigability as manifestations of mitochondrial disease "that are not typical co-morbidities of primary autism."

This article may provide an answer to the previous question that genes and epigenetic expression is influenced by environmental insults

An article published in 2016 in the ***Journal Autoimmunity*** titled, **Risk factors in autism: Thinking outside the brain** emphasizes environmental toxicity and immunological insults as major risk factors for Autism Spectrum Disorder (ASD). Certainly, ample research shows that vaccines can trigger these effects during critical developmental periods.

From the article: "ASD are influenced by a variety of genetic, environmental, and possibly immunological factors that act during critical periods to alter key developmental processes. This can affect multiple systems and manifests as the social and behavioral deficits that define these disorders. The interaction of environmental exposures in the context of an individual's genetic susceptibilities manifests differently in each case, leading to heterogeneous phenotypes and varied comorbid symptoms within the disorder."

Chronic diseases produce demand for many other medications- The vicious cycle

The evidence of a connection between vaccines and autoimmune disease is strong and growing, so how are the vaccine makers responding to that? They are making new vaccines against autoimmune diseases!

A 2018 study published in the journal ***Vaccine*** titled, **Recent advances in the development of vaccines for chronic inflammatory autoimmune diseases**, touts the development of vaccines to address the rising prevalence of inflammatory autoimmune diseases.
https://www.ncbi.nlm.nih.gov/pubmed/?term=29706295

This study exemplifies the mindset of big pharma. Treat symptoms > other symptoms…treat those symptoms > other symptoms…and around and around you go! If vaccines are at least in part responsible for the rising prevalence of autoimmune disease, how is creating more vaccines to treat the autoimmune diseases going to solve the problem. **Let's fix the problem with the same approach that caused the problem in the first place. Sounds like a perfect case of circular reasoning to me.**

Vaccines like other medications, create a huge demand for other medications and medical care…at a very high cost!

Isn't that just like pharma? Rather than accepting responsibility for the contribution of a product to an epidemic of autoimmune diseases, they see it as opportunity for an additional market share. The same thing occurs in other drug categories. Statins (cholesterol drugs) are a good example of that. One of the more common side effects of statins is erectile dysfunction or E.D. Of course, drug companies have a solution for that. E.D. drugs. Another is Non-steroidal anti-inflammatories like aspirin, ibuprofen (i.e. Motrin and Advil), celecoxib (i.e. Celebrex), to name just three of the most popular ones. These drugs commonly cause stomach pain, heartburn and ulcers. Well, we have a drug for that! It's called acid blocking medications. The three main types are antacids (i.e. Tums, Pepto Bismol, Mylanta, Rolaids), H2 blockers or antagonists (i.e. Zantac, Tagamet HB and Pepcid AC) and proton pump inhibitors (PPIs) like Prevacid, Nexium, Prilosec and Protonix). The list of choices is truly dizzying! These "acid blocking" drugs then interfere with proper digestion, leading to lower bowel (colon) problems dysbiosis, lowered immune competency, overgrowth of pathogenic micro-organisms, inflammatory bowel, poor digestion and assimilation and sluggish elimination (constipation). Oh, but we have a med for that! The downward spiral just keeps spiraling deeper and deeper. NSAIDS can also cause headaches, (got some meds for that), high blood pressure (got some meds for that), and more serious problems like liver and kidney damage (even have some for that). Then the high blood pressure drugs have common side effects like Cough, Diarrhea or constipation,

erectile dysfunction, anxiety, tiredness and fatigue, dizziness, headache and nausea. BUT, we have meds for all of those! Can you see a pattern here? It is a vicious cycle. All the while, Big Pharma hears a steady sound…cha ching!!!

This is a real problem. As reported in 2015, in the Huffington Post, "**Those aged 65 to 69 take an average of 15 prescriptions per year, while those from 80 to 84 take an average of 18, according to the American Association of Consultant Pharmacists**." Apparently, the practice begins early. The report says that on average, **45-year olds take 4 prescription drugs every day!** And this practice has a high price tag. The report cites the economic impact of medication related problems to cost **$177.4 BILLION** per year, **rivaling the costs of Alzheimer's, cancer, diabetes and heart disease**.
https://www.huffingtonpost.com/ann-brenoff/elderly-taking-too-many-pills_b_7079060.html

Polypharmacy is a dangerous and even deadly practice

This is called polypharmacy and it is killing thousands of Americans annually. According to FDA statistics 1.3 million people are injured annually due to medication error.
https://www.medicinenet.com/drugs_the_most_common_medication_errors/views.htm

Injuries and deaths due to medication errors is out of control

According to a 2016 article published in the ***Journal of Community Hospital Internal Medicine Perspectives,*** titled **The alarming reality of medication error: a patient case and review of Pennsylvania and National data,** there is a dangerous and costly number of medication errors annually in the U.S.
https://www.ncbi.nlm.nih.gov/pubmed/?term=27609720

From the Abstract:
"Errors occurred at multiple care levels, including prescribing, initial pharmacy dispensation, hospitalization, and subsequent outpatient follow-up. This exemplifies the *Swiss Cheese Model* of how errors can occur within a system. **Adverse drug events (ADEs) account for more than 3.5 million physician office visits and 1 million emergency department visits each year. It is believed that preventable medication errors impact more than 7 million patients and cost almost $21 billion annually across all care settings**. About 30% of hospitalized patients have at least one discrepancy on discharge medication reconciliation. **Medication errors and ADEs are an underreported burden that adversely affects patients, providers, and the economy**."

What can be done if anything, to prevent damage from heavy metals like aluminum and mercury?

DHA can help prevent aluminum induced neurological damage

The Annals of Neurosciences Journal January 2014, published an article titled **Docosahexaenoic acid ameliorates aluminum induced biochemical and morphological alteration in rat cerebellum**. https://www.ncbi.nlm.nih.gov/pubmed/?term=25206046

The article states:
"It is suggestive that loss of brain and cerebellum indicates that Aluminum induces **neurotoxicity** and it may be due to loss of lipid, protein and other biomolecules. **Several neurological manifestations have already been attributed to Aluminum administration in humans, including memory loss, tremors, jerky movements, loss of curiosity, ataxia, myoclonic jerk and convulsion**".

Interestingly, DHA, which is a component of fish oil prevented a good percentage of the damage caused by the aluminum.

In addition to the preventative effects of DHA, there are various way to "chelate" these metals from the tissues and excrete them from the body. **Two such ways are oral and intravenous chelation**. Seek a medical practitioner specializing in this therapy to determine if you are a candidate. I have had very good success in helping patients through an oral chelation process for heavy metal toxicity in my career.

Beneficial approaches include:

- Intravenous chelation

-Oral chelation and detoxification

- Chlorophyll supplements, including algae products which are high in chlorophyll
- Increasing glutathione production in the body. Glutathione is considered the "Master Antioxidant" and especially effective in countering oxygen free radicals produced in response to heavy metal exposure. Oral glutathione supplementation is considered only mildly effective as the glutathione can be degraded in the G.I. tract, thus results are poor. Supplementing with pure undenatured whey protein, N-Acetyl Cysteine (NAC), Vitamin C and magnesium has been shown to be effective in providing the "building blocks" for the body to produce glutathione. Liposomal delivery is another method that some believe to be better absorbed and assimilated than orally. Another method, although more inconvenient, invasive and requiring more expense, is intravenous administration.
- Various nutritional formulas containing zinc, andrographis, turmeric (Curcumin), hops, Lipoic acid, multi-mineral complex, selenium, folic acid, B-Complex, and vitamin E. Flavonoids such as catechins and epigallocatechin gallate found in green tea have also been shown to offer neuroprotection.

-Far infrared saunas – Saunas have been used for decades in many cultures as a way to sweat out toxins. The far infrared saunas have heaters that emit an infrared energy which stimulates release of cellular toxins, which allows for a very effective result without the need for very high heat or longer sessions.

BIAS, CONFLICTS OF INTEREST AND SCIENTIFIC DECEPTION

Before I launch into this, I would like to make a couple very important points. Throughout this document and particularly during this section, I will be identifying certain people as we discuss bias, ethics and integrity. I'm not saying that they are bad people with malicious intent. I'm not saying that in their own heart of hearts, they don't think they're doing the right thing for children and humanity. There are many good people that believe something based on their education or their life or work experiences, but in the end their beliefs either don't hold up to scrutiny, or new information comes to light that proves their beliefs wrong. Is it possible that they don't know that all of the science I'm presenting in this document exists? I believe there's a possibility, but not much probability. A true scientist or researcher has an inquisitive mind. They should always be looking at alternative concepts and testing them against what they currently know. Another consideration is financial interests or gain. When a person has a financial interest in something, often times opposing viewpoints or opinions become clouded. Then there is the aspect of when you adamantly proclaim or deny something for so long that you own it, it's very difficult to consider that what you have held as gospel could possibly be wrong, especially when you have put your beliefs in writing for the world to see. Pride even factors in here. At any rate, keep all of that in mind as we move ahead.

Conflicts of interest and unethical deception in the vaccine industry

This first example is like a shell game. One thing is cited and implied to relate to another, yet it's completely different, like comparing apples to oranges

Oral absorption rates of aluminum are compared to vaccines (which are injected)

http://europepmc.org/abstract/med/8261684 This article verifies that oral absorption of aluminum is low. It is titled, **Gastrointestinal absorption of aluminum in rats using 26Al and accelerator mass spectrometry**, and was published in the Journal ***Clinical Nephrology.***

From the article:
"**Our data shows that under physiological conditions, namely at normal levels of dietary intake, intestinal aluminum absorption is approximately 0.04%**."

This is yet another example of exposing how deceptive some researchers can be, when they compare studies of aluminum exposure orally and claim that aluminum doesn't accumulate in the brain and tissues at certain levels of exposure. **Vaccines are injected directly into the body and are absorbed at 100%. That is approximately 250 times greater absorption that orally. It's a real case of smoke and mirrors in an effort to hide the facts.**

Now keep that in mind as you read this….

Conflicts of interest and weak arguments

Let's look at a study published by the FDA that stated that the amount of aluminum children receive from vaccines is not of concern. The 2011 study was published in the Journal ***Vaccine*** and titled, **Updated aluminum pharmacokinetics following infant exposures through diet and vaccination.** https://www.ncbi.nlm.nih.gov/pubmed/?term=22001122 This study is often held up as one of those few cherry-picked studies regularly marched out there that "prove" vaccines are safe.

Let's dissect this study to check for conflicts of interest and flaws as we have just described.

Author Information published with the study:
The lead author is Robert J. Mitkus. Office of Biostatistics and Epidemiology, USFDA Center for Biologics Evaluation and Research, 1401 Rockville Pike, HFM-210, Rockville, MD 20852, United States. Robert.Mitkus@fda.hhs.gov

Three of Dr. Mitkus' articles he has authored between 2011 and 2014, have minimized the effects of mercury, aluminum and formaldehyde in children from vaccines. In looking at Dr. Mitkus work history, it is interesting to note that **since 2014 he has been working for BASF, the World's largest chemical manufacturer.** BASF had $78.7 billion in sales I the U.S. in 2014. To put things into perspective, Dow Chemical only had $58.2 billion in sales. **Interestingly, BASF produces aluminum, mercury and formaldehyde, the same ingredients found in many vaccines.**

So, think about the conflict of interest. In addition to his position at the FDA, Dr. Mitkus also works for BASF. Dr. Mitkus was an attendee at the ***Society of Toxicology's (S.O.T.) Annual Meeting*** in San Antonio TX., March 11-15, 2018 and listed his employer as BASF. To confirm, see page 257 of the attendees list at the link below. The Society's disclaimer at the bottom of each page states the following: **"The attendee information provided in this PDF is supplied directly to S.O.T. by the attendee. The content has not been edited by The Society." So, Dr. Mitkus listing his connection to BASF was on his own accord.**
https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=9&ved=2ahUKEwjG6eGowqfeAhUEE3wKHU3oCKoQFjAIegQIAxAC&url=http%3A%2F%2Ftoxicology.org%2Fapplication%2FSOTAttendeeListExport%2F&usg=AOvVaw1YqmDipvd7mbeeGBMI7A9r

An additional review of the ***2017 S.O.T. Annual Meeting*** Attendees list (page 285), also has Dr. Mitkus listing BASF as his employer.

Several study flaws exposed

1. Despite all of that, since they relied on a paper called **The Toxicological Profile for Aluminum** as their factual source, I thought that it would be interesting to see what else that document has to say. It is published by the ***U.S. Department of Health and Human Services***; ***Agency for Toxic Substances and Disease Registry.*** **As you read this, remember that It is one of the references the authors of this article hold out to be an authoritative source for their information**. https://www.atsdr.cdc.gov/toxprofiles/tp22.pdf

   Here are some excerpts from that H.H.S. document that don't bode too well for the conclusions of this FDA backed study:

   a. "There are **critical periods** of structural and functional development during both **prenatal and postnatal life, and a particular structure or function will be most sensitive to disruption during its critical period(s). Damage may not be evident until a later stage of development**. **There are often differences in pharmacokinetics and metabolism between children and adults**. For example, absorption may be different in neonates because of the immaturity of their gastrointestinal tract and their larger skin surface area in proportion to body weight."

   b. "The infant also has an **immature blood-brain barrier** and probably an immature blood-testis barrier."

   c. "**Children are not small adults**. They differ from adults in their exposures and may differ in their susceptibility to hazardous chemicals. **Children's unique physiology and behavior can influence the extent of their exposure**."

   d. "**Children and adults may differ in their capacity to repair damage from chemical insults.** Children also have a longer remaining lifetime in which to express damage from chemicals; this potential is particularly relevant to cancer."

   e. "**Another subpopulation of children that may be particularly sensitive to the toxicity of aluminum is preterm infants**. The observed elevated plasma aluminum levels may be due to the higher aluminum content of premature infant formula and/or limited renal capacity of preterm infants to excrete aluminum."

   f. "**Fetal exposure may result in a higher distribution of aluminum to the brain, as compared to adults**. In the **fetuses of rats** receiving a single subcutaneous injection of aluminum on gestation day 5, **the amount of the radiolabeled aluminum in the brain was 30% higher than in the liver; in the dams, brain aluminum levels were only 1% of the levels found in the liver**."

   g. "**Aluminum is distributed transplacentally *(across the placenta to the fetus)*,** and elevated levels of aluminum have been measured in the fetus and placenta following

oral, dermal, or parenteral exposure to aluminum. There is also evidence that oral or parenteral exposure to aluminum can result in elevated levels in breast milk."

h. "The most sensitive known effect following oral exposure to aluminum is **neurotoxicity**."

i. In a pamphlet put out by the same ***Agency for Toxic Substances and disease Registry*** (the publisher for their reference), called ***The ToxGuide for Aluminum***, **the health effects of aluminum exposure are as follows: "The most sensitive target of aluminum toxicity is the nervous system. Impaired performance on neurobehavioral tests of motor function, sensory function, and cognitive function have been observed in animals. Neurobehavioral alterations have been observed following exposure of adult or weanling animals and in animals exposed during gestation and/or lactation."** https://www.atsdr.cdc.gov/toxguides/toxguide-22.pdf

2. When they reference the "**body burdens**" and **Minimal Risk Levels (MRLs), they used a single animal study which cited information about the amount of aluminum mice could tolerate, which had been disproven both before and after this study by studies showing much lower levels of tolerance**.

3. **They are comparing a study that used ONE ADULT and tried to extrapolate that to an infant**. Their methodology just doesn't make sense. **Infants, young children and especially preemies have much slower clearance of toxins including aluminum, because their kidneys are not yet functioning nearly as efficiently as with an adult**. **Therefore, the aluminum stays in their body much longer allowing it to be absorbed into organs, glands and tissues.**

4. **They attempt to compare oral loads of aluminum in food and felt it appropriate to compare it to the amount of aluminum injected into the bodies of infants and young children.** That just doesn't fly for many reasons. As we have mentioned previously, **studies confirm that only 0.04% to 1.5% of orally ingested aluminum is absorbed into the blood stream. When a needle is put into a child's body and the aluminum is injected directly, it is 100% absorbed into their body**.

5. Not only that, but if you recall the two articles I presented earlier that were published in 1996, in the ***Journal Pediatrics*** and in 1997, in the ***New England Journal of Medicine*** which discussed intravenous feeding solutions and that **children receiving less that the amounts from vaccines had delayed mental test scores**. **And as mentioned previously, according to the CDC's schedule as of 2009 and the product inserts from those vaccines, the average child was receiving nearly 5,000 mcg (or 5 mg) of aluminum by 18 months of age. Yet, the FDA says that anything over 850 mcg (.85 mg), of aluminum can be dangerous. Yes, that's the same FDA that published this study! Do the math yourself. The average child receives approximately 600% more aluminum from vaccines by 18 months alone than the FDA deems safe. Isn't it strange that the FDA publishes data showing the extreme dangers of intravenous aluminum in infants caused by**

1/6th of the aluminum found in vaccines by 18 months of age? How about the FDA's poor short-term memory? Fourteen years later in this study, they "endorse" completely contradictory findings when this study is associated with a vaccine rather than I.V. feeding solutions.

An article published on www.InfoWars.com January 10, 2018 and written by ***J.B. Handley*** covers the flaws and incorrect conclusions of this study very well. The article is titled, **Lone FDA Scientist Could End Autism Epidemic.**

The beginning of the article states the following: "Dr. Robert J. Mitkus — author of the misleading aluminum safety study from 2011 — could change the autism debate forever by telling the truth." https://www.infowars.com/lone-fda-scientist-could-end-autism-epidemic/

The article highlights a study released online on December 27th, 2017 and published in the ***Journal of Inorganic Chemistry*** titled, **Critical analysis of reference studies on the toxicokinetics of aluminum-based adjuvants. This study is highly critical of the Mitkus study and two others for their study flaws.** https://www.sciencedirect.com/science/article/pii/S0162013417303380

From the study:
"Mitkus et al. (Vaccine, 2011) **only considered solubilized Al, with erroneous calculations of absorption duration. Systemic Al particle diffusion and neuro-inflammatory potential were omitted. The MRL they used was both inappropriate (oral Al vs. injected adjuvant) and still too high (1 mg/kg/d) regarding recent animal studies. Both paucity and serious weaknesses of reference studies strongly suggest that novel experimental studies of Al adjuvants toxicokinetics should be performed on the long-term, including both neonatal and adult exposures, to ensure their safety and restore population confidence in Al-containing vaccines**."

The article includes videos of interviews of two of the study's authors, Dr. Chris Exley and Dr. Romain Gherardi. **Dr. Exley explains about a study he was involved with in which high levels of aluminum were found in the brains of deceased autistic children. He said that it was far higher than non-autistic individuals and similar to brains of Alzheimer's victims**. Where do you think the aluminum came from? Vaccines are the only plausible explanation. It is the only environmental exposure that all of the autistic children had in common.

More from the InfoWars article:
"Dr. Mitkus' published study, "**Updated aluminum pharmacokinetics following infant exposures through diet and vaccination**" **from 2011 is the Gold standard and the primary document the FDA relies upon to declare injected aluminum safe for use in infants. It is, quite literally, the SOLE defense the FDA and CDC cite for any concerns raised about injected aluminum**.
https://www.ncbi.nlm.nih.gov/pubmed/22001122

In fact, Dr. Mitkus' study was in part a response to safety concerns about aluminum, as he writes in the Abstract of his study:"

"Because concerns have been expressed by the public that aluminum in vaccines may pose a risk to infants, we developed an up-to-date analysis of the safety of aluminum adjuvants."

"As you can guess, Dr. Mitkus' paper gave aluminum the "all clear" sign."

"…for infants, our study demonstrates that there is little risk for aluminum toxicity following immunizations administered according to ACIP recommendations even with maximal exposures to aluminum adjuvant. For the general population of infants, who receive less than the maximal dose, the risk is even lower."

"To the layperson, this study would probably be reassuring. To scientists who are closely studying the issue of injected aluminum adjuvant, and particularly to scientists who are doing their own biological studies of aluminum adjuvant, Dr. Mitkus' study is somewhere between a professional disgrace and a fraudulent disaster, but I'll let them explain."

It then goes on to describe what scientists from all over the world are saying about aluminum in vaccines and how they have confirmed the mechanism for the way it is transported and deposited into the brain. These scientists completely debunk the junk science presented in the article.

Further evidence of ignorance as to the high degree of susceptibility of the immature brain and nervous system to toxic aluminum

A footnote to the **ToxGuide for Aluminum** published by the ***Agency for Toxic Substances and Disease Registry*** which I mentioned above, in the section titled Children's Health states the following:

- Children who are exposed to high levels of aluminum exhibit symptoms similar to those seen in adults, including neurological effects and skeletal effects.
- We do not know if children are more susceptible than adults to aluminum toxicity.

What? They need to do their homework. In a few pages, you will learn about the immature Blood Brain Barrier (BBB), and the vulnerability that presents for fetuses, infants and young children. This anatomical immaturity of the brain's blood vessels has been known since the 1880's and become more understood in the early 1900's. It has been taught to every medical doctor as referenced in *Guyton's Physiology*, THE physiology textbook used in virtually every medical school. This has been no secret!

Vaccine research uses aluminum as the "placebo" in research to skew the results in their favor- What? Really?

In an article published in the ***Journal of Immunologic Research***, 2017 titled, **Behavioral abnormalities in female mice following administration of aluminum adjuvants and the human papillomavirus (HPV) vaccine Gardasil**, a shocking admission is made.

"Vaccine adjuvants and vaccines may induce autoimmune and inflammatory manifestations in susceptible individuals. **To date most human vaccine trials utilize aluminum (Al) adjuvants as placebos despite much evidence showing that Al in vaccine-relevant exposures can be toxic to humans and animals.**"

That statement about drug companies using aluminum adjuvants as placebos in vaccine studies, flies in the face of intellectual honesty. **A placebo is something that should be innocuous, meaning it should contain nothing that would illicit a response in the individual**. Pure saline solution for example, would make a great placebo. The reason is that using aluminum as a placebo will give erroneous results is that a much larger percentage of that group will experience an adverse response than if they used a true placebo like saline. Therefore, when they compare the vaccine group which contains aluminum with the "placebo" group which also contains aluminum, there will be very little difference in the percent who experience adverse reactions. Therefore, they can then say that the group getting the vaccine did not have a significantly higher number of adverse reaction than the placebo. In other words, if saline were used as the placebo, there would be a very significant difference between the vaccine group and the placebo group. But since that wouldn't be good for business, they just "cook the books".

A major review is underway, looking at the studies behind the use of aluminum vaccine adjuvants, finding bias and methodology flaws like using aluminum as the placebo

In 2018, the principals for the ***Cochrane Database of Systematic Reviews*** a world-renowned research review organization, published an outline describing a review of the safety and effectiveness of aluminum adjuvants in vaccines that they are going to publish. About the Cochrane Review, (according to their web description), "***The* Cochrane Database of Systematic Reviews *(CDSR)*** is the leading resource for *systematic reviews* in health care. Editorials aim to stimulate discussion and ideas around the development of evidence synthesis to promote good decision-making in clinical care and health policy."

The review will be titled, **Aluminium adjuvants used in vaccines versus placebo or no intervention**
http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD012805/epdf

From the description of the coming review:

"Why it is important to do this review
One previous attempt to assess the potential toxic effects of aluminium adjuvant with a systematic review was undertaken in 2004 by Jefferson and colleagues (Jefferson 2004). The systematic review covered existing evidence of adverse events after exposure to the aluminium-containing DTP vaccine, but it did not assess benefits (Jefferson 2004). **The authors included three randomised trials, four semi-randomised trials, and one cohort study, and they were unable to demonstrate that aluminium adjuvant was responsible for any serious or long-lasting adverse events** (Jefferson 2004). **The authors advised the ending of future research despite concluding that their finding was based on poor-quality evidence** (Jefferson 2004)."

"More than 10 years has passed since the systematic review by Jefferson and colleagues, **new adjuvants are being introduced continuously, and FDA and WHO do not require genotoxicity or cardiotoxicity studies of new aluminium adjuvants** (WHO2014a; FDA 2015). **Lately, symptoms following HPV vaccination have been suspected of being caused by the addition of aluminium adjuvant** (Tomljenovic 2011; Lee 2012; Poddighe 2014; Brinth 2015a; Gruber 2015; Martinez-Lavin 2015). **A recent animal**

study by Inbar and colleagues managed to spark further controversy by demonstrating behavioral abnormalities in mice administered the aluminium-containing HPV vaccine Gardasil (Inbar 2016a). **Compared to previous animal studies on HPV vaccines, the authors included two control groups: one where mice were administered aluminium adjuvant alone and another with placebo without adjuvant** (Inbar 2016a). **Inbar and colleagues concluded that Gardasil via both its aluminium adjuvant and HPV antigens can trigger neuro-inflammation and autoimmune reactions, leading to behavioural changes in mice** (Inbar 2016a). Upon submission to a peer-reviewed journal, the paper was accepted with revisions, and published. However, it was soon withdrawn by the editor (Inbar 2016), only to be published in a competing journal shortly thereafter (Inbar 2016a). The initial withdrawal was allegedly due to "unsound scientific results"; an assertion which was not supported by the final publisher."

"The theory that aluminium adjuvant is responsible for symptoms following HPV vaccination is impossible to refute or prove based on the current data. **Aluminium adjuvant has been administered to both experimental and control group in the vast majority of randomized clinical trials on HPV vaccines, thus masking its potentially harmful effects** (Exley 2011**). Clinical trials designed to administer vaccine adjuvants to the experimental group as well as the placebo group do, *de facto,* not compare an intervention against a true placebo, and therefore, do not adequately assess safety** (Exley 2011). **Indeed, aluminium adjuvants, new or old, should be evaluated for benefits and harms on their own merits."**

"Aluminium is the most frequently used adjuvant, introduced in vaccination programmes worldwide (Tritto 2009). While the consequences of adding aluminium to vaccines have been discussed broadly, **no systematic review has been conducted to assess the effects of aluminium adjuvants across vaccines**. The effects of aluminium adjuvants remain to be properly assessed using Cochrane methodology to determine whether they are beneficial, or causally linked to the numerous adverse events reported following immunisation."

"In animal and human studies, it has been shown to act as a powerful neurological toxicant and provoke toxic effects in foetuses and embryos if exposed during pregnancy (Reinke 2003). This is supported by recent data indicating that aluminium is able to cross the blood brain barrier by directly affecting the cerebral blood vessels (Chen 2008; Sharma 2010)."

The ***Cochrane Review*** allows feedback on their proposed study. At the end of this paper there is an excellent exchange of feedback asking whether this review will include certain very important considerations. In the interest of space considerations, I will summarize the points that were made. Should you want to read the entire comments as they are excellent, you may click on the link to the paper above and scroll down to pages 18-26.

Questions asked:

- Will this review investigate/consider the impact of the unnaturally high antibodies induced by HPV vaccination? The antibody titers following HPV vaccine administration are 80-100 times that of a natural infection. Is that safe?

- The maker of Cervarix HPV vaccine stated that one dose-maintained titers for up to 48 months, yet 3- 4 doses are recommended. It appears that the titers of HPV have not been measured after each of the four doses. Why not? What if 3 or 4 doses are not necessary?

- Do repeat doses increase the risk of a vaccine reaction?

- Admittedly, the mechanism of how these ultra-high antibody responses impact the body and the potential for adverse reactions is poorly understood. How then, were these HPV vaccines fast-tracked to production and delivered to millions of girls worldwide?

- As vaccine package inserts state, vaccines are not tested for mutagenicity and carcinogenicity

- The autoimmune risks have not been tracked

- How does cow's milk contaminated vaccines affect infants and young children that have not been exposed to cow's milk?

- The question of the "ethics" of using a true saline placebo is brought up

Other serious questions raised about the validity of the 2004 Jefferson study

In an article posted by Vinu Arumugham on ResearchGate.net titled, **Safety studies of aluminum in vaccines lack immunotoxicity analysis of this immunological adjuvant: Ignorance or deception?**, he points out some glaring flaws and omissions from the 2004 study that so many vaccine advocates love to cite.

https://www.researchgate.net/publication/325393007_Safety_studies_of_aluminum_in_vaccines_lack_immunotoxicity_analysis_of_this_immunological_adjuvant_Ignorance_or_deception

"Jefferson et al. reviewed eight studies (listed in Table 2 of Jefferson et al.) on the effect of aluminum adjuvants. Any vaccine will need about 3-4 weeks to take effect. That's how long it takes for the immune system to develop the appropriate immune response and antibodies. For this reason, vaccine effectiveness investigators wait at least one-month post vaccination to assess effectiveness."

"**Aluminum compounds are of course an immunological adjuvant in vaccines. So their immunological effect (positive or negative) can only be assessed, if the follow-up period is greater than 4 weeks. Only two out of eight studies in Jefferson et al. had a follow up period of >4 weeks. So rest of the studies they included were useless to assess immunological safety of aluminum adjuvants.** Even those two studies ignored immune disorders such as allergies, asthma, autism or autoimmunity. As previously described, all these immune disorders can be initiated by IgE mediated allergy or the Th2 response, which aluminum adjuvants are known to produce. So not only were the original studies flawed, Jefferson et al. made the mistake of including these flawed studies in their analysis."

The "excuse" that it is unethical to use a true placebo like saline is a bogus argument

Vaccine proponents argue that the reason they put aluminum in the placebo during clinical trials is that it would be unethical to deny the control group children the real vaccine. First of all, if the drug companies were willing to put their money where their mouth is, and do a true scientific study using a bonafide placebo, **there would be hundreds if not thousands of parents who would volunteer their children to take the saline shot**. **The truth is that, parents who question the safety and efficacy of vaccine have been urging that this be done for many years! Parents of non-vaccinated children would love to challenge the false narrative of big pharma.**

The reality is that the drug companies and their biased researchers know, that **using aluminum in the control group as their placebo simply masks and difference in the rates of adverse reactions**. **It's pseudo-science. It's a sham.**

The other fallacy in the clinical trials as mentioned in this document is the short length of time that children are followed after administration of their vaccines. See more on this on the previous page,page 380-381, 383-384, 557-558 and 602. Couple a true placebo and tracking the children for 10-15 years and I guarantee you will see a shocking difference in the rates of neurological, behavioral, immunological and other chronic and debilitating disorders between the vaccinated versus unvaccinated groups. A good snapshot of what you would see can be found on page 655-659.

The International Journal of Vaccines and Vaccination calls out the unethical and deceptive practice of using aluminum in the "placebo" groups

This 2017 article previously discussed titled, **Short Review of Aluminum Hydroxide Related Lesions in Preclinical Studies and their Relevance**, makes it clear that the way the vaccine makers shield their adverse reactions by using aluminum in the placebo groups need to stop.
https://pdfs.semanticscholar.org/2018/02108484552f4bf614e80fbf5d029e3576c2.pdf

"An aluminum-containing placebo is often used while evaluating safety and efficacy of vaccine clinical trials, either containing equal or greater amount of aluminum as to the test vaccine. Without exception, **these trials shown a comparable rate of adverse reactions between the placebo and the test group. According to the FDA, a placebo is "an inactive pill, liquid, or powder that has no treatment value". The established neurotoxic properties of aluminum therefore suggest that aluminum-containing formulations cannot serve as a valid placebo.**"

World Health Organization documentation questions the practice of using other vaccines or non-inert placebos, saying it may be impossible to determine the safety of the vaccine

The ***World Health Organization's*** 2013 Report titled, **Expert Consultation on the Use of Placebos in Vaccine Trials**, sheds some light on the practice of using vaccines and components of vaccines as placebos rather than inert substances like saline, which is the standard for placebos.

"In place of a placebo, a vaccine against a disease that is not the focus of the trial is given to participants who do not receive the trial vaccine. Typically the control vaccine is a licensed vaccine for which efficacy has been demonstrated and the safety profile is well characterized. The motivation for using active rather than inert "placebos" is to fulfil the ethical duty of beneficence and, sometimes, to avoid giving an injection with an inert substance. A methodological disadvantage, however, is that trials using these types of placebos provide a less perfect control. It may be difficult or impossible to assess fully the safety and reactogenicity of the trial vaccine…"

"Add-on vaccine"
"In this design, the trial vaccine or placebo product is **mixed with an existing vaccine not studied in the trial, and subjects are given either (a) the trial vaccine mixed with the existing unrelated vaccine or (b) the combination of a placebo and the existing unrelated vaccine. The use of an "add-on" vaccine is used to avoid giving an "empty" injection."**

Empty injection? Why not fill the syringe with saline to avoid giving an "empty" injection. That way researchers could distinguish between the vaccine reactions from the vaccine group and the lack of reactions from the inert placebo group. That is the way true science is supposed to be done. But then again, that would make it way too easy to identify the real gap (or would it be a chasm), between the number of adverse reactions from the vaccine group and the saline solution group?

Link to the full report:
https://apps.who.int/iris/bitstream/handle/10665/94056/9789241506250_eng.pdf;jsessionid=4F5D8267B8D420C8DE52A10B74A9EB8F?sequence=1

Conflicts of Interest in Pro-Vaccine Research- The "Six Studies"

Shooting holes in the six studies that are always held up as "proof" that Thimerosal does not cause autism

There are 6 studies that are repetitively cited as the "proof" that Thimerosal does not cause autism. If you go to this website https://www.fourteenstudies.org/studies.html you will actually see 19 such studies, including the 6 often repeated ones that have been exposed for having conflicts of interest or methodology flaws. You can see the entire studies here and read those challenges to the studies. *(A conflict of interest, is where one or more of the researchers/authors has worked for a vaccine*

manufacturer in the past or currently, or the funding for the studies comes from a pharmaceutical company, or organization with a biased slant in favor of vaccinations).

At this link https://www.fourteenstudies.org/ranked.html you will find the method they used for rating the levels of conflict within each study. At the bottom of that page you will see two links that will take you to the thimerosal studies and the MMR studies, showing the scores and reasons for those scores.

The most quoted of all of these articles is "Safety of Thimerosal-Containing Vaccines: A Two-Phased Study of Computerized Health Maintenance Organization Database" *Pediatrics*, Thomas Verstraeten, MD (November 2003).

***Conflicts of Interest**:* "Written by the Centers for Disease Control, the federal agency in charge of the vaccine program. The lead author, Thomas Verstraeten, left to take a job with Glaxo SmithKline -- a vaccine manufacturer -- after the study was written and before it was published. The U.S. Congress later cited this as an ethical violation."

Glaring flaws

It was later revealed in an article by David Kirby of the Huffington Post that the study was admittedly flawed. From the article:

"CDC Director Dr. Julie Gerberding has delivered a potentially explosive report to the powerful House Appropriations Committee, in which she admits to a startling string of errors in the design and methods used in the CDC's landmark 2003 study that found no link between mercury in vaccines and autism, ADHD, speech delay or tics."

That is just one example of the 19 articles on their site, exposing the corruption surrounding these articles "proving" a negative association of thimerosal with autism. The methods employed by the pharmaceutical industry are identical to what the tobacco industry did for many years. They have literally taken a page out of the tobacco industry's playbook. They manufacture bought and paid for studies, that are reverse-engineered to show the outcome that they want them to show. It is interesting to note that the CDC has never been willing to do a study comparing vaccinated to non-vaccinated children, even though numerous scientists and researchers have urged them to do so. I wonder why???

More evidence that the Six Studies are Flawed- Over 165 studies have found a positive association between thimerosal and autism

This article published in ***Biomed Research International*** in 2014, titled **Methodological Issues and Evidence of Malfeasance in Research Purporting to Show Thimerosal in Vaccines Is Safe.** This article exposes serious flaws and conflicts of interest in the 6 most commonly cited studies when people claim that research has "debunked" (the one word they like to use), the "theory" (the other word they like to use), about mercury and autism. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4065774/

Abstract: **"There are over 165 studies that have focused on Thimerosal, an organic-mercury (Hg) based compound, used as a preservative in many childhood vaccines, and found it to be harmful**. Of these, 16 were conducted to specifically examine the effects of Thimerosal on human infants or children with reported outcomes of death; acrodynia; poisoning; allergic reaction; malformations; auto-immune reaction; Well's syndrome; developmental delay; and neurodevelopmental disorders, including tics, speech delay, language delay, attention deficit disorder, and autism. In contrast, the United States Centers for Disease Control and Prevention states that Thimerosal is safe and there is "no relationship between Thimerosal containing vaccines and autism rates in children." This is puzzling because, **in a study conducted directly by CDC epidemiologists, a 7.6-fold increased risk of autism from exposure to Thimerosal during infancy was found.** The CDC's current stance that Thimerosal is safe and that there is no relationship between Thimerosal and autism is based on six specific published epidemiological studies coauthored and sponsored by the CDC. The purpose of this review is to examine these six publications and analyze possible reasons why their published outcomes are so different from the results of investigations by multiple independent research groups over the past 75+ years".

"**These six studies are in sharp contrast to research conducted by independent researchers over the past 75+ years that have consistently found Thimerosal to be harmful**. As mentioned in the Introduction section, many studies conducted by independent investigators have found Thimerosal to be associated with neurodevelopmental disorders. Several studies, for example, including three of the six studies covered in this review, have found Thimerosal to be a risk factor for tics [10, 17, 24, 25, 34, 35]. In addition, Thimerosal has been found to be a risk factor in speech delay, language delay, attention deficit disorder, and autism [10, 11, 15–17, 24, 25, 34]." *(links are active for easy access. Hover your cursor over the number, hold the control key down and click to follow)*

Financial ties between researchers, the vaccine industry and the American Academy of Pediatrics (AAP)

CBS News reports on financial ties with the ***American Academy of Pediatrics (AAP)*** and the vaccine industry - One notable consideration is the **Journal Pediatrics** is their flagship journal which publishes often reported studies supporting vaccines.

In a July 25, 2008 article titled, **How Independent Are Vaccine Defenders? by Sharyl Attkisson**, the financial ties binding researchers, with pharmaceutical companies, with a medical association and journal whose members financial livelihoods proportionately depend on the success of vaccination programs are the ties that bind. The real question is, how can these groups be unbiased with so much to lose? https://www.cbsnews.com/news/how-independent-are-vaccine-defenders/

The article is short, so I am providing it in its entirety:

"For years some parents and scientists have raised concerns about vaccine safety, including a possible link to autism and ADD. ***Many independent experts have sided with government officials and other***

scientists who say there's no possible connection. But how "independent" are they? CBS News investigative correspondent Sharyl Attkisson shares here's what she found.

They're some of the most trusted voices in the defense of vaccine safety: the American Academy of Pediatrics, Every Child By Two, and pediatrician Dr. Paul Offit.

But CBS News has found these three have something more in common - strong financial ties to the industry whose products they promote and defend.

The vaccine industry gives millions to the Academy of Pediatrics for conferences, grants, medical education classes and even helped build their headquarters. The totals are kept secret, but public documents reveal bits and pieces.

- A $342,000 payment from Wyeth, maker of the pneumococcal vaccine - which makes $2 billion a year in sales.
- A $433,000 contribution from Merck, the same year the academy endorsed Merck's HPV vaccine - which made $1.5 billion a year in sales.
- Another top donor: Sanofi Aventis, maker of 17 vaccines and a new five-in-one combo shot just added to the childhood vaccine schedule last month.

Every Child By Two, a group that promotes early immunization for all children, admits the group takes money from the vaccine industry, too - but wouldn't tell us how much.

A spokesman told CBS News: "There are simply no conflicts to be unearthed." But guess who's listed as the group's treasurers? Officials from Wyeth and a paid advisor to big pharmaceutical clients.

Then there's Paul Offit, perhaps the most widely quoted defender of vaccine safety.

He's gone so far as to say babies can tolerate "10,000 vaccines at once."

This is how Offit described himself in a previous interview: "I'm the chief of infectious disease at Children's Hospital of Philadelphia and a professor of pediatrics at Penn's medical school," he said.

Offit was not willing to be interviewed on this subject but like others in this CBS News investigation**, he has strong industry ties. In fact, he's a vaccine industry insider**.

Offit holds in a $1.5 million-dollar research chair at Children's Hospital, funded by Merck. He holds the patent on an anti-diarrhea vaccine he developed with Merck, Rotateq, which has prevented thousands of hospitalizations. And future royalties for the vaccine were just sold for $182 million cash. Dr. Offit's share of vaccine profits? Unknown. ***(This is the Rotavirus vaccine that it has been reported that Dr. Offit made $30 million dollars on… emphasis mine).***

There's nothing illegal about the financial relationships, but to critics, they pose a serious risk for conflicts of interest. **As one member of Congress put it, money from the pharmaceutical industry can shape the practices of those who hold themselves out to be "independent**."

The ***American Academy of Pediatrics***, Every Child By Two and Dr. Offit would not agree to interviews, but all told us they're up front about the money they receive, and it doesn't sway their opinions.

Today's immunization schedule now calls for kids to get 55 doses of vaccines by age 6. *(This article was published in 2009).*

Ideally, it makes for a healthier society. But critics worry that industry ties could impact the advice given to the public about all those vaccines."

Another study finding no association between thimerosal and autism used previously discredited studies to base their conclusions on

A 2014 study titled, **Vaccines are not associated with autism: an evidence-based meta-analysis of case-control and cohort studies** and published in the Journal ***Vaccine*** looked at 10 studies, 5 cohort and 5 case-controlled and concluded that there is insufficient evidence to link thimerosal and autism. https://www.ncbi.nlm.nih.gov/pubmed/?term=24814559

The problem is, that five of the studies used are part of the studies exposed by www.fourteenstudies.org for having significant design flaws and/or conflicts of interests by the authors. One of the other 5 studies was authored by Frank DeStefano, who as you will as reported on page 317, left the CDC to work in the pharmaceutical industry and later returned to the CDC again. This is part of the revolving door mentioned between the CDC and pharmaceutical companies. Dr. DeStefano is the current Director of the Immunization Safety Office at the CDC.

I have a problem with new studies using the same few old studies to support vaccine "science", as seems to happen a lot in the literature. If the vaccine proponents want to build credibility, they need NEW research using research scientists without financial ties to the CDC, vaccine research institutions or the pharmaceutical industry and do that research comparing vaccinated and non-vaccinated children. That has been called for, for over two decades now. Why hasn't it been done? I have my suspicions.

In the epilog of the study, one of the study's authors make this pretty amazing statement: "However, as a parent of three children I have some understanding of the fears associated with reactions and effects of vaccines. My first two children have had febrile seizures after routine vaccinations, one of them a serious event. These events did not stop me from vaccinating my third child, however, I did take some proactive measures to reduce the risk of similar adverse effects. I vaccinated my child in the morning so that we were aware if any early adverse reaction during the day and I also gave my child a dose of paracetamol 30 min before the vaccination was given to reduce any fever that might develop after the injection. As a parent I know my children better than anyone and I equate their seizures to the effects of the vaccination by increasing their body temperature. For parents who do notice a significant change in their child's cognitive function and behaviour after a vaccination I encourage you to report these events immediately to your family physician and to the 'Vaccine Adverse Event Reporting System'."

The fact that he gave his child paracetamol (acetaminophen), tells me that he must not know the connection between that drug and autism (see the section on the connection between acetaminophen and autism starting on page 282.

In this study the authors only considered studies that showed no association between vaccines and autism, even though there are plenty of published studies showing the opposite. If you only include studies that reach the same conclusion…you'll be certain to get the result you are looking for.

As Dr. Janet Kern a neuroscientist with the Institute of Chronic Illnesses, Inc. in Silver Spring Maryland correctly pointed out in her criticism of this study published on PubMed: "The following studies that showed an association between Thimerosal and the risk of autism were not included in the Taylor et al. (2014) meta-analysis even though they were published within the same time frame as the studies that were included." Then, she goes on to list four studies that found a direct association between vaccines and autism.

- Gallagher CM, Goodman MS. Hepatitis B vaccination of male neonates and autism diagnosis, NHIS 1997–2002. J Toxicol Environ Health A 2010;73(24):1665–1677.

- Geier DA, Hooker BS, Kern JK, King PG, Sykes LK, Geier MR.A two-phase study evaluating the relationship between Thimerosal-containing vaccine administration and the risk for an autism spectrum disorder in the United States. Transl Neurodegener 2013;2(1):25.

- Young HA, Geier DA, Geier MR. Thimerosal exposure in infants and neurodevelopmental disorders: an assessment of computerized medical records in the Vaccine Safety Datalink. J Neurol Sci 2008;271(1–2):110–118.

- Geier DA, Geier MR. An evaluation of the effects of Thimerosal on neurodevelopmental disorders reported following DTP and Hib vaccines in comparison to DTPH vaccine in the United States. J Toxicol Environ Health A. 2006;69(15):1481–95."

Natural News calls out two prominent vaccine researchers for conflicts of interest, integrity and ethical issues

https://www.naturalnews.com/050334_population_control_Jim_Marrs_autism_debate.html

Posted July 08, 2015 and is an excerpt from ***Investigative Journalist Jim Marr's book,*** **Population Control- How Corporate Owners are Killing us**

Dr. Thomas Verstraeten

The outside pressure the pharmaceutical industry brings to bear on anti-vaccine advocates explains why many doctors are wary of making any controversial statements about the effects of vaccines. Dr. Thomas Verstraeten is one such case. Verstraeten entered the vaccine fray when he authored a **2001 study whose initial phase seemed to indicate a potential link between thimerosal and autism**. However, **by 2003, Verstraeten said his study ultimately did not support such a link**, and he became a supporter of the vaccines. **He was accused of yielding to outside pressure to alter studies indicating a**

link between thimerosal and autism. One internal CDC document obtained after a FOIA request, showed Verstraeten sent an email that many have interpreted as referring to his difficulty in making the statistical association between thimerosal and autism disappear with the words, "It just won't go away."

In June 2005, Rolling Stone published an article written by Robert F. Kennedy Jr. entitled "**Deadly Immunity**," which claimed that the federal government and the pharmaceutical industry colluded to withhold information concerning vaccine safety. **Kennedy also accused Verstraeten of modifying his data to fit the CDC's claim that there is no link between thimerosal and autism, an accusation that Verstraeten has vehemently denied. Yet his personal career choices suggest something sinister: shortly after publishing his findings, Verstraeten left the CDC for a position with the pharmaceutical giant GlaxoSmithKline. Verstraeten's jump is just another illustration of the "revolving door" policy between government regulators and the corporate world. In 2009, for instance, CDC Director Julie Gerberding left the organization for a job as president of the $5 billion vaccine division of Merck.**

Poul Thorsen

Poul Thorsen is another pro-vaccine doctor whose legitimacy has been called into question. Thorson coauthored some of the most frequently cited CDC studies denying the link between thimerosal-containing vaccines and autism. **Much of the data cited in these studies remain unavailable to the public.** Yet despite the lack of transparency, Thorsen's research has been hailed by the corporate mass media, public health establishment, and Big Pharm as "proof" that there is no connection between vaccines and autism.

In 2014, Thorsen was indicted for fraud and stealing grant money while working for the CDC. The CDC had awarded him grant money for research in Denmark involving infant disabilities, autism, genetic disorders, and fetal alcohol syndrome. According to the U.S. Department of Health and Human Services' inspector general, **Thorsen reportedly diverted more than $1 million of the CDC grant money to his own personal bank account and submitted fraudulent invoices on CDC letterhead to medical facilities assisting in the research for reimbursement of work allegedly covered by the grants.**

Paul Thorson is still a fugitive as the Danish Government refuses to extradite him as he is a Danish citizen. He is one of the authors on a 2002 study that found no link between the MMR shot and autism. It was a study looking at all children born in Denmark between January 1991 and December 1998. http://www.nejm.org/doi/full/10.1056/NEJMoa021134

Here is another source covering this story- http://www.ageofautism.com/2012/11/wanted-by-the-feds-poul-thorsen-who-helped-pull-off-cdc-vaccine-autism-heist.html

In order to find out who is in the right in the vaccine debate, one need only follow the money. Mass inoculations bring more than **$25 billion** in revenues to the giant pharmaceutical firms and their hirelings while physicians and researchers who question mass vaccinations make nothing. In fact, many of them risk loss of income and ostracism from the conventional medical establishment. Meanwhile,

those who trumpet the benefits of vaccines and downplay their risks can profit enormously. **(end of book quote)**

The "Denmark" study Dr. Thorsen authored, which found no association between the MMR vaccine and autism is found to have serious flaws

In addition to the question of integrity and honesty of the alleged criminal activity of one of the authors of the study, the validity of this study has come into question by many researchers. Was there intentional malfeasance? Some think so. Others think that poor study design is to blame. In a paper written in 2004 titled, **MMR and Autism in Perspective: the Denmark Story** and published in the ***Journal of American Physicians and Surgeons***, the authors point out several methodological flaws as corroborated by other studies that took a critical look at the Denmark study. This study has some very telling graphics showing the rise in autism during the period in question after taking into consideration the design and methodology flaws.

From the article: "In summary, it appears that a new trend in PDD emerged in children born in Denmark in the late 1980s, a change that coincided with the introduction of MMR and which is obscured rather than explained by diagnostic change. **The data of Madsen et al., unadjusted for age, support an autism-MMR association**."

One such study mentioned in this previous study and also published in 2004 in the ***Journal of American physicians and surgeons*** titled, **An Investigation of the Association Between MMR Vaccination and Autism in Denmark**, found an association with the rise in autism and the use of thimerosal containing vaccines. http://www.jpands.org/vol9no3/goldman.pdf

The conclusion from this article: "**Trends in prevalence data in Denmark suggest a temporal association between the introduction of MMR vaccine and the rise in autism**. Because thimerosal was not used in any pediatric vaccine in Denmark since 1992 and the greatest increase in autism prevalence followed that year, it is likely that one or more of the viral components or their combination in the MMR vaccine contributed to the reported increase."

"Autism rates in the U.S. have surpassed those of Denmark. Notably, in the U.S. the MMR vaccine was administered at the age of 12 months, often with two thimerosal- containing products, the B and hepatitis B vaccines, while it was usually administered alone in Denmark at the age of 15 months. Additionally, by the age of 6 months, infants in the U.S. had been exposed to 12 vaccines and up to 187.5 micrograms of thimerosal, compared to 6 vaccines with no thimerosal in Denmark."

Let's not forget the dramatic increase in aluminum containing vaccines given to children after thimerosal was removed from the MMR vaccine. Many scientists consider aluminum to be far more neurotoxic than even mercury.

And one last study mentioned in the **MMR and Autism in Perspective: the Denmark Story** paper is **critical of the Thorsen Denmark study methodology**. "Lauritsen et al. have recently contributed to the Danish debate, **with data that confirm a striking change in the reported incidence and prevalence of autism and related PDDs in Denmark over the period 1971-2000, endorsing the fact that, among other things, children born in the latter part of the study cannot be considered representative of the autism population over the entire period, an important factor in the aforementioned process of age-adjustment**." https://www.ncbi.nlm.nih.gov/pubmed/15697060

Ethics in research should matter- One high profile Pediatric Neurologist weighs in on the questionable value of research conducted by dishonest people

Max Wiznitzer M.D. is a vaccine/autism denier and spokesperson with a history of defending vaccines as safe. Even he was quoted in the aforementioned article posted on ***ageofautism***'s web site on Dr. Thorson as saying…"*If you can't trust the researcher, you can't trust the research.*"

Merck accused of rigging results using rabbit blood to "doctor" MMR study results as revealed by two former Merck scientists

An article published on ***Global Research*** reveals how vaccine manufacturers can cook the books when research doesn't come out the way they would like. The article titled, **Merck Senior Management Tried to Pay Off its Own Vaccine Scientists to Remain Silent About Scientific Fraud**, discussed shocking revelations of Merck's deception in their MMR research - https://www.globalresearch.ca/merck-senior-management-tried-to-pay-off-its-own-vaccine-scientists-to-remain-silent-about-scientific-fraud/5430364

From the article:

Back in 2010, **two former Merck scientists, repulsed by what they saw taking place at the highest levels of the company, filed a False Claims Act in the U.S. District Court for the Eastern District of Pennsylvania. The filing accuses Merck of lying about the safety and effectiveness of MMR vaccines, tampering with study data, defrauding the U.S. government and various other high-level crimes**.

Claims by Merck that the mumps component of the MMR vaccine is "95 percent effective" are also questioned in the filing. **Stephen Krahling and Joan Wlochowski say Merck senior management falsified data specifically on the effectiveness of the mumps vaccine, intentionally spiking blood samples with animal antibodies in order to trick the public into thinking that the vaccine is effective**.

"**Merck… added animal antibodies to blood samples to achieve more favorable test results, though it knew that the human immune system would never produce such antibodies, and that the antibodies created a laboratory testing scenario that 'did not in any way correspond to, correlate with, or represent real life… virus neutralization in vaccinated people,'" explains *CourthouseNews.com***.

Other alleged transgressions include Merck swindling the U.S. government out of "hundreds of millions of dollars for a vaccine that does not provide adequate immunization," as well as promoting the spread of mumps with its fraudulent vaccine. This elaborate scam, which the duo says has been taking place since the late 1990s, has allowed Merck to monopolize the vaccine market, specifically with regard to MMR vaccines.

The only way Merck was able to gain this monopoly in the first place was by demonstrating to the FDA that the mumps vaccine is at least 95 percent effective. According to the federal agency, this is the designated threshold at which so-called "herd immunity" is activated, supposedly providing near-total protection against infection.

Initial tests failed to reach this necessary threshold, so Merck resorted to data manipulation and blood sample tampering, the false results of which were submitted to the FDA as evidence of the vaccine's efficacy. For years, this was all kept tightly under wraps, only recently emerging into the public sphere — and **yet the mainstream media has completely ignored it!**

"Krahling and Wlochowski participated on the team that conducted this supposedly enhanced test," reads the original filing. "Each of them witnessed firsthand the falsification of the test data in which Merck engaged to reach its 95 percent efficacy threshold. In fact, each was significantly pressured… to participate in this fraud."

The plaintiffs charge that Merck defrauded the U.S. for more than a decade by faking a vaccine efficacy rate of 95% even though the real rate was significantly lower.

On January 31, 2016, the court ordered that discovery, the process of gathering evidence, must be completed by March 01, 2017. The court also ordered that expert discovery needs to be completed by 31 October 2017.

Other motions must be filed by December 20, 2017. A motion for class action certification must be filed by March 01, 2018; and Merck must file its opposition to class certification by April 05, 2018. As far as I have been able to find out, this case is still winding its way through the court system.

Fraud and deception- More bad news for the MMR vaccine

In 2010, researchers came forward that had worked on the MMR vaccine for Merck and disclosed that Merck had falsified data in order to make the effectiveness of their vaccine look much better than it was. http://www.globalresearch.ca/merck-mumps-vaccines-are-a-total-fraud-company-can-only-provide-the-courts-with-efficacy-data-from-50-years-ago/5455709 This article titled, **Merck Mumps Vaccines Are a Total Fraud: Company Can Only Provide the Courts with Efficacy Data from 50 Years Ago**, describes a culture of fraud and deception:

"The two scientists, Stephen Krahling and Joan Wlochowski, filed their whistleblower lawsuit in 2010 claiming Merck, the only company licensed by the Food and Drug Administration to sell a mumps vaccine in the United States, skewed tests of the vaccine by adding animal antibodies to blood samples."

"As a result, they said, Merck was able to produce test results showing that the vaccine was 95 percent effective, even though more accurate tests would have shown a lower success rate. The plaintiffs said these false results kept competitors from trying to produce their own mumps vaccines, since they were unable to match the effectiveness Merck claimed."

"Ripped off governments"

"In 2012, Chatom Primary Care, which is based in Alabama, and two individual physicians – all buyers of the Merck mumps vaccine – filed a proposed antitrust class action based on allegations in the whistleblowers' suit. The two cases are now being coordinated before Sitarski and U.S. District Judge C. Darnell Jones, said Reuters."

"As noted by *Natural News* editor Mike Adams, the Health Ranger, in this June 2012 report, Merck knowingly falsified its mumps vaccine test data, spiked blood samples with animal antibodies, sold a vaccine "that actually *promoted* mumps and measles outbreaks, and ripped off governments and consumers who bought the vaccine thinking it was '95% effective.'"

"As further reported by *Courthouse News* at the time:

Merck also added animal antibodies to blood samples to achieve more favorable test results, though it knew that the human immune system would never produce such antibodies, and that the antibodies created a laboratory testing scenario that "did not in any way correspond to, correlate with, or represent real life… virus neutralization in vaccinated people," according to the complaint."

"Falsely represented in its labeling "

"Merck's allegedly fraudulent claims were made so that the company could corner the mumps vaccine market, Adams noted, adding that the Merck scientists – who are virologists – state the fraud has been ongoing since the 1990s."

"But there is even more complicity, as Adams pointed out:

Rather than taking action on these false claims act, the U.S. government simply ignored it, thereby protecting Merck's market monopoly instead of properly serving justice. This demonstrates the conspiracy of fraud between the U.S. government, FDA regulators and the vaccine industry."

"In its court filing,[PDF] Chatom alleged:

Merck fraudulently represented and continues to falsely represent in its labeling and elsewhere that its Mumps Vaccine has an efficacy rate of 95 percent or higher."

"In reality, Merck knows and has taken affirmative steps to conceal — by using improper testing techniques and falsifying test data — that its Mumps Vaccine is, and has been since at least 1999, far less than 95 percent effective. …"

"Merck designed a testing methodology that evaluated its vaccine against a less virulent strain of the mumps virus. After the results failed to yield Merck's desired efficacy, Merck abandoned the methodology and concealed the study's findings."

Towing the party line, despite overwhelming evidence to the contrary

Despite all the questions about impropriety, conflicts of interest and tone deafness to the meteoric rise of autistic spectrum and neurodevelopmental disorders, the party line still remains the same. This quote from Dr. Frank DeStefano, from a 2015 post he did on Web MD regarding the question that was asked; Do vaccines cause autism? His response: "The scientific evidence is clear that vaccines do not cause autism. The Institute of Medicine, IOM, issued a report in 2004 concluding that the MMR vaccine and thimerosal-containing vaccines do not cause autism. In 2012, the IOM issued an updated report concluding that the MMR vaccine does not cause autism." *This answer should not be considered medical advice...Posted: November 30, 2015* http://answers.webmd.com/answers/1194718/do-vaccines-cause-autism?guid=1&clientid=&referraltopic=undefined

Notice that he said, "The scientific evidence is clear..." CLEAR?! REALLY?!!! Since Dr. DeStefano is the acting Director of the Immunization Safety Office at the CDC, this **clearly** indicates that government officials are holding fast to their myopic position despite the overwhelming evidence to the contrary! And the 2004 report he cites? Oh yes, that was the one I just mentioned. The one he co-authored with William Thompson PhD, that is at the center of the allegations, that statistics showing that there is an association with the MMR shot and increased rates of autism. The one where the actual data was altered, and the original records destroyed.

A review of 63 Studies on the MMR vaccine finds the pre and post studies "largely inadequate"

In another 2012 study titled, **Vaccines for measles, mumps and rubella in children**, and published as part of the ***Cochrane Database Systematic Review*** looked at 5 randomized controlled trials, 27 cohort studies, 17 case control studies, 5 time-series trials, 1 case cross over trial, 2 ecological studies, 6 self-controlled case series studies involving in total about 14,700,000 children up to the age of 15. https://www.ncbi.nlm.nih.gov/pubmed/22336803

After looking at the effectiveness and rates of adverse events following MMR vaccination the author's conclusion stated: "**The design and reporting of safety outcomes in MMR vaccine studies, both pre- and post- marketing are largely inadequate."**

Doctors are essentially coached to lie when parents ask about the association between the MMR vaccine and autism

In a paper published in ***Pediatrics Perspectives*** as part of the ***American Academy of Pediatrics, Pediatric History Center*** and written by ***Jeffrey P. Baker M.D., PhD. from the Department of Pediatrics, Duke University School of Medicine*** titled, **The First Measles Vaccine,** doctor Baker chronicles the development of vaccines including the measles vaccine. Then when discussing the MMR/autism connection and how to handle those concerns when brought by parents, he makes one of the most outlandish statements I have ever heard. He writes the following: "**For parents, one of the most**

intuitively persuasive objections may simply be the fact that the United States had used the MMR vaccine widely since the early 1970s and yet experienced no corresponding rise in autism cases." Huh? What did he say? The United States has not experienced any rise in autism cases since the 1970s?!!! What planet has he been living on? Seriously! And he is associated with a reputable institution like the Duke University School of Medicine?

For the record, the rates of autism as cited earlier in this document were approximately 1 in 5,000 in the 1970s. In 2011 when Dr. Baker wrote this article, the autism prevalence rates published by the CDC were approximately 1 in 59. Two recent studies listed below, estimate autism prevalence at 1 in 40 as of 2016 and estimates are that when the statistics come out for 2019, the rate may be as high as 1 in 30!

Two independent studies published December 2018, one in the journal ***Pediatrics*** titled, **The Prevalence of Parent-Reported Autism Spectrum Disorder Among US Children** and one in ***JAMA Pediatrics*** titled, **Prevalence and Treatment Patterns of Autism Spectrum Disorder in the United States, 2016** estimate that 1 in 40 children have autism spectrum disorder (ASD). Both studies obtained data from the ***2016 National Survey of Children's Health.*** The studies looked at more than 43,000 children ages 3 to 17.

Any comments Dr. Baker?

Sources:
Journal ***Pediatrics*** article: https://pediatrics.aappublications.org/content/142/6/e20174161
JAMA Pediatrics article: https://www.ncbi.nlm.nih.gov/pubmed/30508021

Here's the most ironic thing. The article written by Dr. Baker in ***Pediatrics Perspective*** in which he says the rates of autism have not increased since the early 1970s, and the article published in the journal ***Pediatrics*** that is citing the 1 in 40 autism prevalence rates, are both official publications of the ***American Academy of Pediatrics.***

This is one way you can easily check for conflicts of interest in research

This is how you can tell who the people/institutions/companies involved in the study are and what their affiliations are. There are times however, where you need to dig a little more. Google, or your favorite search engine can help you with that.

This is a research article titled, **An Overview of the Quadrivalent Human Papillomavirus Vaccine Safety: 2006 to 2015** that concluded that the HPV vaccine "has a favorable safety profile."
https://www.ncbi.nlm.nih.gov/pubmed/26107345

I would like to show you something very interesting about this article. When you go to the link, this is what you will see at the top of the page.

Pediatr Infect Dis J. 2015 Sep;34(9):983-91. doi: 10.1097/INF.0000000000000793.

An Overview of Quadrivalent Human Papillomavirus Vaccine Safety: 2006 to 2015.

Vichnin M[1], Bonanni P, Klein NP, Garland SM, Block SL, Kjaer SK, Sings HL, Perez G, Haupt RM, Saah AJ, Lievano F, Velicer C, Drury R, Kuter BJ.

Author information

Once there, I would like you to click on the + to the left of "author information". And this is what you will see.

Author information

1 From the *Merck & Co., Inc., Kenilworth, New Jersey; †University of Florence, Florence, Italy; ‡Kaiser Permanente Vaccine Study Center, Oakland, California; §The Royal Women's' Hospital, Murdoch Childrens Research Institute, University of Melbourne, Parkville, Victoria, Australia; ¶Kentucky Pediatric Research, Inc., Bardstown, Kentucky; ‖Danish Cancer Society Research Center, Copenhagen, Denmark; **Department of Gynaecology, Rigshospitalet, Copenhagen University Hospital, Copenhagen, Denmark; ††Universidad del Rosario, Bogota, Colombia; and ‡‡Sanofi Pasteur MSD, Lyon, France.

Notice who is the first acknowledgment listed in the study. Merck, the maker of Gardasil, the HPV vaccine that was being studied!

Even more interesting look at who the lead author is (they are the first one listed under the title of the study). It is Vichnin, M. (Michelle Vichnin MD). Let's take a look at her bio and see if by chance, she might be associated with Merck. Here is a link with her bio.

http://theconferenceforum.org/conferences/patients-as-partners/2017-speakers/michelle-vichnin-md/

Here is what it says:

Michelle Vichnin, MD, Executive Director, Oncology, Office of the Chief Medical Officer Merck

Michelle Vichnin, MD, is the Executive Director for Scientific, Medical and Patient Perspective for Oncology within the Office of the Chief Patient Officer **at Merck**. In this role, she supports the needs of the Chief Patient Officer with her medical and scientific expertise. In addition, Dr Vichnin **collaborates with stakeholders** to incorporate the voice of patients into decision-making throughout the company.

Prior to this role, she was a medical director in Merck Vaccines, Adolescent Vaccines. **She was as one of the Medical Affairs Leads for the second generation nonavalent HPV Vaccine (Gardasil 9) and for the quadrivalent HPV Vaccine (Gardasil)**, and has substantial experience in cervical cancer prevention. She has interacted with top scientific leaders, recommending organizations and government officials to present data **and to discuss implementation of HPV vaccination programs**.

Dr Vichnin joined Merck as a US Medical Director for adolescent vaccines in 2007, and became a Global Medical Director in 2009. She is a graduate of the Pennsylvania State University/Jefferson Medical College accelerated six-year medical program. She performed her residency in Obstetrics and Gynecology at the New York Hospital-Cornell Medical Center, and is board-certified.

Hmmm… conflict of interest? I can't tell you what to think. You be the judge.

This often-quoted study finding no association between mercury and autism, is stacked with researchers that work for the drug companies that make the vaccines

This 2007 study published in the prestigious ***New England Journal of Medicine*** titled, **Early Thimerosal Exposure and Neuropsychological Outcomes at 7 to 10 Years**, discloses the conflicts of interest at the end of the article. Even so, the general public only hears the "results" of the study where the researchers find no association between mercury and autism. Not surprising however, when you consider that if the results were not favorable to the pharmaceutical industry, there would be some pink slips handed out and the lucrative consulting and speaking fees would dry up.
http://www.nejm.org/doi/full/10.1056/NEJMoa071434

The conflict of interest disclosure at the end of the article: "Dr. Thompson reports being a former employee of Merck; Dr. Marcy, receiving consulting fees from Merck, Sanofi Pasteur, GlaxoSmithKline, and MedImmune; Dr. Jackson, receiving grant support from Wyeth, Sanofi Pasteur, GlaxoSmithKline, and Novartis, lecture fees from Sanofi Pasteur, and consulting fees from Wyeth and Abbott and serving as a consultant to the FDA Vaccines and Related Biological Products Advisory Committee; Dr. Lieu, serving as a consultant to the CDC Advisory Committee on Immunization Practices; Dr. Black, receiving consulting fees from MedImmune, GlaxoSmithKline, Novartis, and Merck and grant support from MedImmune, GlaxoSmithKline, Aventis, Merck, and Novartis; and Dr. Davis receiving consulting fees from Merck and grant support from Merck and GlaxoSmithKline. No other potential conflict of interest relevant to this article was reported."

Even those whose research has exposed conflicts of interest in vaccine research are targeted by censoring or discrediting their findings

This article published in ***Science and Engineering Ethics*** in 2015 titled, **Systematic Assessment of Research on Autism Spectrum Disorder (ASD) and Mercury Reveals Conflicts of Interest and the Need for Transparency in Autism Research**, has since been retracted by the publisher.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5705731/

After the article abstract, I have listed the authors and their disclosed conflicts of interest statement. As you can see, many have been working in the field of scientific research into the causes of and support for those with autism and neurodevelopmental conditions. In my opinion, that should no more discredit them from publishing their findings than current and former pharmaceutical scientists and administrators claiming to be unbiased and publishing articles in scientific journals. In fact, the former have no monetary or career building incentive, whereas the latter most definitely do. When you follow the money trail, you usually find a heap of bias.

In fact, what you will find if you read the article, is that many of the studies that they found bias, methodological flaws and conflicts of interest in, are the dozen or so commonly publicly heralded ones that show "proof" that vaccines are safe and effective by the vaccine lobby. It's no wonder their study became a target to get retracted.

Article Abstract:
"Historically, entities with a vested interest in a product that critics have suggested is harmful have consistently used research to back their claims that the product is safe. Prominent examples are:

tobacco, lead, bisphenol A, and atrazine. **Research literature indicates that about 80–90% of studies *with* industry affiliation found no harm from the product, while only about 10–20% of studies *without* industry affiliation found no harm.** In parallel to other historical debates, recent studies examining a possible relationship between mercury (Hg) exposure and autism spectrum disorder (ASD) show a similar dichotomy. **Studies sponsored and supported by industry or entities *with* an apparent conflict of interest have most often shown no evidence of harm or no "consistent" evidence of harm, while studies *without* such affiliations report positive evidence of a Hg/autism association**. The potentially causal relationship between Hg exposure and ASD differs from other toxic products **since there is a broad coalition of entities for whom a conflict of interest arises. These include influential governmental public health entities, the pharmaceutical industry, and even the coal burning industry**. **This review includes a systematic literature search of original studies on the potential relationship between Hg and ASD from 1999 to August 2015, finding that of the studies *with* public health and/or industry affiliation, 86% reported no relationship between Hg and ASD. However, among studies *without* public health and/or industry affiliation, only 21% find no relationship between Hg and ASD. The discrepancy in these results suggests a bias indicative of a conflict of interest**."

Disclosed conflict of interest statement:
"Janet Kern is a board member of the Council for Nutritional and Environmental Medicine (CONEM) and Geir Bjørklund is that organization's founder and president. Mark Geier and David Geier do work under the auspices of the non-profit Institute for Chronic Illnesses, Inc. Lisa Sykes, Mark Geier and David Geier are officers of the Coalition for Mercury-free Drugs (CoMeD, Inc). Richard Deth is on the scientific advisory board of the National Autism Association. Brian Hooker is on the board of Focus for Health. James Love has been involved in amalgam litigation. Boyd Haley is involved in the development of a mercury-chelating agent. Some of the authors have a personal as well as a professional interest in autism. In addition, some authors have been involved in litigation related to vaccines and autism."

Medical journals are an extension of the marketing arm of the pharmaceutical companies

That in fact is the name of an article that appeared on Plosmedicine.org. The opening paragraph really sums it up. "**Journals have devolved into information laundering operations for the pharmaceutical industry", wrote Richard Horton, editor of the *Lancet*, in March 2004. In the same year, Marcia Angell, former editor of the *New England Journal of Medicine*, lambasted the industry for becoming "primarily a marketing machine" and co-opting "every institution that might stand in its way**."
https://journals.plos.org/plosmedicine/article/file?id=10.1371/journal.pmed.0020138&type=printable

Pretty strong words from a notable person as the editor of one of the world's top-notch medical journals! That article was written 15 years ago, and things have only gotten worse.

The article goes on to say…
"**The most conspicuous example of medical journals' dependence on the pharmaceutical industry is thesubstantial income from advertising**, but this is, I suggest, the least corrupting form of dependence. The advertisements may often be misleading and the profits worth millions, but the advertisements are

there for all to see and criticise. Doctors may not be as uninfluenced by the advertisements as they would like to believe, but in every sphere, the public is used to discounting the claims of advertisers."

"**The much bigger problem lies with the original studies, particularly the clinical trials, published by journals. Far from discounting these, readers see randomised controlled trials as one of the highest forms of evidence. A large trial published in a major journal has the journal's stamp of approval (unlike the advertising), will be distributed around the world, and may well receive global media coverage, particularly if promoted simultaneously by press releases from both the journal and the expensive public-relations firm hired by the pharmaceutical company that sponsored the trial. For a drug company, a favourable trial is worth thousands of pages of advertising, which is why a company will sometimes spend upwards of a million dollars on reprints of the trial for worldwide distribution**. The doctors receiving the reprints may not read them, but they will be impressed by the name of the journal from which they come. **The quality of the journal will bless the quality of the drug**."

"Fortunately from the point of view of the companies funding these trials—but unfortunately for the credibility of the journals who publish them—**these trials rarely produce results that are unfavourable to the companies' products. Paula Rochon and others examined in 1994 all the trials funded by manufacturers of nonsteroidal anti-inflammatory drugs for arthritis that they could find. They found 56 trials, and not one of the published trials presented results that were unfavourable to the company that sponsored the trial. Every trial showed the company's drug to be as good as or better than the comparison treatment**."

The article goes on to list some of the ways drug companies accomplish the desired outcomes from their clinical trials-

• Conduct a trial of your drug against a treatment known to be inferior.
• Trial your drugs against too low a dose of a competitor drug.
• Conduct a trial of your drug against too high a dose of a competitor drug (making your drug seem less toxic).
• Conduct trials that are too small to show differences from competitor drugs.
• Use multiple endpoints in the trial and select for publication those that give favourable results.
• Do multicentre trials and select for publication results from centres that are favourable.
• Conduct subgroup analyses and select for publication those that are favourable.
• Present results that are most likely to impress—for example, reduction in relative rather than absolute risk.

One would be naive to think that these kinds of things don't go on. That is exactly what makes ***1200 Studies*** that much more powerful and compelling. The fact that this document contains well over 1,200 studies that refute the claims we are told about vaccines, and that these researchers do not have the backing of Big Pharma or other lucrative financial incentives to make the outcome of their studies favor the "Lords" with the money and the funding that many researchers so often bow down for. Researchers conducting their studies without the influence of money, prestige or career advancement as a dangled "carrot", will always be more honest, unbiased and fair in their interpretation of the results. Always keep this article in mind when you see the highly promoted studies marched out in the media as "proof"

that vaccines do this, or that. As you have seen and will see again in this eBook, careful dissection of those studies typically reveal highly suspect flaws and biases that if removed, completely discredit the vaccine or outcomes the study claims.

Drug companies stack the deck, by financially incentivizing major scientific journals to publish their studies instead of those from independent researchers

Neil Z. Miller author of several published studies and books, said this in an interview posted on ***YouTube*** June 29th, 2018 by The Real Truth About Health, sponsored by the Hypocrites Health Institute. "There's a dirty little secret that very few people know about. That there's an unspoken agreement between the pharmaceutical companies and some of these big journals, that if a pharmaceutical company produces a study and they want that study to get published in the journal, they will buy up maybe 500,000 copies of that study at full price when that study gets published. That translates into millions of dollars to the journal editors. And you have to understand that there's a limited amount of space for these studies going into the journal every week or every month, however often the journal comes out. So, a lot of times you'll have an independent researcher that comes up with an important study and that's getting pitted up against a big pharmaceutical company that is going to buy up 500,000 copies of this journal after it gets published. …That independent research never gets published and you don't even know about that study, because it just never makes it into the journal."

Researchers discover that sudden infant deaths after vaccination from a hexavalent (6) vaccine were deleted from a periodic safety report

In a 2018 study published in the ***Indian Journal of Medical Ethics*** titled, **Infanrix hexa and sudden death: a review of the periodic safety update reports submitted to the European Medicines Agency** discusses the connection with 2 pediatric hexavalent vaccines (Infanrix hexa and Hexavac) and a cluster of sudden infant deaths post vaccination after approval in October of 2000 in Germany, France and the Netherlands. In 2005, this association was discovered and found a significant association with the Hexavac vaccine, but not the Infanrix hexa. The Hexavac vaccine was removed from the market in 2005 and the Infanrix was continued. Subsequent information showed that deaths that were acknowledged in one safety review were deleted from a subsequent review, thus giving the appearance of lower than actual death ratios for the Infanrix hexa. Was this intentional? It is not known for sure, but the millions of children that were exposed to a much higher risk of dying including the ones that did die as a result, were unnecessarily exposed none the less. With over 60,000,000 doses given (just during that time period only), that is a lot of exposed children! And keep in mind, the Infanrix hexa vaccine is still in use today. http://ijme.in/articles/infanrix-hexa-and-sudden-death-a-review-of-the-periodic-safety-update-reports-submitted-to-the-european-medicines-agency/?galley=html

From the Commentary:
"On October 23, 2000, the marketing of two hexavalent vaccines, Infanrix hexa® (GlaxoSmithKline plc-GSK) and Hexavac® (Sanofi Pasteur MSD, SNC), which combine diphtheria, tetanus, acellular pertussis,

hepatitis B, inactivated poliomyelitis and Haemophilus influenza type B, was authorised in the European Union. **Following authorisation, there were several spontaneous reports of sudden unexpected death soon after the administration of these hexavalent vaccines. In 2005, von Kries and colleagues performed a detailed analysis in which they compared the observed deaths soon after vaccination with the deaths expected by chance. They found that the standardised mortality ratio (SMR) within two days of the Hexavac vaccination was significantly increased among children vaccinated in the second year of life. This was not the case with Infanrix hexa. At the request of the marketing authorisation holder, Hexavac was withdrawn in 2005 and Infanrix hexa continued to be marketed in Europe**."

"This commentary focuses on that aspect of the PSUR which has a bearing on policy decisions. We analysed the data provided in the PSURs. It is apparent that the deaths acknowledged in the PSUR 16 were deleted from the PSUR 19**. The number of observed deaths soon after vaccination among children older than one year was significantly higher than that expected by chance once the deleted deaths were restored and included in the analysis**."

"The number of observed deaths was less than what was expected (Table 1). However, among the infants, there was a clustering of deaths immediately following vaccination, **with 42 deaths taking place in the first three days after vaccination, and only 8 in the next 3 days**. **Among those below one year of age, 54 deaths (93%) occurred in the first 10 days, and 4 (7%) in the next 10 days**. **Had the deaths been "coincidental SIDS deaths", this disparity in the number of deaths in the two time periods would not have been observed. SIDS deaths would have been spread uniformly over the 20-day period.** The fact that the rate of death decreases rapidly with the passage of time following immunisation suggests that the deaths could be related to vaccination."

"**Similarly, among children older than one year, 5 deaths (83.3%) occurred in the first 10 days and 1 death (17%) occurred in the next 10 days**. The clustering of deaths reported in the PSUR 15 was noticed in the PSUR 16 as well, and this has been commented upon previously."

GlaxoSmithKline's response is also published in the commentary.

The Infanrix hexa 6 vaccine combo is still used today. The list of ingredients in addition to the toxoids (diphtheria toxoid, tetanus toxoid, pertussis toxoid, poliovirus Type 1, 2 and 3, purified capsular polysaccharide of Hib covalently bound to tetanus toxoid (viral/bacterial components), **2-phenoxyethanol**, lactose, sodium chloride, **aluminum hydroxide AND aluminum phosphate adjuvant** (as aluminum salts), Medium 199, **residual formaldehyde**, **polysorbate 20 and 80 (Tween 20 and 80)**, M199, potassium chloride, filamentous haemagglutinin, disodium phosphate, pertactin, monopotassium phosphate, glycine, **neomycin sulphate, polymyxin B sulphate,** sodium chloride and water for injection. (Ingredients bolded by me)
Source: https://www.medbroadcast.com/drug/getdrug/infanrix-hexa

An article titled, **Vaccine Bombshell: Leaked Confidential Document Exposes 36 Infants Dead After this Vaccine**, written by Christina England and published online by ***GreenMedInfo***, reveals some disturbing

facts that have come to light about the numbers of adverse reactions including deaths, attributed to the Infanrix Hexa.

From the article:
"**A confidential GlaxoSmithKline document recently leaked to the press exposed that within a two-year period, a total of 36 infants died after receiving the 6-in-1 vaccine, Infanrix Hexa. [1] According to the website Initiative Citoyenne [2] who reported the news, the 1271 page document revealed that GlaxoSmithKline received a total of 1,742 reports of adverse reactions between October 23, 2009, and October 22, 2011, including 503 serious adverse reactions and 36 deaths. Initiative Citoyenne stated: "It's not that 14 deaths were recorded by GSK between October 2009 and end in October 2011 as we had originally calculated but 36 (14 from 2010 to 2011 and 22 from 2009 to 2010). In addition to these 36 deaths at least 37 other deaths (sudden death mainly), bringing the total to at least 73 deaths since the launch of the vaccine in 2000, and again, this concerns only the death by sudden death, no further recovery of under-reporting.**"

"**Using the figure of 36 deaths over a two-year period, this averages 1.5 deaths per month, which by anyone's standard is extremely high. Note that only 1 to 10% of adverse reactions to vaccines are actually reported. Therefore, in reality, the problem could potentially be far more serious and the actual number of fatalities much higher.**"

Given that this information has come to light, there should be an independent review of the data in the United States. Again I have to ask, is it worth giving 6 different vaccines containing all of those ingredients at once to an infant in the name of expediency? The cumulative effect on the immune and nervous system, especially in a genetically susceptible child puts them at a much higher level of risk.

You can read the entire article here:
http://www.greenmedinfo.com/blog/vaccine-bombshell-leaked-confidential-document-exposes-36-infants-dead-after-vacc

If interested, the link to the 1,271-page GSK report is embedded in the article, reference #1.

CONFLICTS OF INTEREST AT THE CDC

Also, more on the inadequacy of vaccine research in this section

I feel that including the Executive Summary from the Children's Defense Fund free eBook titled **Conflicts of Interest Undermine Children's Health** would be a great way preamble to this section. Robert F. Kennedy Jr. is the founder and Chairman of the Board of ***Children's Health Defense*** https://childrenshealthdefense.org/ , a wonderful organization that is trying to expose the corruption

endemic in the vaccine paradigm/industry and fight to save our children from the unprecedented health crises that they face as a result. I feel that the Executive Summary does an excellent job of summarizing the components and the gravity of the problems we face.

Executive Summary:

- Confidence in vaccine programs is declining worldwide. Nearly nine in ten U.S. pediatricians have encountered parents who question the Centers for Disease Control and Prevention (CDC) vaccine schedule.

- Factors contributing to the erosion of public trust include growing awareness of outsized vaccine industry profits, lack of scientific integrity and transparency, politicization of vaccine recommendations and misleading safety claims that exaggerate benefits and conceal risks.

- Conflicts of interest and unethical behavior encumber the key public and private players involved in U.S. and global vaccination programs to such an extent that public skepticism is not only understandable but justified.

- In 1986, Congress passed the National Childhood Vaccine Injury Act (NCVIA), giving pharmaceutical companies blanket immunity from liability for injuries resulting from childhood vaccines. The liability protections converted vaccines from a “neglected corner of the drugs business” into a major economic driver of the pharmaceutical industry.

- Four pharmaceutical giants—GlaxoSmithKline, Merck, Pfizer and Sanofi Pasteur—manufacture and profit from every vaccine on the U.S. childhood vaccine schedule.

- The NCVIA also created the National Vaccine Injury Compensation Program (NVICP), a burdensome administrative mechanism that allows vaccine-injured individuals to seek financial compensation. In three decades, the program has paid out $4 billion to a subset—barely a third—of petitioners, dismissing well over half of filed claims.

- NVICP claims represent the tip of a vast vaccine injury iceberg. As per the U.S. Department of Health and Human Services, fewer than 1% of vaccine adverse events ever get reported.

- Government officials have found many ways to limit the number of NVICP petitioners awarded compensation, for example, exhibiting “highly unethical and appallingly consequential official misconduct” in a 2007-2008 Omnibus Autism Proceeding for thousands of families filing claims for vaccine-induced autism.

- The Food and Drug Administration (FDA) and the CDC have played a pivotal role in the U.S. vaccine “renaissance.” Because the two regulatory agencies work hand in glove with vaccine companies to protect and grow the liability-free childhood vaccine market, neither has the

impartiality required to oversee vaccine safety. The CDC owns over 50 vaccine-related patents; the CDC also purchases half of all U.S. childhood vaccines—a 15-fold increase from three decades ago.

- Vaccine makers, the CDC and other government and private partners have fudged vaccine science for decades, attending secret meetings; hiding, destroying or fraudulently manipulating publicly funded data; and engaging in other unethical actions.

- In exchange for guaranteed advertising revenues from pharmaceutical companies, medical journals play a key role in suppressing studies that question vaccine safety, while publishing skewed write-ups that are more marketing than science.

- Most medical trade groups and physicians have been willing participants in the U.S. vaccine program due to the financial incentives that can result in thousands of dollars of kickbacks for enforcing the CDC-recommended schedule, despite acknowledgement by Congress and the Supreme Court that vaccines are "unavoidably unsafe."

- The status quo is untenable. Three urgently needed steps include repealing the NCVIA, eliminating vaccine mandates and establishing a fully transparent and independent vaccine safety commission. It is essential that conflicts of interest be addressed so that sound science—rather than deep pockets—can form the basis of vaccine policy-making.

Institutional and special interest corruption at the CDC is exposed by the British Medical Journal

Not only do they lie about their independence, they have lied in their own research, they are the accused in this instance, they cannot investigate allegations against themselves.

"Today, the goals of pharmaceutical policy and medical practice are often undermined due to institutional corruption — that is, widespread or systemic practices, usually legal, that undermine an institution's objectives or integrity."

In an article published May 2015 in the ***British Medical Journal*** (BMJ) titled, **Centers for Disease Control and Prevention: protecting the private good?**, the questions about industry and special interest funding of the CDC was investigated. Centers for Disease Control and Prevention: protecting the private good? BMJ 2015;350:h2362 (Published 15 May 2015)

The following excerpts are from the article:

"The Centers for Disease Control and Prevention (CDC), includes the following disclaimer with its recommendations: "**CDC, our planners, and our content experts wish to disclose they have no financial**

interest or other relationships with the manufacturers of commercial products... CDC does not accept commercial support." *(This is the CDC's official position, which is disputed by this article)*

"The CDC's image as **an independent watchdog** over the public health has given it enormous prestige, and its recommendations are occasionally enforced by law."

"Despite the agencies disclaimer, the CDC does receive millions of dollars in industry gifts and funding, both directly and indirectly, and several recent CDC actions and recommendations have raised questions about the science it cites, the clinical guidelines it promotes, and the money it is taking."

"Marcia Angell, former editor-in-chief of the ***New England Journal of Medicine***, told the ***BMJ***, "the CDC **has enormous credibility among physicians, in no small part because the agency is generally thought to be free of industry bias. Financial dealings with biopharmaceutical companies threaten that reputation**."

"**Industry funding of the CDC has taken many doctors, even some who worked for the CDC, by surprise**. Philip Lederer, an infectious diseases fellow at Massachusetts General Hospital and Brigham and Women's Hospital in Boston, Massachusetts, and a former CDC epidemic intelligence service officer, told the BMJ he was "saddened" to learn of industry funding."

See these 16 articles that investigate the corruption of pharmaceutical policy

Experts Shocked to Learn US Centers for Disease Control Taking Drug Company Funding
Institutional Corruption and Pharmaceutical Policy. Harvard Journal of Law, Medicine and Ethics; Vol. 41, No. 3 (2013)

The CDC has been the subject of four scathing government studies that depict the corruption, mismanagement, dysfunction and conflict of interests suborning its research, regulatory, and policy making functions. These are outlined by Robert F. Kennedy Jr. in this article:
RFK, JR manifesto on mercury and vaccines

The Office of Inspector General of the Department of Health and Human Services finds serious deficiencies in reporting conflicts of interest at the CDC

In December 2009, a report by the ***Inspector General of H.H.S. Daniel R. Levinson***, found serious inadequacy in the reporting of conflicts of interest between individuals having ties with pharmaceutical companies and also sitting on committees and working in agencies that are supposed to be unbiased in their approval and oversight of vaccines. https://oig.hhs.gov/oei/reports/oei-04-07-00260.pdf

According the report:

FINDINGS

- For almost all special Government employees, CDC did not ensure that financial disclosure forms were complete in 2007. CDC certified OGE Forms 450 with at least one omission in 2007 for 97 percent of SGEs. Most of the forms had more than one type of omission.
- CDC did not identify or resolve potential conflicts of interest for 64 percent of special Government employees in 2007. Sixty-four percent of SGEs had potential conflicts of interest in 2007 that CDC did not identify and/or resolve before it certified their OGE Forms 450. Specifically, 58 percent of SGEs had potential conflicts of interest that CDC did not identify. In addition, 32 percent of SGEs had potential conflicts of interest that CDC identified but did not resolve. Twenty-six percent of SGEs had both CDC-unidentified and unresolved potential conflicts of interest.
- CDC did not ensure that 41 percent of special Government employees received required ethics training in 2007.
- CDC did not ensure that 41 percent of SGEs had ethics training certificates on file to document that SGEs received initial or annual ethics training within required timeframes in 2007.
- Fifteen percent of special Government employees did not comply with ethics requirements during committee meetings in 2007.
- Specifically, 13 percent of SGEs participated in committee meetings in 2007 without having current, certified OGE Forms 450 on file.
- In addition, 3 percent of SGEs voted on particular matters when their waivers prohibited such participation.
- Four SGEs both participated in committee meetings without current, certified OGE Forms 450 on file and voted on particular matters when their waivers prohibited such participation.

This report describes an outrageous lack of oversight by the CDC, especially considering that the health and well-being of 78 million children in the U.S. depend on it!

CDC data manipulation on the MMR vaccine exposed

(More on this later in the section on the MMR Vaccine)

A 2017 paper by Brian S. Hooker, Ph.D., P.E., and published in the ***Journal of American Physicians and Surgeons*** titled, **CDC Data Manipulation Exposed- Four Years Later**, looks at the lack of action on the fraud perpetrated by the destruction of data and overt manipulation of the data, as alleged by one of the lead researchers on the study itself. It is important to note, that Brian Hooker is the person that William Thompson, a lead scientist and author of the study in question, chose to tell about the ordered destruction of the data and the subsequent alteration of the findings. Dr. Thompson secretly kept a copy of all of the data and later provided that information to Brian Hooker. Dr. Thompson's conscious and feelings of guilt is eventually what led to him coming forward.
https://www.jpands.org/vol22no4/hooker.pdf

While I haven't quoted the whole paper, I have chosen to include enough to paint a picture of what went on with regard to the data manipulation and cover-up.

From the paper: *(references are in the PDF above)*
"It has been more than four years since I received that first phone call from Dr. William Thompson, a scientist at the Centers for Disease Control and Prevention (CDC), who is now under whistleblower protection. During these years, I was in direct contact with Dr. Thompson. We probably had more than had 40 phone conversations and exchanged more than 10,000 pages of documents. All of the information was then shared with Rep. William J. Posey (R-8-Fla.) The phone conversations including both audio and written transcripts are available at the website: http://fearlessparent.org/why-is-thimerosal-still-in-vaccines-recording-1/."

"Dr. Thompson revealed to me the gross bias of CDC leadership in covering up for vaccines at all costs. One CDC official worked especially hard in the background to dilute Dr. Thompson's strong and statistically significant finding in his 2007 paper in the *New England Journal of Medicine***3** that thimerosal exposure via infant vaccines causes tics in boys. In addition, she supervised numerous efforts within CDC's Immunization Safety Office to cover up the relationship between vaccines and autism, among many other childhood developmental disorders."

"Two other CDC officials were central figures in hiding the relationship between the measles, mumps, and rubella (MMR) vaccine and autism in African-American boys. A CDC official ordered that all documents showing this relationship be destroyed, as was done in a September 2002 meeting, prior to the publication of the now discredited 2004 paper by DeStefano et al. in the journal *Pediatrics*. Further, a CDC official was complicit in the whole debacle involving Dr. Poul Thorsen, in which data showing that autism rates went down in Denmark after the removal of thimerosal from vaccines were omitted from the now thoroughly debunked 2003 *Pediatrics* paper by Madsen et al."

"Yet, these individuals remain in place in their comfortable leadership jobs at CDC, despite the revelation of data manipulation. This destroys confidence in the CDC's assurances of the safety of the now-bloated vaccine schedule and instead shows its leaders' dedication to protecting their institution at all costs."

"Regarding Dr. Thompson's earlier work, he asked me to start a campaign to publicize the fact that multiple CDC-sanctioned publications show that thimerosal causes tics. This issue has never been addressed by CDC. Instead, CDC's website falsely states: "There is no evidence of harm caused by the low doses of thimerosal in vaccines, except for minor reactions like redness and swelling at the injection site." Soon after the revelations of the CDC whistleblower went public in August 2014, I filed a complaint with the Department of Health and Human Services (DHHS) Office of Research Integrity (ORI) regarding the data manipulation associated with the 2004 Destefano paper. The ORI handed the complaint over to CDC to "investigate itself." Obviously, this type of self-review inspires no confidence, especially given CDC's very poor track record."

"When the CDC team responsible for the paper by Destefano et al. originally completed the analysis regarding MMR timing and autism in black male children, an odds ratio of 2.56 was obtained when comparing those children receiving the MMR vaccine before 36 months of age with those who didn't receive MMR until after 36 months of age. This result was statistically significant, with a *p*-value less

than 0.01. This result alarmed Dr. Thompson's co-authors on the paper, especially those who were in leadership positions at CDC."

"In order to dilute this association, Dr. Thompson was asked to eliminate any children in the sample who did not possess a valid State of Georgia birth certificate. This eliminated children living in the Atlanta area but not born in Georgia—about 40 percent of the sample. When this was done, the odds ratio was reduced to 1.68 but more importantly, statistical significance was obviated (i.e., $p > 0.05$). In the final paper, only the result for the "birth certificate" sampling was reported. In addition, according to Dr. Thompson, all data showing the original effect for African-Americans were destroyed in the September 2002 meeting, despite the fact that the original analysis plan for the study explicitly stated: "The only variable available to be assessed as a potential confounder using the entire sample is child's race." DeStefano et al. deviated from the original analysis plan, expressly to avoid reporting the statistically significant finding."

"It is important to note that statistically significant relationships were actually observed and reported in the final paper. Specifically, the odds ratio for boys in the study was 1.67 (95% CI 1.10–2.53), when comparing those who received the MMR before and after 36 months of age. However, the authors of the paper dismissed these findings by stating:

> "Vaccination before 36 months was more common among case children than control children, especially among children 3 to 5 years of age, likely reflecting immunization requirements for enrollment in early intervention programs."

"If the authors' assertion regarding early intervention had indeed been correct, then a significant effect would have been consistent within all gender, race, and demographic categories studied. However, this was not the case as seen in boys versus girls (odds ratio 1.06, 95% CI 0.51–2.20). Ultimately, the statistically significant result here was specific to blacks, and CDC chose to hide the relationship in order to protect the program, rather than protecting children."

"CDC's investigation into itself has dragged on for three years now with no resolution. Unofficially, I have heard that, as a result of the investigation, there may be some type of report released in late 2018. Yet, how many lives of children have been needlessly sacrificed for the good of a profit-driven vaccination program over this protracted period during which CDC has failed to resolve the issue long after having been exposed for data manipulation?"

There has been a constant drumbeat of calls for congress to look into this matter and allow William Thompson the opportunity to testify and tell his story. It is mid-July 2019 as I am writing this, approximately 18 months since this paper was written and nothing has been done by our government to investigate this information and to give William Thompson the opportunity to appear. Realizing that Washington is in gridlock and not getting much of anything done, one has to wonder if matters such as these, vital to the health, lives and future of millions of Americans will ever see the justice they deserve.

The CDC Has a vested interest in the promotion and proliferation of Vaccines! What?

The Centers for Disease Control is supposed to be a governmental agency which oversees and regulates health and safety of the American public. Would it surprise you to find out that the CDC is intimately involved with the production and sales of vaccines? **According to *Robert F Kennedy Jr.*, the CDC sells $4.6 billion of vaccines a year**. ***Ty Bollinger***, the producer of the immensely popular documentary series, **The Truth About Vaccines** (www.thetruthaboutvaccines.com), **did a patent search and found that the CDC is an assignee on more than 50 vaccine patents!** How can this be? And they are supposed to be regulating the very industry that they are in bed with? It's truly and fox guarding the hen house scenario.

Commonly, researchers and employees of pharmaceutical companies are given positions at the CDC. Dr. William Thompson (a whistleblower I will talk about in a moment), worked at Merck before taking a position at the CDC. Not only that, but top CDC officials are frequently rewarded with very lucrative positions by vaccine manufacturers when they leave the CDC. It's a revolving door that rewards loyalty with promotion between industry and the CDC. According to Ty Bollinger, ***Dr Julie Gerberding*** who was the Director of the CDC from 2001-2008, received the job of head of the vaccine division for Merck after leaving the CDC in 2009. ***Dr. Frank DeStefano*** who is the current Director of the Immunization Safety Office at the CDC, actually left the CDC, then went into the pharmaceutical industry and then came back to the CDC again. Another example of questionable methods, motives and mixed loyalties is research on the effects of Thimerosal and autism by lead author ***Dr. Thomas Verstraeten*** published in the journal ***Pediatrics*** and titled, **Safety of thimerosal-containing vaccines: a two-phased study of computerized health maintenance organization databases.** https://www.ncbi.nlm.nih.gov/pubmed/14595043 According to ***Brian Hooker***, "**But anybody who's followed the story knows the Verstraeten study actually had five different iterations, and in each time, they were watering down the associations between vaccines and autism, vaccines and speech delay, vaccines and language delay, all of these things that originally they found statistically significant associations. They then started limiting the number of children and the cohort, limiting the age of the children of the cohort, taking out specific clinics where they saw specific effects." Apparently, this process continued until the study showed no relationship. According to Brian Hooker, "Dr. Verstraeten was a CDC scientist. And interestingly he left the CDC in 2001, before the study was completed. And he spent two years at Glaxo Smith Kline, actually as co-author and collaborator on this study. Glaxo Smith Kline was making thimerosal-containing vaccines. And so, there was a distinct conflict of interest**."

So, there is this incestuous relationship between the CDC and the pharmaceutical industry. And just as with familial incest, the gene pool become corrupted. The Truth About Vaccines documentary chronicles many other examples of corruption and conflicts of interests.

To revisit something I reported on earlier in this document; even individual patent holders of vaccines have been allowed to vote on the approval and recommendation to the CDC schedule of those same vaccines from which they would benefit tremendously financially.

Paul Offit M.D. and Stanley Plotkin M.D. are patent holders on the first failed Rotavirus Vaccine. Offit sat on the Advisory Committee on Immunization Practices (ACIP), that voted whether the Rotavirus Vaccine should be approved and added to the schedule. As the patent holder for the vaccine, how he can even participate in the process, much less vote on its approval? In these proceedings, often times if conflicts are brought up, the person can state their case and still gain approval to participate in the discussions and even vote.

It is worth revisiting some quotes from an article posted February 05, 2019 on the ***Children's Health Defense*** web site titled, **The Rotavirus Vaccine: A Case Study in Government Corruption and Malfeasance** summarized the conflicts of interest nicely. https://childrenshealthdefense.org/news/the-rotavirus-vaccine-a-case-study-in-government-corruption-and-malfeasance/

"Among the Congressional investigation's findings were that three out of five members of the FDA's Vaccines and Related Biological Products Advisory Committee (VRBPAC) "who voted to approve the rotavirus vaccine in December 1997 had financial ties to pharmaceutical companies that were developing different versions of the vaccine", while four out of eight members of the CDC's Advisory Committee on Immunization Practices (ACIP) "who voted to approve guidelines for the rotavirus vaccine in June 1998 had financial ties to pharmaceutical companies that were developing different versions of the vaccine".

The Rotavirus debacle and the numerous improprieties involved in the approval process, triggered a congressional investigation and report titled, **Conflicts of Interest in Vaccine Policy Making** by the ***Committee on Government Reform, U.S. House of Representatives*** dated August 21, 2000. There were several recommendations made designed to correct the blatant lack of oversight in preventing conflict of interest and financial interest bias from members of these committees who have ties to the pharmaceutical companies that manufacture the very vaccines that they are deciding whether to approve or not. The real question is, have those safeguards been put in place and followed?

Is the CDC a case of the fox watching the hen house?

The CDC holds 56 patents on vaccines, vaccine development and vaccine processes. What does that say about its purported neutrality and duty to oversight of the vaccine industry?

In an article published on July 02, 2018 by ***NWO Report*** cites **Robert F. Kennedy Jr.** and research into the vaccine patent holding of the CDC. The shocking discovery found that the CDC is the patent holder on **56 vaccine related U.S. patents**. The article has direct links to each of the patents individually, as well as a link to the Google search and the results showing all of the patents.
https://nworeport.me/2018/07/02/robert-kennedy-jr-cdc-is-a-privately-owned-vaccine-company/

The author of the article states the following:
"I am fortunate to have, as one of my partners in advocacy, fellow autism parent **Mark Blaxill**, an Intellectual Property expert who has been employed by billion-dollar corporations to manage their

patents. Blaxill was the man who found out that HHS, through NIH, owns patents on all HPV vaccines, and receives a percentage of the profits for each dose of Gardasil and Cervarix administered anywhere in the world." (They include a link whereby Blaxill exposes this story).

How unbiased can the CDC be when they are in the vaccine business and there is a revolving door for researchers, scientists and administrators between the CDC and the vaccine industry?

This is a great lead-in to the next topic exposing shoddy vaccine research and conflicts of interests at the Department of Health and Human Services (HHS). **Remember the CDC operates under the auspices of HHS.**

An excellent fact filled open letter dated October 12, 2017 challenging HHS regarding the inadequacy of vaccine research and rampant conflicts of interest

This letter by ***Del Bigtree*** is filled with references showing the failure on the part of the pharmaceutical industry and our own government agencies to address serious inadequacy in the approval and post-release surveillance of vaccines. **Del Bigtree was an Emmy Award-winning producer on the daytime talk show The Doctors, for six years. He has a background both as a filmmaker and an investigative medical journalist.** His letter fully exposes the admission by government expert panels that the research is sorely lacking, yet nothing is being done to rectify this glaring deficiency. It challenges the Department of Health and Human Services (HHS), to clean up its act and eliminate the obvious conflicts of interest between the pharmaceutical industry and government agencies and panels that oversee the approval, the safety and the efficacy of vaccines. **The scope and extent of this excellent and fully referenced letter is too much to include in its entirety here, but it can be found at** http://icandecide.com/white-papers/ICAN-HHS-Notice.pdf

The outline of the letter and the challenges to HHS it contains, consists of the following sections:

Introduction

- **I. Background**
- II. **Deficiencies in the Pre-Licensure Safety Review of Pediatric Vaccines**
  - (1) Please explain how HHS justifies licensing any pediatric vaccine without first conducting a long-term clinical trial in which the rate of adverse reactions is compared between the subject group and a control group receiving an inert placebo?
  - (2) Please list and provide the safety data relied upon when recommending babies receive the Hepatitis B vaccine on the first day of life?
- III. **Post-Licensure Surveillance of Vaccine Adverse Events**
  - (3) Please explain why HHS failed to cooperate with Harvard to automate VAERS reporting? And detail any steps that HHS has taken since toward automating VAERS reporting?
  - (4) Please explain any specific steps taken by HHS to improve adverse reaction reporting to VAERS?
- IV. **Identifying What Injuries Are Caused by Vaccines**

(5) For each of the 38 vaccine-injury pairs reviewed in the 1994 IOM Report which the IOM found lacked studies to determine causation, please identify the studies undertaken by the HHS to determine whether each injury is caused by vaccination?

(6) For each of the 135 vaccine-injury pairs reviewed in the 2011 IOM Report which the IOM found lacked studies to determine causation, please identify the studies undertaken by the HHS to determine whether each injury is caused by vaccination?

(7) Please explain what HHS has done to assure that health care providers record the manufacturer and lot number for each vaccine they administer?

V. **Identifying Which Children are Susceptible to Vaccine Injury**

(8) Please advise when HHS intends to begin conducting research to identify which children are susceptible to serious vaccine injury? If HHS believes it has commenced this research, please detail its activities regarding same?

VI. **Removing Claim "Vaccines Do Not Cause Autism" from the CDC Website**

(9) Please confirm that HHS shall forthwith remove the claim that "Vaccines Do Not Cause Autism" from the CDC website, or alternatively, please identify the specific studies on which HHS bases its blanket claim that no vaccines cause autism?

VII. **Refusal to Conduct Vaccinated Versus Unvaccinated Study**

(10) Please advise whether HHS intends to forthwith conduct adequately powered and controlled prospective as well as retrospective studies comparing total health outcomes of fully/partially vaccinated children with completely unvaccinated children?

VIII. **Reducing Conflicts of Interest at HHS**

- HHS Licenses & Recommends Vaccines
- HHS Promotes Vaccines
- HHS Defends Vaccines

(11) Please advise if you will:

a. prohibit conflict waivers for members of HHS's vaccine committees (ACIP, VRBPAC, NVAC & ACCV)?

b. prohibit HHS vaccine committee members or HHS employees with duties involving vaccines from accepting any compensation from a vaccine maker for five years?

c. require that vaccine safety advocates comprise half of HHS's vaccine committees?

d. allocate toward vaccine safety an amount at least equal to 50% of HHS's budget for promoting/purchasing vaccines?

e. support the creation of a vaccine safety department independent of HHS?

f. support the repeal of the 1986 Act to the extent it grants immunity to pharmaceutical companies for injuries caused by their vaccine products?

IX. **Conclusion-** ***(It is essentially is a call to action. It can be read in its entirety at the link above)***

This must watch short video, explains not only the corruption and conflicts of interest around the vaccine controversy, but how the system handcuffs parents of damaged children from getting a fair hearing

https://tv.greenmedinfo.com/vaccines-cause-autism/

The disturbing and disheartening fact is that even though the facts in this video exposing the tainted system are shocking, nothing has changed in the 5 years since its production. And the pharmaceutical industry has no oversight or accountability, makes record profits, yet cannot be held accountable for the damaged children and devastated families left behind.

Mandatory reporting of study results is sadly deficient

According to prsinfo.clinicaltrials.gov, "The *Food and Drug Administration Amendments Act* of 2007 (*FDAAA*) established a requirement for certain clinical trials to be registered at trial initiation and to report summary results after trial completion in the public registry and results database called ClinicalTrials.gov. This law is intended to facilitate enrollment in clinical trials, allow for tracking of the progress of such trials and address problems with the lack of timely dissemination of research findings….. ClinicalTrials.gov was launched in February 2000 by the National Library of Medicine (NLM), a component of the National Institutes of Health (NIH). Since its launch, the policies and laws related to registration of clinical trials have evolved, with *FDAAA* being the most comprehensive US law to date…. *FDAAA* requires that a "responsible party" register and submit results for "applicable clinical trials" of drugs and devices.

After an applicable clinical trial is completed, the results must be submitted to ClinicalTrials.gov via the PRS no later than 12 months after reaching the "completion date" or within 30 days of approval, licensure or clearance of the drug or device."
https://prsinfo.clinicaltrials.gov/publications/Wong-Williams-RAPS-Regulatory-Focus-8May2012.html

A report published in the New England Journal of Medicine, cites poor reporting to ClinicalTrials.gov

The report titled, **Compliance with Results Reporting at ClinicalTrials.gov** cited the following:

"From all the trials at ClinicalTrials.gov, we identified 13,327 HLACTs *(highly likely applicable clinical trials),* that were terminated or completed from January 1, 2008, through August 31, 2012. Of these trials, 77.4% were classified as drug trials. A total of 36.9% of the trials were phase 2 studies, and 23.4% were phase 3 studies; 65.6% were funded by industry. Only 13.4% of trials reported summary results within 12 months after trial completion, whereas 38.3% reported results at any time up to September 27, 2013. Timely reporting was independently associated with factors such as FDA oversight, a later trial phase, and industry funding. A sample review suggested that 45% of industry-funded trials were not required to report results, as compared with 6% of trials funded by the National Institutes of Health (NIH) and 9% of trials that were funded by other government or academic institutions. Despite ethical and legal obligations to disclose findings promptly, most HLACTs did not report results to ClinicalTrials.gov in a timely fashion during the study period. Industry-funded trials adhered to legal

obligations more often than did trials funded by the NIH or other government or academic institutions." *Compliance with Results Reporting at ClinicalTrials.gov*. Available from: https://www.researchgate.net/publication/273468962_Compliance_with_Results_Reporting_at_ClinicalTrialsgov

Without a compliance system for reporting that is universally followed, there naturally are gaps that allow researchers and special interests to sweep results and data under the rug, if it doesn't fit the narrative of the desired outcome. Yes it may come as a surprise to many, but some of the research that is done starts with the outcome they want and is "reverse engineered" in such a way that the methods reach the pre-determined outcome.

VACCINE SAFETY

How safe are vaccines really? This section will answer that question and (spoiler alert), it's not what we are told

The following is taken directly from the FDA's website at
https://www.fda.gov/AboutFDA/Transparency/Basics/ucm194586.htm

How does FDA assess the safety of vaccines?

Vaccines undergo rigorous and extensive testing to determine their safety and effectiveness. Highly trained scientists and medical personnel at FDA carefully review all of the information in a marketing application before a vaccine can be approved for use by the public.

Following approval, FDA also carefully monitors the quality of vaccines—all manufactured lots must pass tests before they can be used. And as with all manufacturers of medical products, vaccine manufacturers must follow strict manufacturing standards. In addition, FDA conducts routine inspections of manufacturing sites.

FDA also works closely with the Centers for Disease Control and Prevention (CDC) to monitor reports of side effects (adverse events) of vaccines. FDA and CDC take all reports seriously, and work together to evaluate and address any potential problems.

Now, let's take a look at their claims…

The Vaccine Injury Compensation System – Part 1

As of May 1st, 2021, the vaccine court has awarded over 4.5 billion dollars, and a record number of new petitions have been filed over the last 3 years

There has been over 4.5 billion dollars paid out for compensation for vaccine injury to vaccine injured individuals. That number is going up by millions monthly. Since the vaccine court has awarded 4.5 billion dollars (including attorney's costs), as compensation for vaccine injured children, **that certainly doesn't support the claim that vaccines are completely safe.**

You can see the amounts of petitions filed, the awards given, and the number of cases filed and compensated for each vaccine here

The most current data through April 2021 can be found here:
https://www.hrsa.gov/sites/default/files/hrsa/vaccine-compensation/data/data-statistics-report.pdf

The previous link provides the data for the next sections also-

Statistics on which vaccines are connected with the most compensated cases in the vaccine court. The flu vaccine is far and away the most compensated one, with the DTP next

The trend for number of petitions and cases compensated is upward

FY 2006	325
FY 2007	410
FY 2008	417
FY 2009	397
FY 2010	448
FY 2011	386
FY 2012	401
FY 2013	504
FY 2014	633
FY 2015	803
FY 2016	1,120
FY 2017	1,243
FY 2018	1,238
FY 2019	1,282
FY 2020	1,192
FY 2021	1,690

Look at the numbers filed already as of May 1st, 2021!

Could the ever-increasing vaccine dose schedule, the multi-dose combo vaccines and the pharma backed media sensationalism of the flu, whooping cough and measles cases have something to do with the increasing number of people injured by vaccines? The COVID-19 vaccines are not eligible for compensation under this program, so that shouldn't account for the large jump in numbers. Although, when you see the mass casualty event that the COVID-19 vaccines are causing in that section later in this eBook you will be SHOCKED!

The number of compensated awards is increasing consistently since 2004 and is on track for a big jump in 2021

2004 - 57
2005 - 64
2006 - 68
2007 - 82
2008 - 141
2009 - 131
2010 - 173
2011 - 251
2012 - 249
2013 - 375
2014 - 365
2015 - 508
2016 – 689
2017 – 706
2018 – 521
2019 – 653
2020 - 734
2021 – 399 (As of May 1st, 2021.That puts the total on track for well over 900 in 2021)

Consider this: In 2017 $282,096,906 (over 280 million dollars), was paid out. That is over $23 million a month or nearly $5.5 million A WEEK!

As of May 1st, 2021, there was $142,333,145.93 paid out for the year. That is on pace for a total payout in 2021 of well over 300 million dollars!

The maximum award is $250,000

The maximum award for even for death is $250,000. Considering that it is estimated that it may cost as much a $2.5 million to raise and support an autistic child through adulthood, the maximum award is just a drop in the bucket (even though you will see in a minute that it is nearly impossible to get compensated for autism). For other severe and lifelong disabling conditions, the costs can be nearly as much. And for the death of a child, well let's just say it could never be enough!
https://www.nvic.org/faqs/vaccine-injury-compensation.aspx

Autism is no longer considered a compensable condition because the number of cases would overwhelm the system

According to an article published December 02, 2018 on ***VaccineImpact.com*** titled, **Get Your Flu Shot? DOJ Report From Vaccine Court Reveals Flu Shot is Most Dangerous Vaccine in U.S.**, the number of autism claims as of 2010 was threatening to bankrupt the system, so the government figured out a clever way to deny autism as a compensable claim. https://vaccineimpact.com/2018/get-your-flu-shot-doj-report-from-vaccine-court-reveals-flu-shot-is-most-dangerous-vaccine-in-u-s/

From the article:
"**1989 through 2017, the NVICP has paid out $3,761,572,346.69 (over $3.7 BILLION) in settlements for vaccine injuries and deaths**, and yet the *Vaccine Injury Compensation Trust Fund,* funded through taxes the public pays on vaccines, has a balance of $3,768,655,418 as of July 31, 2018, almost the same amount that has been paid out to victims from 1989 through 2017." ***Now that amount has topped 4.5 BILLION DOLLARS.***

'The main reason why the fund has become so large, besides the fact that most U.S. citizens are not even aware of it and never file claims for vaccine injuries and deaths, **is because autism injuries due to vaccines are no longer allowed**."

Autism Vaccine Injuries Not Allowed: Too Many
"One indication that the problem is more widespread than what the public is being told is the increasing rate of autism among children."

"The U.S. government vaccine court will no longer hear cases of vaccines causing autism. When the *Vaccine Injury Compensation Trust Fund* was set up in 1988, autism was the most prevalent vaccine injury brought before the vaccine court, mostly from the MMR (measles, mumps, rubella) vaccine. **It soon became apparent that the trust fund would not be sufficient to litigate all the claims for autism as a vaccine injury**. By March 1, 2010, 13,330 cases had been filed in the special vaccine court, with 5,617 representing autism cases. Of those 13,330 cases filed up to March 1, 2010, only 2,409 were compensated. The rest were dismissed, but there were 5,933 cases still pending, and most of those were claims for vaccine-induced autism, mostly due to either the MMR vaccine, or vaccines containing thimerosal (mercury)."

Starting on page 407-408, you will see more about how the game of "semantics" is played with regard to the way cases of brain injury are sometimes compensated (even through the injured children are clearly autistic).

The reason that there is a vaccine court, is that the pharmaceutical companies cannot be sued for vaccine injuries or deaths. The government has given them immunity and tax payers (you and I), are footing the bill to compensate families that are lucky enough to win their case in vaccine court. Vaccines are the only class of drugs that have been given this special kind of protection. Think about

it. Vaccines also are streamlined into production without the same scrutiny necessary for all other kinds of drugs and yet, vaccine manufacturers have no accountability for quality control. That is a recipe for disaster when they have no ramifications for inadequate safety studies, lack of long-term follow-up studies, sloppy manufacturing processes or poor-quality control.

If 4 billion dollars have already been paid out and the same vaccines that have been proven in court to have damaged children are still being used on millions of children, what does that say about the statements above from the FDA? (*"FDA and CDC take all reports seriously, and work together to evaluate and address any potential problems").*

Really? Then why haven't they launched extensive and independent long-term safety studies and surveillance programs?

Regarding quality control, the drug industry has a long track record of skirting their responsibility

This is a quote from an excellent eBook that the Children's Health Defense has put out titled, Conflicts of Interest- Undermine Children's Health. This eBook has 282 references and does an outstanding job of documenting the extent and depth of the corruption in the vaccine industry and our own government. https://childrenshealthdefense.org/ebook-sign-up-conflicts-of-interest/

"From a consumer standpoint, Merck's track record with Vioxx raises the question of whether the American public can believe Merck's claims about the safety of its vaccines .**Can a company that confessed to illegal activity and paid out almost $5 billion to settle lawsuits for a drug it knew to be harmful be considered trustworthy when it markets expensive and profitable vaccines such as Gardasil?** In 2008, an investigation by the *Philadelphia Inquirer* described an unpublished FDA review of one of Merck's largest U.S. vaccine plants, **which identified contaminated children's vaccines and a failure to follow good manufacturing practices—noting 49 areas of concern in all**. The plant leadership's response to the FDA's troubling findings was that "Nobody's perfect." **Previously, in 2007, Merck had to recall over a million doses of two childhood vaccines because it "could not guarantee the products' sterility."**

Adverse reactions to vaccines

These are some of the well acknowledged vaccine adverse reactions:

Vaccine Package inserts catalog a range of adverse reactions that sometimes affect over half of vaccine trial participants. These include:

- Injection-site reactions (e.g., pain, redness, “increase in arm circumference”)
- Immune system responses such as fever and swollen lymph nodes
- Allergic reactions such as hives, rash, rhinitis and runny nose
- Diarrhea, vomiting, upper respiratory infection
- Fatigue, drowsiness, lethargy, malaise, loss of appetite
- Muscle aches and pain
- Headaches, febrile seizures
- Behavioral indictors of distress such as irritability, restlessness or inconsolable or prolonged crying

VAERS reports include adverse events of even greater severity. To date, VAERS has received thousands of reports for each of the following symptoms:

- Arthralgia (joint pain)
- Breathing difficulties
- Chest discomfort and pain
- Convulsions
- Death
- Decreased mobility
- “Feeling abnormal”
- Gait disturbances
- Increased heart rate, palpitations
- Loss of consciousness
- Musculoskeletal pain, extremity pain
- Otitis media (ear infection)
- Pneumonia
- Screaming
- Skin disorders
- Sleep disorders
- Stupor

- Tremors
- Viral infections

The **Vaccine Injury Compensation Program (VICP)**, has paid awards for many of the more serious conditions listed above. In addition, they have paid awards for:

- Brain damage (encephalopathy, and cases of autism [although they insist on calling it "brain damage"])
- Autoimmune conditions
- Long-term seizure disorders

The government maintains a detailed database on adverse events from vaccines

The studies show that only 1-2% of adverse reactions are even reported

VAERS Data- Vaccine adverse events are reported to the **Vaccine Adverse Event Reporting System (VAERS).** The numbers don't lie. **In 2016, there were 59,244 reports of reactions to vaccines**. **That number has grown annually.** In 1991, there were 9,935 adverse reactions reported, one sixth of those reported in 2016. The system is **entirely voluntary reporting**, often called **a "passive reporting system**". **Therefore, studies estimate that only between 1-2% of all vaccine reactions are ever reported to VAERS. That means that the number of reactions annually in the U.S. may be more accurately somewhere between 3,000,000 -6,000,000 adverse reactions, which is a VERY significant number!** That data can be **found here on the VAERS web site** https://vaers.hhs.gov/data/index Go here, scroll down and click on the "Click here to proceed to the VAERS Database" button.

This site explains about many of the limitations of the VAERS System. http://www.medalerts.org/analysis/archives/504 VAERS isn't perfect, but **it does act as a warning system that allows for identifying trends in vaccine dangers**. Unfortunately, it's all we have right now. **Again, I have to ask. With these astounding numbers of adverse reports of injury from vaccines, where is the FDA and the CDC?**

The U.S. government funded a study that found that less than 1% of adverse reactions to vaccines are reported

Harvard Pilgrim Health Care performed the study between 12/01/2007 -09/30/2010. The report was titled, **Electronic Support for Public Health–Vaccine Adverse Event Reporting System (ESP: VAERS)** https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf

The Purpose of the Study:
"This research project was funded to improve the quality of vaccination programs by improving the quality of physician adverse vaccine event detection and reporting to the national Vaccine Adverse Event Reporting System (VAERS)...

"The CDC's Public Health Information Network Messaging System (PHIN-MS) software was installed within the facilities so that the approved reports could be securely transferred to VAERS as electronic messages in an interoperable health data exchange format using Health Level 7 (HL7)."

Results from the study:
"Preliminary data were collected from June 2006 through October 2009 on 715,000 patients, and 1.4 million doses (of 45 different vaccines) were given to 376,452 individuals. Of these doses, 35,570 possible reactions (2.6 percent of vaccinations) were identified. This is an average of 890 possible events, **an average of 1.3 events per clinician, per month**. These data were presented at the 2009 AMIA conference."

Dividing 1.4 million doses between 376,452 people is an average of 3.72 doses per person. ***And, if there were 35,570 reactions in 1.4 million doses given, that is one adverse reaction for every 39.4 doses. Perhaps what is most striking here is that if each person reacting experienced on adverse reaction only, of the 376,452 individuals vaccinated, nearly 10% experienced a possible reaction!***

In addition, ESP: VAERS investigators participated on a panel to explore the perspective of clinicians, electronic health record (EHR) vendors, the **pharmaceutical industry**, and the FDA towards systems that use proactive, automated adverse event reporting." ***(Since in the end, this improved automated reporting system was stymied and went nowhere, one has to wonder what influence the pharma reps on the panel had on that).***

"**Adverse events from drugs and vaccines are common, but underreported**. Although 25% of ambulatory patients experience an adverse drug event, less than 0.3% of all adverse drug events and 1-13% of serious events are reported to the Food and Drug Administration (FDA). Likewise, **fewer than 1% of vaccine adverse events are reported**. Low reporting rates preclude or slow the identification of "problem" drugs and vaccines that endanger public health."

"**New surveillance methods for drug and vaccine adverse effects are needed.** Barriers to reporting include a lack of clinician awareness, uncertainty about when and what to report, as well as the burdens of reporting: reporting is not part of clinicians' usual workflow, takes time, and is duplicative. Proactive, spontaneous, automated adverse event reporting imbedded within EHRs and other information systems has the potential to speed the identification of problems with new drugs and more careful quantification of the risks of older drugs."

Here's the kicker. After spending nearly 3 years and a million dollars, the CDC went dark on the program. Was it because the surveillance system would significantly increase the reporting of vaccine adverse reactions?

The last statement from the Results section of the article says it all…

"Unfortunately, there was never an opportunity to perform system performance assessments because the necessary CDC contacts were no longer available and the CDC consultants responsible for receiving data were no longer responsive to our multiple requests to proceed with testing and evaluation."

One has to wonder what is stopping the automation of the vaccine adverse reporting system from being implemented. **This report suggested that its implementation would be easy to accomplish. That was in 2010. It is now 2018 and nothing has been done to accomplish this vital information system**. And lives hang in the balance. **It is estimated that if a system like this was incorporated into the electronic records databases, it would reveal that ten times more adverse vaccine reactions would be reported. There are powers that be, who would never want to see that happen.**

The significance of this and the ramifications are MIND BOGGLING!

According to Jeffrey Jaxon's article titled, **Merck's HPV Vaccine Research Scandal Gains Mainstrem Attention** dated 12-30-17, "**VAERS** has logged **54,105 adverse reactions related to the HPV vaccine**. Among those, 2,227 are listed as "**disabled**," 10,416 are listed as "**did not recover**," 7,418 are listed as "**serious**," and 362 **deaths** have been reported. Many other reports were listed on VAERS including **emergency room visits after vaccination** [14,928], **hospitalized** [5,155], and **life-threatening** [868]."

Keeping that in mind, consider this…

Reports to VAERS represent less than 1% of all adverse vaccine reactions, according to a CDC funded study conducted by Harvard Pilgrim Health Care

A US Health and Human Services-funded study by Harvard Medical School tracked reporting to VAERS over a three-year period at Harvard Pilgrim Health Care **involving 715,000 patients** and found that *"***fewer than 1% of vaccine adverse events are reported.***"*

A ***US House*** Report similarly stated: "Former FDA Commissioner David A. Kessler has estimated that VAERS reports **currently represent only a fraction of the serious adverse events.**"

Recalculating the VAERS HPV reports using Harvard Medical School's findings of only one percent reporting, the current VAERS information from the HPV vaccine reporting could in reality be as high as 5,410,500 adverse reactions, 1,041,600 disabled, and 36,200 deaths over the first 10 years it has been in use. And that is just the HPV Vaccine which is responsible for the third highest number of vaccine court compensation awards at 126 through 2016. The DTaP vaccine and its versions is second (208 through 2016) and the flu vaccine is responsible for the highest number of vaccine court compensation awards (2,439 through 2016).
https://www.jeffereyjaxen.com/blog/mercks-hpv-vaccine-research-scandal-gains-mainstream-attention

If CDC estimates of adverse vaccine reaction underreporting is accurate, the actual number that occurs is MIND BLOWING!

VAERS is a passive reporting system, relying on voluntary, rather than mandatory, reporting. Assuming VAERS captures 1 percent of adverse events (which is more than the less than 1% estimated), then the number of adverse events reported to VAERS in 2016 would reflect for that year 5,911,700 adverse events, 43,200 deaths 109,100 permanent disabilities 413,200 hospitalizations and 1,028,400 emergency room visits related to vaccines. Capturing "fewer than 1% of vaccine adverse events" thirty years after the passage of the 1986 Act is unacceptable – and potentially deadly.

In 2017, The VAERS Database reports 56,263 adverse reactions. Once again, if the less than 1% reporting estimations are accurate, the actual adverse reactions to vaccines are in excess of 5,626,300!

Let's have some fun with this. Vaxopedia reports that there has been an average of 286 million doses of vaccines distributed between 2006 and 2016. There are 325,000,000 people in the U.S. If you divide 286 million by 5,626,300 (the number of probable vaccine adverse reactions), you come up with 1 adverse reaction for every 51 doses.
https://vaxopedia.org/2018/01/10/vaccines-statistics-and-numbers/
Vaxopedia is a website that espouses the benefits of vaccines and vaccinating your children.

Disclaimer: Now, I know that my example isn't 100% accurate, because we don't know exactly how many does of vaccines were distributed in 2017 alone. But it does give one pause to think about how very common vaccine adverse reactions really are.

Weekly updates of Vaccine Injury Compensation Data
https://www.hrsa.gov/vaccine-compensation/data/index.html

VAERS Database downloadable spreadsheets
https://vaers.hhs.gov/eSubDownload/verification

Other countries also track adverse reactions. A 2016 study reveals some fascinating statistics about adverse reactions in Brazil.

An article published in ***Epidemiologia e servicos de saude*** titled, **Analysis of adverse events following immunization in Minas Gerais, Brazil, 2011: a cross-sectional study**, reveals some interesting statistics about the most common age for adverse reactions (under age 1), the most common vaccine to cause reactions (the DPT, Hib tetravalent combo), of which 1 out of every 393 children had a reaction to, nearly 30 percent had severe reactions and one died of febrile seizures.
https://www.ncbi.nlm.nih.gov/pubmed/?term=27861677

From the study:
"Throughout the time of the study, 1,458 adverse events following immunizations recommended by the National Immunization Program (*PNI*) were notified. Nine events had inconsistencies in the variable "age", and were excluded from the analyses. **Thus, 1,449 AEFI were included in this study**." ***(The overall rate of adverse reactions was approximately 1 per 5,000 doses). Bear in mind that admittedly, this article admits that the adverse reactions are under-reported. Chances are the rate of people reporting adverse reactions in this area of Brazil which includes some relatively primitive areas are lower than in the U.S., where it is estimated that less than 1% of adverse reactions are reported. If 1 in 5,000 experienced a reaction and the rate of under-reporting is the same as in the U.S., that would mean that the real rate of adverse reactions was in excess of 1 in 50.***

"**The immunobiological with the greatest incidence of adverse events was the tetravalent vaccine *(46.1%)* – a combination of the DTP and the *Haemophilus influenzae* b vaccines –, administered to 2, 4, and 6 month-olds to prevent morbidity and mortality by diphtheria, tetanus, pertussis and meningitis caused by *H. influenzae* b. The results of that investigation corroborate a study carried out in 2006, in the municipality of Teresina, Piauí State, where 63.0% of the notified events were found to be related to the tetravalent vaccine.**"

"Over half of AEFI occurred in the population younger than 1 year of age (56.1%)…" ***Looking at the adverse reaction statistics for the Diphtheria, Tetanus, Pertussis Haemophilus Influenza type B (Tetravalent Vaccine), which is the one with by far the greatest percentage of reactions and the fact that the report indicated that children were vaccinated with that combo vaccine at 2, 4 and 6 months,***

I did some calculations to see how many children, not doses were affected statistically. Dividing the 787,067 doses by 3 (which is the number each child would have received), you get 262,366 children. Taking the number of adverse reactions listed at 668 for the DTPHib and dividing by 262,356 children = .2546% or 1 out of every 393 children. That is an extremely high rate of adverse reactions! Again, if the rate of under-reporting is considered, that would mean adverse reaction rate of 1 in 4! And when over half of the adverse reactions were occurring in children younger than one year of age, isn't that telling us something? Infants and young children are much more susceptible to the effects of the heavy metals and chemicals in the excessive amounts of vaccines they are given.

This is a disturbing reaction to the vaccines:

"HHE *(Hypotonic Hyporesponsive Episodes which means the child is not responding or is "out of it"),* is a severe event, of difficult clinical characterization…"…."HHE can be associated to various vaccines; **however, it is usually related to the pertussis component of the DTP vaccine**. **In this study, this adverse reaction accounted for 15.9% of all the adverse reactions**. A survey based on data from the Vaccine Adverse Event Reporting System (VAERS), Canada's AEFI notification system, found that, in the 215 cases evaluated, the average age at the start of an HHE **was four months of age**, over half of the children affected were female, **with an average interval of 210 minutes between the immunization and the episode**. **93% of the children affected had received a vaccine with pertussis**. **According to that same study, during HHE, 90.1% of the children presented pallor *(loss of color)* and 49%, cyanosis *(turned blue)***. **Another frightening adverse response listed in Table 5 is "Other grave and unusual events". What is that? Those AEFIs accounted for 13.9% of all adverse reactions**. **This means that those two classifications of serious adverse reactions accounted for nearly 30% of all reactions.** ***(That is scary stuff!). In addition, one child passed away from seizures; quote "1 died of febrile seizure".***

"Regarding the distribution of doses administered per immunobiological (Table 3), it was observed that the **tetravalent vaccine had the greatest reactogenicity (46.1%),** followed by the influenza vaccine (14.3%). Those and the pneumococcal 23-valent vaccine were the immunobiologicals with the greatest risk of causing adverse events among the people vaccinated in that period. Analyzing the association between the presence of AEFI by the type of immunobiological (inactivated or attenuated vaccines), it was found that inactivated vaccines…had greater chances of causing adverse events when compared to attenuated vaccines (Table 4)."

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"**The presence of aluminum as an adjuvant in inactivated vaccines predisposes the immunized individual to more significant local adverse events**, such as hyperemia, edema, and pain at the

application local, **besides increasing the adverse events' risk with subsequent doses**, **related to immune complex deposition**. It is also noticeable that flaws in the vaccines preservation, such as exposure to low temperatures, may result in the inactivation of the aluminum adjuvant, by freezing. **In this case, the efficacy of the vaccine may decrease, and the risk of adverse events following immunization, such as sterile abscesses, increase**."

"The limitations of this study were, thus, notably, **the under notification of adverse events** and the quality of the data available at *SI-EAVP*." ***This indicates that the rate of reporting is low, which squares with the aforementioned U.S. reporting rates of less than 1%. Therefore, the percentage of individuals suffering adverse events after vaccination is actually much higher than was reported***.

Another important consideration is that the study **tracked only the adverse reactions post vaccination**. These would be the things that are commonly associated post-vaccination. In other words, **it did not track the development of other illnesses that this manuscript demonstrates have strong connections to vaccines. These would be things like allergies, asthma, autoimmunity, neurological developmental delays and learning disabilities, just to name a few**.

Studies are loaded with evidence of vaccine adverse event data. 34,189 studies came up on a recent PubMed search for VACCINE ADVERSE EFFECTS

A 07-31-19 search for **vaccine adverse effects** on the world's largest database of peer-reviewed literature Pubmed **revealed 34,189 articles discussing reactions to vaccines.**
A 08-15-18 search for **vaccine adverse effects**, **revealed 32,930 articles**.
When I ran the search on 06-29-15, there were 28,753 articles. The most recent amount represents 5,436 additional articles posted in 4 years. If there was nothing there with regard to reactions to vaccines, why are there tens of thousands of scientific peer-reviewed journal articles discussing "nothing".

Additionally, the ***Institute of Medicine of the National Academy of Sciences*** in Washington D.C., has published a book in 2012 called the **Adverse Effects of Vaccines**. In Chapter 4 (a chapter about the MMR vaccine), it lists 29 possible serious adverse effects from the MMR vaccine alone.

The irony and tragedy is, that many families have proven vaccine injury causing various severe and debilitating conditions in court, yet many of those conditions are still not required to be listed on vaccine package inserts or as informed consent given to parents before their child is vaccinated.

Reports regarding pre-VAERS monitoring also suggest that adverse events after vaccination were dramatically under-reported

The following is an excerpt from **Adverse Events Associated with Childhood Vaccines: Evidence Bearing on Causality,** a publication produced by the ***National Academies Press*** a division of the ***National Academy of Sciences. "This report comprises the deliberations and conclusions of that committee, the Vaccine Safety Committee",*** which is a ***Division of Health Promotion and Disease Prevention*** at the ***INSTITUTE OF MEDICINE***

The introduction of the book contains the following:

NOTICE: The project that is the subject of this report was approved by the Governing Board of the National Research Council, whose members are drawn from the councils of the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine. The members of the committee responsible for the report were chosen for their special competences and with regard for appropriate balance. This report has been reviewed by a group other than the authors according to procedures approved by a Report Review Committee consisting of members of the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine.

Page 328- James Froeschle, Connaught Laboratories, Swiftwater, Pennsylvania discusses the percentage of adverse events that were reported through their internal system prior to the VAERS.

"Dr. Froeschle gave information about adverse events following diphtheria and tetanus toxoids (DT) that had been reported to Connaught. From a comparison of spontaneous reports with postmarketing surveillance data, **the company estimates about a 50-fold underreporting of adverse events in the passive reporting system**. **The distribution of types of events, however, was found to be approximately the same**; in both cases, the majority of reported events were local reactions or fever. The company has seen a marked decrease in adverse event reports since the inception of VAERS late in 1991, because physicians are now requested to send reports directly to the VAERS contractor."

As an aside, in my opinion this statement from the report communicates the honest truth, that at least at that time the answers to the questions of causality were not easily answered…

"As this report describes in detail, it was possible with some of the vaccine adverse event pairs to reach a conclusion one way or the other—either that the evidence favored rejection (category 3) or that the evidence weighed more or less heavily for acceptance (categories 4 and 5) of a causal relation (see Chapter 2 for explanations of the five categories). With the majority of vaccine adverse event pairs the evidence was considered inadequate to accept or reject causality. In some instances, the relation has not been well studied and the data are scarce; in others, the data are abundant but the evidence, on the whole, was not conclusive. Category 2 does not distinguish between these two situations, since the conclusion is the same. It could be argued in these cases that since the body of available evidence did not support causality, a causal relation does not exist. It could also be argued that in the absence of evidence favoring rejection of causality, it is possible that the vaccine could cause the adverse event. Both of these interpretations are possible. The committee regrets that this uncertainty may not make it easier to resolve litigation centered on individual instances of putative causality. However, the stringency of our charge precluded statements beyond what the evidence allowed. **Concern about this**

unfortunate condition of uncertainty has led the committee to urge that more definitive research be done on possible adverse events during the development of new vaccines or vaccine combinations and to urge that efforts to sharpen current postmarketing surveillance systems be accelerated." (Emphasis mine)

With regard to the bold underlined text, the big question is, has that been accomplished? As the evidence in this eBook suggests, the answer is no. Giving the vaccine industry complete immunity from responsibility to produce safe vaccines and to conduct their safety studies far less rigorously than FDA approved drugs has led to the continuance poor scientific methods in development, safety studies and post-marketing surveillance of vaccines. The content of this eBook gives dozens if not hundreds of examples of that.

Vaccine safety testing is far less rigorous than other FDA approved drugs

Vaccine package inserts reveal how limited vaccine safety testing is compared to all other drugs on the market

Vaccine reactions are only monitored for 5 days

The following is directly from **the Hepatitis B Vaccine package insert.**

https://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM110114.pdf

6. ADVERSE REACTIONS

In healthy infants and children (up to 10 years of age), the most frequently reported systemic adverse reactions (>1% injections), in decreasing order of frequency, were irritability, fever, diarrhea, fatigue/weakness, diminished appetite, and rhinitis. In healthy adults, injection site reactions and systemic adverse reactions were reported following 17% and 15% of the injections, respectively.

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a vaccine cannot be directly compared to rates in the clinical trials of another vaccine and may not reflect the rates observed in practice.

In three clinical studies, 434 doses of RECOMBIVAX HB, 5 mcg, were administered to 147 healthy infants and children (up to 10 years of age) who were monitored for 5 days after each dose. Injection site reactions and systemic adverse reactions were reported following 0.2% and 10.4% of the injections, respectively. The most frequently reported systemic adverse reactions (>1% injections), in decreasing

order of frequency, were irritability, fever (≥ 101°F oral equivalent), diarrhea, fatigue/weakness, diminished appetite, and rhinitis.

In a study that compared the three-dose regimen (5 mcg) with the two-dose regimen (10 mcg) of RECOMBIVAX HB in adolescents, the overall frequency of adverse reactions was generally similar. In a group of studies, 3258 doses of RECOMBIVAX HB, 10 mcg, were administered to 1252 healthy adults who were monitored for 5 days after each dose. Injection site reactions and systemic adverse reactions were reported following 17% and 15% of the injections, respectively.

6.2 Post-Marketing Experience

The following additional adverse reactions have been reported with use of the marketed vaccine. Because these reactions are reported voluntarily from a population of uncertain size, it is not possible to reliably estimate their frequency or establish a causal relationship to a vaccine exposure. ***(Essentially, they are saying "we have done no long-term studies or follow-up with persons injected with this vaccine").***

Immune System Disorders- Hypersensitivity reactions including anaphylactic/anaphylactoid reactions, bronchospasm, and urticaria have been reported within the first few hours after vaccination.

An apparent **hypersensitivity syndrome** (serum-sickness-like) of delayed onset has been reported days to weeks after vaccination, including: arthralgia/arthritis (usually transient), fever, and dermatologic reactions such as urticaria, erythema multiforme, ecchymoses and erythema nodosum [see Warnings and Precautions (5.1)].

Autoimmune diseases- including systemic lupus erythematosus (SLE), lupus-like syndrome, vasculitis, and polyarteritis nodose have also been reported.

Gastrointestinal Disorders- Elevation of liver enzymes; constipation

Nervous System Disorders- Guillain-Barré syndrome; multiple sclerosis; exacerbation of multiple sclerosis; myelitis including transverse myelitis; seizure; febrile seizure; peripheral neuropathy including Bell's Palsy; radiculopathy; herpes zoster; migraine; muscle weakness; hypesthesia; encephalitis

Skin and Subcutaneous Disorders- Stevens-Johnson syndrome; alopecia; petechiae; eczema

Musculoskeletal and Connective Tissue Disorders- Arthritis, Pain in extremity

Blood and Lymphatic System Disorders- Increased erythrocyte sedimentation rate; thrombocytopenia

Psychiatric Disorders- Irritability; agitation; somnolence

Eye Disorders- Optic neuritis; tinnitus; conjunctivitis; visual disturbances; uveitis

Cardiac Disorders- Syncope; tachycardia

Vaccines are often released without adequate long-term trials

The following is an example of public exposure to an unsafe vaccine that was released without adequate pre-release trials and then removed after severe adverse reactions were reported.

Rotavirus vaccine and increased rates of intussusception (one section of bowel telescopes into another causing a blockage)

This 2004 article titled **Suspension of Rotavirus Vaccine After Reports of Intussusception ---United States, 1999** and published on the CDC website, chronicles the introduction and subsequent removal of the licensed rhesus-human rotavirus reassortant-tetravalent vaccine (RRV-TV) RotaShield. Note: "rhesus" is the type of monkey, from which the virus was extracted and then cultured in monkey kidney tissue. This article has a graphic showing the correlation between the introduction of the new vaccine and cases of infant intussusception (i.e., a bowel obstruction in which one segment of bowel becomes enfolded within another segment) among infants who received RRV-TV shortly after the shots. **There is a telling graphic in this article which shows that once the shots were discontinued (July 17, 1999 after 9 months on the market), all of the cases of intussusception immediately ceased.**
https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5334a3.htm

Not only did that rotavirus vaccine cause serious and even life-threatening complications in some children, it also caused other gastrointestinal problems. A study published in the Journal ***Pediatrics*** in 2004, and titled **An analysis of rotavirus vaccine reports to the vaccine adverse event (VAERS) reporting system: more than intussusception alone?**
https://www.ncbi.nlm.nih.gov/pubmed/?term=15060267

Researchers looked at the adverse events caused by the rhesus-human rotavirus reassortant-tetravalent vaccine. **Keeping in mind, that it is commonly reported that less than 1% of adverse reactions are reported to the VAERS database, this is what they found:**

RESULTS: "Even after excluding intussusception cases, a higher proportion of RRV-TV reports than non-RRV-TV reports included fever and various gastrointestinal symptoms, most notably bloody stool but also vomiting, diarrhea, abdominal pain, gastroenteritis, abnormal stool, and dehydration. Distribution of RRV-TV reports by clinical groups was as follows: diagnosed intussusception (109 [24%], suspected intussusception (36 [8%]), and illness consistent with gastroenteritis or intussusception (33 [7%]), gastroenteritis (101 [22%]), other gastrointestinal diagnoses (10 [2%]), and non-gastrointestinal outcomes (159 [35%]). The median time interval between vaccination and illness onset decreased incrementally among the first 4 clinical groups: from 7 days for diagnosed intussusceptions to 3 days for gastroenteritis."

Even studies like this showing significant adverse reactions have one major shortfall, they are only looking at short-term onset reactions. **Development of long-term disease and illness from gastrointestinal insults have become extremely common in our society**. Conditions like Crohn's disease, ulcerative colitis, diverticulitis, intestinal permeability, intestinal inflammation and chronic dysbiosis (a proliferation of unhealthy organisms over healthy organisms in the gut). Since scientists now call the gut the second brain, conditions such as these that negatively impact the G.I. tract have far-reaching implications for neurological and neurodegenerative disorders. Not only that, but approximately 70% of the body's immune system resides in the gut associated lymphoid tissue (GALT). Dysbiosis and chronic inflammatory changes to the intestinal lining contribute to an increase in pro-inflammatory cytokines which contribute to allergic conditions, weakened immunocompetence and autoimmune conditions. **One has to ask the question, how much of the astounding rise in the incidence of these disorders over the last 30 years might be attributed to long-term effects of vaccines?**

Two Rotavirus vaccines are still on the market despite increased intussusception rates and contamination with 2 pig circoviruses

According to a report on the ***Children's Health Defense*** web site, a significant post marketing rate of intussusception has not caused the recall of the vaccines.
https://childrenshealthdefense.org/news/vaccine-rhetoric-vs-reality-keeping-vaccinations-unflattering-track-record-secret/

From the article:
"**Two new genetically engineered oral rotavirus vaccines entered the vaccine marketplace in 2006 and 2008, respectively: RotaTeq, a pentavalent (five-strain) bovine-human reassortant rotavirus vaccine made by Merck, and Rotarix, a live-attenuated single-human-strain rotavirus vaccine manufactured by GlaxoSmithKline (GSK).** Although pre-licensure trials found no evidence of an association between the two vaccines and intussusception, **post-licensure monitoring later indicated a statistically significant increased risk of intussusception events for all rotavirus vaccines**. Unlike with RotaShield, FDA merely instructed Merck, in 2013, and GSK, in 2014, to update their labeling and prescribing information to include brief statements about increased intussusception risks but **otherwise allowed the two vaccines to remain on the market**." https://www.ncbi.nlm.nih.gov/pubmed/28648544

Another problematic issue discovered:
"Meanwhile, the much-vaunted industry and governmental safety systems that ushered the two rotavirus vaccines to market **failed to detect an additional and highly concerning problem, which an academic research team "unexpectedly" identified in 2010. While conducting "a novel, highly sensitive analysis not routinely used for adventitious agent screening," the researchers discovered that RotaTeq and Rotarix were contaminated with DNA from two porcine circoviruses—PCV1 (in Rotarix) and both PCV1 and PCV2 (in RotaTeq). Both GSK and Merck later confirmed these findings. The PCV2 pathogen is associated with severe wasting and immunodeficiency in pigs**."
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3981850/
https://www.ncbi.nlm.nih.gov/pubmed/24056737

"Although the short- and long-term dangers from PCV1 and PCV2 are as yet unknown, **the pioneers of genetic engineering foresaw horizontal gene transfer—the direct uptake and incorporation of genetic material from unrelated species—as a clear risk of genetically engineered vaccines**. **Unlike chemical pollutants, nucleic acids are infectious and can invade cells and genomes, multiplying, mutating and recombining indefinitely. Potential hazards of horizontal gene transfer include generation of new disease-causing viruses and bacteria (or reactivation of dormant viruses); spread of drug and antibiotic resistance genes among viral and bacterial pathogens; and random insertion into genomes of cells resulting in cancer**."

My question is, if an increased risk of intussusception and the contamination of the DNA from the porcine (pig) circoviruses would have disqualified the vaccine from getting to market, why shouldn't it be removed now? Keeping it on the market with the unknown health consequences is little more than an ongoing human experiment with unknowing participants. Once again, this smacks of a true violation of the Nuremberg Code.

This next study is one of those mentioned in the previous report.

Post-licensure studies of the currently available second-generation rotavirus vaccines (Rotateq (RV5) and Rotarix (RV1), reveal a similar risk of life threatening bowel intussusception that caused removal of the first rotavirus vaccines

A 2017 article in the journal ***Vaccine*** titled, **Risk of intussusception following rotavirus vaccination: An evidence based meta-analysis of cohort and case-control studies**, looked at 11 total studies in a meta-analysis and found a significant relationship especially on the first dose of the vaccine.
https://www.ncbi.nlm.nih.gov/pubmed/28648544

The data found that the risk of intussusception after the first dose was increased 3.7 times in the studies using cohort data and increased 8.45 times in the case-control data studies (that's over an 800% increase!).

From the abstract:
Findings of this meta-analysis suggest that the rotavirus vaccine is associated with an increased risk on the development of intussusception, principally seen after administration of the first dose of vaccine.

Why are these vaccines still on the market? If you recall the studies from a couple of pages ago, that addressed the issues with the first Rotavirus vaccine and its removal from the market, they found that **the vaccine also caused a whole host of gastrointestinal problems** other than just the intussusception issue covered by this study. **Those included fever and various gastrointestinal symptoms, most notably bloody stool but also vomiting, diarrhea, abdominal pain, gastroenteritis, abnormal stool, and dehydration. What other complications is this vaccine causing also?**

Typical drug trials follow participants for years rather than days

Lipitor, used for high cholesterol is one of the most widely prescribed drugs in the world. How long did they follow participants in the clinical trials? These are four studies listed on the Lipitor package insert.

Collaborative Atorvastatin Diabetes Study (CARDS) In CARDS [see Clinical Studies (14.1)] involving 2,838 subjects (age range 39–77 years, 32% women; 94.3% Caucasians, 2.4% South Asians, 2.3% Afro-Caribbean, 1.0% other) with type 2 diabetes treated with LIPITOR 10 mg daily (n=1,428) or placebo (n=1,410), there was no difference in the overall frequency of adverse reactions or serious adverse reactions between the treatment groups **during a median follow-up of 3.9 years**. No cases of rhabdomyolysis were reported.

Treating to New Targets Study (TNT)

In TNT [see Clinical Studies (14.1)] involving 10,001 subjects (age range 29–78 years, 19% women; 94.1% Caucasians, 2.9% Blacks, 1.0% Asians, 2.0% other) with clinically evident CHD treated with LIPITOR 10 mg daily (n=5006) or LIPITOR 80 mg daily (n=4995), there were more serious adverse reactions and discontinuations due to adverse reactions in the high-dose atorvastatin group (92, 1.8%; 497, 9.9%, respectively) as compared to the low-dose group (69, 1.4%; 404, 8.1%, respectively) **during a median follow-up of 4.9 years**. Persistent transaminase elevations (≥3 x ULN twice within 4–10 days) occurred in 62 (1.3%) individuals with atorvastatin 80 mg and in nine (0.2%) individuals with atorvastatin 10 mg. Elevations of CK (≥10 x ULN) were low overall, but were higher in the high-dose atorvastatin treatment group (13, 0.3%) compared to the low-dose atorvastatin group (6, 0.1%).

Incremental Decrease in Endpoints through Aggressive Lipid Lowering Study (IDEAL)

In IDEAL [see Clinical Studies (14.1)] involving 8,888 subjects (age range 26–80 years, 19% women; 99.3% Caucasians, 0.4% Asians, 0.3% Blacks, 0.04% other) treated with LIPITOR 80 mg/day (n=4439) or simvastatin 20–40 mg daily (n=4449), there was no difference in the overall frequency of adverse reactions or serious adverse reactions between the treatment groups **during a median follow-up of 4.8 years.**

Stroke Prevention by Aggressive Reduction in Cholesterol Levels (SPARCL)

In SPARCL involving 4731 subjects (age range 21–92 years, 40% women; 93.3% Caucasians, 3.0% Blacks, 0.6% Asians, 3.1% other) without clinically evident CHD but with a stroke or transient ischemic attack (TIA) within the previous 6 months treated with LIPITOR 80 mg (n=2365) or placebo (n=2366) **for a median follow-up of 4.9 years**, there was a higher incidence of persistent hepatic transaminase elevations (≥3 x ULN twice within 4–10 days) in the atorvastatin group (0.9%) compared to placebo (0.1%). Elevations of CK (>10 x ULN) were rare, but were higher in the atorvastatin group (0.1%) compared to placebo (0.0%). Diabetes was reported as an adverse reaction in 144 subjects (6.1%) in the atorvastatin group and 89 subjects (3.8%) in the placebo group [see Warnings and Precautions (5.5)]

This 5-year follow-up is typical of pharmaceutical trials. So why don't these drug companies that make many of these other drugs and follow the subjects for years do the same follow-up time with vaccines? The answer is obvious. Because they know that they will not like what they see. So instead, they just omit good scientific scrutiny so that they can continue to market their product without any liability or consequences.

A disgusting example of how the failed Rotavirus vaccine was produced

According to an article on the CDC site from March 1999, Titled, **Rotavirus Vaccine for the Prevention of Rotavirus Gastroenteritis Among Children Recommendations of the Advisory Committee on Immunization Practices (ACIP)** describes the shocking way that the virus was acquired and used to make a human vaccine…."The parent rhesus rotavirus strain MMU 18006 was isolated from a rhesus monkey with diarrhea at the California Regional Primate Center in Davis and was passed nine times in monkey kidney cells and seven times in normal fetal rhesus diploid cells (FRhL-2) cells. The vaccine virus strains are grown in FRhL-2 cells." Source: https://www.cdc.gov/mmwr/preview/mmwrhtml/00056669.htm

This is yet another good example of vaccines that were brought to market before sufficient safety testing was done to ensure the protection of the children it was administered to. Once you add all of the accounts of studies reporting vaccine adverse events I have already shared and will continue to share in this paper, one can only conclude that it is obvious that mankind is an unknowing party to massive human experimentation.

The CDC's website admits the limitations on their knowledge of vaccine reactions, deficiencies in studies and inadequate reporting systems

Copied directly from https://www.cdc.gov/vaccinesafety/ensuringsafety/history/index.html

The NCVIA established a committee from the Institute of Medicine (IOM) to review the literature on vaccine reactions. This group concluded that there are limitations in our knowledge of the risks associated with vaccines. The group looked at 76 health problems to see if they were caused by vaccines. Of those, 50 (66%) had no or inadequate research to form a conclusion. [6, 7] Specifically, the IOM identified the following problems:

1. Limited understanding of biological processes that underlie adverse events.
2. Incomplete and inconsistent information from individual reports.
3. Poorly constructed research studies (not enough people enrolled for the period of time).
4. Inadequate systems to track vaccine side effects.
5. Few experimental studies were published in the medical literature.

Become your own researcher. Here is how you can be update daily or weekly on any new studies released on *PubMed.com* related to vaccines, vaccine advances and/or their harmful effects

I would like as many people as possible to stay current with the all the science that is coming out on vaccines from the published literature. This can create an army of people as Watchdogs, who can stay abreast on the latest in vaccine related science.

The process I am about to describe will help you to do just that. The highlights and links to each article will be delivered right to your inbox as soon as they are accepted on PubMed. That way you can see for yourselves what is happening in the world of vaccine research.

Here is how you do it!

Register for an NCBI account:
NCBI stands for the National Center for Biotechnology Information. The National Center for Biotechnology Information (NCBI) is part of the United States National Library of Medicine (NLM), a branch of the National Institutes of Health (NIH). PubMed is the searchable database containing more than 3 million articles.

- Go to www.pubmed.com
- In the upper right it says…Sign in to NCBI. Click on that.
- On the page that opens, on the left side of the page under where someone with an account would sign in, click on Register for an NCBI account.
- Complete registration by filling out your information.
- Click on the link to the main site landing page.

Now to search a topic and then assign your search criteria for your saved search

- Put in the key words that you would like to stay updated on. Examples may include vaccine adverse effects, aluminum and vaccines, mercury and vaccines, MMR vaccine, vaccine adjuvants, autism and vaccines, learning disabilities and vaccines, etc. When you click on the ***Search*** button to the right, the list the database contains that match that search criteria will come up. You can see the total number that match your search criteria. At the top you can see how it is sorted and change that if you would like. ***Best match*** is the default. You can change it to publication date, author, etc.
- **Now, to create your alert….**
    - Directly below the window you typed your key words into, you will see a link that says ***create alert***. Click on that.

- Choose how often you want to receive the emails with the article links
- ***Format-*** I typically select either the Abstract or the Summary
- ***Number of items-*** What is the maximum number of article abstracts or summaries do you want to receive at a time?

There you have it! You are now officially a research consumer. No matter on which side of this topic you reside, you will see both perspectives. Through my regular updates, I have discovered that scientists are working on different types of adjuvants for vaccines. This may be a step in the right direction, as long as the heavy metals and other immune stimulators aren't replaced with something as potentially harmful.

OUR GOVERNMENT (WE THE PEOPLE), BAILED OUT THE VACCINE INDUSTRY

The National Childhood Vaccine Injury Act of 1986 protects vaccine manufacturers from lawsuits

In the mid-1980s, the vaccine industry was facing the threat of bankruptcy, because of the large number of lawsuits brought by and won by vaccine injured individuals. So, rather that requiring the industry clean up their act, Uncle Sam decided to require the complaints come before a special magistrate and the government defended against those complaints with government attorneys. Severe limits to awards were imposed and the complainants are required to prove their case, WITHOUT the ability to subpoena records like they would in any other legal proceeding. Despite the cards being stacked against families of vaccine injured children, the "Vaccine Court" has awarded over 4 BILLION DOLLARS to date!

The ***National Childhood Vaccine Injury Act of 1986*** (NCVIA or Act) created a no-fault compensation program to stabilize a vaccine market adversely affected by an increase in vaccine-related tort litigation. This absolved vaccine manufacturers from all liability and shielded them from lawsuits by families of vaccine injured children.

From the legislation: "No vaccine manufacturer shall be liable in a civil action for damages arising from a vaccine-related injury or death associated with the administration of a vaccine after October 1, 1988, if the injury or death resulted from side effects that were unavoidable even though the vaccine was properly prepared and was accompanied by proper directions and warnings."

This was challenged in a 2011 U.S. Supreme Court Case, where parents of a vaccine injured child challenged that protective veil, claiming that the DPT vaccine she received in 1992 caused their daughter's (Hannah Bruesewitz's) permanent brain damage, had a design-defect which led to her injury. Hannah, a normal healthy child, started having seizures within 24 hours after receiving the DPT vaccine and had over 100 in the month following. Today, Hannah still suffers the effects from her injury.

In this case, the court upheld that the NCVIA preempts all design-defect claims against vaccine manufacturers brought by plaintiffs seeking compensation for injury or death caused by a vaccine's side effects.

A note about the Supreme Court opinion and a main underlying reason the judges ruled the way they did, said the following:

"**Respondent notes that there are some 5,000 petitions alleging a causal link between certain vaccines and autism spectrum disorders that are currently pending in an omnibus proceeding in the Court of Federal Claims (Vaccine Court).** Brief for Respondent 56–57. According to respondent, **a ruling that §22(b)(1) does not pre-empt design defect claims could unleash a "crushing wave" of tort litigation that would bankrupt vaccine manufacturers and deplete vaccine supply**. *Id.*, at 28. This concern underlies many of the policy arguments in respondent's brief and appears to underlie the majority and concurring opinions in this case."

Unfortunately, in Hannah's case, there were changes made to the list of compensated injuries just prior to the filing of her claim. According to the petition filed with the Supreme Court by Petition of AMICI CURIAE National Vaccine Information Center, its cofounders and 11 other organizations in support of petitioners…

"Had the Bruesewitz family filed its initial claim one month earlier in 1995, Hannah's residual seizure disorder presumptively would have been compensated. However, in an administrative sleight of hand, HHS removed this presumption from the Vaccine Injury Table in March 1995, forcing Hannah Bruesewitz and similar DPT-injured children to prove causation. 60 Fed. Reg. 7678 (Feb. 8, 1995); see also Andreu v. Secretary of HHS, 569 F.3d 1367, 1374 (2009). Fourteen years of litigation later, Hannah Bruesewitz has yet to receive one penny in federal compensation for vaccine injury." (As of the filing date of September 08, 2009).

"Furthermore, HHS has not expanded presumptions for recovery, as the 1986 Report recommended. H.R. Rep. 99-908 at 19-20, reprinted in 1986 U.S.C.C.A.N. at 6360-61. **While the Center for Disease Control has added 46 doses of nine new vaccines for girls (43 doses of eight new vaccines for boys),[3] "no new signs, symptoms or injuries have been added to the Table of Injuries…– except anaphylaxis within four hours for the hepatitis B vaccine."**"

In the brief written by Justice Antonin Scalia, he disclosed the reason that the National Childhood Vaccine Injury Act was passed. Referring to the significant increase in vaccine suits as a result of vaccine injuries to children, he stated the following…

"**Much of the concern centered around vaccines against diphtheria, tetanus, and pertussis (DTP)**, which were blamed for children's disabilities and developmental delays. **This led to a massive increase in vaccine-related tort litigation. Whereas between 1978 and 1981 only nine product-liability suits**

were filed against DTP manufacturers, by the mid-1980's the suits numbered more than 200 each year. This destabilized the DTP vaccine market, causing two of the three domestic manufacturers to withdraw; and the remaining manufacturer, Lederle Laboratories, estimated that its potential tort liability exceeded its annual sales by a factor of 200." (That means that the money they would have to pay out in damages, would exceed their sales by 200 times!)! How does that fact speak to the safety of vaccines?

Much of the argument in the case, centered on the meaning around language is the Vaccine Injury Act that said vaccines are "unavoidably unsafe". The fact that congress felt it important to include that language in the bill, says much about the safety (or lack thereof) of vaccines.

You can read the case and opinions here:
http://caselaw.findlaw.com/us-supreme-court/09-152.html#FNopinion1.5

With very limited recourse for families with children that have suffered certain vaccine injuries, it is sad that the reason they cannot receive restitution doesn't lie with the fact as to whether they deserve it or not, it is because of the fear by government officials and judges that if they allow them to be fairly compensated, it would **unleash a "crushing wave" of tort litigation that would bankrupt vaccine manufacturers** and deplete the vaccine supply. Again, what does that say about the safety of vaccines? If there are that many families that have vaccine injured children that it would cripple the pharmaceutical companies, **why are we allowing our healthy kids to become sacrificial lambs, to the dogma those same pharmaceutical companies manufacture for the doctors and the media in order to sustain huge profits? It makes no logical sense! But then again, if you have enough money and power you can defy logic, sense, reason, truth and justice.**

An experiment on humanity

Since 1986, there are forces within the federal government that have acted to weaken the protections and restitution that families were afforded in the legislation.

This is an excellent article by Barbara Loe Fisher, the founder and director of the National Vaccine Information Center, that describes these concerted efforts.
http://www.nvic.org/NVIC-Vaccine-News/November-2015/vic-governments-broken-contract-with-parents.aspx

From the article: "The history of the National Childhood Vaccine Injury Act is one that has been marked by a profound betrayal of the public trust by government. At the center of that betrayal are doctors and scientists working for government and with industry, who are so determined to deny vaccine risks and cover up the casualties of one-size-fits-all vaccine policies, that they will throw innocent children under the bus to do it."

Currently, there is a huge cloud of uncertainty and thus controversy over the mass immunization debate. There are many credible scientists that are questioning many different aspects of this "experiment" on humanity. There are so many unanswered and un-tested questions that are being contested through epidemiological results. This essentially means that we are learning as we go. We are

finding out based on what we see happening over time to individuals and groups of people that have been vaccinated. We are witnessing trends and observing what the fallout and consequences are from an ever-increasing vaccine schedule. There is, as with everything a "risk vs. reward" equation, but what is eroding is the individual's right to choose for themselves. This is a very slippery slope indeed. There will be more on this later in this document when I discuss Informed Consent.

No one is policing the vaccine industry

Lack of oversight on vaccines by Health and Human Services (HHS)-

The ***National Childhood Vaccine Injury Act of 1986***,… granted economic immunity to pharmaceutical companies for the injuries caused by their vaccines. The responsibility for vaccine safety was therefore placed in the hands of the ***United States Department of Health and Human Services ("HHS")***…, which provided…, **that the Secretary of HHS "shall … make or assure improvements in … the licensing, manufacturing, … adverse reaction reporting, … and research on vaccines, in order to reduce the risks of adverse reactions to vaccines.**"

HHS was supposed to set up a task force to monitor and report back to Congress-

"To assist the Secretary of HHS in performing these duties, Section 300aa-27(b) directs the Secretary to establish a task force responsible for making recommendations to the Secretary concerning implementation of the requirements of Section 300aa-27(a). **This task force is entitled the "*task force on safer childhood vaccines*."** …**The Director of the *National Institute of Health* *(NIH)* is the chair of the Task Force, which by statute also includes the *Commissioner of the FDA* and the *Director of the CDC***.

To track HHS's fulfillment of these vaccine safety obligations, the following order was given… "**Within 2 years after December 22, 1987, and periodically thereafter, the Secretary [of HHS] shall prepare and transmit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report describing the actions taken pursuant to subsection (a) of this section during the preceding 2-year period."**

Keeping all of that in mind, check out this next section…

In lieu of the vaccine industry's new liability free business environment and protections, accountability for that was placed in the hands of HHS and they have failed MISERABLY!

As part of the congressional action granting vaccine makers immunity from lawsuit, Health and Human Services (HHS), was charged with oversight of vaccine safety and practices. The HHS Secretary was supposed to submit a "safety" report every two years that would detail that oversight and any violations or recommendations to be made at that time.

The following is a summary published on the website of ***AIM Integrative Medicine*** titled, **Why Kennedy Sued the Government Over Vaccine Safety & Won**

"In recent news, the ***Informed Consent Action Network (ICAN) and Robert F. Kennedy Jr.*** sued the United States government and won in an issue regarding vaccine safety. **According to a legal document entitled, "Mandate for Safer Childhood Vaccines," Health and Human Services (HHS) has openly admitted to not having filed any vaccine safety reports in over 30 years**."

"In May 2017, ICAN Founder, Del Bigtree, Robert F. Kennedy, Jr., as well as other parties concerned about vaccine safety were selected by the White House to conduct a meeting with the Counselor to the Secretary of HHS, the heads of the National Institute of Health, NIH, the Center for Disease Control, CDC, and Food and the Drug Administration, FDA. Del Bigtree and Robert F. Kennedy, Jr. suspected that HHS was not fulfilling its critical vaccine safety obligations as required by Congress in ***The National Childhood Vaccine Injury Act of 1986***."

"The 1986 Act granted unprecedented, economic immunity to pharmaceutical companies for injuries caused by their products and eviscerated economic incentive for them to manufacture safe vaccine products or improve the safety of existing vaccine products. Congress therefore charged the Secretary of HHS with the explicit responsibility to assure vaccine safety.

Hence, since 1986, HHS has had the primary and virtually sole responsibility to make and assure improvements in the licensing, manufacturing, adverse reaction reporting, research, safety and efficacy testing of vaccines in order to reduce the risk of adverse vaccine reactions. In order to assure HHS meets its vaccine safety obligations, Congress required as part of the 1986 Act that the Secretary of HHS submit a biennial report to Congress detailing the improvements in vaccine safety made by HHS in the preceding two years."

"In an effort to gain access to these safety reports, ICAN filed a Freedom of Information Act request In August of 2017 to the HHS only to be blocked from receiving information for over eight months. Do to this delay, ICAN and Kennedy were forced to bring a lawsuit against HHS to provide copies of these reports to Congress or to admit that they never actually filed these reports."

"The result of the lawsuit is that HHS had to finally and shockingly admit that it never, not even once, submitted a single biennial report to Congress detailing the improvements in vaccine safety. This speaks volumes to the seriousness by which vaccine safety is treated at HHS and heightens the concern that HHS doesn't have a clue as to the actual safety profile of the now 29 doses, and growing, of vaccines given by one year of age."

https://www.aimintegrativemedicine.com/aim-integrative-medicine-blog/why-kennedy-sued-the-government-over-vaccine-safety-won

According to ICAN (document link to follow)

"The result of the lawsuit is that HHS had to finally and shockingly admit that it never, not even once, submitted a single biennial report to Congress detailing the improvements in vaccine safety. This speaks volumes to the seriousness by which vaccine safety is treated at HHS and heightens the concern that HHS doesn't have a clue as to the actual safety profile of the now 29 doses, and growing, of vaccines

given by one year of age."

"In contrast, HHS takes the other portions of the 1986 Act, which require promoting vaccine uptake, very seriously, spending billions annually and generating a steady stream of reports on how to improve vaccine uptake. Regrettably, HHS has chosen to focus on its obligation to increase vaccine uptake and defend against any claim vaccines cause harm in the National Injury Vaccine Compensation Program (aka, the Vaccine Court) to such a degree that it has abandoned its vaccine safety responsibilities. If HHS is not, as confirmed in Court this week, even fulfilling the simple task of filing a biennial report on vaccine safety improvements, there is little hope that HHS is actually tackling the much harder job of actually improving vaccine safety."

The court filing, ICAN's summary of events and the HHS response revealing that they have no records can be found here: http://icandecide.org/government/ICAN-HHS-Stipulated-Order-July-2018.pdf

In light of those shocking revelations and considering that the FDA was charged as one of the entities to oversee and report on vaccine safety to the congress every two years, this statement from the FDA website is incongruent with what has happened… "The FDA, an agency within the U.S. Department of Health and Human Services, protects the public health by assuring the safety, effectiveness, and security of human and veterinary drugs, vaccines and other biological products for human use, and medical devices. The agency also is responsible for the safety and security of our nation's food supply, cosmetics, dietary supplements, products that give off electronic radiation, and for regulating tobacco products." https://www.fda.gov/news-events/press-announcements/fda-approves-first-cancer-treatment-any-solid-tumor-specific-genetic-feature

Delitigation of the vaccine industry has opened the door for major neglect of product safety

In a 78-page article dated March 30, 2019 by ***Gayle Delong*** and published on ***Research Gate*** titled, **Is "Delitigation" Associated with a Change in Product Safety? The Case of Vaccines**, the author uses very sophisticated analysis of the adverse events from vaccines before congress passed the National Childhood Vaccine Injury Act (NCVIA) in 1986.
https://www.researchgate.net/publication/317990404_Is_Delitigation_Associated_with_a_Change_in_Product_Safety_The_Case_of_Vaccines/link/5c9f5af145851506d734943d/download

The NCVIA shielded vaccine manufacturers from lawsuits for damages caused by their vaccines. What the results show is not surprising to many. Once the threat of being held accountable is removed, manufacturers can become complacent, take greater chances with pushing products out into the market without adequate safety trials and stop looking for safer ways of doing things. The vaccine industry has shown the propensity to do all of these and more. In light of the previous article, it is apparent that the agencies that have been entrusted by "We the People" through the legislative branch, have failed miserably to provide oversight to an industry that has zero incentives to police themselves.

The Abstract:

"This study investigates whether the threat of litigation induces firms to provide safer products in a regulated industry. I analyze whether removing litigation risk or "delitigation" of product liability is associated with a change in the safety of vaccines. Using U.S. nationwide and state-level data, **I find that vaccines that were licensed after legislation that preempted most product liability lawsuits are associated with a significantly higher incidence of adverse events than were vaccines that were licensed under a previous regime that permitted consumers to sue.** Oaxaca decomposition suggests that the difference is due to the policy change. **The results suggest that product safety deteriorates when consumers are no longer able to sue manufacturers**."

From the study:
"This study shows that vaccine safety deteriorates after consumers are not able to sue vaccine manufacturers. The ratios of reported adverse events (AEs)1 to vaccine recipient or AEs to vaccine dose are greater on average for the vaccines that the U.S. Food and Drug Administration (FDA) licensed after legislation that preempted product safety lawsuits than before the legislation. Oaxaca decomposition of state-level data **confirms the result that the vaccines that the FDA licensed after the legislation are associated with more AEs: both serious and nonserious**."

"The decrease in safety may be partially due to the expanded array of vaccines that the legislation allowed. Pharmaceutical companies developed some vaccines that they otherwise would not have developed had consumers retained the right to sue. **The risks from newer vaccines may outweigh the benefits: The likelihood of reporting a serious side effect from a vaccine reaction is greater than of suffering a serious complication from the disease in the five years before the FDA licensed the vaccine**."

"**For many vaccines, the CDC recommends more than one shot, so I include the number of shots to complete a series in the analysis. In rows 16 through 21 of Table 2, I show AEs per series. The difference between the weighted AEs per 100,000 series before and after the legislation (row 18) is 26.9 and statistically significant (p-value = 0.0000). Comparing AEs per dose ratios of vaccines that were licensed after 1995 with those of vaccines that were licensed before the legislation yield a statistically significant increase of 15.7 (row 21).**"

"Analysis of serious AEs per dose and per series, which I report in rows 31 through 42 of Table 2, **show that the pre- and post-legislative differences are statistically significant at either the 1% or 5% levels**."

It also cites a quote by Dr. Jonas Salk…

"I have two serious concerns with regard to … legislation [that indemnifies producers of biologics]:
- One is the removal of the incentive for manufacturers and the scientific community to improve existing vaccines – for example, the pertussis component of the DPT vaccine.
- The other is the removal of the incentive to change policy when equally effective but safer vaccines already exist, for example, poliomyelitis vaccine."

Dr. Jonas Salk (1984)

Many are calling for the repeal of the NCVIA, feeling that vaccine manufacturers that have enjoyed an extremely lucrative business model, should be required to stand on their own claims that they make "safe and effective" vaccines. If they do, great. They can continue to enjoy record profits for themselves and their shareholders. But if they don't, they should be held accountable just like for any other drug on the market, or any other product produced for consumer use for that matter.

Informed Consent – Sorely lacking for Vaccines

Not only is our government not properly monitoring the safety of vaccines as required by law, individuals and parents of children who receive vaccines are denied a fundamental right of full informed consent, including all potential risks BEFORE shots are given.

Parents denied the standard medical Informed Consent for their children

What is Informed Consent?

The hallmark of modern medicine is **Informed Consent**. It is ethically mandatory that doctors give patients the right to choose whether to comply with recommended treatment based on full disclosure of the risks and benefits of every procedure, EXCEPT FOR VACCINATION!

"For an informed consent to be considered ethically valid, there must be full disclosure. This entails that the potential participant must be thoroughly informed as to the purpose of the research, the procedures to be used, the benefits to the participant, if any, **and the potential risks and discomforts** of participating in the research. Any deception jeopardizes the integrity of the informed consent process. There should also be assurances of confidentiality or anonymity of the participant. **The participant's consent to participate in the research must also be voluntary and free of any coercion. It is vital that the participant understand what has been explained and be given the opportunity to ask questions.** It is also necessary that the participant be competent to give consent. In the absence of competency, a legally approved advocate may provide consent. Participation in the research study should be authorized, preferably in writing. Everything should be clearly stated in an informed consent document, written in an easily understood format that avoids or explains technical terms, and whom to contact with further questions: http://depts.washington.edu/bioethx/topics/resrch.html#ques1."
Obviously, the mass immunization experiment, or research project is not declared as such, even though the reality is that it is just that. Therefore, parents representing their children and older individuals are never informed that they are part of a massive human experiment as the Nuremberg Code declares must happen.

The Nuremberg Code cites that "The voluntary consent of the human subject is absolutely essential"

This is being violated by denying parents informed consent regarding risks before subjecting their children to vaccination.

According to **The Ethical Considerations of Medical Experimentation on Human Subjects** by Manny Bekier, M.S., published November 18, 2010 (see reference… http://www.qcc.cuny.edu/SocialSciences/ppecorino/MEDICAL_ETHICS_TEXT/Chapter_7_Human_Experimentation/Reading-Nazi-experimentation.htm). *Italicized comments are added by me.*

"The Nuremberg Code of 1947 came into being as a result of the heinous human experimentation performed by the Nazi doctors in the many concentration camps throughout the German Third Reich. The judgment by the war crimes tribunal, as a result of the "Doctors Trial" at Nuremberg, established 10 principles to guide physicians in all human experimentation: http://www.cirp.org/library/ethics/nuremberg/.

Prior to the Nazi war crimes tribunal, there was no written international code for doctors. Lawyers defending the Nazi doctors pointed to events in the U.S., attempting to argue, for example, that similar wartime experiments were conducted with prisoners at the Illinois State Penitentiary, who allegedly, deliberately infected prisoners with malaria http://www.whale.to/a/cantwell9.html. "

"The experience of the Nazi medical experiments performed in the concentration camps has made it painfully aware that medical experiments on human beings need to conform to well-defined ethical standards and should supersede the justification that such experiments may yield results for the "greater good of society" that might not be obtained by other methods or means of study. *(This is the argument that many make today about vaccination. They insinuate that the collateral damage that occurs to the few is acceptable because of the benefits to the many).* **The first principle of the Nuremberg Code clearly states, "The voluntary consent of the human subject is absolutely essential".** This is followed by an explicit clarification of all the associated requirements, making it extremely difficult for research principle investigators to twist it's meaning:

"This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment."

"The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity."

https://www.ushmm.org/information/exhibitions/online-exhibitions/special-focus/doctors-trial/nuremberg-code

More about informed consent and a call for pediatricians to give proper, legal and ethical informed consent to parents-

Informed consent is the process whereby a healthcare provider discloses the risks of a recommended procedure in writing, to a patient prior to administration of that procedure. This is something that is required with all medical procedures. I have always provided informed consent prior to treatment with my patients. Failure to do so, can open the physician up to a malpractice claim in the event of any adverse reactions to the treatment. These are some comments from an excellent article on informed consent from the Journal of ***Cutaneous Anesthetic Surgery***
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2840885/

Ethical angle: "Patient's has all the freedom to decide what should or should not happen to his/her body and to gather information before undergoing a test/procedure/surgery. No one else has the right to coerce the patient to act in a particular way. Even a doctor can only act as a facilitator in patient's decision making."

Legal angle: "No one has the right to even touch, let alone treat another person. Any such act, done without permission, is classified as "battery" - physical assault and is punishable. Hence, obtaining consent is a must for anything other than a routine physical examination."

Disclosure of Information:
"The information disclosed should include:

- The condition/disorder/disease that the patient is having/suffering from
- Necessity for further testing
- Natural course of the condition and possible complications
- Consequences of non-treatment
- Treatment options available
- Potential risks and benefits of treatment options
- Duration and approximate cost of treatment
- Expected outcome
- Follow-up required

Patient should be given opportunity to ask questions and clarify all doubts. There must not be any kind of coercion. Consent must be voluntary and patient should have the freedom to revoke the consent. Consent given under fear of injury/intimidation, misconception or misrepresentation of facts can be held invalid."

And finally, the **Conclusion:** "Obtaining consent is not only an ethical obligation, but also a legal compulsion. The level of disclosure has to be case-specific."

The underlined sections were added by me, to underscore what commonly happens or does not happen in a pediatric office visit related to immunization. It is commonplace for physicians to magnify the claimed benefits of the immunization and minimize the potential risks. I have personally heard numerous stories from my own patients, about doctors belittling them for asking questions about

potential risks, even to the point of intimidation or threat of expulsion from the practice. This is not only wrong practice, but it violates the ethical and legal obligations of a physician to their patient.

This is one of the biggest bones of contention that I have with the whole immunization process. It is extremely rare that a doctor gives full informed consent to a parent regarding the potential risks of the vaccination of their child. Because the doctor and pharmaceutical company have a blanket protection from lawsuit due to the National Childhood Vaccine Injury Act, they feel empowered to omit vital information that the patient has a legal right to. This flies in the face not only of a physician's obligation to their patient, but in all measures of decency is truly the right thing to do. There is a growing movement by ethical pediatricians in this country to promote proper informed consent to parents bringing their children for immunization. I strongly applaud this movement and recommend that all parents should seek out pediatricians that are willing to do the right thing. For more information about this movement visit https://physiciansforinformedconsent.org/

Vaccine Information Statements (VIS), have been required to be given to vaccine recipients for many years…BUT AREN'T routinely given

Not to be confused with informed consent (although it is similar), the Vaccine Information Statements (VIS) are required to be produced by the CDC according to the National Childhood Vaccine Act of 1986. https://www.cdc.gov/vaccines/hcp/vis/vis-dates.html

The information sheets detailing the benefits AND RISKS of vaccines, are and have been required to be given out FOR EACH VACCINE a medical provider administers since 1986. The original materials were pamphlets and statements prior to the VIS. Has anyone reading this ever been given one of these to read prior to the administration of a vaccine, or every vaccine to yourself or your child? Since discovering this, I have asked numerous people and not one of them had ever received any of this information, much less full informed consent.

If you look at **the table on the following page**, you will see how the requirements of 1986 have been watered down, essentially eliminating extremely important information for a vaccine recipient to know. The highlighted information in column one are the eliminated subjects. Looking at them, it is obvious that for a person to be fully informed would require they have access to this information. The reasons given for removing those sections, is primarily that there was too much information for a person to absorb, (among others as described in this statement from the CDC's History of VIS's). https://www.cdc.gov/vaccines/hcp/vis/downloads/vis-history.pdf

From the History of VIS Document: "In spite of the time and effort spent developing the VIPs, and the fact that many patients found them informative and easy to understand, they were criticized by both providers and patients for the overwhelming amount of information they contained, for being too unwieldy to be read and comprehended during a clinic visit, and for the amount of time required to develop and finalize them.8 It was even suggested that the VIPs' length discouraged careful reading, resulting in patients who were actually less informed than they would have been given simpler materials."9

To me, it would be analogous to dumbing down educational materials in the public-school system to the level of the slowest learners. It helps them keep up with the material, but denies those that could grasp that information and allow them to move forward faster the opportunity to do so. By saying, "we just won't put all the **scary** stuff in there", so it won't overwhelm them (and possibly make them question the safety of the vaccine). **This undermines the opportunity of educated, conscientious and concerned individuals to make an informed decision about their health decisions.** Just look at what the article referenced in number 10 below from the CDC's document. The ***Journal of the American Medical Association*** published this article calling the immunization information given to patients "anxiety-Provoking". Is it possible that all the "anxiety" of reading the possible adverse reactions may sway some to deny the vaccines. Could this be the real reason that they stopped using them? It reduced vaccine compliance? Yet, if you look at the VIS produced over the last few years, you will see they still made the point to describe the symptoms that can occur with the disease the vaccine is designed to prevent.

8. Goldsmith MF. Vaccine information pamphlets here, but some physicians react strongly. JAMA. 1992;267(15):2005-2007.
9. Clayton EW, Hickson G, Miller, CS. Parents' responses to vaccine information pamphlets. Pediatrics. 1994;93(3):269-272.
10. Marwick C. Congress to simplify those complex, **anxiety-provoking** immunization booklets. JAMA. 1992;268(24):3413.

ORIGINAL 1986 LAW	AMENDED LAW- 1993
1. The frequency, severity, and potential long-term effects of the disease to be prevented by the vaccine	1. A concise description of the benefits of the vaccine
2. The symptoms or reactions to the vaccine which, if they occur, should be brought to the immediate attention of the health care provider	2. A concise description of the risks associated with the vaccine
3. Precautionary measures legal representatives should take to reduce the risk of any major adverse reactions to the vaccine that may occur	3. A statement of the availability of the National Vaccine Injury Compensation Program
4. Early warning signs or symptoms to which legal representatives should be alert as possible precursors to such major adverse reactions	4. Such other relevant information as may be determined by the Secretary
5. A description of the manner in which legal representatives should monitor such major adverse reactions, including a form on which reactions can be recorded to assist legal representatives in reporting information to appropriate authorities	
6. A specification of when, how, and to whom legal representatives should report any major adverse reactions	

7. The contraindications to (and bases for delay of) the administration of the vaccine

8. An identification of the groups, categories, or

characteristics of potential recipients of the vaccine who may be at significantly higher risk of major adverse reaction to the vaccine than the general population

9. A summary of:

a. Relevant federal recommendations concerning a complete schedule of childhood immunizations, and

b. The availability of the National Vaccine Injury

Compensation Program

10. Such other relevant information as may be determined by the Secretary [of Health and Human Services]

Historically, the VIS statements would only inform of the reactions that the ACIP would determine, not what research or even VAERS has demonstrated. They were only willing to list those adverse reactions that in their opinion were "proven" to be caused by the vaccine. Remember, many of the advisors sitting on that committee have pharmaceutical industry ties. Unfortunately, as you have seen and will continue to see in this document, there is lots of credible science linking vaccines to numerous health problems, which government agencies still deny are possible. However, in an encouraging development, it looks as though there may be some improvement in the more recent releases of these VIS forms. Let's take the Varicella (chickenpox) VIS just released February 12, 2018. You will see a much longer list of possible adverse reactions than used to be shown with many past VIS. Could this be a sign of better things to come? One could only hope.

From the Varicella VIS online-

https://www.cdc.gov/vaccines/hcp/vis/vis-statements/varicella.html

Some people should not get this vaccine

Tell your vaccine provider if the person getting the vaccine:

- **Has any severe, life-threatening allergies.** A person who has ever had a life-threatening allergic reaction after a dose of chickenpox vaccine or has a severe allergy to any part of this vaccine, may be advised not to be vaccinated. Ask your health care provider if you want information about vaccine components.

- **Is pregnant or thinks she might be pregnant.** Pregnant women should wait to get chickenpox vaccine until after they are no longer pregnant. Women should avoid getting pregnant for at least 1 month after getting chickenpox vaccine.
- **Has a weakened immune system** due to disease (such as cancer or HIV/AIDS) or medical treatments (such as radiation, immunotherapy, steroids, or chemotherapy).
- **Has a parent, brother, or sister with a history of immune system problems.**
- **Is taking salicylates (such as aspirin).** People should avoid using salicylates for 6 weeks after getting varicella vaccine.
- **Has recently had a blood transfusion or received other blood products.** You might be advised to postpone chickenpox vaccination for 3 months or more.
- **Has tuberculosis.**
- **Has gotten any other vaccines in the past 4 weeks.** Live vaccines given too close together might not work as well.
- **Is not feeling well.** A mild illness, such as a cold, is usually not a reason to postpone a vaccination. Someone who is moderately or severely ill should probably wait. Your doctor can advise you.

Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.
Getting chickenpox vaccine is much safer than getting chickenpox disease. Most people who get chickenpox vaccine do not have any problems with it.

After chickenpox vaccination, a person might experience:

Minor events:

- Sore arm from the injection
- Fever
- Redness or rash at the injection site

If these events happen, they usually begin within 2 weeks after the shot. They occur less often after the second dose.
More serious events following chickenpox vaccination are rare. They can include:

- Seizure (jerking or staring) often associated with fever
- Infection of the lungs (pneumonia) or the brain and spinal cord coverings (meningitis)
- Rash all over the body

A person who develops a rash after chickenpox vaccination might be able to spread the varicella vaccine virus to an unprotected person. Even though this happens very rarely, anyone who gets a rash should stay away from people with weakened immune systems and unvaccinated infants until the rash goes away. Talk with your health care provider to learn more.

Other things that could happen after this vaccine:

- People sometimes faint after medical procedures, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting and injuries caused by a fall. Tell your doctor if you feel dizzy or have vision changes or ringing in the ears.

- Some people get shoulder pain that can be more severe and longer lasting than routine soreness that can follow injections. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions to a vaccine are estimated at about 1 in a million doses and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

What if there is a serious problem?

What should I look for?

- Look for anything that concerns you, such as signs of a **severe allergic reaction**, very high fever, or unusual behavior.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would usually start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a **severe allergic reaction** or other emergency that can't wait, call 9-1-1 and get to the nearest hospital. Otherwise, call your health care provider.

Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS website, or by calling **1-800-822-7967**.
VAERS does not give medical advice.

The National Vaccine Injury Compensation Program (NVICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website. There is a time limit to file a claim for compensation. **(END)**

In comparing this to many of the other VIS forms, especially the older ones, it is a good improvement. People should have all of the available information in order to make an educated decision. Hopefully this is a step in the direction towards transparency and full disclosure.

Physician compliance with VIS education is poor and could be better with a little effort

A 2002 study published in the journal ***Ambulatory Pediatrics*** titled, **Improving vaccine risk/benefit communication with an immunization education package: a pilot study**, found that the rate of physician compliance with Vaccine Information Statements was poor. It also found that an initiative to improve the communication on the subject made a significant difference.
https://www.ncbi.nlm.nih.gov/pubmed/?term=12014979

Background from the article: "In a national study, 31% of pediatricians reported not using the VIS and 56% indicated that time was a barrier to vaccine risk/benefit communication. **Parents, however, indicated they want their primary providers to personally tell them about risks/benefits**."
*(I would bet that the rate of pediatricians **not** complying with the VIS education is much higher than 31%. When a professional like a doctor is asked on a survey if they are complying with the law, I would bet that a good percentage would indicate that they were, even if they weren't. Sorry docs, I'd like to think that few of you would do that, but fear of legal/board repercussions could motivate some for sure.*

Results: …"These vaccine communication improvements were made with a very small (20-second) increase in physician time. In post-intervention focus groups, provider staff endorsed the IEP method."

Conclusions: "This IEP was a feasible way to facilitate compliance with the NCVIA. A significant amount of additional information was provided to parents with only a slight increase in time."

One thing I noted that I have bolded above is that parents want the provider to personally tell them about the risks/benefits. I honestly think that is the best way to handle it. They should receive a written explanation like the V.I.S., but it should be the responsibility of the doctor to look the parent in the eye and make sure they understand the risks and benefits.

MORE ON THE NATIONAL VACCINE INJURY COMPENSATION PROGRAM (NVIC) – Part 2

In a roundabout way, taxpayers pay for vaccine damages rather than the vaccine manufacturers

The National Vaccine Injury Compensation Program (NVICP) started in 1986, is a "court" that was created to compensate people injured by certain vaccines. **To date they have paid out over 4 billion dollars in claims and attorney's fees for victims of vaccine injury. Each dose of vaccines is charged a surcharge to be paid into the fund. However, we all know how this works when for-profit companies are charged a surcharge or tax. They pass that on in the pricing of their product to make it a wash and keep their profits intact. Since much of the cost of vaccines and vaccine programs are underwritten by our government, in a roundabout way we are all footing the bill.**

The play on words. Compensation for damage to children who developed autism, are told the settlement is for brain damage NOT autism.

The Pharma-Government-Medical Complex goes to extreme lengths to avoid linking autism to vaccines, even though the Vaccine Injury Compensation Program has compensated hundreds of such cases

In an interview of ***Mary Holland, a Harvard and Columbia University*** trained legal scholar on the recent Docu-series called ***Vaccines Revealed***, she discusses the work she was involved with whereby she and a team of researchers interviewed and looked at cases where families were **compensated** due to their child being brain damaged. In fact, they published a study of their findings as you will read below.

Working with a Developmental Pediatrician their analysis found 83 out of 150 cases they looked at compensated through the *Vaccine Injury Compensation Program*, were cases which had been officially diagnosed with autism (even though they had to avoid using that term to be considered by the court). **That figure represents greater than 50% of compensated cases, where the vaccines the child was given were associated with the child's brain injury and subsequent diagnosis of autism**.

Yet, the courts and the government will go to extraordinary lengths to deny the connection between vaccines and autism. The convoluted admittance of the brain injury, yet denial of the autism connection goes something like this….Vaccines (A) caused the brain damage (B). And the brain damage (B), caused the autism (C). But the vaccines (A), did not cause the autism (C). In other words, A+B=C, but A isn't associated with C. What?

In fact, as you will see below, the court will routinely deny all claims where the diagnosis of autism is brought before them, yet accept and even compensate cases that use the diagnosis of encephalopathy (brain damage, disease or malfunction), multiple seizure disorder, etc.

In a case of selective semantics, the courts won't compensate for Autism, but will for encephalopathy (brain damage, disease or malfunction)

The conclusion of their 2011 study titled, **Unanswered Questions from the Vaccine Injury Compensation Program: A Review of Compensated Cases of Vaccine-Induced Brain Injury**, which was published in the ***Pace Environmental Law Review*** and said the following: *(Note: VICP stands for Vaccine Injury Compensation Program)*

"**While there are likely many routes to "autism", including prenatal neurological insults and toxic post-natal exposures, this preliminary analysis of VICP-compensated cases suggests that autism is often associated with vaccine -induced brain damage**. It raises the question that if the VICPs decisions have

been fair to reject all claims of vaccine injury that use the term “autism”. **This preliminary assessment also suggests the possibility that other contemporary childhood neurological disorders, including attention deficit disorder and learning disabilities, might be less severe after-effects, on the same spectrum of vaccine -induced brain injury**.”

“Based on this preliminary assessment, there may be no meaningful distinction between the cases of encephalopathy and residual seizure disorder that the VICP compensated over the last 20 years and the cases of “autism” that the VICP he has denied. If true, this would be a profound injustice to those denied recovery and to all who have invested trust in the system that Congress created. This preliminary study calls for Congress to investigate the VICP and for scientists to investigate all compensated cases of vaccine injury to gain a fuller understanding of the totality of consequences of vaccine injury.” http://digitalcommons.pace.edu/pelr/vol28/iss2/6/

Autism Spectrum Disorder like symptoms have been compensated hundreds of times by the Vaccine Compensation Program (Court)- But they don’t call it autism. They call it “brain damage”

This section serves an excellent follow-up to the last one.

In a response to a letter written by Sharyl Attkisson a CBS News Journalist to Tina Cheatham from the Health Resources and Service Administration (HRSA.gov), the cautious semantics reveal the strategy regarding the refusal to admit vaccines cause autism.

From the HRSA response:
From: Cheatham, Tina (HRSA) [mailto:TCheatham@hrsa.gov]
Sent: Monday, May 05, 2008 4:14 PM
To: Attkisson, Sharyl
Subject: RE: HHS question

Hi Sharyl,

Here are the numbers of compensable cases for encephalitis/encephalopathy and seizures in our database from October 1, 1988 to March 4, 2008.

Encephalitis/Encephalopathy 611
Seizure Disorders 711
Total 1,322

I'm providing both numbers to you, because there's not much difference in the medical history and outcomes for children that were compensated for "encephalopathy" versus "seizures." Those compensated for encephalopathy often had seizures as part of their clinical picture, and vice versa.

Your Questions
1. How many vaccine court cases has the government compensated, been ordered to compensate, and/or agreed to compensate in which a vaccine-injured child ended up with and/or claimed autism and/or autistic symptoms? (We know of a number of cases, but have been told it is not a complete list.)
Please break down these compensations by year.

Answer:
The government has never compensated, nor has it ever been ordered to compensate, any case based on a determination that autism was actually caused by vaccines. We have compensated cases in which children exhibited an encephalopathy, or general brain disease. Encephalopathy may be accompanied by a medical progression of an array of symptoms including autistic behavior, autism, or seizures.

Some children who have been compensated for vaccine injuries may have shown signs of autism before the decision to compensate, or may ultimately end up with autism or autistic symptoms, but we do not track cases on this basis.

My comment: Just call a spade a spade. I'm sure they know that the floodgates would open if they admitted vaccines caused autism. The truth is that in some cases, they do. The truth is and will continue to come to light. It cannot be suppressed forever.

Pertussis toxin combined with bovine (cow) serum albumin leads to potentially lethal encephalopathy (swelling of the brain)

A 1985 article from ***The Proceedings of the National Academy of Sciences of the United States of America*** titled, **Pertussis toxin is required for pertussis vaccine encephalopathy**, discusses the correlation between pertussis toxin and convulsions, seizures, coma, encephalopathy and death.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC391511/

From the article:
"The pertussis vaccine component of diphtheria-pertussis- tetanus (DPT) vaccine is associated with convulsions in one of 1750 doses, while severe and permanent neurologic damage has been calculated to occur with one of every 310,000 doses."

"Pertussis toxin, also referred to as pertussinogen, lymphocytosis-promoting factor, islet cell activating protein, and histamine-sensitizing factor, **is an oligomeric protein toxin with a wide range of physiologic effects, including increased sensitivity to anaphylaxis, hyperinsulinemia, and increased vascular permeability. In addition to encephalopathic signs such as seizures and coma, systemic manifestations prior to death include cyanosis *(a blue coloration of the skin)* and tachypnea *(abnormally rapid breathing)*."**

"**A mouse model for encephalopathy induced by pertussis immunization has been described; it has features that closely resemble some of the severe reactions, including seizures and a shock-like state leading to death, occasionally seen after administration of Bordetella pertussis (whooping cough) vaccine.**"

"**Purified pertussis toxin plus bovine serum albumin was tested and found to induce the lethal encephalopathy, demonstrating that the toxin was the critical constituent of B. pertussis responsible for encephalopathy**."

"**Thus, we hypothesize that pertussis toxin contained in B. pertussis vaccine plus antibody to BSA triggers the encephalopathy**. **Part of the genetic susceptibility to encephalopathy resides in the capacity of the vaccine recipient to mount an anti-BSA response, while another component of susceptibility resides in the amount of pertussis toxin in the vaccine**."

The DTaP-IPV/Hib (Pentacel) vaccine contains both the pertussis toxin and bovine serum albumin. It appears to be the only pertussis containing combination vaccine that does. **The MMRV vaccine contains serum bovine albumin, so if any of the other pertussis containing vaccines were to be given together with the MMRV, it could be an issue.**

MITOCHONDRIAL INJURY AND SUBSEQUENT DYSFUNCTION IS ONE OF THE HALLMARKS OF VACCINE DAMAGE

Daughter of Johns Hopkins trained neurologist father, and nurse mother win case in vaccine court, after their daughter is permanently damaged from vaccines- Mitochondrial disorder connection is made

In an article published in ***Scientific American*** April 22nd, 2008 and titled, **Vaccine Injury Case Offers a Clue to the Causes of Autism**, the case of a 19-month-old girl **given 5 shots, containing 9 vaccines** is highlighted. **The girl, Hannah Poling, who was a normally developing child regressed into autism**. https://www.scientificamerican.com/article/vaccine-injury-case-offer/

The subtitle of the article sheds light on what may be one of the keys to vaccine induced damage in susceptible children…***Could a group of disorders involving the "power plants of the cell" explain why***

some vaccinated children develop autism but the vast majority don't? See a nice explanation of how this may happen in a couple paragraphs.

From the article:
"The girl had been developing normally, according to her parents—**her father, Jon, is a Johns Hopkins–trained, practicing neurologist, her mother is an attorney and registered nurse**—but in the months after the shots, she developed a fever and litany of other symptoms: diarrhea, appetite loss and intermittent screaming. A pediatric neurologist examining her in February 2001 later noted that she had lost some of the speech she had previously acquired, was no longer making eye contact, and was no longer sleeping through the night."

"That little known condition—"**mitochondrial disorder**"—involves the parts of cells frequently referred to as their "power plants," because they turn sugar into energy. Mitochondria are found in all tissues and organs in the body, and when they do not work properly they can cause or worsen diseases from diabetes to brain disorders. Jay Gargus, a specialist in human genetics and metabolism at the University of California, Irvine, says mitochondrial disorders are a bit like an electrical brownout: "As the electrical voltage starts falling, different appliances will start to fail," he says. "First, the television might turn off, then the lights might go off."

This "power failure" affects regions of the body that rely heavily on mitochondria. The brain is an organ that weights around 3 percent of the total weight of the body but uses around 20 percent of the oxygen provided by the lungs. The oxygen and either glucose of ketones are utilized by the mitochondria in the brain cells to produce energy. Damage to the astrocytes which are the immune cells in the brain, have been implicated with neurodevelopmental disorders including autism. The health and function of the astrocytes happen to be extremely dependent on the mitochondria which produce the energy in the form of ATP required for the cell to function.

Another body system that depends heavily on the energy produced by mitochondria are the muscles. The article discussed research of 40 autistic children which showed that two thirds of them had muscle weakness.

The real question is, do some children already have an underlying or hidden mitochondrial deficiency disorder and vaccines amplify or trigger that already present genetic condition, or do vaccines trigger a reaction that damages the mitochondria in environmentally susceptible children? Either way, vaccines which introduce foreign matter (chemicals, human and animal DNA, heavy metals and retroviruses), into a fetus (through maternal vaccines) or into babies and young children, could be the proverbial "straw that breaks the camel's back."

The mitochondria have DNA that is separate and distinct from the DNA of all the rest of the cells of the body, which is called nuclear DNA. One major consideration in implicating the vaccine causing mitochondrial DNA damage, is that mitochondrial DNA is much more susceptible to oxidative damage than nuclear DNA. And as much of the research looking at the mechanisms of thimerosal, aluminum, MSG and other chemicals found in vaccines in creating an oxidative stress reaction in the cells of the brain shows, this triggers a deadly form of free radical called "Reactive Oxygen Species" or ROS. These dangerous free radicals in turn trigger more oxidative stress, damaging the mitochondria. This vicious cycle is often referred to as a "death spiral."

As these articles suggest, the mitochondrial DNA is highly susceptible to damage, including DNA strand breaks due to oxidative stress which vaccines most certainly produce.

Oxidative stress induces degradation of mitochondrial DNA- **2009**
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2677867/

Oxidative damage of mitochondrial DNA: the result or consequence of enhanced generation of reactive oxygen species- 2010 https://www.ncbi.nlm.nih.gov/pubmed/20873108

Mitochondrial DNA damage is more extensive and persists longer than nuclear DNA damage in human cells following oxidative stress https://www.ncbi.nlm.nih.gov/pmc/articles/PMC19544/

Mitochondrial Dysfunction in Autism Spectrum Disorders
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5137782/pdf/emss-70523.pdf

Mitochondrial disorders affect about 1 in 4,300 persons born in the U.S.

In an article from ***Mitochondrial Disease News*** July 05, 2017 titled, **Mitochondrial Disease an Enormous Burden on U.S. Patients, Study Finds**, researchers estimate approximately 1 person in 4,300 suffers from a mitochondrial disorder and it stands to have an enormous impact on medical costs and mortality for those affected by it.
https://mitochondrialdiseasenews.com/2017/07/05/mitochondrial-disease-enormous-burden-us-patients-study-finds/

Recent evidence suggests that approximately half of all autistic individuals have mitochondrial dysfunction

A 2015 article in the journal ***Biomarkers in Medicine*** titled, **Mitochondrial enzyme dysfunction in autism spectrum disorders; a novel biomarker revealed from buccal swab analysis** suggests that as 42% or more of individuals with autism have mitochondrial respiratory enzyme deficiencies. In cases of severe autism, the percentage was much higher. This study suggests that a much higher percentage of autistic persons have issues with their mitochondria than just a few years prior. The researchers used a swab of the inside of the mouth (buccal), to look for a biomarker of mitochondrial dysfunction.
https://www.ncbi.nlm.nih.gov/pubmed/?term=26439018

From the article: "Significant RC activity deficiencies were found in 39 (42%) ASD patients ($p < 0.01$) and more prevalent in more severe cases. Aberrant RC overactivity was seen in 9 children. RC-I/RC-IV activity ratio was significantly increased in 64% of the entire ASD cohort including 76% of those more severely affected ($p < 0.05$)." *(RC stands for Respiratory Complex…i.e. Part of the energy generating mechanism of the mitochondria)*

The real question is, is it the chicken (the vaccine or environmental chemical exposure) or the egg (an inherited mitochondrial disorder), that is a causative factor for autism? The next article may shed some light on that dilemma.

Aluminum is implicated as a primary source of mitochondrial damage

A 2011 article published in the journal of ***Experimental Cell Research*** titled, **Hepatic response to aluminum toxicity: dyslipidemia and liver diseases** discusses how aluminum causes an increase in Reactive Oxygen Species (ROS) leading to mitochondrial damage.
https://www.ncbi.nlm.nih.gov/pubmed/?term=21787768

From the article: "Mitochondrial metabolism is the main site of the toxicological action of Aluminum."

The reality is that **there are currently 23 vaccines on the CDC's Vaccine Excipient list that contain aluminum. Some contain 2 versions of aluminum (Hep B *Recombivax* and Hep A/Hep B *Twinrix* vaccines) and one (the DTaP-HepB -IPV *Pediarix* vaccine) contains 3!** Click here and see for yourself.
https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/b/excipient-table-2.pdf

The excessive numbers of doses in the ever-increasing vaccine schedule is increasing adverse reactions and infant death rates

The dramatic increase in the number of mandated vaccines, a primary cause of adverse event injuries and deaths

A major part of the problem is that the vaccine schedule had increased the number of recommended vaccine exponentially over the last 30 years. This just multiplies the stress on the immune and nervous systems of these small children. See this infographic that clearly shows the huge increase in the number of vaccines from 1983 to 2008.
https://www.sciencebasedmedicine.org/wp-content/uploads/2011/07/GR-USA-Today-Ad.pdf

The dose schedule has tripled in the last 30 years and more than quadrupled since 1953

In addition to an infant's "leaky" brain blood vessels that allow toxins to flow freely into the brain, there are far too many vaccine doses given to children now, as compared to 30-50 years ago.

According to the National Vaccine Information Center:

- **In 1953**, there were **16 doses of 4 vaccines** (smallpox, diptheria/pertussis/tetanus) between 2 months and age 6.

- In the **mid-1980s**, the vaccine schedule called for **23 doses of seven vaccines** starting at two months old. Those included diphtheria, pertussis and tetanus (3 vaccine DPT combo), oral polio, and the measles, mumps and rubella (3 vaccine MMR combo).

- In the year **2000**, children were getting **33 doses of 10 vaccines** starting on the day of birth, with the addition of the Hepatitis B vaccine. The other ***additions*** were the Haemophilus Influenza Type B (Hib), Varicella and Hepatitis A in selected areas.
  https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4902a4.htm

- By **2010**, the CDC recommendations were to give children **69 doses of 16 vaccines** starting on the day of birth through age 18, with 48 of those vaccinations given before age 6. The ***additions*** over the previous schedule are Rotavirus, Pneumococcal, Influenza and Meningococcal vaccines.
  https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5851a6.htm

Since 2008 two three-vaccine combo products have been available, Pentacel and Pediarix

- Pentacel contains: DTaP, IPV and Hib
- Pediarix contains DTaP, IPV and Hep B

The schedule for the administration and timing compared to the individual vaccines change when either of these combo products are used. That can be viewed here:
http://www.immunize.org/cdc/pentacel_pediarix.pdf

One interesting caveat is that the CDC **Guidance on the use of Pentacel and Pediatrix** notice August 2008 states that, "…Pentacel can be used when a child needs one or two components, but does not need the others". In other words, if a child is up to date on their Hep B and IPV vaccine doses, but needs DTaP, **they say it is permissible to just give them the 3-vaccine combo to cover the one vaccine that is needed (see the reference above).**

That would give the child 2 additional doses that they don't need. That is not only unnecessary, but totally irresponsible. As you read the following CDC 2017 schedule, realize that many children may be getting additional doses to the 69 they are already getting because of this policy.

The 2017 CDC schedule is up to 69 doses:

1. Hep B- 3 doses

2. Rotavirus (RV-5)- 3 doses
3. DPT- 5 doses
4. Tdap- 1 dose
5. Hib- 4 doses
6. Pneumococcal- 4 doses
7. Polio- 4 doses
8. Influenza- up to 28 doses
9. MMR- 2 doses
10. Varicella- 2 doses
11. Hep A- Up to 4 doses (geographically dependent)
12. Human Papillomavirus (HPV)- 3 doses
13. Meningococcal- 2 doses
14. Pneumococcal- 4 doses

https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html

INFANT MORTALITY RATES OF INDUSTRIALIZED COUNTRIES AND THEIR RATES OF VACCINE DOSES – A TROUBLING CORRELATION

In 2009, the U.S. had the highest number of vaccine doses and was 34th in infant mortality rate

In 2009, the U.S. had the highest vaccine rate and 33 other nations had better infant (<1 year-old) mortality rates- A linear correlation

A fascinating study showing the comparison of number of vaccines given by age 1 and the corresponding infant mortality rate is called**, Infant mortality rates regressed against number of vaccine doses routinely given: Is there a biochemical or synergistic toxicity?** It was published in 2011 in the ***Journal Human and Experimental Toxicology***. The article states: "The infant mortality rate (IMR) is one of the most important indicators of the socio-economic well-being and public health conditions of a country. The US childhood immunization schedule specifies 26 vaccine doses for infants aged less than 1 year—the most in the world—yet 33 nations have lower IMRs." It goes on to state, "Linear regression analysis of unweighted mean IMRs showed a high statistically significant correlation between increasing number

of vaccine doses and increasing infant mortality rates" Looking at the two charts side by side is eerie the correlation is so striking. You can see it here. https://www.ncbi.nlm.nih.gov/pubmed/21543527 When you look at Figure 2, you can clearly see the direct correlation between the number of doses of vaccines given and the proportional rising rate of infant mortality. The article also makes reference to previous studies that show a possible link between some cases of Sudden Infant Death (SIDS) and vaccination, specifically the DPT vaccine.

According to the ***CIA World Factbook***, "Infant mortality rate compares the **number of deaths of infants under one year old in a given year per 1,000 live births** in the same year. This rate is often used as an indicator of the level of health in a country".

Source for infant mortality rates: CIA Country comparison: infant mortality rate (2009). The World Factbook.

Sweden has the lowest infant mortality rate (2009 statistics) and also has the lowest number of doses of vaccines at 12, given before age 1. **The U.S. ranked 34th and had the highest infant mortality rate along with the greatest number of vaccinations given by age 1 at 26.**

Maternal Vaccines, an important component and often forgotten component to infant mortality

For more on the apparent inherent risks and dangers of vaccines given to expectant mothers, refer to this link to be taken back to that section which was presented earlier in this document.
Shocking revelations from the flu vaccine package insert regarding pregnant women, nursing mothers and young children- NEVER been tested in pregnant women (and then scroll down from there)

Suffice to say, there is much evidence that would suggest that these vaccine components will pass through to the fetus at a time when it is most vulnerable to toxins. If the EPA puts strict limits on the amount of tuna fish pregnant women should eat when only a small percentage of what is ingested is actually absorbed into the bloodstream, why would we think it would be okay to inject metals and other toxic substances directly into the mother's circulation?

Check out the next graphic, showing numbers of Vaccines given by age 5 (2006) and the rates of autism!

These are 2006 statistics

TABLE 3: VACCINE SCHEDULES, AUTISM RATES, AND UNDER 5 MORTALITY FOR SELECT COUNTRIES

Country	# of Mandatory Vaccines (<5 yrs old)	Autism Rate	US Autism Rate Multiplier	Mortality Rates Per 1,000 children Under 5 years old	Mortality Rate Worldwide Rank
United States	36	1 in 150		7.8	34
Iceland	11	1 in 1,100 [ii]	7.3 x	3.9	1
Sweden	11	1 in 862 [iii]	5.7 x	4.0	2
Japan	11	1 in 475 [iv]	3.2 x	4.2	4
Norway	13	1 in 2,000 [v]	13.3 x	4.4	5
Finland	12	1 in 719 [vi]	4.8 x	4.7	6
France	17	1 in 613 [vii]	4.1 x	5.2	11
Israel	11	1 in 1,000 [viii]	6.7 x	5.7	17
Denmark	12	1 in 2,200 [ix]	14.6 x	5.8	18

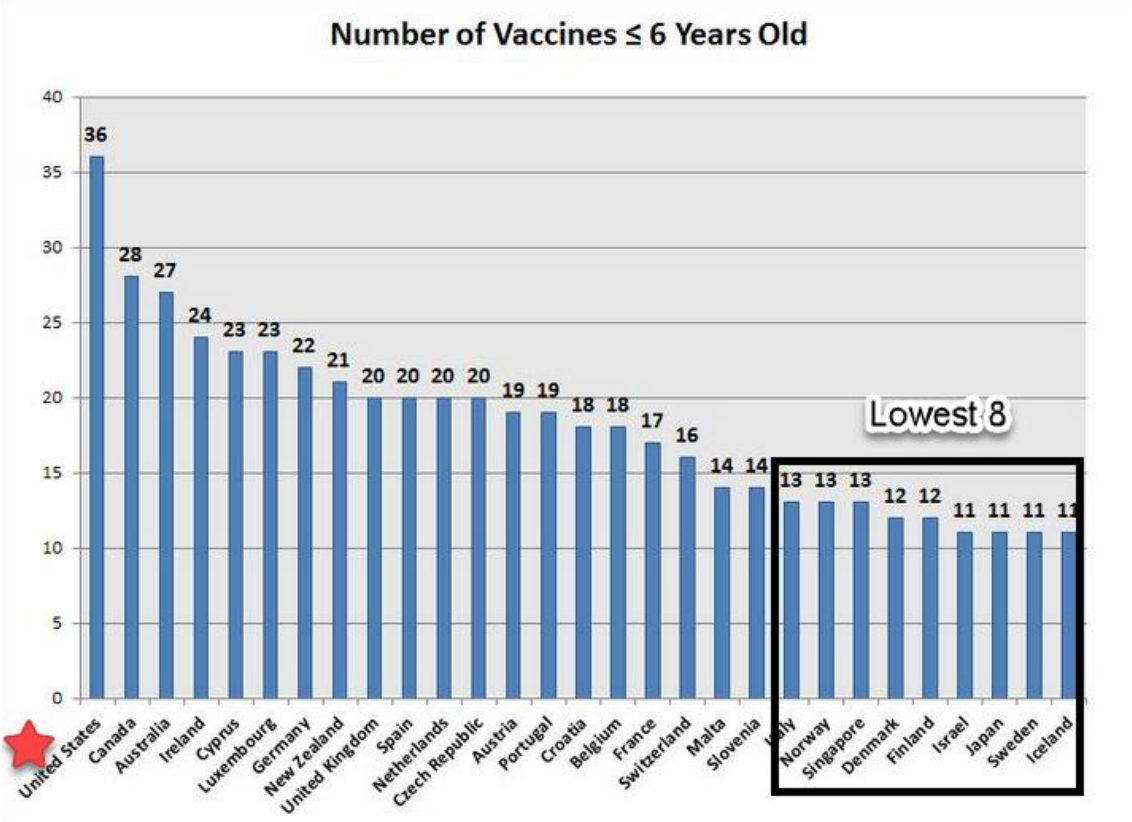
Source: Vaccine Schedules, Autism Rates, and Under 5 Mortality, ***Generation Rescue 2009***
http://www.generationrescue.org/

- Look at the number of mandatory vaccines by age 5 column. The U.S. far exceeds the other nations.
- The US Autism Rate Multiplier column, is how many times greater the U.S. autism rate is than that country. For example, the rate of autism in the U.S. is 7.3 times greater than in Iceland and 13.3 times greater than in Norway.
- The Mortality Rate per 1,000 children column is the number of deaths per 1,000 children by age 5. The lower the number the better the survival rate. As you can see the U.S. ranked 34th.

The U.S. has now slipped to 57th in infant mortality, dropping 23 positions in just eight years, as doses of vaccines have increased

As of 2016, the U.S. was ranked 57th in the world in **infant mortality** according to the ***CIA World Factbook***. AND 32nd in **under-5 mortality** according to the ***Organisation for Economic Co-operation and Development (O.E.C.D.)***. Before you get too excited and say, "well 32nd is better than 57th. We must be making progress", think again. The 32nd ranking is out of a group of the 35 country members of the O.E.C.D. The O.E.C.D. member nations are "developed nations whose goal is to stimulate economic progress and world trade."
https://en.wikipedia.org/wiki/List_of_countries_by_infant_and_under-five_mortality_rates

What has happened?



What do the current comparisons between the BEST infant mortality rates in the world and number of vaccines by age 6 look like?

218	SWEDEN	The top 8 infant mortality rates in the world- 2017	2.60	2017 EST.
219	BERMUDA		2.50	2017 EST.
220	FINLAND		2.50	2017 EST.
221	NORWAY		2.50	2017 EST.
222	SINGAPORE		2.40	2017 EST.
223	ICELAND		2.10	2017 EST.
224	JAPAN		2.00	2017 EST.
225	MONACO	The best infant mortality rate in the world	1.80	2017 EST.

There are now several third world countries with better infant mortality than the United States at 5.8 deaths per 1,000 births.

Here is an example of just a few countries you would never think would have better infant mortality rates than the United States of America.

- **Serbia**
- **Bosnia**
- **Faroe Islands**
- **Cuba**
- **French Polynesia**
- **Wallis and Futuna**
- **Taiwan**
- **Isle of Man**
- **Jersey**
- **Estonia**
- **Anguilla**
- **Czechia**
- **Singapore**

How do you explain that?

- We have the "best" medical care in the world.
- We have the best medical technology in the world.
- We have the best access to medical care in the world.
- We have the best hospitals in the world.
- We have the most highly trained and specialized doctors in the world.
- We have the best nurses and pediatric care in the world.
- We have the best pediatric intensive care in the world.
- We give the highest number of vaccines by age 6 in the world.

Yet, 56 countries have better infant mortality than the U.S.! As you can see from the charts above, we are injecting our children with triple the number of vaccines as the countries with the lowest infant death rates. And as mentioned, we are injecting pregnant women with additional vaccines.

A shocking study, showing that hospitalizations and deaths in infants increase in proportion to the number of vaccine doses

A 2012 article published in the journal of ***Human and Experimental Toxicology*** titled, **Relative trends in hospitalizations and mortality among infants by the number of vaccine doses and age, based on the Vaccine Adverse Event Reporting System (VAERS), 1990-2010**, cites an alarming correlation between the number of vaccine doses and the rates of subsequent hospitalization and death. The study analyzed data from the Vaccine Adverse Event Reporting System (VAERS) over a 20-year period.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3547435/pdf/10.1177_0960327112440111.pdf

From the study:
"In this study, the Vaccine Adverse Event Reporting System (VAERS) database, 1990–2010, was investigated; cases that specified either hospitalization or death were identified among **38,801 reports** of infants. Based on the types of vaccines reported, the actual number of vaccine doses administered, from 1 to 8, was summed for each case."

"Our findings show a positive correlation between the number of vaccine doses administered and the percentage of hospitalizations and deaths."

"**The hospitalization rate increased linearly from 11.0%** (107 of 969) **for 2 doses to 23.5%** (661 of 2817) **for 8 doses and decreased linearly from 20.1%** (154 of 765) **for children aged <0.1 year to 10.7%** (86 of 801) **for children aged 0.9 year**."

Doses	**Hospitalization Rate**
2	11%
8	23.5%

Age	**Hospitalization Rate**
<5 weeks	20.1%
10 months	10.7%

The rate ratio (RR) of the mortality ***(Death)*** rate for 5–8 vaccine doses to 1–4 vaccine doses is 1.5 (95% confidence interval (CI), 1.4–1.7), indicating a statistically significant increase **from 3.6%** (95% CI, 3.2–3.9%) **deaths associated with 1–4 vaccine doses to 5.5%** (95% CI, 5.2–5.7%) **associated with 5–8 vaccine doses.**

Doses	**Death Rate**
1-4	3.6%
5-8	5.5%

"The male-to-female mortality (Death) RR was 1.4 (95% CI, 1.3–1.5)." ***(1.4 males affected per female)***

"Since vaccines are given to millions of infants annually, **it is imperative that health authorities have scientific data from synergistic toxicity studies on all combinations of vaccines that infants might receive. Finding ways to increase vaccine safety should be the highest priority."**

"Studies have not been conducted to determine the safety (or efficacy) of administering multiple vaccine doses in a variety of combinations as recommended by CDC guidelines. Our findings show a positive correlation between the number of vaccine doses administered and the percentage of hospitalizations and deaths reported to VAERS. In addition, younger were significantly more likely than older infants to be hospitalized or die after receiving vaccines. Since vaccines are administered to millions of infants every year, it is imperative that health authorities have scientific data from synergistic toxicity studies on all combinations of vaccines that infants are likely to receive; universal vaccine recommendations must be supported by such studies."

A call for screening newborns for immune-deficiency before vaccination

To underscore the importance of screening before vaccinating, this study titled, **Adverse events following Immunization in patients with primary immunodeficiencies**, published in the Journal ***Vaccine*** March 2016 and warned of the increased risk of serious adverse reaction in this population. https://www.ncbi.nlm.nih.gov/pubmed/26850760

The conclusion from the article: "Our study included a large cohort of Primary Immunodeficiency Disease (PID), patients and **confirmed an increased risk of serious Adverse Events Following Immunization in these populations**. **The design and implementation of neonatal screening strategies for the early detection of congenital lymphopenias and other PID are urgently needed to avoid serious complications of the Bacille Calmette-Guerin, is a vaccine for tuberculosis (BCG),** vaccine usually applied immediately after birth *(in Columbia)*. Our findings also support the use of the acellular pertussis vaccine to minimize the appearance of seizures in PID patients vaccinated with diphtheria, pertussis and tetanus (DPT)."

The Institute of Medicine of the National Academy of Sciences calls into question how all of these different vaccines may be interacting with each other and the lack of research to find out

In 2013, the ***National Academies Press*** published a report by the ***National Academy of Sciences*** based on the investigative work done by the ***Committee on the Assessment of Studies of Health Outcomes Related to the Recommended Childhood Immunization Schedule***, titled **The Childhood Immunization Schedule and Safety: Stakeholder Concerns, Scientific Evidence, and Future Studies**. The report took a comprehensive look at the issue taking into consideration all of the different parties with interests at stake. https://www.ncbi.nlm.nih.gov/books/NBK206948/pdf/Bookshelf_NBK206948.pdf

From the Report:
"Conclusions about Scientific Findings"

"The committee encountered **two major issues** in its review of the findings in the scientific literature. **First, the concept of the immunization "schedule" is not well developed**. Most vaccine-related research focuses on the outcomes of single immunizations or combinations of vaccines administered at a single visit. Although each new vaccine is evaluated in the context of the overall immunization schedule that existed at the time of review of that vaccine, elements of the schedule are not evaluated once it is adjusted to accommodate a new vaccine. **Thus, key elements of the entire schedule—the number, frequency, timing, order, and age at administration of vaccines—have not been systematically examined in research studies.**"

"**The second major issue** that the committee encountered **was uncertainty over whether the scientific literature has addressed all health outcomes and safety concerns**. The committee could not tell

whether its list was complete or whether a more comprehensive system of surveillance might have been able to identify other outcomes of potential significance to vaccine safety. **In addition, the conditions of concern to some stakeholders, such as immunologic, neurologic, and developmental problems, are illnesses and conditions for which etiologies, in general, are not well understood.**"

"**Finally, the committee found that evidence assessing outcomes in subpopulations of children who may be potentially susceptible to adverse reactions to vaccines** (such as children with a family history of autoimmune disease or allergies or children born prematurely) **was limited** and is characterized by **uncertainty** about the definition of populations of interest and definitions of exposures and outcomes."

"**In summary, to consider whether and how to study the safety and health outcomes of the entire childhood immunization schedule, the field needs valid and accepted metrics of the entire schedule (the "exposure") and clearer definitions of health outcomes linked to stakeholder concerns (the "outcomes") in rigorous research that will ensure validity and generalizability**."

That was 2013. We are still waiting on the recommended "rigorous research" that would help to answer those serious concerns.

Central Nervous System Demyelinating Diseases

High correlation with Multiple Sclerosis and the Hepatitis B Vaccine

Speaking of the vaccine connection to multiple sclerosis, this link will take you to a graph on the ***MedAlerts Blog***, that **shows a high correlation of multiple sclerosis with the Hepatitis B vaccine.** http://www.medalerts.org/analysis/archives/650

The site also shows and describes **how to create a graph from VAERS data, allowing the ability to identify which vaccine adverse events are associated with particular vaccines.** The site is designed and maintained by a computer scientist named **Steven H. Rubin PhD**. Dr. Rubin is not a medical professional. Instead, **he has over 40 years of experience as a computer scientist and knows how to decipher the numbers behind the statistics**. The about tab on his site explains about his experience and what he monitors.

Documented cases of Central Nervous System (CNS) demyelinating diseases caused by vaccine reactions

A study published in the Journal of ***Autoimmunity Reviews*** 2014, titled, **The spectrum of post-vaccination inflammatory CNS demyelinating syndromes**, cites numerous published cases of CNS demyelinating diseases caused by vaccination. https://www.ncbi.nlm.nih.gov/pubmed/?term=24514081

From the article:

"A wide variety of inflammatory diseases temporally associated with the administration of various vaccines, has been reported in the literature."

The most commonly reported vaccinations that were associated with CNS demyelinating diseases included:

- Influenza
- human papilloma virus (HPV)
- hepatitis A or B
- rabies
- measles
- rubella
- yellow fever
- anthrax
- meningococcus
- tetanus.

"The vast majority of post-vaccination CNS demyelinating syndromes, are related to influenza vaccination and this could be attributed to the high percentage of the population that received the vaccine during the HI1N1 epidemia from 2009 to 2012. Usually the symptoms of the CNS demyelinating syndrome appear few days following the immunization (mean: 14.2 days) but there are cases where the clinical presentation was delayed (more than 3 weeks or even up to 5 months post-vaccination) (approximately a third of all the reported cases). In terms of the clinical presentation and the affected CNS areas, there is a great diversity among the reported cases of post-vaccination acute demyelinating syndromes."

The percentage of cases are as follows:
Optic neuritis- 35% (Inflammation of the optic nerve)
Multifocal disseminated demyelination*- 28%
Myelitis- 22% (Inflammation of the myelin)
Encephalitis- 16% (Brain inflammation)

*According to Wikipedia- "A *demyelinating* disease is any disease of the nervous system in which the myelin sheath of neurons is damaged. This damage impairs the conduction of signals in the affected nerves." Multiple Sclerosis is the most common demyelination disease and is an autoimmune condition. Multifocal means "multiple locations"

It's important to remember, that this article only focused on CNS demyelinating diseases and just on the few cases that were reported in the literature. Bear in mind, the number of actual cases that are reported to VAERS are between 1-10 percent and the number of reports making it into the literature is miniscule compared to the total number that are eventually reported to VAERS. It does shed some light on the approximate percentages of the different types of CNS demyelinating disorders caused by vaccine adverse reactions.

2018 study finds up to nearly 6 times greater chance of developing central nervous demyelinating disease like Multiple Sclerosis, in adults given the Hepatitis B vaccine, when compared to other vaccines

A 2018 study in the journal ***Drug Safety*** titled, **Central Demyelinating Diseases after Vaccination Against Hepatitis B Virus: A Disproportionality Analysis within the VAERS Database**, **finds that the incidence of central nervous system demyelinating diseases like Multiple Sclerosis are as much as 5.56 times greater of developing within 120 days after receiving the Hepatitis B vaccine when compared to other vaccines**. https://www.ncbi.nlm.nih.gov/pubmed/29560597

From the study:
"We calculated the proportional reporting rate (PRR) and reporting odds ratio (ROR) **of MS having occurred within the 120 days following HB immunization in adults aged 19-49 years when compared with other vaccines using the reports recorded in the VAERS database**."

"All computed ratios were found to be **statistically significant**, with PRRs ranging from **3.48 to 5.56** and RORs ranging from **3.48 to 5.62**. When considering the geographical origin, similar RORs were obtained for both US and non-US cases." ***(That translates into a 350-550% increase in developing central nervous system demyelinating disease like multiple sclerosis).***

"In VAERS, **MS cases were up to five times more likely to be reported after an HB vaccination than after any other vaccination**. Since DPA is mainly suited for hypothesis generation, further studies evaluating the nature of the link between MS and HB vaccination would be of considerable importance."

TRANSMISSION OF THE VACCINE VIRUS TO OTHERS AND MUTANT STRAINS

Persons getting certain vaccines pose a risk of transmission of that virus to others around them

Recipients of the shingles vaccine Zostavax can transmit the virus to others through saliva

https://www.ncbi.nlm.nih.gov/pubmed/21592982
This article appeared in the ***Journal of Infectious Diseases*** June 2011. It is titled, **Varicella zoster virus DNA at inoculation sites and in saliva after Zostavax immunization**. Zostavax is a herpes zoster (Shingles) vaccine made by Merck. From the article:

"The detection of VZV DNA in saliva of Zostavax recipients for up to 28 days suggests that contact with saliva of recently immunized individuals represents a potential source of transmission."

"Zostavax contains live attenuated VZV, and the package insert warns newly vaccinated individuals to avoid contact for an unspecified time with newborn infants, immunosuppressed individuals, and pregnant women who have not had chicken pox or have not been immunized for chicken pox. Because VZV DNA is present in saliva of zoster patients for at least 2 weeks [5] and VZV in saliva can also be infectious [6], we examined the inoculation site and saliva of Zostavax-vaccinated subjects for the presence of VZV DNA for 4 weeks after immunization."

"In saliva collected over 28 days in 21 (58%) of 36 subjects (copy number, 20 to 248). Genotypic analysis of DNA extracted from 9 random saliva samples identified vaccine virus in all instances." That means that in 58% of the study subjects, the shingles (zoster) virus was identified in all 9 random samples collected from those subjects. That means that their body was shedding the virus. This makes transmission and infection highly likely of anyone is exposed to the saliva of those receiving the vaccine. This is one of the reasons that many vaccine manufacturers have gotten away from the live viruses and moved to the dead ones instead.

Taking certain vaccines may put you at increased risk for infections from other strains of the disease.

The flu vaccine (TIV), increases risk by 440% of catching other non-influenza viruses

This article appeared in the ***Clinical Infectious Diseases Journal*** in 2012 titled, **Increased risk of non-influenza respiratory virus infections associated with receipt of inactivated influenza vaccine**. This is a quote from that article. "Over the following 9 months, Trivalent Influenza Vaccine (TIV) recipients had an increased risk of virologically confirmed non-influenza infections (relative risk: 4.40; 95%confidence interval: 1.31-14.8). Being protected against influenza, TIV recipients may lack temporary non-specific immunity that protected against other respiratory viruses".

"The phenomenon of virus interference has been well known in virology for >60 years".

Strains are mutating due to the pertussis vaccination program making the vaccine ineffective

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3966384/ This article from the Journal ***Emerging Infectious Disease*** April 2014 titled, **Rapid Increase in Pertactin-deficient *Bordetella pertussis* Isolates, Australia**, expresses serious concerns that Pertussis strains are mutating beyond what the vaccine can protect against and the sharp rise in cases of pertussis are caused by this adaptation to the vaccine.

"This pattern is consistent with continuing evolution of *B. pertussis* in response to vaccine selection pressure."

"The multiple origins of prn-negative isolates also point strongly to selective pressure *(from vaccination against Pertussis),* on the bacterium. Therefore, it is conceivable that these prn-negative isolates are more likely to evade a vaccine-induced immune response."

"Continued monitoring of genotypic and phenotypic properties of *B. pertussis* is required to better understand the effects of vaccination on the evolution of the organism."

This study and many other current studies expressed the concern in the scientific community regarding the mutation of the pathogenic bacteria or virus that the vaccines are designed to protect against. This is reminiscent of what is happened with antibiotics. The overuse and overprescribing of antibiotics has contributed to massive mutation of bacteria into strains that are highly resistant to today's antibiotics. Concerns are arising in the scientific community that a similar phenomenon is emerging as a result of mass vaccination.

Vaccines can cause mutant and more virulent (harmful) strains

A 2006 article from the ***The International Journal of Evolution,*** titled, **Vaccination, within-host dynamics, and virulence evolution,** scientists contend that vaccination can contribute to faster spreading and more harmful strains.

"We explore the potential consequences of vaccination on parasite epidemiology and evolution". *The reference to parasite in this case, can mean bacteria or viruses that uses the human as the host to replicate and thrive).*

"**We analyze the evolution of the replication rate of parasites and show that vaccination may promote the evolution of faster replicating and, consequently, more virulent strains."**

THE SUDDEN INFANT DEATH CONNECTION WITH VACCINES

Research scientist and author of 90 peer-reviewed papers lays out a credible case

Sudden Infant Death (S.I.D.S.), SIDS is defined as "the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, death scene investigation, and review of the clinical history."

Viera Scheibner Ph.D. is a former research scientist. She has published three books and has authored 90 papers published in peer-reviewed scientific journals. She has done extensive research into vaccines and adverse reactions in children. In 1983, she published the highly acclaimed book **The Medical Assault on the Immune System**. She has acted as an expert witness in vaccine cases world-wide.

This is a commentary from her on S.I.D.S. posted on Health Freedom Idaho's website…
https://healthfreedomidaho.org/court-rules-vaccines-contribute-to-and-cause-sids-deaths

LITERATURE SEARCH ON SIDS
"Then I asked myself, are we the only people who stumbled over the dangers of vaccines? Does the medical profession know about all this? Is there anything published in the medical literature? I began to do research in medical libraries, and to my absolute astonishment, there is no end to it. For my book, Vaccination, **I studied more than 30,000 pages of data published in medical journals about Crib Deaths after vaccinations.** In one study, there were 41 babies who died within 21 days of their first Triple Antigen injection, and there was a clustering of these deaths along those critical days we recorded in the babies' breathing after vaccination. **This is the ultimate evidence of the causal link between the administration of those vaccines and these deaths. In the so-called "Tennessee Deaths", hundreds of babies died there, after their DPT injections. *We soon established that the vaccines are killing babies, and Crib Deaths (SIDS) are 95% vaccine deaths.***"

United States Vaccine Court ruling July 10, 2017 finds the Sudden Infant Death of a 4-month-old boy was vaccine related

In article published on the Vaccine Awareness Organizations website discusses a recent decision by the Office of Special Masters of the U.S. Court of Federal Claims, known as the vaccine court, that **sufficient**

evidence was put forth to rule that vaccination caused a child to die from Sudden Infant Death Syndrome (SIDS).

https://www.vaccine-awareness.info/single-post/2017/11/08/New-Decision-in-US-Vaccine-Court-SIDS-Case-Is-Significant

The young boy, referred to here as J.B. had gone to the pediatrician monthly for well-will baby visits. Each but me he met or exceeded rule his developmental milestones. Then his parents took him in for his 4-month well-baby visit. During that visit, the pediatrician made the following notes: **"smiling and cooing like normal."** According to the court documents, **he was described as "healthy appearing and cooperative…well-nourished and well developed."** In addition, J. B. Had achieved several developmental milestones for a healthy four-month-old. According to the report, "**During the 4-month well-baby visit, J.B. received DTaP, IPV, PCV, rotavirus, and Hep B vaccinations.** Testimony from his parents show later that day J.B. "**was not laughing or cooing like he normally did,** he was not moving as much and he seemed quiet and withdrawn." That night, J.B. had a fever and he did not sleep well. **Less than 24 hours later J.B. passed."** His parents pursued a case in the ***United States Court of Federal Claims***, **otherwise known as Vaccine Court**. After a lengthy process and painstaking trial, the verdict came down in favor of the parents.

This is the official conclusion of special master Gowen, the judge presiding over the case:

*"In this case, **I have concluded that petitioners have presented sufficient evidence and testimony to entitle them to compensation** in the Vaccine Program. I have not concluded that vaccines present a substantial risk of SIDS….In this case, I have concluded, after review of the evidence, **that it is more likely than not that the vaccines played a substantial causal role in the death** of J.B. without the effect of which he would not have died."*

"*The role of inflammatory cytokines as neuro-modulators in the infant medulla has been well described and **is likely the reason for a significant number of SIDS deaths occurring in conjunction with mild infection.** I have concluded that it is more likely than not that the vaccine-stimulated cytokines had the same effect in this vulnerable infant during sleep."*

A well-known and respected neurosurgeon answers the question, how could a vaccine cause Sudden Infant Death?

How would it be possible for the vaccine to do that? Russell Blaylock M.D., the prominent neurosurgeon that wrote the articles presented on pages 230 and 243.
http://articles.mercola.com/sites/articles/archive/2008/03/14/the-danger-of-excessive-vaccination-during-brain-development.aspx

This article titled, **The Danger of Excessive Vaccination During Brain Development**, answers that question. Here are some quotes from Dr. Blaylock summarizing what vaccines can do to the brain as it relates to SIDS and other neurological damage, especially when multiple vaccines are given.

"They [pediatricians] hardly ever want to debate. But if you could tie one to a chair and debate them, ***all they would talk about is one vaccine.*** *[They would say] Well, the adjuvant in one vaccine is really not that strong, it's weaker than it used to be and all this nonsense."*

"*And then you say, Mr. Pediatrician,* ***what if I multiply that times six?*** *Now that child is getting six times as high a dose of just the adjuvant. Some of these vaccines have three different viral antigens in them. So now* ***we're talking about dozens of immune stimulations****…all in one sitting…in a tiny baby. That's already had its microglia primed. You get an enormous secretion of inflammatory cytokines and glutamate powerfully. The child can die [of]…SIDS because remember the brainstem has the highest microglial concentration. That's where your breathing apparatus and cardiovascular system is controlled."*

Considering that J.B. received 5 vaccines in that one visit, combined containing significant amounts of aluminum, neuroexcitatory chemicals, formaldehyde, polysorbate 80 and numerous other ingredients including foreign DNA.

Not every child suffers sudden infant death or even a serious adverse reaction to vaccines, but there is no denying that thousands of children are damaged every year. We need to figure out ways to identify children that are at risk due to genetic, maternal, environmental or co-morbidity factors.

The Haemophilus Influenza Type B (HIB) vaccine and Sudden Infant Deaths

An article published in the Journal ***Pediatrics*** in 2015 titled, **Adverse events following Haemophilus influenzae type b vaccines in the Vaccine Adverse Event Reporting System, 1990-2013**, reveals some disturbing statistics about the HIB vaccine, sudden infant deaths and other serious adverse reactions. The article looked at VAERS data from 1990-2013. https://www.ncbi.nlm.nih.gov/pubmed/25598306

"RESULTS: VAERS received 29,747 reports after Hib vaccines; 5179 (17%) were serious, including 896 reports of deaths. Median age was 6 months (range 0-1022 months). **Sudden infant death syndrome was the stated cause of death in 384 (51%) of 749 death reports with autopsy/death certificate records. The most common nondeath serious AE categories were neurologic (80; 37%), other noninfectious (46; 22%) (comprising mainly constitutional signs and symptoms); and gastrointestinal (39; 18%) conditions".**

IMPORTANT: Considering that only 1-10% of adverse reactions are even reported to VAERS, even taking the more conservative 10% reporting into consideration, it would mean that 3,840 of the 8,960 reported deaths were classified as SIDS deaths during this time period.

Study finds a 16 times greater incidence of Sudden Infant Death after the fourth vaccine series

A 2011 study published in ***Statistics in Medicine***, titled **A modified self-controlled case series method to examine association between multidose vaccinations and death**, found a significant link between

multi-dose vaccinations and Sudden Infant Death (SIDS), or what they call Sudden Unexpected Death (uSUD). https://www.ncbi.nlm.nih.gov/pubmed/?term=21337361

From the study:
"**We consider penta-*(5 in 1)* or hexavalent *(6 in 1)* vaccination as the exposure and unexplained sudden unexpected death (uSUD) as the event**."

"By means of a study including 300 uSUD *(cases of Sudden Infant Death)*, a 16-fold risk increase after the 4th dose could be detected with a power of at least 90 per cent. A general 2-fold risk increase after vaccination could be detected with a power of 80 per cent."

A Study from the Journal *Vaccine* expresses concerns over a 1,300 percent increase in cases of Sudden Infant Death Syndrome (SIDS) after the introduction of the 6 vaccine combo shots

A 2006 German study from the Journal ***Vaccine*** titled, **Unexplained cases of sudden infant death shortly after hexavalent vaccination**, finds pathological changes in the brain from immune over-reactivity during the post-mortem autopsies.
It also cites a possible 1,300 percent increase in SIDS after the hexavalent vaccine (six vaccine combo shot) between 2001-2004.
https://www.researchgate.net/publication/7833641_Unexplained_cases_of_sudden_infant_death_shortly_after_hexavalent_vaccination

"Polyvalent vaccines like Hexavac® and Infanrix Hexa® were developed to increase acceptance of vaccinations by decreasing the number of necessary injections. Compared to their pentavalent predecessors, these hexavalent vaccines additionally contain hepatitis B serum. They are used for immunisation against diphtheria, pertussis, tetanus, influenza, poliomyelitis and hepatitis B. Hexavac® and Infanrix Hexa® are available in European markets since October 2000. Until April 2003, approximately 3 million children have been vaccinated in this way and about 9 million doses were sold in the European union during this time. Children are to be vaccinated with these vaccines at the age of 2, 4, 6 and 12–14 months."

"We report six cases of sudden infant death after hexavalent vaccination that were autopsied and examined at the Munich Institute of Legal Medicine from 2001 to 2004. Among those investigated children, three were male and three female, ageing between 4 and 17 months. Five children had been vaccinated with Hexavac®, one with Infanrix Hexa® **during the past 48 h before death**. **Shortly after the vaccination, three of the children developed symptoms like tiredness, loss of appetite, fever up to 39 ◦C and insomnia. All children were found dead without explanation 1–2 days after the vaccination**. These children underwent a forensic post-mortem examination. They were assumed to be typical cases of SID (sudden infant death) because there was no history of a serious illness, and since all children died suddenly and unexpectedly. **In addition to neuropathologic and histologic abnormalities, all of these children showed an extraordinary brain edema**, which made them exceptional to other SID cases."

"Abnormal neuropathologic findings were acute congestion, **defective blood–brain barrier**, slight infiltration of the leptomeninx *(coverings of the spinal cord)* by macrophages and lymphocytes, perivascular lymphocytic infiltration, diffuse **infiltration of the pons**, mesencephalon and cortex by T-lymphocytes, **microglia in the hippocampus and pons, and in one case a necrosis *(dead tissue)* in the cerebellum.**" **All of this indicates significant immune activation.**

Interestingly, the pons is a part of the brain that relays signals from the brain into the spinal cord. **One of the functions it controls is respiration (breathing). The pons is part of the brain stem**. *(see the picture here)* https://sciencetrends.com/function-pons-brain/ .

Three of the vital functions of the brain stem is breathing, consciousness and cardiac function. https://www.princetonbrainandspine.com/brain/brain-anatomy/

Apparently, the multi-dose vaccines cause an upregulation of immune activity and swelling in vital areas of the brain that control breathing, cardiac function and consciousness. Loss of these functions can most certainly cause death.

Continuing from the article: "Autopsy and all further investigations did not reveal other serious abnormalities that could have lead to the deaths of the children."

"**The increased tryptase levels and numbers of eosinophile granulocytes suggest that an anaphylactic reaction developed after the vaccination**. As time to death seems comparably long for an acute anaphylactic reaction, **a delayed immune reaction has to be discussed**."

"**Prior to the release of hexavalent sera (in the years 1994–2000), we observed only one child out of 198 cases with sudden unexplained infant death who died shortly after vaccination (DTP). However, between 2001 and 2004 five of such cases were identified in our institution among 74 children with SID. This would indicate a 13-fold increase** (the local autopsy rate for infants is about 70%). **A recent analysis of all cases known to German authorities showed death rates that were to be expected statistically for the first day after vaccination. As four of those 10 cases were autopsied at Munich, although the Munich institute represents just 7.8% of the German population, a real number of about 50 cases might be expected, that is, 500% of the statistic figures to be expected.**"

"**We reported these six cases to direct attention to a possibly serious vaccination side effect**. So far, there is no way to proof that these infant deaths are caused by vaccination. Therefore, the relation between the vaccinations and the death of the children must remain uncertain. Nevertheless, we feel that **it is important to inform vaccinating physicians and pediatricians as well as parents about such possibly fatal complications after application of hexavalent vaccines**."

The multiple vaccines are a way to help insure compliance, **but at what cost? Aside from the increased risk of SIDS, what are the additional immune and neurological ramifications of dumping a combination of chemicals, adjuvants, foreign DNA and other biological components into the body all at once**. This is especially concerning in young children when the **Blood Brain Barrier** has not matured enough to prevent direct access into the brain. And remember, it's not just the combo vaccines that increase the risk of adverse reactions. **Children are often given several different individual vaccines at the same visit for a matter of convenience and an attempt to increase compliance. This practice needs to be DISCONTINUED.**

Increase in S.I.D.S. after vaccination with 6 in 1 vaccines

The European Journal of Pediatrics echoes the concern over the increase in SIDS after hexavalent (combo of six) vaccines

A 2005 study published in the ***European Journal of Pediatrics*** titled, **Sudden and unexpected deaths after the administration of hexavalent vaccines (diphtheria, tetanus, pertussis, poliomyelitis, hepatitis B, Haemophilius influenzae type b): is there a signal?**, finds that the hexavalent vaccine given in the second year of life caused mortality rates **(death rates) on the first day after vaccination that were 31.3 times greater than national vital statistics rates! Sudden unexpected death (SUD), rates on the second day after vaccination were 23.5 times greater than the national rates!**
https://www.ncbi.nlm.nih.gov/pubmed/15602672

From the abstract:
"**Deaths in temporal association with vaccination of hexavalent vaccines have been recently reported.** The objective of this paper is to assess whether these temporal associations can be attributed to chance. **Standardised mortality ratios (SMR)** for deaths within 1 to 28 days after administration of either of the two hexavalent vaccines in the 1st and 2nd year of life were determined using the respective annual rates for sudden unexpected deaths (SUDs) from the national vital statistics."

"Vaccine A, SMRs exceeded one insignificantly on the 1st day after vaccination in the 1st year of life. In the 2nd year of life, however, **the SMRs for SUD cases within 1 day of vaccination with vaccine A were 31.3…; two cases observed; 0.06 cases expected) and 23.5…; for within 2 days after vaccination (three cases observed; 0.13 cases expected)."**

The article goes on to say that the research does not prove a "causal" relationship between the vaccine and the unexpected deaths, but that it is a signal to prompt intensified surveillance. **If a 3,130% (31 times) increase in unexpected deaths does not prove a causal relationship I don't know what would! Yet, they call it a signal. I would call that a major understatement! It would be like someone calling the first torpedoes hitting our fleet in Pearl Harbor just a "signal" that Japan may be interested in hostilities. Signal indeed!**

Another hexavalent vaccine related sudden infant death

A 2008 article from Forensic Science International titled, **Beta-tryptase and quantitative mast-cell increase in a sudden infant death following hexavalent immunization**, cited that investigators concluded that the infant died from "acute respiratory failure, likely due to post-hexavalent immunization-related shock was the cause of death." https://www.ncbi.nlm.nih.gov/pubmed/18538957

From the Abstract:
"The association between sudden infant death syndrome and immunization is frequently discussed. Serious adverse events following vaccination have generally been defined as those adverse events that result in permanent disability, hospitalization or prolongation of hospitalization, life threatening illness, congenital anomaly or death. They are generally referred to the inherent properties of the vaccine (vaccine reaction) or some error in the immunization process (programme error). The event could also be totally unrelated but only temporally linked to immunization (coincidental event). **A fatal case of a 3-month-old female infant, who died within 24 h of vaccination with hexavalent vaccine is presented**. Clinical data, post-mortem findings (acute pulmonary oedema, acute pulmonary emphysema), quali-quantitative data collected from immunohistochemical staining (degranulating mast cells) and laboratory analysis with a high level of beta-tryptase in serum, 43.3 microg/l, **allows us to conclude that acute respiratory failure likely due to post hexavalent immunization-related shock was the cause of death.**"

Case study discovers pathological changes in the area of the brainstem that controls the cardiac system and suspects the hexavalent vaccine as the cause

This 2006 case study is from **Virchows Archiv*. European Journal of Pathology.*** After post-mortem analysis, the researchers concluded that ALL instances of Sudden Infant Death, especially when the death occurs soon after a vaccination should undergo a full autopsy study of the brainstem region of the brain. This is area that controls breathing and heart functions and the area where they found damage to that vital area consistent with the vaccine given.

The abstract:
Experts from panels of ***the European Agency for the Evaluation of Medical Products*** have investigated whether there might be a link between hexavalent vaccines and some cases of deaths that occurred. Participants included pathologists with experience in the field of vaccines and sudden infant death syndrome who conducted autopsies. However, to the best of our knowledge, little, if any, attention was paid to examination of the brainstem and the cardiac conduction systems on serial sections, nor was the possibility of a triggering role of the vaccine in these deaths considered. **Herein we report the case of a 3-month-old female infant dying suddenly and unexpectedly shortly after being given a hexavalent vaccination. Examination of the brainstem on serial sections revealed bilateral hypoplasia of the arcuate nucleus. The cardiac conduction system presented persistent fetal dispersion and resorptive degeneration. This case offers a unique insight into the possible role of hexavalent vaccine in triggering a lethal outcome in a vulnerable baby. Any case of sudden unexpected death occurring perinatally and in infancy, especially soon after a vaccination, should always undergo a full necropsy study according to our guidelines.** https://www.ncbi.nlm.nih.gov/pubmed/16231176

That recommendation to evaluate ALL infants dying from SIDS for this type of damage, was made over 12 years prior to the publishing of 1200 Studies. I have found zero information that this recommendation was EVER followed and to the best of my knowledge is NEVER done today. If not, why not?! Note: That was a rhetorical question, because I think those who understand the economic gain and power plays at work here know the answer full well.

For another example of the SIDS/vaccine connection, refer back to the 2018 article from the *Indian Journal of Medical Ethics* on pages 351-353, discussing the Pediarix hexavalent vaccine and the possible association with S.I.D.S. As you have seen in this document, there have been credible associations of vaccine related SIDS deaths from HIB, DTaP, Tdap, DPT and various combo vaccines including up to 6 vaccines given at once. Additionally, it is the practice of many doctors to add more vaccines on to the combo vaccines in the very same doctor visit. In my opinion, this is reckless and extremely risky, especially for those genetically susceptible children which have yet decided to screen and identify.

Vaccines may cause an increase in contracting other infections, in some cases resulting in death

New evidence that the DPT Vaccine in Africa kills more children from other causes than it saves from Diphtheria, Pertussis, or Tetanus

A study published March 17, 2017 in the journal ***E BioMedicine*** titled, **The Introduction of Diphtheria-Tetanus-Pertussis and Oral Polio Vaccine Among Young Infants in an Urban African Community: A Natural Experiment.** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5360569/

The lead author is famous for his work with vaccines in third world countries. He decided to look back at the data from the early 1980's and what he found was very alarming. Children that got the DPT vaccine had a 5X greater mortality (death) than those that did not get it. They did not die from diphtheria, pertussis or tetanus. They died from seizures, and other kinds of infections. Their immune systems were compromised by the DPT vaccine.

From the article:
This is **not** the first time this association has been recognized. **Multiple previous studies have found that the DPT shot leads to an increase in mortality due to susceptibility to other infections. "Though protective against the target diseases, DTP may increase susceptibility to unrelated infections."**

One problem this study identified from previous studies was that the "unvaccinated" groups were usually children that were too sickly or frail to receive the vaccine. **That is why the significantly negative effects of the DPT vaccine were not recognized**. When the control group is that sickly compared to the vaccinated group, it makes sense that the problems in the DPT group didn't stand out from the sickly controls.

The authors said, "**The negative effect of DTP was much worse in this natural experiment than has been reported in previous studies of DTP. This is presumably due to the "unvaccinated" control**

children in previous studies having been a frail subgroup too frail to get vaccinated. Previous studies have not been able to compare DTP-vaccinated children with "normal" controls. Hence, most previous studies have probably underestimated the negative effect of DTP."

The Conclusion: "**It should be of concern that the effect of routine vaccinations on all-cause mortality was not tested in randomized trials. All currently available evidence suggests that DTP vaccine may kill more children from other causes than it saves from diphtheria, tetanus or pertussis**."

The flu shot is also linked to increasing susceptibility to other viral respiratory infections

A 2012 study published in the Journal ***Clinical Infectious Diseases***, titled **Increased Risk of Noninfluenza Respiratory Virus Infections Associated With Receipt of Inactivated Influenza Vaccine**, found that children who were vaccinated against influenza with the Trivalent Inactivated Influenza Vaccine (TIV), were nearly 4 ½ times more likely to develop laboratory confirmed secondary viral respiratory illness. Those infections included including significant increases in the risk of rhinovirus and coxsackie/echovirus infection and also included coronaviruses. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3404712/

From the study: "We randomized 115 children to trivalent inactivated influenza vaccine (TIV) or placebo. Over the following 9 months, TIV recipients had an increased risk of virologically confirmed non-influenza infections (relative risk: 4.40; 95% confidence interval: 1.31-14.8). Being protected against influenza, TIV recipients may lack temporary non-specific immunity that protected against other respiratory viruses."

GENETIC FACTORS PLAY A ROLE IN VACCINE INJURY

Factors that increase the risk of autism or other neurological/neurodevelopmental/immunological vaccine injury

An inability to regulate oxidative stress and to methylate effectively, can contribute to damage from toxic metals and chemicals

A 2004 article published in the ***American Journal of Clinical Nutrition*** titled, **Metabolic biomarkers of increased oxidative stress and impaired methylation capacity in children with autism**, hypothesized that oxidative stress and faulty methylation contribute to regressive autism. Oxidative stress is damage that occurs when "free radicals" or reactive molecules, exceed the body's anti-oxidant mechanisms. Methylation is a process that influences nearly every function in the body. It adds one carbon and three hydrogens to turn on and removes them to turn off systems in the body. It's like billions of little on and off switches in your body correlating and regulating nearly everything. It also has to do with how our genes are expressed by interacting with our DNA. http://ajcn.nutrition.org/content/80/6/1611.long

From the discussion:
"Nineteen of the 20 children participating in the study **were diagnosed with "regressive" autism (apparently normal development, until regression into autism between ages 1.5 and 3 years)**.

"Relative to the control children, the children with autism had significantly lower baseline plasma concentrations of methionine, SAM, homocysteine, cystathionine, cysteine, and total glutathione and significantly higher concentrations of SAH, adenosine, and oxidized glutathione. **This metabolic profile is consistent with impaired capacity for methylation (significantly lower ratio of SAM to SAH) and increased oxidative stress (significantly lower redox ratio of reduced glutathione to oxidized glutathione) in children with autism**. The intervention trial was effective in normalizing the metabolic imbalance in the autistic children."

"On the basis of their abnormal metabolic profiles, **we hypothesize that an increased vulnerability to oxidative stress (environmental, intracellular, or both) and impaired methylation capacity may contribute to the development and clinical manifestation of regressive autism.**"

Decreased ability to detoxify

This article titled, **Mercury and Autism: Accelerating Evidence** and published in ***Neuroendocrinology Letters*** Oct 26, 2005, suggested that children with autism have a decreased capacity for detoxification. https://www.ncbi.nlm.nih.gov/pubmed/?term=16264412

"Recently, it was found that autistic children had a higher mercury exposure during pregnancy due to maternal dental amalgam and thimerosal-containing immunoglobulin shots (*vaccines given to the mother)*. It was hypothesized that children with autism have a decreased detoxification capacity due to genetic polymorphism (*defect*). In vitro, mercury and thimerosal in levels found several days after vaccination inhibit methionine synthetase (MS) by 50%. Normal function of MS is crucial in biochemical steps necessary for brain development, attention and production of glutathione, an important antioxidative and detoxifying agent. Repetitive doses of thimerosal lead to

neurobehavioral deteriorations in autoimmune susceptible mice, increased oxidative stress and decreased intracellular levels of glutathione in vitro. Subsequently, autistic children have significantly decreased level of reduced glutathione (*this reduces their ability to eliminate toxins and metals*). Promising treatments of autism involve detoxification of mercury, and supplementation of deficient metabolites." (Italicized comments are mine).

An impaired ability to produce glutathione (the body's master antioxidant)

A 2009 article published in the ***Journal of Toxicology*** titled, **The Severity of Autism Is Associated with Toxic Metal Body Burden and Red Blood Cell Glutathione Levels**, suggests that the severity of autism is related to the body burden (load), of toxic metals.
https://www.ncbi.nlm.nih.gov/pubmed/?term=20107587

From the conclusions:
"Overall, the correlation analysis **found multiple significant correlations of severity of autism and the urinary excretion of toxic metals, such that a higher body burden of toxic metals was associated with more severe autistic symptoms**. The results of the regression analyses ($P < .005$ in all cases) indicate that variations in **the severity of autism may be partially explained in terms of toxic metal body burden**."

A reduced ability to excrete heavy metals

Studies indicate that autistic individuals do not excrete heavy metals like aluminum and lead through the hair and nails like non-autistic individuals do.

In an article from the ***International Journal of Toxicology*** titled, **Reduced levels of mercury in first baby haircuts of autistic children**, researchers found that mothers of non-autistic children had higher levels of mercury exposure through dental amalgams, fish consumption and prenatal vaccines and that the correlation was linear, **meaning the level of mercury in the child's hair matched the level of mercury exposure from the mother and the childhood vaccines that they received. The higher levels of mercury in the child's hair (greater than seven times higher), indicated that their body was effectively excreting the mercury out of the tissues and through the hair. IMPORTANTLY, autistic children's hair samples showed significantly less excretion of the mercury, indicating that the toxic metal was staying in their tissues and not being eliminated.** And importantly, the severity of autism correlated with the degree of excretion through the hair, meaning that the most severe cases had the least excretion and the less severe cases were excreting more mercury. **This is a highly significant finding that lends credence to the claim that mercury exposure though vaccines correlates with autism.**
https://www.ncbi.nlm.nih.gov/pubmed/?term=12933322

From the study:
"Reported rates of autism have increased sharply in the United States and the United Kingdom. One possible factor underlying these increases is increased exposure to mercury through thimerosal-containing vaccines, but vaccine exposures need to be evaluated in the context of cumulative exposures during gestation and early infancy. Differential rates of postnatal mercury elimination may explain why similar gestational and infant exposures produce variable neurological effects."

"**Hair mercury levels in the autistic group were 0.47 ppm versus 3.63 ppm in controls, a significant difference**. The mothers in the autistic group had significantly higher levels of mercury exposure through Rho D immunoglobulin injections and amalgam fillings than control mothers. Within the autistic group, hair mercury levels varied significantly across mildly, moderately, and severely autistic children, with mean group levels of 0.79, 0.46, and 0.21 ppm, respectively. Hair mercury levels among **controls** were significantly correlated with the number of the mothers' amalgam fillings and their fish consumption as well as exposure to mercury through childhood vaccines, correlations that were absent in the autistic group. **Hair excretion patterns among autistic infants were significantly reduced relative to control**."

The suggests that autistic individuals do not excrete mercury efficiently. Therefore, the mercury in the system has greater opportunity to become stored in the brain and other organs.

Genetic susceptibility to Thimerosal needs to be addressed

This article from the ***Journal of Toxicology*** 2013 titled, **B-Lymphocytes from a population of Children with Autism Spectrum Disorder and their unaffected siblings exhibit hypersensitivity to thimerosal**, showed that there is **a genetic predisposition to sensitivity to thimerosal**.
https://www.ncbi.nlm.nih.gov/pubmed/23843785

From the study:
"ASD is a disorder caused by a problem in brain development. If the B-cells from the families in the AGRE collection are at all representative of the neurons in the brains of the cell donors, we can say that a third of them have a sensitivity to thimerosal that would restrict cell proliferation at levels that were/are typically found after vaccination."

"In our recently published work, we have shown that the mitochondria of normal human astrocytes accumulate the ethylmercury lipophilic cation and that after this primary insult cell death occurs. Here we show that a subpopulation of four individuals with autism, along with some of their siblings, have B-cells exhibiting hypersensitivity toward thimerosal that can be attributed to their mitochondrial phenotype. **Thus, certain individuals with a mild mitochondrial defect may be highly susceptible to mitochondrial specific toxins like the vaccine preservative thimerosal**."

Other studies have implicated genetic variances that render certain individuals from excreting heavy metals like mercury, aluminum and lead. Furthermore, antibiotics seem to contribute to this susceptibility in certain children. http://www.1796kotok.com/pdfs/haley.pdf

Here are some excerpts from this study:
"**In summary, it appears as if autistics represent a subset of the population that are more susceptible to the toxic effects of mercury and thimerosal because they are not efficient excretors of these toxic materials**. **Further, it appears as if the sex hormones play a major role in susceptibility with the male hormones increasing susceptibility to the neurotoxicity of ethylmercury and the female hormones affording a good degree of protection.** Common sense tells us that a lead toxic person would be more susceptible to mercury toxicity than a healthy, non-toxic person. Research confirms this and we routinely observe that many heavy metals increase the apparent toxicity of low levels of mercury. **It is well known that a milk diet will cause the retention of mercury as does the exposure of mammals to certain antibiotics. This would make infants with ear infections prime candidates for mercury retention toxicity. Certainly, the findings of aberrant biochemistries in the autistic child that appear to correlate with mercury sensitive enzymes increases the possibility of mercury involvement in autism causation**."

"Finally, the synergistic effects of other heavy metals, diet, antibiotics, etc. on mercury toxicity **make it impossible to define a "safe level of mercury exposure**." Therefore, it is imperative that we try to eliminate all exposure to mercury; and removal from dentistry and medicines is most important and critical for human health."

Aluminum and other adjuvants in vaccines can stimulate inflammatory cytokines and increase allergic reaction in genetically susceptible individuals

In the ***Journal of Immunotoxicology*** 2013, an article appeared titled, **How aluminum adjuvants could promote and enhance non-target IgE synthesis in a genetically-vulnerable sub-population**. The researchers in this study **found that the adjuvants including aluminum, can increase levels of inflammatory cytokines (proteins) that stimulate IgE antibody reactions (immediate strong allergic reactions) in excess, and can lead to atopy (allergies, asthma and eczema) in genetically susceptible individuals**. https://www.ncbi.nlm.nih.gov/pubmed/?term=22967010

From the study:
"Aluminum-containing adjuvants increase the effectiveness of vaccination, but their ability to augment immune responsiveness also carries the risk of eliciting non-target responses, especially in genetically susceptible individuals."

"These genetic factors may therefore define a genetically-vulnerable sub-population, children with a **family history of atopy *(allergies, asthma and eczema)*,** who may experience an exaggerated T(H)2 immune response to aluminum-containing vaccines. IL-4, sCD23, and IgE are common factors for both atopy and the immune-stimulating properties of aluminum adjuvants."

"These actions provide a mechanism for aluminum-adjuvant promotion and enhancement of non-target IgE in a genetically vulnerable sub-population. **Identification of these individuals may decrease the risk of adverse events associated with the use of aluminum-containing vaccines**."

Ultimately, vaccine manufacturers need to clean up their act and develop technologies that replace the ingredients in vaccines that are potentially harmful. Until then, one of my greatest desires is that genetic testing will become available for infants that can identify those infants that are at risk for being damaged by these immune stimulating adjuvants in vaccines.

Genetic variations discovered leading to increased risk of adverse reactions to vaccines

A 2008 study published in the ***Journal of Infectious Diseases*** titled, **Genetic Basis for Adverse Events Following Smallpox Vaccination** identified common genetic variations that can make a person susceptible to adverse reactions to toxins in vaccines.
https://academic.oup.com/jid/article/198/1/16/841083

Conclusions—"Genetic polymorphisms in an enzyme previously associated with adverse reactions to a variety of pharmacologic agents (*MTHFR*) and an immunological transcription factor- *IRF1(Interferon Regulatory Factor),* were associated with AEs after smallpox vaccination in two independent study samples. These findings highlight common genetic variants with promising clinical significance that merit further investigation."

Further evidence that an interplay between genetics and environmental triggers can be at the root cause of Autism Spectrum Disorder

A 2017 article published in the journal ***Advances in Experimental Medicine and Biology*** titled, **Epigenetics of Autism Spectrum Disorder,** explores the connections between genetic predisposition including DNA methylation abnormalities, environmental influences and gene expression on brain development. https://www.ncbi.nlm.nih.gov/pubmed/?term=28523541
From the article: "The etiopathogenesis *(cause),* of ASD is known to be complex, including genetic, environmental and epigenetic factors. Normal epigenetic marks modifiable by both genetics and environmental exposures can result in epigenetic alterations that disrupt the regulation of gene expression, negatively impacting biological pathways important for brain development."

Genetic predispositions that reduce the capability to detoxify, linked to autism

In an excellent 2018 article with 230 references, published in ***Autism Open Access*** titled, **Autism is an Acquired Cellular Detoxification Deficiency Syndrome with Heterogeneous Genetic Predisposition**, Dr. James Lyons-Weiler does an outstanding job of tying together very complicated genetic predispositions, biochemical relationships and their role is the development of autism.

From the Abstract:
"Neurodevelopmental disorders, including autism spectrum disorders, have a complex biological and medical basis involving diverse genetic risk and myriad environmental exposures. Teasing apart the role of specific stressors is made challenging due to the large number of apparently contributing associations, gene x environment interactions and phenomimicry." *Phenomimicry is where two separate distinct conditions can have overlap in traits, as in Autism Spectrum Disorder (ASD) and Specific Language Impairment (SLI).*

"This model explains the aberrant protein disorder observed in ASD; the great diversity of genes that are found to have low, but real contributions to ASD risk and the sensitivity of individuals with ASD to environmental toxins. The hindrance of detoxification and loss of cellular energetics leads to apoptosis, release of cytokines and chronic neuroinflammation and microglial activation, all observed hallmarks of ASD."

"Reduction of exposure to toxins known to cause mitopathy (mercury) and endoplasmic reticulum dysfunction (mercury and aluminum) during pregnancy and during the early years of development will reduce the risk of ER overload and ER hyperstress, and of ASD diagnosis. This knowledge has immediate clinical translational relevance: Post-vaccination symptoms should be heeded as a sign of susceptibility to toxin; Vitamin D can be increased to drive the healthy early phases of the unfolded protein response (UPR), and mutations in ASD genes encoding proteins with high intrinsic disorder may contraindicate the use of aluminum and mercury for carriers of risk alleles. Clinicians should be alert to a patient's Vitamin D receptor (BSM) mutational status prior to recommending increased doses. Approaches to improving overall brain health in autistics must be de-stigmatized and given high priority. Reduction of lifetime exposures of industrial and agricultural toxins will improve brain health for the entire human population. **Purely genetic studies of ASD, and studies that do not include vaccination as an environmental exposure with potential liability and interactions with genes, are unethical**."

"Skilled pediatricians and ob/gyns will seek evidence of genetic predisposition to environmental susceptibility in the form of non-synonymous substitutions in brain proteins that require ER-folding, and they will provide informed cautions on exposures (from all sources) to environmental toxins to patients and parents of patients with signs of metal and chemical sensitivity. To aid in this, a list of ASD environmental susceptibility protein-encoded genes is presented. A clinical exome sequence test, followed by loss-of-function prediction analysis, would point to individuals most susceptible to vaccine metal-induced ER hyper stress."

From the Conclusion:
"Since a small percentage is influenced, one can predict the failure of most epidemiological studies to detect the effect at the whole-population level. **Mandates for vaccinations are not ethical, as the condemn with certainty a minority of individuals to pain and suffering for the benefit of the majority. Medical clinical exome sequencing will also prove lucrative to pediatric and ob/gyn practices, the freedom of choice to vaccinate or not vaccinate can be better respected, and doctors will be able to fulfill their duty to obtain truly informed consent on risk instead of relying on overgeneralizations that place families in their care at increased risk of stresses from lifelong disability, increased cost of medical care, job loss, and divorce.** Studies are needed to determine the

relative contribution of various sources of ER-stress to ASD and other neurodevelopmental disorders and the effects of avoidance of ER stressors on ASD risk. The most ethical of these studies would be interventional, (eg: Vaccination cessation in ASD) to measure the effects of avoidance of these toxins alone and in pairs to measure singular and interaction neurotoxities, combined with vitamin supplementation and serum level monitoring of both vitamin levels and parochial pollutants that accumulate due to detoxification deficiency. **Much additional published research is consistent with the vaccine/autism hypothesis, which should now be formally adjusted to "Vaccines may induce autism in a genetic minority of patients**".

Genetic factors triggered by various chemicals, heavy metals like mercury or aluminum and even maternal antibodies can manifest in autistic spectrum disorders

A 2010 study from the ***Journal of Cellular Molecular Neurobiology*** titled, **Understanding and determining the etiology of autism,** identifies yet another genetic predisposition which can trigger reactions to heavy metals, vaccines and other environmental insults causing neurological and developmental delays. https://www.ncbi.nlm.nih.gov/pubmed/?term=19774457

From the summary: "Worldwide, the rate of autism has been steadily rising. There are several environmental factors in concert with genetic susceptibilities that are contributing to this rise. Impaired methylation and mutations of mecp2 have been associated with autistic spectrum disorders, and related Rett syndrome. Genetic polymorphisms of cytochrome P450 enzymes have also been linked to autism, specifically CYP27B1 that is essential for proper vitamin D metabolism. Vitamin D is important for neuronal growth and neurodevelopment, and defects in metabolism or deficiency have been implicated in autistic individuals. Other factors that have been considered include: maternally derived antibodies, maternal infection, heavy metal exposure, folic acid supplementation, epigenetics, measles, mumps, rubella vaccination, and even electromagnetic radiation. In each case, the consequences, whether direct or indirect, negatively affect the nervous system, neurodevelopment, and environmental responsive genes."

Parents, especially mothers with autoimmune disease are 50% more likely to have an autistic child

Another article published in 2010 titled, **Parental Autoimmune Diseases Associated With Autism Spectrum Disorders in Offspring**, published in the journal ***Epidemiology*** found that parents with autoimmune conditions (especially mothers), have up to a 50% greater chance of having an autistic child. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3115699/

From the study: "This study supports previous reports that the prevalence of autoimmune disorders is elevated in families of persons diagnosed with an autism spectrum disorders, especially for mothers of children with autism. This study was large and population-based, and it used complex record linkages to

provide extensive health data on individuals for many years, which may have avoided some selection and recall issues of earlier studies."

"Animal studies have shown differential cytokine profiles and autism-like characteristics in offspring induced by prenatally exposing mice and rhesus monkeys to a human case-mother's IgG. Together, these studies suggest that nonspecific autoimmune reactivity in parents, (primarily mothers) may be related to autism in offspring. This literature could be interpreted in 2 ways: (1) some cases of autism spectrum disorders result from adverse conditions caused by altered autoimmune response during the prenatal or early postnatal period, **possibly by enhancing susceptibility to other agents *(i.e.chemicals or vaccines)***, or (2) some familial factors are concurrently associated with both autism spectrum disorders and autoimmunity."

"**We observed nearly 50% higher odds of being diagnosed with autism by age 10 years among children whose parents had any autoimmune disease**."

One possible explanation as to why boys are more susceptible than girls to autism or intellectual disability

A 2010 article from the journal ***Science Translational Medicine*** titled, **Disruption at the *PTCHD1* locus on Xp22.11 in autism spectrum disorder and intellectual disability**, offers one possible explanation for the approximately 4 times greater incidence of autism in boys than girls. It has to do with mutations at a particular gene (PTCHD1), or nearby DNA sequencing on the X chromosome inherited from their mother. The father contributes a Y chromosome and the mother an X chromosome. Girls have 2 X chromosomes, which help to shield them from having one of them dysfunction at this gene level. The study found that approximately 1 percent of those individuals with autism have mutations relating to the PTCHD1 gene. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2987731/

From the article:

"We have identified microdeletions that directly disrupt the *PTCHD1* gene in males in three families affected with either ASD, ID or learning disability. These deletions are maternally inherited and were not observed in more than 10,000 controls, **which indicates that these alterations are associated with ASD and ID**. We also report seven maternally inherited missense mutations in eight male probands. These variants were not seen in more than 500 controls, **which further supports a possible role of this gene in autism and ID.**"

"Moreover, mutations in several X-linked ID (XLID) genes (e.g. *NLGN4* and *IL1RAPL1*) **have been shown to result in an autistic phenotype, which suggests that autism and ID may often share a common genetic etiology**."

To emphasize, this study and others like it do not mean that there is a genetic **cause** of autism. The genetic defects (which we all have various forms of), **predispose** an individual to developmental issues, or even health problems later in life. This is part of our "hard wiring" of our genes. Despite our hard wiring faults, we don't necessarily express those problems unless we are exposed to different "triggers"

that activate or turn on that part of the gene sequence. The ability to control or determine the **expression** of our genetic makeup in this way is called ***epigenetics.***

Learning about these variations and mutations, **can afford us the opportunity to intervene by avoiding potential triggering mechanisms. Vaccines given prenatally or after birth, may very well be one of the primary triggering mechanisms that cause the manifestation or expression of these neurodevelopmental and learning disabilities, including autism**. Other triggers may include exposure to environmental chemicals and toxicity, whether in utero or after birth.

We need to further develop and utilize genetic screening for women who become pregnant and for their newborn children. This will afford doctors the ability to discern which women and newborns will need to forego the introduction of chemicals, metal, foreign DNA and other component contained in vaccines. **These women and children will also need to avoid exposure to other chemicals and toxins. Pregnant women minimizing the consumption of swordfish and tuna, thus avoiding mercury is a good example of this.** That practice is good to follow regardless, but if you know that you are at higher risk you should take that advice and implement it on a total avoidance level.

Vaccinomics is a concept that may provide assistance in identifying people who are genetically susceptible to vaccine injury and offer alternative options

This concept has been around in the research circles for many years, but has yet to gain real practical traction. The article in **Scientific American** by Melinda Wenner-Moyer dated June 24, 2010, titled, **Vaccinomics: Scientists are Devising Your Personal Vaccine**, addresses the different benefits of creating a personalized approach to vaccine administration. According to the article, Gregory Poland, the head of the ***Mayo Clinic's Vaccine Research Group***, has been working to unite the fields of genomics and vaccinology – what he calls vaccinomics for 22-years. The article states that he has been trying to do this in part, because "he has never been fully pleased with the vaccine paradigm."
https://www.scientificamerican.com/article/vaccinomics-personal-vaccine/

It is encouraging on one hand that there are scientists that are trying to make safer and more effective vaccines, but on the other hand it is discouraging that at the time this article was written, Dr. Ploand had been working on this concept for 22-years. That means he started in 1988. It is now 2019 and I'm not too sure that we are any closer to a shift in the vaccine paradigm that we were in 2010, or 1988 for that matter. Could it be that Big Pharma is just too comfortable with the status quo? They are making billions of dollars just the way things are. The one size fits all approach has returned record and ever-increasing profits to their shareholders. And it's done it with ZERO liability to them for the people that are left damaged in the wake of their juggernaut. What's their motive to change? (That is a rhetorical question of course).

VACCINES ARE SUSPECTED TO CAUSE DNA DAMAGE THAT IS PASSED DOWN MULTIPLE GENERATIONS

Solid evidence suggests that prenatal environmental exposures by chemicals and metals, can cause adult diseases and even generational DNA mutations!

A 2011 study published in Reproductive Toxicology titled, **Prenatal environmental exposures, epigenetics, and disease**, **mirrors several other articles in recent years finding that prenatal exposure to toxins including heavy metals and endocrine disrupting chemicals (which are found in numerous vaccines), can lead to DNA mutations and result in disease later in life. The absolutely crazy thing is that these mutations are also thought to carry on to up to 3 or more generations.** In other words, if you are exposed to these toxins as a pregnant mother and those toxins create DNA mutations in your child, the same mutations and thus predisposition to resultant disease could be carried down to the woman's grandchildren, great grandchildren and even great-great grandchildren!
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3171169/

From the article:
Abstract- "This review summarizes recent evidence that prenatal exposure to diverse environmental chemicals dysregulates the fetal epigenome, with potential consequences for subsequent developmental disorders and disease manifesting in childhood, over the lifecourse, or even transgenerationally *(WOW!)*. The primordial germ cells, embryo, and fetus are **highly susceptible** to epigenetic dysregulation **by environmental chemicals**, which can thereby exert multiple adverse effects. The data reviewed here on environmental contaminants have potential implications for risk assessment although more data are needed on individual susceptibility to epigenetic alterations and their persistence before this information can be used in formal risk assessments. The findings discussed indicate that identification of environmental chemicals that dysregulate the prenatal epigenome should be a priority in health research and disease prevention."

"The epigenome is susceptible to dysregulation throughout life; however, it is thought to be most vulnerable to environmental factors during embryogenesis, which is a period of rapid cell division and epigenetic remodeling."

"In 1992, Barker and colleagues laid the groundwork for the "fetal basis of adult disease" (FEBAD) hypothesis, postulating that, because organs undergo developmental programming *in utero* that predetermines subsequent physiologic and metabolic adaptation during adult life, **prenatal insults** such as nutritional deprivation or **environmental exposures that**

disturbed developmental programming could lead to a higher risk of disease in adulthood."

"The FEBAD hypothesis has been supported by evidence that fetal nutrient availability, other intrauterine factors, and external environmental factors **can cause serious consequences in later life by permanently reprogramming** the functional capacity of organs. Classical examples include the association of low or lower birth weight with increased risk of adult onset cardiovascular disease, type 2 diabetes mellitus, osteoporosis, depressive disorders and certain cancers."

"As reviewed by Baccarelli and Bollati, studies in adults **have demonstrated epigenetic changes related to environmental exposure to metals, air pollution, benzene and persistent organic pollutants**. For example, in a study of adult coke oven workers and controls, global and IL-6 hypermethylation and *p53* hypomethylation were associated with PAH exposure [58]. In workers exposed to the leukemogen, benzene, epigenomic data showed effects of benzene on DNA methylation of a number of specific genes."

"With respect to prenatal exposures, there is an increasing body of evidence that **diverse pollutants alter epigenetic programming and disease risk in the F1 and even F2 and F3 generations**. **These include arsenic, tobacco smoke, air pollutants, and endocrine disrupting chemicals."**

"**Three generations at once are exposed to the same environmental conditions (diet, toxics, hormones, etc.)." The three are the mother (1), the fetus (2) and the fetuses' reproductive cells (testes or ovaries) (3). "In order to provide a convincing case for epigenetic inheritance, an epigenetic change must be observed in the 4th generation**." "Transgenerational epigenetic inheritance" refers to the transmission of a biological trait to subsequent generations via epigenetic modifications in the germline."

This is of huge importance when it comes to the question of vaccines! Imagine the potential impact of the many chemicals highlighted earlier that are found in vaccines. There are known and suspected carcinogens (causes cancer), mutagens (causes genetic mutations), teratogens (causes malformation of an embryo), endocrine (hormone) disrupting chemicals (see in 2 pages), heavy metals like mercury and aluminum, neurotoxins, fetotoxins (poisonous to a fetus), neuroexcitatory agents, multiple antibiotics that are not supposed to be given together, solvents, disinfectants, foreign animal and human DNA fragments and retroviruses all found in vaccines! (see details and verification of all of these claims starting on page 109).

How with any semblance of conscious, can we think that putting these types of compounds into the bodies of developing fetuses through their mother and into young infants, babies, toddlers and children would not be putting them at risk? Massive amounts of credible science disagree with this practice. In addition to all of that, the long-term longitudinal studies of combining all of these toxic compounds have not been done. How may this be contributing to the epidemic of chronic childhood and adult diseases we are seeing in westernized societies? And the thought of it impacting generations to come is a daunting one. In other words, we could stop everything we are doing to cause the DNA and genetic

damage and the descendants of today's impacted people, will still suffer from many of these epigenetic based toxicologically induced diseases.

Damage to the germline (sperm or ova), can result in genetic defects affecting health for generations

A 2017 article published in ***Science*** titled, **Transgenerational transmission of environmental information in C. elegans,** found that in nematodes (roundworms) epigenetic influences are passed down at least 14 generations. https://www.ncbi.nlm.nih.gov/pubmed/?term=28428426

From the Abstract:
"The environment experienced by an animal can sometimes influence gene expression for one or a few subsequent generations. Here, we report the observation that a temperature-induced change in expression from a *Caenorhabditis elegans* heterochromatic gene array can endure **for at least** 14 generations."

Granted these creatures are not human beings and for us, we don't have the capability to look in the past and trace genetic deviations from epigenetic influences. In humans, given our lifespan and age of reproductive maturity, tracking future generational RNA and DNA mutations from as a result of epigenetic influences would take many decades by following generations of offspring. It does underscore however, the critical nature of the generational damage that exposure to chemicals un utero during developmental stages may cause.

More evidence of chemical exposure causing disease in subsequent generations of offspring

In a 2014 study published in the Journal ***PLOS ONE*** titled, **Pesticide Methoxychlor Promotes the Epigenetic Transgenerational Inheritance of Adult-Onset Disease through the Female Germline**, demonstrates that a wide varity of chemicals can cause transgenerational mutations and disease. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4109920/pdf/pone.0102091.pdf

From the study:
"Environmental compounds including fungicides, plastics, pesticides, dioxin and hydrocarbons can promote the epigenetic transgenerational inheritance of adult-onset disease in future generation progeny following ancestral exposure during the critical period of fetal gonadal sex determination. This study examined the actions of the pesticide methoxychlor to promote the epigenetic transgenerational inheritance of adult-onset disease and associated differential DNA methylation regions (i.e. epimutations) in sperm."

"Observations indicate that the pesticide methoxychlor has the potential to promote the epigenetic transgenerational inheritance of disease and the sperm epimutations appear to provide exposure specific epigenetic biomarkers for transgenerational disease and ancestral environmental exposures."

"**The critical window of exposure for the germline is during fetal gonadal sex determination when epigenetic reprogramming in the primordial germ cell undergoes a DNA demethylation and remethylation**. The environmental insults promote an apparent **permanent** alteration in the germline epigenome (DNA methylation) that escapes epigenetic reprogramming after fertilization, **similar to an imprinted gene**. **This germline epigenetic inheritance will alter the embryonic stem cell epigenome such that all cell types derived will have an altered epigenome and transcriptome and those somatic cell types sensitive to this altered epigenome and gene expression will be susceptible to develop adult onset disease across generations**. A number of previous studies have shown environmental toxicants including the fungicide vinclozolin, plastics (bisphenol A and phthalates), pesticide (DEET and permethrin), dioxin, hydrocarbons (jet fuel), and dichlorordiphenyltrichloroethane (DDT) promote the epigenetic transgenerational inheritance of adult onset disease and sperm epimutations. Interestingly, the transgenerational epigenetic alterations (epimutations) in sperm appear exposure specific and may be useful as biomarkers of ancestral toxicant exposure and susceptibility to develop transgenerational adult onset disease."

"The toxic effects of methoxychlor in animal studies have been reviewed and they include adverse effects on fertility, early pregnancy and in utero development in females, **as well as altered social behavior in males after prenatal exposure**." *(Interesting, considering the behavioral and social effects we have learned in neurodevelopmental disorders including autism is predominant in males).*

THE IMPACT OF ALL OF THIS IS HUGE, not only for the topic of the potential for damage chemicals in vaccines can cause, but prenatal environmental exposure as a whole. Vaccines contain endocrine (hormone) disrupting chemicals (EDCs). Examples discussed previously include nonylphenol ethoxylate, octylphenol ethoxylate and octoxynol-10 (Triton X-100). They also contain toxic metal like aluminum and mercury. They also contain chemicals that the material data safety sheets say have mutagenic (causing mutations of genes), teratogenic (causing malformation of an embryo) and carcinogenic (causing cancer) potential. Examples are phenol, Cetyltrimethylammonium bromide, 2-phenoxyethanol, β-propiolactone (carcinogenic), squalene, and polysorbate 80 (Tween-80). As you will learn later in this document, when polysorbate 80 was injected into newborn rats, it caused similar ovarian damage to injected diethylstilbestrol or D.E.S. (D.E.S. is the BANNED mutagenic chemical that caused birth defects mentioned in the medical errors section at the beginning of this e-Book). As the evidence previously in this document showed many of these chemicals and toxins can cross the placenta into the developing fetus! And many can easily cross the immature blood-brain-barrier (BBB).

Considering all of that, which of these chemicals are in the influenza and Tdap vaccines routinely given to pregnant women?

Vaccines given to pregnant women contain several chemicals and toxins that have the potential to cause damage to the fetal germ layer developmentally, potentially causing generational defects- Read which ones here:

The T-dap and flu vaccines are recommended for pregnant women. The various brands contain these different ingredients: aluminum, mercury (multi-dose shots), formaldehyde, 2-phenoxyethanol, glutaraldehyde, polysorbate 80 (Tween 80), octylphenol ethoxylate (Triton X-100), nonylphenol ethoxylate, Cetyltrimethylammonium bromide, MSG, the antibiotics mentioned previously that are not supposed to be given in pregnancy because the warnings say they can cause fetal harm (Neomycin, Polymyxin, Gentamicin sulfate and Kanamycin). You can review the dangers of these ingredients in the section on vaccine ingredients starting on page 109.

You can see that these ingredients are in the influenza and Tdap vaccines here…
https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf

Some of those ingredients are listed as endocrine disrupting chemicals according the Material Safety Data Sheet (MSDS).

Now, with that in mind, read on…….

Endocrine (hormone) disrupting chemicals found in vaccines cause numerous health problems

A 2017 article confirms the damaging effects of prenatal exposure to mercury, Endocrine Disrupting Chemicals (EDCs) and other toxins found in vaccines

This article ties the last section and this section together nicely. It discusses the effects of vaccine ingredients on the germ layer and generational DNA damage, as well the effects of Endocrine Disrupting Chemicals found in vaccines.

The article published in the journal ***Epigenomics*** and titled, **Effects of prenatal exposure to endocrine disruptors and toxic metals on the fetal epigenome**, provides convincing evidence that prenatal exposure to these toxins can cause altered epigenetic programming that will lead to adverse health outcomes later in life. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5827796/

From the article: "Exposure to environmental contaminants during pregnancy has been linked to adverse outcomes at birth and later in life. The link between prenatal exposures and latent health outcomes suggests that **these exposures may result in long-term epigenetic reprogramming**. **Toxic metals and endocrine disruptors are two major classes of contaminants that are ubiquitously present in the environment and represent threats to human health. In this review, we present evidence that prenatal exposures to these contaminants result in fetal epigenomic changes, including altered global DNA methylation, gene-specific CpG methylation and microRNA expression. Importantly, these changes may have functional cellular consequences, impacting health outcomes later in life**. Therefore, these epigenetic changes represent a critical mechanism that warrants further study."

"**Mercury (Hg)-** Long known to be linked to adverse neurological outcomes, Hg exposure during pregnancy is associated with impaired attention, visuospatial and motor functioning, among other outcomes…. **Importantly, Hg bioaccumulates within the fetus**, suggesting an active transport mechanism across the placenta, although the mechanisms for such transport are unknown."

"While we have separated metals and endocrine disruptors in this review, it is important to note that **some toxic metals also act as endocrine disruptors**." ***Toxic metals are often referred to as metalloestrogens in the literature. This means that they act as pseudo or false estrogens in the body.***

"**As noted above with respect to toxic metals, all of the endocrine disruptors discussed here are known to cross the placental barrier**."

"Mixtures- In the environment, human populations are more likely to be exposed to mixtures of toxic substances, rather than single contaminants. Yet, few studies have been published that examine the effects of compound mixtures on the fetal epigenome, despite the fact that the chemicals reviewed here are often found within cord blood together. Those that were identified examine interactions between compounds, such as DDT and PBDE, or how cumulative exposure to a group of varied chemicals, **such as phenols** *(which are found in vaccines)*, may correspond to epigenomic changes in the fetus."

"Discussion & future perspective- There is a growing body of evidence linking *in utero* and early life exposures to both toxic metals and endocrine disruptors to disorders present during early life and emerging later in life. A mechanistic basis underlying the associations between these exposures and adverse health outcomes have often been difficult to elucidate. However, current research suggests that the epigenome may provide this critical link. With modifications that are both responsive to the environment **and may persist throughout the lifetime, epigenetics provides a mechanism for how environmental exposures create long-lasting biological changes in cellular functioning**. While, the epigenome plays a critical role throughout the human lifetime, **the prenatal period represents an especially sensitive developmental window during which epigenetic marks are first being established.** Notably, the specific window of environmental exposure during reproductive development is important in determining the effects observed. For instance, if exposure occurs during a critical developmental period for reproductive system development, these tissues may be especially susceptible to epigenetic alterations and downstream adverse health outcomes. Additionally**, if germ cells are exposed to toxic metals or endocrine disruptors, exposure may yield epigenetic reprogramming within every cell of the offspring. Then, during development, tissues sensitive to the resulting epigenomic reprogramming**

may have an elevated risk for disease development. **Moreover, if germ cells are exposed, then multi- and transgenerational impacts may be observed."**

Endocrine disrupting chemicals found in vaccines, pose a critical risk in utero and early in life

A 2014 article from the journal ***Vitamins and Hormones*** titled, **Endocrine-disrupting chemicals and human growth and maturation: a focus on early critical windows of exposure**, describes the very vulnerable time frame for exposure to endocrine disrupting chemicals during prenatal, neonatal and infancy. It also warns of the effects of these chemicals affecting future generations by damaging the reproductive DNA.

From the abstract:
"Endocrine-disrupting chemicals (EDCs) are exogenous substances that interfere with hormone synthesis, metabolism, or action. In addition, some of them **could cause epigenetic alterations of DNA that can be transmitted to the following generations**. **Because the developing organism is highly dependent on sex steroids and thyroid hormones for its maturation, the fetus and the child are very sensitive to any alteration of their hormonal environment**. An additional concern about that early period of life comes from the shaping of the homeostatic mechanisms that takes place also at that time with involvement of epigenetic mechanisms along with the concept of fetal origin of health and disease." https://www.ncbi.nlm.nih.gov/pubmed/24388185

Endocrine disrupting and mimicking chemicals found in vaccines pose a significant risk

An article published in 2017 in the ***Annual Review of Public Health*** titled, **The Changing Epidemiology of Autism Spectrum Disorders** discusses endocrine disrupting chemicals found in vaccines as possible causative factors form autism. https://www.ncbi.nlm.nih.gov/pubmed/?term=28068486

From the article: "Certain environmental chemicals cross the placenta and the blood–brain barrier, accumulate in developing brains, and interfere with normal neurodevelopment. Others disrupt hormone pathways or act on inflammatory pathways that may have downstream effects on brain development. Epidemiologic investigation of environmental chemicals as potential ASD risk factors has increased over the last decade; most of this work is being done in the areas of air pollution and potential **endocrine disrupting chemicals (EDCs)**, topics on which we focus here."

"…EDCs are of concern because **they interfere with the activity of hormones critical in neurodevelopment, may interfere with immune system activity, and have been associated with a range of other neurodevelopmental endpoints**."

The EDCs found in vaccines are:

Mercury and Aluminum- As discussed above, toxic metals like mercury and aluminum act as endocrine disruptors.

Nonylphenol ethoxylate- Found in The Fluvirin influenza vaccine.

Octylphenol ethoxylate (Triton X-100)- Found in the Fluzone Quadrivalent, High Dose and Intradermal influenza vaccines.

Octoxynol-10 (Triton X-100)- Found in the Fluarix Trivalent and Quadrivalent influenza vaccine.

These chemicals are commonly found in paints, solvents and adhesives. They have become a major problem as environmental pollutants making their way into our food and water and wreaking havoc on human health. These chemicals have no place in vaccines. Safe and non-toxic alternatives need to be sought.

Endocrine disrupting chemicals interfere with the neuroendocrine (nervous system & hormonal) system adversely affecting maturation and development

A 2014 article from the journal ***Reproductive Toxicology*** titled, **Endocrine disrupting chemicals affect the gonadotropin releasing hormone neuronal network,** implicates these chemicals as acting adversely on reproductive development in a variety of ways.
https://www.ncbi.nlm.nih.gov/pubmed/24211603

From the abstract:
"Endocrine disrupting chemicals **have been shown to alter the pubertal process**.... EDCs alter the neuroendocrine GnRH regulatory network **at all hierarchical levels**."

Carefully consider the first sentence of this study abstract and consider that we are intentionally injecting EDCs into our babies

A 2002 study published in the journal ***Molecular and Cellular Endocrinology*** titled, **Organochlorine pesticides directly regulate gonadotropin-releasing hormone gene expression and biosynthesis in the GT1-7 hypothalamic cell line**, is a very complex study of the effects of two specific Endocrine Disrupting Chemicals (EDCs) and how they disrupt the neurological/reproductive axis.

From the abstract:
"**Environmental toxicants profoundly affect growth and developmental processes**. In the present study, we hypothesized that **hypothalamic gonadotropin-releasing hormone (GnRH) neurons, which regulate the reproductive axis, are targets of environmental endocrine disrupting chemicals**."

The rates of premature puberty are greatly increased in neurodevelopmentally challenged individuals- A common cause?

A study from the journal ***Developmental Medicine and Child Neurology*** titled, **Premature sexual development in individuals with neurodevelopmental disabilities**, found that compared to the general population, rates of premature sexual development is much higher in children with neurodevelopmental problems. https://www.ncbi.nlm.nih.gov/pubmed/?term=10400173

From the study:

"In the United States of America, normal puberty has been reported as occurring **between 8 years 6 months and 13 years of age in girls, and between 9 and 14 years in boys**."

"This study reviewed diagnostic data from the records of **15,719 patients** with neurodevelopmental disabilities for diagnoses associated with premature sexual development/precocious puberty. **Thirty-two individuals with premature sexual development were identified,** with the earliest changes seen in one girl at 1 year 7 months of age. **In this group, the mean age at onset was 7 years 2 months in boys and 5 years 11 months in girls**. Central precocious puberty, which was the most common cause of onset of early pubertal changes, was present in 15 of the 32 children. **The results of this study suggest that children with a neurodevelopmental disability are at increased risk of premature pubertal changes when compared to children without a neurodevelopmental disability**."

"***The US Department of Health and Human Services*** and the ***National Institute of Child Health and Development (NICHD)*** of the ***National Institutes of Health (NIH)*** estimate the incidence of precocious puberty in the general population **to be approximately one in 10 000 children** (US Department of Health and Human Services 1997)."

"Our retrospective review of this population with neurodevelopmental disabilities suggested that **a child with a neurodevelopmental disability was at least 20 times more likely to experience early pubertal changes**."

Now, I am completely speculating here, but could it be that the endocrine disrupting nature of the mercury, aluminum (heavy metals are considered Endocrine Disrupting Chemicals (EDCs)), and other EDC chemicals found in vaccines (you will see in the vaccine ingredients section), is causing reproductive alterations and early puberty in the same genetically susceptible individuals that those same chemicals and metals cause neurodevelopmental disabilities in? Again, I don't have proof of the cross correlation, but you will see plenty of evidence contained herein, that strongly implicates those toxins with both neurological and reproductive damage in addition to immunological adverse effects. An example that many people are familiar with is that of BPA. Bisphenol A (BPA) has been removed from many plastic food and beverage containers since it has been shown to be an EDC. One of the studied effects of BPA, is that it contributes to premature puberty in the general population.

This study did not look specifically at how many of those children developed a neurodevelopmental delay after a series of vaccines, however of the 32 children evaluated 14 had seizure disorder, 12 mental

retardation (I don't like that term, but that is what the study used) and 10 had cerebral palsy (C.P.). All three of those conditions could be the result of a vaccine adverse reaction. Seizures and developmental delays are more commonly associated with vaccine reactions; however it is plausible that some cases of C.P. could be caused by vaccines.

More on these chemicals:

Nonylphenol causes adverse effects on reproductive, immune and central nervous system of embryos and offspring

According to a 2017 article in ***Water*** titled, **Distribution and Removal of Nonylphenol Ethoxylates and Nonylphenol from Textile Wastewater**, "Nonylphenol ethoxylates (NPEOs) are indirectly responsible for endocrine disruption among wildlife and human beings via their metabolites, especially nonylphenol (NP). NP has been detected in foodstuffs, drinking water, human adipose tissue, urine, maternal blood plasma and amniotic fluid, blood serum, and breast milk. The presence of NP in pregnant women's decidua *(the maternal part of the placenta),* and early embryos along with maternal transfers has also been observed."

"**Adverse effects of NP on reproductive, immune, and central nervous systems have been discovered in fish, rats, birds, and humans with possible abnormalities in embryos and offspring**. **Recent studies on carcinogenesis have reflected the relation of exposure to NP to the possibilities of breast cancer in women and prostate cancer in men**." http://www.mdpi.com/2073-4441/9/6/386

Why is this important? If NPEOs are found in maternal blood plasma, amniotic fluid, maternal placenta, early embryos and **maternally transferred to the fetus and flu shots containing these compounds are being recommended to pregnant women, there is a cause for concern**. **Not to mention that infants and very young children are given flu vaccines on a regular basis during critical early endocrine, reproductive, immune system and neurological development.**

Nonylphenol affects placental cells raising concerns over its adverse effects on the fetus

A 2006 article published in ***Toxicological Sciences*** and titled, **Estrogen-like response to p-nonylphenol in human first trimester placenta and BeWo choriocarcinoma cells**, shows that p-nonylphenol reacts with cells in the trophoblast (which becomes the placenta and feeds the embryo), raising concerns about adverse effects in the health of the fetus. https://www.ncbi.nlm.nih.gov/pubmed/?term=16790488

From the article:
"p-Nonylphenol (p-NP) is a metabolite of alkylphenol ethoxylates used as surfactants in the manufacturing industry. Although it is reported to have estrogenic activity and to be transferred from the mother to the embryo, no data are available on its effects on the development of the human placenta. In the present study, we investigated estrogen receptors' (ERs) expression in the first trimester human placenta."

"**These findings suggest that the human trophoblast may be highly responsive to p-NP and raise concern about maternal exposure in early gestation**."

Nonylphenol (NP) has deleterious effects on central nervous system (CNS), including neurotoxicity especially during critical windows of brain development (which is when vaccines containing NP are administered)

In a 2013 article titled, **Neurotoxic effects of nonylphenol: a review**, finds that the damaging effects that range from immune to reproductive, to neurological.
https://www.ncbi.nlm.nih.gov/pubmed/?term=23334477

From the article: "Nonylphenol (NP), identified as **an environmental endocrine disruptor**, used as important raw materials for detergents, emulsifiers, and wetting agents in industry and is also found in paints, pesticides, and household toiletries. **NP has been reported to have deleterious effects on central nervous system (CNS) other than reproductive and immune systems including disrupting neuroendocrine homeostasis, altering cognitive function, and neurotoxicity of tissues, etc., particularly when NP's disruption occurs during critical developmental window of brain**."

Prenatal exposure to chemicals assessed at birth contribute to behavioral problems in 7 to 8-year-olds

A 2013 study published in the journal ***Environment International*** titled, **Prenatal exposure to environmental contaminants and behavioural problems at age 7-8 years** identified correlations with the **presence of various heavy metals and chemical contaminants in umbilical cord blood at birth with prevalence of different behavioral problems at ages 7-8.**

From the article:
"When the child reached 7-8 years, 270 mothers completed the Strengths and Difficulties Questionnaire assessing their children's behavioural health……"

"Animal studies showed that the developing brain is particularly sensitive to chemical exposure…. We found that doubling the prenatal lead exposure (cord blood lead levels) was associated with **a 3.43 times higher risk for hyperactivity in both boys and girls**. In addition, total difficulties were **5.08 times more likely** in the highest tertile for prenatal lead exposure compared to the lowest tertile *(tertile means third)*. **In girls, total difficulties were 4.92 more likely when doubling cord blood** p,p'-DDE, whereas no significant association was found in boys. Further, we noted in boys a 1.53 times higher risk for emotional problems when doubling cord blood cadmium, whereas no significant association was found in girls. **These results indicate that the presence of environmental contaminants influences the mental health of the next generation."**

It is true that the heavy metals they evaluated for were lead and cadmium. However, **all heavy metals share certain characteristics of disruption in neurological, immunological and reproductive systems**. Interestingly, the results seem to indicate that certain contaminants have a greater behavioral influence in one gender over another.

Screening for individuals at risk needs to be done

In addition, certain familial tendencies should be considered. In fact, one study titled, **Familial clustering of autoimmune disorders and evaluation of medical risk factors in autism,** from the ***Journal of Child Neurology*** **found that mothers and first-degree relatives of autistic children are approximately 8 times more likely to have autoimmune disease**. https://www.ncbi.nlm.nih.gov/pubmed/?term=10385847

Unfortunately, screening for those at risk is still not done today. In fact, immunocompromised individuals are one of the target groups for vaccines. The narrow focus on the concept that immunocompromised individuals need the "protection" of the vaccine may be the very thing that dooms many to devastating lifelong consequences.

Is the science settled?

Two of the most important, if not the most important questions are:

1. Is the science settled?
2. Has it been proven one way or the other whether the current vaccine schedule has a role to play in the greatly increased incidence of autism, neurodevelopmental or immunological problems seen in children today?

The magnitude of the research presented throughout this document answers both of those questions with a resounding and emphatic NO! Still not convinced….read on.

The Institute of Medicine (IOM), National Academy of Sciences say more safety studies are needed

In 2013, a physician committee at the ***Institute of Medicine (IOM), National Academy of Sciences***, concluded that the current federally recommended childhood vaccine schedule for infants and children from birth to age 6 **had not been adequately studied for safety**, and that **studies are needed** to examine the:

- Long-term cumulative effects of vaccines
- Timing of vaccination in relation to the age and health of the child
- Effects of the total load or number of vaccines given at one time
- Effect of vaccine ingredients in relation to health outcomes
- Biological mechanisms of vaccine-associated injury

Source: Institute of Medicine (2013) The childhood immunization schedule and safety: Stakeholder concerns, scientific evidence and future studies

Just based on this government report I would say that the answer to the two questions, is the science settled and has it been proven that vaccines are not the cause of the epidemic of autoimmune, neurological and developmental/behavioral/learning problems is a resounding no! When you couple the recommendations of the *Institute of Medicine (IOM), National Academy of Sciences,* with all of the other evidence I am supplying within this document, one would have to conclude that the answers are an overwhelming and emphatic no!

Based on the massive amount of evidence presented in this document, the government is still misinforming the public

The government's website ***vaccines.gov*** makes it sound like there is virtually no risk from vaccines or their ingredients. I have copied and pasted those questions and answers the web site gives. This eBook gives a multitude of reasons in great detail as to why these assertions are false, but I will cover just a couple of the key ones for each. **I bolded the false statements** that have already been categorically disproven in this document.
https://www.vaccines.gov/basics/vaccine_ingredients/index.html

My responses are in italics…..

From the web page:
Question: Can vaccines with thimerosal cause mercury poisoning?
A: **No**. **Thimerosal has a different form of mercury (ethylmercury) than the kind that causes mercury poisoning (methylmercury). It's safe to use ethylmercury in vaccines because it's less likely to build up**

in the body — and because it's used in very, very small amounts. Even so, most vaccines do not have any thimerosal in them. If you're concerned about thimerosal or mercury in vaccines, talk with your doctor.

This is so untrue!

In 1999, the U.S. government agreed that the amounts of ethylmercury in the form of Thimerosal, was putting children at so much risk, that they asked vaccine manufacturers and the CDC to remove it from childhood vaccines.

https://www.gpo.gov/fdsys/pkg/CREC-2003-05-21/html/CREC-2003-05-21-pt1-PgE1011-3.htm

Quotes from the Congressional Hearing: "At the time of the 1999 FDA review on thimerosal, it was learned that over 50 vaccines contained thimerosal. On July 9, 1999, the American Academy of Pediatrics joined the U.S. Public Health Service in issuing a joint statement recommending the removal of all thimerosal from vaccines."

Even after this decision was rendered, the FDA slow-rolled the removal well into 2001, putting many other children at risk. "In 1999, the FDA was criticized by some for not taking more forceful action to remove thimerosal from vaccinations; as a result of the FDA decision to seek a gradual removal, many children continued to receive injections of the DTaP, Hib, and Hepatitis B vaccine that contained mercury well into 2001".

Additional pressure was brought to bear in order to get the mercury out of many different vaccines. This letter (see the link), was in response to public pressure about the adverse reactions to vaccines. This should be a good example for all of us today that consider ourselves vaccine skeptics. Until we spread the word and eventually bring enough pressure to our public officials and governmental agencies, nothing will change. We ALL have to get involved with grassroots efforts to create the momentum that will effect a change.

https://worldmercuryproject.org/wp-content/uploads/2016/11/Scott_Bloch_letter_to_Congress.pdf

Additionally, the research that this document presents clearly shows that ethylmercury is as, if not more dangerous than methylmercury. All you need to do is read some of the studies in the section titled, ***Mercury – An initial intro,*** *beginning on page 84 and 85, then later with a CDC Study that cites it being toxic at extremely small amounts on page 104. This is just a very small sampling of the evidence disagreeing with this statement: You will see much more in this eBook.*

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3395253/
https://www.ncbi.nlm.nih.gov/pubmed/?term=27816865
https://www.ncbi.nlm.nih.gov/pubmed/?term=25708367

Ethylmercury does build up in the body as shown previously, and in fact has a longer half-life in the body than methylmercury. According to ***the Journal of the Neurological Sciences****.*

https://www.ncbi.nlm.nih.gov/pubmed/18482737

From the article: "In addition, post-dosing-schedule testing found the concentration of inorganic mercury (formed from the ethylmercury entering the brain) averaged 16 ppb in the brains of the Thimerosal-treated infant monkeys. Moreover, the half-life of this inorganic mercury in the monkeys' brains was too long to estimate a value from the available data (no significant measurable decline was detectable by 120 days)."

And, Dr. Neal Halsey, the Director of ***the Institute of Vaccine Safety at Johns Hopkins University*** agrees: http://www.whale.to/vaccines/thimerosal3.html *Dr. Halsey* also agrees.

This article from ***The Journal of Toxicological Sciences agrees:***
From the article: Ethylmercury and its decomposition product, Hg2þ, rapidly accumulate in the tissues, preferentially in the kidneys and brain. Following in vivo administration, ethylmercury passes through cellular membranes and concentrates in cells of vital organs, including the brain, where it releases inorganic mercury, raising its concentrations higher than equimolar doses of its close and highly toxic relative methylmercury. https://www.ncbi.nlm.nih.gov/pubmed/15843506

ANOTHER QUESTION AND ANSWER FROM THE VACCINE.GOV WEB SITE
Question: Can people who are allergic to antibiotics get vaccinated?
A: Yes. However, if you have an allergy to antibiotics, it's a good idea to talk with your doctor about getting vaccinated. But in general, antibiotics that people are most likely to be allergic to — like penicillin — aren't used in vaccines.
This is not always the case. There are people that are allergic to other antibiotics than those in the penicillin class. And as stated earlier, there are potentially dangerous and contraindicated combinations of antibiotics in some single vaccines and some with a single antibiotic in them are often given at the same time with other vaccines that have the contraindicated antibiotic in them. This is especially dangerous with regard to pregnant women, their fetus, babies and young children. Unfortunately, if we rely solely on the doctor to first know this and second to act on it by excluding those groups from these vaccines, we are in deep trouble. It should be the obligation of the government run web sites to have these warnings, so that those who are considering the recommendations of their uneducated doctor and doing their own due diligence can be forewarned!

As discussed previously on pages 120-121, the four antibiotics most in question are and contained in several vaccines often in combination or given together are:

1. *Neomycin Sulfate*
2. *Gentamicin Sulfate*
3. *Kanamycin*
4. *Polymyxin B*

Visit the CDC's vaccine excipient (ingredients) list to see which vaccines contain these antibiotics at https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf

Sources:

https://medlibrary.org/lib/rx/meds/neomycin-sulfate/

https://www.webmd.com/drugs/2/drug-94473/gentamicin-sulfate-pf-intravenous/details

https://www.rxlist.com/kantrex-drug.htm#warnings_precautions

https://www.rxlist.com/polymyxin-b-drug.htm#description

https://www.everydayhealth.com/drugs/polymyxin-b-trimethoprim-ophthalmic

Question: Is the aluminum used in some vaccines dangerous?

A: No. Vaccines made with aluminum have only a very small amount of aluminum in them. For decades, vaccines that include aluminum have been tested for safety — **these studies have shown that using aluminum in vaccines is safe**.

The issues I have with these statements are as follows:

- *As indicated earlier, **when you add the amounts of aluminum in the current dosing schedule for children, the amounts far exceed the FDA safe limits!***

- *Secondly, as we have seen **vaccine trials are very short lived and typically do not have long term follow-up**. Trends in adverse events are only discovered after the fact, often many years later by looking at the VAERS System. We already know that the VAERS reporting system only captures about 10% of all the adverse reactions from vaccines. Therefore, it makes it a poor indicator of the magnitude of adverse vaccine reactions.*

The government needs to be transparent with the American public. They need to be honest about the very real risks associated with vaccines, including the limited benefits as the rest of this document will show.

PERSECUTION OF DOCTORS THAT DON'T TOE THE LINE

Truth doesn't seem to matter when you want to make an example out of someone

Dr. Andrew Wakefield- A tragic mischaracterization of the truth…(The BIG lie)

The example that those dedicated to the party line on this is always bringing up ***Dr. Andrew Wakefield***, the medical doctor from Great Britain that they claim published an article saying that the mercury in vaccines causes autism. Then they always say that this has been proven untrue. Dr. Wakefield has become the "whipping boy" for the pro-vaccine lobby. The truth is that Dr. Wakefield **NEVER** made that claim. Want to see for yourself? Check out the conclusion from the infamous beleaguered 1998 study that he performed titled, **Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children.** *(see the link below)*

These are the Findings and Interpretation copied directly from his article.

FINDINGS: Onset of behavioural symptoms was associated, by the parents, with measles, mumps, and rubella vaccination in eight of the 12 children, with measles infection in one child, and otitis media in another. All 12 children had intestinal abnormalities, ranging from lymphoid nodular hyperplasia to aphthoid ulceration. Histology showed patchy chronic inflammation in the colon in 11 children and reactive ileal lymphoid hyperplasia in seven, but no granulomas. Behavioural disorders included autism (nine), disintegrative psychosis (one), and possible postviral or vaccinal encephalitis (two). There were no focal neurological abnormalities and MRI and EEG tests were normal. Abnormal laboratory results were significantly raised urinary methylmalonic acid compared with age-matched controls (p=0.003), low haemoglobin in four children, and a low serum IgA in four children.

INTERPRETATION: We identified associated gastrointestinal disease and developmental regression in a group of previously normal children, which was generally associated in time with possible environmental triggers.

You can read the article here: https://www.ncbi.nlm.nih.gov/pubmed/9500320

So, you can read yourself, he didn't claim that the MMR vaccine or the mercury (Thimerosal) caused autism. He simply reported the gastrointestinal pathology results of the evaluations of the 12 children that he examined, discussed a possible environmental trigger and he suggested that further research is warranted. He also suggested during the follow-up period, that it may be better to give the MMR vaccines in separate doses rather than in the 3-vaccine combination **because that could be an environmental trigger**. I see nothing wrong with that very honest and accurate assessment and recommendation, especially in light of the mountain of evidence reported in this document implicating vaccines and autism, including the MMR vaccine. Even so, Dr Wakefield's name is discredited every time a talking head goes on a television show or news program. **Moreover, numerous scientific studies and reports now recognize the "cross-talk" between the gut and the brain and that gut inflammation causes brain dysfunction. This research also vindicates Dr. Wakefield and his findings, yet conveniently it is never mentioned when he is slandered because it doesn't fit their narrative.** Today, we have the advantage of retrospect, **yet any evidence that doesn't agree with the vaccine mantra**

never sees the light of day. That has been true at least until now, where you have the chance to make sure the world knows the truth about vaccines.

Now that you have read the results of his findings and conclusions of his study directly from the study itself, does it change how you feel about the way that Dr. Wakefield has been vilified, lied about and his career destroyed? Now that you know some of the contradictory evidence and will see much more including some in just a few pages and also in the section on the MMR on pages 552-585, you will see that Dr. Wakefield was really just a pioneer in the discovery of these kinds of connections and unfortunately as a result part of a smear campaign.

The way Dr. Wakefield has been treated is **reminiscent of the treatment of Dr. Ignaz Semmelweis**, who I referenced earlier in this article. He was ostracized for suggesting that doctors should disinfect their hands and surgical instruments to reduce infections. He was seen as a heretic, shunned and vilified. Like Dr. Semmelweis, I believe that Dr. Wakefield will also be vindicated in the end. **History has shown however, the bigger the lie, the longer the lie is perpetuated and the greater the force and amplification of the lie, the greater the difficulty for those responsible to admit the errs of their ways. It boils down to pride, arrogance and preserving self- interests. Certainly, there is plenty of that at work here.**

The Wakefield Witch Hunt- What the propagandists are not telling you

For an excellent review of the what I will call "The Wakefield Witch Hunt" perpetrated on Dr. Wakefield, you can read this nine-page summary from Mary Holland JD's excellent book The Vaccine Epidemic. http://vaxxedthemovie.com/wp-content/uploads/2016/04/Who-is-Dr.-Andrew-Wakefield-by-Mary-Holland-JD.pdf

Mary Holland is an attorney and a research scholar at NYU School of Law. She has written and edited books and articles on human rights and law. She has clerked for a federal judge, worked at the Lawyers Committee for Human Rights, and at prominent U.S. law firms. She has testified before Congress, filed amicus briefs, and appeared on Court TV, Fox, CBS, and NBC. She graduated from Harvard College and holds graduate degrees from Columbia University. She is a cofounder and board member of ***the Center for Personal Rights***.

"In 1998, to announce the publication of The Lancet article coauthored by Dr. Wakefield and twelve other scientists, the dean of St. Mary's Medical School called a press conference. At the press conference, Dr. Wakefield was asked about the safety of the MMR vaccine. In 1992, two different combination MMR vaccines had been withdrawn from the U.K. marketplace because they were unsafe, so MMR vaccination was already a hot topic before The Lancet article was published. Dr. Wakefield responded that, given the paucity of combination MMR vaccine safety research, and until further safety studies were done, the vaccines should be separated into their component parts. He had previously informed his colleagues that this was his view and that he would express it if asked."

"The 1998 press conference set off a media firestorm, with large numbers of parents raising

uncomfortable questions about the safety of the "triple jab" and requesting single measles, mumps, and rubella vaccines. **In the midst of the controversy, in August 1998, the British government took an extraordinary step. It made separate measles, mumps, and rubella vaccine components unavailable, thereby forcing the hand of concerned parents**."

Notice that Dr. Wakefield did not tell parents not to vaccinate their children. In fact, Dr. Wakefield was a vaccine proponent. He simply suggested that rather than giving all three vaccines in the one MMR shot, they be given in separate doses spaced apart, until further investigation could be completed. That sounds very rational to me!

CONCLUSION:
"**CPR finds no evidence of Dr. Wakefield's scientific fraud.** On the contrary, many scientists and laboratories around the world have confirmed Dr. Wakefield's findings regarding severe gastrointestinal inflammation and symptoms in a high percentage of children with autism."

"What, then, was this high-profile prosecution really about? If there was no scientific fraud, no undisclosed financial conflicts of interest, no ethical breaches in performing tests on sick children, and no complaints from patients or their families, then what was the big deal? Did the international scandal and multi-million dollar prosecution proceed merely to chastise a doctor for drawing blood from children at a birthday party, with their consent and their parents' consent? Of course not.
Dr. Wakefield was, and remains, a dissident from medical orthodoxy. The medical establishment subjected him to a modern-day medical show trial for his dissent. Dr. Wakefield's research raised fundamental doubts about the safety of vaccines and the etiology of autism. Dr. Wakefield was punished for his temerity to caution the public about vaccine risks and to urge them to use their own judgment. Dr. Wakefield was punished for upholding vaccination choice….
Dr. Wakefield was made an example."

It is amazing how a lie like this can be perpetuated by collusion by big pharma, doctors and the media for nearly 20 years. The opinions of pharmaceutical companies can never be taken as true, because they are by nature biased. Their profit motives blind them from objectivity! That is also why, they or their agents can never be involved with safety or efficacy studies on vaccination.

World-renowned pediatric neurologist believes that certain individuals are susceptible to vaccines triggering autism, but paid the price for saying so

In a January 2019 article, published in ***The Hill*** and written by Sharyl Attkisson titled, **How a pro-vaccine doctor reopened debate about link to autism**, world-renowned pediatric neurologist, who previous testified against parents claiming that vaccines caused their child's autism has reversed his opinion.
https://thehill.com/opinion/healthcare/425061-how-a-pro-vaccine-doctor-reopened-debate-about-link-to-autism

From the Article:
"Pediatric neurologist Dr. Andrew Zimmerman originally served as the expert medical witness for the government, which defends vaccines in federal vaccine court. He had testified that vaccines do not cause autism in specific patients.

Dr**. Zimmerman now has signed a bombshell sworn affidavit. He says that, during a group of 5,000 vaccine-autism cases being heard in court on June 15, 2007, he took aside the Department of Justice (DOJ) lawyers he worked for defending vaccines and told them he'd discovered "exceptions in which vaccinations could cause autism."**

"**I explained that in a subset of children, vaccine-induced fever and immune stimulation did cause regressive brain disease with features of autism spectrum disorder**," Dr. Zimmerman now states. He said his opinion was based on "scientific advances" as well as his own experience with patients.
For the government and vaccine industry's own pro-vaccine expert to have this scientific opinion stood to change everything about the vaccine-autism debate — if people were to find out.
But they didn't.

Dr. Zimmerman goes on to say that once the DOJ lawyers learned of his position, they quickly fired him as an expert witness and kept his opinion secret from other parents and the rest of the public. What's worse, he says the DOJ went on to misrepresent his opinion in federal vaccine court to continue to debunk vaccine-autism claims.

Records show that on June 18, 2007, a DOJ attorney to whom Dr. Zimmerman spoke told the vaccine court: "We know [Dr. Zimmerman's] views on the issue. … There is no scientific basis for a connection" between vaccines and autism.

Dr. Zimmerman now calls that "highly misleading" and says he'd told them the opposite."

Article continues….see the link above to read the rest of the article.

To the vaccine establishment, free speech and personal opinion are attacked vehemently. This doctor from the prestigious Cleveland Clinic paid a heavy price for daring to question the vaccine dogma.

This is a community blog post from a January 06, 2017 commentary on a community blog, written by Daniel Neides, MD, who WAS *(more on this later)*, the **Medical Director and Chief Operating Officer of the *Cleveland Clinic Wellness Institute*.** He was also the **Acting Medical Director of the *Tanya I. Edwards Center for Integrative Medicine***. In addition, he was the **Associate Director of Clinical Education for *The Cleveland Clinic Lerner College of Medicine (CCLCM)***, where he oversaw all clinical activities of students during years three through five of the medical school. **So, let's be clear, this is a man that is very accomplished, successful and one that was esteemed in medical circles.**

I have decided to include the post in its entirety. It is three pages long, but I feel that it is important for you to understand the full context of what Dr. Neides was communicating and that it was not completely vaccine bashing as some believe. If you haven't been convinced already from this eBook, that we have a real problem with the credibility of what we are boing told and what the science shows, you certainly should by the end of it. Once you understand the evidence **the science presents**, **NOTHING Dr. Neides said, is even remotely off base**. **I believe that Dr. Neides is a hero for voicing his personal beliefs, (which again are rooted in strong science). He has essentially become a martyr for the cause of changing the status quo and getting to the bottom of the downward spiral for the chronic health problems of western societies.** For our country, it truly is a national security and economic crisis that we all face. If by 2032 one is two boys become autistic, what will that do to our military readiness, our intellectual capacity to churn out scientists, inventors and business innovators and therefore our economic future. And what about an individual's opportunity for the pursuit of health, happiness and the American Dream?

Immediately when this was posted, a firestorm of angry responses against Dr. Neides and Cleveland Clinic was launched by medical doctors and others. As you read this, you will notice two blocks with green text. These represent the response by the institutions he worked for, to his controversial comments.

HERE IS THE POST HE WROTE:

LYNDHURST, Ohio--I am tired of all the nonsense we as American citizens are being fed while big business - and the government - continue to ignore the health and well-being of the fine people in this country. Why am I all fired up, you ask?

I, like everyone else, took the advice of the Centers for Disease Control (CDC) - the government - and received a flu shot. I chose to receive the preservative free vaccine, thinking I did not want any thimerasol (i.e. mercury) that the "regular" flu vaccine contains.

Makes sense, right? Why would any of us want to be injected with mercury if it can potentially cause harm? However, what I did not realize is that the preservative-free vaccine contains formaldehyde. WHAT? How can you call it preservative-free, yet still put a preservative in it? And worse yet, formaldehyde is a known carcinogen. Yet, here we are, being lined up like cattle and injected with an unsafe product. Within 12 hours of receiving the vaccine, I was in bed feeling miserable and missed two days of work with a terrible cough and body aches.

My anger actually stems from a constant toxic burden that is contributing to the chronic disease epidemic. And yet the government continues to talk out of both sides of its mouth. We want our citizens to be healthy and take full advantage of the best healthcare system in the world (so we think), yet we don't treat our bodies with the love and attention they deserve.

Our air, water, and food supplies are completely compromised and so it is time for us to take matters into our own hands. This year, I am committing to providing you with the educational resources to make

you the best YOU. It may get confusing and frustrating at times but stressing out over this won't help. Take three deep belly breaths and let's get started.

This column's discussion about vaccines has caused international controversy. Read a Q&A explainer about cleveland.com's role. Have questions about the anti-vaccine column posted by a Cleveland Clinic doctor? We have some answers

We live in a toxic soup. There are over 80,000 chemicals used in various industries country wide. There are over 2,000 new chemicals being introduced annually. We breathe in these chemicals through exhaust, eat them in our processed foods (just look at the labels that have 20 or 30 ingredients and good luck pronouncing their names), textiles (clothing, bedding, furniture), and personal care products, including make-up, deodorant, shampoos, and soaps.

Toxins accumulate in our fat cells if they are not eliminated and interrupt normal bodily functions. Your body should be a finely tuned machine with all of the organ systems working in concert together. But when toxins disrupt normal function, problems can occur. Those problems include cancers, auto-immune diseases, neurologic problems like autism, ADHD, and Parkinson's disease, and the most prevalent chronic diseases like obesity, diabetes, and heart disease.

Why are we so sick in 2017 despite the best access to healthcare? The body has wonderful built-in systems to help us detoxify. The liver and kidneys try to do an exceptional job keeping up with filtering out the "stuff" (toxins included) we don't need. Our skin - the largest organ in the body - will release toxins in the form of perspiration. Our breath will release toxins with each exhalation. When our gut is healthy and our microbiome (100 trillion organisms that live in our intestinal tract, within our airway, and on our skin) intact, our bowel movements help rid unwanted toxins.

I like to think of our detoxification system as a big bucket. As long as the toxic soup stays within the bucket, our body can naturally eliminate what we don't need and help us live at the highest quality of life. But what happens when the bucket starts to overflow - which is exactly what many of us have been facing our entire lives? The body may not have the capacity to eliminate our current exposures and THAT IS WHEN BAD THINGS START TO OCCUR.
Link to autism?

We must wake up and really, truly realize that we are the masters of our domain. If we don't look out for ourselves and each other, we can expect to hear about more cancers, more autism, and more auto-immune diseases. As a doctor, I should be thinking - great, this is perfect for business. I am a primary care doctor with a three month wait to get in. That is unacceptable. So, YOU have to help yourself if you want me to help you.

Slight detour. Why do I mention autism now twice in this article? Because we have to wake up out of our trance and stop following bad advice. Does the vaccine burden - as has been debated for years - cause autism? I don't know and will not debate that here. What I will stand up and scream is that newborns without intact immune systems and detoxification systems are being over-burdened with PRESERVATIVES AND ADJUVANTS IN THE VACCINES.

The Cleveland Clinic has disavowed this column, and the author has apologized for the uproar it caused. The Clinic says it will take "appropriate disciplinary action" against Neides for his guest column that bashed vaccines.

The adjuvants, like aluminum - used to stimulate the immune system to create antibodies - can be incredibly harmful to the developing nervous system. Some of the vaccines have helped reduce the incidence of childhood communicable diseases, like meningitis and pneumonia. That is great news. But not at the expense of neurologic diseases like autism and ADHD increasing at alarming rates.
When I was in medical school in the late 1980s, the rate of autism was 1 in 1,000 children. For those born in the 1950's and 60's, do you recall a single student in your grade with an Individualized Education Program (IEP) for ADHD or someone with a diagnosis of autism? I do not.

As of 2010, the rate of autism in the U.S. escalated to 1 in 68 children. The deniers will simply state that we do a better job of diagnosing this "disorder". Really? Something (s) are over-burdening our ability to detoxify, and that is when the problems begin.

So let me be clear - vaccines can be helpful when used properly. But the vaccination timing and understanding one's epigenetics (how your genes interact with the environment) are all critical to our risk of developing chronic disease. Please talk to your doctor about the optimal timing of vaccinations for your children, and therefore reduce your risk of raising a child with a neurologic complication.
For those who want to dive in further, help me understand why we vaccinate newborns for hepatitis B - a sexually transmitted disease. Any exposure to this virus is unlikely to happen before our second decade of life, but we expose our precious newborns to toxic aluminum (an adjuvant in the vaccine) at one day of life.

And when they actually need the protection, many who have received this three-shot series in the first year of life will lack antibody protection--as immunity may not last. Perhaps delaying the series until the immune system is more mature would reduce the risk of neurologic complications.

My goal is to help you think about your total body burden related to toxic exposures. The more mindful you are at reading labels, thinking about what you are ingesting, and how you manage your stress will go a long way toward living a life free from chronic disease. Never assume that products are safe just because they are on a store shelf.

Together we will learn what to stay away from and what to consume. Become a voice for yourself and your family. Blind faith must become a thing of the past. And by educating your loved ones, you will actually help society reduce the chronic disease burden.

In a 2015 article in U.S. News and World Report, Jessica Hutchins, M.D., IFM certified practitioner, states, "Information on eating toxin-free food and pushing food manufacturers to stop using harmful ingredients can be found at foodbabe.com. When we vote with our dollars by choosing to buy products that are sustainably produced and chemical-free, we actively shape the marketplace. Help change the

way [loved ones] nourish their precious bodies, starting with yourself as an example."

I cannot think of a better way to start off the New Year (Wishing you and yours a happy and healthy 2017!). Together we will uncover the exposures that can make us sick and discover ways to assist our bodies to optimally detoxify. This is how we will truly achieve the highest quality of life. Until next time, really open your eyes, and be well.

https://www.cleveland.com/lyndhurst-south euclid/index.ssf/2017/01/make_2017_the_year_to_avoid_to.html

My take on all of this:
Now what was wrong with that?....other than Dr. Neides spoke truth to power. Unfortunately, he took the slings and arrows for his beliefs. Many mainstream doctors ridiculed him for talking about toxins and detoxification. Their ignorance really showed as there is a huge amount of data that agrees with Dr. Neides. There is an unprecedented number of toxic chemicals that we are exposed to in just about everything we come in contact with. And, thousands of doctors successfully utilize detoxification programs of various kinds to assist the body in reducing the total body burden. Many articles in this document corroborate what I am saying. That is the problem that many doctors in mainstream medicine have had over the years. They have a minor deity complex and berate their patients if they even dare to question their "expert" opinion or "knowledge". The truth is, we all only know what we know and those with a rigid and closed mind will never learn or accept any new information that doesn't agree with their narrow and limited perspective. As we have seen, patients have left those types of doctors in droves. Patients are tired of the arrogance and condescension. I am happy to report, that I have also seen a change in those attitudes by many doctors over the years. The consumer will dictate the fate of the doctors they trust with their health, by their loyalty and their pocketbooks.

Dr. Neides is no longer with Cleveland Clinic. He is in private practice and from what I have read is happy practicing the way he wants to, without censorship and prejudice *(my words not his)*.

As more doctors begin to think for themselves, do their homework and realize that they have been spoon-fed what the industry wants them to know, my honest prayer is that more brave and courageous doctors and scientists will step-up. There is power in numbers. A flash flood always starts with a trickle!

Culpability for misinformation- Place the blame where it belongs

As far as the other ***two culpable groups, doctors and journalists.*** I am not insinuating that all doctors all media that have parroted these talking points did so knowing they were misleading people. I would even go so far as to say, that I believe the majority of doctors and people in the media have children and parent's best interest at heart. But let me ask you this. **Isn't it a doctor's responsibility to validate and verify information that they hear before repeating that information to others? It literally takes seconds for someone that knows what they are doing to search for and find articles like I am**

presenting here. To not do that, is pure laziness and dangerous. What if a doctor recommends a drug or a treatment to a patient that injures the patient? In the course of malpractice litigation, it is discovered that the doctor had easy access to information that would have warned the doctor about the fact that the patient in question was at risk without that information. What if the doctor failed to do his or her due diligence? In that case, the doctor would be held liable for professional malpractice. This is a serious issue! As I mentioned earlier, doctors **rarely even give parents informed consent, much less FULL informed consent about all of the possible risks** of the different vaccines they are administering to their child, like they have to do with any other medical procedure. Doctors must be held to a very high standard, because most claim to adhere to an important tenant of medicine which says, "First do no harm."

And as for journalists, isn't it a journalist's job to investigate claims they hear, so that they can be assured that the information they are about to disseminate broadly through the very large megaphone they have is accurate? What ever happened to investigative journalism? Instead of being a naive and willing mouthpiece for an whole industry, I would challenge those with any level of integrity to put in the time and do the work that will uncover the truth, rather than perpetuating the agenda driven messaging of billion dollar companies.

These are two groups of people that have a higher level of responsibility and accountability because of the platforms and reach that they have. **Of the two, doctors have the highest level of accountability because they have the training and knowledge to research the scientific databases such as PubMed, the largest archived medical and scientific database in the world.**

Lastly, there are the legislators and government officials. One would like to believe that elected officials are unbiased and are motivated by a pure desire to serve their constituents and their best interests. I am sure that the vast majority of them have the best interests of all people at heart. The unfortunate reality however is, that **the pharmaceutical industry has the most powerful lobbying machine, not only in Washington but on the local levels as well.**
https://www.publicintegrity.org/2013/02/11/12175/opinion-big-pharmas-stranglehold-washington

These lobbyists and the powerful companies they represent provide financial resources and a steady stream of biased information that they spoon-feed to representatives and government officials. Under those circumstances, it makes it very difficult to make decisions that may go against all of that momentum**. I am calling on all government officials, whether elected or appointed to demand the radical changes that need to be made to completely overhaul the vaccine system and paradigm. Who will be the ones that will step out boldly and demand action? Which of them will refuse to cow-tow to the pharmaceutical machine whether they are getting campaign contributions or not?**

The preponderance of evidence is now available right here. This is where I am hoping to make a difference. By providing alternative evidence and easy access to the information that I am citing, I would hope that any honest, ethical, moral and pure hearted individual, regardless of the career, financial or political ramifications, will take the time to follow the evidence wherever it may lead and make their decisions on the truth rather than on biased talking points.

The true cost of mass vaccination campaigns

What about the push to mandate additional vaccine requirements?

In an article from Green Med Info dated July 03, 2017, and written by ***Robert F. Kennedy Jr***., the issue of requiring Colorado College students to be vaccinated with the Meningococcal vaccine to attend school. http://www.greenmedinfo.com/blog/doing-math-meningitis-vaccinations

The push for the requirement is based on the fact that there were 3 cases in Colorado and 1 resulted in death. According to the article, "Thirty percent of the meningitis cases are the B strain, which typically occur in college-aged kids and against which the three vaccines are completely ineffective. The FDA recently approved two B strain meningococcal vaccines, Trumenba and Bexsero. Vaccine makers are pushing government officials to add them to the recommended schedule for the fall semester. **Critics have faulted the government's expedited safety and efficiency testing for the new B strain vaccines citing glaring lapses in safety protocols including the absence of inactive placebos**. In addition, both new B vaccines are "pregnancy category B," meaning that they should be administered to pregnant women only when necessary. **Neither vaccine has been tested for carcinogenicity, mutagenicity or effects on male fertility**."

The cost of mass vaccination vs. the prevalence- The math just doesn't add up

"**According to their package inserts, Menactra and Menveo produce "serious adverse events" in 1 percent of recipients. Menomune, with its hefty mercury load, sickens 1.3 percent of those receiving it. According to the CDC Pink Book, 0.3 percent of those with "serious adverse events" from meningitis vaccines will die**. **So here is the math calculation that thoughtful student governments in Colorado must consider: If you inoculate Colorado's 400,000 college students with the older vaccines, you can expect 4,000 serious adverse events and 12 dead. We do not yet know the effects of widespread vaccination of the hastily-expedited B vaccines, but according to their package inserts, about 2 percent of students who receive the B vaccine will be sickened or hospitalized with a serious adverse event. This could translate into an additional 8,000 sick students and 24 deaths, for a total of 12,000 sick and 36 dead in the attempt to possibly avert three meningitis cases**."

"**The budgetary issues are significant. Administering Bexsero will cost an estimated $320 per student according to the CDC vaccine price list. For Colorado's 400,000 students, the cost for the B vaccine alone would be $128 million annually**."

The numbers cited in articles when you do an internet search say that there are about 4,000 cases of meningitis annually in the U.S., resulting in about 500 deaths. But according to the CDC's own data published weekly called the Morbidity and Mortality Weekly Report (MMWR), there were only 340 "provisional" cases as of December 31st, 2016 for the year.
See https://www.cdc.gov/mmwr/volumes/65/wr/pdfs/mm6552md.pdf .

Provisional cases mean that the number reported is a temporary estimate, until all the reporting comes in, which is generally considered to be final approximately 6 months afterwards, in this case after the end of the year. As of July 2017, the MMWR table reported 371 cases for 2016.
See https://www.cdc.gov/mmwr/volumes/66/wr/mm6621md.htm?s_cid=mm6621md_w .

Considering that there are 320 million people in the U.S., it means that there was only one case for every 863,000 people. That is barely more than a one in a million chance! That is far less (64 times less), than the chances of getting struck by lightning! According to the National Oceanic and Atmospheric Administration, the chance of getting struck by lightning in one's lifetime (80 years), is 1 in 13,500. http://www.lightningsafety.noaa.gov/odds.shtml

Not only are the odds of contracting bacterial meningitis extremely rare (although it can be serious and even fatal), most cases are very treatable and result in no lasting complications. **Since the CDC estimates that approximately 12.5% are fatal, it means your chance of dying from bacterial meningitis is approximately 1 in 7 million. To put that another way, the chances of dying from it, is around 512 times less than getting struck by lightning!**

So, let's do the math using the statistics given above by Robert F. Kennedy Jr., and extrapolating the 400,000 students he used to calculate the severe adverse reactions, deaths and cost of vaccinating every man, woman and child in the U.S. (which I'm sure would be big pharma's dream). **Taking the population of the U.S. (320 million) and dividing that by the 400,000 students he mentioned, we see that our multiplier for the stats he gave is 800. Therefore, if every person was vaccinated using the older vaccines, there would be approximately 3.2 million serious adverse reactions and 9,600 deaths! Contrast that with the 371 cases in 2016, of which 47 died (or even the 4,000 cases 500 deaths cited by some sources, even though that isn't corroborated by the CDC's MMWR report). With the newer less tested vaccine, the one where the vaccine insert estimates that 2 percent will have a serious adverse reaction that may require hospitalization, it would triple the numbers just cited! That would mean approximately, 9.6 million serious adverse reactions and 28,800 deaths. And, at the $320 cost per person, it would mean that it would cost over 102 billion dollars to vaccinate every man, woman and child in America with the Meningococcal vaccine! Put another way, $102,400,000,000 (yes that's BILLION), "invested" to prevent something that each person would be 64 times less likely to even contract than they would to be struck by lightning and end up with an estimated 29,000 people dead (versus between 47 and 500 fatalities depending on the source you want to believe). What? Can you believe that? If that isn't outlandish enough, take into consideration the medical costs (hospitalizations, doctor visits, medication, etc.), to care for the 9.6 million adverse reactions! That would be well into the billions of dollars as well. And lastly, but certainly NOT least, the toll on the millions of families of those that were vaccine injured, disabled or even dead.**

The next time you hear the fear mongering, name calling and hysteria of those citing numbers of potential casualties without full compliance vaccination being thrown around by the media or the pharmaceutical talking heads, just **DO THE MATH.**

THE TRUTH ABOUT THE DECLINE OF INFECTIOUS DISEASES

The facts about the decline of measles

These 2 graphs showing the decline of the death rate due to measles in the US and the UK speak volumes

This first graph (see the link), **shows how the trajectory for the decline of measles from 1912 was on pace to reduce the measles death rate to 1 person in 25 million by 2010, even without regard to measles vaccination**. In other words, based on the annual rate of deaths due to measles historically, if the measles vaccine was never used, the rate of deaths due to measles would still be right where we are today. https://childhealthsafety.files.wordpress.com/2009/01/measlesmortalityusa1971-75_1.jpg

In this second graph (see link), you can see the same trend **in the U.K. from 1912 to 2006**. If you were to extend the red line out to 2010, as in the case of the graph for the U.S., you would be at **the same death rate of 1 per 25 million people.**
https://childhealthsafety.files.wordpress.com/2009/01/0707275measleslog.jpg

An optical illusion- Showing only part of the graphs of the decline of infectious diseases

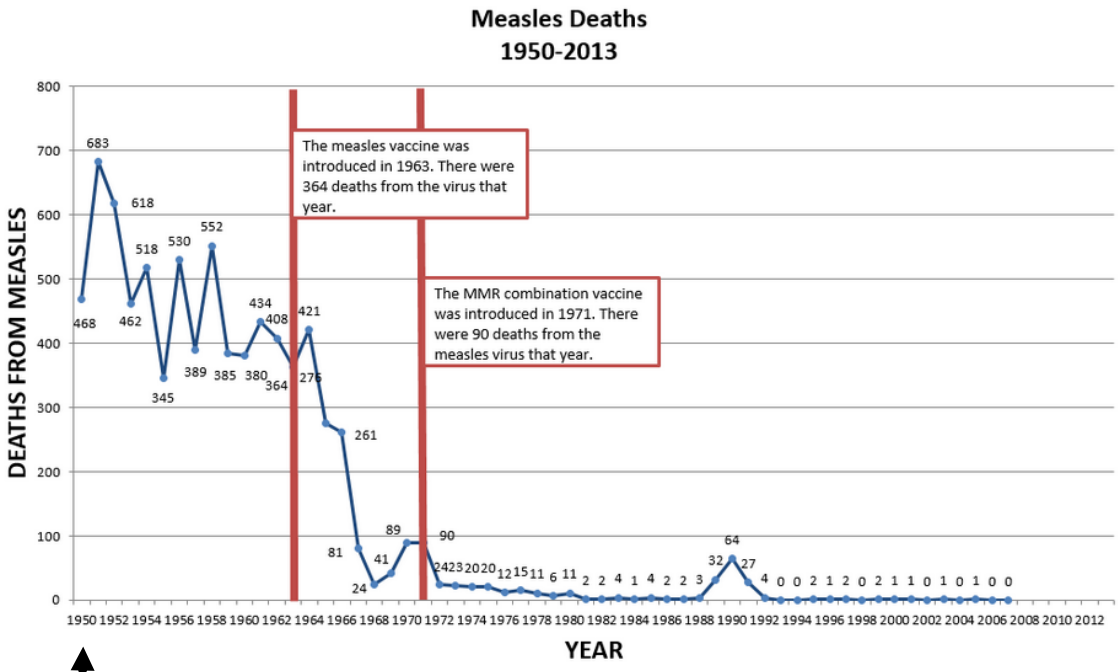
One interesting tactic by vaccine proponents when showing graphs of the decline of measles deaths and incidence of other infectious diseases, is that they only show the period shortly before when the vaccine was introduced. That way you can't see the dramatic and steep decline of the rates and deaths from those diseases from 1900 to shortly before the vaccine was introduced. These next 2 graphs demonstrate that effect. Whether it is intentional or not may be a topic to debate, but the visual effect it gives them to make their case isn't. The reality however, is that is only PART of the story.

Another thing to consider, is that medical historians agree that measles cases were significantly **UNDER-reported** in the first half of the 20th century. **That was because almost everyone contracted measles as a child. It was not considered out of the ordinary and the majority of parents nursed their child back to health without consulting a** doctor. For many, access to medical care was inconvenient or unaffordable, especially for an illness that most children recovered from with no ill effects.

The first graph on the next page shows measles deaths from 1950-2007. By omitting the first 50 years of the century, it gives the impression that the vaccine was instrumental in the decline.

The second graph then shows measles deaths from 1900-1970. You can see the precipitous decline of measles deaths throughout the 20th Century, with the steep downward trajectory from its peak in 1915 to 1963 when the measles vaccine was introduced. For the pharmaceutical industry and medical doctors to claim that vaccines save thousands of deaths annually is simply a lie. How can vaccines get the credit for the 98% reduction in deaths BEFORE the vaccine existed?

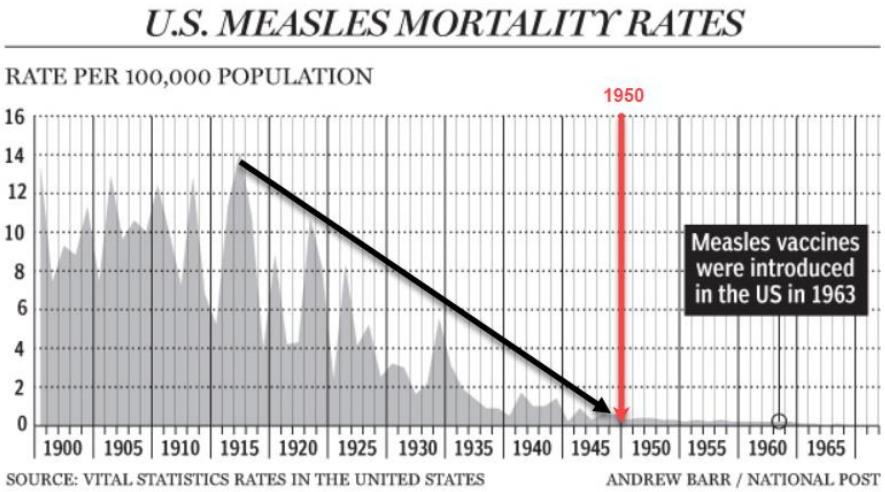
THIS GRAPH IS A CASE OF SELECTIVE REPORTING INTENDED TO SHOW ONLY ENOUGH TO MAKE IT LOOK LIKE THE MEASLES VACCINE HAD MAORE OF AN IMPACT THAN IT DID



1950 (arrow added by me)

Source: https://vaccines.procon.org/view.additional-resource.php?resourceID=005969

Now look at the next graph. The chart above starts at 1950 where the red line is. This omission of the sharp decline of measles from 1900 to 1950 hides the truth about what was occurring in the sharp decline of the disease attributed to better nutrition, hygiene, sanitation, clean water, etc.

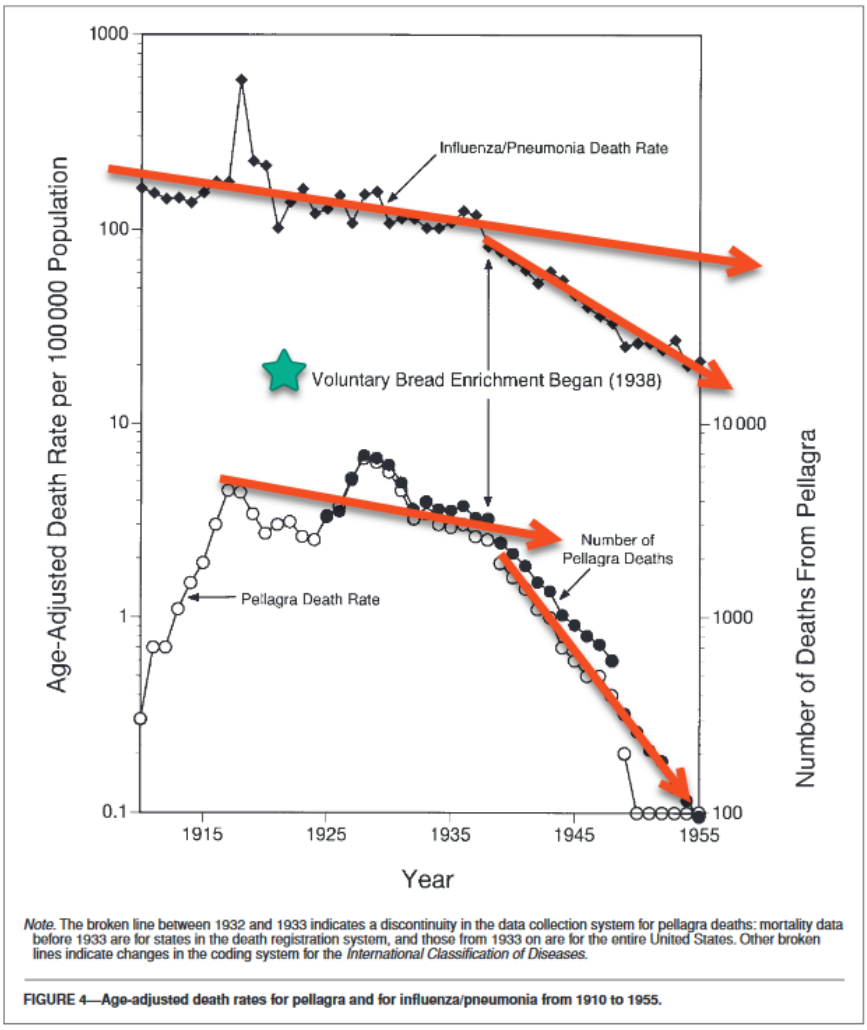


(arrows added by me)
Source: https://business.financialpost.com/opinion/lawrence-solomon-the-untold-story-of-measles

All other infectious diseases followed this same trend as evidenced by the must-see graph links in the section in a few pages titled, "Should vaccines really get the credit for the decline of infectious diseases"

Now let's see what fortifying foods with vitamins has done to the death rates in the U.S. over that same time period

Check out this graph representing the impact of the fortification of bread in 1938 with vitamins, including niacin, a B vitamin which can prevent Pellagra a potentially deadly disease.



Note. The broken line between 1932 and 1933 indicates a discontinuity in the data collection system for pellagra deaths: mortality data before 1933 are for states in the death registration system, and those from 1933 on are for the entire United States. Other broken lines indicate changes in the coding system for the *International Classification of Diseases.*

FIGURE 4—Age-adjusted death rates for pellagra and for influenza/pneumonia from 1910 to 1955.

Source: Effectiveness of Food Fortification in the United States: The Case of Pellagra, *The American Journal of Public Health, May 2000.* http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.90.5.727

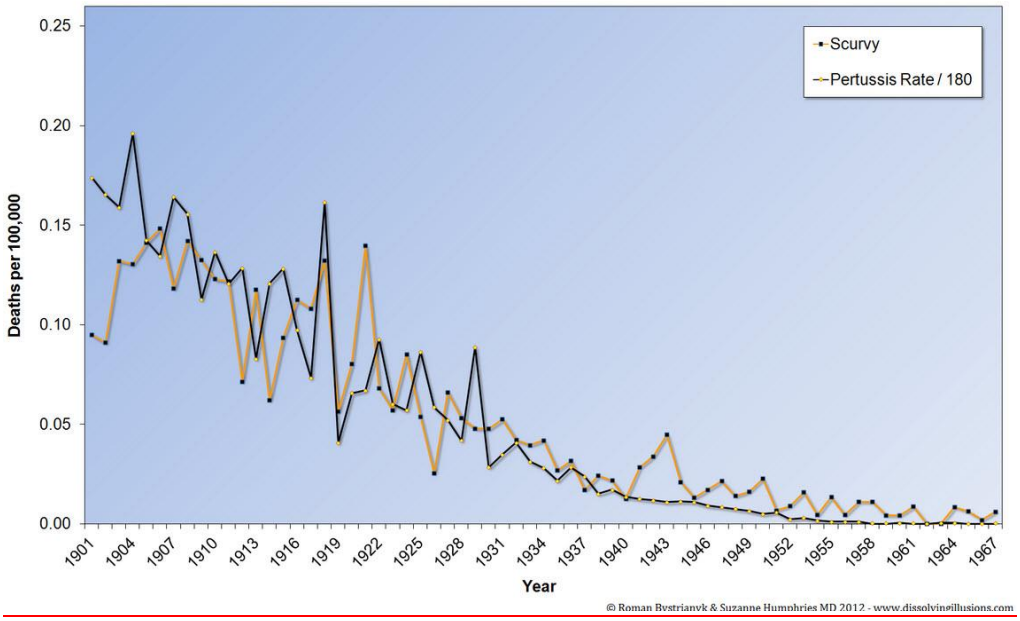
The arrows I have added show the change in trajectory of **deaths due to influenza (flu)/pneumonia on the top half of the graphic and the change in the death rate due to pellagra on the bottom half.** What a HUGE change in the outcomes of an infectious disease AND a nutritional deficiency disease.

*Note: The decline of the trajectory of measles and its level at the very bottom of the graph had reached that tremendous decline 8 years before the vaccine is introduced

Another major factor in the drop of complications and deaths from the measles, the addition of Vitamin A to fortified foods as you will see in the report in a few pages. Vitamin A has been credited by the World Health Organization, as one of the most influential factors in lowering the mortality rate from measles around the world. The following link will take you to a graph that shows the percent of four different nutrients from food fortification in the U.S. over the years. You will notice that from 1950-1968 vitamin A fortification went from 3 percent to 12 percent, a 300 percent increase. The sharpest decline in measles cases during that time period occurred in 1963-64 with another even sharper rate of decline around 1967 (see the link to the first graph on the previous page).
http://perfecthealthdiet.com/wp/wp-content/uploads/2012/03/Slide1.jpg

Other nutritional initiatives for infant baby formula and children went into effect at the same time the measles vaccine was introduced (see "other factors" in a couple pages). The addition of all of these nutritional fortifications make it impossible to say it was the vaccine was THE reason for the decline that occurred after its introduction.

This graph shows the precipitous decline of scuvy (caused by a deficiency of Vitamin C) and Pertussis an infectious disease over 70 years



Graph Courtesy of Roman Brystrianyk and Suzanne Humphries MD

***Note that the pertussis vaccine was not in widespread use until the mid-1940s**

This is a powerful example of how as nutritional deficiencies were corrected by better diet, the rates of infectious diseases also fell.

In just a couple of pages under the title **Should vaccines really get credit for the decline of infectious diseases?,** you will see how infectious disease ran rampant in overcrowded dirty cities, both here and in Europe in the 19th and early 20th centuries. **Thanks to improved nutrition, better waste disposal and sanitation, improved personal hygiene, increased prosperity and less crowded living conditions, the rates of infectious diseases began to plummet.**

Statistics can be manipulated and often are, even by omission

While it is true that measles has led to deaths and complications, like anything else you have to keep things in perspective.

Considering that estimates are that between 3 and 4 million people contracted measles prior to the vaccine's introduction in 1963 and approximately 400-500 people died annually from measles complications. https://www.cdc.gov/measles/about/history.html

That means that at an average of 450 deaths, there was 1 death in between 6,667- 8,889 cases.

In 1963, the population of the U.S. at that time was 189,241,798. Therefore prior to the vaccine, the U.S. death rate from measles was .00000238. That is "two hundred thirty-eight hundred-millionths", or .000238 percent.

To compare the 450 deaths from measles to other causes of death I'll quote from an article written by Dawn Babcock Papple on Vaxtruth.org

"*Meanwhile,* about 12,000 people died from stomach ulcers and the likes. Just over 43,000 people died from car accidents in 1963. Over 700,000 people died from heart disease.

In 1963, you were more likely to be one of the 9200 people murdered that year than to die of measles. If you were born in 1963, you were more likely to die from a congenital disease than from measles. In 1963, it was about 46 times more likely for a child to die from a congenital malformation than for someone to die from the measles.

Frankly, in 1963, you were about 46 times more likely to kill yourself than you were to die from measles."

Now an important consideration on those numbers we just discussed. We are taking the CDC statistics on face value. Those numbers are on the number of diagnosed not confirmed cases. So, how accurate are doctor's diagnoses of measles infection? There are many sources that say measles are highly over diagnosed. When studies of diagnosed cases have been tested for measles, the rate of those cases positively confirmed has been very low.

Other important considerations from the article:

"The CDC uses the number of cases, as opposed to the rate of cases of measles infections, making no attempt to adjust for the drastic population growth in the decade just before the first vaccine was licensed: The Baby Boom. In addition, they do not address the historic 2-3 year cycle of measles."

DRASTIC POPULATION INCREASE, PLATEAUED CASES *(The Baby Boomers)*

"Our population rose from 139.9M in 1945 to 189.5M in 1963: That's almost FIFTY MILLION new Americans. Greater than an additional 1/3 of the population was added to the U.S., but it is not even considered when presenting measles data." *(This is important because there would obviously be a significant increase in the number of cases, whereas if they used the rate per 100,000 people there would not be the same spike).*

"In 1958, we saw a large spike in the actual number measles cases (nearly 800K), that is true." *(U.S. Census figures show a large spike in 1951 and then continued to increase until 1957, when it slowly started to decline until 1964, after which there was a sharp decline in births in 1965).* "

This would be expected, given that the Baby Boomers were highly susceptible because they were children, previously unexposed and almost exclusively fed formula (and did not get measles antibodies during infancy from their mothers' milk.) After that spike, we would expect to see another spike in two to three years, because that is the historic cycle. But that never happened. The number of cases held at around the 400K level, despite the population continuing to increase."

"Though the first measles vaccines (which was deemed a failure in ability to create antibodies) was not licensed until the later part of the measles season on the sixth year of the cycle, there was still no major spike. The next measles vaccine was licensed near the end of that measles season that same year. Meanwhile, in the five year span between the 1958 spike and the first vaccines, the population grew by 14.6 million."

https://census.gov/content/dam/Census/library/publications/2014/demo/p25-1141.pdf

OTHER FACTORS

"In 1957, the AAP's new committee on nutrition released the new guidelines that doctors would use. In 1958 and 59, when almost every single baby was drinking formula instead of breastmilk, commercial infant formulas were finally fortified with iron. In 1960, Miles Laboratory developed Chocks, the first chewable multivitamin aimed at children. Flintstones followed shortly thereafter. In January of 1961 Kennedy's first executive order mandated that the USDA donations to the poor include a variety of fresh foods rather than whatever was at a surplus that year. Later, that same year, the USDA was required to donate foods to schools for children who could not afford food. Kennedy continued to support initiatives that helped the poor and minorities until his death in November 1963. The work he began

continued after his death. In 1964, President Johnson launched the "War on Poverty." 1964 brought on the "Food Stamp Act." Medicare and Medicaid were offered to Americans in 1965. Additionally, by 1965 the proportion of people living in poverty decreased by about 1/3 when compared to the numbers in 1950."

ADDITIONAL SUPPORTING DATA

"Another great way to show that measles cases had been declining is to look at military records. They used actual rates, kept great records and focused in one specific age range. In the Civil War, which was in the 1860, the cases reported were 32.2 per 1000-person years. The rate drops to 26.1 in the Spanish American War. During World War I, it was 23.8. And in the second world war, it was down to 4.7 per 1000 man years. It was the same rate decline in the Royal Navy records as well, which recorded a little differently, but still showed a decline. In WWI, the rate of measles was 16.0 per patients admitted for the entire duration. In WWII, the case rate was 2.9 per patients admitted."

Measles are significantly over diagnosed, making the numbers look much higher than they really are– Up to 7400%

There are several diseases and conditions that have very similar symptoms to measles. If doctors don't actually run blood work looking for the measles titer, **studies show they are wrong over 90 percent of the time.**

Two studies:

A. Laboratory confirmed cases of measles, mumps, and rubella, England and Wales: October to December 2004. Notified: 474, Tested: 589†, Confirmed cases: 8

RATE OF OVER-DIAGNOSIS: 589/8 = proportionately **7400% or 74 times over diagnosed**

SOURCE: CDR Weekly, Volume 15 Number 12 Published: 24 March 2005
http://webarchive.nationalarchives.gov.uk/+/http://www.hpa.org.uk/cdr/archives/2005/cdr1205.pdf

[Note from Source: "†Some oral fluid specimens were submitted early from suspected cases and may not have been subsequently notified, thus the proportion tested is artificially high for this quarter."]

B. Total confirmed cases of measles and oral fluid IgM antibody tests in cases notified to ONS*: weeks 40-52/2005. Notified: 408, Tested: 343, Confirmed cases: 22

RATE OF OVER DIAGNOSIS: 343/22 = proportionately **1560 % or 15.6 times over diagnosed**

SOURCE: CDR Weekly, Volume 16 Number 12 Published on: 23 March 2006…Page 7
http://webarchive.nationalarchives.gov.uk/+/http://www.hpa.org.uk/cdr/archives/2006/cdr1206.pdf

Other conditions often mistaken for measles

- Fifth Disease
- Roseola
- Mononucleosis
- Parovirus
- Enterovirus
- Adenovirus
- HHV-6
- Allergic reactions

Sources:

Etiology of Measles- and Rubella-like Illnesses in Measles, Mumps, and Rubella—Vaccinated Children
Journal of Infectious Diseases- 1998 https://academic.oup.com/jid/article/178/6/1567/844652

Pediatric Viral Exanthems, ***Children's National Health System***
https://childrensnational.org/choose-childrens/conditions-and-treatments/skin-disorders/viral-exanthems-rashes

Rates of measles deaths fell more than 95% BEFORE the vaccine was introduced

As with other infectious diseases, government statistics show that they were on decline of a steep trajectory throughout the 20th century long before the vaccine. I will discuss the reasons why in the next few pages.

Measles Mortality UK & USA

Rubella Mortality – England and Wales

Validation of the drop in infectious diseases PRIOR to mass vaccination directly from U.S. government statistics and located on the CDC's website

Visit this site and you will see the same trends of greater than 90% reduction of infectious diseases PRIOR to vaccine introduction and mass vaccination programs. **See pages labeled 79-85 and page 92.**
https://www.cdc.gov/nchs/data/vsus/vsrates1940_60.pdf

The Journal of the American Medical Association shows that the death rates from infectious diseases had dropped to modern-day levels prior to mass vaccination campaigns

A 1999 article published in the ***Journal of the American Medical Association*** titled, **Trends in infectious disease mortality in the United States during the 20th century**, clearly shows that the rates of death from infectious diseases had reached a low point before mass vaccination for modern day infectious diseases in the 1960s. In fact, since the 1960's there had been no reduction in mortality from infectious diseases in the U.S. over the 30-year period up until the mid-1990s. This article contains some fascinating graphs showing the rates of decline of various infectious diseases combines and overall, as well as by age groups. https://www.ncbi.nlm.nih.gov/pubmed/9892452

Results: "Infectious disease mortality declined during the first 8 decades of the 20th century from 797 deaths per 100,000 in 1900 to 36 deaths per 100,000 in 1980. From 1981 to 1995, the mortality rate increased to a peak of 63 deaths per 100,000 in 1995 and declined to 59 deaths per 100,000 in 1996. The decline was interrupted by a sharp spike in mortality caused by the 1918 influenza epidemic. From 1938 to 1952, the decline was particularly rapid, with mortality decreasing 8.2% per year."

This begs the question, since vaccines have been sold to the public as saving millions of lives and have reduced these "devastating" diseases to a mere fraction of what they used to be, then why don't the statistics support that? I am willing to give credit where credit's due, but the government's own data clearly doesn't support the claims!

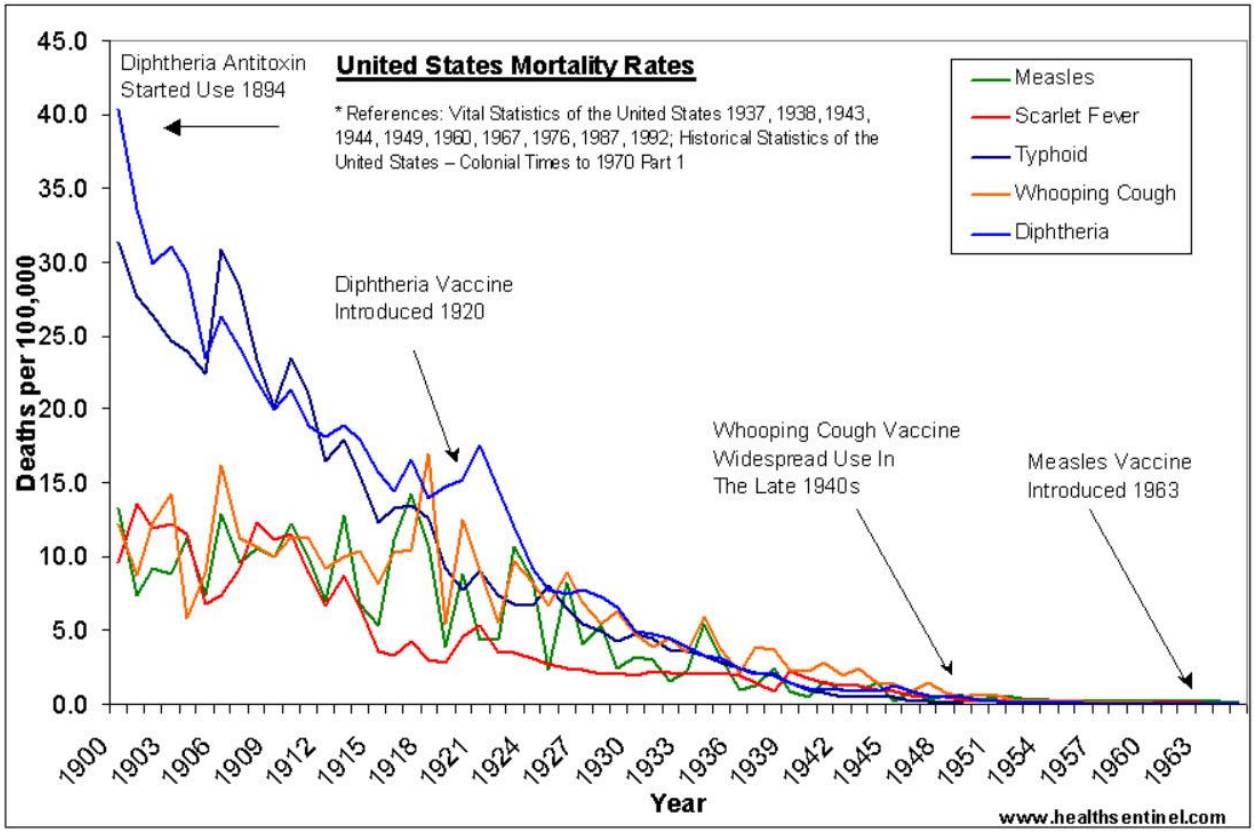
One more excellent source that reinforces the prior evidence

Scroll down in the article to see excellent statistics, commentary and graphs on the decline of infectious disease prior to introduction of vaccines.
https://childhealthsafety.wordpress.com/graphs/#Mumps_Eng_Wales

Should vaccines really get credit for the decline of infectious diseases?

A picture is worth a thousand words- These must-see graphs say it all!

Is this a simple case of mistaken identity? A vaccine is introduced, and the trajectory of the disease goes down. **The most important question that no one ever asks is, what was the trajectory before the vaccine was introduced? If the trajectory was in a steep decline at or greater, than after the vaccine was introduced, it is probable that the vaccine got the credit for something it did not do.** Re-read the statistics here > http://www.vaccinationcouncil.org/2013/11/12/vaccines-a-peek-beneath-the-hood-by-roman-bystrianyk-and-suzanne-humphries-md/



Source: http://drsuzanne.net/dr-suzanne-humphries-vaccines-vaccination/

Here is another source showing the decline of various diseases from many countries around the world before the vaccines were introduced… http://www.whale.to/vaccines/decline1.html

As you can see, the sharp decline in mortality from all of these infectious diseases was greater than 90% BEFORE any of the vaccines were even in existence. The reason is, that history shows that significant improvements were made in personal hygiene, improved sanitation habits, refrigeration, sewage elimination, better nutrition and cleaner water supplies during the previous 100 years. Improvements in trade and commerce also contributed to access to higher quality nutrition. In recent history in underdeveloped and third-world nations, we have seen rates of infectious disease very similar to what they used to be in western countries 100 years ago, prior to all of these improvements. And yet, many of these impoverished nations are seeing dramatic improvements in hygiene, sanitation, better nutrition and clean water as a result of efforts provided by outside government funding and charitable organizations. Not coincidentally, the rates of infectious disease complications and deaths are also dropping significantly.

Yet, vaccine proponents point out that rates of cases of infectious disease that are immunized against dropped significantly when the vaccines were introduced. **My question to them is, why did all the other cases of infectious diseases that have not been immunized against in the United States drop at the same trajectory as the ones that were? Look at this chart** https://www2.census.gov/library/publications/2004/compendia/statab/123ed/hist/hs-18.pdf It is from

the U.S. Census Bureau (cases per 100,000 population), it is clear that the rates of all infectious diseases dropped together. The first five diseases (Tuberculosis, Syphilis, Gonorrhea, Malaria and Typhoid Fever) are not vaccinated against in the U.S. If you look at the trends throughout the chart and look at the bottom of the chart at the highest and lowest numbers, you can see that compared to the three diseases that are regularly vaccinated against (Diphtheria, Pertussis or whooping cough and Measles) the decreases are the same (although admittedly, the pre-vaccine rates for measles had dropped less until after the vaccine was introduced). As a contrast to the rate of decline in the number of measles cases, the rate of deaths due to measles declined sharply over the sixty years prior to the introduction of the measles vaccine, due to better sanitation, health conditions, access to better food (including vitamin fortification) and cleaner water, etc. **One could argue that the number of deaths and illness due to measles in the U.S. just prior to the vaccine's introduction could have been reduced almost entirely, if a campaign to educate parents about supplementing their children with inexpensive vitamin A would have been implemented. But of course, that would not be patentable and marketable by the pharmaceutical industry. The *World Health Organization* has touted the success of vitamin A in reducing mortality and morbidity from measles in many third-world countries. You will see some research discussing that next**.

The realization that vaccines and medical interventions did not contribute much if at all, to the decline of deaths from infectious diseases is not new, as this 1977 paper discloses

A 1977 paper titled, **The Questionable Contribution of Medical Measures to the Decline of Mortality in the United States in the Twentieth Century**, describes, and shows graphically in detail that the statistical facts do not support the marketing propaganda that vaccines are responsible for "saving countless lives".
http://www.columbia.edu/itc/hs/pubhealth/rosner/g8965/client_edit/readings/week_2/mckinlay.pdf

The authors this study, John B. and Sonja M. McKinlay are from the Department of Sociology of Boston University and Massachusetts General Hospital, the Department of Mathematics of Boston University, Radcliffe Institute and from Harvard University.

This article produces some fascinating insights. Since a picture is truly worth a thousand words, I will add a couple of the graphs starting on the next page.

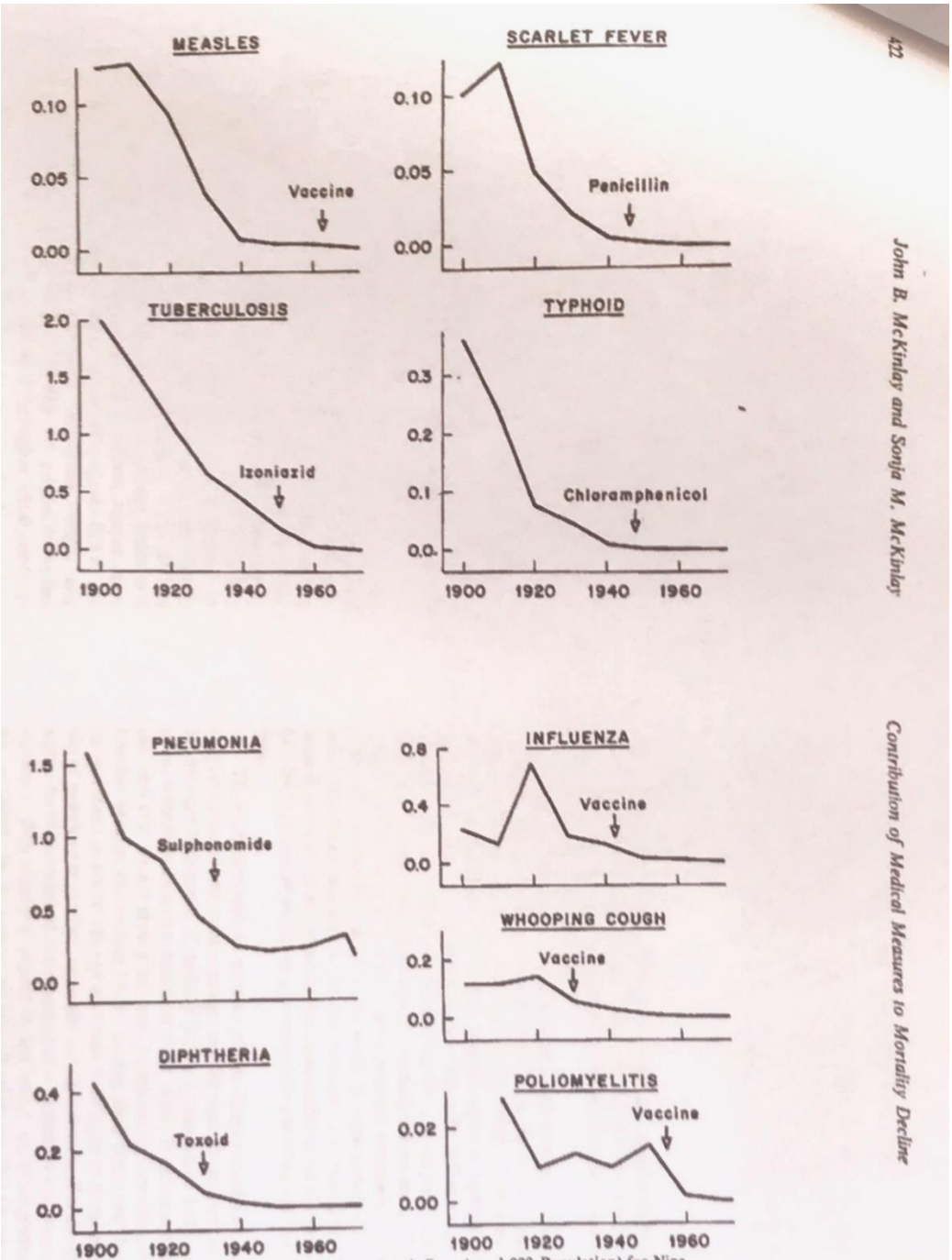


FIG. 4. The Fall in the Standardized Death Rate (per 1,000 Population) for Nine Common Infectious Diseases in Relation to Specific Medical Measures, for the United States, 1900–1973.

When you look at the trajectory of the decrease in mortality before and after the introduction of the medical intervention (vaccine/treatment drug), you can see that there is virtually no change in nearly every case (including measles, for which the propaganda about the vaccine saving us in the U.S. is at a "fever pitch" as I write this). The report did say that the introduction of the polio vaccine did appear to

make some difference in the decline of the mortality rate, however as my section on pages 470-472 and the next section points out, the fortification of foods also corresponded with those change points. Additionally, as described on pages 641-645, the decline of DDT also correlated with the decline in cases of polio. The symptoms of DDT poisoning are said to be “indistinguishable” from those of poliomyelitis.

From the article: (remember this covered up until 1973 and was written in 1977)
“Certainly, from the evidence considered here, only poliomyelitis appears to have had a noticeably changed death rate subsequent to intervention. Even if it were assumed that this change was entirely due to the vaccines, then only about one percent of the decline following interventions for the diseases considered here (column d of Table I) could be attributed to medical measures.”

“A major part of the decline in deaths from these causes since about 1900 may be attributed to the virtual disappearance of these infectious diseases.”

“In 1900, about 40 percent of all deaths were accounted for by eleven major infectious diseases… By 1973, only 6 percent of all deaths were due to these eleven infectious diseases.”

The conclusion:

“In general, medical measures (both chemotherapeutic and prophylactic) appear to have contributed little to the overall decline in mortality in the United States since about 1900-having in many instances been introduced several decades after a marked decline had already set in and having no detectable influence in most instances. More specifically, with reference to those five conditions (influenza, pneumonia, diphtheria, whooping cough, and poliomyelitis) for which the decline in mortality appears substantial after the point of intervention- and on the unlikely assumption that all of this decline is attributable to the intervention-ii is estimated that at most 3.5 percent of the total decline in mortality since 1900 could be ascribed to medical measures introduced f or the diseases considered here.”

This next graph shows an interesting comparison of total mortality, mortality minus 11 infectious diseases and the increase in the Gross National Product spent on medical care in the U.S. As medical expenditures skyrocketed from the mid 1950’s to 1973, you cannot see any perceptible change in the rate of decline of either total mortality (includes heart disease, cancer, stroke, accidents and all other causes), or in the death rates from infectious diseases. In fact, shortly after the steep increase in G.N.P on medical care you can see an INCREASE in all cause and infectious disease mortality for about 10 years (1960-1970).

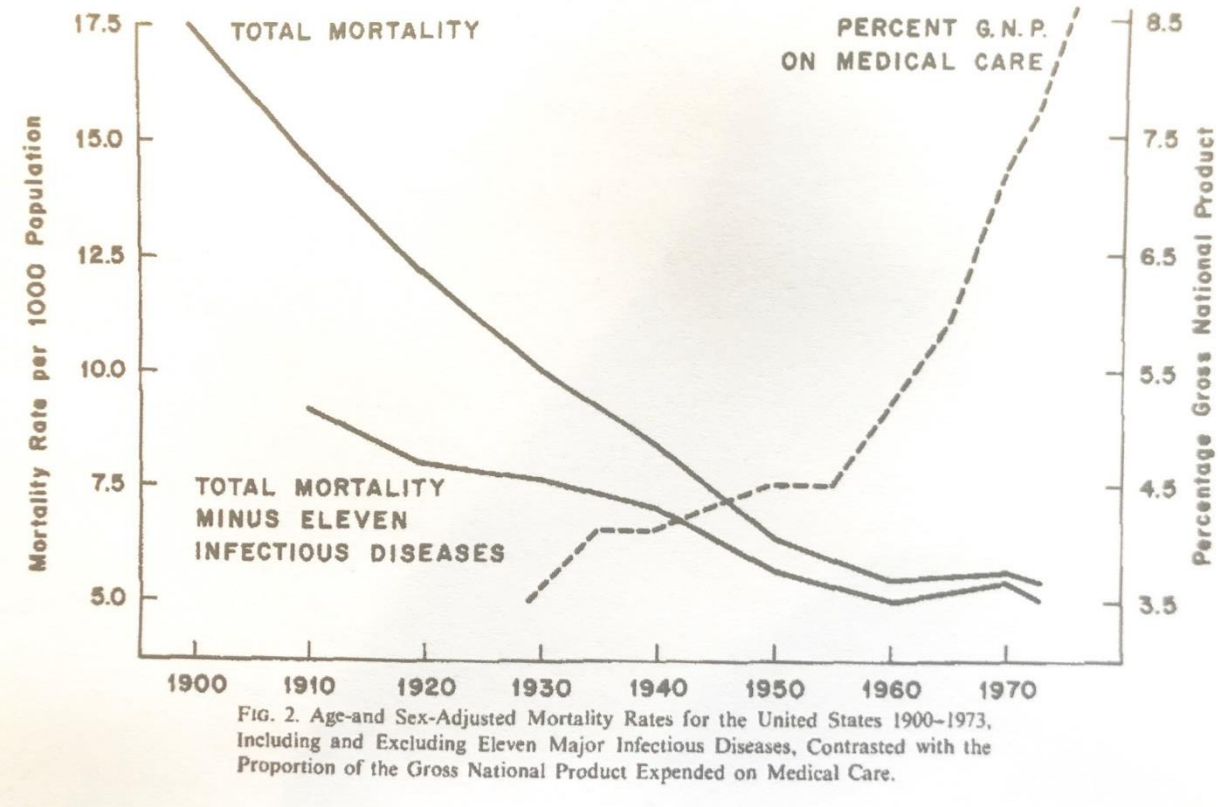


FIG. 2. Age-and Sex-Adjusted Mortality Rates for the United States 1900–1973, Including and Excluding Eleven Major Infectious Diseases, Contrasted with the Proportion of the Gross National Product Expended on Medical Care.

Since it has been obvious since at least 1977, that vaccines had very little if anything to do with the decline of the numbers of deaths from infectious diseases, how did that myth continue to be perpetuated even to this day, over 40 years later? It comes down to one word….**MARKETING!**

Looking at that steep incline of spending on health care through 1973 is just a preview of the rising costs since then. As of 2017, in the U.S., we spend an average of $10,739 for every man, woman and child. That is by far the highest of any nation in the world. This is more than double what the United Kingdom, Belgium, Australia, Japan, France and Canada spend. In 2017, the U.S. also had by far the highest percentage of Gross Domestic Product (GDP) spending on health care in the world at 17.9%.

https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html

So as the world's most expensive health care system, how does all that spending translate into health care access, quality and efficiency? According to an extensive report published in the British medical journal Lancet, not very well. The U.S. ranked 29th in the world according to their metrics. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30994-2/fulltext

Fortification of foods with micronutrients like vitamin A and zinc, recognized as part of a cost-effective strategy in developing countries

A 2005 article from the ***British Medical Journal*** titled, **Cost effectiveness analysis of strategies for child health in developing countries,** touts the value of nutritional supplementation to boost immunocompetence in children as a cost-effective strategy to prevent measles. https://www.ncbi.nlm.nih.gov/pubmed/16282378

RESULTS:
"Cost effectiveness ratios clustered in three groups, **with fortification with zinc or vitamin A as the most cost-effective intervention**, and provision of supplementary food and counselling on nutrition as the least cost effective. Between these were oral rehydration therapy, case management of pneumonia, vitamin A or zinc supplementation, and measles immunisation."

CONCLUSIONS:
"On the grounds of cost effectiveness, micronutrients and measles immunisation should be provided routinely to all children, in addition to oral rehydration therapy and case management of pneumonia for those who are sick. The challenge of malnutrition is not well addressed by existing interventions."

Another article touts the life-saving effects of vitamin A

A study published in ***Health Policy and Planning*** 2008 titled, **The cost of Child Health Days: a case study of Ethiopia's Enhanced Outreach Strategy (EOS)**, made the following statement:

"**Taking into account only the mortality impact of vitamin A, EOS saved 20,200 lives and averted 230,000 DALYs of children 6-59 months**." DALY stands for Disability Adjusted Life Year, a measure of the number of years lost due to ill-health, disability or early death.

Vitamin A supplementation reduces death and disease rates including blindness and other visual disorders in children under 5

A 2011 study published in the prestigious ***British Medical Journal*** titled, **Vitamin A supplements for preventing mortality, illness, and blindness in children aged under 5: systematic review and meta-analysis,** found Vitamin A to be a low-cost and effective way to improve health outcomes in children in low and middle income countries, especially where access to quality nutrition is limited. This study was a meta-analysis of other studies and included 43 trials, with about 215,633 children aged 56 months to 5 years of age. https://www.ncbi.nlm.nih.gov/pubmed/?term=21868478

Incredibly, this study found that vitamin A supplementation could reduce the incidence of measles infection by 50% and the death rate from measles by 20%.

In addition, the article looks at the even bigger picture

Implications for policy:
Vitamin A deficiency is a common condition that contributes to illness, blindness, and death; supplements can reduce these problems for children aged under 5 in low- and middle-income countries. National and regional supplementation programmes could be among the world's most cost effective public health interventions. If the risk of death for 190 million children deficient in vitamin A were reduced by 24%, estimates from 2008 suggest that over 600,000 lives could be saved each year and 20 million disability adjusted life years would be gained.

Discussion:
"Comparable with previous reviews, this review shows that **vitamin A supplementation is associated with large and important reductions in mortality for children in low- and middle-income countries. This adds substantively to previous reviews in providing a plausible pathway and indicating that vitamin A supplementation reduces the incidence of and mortality from diarrhoea and measles**."

Conclusions:
"**Vitamin A supplementation is associated with large reductions in mortality, morbidity, and vision problems in a range of settings, and these results cannot be explained by bias**. Further placebo controlled trials of vitamin A supplementation in children between 6 and 59 months of age are not required. However, there is a need for further studies comparing different doses and delivery mechanisms (for example, fortification). **Until other sources are available, vitamin A supplements should be given to all children at risk of deficiency, particularly in low- and middle-income countries**."

Now I'm going to express some righteous anger here…With al, the hysteria about the measles in the media, why in the h_ _ _ aren't we hearing anything on the nightly news and cable channel programming about the use of vitamin A to protect from and treat children for infectious diseases? A simple, low cost and VERY effective way to **prevent** and **treat** to reduce the complications from infectious diseases like measles and influenza is readily available to everyone, yet all we hear about is how without vaccines children will be dying by the thousands or tens of thousands here in the U.S. This is not only ridiculous, it is shameful, reckless and irresponsible! When will our government officials, medical doctors and institutions start telling the truth and stop enriching the pharmaceutical industry by lying to the public? If only the honest and ethical ones would step up and break free of the dogma and disinformation, we could truly begin to change the trajectory of this failed paradigm and the fallout for the health of our population.

The World Health Organization's recommendations include Vitamin A as a cost-effective way to prevent infectious diseases

Vitamin A supplementation in infants and children 6–59 months of age- Guidance summary*
http://www.who.int/elena/titles/guidance_summaries/vitamina_children/en/

***The W.H.O. dose recommended for malnourished infants and children is way too high for the vast majority of children in first-world countries. See page 687 for a very important caution on dosing.**

The real cause of infectious disease

Historical accounts of the conditions making it ripe for infectious disease epidemics (similar in many ways to third-world conditions today)

A look at 19th century and early 20th century U.S. and Western European cities; overcrowded, unsanitary conditions and more…

The following excerpt is from a book by Frederick Engels in 1845 titled, <u>The Condition of the Working Class in England in 1844</u>. It powerfully highlights exactly what I was just saying, by describing the terrible living conditions in the 19th and early 20th centuries. His book details the living conditions on many of the cities of Europe at that time. This excerpt is from page 97. It is really worth taking the time to read

"That a class which lives under the conditions already sketched and is so ill-provided with the most necessary means of subsistence, cannot be healthy and can reach no advanced age, is self-evident. Let us review the circumstances once more with especial reference to the health of the workers. The centralisation of population in great cities exercises of itself an unfavourable influence; the atmosphere of London can never be so pure, so rich in oxygen, as the air of the country; two and a half million pairs of lungs, two hundred and fifty thousand fires, crowded upon an area three to four miles square, consume an enormous amount of oxygen, which is replaced with difficulty, because the method of building cities in itself impedes ventilation. The carbonic acid gas, engendered by respiration and fire, remains in the streets by reason of its specific gravity, and the chief air current passes over the roofs of the city. The lungs of the inhabitants fail to receive the due supply of oxygen, and the consequence is mental and physical lassitude and low vitality. For this reason, the dwellers in cities are far less exposed to acute, and especially to inflammatory, affections than rural populations, who live in a free, normal atmosphere; but they suffer the more from chronic affections. And if life in large cities is, in itself, injurious to health, how great must be the harmful influence of an abnormal atmosphere in the working-people's quarters, where, as we have seen, everything combines to poison the air. In the country, it may, perhaps, be comparatively innoxious to keep a dung-heap adjoining one's dwelling, because the air has free ingress from all sides; but in the midst of a large town, among closely built lanes and courts that shut out all movement of the atmosphere, the case is different. All putrefying vegetable and animal substances give off gases decidedly injurious to health, and if these gases have no free way of escape, they inevitably poison the atmosphere. The filth and stagnant pools of the working-people's quarters in the great cities have, therefore, the worst effect upon the public health, because they produce precisely those gases which engender disease; so, too, the exhalations from contaminated streams. But this is by no means all. The manner in which the great multitude of the poor is treated by society today is

revolting. They are drawn into the large cities where they breathe a poorer atmosphere than in the country; they are relegated to districts which, by reason of the method of construction, are worse ventilated than any others; they are deprived of all means of cleanliness, of water itself, since pipes are laid only when paid for, and the rivers so polluted that they are useless for such purposes; they are obliged to throw all offal and garbage, all dirty water, often all disgusting drainage and excrement into the streets, being without other means of disposing of them; they are thus compelled to infect the region of their own dwellings. Nor is this enough. All conceivable evils are heaped upon the heads of the poor. If the population of great cities is too dense in general, it is they in particular who are packed into the least space. As though the vitiated atmosphere of the streets were not enough, they are penned in dozens into single rooms, so that the air which they breathe at night is enough in itself to stifle them. They are given damp dwellings, cellar dens that are not waterproof from below or garrets that leak from above. Their houses are so built that the clammy air cannot escape. They are supplied bad, tattered, or rotten clothing, adulterated and indigestible food."
http://www.gutenberg.org/files/17306/17306-h/17306-h.htm

Disease promoting conditions were not limited to the working classes in Europe. U.S cities suffered from the same scenario. This is from an article by Ted Brackemyre titled, **19th Century Immigrants, Cities, and Disease - Immigration and Health Concerns in Late Nineteenth Century America**.
http://ushistoryscene.com/article/immigrants-cities-disease/

This is another very descriptive and graphic explanation of why infectious disease was so rampant at that time

This is the section titled: **Urban Disease and New York City**

"Large waves of immigration in the nineteenth century, made New York City America's largest and most diverse city, but also its most unhealthy, as the large spike in population made it more susceptible to disease. Compared to other large urban areas, such as Boston or Philadelphia, New York's death rate due to disease was considerably higher. It was not until the middle of the century that New Yorkers realized that their poor living conditions might be the cause of the city's poor health. By the 1840's high rates of disease were ascribed to the housing many of New York's poverty-stricken immigrants lived in. Fear spread that while disease was rooted in the polluted living conditions of New York's poorer communities, disease could easily spread to the more well off citizens too. Public health officials realized that the city's soiled streets and polluted sewers were a health risk to all New Yorkers. In the mid-nineteenth century, New York possessed a primitive sewage system. Poorly planned sewers spanned the city, but most citizens' homes did not connect to these pipes. Instead, most New Yorkers relied on outdoor outhouses and privies. These outhouses were usually poorly maintained and covered in filth. Poorer families did not even have the luxury of an outhouse. They simply dug a small trench into the ground outside of their homes. Trenches and outhouses were both unsavory solutions as waste was rarely removed from them and frequently flowed into the streets of the city."

"Because of the high levels of unmanaged waste, epidemics of infectious diseases were commonplace in New York. The city battled outbreaks of smallpox, typhoid, malaria, yellow fever, cholera, and tuberculosis. In 1849, a rash of cholera struck the city, killing more than five thousand people. A wave of typhoid in the mid-1860's resulted in a similar amount of deaths. Port cities and transportation hubs, like New York, were especially prone to outbursts of infectious diseases because of the high volume of travelers that passed through the city. Cholera, for instance, was never a problem in New York until the overseas shipment of goods and persons between Asia and New York drastically increased in the mid-nineteenth century."

This very extreme example of how poverty, unsanitary living conditions and poor nutrition breeds conditions ripe for infectious disease and leads to much higher rates of complications and death, can be seen in a less dramatic example from less than 50 years ago. A study that looked at measles complications and deaths between the years of 1971-1975 found that the death rate from measles was significantly higher in low income families than higher income families. Standard of living was a definite factor. This is that study.

Historically, lower income families have higher death rates from measles

The study titled, **Measles Mortality in the United States 1971-1975** and published by the ***American Journal of Public Health*** in 1980, found some very insightful correlations between poverty and higher rates of fatalities from measles. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1619577/

From the article:
"**There was an inverse correlation between median annual family income of a county and measles death rates of a county, with measles death rates being nearly 10 times higher in counties where median family income was less than $5,000 than in counties where median family income was over $10,000**….. This report reviews death certificate information recorded by the National Center for Health Statistics (NCHS) for the period 1971-75."

The numbers cited related to death rates in the different economic sectors are as follows:

- Family incomes less than or equal to $5,000/year, 1 death in 237,467 cases
- Family incomes between $5,000 and $10,000/year, 1 death in 1, 009, 437 cases
- Family income over $10,000/year, 1 death in 2,190,837 cases

The study also cited **a previous study** published in the ***American Journal of Epidemiology*** by Barkin titled, **Measles mortality: a retrospective look at the vaccine era** that found similar results. "Barkin studied death certificate data for measles mortality for a prevaccine period (1958-1963) and during the vaccine era (1965-1970). Highest measles mortality rates were for children 6-11 months of age in areas with fewer than 10,000 people, **and in counties where more than 60 per cent of the population had incomes below poverty level.**"

In addition, Barkin found that **"the death-to-case ratio was highest for children who developed measles when less than 1 year of age, lowest in children ages 8-15 years, and rose again in persons over 25 years of age"**. https://www.ncbi.nlm.nih.gov/pubmed/?term=1180255

These findings confirm that contracting the wild measles virus between the ages of 4 and 15, is when a child has the most resilience to fight the virus and the rates of complications are lower. This is what happened when we had true herd immunity from would measles. Now, in the post-vaccine era we have seen those persons that have life-long immunity from wild measles infection gradually aging and a vaccinated population getting older with time and as they do their measles antibody titers are dropping. Now, we have seen in the outbreaks in recent years that the demographics have changed, with the

majority of cases occurring in children under 1 year of age and in adults, two populations where measles infections have a greater rate of serious complications. With the waning of vaccine immunity now leaving adults vulnerable and vaccinated mothers having lower antibody levels to pass on to their newborns than in the pre-vaccine era leaving them more vulnerable, these populations are now exposed to greater risk than ever before.

With the death rates from measles just prior to the pre-vaccine era being approximately 1 in 10,000 cases overall and the majority of deaths in areas of poverty, malnutrition and less than sanitary living conditions, one has to wonder what the death rate was if excluding all of those low-income case fatalities. Since this study found the death rate 10 times higher in the lowest-income communities (poverty), I would propose that the death rate in persons that had optimal living conditions, good nutrition, good personal hygiene, clean water, sanitation and access to medical care if necessary, may have been somewhere near 1 in 100,000 cases. Let's look at the logic behind that. In the years just prior to the release of the vaccine in 1963, the death rates were about 400 per year. If 90% of those, or 360 deaths were due to the living conditions impoverished children existed in, that would mean only about 40 deaths were in children that had higher living standards and better access to medical care. That is a death rate of 1 in 100,000 cases. How would that translate to modern day America? My guess would be and it's only a guess, but I would expect that the death rate if measles cases were to return to pre-vaccine levels, would be somewhere in the neighborhood of 1 in 200,000 cases. I am speculating but let me explain my rationale. One of the reasons I am confident of that is that the vast majority of American children today have excellent living conditions comparatively and have access to vitamin A and other immune boosting supplementation, access to medical care if necessary and so many more advantages than in the last century, especially the first half of the twentieth century. I know that many reading this will say, that one death is too many and I agree. The truth is however, that the MMR vaccine caries significant risks of injury and death also. We will look at that next, but first how would the statistics on morbidity and mortality from the measles in 2019 modern day prosperous America compare to rates of adverse consequences of the ever-increasing mass immunization programs? Let's first look at that and then I will get back to making my case for the other reasons why I believe the measles death and morbidity rates would be so low today.

Consider casualty statistics from the MMR Vaccine in comparison

Consider the fallout from the MMR Vaccine in comparison to what complications and deaths may be from the measles in modern western societies. According to an excellent article published on the ***National Vaccine Information Center's*** web site titled, **Can Measles Vaccine Cause Injury & Death?** "**As of November 30, 2018, there have been more than 93,179 reports of measles vaccine reactions, hospitalizations, injuries and deaths following measles vaccinations made to the federal Vaccine Adverse Events Reporting System (VAERS)**, **including 459 related deaths**, **6,936 hospitalizations, and 1,748 related disabilities**. Over 50% of those adverse events occurred in children three years old and under. However, the numbers of vaccine-related injuries and deaths reported to VAERS may not reflect the **true** number of serious health problems that occur develop after MMR vaccination." https://www.nvic.org/vaccines-and-diseases/measles/measles-vaccine-injury-death.aspx

The real numbers are DEFINITELY much higher than these. The reason is, as reported in several places in this document, CDC sponsored research shows that less than 1% of adverse reactions ever get reported to VAERS. The other reason that those statistics don't tell the whole story is, that as has been reported in dozens of studies contained in this document, there is an overwhelming amount of evidence that the MMR Vaccine is connected with autoimmune diseases, neurodevelopmental delays and disabilities including brain damage and autism, learning and behavioral problems and more. Remember that VAERS data will never reflect all of those conditions in which significant delays occur from dates the vaccines were administered and the onset of symptoms from latent disease processes.

I would also invite you to go to the article and look and the long laundry lists of serious adverse reactions that have occurred in the post marketing surveillance phase, of both the ProQuad (MMR-V) and the MMRII, as reported my Merck in their product inserts. You can easily find them online.

Other reasons that modern day American measles morbidity and mortality stats should not be compared to 60 years or more ago as is often done

I would like to follow-up on that last article about the death rates from Measles being 10 times higher in persons living near or below the poverty level (therefore SIGNIFICANTLY lower in higher income families). To support my theory that the death rates today would be incredibly low, even if we went back to allowing all children to get the measles (as radical as that will sound to many), my assertion is based on several things including, all of those cited above pertaining to standard of living, modern public health advancements, hygienic awareness, better quality nutrition and nutritional supplementation, medical advances in caring for cases of infectious disease, etc., etc. But in addition, according to U.S. Census data, the percentage of people living near or below the poverty rate in 1959, was double what it was in 2017.
https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-people.html
(*See tables 6 & 13)

So, with the number of families and children having been elevated to a higher standard of living, better able to afford nutritious food and even nutritional supplements, enjoying cleaner living conditions, access to better medical and social services, and access to better knowledge of health principles, it only makes sense that the morbidity and mortality rates would plummet. When it comes to the advancements in quality of living, the easy access to all the resources that can promote better health, wouldn't you agree that we are the polar opposite of what nations whose people live in abject poverty experience? Yet, big pharma wants all of us to believe that if everyone doesn't take all the vaccines they can muster, we are in danger of sliding back to the dark ages where millions of people's lives are ravaged by infections and hanging on by an extremely fine and frayed thread.

Why is all this important? Because I am shining a bright light on the lies that we are being told and the fear mongering that permeates our media, in order to push a vaccinate everyone agenda in order to make the drug companies and all of their surrogates wealthier. When the media tells us that measles is fatal in 1 out of every 1,000 cases, it simply is not even close to the truth! It is pure deception to push an agenda. You will see exactly what I mean when I cover the section titled, Measles hysteria, another example of irrational fear mongering later in this document.

So, what is the best way to resist becoming infected and if you do, to get over it quickly?

A healthy immune supporting diet helps the “terrain” resist infection

Diet is a primary determining factor in the competency and effectiveness of our immune system. Remember the germ vs. terrain debate? A person’s diet just may be the greatest influence over keeping the terrain healthy and resistant to pathogens. Remember the discussion about the reason for the outbreaks of infectious diseases in overcrowded and filthy cities, without proper sanitation and waste disposal in the late 1800s and early 1900s? Think about what would happen in a modern-day city, in which the garbage collectors have gone on strike for a several months. As the garbage piles up, flies and rats proliferate. As the garbage rots, opportunistic “organisms” (the flies and rats) breed and multiply. A question I have for you is, did the flies and rats cause the rotting garbage? Or are the flies and rats and consequence of the rotting garbage? It’s obvious right? Without the right conditions, flies and rats remain controlled. In the same way, bacteria, viruses and other opportunistic microorganisms didn’t make the terrain ripe for their habitation. In the majority of cases, the person “invited” them in. An unhealthy diet, lifestyle, environment, habits and mental mindset all play THE most important roles as to who gets sick and who doesn’t. And some people have genetic predispositions that make them more vulnerable, even if they do all the other things right. BUT, if they do all of the other things right, they will drastically lower their risk of contracting an infectious disease.

In the same way, harmful micro-organisms can gain a foothold in tissue that is congested or decayed. Some examples are people with diabetic ulcers, sinus congestion or sluggish bowel function. All of those environments are ripe for invasion of opportunistic pathogens. The decaying flesh, the thick mucus in the sinus and the rotting undigested food in the colon attract these harmful germs.

In the case of all of those examples, diet can play a huge role, for better or worse. In the case of Type 2 diabetes, diet and exercise are the two most important lifestyle factors in that order. Shifting one’s diet to lower sugar/glycemic foods and increasing healthy fats and medium chain triglycerides to supply energy demands without spiking insulin, are just a couple dietary tips that can be very effective. For sinus congestion, eliminating mucous forming, allergenic, deep fried and high sugar/glycemic foods will go a long way to change the environment. In the case of sluggish intestinal motility and poor digestion, eating a diet higher in raw foods with lots of fiber and fermented foods, staying well hydrated, reducing dairy, cheese, fried and processed foods and emphasizing smaller portions of meat and increasing portions of greens and fresh vegetables will help tremendously.

The point I would like to emphasize, is that if parents would feed their children a healthy diet consisting of very limited sugar, dairy, processed foods and fried foods which are all immune suppressing and mucous generating, they would have much higher resistance against the “flies and rats” looking for a place to take up residence.

The REAL reason for the drop of infectious diseases long before the introduction of vaccines

Remember the article I shared a few pages ago from Suzanne Humphries and Roman Bystrianyk, about the dramatic drop in infectious disease long before vaccines were introduced?

If you go back and revisit the graphs from their article showing this steep decline of infectious disease, you will see that drop beginning to occur in the late 19th century and early part of the 20th century. This is exactly the timeframe in which sewer systems, garbage disposal, improved sanitation practices, refrigeration and improved working conditions and nutrition all made its way into society.

Is there any doubt as to why disease was so rampant prior to these improvements? And where do we still see these conditions today?

Unfortunately, these conditions still exist in some of the most impoverished countries of the world. Interestingly however, as charitable organizations improve food supply and the quality and quantity of freshwater, the rates of infectious disease go down proportionally. My purpose for pointing that out is that it supports the argument I made previously about the improvements in sanitation, waste disposal (sewer systems), food availability, access to improved nutrition, advances in food preservation (ice boxes and eventually refrigerators/freezers), better transportation methods and commerce, and progress with personal hygiene all preceded the introduction of vaccines. All of these improvements correlated directly to the significant decline of infectious diseases as demonstrated earlier in this article which preceded the introduction of immunization.

The CDC's website affirms the role of sanitation and hygiene in the reduction of infectious disease

The CDC's weekly report ***MMWR Weekly*** July 30th, 1999 ran an article titled, **Achievements in Public Health, 1900-1999: Control of Infectious Diseases** in which acknowledgement of public health initiatives and the subsequent reduction of infectious diseases was discussed.
https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4829a1.htm

From the article:
Sanitation and Hygiene
"The 19th century shift in population from country to city that accompanied industrialization and immigration led to overcrowding in poor housing served by inadequate or nonexistent public water supplies and waste-disposal systems. **These conditions resulted in repeated outbreaks of cholera, dysentery, TB, typhoid fever, influenza, yellow fever, and malaria**."

"**By 1900, however, the incidence of many of these diseases had begun to decline because of public health improvements, implementation of which continued into the 20th century**. Local, state, and

federal efforts to improve sanitation and hygiene reinforced the concept of collective "public health" action (e.g., to prevent infection by providing clean drinking water). By 1900, 40 of the 45 states had established health departments. The first county health departments were established in 1908. **From the 1930s through the 1950s, state and local health departments made substantial progress in disease prevention activities, including sewage disposal, water treatment, food safety, organized solid waste disposal, and public education about hygienic practices (e.g., food handling and handwashing). Chlorination and other treatments of drinking water began in the early 1900s and became widespread public health practices, further decreasing the incidence of waterborne diseases. The incidence of TB also declined as improvements in housing reduced crowding and TB-control programs were initiated**. In 1900, 194 of every 100,000 U.S. residents died from TB; most were residents of urban areas. In 1940 (before the introduction of antibiotic therapy), TB remained a leading cause of death, but the crude death rate had decreased to 46 per 100,000 persons."

Another key factor in the elimination of infectious disease

An amazing short video portraying the huge changes and disparity in prosperity and health of 200 countries in 200 years

Dr. Rosling teaches global health and has created an incredible visual demonstration of the global changes in wealth and longevity. In this amazing short video clip, he demonstrates the dramatic way in which affluence and longevity have increased throughout the developed world over the last 200 years. As you are watching this, take note at where the various countries are by the 1960s when many of the vaccines were produced for diseases like polio, measles and mumps. And then later compare what you see in this video with the discussion we just heard about the real reason for the decline of infectious disease here and around the world. Also, note where the countries that still have much higher rates of infectious diseases. You will see that those countries are the underdeveloped nations in which sanitation, nutrition, living conditions, access to clean healthy water, and proper hygiene are all sorely lacking.

BBC (British Broadcasting Corporation's), Hans Rosling's 200 countries, 200 years, 4 minutes-

Hans Rosling's famous lectures combine enormous quantities of public data with a sport's commentator's style to reveal the story of the world's past, present and future development. Now he explores stats in a way he has never done before - using augmented reality animation.

In this spectacular section of 'The Joy of Stats' he tells the story of the world in 200 countries over 200 years using 120,000 numbers - in just four minutes.

https://www.youtube.com/watch?v=Z8t4k0Q8e8Y **Release date:** 30 November 2010

A major disconnect with our vaccine policy, is that governments are treating infectious disease in the west like we are still third world countries

When overwhelming evidence and real-third-world communities serving as "laboratories" are proving that improvements in living conditions reduce infectious disease and deaths from those diseases, why are we still insisting on vaccinating our entire population for everything? We live in the most prosperous nation in the history of the world, with access to the best nutrition, sanitation, waste disposal, hygienic products and medical care. We have every advantage that people in third-world countries would love to have. Given the explanation I have just presented, regarding the eclipse of infectious disease as a result of all the advancements of the 20th century and BEFORE the advent of vaccines, isn't it odd that we are still told that vaccines are our savior and we can't live without them? And with nearly 300 more vaccines in the pipeline, I think by now we know the reason for that. It's all about the money. Not convinced of that yet? Keep reading this eBook and I will bet by the end of it, you will change your mind.

Is it the germ or the terrain? The Great Debate is the foundation of the points I just made

A historical debate helps this all make sense- Pasteur vs. Bechamp

Lewis Pasteur is a name that many people have heard of. In the early 20th century he coined the term "germ theory". The germ theory gives credence to the belief that germs cause disease. That theory led to the development of antibiotics by Alexander Fleming who created penicillin. The fact that we have antibiotics is not a bad thing, it's a good thing when used appropriately. That isn't the crux of my argument. The crux of my argument is the principal of how infectious disease develops in the first place.

Antoine Bechamp, a French biologist and researcher believed that disease was caused by opportunistic organisms (germs), that were able to take advantage of an unhealthy environment or terrain. He called it the "Host Theory". His argument was that a healthy human body, well-nourished, well rested, with a strong immune response and living in sanitary conditions would not make a good host for germs. On the other hand, a human body that was malnourished, stressed and living in unsanitary conditions, drinking dirty water with a weakened immune response would be ripe for invasion by these microorganisms. Think of it this way, he believed that germs no more caused disease than rats cause garbage. Let me explain. In the overcrowded inner cities that I just discussed, there was no garbage service to pick up the trash. Often, garbage would line the streets alongside buildings and in alleyways. As a result, rats would take advantage of the availability of an easy meal. Therefore, the rats proliferated. Did the rats cause the garbage, or did the garbage create the environment for rats to proliferate? In the same way, germs don't cause disease without a host that is compromised, permitting those germs to move in and set up

shop. This is exactly why impoverished conditions allow for disease to flourish. Bechamp's premise was that it is all about the terrain.

So, the bottom line is, would it be better to fight disease with expensive drugs (which by the way in the case of antibiotics cause antibiotic resistance and a whole host of other immune problems and in the case of vaccines, cause irreparable harm to certain vulnerable individuals), or would it be better to provide better nutrition, clean water, better hygiene and create sanitary conditions? Which solution addresses the cause of the problem? And which solution merely addresses the symptoms of an underlying problem?

I propose that Pasteur's argument became more appealing because it was sexier to develop something that could fight bacteria, (not to mention it was immensely profitable), rather than supporting public infrastructure and improving public education about the importance of a healthy diet, clean water, proper hygiene and wise lifestyle choices. Truth be told, the whole vaccine philosophy is built on The Germ Theory, which is a failing paradigm. In fact, exposure to bacteria, viruses and other microorganisms build our immune system and make it stronger and more capable of defending us against more virulent strains.

Parents need to take responsibility for their children's immune competency

An obvious issue with Bechamp's approach would be that it would require a change in dietary and lifestyle habits by people and families. This requires discipline. Unfortunately, human nature is to take the shortcut approach, the easy or convenient path of least resistance. People who are disciplined about making a commitment to their health are far and few between. In other words, most people don't (or won't), address an issue until it becomes a problem, or a problem until it become an intolerable problem. Part of the challenge is education. Some parents are willing to become educated, some aren't. Another part of the challenge is laziness. It's much easier for a parent to pour their kids a bowl of Lucky Charms and a glass of orange juice, than it is to make them a nutritious breakfast. In doing so, some parents don't know what they're doing is compromising their child's health and immune competence. Yet, some know but are too lazy to make the changes needed for their child's benefit. If you are a parent that is willing to learn and make those simple changes, but don't know what to do, I would like to visit my website at www.wellnessdoc.com . I have designed wellnessdoc to be a reliable and scientifically valid resource for people who desire to learn more about a natural approach to better health.

So here we are, right back to the vaccine debate. Is it easier to take a "magic" shot, or to live in such a purposeful and intentional way that would reduce yours and your children's chance of contracting a disease? Or, if they did contract one of the "dreaded" childhood diseases, and their immune system responded as designed, allowing their body to fight it off effectively and thereby receiving lifelong immunity, wouldn't that be awesome? Isn't that the way it's supposed to work? After all, it's all about the terrain!

New research sheds light on how viruses interact with our cells and how they often benefit us

Fascinating new research shedding light on the makeup of viruses and the way they interact with us has been published widely over the last few years. This article on GreenMedInfo's website does a very nice job of summarizing some very nerdy/geeky science technojargon, into regular human-speak. Well, honestly it is still a little challenging, but if you like this kind of thing like me you will probably love it. http://www.greenmedinfo.com/blog/why-only-thing-influenza-may-kill-germ-theory

Here is a summary of what the article and others from GreenMedInfo have reported:
"Groundbreaking research indicates that most of what we believed about the purportedly deadly properties of viruses like influenza is based on nothing more than institutionalized superstition and myth
Germ theory is an immensely powerful force on this planet, affecting everyday interactions from a handshake, all the way up the ladder to national vaccination agendas and global eradication campaigns. But what if fundamental research on what exactly these 'pathogens' are, how they infect us, has not yet even been performed? What if much of what is assumed and believed about the danger of microbes, particularly viruses, has completely been undermined in light of radical new discoveries in microbiology?"

"Some of our readers already know that in my previous writings I discuss why the "germs as our enemies" concept has been decimated by the relatively recent discovery of the microbiome. For in depth background on this topic, read my previous article, "How The Microbiome Destroyed the Ego, Vaccine Policy, and Patriarchy." You can also read Profound Implications of the Virome for Human Health and Autoimmunity, to get a better understanding of how viruses are actually beneficial to health."

Assumption #3- Vaccines are proven to be effective. Without them there would be countless deaths annually in the United States. Really?

Misinformation and marketing- A prevalent tandem in the vaccine world

Marketing drives the misinformation campaigns

According to an article published in the ***British Medical Journal*** (BMJ) *BMJ* 2013; 346:f3037 doi: 10.1136/bmj.f3037 (Published 16 May 2013), by Peter Doshi, Johns Hopkins University School of Medicine titled **Influenza: marketing vaccine by marketing disease.**
https://www.ncbi.nlm.nih.gov/pubmed/23682040

Here are some quotes from the article:

"**Closer examination of influenza vaccine policies shows that although proponents employ the rhetoric of science, the studies underlying the policy are often of low quality, and do not substantiate officials' claims. The vaccine might be less beneficial and less safe than has been claimed, and the threat of influenza appears overstated**."

"Yet for most people, and possibly most doctors, officials need only claim that vaccines save lives, and it is assumed there must be solid research behind it. **But for those that bother to read the CDC's national guidelines, a 68-page document of 33,360 words and 552 references–one finds that the evidence cited is these observational studies that the agency itself acknowledges may be undermined by bias**. The guidelines state:" . . . **studies demonstrating large reductions in hospitalizations and deaths among the vaccinated elderly have been conducted using medical record databases and have not measured reductions in laboratory-confirmed influenza illness**. These studies have been challenged because of concerns that they have not controlled adequately for differences in the propensity for healthier persons to be more likely than less healthy persons to receive vaccination."

"Theoretically, a randomized trial might shine some light—or even settle the matter. **But there has only been one randomized trial of influenza vaccines in older people—conducted two decades ago—and it showed no mortality benefit** (the trial was not powered to detect decreases in mortality or any complications of influenza). This means that influenza vaccines are approved for use in older people despite any clinical trials demonstrating a reduction in serious outcomes. Approval is instead tied to a demonstrated ability of the vaccine to induce antibody production, without any evidence that those antibodies translate into reductions in illness."

"…**recorded deaths from influenza declined sharply over the middle of the 20th century, at least in the United States, all before the great expansion of vaccination campaigns in the 2000s**, and despite three so-called "pandemics" (1957, 1968, 2009) (fig 1). But perhaps the cleverest aspect of the influenza marketing strategy surrounds the claim that "flu" and "influenza" are the same. The distinction seems subtle, and purely semantic. But general lack of awareness of the difference might be the primary reason few people realize that even the ideal influenza vaccine, matched perfectly to circulating strains of wild influenza and capable of stopping all influenza viruses, can only deal with a small part of the "flu" problem because **most "flu" appears to have nothing to do with influenza**. Every year, hundreds of thousands of respiratory specimens are tested across the US. **Of those tested, on average 16% are found to be influenza positive**. **All influenza is "flu," but only one in six "flus" might be influenza. It's no wonder so many people feel that "flu shots" don't work: for most flus, they can't.**"
"**Drug companies have long known that to sell some products, you would have to first sell people on the disease."**

COMMON MYTHS BEING PERPETUATED

Herd Immunity- Are unvaccinated individuals really putting "the herd" at risk?

The misused "buzz-phrase" Herd Immunity of the pro-vaccine lobby is a false narrative

The term "herd immunity" used by the media and pharma talking heads is a fake talking point, used to make the conversation sound intellectual to the general public

The definition from ***Vaccines Today***…

'Herd immunity is a form of immunity that occurs when the vaccination of a significant portion of a population (or herd) provides a measure of protection for individuals who have not developed immunity.' https://www.vaccinestoday.eu/stories/what-is-herd-immunity/

So, remember, the HIT or herd immunity threshold is the **hypothetical** percentage of the population that must be immune to the disease in order to keep it from spreading to others. **Since the CDC's statistics you are about to see in 4-5 pages, show that the percentage of the population that are vaccinated are typically less than half (and often far less than half), of what conveys the herd immunity threshold, there is no herd immunity to blame non-vaccinated individuals for "ruining".**

Achieving herd immunity not possible since no vaccine works in every individual

An article published in 2011 in the ***Journal of Clinical and Infectious diseases*** titled, **"Herd Immunity": A Rough Guide** describes some of the complications that can occur within the vaccination herd immunity concept. https://academic.oup.com/cid/article/52/7/911/299077

From the article:
Imperfect Immunity
"**If vaccination does not confer solid immunity against infection to all recipients, the threshold level of vaccination required to protect a population increases." *(Since no vaccine confers solid immunity to all recipients, this creates a major challenge)*…. We can see from this that if E is $<(1-1/R_0)$ it would be**

impossible to eliminate an infection even by vaccinating the whole population. **Similarly, waning vaccine-induced immunity demands higher levels of coverage or regular booster vaccination**. Important among illustrations of this principle are the shifts to multiple doses (up to 20) and to monovalent vaccines in the effort to eliminate polio in India, where the standard trivalent oral polio vaccines and regimens produce low levels of protection."

True Herd Immunity in the Pre-Vaccine Era and "Pseudo" Herd Immunity in the Post-Vaccine Era

An excellent description over the next 3 pages, of the difference between true herd immunity as conveyed by natural infection versus pseudo-herd immunity as conveyed by vaccination is provided here. It covers the measles, mumps and chickenpox.

"Herd Immunity is a term that is bandied around in defense of mass and mandatory vaccination. What is it and why is it important?

Let's set out a working definition of what Herd Immunity is at a functional level in the population: Herd Immunity is the presence of adequate immunity within a population against a specific infection that operates to protect those at **high risk of serious infection** and consequently, reduce morbidity and mortality from that infection.

Now let's separate out Herd Immunity, **comparing what it meant in the pre-vaccine era compared with what it means in the vaccine era**, using specific infections as examples.

Measles: Herd Immunity in the pre-vaccine era

- When measles first enters a population that has not been exposed to measles before, Herd Immunity is zero and there is, initially, a very high morbidity (illness) and mortality.
- This occurs in large part as a consequence of **high dose exposure.**
- **High dose exposure** occurs because, in the absence of viral immunity, viral replication is unimpeded in the multiple susceptible human reservoirs in which it thrives. High doses of measles virus are transmitted from one person to the next. Added to this, socioeconomic circumstances contribute to high dose exposure. This includes high population density (easy transmission) and poor antiviral defenses (e.g. low vitamins A, D, and C). An example is the ravage of measles in Confederate soldiers amassed in barracks and hospitals in the American Civil War.
- Over time, as measles becomes endemic (constantly circulating) in a population with typical 2-yearly epidemics, Herd Immunity increases rapidly. Natural exposure leads to long term immunity. Immunity limits viral transmission and opportunities for viral replication. Concomitantly, developed countries have experienced an improvement in nutritional status and

consequently antiviral immunity. Dose of exposure falls and a dramatic reduction in morbidity and mortality is observed.

- **As a consequence of natural Herd Immunity, in the developed world measles mortality had fallen by 99.4% before measles vaccines were introduced**. A fall in morbidity will have paralleled the fall in mortality (mortality is the extreme of morbidity).
- **See a graph showing the measles deaths from 1900-1995 here >** http://www.whale.to/m/measlesdeaths1.html (and scroll down). **The graph shows that measles deaths had reduced 99.4% before the measles vaccine was introduced.**

Let us look at an example of how natural Herd Immunity operated to provide **age-appropriate immunity**.

- Infants less than one year of age have a limited ability to generate adequate immunity and are susceptible to serious measles infection.
- **In the pre-vaccine era mothers conferred good passive immunity on their infants by transplacental and breast milk transfer**.
- This **passive immunity** protected infants through a period of vulnerability until they were better able to cope with measles through the generation of their own active immunity.

Measles: Herd Immunity in the vaccine era

Measles vaccine has destroyed natural Herd Immunity **and replaced it with a temporary and inadequate quasi Herd Immunity that necessitates a dependence on vaccination along with an increased risk of severe adverse outcomes. Here are some examples of how natural Herd Immunity has been destroyed.**

- The increasing Herd Immunity associated with natural measles and the accompanying decrease in morbidity and mortality, has been interrupted by vaccination. This makes it difficult to predict how vaccinated populations might respond to, say, a new strain of measles virus that has escaped the 'protection' conferred by measles vaccine (escape mutant). **Because that population is not immune to the escape mutant we risk high morbidity and mortality from measles once again**.
- **Vaccinated mothers do not confer adequate passive immunity upon their infants** (< 1 year of age). Infants are unable to generate an adequate immune response to measles vaccine and in the absence of passive maternal immunity, are unprotected during the first year, putting them at risk of serious measles infection.
- Unlike natural measles**, measles vaccine does not provide lasting immunity and a substantial proportion of measles cases are reported in those who have been vaccinated against measles.**
- **Boosting of immunity using repeated doses of measles vaccine is not sustained and falls off rapidly. The only answer to this diminishing return that is offered by the regulators and**

manufacturers is to give more and more vaccines. The vaccine is highly profitable in terms of volume of sales, precisely because it is inadequately effective.

Mumps and Herd Immunity

Mumps is acknowledged to be a trivial disease in children; many do not even know they have had mumps the symptoms are so mild. **Mumps is not a trivial disease in post-pubertal males where it can cause testicular inflammation and sterility**.

Mumps vaccine does not work. Protection is way below the 96% claimed by Merck and mumps epidemics are occurring worldwide in highly vaccinated populations. **Merck is accused of fraudulently misrepresenting the efficacy of their mumps vaccine in order to protect their US monopoly on the MMR vaccine.** I would suggest that everyone who has suffered mumps and particularly its complications despite mumps vaccination, has a valid legal claim against Merck.

Mumps vaccine failure is associated with inadequate immunity following vaccination (primary failure) and rapidly waning immunity after vaccination (secondary failure). These factors mean that populations are at greater risk as they grow older. Since severe side effects are more common in mature males, mumps vaccine has made mumps a more dangerous disease.

Natural Herd Immunity, that is, lifelong immunity following exposure of children to mumps in the pre-vaccine era, has been destroyed by mumps vaccination.

Chickenpox and Herd Immunity

The chickenpox virus (varicella zoster) causes a mild self-limiting disease in healthy children. The virus frequently establishes latent infection in the cell bodies of sensory nerve roots **where it has the potential to episodically reactivate and cause shingles, a very painful and debilitating condition**. Shingles can cause blindness. Historically, shingles was an uncommon disease occurring in, for example, people with immune deficiency due to cancer or immunosuppressive drug therapy.

Reactivation of zoster is inhibited by an adequate level of immunity to this virus which, in turn, is maintained by boosting of immunity in parents and grandparents by re-exposure via children with chickenpox. **Natural epidemics of chickenpox maintained Herd Immunity by 'wild-type boosting' (referring to the natural virus) of adults which prevented shingles in otherwise healthy individuals. This is no longer the case**.

Widespread chickenpox vaccination has removed natural Herd Immunity by preventing epidemics, eliminating 'wild-type' boosting, and allowing immunity to fall in individuals to the point **where shingles is now much more common, occurring in young, apparently healthy people**. **Vaccination has created a new epidemic to which Merck's response is, 'we've created a market; now let's make a vaccine to prevent shingles.'"** *(which of course they have)*

Source: http://vaxxedthemovie.com/notes-herd-immunity-andrew-wakefield/

Now, let's take a look at the scientifically established rates for herd immunity (HIT) to be effective

This chart is available through many sources online. One link to access it is http://www.adultimmunisation.eu/communications/herd-immunity-what-is-it-and-why-does-it-matter-social-media-resources/

Disease	Herd Immunity Threshold (HIT)
Diphtheria	85%
Measles	83-94% (93-95% source: W.H.O.)
Mumps	75-86%
Pertussis	92-94%
Polio	80-86%
Rubella	80-85%
Smallpox	83-85%

Aren't unvaccinated individuals "free riding" off of the "herd immunity" of others?

NO, because we are far from achieving the herd immunity threshold (HIT)

Vaccine proponents commonly criticize those who choose not to vaccinate, saying that they are getting **a "free ride off of the herd"** immunity created by those that do vaccinate. This is simply fallacious, because as the CDC even admits, the percentage of people vaccinated against the various diseases are far below what is considered true herd immunity by science. **This page on the CDC website displays the 2014 rates of the population that are vaccinated against the most common diseases vaccines are said to prevent**. https://www.cdc.gov/mmwr/volumes/65/ss/ss6501a1.htm

Here are the CDC Statistics, showing how far below scientific established levels to achieve Herd Immunity we really are

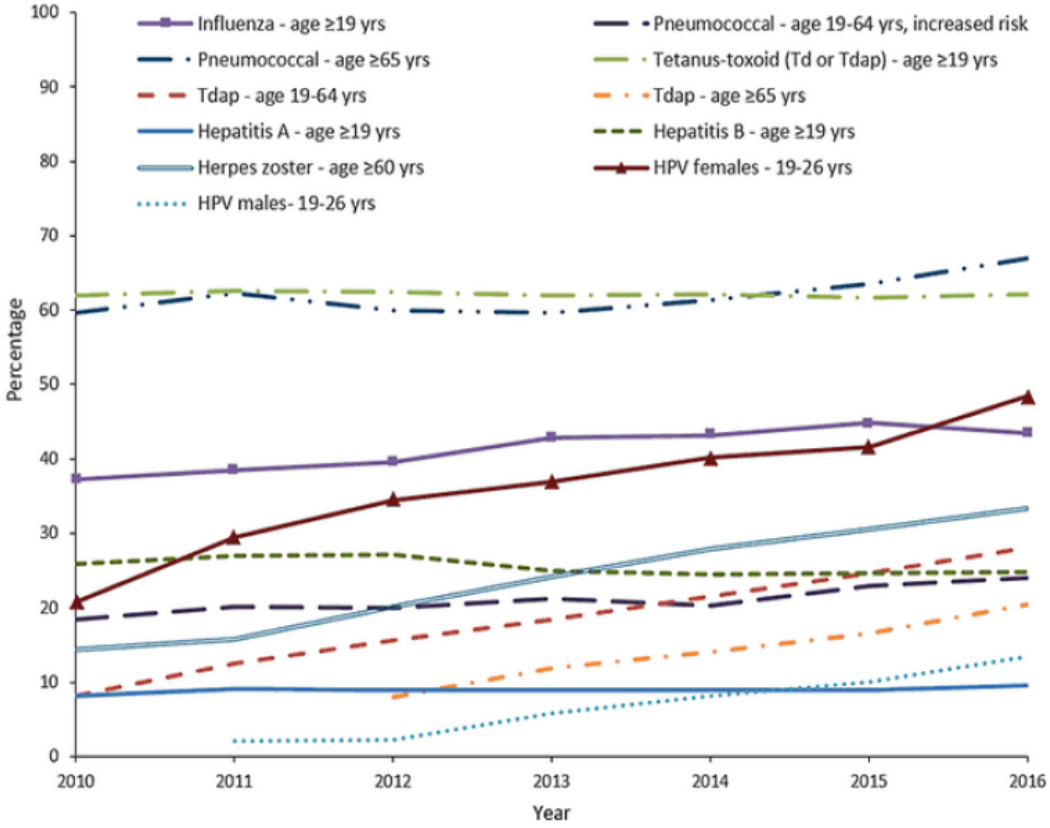
Another CDC source looking at the years 2010-2016, provides great insight into how far from "herd immunity" we really are. Here is a summary from the CDC of the more common vaccines and coverage rates of those >18 years of age:

- Influenza vaccination, ≥19 years—range: 37.2%–44.8%.
- Pneumococcal vaccination, 19-64 years at increased risk—range: 18.5%–24.0%.
- Pneumococcal vaccination, ≥65 years—range: 59.7%–66.9%.
- Tdap vaccination, 19-64 years—range: 8.2%–28.0%.
- Tdap vaccination, ≥65 years (2012-2016)—range: 8.0%–20.4%.

- Hepatitis A vaccination, ≥19 years—range: 8.1%–9.5%.
- Hepatitis B vaccination, ≥19 years—range: 24.5%–27.1%.
- Herpes zoster vaccination, ≥60 years—range: 14.4%–33.4%.
- HPV vaccination, females 19-26 years—range: 20.7%–48.5%.
- HPV vaccination, males 19-26 years (2011-2016)—range: 2.1%–13.5%.

The CDC's website has a document titled, ***Trends in Adult Vaccination Coverage: 2010 to 2016***. That document is from the ***National Health Interview Survey*** and shows the percentages of the adult population who say they have been vaccinated against various infectious diseases.

FIGURE. Estimated proportion of adults ≥19 years who received selected vaccines, by age group and increased risk status— National Health Interview Survey, United States, 2010–2016. See data file [1 sheet].



Source: https://www.cdc.gov/vaccines/imz-managers/coverage/adultvaxview/pubs-resources/NHIS-2016.html

And incidentally, the immunity from vaccines tends to wane or decrease over time, so in reality many of those adults included in those percentages have most certainly lost that temporary immunity, and don't really belong in that cohort of "vaccinateds" anyway. That of course would drop those percentages even lower. **In 2-6-year-olds, the vaccine coverage rates are in the 80-90% range, but they are just a small part of the herd (maybe 5%). And, persons under 18 years of age account for less than 20% of the entire population. The pro-vaccine herd immunity argument may hold water if all the young children were kept in a bubble, fully sequestered from all those adults who are not vaccinated,**

but we know that is not the case. We all live together mingling with cross-exposure in this big herd we call humanity. So, the reality is that their argument is really a talking point with no basis in fact. It is an intentional strategy used to create fear in order to achieve their objectives of full vaccination compliance in children. In fact, when you look at the "outbreaks" we occasionally see, when a few people contract illness like the recent measles cases, often, nearly half of those infected were fully vaccinated. This reality of vaccine ineffectiveness further damages the herd percentages and their false narrative.

Another consideration worth noting, is that I could find no government statistics showing the percentage of adults who are adequately immunized against the measles, mumps and rubella. I would suspect that is because in adults it is extremely unusual for them to maintain a regular immunization for MMR.

Comparing those CDC vaccination coverage numbers from above (ranging between 8% and 45%), compared to the herd immunity threshold required for the various diseases (ranging between 80% and 95%), clearly fall far short of the stated requirements for herd immunity.

In addition, as you can see, even though all of the common diseases mentioned in the CDC document are not represented in this table, the general consensus for reaching herd immunity is between 80-95%. **Therefore, we are not even close to achieving the magical theoretical threshold for herd immunity.**

Another compelling consideration is noted that the herd immunity threshold for smallpox is 83%-85%, yet how many people in the U.S. are, or have ever been immunized against smallpox? I have never met anyone that has ever been immunized against smallpox. I'm sure that some exist, but they are probably as rare as the disease itself. Is it possible that the disease no longer exists because of the excellent living conditions we enjoy in western civilization? (i.e. good nutrition/food supply, personal hygiene, fresh clean sterilized water, sanitation and social support)

As a result of this false narrative being perpetuated on the public by criticizing unvaccinated individuals as "free loaders" on the herd is completely unjustified as THERE IS NO VACCINE INDUCED HERD IMMUNITY AND THERE NEVER WAS. The closest we ever came to true herd immunity was when nearly all children acquired these childhood illnesses and developed a true and lasting, (typically lifelong) immunity.

On that subject, the discussion over the last several pages have made the case that vaccination **only confers short term partial immunity**. The reality is, that the period of time any possible immunity is conveyed is short, and **many adults who are "calculated" as vaccinated because they have been in the past, do not keep up with their booster shots, therefore are no longer protected means that the percentage figures of the population that are vaccinated are inflated.** All of that just confirms, that not only is the often referred to vaccine herd immunity nowhere near the coverage that would convey protection to the herd, **it is not true herd immunity (which can only come from natural exposure to wild strains conferring long term immunity to a large enough percentage of the population). This "pseudo" and artificial immunity negatively affects older people in the herd, because they are not**

receiving the natural "booster" exposures from unvaccinated children in the population that contract the disease. See the next article for proof of that.

Immunization ACTUALLY DESTROYS natural herd immunity and leads to increased incidence of the disease in older people years later

A 2013 article published in the Journal ***Vaccine*** titled, **Can vaccine legacy explain the British pertussis resurgence?** raises questions about the efficacy of temporary vaccination immunity and how that may be playing a role in the uptick of pertussis cases despite good vaccination coverage, hello versus lifelong immunity via acquiring pertussis naturally.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3856947/pdf/nihms531993.pdf

From the article:
"**Our results suggest that rising pertussis incidence among adults and adolescents should not be surprising**. Indeed, our simulations, even with the conservative assumptions of lifelong natural immunity, a 70-year mean duration of vaccine immunity *(because they naturally contracted the disease and gained life-long immunity)* and 85% efficacy predicted a long- lasting honeymoon period, followed by a resurgence among older age groups. **This pattern is a legacy of incomplete vaccination with an imperfect vaccine: individuals born in the vaccine era are less likely to be infected as children *(because of being artificially immunized),* and more likely to remain susceptible as teens and adults than their pre-vaccine predecessors. Thus, during the first few decades of vaccination, the population benefits both directly from vaccine protection of children and indirectly from herd immunity established by natural infection in the pre-vaccine era. As cohorts of children born in the vaccine era grow up, the latter effect diminishes and incidence among adults inevitably rises."**

"When infection-derived immunity was lifelong, an increase in incidence among adolescents and adults was inevitable if vaccine-induced protection was not permanent."

See the article found in the effectiveness of the Varicella (Chicken Pox) Vaccine coming up, about how the U.K. no longer includes this vaccine for these very reasons

Modern day post-vaccine era cases of chicken pox, measles and rubella are much worse than during the pre-vaccine era

The following information comes from a 2015 article from the British medical journal ***Lancet*** titled, **Dangers of vaccine refusal near the herd immunity threshold: a modelling study**.
https://www.ncbi.nlm.nih.gov/pubmed/?term=25981883

From the Abstract:

"**Our calculations show that negative outcomes are 4.5 times worse for measles, 2.2 times worse for chickenpox, and 5.8 times worse for rubella than would be expected in a pre-vaccine era in which the average age at infection would have been lower**."

INTERPRETATION:
As vaccination makes preventable illness rarer, for some diseases, it also increases the expected severity of each case. Because estimates of case risks rely on data for severity generated during a pre-vaccine era they underestimate negative outcomes in the modern post-vaccine epidemiological landscape. Physicians and parents should understand when making decisions about their children's health and safety that remaining unvaccinated in a predominantly vaccine-protected community exposes their children to the most severe possible outcomes for many preventable diseases.

This study demonstrates that the childhood vaccine programs have increased the risk of more severe cases to those that are "unprotected" from the vaccine. Those include not only unvaccinated individuals as this study mentions, but also cases of primary vaccine failure (those who do not produce adequate antibodies as a result), and secondary vaccine failure (all people that get vaccinated face this as time goes on and the vaccine "wanes" and antibody rates fall). We are finding that a significant number of fully vaccinated individuals are contracting measles and other diseases during outbreaks. Because we are learning that the rates of vaccine failure are much higher than ever predicted, the ability of bacteria and viruses to mutate and that continued "boosters" or revaccination does not work, we face creating a massive problem that we will have no solutions for. Read more about vaccine failure in the measles section later in this document.

An immunologist explains why vaccination will never work like naturally acquired immunity

Tetyana Obukhanych is an immunologist and author of the 2012 book, **Vaccine Illusion- *How Vaccination Compromises our Natural Immunity and What we can do to Regain our Health*.**

In the Introduction, Dr. Obukhanych makes the following statement:

"The biological term *immunity* refers to a universally observed phenomenon of becoming unsusceptible to a number of infectious diseases through prior experience. Because of the phonetic similarity between the words *immunology* and *immunity*, it is tempting to assume that immunology is a science that studies the state of immunity, **but this is not the case**. **Immunology** is a science that primarily studies an **artificial process of *immunization*** - i.e., the immune system's response to injected foreign matter. Immunology **does not attempt** to study and therefore **cannot** provide understanding of natural diseases and immunity that follows them. The "knowledge" about the function of the immune system during the natural process of infection is nevertheless inferred from contrived immunologic experiments, which typically consist of injecting laboratory-grown microorganisms (live or dead) or their isolated parts into research animals to represent the state of infection. Because immunologic experiments are **unrealistic simulations of the natural process**, immunologists' understanding of nature is limited to understanding

their own experimental models. Immunologists have confined the scope of their knowledge to the box of experimental modeling, and they do not wish to see beyond that box. Thinking within the box only reinforces the notion of vaccination and cannot provide any other solution to the problem of diseases."

"Despite the fact that the biological basis of naturally acquired immunity is not understood, present day medical practices insist upon artificial manipulation of the immune response (a.k.a. immunization or vaccination) to secure "immunity" without going through the natural infection process. The vaccine-induced process, although not resembling a natural disease, is nevertheless still a process with its own risks. **And it is not life-long immunity that we gain via vaccination but only temporary immunity**. For this reason, **vaccination at its core is neither a safe nor an effective method of disease prevention**. Yet, immunologists have nothing better to offer because they can only go as far as their deeply rooted immunologic dogma allows them."

This is a short Bio about her from her web site http://www.tetyanaobukhanych.com/ :
"Born in Ukraine, Tetyana Obukhanych came to the United States to pursue her education. In 2006, she defended her Ph.D. thesis in Immunology at The Rockefeller University, New York, NY. She subsequently held postdoctoral research training appointments in prominent immunology laboratories affiliated with Harvard Medical School and Stanford University School of Medicine. In 2015, she became a Founding Director of ***Physicians for Informed Consent***, a 501(c)(3) nonprofit dedicated to safeguarding informed consent in vaccination and educating the public on infectious disease and the immune system."

Waning immunity is problematic with vaccination, including the "holy grail" of vaccines the MMR vaccine

A 2018 article published in the journal ***Vaccine***, titled, **Measles, mumps, and rubella antibody patterns of persistence and rate of decline following the second dose of the MMR vaccine**, states that the immunity wanes annually after vaccination. https://www.ncbi.nlm.nih.gov/pubmed/29317117

From the Abstract:
"One month post-MMR2, geometric mean titer (GMT) to measles was high (3892 mIU/mL), **but declined on average 9.7% per year** among those with the same baseline titer and <2-fold increase post-MMR2. Subjects with ≥2-fold **experienced a slower decline (≤7.4%). GMT to rubella** was 149 **one month post-MMR2, declining 2.6% and 5.9% per year among those who received MMR1 at 12-15 months and >15 months, respectively**. **GMT to mumps one month post-MMR2 was 151, declining 9.2% per year**".
Sources vary as to the length of time that the MMR provides immunity between 10 and 20 years for measles and rubella, with the mumps much less. Considering that this study found between an approximate 6% to 10% ANNUAL decline in antibodies, that certainly doesn't support the kind of long-lasting immunity we are hearing from the CDC via the media.

Aren't non-immunized children putting children who are immunized at risk if they come in contact with them?

This is the main argument vaccine proponents use to try to keep unvaccinated children from attending school. It is also the main argument proponents of universal vaccination of both children and adults are professing.

This is **another myth propagated by fear mongering**. **In fact, the science says just the opposite. Live viruses given in vaccine form undergo a process called shedding, which can go on for up to three weeks or longer. Shedding is where the virus that was given in the vaccine is "shed" in the nasal and oral secretions. This in fact puts both vaccinated and unvaccinated children at risk of infection. For a great exposé on this topic go to** http://www.nvic.org/cmstemplates/nvic/pdf/live-virus-vaccines-and-vaccine-shedding.pdf

This article has 276 different references supporting the evidence of ineffectiveness, the increased risk to others of viral shedding and long-term complications associated with artificial immunization. These references also support the importance of the role of naturally acquired viral infections and healthy lifelong innate immunity. Just like it has been discovered that exposure of children to dirt, dander and microorganisms at a young age help to develop a healthy, strong and balanced immune system, suppressing this natural maturing process of the immune system is ill advised.

THE INEFFECTIVENESS AND DANGERS OF COMMON VACCINES

If you are interested in the darker side of the history of vaccines, an excellent well-referenced article written by Jagannath Chatterjee, can be found here http://www.greenmedinfo.com/blog/anti-vaccination-pro-science-pro-health-anti-industry . It was posted on April 15, 2019 on Green Med Info's web site. It chronicles the many little-known facts about the history of vaccines including failures, bias and statistical manipulation, real reasons for outbreaks of infectious diseases, and even current day vaccine scandals, disinformation and fallout. GreenMedInfo is an excellent resource for accessing studies and scientific articles on vaccines.

This section will highlight specific vaccines and present additional studies over and above the dozens of ones that you have read throughout this document that have implicated vaccines in many serious and often debilitating conditions. Many of those articles have also exposed the paucity of evidence regarding the effectiveness of vaccines and the need to continue to treat first world countries like third world countries when it comes to vaccine policy. These will add emphasis to the evidence that has been previously presented.

The flu vaccine, with its miserable track record is a sham according to the evidence- You be the judge

Keep in mind that I have already presented a tremendous amount of negative information about the flu vaccine, especially with regard to pregnant women and children (see the section starting on page 253 through 275). All of this data to follow, simply adds emphasis to the point that the flu vaccine is a miserable failure and presents a significant risk.

It seems that every person you speak to about the flu vaccine says something like this…"The last time I got a flu shot I got the flu." Ever wonder why that is? It is because, as you will see in this section of ***1200 Studies***, getting the flu shot MAY protect you from the two or three influenza viruses they guess will be prevalent the next flu cycle, but it makes you susceptible to over 200 other viruses that produce similar symptoms.

Before looking at the lack of effectiveness of the flu shot, let's look at what percentage of hospitalizations and deaths are attributable to the influenza strains that the vaccines would even cover. The CDC lumps all seasonal respiratory deaths in the influenza and pneumonia category, but they and the media call them "FLU" deaths incinuating they are preventable with the flu vaccine. But what is the truth?

NEW - Influenza is responsible for only a small percentage of hospitalizations and deaths from respiratory illness

The vast majority of hospitalized patients with respiratory infections, have infections from other microbes than the various strains of influenza virus, as reported in a highly touted 2015 study **published in the *New England Journal of Medicine*** titled, **Community-Acquired Pneumonia Requiring Hospitalization among U.S. Adults**, found that **only 6% of cases of pneumonia were caused by one of the influenza strains**. Remember the flu vaccine typically contains only 3 influenza strains. It is completely disingenuous to claim that between 50,000 and 80,000 people die annually of the flu, when according to one study only 6% of cases of pneumonia are influenza related! In fact, in the study, pathogenic microbes were found in only 38% of confirmed cases of pneumonia. One or more viruses were found in 23%, with rhinovirus being the most common virus at 9% and bacterial microbes accounted for 11%.

Another consideration is hospital acquired infections. The CDC estimates that there are 1.7 million hospital acquired infections annually and 99,000 people die from them. So, the shocking reality is that many people that die from pneumonia in the hospital actually contract their deadly infection there. Yet, if they had entered the hospital with influenza or influenza like illness from one of dozens of other viruses, but died from a hospital acquired infection, they are often categorized as "flu" deaths. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6245375/pdf/idr-11-2321.pdf .

In 2018, the Cochrane Review released 3 reviews of published research on the flu shot's effectiveness over the last 30-40 years in children, adults and the elderly- The results show poor performance

The Cochrane Collaboration is a highly respected and acclaimed organization, that does a meta-analysis which looks at all the studies that have been published on a particular topic. They then scrutinize the results for accuracy and bias before making their determinations and report. In a few pages you will see some reports by them that looked at hundreds of studies and hundreds of thousands of people. And the results will surprise you. (**Spoiler alert**) **They found that the flu shot's effectiveness in abysmal.**

A 2018 Cochrane Review of 41 studies on the effectiveness of the flu vaccine IN HEALTHY CHILDREN, reveals very limited efficacy

The ***Cochrane Database of Systematic Reviews*** published a review in 2018 titled, **Vaccines for preventing influenza in healthy children**, looked at **41 studies**, **encompassing over 200,000 children** aged 3-16 years, from 1984-2013. It is an update of a previous review that was published in 2011. The reviewed studies were from 4 different regions of the world including the United States and **looked at the live attenuated virus and the inactive virus vaccines compared to a placebo or no vaccine.** The results on effectiveness **were not very impressive** at all.
https://www.ncbi.nlm.nih.gov/pubmed/29388195

From the Abstract: *(I.L.I. stands for Influenza Like Illness)*
"We included 41 clinical trials (> 200,000 children). Most of the studies were conducted in children over the age of two and compared live attenuated or inactivated vaccines with placebo or no vaccine. Studies were conducted over single influenza seasons in the USA, Western Europe, Russia, and Bangladesh between 1984 and 2013."

"Compared with placebo or do nothing, **live attenuated influenza vaccines** probably reduce the risk of influenza infection in children aged 3 to 16 years from 18% to 4%.... and they may reduce ILI by a smaller degree, from 17% to 12%.... **Seven children would need to be vaccinated to prevent one case of influenza, and 20 children would need to be vaccinated to prevent one child experiencing an ILI."**
(This represents a 14% effectiveness rate for influenza and a 5% effectiveness rate in preventing influenza like illness)

"Inactivated vaccines Compared with placebo or no vaccination, inactivated vaccines reduce the risk of influenza in children aged 2 to 16 years from 30% to 11% … and they probably reduce ILI from 28% to 20%.... **Five children would need to be vaccinated to prevent one case of influenza, and 12 children would need to be vaccinated to avoid one case of ILI."**
(This represents a 20% effectiveness rate for influenza and an 8% effectiveness rate in preventing influenza like illness)

"One brand of monovalent pandemic vaccine was associated with a sudden loss of muscle tone triggered by the experience of an intense emotion (cataplexy) and a sleep disorder (narcolepsy) in children."

The rationale that getting children vaccinated saved millions of dollars in lost wages due to parents having to take off work, or children missing school is often thrown out there. So, what did the review find on those concerns?

"There was insufficient information available to determine the effect of vaccines on school absenteeism due to very low-certainty evidence from one study. We identified no data on parental working time lost, hospitalisation, fever, or nausea." **When 41 of the best and most reliable studies out there do not even address those issues, one has to wonder where those person's citing those concerns are getting their information from.**

A 2018 Cochrane Review of 52 studies on the effectiveness of the flu vaccine IN HEALTHY ADULTS, shows that being vaccinated is only 1% better than not being vaccinated

The ***Cochrane Database of Systematic Reviews*** published a review in 2018 titled, **Vaccines for preventing influenza in healthy adults.** The results of looking at 52 clinical trials and over 80,000 people show a very low effectiveness of the flu vaccine. https://www.ncbi.nlm.nih.gov/pubmed/29388196

From the Abstract: *(I.L.I. stands for influenza Like Illness)*
"The consequences of influenza in adults are mainly time off work. Vaccination of pregnant women is recommended internationally. This is an update of a review published in 2014.

Randomised controlled trials (RCTs) or quasi-RCTs comparing influenza vaccines with placebo or no intervention in naturally occurring influenza in healthy individuals **aged 16 to 65 years**."

"We included **52 clinical trials of over 80,000 people** assessing the safety and effectiveness of influenza vaccines. **[15 included Randomized Clinical Trials were industry funded (29%)]."**

We have presented findings from 25 studies comparing inactivated parenteral influenza vaccine against placebo or do-nothing control groups as the most relevant to decision-making. The studies were conducted over single influenza seasons in North America, South America, and Europe between 1969 and 2009. We did not consider studies at high risk of bias to influence the results of our outcomes except for hospitalisation. Inactivated influenza vaccines probably reduce influenza in healthy adults from 2.3% without vaccination to 0.9%... and they probably reduce ILI from 21.5% to 18.1%..."

"71 healthy adults need to be vaccinated to prevent one of them experiencing influenza, and 29 healthy adults need to be vaccinated to prevent one of them experiencing an ILI."
(This represents a 1.4% effectiveness rate for influenza and a 3.4% effectiveness rate in preventing influenza like illness). Those are MISERABLE statistics on effectiveness.

"Healthy adults who receive inactivated parenteral influenza vaccine rather than no vaccine probably experience less influenza, from just over 2% to just under 1% (moderate-certainty evidence)."

"Vaccination may lead to a small reduction in the risk of hospitalisation in healthy adults, **from 14.7% to 14.1%."** ***(approximately one half of one percent)***

"Vaccines may lead to little or no small reduction in days off work (-0.04…)."

"Inactivated vaccines cause an **increase** in fever from 1.5% to 2.3%."

"**Protection against influenza and ILI in mothers and newborns was smaller** than the effects seen in other populations considered in this review. Vaccines **increase the risk of a number of adverse events**, including a small increase in fever, but rates of nausea and vomiting are uncertain."

According to the article, "**Fifteen included trials were industry funded (29%)**". This makes the findings of minimal overall benefit all the more interesting! What I mean by that is, **if nearly a third of the studies they looked at were funded by the drug industry (and you can bet they put their best numbers forward), and that didn't even skew the results in their favor, most likely the non-drug industry studies found even less or no benefit at all.**

So, one has to ask oneself, is it worth playing Russian Roulette with all the toxic ingredients from the flu vaccine in order to have any questionable benefit at all? Why not just optimize your vitamin A, C & D levels, eat healthy, get quality sleep, practice good hygiene and you could lower your risk much more than risking the flu shot.

A 2018 Cochrane Review of 8 studies on the effectiveness of the flu vaccine ON THE ELDERLY, shows absolutely terrible results for efficacy

The ***Cochrane Database of Systematic Reviews*** published a review in 2018 titled, **Vaccines for preventing influenza in the elderly.** https://www.ncbi.nlm.nih.gov/pubmed/29388197 Once again, the success of the flu vaccines in elderly adults is very low.

From the Abstract: *(I.L.I. stands for Influenza Like Illness)*
"The consequences of influenza in the elderly (those age 65 years or older) are complications, hospitalisations, and death. The primary goal of influenza vaccination in the elderly is to reduce the risk of death among people who are most vulnerable. This is an update of a review published in 2010."

"We identified **eight RCTs (over 5000 participants)**, of which four assessed harms. The studies were conducted in community and residential care settings in Europe and the USA **between 1965 and 2000**."

"Older adults receiving the influenza vaccine may experience less influenza over a single season compared with placebo, **from 6% to 2.4%**... We rated the evidence as low certainty due to uncertainty over how influenza was diagnosed. Older adults probably experience less ILI compared with those who do not receive a vaccination over the course of a single influenza season **(3.5% versus 6%...)"**

"These results indicate that 30 people would need to be vaccinated to prevent one person experiencing influenza, and 42 would need to be vaccinated to prevent one person having an ILI" ***(This represents a 3% effectiveness rate for influenza and a 2% effectiveness rate in preventing influenza like illness). Those are MISERABLE statistics on effectiveness!***

"We are uncertain how big a difference these vaccines will make across different seasons. **Very few deaths occurred, and no data on hospitalisation were reported**. No cases of pneumonia occurred in one study that reported this outcome."

Mainstream pediatric journal finds the flu shot INEFFECTIVE in children under five

In a 2008 study published in ***Archives of Pediatrics and Adolescent Medicine*** titled, **Influenza vaccine effectiveness among children 6 to 59 months of age during 2 influenza seasons: a case-cohort study**, researchers found that the flu vaccine did NOT demonstrate vaccine effectiveness (over two different flu seasons), in preventing the flu. https://www.ncbi.nlm.nih.gov/pubmed/?term=18838647

"**In 2 seasons with suboptimal antigenic match between vaccines and circulating strains, we could not demonstrate vaccine effectiveness in preventing influenza-related inpatient/emergency department or outpatient visits in children younger than 5 years**. Further study is needed during years with good vaccine match."

Children that get the flu shot have 3 times the risk of subsequent hospitalization, as documented by Mayo Clinic Researchers

In a public report released by the ***American Thoracic Society*** dated May 19, 2009 titled, **Flu Vaccination May Triple Risk for Flu-Related Hospitalization in Children With Asthma**, reviewed a study performed through Mayo Clinic that looked at children over a 10 year period who did and did not receive the flu vaccine, **It was determined that children that got the flu vaccine were 3 times more likely to be hospitalized than those that were not vaccinated**.

From the report: "In order to determine whether the vaccine was effective in reducing the number of hospitalizations that all children, and especially the ones with asthma, faced over eight consecutive flu seasons, the researchers conducted a cohort study of 263 children who were evaluated at the Mayo Clinic in Minnesota from six months to 18 years of age, each of whom had had laboratory-confirmed influenza between 1996 to 2006. The investigators determined who had and had not received the flu vaccine, their asthma status and who did and did not require hospitalization. Records were reviewed for each subject with influenza-related illness for flu vaccination preceding the illness and hospitalization during that illness. **They found that children who had received the flu vaccine had three times the risk of hospitalization, as compared to children who had not received the vaccine. In asthmatic children,**

there was a significantly higher risk of hospitalization in subjects who received the Trivalent Influenza Vaccine, as compared to those who did not (p= 0.006)."
ATS 2009: **Flu Vaccination May Triple Risk for Flu-Related Hospitalization in Children With Asthma** - *Medscape* - May 25, 2009. https://www.medscape.com/viewarticle/703235

A 2017 study finds very poor effectiveness of the 2014-2015 flu vaccine

A 2017 study in the Journal of ***Clinical Infectious Diseases*** titled, **The Household Influenza Vaccine Effectiveness Study: Lack of Antibody Response and Protection Following Receipt of 2014-2015 Influenza Vaccine**, found that the protection from the 2014-2015 flu vaccine was extremely poor. They followed 1,341 people older than age 13 from 340 households. The background for the article even cited a study that found that persons that were vaccinated against the flu for 3 years in a row had a greater chance of contracting the flu. "At least one study paradoxically observed increased A(H3N2) infection among those vaccinated 3 consecutive years." https://www.ncbi.nlm.nih.gov/pubmed/?term=29020179

From the Abstract: (VE stands for Vaccine Effectiveness)
"Influenza A(H3N2) was identified in 166 (12%) individuals and B(Yamagata) in 34 (2%). **VE against A(H3N2) was -3%... and similarly ineffective between age groups**; increased risk of infection was not observed among those vaccinated in 2 or 3 previous years. **VE against influenza B(Yamagata) was 57%... but only significantly protective in children <9 years**.... **Less than 20%** of older children and adults had ≥4-fold antibody titer rise against influenza A(H3N2) and B antigens following vaccination; **responses were surprisingly similar for antigens included in the vaccine and those similar to circulating viruses**. **Antibody against A/Hong Kong/4801/14, similar to circulating 2014-2015 A(H3N2) viruses and included in the 2016-2017 vaccine, did not significantly predict protection**."

From the Conclusion:
"**Absence of VE against A(H3N2) was consistent with circulation of antigenically drifted viruses; however, generally limited antibody response following vaccination is concerning even in the context of antigenic mismatch."**

A revealing warning about widespread bias and manipulation of conclusions in vaccine research, by one of the world's most respected research review

As an example of bias often seen with industry funded research, the Cochrane Collaboration Review in 2010 published a report titled, **Vaccines for preventing influenza in healthy adults (Review)**, which gave the following warning at the beginning of their paper.
http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001269.pub4/epdf

WARNING:
"This review includes **15 out of 36 trials funded by industry** (four had no funding declaration). An earlier systematic **review of 274 influenza vaccine studies** published up to 2007 **found industry funded studies**

were published in more prestigious journals and cited more than other studies independently from methodological quality and size. **Studies funded from public sources were significantly less likely to report conclusions favorable to the vaccines**. The review showed that **reliable evidence on influenza vaccines is thin** but **there is evidence of widespread manipulation of conclusions and spurious notoriety of the studies**. The content and conclusions of this review should be interpreted in light of this finding."

More from the Review:
"Authors of this review assessed all trials that compared vaccinated people with unvaccinated people. The combined results of these trials showed that under ideal conditions **(vaccine completely matching circulating viral configuration), 33 healthy adults need to be vaccinated to avoid one set of influenza symptoms. In average conditions (partially matching vaccine) 100 people need to be vaccinated to avoid one set of influenza symptoms.** Vaccine use **did not** affect the number of people hospitalised or working days lost but caused one case of Guillian-Barré syndrome (a major neurological condition leading to paralysis) for every one million vaccinations."

Discussion from the article: "Although this review presents a large number of comparisons and outcomes based on a number of different groupings of studies and trials, most of the discussion was based on the results of the analysis of a WHO recommended vaccine against placebo. Parenterally *(intravenous)* administered influenza vaccines appear significantly better than their comparators and can reduce the risk of developing influenza symptoms by around 4%, **if** the WHO recommendations are adhered to **and the match is right"***(which it rarely is)*. "However, whilst the vaccines do prevent influenza symptoms, this is only one part of the spectrum of "clinical effectiveness" **as they reduce the risk of total "clinical" seasonal influenza (i.e. influenza-like illness) symptoms by around 1%**. When the results of our analysis are expressed as RD the effect appears minimal. This is remarkable as healthy adults are the population in which inactivated vaccines perform best." *(Remember this study looked at "healthy" adults, which means that the effectiveness won't be nearly as good in unhealthy persons, which is a large percentage of the population).* "**We found no evidence that vaccines prevent viral transmission or complications.**"

Number of deaths due to influenza is dramatically inflated

According to an October 03, 2012 article posted on the ***National Vaccine Information Center's*** web site, **the CDC statistics lump all pneumonia related and cardiopulmonary death with influenza deaths.** Yet only a small percentage of pneumonia cases test positive for influenza. **There are many "influenza like" viral respiratory illnesses that the flu shots don't cover and are completely ineffective against**. The article says that "**CDC now says that only 8.5 percent of all pneumonia and influenza deaths and only 2.1 percent of all respiratory and circulatory deaths are influenza related**." https://www.nvic.org/NVIC-Vaccine-News/October-2012/Influenza-Deaths--The-Hype-vs--The-Evidence.aspx#_edn46

Article in the British Medical Journal says, U.S. cited "flu deaths" are more of a P.R. stunt than science

In a 2005 story published in the ***British Medical Journal*** titled, **Are U.S. Flu Death Figures More PR than Science**? discrepancies and reporting inaccuracies are cited.
https://www.sciencedaily.com/releases/2005/12/051210120020.htm

From the article:
"The ***Centers for Disease Control and Prevention (CDC)*** acknowledges a difference between flu death and flu-associated death yet uses the terms interchangeably", writes Peter Doshi. Statistical incompatibilities also exist between official estimates and national vital statistics data. "

"For example, CDC states that the historic 1968-9 "Hong Kong flu" pandemic killed 34,000 Americans. At the same time, CDC claims 36,000 Americans annually die from flu. What is going on, asks Doshi?
The CDC uses indirect modelling methods to estimate the number of deaths associated with influenza. Thus the much publicised figure of 36,000 is **not an estimate of yearly flu deaths, as widely reported** in both the lay and scientific press, but an estimate - generated by a model - of flu-associated death", he says."

"Compounding these problems is **a marketing of fear** – "a CDC communications strategy in which medical experts "predict dire outcomes" during flu seasons", he adds."

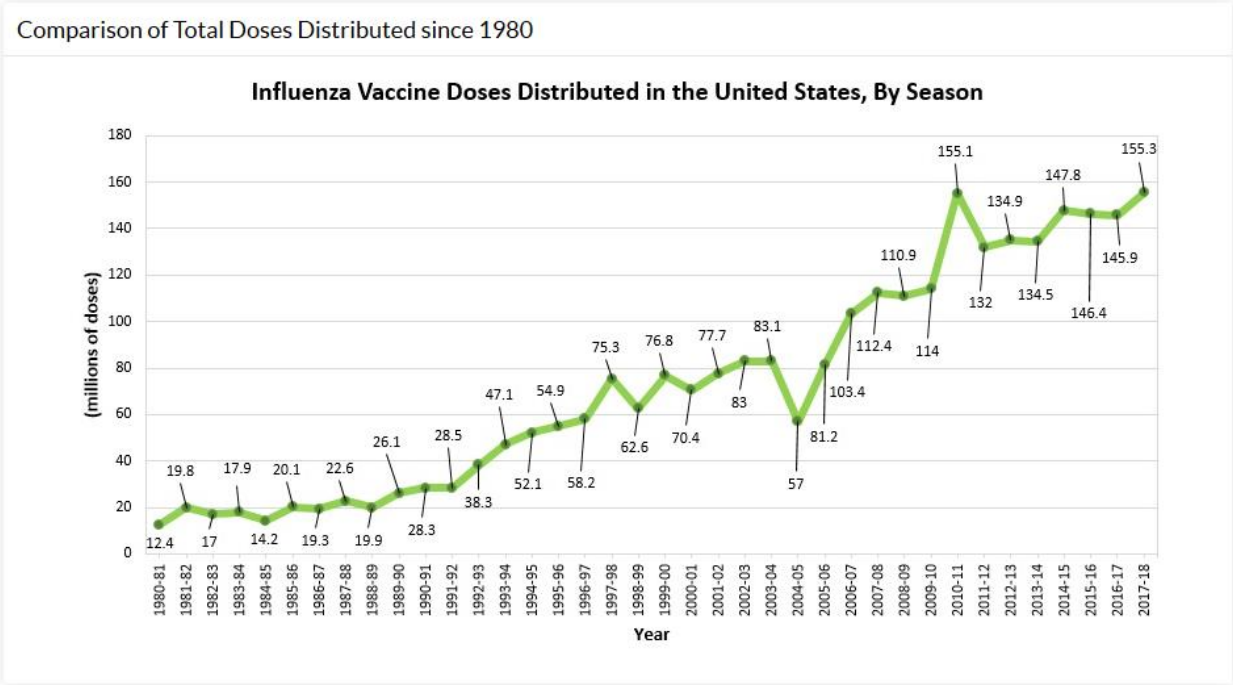
"Yet Doshi believes that this bill obscures the fact that **CDC is already working in manufacturers' interest by conducting campaigns to increase flu vaccination**."

"If flu is in fact not a major cause of death, **this public relations approach is surely exaggerated**, he says. **Moreover, by arbitrarily linking flu with pneumonia, current data are statistically biased**. **Until corrected and until unbiased statistics are developed, the chances for sound discussion and public health policy are limited**, he concludes."

Yet, we still hear **hyper-inflated** numbers being reported on television. **Just this week, I heard the doctor promoting the flu vaccine cite that in the U.S. 80,000 deaths are caused by the flu annually**. So, if that is the case, the graphic in the next section should make every doctor promoting flu shots and the flu manufacturers themselves cringe. **The graph below, shows a 1,152% increase in doses of the flu vaccine over the last 37 years, yet according to them our death rates continue to set record highs. If the numbers they report are true and not sensationalized to scare people into getting the flu vaccine, what exactly does that say for the effectiveness of the flu vaccines?**

The paradox- The number of doses of flu vaccine has increased from 12.4 million in 1980-1981, to 155.3 million in 2017-2018 (a 1,250 percent increase), yet we are told flu deaths are rampant

This graph on this page posted by the CDC shows the huge increase in vaccination for the flu in the United States. https://www.cdc.gov/flu/prevent/vaccine-supply-historical.htm



That number of doses on that chart calculates to two trillion, eight hundred sixty-nine billion doses of the flu vaccine over the last 37 years. In number form it looks like this 2,869,000,000,000.

Yet, it has been widely reported that 80,000 people died from the flu last year alone in the U.S.!
Flu Caused 80,000 Deaths in US Last Year- As reported on ***Medscape*****,** September 27, 2018.

"Influenza was especially severe in the United States last year. According to new data released today at a news briefing held by the Centers for Disease Control and Prevention (CDC) and National Foundation for Infectious Diseases (NFID), 900,000 people were hospitalized and 80,000 died from the flu in the US last season." https://www.medscape.com/viewarticle/902666

The number of annual doses given has increased 1,300% over those 38 years. With that many doses given and the rate at which those doses have increase over nearly four decades, wouldn't you think the number of people suffering and dying from the flu would be better? You would never know it from the abysmal statistics we are spoon fed, leading up to and during every "flu season".

And other than hand washing, if the CDC and the medical spokespersons really wanted to make a difference in the number of people suffering from the flu and other viral conditions that often mimic the flu, they would recommend dietary strategies, nutritional supplements and lifestyle improvements that would boost a person's own immune competency against viruses. You don't hear

them doing that, though do you? The best you get from them is they say something like, "a 20% flu vaccine effectiveness is better than nothing", like that is the only two options the shot or nothing! Comments like that, should give you a good idea as to what their true agenda is!

Revisit pages 478, 482. That confirms that vitamin A supplementation is a world-wide strategy by the *World Health Organization* for improving children's immune protection against infectious diseases. I know it's not part of the talking points, but why can't the CDC, the medical representatives doing their PSAs on television and the media at least make the same recommendations for our children!

To put an exclamation point on the decreasing rate of deaths in those people that contract the flu, The National Center for Health Statistics confirms that flu related deaths have dropped dramatically over the last 50 years

The ***National Vaccine Information Center*** has created a chart using statistics from the National Center for Health Statistics reports. The chart shows that the number of influenza confirmed related deaths per capita has dropped significantly since 1940 (1,000% lower in 2010 than 1940). http://mercola.fileburst.com/PDF/NVICCHART-InfluenzaPneumoniaDeaths1940-2010.pdf

Here is a brief snapshot of deaths per decade compared to the population of the U.S.:

- In 1940, the death rate was one in 6,555
- In 1950, the death rate was one in 23,082
- In 1960, the death rate was one in 22,951
- In 1970, the death rate was one in 55,315
- In 1980, the death rate was one in 84,095
- In 1990, the death rate was one in 118,905
- In 2000, the death rate was one in 159,447
- In 2010, the death rate was one in 624,990

Is there a flu shot and Alzheimer's connection?

Hugh Fudenberg M.D., was editor of the journal ***Clinical Immunology and Immunopathology*** for 15 years and one of the world's most renowned immunologists. He was the 13th most quoted biologist of our times and **authored over 600 papers in peer review journals**. Dr. Fudenberg had this to say regarding the annual flu vaccine program while giving a speech at the **1st annual International Public Conference on Vaccination**, held by the ***National Vaccine Information Center*** in Arlington, Virginia in 1997.

"**If an individual has had 5 consecutive flu shots between 1970 – 1980 (the years of the study he was referencing) his/her chance of developing Alzheimer's Disease is 10 times greater than if they had one, two or no shots**." When asked why this is, Dr. Fudenberg stated that, "**It is due to the mercury and aluminum buildup that is in every flu shot. The gradual mercury and aluminum buildup in the brain causes cognitive dysfunction**."

Vaccines can trigger the paralytic autoimmune syndrome called Guillain-Barré syndrome

A 2017 article published in the ***Journal of Korean Medical Science*** titled, **Clinical Features of Post-Vaccination Guillain-Barré Syndrome (GBS) in Korea**, reports that "Guillain-Barré syndrome (GBS) is the most common immune-mediated polyradiculoneuropathy and **it is also the most commonly reported severe adverse event following immunization in adults**."
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5461320/

From the study:
"**G.B.S. is an acute or subacute peripheral polyneuropathy, which is accompanied by symmetric flaccid paralysis of the extremities, sensory abnormalities, and cranial nerve palsy**."

"Although the pathogenesis of the GBS has not been clearly elucidated, recent immunological evidence has supported a mechanism of autoimmune damage. Interest in the risk of GBS after vaccination increased after **approximately 500 cases of GBS were reported after the mass administration of the A/New Jersey/76 vaccine during the swine flu epidemic in the United States in 1976**."

G.B.S. is most commonly triggered after administration of flu vaccine, **although it can also be triggered by vaccination with other vaccines**. "**In addition to influenza vaccines, cases of GBS have been reported after immunization with various vaccines, including measles, mumps, and rubella (MMR), hepatitis B, diphtheria, tetanus, and pertussis (DTP) and polio**." The autoimmune reaction that causes G.B.S. certainly fits with the widespread reports and scientific conclusions many researchers are making about the vaccine-autoimmune connection. You will see much more evidence of this throughout this document.

A likely flu shot connection with pericarditis (inflammation of the covering of the heart)

A 2004 study published in ***Arquivos Brasileiros de Cardiologia*** titled, **Pericarditis. Series of 84 consecutive cases**, found a very strong association between the flu shot and cases of pericarditis in individuals that had not been previously diagnosed.
https://www.ncbi.nlm.nih.gov/pubmed/?term=15320556

From the abstract:
"The individuals were divided into 2 groups: **group A** comprised 61 patients **with known causes** of pericarditis and **group B** comprised 23 patients **with idiopathic *(unknown)* causes**."

Twenty-three (100%) group B patients received anti-influenza vaccine versus none in group A."

Healthcare workers resist the flu shot- The studies show low compliance does NOT increase patient risk

Sixty-five percent of health care workers in the U.S. refuse the flu shot

A report on ***Fox News*** titled, **Half of Health Care Workers Will Likely Refuse H1N1 Vaccine, Research Finds**, says that only 35% of U.S. health care workers trust the flu shot as being safe and effective. http://www.foxnews.com/story/2009/08/26/half-health-care-workers-will-likely-refuse-h1n1-vaccine-research-finds.html

From the report: "**Fewer than 60 percent** of health workers in most countries get vaccinated against regular flu, thought to be a reliable indicator of whether they might get a H1N1 flu shot. **In the U.S., about 35 percent of health workers get a regular flu shot, while in Britain, only about 17 percent do**."

So why don't the pompous talking heads, that think they represent intellectual superiority and believe that they know more than parents that have researched the issue, not know that the majority of the smartest people on the front lines of health care opt out?

A 2012 editorial written by a paid vaccine consultant, chastises the American Nurses Association for not "mandating" vaccines for its members

An editorial published in ***Vaccine*** titled, **The nurses profession and patient safety and healthcare provider influenza immunization: The puzzling stance of the American Nursing Association**, is critical of the ***American Nursing Association*** for not taking a stronger stance with its members on the vaccine issue. Currently, the American Nurses Association policy on vaccination allows for medical and religious exemption for its members. The American Nurses Association is the largest association representing nurses in the U.S. **One of the two authors of this editorial Dr. Gregory A. Poland discloses his relationship to vaccine manufacturers at the end of the editorial: "Dr. Poland has provided consulting advice on novel, nonlicensed influenza vaccine development Avianax, Theraclone Sciences, MedImmune LLC, Liquidia Technologies, Inc., Novavax, Novartis Vaccines and Therapeutics and PAXVAX, Inc. Dr. Poland has authored other studies in support of mandated vaccination for health care workers." *(I would say his opinion is tainted by the financial gain he receives from vaccine manufacturers. Another example of bias reporting and commentary).***
http://www.edwardjennersociety.org/wp-content/uploads/The-nursing-profession.pdf

The statistics about compliance by health care workers to seasonal flu vaccines is cited by the following: "**More compelling is that despite readily available knowledge, and despite the reality of an influenza pandemic, only 37% of US HCWs received both seasonal and monovalent pandemic vaccines in 2010,**

and only 34% received the pandemic H1N1 vaccine *alone* *(Centers for Disease Control and Preventiont (CDC). Interim results: influenza A (H1N1) 2009 monovalent and seasonal influenza vaccination coverage among health-care personnel – United States, August 2009–January 2010. MMWR Morb Mortal Wkly Rep 2010;59(April 12):357–62).* A recent report demonstrated that in the 2010–2011 flu season only 62% of all US HCWs received seasonal influenza vaccine*. (Centers for Disease Control and Preventiont (CDC). Influenza vaccination coverage among health-care personnel – United States, 2010 11 influenza season. MMWR Morb Mortal Wkly Rep 2011;60(August 32):1073–77).*"

As of 08-10-19, the American Nurses Association has the following position on vaccines.

ANA Position Statement

Note: This position statement is under revision as of 6/22/19. See this link https://www.nursingworld.org/news/news-releases/2019-news-releases/american-nurses-association-takes-action-on-critical-public-health-issues/ for more information.

Approved: July 21, 2015

This position statement supersedes the Position Statement on Mercury in Vaccines, June 21, 2006.

Purpose

Historically, ANA has strongly supported immunizations to protect the public from highly communicable and deadly diseases such as measles, mumps, diphtheria, pertussis, and influenza (ANA, 2014; ANA, 2006), and has supported mandatory vaccination policies for registered nurses and health care workers under certain circumstances. However, in light of a recent and significant measles outbreak in the United States, ANA has reviewed current and past position statements for clarity and intent, and current best practices and recommendations from the broader health care community. Based on that review, it was determined that a revised position statement is needed to clarify ANA's position and incorporate current best practices.

Statement of ANA Position

To protect the health of the public, all individuals should be immunized against vaccine-preventable diseases according to the best and most current evidence outlined by the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP). All health care personnel (HCP), including registered nurses (RNs), should be vaccinated according to current recommendations for immunization of HCP by the CDC and Association for Professionals in Infection Control and Epidemiology (APIC).

ANA supports exemptions from immunization only for the following reasons:

1. Medical contraindications
2. Religious beliefs

All requests for exemption from vaccination should be accompanied by documentation from the appropriate authority to support the request. Individuals who are exempted from vaccination may be

required to adopt measures or practices in the workplace to reduce the chance of disease transmission. Employers should ensure that reasonable accommodations are made in all such circumstances.

https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/immunizations/

In two pages, you will see research demonstrating the ineffectiveness of high health care worker compliance with vaccines.

Often cited studies showing health care workers refusing the flu shot put patients at risk, use GROSS exaggeration

Four studies that are frequently used as leverage to try to convince all health care workers to receive the flu shot are found to be beyond ridiculously exaggerated.

A 2017 study published in the PloS One Journal titled, **Influenza Vaccination of Healthcare Workers: Critical Analysis of the Evidence for Patient Benefit Underpinning Policies of Enforcement**, takes a critical look at the studies that are used to persuade health care workers to get a flu shot in order to protect patients. http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0163586

From the study:
Results: "In attributing patient benefit to increased HCW *(Health Care Worker)* influenza vaccine coverage, **each cRCT *(cRCT = Randomized Clinical Trial),* was found to violate the basic mathematical principle of dilution** by reporting greater percentage reductions with less influenza-specific patient outcomes (i.e., all-cause mortality > Influenza like illness (ILI) > laboratory- confirmed influenza) and/or patient mortality reductions exceeding even favourably derived predicted values **by at least 6- to 15-fold *(600% to 1,500% higher)***. If extrapolated to all LTCF *(Long-Term Care Facilities)* and hospital staff in the United States, the prior cRCT-claimed NNV *(Number Needed to Vaccinate)* of 8 would implausibly mean >200,000 and >675,000 patient deaths, respectively, could be prevented annually by HCW influenza vaccination**, inconceivably exceeding total US population mortality estimates due to seasonal influenza each year, or during the 1918 pandemic, respectively. More realistic recalibration based on actual patient data instead shows that at least 6000 to 32,000 hospital workers would need to be vaccinated before a single patient death could potentially be averted**."

Another article takes aim at the flawed studies often used to support mandatory flu vaccines for health care workers

An article at www.statnews.som titled **Contentious flu vaccine policies at hospitals are based on flawed research, study says**, exposes the fallacy of those flawed studies.
https://www.statnews.com/2017/01/27/flu-vaccine-health-care-workers/

From the article:
"Some policies and firings have been challenged in front of labor tribunals or courts. In those cases, **employers regularly point to four specific studies to bolster the argument that vaccinating health care workers reduces the risk of vulnerable patients contracting influenza from caregivers**."

"But the methodology of the studies produced results that don't stand up to scrutiny, the authors of the new paper said. **None of the studies were conducted in hospitals**; **all took place in long-term care facilities. One the studies, from Britain, calculated that one influenza death would be averted for every eight staff members vaccinated. But if that were correct, vaccinating the estimated 1.7 million health care workers employed in long-term care in the United States should prevent 212,500 flu deaths a year among residents. There's an obvious problem though, the paper noted. Nowhere near that many people die from flu in the U.S."** Bear in mind that the studies looked at deaths in in long-term care facilities only. So, the 215,000 projected prevented deaths would be in long term care facilities only.

My comment: Considering that the total number of deaths actually due to the flu annually in the U.S. was 4,605 in 2014*, how can these studies possibly say that getting the additional non-vaccinated health care workers in long-term care facilities vaccinated would save over 200,000 lives per year IN LONG-TERM CARE FACILITIES? That makes absolutely NO SENSE! Yet this is the kind of propaganda that they put out there!

***Annual number of deaths attributed to the flu from the CDC**
https://www.cdc.gov/nchs/fastats/flu.htm

The highly acclaimed Cochrane Collaboration Review find no evidence of benefit in vaccinating health care workers with the flu vaccine

Authors' conclusions
"**Our review findings have not identified conclusive evidence of benefit of HCW vaccination programmes on specific outcomes of laboratory-proven influenza, its complications (lower respiratory tract infection, hospitalisation or death due to lower respiratory tract illness), or all cause mortality in people over the age of 60 who live in care institutions**."
http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005187.pub5/pdf/abstract

Recent study shows that healthcare worker compliance with influenza vaccination from 47% to 90% over a five-year period, does not change the rate of hospital acquired influenza in patients

In a 2016 study published in the ***Journal of Infection Control and Hospital Epidemiology*** titled, **Potential Ceiling Effect of Healthcare Worker Influenza Vaccination on the Incidence of Nosocomial Influenza Infection, the authors determined that over a five-year period when healthcare worker compliance with influenza immunization increased from 47% to 90%, there was no significant reduction of**

hospital acquired influenza by patients. Nosocomial means "originating in a hospital."
https://www.ncbi.nlm.nih.gov/pubmed/?term=27098758

Methods: "All admitted patients with a direct fluorescent antibody (DFA) or polymerase chain reaction (PCR) assay positive for influenza ordered between October 1 and May 31 from 2010 to 2015 were eligible for inclusion. **Nosocomial influenza was defined as a positive influenza test collected ≥48 hours after admission in patients without influenza-like illness present within 24 hours of admission**. Relative nosocomial influenza frequency was calculated by dividing the number of nosocomial cases by the total number of admitted patients with influenza for each season."

Results: "Over 5 seasons *(2010-2015)*, 533 patients had positive influenza tests during their hospitalization; 29 of these patients (5.4%) acquired influenza during their hospitalization. **HCW vaccination coverage increased over the 5 seasons from 47% to 90% Despite an initial decrease in relative nosocomial influenza frequency during the first year (9% to 4.9%), subsequent seasons failed to show an additional decrease in nosocomial infections (4.3%, 5.2%, and 4.8%, respectively); the overall decrease in nosocomial influenza from the first season to the final season was not significant. No association was detected between HCW vaccination coverage and nosocomial influenza.**"

Narcolepsy a sleep disorder, is a consequence of the H1N1 flu vaccine

About narcolepsy

First, what is narcolepsy? According to https://narcolepsynetwork.org/about-narcolepsy/faq/ ,

the symptoms are as follows:

Narcolepsy has five primary symptoms:

- Excessive Daytime Sleepiness (EDS) – An overwhelming sense of tiredness and fatigue throughout the day
- Cataplexy (C) – Events during which a person has no reflex or voluntary muscle control. For example knees buckle and even give way when experiencing a strong emotion – laughter, joy, surprise, anger or heads drop or jaws go slack from the same kind of stimuli
- Sleep paralysis – A limpness in the body associated with REM sleep resulting in temporary paralysis when the individual is falling asleep, or awakening. Episodes can last from a brief moment to several minutes.
- Hypnogogic hallucinations – Events of vivid audio and visual events that a person with narcolepsy experiences while falling asleep, or while awakening
- Disrupted Nighttime Sleep (DNS) – The inability to maintain sleep for more than a few hours at a time.

Other symptoms reported by people with Narcolepsy can include:

- Automatic Behavior (AB) – The performance of tasks that are often routine, dull or repetitive without conscious effort or memory.
- Memory Lapses – Difficulty in remembering recent events, actions or words

…End of narcolepsy network post

When I first read that list of symptoms, it struck me that narcolepsy can be an extremely debilitating disorder. The disruption and adverse consequences on a person's life dealing with narcolepsy must be tremendous.

So, what is the connection with vaccines?

Narcolepsy 25 rates times higher after the vaccine

A 2013 article from the Journal ***Neurology*** ("The most widely read and highly cited peer-reviewed neurology journal") titled, **Increased childhood incidence of narcolepsy in western Sweden after H1N1 influenza vaccination**, stated the following:

"Conclusion: Pandemrix vaccination is a precipitating factor for narcolepsy, especially in combination with HLA-DQB1*0602. **The incidence of narcolepsy was 25 times higher after the vaccination** compared with the time period before. The children in the postvaccination group had a lower age at onset and a more sudden onset than that generally seen."
https://www.ncbi.nlm.nih.gov/pubmed/?term=23486871

Squalene adjuvant implicated in H1N1 narcolepsy outbreak

In an editorial published in ***Neurology*** 2013, titled, **Association between H1N1 vaccination and narcolepsy–cataplexy- Flu to sleep**, the following clue to a possible cause of the autoimmune reaction caused by the vaccine surfaced. http://n.neurology.org/content/80/14/1276

"After the beginning of the influenza A (H1N1 pdm09) pandemic in 2009, several monovalent pandemic H1N1 vaccines were licensed **using fast track procedures**, **with limited safety data in children and adolescents**.[1] **Nonadjuvant** monovalent vaccines were used in the United States and Australia, and on a limited scale, in Europe (France, Spain) and other countries. **Within the European Union (EU), 2 different vaccines with adjuvant were licensed, both containing a new generation of squalene-based adjuvant**: Focetria (Novartis, Philadelphia, PA), with the MF59 adjuvant, and Pandemrix (GSK, Philadelphia, PA), containing AS03 (squalene and α-tocopherol). Arepanrix, similar to Pandemrix, was used in Canada and Brazil. The vaccine program started in the EU by September 2009; concurrently, the European Center for Disease Prevention & Control (ECDC), Vaccine Adverse Event Surveillance and Communication, and other agencies initiated an active surveillance program to monitor safety and adverse events associated with this vaccine."

Essentially what this means, is that certain parts of the world utilized an H1N1 flu vaccine which was without an adjuvant, and certain parts of the world used the adjuvant squalene. Sweden happened to be one of those countries where the Pandemrix H1N1 vaccine was utilized. **Squalene is a very controversial vaccine component that has long been suspected to contribute to many serious disorders, including Gulf War Syndrome. As a footnote, keep in mind that even in areas of the world where squalene was not utilized in that vaccine, thimerosal was still used in the multi-dose vials.**

Narcolepsy appears to be an autoimmune condition, caused by damage to particular cells in the brain by the immune system - therein lies the vaccine connection

In an article published in ***Lancet Neurology*** in 2014 and titled, **Narcolepsy as an autoimmune disease: the role of H1N1 infection and vaccination**, researchers found what may be the missing link in the vaccine/narcolepsy chain of events. https://www.ncbi.nlm.nih.gov/pubmed/24849861

According to the article:
Narcolepsy is a sleep disorder characterised by loss of hypothalamic hypocretin (orexin) neurons. The prevalence of narcolepsy is about 30 per 100 000 people, and typical age at onset is 12-16 years. Narcolepsy is strongly associated with the HLA-DQB1*06:02 genotype, and has been thought of as an immune-mediated disease. Other risk genes, such as T-cell-receptor α chain and purinergic receptor subtype 2Y11, are also implicated**. Interest in narcolepsy has increased since the epidemiological observations that H1N1 infection and vaccination are potential triggering factors, and an increase in the incidence of narcolepsy after the pandemic AS03 adjuvanted H1N1 vaccination in 2010 from Sweden and Finland supports the immune-mediated pathogenesis**. Epidemiological observations from studies in China also suggest a role for H1N1 virus infections as a trigger for narcolepsy. Although the pathological mechanisms are unknown, an H1N1 virus-derived antigen might be the trigger.

The H1N1 vaccine triggered an autoimmune reaction, damaging nerve cells in the brain associated with sleep/wake control

A 2014 article from the ***Journal of Autoimmunity*** titled, **A/H1N1 antibodies and TRIB2 autoantibodies in narcolepsy patients diagnosed in conjunction with the Pandemrix vaccination campaign in Sweden 2009-2010**, confirmed the autoimmune connection and the H1N1 correlation.
https://www.ncbi.nlm.nih.gov/pubmed/24485154

From the abstract: "**Narcolepsy is a lifelong sleep disorder** related to hypocretin deficiency resulting from a specific loss of hypocretin-producing neurons in the lateral hypothalamic area. The disease is thought to be autoimmune due to a strong association with HLA-DQB1*06:02**. In 2009 the World Health Organization (WHO) declared the H1N1 2009 flu pandemic (A/H1N1PDM09). In response to this, the Swedish vaccination campaign began in October of the same year, using the influenza vaccine Pandemrix(®). A few months later an excess of narcolepsy cases was observed."**

"The narcolepsy patients had higher median levels of A/H1N1 antibodies than the controls."

"**In conclusion, following the 2009 influenza pandemic vaccination, A/H1N1 antibody levels were associated with young age-at-onset narcolepsy patients positive for HLA-DQB1*06:02**." *(HLA-DQB1*06:02 is a genetic marker correlated with the predisposition toward developing narcolepsy)*

Other scientific articles have come to the same conclusions. It appears that certain persons with a genetic predisposition to narcolepsy, when exposed to an environmental trigger like an adjuvant or antigen in a vaccine (or other triggers listed below) will develop narcolepsy. The fact that they have the genetic hard wiring, is not the definitive reason for development of the disorder however. A sizable percentage of the population have this genetic predisposition, but never develop narcolepsy. **According to the Narcolepsy Network… "About one quarter of the general population in the U.S. carries the HLA-DQB1* o602 genetic marker but only one person out of about 500 of these people will develop this form of Narcolepsy**." **This underscores the role of epigenetics in the manifestation of a condition a person may have a genetic predisposition to. Epigenetics is involved in gene expression. Many different factors determine how a gene is expressed, including diet, quality of sleep, exposure to toxins, level of exercise, ability to manage stress, lifestyle and behavioral factors, faith life and even degree of optimism versus pessimism.**

A lack of controlled trials

*In fact, **the Flulaval Influenza Vaccine package insert** states: …." **There have been no controlled trials adequately demonstrating a decrease in influenza disease after vaccination with Flulaval**."

Scientific evidence of benefit is sorely lacking

An article published in the ***British Medical Journal (BMJ)*** titled, **Belief not science is behind flu jab promotion** exposes the lack of science behind the flu shot.

From the article…

"**An independent meta-analysis of vaccines against influenza has found that claims of benefit have been significantly exaggerated**."

"The report, released last month by the ***University of Minnesota's Center for Infectious Disease Research and Policy***, was based on a comprehensive review of data published from 1967 to 2012." *(That's 45 years)*

"" **Evidence for "consistent high-level protection is elusive**," the researchers concluded. Although vaccination was found to provide modest protection from infection in young healthy adults who rarely have complications of flu, the authors found that "**evidence for protection in adults 65 years of age and older [who represent over 90% of deaths from flu] . . . is lacking**.""

The Afluria flu vaccine not much better than a placebo

According to the Afluria flu vaccine package insert, Section 14.1, pages 16-17 report on the clinical trial demonstrating the effectiveness of the vaccine.
https://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM263239.pdf

The conclusion of the data:

Based on 10,000 people and looking at those contracting the vaccine-matched strains of the flu:
Vaccinated = 59 people (adjusted up by one to reflect 10,000 who received the vaccine))
Placebo = 147 (adjusted to reflect 10,000 who received the placebo)
(So out of 100 people, .59 vaccinated people got that strain and 1.47 unvaccinated people got it)
Number of unvaccinated contracting the **specific** viral strain more than vaccinated = 88 or 0.88%
This means that the vaccine is less than 1% effective in protecting from the specific strain of the flu it is designed to protect against, compared to a placebo!

Based on 10,000 people and looking at those contracting any strain of the flu:
Vaccinated = 224
Placebo = 387
(So out of 100 people, 2.24 vaccinated people got the flu (any strain) and 3.87 unvaccinated did also)
Number of unvaccinated contracting the specific viral strain more than vaccinated = 163 or 1.63%
This means that the vaccine is only 1.63% more effective than a placebo in protecting from any strain of the flu!

More on the flu vaccine's ineffectiveness:

This article from ***the Pediatric Infectious Disease Journal*** titled, **Vaccine Effectiveness Against Laboratory-confirmed Influenza in Healthy Young Children: A Case-Control Study** puts the effectiveness of the flu vaccine at 58%. "Using all the influenza-negative controls, the adjusted vaccine effectiveness (VE) was 58%". https://www.ncbi.nlm.nih.gov/pubmed/21079528

As you will see in many other reports and studies in this book, 58% is one of the best effectiveness rates you will see. Most statistics put it much lower. There are so many variables with guessing on the strains for the following year. Even if they guess right, those virus strains have the ability to mutate over the course of the year making the vaccine ineffective. Imagine a vaccine manufacturer with billions of dollars into production and ramp up worldwide, knowing the probability of a very low chance of next year's flu vaccine even working, having to convince hundreds of millions of people that they need to get injected. But the marketing machine does it anyway.

My question is, if only between 10% and 58% of children getting the vaccine are protected, is that really any better than those that were not vaccinated? My experience with myself, my family and those families I know and in my practice that do not vaccinate their children against the flu, is that it is rare for any of them to contract influenza or the flu. I believe in many cases, it is because health conscious families provide nutritious food and appropriate vitamins including vitamins A, C and D and

probiotics for themselves and their children. Additionally, they restrict immune suppressing things like excess ingestion of sugar, fried or hydrogenated foods or antibiotics. Many families practicing a healthy lifestyle also reduce or eliminate dairy and wheat which are two of the most common allergenic foods. These foods also cause excess mucous production, providing a fertile breeding ground for pathogenic organisms.

Good Morning America cites the flu vaccine as only 10% effective

On November 30, 2017, Good Morning America had a segment on the upcoming flu season. Their Medical Correspondent Dr. Jennifer Ashton was on the show discussing the fears about the severity of the upcoming season. They based their prediction on what they have seen in the Southern Hemisphere, Australia in particular. **The graphic they showed cited that the vaccine has been only 10% effective for the current strains**. http://abcnews.go.com/GMA/video/experts-warn-flu-season-bad-51477136

When George Stephanopoulos questioned the 10% effectiveness rate as not being very good, Dr. Ashton said the following "It's the worst vaccine we have, and that's why there's so much interest in research and need to develop what's called a universal vaccine. Right now, the flu vaccine takes a long time to develop, it's still grown in chick eggs. Adaptations can occur in that process that makes it not a great vaccine." She went on to say, "Ten percent efficacy is better than zero…" She then gave some good hygiene measures to prevent infection which I applaud.

The 2018-2019 flu vaccine predicted to be only 20% effective

The Journal of ***Clinical Infectious Diseases*** predicts another miserable success rate for the flu vaccine. In an article published April 17, 2018 titled, **Predicting Influenza H3N2 Vaccine Efficacy From Evolution of the Dominant Epitope.** In an April 23, 2018 article on ***Fierce Pharma's*** web site titled, **No thanks to eggs: Next year's flu shot will shield only 20% against dominant strain** the study was discussed. https://www.fiercepharma.com/vaccines/2018-19-season-s-flu-shot-only-20-effective-under-egg-based-production-study

The following is from the article:
"**Protection against the dominant H3N2 flu strain offered by the coming season's flu vaccine will still be far from optimal—putting it mildly**. And that's thanks to the widely used manufacturing process based on eggs, a new study predicts."

"**Using a method known as pEpitope, two Rice University researchers analyzed the newly proposed flu vaccine formulation. Their conclusion? An estimated 20% efficacy against H3N2, as published in Clinical Infectious Diseases**."

"The vaccine has been changed **for 2018-19**, but unfortunately it still contains two critical mutations that arise from the egg-based vaccine production process," said study author Michael Deem, Rice's John

W. Cox Professor in biochemical and genetic engineering. "**Our study found that these same mutations halved the efficacy of flu vaccines in the past two seasons, and we expect they will lower the efficacy of the next vaccine in a similar manne**r."

It seems that not only is guessing the predominant strains for next year's flu season a challenge, but the viral mutations in the process are as well. **Maybe that is why more and more people feel that the risk of the flu shot outweighs the stated benefits**.

The prestigious Cochrane Collaboration finds the flu vaccine only protects 1 of every 100 people

A 2013 comprehensive review of 50 published papers of over 70,000 people titled, **Vaccines for preventing influenza in healthy adults**, by the world-renowned Cochrane Collaboration finds the effectiveness of the flu vaccine to be pitiful.
http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001269.pub4/epdf

From the report:

Vaccines to prevent influenza in healthy adults

"**Over 200 viruses cause influenza and influenza-like illness which produce the same symptoms (fever, headache, aches and pains, cough and runny noses). Without laboratory tests, doctors cannot tell the two illnesses apart. Both last for days and rarely lead to death or serious illness. At best, vaccines might be effective against only influenza A and B, which represent about 10% of all circulating viruses**. Each year, the World Health Organization recommends which viral strains should be included in vaccinations for the forthcoming season."

"Authors of this review assessed all trials that **compared vaccinated people with unvaccinated people**. **The combined results of these trials showed that under ideal conditions (vaccine completely matching circulating viral configuration) 33 healthy adults need to be vaccinated to avoid one set of influenza symptoms. In average conditions (partially matching vaccine- *by far the most common scenario*) 100 people need to be vaccinated to avoid one set of influenza symptoms.** Vaccine use did not affect the number of people hospitalised or working days lost but caused one case of Guillian-Barré syndrome (a major neurological condition leading to paralysis) for every one million vaccinations. **Fifteen of the 36 trials were funded by vaccine companies and four had no funding declaration. Our results may be an optimistic estimate because company-sponsored influenza vaccines trials tend to produce results favorable to their products and some of the evidence comes from trials carried out in ideal viral circulation and matching conditions and because the harms evidence base is limited**." *(Interpretation: Because about half of the studies were performed by vaccine manufacturers and they optimize studies to come out favorably, had that not been the case the results would have been worse than 100 people vaccinated to save 1 case of influenza. That's not very impressive at all).*

Flu marketing continues the fear mongering

Despite all the false alarms in the past, the media continues the steady drum beat in their annual hype of impending doom. One has to ask, how long it will take before the public ignores their warnings? Like the boy that cried wolf, the continual overhype is likely to fall on deaf ears.

CNN*: September 24, 2017- The big one is coming, and it's going to be a flu pandemic**, by ***Dr. Sanjay Gupta, Chief Medical Correspondent.

"Experts say we are "due" for one. When it happens, they tell us, it will probably have a greater impact on humanity than anything else currently happening in the world."

WHO can we trust? The World Health Organization- Think again!

An article published in the ***British medical Journal*** June 12, 2010 titled, **WHO and the pandemic flu "conspiracies", exposed conflicts of interest within the World Health Organization and the pharmaceutical industry.** https://www.bmj.com/content/340/bmj.c2912/rapid-responses

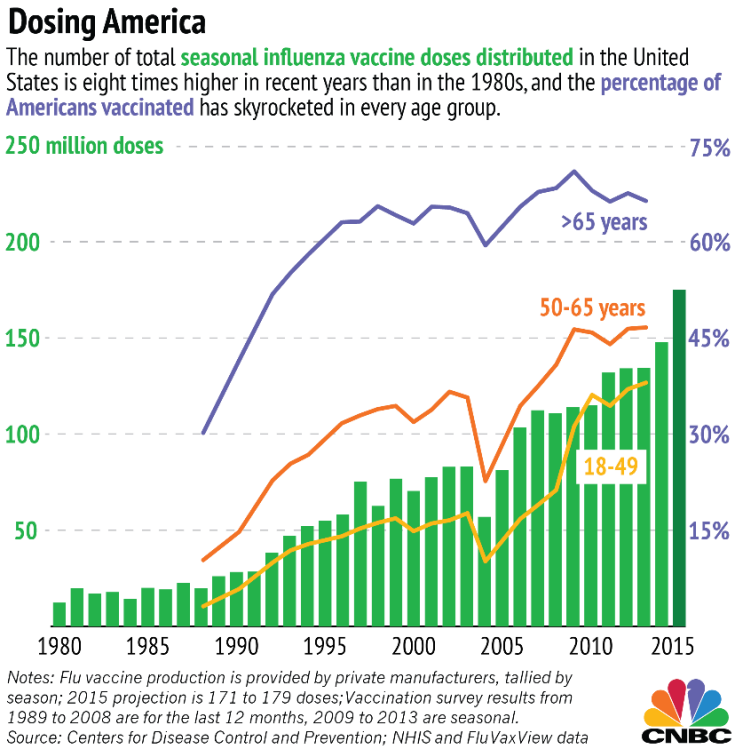
The article stated, "the investigation reveals a system struggling to manage the inherent conflict between the pharmaceutical industry, WHO, and the global public health system, which all draw on the same pool of scientific experts." Gerd Gigerenzer, director for the Center for adaptive behavior and cognition at the Max Planck Institute in Germany, told the ***British medical Journal***/the Bureau: "the problem is not so much that communicating uncertainty is difficult, but that uncertainty was not communicated. **There was no scientific basis for the WHO's estimate of 2 billion for likely H1N1 cases, and we knew little about the benefits and harms of the vaccination. The WHO maintained this 2-billion-dollar estimate, even after the winter season in Australia and New Zealand showed that only about one or 2 per1000 people were infected. Last, but not least, it changed the very definition of a pandemic.**" The article goes on to disclose that a document created by WHO in 1999 titled, **Influenza Pandemic Plan: The Role of WHO and Guidelines for National and Regional Planning**, was produced by the World Health Organization in collaboration with the European Scientific Working Group on influenza (ESWI). **What this document did not disclose, is that ESWI is funded entirely by Roche and other influenza drug manufacturers. The article goes on to identify certain key players and their conflicts of interest between seemingly independent and unbiased public health agencies and the pharmaceutical industry.**

This article drew a critical review from the editor of Nature, to which the editor of the British Medical Journal strongly countered in this rebuttal. https://www.bmj.com/content/340/bmj.c2912/rapid-responses

The marketing the illusion of “grave danger” and exaggerated efficacy pays off big time

How has the marketing of flu hysteria affected the rates of compliance, and therefore the profits of the pharmaceutical industry?

This story reported by CNBC in October 2015, discusses the $1.6 billion-dollar flu industry and displays a graph showing the dramatic 800% increase in the number of flu doses from the 1980’s until 2015. This graph breaks the total number of doses into 3 different age groups.
http://www.cnbc.com/2015/10/19/the-16-billion-business-of-flu.html



Circulating viruses are different than what is predicted

The ***USA Today*** reported in their 06-05-15 issue that the CDC reported that the flu vaccine was only 19% effective, because they have difficulty matching the strains with the vaccines being produced.
http://www.cbc.ca/news/health/flu-vaccine-only-23-effective-in-u-s-even-less-effective-in-canada-1.2902091

This release by CBC Radio Canada, reported on data released by the CDC for the 2014 fall flu season. **The data showed an overall effectiveness of the flu shot of only 23%. The additional results revealed are even more discouraging**.

According to the article:
The poor effectiveness likely reflects the fact that more than two-thirds of circulating flu viruses are genetically different or "drifted" from seasonal flu vaccines, the CDC said in its Morbidity and Mortality Weekly Report.

The effectiveness was highest among children aged six months to 17 at 26 per cent. **Effectiveness fell to about 12 per cent among people aged 18 to 49 and 14 per cent for those aged 50 and older**.

In Canada, the flu vaccine could be working even more poorly, with "little or no protection."

"**About 98 per cent of the viruses are mismatched that have been characterized in Canada**, whereas in the U.S. its closer to about **68 per cent**, **or about two-thirds are mismatched**. So, it's not a good omen," said Dr. Danuta Skowronski of the British Columbia Centre for Disease Control.

"There are other ways to protect yourself and others besides the flu shot, such as handwashing and staying home when sick", said Dr. Michael Gardam, director of infection prevention and control at Toronto's University Health Network.

"This year you could go off and get your flu shot and who cares? It really is not providing a great deal of protection," Gardam said.

NEW - A key reason why flu shots do not boost immunity long-term

This second study was published August 13th in ***Science*** and titled, **Influenza vaccine–induced human bone marrow plasma cells decline within a year after vaccination.**

The study provides evidence as to one of the reasons why influenza vaccine effectiveness is so short lived. Long-term serum antibodies are maintained by bone marrow plasma cells and these cells influenza specific bone marrow plasma cells wane over the course of one year.
https://science.sciencemag.org/content/early/2020/08/12/science.aaz8432/tab-pdf

Risk vs Reward- At what point does the risk of the toxic soup in the vaccine become greater than the perceived benefit?

My question is, how low would the effectiveness of the flu vaccine have to go before the talking heads would admit that the risk of putting mercury, Polysorbate-80, squalene, formaldehyde, MDCK (dog kidney cell protein), antibiotics, egg proteins, nonylphenol ethoxylate, MSG, various antibiotics which in some cases such as with polymyxin B and neomycin, (which are not supposed to be used together), octylphenol ethoxylate (Triton X-100), beta-propiolactone among many other ingredients into your body would no longer be worth it?

Another good question is, at what point does the risk of putting all of those chemicals, foreign DNA and metals into your body outweigh the reward? Virtually every decision we make goes through a filter of risk versus reward. In other words, what do we have to gain versus what do we have to lose? On the topic of vaccines, I would like to ask you, what is your risk/reward threshold? If the shot is only 10% effective, is the risk worth the reward? If the shot is only 5% effective, is the risk worth the reward? If the shot was only 1% effective, is the risk worth the reward? And, at what point of ineffectiveness should there be public push back against the mantra, that "X% is better than zero"?

This is a GREAT Segway to my next topic…….

The flu vaccine causes other health risks

The Trivalent Influenza Vaccine, caused a higher rate of the flu cases in those receiving it the following year

A study looking at 4 other studies on the subject published in 2010 titled, **Association between the 2008–09 Seasonal Influenza Vaccine and Pandemic H1N1 Illness during Spring– Summer 2009: Four Observational Studies from Canada**, **shows that those who were vaccinated for the flu with the Trivalent Influenza Vaccine (against three strains), were approximately twice as likely to contract the pH1N1 illness during the spring–summer 2009 in Canada.**
http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1000258

From the study: "In contrast, estimates from the sentinel and three other observational studies, involving a total of 1,226 laboratory-confirmed pH1N1 cases and 1,505 controls, **indicated that prior receipt of 2008–09 TIV was associated with increased risk of medically attended pH1N1 illness during the spring–summer 2009, with estimated risk or odds ratios ranging from 1.4 to 2.5.** Risk of pH1N1 hospitalization was not further increased among vaccinated people when comparing hospitalized to community cases."

The flu vaccine leads to an increase in other respiratory infections

A 2012 study published in the ***Clinical Infectious Diseases Journal*** titled, **Increased Risk of Non-influenza Respiratory Virus Infections Associated With Receipt of Inactivated Influenza Vaccine**, challenges the thinking that immunization against the flu reduces flu symptoms such as upper respiratory infections, often considered a hallmark of flu infection. **The reality is that vaccination against the flu appears to increase the rates of other non-influenza upper respiratory infections by greater than 400%!**
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3404712/

From the study:
"We randomized 115 children to trivalent inactivated influenza vaccine (TIV) or placebo. Over the following 9 months, TIV recipients had an increased risk of virologically-confirmed non-influenza infections. **Being protected against influenza, TIV recipients may lack temporary non-specific immunity that protected against other respiratory viruses**."

A 2018 study from the Journal Vaccine finds children vaccinated against the flu have a higher rate of other respiratory illness within 14 days than non-vaccinated children

A 2018 article published in the Journal ***Vaccine*** titled, **Assessment of temporally-related acute respiratory illness following influenza vaccination**, **found that children who are vaccinated for influenza develop a higher rate of non-influenza acute respiratory illness in the 14 days after the vaccination than those that are not vaccinated**.
https://www.ncbi.nlm.nih.gov/pubmed/?term=29525279

From the Abstract: *(ARI stands for Acute Respiratory Illness)*
"We conducted a cohort sub-analysis of children and adults in the MoSAIC community surveillance study from 2013 to 2016."

"Of the 999 participants, 68.8% were children, 30.2% were adults. Each study season, approximately half received influenza vaccine and one third experienced ≥1 ARI. **The hazard of influenza in individuals during the 14-day post-vaccination period was similar to unvaccinated individuals during the same period…** *(this indicates that non-vaccinated people had no higher incidence of the flu).* **The hazard of non-influenza respiratory pathogens was higher during the same period**… when stratified by age the hazard **remained higher for children**… but not for adults."

From the Conclusion:
"**Among children there was an increase in the hazard of ARI caused by non-influenza respiratory pathogens post-influenza vaccination** compared to unvaccinated children during the same period. Potential mechanisms for this association warrant further investigation."

NEW - Influenza vaccines are contaminated with proteins that can cause allergy, anaphylaxis and even increased severity of COVID-19

This first article is an August 2020 pre-print and has not yet been published, but I found it fascinating and worth including in this month's issue. The author is Vinu Arumugham. The article is titled, **Proteins that contaminate influenza vaccines have high homology to SARS-CoV-2 proteins thus increasing risk of severe COVID-19 disease and mortality**.

In the article, the author makes a good case about the cross-reactivity of proteins of various kinds and even retro-viruses in vaccine that can trigger an allergy or even an anaphylaxis type of reaction in the recipient. I have read many of his previous articles. He has an incredible amount of knowledge and experience studying and publishing articles regarding these particular relationships with vaccines.

From the intro:

Influenza vaccines are manufactured using chicken eggs, canine kidney cells or insect cells. Chicken and dogs can be infected with numerous viruses including coronaviruses. Therefore influenza vaccines can be contaminated with coronavirus proteins. These coronavirus proteins of course have high homology to SARS-CoV-2 proteins. Further, we show that even chicken egg proteins have high homology to SARS-CoV-2 proteins. Influenza vaccine administration is known to create IgE mediated sensitization (allergy) to all proteins in the vaccine. In fact, vaccine-induced egg allergy is required for the vaccine to work and protect against influenza. This is because most influenza vaccines lack an adjuvant and they depend on the allergic reaction at the injection site to provide an adjuvant effect.

Upon COVID-19 infection, patients will suffer an allergic reaction due to cross reaction against SARS-CoV-2 proteins. This predictably produces anaphylaxis symptoms. Since the viral load increases over a few days, we have slow rolling anaphylaxis. The result is damage to multiple organs. Acute respiratory distress syndrome results from lung damage. Cardiac injury due to Kounis syndrome. Coagulation dysfunction, hypotension and shock are other possible outcomes. As in anaphylaxis treatment, epinephrine, histamine H1 and H2 blockers, etc. help prevent or treat these conditions. https://zenodo.org/record/3997694

10 Tips to Avoid and Treat the Flu

Here is a link to an article I posted on my web site, that will give you a great strategy to help your own immune system defend you from infections, and particularly viral ones like the flu.
https://www.wellnessdoc.com/2018/11/10-ways-to-avoid-the-winter-flu/

Natural protection and treatment for the flu and other viral conditions

VIEW

10 Effective Ways to Prevent and Treat Viral Infections

Hepatitis B Vaccine- A dangerous and unnecessary risk

Hepatitis B at Birth – Is it really necessary?

The absurdity that an infant born to a Hepatitis B negative mother would need a Hepatitis B Vaccine is beyond comprehension. Hepatitis B is a disease spread by bodily fluids. It is transmitted mostly through sexual contact or sharing needles, syringes, or other drug-injection paraphernalia, something that the potential of happening to an infant or young child is nearly zero. However, the CDc has alleged that they felt that children could pick up Hep B on the school playground or in an elementary, middle or high school setting.

So, the ***Informed Consent Action Network (ICAN)*** challenged the CDC to produce evidence of any transmission that has ever occurred by these means.

The following is from ICAN's Legal Update dated December 30th, 2020

The CDC nonetheless actively encourages this vaccination for all 1-day old babies and also encourages states to mandate that any child that does not receive the Hepatitis B vaccine series to be expelled from school. Exclusion from school is well documented to result in various psychological, developmental, and opportunity harms.

The fact that the CDC actively encourages expelling children from school for not being fully vaccinated with the Hepatitis B vaccine series while not being able to point to *one single case of transmission in a school setting* reflects that the CDC's real concern is not with the health of children, but rather with its blind, religious, and unquestionable belief in vaccination. This is also evidenced by the fact that children *with* Hepatitis B are permitted to attend school yet those who have not been vaccinated but are uninfected are not.

Also alarming, as pointed out in a prior legal update, is that ICAN provided the CDC, FDA, and HHS numerous opportunities over the past three years to provide proof that it licensed the Hepatitis B vaccines based on clinical trials that reviewed safety for more than five days after injection. All they were able to provide was a litany of excuses – not science. In response, ICAN's legal team formally filed a petition to the FDA on September 2, 2020, demanding that the licensure of the Hepatitis B vaccines be revoked or suspended until their safety, as required by law, is determined in a properly designed clinical trial of sufficient duration.

If the CDC does not have documentation to support Hepatitis B being transmitted in a school setting, it should, at least, direct schools to stop excluding students who are not vaccinated for Hepatitis B and, at best, immediately cease encouraging states to require this vaccine to attend school. ICAN will be taking further action in this regard and will keep fighting to bring the truth to light regarding this product.

After pressing the CDC **After a search of its records, CDC conceded that "A search of our records failed to reveal any documents pertaining to your request." Meaning, the CDC could not find documentation of a single case of Hepatitis B being transmitted in a school setting.**

It's time that parents demand that the Hepatitis B vaccine be dropped from the childhood schedule.

Director of a major medical association disagrees with the addition of the Hep B Vaccine

According to testimony before Congress given in 1999 by ***Jane Orient, MD***., ***Executive Director of the Association of American Physicians and Surgeons***, when the government was planning to add Hepatitis B to the mandatory childhood schedule.

Dr. Orient stated:
"**VAERS contains 25,000 reports related to hepatitis B vaccine, about one-third of which were serious enough to lead to an emergency room visit, hospitalization, or death**."

"**It is often assumed that only 10% of reactions are reported**. (This committee has heard testimony about persons being actively discouraged from reporting, even if they are aware of the reporting system.) **Thus, if there have been some 80,000 serious adverse reactions associated with 20 million doses of vaccine, the risk is about 4 in 1000**."

Her conclusion: Public policy regarding vaccines is fundamentally flawed, permeated by conflicts of interest and based on poor scientific methodology

She concluded:
"**Public policy regarding vaccines is fundamentally flawed. It is permeated by conflicts of interest. It is based on poor scientific methodology (including studies that are too small, too short, and too limited in populations represented), which is, moreover, insulated from independent criticism. The evidence is far too poor to warrant overriding the independent judgments of patients, parents, and attending physicians, even if this were ethically or legally acceptable**." ***Did you get that? The evidence is far too poor to warrant overriding the independent judgments of patients and parents! I completely concur!***
Reference: http://www.aapsonline.org/testimony/hepbcom.htm

Since 2017, premies weighing under 4.41 pounds get a very short time delay before the shot

A **minor** "victory" in 2017 for those alleging that premature born infants are more susceptible to injury from vaccines has occurred by **the CDC is now recommending that preemie babies born to Hep B negative mothers and weighing under 2,000 grams (4.41 pounds) should not receive their first dose until 1 month after birth, or at hospital discharge**. If the mother has tested **positive** or if the mother's status in **unknown** for Hep B, the preemie should still receive the dose at birth. I say minor victory because, the slight delay of 1 month in administering the vaccine will make very little difference as it

relates to reducing risk to the baby. A 4-pound baby may still only weight 5 pounds at one month of age. Additionally, the Hep B virus can only be contracted by sexual activity, dirty needles or from a Hepatitis B positive mother during the birth process. The fact that infants should require this vaccine makes no sense whatsoever, especially to Hepatitis B negative mothers. Why not just test the mothers and at least give the babies born from mothers that have tested negatively a pass? **Yet, the CDC's schedule calls for up to 4 doses before 6 months for ALL babies! In addition, the schedule calls for pregnant women to receive the Hep B vaccine with the tiny fetus in utero. This is all complete insanity!** You can verify everything I am saying right here with the CDC's 2018 schedule.
https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf

Yet, another example of the Hep B vaccine and subsequent autoimmune problems-

From the ***Journal Lupus***, Feb 21, 2012. An article titled **Autoimmunity following hepatitis B vaccine as part of the spectrum of 'Autoimmune (Auto-inflammatory) Syndrome induced by Adjuvants' (ASIA): analysis of 93 cases.** https://www.ncbi.nlm.nih.gov/pubmed/22235045

This is the conclusion:
"**Common clinical characteristics were observed among 93 patients diagnosed with immune-mediated conditions post-Hepatitis B Vaccination, suggesting a common denominator in these diseases**."

The Hepatitis B Virus is a known human carcinogen according to the HHS National Toxicology Program

The Department of Health and Human Services puts out their report on known and suspected human carcinogens every couple of years. The current 2016 report includes 248 listings of agents, substances, mixtures, and exposure circumstances that are known or reasonably anticipated to cause cancer in humans. The hepatitis b virus is one that is categorized as a known human carcinogen as it can cause liver cancer. https://ntp.niehs.nih.gov/pubhealth/roc/index-1.html

While the live virus is not injected along with the vaccine, the cultured hepatitis B surface antigen is**. It is not known whether the surface antigen itself has the same carcinogenic properties or potential as the virus itself**. This remains to be seen. As we know from many other instances of compounds that have made their way into the human population through consumer products and medicines, the recognition of the hazards of those substances **often takes a very long time**. **This is often revealed by looking backward through epidemiological studies. Unfortunately, those connections may take decades to come to light. It would be a tragedy to find out many years later that the same vaccine that was designed to prevent liver cancer, was actually causing that same cancer that it was designed to prevent**.

Study shows a significant increase in special education services in boys exposed to the hepatitis B vaccine

A 2018 article published in ***The International Journal of Environmental Research and Public Health*** titled, **A Cross-Sectional Study of the Association between Infant Hepatitis B Vaccine Exposure in Boys and the Risk of Adverse Effects as Measured by Receipt of Special Education Services**,

The Abstract:

"**The National Center for Education Statistics reported that between 1990–2005 the number of children receiving special education services (SES) rose significantly, and then, from 2004–2012, the number declined significantly. This coincided with the introduction of Thimerosal-containing hepatitis B vaccine in 1991, and the subsequent introduction of Thimerosal-reduced hepatitis B vaccine in the early 2000s.** This study examined the potential relationship between infant exposure to mercury from three doses of Thimerosal-containing hepatitis B vaccine and the risk of boys being adversely affected (as measured by receipt of SES). This cross-sectional study examined **1192 boys** (weighted n = 24,537,123) **7–8 years of age** (born: 1994–2007) **from the combined 2001–2014 National Health and Nutritional Examination Survey (NHANES)**. Survey logistic regression modeling revealed that an exposed population receiving three doses of infant Thimerosal-containing hepatitis B vaccine (weighted n = 11,186,579), in comparison to an unexposed population (weighted n = 704,254), were at an increased risk of receipt of SES. **This association was robust** (crude odds ratio = 10.143, p = 0.0232), **even when considering covariates, such as race and socioeconomic status** (adjusted odds ratio = 9.234, p = 0.0259). **Survey frequency modeling revealed that receipt of SES for the population that was exposed to three doses of Thimerosal-containing hepatitis B vaccine in infancy (12.91%) was significantly higher than the unexposed population (1.44%)** (prevalence ratio = 8.96, p = 0.006, prevalence attributable rate = 0.1147). **Despite the limitation of this cross-sectional study not being able to ascribe a direct cause-and-effect relationship between exposure and outcome, it is estimated that an additional 1.2 million boys received SES with excess education costs of about United States (US) $180 billion associated with exposure to Thimerosal-containing hepatitis B vaccine. By contrast, exposure to Thimerosal-reduced hepatitis B vaccine was not associated with an increased risk of receiving SES. Therefore, routine childhood vaccination is important to reduce the morbidity and mortality of infectious diseases, but every effort should be made to eliminate Thimerosal from all vaccines**."

From the Conclusion:
"This cross-sectional study provides new evidence consistent with and extends the results from previous epidemiological and biological studies on the adverse effects of Hg exposure from Thimerosal-containing childhood vaccines. This study supports a significant about nine-fold increase in the risk of adverse effects as measured by receipt of special education services among boys receiving infant Thimerosal-containing hepatitis B vaccination."

"**In light of the findings in this study, it is recommended that Thimerosal be removed from all of the vaccines given to pregnant women and children worldwide.** This includes the Thimerosal-containing hepatitis B vaccine and all other Thimerosal-containing childhood vaccines that

are still being used in the developing world, **as well as the Thimerosal-containing influenza vaccines, the Thimerosal-containing meningococcal vaccines, and the Thimerosal-containing tetanus toxoid vaccines that are still used in the US to date. The removal of Thimerosal should take place as soon as possible, since the use of Thimerosal in vaccines is avoidable and unnecessary."**

Hep B Vaccine in the first month of life, increases the risk of Autism in boys by 300 percent

A 2010 study published in the ***Journal of Toxicology and Environmental Health*** titled, **Hepatitis B vaccination of male neonates and autism diagnosis, NHIS 1997-2002**, confirms a **three times greater risk of autism** when boys were vaccinated within the first month of life.
https://www.ncbi.nlm.nih.gov/pubmed/?term=21058170

The Abstract:
"Universal hepatitis B vaccination was recommended for U.S. newborns in 1991; however, safety findings are mixed. The association between hepatitis B vaccination of male neonates and parental report of autism diagnosis was determined. This cross-sectional study used weighted probability samples obtained from ***National Health Interview Survey 1997-2002 data sets***. Vaccination status was determined from the vaccination record. Logistic regression was used to estimate the odds for autism diagnosis associated with neonatal hepatitis B vaccination among boys age 3-17 years, born before 1999, adjusted for race, maternal education, and two-parent household. **Boys vaccinated as neonates had threefold greater odds for autism diagnosis compared to boys never vaccinated or vaccinated after the first month of life**. **Non-Hispanic white boys were 64% less likely to have autism diagnosis relative to nonwhite boys. Findings suggest that U.S. male neonates vaccinated with the hepatitis B vaccine prior to 1999 (from vaccination record) had a threefold higher risk for parental report of autism diagnosis compared to boys not vaccinated as neonates during that same time period. Nonwhite boys bore a greater risk**."

The various versions of the Hep B vaccine contain aluminum, formaldehyde, polysorbate 80 and other compounds, which can be viewed at:
https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf

A 2018 study identifies one way the hepatitis B vaccine causes brain damage

A 2018 study published in the journal ***Cytokine*** titled, **IL-4 mediates the delayed neurobehavioral impairments induced by neonatal hepatitis B vaccination that involves the down-regulation of the IL-4 receptor in the hippocampus**, describes the mechanism for brain damage from the hepatitis B vaccine.
https://www.ncbi.nlm.nih.gov/pubmed/29751176

From the Abstract:
"**We have previously verified that neonatal hepatitis B vaccination induced hippocampal neuroinflammation and behavior impairments in mice**. However, the exact mechanism of these effects

remain unclear. In this study, we observed that neonatal hepatitis B vaccination induced an anti-inflammatory cytokine response lasting for 4-5 weeks in both the serum and the hippocampus, primarily indicated by elevated IL-4 levels. **Three weeks after the vaccination schedule, however, hepatitis B vaccine (HBV)-mice showed delayed hippocampal neuroinflammation**."

"Thus, we investigated whether neonatal over-exposure to systemic IL-4 influences brain and behavior. We observed that mice injected intraperitoneally with recombinant mouse IL-4 (mIL-4) during early life had similar neuroinflammation and cognition impairment similar to those induced by neonatal hepatitis B vaccination. Next, the mechanism underlying the effects of IL-4 on brain in mice was explored using a series of experiments. **In brief, these experiments showed that IL-4 mediates the delayed neurobehavioral impairments induced by neonatal hepatitis B vaccination, which involves the permeability of neonatal blood-brain barrier and the down-regulation of IL-4 receptor. This finding suggests that clinical events concerning neonatal IL-4 over-exposure, including neonatal hepatitis B vaccination and allergic asthma in human infants, may have adverse implications for brain development and cognition.**"

Hepatitis B Vaccine in newborn mice impairs brain development at 6 weeks from microglial activation and altered behavior in early adulthood

A 2016 study published in ***Psychoneuroendocrinology*** journal titled, **Neonatal hepatitis B vaccination impaired the behavior and neurogenesis of mice transiently in early adulthood**, showed a "neurotoxic profile" of neuroimmune molecule expression, AKA extreme activation of inflammatory markers leading to immune activation, delayed brain development and even neurobehavioral changes in early adulthood. https://www.ncbi.nlm.nih.gov/pubmed/?term=27501128

From the Abstract:
"The immune system plays a vital role in brain development. The hepatitis B vaccine (HBV) is administered to more than 70% of neonates worldwide. Whether this neonatal vaccination affects brain development is unknown. Newborn C57BL/6 mice were injected intraperitoneally with HBV or phosphate-buffered saline. HBV induced impaired behavioral performances and hippocampal long-term potentiation at 8 weeks (w) of age without influence at 4 or 12w. **At 6w, there was decreased neurogenesis, M1 microglial activation and a neurotoxic profile of neuroimmune molecule expression** [increased tumor necrosis factor-α and reduced interferon (IFN)-γ, brain-derived neurotrophic factor and insulin-like growth factor-1] in the hippocampus of the HBV-vaccinated mice. In the serum, HBV induced significantly higher levels of interleukin (IL)-4, indicating a T helper (Th)-2 bias. Moreover, the serum IFN-γ/IL-4 ratio was positively correlated with the levels of neurotrophins and neurogenesis in the hippocampus at the individual level. **These findings suggest that neonatal HBV vaccination of mice results in neurobehavioral impairments in early adulthood by inducing a proinflammatory and low neurotrophic milieu in the hippocampus, which follows the HBV-induced systemic Th2 bias**."

New Hepatitis B Vaccine Dynavax caused a seven times greater risk of heart attacks

An article dated August 02, 2017 from ***Med Page Today***, by Milton Packer M.D., calls into question the **potential increased risk of myocardial infarction (heart attack) from the new Hepatitis B drug Dynavax**. https://www.medpagetoday.com/Blogs/RevolutionandRevelation/67019

According to his bio on BaylorHealth.edu, "Dr. Packer is an internationally recognized clinical investigator who has made many seminal contributions to the field of heart failure, both in understanding its mechanisms and defining its rational management."

According to Dr. Packer, "In the trial, an acute myocardial infarction occurred in 14 people in the Dynavax group, but in only one person receiving the conventional vaccine. The events were confirmed by adjudication. Since the Dynavax group was twice as large, the risk of acute myocardial infarction in the trial was seven times greater with the new vaccine."

"Was it biologically plausible for the new vaccine to cause heart attacks? **The new adjuvant in the vaccine caused an inflammatory response (of uncertain duration), and inflammation is an important cause of rupture of atherosclerotic plaques**. So a causal linkage was not out of the question."

Dr. Packer abstained from voting as to whether the FDA should approve the vaccine, because he felt a much larger sample size was warranted before a definitive conclusion. "If you wanted to know if the 14:1 imbalance represented a real risk, you needed more information. You needed comparative data in 50,000 people. The fastest way of obtaining that evidence was through a post-marketing trial. **But a post-marketing trial was possible only if the vaccine was approved for public use**." *In other words, like in the infamous words of congresswoman Nancy Pelosi, when speaking about the Obama Health Care bill, AKA the Affordable Care Act, "But we have to pass the bill so that you can find out what is in it, away from the fog of the controversy," this is a similar scenario…we just have to approve the drug for market and do the expansive study on a much larger number of people. Then we can make a determination. There's got to be a better way to determine safety and effectiveness, than put thousands of people's life at risk.*

I have a question. If 50,000 people get the Dynavax vaccine and the initial numbers are proved out, that means 125 people will have suffered a heart attack as a result. There's no telling how many of those will die as a result. But I guess that's the risks you take in the name of science! (note the sarcasm)

Population adjusted data shows that deaths from Hepatitis B have gone up significantly since before the vaccine came to market in 1981

The **first graph** found at the link below, shows that the **number of cases of Hepatitis B** were 21,152 in 1981 when the vaccine was introduced, up from less than 2,000 in 1966. Cases then peaked in 1985 at around 27,000 and have been declining steadily ever since. As of 2013, the number of cases of Hep B were still higher than in 1966. More on this below.

The **second graph** shows the **death rate** for every year since 1979, when 260 people died from Hepatitis B. That was two years before the introduction of the Hepatitis B vaccine in 1981. Deaths then reached a peak in 1994, thirteen years after the introduction of the Hep B Vaccine at 1,120 deaths (a 431% increase from 1979). To be fair, the population in 1979 was 225 million and increased to 318.6 million by 2014, a 29% increase. **Even so, a 431% increase in deaths with only a 29% increase in population doesn't speak to any degree of success in mortality rates from the vaccine. Even as of 2010 (the last reported year on the chart), the death rate was still 588 annually, more than double the rate two years before the vaccine was first introduced.**

The **third graph** shows the **rates of vaccination coverage of children under 3 years old**. Those rates have been consistently **over 90% since 2002**, yet as just mentioned **the death rate in 2010 was still more than double what it was 31 years prior in 1979**.

Graphs: https://vaccines.procon.org/view.resource.php?resourceID=005968

CDC chart of cases and death rates: https://vaccines.procon.org/sourcefiles/cdc-reported-cases-and-deaths-from-vaccine-preventable-diseases.pdf

So, how effective has the vaccination campaign against Hep B been since its inception in 1981? The population of the U.S. in 1966 was 196.6 million. By the year 2013 it had grown to 316.2 million, a 62% increase. There were 1,497 reported cases of Hepatitis B in 1966. In 2013, the number of cases was 3,050, or a 100% increase as compared to 1966. The point of showing you all of these statistics, is to demonstrate that after over 37 years of injecting adults and tens of millions of babies on their first day of birth and two more doses by their first birthday with the Hepatitis B vaccine, containing aluminum, formaldehyde, polysorbate 80 and other chemicals and biological compounds, the statistics are still worse than they were 15 years before the vaccine was ever introduced! And, at what cost financially and to the health of our children, and now our adult population? The madness of continuing something that isn't working and the evidence showing that it is causing collateral damage, must stop!

Population statistics were obtained here: http://www.multpl.com/united-states-population/table

A Hepatitis B Vaccine Recombivax shortage in 2018, resulted in a 75% decrease in infant death rates

A computer system malware problem that infected Merck's computer systems caused a significant shortage of their Hepatitis B Vaccine Recombivax and cost Merck $670 million to remediate according the article published January 22, 2019, on the Children's Health Defense web site. https://childrenshealthdefense.org/news/mercks-recombivax-vaccine-shortage-causes-reduced-deaths-in-babies-a-natural-experiment/?utm_source=mailchimp

The CDC asked GalaxoSmithKline (GSK), to assist by providing their version of the Hepatitis B Vaccine Engerix-B to meet demands. Currently as of this update, the estimated return of Recombivax until the middle of 2019.

Interestingly Recombivax contains not one, but two different versions of aluminum adjuvant (potassium aluminum sulfate and amorphous aluminum hydroxyphosphate or AAHP), whereas Engerix-B only contains one (aluminum hydroxide). The AAHP version found in Recombivax has drawn significant scrutiny as being suspected to be much more reactogenic. In fact, the article I highlight after this section demonstrates the increased reactivity/toxicity of AAHP very well.

From the article:
"Following the cyber-attack in June 2017, for the first time in a very long time, researchers have the ability to view in plain sight, a natural experiment whereby one vaccine was abruptly swapped out for another – replacing the very adjuvant many critics are concerned about, AAHS – with an aluminum hydroxide adjuvant contained in Engerix-B. Neither has a published independent safety profile but AAHS is suspected to be more problematic due to its immunogenicity profile."

"We now have more than a year's worth of data to examine since the attack in 2017 when Engerix-B was introduced. On average there were 29 deaths reported annually for fifteen years prior to the attack (2003 to 2017). In 2018 there were only 6 reported (to end of November 2018). Two of those deaths followed Recombivax. Assuming the same death rate to the end of the year, at most there will be 7 deaths recorded, resulting in roughly 75% less deaths since Recombivax was discontinued as a pediatric vaccine."

Bear in mind that the data reported is from the Vaccine Adverse Event Reporting System (VAERS), which based on a CDC funded study reported earlier in this eBook showed that less than 1% of adverse reactions are reported through VAERS. Therefore with 99% of adverse reactions going unreported, one must take that into consideration when looking at VAERS tables.

The chart in the article shows Hepatitis B Vaccine "Reported" deaths from 2003-2018. There were on average, 29 deaths annually attributed to the Hep B Vaccine. Since the unavailability of Recombivax and the substitution of Engerix-B, there were only 6 reported in 2018, which a by far the lowest total since 2003. Injuries related to Hep B vaccines also reduced 50%, from an average of 1,400 reported annually to 756 in 2018.

It appears that the GSK Hep B Vaccine is safer than the Merck's Recombivax. The FDA should take a very close look at these associations and put a moratorium in the return of the Recombivax until a thorough investigation can be completed. To be clear, I do NOT endorse any Hepatitis B Vaccines given to children born of a Hepatitis B negative mother. Unless that baby is going to engage is unprotected sex or share dirty needles with another user, there is no risk of that baby contracting Hep B.

2018 study finds up to nearly 6 times greater chance of developing central nervous demyelinating disease like Multiple Sclerosis, in adults given the Hepatitis B vaccine, when compared to other vaccines

A 2018 study in the journal ***Drug Safety*** titled, **Central Demyelinating Diseases after Vaccination Against Hepatitis B Virus: A Disproportionality Analysis within the VAERS Database**, **finds that the incidence of central nervous system demyelinating diseases like Multiple Sclerosis** **are as much as 5.56 times greater of developing within 120 days after receiving the Hepatitis B vaccine when compared to other vaccines**. https://www.ncbi.nlm.nih.gov/pubmed/29560597

From the study:
"We calculated the proportional reporting rate (PRR) and reporting odds ratio (ROR) **of MS having occurred within the 120 days following HB immunization in adults aged 19-49 years when compared with other vaccines using the reports recorded in the VAERS database**."

"All computed ratios were found to be **statistically significant**, with PRRs ranging from **3.48 to 5.56** and RORs ranging from **3.48 to 5.62**. When considering the geographical origin, similar RORs were obtained for both US and non-US cases." ***(That translates into a 350-550% increase in developing central nervous system demyelinating disease like multiple sclerosis).***

"In VAERS, **MS cases were up to five times more likely to be reported after an HB vaccination than after any other vaccination**. Since DPA is mainly suited for hypothesis generation, further studies evaluating the nature of the link between MS and HB vaccination would be of considerable importance."

High correlation with Multiple Sclerosis and the Hepatitis B Vaccine

Speaking of the vaccine connection to multiple sclerosis, this link will take you to a graph on the ***MedAlerts Blog (2014)***, that **shows a high correlation of multiple sclerosis with the Hepatitis B vaccine.** **You really have to see it to appreciate how dramatic it is.**
http://www.medalerts.org/analysis/archives/650

From the page:
"There aren't many VAERS cases that mention Multiple Sclerosis (only 1,116 out of the 480,754 cases). But of those cases, a whopping 682 are associated with a Hepatitis B vaccine (that's 61%). **If any vaccine is linked to multiple sclerosis, it's certainly Hepatitis B.**"

The site also shows and describes **how to create a graph from VAERS data, allowing the ability to identify which vaccine adverse events are associated with particular vaccines.** The site is designed and maintained by a computer scientist named **Steven H. Rubin PhD**. Dr. Rubin is not a medical professional. Instead, **he has over 40 years of experience as a computer scientist and knows how to decipher the numbers behind the statistics**. The about tab on his site explains about his experience and what he monitors.

Research on the Hepatitis B Vaccine show convincing evidence for at least one of the ways it damages the brain

A 2015 study from the ***Journal of Neuroimmunology*** titled, **Neonatal vaccination with bacillus Calmette-Guérin and hepatitis B vaccines modulates hippocampal synaptic plasticity in rats**, identifies very specific ways that the Hepatitis B Vaccine can trigger brain pathology.
https://www.ncbi.nlm.nih.gov/pubmed/?term=26531688

First, some definitions would be helpful…

Cytokine- A small protein released by cells that perform communication and regulatory functions, ie. cell signaling. They serve many roles. As they relate to inflammation, some are inflammatory in nature and some are anti-inflammatory in nature. This is important with regard to this discussion.

HEALTHY/BENEFICIAL CYTOKINES

IFN-y (Interferon Gamma), is a cytokine that helps regulate many beneficial immune functions.

IL-4 is an Interleukin (IL), that plays a very important role in brain development and cognition.

BDNF (Brain Derived Neurotrophic Factor), is a nerve growth agent. It helps with neuroplasticity or rewiring and repairing the brain.

IGF-1 (Insulin Like Growth Factor), is a hormone that mediates Growth Hormone, which is involved in childhood growth and anabolic (repair), effects in adults.

UNHEALTHY/DETRIMENTAL CYTOKINES

IL-1B is an inflammatory cytokine that can have many negative effects in the body including brain inflammation and activation of a shift in T-cells (immune cells), towards Th17. Th17 cells are implicated in the development of autoimmune disease.

IL-6 is an inflammatory cytokine that is linked to numerous pathological states and diseases, including pain, autoimmune reactions and systemic inflammation. In appropriate small roles it has beneficial effects, but when over-stimulated can cause the aforementioned problems.

TNF-a (Tumor Necrosis Factor- alpha), is a major early inflammatory cytokine that also triggers other inflammatory and damaging chemicals including Reactive Oxygen Species (ROS), with are some of the most damaging pro-oxidants, causing oxidative stress and damage to healthy cells and tissue.

BCG = Bacillus Calmette-Guérin

HBV = Hepatitis B Vaccine

***The italicized comments in parentheses are mine**

Now, from the abstract:

"Immune activation can exert multiple effects on synaptic transmission. **Our study demonstrates the influence of neonatal vaccination on hippocampal synaptic plasticity in rats** under normal physiological conditions. **The results revealed that neonatal BCG vaccination enhanced synaptic plasticity."** ***(good)*** **"In contrast, HBV hampered it**. Furthermore, we found that the cytokine balance shifted in favour of the T helper type 1/T helper type 2 immune response in BCG/HBV-vaccinated rats in the periphery. **The peripheral IFN-γ:IL-4 ratio was positively correlated with BDNF and IGF-1 in the hippocampus. BCG raised IFN-γ, IL-4, BDNF and IGF-1 "*(good ones)* "and reduced IL-1β, IL-6, and TNF-α" *(bad ones), "* in the hippocampus, whereas, HBV triggered the opposite effects."**

In other words, the Hepatitis B Vaccine triggered all of the bad and none of the good cytokines, including in the hippocampus of the brain. The hippocampus is involved with learning, memory and emotions. If I'm not mistaken, we have been seeing a growing epidemic of these very types of neurodevelopmental dysfunction in our children, ironically matching the growing vaccine schedule over the last 30 years.

Hepatitis B vaccine at birth strongly correlates with increased infant death rates

An article published on the ***Children's Health Defense*** website on April 23, 2019 titled, **Japan Leads the Way: No Vaccine Mandates and No MMR Vaccine = Healthier Children** shows the chart below, that lists the top 20 countries in the world with the best infant mortality rates (2017 data), and whether they administer the Hepatitis B vaccine at birth like we do in the U.S. As you can see, there are only 3 of the top 20 countries with the lowest infant mortality rates that do. The only reason that those countries do, is that they have high rates of Hepatitis B. Refer to the section earlier in this book showing that the countries with the lowest number of total vaccine doses given to infants and children, also have the lowest infant and under age 5 mortality rates.

https://childrenshealthdefense.org/news/vaccines/japan-leads-the-way-no-vaccine-mandates-and-no-mmr-vaccine-healthier-children/

***See the chart below**

Table 1. Hepatitis B Vaccine at Birth and Infant Mortality

RANK	COUNTRY	DEATHS PER 1,000 BIRTHS	YEAR	AUTOMATIC HepB VACCINE AT BIRTH	HepB AT BIRTH IF MOTHER IS HepB POSITIVE
56	**United States**	**5.8**	2017 EST.	**YES**	
20	BELGIUM	3.4	2017 EST.	NO	**YES**
19	AUSTRIA	3.4	2017 EST.	NO	**YES**
18	LUXEMBOURG	3.4	2017 EST.	NO	**YES**
17	ITALY	3.3	2017 EST.	NO	**YES**
16	ANGUILLA	3.3	2017 EST.	NO	**YES**
15	SPAIN	3.3	2017 EST.	NO	**YES**
13	FRANCE	3.2	2017 EST.	NO	**YES**
12	MACAU	3.1	2017 EST.	**YES***	
11	KOREA, SOUTH	3.0	2017 EST.	NO	**YES**
10	HONG KONG	2.7	2017 EST.	**YES***	
9	CZECHIA	2.6	2017 EST.	NO	**YES**
8	SWEDEN	2.6	2017 EST.	NO	**YES**
7	BERMUDA	2.5	2017 EST.	NO	**YES**
6	FINLAND	2.5	2017 EST.	NO	**YES**
5	NORWAY	2.5	2017 EST.	NO	NO
4	SINGAPORE	2.4	2017 EST.	**YES***	
3	ICELAND	2.1	2017 EST.	NO	NO
2	JAPAN	2.0	2017 EST.	NO	**YES**
1	MONACO	1.8	2017 EST.	NO	**YES**

***HIGHER INCIDENCE OF HEPATITIS B IN POPULATION**

Sources: Komatsu 2014; UNICEF Immunization Summary; Vaccination schedule recommended by the Japan Pediatric Society; Vaccine schedules in all countries of the European Union

Look at the abysmal infant mortality rate for the U.S., 56th in the world! The U.S. also has the highest rates of infant and under age 5 vaccination in the world. Is there a connection? You decide.

The Hepatitis B vaccine is not the only consideration when it comes to the association of vaccines and infant mortality. One also must consider the total number of vaccines given and the total number and "load" of vaccines with the deadly and neurotoxin aluminum. As mentioned previously, babies in the U.S. get 5,820 micrograms of aluminum from their vaccines by 18 months of age. In addition, Japan does not give pregnant women the TDaP or flu vaccines.

A 2008 article titled **Vaccine Excipients**, from the Japanese journal ***Nihon Rinsho, the Japanese Journal of Clinical Medicine,*** cited that the vaccines used in Japan are "highly purified". Could that be one of the reasons that Japan has been able to maintain a low infant mortality rate?

The abstract:
"Several substances other than antigens are included in vaccines. These are classified as follows: stabilizers, preservatives, buffer, adjuvants, antibiotics etc. Some of these substances, for example gelatin and thimerosal, have been removed from vaccines because of their undesirable side effects.

However, stability and sterility are very important conditions for vaccines. Therefore, removal of excipients from vaccines should be investigated very carefully. Impurities derived from culture substrates for bacteria and viruses should be reduced as much as possible. Japanese vaccines are highly purified. For example, influenza vaccines contain only a few ng/dose of OVA which are significantly lower than the WHO standards (5 microg/dose)."
https://www.ncbi.nlm.nih.gov/pubmed/?term=18939492

OVA stands for Ovalbumin, the major protein constituent of chicken egg whites. It is a glycoprotein that is sufficiently large and complex to be mildly immunogenic and is widely used as an antigen for immunization research. It sounds like the Japanese have allegedly attempted to lower the levels of some of the excipients in vaccines to reduce the potential for adverse reactions. If that is the case kudos to them! My research has not been able to find additional information corroborating this however.

As this information reveals, the policy on Hepatitis B vaccine for infants isn't the only reason for their low infant mortality rate. Some of these other factors are also likely involved. One must also take into consideration levels of environmental toxicity, nutrient values and levels in traditional diets, maternal prenatal care and levels of risk factors. No doubt, it is a complex issue.

Japan has gradually bent under pressure to "keep up with the Jones's" and catch up to other western countries with the numbers of vaccines on their schedule. They still recommend far less that in the U.S., but are slowly and hesitantly moving to add more. Japan now recommends 3 doses of the Hepatitis B vaccine starting at 2 months, 3 months and between 6 months and 1 year as "routine". Prior to that it was considered voluntary. That change became part of the schedule in October 2016. If the mother is Hep B positive, the infant would receive it at birth. The first Hep B shot at 2 months is better than on day 1, but not by much. It will be interesting to track Japan's Infant Mortality Rates in the future and see if there is a change in their ranking.

NEW - Hepatitis B Vaccine in adults foud to correlate with increased levels of autoimmune disease

A study published July 2009 the the journal ***Autoimmunity*** titled, **A case-control study of serious autoimmune adverse events following hepatitis B immunization**, found an increase in autoimmune related conditions in adults after receiving the Hepatitis B Vaccine.

Abstract

Hepatitis B infection is one of the most important causes of acute and chronic liver disease. During the 1980s, genetically engineered hepatitis B vaccines (HBVs) were introduced in the United States. A large-series of serious autoimmune conditions have been reported following HBVs, despite the fact that HBVs have been reported to be "generally well-tolerated." A case-control epidemiological study was conducted to evaluate serious autoimmune adverse events prospectively reported to the vaccine adverse events reporting system (VAERS) database following HBVs, in comparison to an age, sex, and vaccine year matched unexposed tetanus-containing vaccine (TCV) group for conditions that have been

previously identified on an *a priori* basis from case-reports. **Adults receiving HBV had significantly increased odds ratios (OR) for multiple sclerosis (OR = 5.2, *p* < 0.0003, 95% Confidence Interval (CI) = 1.9 ™ 20), optic neuritis (OR = 14, *p* < 0.0002, 95% CI = 2.3 – 560), vasculitis (OR = 2.6, *p* < 0.04, 95% CI = 1.03 ™ 8.7), arthritis (OR = 2.01, *p* < 0.0003, 95% CI = 1.3 – 3.1), alopecia (OR = 7.2, *p* < 0.0001, 95% CI = 3.2 – 20), lupus erythematosus (OR = 9.1, *p* < 0.0001, 95% CI = 2.3 – 76), rheumatoid arthritis (OR = 18, *p* < 0.0001, 95% CI = 3.1 – 740), and thrombocytopenia (OR = 2.3, *p* < 0.04, 95% CI = 1.02 – 6.2) in comparison to the TCV group.** Minimal confounding or systematic error was observed…. Adults should make an informed consent decision, weighing the risks and benefits of HBV, as to whether or not to be immunized.
https://www.tandfonline.com/doi/full/10.1080/08916930500144484?scroll=top&needAccess=true

The CDC calls for 3 Hepatitis B doses between birth and 18 months, but the makers of Pediarix (GlaxoSmithKline), says it's ok for them to have a 4th dose

Well that's just great. Another dose of aluminum and other components added to the CDC Schedule without the CDC actually adding it to their schedule. How does that work?

If you recall, Pediarix is a 5 vaccine in 1 shot combo vaccine for diphtheria, tetanus, pertussis, hepatitis B and poliomyelitis.

According to page 3 of the Pediarix package insert:
"**A 3-dose series of PEDIARIX may be administered to infants born of HBsAg-negative mothers and who received a dose of hepatitis B vaccine at or shortly after birth. However, data are limited regarding the safety of PEDIARIX in such infants [see Adverse Reactions (6.1)]."**

In this instance, one could add the additional estimated 250 mcg. of aluminum to the 5,825 mcg. babies already get in their first 18 months of life. That's just great. Children that follow that recommendation plus the CDC schedule are now getting 36 doses by 18 months, instead of 35. Awww, what's the difference? "It's only one more vaccine". Why not just pile more on!

So, I was curious about the adverse reaction section 6.1 that was mentioned after the recommendation that it was alright to administer a 3-dose series, after an infant had previously been given Hep B at or shortly after birth.

And this is what it said….
"**Safety of PEDIARIX after a Previous Dose of Hepatitis B Vaccine.**
Limited data are available on the safety of administering PEDIARIX after a previous dose of hepatitis B vaccine. In 2 separate studies, 160 Moldovan infants and 96 US infants, respectively, received 3 doses of PEDIARIX following 1 previous dose of hepatitis B vaccine. Neither study was designed to detect significant differences in rates of adverse events associated with PEDIARIX administered after a previous dose of hepatitis B vaccine compared with PEDIARIX administered without a previous dose of hepatitis B vaccine."

WHAT? Why do the study then? What were they looking for if not differences in adverse reactions? That makes no sense whatsoever. I hate to sound cynical, but is it possible that the data just got buried?

The Varicella (Chickenpox) Vaccine- Ineffective and poses other health risks

The chickenpox vaccine is not only ineffective, but results in a more severe manifestation for adults called shingles

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4363126/ This article from the ***Journal of Human and Experimental Toxicology*** titled, **Vaccination to prevent varicella: Goldman and King's response to Myers' interpretation of Varicella Active Surveillance Project data, states that not only is the chickenpox vaccine ineffective and inefficient, it also has contributed to the dramatic rise in adult shingles cases. It also suggests that since not as many children are contracting chickenpox which would provide lifelong immunity, the temporary immunity provided by the vaccine not only requires regular booster shots but allows the virus to remain dormant in the body until much later in life when it can manifest itself as herpes zoster or what's more commonly known as shingles. Shingles can be a very painful and debilitating condition especially in the elderly**.

From the study:

"…the protection provided by varicella vaccination is **neither lifelong nor complete**. **Moreover, dramatic increases in the incidence of adult shingles cases have been observed since HZ (herpes zoster), was added to the surveillance in 2000."**

"**Unfortunately, costs associated with increases in adult HZ far outweigh any medical and societal savings associated with varicella epidemiology**, especially considering the additional costs associated with (1) the adoption of the two-dose childhood varicella vaccination protocol, (2) the increased hospitalizations due to increased shingles recurrences, and (3) the necessary addition of a shingles vaccine to boost protection in adults who previously received natural exogenous boosts at no cost from children shedding VZV in the community."

And in conclusion: "When the costs of the booster dose for varicella and the increased shingles reoccurrences are included, the universal varicella vaccination program is neither effective nor cost-effective."

Oh, but of course now the pharmaceutical industry has cashed in on convincing people that they need the Shingles vaccine. A brilliant strategy. Sell them something that causes something else and then sell them that something else, for the sickness that the thing they sold you in the first place caused. Confused yet? Me too. It can make your head spin!

It is similar to the statin drugs given for high cholesterol. One of the common side effects in men is erectile dysfunction or E.D. But guess what? The same manufacturers of the statin drugs have an answer to that. Yes, E.D. drugs! A ready-made market and a "convenient" and available solution. Cha-ching! Just like the polypharmacy issue discussed earlier, the business of managing symptoms leads to the cyclical downward spiral of drug overuse.

Scientists find a correlation between persons that have had chickenpox and a lower risk of glioma (brain cancer)

The American Journal of Epidemiology published an article in 1997 titled, **Does prior infection with varicella-zoster virus influence risk of adult glioma? The article found that people that have had chickenpox have less than half the incidence of glioma**. Glioma's comprise about 30 percent of all brain tumors and 80 percent of all malignant brain tumors. https://www.ncbi.nlm.nih.gov/pubmed/9098175

From the abstract:
"To evaluate a possible association between varicella-zoster virus infection and glioma, the authors asked adults with glioma (n = 462) whose tumors were diagnosed between August 1, 1991, and March 31, 1994, and age-, sex-, and ethnicity-matched controls (n = 443) about their histories of **chickenpox or shingles. Cases were significantly less likely than controls to report a history of either chickenpox (odds ratio = 0.4, or shingles (odds ratio = 0.5**."

"This suggests that adults with glioma were less likely than controls either to have had prior varicella-zoster virus infection or to have an immunoglobulin G antibody response adequate to indicate positivity."

It has been shown that **people who are vaccinated against chickenpox, have a greater chance of developing shingles when they are older**. Because the immune response is much stronger to the natural infection and those people when older being exposure to children with the natural virus (effectively giving them a booster), the chances of a shingles outbreak go down dramatically. Vaccinating produces a milder response that doesn't last as long. **Plus the fact that children no longer carry the virus, prevents older people from getting that natural booster and preventing them from contracting the shingles.** The virus moves into the nerve bundles along the spine where is lays dormant, essentially hibernating and later manifests as shingles. This is when it is much more severe.

The United Kingdom does not include the Chicken Pox vaccine in their vaccination schedule because of the negative effects on the population as a whole

According to the ***U.K. National Health Service*** (NHS), **there are negative effects to vaccinating children that are significant enough to warrant eliminating the Chicken Pox vaccine from the NHS immunization schedule**. On their website, a page titled **Why aren't children in the UK vaccinated against chickenpox?,** details the reasons for that.
https://www.nhs.uk/chq/Pages/1032.aspx?CategoryID=62

From the site:

"The chickenpox vaccine is not part of the routine UK childhood vaccination programme because chickenpox is usually a mild illness, particularly in children.

There's also a worry that introducing chickenpox vaccination for all children could increase the risk of chickenpox and shingles in adults."

Chickenpox in adults

"In adults, chickenpox tends to be more severe and the risk of complications increases with age.

If a childhood chickenpox vaccination programme was introduced, people would not catch chickenpox as children because the infection would no longer circulate in areas where the majority of children had been vaccinated.

This would leave unvaccinated children susceptible to contracting chickenpox as adults, when they are more likely to get a more serious infection, or in pregnancy, where there is a risk of the infection harming the baby."

Shingles in adults

"We could also see a significant increase in cases of shingles in adults.

Being exposed to chickenpox as an adult – for example, through contact with infected children – boosts your immunity to shingles.

If you vaccinate children against chickenpox, you lose this natural boosting, so immunity in adults will drop and more shingles cases will occur."

The benefit of the Chickenpox vaccine is short lived and increases the risk of hospitalization (by 10-15 times) and death (by 20 times) in older people

Another important question I have touched on already is, how effective are vaccines at imparting long-term immunity? And what are the vaccine caused consequences of suppressing the body's ability of creating life-long immunity by contracting the illness as a child and delaying it until adulthood?

An article was published in the ***Journal Vaccine*** in 2012 titled, **Review of the United States universal varicella vaccination program: Herpes zoster incidence rates, cost-effectiveness, and vaccine efficacy**

based primarily on the Antelope Valley Varicella Active Surveillance Project data, cites the usually benign naturally acquired chickenpox providing long-tern immunity as superior to the temporary immunity of the vaccine variety, which they say has compromised the protection of the population afforded by the natural immunity. The authors claim this shifts the disease to an older population, which increases the risk of death by 20 times and hospitalization by 10-15 times. This article has 168 references. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3759842/pdf/main.pdf

Conclusion- "Prior to the universal varicella vaccination program, **95% of adults experienced natural chickenpox (usually as pre-school to early elementary school children)—**these cases were usually benign. In the prelicensure *(vaccine)* era, the periodic exogenous boosting that adults received from those shedding VZV resulted in long-term immunity. (*Meaning that adults who had previously contracted chicken pox were exposed to children with it, it would boost their natural immunity).* This high percentage of seropositive individuals and their long-term immunity **have been compromised by the universal varicella vaccination of children which provides at best 70–90% protection that is temporary and of unknown duration—shifting chickenpox to a more vulnerable adult population which**, as Dr. Jane Seward cautioned in 2007, **carries 20 times more risk of death and 10–15 times more risk of hospitalization compared to chickenpox in children**. Thus, the proponents for universal varicella vaccination have failed to consider increased HZ-related morbidity as well as the adverse effects of both the varicella and HZ vaccines which have more than offset **the limited benefits** associated with reductions in varicella disease. The universal varicella (chickenpox) vaccination program **now requires a booster vaccine for children and an HZ vaccine to boost protection in adults. However, these are less effective** than the natural immunity that existed in communities prior to licensure of the varicella vaccine. **Hence, rather than eliminating varicella in children as promised, routine vaccination against varicella has proven extremely costly and has created continual cycles of treatment and disease**."

The Chickenpox Vaccine damages true herd immunity and leads to more cases of the much more serious adult Chickenpox and Shingles

According to Tony Bark M.D. in an interview for the Movie ***Bought***, "When I was a resident in pediatrics I was told, "we'll never promote this vaccine, this vaccine will never be a recommended or mandated vaccine **because all vaccines come with risks and Chickenpox is so risk-free**."

"The problem with that vaccine is **there are many more deaths from the vaccine then we would have seen from Chickenpox because now what we've done is we've shifted the burden of disease from Chickenpox to shingles**."

"What a lot of doctors don't even understand is that Chickenpox, like pertussis, needs to be in the environment so we can be constantly exposed and the constant exposure maintains our antibodies which keeps us from getting Shingles. Which is why when I was a young kid the only people that got Shingles we're very old people because they weren't exposed to young children anymore."

"If you're out in the environment and you're exposed to the population at large and young people, you are exposed to Chickenpox, or you were exposed to Chickenpox and it kept your antibodies adequate to suppress Shingles from coming out."

In another interview from ***Bought***, ***Suzanne Humphries, M.D.*** a Board Certified Internal Medicine and Nephrologist said, "Most people know Chickenpox is a pretty benign entity, now we're vaccinated for Chickenpox and, "hey, the vaccines working, we're not seeing as much Chickenpox" right, so that seems like a good thing."

"However, what we're seeing more of now is Shingles because those us adults who need to be exposed to ongoing Chickenpox through children, aren't. So, we're not getting those natural boosters and so what happens is our immunity level starts to drop. This is happening both in children and adults now."

"I don't think this is an overall benefit. The UK is not using that vaccine, they have looked into the danger of Chickenpox and the cost-effectiveness of vaccinating the entire population and they have decided not to implement that in their vaccine schedule."

"**There are other countries as well who have decided not to use the Chickenpox vaccine. United States is one of the most heavily vaccinated countries. South Korea comes close and our childhood chronic disease rates are actually also among the highest**."
http://www.boughtmovie.com/bought-movie-bonus-short-chickenpox/

In case you think I am not concerned about vulnerable and weak children and individuals, you are wrong. The truth is that most of the diseases we immunize for that are still in existence even in societies with better sanitation, nutrition, hygiene and living conditions are only dangerous to those with impaired immune systems. If proper diet, nutritional supplementation and lifestyle management was employed for all persons, including children and especially at-risk individuals, many of them would either never contract these diseases, or would easily be able to fight it and beat it in short order (leaving them with life-long immunity). Therefore, in the long run they would be better off immunologically for it. I believe in conveyance of lifelong immunity from contracting the wild viral strains of these infectious diseases and the natural booster effect in the population from later being around children with the infection, who are establishing their own immune competency as a result. You can find my strategies at the end of this document for building and maintaining a strong and healthy immune system.

Shingles vaccine not any better

Zostavax shingles vaccine, can cause shingles, loss of vision, and many other adverse side effects and has been found to be very ineffective

http://info.cmsri.org/the-driven-researcher-blog/merck-admits-shingles-vaccine-can-cause-eye-damage-and-shingles

The **Children's Medical Safety Research Institute** **(CMSRI)** is the source of this article. They are a medical and scientific collaborative established to provide research funding for independent studies on causal factors underlying the chronic disease and disability epidemic.

From the article: "**Two important FDA approved changes to the warning label of Merck Pharmaceutical's shingles vaccine, Zostavax**, have been made since the controversial drug was introduced in 2006. The first was in August 2014, when, **in addition to potentially causing chickenpox, another side effect was added: shingles! That's right. The vaccine that had been – and continues to be -- aggressively marketed to prevent seniors from contracting this excruciating condition was found to actually cause shingles in some individuals**."

"In February of this year, the FDA approved a label change **to warn those who prescribe the Zostavax vaccine of another potential side effect: "Eye Disorders: necrotizing retinitis**.""

"This disorder, as well as keratitis, causes inflammation and scarring of the eye tissue and **can lead to permanent vision loss** if not treated quickly. It was reported by WebMD 20 individuals (children and adults) developed keratitis within a month of receiving a chickenpox or shingles vaccine. Keratitis symptoms for adults developed within 24 days of vaccination, while symptoms in children began within 14 days of vaccination."

Zostavax is extremely INNEFFECTIVE according to a UCLA Study

"According to the authors of a Health Sciences Institute (HSI) article in January 2016, "UCLA researchers found that **only one in 175 people who get the vaccine will be able to dodge a shingles flare-up.**" **While Merck claims Zostavax is 50% effective, in the placebo group, 3.3 percent of the study participants developed shingles, compared to 1.6 percent in the vaccine group. So, while that is a 50% difference, the real, absolute risk reduction is just 1.7 percentage points**."

In fact, there are law firms representing people that have been damaged by Zostavax that have launched class action lawsuits to help them recover damages.

The MMR vaccine- Tainted research and increased risk of developmental problems including autism

In addition to what you are about to read (and there's a lot!), there are numerous examples of problems posed by the MMR vaccine contained in many studies throughout this document. This 3-vaccine combo has so much riding on it for the vaccine industry and the CDC as you will see. It has become second only to the polio vaccine as the holy grail of the vaccination "religion". Well, I am about to blow that perception right up. They have gone all-in to make this their shining example of "safety and

effectiveness", even to the extent of ruining careers and lying to cover up results of studies showing the relationship with the MMR and autism. Is the MMR the sole cause for the dramatic increases in autism? I don't believe it is the sole cause, but at the point where mercury was being phased out of most vaccines, vaccines like the MMR which include human fetal DNA fragments, neuroexcitatory agents, antibiotics with questionable safety profiles and recombinant human albumin were on the rise.

On page 590, I have included an article that I wrote titled **The Measles Vaccine Narrative is Collapsing**. It will provide you with the 5 main pro-measles and measles vaccine talking points repeated ad nauseum in the pharma-controlled media. Then I will dismantle their assertions one by one, using contemporary published peer-reviewed science, U.S. Government historical facts and even information from the CDC itself.

Other relevant MMR articles related to this section are presented on pages 340-346 and 357-359 among many others. I recommend that you re-visit those sections after viewing this one.

The MMR Cover-up and Scandal

Former Chief Scientific Officer fears the MMR vaccine causes serious risk of brain damage and implicates a cover-up by "powerful" people

http://www.dailymail.co.uk/health/article-376203/Former-science-chief-MMR-fears-coming-true.html
This article from ***The Daily Mail***, titled **Former science chief: 'MMR fears coming true'** features ***Dr. Peter Fletcher***, **the former Chief Scientific Officer at the *Department of Health* in Great Britain**. **Dr. Fletcher also served as the Medical Assessor to the Committee on Safety of Medicines, meaning he was responsible for deciding if new vaccines were safe.**

According to Dr. Fletcher, "the refusal by governments to evaluate the risks properly will make this one of the greatest scandals in medical history". He added that after agreeing to be an expert witness on drug-safety trials for parents' lawyers, he had received and studied thousands of documents relating to the case which he believed the public had a right to see. **He said he has seen a "steady accumulation of evidence" from scientists worldwide that the measles, mumps and rubella jab is causing brain damage in certain children. But he added: "There are very powerful people in positions of great authority in Britain and elsewhere who have staked their reputations and careers on the safety of MMR and they are willing to do almost anything to protect themselves**."

He first expressed concerns about MMR in 2001, saying safety trials before the vaccine's introduction in Britain were inadequate. **Now he says the theoretical fears he raised appear to be becoming reality. He said the rising tide of autism cases and growing scientific understanding of autism-related bowel disease have convinced him the MMR vaccine may be to blame. "Clinical and scientific data is steadily accumulating that the live measles virus in MMR can cause brain, gut and immune system damage in a subset of vulnerable children," he said.**

"**But it is the steady accumulation of evidence, from a number of respected universities, teaching hospitals and laboratories around the world, that matters here. There's far too much to ignore. Yet government health authorities are, it seems, more than happy to do so.**"

'**Dr Fletcher said he found "this official complacency utterly inexplicable" in the light of an explosive worldwide increase in regressive autism and inflammatory bowel disease in children, which was first linked to the live measles virus in the MMR jab by clinical researcher Dr Andrew Wakefield in 1998.** "**When scientists first raised fears of a possible link between mad cow disease and an apparently new, variant form of CJD they had detected in just 20 or 30 patients, everybody panicked and millions of cows were slaughtered," said Dr Fletcher. "Yet there has been a tenfold increase in autism and related forms of brain damage over the past 15 years, roughly coinciding with MMR's introduction, and an extremely worrying increase in childhood inflammatory bowel diseases and immune disorders such as diabetes, and no one in authority will even admit it's happening, let alone try to investigate the causes. "He said there was "no way" the tenfold leap in autistic children could be the result of better recognition and definitional changes, as claimed by health authorities**. "It is highly likely that at least part of this increase is a vaccine related problem." he said. "But whatever it is, why isn't the Government taking this massive public health problem more seriously?"

The Bombshell Revelation, that scientists at the CDC falsified data on the MMR trials to cover up an association between the MMR vaccine and autism.

I mentioned Dr. William Thompson in the previous section. Dr. Thompson was a senior scientist and researcher with the CDC and involved with Dr. Frank DeStefano (also just mentioned), as co-authors of the now infamous study by the CDC seemingly "proving" a lack of connection between the MMR vaccine and autism. The 2004 study was titled, **MMR vaccine and autism: an update of the scientific evidence**, and published in ***Expert Review of Vaccines***. **This seminal study attempting to finally put the question about the connection between autism and the MMR shot to rest, has been rocked by allegations from Dr. Thompson that the he and the researchers had "cooked the books". To Dr. Thompson's credit, after 13 years his conscience finally got the best of him. Dr. Thompson has admitted that the researchers had changed criteria and the methods of the study in order to skew the results. He said they also collaborated to destroy documents to hide the evidence, that showed when the MMR shots were given to African American boys given the vaccine before 36 months, on the vaccine timetable, they had a 250% greater risk of developing autism. According to Dr. Thompson, in 2002 they brought in large trash cans and required all of the researchers to bring the data they were holding showing the association with the increase in autism and throw them into the cans for destruction**.

Fortunately, Dr. Thompson felt uneasy about the fraud and kept copies of the original documents, which he has turned over the Brian Hooker, an investigative reporter.

The following is from an article about Dr. Thompson and his revelations published on the web site of an organization named ***A Choice for Choice***. Their mission statement states: A Voice for Choice promotes

people's rights to make fully informed choices and know the composition, quality and short and long-term health effects of food and pharmaceutical products. http://avoiceforchoice.org/cdcwhistleblower/

"Dr. William Thompson stated:
"I regret that my coauthors and I omitted statistically significant information in our 2004 article published in the journal Pediatrics. The omitted data suggested that African American males who received the MMR vaccine before age 36 months were at increased risk for autism. Decisions were made regarding which findings to report after the data were collected, and I believe that the final study protocol was not followed."

"My concern has been the decision to omit relevant findings in a particular study for a particular sub group for a particular vaccine. There have always been recognized risks for vaccination and I believe itis the responsibility of the CDC to properly convey the risks associated with receipt of those vaccines."

"**Dr. William Thompson is an author of two of the three epidemiological studies…touted by the CDC to "prove" the safety of Thimerosal. He is also coauthor of the the CDC's…2004 [DeStefano] study…which dismissed the link between the MMR vaccine and autism. That study has been cited in 91 subsequent published studies, and is one of the principal cornerstones for claims by the CDC and the vaccine industry that vaccines do not cause autism. Thompson now confesses that he and his fellow CDC researchers found a strong autism signal in children who received the MMR vaccine before their third birthday…Under orders from their bosses…the scientists eliminated this data from the final published study." (Vaccine Whistleblower – Exposing Autism Research Fraud at the CDC, by Kevin Barry, Esq., with a Foreword by Robert F. Kennedy, Jr., JD, LLM, xiv)**

"In calls with Dr. Brian Hooker, Dr. William Thompson admits to the widespread fraud at the CDC. **The full transcripts of the conversations between Dr. Brian Hooker and Dr. William Thompson can be read in the** Vaccine Whistleblower – Exposing Autism Research Fraud at the CDC, by ***Kevin Barry, Esq***., with a Foreword by ***Robert F. Kennedy, Jr., JD, LLM***."

"**The CDC claims to be an 'independent' watchdog, but by definition, it is a private corporation working on behalf of its stakeholders, which include key players in the pharmaceutical and vaccine industries that profit from the spread of disease, not from real prevention and cures. The CDC and pharmaceutical companies are marketing medications, including vaccines, for profit over people's health**."

A re-analysis of the same data that the lead scientist preserved after being ordered to destroy it, reveals the increased rates of autism shown in the original study before it was allegedly "altered"

A 2014 study published the Journal ***Translational Neurodegeneration*** titled, **Measles-mumps-rubella vaccination timing and autism among young African American boys: a reanalysis of CDC data**, reveals the data that caused the alleged whitewash in the previous section.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4150057/

From the Abstract:
Background:
"A significant number of children diagnosed with autism spectrum disorder suffer a loss of previously-acquired skills, suggesting neurodegeneration or a type of progressive encephalopathy with an etiological basis occurring after birth. **The purpose of this study is to investigate the effect of the age at which children got their first Measles-Mumps-Rubella (MMR) vaccine on autism incidence. This is a reanalysis of the data set, obtained from the U.S. Centers for Disease Control and Protection (CDC), used for the Destefano et al. 2004 publication on the timing of the first MMR vaccine and autism diagnoses**."

Methods:
"The author embarked on the present study to evaluate whether a relationship exists between child age when the first MMR vaccine was administered among cases diagnosed with autism and controls born between 1986 through 1993 among school children in metropolitan Atlanta. The Pearson' s chi-squared method was used to assess relative risks of receiving an autism diagnosis within the total cohort as well as among different race and gender categories."

Results:
"**When comparing cases and controls receiving their first MMR vaccine before and after 36 months of age, there was a statistically significant increase in autism cases specifically among African American males who received the first MMR prior to 36 months of age. Relative risks for males in general and African American males were 1.69 (p=0.0138) and 3.36 (p=0.0019), respectively. Additionally, African American males showed an odds ratio of 1.73 (p=0.0200) for autism cases in children receiving their first MMR vaccine prior to 24 months of age versus 24 months of age and thereafter**."

From the study body:
"MMR vaccine before and after 18 months, 24 months and 36 months of age. Destefano et al. [14] found a statistically significant relative risk of 1.49 (95% confidence interval [CI]: 1.04 – 2.14) at the 36 month cut- off (i.e., in a comparison of children receiving the MMR before versus after 36 months). **Rather than concluding that the first MMR vaccine could be playing a causal role in autism in these children, the study authors instead attributed the increased risk to greater numbers of autistic children receiving timely vaccinations in order to participate in State of Georgia special education services**."

"In this paper, we present the results of a cohort study using the same data from the Destefano et al. [14] analysis. The focus of the current study is differences in results in specific gender and race groups.

Conclusions:
"**The present study provides new evidence of a statistically significant relationship between the timing of the first MMR vaccine and autism incidence in African American males. Using a straight-forward, Pearson's chi-squared analysis on the cohort used in the Destefano et al. [14] (CDC) study, timing of**

the first MMR vaccine before and after 24 months of age and 36 months of age showed relative risks for autism diagnoses of 1.73 and 3.36, respectively."

Brian Hooker is the author of this article and is also the person that William Thompson, the lead researcher on that infamous MMR study, contacted to disclose the CDC cover-up. Brian Hooker is a researcher and was able to re-analyze the data from the original dataset that Dr. Thompson provided him.

Interestingly, this article has since been retracted by the publisher.
The statement by the publisher: "The Publisher of this article [1] has serious concerns about the validity of its conclusions because of possible undeclared competing interests of the author and peer reviewers. The matter is undergoing investigation. In the meantime, readers are advised to treat the reported conclusions of this study with caution. Further action will be taken, if appropriate, once our investigation is complete."

Since this seems to be another is a string of retracted articles questioning the safety and efficacy of vaccines in the last couple years, one has to wonder if there is not a concerted effort to silence any opposing viewpoints. We'll have to see if the trend continues.

MMR Vaccine licensing called into question after a Freedom of Information Act Request (FOIA) reveals weaknesses in the clinical trials

Freedom of Information Act requests are the latest ways to obtain information related to vaccine safety and oversight and appear to be highly effective in producing documentation that has previously been kept hidden from the public.

According to Del Bigtree, the Informed Consent Action Network (ICAN) founder and host of the weekly fact-based medical news show "The HighWire… "It's alarming that an appeal was required to get this information, but it's more alarming that every time ICAN prevails in obtaining a FOIA disclosure from the FDA, CDC or HHS, we learn about another serious shortcoming in their duties to assure Americans' health and health care."

The MMR vaccine is at the heart of the vaccine debate. **The following are some of the key facts learned from the clinical trial reports produced by the FDA, which the agency relied upon to license the MMR:**

- There were eight clinical trials that in total had **less than 1,000 individuals, out of which only 342 children received the MMR vaccine**
- The safety review period **only tracked 'adverse events' for 42 days after injection**
- **More than half or a significant percent of all participants in each of the eight trials developed gastrointestinal symptoms and upper respiratory infections**
- **All adverse events** were generically described as 'other viruses' **and not considered** in safety profile of licensure

- **The control group received other vaccines for either rubella or measles and rubella, and none of the controls received a placebo (an inert substance such as a saline injection)**

Bigtree, an Emmy-Award winning producer, and director of the documentary "Vaxxed: From Coverup to Catastrophe," says the reason for increased vaccine hesitancy is not unreasonable fear, but a growth in awareness of the corruption, secrecy and obvious overt propaganda surrounding vaccines and the pharmaceutical industry. https://finance.yahoo.com/news/mmr-vaccine-licensing-called-following-131500482.html

***In addition to the last 4 pages, revisit pages 342-346 and 358-361 for more information on tainted research and conflicts of interest on the MMR Vaccine**

The MMR vaccine connected with numerous health related issues

This next article that was highlighted in the section on autoimmunity and is worth revisiting here:

Study finds a strong association between the measles component of the MMR and antibody reaction resulting in central nervous system autoimmunity

This study published in the ***Journal of Biomedical Sciences*** in 2002 titled, **Abnormal measles-mumps-rubella antibodies and CNS autoimmunity in children with autism**, describes a statistically significant correlation between laboratory findings of an unusual MMR antibody specific only to the measles component of the vaccine in 60% of autistic children and none of the controls (non-autistic children). https://www.ncbi.nlm.nih.gov/pubmed/12145534

The abstract:
"Autoimmunity to the central nervous system (CNS), especially to myelin basic protein (MBP), may play a causal role in autism, a neurodevelopmental disorder. Because many autistic children harbor elevated levels of measles antibodies, we conducted a serological study of measles-mumps-rubella (MMR) and MBP autoantibodies. Using serum samples of 125 autistic children and 92 control children, antibodies were assayed by ELISA or immunoblotting methods. ELISA analysis showed a significant increase in the level of MMR antibodies in autistic children. Immunoblotting analysis revealed the presence of an unusual MMR antibody in 75 of 125 (60%) autistic sera but not in control sera. This antibody specifically detected a protein of 73-75 kD of MMR. This protein band, as analyzed with monoclonal antibodies, was immunopositive for measles hemagglutinin (HA) protein but not for measles nucleoprotein and rubella or mumps viral proteins. Thus the MMR antibody in autistic sera detected measles HA protein, which is unique to the measles subunit of the vaccine. Furthermore, over 90% of MMR antibody-positive autistic sera were also positive for MBP autoantibodies, **suggesting a strong association between MMR and CNS autoimmunity in autism**. Stemming from this evidence, we suggest that **an inappropriate antibody**

response to MMR, specifically the measles component thereof, might be related to pathogenesis of autism."

Primate study concludes that vaccines can significantly alter brain volume and influence behavior including abnormal social interaction and absence of facial and body expression

A 2010 study from the journal ***ACTA Neurobiologiae Experimentalis*** titled, **Influence of pediatric vaccines on amygdala growth and opioid ligand binding in rhesus macaque infants: A Pilot Study**, finds some very disturbing brain alterations in primate infants following the MMR, DTaP and Hib vaccine schedule. https://www.ncbi.nlm.nih.gov/pubmed/?term=20628439

From the abstract:
"These results suggest that maturational changes in amygdala volume and the binding capacity of DPN in the amygdala **was significantly altered in infant macaques receiving the vaccine schedule**. **The macaque infant is a relevant animal model in which to investigate specific environmental exposures and structural/functional neuroimaging during neurodevelopment**."

From the article:
"When neonatal macaques received lesions to the amygdala they **showed increasing socio-emotional disturbances including abnormal social interaction, absence of facial and body expression, and stereotypic behaviors**."

"**These results raise the possibility that multiple vaccine exposures during the previous 3-4 months may have had a significant impact on brain growth and development. However, for the amygdala, volumetric and DPN binding differences between groups appeared to be a function of more recent vaccine exposures, the primary MMR vaccine and the DTaP and Hib boosters given between T1 and T2."** *(T1 stands for Time 1, which correlates with 4 months of age. T2 stands for Time 2, which stands for 6 months of age). "*The functional observations on the differential avidity of the amygdala for DPN after vaccine exposure are novel and require further study. **Interestingly, a rapid increase in total brain volume between 6 and 14 months is generally considered to be a consistent finding for many children with an Autism Spectrum Disorder (ASD)**…"

"In the present study, amygdala volumes were significantly increased in the vaccine exposed animals relative to the unexposed animals at T2."

"The data suggest that vaccine exposure may be associated with significant disturbances in central opioidergic pathways in this model."

This study shows obvious and significant changes in brain morphology and behavioral function and as they say, is interestingly similar to those found in Autism Spectrum Disorder.

Japan banned the MMR shortly after it was introduced due to high rates of complications

According to an article posted on the Daily Mail website titled, Why Japan banned MMR Vaccine, the complications far exceeded the projected rates of adverse reactions.

From the article:
"Government health chiefs claim a four-year experiment with it has had serious financial and human costs."

"Of the 3,969 medical compensation claims relating to vaccines in the last 30 years, a quarter had been made by those badly affected by the combined measles, mumps and rubella vaccine, they say."

"The triple jab was banned in Japan in 1993 after 1.8 million children had been given two types of MMR and a record number developed non-viral meningitis and other adverse reactions."

"Official figures show there were three deaths while eight children were left with permanent handicaps ranging from damaged hearing and blindness to loss of control of limbs.

"The British Department of Health said Japan had used a type of MMR which included a strain of mumps vaccine that had particular problems and was discontinued in the UK because of safety concerns.
The Japanese government realised there was a problem with MMR soon after its introduction in April 1989 when vaccination was compulsory. Parents who refused had to pay a small fine."
"An analysis of vaccinations over a three-month period showed one in every 900 children was experiencing problems. This was over 2,000 times higher than the expected rate of one child in every 100,000 to 200,000."

"The ministry switched to another MMR vaccine in October 1991 but the incidence was still high with one in 1,755 children affected. No separate record has been kept of claims involving autism."

Japan Leads the Way: No Vaccine Mandates and No MMR Vaccine = Healthier Children

In another related story, this is the headline of an April 23, 2019 article on the ***Children's Health Defense*** website. It contrasts the abysmal infant mortality and under age 5 mortality rates of the U.S. with Japan's, which are rated among the best in the world.
https://childrenshealthdefense.org/news/vaccines/japan-leads-the-way-no-vaccine-mandates-and-no-mmr-vaccine-healthier-children/

From the article:
"The U.S. has the very highest infant mortality rate of all industrialized countries, with more American children dying at birth and in their first year than in any other comparable nation—and more than half of those who survive develop at least one chronic illness."

"American children would be better served if these officials—before imposing questionable and draconian measures—studied child health outcomes in Japan. With a population of 127 million, Japan has the healthiest children and the very highest "healthy life expectancy" in the world—and the least vaccinated children of any developed country. The U.S., in contrast, has the developed world's most aggressive vaccination schedule in number and timing, starting at pregnancy, at birth and in the first two years of life. Does this make U.S. children healthier? The clear answer is no. The U.S. has the very highest infant mortality rate of all industrialized countries, with more American children dying at birth and in their first year than in any other comparable nation—and more than half of those who survive develop at least one chronic illness. Analysis of real-world infant mortality and health results shows that U.S. vaccine policy does not add up to a win for American children."

"In 1994, Japan transitioned away from mandated vaccination in public health centers to voluntary vaccination in doctors' offices, guided by "the concept that it is better that vaccinations are performed by children's family doctors who are familiar with their health conditions." The country created two categories of non-compulsory vaccines: "routine" vaccines that the government covers and "strongly recommends" but does not mandate, and additional "voluntary" vaccines, generally paid for out-of-pocket. Unlike in the U.S., Japan has no vaccine requirements for children entering preschool or elementary school."

"Here are key differences between the Japanese and U.S. vaccine programs:

- Japan has *no* vaccine mandates, instead recommending vaccines that (as discussed above) are either "routine" (covered by insurance) or "voluntary" (self-pay).
- Japan does *not* vaccinate newborns with the hepatitis B (HepB) vaccine, unless the mother is hepatitis B positive.
- Japan does *not* vaccinate pregnant mothers with the tetanus-diphtheria-acellular pertussis (Tdap) vaccine.
- Japan does *not* give flu shots to pregnant mothers or to six-month-old infants.
- Japan does *not* give the MMR vaccine, instead recommending an MR vaccine.
- Japan does *not* require the human papillomavirus (HPV) vaccine."

"Unlike Japan, the U.S. administers flu and Tdap vaccines to pregnant women (during any trimester) and babies receive flu shots at six months of age, continuing every single year thereafter. Manufacturers have never tested the safety of flu shots administered during pregnancy, and the FDA has never formally licensed any vaccines "specifically for use during pregnancy to protect the infant."
This clearly shows that vaccine mandates are not only unnecessary but will lead to a further degradation of our life and health expectancies of not only our children, but our population as a whole."

"Japan initially recommended the HPV vaccine but stopped doing so in 2013 after serious health problems prompted numerous lawsuits. Japanese researchers have since confirmed a temporal

relationship between HPV vaccination and recipients' development of symptoms. U.S. regulators have ignored these and similar reports and not only continue to aggressively promote and even mandate the formerly optional HPV vaccine beginning in preadolescence but are now pushing it in adulthood. The Merck-manufactured HPV vaccine received fast-tracked approval from the FDA despite half of all clinical trial subjects reporting serious medical conditions within seven months."

NEW – Passive reporting systems are wholey inadequate and active systems are needed

An Italian study last updated December 3rd, 2020 and published in the journal ***F1000 Research*** titled, **Adverse events following measles-mumps-rubella-varicella vaccine: an independent perspective on Italian pharmacovigilance data**, reveals an unbelievable disparity between passive and active vaccine adverse event reporting systems. It also shows how high the rates of serious adverse reaction really are after MMRV vaccination in children.

From the study
Vaccine surveillance programs are crucial for the analysis of the vaccine's safety profile and the guidance of health policies. The Epidemiological Observatory of the Italian Apulia Region carried out an **active** surveillance program of adverse effects following immunization (AEFI) after the first dose of the measles-mumps-rubella-varicella (MMRV) vaccine, finding 462 AEFIs per 1000 doses, with 11% rated serious. Applying the World Health Organization (WHO) causality assessment algorithm, **38 serious AEFIs/1000** enrolled were classified as 'consistent causal associations' with MMRV immunization. Severe hyperpyrexia, neurological symptoms and gastrointestinal diseases occurred in 38, 20 and 15 cases/1000 enrolled, respectively. A projection of such AEFIs in an Italian birth cohort would give tens of thousands of serious AEFIs.

Among the AEFIs reported, 883 (89.0%) were not serious, while 109 (11.0%) were rated as serious according to the WHO Guidelines15. Events are classified as serious when they result in death, are life-threatening, require in-patient hospitalization or prolongation of existing hospitalization, cause persistent or significant disability/incapacity, are a congenital anomaly/birth defect, or require intervention to prevent permanent impairment or damage.

In a previous epidemiological study in the same Italian Region, during an eight year **passive** surveillance, **the reporting rate of serious AEFI was 0.06/1000 doses**, and no cases of febrile seizures were detected applying the WHO algorithm. Taken together, the data suggest that passive pharmacovigilance is utterly inadequate to document the real incidence of serious AEFIs and that current methods of assessing causality may be questioned

https://pubmed.ncbi.nlm.nih.gov/33335717/

The shocking bottom line: Assuming all confounding factors are equal, my estimation would be that passive reporting only captures 0.16 percent of serious adverse events as compared to active surveillance reporting in that region of Italy. If my math is correct, that would mean only 1.6 out of every 1,000 serious reactions are reported in that region. These results cannot be extrapolated to the United

States or all areas of all countries, but it underscores in a powerful way how inadequate passive reporting systems like the **Vaccine Adverse Event Reporting System (VAERS)** is in the U.S.

NEW - High rates of adverse reactions from the MMR vaccine in children with underlying neurological disease

A 2020 study published in the journal ***Vaccine*** titled, **Effects of measles-containing vaccination in children with severe underlying neurologic disease**, seemed to come to a different conclusion than I did.

From the abstract
Patients and methods: Measles-containing vaccine was offered to unvaccinated children with severe neurologic diseases during a measles outbreak. Vaccination adverse events were reported by parents 30 days following vaccination. Long term effects were evaluated 12 months post vaccination.

Results: Twenty-seven children were vaccinated (36 doses given). Half of parents (51.8%) reported no adverse events following immunization. Adverse events included afebrile seizures (6/36), fever alone (5/36) and febrile seizures (5/36). Two children required hospitalization. Quadrivalent measles-containing vaccine combined with varicella was associated with febrile seizures (p = 0.04). No child needed adjustment of the anti-epileptic treatment or exhibited developmental regression.

Conclusion: In a series of children with prior severe neurologic disease, the safety-tolerability profile of vaccines containing a measles vaccine component suggests that vaccination is justified. Main side effect was seizure aggravation in children with known epileptic disease.

https://pubmed.ncbi.nlm.nih.gov/33280857/

My comments:
First and foremost, coming from the perspective of someone that has done extensive literature review and has witnessed the evidence of the risks of neurological damage from vaccines in children that are predisposed due to genetic polymorphisms (defects). So, to me the thought of vaccinating children that are already neurologically impaired sounds reckless and irresponsible.

Secondly, the way they state “Half of parents (51.8%) reported no adverse events following immunization”, is an obvious way to make the high rates of adverse reactions sound better than the converse…”half of parents reported adverse events following immunization”. A 48.2% rate of adverse events is horrible, especially when many doctors still tell parents that adverse reactions are “one in a million.”

Measles hysteria, another example of irrational fear mongering

Statistical manipulation is one of the most deceitful methods the vaccine/medical industry's tactics for misleading the public

The big lie about 1 death in 1,000 measle cases.

We are hearing all over the media that the death rate for measles is 1 in 1,000 cases, So what's the lie by omission and the truth according to the CDC's own statistics?

In 1962 BEFORE the vaccine was introduced, there were just over 400,000 measles cases REPORTED annually and about 400 deaths due to complications of the measles. That equates to about 1 death in 1,000 REPORTED cases. Yet, the CDC says that there may have been as many as 4 million cases annually. That equates to 1 death in 10,000 cases. Therefore, the word omitted by design in media stories in order to spread public fear, is the word REPORTED.

So, what's the big deal?

A 1,000 percent difference! That is a BIG deal! If the media were to tell you that 10,000 children came down with the measles and we later found out that it was only 1,000, wouldn't that be considered a significant exaggeration? My point is that when a statistic is repeated over and over as a fact and an incredibly significant word is omitted to increase the fear factor and gin up a level of hysteria, it is not only disingenuous, it is a sure indication of the corrupt nature of the whole agenda.

Cases that are REPORTED are typically the ones where medical intervention is required. They are the worst of the worst. To understand the context, one must understand that in the 1950's and 1960's EVERY child got measles. There was on average, over 4 million children born annually. Therefore, I would contend that there must have been over 4 million cases annually in the late 1950's and early 1960's. In fact, the CDC's website even admits that prior to the introduction of the vaccine there were 3-4 million cases of measles annually. (https://www.cdc.gov/vaccines/pubs/pinkbook/meas.html). I still contend that based on population statistics of births, it was at least 4 million.

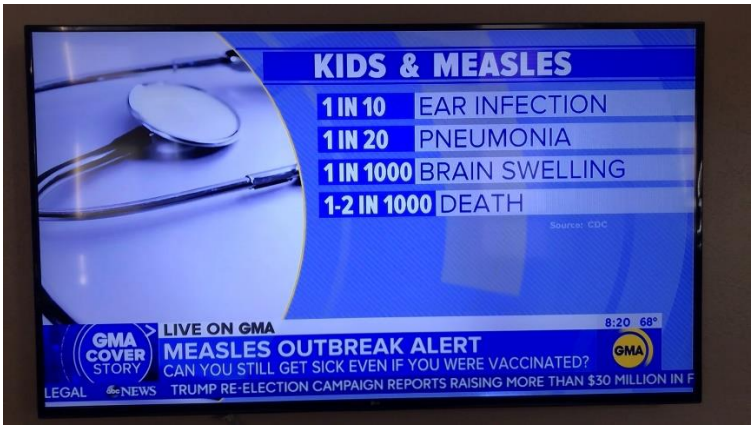
Why weren't cases often reported?

If you are a younger person, ask your parents or grandparents about the measles. They will tell you that measles was no big deal, and everyone got them. As a result of their benign nature, 90% of kids with measles just stayed home from school for a few days and never went to the doctor. That's why 90% of those cases were never REPORTED cases! Hence the big deception in the "1 in 1,000" death reports. They "forgot" to tell you it was 1 in 1,000 REPORTED cases.

Another consideration with the way serious complications and death statistics are reported is, where do the statistics they are reporting come from geographically? Where is measles the deadliest? The answer: In third-world countries where children suffer from severe malnutrition, terrible sanitation and waste management, contaminated water supplies, etc. Where their immune systems are incredibly weak and fragile. That certainly is NOT the case here in the U.S. So, I wonder are they citing that 1 in 1,000 statistic

as the death rate in these impoverished nations and therefore intentionally misleading the American public? Are they using the worst of the worst and implying that the death rate would be that here, to build support for their mass immunization campaigns in the U.S.? That is just another example of another possible way to lie by stats.

This is a screen shot of the report on Good Morning America by Dr. Jennifer Ashton, their medical correspondent, on April 15th, 2019.



Her reading of these stats clearly indicated the worst. She said, "One to two in 1,000 children will die of measles." "…2017, over 100,000 people worldwide died of measles. We take this seriously." Are these 1962 stats and you are conveniently leaving out the "of REPORTED cases"? Or, are these third-world country stats of 1 in 1,000 total cases and applying them to the cases here in the U.S. in order to spread fear? And thirdly, who is the "we" Dr, Ashton? If you are referring to the we as being the World Health Organization and its efforts in third-world impoverished nations, that's great and I get it. It the "we" is you doctors here is the U.S. and your "heroic effort" to save us from measles, you are misleading the public and WAYYYY overstating any need for your intervention and your arrogant agenda driven coercion of the masses. History will judge your flawed paradigm and your indifference towards the toxicity and health problems caused by the vaccines you promote, especially in genetically susceptible individuals. In fact, history already has judged you. It's just that people like you are suppressing the truth with the power of media dollars and censorship of information. But in the end, the facts will come to light and the Truth Will Prevail!

The historical reality that no one seems to ever mention in the media, is that **according to US Vital Statistics reports over the course of the 20th century, measles deaths had declined by 99.4% BEFORE the vaccine was ever introduced**. But we all know if we listen to media reports at all, vaccines get all the credit. It wasn't advances in nutrition, sanitation and waste disposal, access to clean water, personal hygiene education, public health measures, and Vitamin fortification of foods. Thank God for the vaccine industry because they saved us! LOL

What about measles benefits? Why is that never mentioned?

When every child got the measles, that infection imparted a natural LIFE-LONG immunity which was boosted when aging adults were exposed to children that had the measles. That is an example of true herd immunity. Because mothers had acquired wild measles when they were children, they had sufficient antibodies passed on to their babies that would protect them during the first few months of

their lives. That is when they are most susceptible to complications. Vaccination has damaged this natural protective effect, putting newborns at higher risk of complications if they were to contract the measles. According to the CDC, the vaccine is not safe to be administered before about 12 months. And now, research is showing that measles and other childhood illnesses may protect us from cancer and other serious diseases as we age. More and more studies are emerging in recent years that suggest a link between naturally acquired measles infection and a reduced risk of Hodgkin's and non-Hodgkin's lymphomas, a reduced risk of atopic diseases such as hay fever, eczema and asthma and a lower risk of mortality from cardiovascular disease in adulthood.

Interestingly, the use of the measles virus to attack and destroy cancer is getting attention. Mayo Clinic Researchers as reported in Mayo Clinic Proceedings, used the measles virus as "virotherapy" to "explode" a tumor and stimulate the immune system to clean up the debris, as reported by Mayo Clinic Researcher Dr. Angela Dispenzieri. This presents and interesting and promising approach for treatment of certain tumors. https://www.cybermedlife.eu/index.php/health1/5345-measles-is-a-natural-cancer-killer

Another thing to remember when citing stats from before the advent of the first measles vaccine in 1963, is that was nearly 60 years ago. Our ability to prevent complications for illness and treat viral illness has come light years in the past 6 decades. It is just speculation, but I would bet that the 1 death in 10,000 total cases from 1960, would be more like 1 in 30,000 or less in today's age of nutritional knowledge and medical treatments that could be employed for the few serious cases. If we even used the World Health Organization's strategy of using vitamin A to reduce the complications for measles here in the U.S. as they have done so successfully in the highest risk populations, it would protect our own children even more. But you don't hear that recommendation on Good Morning America. It doesn't fit the narrative.

Now, I recognize that 1 death is one too many, but my fear is that we are trading a low mortality illness for dozens of chronic diseases including cancers, neurological and autoimmune conditions, not to mention numerous behavioral and learning problems that are robbing our youth of their ultimate potential in life. The rates of these autoimmune, neurological, behavioral and learning conditions have increased sharply in parallel with the ever-increasing vaccine schedule over the last 60 years (from 5 doses of vaccines by age 18 to 72…and 35 of those are given by 18 months of age). Currently approximately 1 in 30 children have autism (from 1 in 10,000 back then) and 1 in 4 children suffers from some form of neurodevelopmental, behavioral or learning problem. Additionally, 1 in 6 Americans suffers from some form of autoimmune disease another pattern of increased incidence that has tracked with the vaccine schedule.

Measles Vaccine Risks

Not only that, but despite what we are commonly told the vaccine itself does pose risk. As reported on the ***National Vaccine Information Center's*** website**…"As of November 30, 2018, there have been more than 93,179 reports of measles vaccine reactions, hospitalizations, injuries and deaths following measles vaccinations made to the federal Vaccine Adverse Events Reporting System (VAERS), including 459 related deaths, 6,936 hospitalizations, and 1,748 related disabilities."** References are included in the article at https://www.nvic.org/vaccines-and-diseases/measles/measles-vaccine-injury-death.aspx

Considering the CDC funded study I covered earlier, showing that only less than 1% of all vaccine adverse reactions are ever reported, you can add two zeros after those reported reactions numbers to attain a more accurate number. https://www.ncbi.nlm.nih.gov/pubmed/?term=26060294

From the CDC's website:
"Before 1963, approximately 500,000 cases and 500 deaths were reported annually, with epidemic cycles every 2–3 years. However, the actual number of cases was estimated at 3–4 million annually." *(with over 4 million live births annually and virtually everyone getting measles I contend that the real number is at least 4 million)* "More than 50% of persons had measles by age 6, and more than 90% had measles by age 15. The highest incidence was among 5–9-year-olds, who generally accounted for more than 50% of reported cases." https://www.cdc.gov/vaccines/pubs/pinkbook/meas.html

Unfortunately, now we are seeing measles cases in older and older children and young adults when they can be much more severe. Another wonderful ramification of tinkering with mother nature. I'm sure their solution will to add another dose of MMR…and then another…and then another…

CBS Austin report cites a vaccine spokesperson, who uses fear mongering and unfounded statements- Contrast what he says to what you just learned

In a report dated January 26, 2017 CBS Austin quotes vaccine spokesperson Dr. Peter Hotez as he makes some outrageous comments obviously designed to incite fear.
http://cbsaustin.com/news/local/texas-doctor-sounding-alarm-about-potential-measles-outbreak

From the report:
Vaccinations and your family's safety are taking center stage at the State Capitol as a Texas doctor sounds the alarm about a potential measles outbreak.

"What we've seen in Texas in the last few years is a very alarming trend," Dr. Peter Hotez said.

Dr. Hotez is a vaccine scientist and the dean of the National School of Tropical Medicine at Baylor College of Medicine in Houston. He says he's worried about more and more Texas families opting out of vaccines.

"It could allow a measles epidemic to take hold," Dr. Hotez said. "Measles, I can't emphasis enough, is a deadly and serious disease."

The magic number is 90 percent. Dr. Hotez says if the immunity numbers drop below that it could trigger an outbreak and babies under one year of age would be most at risk.

"Then if you've a mother or a parent with a young baby you have to be terrified about going into shopping malls or going into public libraries or any public space because you're worried your baby is going to get measles," Dr. Hotez said.

(**End of article contribution)**

Talk about a case of exageritis! I think we should look at some of the facts about measles, including their historic incidence and mortality rates prior to and post the introduction of the measles vaccine.

Dr. Hotez accused of bullying parents of vaccine injured children in an article posted on the National Vaccine Information Center's (NVIC) web site

In an excellent article posted by Barbara Loe Fischer, mother of a vaccine injured child and founder of the NVIC on March 10, 2018 is titled, **Baylor's Doc Hotez Bullies Parents of Vaccine Injured Children**.

From the article: "According to an article in the *Duke Chronicle*, Peter Hotez, MD, PhD gave a global health lecture at Duke University in which he called on medical scientists to "engage the public" to promote more financial investment into the development of more vaccines."

"Apparently, he also called on them to counter what he labeled as the "anti-vaccine movement," which he believes has been "propelled" because "anti-vaccine websites exist with names such as the National Vaccine Information Center." The article reported that Dr. Hotez castigated politicians from the "peace, love, granola" political left, who believe that "we have to be careful what we put into our kid's bodies," and politicians from the political right, who tell doctors like him "you can't tell us what to do with our kids."

But Dr. Hotez reserved the bulk of his venom for parents of vaccine injured children. Like a schoolyard bully who engages in name calling when he can't come up with anything intelligent to say, he slapped the label "anti-vaccine" onto parents of vaccine injured children speaking about what happened to their children after vaccination. Then, he went further and viciously accused those parents of hating their children:

"Anti-vaccine organizations camouflage themselves as a political group, but I call them for what they really are: a hate group," Hotez said. "They are a hate group that hates their family and hates their children."

"This is not the first time that Dr. Hotez has revealed his prejudice against parents, who disagree with him about the safety of vaccines and one-size-fits-all mandatory vaccination policies. In 2017, in *Scientific American* magazine, Dr. Hotez said that "an American anti-vaccine movement is building" and called on the U.S. government and G20 nations to "take steps now to snuff it out." [9] To "snuff out" means to "crush or kill."

So where is Dr. Hotez coming from? According to the article, he is "A vaccine developer, a former president of the Sabin Vaccine Institute and director of the Texas Children's Center for Vaccine Development…" He has and continues to make large sums of money on vaccines. Need I say more?

"Prestigious universities like Baylor and Duke, which receive substantial funding from government health agencies to develop and test new vaccines, should have a minimum standard of conduct for professors, whether they are employed to teach students or perform research. Engaging in defamatory speech and using violent imagery to call on governments to "snuff out" people for exercising freedom of thought, speech, conscience and religious belief does not meet even a minimum standard for civil conduct."

"Regardless of what vaccine developers and forced vaccination proponents like Dr. Hotez choose to do, the National Vaccine Information Center (NVIC) will continue to publish well referenced information on NVIC.org is anchored with links to the CDC, FDA, NIH, National Academy of Sciences, vaccine manufacturer package inserts, articles published in the medical literature, state vaccine laws and other information resources to assist those making educated decisions about vaccination for themselves and their minor children. We will continue to provide a forum for Americans to testify about their personal experiences with vaccination, and we will continue to defend the legal right to exercise freedom of thought, speech, conscience, religious belief and informed consent, all of which have been recognized internationally as human rights."

References in the article online at https://www.nvic.org/NVIC-Vaccine-News/March-2018/doc-hotez-bullies-parents-vaccine-injured-children.aspx#_edn1

The Physicians for Informed Consent has published excellent position papers on the measles and the MMR Vaccine, using rational fact-based statistics

The ***Physicians for Informed Consent***, is a non-profit organization whose stated mission is the following; *"The mission of Physicians for Informed Consent is to unite doctors for informed consent in vaccination, and educate the public on infectious disease, the immune system, and informed consent."*

Measles; what parents need to know
https://physiciansforinformedconsent.org/wp-content/uploads/2018/09/Measles-DIS.pdf

MMR Vaccine; Is it safer than measles?
https://physiciansforinformedconsent.org/wp-content/uploads/2018/05/MeaslesVRS.pdf

FAQs: THE MEASLES, MUMPS AND RUBELLA (MMR) VACCINE VS. MEASLES
https://physiciansforinformedconsent.org/wp-content/uploads/2019/05/PIC_MMRVaccine-vs-Measles-FAQs-2019.pdf

The measles vaccine is also largely ineffective

The majority of measles cases can occur in vaccinated individuals

In an article title, **Failure to reach the goal of measles elimination. Apparent paradox of measles infections in immunized persons**, and published in the ***Archives of Internal Medicine***, found that outbreaks of measles occur primarily in immunized children.
https://www.ncbi.nlm.nih.gov/pubmed/?term=8053748

From the article:
"**We found 18 reports of measles outbreaks in very highly immunized school populations where 71% to 99.8% of students were immunized against measles**. Despite these high rates of immunization, 30% to 100% (mean, **77%) of all measles cases in these outbreaks occurred in previously immunized students.**"

Conclusion: "The apparent paradox is that as measles immunization rates rise to high levels in a population, measles becomes a disease of immunized persons. Because of the failure rate of the vaccine and the unique transmissibility of the measles virus, the currently available measles vaccine, used in a single-dose strategy, is unlikely to completely eliminate measles."

Vaccine failure of two different types cause vaccinated individuals to be unprotected

A 1995 paper published in ***Clinical Microbiology Reviews*** titled, **Measles Control in the United States: Problems of the Past and Challenges for the Future,** demonstrates that outbreaks can occur in highly vaccinated populations and that the demographics have changed since the pre-vaccine era, whereby children under age 1 and late teen to young adults are more at risk. These populations tend to have more severe cases of measles than elementary school age children which was the predominant age that children used to contract wild measles. Infants are more at risk due to decreased maternal antibodies in vaccinated mothers as compared to mothers that have had wild measles. And late teen and young adults are more at risk due to waning antibody levels.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC172858/

From the study:
"Before the introduction of the measles vaccine in 1963, **400,000 to 500,000 cases were reported** and **an estimated 5 million cases of measles occurred in the United States annually**."

"**From 1985 to 1988** there were a median of 47 outbreaks among school-age populations and only 8 outbreaks among preschool populations; **42% of the affected children had been appropriately vaccinated for measles.**"

"**In 1989, the majority of reported cases were in school-age or college-age individuals** and a minority were in preschool children."

"During the 1989 to 1991 epidemic, **the attack rate for children under 1 year of age in urban communities reached 119/100,000, the highest of any age group**." *(Again, this age group is the most vulnerable to serious consequences. When everyone got the measles, women had high antibody titers for life and their babies benefited from that. Vaccines have changes all that making infants much more vulnerable to the measles).*

"**Approximately 80% of the affected school-age children were appropriately vaccinated**. **Studies have documented that epidemics of measles can be sustained in school-age populations despite their having very high vaccination rates. For example, an outbreak of measles was sustained in two Texas schools when only 4.2% of the students were seronegative** before the epidemic." *(This means 95.8% of children had vaccine induced antibodies to measles)*

In these outbreaks that paper looked at, the first reason that was given was listed as **Primary Vaccine Failure**. **This is where the recipient does not respond to the vaccine. That happens in approximately 1 out of 20 , or 5% of cases.**

The second reason given is called **Secondary Vaccine Failure**. **This is where antibodies produced in response to the vaccine wane over time**. "A second possible reason for epidemics of measles among highly vaccinated populations is the waning of immunity with time."

Twice vaccinated persons still susceptible to infection

A 2014 study titled, **Outbreak of measles among persons with prior evidence of immunity, New York City, 2011**, published in the ***Journal of Clinical Infectious Diseases*** discusses cases of infected persons that had been previously immunized against measles.
https://www.ncbi.nlm.nih.gov/pubmed/?term=24585562

Results: "The index patient had 2 doses of measles-containing vaccine; of 88 contacts, 4 secondary patients were confirmed who had either 2 doses of measles-containing vaccine or a past positive measles IgG antibody."

130% more cases of measles in 2 dose recipients

An article published in the ***Journal of Infectious Diseases*** in 2013, titled **Largest measles epidemic in North America in a decade--Quebec, Canada, 2011: contribution of susceptibility, serendipity, and superspreading events**, discovered that a large percentage of measles cases had been vaccinated.
https://www.ncbi.nlm.nih.gov/pubmed/?term=23264672

From the report:
"There were 21 measles importations and 725 cases. A superspreading event triggered by 1 importation resulted in sustained transmission and 678 cases. The overall incidence was 9.1 per 100,000; the highest incidence was in adolescents 12-17 years old (75.6 per 100,000), who comprised 56% of case patients. Among adolescents, 22% had received 2 vaccine doses. Outbreak investigation showed this proportion to have been an underestimate; **active case finding identified 130% more cases among 2-dose recipients."**

Quebec has had very high vaccination rates historically. The MMR vaccine coverage for 2 doses has been at 90% by 28 months of age. This study stated, that those between the ages of 12-17 "comprised 56% of case patients". Considering there were 678 total cases, 56% is 380 cases. If the 2-dose MMR coverage is 90%, that means that approximately 342 of those teenagers that got the measles had received 2-doses of MMR earlier in life. The fact that a combination of ineffectiveness and waning (wearing off) in 10-15 years, speaks very poorly for the effectiveness of the vaccine and suggests that it leaves older children susceptible at an age when measles can be more serious.

Vaccinated individuals can contract and spread the measles

A 1998 study from the ***American Journal of Epidemiology*** titled, **Explosive school-based measles outbreak: intense exposure may have resulted in high risk, even among revaccinees.** https://www.ncbi.nlm.nih.gov/pubmed/9850133

The Abstract:
"**Even high levels of measles vaccination coverage have not always prevented outbreaks of measles spread by airborne transmission**. It has been suggested that a large inoculum might increase vaccine failure risk. Airbome transmission might occasionally entail a large measles inoculum. The epidemiologic relevance of measles among properly vaccinated persons (i.e., those vaccinated after 15 months of age and with live attenuated virus) is increased when they become contagious. The authors studied inoculum intensities as measured by proxy variables and the contagiousness of properly vaccinated persons who contracted measles among 51 measles patients infected in one school, at home, or elsewhere, utilizing preexisting records of measles cases and 214 healthy controls from an explosive school outbreak that occurred in a rural Finnish municipality in 1989. **One "super-spreader" infected 22 others in one day, including eight once-vaccinated students and one twice-vaccinated student**, probably during an assembly of 144 students in a poorly ventilated hallway with no sunlight. **Those infected later at home had high measles risk, even if they were revaccinees. When siblings shared a bedroom with a measles case, a 78 percent risk (seven out of nine children) was observed among vaccinees**. Vaccinees had approximately 2 days' shorter incubation time than unvaccinated persons. **Vaccinated and unvaccinated students were equally able to infect their siblings. Total protection against measles might not be achievable, even among revaccinees, when children are confronted with intense exposure to measles virus**."

The measles vaccine has a high rate of failure as evidenced by the high number of fully vaccinated individuals contracting measles in "outbreaks"

A 2017 article from the ***Journal of Clinical Microbiology*** titled, **Rapid Identification of Measles Virus Vaccine Genotype by Real-Time PCR**, discussed the failure of the measles vaccine to protect from the measles virus. https://jcm.asm.org/content/jcm/55/3/735.full.pdf

Using advanced genomic typing technology to differentiate between wild measles and vaccine strain measles, has revealed that in a high percentage of those cases, the strain of the virus causing their infection was the vaccine strain.

From the article:
"During the measles outbreak in California in 2015, a large number of suspected cases occurred in recent vaccinees. Of the 194 measles virus sequences obtained in the United States in 2015, 73 were identified as vaccine sequence."

Measles, mumps and Rubella rates can remain high even with 99% vaccination coverage

A 2014 study published in ***PLoS One*** titled, **Difficulties in eliminating measles and controlling rubella and mumps: a cross-sectional study of a first measles and rubella vaccination and a second measles, mumps, and rubella vaccination**, verifies the waning effect on MMR antibody titers.

From the Study:
"The reported coverage of the measles-mumps-rubella (MMR) vaccine is greater than 99.0% in Zhejiang province. However, the incidence of measles, mumps, and rubella remains high."
https://www.ncbi.nlm.nih.gov/pubmed/24586717

High rates of vaccine failure have been recognized for decades

A 1994 article from the ***South African Medical Journal*** titled, **The 1992 measles epidemic in Cape Town--a changing epidemiological pattern**, reports on an outbreak in which a very high percentage of children contracting measles had been vaccinated. https://www.ncbi.nlm.nih.gov/pubmed/?term=7740350

From the Abstract:
"Investigation of the outbreak at one school revealed that the attack rate was 7.6% (25/329 children). **Immunisation coverage (at least one dose of any measles vaccine) was 91% and vaccine efficacy was estimated to be 79% (95% CI 55-90); it was highest for monovalent measles (100%) and lowest for measles-mumps-rubella (74%)**. The epidemiology of measles in Cape Town has thus changed as evinced in this epidemic, **with an increase in the number of cases occurring in older, previously vaccinated children. The possible reasons for this include both primary and secondary vaccine failure**."

Measles continue to "strike back" even in populations with high vaccine coverage

A 2019 article from the ***Journal of Korean Medical Science*** titled, **The Measles Strikes Back**, discusses some of the problems contributing to measles outbreaks in highly vaccinated populations.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6374549/

From the Article:
"In Korea, large-scale measles catch-up vaccination was conducted on 5,860,000 children aged 8–16 years with low measles antibody levels through a measles immunodynamic study in 2001 because of a massive measles epidemic in 2000–2001. Since then, the measles-mumps-rubella (MMR) inoculation rate was maintained at 95% or more in children. And measles elimination was approved by World Health Organization in 2014 after a keep-up program to confirm MMR second vaccination before admission."

"However, as in other countries with high measles coverage rates, small-scale epidemics have been repeated in Korea since 2013. This was due to the import of measles from other countries. These events have also been reported in other countries where measles elimination has been confirmed.
Even after the global high rate of measles vaccination has been maintained, **the recurrence of small-scale epidemics has been attributed to factors such as vaccine cold chain handling issues, age-related vaccination policies, individual waning immunity or suboptimal immunity, and heavy exposure**.
Despite the high rate of measles vaccination, the common cause of measles epidemics is that **measles neutralizing antibodies are reduced to less than protective immunity after more than 10 years after the second dose of measles vaccine**. It is natural that they become vulnerable to measles if they are not given additional vaccination with low antibody. Therefore, there is a need for countermeasures against this problem."

Parents who vaccinate their children for MM & R should have the option for a titer test after the first dose to see if there is sufficient "protection"

In a May 20, 2019 letter to the editor of the ***British Medical Journal***, **John Stone**, UK Editor for ***AgeofAutism.com***, makes an excellent case for giving parents the ability to have their children's measles antibody levels tested, so that they can opt out of an unnecessary second dose. An example he cites is a New Jersey Law that called Holly's Law, named after five year old Holly Marie Stavola who died of encephalopathy she developed seven days after receiving her second dose of MMR vaccine.
https://www.bmj.com/content/365/bmj.l1932

His comments:
"In regards to vaccine hesitancy and the measles, mumps and rubella (MMR) vaccine, why are parents not being offered the opportunity to have an antibody titre test for their children after the first dose of live MMR vaccine, rather than being coerced to have what is likely to be an arbitrary second dose?

In regards to measles vaccination, the US Advisory Committee on Immunization Practices (ACIP) report on MMR vaccination (June 2013) admits that: "The second dose of measles-containing vaccine primarily was intended to induce immunity in the small percentage of persons who did not seroconvert after vaccination with the first dose of vaccine (primary vaccine failure)."

According to this information from the US ACIP, it appears most children are being over-vaccinated with the second dose of MMR vaccine.

Many cautious parents who might be averse to unnecessarily over-vaccinating their children might be willing to pay for the option of antibody testing to check immunity after the first dose of this live vaccine combination, why are they being denied this evidence-based option?

It's notable that in the state of New Jersey in the United States, the health department provides information on antibody titre testing. The Antibody Titer Law (Holly's Law) allows parents to seek testing to determine a child's immunity to measles, mumps and rubella before receiving the second dose of MMR vaccine: https://www.state.nj.us/health/cd/documents/antibody_titer_law.pdf

The Antibody Titer Law was enacted in response to the death of five year old Holly Marie Stavola who died of encephalopathy which she developed seven days after receiving her second dose of MMR vaccine: http://www.hopefromholly.com/hollys-story/

Why aren't we all allowed to have the option of antibody titre testing?

Information on antibody titre testing generally continues to be withheld from parents and other individuals, citizens are not being properly informed about this option instead of an arbitrary second dose of MMR vaccine. This is a serious infringement of citizens' right to 'informed consent' before this medical intervention."

Antibody levels of fully vaccinated individuals shown to decline rapidly over time

A 2017 article from the journal ***Vaccine*** titled, **An increasing, potentially measles-susceptible population over time after vaccination in Korea**, finds that the antibody levels and seropositivity of fully vaccinated individuals is declining.
https://www.sciencedirect.com/science/article/pii/S0264410X17308551

Results:
"The overall seropositivity and measles antibody concentrations were 71.5% and 1366 mIU/mL, respectively. **Progressive decline in antibody levels and seropositivity were observed over time after vaccination in infants, adolescents, and young adults**. **The accumulation of potentially susceptible individuals in the population was confirmed by comparing data from 2010 and 2014 seroprevalence surveys**. The statistical correlation between measles incidence and measles seronegativity was determined."

Conclusions
"**Waning levels of measles antibodies with increasing time post-vaccination suggests that measles susceptibility is potentially increasing in Korea. This trend may be related to limitations of vaccine-induced immunity in the absence of natural boosting by the wild virus, compared to naturally acquired immunity triggered by measles infection.** This study provides an important view into the current measles herd immunity in Korea."

Vaccine immunity against measles wanes as early the teenage years

A 2000 article from the journal ***Epidemiology and Infection*** titled, **Secondary measles vaccine failures identified by measurement of IgG avidity: high occurrence among teenagers vaccinated at a young age**, once again presents the problem of rapidly decreasing protection from the measles vaccine. The mean age of subjects tested in this study was 16.2 years.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2810910/

From the Abstract:
"**Failure to seroconvert (primary vaccine failure) is believed to be the principal reason (approx. > 95%) why some vaccinees remain susceptible to measles** and is often attributed to the persistence of maternal antibodies in children vaccinated at a young age."

"**Secondary measles-vaccine failures are more common than was more previously thought, particularly among individuals vaccinated in early life, long ago, and among re-vaccinees. Waning immunity even among individuals vaccinated after 15 months of age, without the boosting effect of natural infections should be considered a relevant possibility in future planning of vaccination against measles**."

A 2016 measles outbreak in an Arizona detention facility in vaccinated individuals

A 2018 study from the journal ***Clinical Infectious Diseases*** titled, **Measles Outbreak at a Privately Operated Detention Facility: Arizona, 2016,** reported a very high rate of infection in previously vaccinated persons. Vaccination status for most detainees was unknown, but because of the high rates of vaccination in their countries of origin (>90%), it was assumed that the vast majority had been vaccinated. In addition, laboratory testing was performed on confirmed cases and revealed that approximately 9 out of 10 were previously vaccinated against measles and were cases of vaccine failure. Of the 9 staff member infected, 4 were previously vaccinated, 2 were unvaccinated and 3 had unknown vaccination status. This demonstrates a very poor rate of protection from the MMR Vaccine.
https://academic.oup.com/cid/article/68/12/2018/5106985#124256187

Results. "We identified 32 measles case-patients (23 detainees, 9 staff); rash onsets were during 6 May–26 June 2016**. High IgG avidity and neutralizing-antibody titers >40 000 to measles (indicating reinfection) were identified in 18 (95%) and 15 (84%) of 19 tested case-patients, respectively**."

High IgG avidity means that the person was previously vaccinated and that the vaccine had failed (see the next paragraph).

***According to the article*:** "Additionally, because the vaccination status of most case-patients was unknown, a subset of specimens (based on availability of sera) were sent to the CDC for avidity and plaque reduction neutralization (PRN) testing to determine whether case-patients were unvaccinated, primary, acute case-patients; primary vaccine failures (failure to seroconvert); or secondary vaccine failures (waning immunity). **IgG avidity measures antibody binding force**, which is low after the first exposure to an immunogen, but increases (affinity maturation) over time, **such that unvaccinated persons or primary–vaccine-failure case-patients would have low-avidity IgG antibodies, whereas secondary–vaccine-failure case-patients would have high-avidity IgG antibodies**."

Conclusions. "**Although ARs were low, measles outbreaks can occur in intense-exposure settings, despite a high population immunity…**"

This is a very interesting microcosm of what happened in the late 19th century and early 20th century in large cities in the U.S. and Europe as I described earlier in this document. Not only were the

overcrowded, unsanitary and impoverished conditions ripe for spread of disease, but under those disgusting conditions, casualty rates were very high also. These modern-day detention centers are no doubt more sanitary and the employees and detainees much better fed and hydrated with access to clean water, as compared to the tenement houses in that era. Yet, the mere fact that they are overcrowded and as the conclusion states, "intense exposure settings", contributed to a high rate of transmission. Fortunately, as a result of the relatively good living conditions and better nutritional status in the detention center, the rates of complications and mortality are far better than a century ago, or in third-world countries today for that matter.

A 2018 study from the journal Vaccine, shows that the MMR Vaccine's protection decreases up to nearly 10% annually, even after the second dose

A 2018 article published in the journal ***Vaccine***, titled, **Measles, mumps, and rubella antibody patterns of persistence and rate of decline following the second dose of the MMR vaccine**, states that the immunity wanes significantly each year after vaccination.
https://www.ncbi.nlm.nih.gov/pubmed/29317117

From the Abstract:
"One-month post-MMR2, geometric mean titer (GMT) to measles was high (3892 mIU/mL), **but declined on average 9.7% per year** among those with the same baseline titer and <2-fold increase post-MMR2. Subjects with ≥2-fold **experienced a slower decline (≤7.4%). GMT to rubella** was 149 **one month post-MMR2, declining 2.6% and 5.9% per year among those who received MMR1 at 12-15 months and >15 months, respectively**. **GMT to mumps one month post-MMR2 was 151, declining 9.2% per year**".

Sources vary as to the length of time that the MMR provides immunity. Most claim between 10 and 20 years for measles and rubella, with the mumps much less. **News reports in early 2019 were claiming that the CDC says that the measles vaccine provides life-long immunity. That is confirmed on the CDC's website here:** https://www.cdc.gov/vaccines/vpd/mmr/hcp/about.html

Considering that this study found between an approximate 7.5% to 10% ANNUAL decline in measles antibodies, that doesn't give one much confidence in the ability to be protected years down the road. In fact, 7 years after the second dose of MMR a person may only have a 10-25% chance of being "protected", and nearly 0% after 10 years. That certainly contradicts the CDC's claim of life-long immunity doesn't it?

Wild type measles infection provides better protection against the various measles subtypes than the measles vaccine

In a 2000 study published in the ***Journal of Medical Virology*** titled, **Resistance of recent measles virus wild-type isolates to antibody-mediated neutralization by vaccinees with antibody**, researchers found

significant differences in antibody protection to various strains of the measles in women that had contracted wild measles. https://www.ncbi.nlm.nih.gov/pubmed/?term=10935994

From the abstract: ("Late convalescent" refers to the women with the wild measles induced immunity)

"…12 of the 22 *(55%)* late convalescent sera, and only 6 of 24 *(25%)* vaccinees neutralized all viruses. Similarly, **only 2 of 20** *(10%)* **viruses were not neutralized by at least 75% of late convalescent sera**, **in comparison to 10 of 20** *(50%)* **viruses that resisted neutralization by at least 75% of the vaccinees.**"

"One Nigerian virus **was resistant** to neutralization **by 30% of the late convalescent women** and **by 75% of vaccinees.**"

Waning antibodies for MMR protection confirmed by the Journal of Infectious Diseases

A 2012 study from the ***Journal of Infectious Diseases*** titled, **Waning antibody levels and avidity: implications for MMR vaccine-induced protection,** found that the antibodies from the MMR vaccine waned over time, with the mumps component performing the poorest of the three. https://www.ncbi.nlm.nih.gov/pubmed/22966129

From the Abstract:
"**The antibody avidity indexes were high for measles and rubella but low for mumps. Twenty years after a second MMR vaccination, antibody levels for all 3 viruses waned**."

"Measles and rubella induced high-avidity antibodies and mumps induced low-avidity antibodies after both vaccination and natural infection. **Waning of both the concentration as well as the avidity of antibodies might contribute to measles and mumps infections in twice-MMR-vaccinated individuals**."
(Avidity refers the strength of binding between an antibody and an antigen)

Measles antibodies wane within a few years of the second dose of MMR

A 2007 article from the journals ***Archives of Pediatric and Adolescent Medicine*** titled, **Persistence of measles antibodies after 2 doses of measles vaccine in a postelimination environment,** found that declining neutralizing measles-antibody titers were detected in both kindergarteners and middle schoolers, 5 years and 10 years after a secondary vaccine dose (2814 decreased to 641 mIU/ml, and 1672 decreased to 737 mIU/ml, respectively). https://www.ncbi.nlm.nih.gov/pubmed/17339511

From the article:
"**Many studies have suggested that vaccine induced immunity is persistent, perhaps even lifelong, but most were performed in an era when boosting from wild-type virus was common**. Some investigators have raised concerns that, in the absence of such boosting, waning immunity may produce a population of susceptible persons sufficient to sustain renewed measles transmission. **Because measles tends to be more severe clinically among adults, progressive waning immunity might have important clinical and public health consequences**."

"Projections suggest that **the proportion of persons with low antibody levels may increase over time**."

The results from this article support the fact that vaccines have destroyed natural herd immunity. As discussed earlier in this eBook, in a natural herd immunity environment, older individuals are given a "booster" from younger ones with measles, which increases their antibody titer and further protects them from infection. Since we have vaccinated virtually all of the young children, there are no longer those opportunities for those with waning antibodies to get that natural boosting effect.

Will implementing regular booster shots for all adults work? The science says NO!

So, does that mean we are all facing a 3rd dose recommendation of MMR? According to a 2016 article from the Journal of Infectious Diseases, that doesn't work

A 2016 article from the ***Journal of Infectious Diseases*** titled, **Measles virus neutralizing antibody response, cell-mediated immunity, and IgG antibody avidity before and after a third dose of measles-mumps-rubella vaccine in young adults**, finds that a third dose of the MMR added very little protection. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5729920/

From the study:
"Overall, MeV neutralizing antibody concentrations initially increased after MMR3 **but declined to near-baseline levels one year later.** Although our findings showed that MMR3 increased antibody levels for the small percentage of subjects with low MeV neutralizing antibody concentration levels who were on the cusp of protection, **the CMI and avidity results in the subset tested showed that MMR3 did not result in substantial improvements in the quality of the immune response. While a third MMR dose may successfully immunize the rare individual who failed to respond after two doses, MMR3 is unlikely to solve the problem of waning immunity in the U.S.**"

The conclusion:
"Most subjects were seropositive pre-MMR3 and **very few had a secondary immune response post-MMR3.** Similarly, CMI and avidity results showed minimal qualitative improvements in immune response post-MMR3. **We did not find compelling data to support a routine third dose of MMR vaccine**."

A 2017 article from the Journal of Infectious Diseases confirms that adult boosters are not effective

The article titled, **Measles Virus Neutralizing Antibodies in Intravenous Immunoglobulins: Is an Increase by Revaccination of Plasma Donors Possible?**, casts serious doubts on the success of a

perpetual booster program should that be recommended.
https://www.ncbi.nlm.nih.gov/pubmed/?term=28968738

From the Abstract:
"We report a screen of plasma donors confirming that widespread use of childhood measles vaccination since 1963 resulted in a decrease in average measles virus antibody titers among plasma donors, which is reflected in **intravenous immunoglobulins (IVIGs)**. The measles virus antibody titer, however, is a potency requirement for IVIGs, as defined in a Food and Drug Administration regulation. To mitigate the decline in measles virus antibody titers in IVIGs and to ensure consistent product release, revaccination of plasma donors was investigated as a means to boost titers. **However, revaccination-induced titer increases were only about 2-fold and short-lived." *(The antibody titers returned to baseline in 150 days [5 months])*.**

From the Study:
"**Measles virus antibody titers are lower in children after vaccination than after natural infection, and the wide deployment of childhood measles vaccination since 1963 is believed to have resulted in lower average measles virus antibody titers in the US general population**, as well as in blood and plasma donors and correspondingly in the IVIG preparations fractionated from these donations. **Waning of vaccine-induced immunity might further contribute to the decline in measles virus anti-body titers in IVIG.** Routine measles vaccination is given twice, typically at age 12–15 months and then around school entry at age 4–6 years. Plasma donors, at a minimum age of 18 years, would be expected to present antibody titers even lower than occurring immediately after vaccination."

"The 3312 samples were sorted by birth year and separated into 8 cohorts, spanning 4–5 birth years per cohort except for samples from donors born between 1938 and 1957, which were merged into a single cohort."

"The M-M-R II (Measles, Mumps, and Rubella Virus Vaccine Live) vaccine (Merck) was used for revaccination of plasma donors."

See graph next page…

This graph shows the Measles virus neutralizing antibody concentrations and how vaccination has caused the levels to drop since the vaccine was introduced. The year ranges are the birth years for each cohort. Essentially, the vaccine has destroyed natural herd immunity.

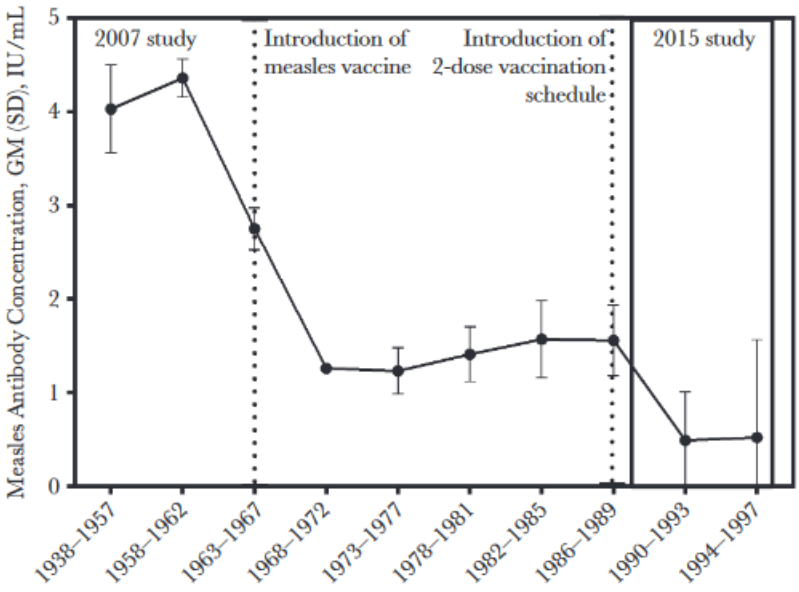


Fig 1. Cohorts (Birth Years)

A further reduction in Measles antibody titers occurred after the introduction of the second dose on the vaccine schedule (1989).

Why is this so significant? This creates the potential for a very dangerous scenario. Because as the next article will communicate, "escape mutant" strains of measles are developing due to vaccine pressure and many of these are more virulent and dangerous than the strains that were prevalent in the 1960s AND the vaccine does not protect against them. Because we have destroyed natural herd immunity as it existed in the early 1960s with mass vaccination campaigns, our population consisting of people that have very low antibody titers could be ripe for a catastrophic man-made epidemic. Just like the super-germs that we have created by over prescribing antibiotics, the measles virus, which actually consists of a couple dozen sub-types, will always stay one step ahead of the vaccine paradigm.

"Escape Mutant" viruses present a potential danger for vaccinated individuals

A 2017 article from the ***Journal of Virology*** titled, **Antigenic Drift Defines a New D4 Subgenotype of Measles Virus**, looks at subtypes of the 24 genotypes of the measles virus and identifies two sub-types that have developed "antigenic drift", which is a mechanism for variation in viruses that involves the accumulation of mutations within the genes that code for antibody-binding sites. This has implications which could affect the ability for antibodies produced by the measles vaccine from working effectively. The measles is a monotypic virus, in which being inoculated against one strain will protect a person from

other strains. This is unlike many of the other infectious diseases we vaccinate against whereby the vaccine will only be effective for a specific strain or serotype that matches up with the strain contained in that particular vaccine. The problem that has emerged which this article discusses, is that vaccine pressure has caused a mutation that leaves millions of people that have been vaccinated with MMR completely vulnerable. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5432853/pdf/e00209-17.pdf

From the Study:
"Measles virus is a paradigmatic RNA virus, as the antigenic composition of the vaccination has not needed to be updated since its discovery. **The vaccine confers protection by inducing neutralizing antibodies that interfere with the function of the hemagglutinin protein**. **Viral strains are indistinguishable serologically, although characteristic nucleotide sequences differentiate 24 genotypes. In this work, we describe a distant evolutionary branch within genotype D4**."

"The **subgenotype D4.1 MeVs** were isolated predominantly in **Kenya and Ethiopia**, whereas the **MAb-resistant subgenotype D4.2 MeVs** were isolated **pre-dominantly in France and Great Britain**, countries with higher vaccine coverage rates."

"During our studies on antigenic variation across MeV genotypes, **we identified a difference in the neutralization sensitivities of two viruses belonging to the D4 genotype.** Subsequent genetic and antigenic analyses of a larger number of genotype D4viruses identified two definable D4 subgenotypes, which we named D4.1 and D4.2. **In contrast to subgenotype D4.1 viruses, subgenotype D4.2 viruses are not neutralized by antibodies targeting the neutralizing epitope (NE), indicating that they lack three of the six known antigenic sites. Perhaps more significantly, the two subgenotypes differ in their susceptibilities to neutralization by pooled human sera from 60 to 80 North American donors**."

"**Interestingly, D4.2 sub-genotype viruses showed a trend toward diminished susceptibility to neutralization by human sera pooled from approximately 60 to 80 North American donors.**"

This could have profound implications if an escape mutant strain of measles virus that is unaffected by the antibodies produced by our MMR vaccine in U.S. populations, comes from another part of the world. Bear in mind, that there are most likely others that have not yet been detected and ones that are and will be mutating in the future. One has to look no farther than the chart on the previous page and see how vulnerable vaccinated individuals have become as compared to my generation who still enjoy a high level of protection from having "survived" (tongue in cheek), WILD measles.

Babies born to vaccinated mothers have lower levels of maternal antibodies putting them at greater risk of infection

Compared to orthodox communities where mothers had previous natural infection, babies of mothers vaccinated with MMR are at greater risk of infection

A 2013 study from the ***Journal of Infectious Disease*** titled, **Waning of Maternal Antibodies Against Measles, Mumps, Rubella, and Varicella in Communities With Contrasting Vaccination Coverage**, warns that because vaccinated mothers pass a lower level of antibodies to their offspring than mothers that have had the wild virus infection, babies are at greater risk of contracting measles, mumps, rubella or chickenpox shortly after birth. **This is when they are most vulnerable to complications.**
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4043230/

From the Article:
"**A known determinant of the maternal measles virus antibody concentration is the vaccination status of the mother. Mothers who received MMR vaccine tend to have a lower concentration of measles virus–specific antibodies than mothers who naturally acquired measles**."

"**The estimated duration of protection by maternal antibodies among infants in the general population, most of whom were born to vaccinated mothers, was short: 3.3 months for measles, 2.7 months for mumps, 3.9 months for rubella, and 3.4 months for varicella. The duration of protection against measles was 2 months longer for infants born in the orthodox communities, most of whom had unvaccinated mothers. For rubella, mothers in the orthodox communities had higher concentrations of antibodies as compared to the general population**."

Conclusion. "**Children of mothers vaccinated against measles and, possibly, rubella have lower concentrations of maternal antibodies and lose protection by maternal antibodies at an earlier age than children of mothers in communities that oppose vaccination. This increases the risk of disease transmission in highly vaccinated populations**."

Another article determining that vaccinated mothers provide inferior antibody coverage to their babies

A 2010 article in ***Virology Journal*** titled, **Low titers of measles antibody in mothers whose infants suffered from measles before eligible age for measles vaccination,** confirms that women who have been vaccinated against the measles are putting their infants at risk due to conferring lower antibody titers than women that have had natural wild measles prior.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2874774/pdf/1743-422X-7-87.pdf

From the article:
"Currently, the measles antibodies in the vast majority of mothers in China are induced by vaccination rather than by the natural infection. Therefore, it is speculated that infants may acquire fewer antibodies from their mothers, **resulting in the reduced duration of protection against measles and leading to the onset of measles before the age of receiving vaccine**." *(This puts this highly vulnerable population at risk)*
"However, the changing age distribution of measles in infants younger than 1 year of age, which is at least partially caused by low maternally acquired measles antibody as demonstrated in this study, casts doubt on the effectiveness of current strategy in elimination of measles."

"**Conclusions:** Our results suggest that infants born to mothers who acquired immunity to measles by vaccination may get a relatively small amount of measles antibody, resulting in loss of the immunity to measles before the vaccination age. Measures to improve the immunity in young infants not eligible for measles vaccination would be critical to interrupt the measles transmission in China."

This detriment to infants has been known for decades

A 1996 article published in the journal ***Pediatrics*** titled**, Changing levels of measles antibody titers in women and children in the United States: impact on response to vaccination. Kaiser Permanente Measles Vaccine Trial Team**, reveals the gap in protection for newborns of vaccinated mothers.
https://www.ncbi.nlm.nih.gov/pubmed/?term=8545224

From the Abstract:
"Among women born in the United States (n = 614), geometric mean titers (GMTs) of measles antibodies decreased with increasing birth year. **For those born before 1957, 1957 through 1963, and after 1963, GMTs were 4798, 2665, and 989, respectively**. Among women born outside of the United States (n = 394), there were no differences in GMTs by year of birth. **Children of younger women born in the United States were less likely than those of older women to be seropositive at 6, 9, or 12 months**."

Options for parents wanting to separate MMR into individual vaccines are unavailable

Mumpsvax no longer available from Merck – 11/13/2009
Source: http://www.londonmmr.co.uk/faq.php

"Unfortunately, much to our shock and dismay, Merck have announced that they have decided not to resume production of the single vaccines for Measles (Attenuvax), Rubella (Rudivax) and Mumps (Mumpsvax)."

At the beginning of November 2009, Dr Mark Feinberg, the Vice President of Merck Vaccines stated the following:

"Based on input from the Advisory Committee on Immunization Practices (ACIP), professional societies, scientific leaders, and customers, Merck has decided not to resume production of ATTENUVAX (Measles Virus Vaccine Live), MUMPSVAX (Mumps Virus Vaccine Live), and MERUVAXII (Rubella Virus Vaccine Live). This science-based decision will support vaccination of the largest group of appropriate individuals. We will continue to focus necessary resources to ensure that we can help meet current and future global public health needs for our combination measles, mumps, and rubella vaccine, M-M-RII (Measles, Mumps and Rubella Virus Vaccine Live).

"The combination vaccine M-M-RII is recommended by the ACIP, the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), and is preferred over the monovalent

vaccines because it eliminates the need for 3 separate injections and reduces the chance of delays in helping protect against any of these potentially serious diseases. There is no medical reason to administer the measles, mumps, and rubella antigens separately, and ACIP guidelines do not support their use."

Persons vaccinated for the measles shed the virus and can potentially infect others

In an article published in 1995 in the ***Journal of Clinical Microbiology*** titled, **Detection of Measles Virus RNA in Urine Specimens from Vaccine Recipients**, researchers discovered that the vast majority of children vaccinated with the MMR vaccine developed a mild form of measles and that they shed the virus, which could potentially infect others. This article stated that it is unknown whether others could be infected, but in November of 2014, the ***National Vaccine Information Center*** has produced an excellent manuscript with 276 referenced titled, **The Emerging Risks of Live Virus and Virus Vectored Vaccines - Vaccine Strain Virus Infection, Shedding & Transmission**. It not only covers these problems with the MMR vaccine, but the Smallpox, Polio, Influenza, Rotavirus, Varicella (Chickenpox) vaccines as well. That document can be accessed free here… https://www.nvic.org/CMSTemplates/NVIC/pdf/Live-Virus-Vaccines-and-Vaccine-Shedding.pdf Or it can be accessed through their website at

Back to the 1995 study. This study was conducted under the auspices of the ***Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases, Centers for Disease Control and Prevention, Atlanta, Georgia 30333*** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC228449/

Post vaccination, the measles virus RNA was detected in the urine in 10 of 12 children (age 15 months) and all 4 young adults (aged 21-32 years) within 2 weeks.

From the article:
"In our study, individuals received the Moraten strain of measles vaccine as measles-mumps-rubella vaccine." ***This is an attenuated or weakened strain of the measles.***

"Despite the existence of an effective vaccine, measles virus continues to cause sporadic outbreaks and epidemics of disease in the United States and throughout the world. **Most recent outbreaks have involved either children who were too young to be vaccinated or older children and teenagers (5 to 19 years), most of whom had been previously vaccinated (3, 8).** Because of the sporadic nature of outbreaks in populations with high rates of vaccination, the altered presentation of clinical signs that occurs in ''mild measles'' infections (1, 11, 20), and the presence of other exanthem-causing infections, effective public health measures to control measles outbreaks are more dependent on laboratory confirmation of infection than on diagnosis based on clinical presentation. Currently available diagnostic techniques, which include virus isolation, viral antigen detection, and serologic antibody studies, are very sensitive and specific. However, these techniques are labor intensive, require specimen collection by medically trained personnel, and would be inappropriate for screening large numbers of individuals."

"The detection of measles virus RNA in urine by using reverse transcriptase-PCR (RT-PCR) would be a potentially rapid means of detecting measles infections with a clinical specimen which is more readily

and conveniently accessible than serum or nasopharyngeal aspirates." ***This method has proven to be a convenient and inexpensive way to differentiate between wild measles virus and the vaccine produced virus. It is my contention that all cases of measles should be analyzed to see if they are "wild" or vaccine strains as the clinical presentation of the two types are indistinguishable.***

Green Med Info has an excellent article on the failings of the measles vaccine and the high incidence of cases in vaccinated individuals. http://www.greenmedinfo.com/blog/2013-measles-outbreak-failing-vaccine-not-failure-vaccinate1

Newborns and infants are more likely to contract measles and more susceptible to complications and death due to the measles vaccine

Prior to the introduction of the measles vaccine in 1963, nearly everyone contracted the measles. That gave them a strong and lasting protection from every acquiring the measles again in their lifetime. When women gave birth, their newborns had passive immunity from the strong levels of circulating antibodies passed on to them from their mothers. Now with the widespread use of the MMR vaccine and the lack of wild measles infection induced protection, newborns have become highly susceptible for infection and complications.

A 2010 study from the ***British Medical Journal*** titled, **Early waning of maternal measles antibodies in era of measles elimination: longitudinal study**, clearly shows that there is a much stronger presence of maternal antibodies in women that had previously contracted the natural "wild" measle virus that those who had been vaccinated. It also showed that the newborn infants of the women that had prior measles infection benefited to a greater degree than those born from women that had been vaccinated. https://www.ncbi.nlm.nih.gov/pubmed/?term=20483946

From the study:
"Vaccinated women had significantly fewer IgG antibodies (geometric mean titre 779… mIU/ml) than did naturally immune women (2687 (2126 to 3373) mIU/ml)... Maternal values were highly correlated with neonatal values (r=0.93 at birth). Infants of vaccinated women had significantly lower antibody concentrations than did infants of naturally immune women…"

It also cites previous studies with similar results… "Results of previous studies show lower starting concentrations at birth and faster decay of antibodies in infants of vaccinated women".

The younger the infant, the greater the risk of complications from the measles. Antibodies wane within several weeks after birth in both groups, but slower in the newborns with higher titers born of the women that previously had the wild measles. This added protection from the greater number and duration of maternal antibodies reduces risk to those newborns. Conversely, there is an increased risk of complications and even death (in rare instances), to newborns of vaccinated mothers.

Contracting natural measles, mumps and other childhood infectious diseases have future health BENEFITS

Natural measles infection and a lower rate of dying from cardiovascular disease

A 2015 study published in the journal ***Atherosclerosis*** titled, **Association of measles and mumps with cardiovascular disease: The Japan Collaborative Cohort (JACC) study**, finds a strong association with people that has natural measles and mumps infection and lower risk of dying from cardiovascular disease. https://www.ncbi.nlm.nih.gov/pubmed/26122188

Their Conclusion:
Measles and mumps, especially in case of both infections, were associated with lower risks of mortality from atherosclerotic CVD.

Contracting natural measles reducing the rates of allergies

A 2006 study from the journal ***Allergologia et Immunopathologia**** titled, **Frequency of allergic diseases following measles**, found that children that had a history of measles infection had lower rates of allergies and asthma. https://www.ncbi.nlm.nih.gov/pubmed/16854347

FINDINGS:
Sensitivity to Dermatophagoides pteronyssinus *(dust mites),* was less frequent in children with measles than in those without... A history of nebulized salbutamol *(Albuterol),* use in the emergency room in the previous 12 months was also less frequent in the measles group... Inhaled corticosteroid use was more common in the group without measles...

CONCLUSION:
The results of this study indicate that findings of allergic disease are less frequent in children with a history of measles. These children were less sensitive to D. pteronyssinus *(house dust mites)*.

**Allergologia et Immunopathologia* is a forum for those working in the field of pediatric asthma, allergy and immunology.

A 2001 editorial in the British Medical Journal praises the benefits of childhood infections

In a 2001 editorial from the ***British Medical Journal*** titled, **The protective effect of childhood infections**, the author cites the hygiene hypothesis and the fact that exposure to bacteria and viruses in childhood are part of what builds and matures the immune system.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1119618/

The author also points out that children living in overly hygienic or sterile conditions and taking antibiotics lead to an increased risk of allergies later in life.

From the editorial:
"Many common viral infections induce a strong protective host response dominated by the production of interferon γ (IFNγ). This type 1 response is more effective at eliminating viruses than the alternative type 2 response (characterised by the production of interleukin 4 and interleukin 5), which promotes IgE production, eosinophilia, atopy, and asthma. Children are born with strong type 2 responses but mature their type 1 responses in the first year or so of life under environmental influence, mainly that of common childhood infections."

"Thus, having many older siblings; attending day care at an early age; growing up on a farm and in frequent contact with cattle, poultry, and cats; **and having childhood measles** and orofaecal infections such as hepatitis A **are all helpful** (directly or by association) **in promoting normal immunological maturation and in preventing atopic disease. By contrast, living in a small family group in hygienic conditions and taking antibiotics in early life[7] may promote the development of asthma and atopy."**

"In this issue of the *BMJ*, Illi et al show that episodes of uncomplicated common colds (runny nose) during infancy may also protect against episodes of wheezing in later childhood (p 390). **Other childhood infections such as herpetic stomatitis, exanthema subitum, and chickenpox also seemed protective**. By contrast, episodes of wheezy lower respiratory tract infection were strongly associated with subsequent episodes of wheezing by the age of 7 (odds ratio >6). In other words, children with frequent simple infantile colds are less likely to develop wheezing by the age of 7, while children with wheezy lower respiratory illnesses in the first year are more likely to wheeze later on."

"However, the important conclusion is that the risk of a diagnosis of asthma by the age of 7 is reduced by about 50% percent in children with two or more reported episodes of common cold (without associated wheeze) by the age of 1 year."

Natural measles infection provides superior immunity according the World Health Organization

In an April 2017 report issued by ***the World Health Organization***, the benefit of naturally acquired measles was discussed.

Naturally-acquired immunity- "Whereas the presence of circulating, neutralizing antibody against the H antigen is sufficient to prevent infection with measles virus, cell-mediated immunity is required to clear the virus once infection has occurred. **Long-lasting, possibly lifelong, immunological memory following wild-type virus infection *(contracting measles)* includes both continued production of measles virus-specific antibodies and the circulation of measles virus-specific CD4+ and CD8+ T lymphocytes**."

Childhood infectious diseases and lower rates of cancer later in life

A study from the journal ***Medical Hypothesis*** titled, **Febrile infectious childhood diseases in the history of cancer patients and matched control**, Fuond an association with childhood infectious diseases and lower rates of cancer later in life. It also found that the more infectious diseases a person had as a child, the lower the rates of cancer later in life. https://pubmed.ncbi.nlm.nih.gov/9824838/

The abstract

The present study was designed to investigate the hypothesis that febrile infectious childhood diseases (FICDs) are associated with a lower cancer risk in adulthood, since biographical considerations are of great importance in anthroposophic medicine. Cancer patients and control patients of 35 anthroposophic general practitioners in Switzerland were matched with respect to gender, age and physician. All patients completed a questionnaire on their FICD. We collected 424 cases; of these we could analyze 379 matched pairs. The study consistently revealed a lower cancer risk for patients with a history of FICD. The strongest associations were found between patients with non-breast cancers and rubella respectively chickenpox. A strong association was also found with the overall number of FICD. both 'classical' (measles, mumps, rubella, pertussis, scarlet-fever and chikenpox) and 'other'. None of these associations was apparent for patients with breast cancer. Unexpectedly, we found that cancer was diagnosed significantly earlier in life in cancer patients with a history of FICD compared to those without FICD. Our retrospective study showed a significant association between FICD and the risk of developing cancer. The number of FICD decreased the cancer risk, in particular for non-breast cancers. The relationship with tumor site seems to be important also, but can only be addressed in a larger study.

The mumps vaccine has damaged natural protection from ovarian cancer

A 2010 study published in ***Cancer Causes Control*** titled, **Mumps and ovarian cancer: modern interpretation of an historic association**, found an association between getting mumps as a child and a lower risk of ovarian cancer. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2951028/

Conclusion:
"Mumps parotitis may lead to expression and immune recognition of a tumor-associated form of MUC1 and create effective immune surveillance of ovarian cancer cells that express this form of MUC1."

"Showing the relevance of this observation to ovarian cancer clearly requires background data that would link mumps, ovarian cancer, and anti-MUC1 antibodies. Concerning the mumps and ovarian cancer association, we performed a meta-analysis of all published original reports to obtain an overall estimate of the effect. **In eight observational studies addressing the association,** the summary odds ratio was 0.81 with 95% confidence limits of 0.68–0.96 (p = 0.01), **suggesting a 19% decrease in risk of ovarian cancer associated with history of mumps parotitis**."

"Thus, our observation that anti-MUC1 antibodies are elevated in individuals with mumps is consistent with the interpretation that **mumps infection could elicit an immune response to later protect against ovarian cancer.**"

"**Clearly, mumps vaccination only creates anti-viral antibodies and would not lead to anti-MUC1 antibodies, which we show here require an active parotitis. If it is true that symptomatic mumps protected against ovarian cancer through an immune reaction, a logical consequence is that we might expect an increased incidence of ovarian cancer as symptomatic mumps parotitis infections have decreased through vaccination. In a paper examining incidence patterns for ovarian cancer from 1978 to 1998, rates of invasive serous, endometrioid, and clear cell tumor increased over this time period among white females**."

The rubella portion of the vaccine is cultured in aborted fetal tissue and contains DNA fragments that may combine with the recipient's DNA

Rubella is one of those diseases that the CDC has said is basically eradicated from the U.S. as of 2004]. https://www.cdc.gov/rubella/about/in-the-us.html There is **less than 10 cases per year on average and most cases that show up in the U.S. are "imports" from overseas**. **In the 8 years from 2004-2012, there was only one case of congenital rubella documented in the U.S. where the parent had not traveled outside of the U.S**. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6212a3.htm As mentioned and documented earlier in this document, rubella in and of itself is a relatively mild viral disease, although it does pose significant risk to a baby born to an infected mother.

Since native rubella has virtually been eliminated from the U.S., do the benefits of continuing the rubella vaccine outweigh the risks? Remember the evidence from earlier in this document about the increase in autism as fetal cell line components of vaccines were introduced? This trend was strongly associated previously in this document, especially with the MMR. **The discussion with Dr. Theresa Deisher on pages 160-162 implicating the dangers of the human DNA fragments from these aborted fetuses combining with the recipient's own DNA (homologous recombination) poses serious cause for concern. The rubella component of the MMR is the one with the Winster Institute-38 (or WI-38) aborted fetus cell line DNA in it.**

The Rubella portion of the MMR contains the aborted fetal DNA and has been implicated in the meteoric rise of autoimmune diseases and Autism Spectrum Disorder since its inclusion. Re-visit the article presented earlier by doing a key phrase search for **Epidemiologic and Molecular Relationship Between Vaccine Manufacture and Autism Spectrum Disorder Prevalence**. Also, search **Deisher** for a complete review of these connections and the dangers of fetal DNA contamination.

Much more can be read about these fetal cell lines, including the risks and the ethical considerations in the vaccine ingredients section on pages 124-129 and 182-188.

A June 5th, 2019 report in JAMA Dermatology, covers recent cases of Rubella vaccine associated granulomatous skin lesions that can persist many years

The report published online, cites 9 recent cases of granulomatous disease skin lesions in immunocompromised children that had been vaccinated with the MMR vaccine. The report shows 2 cases, one in an 11-year-old boy and one in a 2 ½ year old girl. **Both subject's skin lesions tested positive for the vaccine specific Rubella virus, even though their salivary testing was negative for rubella and any other infectious agents.** The location of the skin lesions was not in proximity of the injection they received when they had been given the MMR vaccine.
https://www.ncbi.nlm.nih.gov/pubmed/?term=31166586

The boy's lesions were on his face and didn't show up until 5 years after his second MMR vaccine, which was given at age 5. The picture at 1-year after initially presenting to the doctor, showed that the tissue had developed **pitting or cratering type lesions** and looked puffy and inflamed. **It looked much worse than it did on the picture taken during his initial presentation.**

The girl developed red pimples on her legs 12-months after her MMR vaccine, which was given at age 1. The skin lesions tested positive for the vaccine specific rubella strain, although her salivary tests were negative. She was then followed up at age 10. **After 8-years, she still had very graphic granulomatous disease lesions which appeared red, puffy, looking inflamed and crusted.** The lesions once again tested positive for the vaccine specific Rubella strain, even though her salivary testing was negative. The report also stated, that the antibody titers to MMR were good, but that the immunity to Streptococcus pneumoniae, Haemophilus influenzae, and tetanus toxoid were low, even though the patient received those vaccines on schedule. Apparently, she was a case of either primary vaccine ineffectiveness or vaccine waning.

The report also suggested that there was a causal relationship between rubella virus in the skin and the development of the granuloma.

It also said that, **these 2 cases were in addition to a growing number of reports regarding *Vaccine-Derived Rubella Virus* and granulomas in patients with immune system deficiencies.**

The Measles Narrative is Collapsing-An effective evidence-based rebuttal to the 5 main measles talking points

This is an article that I wrote rebuking the media barrage of the 5 key vaccine industry talking points about the measles and the measles vaccine. These talking points are designed to instill fear into the population, in an effort to increase compliance with their coersive agenda of compliance. The goal is to drive mandates and the elimination of personal right and freedoms.

The measles vaccine narrative is collapsing

The measles and the MMR vaccine have become the catalyst for the pressure to increase vaccine mandates and to remove freedom of choice in the form of the repeal of personal and religious exemptions. Since the vaccine proponent's agenda is to go with the apocalyptic-fear-mongering measles strategy, let's poke some major holes in it by taking a look at what the contemporary science says about the false narratives being repeated ad nauseum in the media. (All references are found in this eBook)

Key false talking points driving their campaign of fear and coerced compliance-

1. **If the measles returns, thousands of children will die annually in the U.S.**
2. **The 2 dose MMR Vaccine regimen provides lifelong protection in most people**
3. **Previously vaccinated adults with waning antibody protection, can receive effective and lasting protection from MMR booster shots**
4. **We must achieve and sustain a 95% vaccination rate to maintain herd immunity**
5. **The MMR and MMRV will protect against all strains of measles**

Then we will take a look at:

- **Injuries and deaths from the Measles (MMR) Vaccine**
- **The vaccine industry is allowed to operate in a liability-free environment with no oversight or accountability**
- **The accumulative effect of the ever-increasing number of vaccine doses**
- **The long-term BENEFITS of acquiring these childhood infections early in life**

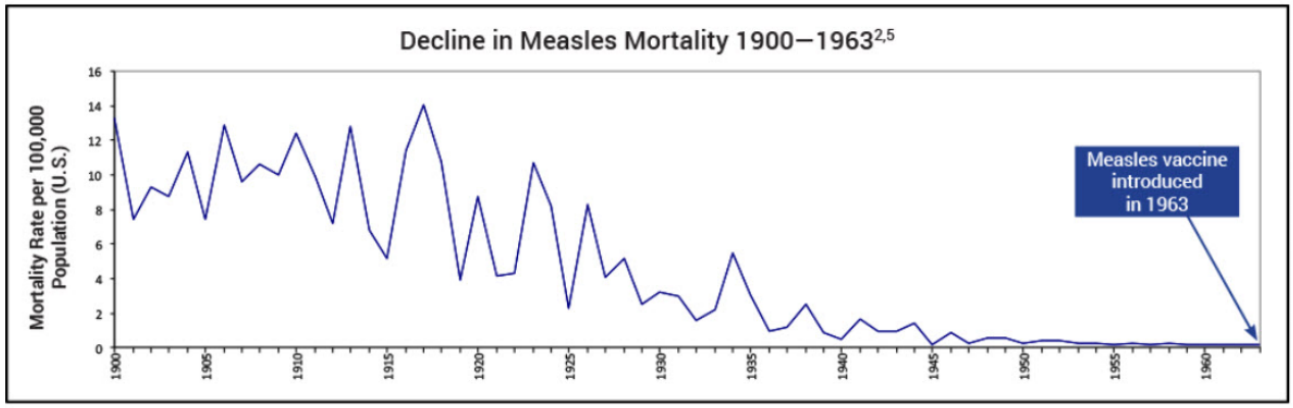
Rebuttals to the five key talking points pushing the measles vaccine agenda:

*As a footnote: There are numerous examples of each of the following points found in ***1200 Studies***. The page numbers cited will serve as an example of the growing scientific consensus and a good starting point for further exploration.

Talking point #1: If the measles returns, thousands of children will die annually in the U.S.-

It is time to put this unreasonable fear of measles to rest. The real risks from measles in modern-day America pales as compared to vaccine injuries and adverse effects on the health of our children (see pages 561-564). I will spend extra time on talking point #1, because it is the hyper-exaggeration of the threat and the fear that threat produces in the population, that the vaccine industry is counting on to drive public compliance and legislative action to remove freedom of choice.

The first measles vaccine was introduced in 1963 and was ineffective and problematic. The second generation of the vaccine was introduced in 1968 and achieved more widespread use and acceptance. The vaccine industry narrative takes credit for the decline in measles deaths as a result of the measles vaccine. However, U.S. Government public health statistics present a very different story. The rate of deaths attributed to measles had declined over 98% between the years of 1900 and 1962 and was continuing in a downward decline at that point (some government statistics say the death rate had decreased 99.4% prior to the measles vaccine introduction in 1963). Regardless, that is nearly a 100% decline. There is no reason to believe that it wouldn't have continued to decrease absent the introduction of the vaccine. To suggest that the measles vaccine had anything to do with the decline in mortality is dishonest and a poor attempt at re-writing history.



The government reported mortality rate for measles prior to the introduction of the vaccine was approximately 1 in 10,000 cases. It is often reported as 1 in 1,000 cases. This is once again an attempt to exaggerate the facts. Ninety percent of all measles cases were never reported because parents never took their children to the doctor. The cases were mild, lasted a few days, the kids went back to school and life went on. No big deal. Approximately 10% of the overall cases were severe enough to seek

medical care. Of those 10% that sought medical care and were REPORTED, the fatality rate was about 1 in 1,000. News outlets often inaccurately report the death rate figure as 1 in 1,000 cases by leaving the word “reported” out. The facts are that the death rate was closer to 1 in 10,000 cases. Another crucial fact to consider, is of those deaths from measles complications, studies show that fatalities were 10 times higher in extremely low income, poverty-stricken communities compared to middle income communities (see page 488). This increased incidence of fatalities drastically skewed the overall death rates. The death rate in middle and upper-income areas is thought to have been 1 in 100,000 cases or less. This points to the fact that malnutrition, overcrowding, decreased personal hygiene, poor sanitary conditions, lack of vitamins and vitamin fortified foods and decreased access to medical care all play a role in the outcome of infectious diseases, as you will see in the next section. Now even one death is too many, but we must also consider that the measles vaccine itself has been responsible for serious vaccine injuries, permanent disabilities and deaths. Stay tuned, that will be covered in more detail in this article. Fast forward 60 years to 2019 and the standard of living has improved for nearly all Americans. We have better access to quality nutrition, vitamins and vitamin fortified foods, clean water, improved public health measures in all sectors including the awareness of proper personal hygiene and access to advanced medical care. All of these factors would significantly reduce the rates of complications and deaths from the measles in modern-day-America as compared to 1960.

So, what made conditions right for the spread and deadliness of infectious disease?

Large cities were ripe for spread of infectious disease in the 1800’s and early 1900’s

You can see by the graph that measles was a deadly disease in the late 19th and early 20th century in the U.S. and Western Europe. That period of time was one where cities were extremely overcrowded, lacked proper sanitation and waste disposal, clean water and access to nutritious food. There was no garbage pickup, therefore trash piled up. There were open sewers behind shacks and overcrowded buildings housing large numbers of people. Horses were the main mode of transportation, so the narrow streets were full of manure and the air was contaminated. Flies and rats were everywhere. The conditions were ripe for infection and all of those factors weakened people’s immune systems.

Why are measles deadlier in some countries than others?

The conditions in the mid to late 1800's and early 1900's were in many ways very similar to impoverished parts of the world today, where there is a lack of all these basic community public services, limited access to healthy food and clean water, filth and garbage everywhere, open sewage, lack of education about personal hygiene and rampant malnutrition is commonplace. These conditions create an environment ripe for infectious disease AND weaken people's immune systems to the point where they are unable to fight even the mildest of infections.

Those descriptions and these pictures certainly do not depict the United States of America, Western Europe and other advanced societies today! This is the reason why the fear mongering, hysteria and lies about measles returning and decimating our children are so disingenuous. It is being pushed by the insatiable profit driven vaccine makers and so the media, who is beholden to them for advertising revenue becomes their mouthpiece. Solutions other than vaccines exist. Even vitamin A supplementation is being used successfully by the ***World Health Organization*** in third world-countries where measles is still epidemic. Their vitamin A campaigns have been heralded as huge successes (see pages 472, 483-485, 700). Today in modern day America, we also have access to other types of herbal

and natural antiviral compounds that could protect a child who may contract the measles from developing complications, reducing the risk of complications and shortening the duration of the illness. Even immune compromised persons now have access to immune globulin therapy that is extremely effective in reducing complications from measles. In the 1950's and 60's, measles was viewed as an inconvenient, yet harmless condition that virtually everyone got, recovered from and then had lifelong protection.

To learn more an understand the dynamics of why measles was so deadly 70 to 100 years ago, and what makes it deadly in impoverished parts of the world today, AND why the death rates declined for measles and other infectious diseases nearly 100% without vaccines, read the section in ***1200 Studies*** titled, **The Truth about the Decline of Infectious Disease.**

Talking point #2: The 2 dose MMR Vaccine regimen provides lifelong protection in most people-

According to the CDC's website… **"***People who receive MMR vaccination according to the U.S. vaccination schedule are usually considered protected for life against measles and rubella. While MMR provides effective protection against mumps for most people, immunity against mumps may decrease over time and some people may no longer be protected against mumps later in life… Both serologic and epidemiologic evidence indicate that vaccine-induced measles immunity appears to be long-term and probably lifelong in most persons."* https://www.cdc.gov/vaccines/vpd/mmr/hcp/about.html .

This information is outdated and has been proven completely wrong!

That information may have been somewhat accurate when there were still large numbers of aging people in the population that had wild measles as children giving them lasting immunity and there were still children with measles in the population to provide natural "boosters" to adults, but that dynamic changes over time as more people are vaccinated. We have learned the last few years, that antibody levels produced by the measles vaccine wanes rapidly, with efficacy lasting no more than 10 years after the second dose (antibody levels dropping approximately 10% per year), and how additional doses provide no lasting protection. This leaves the previously vaccinated adult population completely unprotected. So in essence, the vaccine program works for a period of time (scientists call this the "honeymoon" period), because many of the children that had acquired wild measles and developed lifelong immunity stayed safe and immune as they became adults. That keeps measles infections in check for several years. But as the vaccinated children age-out of protection and vaccination rates for young children remain high, there are no longer young children with wild measles in the population to provide those natural boosters to adults from the exposure to children with measles (as compared to the pre-vaccine era). Over time, vaccine induced antibody levels drop throughout the aging population leaving them vulnerable to infection and sadly, the honeymoon is over (pages 505-507).

These are all reasons why such a high percentage of people contracting the measles in recent outbreaks are adults who have been previously vaccinated. What has happened, is the measles vaccine has destroyed the natural herd immunity we used to enjoy. The pseudo "herd immunity" highly touted by

vaccine proponents turns out to be a complete fallacy and falls apart due to the secondary vaccine failure to provide the lifelong immunity that was previously promised (pages 572-580). During the infamous 2015 Disneyland outbreak and subsequent U.S. measles cases that year, there were 194 cases in which virus sequences were obtained. Of those, 73 (38%), were identified as MMR vaccine sequences (***Journal of Microbiology***, Volume 55, Issue 3, March 2017 https://jcm.asm.org/content/jcm/55/3/735.full.pdf). During these measles outbreaks, the blame is often put on the unvaccinated. These statistics and others from other outbreaks show that the vaccinated are also susceptible. In addition, the age of the California cases ranged from 6 weeks to 70 years old, with an average age of 22 (***Annals of Emergency Medicine***, Vol. 66, No. 1, July 2015 https://www.annemergmed.com/article/S0196-0644(15)00292-9/pdf). The fact that so many of the cases were 22 years old and older, indicates a significant change upward due to vaccine failure as previously described. In the pre-vaccine era, half of all children had the measles by age 6, with the rest acquiring it in the years shortly thereafter. This is when measles is mildest and has the lowest rate of complications.

Another unintended consequence of vaccinated adults having low antibody titers, is that females of childbearing age do not have enough antibodies to pass sufficient amounts to their newborn babies, making their infants more susceptible to contracting the measles (see pages 582-583). Of the 110 California cases from the Disneyland outbreak, 12 (11%), were infants too young to be vaccinated (***Annals of Emergency Medicine***, Vol. 66, No. 1, July 2015). These infants most likely would have been protected if their mothers had contracted wild measles as a child.

The science now shows a shift in the demographics of measles cases due to the vaccine program. This shift has effectively transferred the risk to the two groups most vulnerable to serious complications, newborns and adults. As mentioned previously, this same vaccine failure is being recognized with other infectious diseases that we thought we had achieved control over.

Talking point #3: Previously vaccinated adults with waning antibody protection, can receive effective and lasting protection from MMR booster shots-

2017 research published in the ***Journal of Infectious Diseases*** demonstrated that additional doses of MMR given to adults has minimal effect on raising antibody levels and the increased titers are very temporary decreasing in under 4 months. Therefore, the kneejerk reaction by vaccine proponents that we can mandate adults get their MMR shots every 5-10 years won't work. And it becomes readily apparent that we cannot vaccinate our way out of this problem (see pages 577-578). So, what do we do now? It's like squeezing toothpaste out of the tube. You can't put it back in!

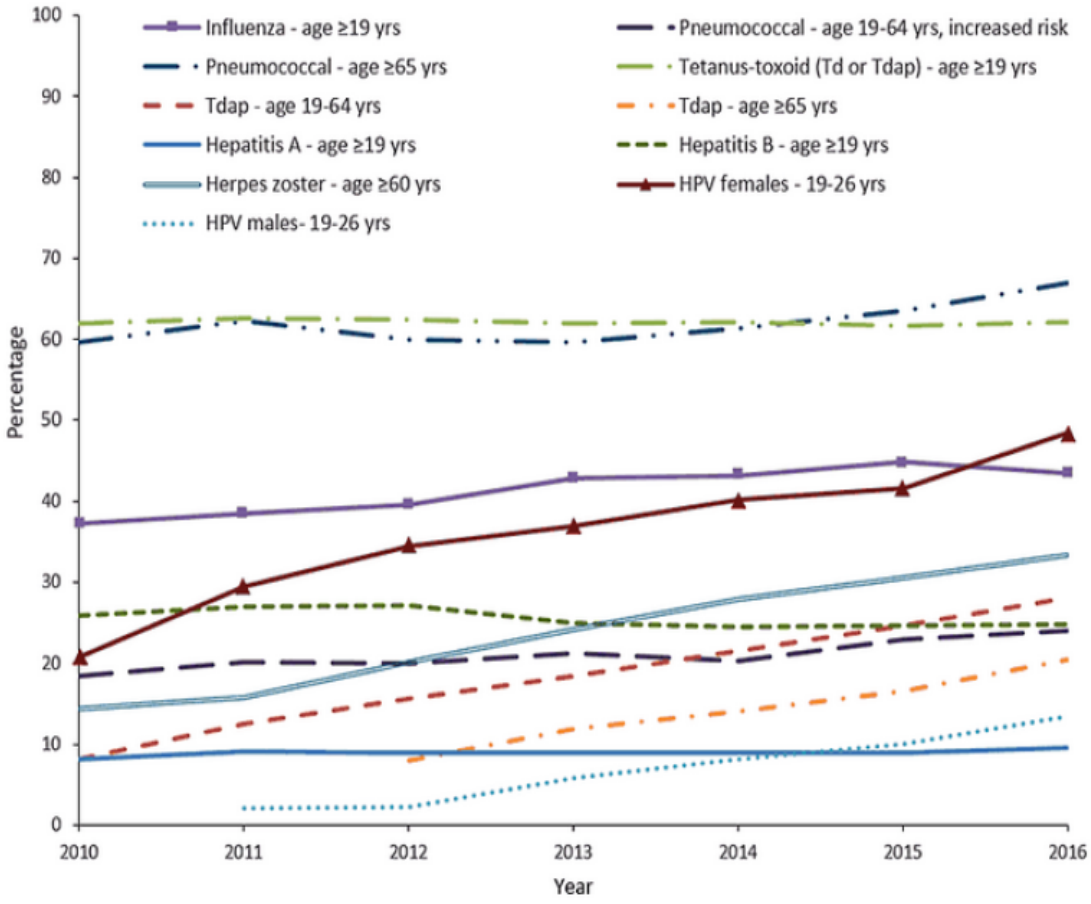
Talking point #4: We must achieve and sustain a 95% vaccination rate to maintain herd immunity-

We hear this all the time. We have to get all the children vaccinated to maintain "herd immunity". And, that this is what will protect the vulnerable that can't be vaccinated. The narrative about protecting

herd immunity is designed to prop up vaccination efforts and public compliance. Yet, with an unprotected adult population, we are nowhere close to the 95% "immune" rate for measles to achieve herd immunity. In fact, as you will now see, CDC stats prove that we are nowhere close to it with any of the infectious diseases that vaccines are given for.

The CDC's website has a document titled, ***Trends in Adult Vaccination Coverage: 2010 to 2016***. That document is from the ***National Health Interview Survey*** and shows the percentages of the adult population who say they have been vaccinated against various infectious diseases. (also shown previously in ***1200 Studies***)

FIGURE. Estimated proportion of adults ≥19 years who received selected vaccines, by age group and increased risk status— National Health Interview Survey, United States, 2010–2016. See data file [1 sheet].



Source: https://www.cdc.gov/vaccines/imz-managers/coverage/adultvaxview/pubs-resources/NHIS-2016.html

Conspicuously, measles, mumps and Rubella are absent from the survey. I have searched extensively and have not found any other surveys where they were included. One has to ask the question why? Especially because the MMR vaccine is one of the mainstays of the vaccine paradigm, if not the holy grail itself. Is it because for adults, the vast majority of them post-vaccine era (under 60-years-old), would not

have been vaccinated since pre-kindergarten and the survey designers would know that the percentage affirming that they are immunized against M, M or R would be extremely low? Or is it that vaccine researchers have known for some time now that the antibody titers wane rapidly and that adults would not be protected? Whatever the reason, the outcomes just wouldn't fit the narrative they are pushing, now would they?

In looking at the graph, realize that this is from the ***National Health Interview Survey***, where adults were asked if they had been vaccinated for various infectious diseases. Since we now know that immunity from vaccines tends to wane or decrease over time, in reality many of the adults answering in the affirmative as to their vaccination status and included in those percentages, would have most certainly lost that temporary immunity, and therefore don't really belong in that cohort of "vaccinateds" anyway. That of course would drop those percentages even lower. In 2-6-year-olds, the vaccine coverage rates are in the 80-90% range, but they are just a small part of the herd (maybe 5%). And, persons under 18 years of age account for less than 20% of the entire population. The pro-vaccine herd immunity argument may hold water if all the young children were kept in a bubble, fully sequestered from all those adults who are not vaccinated, but we know that is not the case. We all live together mingling with cross-exposure in this big herd we call humanity. So, the reality is that their argument is really a talking point with no basis in fact. It is an intentional strategy used to create the appearance of a solution in order to achieve their objectives of full vaccination compliance in children. Also, consider that there is what is called primary vaccine failure. There is a subset of children that the vaccine just doesn't produce sufficient antibody response in. Vaccine proponents claim that this number is only about 5%. But other data suggests that the number may be higher. At any rate, even with 100% vaccine compliance in children, nearly 1 out of every 10 will remain unprotected.

In addition as just mentioned, vaccines have destroyed natural lifelong herd immunity that came from the immune response to wild measles infection, leading to a change in the demographics of the people getting the disease away from 4 to 12-year-olds (pre-vaccine demographics), where the disease is mildest to adults and infants (post-vaccine era demographics), two populations in which the disease causes much greater complications.

Talking point #5: The MMR and MMRV will protect against all strains of measles-

There is now evidence emerging that as a result of intense vaccine pressure, the measles virus is mutating. A 2017 article from the ***Journal of Virology*** warns of this ominous signal, a discovery of what they are calling the D4.2 sub-genotype. So far, this "mutant" has been isolated in France and Great Britain. Experts calling these strains "escape mutants", warn that with an unprotected adult population (whose titers cannot be boosted as just mentioned), we face the potential of unprecedented outbreaks as a result. The mutant was not effectively neutralized when tested against sera from approximately 70 North American vaccinated individuals. The concern is that under high vaccination coverage, the virus is finding ways to survive. Given the short-term temporary immunity provided by vaccines, rather than a whole population that through childhood exposure to wild measles would maintain a lifelong robust protection against all measles variants, we are now at risk for wide-spread outbreaks.

The research is signaling a looming crisis, similar to what we have created with antibiotics. The over-prescribing of antibiotics has created mutations in bacteria that have outpaced the development of new antibiotics. Not only that, but these "superbugs" as they are called are much more virulent (deadly). Currently, well in excess of 100,000 people die annually in the U.S. from antibiotic resistant infections and it is only getting worse. Is it possible that we are setting ourselves up for a similar scenario with vaccines?

Injuries and deaths from the Measles (MMR) Vaccine-

A historical look at the adverse reactions and deaths due to the measles vaccine and the MMR vaccine can be found on the ***National Vaccine Information Center's*** website at www.nvic.org . Pull up the article titled, **Can Measles Vaccine Cause Injury and Death**? https://www.nvic.org/vaccines-and-diseases/measles/measles-vaccine-injury-death.aspx As reported in that article; "As of November 30, 2018, there have been more than 93,179 reports of measles vaccine reactions, hospitalizations, injuries and deaths following measles vaccinations made to the federal Vaccine Adverse Events Reporting System (VAERS), including 459 related deaths, 6,936 hospitalizations, and 1,748 related disabilities."

And these statistics are most certainly just a drop in the bucket, as according to CDC sponsored research, less than 1% of the adverse reactions from vaccines are ever reported to VAERS (Harvard Pilgrim Health Care Study https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf . Consider the statistics above about adverse reactions and vaccine injuries just from the MMR vaccine and multiply by 100 (or add two zeros to those numbers), and you would be closer to the actual number of adverse vaccine reactions. Since there are in the neighborhood of 60,000 adverse reactions reported annually to VAERS, the true number is more likely to be around 6 million.

The vaccine industry is allowed to operate in a liability-free environment with no oversight or accountability-

The vaccine industry has been given a liability free environment to operate in, thanks to the ***National Childhood Vaccine Injury Act of 1986 (NCVIA)***. This occurred because vaccine manufacturers were being forced out of business due to the increasing number of lawsuits from vaccine injury victims (see pages 387-389). It was essentially an ongoing bailout for the pharmaceutical industry. One that taxpayers are continuing to fund today. As a result, the NCVIA prompted the U.S. Government to set up the ***National Vaccine Injury Compensation Program (NVICP).*** This provided vaccine injured individuals the ability to attempt to recover damages (with a limited cap on awards), from vaccine injuries. The number of compensated awards each year is climbing steadily, with 2019 on track to be nearly triple the number awarded in 2018. Considering that 4.2 billion dollars have been paid out through the NVCIP to date and millions of dollars in awards are added to that total monthly, it proves that vaccines are far from safe for everyone as is implied relentlessly in the media.

Another consideration that has recently come to light as a result of a ***Freedom of Information Request*** filed by Robert F. Kennedy Jr. on behalf of the ***Informed Consent Action Network***, is the ***Department of***

Health and Human Services (HHS) which was charged with monitoring the actions of the vaccine manufacturer's practices and safety, essentially providing oversight protections for the American people, has been asleep at the wheel for the last 33 years. The task force required by Congress under the NVCIA was to include "the **Director of the *National Institute of Health (NIH)*** is the chair of the Task Force**,** which by statute also includes the **Commissioner of the *FDA* and the Director of the *CDC***."

This was their job as mandated by Congress…. *"Hence, since 1986, HHS has had the primary and virtually sole responsibility to make and assure improvements in the licensing, manufacturing, adverse reaction reporting, research, safety and efficacy testing of vaccines in order to reduce the risk of adverse vaccine reactions. In order to assure HHS meets its vaccine safety obligations, Congress required as part of the 1986 Act that the Secretary of HHS submit a biennial report to Congress detailing the improvements in vaccine safety made by HHS in the preceding two years."*

In essence, they were to report the results of their oversight of the liability vaccine industry to Congress every 2 years. Guess how often that happened? According to HHS, they have no record of any report ever being filed! As you can see, clearly vaccines are far from harmless like we are told to believe. And it would appear that we cannot count on our government agencies tasked with keeping us safe to ensure that safety.

We certainly can't count on the vaccine industry to police itself. In a 78-page article dated March 30, 2019 by ***Gayle Delong*** and published on ***Research Gate*** titled, **Is "Delitigation" Associated with a Change in Product Safety? The Case of Vaccines**, the author uses very sophisticated analysis of the adverse events from vaccines before congress passed the National Childhood Vaccine Injury Act (NCVIA) in 1986 and compared them with after. An important conclusion from the research… The results suggest that product safety deteriorates when consumers are no longer able to sue manufacturers.

Vaccine injuries from the accumulative effect of dozens of doses is not always immediately apparent-

Learn what thousands of scientists, researchers and doctors are saying in the peer-reviewed published literature about the dangers of the relentless increase of exposure to the rising number of vaccines early in life. They fear that we are trading mostly benign self-limiting childhood diseases for epidemics of chronic lifelong debilitating autoimmune, neurological, immunological and reproductive disorders. We have seen a meteoric rise in all these conditions, and that increase has tracked parallel to the dramatic increase in the number of doses of vaccines added to the CDC schedule over the last 60 years (from 8 doses to 72 doses by age 18 today, with 36 doses by 18 months of age). It is often said that correlation does not equal causation. And while that is true, we now have hundreds if not thousands of published studies identifying direct evidence of causation. You can read more about the association of the various ingredients in vaccines in the sections in ***1200 Studies*** on mercury, aluminum and the many other toxic vaccine ingredients that are implicated in dozens of these same adverse health conditions, many of which were rare or non-existent 60 years ago.

Another great fact and science based resource on the MMR vaccine can be found at www.physiciansforinformedconsent.org. They have 3 excellent evidence based position papers available for download on the measles and the MMR Vaccine.

Benefits of childhood infectious diseases?

Studies over the last several years have also found benefits from getting naturally acquired measles as a child, including a reduced risk of Hodgkin's and non-Hodgkin's lymphomas, atopic diseases such as hay fever, eczema and asthma. Measles infections are also associated with a lower risk of mortality from cardiovascular disease in adulthood (see pages 650-653).

A call for action-

It is time that an exhaustive INDEPENDENT (without the fingerprints of pharma), investigation be initiated to thoroughly exploring the safety and efficacy of vaccines and the risk vs. the reward of continuing the status quo. I would like to urge everyone to send this article to their state and federal elected representatives. Urge them to demand the establishment of an independent Vaccine Commission. I would like to nominate Robert F. Kennedy Jr. as the Chair overseeing the work of the commission. He is the Chairman of the ***Children's Health Defense*** organization (www.childrenshealthdefense.org). He has the working knowledge and experience to facilitate an independent deep dive into the pseudo-science and alleged fraud behind vaccine safety studies and to investigate the potential conflicts of interest and bias in the regulatory agencies and the pro-vaccine studies, which are frequently funded by the pharmaceutical industry and authored by persons receiving financial rewards by that same industry. Our elected officials must consider the input of the growing number of non-conflicted scientists, researchers and medical doctors that are calling for this kind of uncorrupted and broad sweeping investigation.

The right to opt out must be preserved-

What has been presented here is literally the tip of the iceberg. In the end what this boils down to, is an individual must continue to have the right to choose whether they believe the vaccine industry's claims of safety and efficacy, or the growing mountain of scientific evidence that contradicts those claims as presented in ***1200 Studies***. It is imperative that an individual can maintain the right to exercise control over the sanctity of theirs and their children's bodies. Where there is risk (which has been undeniably established), there must be full informed consent and the right to opt out (see pages 394-396). In light of all of the credibility gaps of the false talking points presented in this article and the obvious and well-documented risks of vaccines, freedom of choice and autonomy over one's own health must be preserved.

The pertussis vaccine is also ineffective

A whooping cough outbreak despite high immunization rates

A report dated June 12th, 2014 and aired on ***KPBS San Diego*** revealed that **85% (527), of the 621 people that contracted whooping cough in San Diego County were up to date on their immunizations against the disease.** http://www.kpbs.org/news/2014/jun/12/immunized-people-getting-whooping-cough/

When Immunity Fails: The Whooping Cough Epidemic, a documentary co-reported by ***KPBS*** and **inewsource,** examined the worst epidemic in California in 60 years. The investigation led to several scientific studies which found that immunity faded sooner than expected after people were vaccinated.

Another whooping cough outbreak in immunized children

Scientific American published an article in 2016 titled, **Whooping Cough Outbreak: How Effective Is the Vaccine?** The subtitle was, **Widespread pertussis vaccine use at a Florida preschool failed to keep the disease away from about three dozen students, staff and family members.**

The outbreak occurred in September 2013 at a Florida preschool in which **112 of the 117 students** were previously fully vaccinated **with up to 4 doses of the vaccine**. **The outbreak lasted five months and affected 26 preschoolers, 2 staff members and 11 family members of the students or staff at the facility. Experts looking at the scenario blamed "waning immunity" or the fact that the vaccine's effectiveness is short lived** as one of the causes for the outbreak. This weakness of many vaccines will be covered in more detail on the next page.
https://www.scientificamerican.com/article/whooping-cough-outbreak-how-effective-is-the-vaccine/

The Journal Pediatrics confirms "waning immunity" to be a major flaw

The waning of the pertussis vaccine is discussed in a 2016 article published in the ***Journal Pediatrics*** titled, **Waning Tdap Effectiveness in Adolescents.** The conclusion of the article: **"Routine Tdap did not prevent pertussis outbreaks**. Among adolescents who have only received DTaP vaccines in childhood, Tdap provided moderate protection against pertussis during the first year and then **waned rapidly so that little protection remained 2-3 years after vaccination.**"
https://www.ncbi.nlm.nih.gov/pubmed/26908667

The Journal of Infectious Diseases finds waning immunity of both Tdap brands

The ***Journal of Infectious Diseases*** published a 2014 article titled, **Estimating the effectiveness of tetanus-diphtheria-acellular pertussis vaccine (Tdap) for preventing pertussis: evidence of rapidly waning immunity and difference in effectiveness by Tdap brand.** The article looked at vaccine

effectiveness of tetanus-diphtheria-acellular pertussis vaccine (Tdap) for preventing pertussis among adolescents during a statewide outbreak of pertussis in Wisconsin during 2012. https://www.ncbi.nlm.nih.gov/pubmed/24903664

CONCLUSIONS:
"Our results demonstrate waning immunity following vaccination with either Tdap brand."

Vaccine failure- Whooping cough rates continue to climb despite all-time high vaccination rates

A 2017 article from ***F1000 Research*** titled, **The Relationship Between Mucosal Immunity, Nasopharageal Carriage, asymptomatic Transmission and the Resurgence of Bordetella Pertussis**, looks at the potential reasons for the resurgence of whooping cough despite all-time high vaccination rates. https://f1000research.com/articles/6-1568

From the article:
"The incidence of whooping cough in the US has been rising slowly since the 1970s, **but the pace of this has accelerated sharply since acellular pertussis vaccines replaced the earlier whole cell vaccines in the late1990s**. A similar trend occurred in many other countries, including the UK, Canada, Australia, Ireland, and Spain, following the switch to acellular vaccines. The key question is why. Two leading theories (**short duration of protective immunologic persistence and evolutionary shifts in the pathogen to evade the vaccine**) explain some but not all of these shifts, suggesting that other factors may also be important."

"Poor persistence of anti-pertussis antibodies following aP vaccination: many studies have documented rapid declines in pertussis antibodies, **often to baseline concentrations, within as few as 2–3 years of the last aP vaccination (DTaP or Tdap)**, and these declines coincide with falling clinical efficacy. Klein et al. estimated a 42% increase in the odds of acquiring clinical pertussis disease per year since the fifth dose of DTaP. Similarly, a meta-analysis by McGirr and Fisman estimated that **the odds of pertussis disease increased by 33% for each year after the last aP vaccination**, **such that only 10% of fully vaccinated infants would remain protected after a median of 8.5 years."**

"In our view, we are approaching a critical decision point. In the US, pertussis rates and infant pertussis deaths are now at a 70-year high, and despite record uptake of aP vaccines, pertussis rates in the US have continued to rise, **casting doubt on whether further increasing aP vaccine coverage can ever compensate for their fundamental limitations**. Stanley Plotkin, among others, has offered several possible approaches to deal with this situation: (i) a return to the reactogenic wP vaccines (which would be challenging given our increasingly vaccine-averse population); (ii) integration of wP and aP vaccines in the infant schedules (also a difficult "sell", notwithstanding that there are no longer any wP vaccines licensed in the US); (iii) attempts to broaden and enhance the immunogenicity of aP vaccines by adding in lipopolysaccharide or novel adjuvants; or (iv) developing new pertussis vaccines, including live-

attenuated nasal vaccines that could be delivered directly at the NP mucosa specifically to enhance mucosal immunity."

Certainly, reverting to a whole cell more reactogenic vaccine that will cause a higher rate of adverse reactions is not a viable solution. In my mind, the best strategy for parents is to embrace and implement an immune supportive diet and lifestyle for their infants and young children. Remember the "Terrain" or "Germ" debate? Focusing on creating a terrain that is inhospitable for pathogenic microorganisms is a great place to start.

Whooping cough vaccines don't cover all strains, are of short duration and contribute to mutant strains

This study published in the Journal ***Vaccine*** titled, **Imperfect vaccine-induced immunity and whooping cough transmission to infants**, raises serious concerns about mutant strains and ineffectiveness. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2997163/pdf/nihms247974.pdf

"**Whooping cough, caused by Bordetella Pertussis and Bordetella Parapertussis, has increased in incidence throughout much of the developed world since the 1980s despite high vaccine coverage, causing an increased risk of infection in infants who have substantial disease-induced mortality.** Duration of immunity and epidemically significant routes of transmission across age groups remain unclear and deserve further investigation to inform vaccination strategies to better control pertussis burden. The authors analyze age- and species-specific whooping cough tests and vaccine histories in Massachusetts from 1990–2008. On average, the disease-free duration is 10.5 years. However, it has been decreasing over time, possibly due to a rising force of infection through increased circulation. Despite the importance of teenage cases during epidemics, wavelet analyses suggest that they are not the most important source of transmission to infants. In addition, the data indicate that the B. pertussis vaccine is not protective against disease induced by B. parapertussis." *(which the study indicated is about 10% as common).*

The study also indicated that the group most likely to get the B. parapertussis infection is 5-10 year olds that had already been vaccinated for B. pertussis. "It primarily caused whooping cough in 5–10 year olds, who are expected to have strong vaccine-induced immunity against *B. pertussis."*

The vaccine's effectiveness is of short duration: "…the mean and median times from last vaccination to infection between 6.5 and 7 years for both."

The authors propose that **the mutation of strains of the B. pertussis is in part responsible** for the evolution of more potent strains. Page 7… "Another potential explanation is that vaccine-driven pathogen evolution selected for a strain that **can infect more quickly or symptomatically after vaccination."**

The HPV Vaccine- An ongoing horror story

Profiting from biased estimates of vaccine safety and effectiveness

I have dedicated a significant amount of content (16 pages), to this next section on the Gardasil Vaccine, and for good reason. Gardasil has been responsible for the largest number of adverse drug reactions of all vaccines currently in use.

The Gardasil Story- A horrific trail of damaged children is based on weak science and deception

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3482043/ This article was published in the ***American Journal of Public Health*** 2012 and titled **Who Profits from Uncritical Acceptance of Biased Estimates of Vaccine Efficacy and Safety?** It specifically addresses Gardasil's horrific history of a high incidence of severe side effects in those receiving the vaccine and the fact that there has never been any proof of benefit to those individuals.

Quotes: "The exclusive reliance on Merck for scientific information on behalf of the legislators is unfortunate, especially in the light of independent research which has repeatedly warned that drug companies may manipulate clinical trial designs and subsequent data analysis and reporting to make their drugs look better and safer. Indeed, **careful scrutiny of Gardasil clinical trials shows that their design, as well as data reporting and interpretation, were largely inadequate**."

"Given this, the widespread public optimism regarding Gardasil's clinical benefits appears to rest on an extremely weak base built on a number of untested assumptions and significant misinterpretation of factual evidence. For example, **the claim that Gardasil vaccination will result in approximately 70% reduction of cervical cancers is made despite the fact that the clinical trial data have not demonstrated to date that the vaccine has actually prevented a single case of cervical cancer (let alone cervical cancer death)"**

"**A second equally fallacious claim is that lifelong protection arises from three vaccine doses, although clinical trial follow-up data do not extend beyond five years. The third claim is that Gardasil may induce only minor side effects of negligible clinical importance, although such conclusions are only supported by highly flawed safety trials design."**

"Additionally, we note **evidence of biased and selective reporting of results** from clinical trials, that is, **exclusion** of particular vaccine efficacy figures from peer-reviewed publications, such as those related to study subgroups **in which efficacy might be lower or even negative**."

"All of the above issues suggest that the information presented by Merck to the public and the various state legislators concerning Gardasil safety and true prophylactic value **were incomplete and inaccurate and thus inevitably misleading,** particularly in light of data from various vaccine safety surveillance systems and case reports that **continue to raise significant concerns regarding the safety of Gardasil."**

The article then presents a table that shows the percentage of adverse reactions to Gardasil compared with all other vaccine reactions reported to the Vaccine Adverse Event Reporting System (VAERS). Gardasil is responsible for 46.1% of all reported adverse reactions, with the vaccine being responsible for 81.2% of those individuals that were permanently disabled and 63.8% of those that died as a result of a vaccine reaction.

Finally, the conclusion…. "Keeping in mind that "the primary interest of a pharmaceutical company is developing and selling pharmaceutical product," **one must ask whether rational vaccine policy decisions should be based on conclusions derived from an uncritical acceptance of flawed vaccine safety and efficacy estimates provided by the vaccine manufacturer**. Failure to adhere to principles of evidence-based medicine with respect to Gardasil promotion and vaccination policymaking inevitably raises the question of whether we have learned anything from the Vioxx debacle." (Vioxx was an anti-inflammatory drug made by Merck). Vioxx caused the deaths of more than 60,000 people in addition to causing countless heart attacks before it was withdrawn from the market in 2004. **Merck used ghost written studies to support its claim that Vioxx was safe and effective**. In a 2008 editorial published in the ***Journal of the American Medical Association***, it was questioned as to whether Merck might have deliberately manipulated dozens of studies published in the medical literature to falsely promote Vioxx).

So, do you still think you can trust the drug companies like Merck? Merck is also one of the largest vaccine manufacturers, producing Gardasil which as I mentioned, is responsible for the vast majority of adverse reactions to vaccines. They also produce MMR, tuberculosis, meningococcal, hepatitis A and B, pneumococcal, varicella (chicken pox) and zoster (shingles) vaccines among others.

Let's look deeper into what scientists say about the serious adverse reactions and debilitating conditions tied to the HPV Vaccine

https://www.ncbi.nlm.nih.gov/pubmed/23369430 this article from the ***Journal Infectious Agents and Cancer*** in 2013 titled, **HPV vaccines in cancer prevention, science versus activism**, is a stark assessment of the bad science (pseudoscience) that has pushed this agenda on millions of children worldwide.

The Summary: "**The rationale behind current worldwide human papilloma virus (HPV) vaccination programs starts from two basic premises, 1) that HPV vaccines will prevent cervical cancers and save lives and, 2) have no risk of serious side effects. Therefore, efforts should be made to get as many pre-adolescent girls vaccinated in order to decrease the burden of cervical cancer**. **Careful analysis of HPV vaccine pre- and post-licensure data shows however that both of these premises are at odds with factual evidence and are largely derived from significant misinterpretation of available data**."

NEW - Vaccines have the capability of causing demyelinating diseases

Myelin is what the covering of the nerves and spinal cord are made of. It is often referred to as the myelin sheath. Demyelination is the atrophy or loss of the integrity of that sheath. This often occurs as part of an autoimmune response as is the case with Multiple Sclerosis (MS).

Published in the ***International Journal of Multiple Sclerosis Care.*** This paper was titled:

> ***Case Report:*** **Postvaccination Anti-Myelin Oligodendrocyte Glycoprotein Neuromyelitis Optica Spectrum Disorder: A Case Report and Literature Review of Postvaccination Demyelination.**
> https://pubmed.ncbi.nlm.nih.gov/32410903/
>
> **Abstract**
> "Stimulation of the immune response after vaccination can occasionally result in adverse effects, including demyelination of the central nervous system. The most common presentation of postvaccination demyelination is acute disseminated encephalomyelitis, but cases of optic neuritis, transverse myelitis, and multiple sclerosis relapses have been reported. More recently, an increasing number of postvaccination neuromyelitis optica spectrum disorder (NMOSD) cases have surfaced in the literature, especially in patients with aquaporin-4 antibodies. In this article, we report an unusual case of myelin oligodendrocyte glycoprotein antibody-related NMOSD after the receipt of multiple vaccines in a first-trimester pregnant woman from Africa. We review the reported cases of postvaccination demyelination in the past decade, with a focus on the relationship between NMOSD and vaccination in patients with aquaporin-4 or myelin oligodendrocyte glycoprotein antibodies. Finally, we discuss the clinical relevance of the present case and similar reported cases as it relates to patient care in the neuroimmunology clinic and identify potential areas for future research."

The study lists Influenza and HPV vaccines as the most common ones implicated in autoimmune demyelination after vaccination.

Ten percent of women receiving the HPV vaccine had an emergency room visit or were hospitalized in the following 42 days

http://www.sciencedirect.com/science/article/pii/S0264410X16002036 This 2016 article from the Journal ***Vaccine*** titled, **Adverse events following HPV vaccination, Alberta 2006–2014** demonstrates the high rates of reactions to the HPV vaccine. From the article:

Over the period 195,270 females were vaccinated

- 19,351 *(10%)* had an ED visit within 42 days of immunization.
- 958 were hospitalized

The conclusion: Conclusions: Rates of adverse events after HPV immunization in Alberta are low and consistent with types of events seen elsewhere. **LOW! Approximately 10% of women receiving the HPV vaccine had an emergency room visit within 42 days of the immunization and 958 hospitalized!**

Well, I guess everything is relative, when you asked the question low compared to what? The reason they said it was low is because the article states that **the rates of these reactions to HPV in the U.S. are 50% higher.** Some consolation. There is an article from the ***Journal of the American Medical Association*** published in 2009 showing rates of adverse events of various kinds in the U.S. Regardless, that is anything but low!
https://www.ncbi.nlm.nih.gov/pubmed/19690307 Read more on this study in a couple of pages.

Damage to ovarian function by the HPV vaccine has not been studied

A case study reported in the ***Journal of Investigative Medicine in 2014***, identified a lack of scientific research and oversight of the HPV Vaccine. This report evaluated three young women that developed **Premature Ovarian Insufficiency (P.O.I.), which is essentially premature menopause and infertility** following the HPV Vaccine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4528880

From the study:

"Long-term follow-up data after HPV vaccination **has not** surveyed ovarian function, recorded, measured, or analyzed symptoms or signs of dysfunction. Disparagement of adverse event reporting by licensing bodies' instruction to health providers that "there is no biologically plausible way in which HPV vaccine could cause infertility" **lacks science and compromises safety** monitoring by undermining "reporting efficiency", safety signaling and informed consent."

The authors go on to urge that the science be done to properly determine the safety of the HPV Vaccine.

"Principles of informed consent, population health, and vaccine confidence require careful, rigorous and independent research to establish ovarian safety following HPV vaccination."

Researchers find that the HPV vaccine can trigger a life-altering autoimmune response

A 2013 case study of three young women, published in the ***American Journal of Reproductive Immunology***, found the HPV vaccine had caused the autoimmune ASIA syndrome. The study titled, **Human papilloma virus vaccine and primary ovarian failure**, had some very critical things to say about the potential for adverse reactions following HPV vaccination.
https://www.ncbi.nlm.nih.gov/pubmed/23902317

From the article: "All three patients developed secondary amenorrhea following HPV vaccinations, which did not resolve upon treatment with hormone replacement therapies…. **specific auto-antibodies were detected (antiovarian and anti thyroid), suggesting that the HPV vaccine triggered an autoimmune response**. All three patients experienced a range of common non-specific post-vaccine

symptoms including nausea, headache, sleep disturbances, arthralgia and a range of cognitive and psychiatric disturbances. According to these clinical features, a diagnosis of primary ovarian failure (POF) was determined which also fulfilled the required criteria for the ASIA syndrome."

CONCLUSION: "We documented here the evidence of the potential of the HPV vaccine to trigger a life-disabling autoimmune condition. The increasing number of similar reports of post HPV vaccine-linked autoimmunity and the uncertainty of long-term clinical benefits of HPV vaccination are a matter of public health that **warrants further rigorous inquiry**."

Unfortunately, over four years later that rigorous inquiry has not yet been done.

A study from the Journal of the American Medical Association, reveals that adverse events from the HPV vaccine are very high and hints that the actual numbers may be significantly higher

A study published in the ***Journal of the American Medical Association (JAMA)*** in 2009, titled **Post-licensure safety surveillance for quadrivalent human papillomavirus recombinant vaccine**
https://www.ncbi.nlm.nih.gov/pubmed/19690307

From the Study:
Conclusion: "Most of the Adverse Events from Immunization (AEFI), rates were not greater than the background rates compared with other vaccines, but there was disproportional *(higher)* reporting of syncope *(fainting)* and venous thromboembolic events *(blood clots)*. The significance of these findings must be tempered with the limitations (possible underreporting) of a passive reporting system."

Here is where it gets interesting. When you look at the number of reported events, here is what they show… There is 1 AEFI for every 1,855 doses. Since they recommend 3 doses per person, if all had their 3 doses it means that there is 1 AEFI for every 618 persons immunized. Now consider the last sentence of the previous paragraph *(The significance of these findings must be tempered with the limitations (possible underreporting) of a passive reporting system).* Government statisticians cite that only somewhere between 1% to 10% of vaccine adverse reactions are even reported to the passive reporting system! So, if this study reported 1 AEFI for every 618 persons and 90% of adverse reactions are not reported, what are the REAL numbers? *(Read more about the criticism of this article by Dr. Diane Harper, a former lead researcher from Merck in a couple pages).*

Another study detailing some of the more common adverse effects of the HPV vaccine:

Many researchers are now calling this spectrum of adverse reactions Human Papilloma Virus Vaccination Syndrome.

This 2015 study also from the Journal ***Vaccine*** also correlates the HPV vaccine with the same significant side effects. The study titled, **Orthostatic intolerance and postural tachycardia syndrome as suspected adverse effects of vaccination against human papilloma virus (HPV)**, is just one more of many studies linking the HPV vaccine with this unique subset of adverse side effects. This study reports on a syndrome

characterized by orthostatic intolerance (dizziness or fainting when standing), headache, fatigue, cognitive dysfunction, and neuropathic pain starting in close relation to HPV vaccination. The syndrome has been called **Postural Orthostatic Tachycardia Syndrome (POTS).**
https://www.ncbi.nlm.nih.gov/pubmed/?term=25882168

CONCLUSION:
"In a population referred for symptoms of orthostatic intolerance and other symptoms consistent with autonomic dysfunction **that began in close temporal association with a quadrivalent HPV vaccination, we identified a 60% prevalence of postural orthostatic tachycardia syndrome (POTS)**. Further work is urgently needed to elucidate the potential for a causal link between the vaccine and circulatory abnormalities and to establish targeted treatment options for the affected patients."

NEW - Retrospective study on HPV vaccination shows and increase in need for medical care post-vaccination

A study published in ***Clinical Epidemiology*** September 08, 2020 titled, **General Practitioner Attendance in Proximity to HPV Vaccination: A Nationwide, Register-Based, Matched Case-Control Study**, found a correlation with increased general practitioner visits in girls and young women after HPV vaccination. Interestingly, it appears at the end of the article they try some "gymnastics" to try to explain away the findings. Looking at the graphs really tells the whole story. The study says that in all groups the increase in GP visits began in the first year after vaccination. And, when you see the graphs, you can see that those increases in visits continued at an even higher rate after the first year.

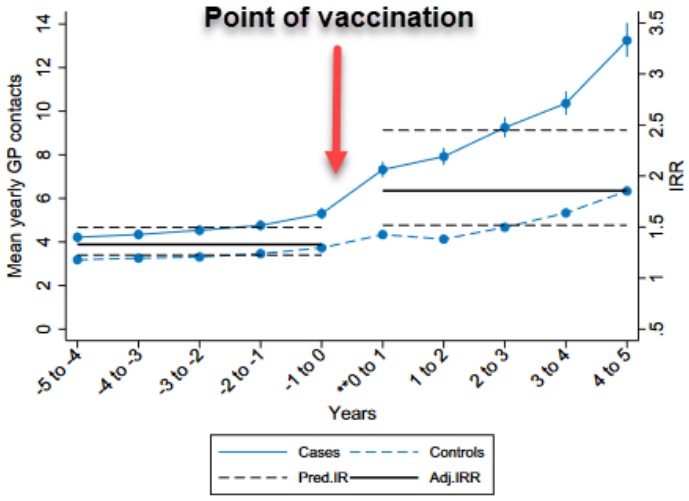


Figure 1 Mean yearly GP contacts and the ratio of the adjusted IRR from prior to vaccination compared to after vaccination between cases and matched controls (entire study population). Cases: 1,458; Controls: 7,212. ** Date of vaccination included.

https://pubmed.ncbi.nlm.nih.gov/32982458/

Debilitating syndromes linked to HPV Vaccine

https://www.ncbi.nlm.nih.gov/pubmed/?term=25990003 This 2015 study published in the Journal of ***Clinical Rheumatology*** titled, **Human papillomavirus vaccination syndrome – small fiber neuropathy in dysautonomia could be its underlying pathogenesis**, puts forth a theory as to the cause of the very severe reactions seen in some individuals receiving the HPV vaccine.

From the article:
"However, seemingly inexplicit adverse reactions have been described after the injection of the newer vaccines vs. human papillomavirus (HPV). The symptoms more often reported are chronic pain with paresthesias (numbness and tingling), headaches, fatigue, and orthostatic intolerance (dizziness or fainting when standing). **Adverse reactions appear to be more frequent after HPV vaccination when compared to other type of immunizations**. Different isolated cases and small series have described the development of complex regional pain syndrome (CRPS), postural orthostatic tachycardia syndrome (POTS), and fibromyalgia after HPV vaccination. These are illnesses often difficult to diagnose that have overlapping clinical features. Sympathetic nervous system dysfunction seems to play a major role in the pathogenesis of these syndromes. Also, small fiber neuropathy has been recently recognized in CRPS, POTS, and fibromyalgia."

"Clinicians should be aware of the possible association between HPV vaccination and the development of these difficult to diagnose painful dysautonomic syndromes."

Natural Health 365 posts individual stories of young girls and teens that have been paralyzed by the HPV vaccine

17-year-old girl paralyzed- https://www.naturalhealth365.com/hpv-vaccine-gardasil-2467.html

13-year-old girl confined to a wheel chair- https://www.naturalhealth365.com/hpv-vaccine-injury-2261.html

12-year-old girl paralyzed from the neck down- https://www.naturalhealth365.com/hpv-vaccine-injury-2198.html

3 Danish girls suffer paralysis- https://www.naturalhealth365.com/hpv-vaccine-side-effects-vaccinations-1520.html

Another study identifying autonomic dysfunction after HPV vaccination

https://www.ncbi.nlm.nih.gov/pubmed/26354426 this study from 2015 and published in the Journal ***Clinical Rheumatology*** titled, **HPV vaccination syndrome. A questionnaire – based study** indicates that

these adverse reactions are a result of advanced autonomic dysfunction. The results also indicate that the vast majority of these individuals suffer unremitting symptoms for many years post-vaccination.

"COMPASS-31 score was 43 ± 21, implying advanced autonomic dysfunction."

"**After a mean period of 4.2 ± 2.5 years post-vaccination, 93% of patients continue to have incapacitating symptoms and remain unable to attend school or work. In conclusion, a disabling syndrome of chronic neuropathic pain, fatigue, and autonomic dysfunction may appear after HPV vaccination**."

A former lead scientist that worked on Gardasil speaks out, criticizing safety claims

Dr. Diane Harper one of Merck's lead researchers on the Gardasil vaccine, speaks out in a CBS news interview from 2009. https://www.cbsnews.com/news/gardasil-researcher-speaks-out/

From the article:

"Dr. Diane Harper says **young girls and their parents should receive more complete warnings before receiving the vaccine to prevent cervical cancer**. Dr. Harper helped design and carry out the Phase II and Phase III safety and effectiveness studies to get Gardasil approved, and authored many of the published, scholarly papers about it. She has been a paid speaker and consultant to Merck. It's highly unusual for a researcher to publicly criticize a medicine or vaccine she helped get approved."

"Dr. Harper joins a number of consumer watchdogs, vaccine safety advocates, and parents who question the vaccine's risk-versus-benefit profile. She says data available for Gardasil shows that it lasts five years; there is **no data showing that it remains effective beyond five years**."

This raises questions about the CDC's recommendation that the series of shots be given to girls as young as 11-years old. "**If we vaccinate 11-year olds and the protection doesn't last... we've put them at harm from side effects, small but real, for no benefit," says Dr. Harper**. "**The benefit to public health is nothing, there is no reduction in cervical cancers**, they are just postponed, unless the protection lasts for at least 15 years, and over 70% of all sexually active females of all ages are vaccinated." **She also says that enough serious side effects have been reported after Gardasil use that the vaccine could prove riskier than the cervical cancer it purports to prevent**. **Cervical cancer is usually entirely curable when detected early through normal Pap screenings.**

(The Screening Pap test (or smear), is a simple procedure in which a number of cells are collected from the cervix, smeared onto a microscope slide and sent to a laboratory for cytological examination to look for changes that might lead to cervical cancer. It is named after the test's inventor, Dr Papanicolaou).

Dr. Harper cites statistics as to how low the percentage of women infected with HPV is, that go on to contract cervical cancer

Cervical tissue health is graded in 5 levels. Level 1 is normal. Level 5 is cancer. Levels 2, 3, and 4 are a gradient of gradually increasing changes of the cells and are termed C.I.N. 1, 2, and 3. CIN stands for

Cervical intraepithelial lesion. This is what is reported on a PAP Smear test result. CIN 1 is used for mild (low-grade) changes in the cells that usually go away on their own without treatment. CIN 2 is used for moderate changes. CIN 3 is used for more severe (high-grade) changes. Moderate and high-grade changes can progress to cancer. For this reason, they may be described as "precancer."

According to Dr. Harper in an interview shown in the documentary called "***One More Girl***"….
(red edits are my summations)
Of all the women who get an HPV infection, approximately 70% of those will clear that infection all by themselves in the first year. You don't even have to detect it or treat it. Within 2 years, approximately 90% of those women will clear it all by themselves. By 3 years, you will have 10% of that original group of women left who still have an HPV infection, and 5% of this 10% will have progressed into a CIN 2 or 3 precancerous lesion *(that is one-half of 1% of those who contracted an HPV infection, or one out of every 200 women that contracted an HPV infection. That is equivalent to 5 in 1,000)*. "So, now you have that small group of women who have precancerous lesions and now let's look at that moving into invasive carcinoma. What we know then, is that amongst women with precancerous (CIN 3) lesions it takes 5 years for about 20% of them to become invasive carcinomas *(so, out of the 5 in 1,000 that got HPV and their body didn't clear it by themselves, one in every 5 of those women will progress to cancer in 5 years. That is 1 out of the 1,000 who got HPV)*. That's a pretty slow process. It takes about 30 years for 40% of them to become invasive cervical carcinomas." *(in other words, of the 5 in 1,000 that got an HPV infection and their body didn't clear it and it progressed into a precancerous lesion, 2 of them will develop cervical cancer as a result* ***within 30 years****)*. Thirty-years is a long time, allowing ample opportunity to discover these slow cellular changes from regular PAP-Smear exams. That is why in every interview she gives, Dr. Harper continues to stress the importance of regular PAP-Smear exams whether a woman has had the HPV vaccine or not. That is the best prevention measure for avoiding developing cervical cancer. The HPV vaccine based on VAERS reports, has the highest rates of serious adverse reactions of any vaccine on the schedule. Once again, each person has to weigh the risk vs. benefit. Based on what one of the foremost experts in the world on the HPV vaccine and cervical cancer has to say about the risks of developing cervical cancer even if one contracts an HPV infection and the risk of vaccine adverse reactions to the HPV vaccine, my money is on regular PAP-Smear exams. But each person must decide for themselves.

As a footnote; the name of the documentary about the adverse effects that the Gardasil vaccine is having on so many girls and young women ***One More Girl***, is a take-off of the marketing campaign that Merck, the manufacturer of Gardasil ran they called ***One Less Girl***.

Dr. Scott Ratner and his wife, who's also a physician, expressed similar concerns as Dr. Harper in an interview with CBS News last year. One of their teenage daughters became severely ill after her first dose of Gardasil. Dr. Ratner says she'd have been better off getting cervical cancer than the vaccination. "My daughter went from a varsity lacrosse player at Choate to a chronically ill, steroid-dependent patient with autoimmune myofasciitis. I've had to ask myself why I let my eldest of three daughters get an unproven vaccine against a few strains of a nonlethal virus that can be dealt with in more effective ways."

Report reveals serious oversight and poor judgment in the autoimmune adverse reaction's investigation of the HPV vaccine Gardasil by the *European Medicine's Agency*

A study published in the ***British Medical Journal's Evidence Based Medicine*** on January 29, 2021 titled, **EMA's mishandling of an investigation into suspected serious neurological harms of HPV vaccines** found serious mishandling of information and terrible judgment by the ***European Medicines Agency*** when the investigated the correlation between the HPV vaccine and autoimmune disorders such as postural orthostatic tachycardia syndrome (POTS) and chronic regional pain syndrome (CRPS).

Abstract:
Concern has been raised about whether HPV vaccines might cause serious neurological disorders including postural orthostatic tachycardia syndrome (POTS) and chronic regional pain syndrome (CRPS). The European Medicines Agency (EMA) investigated the issue and declared in 2015 that there is no link between HPV vaccines and serious neurological adverse events. However, the certainty conveyed in EMA's official report is undermined by a leaked, confidential document that reveals important disagreements among the experts.
Furthermore, in its assessments, EMA relied on the data the drug companies had provided to them even though it had been demonstrated that the companies had underreported possible neurological harms. Even though active comparators were used (aluminium adjuvants and other vaccines), our research group found significantly more serious neurological harms in the HPV vaccine groups than in the comparator groups in a systematic review based on clinical study reports in EMA's possession. We outline areas where we believe the basis for EMA's decision was flawed; highlight that the relationship between HPV vaccines and POTS remains uncertain; and suggest ways forward to resolve the uncertainty and debate.

Conclusions:
Public trust in drug regulation, including for vaccines, relies on transparency, honesty about uncertainties and adequate, unconflicted assessment of benefits and harms. EMA's practice of leaving investigations of suspected serious harms to the manufacturers does not further public trust and should be revised. As is the general rule for other drugs, placebo or no-treatment controls are needed in trials of vaccines in order to study the occurrence of harms before drug approval. If considered unethical for the HPV vaccines, dose– response studies could be carried out. When Merck compared its nine-valent Gardasil 9 with quadrivalent Gardasil in 14215 women, there were more serious systemic adverse events in the Gardasil 9 group (3.3% vs 2.6%, p=0.01, our calculation).22 Gardasil 9 has four more antigens than the quadrivalent vaccine and contains 500µg of the aluminium adjuvant, compared with only 225µg. The safety of the aluminium adjuvants commonly used in vaccines should be tested. EMA should avoid using experts in its committees with conflicts of interest and should make available all reports on its website, including those used for deliberations in its scientific advisory groups.
https://pubmed.ncbi.nlm.nih.gov/33514652/

Studies often mask risk by deceptive means of calculation- HPV is a perfect example

Gardasil has been associated with at least as many serious adverse events as there are deaths from cervical cancer developing each year

Indeed, the risks of vaccination are underreported in Slade's article, as **they are based on a denominator of doses distributed from Merck's warehouse**. Up to a third of those doses may be in refrigerators waiting to be dispensed as the autumn onslaught of vaccine messages is sent home to parents the first day of school. **Should the denominator in Dr. Slade's work be adjusted to account for this, and then divided by three for the number of women who would receive all three doses, the incidence rate of serious adverse events increases up to five-fold**. How does a parent value that information," said Harper. *(Dr. Barbara Slade works for the CDC and wrote a 2009 article in JAMA assessing risk of the Gardasil Vaccine.* https://www.ncbi.nlm.nih.gov/pubmed/?term=19690307 *).*

Annals of Medicine cites a laundry list of severe adverse effects from the HPV vaccine and report the unsustainable impact of the vaccine program

A study published in 2011 in the ***Annals of Medicine*** titled, **Human papillomavirus (HPV) vaccine policy and evidence-based medicine: are they at odds?**, reports on compelling evidence that the risks of HPV Vaccine far outweigh the benefits in industrialized countries.
https://www.ncbi.nlm.nih.gov/pubmed/22462602

From the article:

"**All drugs are associated with some risks of adverse reactions. Because vaccines represent a special category of drugs, generally given to healthy individuals, uncertain benefits mean that only a small level of risk for adverse reactions is acceptable. Further-more, medical ethics demand that vaccination should be carried out with the participant's full and informed consent. This necessitates an objective disclosure of the known or foreseeable vaccination benefits and risks**. The way in which HPV vaccines are often promoted to women indicates that such disclosure is not always given from the basis of the best available knowledge. For example, while the world's leading medical authorities state that HPV vaccines are an important cervical cancer prevention tool, **clinical trials show no evidence that HPV vaccination can protect against cervical cancer. Similarly, contrary to claims that cervical cancer is the second most common cancer in women worldwide, existing data show that this only applies to developing countries. In the Western world cervical cancer is a rare disease with mortality rates that are several times lower than the rate of reported serious adverse reactions (including deaths) from HPV vaccination.** Future vaccination policies should adhere more rigorously to evidence-based medicine and ethical guidelines for informed consent."

"**Cumulatively, the list of serious adverse reactions related to HPV vaccination worldwide includes deaths, convulsions, paraesthesia, paralysis, Guillain–Barré syndrome (GBS), transverse myelitis, facial palsy, chronic fatigue syndrome, anaphylaxis, autoimmune disorders, deep vein thrombosis,**

pulmonary embolisms, and cervical cancers." Nervous system and psychiatric disorders were the most prominent adverse reactions found in a study from western Europe. The most commonly reported Adverse Reactions in the nervous system and psychiatric disorders class were headache, syncope, convulsions, dizziness, hypoaesthesia, paraesthesia, lethargy, migraine, tremors, somnolence, loss of consciousness, dysarthria, epilepsy, sensory disturbances, facial palsy, grand mal convulsion, dysstasia, dyskinesia, hallucination, and insomnia."

While cervical cancer is a real threat the vast majority of cases occur in under-developed countries because Pap smear testing is not readily available. From the article… "Although approximately 275,000 women die annually from cervical cancer worldwide, almost 88% of these deaths occur in developing countries."

"**The efficacy of regular Pap screening procedures in developed countries is further emphasized by the fact that such programmes helped to achieve a 70% reduction in the incidence of cervical cancer over the last five decades**."

"It should be emphasized that HPV vaccination does not make Pap screening obsolete, especially since the current HPV vaccines guard only against 2 out of 15 oncogenic HPV strains. Harper noted that if HPV-vaccinated women stopped going for Pap smears, the incidence rate of cervical cancer would increase. A similar concern was also raised by French and Canadian researchers who suggested the possibility that vaccinated women might be less inclined to participate in screening programmes."

Unsustainable Costs: "According to some estimates, to vaccinate every 11- and 12-year-old girl in the US would cost US $1.5 billion and to protect only these girls for a lifetime would cost US $7.7 billion. If we were to estimate just the cost of initial vaccination excluding the booster shots for 11- and 12-year-old girls, in ten years the US would spend at least $15 billion of limited health care dollars on Gardasil alone. Who then reaps the benefit at no risk from making the HPV vaccine mandatory? The customer or the manufacturer?"

In 2016, The American College of Pediatricians expresses new concerns regarding the HPV vaccine and the dangers to adolescent females of early menopause

A Report released by the ***American College of Pediatricians*** titled, **New Concerns about the Human Papillomavirus Vaccine**, ***raises questions about the use of Polysorbate 80 and aluminum as the "placebo" in Gardasil trials, and the potential that some girls may be developing premature menopause (ovarian failure) as a result***. http://www.acpeds.org/the-college-speaks/position-statements/health-issues/new-concerns-about-the-human-papillomavirus-vaccine

Once again, vaccine makers used ingredients in their "placebo" that masked adverse effects that would have shown up in the trials if saline solution would have been used as the placebo

From the report:
"Few other vaccines besides Gardasil® that are administered in adolescence contain polysorbate 80. **Prelicensure safety trials for Gardasil used placebo that contained polysorbate 80 as well as aluminum**

adjuvant. **Therefore, if such ingredients could cause ovarian dysfunction, an increase in amenorrhea probably would not have been detected in the placebo-controlled trials*.** Furthermore, a large number of girls in the original trials were taking hormonal contraceptives which can mask ovarian dysfunction including amenorrhea and ovarian failure. Thus, a causal relationship between human papillomavirus vaccines (if not Gardasil® specifically) and ovarian dysfunction cannot be ruled out at this time."

This is insane and another example of the pharmaceutical companies intentionally masking the rates of the adverse reactions in the clinical trials to push these drugs to market! And as a result, thousands of beautiful children and young adults are maimed, many for life.

"Many adolescent females are vaccinated with influenza, meningococcal, and tetanus vaccines without getting Gardasil®, and yet only 5.6% of reports related to ovarian dysfunction since 2006 are associated with such vaccines in the absence of simultaneous Gardasil® administration. **The overwhelming majority (76%) of VAERS reports since 2006 with ovarian failure, premature menopause, and/or amenorrhea are associated solely with Gardasil®.**"

"**Nevertheless there are legitimate concerns that should be addressed: (1) long-term ovarian function was not assessed in either the original rat safety studies or in the human vaccine trials, (2) most primary care physicians are probably unaware of a possible association between HPV4 and POF and may not consider reporting POF cases or prolonged amenorrhea (missing menstrual periods) to the Vaccine Adverse Event Reporting System (VAERS), (3) potential mechanisms of action have been postulated based on autoimmune associations with the aluminum adjuvant used and previously documented ovarian toxicity in rats from another component, polysorbate 80, and (4) since licensure of Gardasil® in 2006, there have been about 213 VAERS reports (per the publicly available CDC WONDER VAERS database) involving amenorrhea, POF or premature menopause, 88% of which have been associated with Gardasil**."

A 2018 study shows the HPV vaccine shown to lower a woman's chance of getting pregnant

A 2018 study from the ***Journal of Toxicology and Environmental Health*** titled, **A lowered probability of pregnancy in females in the USA aged 25-29 who received a human papillomavirus vaccine injection**, finds that a disproportionate percentage of women that have had the HPV vaccine have been unable to conceive versus the women that have never had the shot. As you have and will see again in this document, the HPV Vaccine has been associated with a condition called Premature Ovarian Insufficiency making them infertile, which is essentially early menopause.
https://www.ncbi.nlm.nih.gov/pubmed/?term=29889622

The Abstract:
"Birth rates in the United States have recently fallen. **Birth rates per 1000 females aged 25-29 fell from 118 in 2007 to 105 in 2015. One factor may involve the vaccination against the human papillomavirus (HPV). Shortly after the vaccine was licensed, several reports of recipients experiencing primary ovarian failure emerged. This study analyzed information gathered in *National Health and Nutrition Examination Survey*, which represented 8 million 25-to-29-year-old women residing in the United States between 2007 and 2014. Approximately 60% of women who did not receive the HPV vaccine**

had been pregnant at least once, whereas only 35% of women who were exposed to the vaccine had conceived. For married women, 75% who did not receive the shot were found to conceive, while only 50% who received the vaccine had ever been pregnant. Using logistic regression to analyze the data, the probability of having been pregnant was estimated for females who received an HPV vaccine compared with females who did not receive the shot. **Results suggest that females who received the HPV shot were less likely to have ever been pregnant than women in the same age group who did not receive the shot. If 100% of females in this study had received the HPV vaccine, data suggest the number of women having ever conceived would have fallen by 2 million. Further study into the influence of HPV vaccine on fertility is thus warranted.**"

Public interest group that investigates government corruption releases records of deaths after Gardasil Vaccination

Even the independent watchdog group, ***Judicial Watch*** has expressed serious concerns about the harmful effects of Gardasil. In an article titled, **New FDA Records Obtained by Judicial Watch Indicate 28 Deaths Related to Gardasil in 2008**, they raise concerns that the safety studies have not been done.

https://www.judicialwatch.org/press-room/press-releases/new-fda-records-obtained-judicial-watch-indicate-28-deaths-related-gardasil-2008/

From the article:

Judicial Watch, the public interest group that investigates and prosecutes government corruption, **announced today that it has** obtained records from the Food and Drug Administration (FDA) **documenting 28 deaths in 2008 associated with Gardasil**, the vaccination for human papillomavirus (HPV), up from 19 deaths in 2007. **The total number of Gardasil-related deaths is 47 since the vaccine was approved in 2006**. ***(My comment: Bear in mind that this is only from 2006 through 2008. Imagine what that number may be through 2018 as the program has expanded!)*** **Overall, the FDA documented 6,723 "adverse events" related to Gardasil in 2008, of which 1,061 were considered "serious," and 142 considered "life threatening."**

The following are several "adverse events" documented by the FDA's Vaccine Adverse Event Reporting System (VAERS):

- "15 months from the completion of the GARDASIL HPV vaccination, I had full blown cervical cancer. My oncologist would like to do a hysterectomy at this time, but [as I have] always wanted children, I have chosen to wait . . . I have two of the [strains] that the shot is supposed to prevent . . . I now have cervical cancer and I am left wondering what role the GARDASIL HPV vaccination played in the hasty onset." (ID: 319836)
- "After receiving her second dose of GARDASIL … she could crawl but … needed to use crutches or a wheel chair … She was experienced problems breathing and had 'super migraines' that never went away … She had swelling in her face, jaw and wrists. The patient was diagnosed with GUILLAIN-BARRE syndrome, myelin sheath degeneration and peripheral neuropathy. Patient was hospitalized twice … patient has not recovered from symptoms." (ID: 318052)

- A 19-year-old girl with no medical history immediately experienced side effects after receiving the Gardasil vaccine. Within eleven days her symptoms included "Aggression, Arthralgia, Complex partial seizures, Confusional state, Convulsion, Crying, Dizziness, Epilepsy, Fatigue, Feeling abnormal, Grand mal convulsion, Immediate post-injection reaction, Irritability, Myalgia, Nausea, Pain, Postictal state, Somnolence, Syncope, Tremor, and Unresponsive to stimuli." (ID: 320598)
- "Two weeks after the third dose, the patient developed a complication. She was taken to the hospital by ambulance but passed away during the transport from an unknown cause…Upon arrival in ER unresponsive, pupils fixed and dilated, no cardiac activity. Resuscitation unsuccessful and patient expired." (ID: 314769)

The FDA VAERS reports show that since last June, 235 cases detailed permanent disability. There were also 29 new cases of Guillain-Barre Syndrome, and 147 cases of "spontaneous abortions," or miscarriages, when the vaccine was given to pregnant women.

Moreover, 62 girls developed warts after receiving the vaccine. This development is of particular concern because Gardasil, which is designed to prevent two strains of genital warts, is not supposed to react with other HPV strains. However, not only did previously healthy women experience genital warts after the vaccination, but 21 girls developed warts on other areas, most commonly the face, hands and feet, and in one case, "all over her body." (ID: 330671)

Of the 47 reported deaths, 41 occurred within a month of receiving the vaccine and of those 17 were within two weeks or receiving the vaccine. In most of the deaths the cause is still unknown.

"**The FDA is supposed to be a guardian of public health, and yet the agency continues to turn a blind eye to what seems to be an extremely serious public health problem**. The public relations push for Gardasil by Merck, politicians and public health officials needs to pause so that these adverse reactions can be further studied," **said Judicial Watch President Tom Fitton**. "**The already serious problems associated with Gardasil seem to be getting worse. No one should require this vaccine for young children.**"

Robert F. Kennedy Jr. accuses Merck of numerous instances of fraud on the Gardasil vaccine trials and brilliantly makes his case

In this brilliant prosecution of Merck for what he calls blatant fraud, Robert F. Kennedy Jr. presents his case and challenges Merck to sue him if they feel he is not telling the truth.

This section on RFK Jr's presentation is 16 pages long. It is WELL WORTH taking the time to read it in its entirety and get the full context and story in his own words. But just in case you don't want to do that. I am going to summarize some of the main points for you at the beginning. As usual, I have also bolded and red lettered the main take-aways of the transcript itself to help you cut to the chase. Even better yet, if you have 50 minutes to watch his presentation, you will have the opportunity to see him

in action, view his charts and statistics and see him in the role of a prosecuting attorney, effectively making his case for his accusations of fraud by Merck.

Watch the video here: https://childrenshealthdefense.org/video/video-playlist/rfk-jr-video-and-facts-about-gardasil/

A couple of statistics to start:

The danger of dying from cervical cancer in this country is 1 death in 43,500 people. Recent studies show that only approximately a third of those relate to the HP Virus.

Women are 100 times more likely to suffer serious adverse events from the Gardasil vaccine than they are to be protected from cervical cancer by the vaccine.

The main points of research manipulation and fraud he exposes are:

- **Merck used small numbers of subjects and short durations of follow-up in the clinical trials to avoid the latent or delayed onset disabilities from becoming known.**
- **Claiming the vaccine will save lives from cancer, when the vaccine is given to pre-teens and teens (target age 11), yet the median age cervical cancer is detected is 50 years old.**
- Since trying to prove it protects against cancer, which because of what was just stated is impossible, **the claim f protecting against cervical cancer is based on precancerous cell changes of the uterus** (most of which never turn into cancer). Therefore, whether those changes predict a diagnosis of cancer later is still hotly debated.
- **The "control" group got shots with the aluminum adjuvant in them, the very thing that many scientists believe is responsible for much of the adverse events from Gardasil. The Gardasil group and the control group had essentially the same number of injuries. This effectively masks any difference in adverse reactions between the groups.**
- There was a small saline placebo group, in which the number of injuries was cut in half….BUT **Merck ended up mixing those cases in with the control that got the aluminum and never revealed that to regulators!**
- In one of the protocol groups (protocol 18, the one the FDA relied upon for approval), **Merck used what they called the** "**carrier solution," which is all of the components of the vaccine except for the aluminum and the viral particles—the antigen and said they used "a saline placebo**". The carrier solution contains **Polysorbate 80 (one of the other main components scientist now relate to serious adverse responses including infertility)**, sodium borate, genetically modified yeast and more….all things that could also cause adverse reactions. Person's getting this shot were told it was straight saline.
- Participants were **not** told this was a safety study. Instead **they were told that the safety studies had already been done and the vaccine was proven to be safe**. This made the girls less likely to report reactions as they thought the vaccine was already proven safe.

- **They used a specially made preparation of the vaccine, in which they cut the amount of aluminum in half in the Gardasil that they gave to the Protocol 18 vaccine group.**
- **The rate of development of autoimmune disease in the Gardasil group was 2.3% within 7 months of receiving the vaccine, EXACTLY the rate of girls in the aluminum group that developed autoimmune disease!**
- They used "**exclusion criteria**", which means they excluded any individuals from the trial that would be a higher risk for adverse reactions, which reduces the levels of reactions disproportionally as compared to the general population.
- They gave "report cards" **to only 10% of the persons in the study** and told them to only report redness, swelling at the injection site, fever and bruising for just 14 days. **Any persons that reported any more serious reactions were "rebuffed" by the investigators and told that the reaction was not related to the vaccine.**
- Despite these extraordinary efforts to cook the books, **half** of the girls **receiving the Gardasil vaccine** and **half receiving the aluminum** "placebo" reported new medical conditions and serious injuries, over 3% of which required medical procedures or surgeries.
- Merck's own preclinical trial records, and those records show that **girls or women who already had HPV—had been exposed at some point in their life to it—actually had a negative efficacy of 44.6 percent. What is "negative efficacy"? It means those girls had a 44.6 *increased* risk of getting those precancerous lesions.**
- To make things even worse, there are recent scientific studies that suggest a phenomenon of what is known as **type replacement**. **There are some 200 different strains of HPV. Some of them are more cancerous than others, and the current HPV vaccine goes after 9 of those 200 viral types. What these studies indicate is, by eliminating those particular strains of the virus, [the vaccine] opens up an ecological niche in the woman so that more lethal and virulent viruses can actually colonize that spot and dramatically increase the risk of cervical cancer.**

Transcript-

Hi, I'm Robert F. Kennedy, Jr. and I'm making this video for the sake of parents who are trying to make an informed decision of whether or not to give their child, their boy or girl, the Gardasil vaccine.

I'm also making this video as a tool for pediatricians who are trying to understand how this vaccine, if it's actually causing all of these problems with young girls, could have been approved by FDA and then mandated by CDC.

Virtually all of the things that I'm going to talk about in this video are available to the public on public documents, as I'm going to show.

Finally, I want to say this about Merck, which is the company that makes the Gardasil vaccine.

Many of the things that I'm going to say today would be slanderous if they were not true. And if they're not true, then Merck should sue me. But Merck won't do that, and they won't do it because in the United States, truth is an absolute defense to slander. And second of all, Merck knows that if they sue me, I'm going to immediately file a discovery request, and many, many more documents are going to emerge that illustrate even more fraud by this company on the American public and the people all over the world.

Finally, as a footnote, I'm not going to talk today about the specific biological mechanisms that allow this vaccine to cause harm in human beings. That information is out there, it's in dozens of peer- reviewed, published scientific documents. Many of these are described on our website, and I urge people to go to the Children's Health Defense website to educate themselves on those issues.

Today we're going to talk about the clinical trial—about Merck's fraud in that process. And this is Merck's claim:

- **The HPV vaccine will "eliminate cervical cancers and other HPV-associated cancers." The danger of dying from HPV cancer in this country is 1 death in 43,500 people.**

Imagine you have a deck of cards but instead of 50 cards, there are 43,500 on a big, big table, and one of those cards is a black card. If you get that, you die.

So, Merck's deal is that it's going to remove that black card from the deck. But in order to play the game and make sure that Merck removes the black card, everybody who participates has to put in $420 because that's the cost of the three-dose Gardasil vaccine.

So, here's Gardasil by the numbers. So, the cost of the three-jab series averages about $420. There are 76 million children who essentially have been mandated by CDC to receive these vaccines. This is a blockbuster product for Merck, and the global revenues from this vaccine today are about $2.3 billion dollars. It's the third largest product in the company's inventory.

The cost of saving one American life is $18.3 million dollars. People can argue whether or not that's a reasonable value of a human life, what I would say is that the criteria that we should use for evaluating reasonableness is, is there a cheaper way to save more lives, **and many people would argue that Pap smears are the *most* effective way—that 80 percent of cervical cancer deaths have already been eliminated by Pap smears, and this is the most effective technology.**

Incidentally, in another context, HHS has already put a value on human life, and the value is $250,000. That is the maximum number that the Vaccine [Injury] Compensation Program will pay for killing an American citizen.

Prior to marketing a vaccine, the FDA licenses the vaccine. And in that licensing process, **Merck had to show that the [Gardasil] vaccine was safe. According to Federal regulations, "The word *safety* means the relative freedom from harmful effects...taking into consideration the character of the product in relationship to the condition of the recipient at the time."**

So, what is the condition of the recipients—of the target group—for this vaccine? **One is this vaccine targets millions of preteens and teens, for whom the risk of dying from cervical cancer is practically zero. Cervical cancer's median age of death is 58. It is first diagnosed at age 50 (median).**

- **A teenage girl or boy has zero chance of dying of this illness, which means the threshold for giving this medication is very, very high.**
- **Secondly, [the vaccine] is mandated in some jurisdictions, so the government is actually—government officials are actually coming in and ordering people to take this medical intervention. So, we have to be sure that the threshold for risk, "the risk profile" for that medical intervention should be very, very low.**
- **Third, unlike other medical interventions, Gardasil recipients are perfectly healthy. So, when you give medication to a healthy individual, you have to make sure that the risk profile is practically zero. And in order to determine risk, there is a standardized protocol, and it's called "double-blind placebo studies." What does that mean?**

It means that the drug company that's trying to license this product gives the medication to one group of people, maybe 5,000 or 10,000 people, and gives a placebo, an inert placebo, either an identical-looking pill that is inert—it's either saline or sugar—to a similarly situated group of 5,000 or 10,000 people, and it's "double-blind," meaning that neither the patients nor the researchers knew who got the placebo and who got the actual medication.

And you can see here, **here's what the NIH (the National Institutes of Health) says about it: "A placebo is an inactive substance that looks like the drug."**

So, here are typical examples:

Lipitor was given during its study phase to about 17,000 subjects. Half of them received Lipitor, half of them received a sugar pill that looked identical to Lipitor, **and then they were observed and studied for up to 3.3 years.**

Why for so long? Because many of the injuries that are caused by medication are latent—they don't show up for two or three or four or five years. Cancer, for example, may not show up for four or five years after the exposure. Autoimmune diseases and allergies and these kinds of things take a long time to diagnose. Enbrel, for that reason, was studied for 6.6 years and against a control group that received a saline injection.

Botox—there was a national emergency to get Botox to market so people could get their wrinkles cured—was studied for 51 weeks, and it was studied against a saline injection.

Now I'm going to show you one of the really outrageous frauds that Merck committed during the clinical trials. This is an insert that is part of every vaccine package. And you can go on the Internet right now and look up that Merck product and search and find these **two tables.**

In the initial table, you can see there are three columns. This is a table that just looks at injuries at the vaccine site for redness and itching and bruising and pain at the vaccine site.

- **One, there were 5,000 girls—5,088 girls—who got the Gardasil vaccine.**

- **Number two, there were 3,470 girls who got the AAHS control. What is that? That is the adjuvant in the vaccine. That is a toxic neurotoxin that's put in the vaccine to make it more long-lasting, to provoke an immune response in the subject of the vaccine. And most people believe that it is that aluminum adjuvant that is causing all of these injuries in the girls who are getting the vaccine.**
- **And there were 3,470 people who received just the neurotoxin with no antigens and no other vaccine components.**
- **And you have a third group, which is the placebo group. What I want you to look at is at these numbers—that in the Gardasil and AAHS control, there is virtually the same number of injuries.**
- **And when you get to the saline placebo, that injury rate is cut in half.**

Now, let's go to the table where they talk about real systemic injuries—autoimmune diseases. And instead of showing us real science, which is to show us what happened to the saline group.

- **They hide the saline group as a way of fooling you, your pediatrician and the regulatory agency by compressing it into the aluminum group**. And they never tell us. They say, this is a combination of the aluminum adjuvant and the saline placebo. They don't tell us how many in each category were compressed there. The real thing that you need to watch here is what happened. **These are all very, very serious injuries. These are injuries that, in some cases, people would feel were worse than death—and that affect people and debilitate people for a lifetime in many cases.**

- **And if you look at the bottom of the Gardasil group, an astonishing 2.3 percent of the girls in the clinical study who received the Gardasil vaccine got ill from autoimmune diseases, many within seven months of taking the vaccine.**
- **And look what happened in the aluminum group—the same number exactly: 2.3 percent.**

Nobody—no parent—would allow their daughter to take a substance that had a one-in-40 chance of giving them a lifetime disability.

The World Health Organization says that using a spiked placebo—or a faux-cebo—as Merck did with Gardasil puts you at a methodological disadvantage in that "it may be difficult or impossible to assess vaccine safety."

- Dr. Stanley Plotkin, who developed the polio vaccine, who developed the pertussis vaccine, who developed the rotavirus vaccine—the Stanley Plotkin award is the Nobel Prize of vaccinology, it's given to the top vaccinologist every year—and what he says is: Unless you have a true control group, you are in LA-LA LAND.
- Finally, the American Medical Association says, the absence of double-blind placebo testing and short- term studies of chronic disease are "the indicia of marketing masquerading as science."

And that's what Merck gave us.

The Cochrane Collaboration—thirty thousand scientists from all over the world who came together to create an independent assessment of medical protocols, which they saw as being increasingly controlled by the industry—the Cochrane Collaboration said, "**The use of active comparators probably increased the occurrence of harms in the comparator group, thereby masking harms caused by the HPV vaccine."**

And that indeed was Merck's point: to hide those harms.

So, if you do the math, women are 100 times more likely to suffer serious adverse events from the Gardasil vaccine than they are to be protected from cervical cancer.

So now we have a very different bargain in this card game that we're playing with Merck.

- **We have 43,000 cards, and the black card—the death card—is gone, but now, there are 1,000 blue cards, which if you pick one of those by mistake, you have a good chance of getting an autoimmune disease. Nobody would take that bargain.**

So, in order to get the FDA license to market this vaccine, Merck did a number of studies, which it called "protocols." We don't know how many they did because they're not telling us—they never disclosed it.

The one we're most concerned with is protocol 18. The reason protocol 18 is critical is because that was the basis for FDA giving Merck the license to produce and market the vaccine.

Why is that? Because protocol 18 is the only one in which the target audience for this vaccine—11- and 12-year-old girls—was actually tested and had a control group. The other ones that looked at big cohorts of women were [in] 16- to 25-year-old and 16- to 26-year-old women.

Protocol 18 looked at girls and boys from ages 9 to 15. It was a total of 1,200 children and almost 600 controls. **That is a very, very tiny group of people to study in order to determine the safety of a product that is going to be marketed to billions of children around the world.**

Now I'm going to show you one of the key fraudulent flimflams that Merck used to get this license. FDA said they approved Gardasil based on protocol 18 because protocol 18 was of particular interest— because it's the only protocol in which Merck used a true saline placebo instead of the aluminum adjuvant as a control.

That's what Merck *told* FDA and the CDC, but Merck was lying. It actually did not use a true saline placebo. It used what Merck called the "carrier solution," which is all of the components of the vaccine except for the aluminum and the viral particles—the antigen.

Among the compounds that we know were in the carrier solution are:

- **Polysorbate 80**—we have no idea what the safety profile is because it's never been tested for safety independently in vaccines.
- **Sodium borate**, which is borax, which is banned by FDA in food products—in all food products in the United States—and is banned altogether in Europe.

- **Genetically modified yeast** (there's no safety test ever been done on it in vaccines).
- **L-histidine**, the same.
- **And possibly, DNA fragments**. I say "possibly" because we know there are DNA fragments in the final vaccine, we don't know how they got there. And Merck has lied about the DNA fragments from the outset.

And despite these potentially toxic components of compounds that are in the vaccine, the 596 children that were given the carrier solution fared much better than any other cohort in the study. The girls and boys who received the carrier solution were the only significant cohorts with no serious adverse events for the first 15 days.

And here's another one of the gravamen of the fraud that Merck committed in its Gardasil trials. It turns out, in the protocol 18 study, it appears Merck cut the amount of aluminum that was given to the vaccine group in half. They tested a completely different formulation. If true, we theorize that they took the aluminum out to reduce the number of injuries and to mask the really bad safety profile of this vaccine. And since the protocol 18 data are not based on the Gardasil vaccine formulation, the trial itself constitutes rank scientific fraud.

Here's another bag of tricks that was used by Merck in order to skew the clinical trial results in favor of Gardasil.

- **Merck and its researchers used what they call "exclusion criteria"—for example, people who had severe allergies, people who had prior genital infections were thrown out of the clinical trials. People who had over four sex partners in their entire lives were excluded from the trials. Anybody who had a history of immunological or nervous system disorders, people with chronic illnesses and seizure disorders, people with other medical conditions, people who had reactions to vaccine ingredients— including the aluminum, yeast and the benzonase—or anybody with a history of alcohol and drug abuse. If you really wanted to know whether the vaccine was helping people—if it was effective—wouldn't you want those people in your study? Wouldn't you want people who had a genetic vulnerability to cancer in your study, to see if it actually was capable of preventing cancer?**
- **Then Merck had one catch-all exclusion category, which was "Any condition which in the opinion of the investigator might interfere with the evaluation of the study objectives." Well, that gave Merck and its paid investigators complete control to throw people out of the study who they thought might make the study look not successful.** All of these exclusionary categories gave Merck the ability to limit the study to people who were like an elite club of superheroes. The people who [now] get the vaccine are not the same people they tested it on. They tested it on the Avengers. They didn't test it on, you know, Joe Bag-of-Donuts, the people who are actually receiving this vaccine in day-to-day life. **And by doing that, they were able to mask whatever injuries might show up in a larger, more vulnerable population who are actually receiving the vaccine.**

- **Next, Merck used an arsenal of sloppy protocols to, again, hide vaccine injuries. Among these, Merck gave report cards—the daily journal report cards—to only 10 percent of the people who they tested the vaccine on, and it told those people to only make reports for 14 days after the injection. And the report cards were only designed to collect jab site information—so, redness, itching, bruising, fever.**

- **And they ignored altogether the autoimmune diseases and menstrual cycle problems and fertility problems and pain and dizziness and seizures and all of the other things that we've now seen are associated with the vaccine. In fact, there are numerous girls who report that they were injured, that they attempted to report those injuries to Merck and that Merck rebuffed them.**

- **Furthermore, Merck gave extraordinary discretion to its researchers to determine what was a vaccine injury and what was not a vaccine injury. And because there was no inert placebo, it was completely within their discretion, if a girl came back with seizures or autoimmune disease or menstrual cycle problems, they could just say to the girl, "well, that's not related to the vaccine."**

In some cases, we know that Merck actively covered up and lied about injuries that it had a duty to report to the Vaccine Adverse Event Reporting System (VAERS). For example, in the case of Christina Tarsell, a Maryland girl who died from the Gardasil vaccine, Merck lied about that death in its official reports to the Vaccine Adverse Event Reporting System. It told the system that Christina's doctor had told Merck that her death was the result of a virus. And the doctor adamantly denies that. Merck has refused to remove that misinformation from the VAERS system.

- **Furthermore, Merck lied to the girls who participated in these studies, telling them, number one, that the placebo was saline and that it contained no other ingredients. And number two, that the study in which they were participating was not a safety study. They were told that there had already been safety studies and that the vaccine had been proven safe.** What did this do for Merck? It made it so the girls were less likely to report injuries as associated with the vaccine—because they believed that the vaccine that they were receiving had already been proven safe **and that any injuries that they did experience maybe a month or two months or three months after the vaccine must be simply coincidental and had nothing to do with the vaccine.**

But in spite of all these efforts by Merck to discourage girls from reporting vaccine injuries during the clinical trials, half of the girls in the Gardasil group and half of them in the aluminum adjuvant group reported serious injuries after receiving the vaccine.

- **In order to conceal the link between these injuries and the vaccine, Merck invented a brand new medical metric that had never been heard of before called "new medical conditions," and it dismissed all of these new injuries—which affected 50 percent of the girls who received the vaccine and the adjuvant—as "new medical conditions" unrelated to the vaccines, simply sad coincidences.** Many of these diseases were serious diseases—blood and lymphatic diseases, anemia, endocrine diseases, autoimmune diseases, gastrointestinal, Crohn's disease, ulcerative

colitis, vaginal infections, musculoskeletal injuries, arthritis, neoplasm, Hodgkin's disease, neurological diseases, psychiatric diseases, depression, reproductive and breast disorders, menstrual irregularities and pain. **Over 3 percent of the girls—1 in 30—in both groups required surgical and medical procedures.**

So, this card game that we're playing with Merck has now become a *really bad* bet.

Merck has removed the one black card, but you now have a 1-in-40 chance of drawing a blue card and getting an autoimmune disease that may afflict you for the rest of your life—and you have a 1-in-2 chance of having some other serious medical condition.

So now let's look at Merck's central claim, which is that the Gardasil vaccine will prevent cervical cancer.

Merck's in a sweet position here, let's face it, because the target group for this vaccine is 11-year olds and the median age of death for cervical cancer is age 58.

So, Merck essentially is making this bargain: It's telling the 11-year old girl, "If you take our vaccine, 47 years from now you won't die of cervical cancer." And of course, the truth is, you can't make a vaccine that proves that it's going to prevent cancer 47 years from now. There's no way to test for that.

So, Merck used a shortcut. It said, we're going to prove that it prevents what Merck called "surrogate end points." So the best thing that Merck could come up with was CIN2 and CIN3 lesions, which it called "precancerous" lesions, even though most of those lesions never mature into cancer.

So how can you call something "precancerous" when it was never going to turn into cancer?

And here's what a study published in the *American Journal of Epidemiology* said about Merck's scheme: "CIN3 is an imperfect diagnosis of precancer and an intermediate surrogate for cancer."

Their own attorneys told them, "For these products, the indication is the surrogate, not the ultimate, endpoint. Promotion cannot make any claim vis-a-vis the ultimate end point," based upon the fate of a surrogate endpoint.

Merck has another problem. Recent peer-reviewed scientific studies indicate that perhaps only a third of cervical cancer cases are even associated with the HPV virus. That would completely put the lie to Merck's claims that Gardasil is going to eliminate cervical cancer altogether.

So now we have a really dubious deal because we need to put that black card back in the deck. Because now, we have doubts about whether or not this vaccine can prevent cervical cancer at all.

- **But the news gets worse. Gardasil may actually *cause* cancer. Gardasil's insert states, "Gardasil has not been evaluated for potential to cause carcinogenicity or genotoxicity." And Gardasil's ingredients include possible carcinogens, including human DNA.**
- **And look at this. This is Merck's own preclinical trial records, and those records show that girls or women who already had HPV—had been exposed at some point in their life to it—actually had a negative efficacy of 44.6 percent. What is "negative efficacy"? It means those girls had a 44.6 *increased* risk of getting those precancerous lesions. To make things even**

worse, there are recent scientific studies that suggest a phenomenon of what is known as type replacement. There are some 200 different strains of HPV. Some of them are more cancerous than others, and the current HPV vaccine goes after 9 of those 200 viral types. What these studies indicate is, by eliminating those particular strains of the virus, [the vaccine] opens up an ecological niche in the woman so that more lethal and virulent viruses can actually colonize that spot and dramatically increase the risk of cervical cancer.

So now Merck's deal is looking *really* grim. Not only do we have a 1-in-40 chance of getting an autoimmune disease and a 50 percent chance of getting some serious medical condition, but now, the cancer risk has been reinserted and actually amplified.

And now, let's look at some of the non-cancer injuries that Merck found in its preclinical studies.

- **The miscarriage rate in the preclinical studies—after Gardasil—doubled the background rate. The birth defects in the Gardasil group were five times the rate of birth defects from the control group. As to reproductive disorders, an astonishing 10.9 percent of the women in the pooled group reported reproductive disorders within seven months of receiving Gardasil, compared to 1.2 percent in the placebo group. The death rate in the Gardasil group in the clinical trials was 8.5 per 10,000.**
- **The death risk from this vaccine, according to Merck's *own* studies, is 37 times the risk of dying from cervical cancer. So now look at the deal that Merck has offered us: they've actually *increased* our risk of dying by 37 times.**

So now, let's look at **post-licensing surveillance**. So, Merck can argue that, "We might have missed something in our pre-licensing studies but surely if there were any injuries being caused by this vaccine, we would see them in post-licensing surveillance."

And the problem with that is that the post-licensing surveillance system, the principal one, is called the **Vaccine Adverse Event Reporting System. The system is a voluntary system that simply does not work. It's broken. In fact, in 2010, HHS hired another federal agency, the Agency for Healthcare Research Quality, and a group of Harvard researchers to study the Vaccine Adverse Event Reporting System, and those researchers found that fewer than 1 percent of adverse events from vaccines are ever reported.**

But even under that system, Gardasil has distinguished itself as the most dangerous vaccine ever invented.

- In fact, when you compare it to Menactra, which is a meningitis vaccine that's given to the same age group—teenagers—**Gardasil had 8.5 times more emergency room visits, 12.5 times more hospitalizations, 10 times more life-threatening events and 26.5 times more disabilities than Menactra.**
- **The "vaccine court" which is within HHS has made awards for numerous deaths and very serious injuries from the Gardasil vaccine.** So, HHS itself admits that this vaccine kills people, and it's given compensation to the families that were injured.

- The same wave of serious injuries and deaths has been seen in nations around the globe when they adopt mandates for the Gardasil vaccine. **Even Gardasil's own insert, the package insert that the company provides, acknowledges that the injuries that can be caused by this vaccine include death, pancreatitis, fatigue, malaise, immune system disorders, autoimmune diseases, anaphylaxis, musculoskeletal and connective tissue disorders, nervous system disorders, acute disseminated encephalomyelitis—that's brain injuries—Guillain-Barré syndrome, motor neuron diseases, paralysis, seizures, transverse myelitis and vascular disorders.**
- In Australia, in 2015, the Australian Department of Health Therapeutic Goods Administration reported that **the adverse rate in girls is 17 times the incidental rate for cervical cancer throughout their lifespan.** The study only looked at a handful of conditions but excluded demyelinating disorders, complex regional pain syndrome and premature ovarian failure. The study restricted its view to anaphylaxis, fainting, allergic reactions and other conditions that required hospitalization.
- **India suspended its Gardasil trials after numerous deaths and serious injuries.**
- The *South Asian Journal of Cancer* found that "a healthy 16-year old is at zero immediate risk of dying from cervical cancer but is **faced with a small, but real risk of death or serious disability from a vaccine that has yet to prevent a single case of cervical cancer."**
- Japan de-recommended Gardasil three months after it had added the vaccine to the immunization schedule. Japan's health ministry discovered **adverse events reported after Gardasil's approval were many times higher than other vaccines on the recommended schedule—these included seizures, severe headaches, partial paralysis, complex regional pain syndrome and "an undeniable causal relationship between persistent pain and the vaccination."**
    - Japanese researchers found that the **adverse event rate for the HPV vaccine was as high as 9 percent and that pregnant women injected with the vaccine aborted or miscarried 30 percent of their babies.**
    - In 2015, the Japanese Association for Medical Sciences issued official guidelines for managing symptoms of injuries caused by the Gardasil vaccine, and the Association announced that **there was no proof that this vaccine even prevents cervical cancer.**
    - Alarmingly, Merck's own studies indicate that the Gardasil vaccine may disproportionately impact Asian women. For example, in protocol 19, there were 8 deaths among 3800 women, and 7 of those were Asians. **That was 87 percent for Asian women, while only 31 percent of study participants were Asian.**
- Denmark, in 2015, **announced the opening of five new HPV clinics to treat women who were injured by the Gardasil vaccine. The day that they announced that opening, there were 1300 applicants for treatment in those clinics.**

- In Colombia in 2014, **800 girls in the town of Carmen de Bolivar were grievously injured by the Gardasil vaccine.** Protests erupted all over Columbia. The attorney general of Colombia ordered the National Health Service of that country to immediately begin treating girls who were injured by the Gardasil vaccine. In 2017, Colombia's highest constitutional court ruled that the HPV vaccine would no longer be considered mandatory in Colombia and ordered that girls who showed symptoms after receiving the vaccine be given appropriate medical care. Pompilio Martinez, who now teaches at the National University of Colombia, described the HPV vaccine as "a crime against humanity."
- And recent studies have shown that in **nations with robust HPV vaccination programs and heavily vaccinated populations—in the UK, in Sweden, in Australia—we're actually seeing dramatic upticks— rises—in the rate of cervical cancer rather than the downtrends that Merck promised everybody.**

Government agencies compromise the vaccine approval process

(This is still part of RFK Jr.'s presentation)

Now I'm going to show you some of the reasons why your pediatrician is insisting—despite all of this evidence—that your daughter or son get the HPV vaccine. And the reason is, **the pediatrician is getting his information from agencies that have been compromised through financial entanglements with Merck.**

This is what the FDA is telling the public about vaccine safety: it says that vaccines are regulated by FDA and "undergo a rigorous review of laboratory and clinical data to ensure the safety, efficacy, purity and potency of these products."

But this is a very different story the FDA is acknowledging in-house—and this comes from a 2007 document (this is the year that Gardasil got its license from the FDA): **"FDA's inability to keep up with scientific advances means that American lives are at risk. FDA's evaluation methods have remained largely unchanged over the last half century. The world looks to FDA as a leader. Today, not only can the Agency not lead, it cannot even keep up with the advances in science."**

But the most troubling problem at FDA is—it has nothing to do with incompetence—it has to do with corruption. The panel within FDA that licenses new vaccines and anoints them as safe is called the Vaccines and Related Biological Products Advisory Committee; the acronym is VRBPAC. **And in 2000, Congress investigated VRBPAC because of charges of corruption from outside the agency.**

And here's what the congressional committee found: "**The overwhelming majority of [VRBPAC] members, both voting members and consultants, have substantial ties to the pharmaceutical industry."**

In addition, "Conflict of interest rules employed by FDA have been weak, enforcement has been lax, and committee members with substantial ties to pharmaceutical companies have [been] given

waivers to participate in committee proceedings. In many cases, significant conflicts of interest are not deemed to be conflicts at all."

And here, says Congress, are some specific examples of the conflicts of the advisory committee that approves vaccines:

- Three out of five FDA advisory committee members who voted to approve the rotavirus vaccine in December of 1997 had financial ties to the pharmaceutical companies that were developing different versions of the vaccine.
- One of the five voting members had a 9-plus million-dollar contract for a rotavirus vaccine.
- One of the five voting members was the principal investigator for a Merck grant to develop the rotavirus vaccine.
- One of the five voting members received approximately a million dollars from vaccine manufacturers toward vaccine development.

Once they get by FDA, vaccine companies then go to CDC, where another committee, which is called **ACIP—Advisory Committee on Immunization Practices—will then take that vaccine that FDA has licensed, and they will put it on the recommended list, which means it becomes essentially mandatory for 76 million American children.**

A listing on CDC's recommended list is the Holy Grail for vaccine companies. It means a bonanza of wealth for those companies. **If ACIP votes to add your vaccine to the recommended list, it means:**

- **Mandating the vaccine to millions of American children**, and half of those [vaccines] are paid for by the government.
- **Immunity from liability** for the manufacturers so nobody can sue them—no matter how dangerous that vaccine is, no matter how toxic its components, no matter how grievous your injury, you cannot sue that vaccine manufacturer for damages or liability.
- **Inclusion in the Vaccines for Children Program**, which is a program that guarantees that half the vaccines that you manufacture are going to be purchased by the CDC—at full cost.

This means billions of dollars for companies that are fortunate enough to get their vaccines listed on this recommended list. It means that you're going to sell 76 million vaccines to people who have no choice—you have no marketing costs, you have no advertising costs, you have limited testing expenses and you have no liability for injuries caused by your vaccine.

In 2006 and 2007, while Gardasil was getting its approvals, ACIP did not pretend to base its recommendations on scientific evidence. It only adopted evidence-based standards in 2011.

So, what did it base its recommendation on? It turns out it was mainly just friendships and money. The conflicts at ACIP are as bad as the conflicts within the FDA.

This is from the same year-2000 investigation by Congress: "The CDC grants blanket waivers to the ACIP members each year that allow them to deliberate on any subject, regardless of their conflicts, for the entire year. ACIP members are allowed to vote on vaccine recommendations, even when they have financial ties to the drug companies developing related or similar vaccines."

And, "The ACIP's prolific use of working groups to track vaccine policy recommendations outside the specter of public scrutiny opens the door to special interest access." ACIP's policy of allowing government employees to vote "encourages a system where government officials make crucial decisions affecting American children without advice or consent of the governed."

Here is a typical committee panel that approved Merck's rotavirus vaccine. The majority of ACIP's members "were conflicted in their most recent vote." Again, these are Congress's words, not mine.

- The chairman served on Merck's Immunization Advisory Board.
- Another member who shared the patent on a vaccine under development for the same disease had a $350,000 grant from Merck to develop this vaccine and was a consultant for Merck.
- Another member was under contract with the Merck Vaccine Division.
- Another member received salary from Merck and other payments.
- Another member was participating in vaccine studies with Merck.
- And another member received grants from Merck.

And unfortunately, that congressional investigation had virtually no impact on the way CDC does and continues to do business. For example, **a 2009 report by the Inspector General of HHS found the same conditions existed—"CDC had a systematic lack of oversight." Ninety-seven percent of committee members' conflict disclosures had omissions, 58 percent had at least one unidentified potential conflict and 32 percent of the committee members had at least one conflict that remained unresolved. And the CDC continues to grant waivers.**

So, this shows that CDC is really just an arm of the vaccine industry. It shouldn't be regulating the industry—it's part of it.

- **This is CDC's entire budget, $11.5 billion, and almost half of that—almost $5 billion—goes to purchasing and promoting vaccines. And this little sliver here is the Immunization Safety Office.**
- **That's how much money—less than 1 percent of the total—goes to vaccine safety.**
- **Not only that, but Merck exercises control over CDC through the CDC Foundation. Merck contributes millions of dollars every year to the CDC Foundation. The CDC Foundation has received $620 million from Merck and other pharmaceutical companies to pay for 824 programs at the CDC.nMerck representatives sit on the CDC Foundation Board and control the agency's activities.**

This is what the *British Medical Journal* said about those conflicts:

- "Most of us were shocked to learn that the CDC takes funding from the industry. It is outrageous that industry apparently is allowed to punish the CDC if the agency conducts research that has the potential to cut into profits."

The corruption is systemic at FDA, too. Shockingly, 45 percent of FDA's budget comes from the industry. Pharmaceutical companies pay billions of dollars in fees annually to FDA to fast-track drugs.

- Between 2000-2010, pharmaceutical companies paid $3.4 billion to FDA to get drug approvals, and those payments by industry have caused FDA and CDC to treat the vaccine makers not as regulated entities but as partners and clients and friends.

According to Michael Carome, who is a former HHS employee, "Instead of a regulator and a regulated industry, we now have a partnership. That relationship has tilted the FDA away from [a] public health perspective to an industry-friendly perspective." And that's why your doctor does not know the truth about Gardasil.

This is another thing that your doctor probably doesn't know. The government agency NIH actually developed the key component for the Gardasil vaccine, and NIH owns part of the patent and receives royalties on it. Not only does NIH the agency receive millions and millions of dollars annually from the vaccine, but also the individual scientists who worked on the vaccine within the agency are entitled to make $150,000 a year in royalty payments from Merck.

Every time your pediatrician sells one of those $420 vaccines to your child—or you—NIH scientists and HHS scientists and the agencies themselves are making money on that transaction. And that's why your doctor doesn't know what's happening—because he's getting his information or her information from those agencies.

There are many, many other shocking conflicts that I don't have time to talk about today between Merck and the other regulated vaccine makers and the industry that's supposed to be protecting the public from that regulated industry.

I just want to talk for a moment about one example. From 2002 to 2009, Julie Gerberding was the director of CDC, and she oversaw all of this crooked science that went into the approvals in 2006 and 2007 of Merck's Gardasil vaccine.

She was rewarded by Merck.

When she left the agency in 2009, she was hired by Merck as the president of its vaccine division and Merck gave her a salary of $2.5 million a year, and $38 million in stock options. And that kind of dough buys a lot of loyalty from regulators.

They know what's at the end of the line for them if they behave and if they do what Merck and the other companies ask them to do. And these are the reasons that your pediatrician, who's giving your daughter that Gardasil vaccine believing that it may someday save her life, doesn't know about the risk and perils and the inefficacy that are attended to that vaccine, because the regulators from whom he's getting or she's getting her information have been corrupted by this company.

And most of you probably know—this is a difficult issue for people like myself who are concerned with vaccine injuries to address, because **the press will not cover these issues because there's $5.4 billion that go from these companies to advertising on TV and radio and newspapers and on the web every year, and nobody wants to lose that advertising revenue. And the Congress has been bought off, the regulatory agencies have been captured, and we can't use the courts because you cannot sue a vaccine maker for injuring yourself or your child.**

But we've figured out ways around those laws, and **we're going to sue Merck. And if you are Merck and you're listening to this tape: We're going to come for you and we're going to get justice for these girls and these boys who you've injured because of your greed.**

And if you're a mother or a father who are listening to this, we'd like your support. It's just a fact that the more monetary support the Children's Health Defense has, the more of these cases that we can bring, and we're going to get justice. And we're going to bring these cases and sue companies like Merck until we get that justice. So we want your money, and we want your support, and we want your membership.

But more than anything, we want you to protect your child from this vaccine and from other [vaccine] injuries—and for that reason we made this tape. Not only so that you can be informed about the science, but so you can ask the questions of your pediatrician, or you can give him a copy of this video and ask him to watch it and respond to it.

And if you're a pediatrician, I would ask you to actually look at the science and not resort to appeals to authority. Because to say "Well, I know it's safe because CDC says it's safe" or "WHO [the World Health Organization] says it's safe" or "the AAP [American Academy of Pediatrics] says it's safe"—all of those agencies and organizations have been corrupted by pharmaceutical industry money.

You need to actually look at the science, and you need to read the science critically. And if you do that, you'll find that the things that I've talked about in this video are real, that these injuries are real, and that we have got to save our children from this cataclysm.

I want to thank you for listening to this video and urge you to join ***Children's Health Defense***.
End of transcript

25 Reasons to Avoid the Gardasil Vaccine

Another highly recommended resource on the problems associated with the HPV Vaccine is a document titled, **25 Reasons to Avoid the Gardasil Vaccine**. It can be found here on the ***Children's Health Defense*** website. https://childrenshealthdefense.org/news/25-reasons-to-avoid-the-gardasil-vaccine/

Twenty-one-year-old woman's death finally compensated in 2017 after eight years, as the court rules that the HPV vaccine caused her death

Natural News reports on a case whereby a 21-year old woman (***Christina Richelle***), developed an irregular heartbeat, days after receiving her second HPV vaccine Gardasil in November of 2007. Within days after she returned for her third HPV dose in June of 2008. For several days after that third shot, she felt dizzy and faint. She then died after her heart malfunctioned. It was determined that **she had developed an autoimmune reaction that affected the electrical system of her heart**. The family filed a petition to the vaccine court in April of 2010. **After nearly eight long years of battling the court process, the court ruled that the family provided sufficient medical burden of proof that Christina's death was**

attributed to the Gardasil vaccine and they were due for compensation under the Vaccine Injury Protection Act.
https://www.naturalnews.com/2018-04-05-court-ruling-confirms-gardasil-vaccine-kills-people-scientific-evidence-beyond-any-doubt.html

From the court brief filed September 25, 2017, by Special Master Christian J. Moran:

Ultimately, because of the finding that Christina began to experience arrhythmia after her HPV vaccination, Ms. Tarsell has presented preponderant evidence of a logical sequence of cause and effect, connecting the HPV vaccination to the ensuing arrhythmia.

IV. Conclusion

The Court's Opinion and Order required additional consideration consistent with the legal principles articulated by the Court for analyzing the evidence in this tragic case about a woman, Christina Tarsell, who died much too young. Under the approach dictated by the Court, Ms. Tarsell is entitled to compensation. The parties should anticipate that a separate order regarding damages will issue shortly."

Natural News columnist **Lance D. Johnson** goes on the say, "**Never mind that the Gardasil vaccine is responsible for ending the lives of 271 young women to date, according to over 57,520 adverse event reports obtained from the Vaccine Adverse Events Reporting System *(VAERS)*.**

If 271 young people died in a school shooting, the news coverage would be nonstop in support of gun bans. How about a ban on Gardasil – a real modern-day assault weapon?"

"The Tarsell's case was initially taken up by the Vaccine Court, which is a payout system that was set up to compensate families for vaccine damage. Vaccine makers pay an excise tax to this system for every vaccine they sell. This money (cost of doing business) is used to pay out damages to select families who can medically prove they were damaged by a vaccine. This system protects vaccine makers from being sued in a true court of law, ensuring that vaccines will continue to be manufactured for the "good of all.""

"Wow! Medicine has moved ahead only because doctors, researchers, and yes, families, have openly challenged even the most sacred medical dogma. At the risk of incurring the wrath of some of my dearest colleagues, I say thank goodness for the vaccine court."

Postlicensure safety surveillance through VAERS on the HP Vaccine

As this is reported, bear in mind that it has been established that only approximately 1% of all vaccine adverse reactions are reported to VAERS.

A 2009 article published in the ***Journal of the American Medical Association*** (JAMA) titled, **Postlicensure safety surveillance for quadrivalent human papillomavirus recombinant vaccine**, cites some of the reporting statistics **from only a 2 ½ year period. Consider that short time frame and the comment above about under-reporting to VAERS when reading this**.
https://www.ncbi.nlm.nih.gov/pubmed/19690307

From the Abstract:
"**VAERS received 12,424 reports of AEFIs following qHPV distribution, a rate of 53.9 reports per 100,000 doses distributed. A total of 772 reports (6.2% of all reports) described serious AEFIs, including 32 reports of death" *(again, in only a 2 ½ year period)*. "The reporting rates per 100,000 qHPV doses distributed were 8.2 for syncope; 7.5 for local site reactions; 6.8 for dizziness; 5.0 for nausea; 4.1 for headache; 3.1 for hypersensitivity reactions; 2.6 for urticaria; 0.2 for venous thromboembolic events, autoimmune disorders, and Guillain-Barré syndrome; 0.1 for anaphylaxis and death; 0.04 for transverse myelitis and pancreatitis; and 0.009 for motor neuron disease. Disproportional reporting of syncope and venous thromboembolic events was noted with data mining methods**."

As tragic as all of this is, the government continues to push Gardasil

Four years after the previous report on Christina Richelle's death, ***Judicial Watch*** released the following article. **$1.2 Mil to Push Gardasil Among Poor Minority Girls.**
https://www.judicialwatch.org/blog/2013/07/1-2-mil-to-promote-gardasil-among-low-income-minority-girls/

Excerpts from the article:

While the Obama administration tries to keep details involving the dangers of a government-backed cervical cancer vaccine (Gardasil) secret, it continues spending large sums of taxpayer dollars promoting the controversial shot for girls and young women.

This is beyond outrageous because Judicial Watch has exposed the scandal behind Gardasil, manufactured by pharmaceutical giant Merck and promoted as a miracle shot that can prevent certain strains of cervical cancer caused by Human Papillomavirus (HPV). The reality is that droves of government records uncovered by Judicial Watch show that Gardasil has been linked to thousands of adverse reactions and debilitating side effects that the government wants to keep secret.

They include seizures, blindness, paralysis, speech problems, pancreatitis, short-term memory loss and dozens of deaths. Incredibly, the Food and Drug Administration (FDA) fast-tracked Gardasil's approval and the Centers for Disease Control and Prevention (CDC) continues recommending it for girls starting at age 9. JW launched its probe in 2007 and had to sue for the records in the face of Obama administration stonewalling. **In 2008 JW published a special report detailing Gardasil's government approval process, side effects, safety concerns and marketing practices.**

Earlier this year JW uncovered documents from the Department of Health and Human Services (HHS) revealing that its ***National Vaccine Injury Compensation Program (VICP)*** has awarded **nearly $6 million to dozens of victims in claims made against the very HPV vaccine it is pushing on children**. To date 200 claims have been filed with VICP, with barely half adjudicated, according to the documents obtained by JW.

The money has gone to a public university in southern California that will conduct a "culturally sensitive" intervention— in English, Spanish, Cantonese, Mandarin, Armenian and Korean—to increase HPV vaccine receipt among "underserved, high risk girls in Los Angeles."

It's safe to bet that the "culturally sensitive," taxpayer-funded Gardasil campaign won't include the potentially lethal side effects documented in the government's own Vaccine Adverse Event Reporting System (VAERS). The data is kept by the FDA and CDC as a vaccine safety surveillance program that can be easily accessed by the public yet Judicial Watch had to sue for information related to Gardasil.

More evidence that injecting human DNA into other humans is a very bad idea

Dr. Diane Harper - Lead Investigator for the HPV Vaccine Clinical Trials for the Gardasil Vaccine, makes a startling admission about the HPV DNA in the vaccine

Dr. Diane Harper, one of the lead researcher's in studies published by Merck regarding the HPV vaccine was interviewed by ***Toni Bark M.D***., in the highly acclaimed Docu-series **Vaccines Revealed**. (I highly recommend that anyone interested in investigating the vaccine issue watch this excellent series).

In episode 10, when asked by Dr. Bark…"Do we have any evidence to show that injecting HPV DNA into somebody's bloodstream is safe? Dr. Harper's response was one word. "No."

2013 study exposes that viral DNA fragments previously denied to exist in Gardasil, are there bound to the aluminum adjuvant. This raises several safety questions.

The study referenced in the article below was published in ***Advances in Biological Chemistry***, in 2013.
http://offtheradar.co.nz/index.php/vaccines/337-new-study-of-gardasil-raises-more-safety-questions
"By Norma Erickson, President www.sanevax.org Posted 17 March 2013."

"Why were HPV-16 L1 DNA fragments detected in post mortem samples taken six months after Gardasil vaccination and not the other vaccine-relevant types? Dr. Sin Hang Lee, of ***Milford Hospital*** and ***Milford Molecular Laboratory***, may have provided an answer in his most recently published paper entitled, *Topological conformational changes of human papillomavirus (HPV) DNA bound to an insoluble aluminum salt – A study by low temperature PCR.*[1] His findings suggest that non-B-conformational changes in HPV L1 gene DNA fragments bound to the AAHS adjuvant may be genotype related, in other words specific to HPV-16."

"**In September 2011, SaneVax Inc. informed the FDA that despite all claims stating Gardasil contained 'no viral DNA' Dr. Lee had discovered there were indeed fragments of HPV-11, HPV-16 and HPV-18 L1**

DNA firmly attached to Merck's proprietary aluminum adjuvant in 100% of the samples he tested, but all were lacking a region amplifiable by an MY09 degenerate primer."

"**The FDA was quick to confirm that Gardasil does contain residual HPV L1 gene DNA fragments**, but that these fragments posed no health risk. The FDA completely ignored a request for further investigations put forth by the SaneVax Team."

"**In light of the FDA statement corroborating Dr. Lee's previous findings, the presence of HPV DNA fragments of vaccine origin in the bodies of recipients might be anticipated after intramuscular injections of Gardasil**. However, finding HPV-16 L1 DNA fragments in post-mortem blood samples of a teenager who died six months after completion of 3 Gardasil injections without finding any other vaccine-relevant fragments was a surprise. Obviously, further investigations were necessary.
At the request of SaneVax Inc., Dr. Lee agreed to use PCR amplification followed by direct DNA sequencing to try and determine what was going on."

Then the article shares some very technical and complex scientific information, before concluding with the following….

The conclusion of the article is as follows:
"Where does this leave the average medical consumer? Unfortunately, it leaves them with the following unanswered questions:

- **Once injected, how long will the HPV-16 L1 DNA fragments attached to aluminum remain in my body?**
- **Are the non-B conformation HPV fragments in Gardasil potentially harmful?**
- **Will the non-B conformation DNA fragments in Gardasil induce autoimmune disorders?**
- **Will the non-B conformation DNA get integrated in the genome causing mutagenesis and/or cancer?"**

"The scientific community needs to investigate these potential risks immediately. Medical consumers need to know the risks as well as any potential benefits before they decide if Gardasil is right for them. **In the interest of public health and safety, the FDA needs to rescind approval for Gardasil until satisfactory answers are provided to the four questions above**. The time for poke and hope is long since passed. Medical consumers need proof this vaccine is safe."

Once again, this shows that claims from the vaccine manufacturers regarding what is in their vaccines must always be taken with a grain of salt.

HPV messaging gives women a false sense of security leading to decreased PAP screenings and an increase in missed cervical cancer diagnoses

According to Dr. Harper in the same interview, studies looking at very large numbers of young women in Great Britain and Australia, show a reduced rate of screenings for cervical cancers (PAPs), in both

vaccinated and unvaccinated women. She attributes that lack of compliance to the messaging by the pharmaceutical industry about the protective benefits of the HPV vaccine. "The regular screening rate in the U.K., in the United States and developing countries is usually 80% or higher. The U.S. has a goal that we are going to reach 93% of our women..." It seems that as the HPV vaccine "message" of effectiveness is having some negative unintended consequences.

"**In the U.K. study, of the women that had been vaccinated, only 26% of those women came back in for screening**. Of the women who were screened, 14-15% of them had an abnormal screen. 26% coming in for screening is very low." Dr. Bark asked, "So it's as though, the vaccine and **the whole marketing campaign around the vaccine has reduced good behavior**." Dr. Harper replied, "That's right, and that is going to hurt women in the long run."

How important is this? According to an extensive Australian government report in 2005, the Screening Pap test (or smear) is up to 90% accurate and the best way to prevent squamous cervical cancer.

HPV vaccine only protects against a limited number of the viral strains

Let's first look at some statistics from the World Health Organization that will be important to the following discussion. According to this website http://www.who.int/mediacentre/factsheets/fs380/en/ (Bold emphasis mine)

- Human papillomavirus (HPV) is a group of viruses that are extremely common worldwide.
- There are **more than 100 types of HPV**, of which **at least 13 are cancer-causing (also known as high risk type).**
- HPV is mainly transmitted through sexual contact and most people are infected with HPV shortly after the onset of sexual activity.
- Cervical cancer is caused by sexually acquired infection with certain types of HPV.
- **Two HPV types (16 and 18) cause 70% of cervical cancers and precancerous cervical lesions.**

The CDC's website at this link states that the HPV vaccine is not protective of all viral strains and cervical cancer. And importantly, they stress the importance of continuing screening despite being vaccinated. https://www.cdc.gov/std/hpv/stdfact-hpv-vaccine-young-women.htm

One of the questions on the site is…
What does the vaccine *not* protect against?
"The vaccine does not protect against all HPV types— so they will not prevent all cases of cervical cancer. Since some cervical cancers will not be prevented by the vaccine, it will be important for women to continue getting screened for cervical cancer. Also, the vaccine does not prevent other sexually transmitted infections (STIs). So it will still be important for sexually active persons to lower their risk for other STIs."

During the Dr. Harper interview discussed above, Dr. Bark asked Dr. Harper how long the Gardasil HPV vaccine provides protection? Dr. Harper explained the Phase 1 (eight people), Phase 2 (around two to three hundred people), and Phase 3 trial (tens of thousands of people) process. She replied, "The Phase 2 trials is what gives you a lot of information and that's where we have our duration of efficacy. For Gardasil, the Phase 2 trial lasted for 5 years and then was abruptly stopped, so we know in that five-year time frame, those hundreds of women, not thousands, but hundreds of women continued to show protection against HPV 16 and 18. **So we can say very firmly and solidly that Gardasil lasts at least five years. There have been no publications on any further efficacy beyond that**. Merck has presented several abstracts at conferences, but they have never published any data. And those of us in the science world know, that if it's not published, it's not real. So we know that abstracted information is often inaccurate, it's often an early report, it's often something that may change when the full spectrum of data are reported, or when you have reviewers asking questions about the way in which the data are being reported." She goes on to say that the Cerverex vaccine Phase 2 data that was published showed efficacy for 8.4 years.

Since Gardasil has not been proven to convey lifelong protection, research shows there is likely no overall decrease in cervical cancer incidence with early vaccination.

An article published in the ***Lancet Medical Journal*** June 2009 titled, **Preliminary HPV Vaccine results for older women older than 25 years**, states the following conclusion:

"After prophylactic human papillomavirus (HPV) vaccination, cost-effectiveness models predict that a reduction in cervical cancer will occur decades from now, **but only when 90% of all girls aged 11–12 years have been vaccinated for many years, assuming vaccines confer lifelong protection**. ***(My comment: which as we saw in the previous interview, it doesn't)*** **Should prophylactic vaccination protect women for less than 15 years, the incidence of cervical cancer will shift to women older than 25 years, with no overall decrease in cervical cancers from early vaccination**."
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)61045-X/abstract

Women vaccinated with the Gardasil vaccine are more susceptible to other high-risk HPV strains than unvaccinated women

A presentation given at the ***2015 Annual Meeting of the American Association for Cancer Research*** and titled, **Comparison of HPV prevalence between HPV-vaccinated and non-vaccinated young adult women (20-26 years)**,

Results: After controlling for past sexual behaviors, vaccinated women had a lower risk of testing positive for the 4 types included in the HPV vaccine (6, 11, 16, or 18; Table 1). This association became stronger when the number of recent sexual partners was controlled for. However, **vaccinated women had a higher prevalence of nonvaccine high-risk types than unvaccinated women (61.5% vs 39.7%).**

Gardasil research results found to be manipulated to show better results than were actually achieved

In a 2013 article titled**, Human papillomavirus (HPV) vaccines as an option for preventing cervical malignancies: (how) effective and safe?**, and published in the Journal ***Current Pharmaceutical Design*** **makes some absolutely astounding revelations about the corruption and tampering of statistics in the trials of the HPV vaccine clinical trials**.

Abstract Summary: "We carried out a systematic review of HPV vaccine pre- and post-licensure trials to assess the evidence of their effectiveness and safety. We find that HPV vaccine clinical trials design, and data interpretation of both efficacy and safety outcomes, **were largely inadequate**. Additionally, we note **evidence of selective reporting of results from clinical trials** (i.e., exclusion of vaccine efficacy figures related to study subgroups in which efficacy might be lower or even negative from peer-reviewed publications). Given this, the widespread optimism regarding HPV vaccines long-term benefits **appears to rest on a number of unproven assumptions** (or such which are at odd with factual evidence) **and significant misinterpretation of available data**. **For example, the claim that HPV vaccination will result in approximately 70% reduction of cervical cancers is made despite the fact that the clinical trials data have not demonstrated to date that the vaccines have actually prevented a single case of cervical cancer (let alone cervical cancer death),** nor that the current overly optimistic surrogate marker-based extrapolations are justified. **Likewise, the notion that HPV vaccines have an impressive safety profile is only supported by highly flawed design of safety trials and is contrary to accumulating evidence from vaccine safety surveillance databases and case reports which continue to link HPV vaccination to serious adverse outcomes (including death and permanent disabilities). We thus conclude that further reduction of cervical cancers might be best achieved by optimizing cervical screening (which carries no such risks) and targeting other factors of the disease rather than by the reliance on vaccines with questionable efficacy and safety profiles."** **WOW! That's GREAT advise!**

"Placebos" loaded with aluminum, formaldehyde and other noxious components from the actual vaccine used in HPV (Gardasil) and other vaccine safety studies

We have heard this song and dance earlier in this eBook. The use of the same toxic chemicals and heavy metals in the "placebo" as the actual vaccine, to "mask" unwanted lower adverse effects in the control group. All to gain approval for mass distribution.

In an article published in the ***Journal of Immunologic Research***, 2017 titled, **Behavioral abnormalities in female mice following administration of aluminum adjuvants and the human papillomavirus (HPV) vaccine Gardasil**, a shocking admission is made.

"**Vaccine adjuvants and vaccines may induce autoimmune and inflammatory manifestations in susceptible individuals**. **To date most human vaccine trials utilize aluminum (Al) adjuvants as placebos** despite much evidence showing that Al in vaccine-relevant exposures can be toxic to humans and animals."

Again, as I stressed in the earlier comments, the practice of using vaccines containing the "questionable" and potentially toxic components as placebos, to compare for adverse side effects with the "real" vaccine containing essentially the same formula (with viral fragments added), protects against the detection of a gap in the number of adverse reactions in those given the actual vaccine versus the placebo. If a given number of people react to the aluminum, mercury, formaldehyde, recumbent DNA, etc., and whatever is included in the placebo, the difference between the number of adverse reactions between the actual vaccine and what they are calling the placebo will be slim or non-existent. Therefore, the study will show the vaccine causes no more adverse reactions than a placebo. That sounds pretty good, doesn't it? Try those same studies with a saline placebo as should be used and see what happens.

Aluminum and Polysorbate 80 were used in the Gardasil vaccine studies for the control groups as the "placebo"

Listen to what the authors of this study **Adolescent Premature Ovarian Insufficiency Following Human Papillomavirus Vaccination: A Case Series Seen in General Practice**, published in the ***Journal of Investigative Medicine High Impact Case Reports*** in 2014, have to say about the way the Gardasil vaccine studies tilted the adverse side effect outcomes in the control groups to mask differences between the group that got the real vaccine and the "placebo". It also states that a large number of girls in the original trials were taking hormonal contraceptives which can mask ovarian dysfunction including amenorrhea and ovarian failure.

"**A potential ovarian toxin in both control and vaccine arms could obscure the already limited ability to observe risk differences of adverse menstrual events.**"

Additionally, the safety studies of the HPV4 vaccine did not even look at the cellular changes that the vaccine could cause to the female ovaries. It only looked at the male reproductive system. This seems very questionable, since the target market for this vaccine has been young females. This is unbelievable. The authors note: "It is unfortunate that available toxicology studies **only provide histology of the male rodent reproductive system after HPV4 vaccine**…. and not of the female rodent reproductive tract or ovaries. Vaccine-tested rat ovary histology reports would have been useful to consult to better understand any possible link between cases of teenage premature ovarian insufficiency and rat vaccine effects."

This section of the study is somewhat lengthy, **but deserves close scrutiny** because it contains some very rich information. I have underlined and bolded the take-aways…

"The choice of placebo **affects the validity and quality** of scientific information available from placebo-controlled studies. The control in any experiment **should lack the factor being tested**. **The placebo** that formed the control selected for phase III safety studies of Gardasil (older girls) **was the aluminum adjuvant** present in the vaccine solution, amorphous aluminum hydroxyphosphate sulfate. The selection of aluminum as a control in vaccine studies **is at variance** *(not consistent with)* **with the scientific principles of a control. The placebo in the only controlled study of very young girls** was the remainder of the vaccine carrier solution: "**The placebo used in this study contained identical components to**

those in the vaccine, with the exception of HPV L1 VLPs and aluminum adjuvant." **It contained 50 µg polysorbate 80** (polyoxyethylene sorbitan mono-oleate also known as **Tween 80**), **35 µg borax**, 9.56 mg sodium chloride, and 0.78 mg l-histidine."

"Safety studies identified at licensing **did not compare HPV4 with normal saline controls**. The second placebo contained several substances together with saline. The researchers' reference to the "carrier solution" placebo **conflicts with the licensing review**. The ***Center for Biologics Evaluation and Research*** states, "Protocol 018 provides saline placebo-controlled safety data for subjects 9 to 15 years. This is of particular interest because **the other studies used alum placebo as a safety comparison**." Subsequent reviews of safety studies also claim a saline placebo was the comparator of younger girl safety studies and variously refer to this placebo control as "non-aluminum containing (saline) placebo" and "saline placebo." Gardasil Product Information itself refers to the control as a "saline placebo." **Published safety studies only compared HPV4 vaccine with its own components**. **This may be significant since injected substances in both placebo control arms have either a suggested association with autoimmune ovarian damage or known direct ovarian toxicity.**" *(I take this to mean that **both the alum "placebo" and the polysorbate 80 "placebo"** have a suggested association with autoimmune ovarian damage or direct ovarian toxicity)*

Gardasil 9 contains both aluminum and polysorbate 80. As mentioned in several places earlier in this document, polysorbate 80 acts as a carrier to transport particulates into the brain! In this case what that means, is that polysorbate may actually transport the aluminum into the brain. In essence, it helps the aluminum breach the brain's protective blood brain barrier (BBB). I can't stress the importance and significance of this enough. Polysorbate 80 has been used for well over 10 years in experiments and drug trials to transport drugs, particulates including nanoparticles and other compounds that are difficult to cross into the brain, across the BBB into the brain. This has been heralded in scientific research as one solution for treating advanced stage brain disorders with therapeutic drugs. So I have to ask again, why don't scientists working in the vaccine industry know this? Or do they and have just ignored it?

As if that isn't enough, this next study confirms that the Polysorbate 80 used in the placebo as discussed above, is capable of causing ovarian damage.

The fact that polysorbate 80 found in Gardasil 9 can cause ovarian damage has been known for 25 years

This 1993 study titled **Delayed effects of neonatal exposure to Tween 80 on female reproductive organs in rats**, published in the journal ***Food and Chemical Toxicology***: *an international journal published for the **British Industrial Biological Research Association*** **found that Polysorbate 80 which is used in the HPV vaccine Gardasil AND in the placebo during the clinical trials of Gardasil, causes damage to the ovaries**. https://www.ncbi.nlm.nih.gov/pubmed/?term=8473002

From the study…"When polysorbate 80 ("Tween 80") was injected into newborn rats, it caused similar ovarian damage to injected diethylstilbestrol *(D.E.S. is the mutagenic chemical that caused birth defects that I discussed, as my second example of historical examples of medical errors on page 14)*.

Rat ovary effects occurred at **all doses** tested over a tenfold range". **Abnormal histological *(cellular tissue)* changes and shrunken ovaries occurred in all of the rats given Polysorbate 80! WOW! And this shows that these devastating effects of Polysorbate 80 have been known since 1993.**

Carefully examine the words and context used when statistics are presented

An update from ***PubMed Health***, a service of the ***National Library of Medicine, National Institutes of Health***, dated December 14, 2017 answers several questions about the HPV Vaccine.
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0072445/?report=printable

One of those questions is…
How well do HPV vaccines work?
"Research has shown that HPV vaccines are very good at preventing HPV infections caused by the viruses that they target. They reduce the likelihood of cervical cells changing and becoming abnormal, and also lower the risk of cervical cancer.

If the protection lasts a long time, the following could be expected:

- **Without** an HPV vaccine: About 30 out of 1,000 women would develop cervical cancer at some point in their lives – if they **don't** go for cervical screening.
- **With** an HPV vaccine: About 10 out of 1,000 women would develop cervical cancer at some point in their lives – if they **don't** go for cervical screening.

In other words, HPV vaccines could prevent cervical cancer in about 20 out of 1,000 women."

Now that sounds pretty good doesn't it? However, notice that is in women who DON'T go for cervical screening (PAP screenings). Consider that unvaccinated women who get PAP screened regularly have a 90% protection from cervical cancer. So, of the 30 out of 1,000 unvaccinated women that would develop cervical cancer without the vaccine, only 3 would develop cervical cancer if all DID go for regular screenings. Of the vaccinated 10 that would develop cervical cancer without screenings, only one would later develop cervical cancer. See how the words matter? Their wording would suggest a gap of 20 women out of a thousand because they used the example of unscreened women. By introducing screening into the equation, now the gap becomes 2 out of a thousand women. Now a difference of 2 out of a thousand women is still a 0.2% difference, but since statistically it is estimated that approximately 1 in 5 women who develop cervical cancer will die from it, that means with the .2% difference, 1 in 2,500 that get it will actually die from it. The reality is however, that not all women will keep up with their PAP screenings. But what about personal responsibility? Not all persons will abstain from smoking cigarettes, but the ones that do nearly eliminate their chances of getting lung cancer. The ones that smoke assume that risk. In the same way, the women that keep up with their screenings dramatically reduce their chances of contracting cervical cancer and those that do develop it reduce their chances of dying from it significantly more.

The aluminum in Gardasil implicated in neurological and autoimmune conditions

An article published in the Journal of ***Immunologic Research***, 2017 titled, **Behavioral abnormalities in female mice following administration of aluminum adjuvants and the human papillomavirus (HPV) vaccine Gardasil**, implicates the aluminum in the vaccine with serious health consequences.

"It appears that Gardasil via its Al adjuvant and HPV antigens has the ability to trigger neuroinflammation and autoimmune reactions, further leading to behavioral changes."

The BCG (Tuberculosis) Vaccine

Studies confirm the presence of serious adverse events after the BCG Vaccine

A 2016 article from the Journal ***Vaccine*** titled, **Adverse reactions to the Bacillus Calmette–Guérin (BCG) vaccine in new-born infants—an evaluation of the Danish strain 1331 SSI in a randomized clinical trial**, in which 2,118 newborns were vaccinated with the BCG Vaccine. **The adverse events were five times higher than expected.**
https://www.sciencedirect.com/science/article/pii/S0264410X16300974?via%3Dihub

From the Abstract:
"This report focuses on severe adverse reactions categorized as causally related to BCG vaccination."

"Two cases of regional lymphadenitis were hospitalized and thus classified as serious adverse reactions related to BCG. The most severe adverse reactions were 10 cases of suppurative lymphadenitis. This was **nearly a fivefold increase compared to what was expected** based on the summary of product characteristics of the vaccine."

From the article:
"Prior studies of the BCG-vaccine revealed varying rates of ARs: A South African study, evaluating BCG SSI strain 1331, reported an overall AR rate of 3.1/100, whereas an Australian study found an overall AR rate of 5/100. **In France, an overall incidence of 18/100 in a study using active case finding at 4 and 12 months after vaccination were reported**." *That would indicate when the subjects were followed for a longer period of time, the number of delayed adverse reactions (ARs) became evident.*

So, what was the total adverse reports rate per 100 for this study? Interestingly, the study did not report all of the adverse events. One has to wonder why? The official explanation was, "A total of 4262 children were randomized to BCG or control and 2118 children were BCG vaccinated within 7 days of life. **Hospitalization and morbidity were study outcomes and will be reported elsewhere** (Stensballe et al., submitted; Kjærgaard et al., submitted). **Due to the limitations of the non-severe AR data, we are not able to report solid data on all events.**"

A recent study in the Journal Vaccine reports a significant rate and morbidity of adverse reactions to the BCG Vaccine

*Morbidity is the rate of disease

A 2015 study from the Journal ***Vaccine*** titled, **Management and outcome of Bacille Calmette-Guérin vaccine adverse reactions**, details the different reactions that occur from the BCG Vaccine.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4582770/

"A typical reaction following BCG vaccination is a red indurated area at the injection site, which may subsequently ulcerate, then form a crust, which falls off after about 6 weeks leaving a small scar. Axillary lymphadenopathy (<1 cm) is also a normal response to BCG vaccination. **Adverse reactions to BCG vaccine are reported in 1–10% of vaccinees, but are likely to be substantially underreported**. Adverse reactions are usually seen within the first 6 months of vaccination but can present beyond 12 months." (*Lymphadenopathy is swollen lymph glands)*

"**BCG complications can cause significant morbidity in children and anxiety in their parents**. Local adverse reactions include regional suppurative and non-suppurative lymphadenitis, injection site abscesses, persistent injection site reactions, ulceration and uncommonly keloid reactions. Systemic adverse reactions are rare and include osteomyelitis/osteitis and disseminated BCG disease. Systemic dissemination is of particular risk in children with primary immune deficiencies or human immunodeficiency virus (HIV) infection. Local and regional adverse reactions occur most frequently and the majority are self-limiting. However, many clinicians advocate treatment, including use of antimicrobials, needle aspiration and/or surgery and practice is likely to vary substantially across sites."

Diphtheria and Tetanus Vaccines

What about tetanus and diphtheria in the U.S.? How common are those infections and are the risks worth the benefit? And, how effective is the tetanus shot?

Let's look at tetanus first

The CDC published a report in their ***Morbidity and Mortality Weekly Report*** dated April 01, 2011. It is titled, **Tetanus Surveillance --- United States, 2001—2008.**
https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6012a1.htm

The report states that between the years 2001-2008, there were 233 cases of **tetanus** in the U.S. That works out to an average of 33 per year or about 1 case per 10 million people.

Of those 233 cases over the 7 years, vaccination status was known for 92 of those individuals. Of those 92, 55 **(59.3%), had been previously vaccinated.**

Of the 55 that had been previously vaccinated,

- 26 had received one dose
- 5 had received 3 doses
- 24 had received equal to or greater than 4 doses

In addition, medical histories were known for 195 of the cases. Of those 195,

- 30 reported to have diabetes
- 27 were injectable drug users

That being the case, of the 195 cases discussed **57 (29%), were in individuals with serious pre-existing health and risk factor issues. An important point to take away from this is, that the 138 (71%), remaining "healthy or healthier" people that don't have those 2 serious health risk factors reduce the overall annual incidence of tetanus from 33 per year to just over 23 (23.4%) cases in the U.S. Therefore, the incidence in those without diabetes or injectable drug users is approximately 1 in 14 million. Considering that there are numerous other health conditions that predispose people to infection, I would submit that the rate of tetanus in truly healthy people is far less than 1 in 14 million.** You will be introduced later in this document to the great debate that still goes on today. It is over what causes infection. Is it the germ or the terrain? This debate started with Louis Pasteur and Antoine Bechamp as reported on page 493.

What is the case fatality rate? The report states the **overall** case fatality rate is 13.2 %. But included in that is a case fatality rate of 31.3% for persons age 65 or older. **Therefore, the case fatality rate for persons under age 65 must be significantly lower than 13.2%.**

From the report:
"During 2001–2008, the average annual incidence of tetanus in the United States was 0.10 cases overall per 1 million population and 0.23 among persons aged ≥65 years; the case-fatality rate was 13.2% overall but 31.3% among persons aged ≥65 years."

The article states that one of the reasons for the precipitous decline in the incidence of tetanus in the U.S. is **better wound care**.

One last comment. Since the chance of getting struck by lightning is approximately 1 in 700,000, you are 20 times more likely to be struck by lightning in any given year than you are to become infected with tetanus. https://news.nationalgeographic.com/news/2004/06/flash-facts-about-lightning/

What about Diphtheria?

The DPT, DTaP and TD vaccines are still currently used against diphtheria in the U.S., yet the CDC reports that "**Between 2004 and 2015, 2 cases of diphtheria were recorded in the United States**." According to the article, "most physicians will never have seen a case of diphtheria in their lifetime."
https://www.cdc.gov/diphtheria/clinicians.html

Maybe it's time we consider removing the D (Diphtheria) from those vaccines, at least in parts of the world where it is no longer an issue. That would reduce the load of aluminum, polysorbate 80, glutaraldehyde, formaldehyde, the various problematic antibiotics discussed earlier and other chemicals into the bodies of the recipients. With our advanced medical care options, including effective antibiotics and easy access to medical care, a case of diphtheria if one ever presented itself could be easily managed. At what point is a vaccine ever taken off the market? Never? When does the risk vs. reward equation flip? Just asking! My guess is that the answer is never if you are on the profit side of that equation.

The DPT vaccine has a long and storied history of high rates of severe adverse reactions

Rather than add a lengthy section about the DPT vaccine here, I thought I would just add one article and then recommend that you start at the beginning of this eBook and do a key word search for DPT. It will take you to each instance where it is discussed in ***1200 Studies*** (and there are a lot!). As an exclamation point to describe the fallout from DPT, the lawsuits from children damaged by the DPT vaccine had forced 2 of the 3 manufacturers to drop out of the market. Why? Because as referenced by the late Supreme Court Justice Antonin Scalia on page 388, one of the manufacturers that dropped out claimed the **"potential tort liability exceeded its annual sales by a factor of 200"**. That speaks volumes about the problems caused by the vaccine. Incidentally, this was the defining moment that gave us the National Childhood Vaccine Injury Act (NCVIA), otherwise known as COMPLETE IMMUNITY FROM RESPONSIBILITY AND LIABILITY FOR VACCINE MAKERS.

The Pertussis component of DPT was the most problematic

A 1981 article from the journal ***Pediatrics*** titled, **Nature and rates of adverse reactions associated with DTP and DT immunizations in infants and children**, compared the adverse reactions between the DTP and the DT (without the Pertussis component) vaccines. It really is a glaring piece of evidence that shows that the Pertussis component was responsible for a large number of adverse reactions from DPT. Bear in mind that these were only reactions that occurred within 48 hours. Many of the reactions including very severe ones from DPT occurred beyond the first 48 hours.
https://www.ncbi.nlm.nih.gov/pubmed/7031583

The Abstract:
"In 784 DT and 15,752 DTP immunizations given to children 0 to 6 years of age who were prospectively studied for reactions **occurring within 48 hours following immunization**, minor reactions were significantly more frequent following DTP vaccine. **The ratio of reaction rates associated with DTP and DT immunizations (DTP/DT) for selected local and systemic reactions was as follows**: local redness, 37.4%/7.6%; local swelling, 40.7%/7.6%; pain, 50.9%/9.9%; fever, 31.5%/14.9%; drowsiness, 31.5%/14.9%; fretfulness, 53.4%/22.6%; vomiting, 6.2%/2.6%; anorexia, 20.9%/7.0% and persistent crying, 3.1%/0.7%. Following DTP immunization **nine children developed convulsions and nine developed hypotonic hyporesponsive episodes.** No sequelae were detected following these reactions."

NEW - DTP vaccines increase the odds of allergies and related respiratory symptoms in children and adolescents

The study published February 2000 in the ***Journal of Manipulative and Physiological Therapeutics*** was titled, **Effects of diphtheria-tetanus-pertussis or tetanus vaccination on allergies and allergy-related respiratory symptoms among children and adolescents in the United States**.

Abstract

Background: Findings from animal and human studies confirm that diphtheria and tetanus toxoids and pertussis (DTP) and tetanus vaccinations induce allergic responses; associations between childhood vaccinations and subsequent allergies have been reported recently.

Objective: The association of DTP or tetanus vaccination with allergies and allergy-related respiratory symptoms among children and adolescents in the United States was assessed.

Methods: Data were used from the Third National Health and Nutrition Examination Survey on infants aged 2 months through adolescents aged 16 years. DTP or tetanus vaccination, lifetime allergy history, and allergy symptoms in the past 12 months were based on parental or guardian recall. Logistic regression modeling was performed to estimate the effects of DTP or tetanus vaccination on each allergy.

Results: The odds of having a history of asthma was twice as great among vaccinated subjects than among unvaccinated subjects (adjusted odds ratio, 2.00; 95% confidence interval, 0.59 to 6.74). **The odds of having had any allergy-related respiratory symptom in the past 12 months was 63% greater among vaccinated subjects than unvaccinated subjects** (adjusted odds ratio, 1.63; 95% confidence interval, 1.05 to 2.54). The associations between vaccination and subsequent allergies and symptoms were greatest among children aged 5 through 10 years.

Conclusions: DTP or tetanus vaccination appears to increase the risk of allergies and related respiratory symptoms in children and adolescents. Although it is unlikely that these results are entirely because of any sources of bias, the small number of unvaccinated subjects and the study design limit our ability to make firm causal inferences about the true magnitude of effect

Smallpox

The smallpox vaccine carries a risk of deadly encephalitis

The Journal ***Seminars in Neurology*** published an article in 2002 titled, **The smallpox vaccine and postvaccinal encephalitis.** https://www.ncbi.nlm.nih.gov/pubmed/?term=12170398

From the Abstract:
"Smallpox is one of the deadliest infectious diseases in history. The discovery by Edward Jenner that inoculation with a droplet of pus from a cow with cowpox protected a person from smallpox resulted in the successful vaccination of millions of people. **There were, however, complications associated with smallpox vaccination; the most serious complication was postvaccinal encephalitis, which was reported to occur with an incidence of 1 in 110,000 vaccinations and a case-fatality rate of 50%."**

"The first case of postvaccinal encephalitis as a complication of the Jennerian cowpox inoculation was observed in 1905. **A century later, there is no effective therapy**."

For a historical look at the smallpox vaccine, including the deadly side effects and little-known facts go to https://thevaccinereaction.org/2017/06/the-smallpox-vaccine-was-no-silver-bullet/ Also, see the discussion on Vero Cells in the Vaccine Ingredients section of this document.

Polio- The untold story of its pre-vaccine decline and post vaccine adverse effects

This section comes from an article written by Suzanne Humphries MD and appearing in 2012 here: http://www.whale.to/v/cdc_and_friends.html

The article addresses what poliomyelitis really is, its various causes (infectious and non-infectious), and the terrible resurgence of the same paralytic conditions that the CDC claims have been eradicated by their vaccine programs, in what Dr. Humphries calls "misinformation campaigns". The only difference is, that the name has been changed (i.e. Acute Flaccid Paralysis which can be caused by numerous viral and chemical agents, including DDT) and it in many cases is being caused by the polio vaccines themselves. First, what does the term poliomyelitis mean? According to Suzanne Humphries MD, "The term "poliomyelitis" is a description of spinal pathology. The meaning of the word comes from Greek: *polios= gray, and muelos =marrow, itis=inflammation; meaning "inflammation of the gray matter of the spinal cord."*

All poliomyelitis means is that the gray matter of the spinal cord is inflamed. This can occur anywhere from the brainstem to the end of the spinal cord, and it has always had many causes, the least of which is a virus that lives in intestines of healthy people.

The result of this inflammation, whether chemical or viral, leads to certain characteristic muscular symptoms that have been conditioned into the minds of several generations of people to appear as the classic atrophied limbs, iron lungs and other horrifying images.

By definition and by historical documentation, these infamous images of polio should by no means be blamed solely on a specific wild-type (naturally occurring) virus. **Environmental toxins, other infections, and laboratory-derived vaccine viruses were all implicated in paralytic polio over the years. Yet wild virus, even though it is said to be asymptomatic in 95% of infected, and only causes paralysis in a small amount of infected is the excuse for world-wide polio vaccination with live viruses that are known to cause their own outbreaks of polio in China, Nigeria and India**.

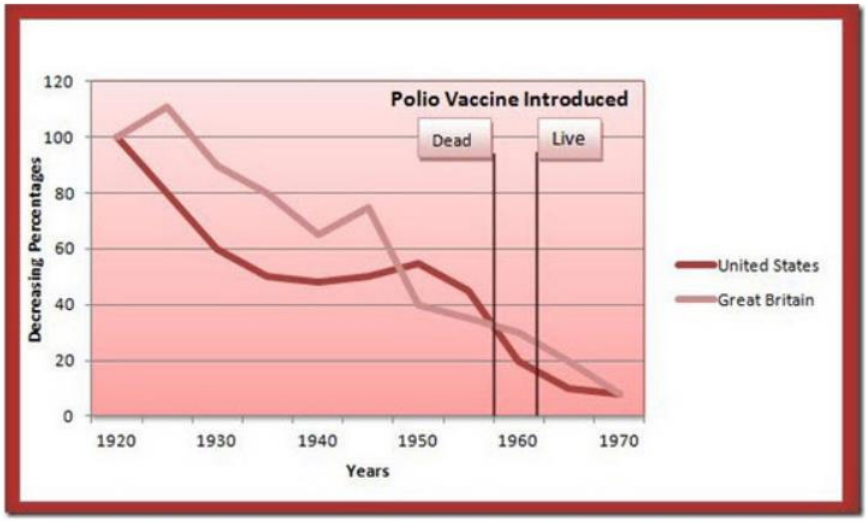
In her article, Dr. Humphries shows an interesting graphic of Polio morbidity showing that 95% of persons infected with the polio virus never develop any symptoms, about 4+% have minor symptoms and less than 1% develop a degree of permanent paralysis. Of those 1%, 5-10% will die due to paralysis of the diaphragm. That is equivalent to approximately 5-10 out of every 10,000 people that contract polio will die as a result.

We commonly hear that vaccines have eliminated dangerous diseases. Polio, the poster child for that statement has a different story to tell.

On the chart discussed previously in the section titled, **A picture is worth a thousand words- These must-see graphs say it all!**
See https://www2.census.gov/library/publications/2004/compendia/statab/123ed/hist/hs-18.pdf,

Check out an interesting caveat to the claims of the polio decline. **On this chart you will want to concentrate on the second column from the right titled "Acute Polio Myelitis." Notice the low rates of polio cases from 1900- 1944. It then peaked in 1952 and began to drop in 1953 (by 38%). By 1955 the rates had dropped by more than 50% from the peak year of 1952. Jonas Salk developed the polio vaccine in 1953, but it was not distributed for use until April 1955, therefore polio had already seen a greater than 50% drop in cases before the vaccine was made available. In other words, it dropped 50% in just 3 years, BEFORE distribution of the vaccine. That is a very precipitous decline!** According to the ***History.com*** website, "In 1954, clinical trials using the Salk vaccine and a placebo began on nearly two million American schoolchildren. In April 1955, it was announced that the vaccine was effective and safe, and a nationwide inoculation campaign began. New polio cases dropped to under 6,000 in 1957, the first year after the vaccine was widely available. In 1962, an oral vaccine developed by Polish-American researcher Albert Sabin became available, greatly facilitating distribution of the polio vaccine." http://www.history.com/this-day-in-history/salk-announces-polio-vaccine Based on these government census records, **cases of polio had dropped 98% by 1961, even before the oral polio was available** ("which greatly facilitated distribution of the polio vaccine").

This chart shows the decline in the death rate from polio between 1920 and 1970 in the U.S. and Great Britain



From 1923 to 1953, before the Salk killed-virus vaccine was introduced, the polio death rate in the United States and England had already declined on its own by 47 percent and 55 percent, respectively. Source: International Mortality Statistics (1981) by Michael Alderson.

According to Leon Chaitow D.O. in his book, **Vaccination and Immunisation: Dangers, Delusions and Alternatives**, "In the UK, the incidence of polio was at its highest in the early 1950s and by the time vaccination was introduced, it had already declined by over 80%."

I will acknowledge that the polio vaccine may have played some role in the reduction of polio, but does it really deserve the "sole" credit that the pharmaceutical industry would have us believe. Nearly all scientists agree that many infectious diseases go through cyclical patterns of outbreaks and diminished activity. Is it possible that the polio epidemic was just another example of that? I realize that I am questioning a "Sacred Cow" in the polio vaccine, but facts are facts. And facts are stubborn things.

Lynne McTaggart, in her major expose book **What Doctor's Don't Tell You**, states what has been obvious in the ebbs and flows of many other infectious diseases, is that they change over time with or without vaccination.

Dr. Chaitow states the following: "Dr. Dr. Bernard Greenberg, the head of the Department of Biostatistics at the University of North Carolina School of Public Health, has gone on record to say that cases of polio increased by 50% between 1957 and 1958 and by 80% between 1958 and 1959 *after* the introduction of mass immunization. In five New England slates cases of polio roughly doubled after polio vaccine was introduced. Nevertheless, in the midst of the polio panic of the 1950s, with pressure to find a magic bullet, statistics were manipulated by health authorities to give the quite the opposite impression."

Dr. Greenberg is a credible witness. He worked on the front lines of the polio epidemic in the 1950s. As a biostatistician, an expert in the area of public health and being a former Chairman of the ***Committee of***

Evaluation and Standards of American Public Health he was uniquely qualified. In addition, he was an expert witness before the ***American Congressional hearings*** on polio vaccination in 1962.

Importantly, he stated that the diagnostic criteria of what was being called polio changed, creating the impression of a drop in polio cases. **"In 1955 we started reporting a new disease - paralytic poliomyelitis with longer lasting paralysis'. Diagnostic procedures continued to be refined. Coxsackie virus infections and aseptic meningitis have been distinguished from poliomyelitis**. **Prior to 1954 large numbers of these cases undoubtedly were mislabeled as paralytic poliomyelitis**. Thus, simply by changes in diagnostic criteria the number of paralytic cases was predetermined to decrease in 1955 to 1957, whether or not any vaccine was used." **In other words, the numbers of polio diagnoses prior to 1954 were higher than after the introduction of the vaccine in 1955-1956, because the very similar presenting cases of Coxsackie and Aseptic Meningitis cases were often misidentified as poliomyelitis**. Laboratory confirmation of residual paralysis was not required. In 1955 as the vaccine was being introduced, the diagnostic criteria was conveniently changed to make the diagnosis of paralytic poliomyelitis much harder. Residual paralysis was determined 10 to 20 days after onset of illness and again 50 to 70 days after onset. Since most cases of wild poliomyelitis were temporary and resolved within this time frame, the incidence of "diagnosed and confirmed" cases naturally went down.

There you have it! Dr. Greenberg sheds light on the truth. **The number of polio cases were decreasing in part, because they changed the diagnostic criteria to make a diagnosis of polio much more stringent.** And coincidently, vaccines could take the credit. **Another miracle of science. The science of manipulating statistics!**

One more caveat. **The March of Dimes contributed $233 million dollars between 1938 and 1955 to caring for children struck with polio. Therefore, virtually any form of paralytic disorder whether viral polio or not was labeled polio**. That way the child could receive coverage for hospital or medical care as needed under the March of Dimes program.

March of Dimes was founded by Franklin D Roosevelt on January 3, 1938 as the ***National Foundation for Infantile Paralysis.*** According to Wikipedia, "Roosevelt was himself diagnosed with polio in 1921, although his symptoms are now known to be more consistent with Guillain–Barré syndrome – an autoimmune neuropathy which Roosevelt's doctors failed to consider as a diagnostic possibility". https://en.wikipedia.org/wiki/March_of_Dimes

The forgotten story of the tragedy caused by the live polio virus: The Cutter Incident

In 1955, ***Cutter Laboratories*** of Berkeley California released a polio vaccine that caused paralysis and death in many children receiving the vaccine. During production, certain batches of the vaccine did not contain enough formaldehyde to effectively kill the live polio virus. According to Dr. Paul Offit, author of the book, **The Cutter Incident: How America's First Polio Vaccine Led to the Growing Vaccine Crisis**, "200,000 people were inadvertently injected with the live polio virus and 70,000 became ill and 200 were permanently paralyzed. In addition, the vaccine resulted in 10 deaths." Paul Offit is a strong vaccine proponent who has been involved in much vaccine research with the CDC.

According to Dr. Offit, "**Seventy-five percent of Cutter's victims were paralyzed for the rest of their lives.**" A team led by epidemiologisit Alexander Langmuir of the Communicable Diseases Center (now the CDC) in Atlanta, GA determined that "the disease caused by Cutter's vaccine was worse than the disease caused by natural polio virus," adds Dr. Offit.

Dr. Suzanne Humphries, details that of those 70,000 that "became ill", 40,000 actually developed polio from the vaccine. A second source on that statistic is listed below.

Sources:
Dr. Humphries Interview with Dr. Joseph Mercola
https://articles.mercola.com/sites/articles/archive/2015/01/18/history-vaccination.aspx

Also, a 2006 article published in The ***Journal of the Royal Society of Medicine*** titled, **The Cutter Incident: How America's First Polio Vaccine Led to a Growing Vaccine Crisis**, tells the story of a failed polio vaccine and the damage it caused.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1383764/ .

Dr. Humphries goes on to say, "Live poliovirus, which was put in an injectable vaccine, would appear to be inactivated right after it was made, but sometimes it would 'resurrect' in the vial… In essence, the formaldehyde did not kill off all the polioviruses in these vaccines, which led to live polio viruses being injected. As a result, more people developed paralysis from the vaccine in 1955 than would have developed it from a wild, normal natural poliovirus."

Additionally, ***Cutter Laboratories*** was not the only manufacturer of the the Salk IPV. Wyeth Laboratories also produced a defective Salk vaccine that caused paralysis. Other pharmaceutical companies are believed to have done so, as well. But only Cutter's vaccine was recalled. This means that, potentially, tens of millions of doses of improperly inactivated "live" Salk vaccine were sold and injected into children in the U.S. and around the world until the "inactivated" Salk vaccine was replaced by the live oral Sabin vaccine in the early-1960s.

Today, most cases of polio are caused by the vaccine

According to Leon Chaitow in his book, **Vaccination and Immunisation: Dangers, Delusions and Alternatives**, "(in the US between 1980 and 1985 there were 55 cases of paralytic polio in the USA. 4 occurred in people returning from abroad and the other 51 resulted from vaccination)."

According to ***National Public Radio***, as reported on their web site June 28, 2017…**Mutant Strains Of Polio Vaccine Now Cause More Paralysis Than Wild Polio**

https://www.npr.org/sections/goatsandsoda/2017/06/28/534403083/mutant-strains-of-polio-vaccine-now-cause-more-paralysis-than-wild-polio

"For the first time, the number of children paralyzed by mutant strains of the polio vaccine are greater than the number of children paralyzed by polio itself.

So far in 2017, there have been only six cases of "wild" polio reported anywhere in the world. By "wild," public health officials mean the disease caused by polio virus found naturally in the environment.

By contrast, there have been 21 cases of vaccine-derived polio this year. These cases look remarkably similar to regular polio. But laboratory tests show they're caused by remnants of the oral polio vaccine that have gotten loose in the environment, mutated and regained their ability to paralyze unvaccinated children."

Michel Zaffran, the director of polio eradication at the World Health Organization, seems to think that the collateral damage is worth it. "Of course we need to recognize that there have been a few cases of children paralyzed because of the vaccine virus, which is regrettable. But, you know, from a public health perspective, the benefits far outweigh the risk."

How typical of many public health officials. It is worth it, to sacrifice a few to benefit the many. That is of course unless your child is the one on the alter!

This is the second time in this document we have seen public health officials take the stance that it's okay to sacrifice "the few" for the many….

This 2018 publication cites violations of ethical principles in the choice to use the live polio virus, versus the inactive version in India and states that hundreds of thousands of children were injured as a result

A 2018 comment published in the ***Indian Journal of Medical Ethics*** titled**, An ethical appraisal of the choice of vaccines against Poliomyelitis**, levies harsh criticism in the choice of polio vaccine used in India. They cite that hundreds of thousands of children suffered adverse events as a result. http://ijme.in/articles/an-ethical-appraisal-of-the-choice-of-vaccines-against-poliomyelitis/?galley=html

The Abstract:

"Medical ethics is invoked for immunisation of children as it involves an interaction between a healthcare professional and the child. Immunisation under the national immunisation programme is a public health intervention and the common belief is **that ethics is not relevant**." *That is a sad statement!*

"Two vaccines with contrasting safety and efficacy profiles were available against polio before the national immunisation programme was launched: the inactivated poliovirus vaccine (IPV) and the live attenuated oral poliovirus vaccine (OPV). India chose OPV and excluded IPV. We carried out an ethical appraisal of that choice. Principles of **medical ethics comprising four elements—non-maleficence, beneficence, autonomy and justice**—was already in vogue at the time. Applying each of them, a head-to-head comparison between IPV and OPV is made. **The results clearly show that the choice of vaccine was made without using ethical principles, resulting in serious adverse effects in hundreds of thousands of children. We recommend that medical ethics must be applied to all choices of public health interventions**."

"We draw an important lesson from this historical national experience: ethical principles must be applied in all public health policies. People on whom public health interventions are applied may not be clients of any transaction, but **they are human beings and the application of ethics is essential**."

What would it look like if we would flip the argument, that "it's worth sacrificing the few for the many"?

In fact, I have heard this rationale repeated many times when stories talk about vaccination being for the greater good of society. **One thought that stuck me is that the argument can and should be flipped on them. It can be said that it is justified that the few that succumb to normal childhood illnesses is tolerable and justifiable, because we spare millions from permanent neurological and immunological illnesses, chronic illnesses and in some cases even death. Look at the rate of these illnesses in the vaccinated population and compare it to the unvaccinated population. It's not just autism and other neuro-developmental conditions, it's all of the other devastating and life altering-life limiting illnesses like autoimmune diseases that we are seeing grow to epidemic proportions.**

We can't be certain that every person that develops these conditions over time can be traced to a vaccine related cause, because as life unfolds people are exposed to an accumulating dose of chemicals and toxins, some by chance and some self-imposed. But, when the research isolating vaccines as a direct cause of a myriad of health problems in early development, doesn't it make sense to start there? Especially given the fact, that babies and young children are born with untapped potential and are at the most vulnerable point of their lives with regard to exposure to heavy metals, toxins, chemicals and foreign DNA, whether human or animal. **LET'S START THERE!** Let's give them a fighting chance right out of the gates. Let's give them the opportunity to develop a healthy and balanced nervous and immune system.

This is why children of chiropractors and naturopathic physicians rarely need to visit the pediatrician and have a significantly lower rate of chronic neurological and immunological disorders. It's no secret. It's something that they have shouting from the roof tops at least since my 30 years of practice if not longer. They and their patients who follow that advice, have been experiencing the same better outcomes their own children for all those years as well. If the population as a whole adopted this approach, there will be an economic cost to certain branches of the medical profession and the pharmaceutical industry, but is protecting those economic interests worth the healthy lives of our children?

This next story underscores the tragic consequences of when vaccination programs go horribly wrong.

The dirty little-known cancer fact about the polio vaccine

Between the years of 1955 – 1963, the polio vaccine unknowingly contained a monkey virus called simian virus – 40 or SV-40. The vaccine was contaminated as a result of being cultured in monkey kidneys. Over the last couple of decades this virus has been showing up in human tumors, leading many scientists to believe that this virus may be contributing to these cancers. Mesothelioma is one of the primary cancers suspected of being influenced by SV-40.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1941725/ this article published in the ***Journal of Infectious Diseases and Cancer*** 2007, titled **Simian Virus 40 in Humans**, discusses some very disturbing evidence regarding this viral contamination of the polio vaccine.

These are quotes from the article:
"Simian virus 40 (SV40) is a monkey virus that was administered to human populations by contaminated vaccines which were produced in SV40 naturally infected monkey cells."

"SV40 footprints in humans have been found associated at high prevalence with specific tumor types such as brain and bone tumors, mesotheliomas and lymphomas and with kidney diseases, and at lower prevalence in blood samples from healthy donors."

"A source of human exposure to SV40 occurred between 1955 and 1963, when inactivated and live anti-polio vaccines, prepared from polioviruses grown in naturally SV40-infected simian cell cultures, were administered to hundreds of millions of people in the United States, Canada, Europe, Asia and Africa."

"The problems related to SV40 infection in the human population and to SV40 contribution to human cancer have been summarized in the recent evaluation of the "***Immunization Safety Review Committee***" established by the ***Institute of Medicine of the National Academies***. The Committee concluded that "the biological evidence is strong that SV40 is a transforming virus, but it is of moderate strength **that SV40 exposure from polio vaccine is related to SV40 infection in humans and that SV40 exposure could lead to cancer in humans under natural conditions**."

This is yet another example of the danger in blindly trusting doctors by allowing them to inject substances into our bodies that cannot be proven safe. By doing so, you are an unwilling participant in a huge human experiment.

Today, there are major concerns regarding confirmed retroviruses, human DNA and other contaminants within many of the vaccines on the current CDC schedule and the undesirable effects in people receiving these vaccines. If history has taught us anything, it's that we should never blindly trust anyone who says a medication of any kind is 100% safe. Yet, isn't that we hear constantly about vaccines in the media?

Now the kicker- What was the REAL cause of the "polio like" symptom epidemic in the 1940s and 1950s? Here is a solid theory.

Here's one credible theory:

Keep this statement from an article published on the EPA's web site titled, **DDT Regulatory History: A Brief Survey (to 1975)**, in mind as you read this next section.

"After 1945, agricultural and commercial usage of DDT became widespread in the U.S. The early popularity of DDT, a member of the chlorinated hydrocarbon group, was due to its reasonable cost, effectiveness, persistence, and versatility. During the 30 years prior to its cancellation, a total of approximately 1,350,000,000 pounds of DDT was used domestically.

After 1959, DDT usage in the U.S. declined greatly, dropping from a peak of approximately 80 million pounds in that year to just under 12 million pounds in the early 1970s".
https://archive.epa.gov/epa/aboutepa/ddt-regulatory-history-brief-survey-1975.html

The DDT, BHC, lead and arsenic connection

This **excellent** article detailing the use of these chemicals and the incredible correlation with the rise and fall of polio prior to the vaccine's introduction is absolutely astounding! When you see the graphs, you will see the incredible association. The use of these chemicals was rampant and their toxic effects on humans was denied for decades. The article even shows dairy farmers spraying DDT on dairy cows in a barn. DDT has an affinity for fat and was transmitted through the cow's milk. All of the above-mentioned chemicals lead to neurological damage and polio like symptoms. And, since the diagnosis of polio back then was based on a symptomatic presentation and typically did not involve laboratory confirmation, it would've been easy to mis-identify this poisoning for the polio virus.

What I couldn't figure out as I first looked at the graphs was, why did the rise of polio precede the use of DDT and BHC by about 6 years? (Incidentally, BHC is considered by many health experts to be even more toxic to humans than DDT). Then the graph you will see showing when the huge increase in the use of lead and arsenic as pesticides answered that dilemma. It perfectly accounted for the six-year gap. What we were seeing is the combined use, accumulation AND combined effect of exposure to these neurotoxins. **As poignant and amazing, is the fall of polio as it correlates directly with the recognition that these chemicals were damaging to health and the environment and their subsequent decline in use.** As you read through the article, you will see the jaw dropping parallels. The last graph found under the **Pesticide Composite Summary**, really brings everything into focus. It shows the combined use of these chemicals foreshadowing and superimposed over the graph of the rise and fall of polio. It is noteworthy to mention, that one of the precipitating factors to the recognition of the dangers of pesticides was the landmark book written by ***Rachel Ward*** in 1962 called **Silent Spring**.
https://www.westonaprice.org/health-topics/environmental-toxins/pesticides-and-polio-a-critique-of-scientific-literature/

Here is a description of DDT poisoning, which is indistinguishable clinically from poliomyelitis.

According to ***Dr. Morton S. Biskind***, "Acute gastroenteritis occurs, with nausea, vomiting, abdominal pain, and diarrhea usually associated with extreme tenesmus. Coryza, cough and persistent sore throat are common, often followed by a persistent or recurrent feeling of constriction or a "lump" in the throat; occasionally the sensation of constriction extends substernally and to the back and may be

associated with severe pain in either arm. Pain in the joints, generalized muscle weakness, apprehension and exhausting fatigue are usual; **the latter are often so severe in the acute stage as to be described by some patients as "paralysis**.

Dr. Biskind's Warnings

"In 1945, against the advice of investigators who had studied the pharmacology of the compound and found it dangerous for all forms of life, DDT (chlorophenoethane, dichloro-diphenyl-trichloroethane) was released in the United States and other countries for general use by the public as an insecticide. . . . "Since the last war there have been a number of curious changes in the incidence of certain ailments and the development of new syndromes never before observed. **A most significant feature of this situation is that both man and all his domestic animals have simultaneously been affected. In man, the incidence of poliomyelitis has risen sharply. . . .**

"**It was even known by 1945 that DDT is stored in the body fat of mammals and appears in the milk. With this foreknowledge the series of catastrophic events that followed the most intensive campaign of mass poisoning in known human history, should not have surprised the experts. Yet, far from admitting a causal relationship so obvious that in any other field of biology it would be instantly accepted, virtually the entire apparatus of communication, lay and scientific alike, has been devoted to denying, concealing, suppressing, distorting and attempts to convert into its opposite, the overwhelming evidence. Libel, slander and economic boycott have not been overlooked in this campaign. . . .**

One last thing on this topic worth mentioning, is that as the health effects of these chemicals became obvious in the U.S. and their use declined, the chemical manufacturers had to find other markets for these chemicals. Guess where they went? To developing and third world countries. One last question…. guess what happened over the next few decades to the incidence of "polio" in those nations? If you guessed that it escalated, you are right. So, since the Salk vaccine got the credit for "eradicating" polio in western countries it naturally became the answer for the worldwide epidemic that followed in under-developed nations and a whole new market for the vaccine was created.

These chemicals can remain persistent in the environment. The half-life or amount of time it takes DDT to degrade in the soil is between 2 and 15 years. It is estimated that the half-life of DDT in an aquatic environment is approximately 150 years. http://npic.orst.edu/factsheets/ddtgen.pdf

A report in the Archives of Pediatrics identifies environmental toxins as the real cause of polio

In a report prepared for ***The Select Committee to Investigate the Use of Chemicals in Food Products, United States House of Representatives***, Washington, D.C. by Ralph R. Scobey M.D. titled, **The Poison Cause of Poliomyelitis and Obstructions to Its Investigation**, the strong connection between poisons or toxins and poliomyelitis is made. The report was published in the ***Archive of Pediatrics*** in April 1952.

In the report Dr. Scobey discusses many different historical instances of poliomyelitis and paralytic conditions caused by various poisons like pesticides, lead, mercury, arsenic, carbon monoxide and potassium cyanide. He goes on to describe various effective treatments for poliomyelitis that work for cases of poisoning but are not effective for infectious diseases. He also details numerous cases where tainted food supplies caused similar outbreaks.

In addition, he explains how certain nutritional deficiency diseases in the past have been mistaken for infectious diseases. He gives this example of **Pellagra a niacin deficiency disease**…." Several commissions, appointed during the first quarter of this century to investigate the cause of pellagra, concluded from their studies that pellagra was an infectious, contagious disease. Harris (1913) was able to inject Berkefeld filtered tissue material from pellagra victims into monkeys to cause a corresponding disease in these animals. He concluded from these experiments that a virus was present in the injected material and that it was the cause of pellagra. If the work of Harris had been followed exclusively, various strains of this "virus" might have been discovered and a vaccine, effective in experimental animals, might have been developed, as in the case of poliomyelitis. Today, as a result of unlimited research, however, we know conclusively that pellagra is not caused by a virus but rather that **it is a vitamin deficiency disease**. It is obvious that if the investigations of pellagra had been restricted to the virus theory, it would still be a mystery."

A 2018 study tells a very different story than the often-heard mantra about the safety and effectiveness of the polio vaccine

A study published in the ***Journal of Virology*** titled, **Newcastle Disease Virus-Based Vectored Vaccine against Poliomyelitis**, claims that the current polio vaccine sometimes causes polio in the recipients and the attenuated virus (the weakened virus in the vaccine), can regain its full virulence or potency. Essentially, they admit that the current vaccines being used can expose recipients to the disease, are ineffective and new vaccines are needed. https://www.ncbi.nlm.nih.gov/pubmed/29925653

From the Abstract:
"The suboptimal properties of the existing vaccines are among the major reasons why the program has repeatedly missed eradication deadlines. **Oral live poliovirus vaccine (OPV), while affordable and effective, occasionally causes the disease in the primary recipients, and the attenuated viruses rapidly regain virulence and can cause poliomyelitis outbreaks. Inactivated poliovirus vaccine (IPV) is safe but expensive and does not induce the mucosal immunity necessary to interrupt virus transmission**. While **the need for a better vaccine is widely recognized**, current efforts are focused largely on improvements to the OPV or IPV, which are still beset by the fundamental drawbacks of the original products."

"A new, safe, and effective vaccine against poliovirus **is urgently needed** not only to complete the eradication of the virus but also to be used in the future to prevent possible virus reemergence in a postpolio world."

How do toxic chemicals contribute to the spread of an infectious disease like polio?

In the case of DDT and other chemical neurotoxic agents like lead, arsenic and BHC, a poliomyelitis syndrome can be triggered in susceptible individuals. The other, but KEY factor is that these chemicals can force a virus, bacteria or yeast pathogen to use very innovative ways to protect itself.

"DDT enhances the release and intracellular multiplication of poliovirus. According to a study titled, **Effects of insecticides on mammalian cells and virus infections** it likely contributes to creating a monster out of a normally benign gut virus. Additionally, exposure to DDT induces symptoms that can be completely indistinguishable from poliomyelitis – even in the absence of a virus." Biskind M., 1949. **DDT Poisoning and the Elusive "Virus X:" A New Cause For Gastroenteritis**. ***Am J Dig Dis***. *Vol 16 Num 3. Pp 79-84*.

According to an article written by Jim West and posted on February 08, 2003, a section titled, **The Symbiotic Poliovirus** had this explanation….

"Having now established the possibility of an innocent poliovirus, its presence in polio can be explained as follows: accelerated genetic recombination. Genetic recombination is accelerated whenever a biological system is threatened[22] and pesticides can be that threat. The proliferation of viruses can be part of the process of accelerated genetic recombination."

"When a cell is critically threatened, accelerated genetic recombination (which may include virus proliferation) is just one of a set of events that may occur. This set of events is called the "SOS response," which is known to be triggered by exposure to toxic chemicals or radiation.[23] Arnold Levine, writing in *Field's Virology*, provides an example: "When lysogenic bacteria were lysed [split open] from without, no virus was detected. But from time to time a bacterium spontaneously lysed and produced many viruses. The influence of ultraviolet light in inducing the release of these viruses was a key observation that began to outline this curious relation between a virus and its host."[24]

"It is ironic that common medical procedures such as chemotherapy, radiation therapy, and the use of toxic pharmaceuticals accelerate genetic recombination and thus the potential for a necessary virus proliferation."

"The SOS response is utilized in the Ames Assay Test, a standard test whereby chemical toxicity is determined. According to the procedure, bacteria are exposed to a chemical solution in question, and if a genetic recombination accelerates via the spontaneous proliferation of viruses from these bacteria, then the chemical is determined to be a poison. The phenomenon is analogous to a poker player with a bad hand who must request an exchange of cards and a reshuffled deck to improve the possibilities for survival. In the Ames Assay Test, bacteria are concerned with their genetic "hand" in order to improve their abilities to metabolize poisons, create utilizations for poisons, and shield against poisons. Thus, they engage in this well-known phenomena of "gene shuffling," facilitated by virus proliferation."

"Thus, I propose that the poliovirus is a symbiotic (and possibly a dormant) virus that behaves in a manner suggested by the phenomenon found in the Ames Assay Test, a test used to determine toxicity."

The latest "polio-like-illness" named AFM demonstrates suspicious spikes in incidence relating to when vaccination rates in children are highest

According the CDC in a document online titled **AFM Investigation**, "Acute flaccid myelitis (AFM) is a rare but serious condition. It affects the nervous system, specifically the area of the spinal cord called gray matter, which causes the muscles and reflexes in the body to become weak. CDC has been thoroughly investigating the AFM cases that have occurred since 2014, when we first noted a large number of cases being reported." https://www.cdc.gov/acute-flaccid-myelitis/afm-surveillance.html

A portion of the facts that CDC has learned (emphasis mine):

- These AFM cases are **not caused by poliovirus**; all the stool specimens from AFM patients that we received tested negative for poliovirus.
- We detected coxsackievirus A16, EV-A71, and EV-D68 in the spinal fluid **of four of 430** confirmed cases of AFM since 2014, which points to the cause of their AFM. **For all other patients, no pathogen (germ) has been detected in their spinal fluid to confirm a cause.**
- **Most patients had onset of AFM between August and October**, with increases in AFM cases every two years since 2014. At this same time of year, many viruses commonly circulate, including enteroviruses, and will be temporally associated with AFM.
- **Most AFM cases are children (over 90%)** and have occurred in 46 states and DC

Symptoms of AFM:
AFM can lead to serious neurologic problems.

- facial droop or weakness
- difficulty swallowing
- difficulty moving the eyes
- drooping eyelids
- slurred speech
- weakness and loss of muscle tone and reflexes in the arms or legs

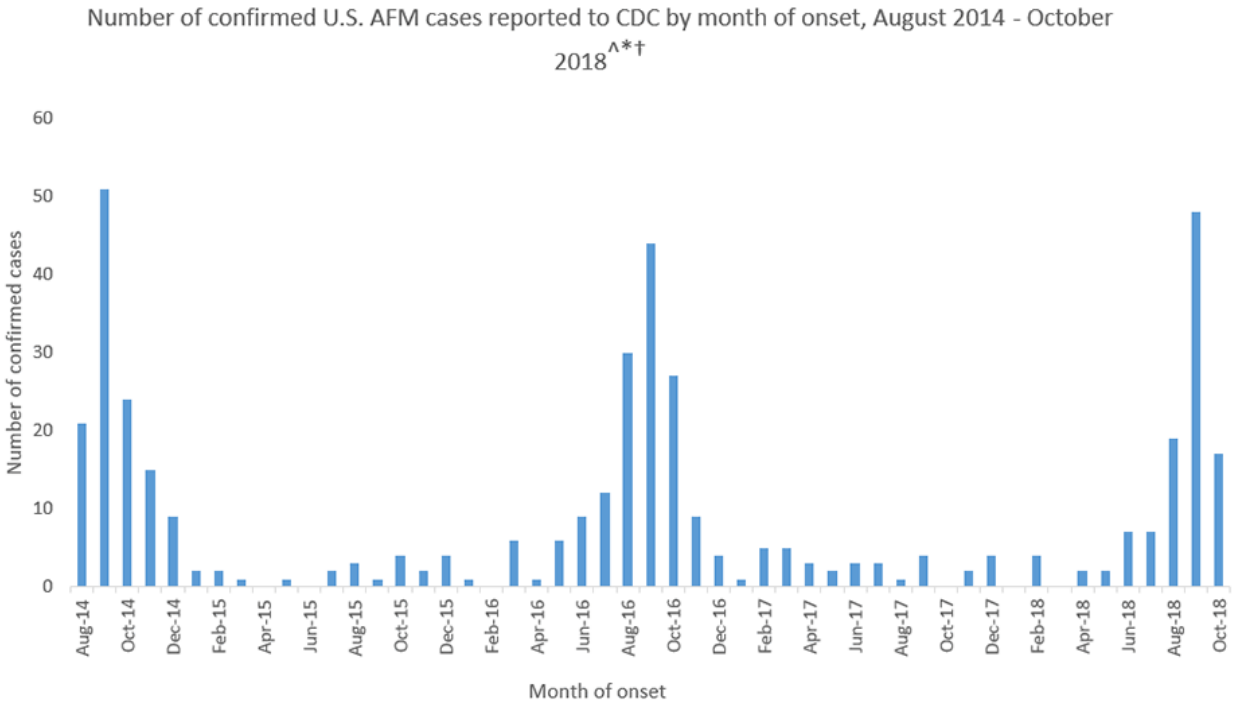
https://www.cdc.gov/features/acute-flaccid-myelitis/index.html

Quoting from an article on CBS News website titled, **CDC director says polio-like illness acute flaccid myelitis "doesn't appear to be transmissible"**, The director of the ***Centers for Disease Control*** and Prevention tells "***CBS This Morning***" that while the agency still doesn't know what's causing the polio-like illness acute flaccid myelitis, it "**doesn't appear to be transmissible from human to human**." The U.S. has seen a recent spike in cases of the rare neurological condition that largely affects children. *The fact that it doesn't appear to be transmissible, means that it most likely is not caused by an infectious organism.*

"CDC's been working very hard on this, since 2014, to try to understand causation and etiology. As we sit here today, we don't have understanding of the cause. We are, you know, continuing to strengthen our efforts, working in partnership with state and territorial health departments, and academic experts to

try to figure this out," Dr. Robert Redfield told "CBS This Morning" co-host John Dickerson in his first TV interview as CDC director. The extended interview will air Tuesday, Oct. 30."

"So far this year, 72 cases of the disease have been confirmed in the U.S. Acute flaccid myelitis, also known as **AFM, is characterized by a sudden onset of arm or leg weakness and loss of muscle tone and reflexes**. Health experts say the disease can lead to paralysis and even death, but no deaths have been reported so far this year."



When I saw this graph the first question in my mind was, with the huge spike in incidence being the same time of the year, **what occurs just prior to the spikes that could be a trigger?**

Hypothesis #1- Vaccines

And the answer hit me…children are vaccinated before the start of the school year! If parents take their children to the pediatrician to get up to date on their vaccines, **they typically do that in July and August**. Sometimes vaccine reactions are immediate and sometimes there is some delay. So that timeline makes perfect sense looking at the graph. There are a couple really puzzling questions about the correlation.

The first is, **why do the occurrences happen every other year (2014, 2016 and 2018)?** I don't have a working theory on that yet.

The second is why the broad age range? The average age contacting the disorder in 2014 was 7.1 years old, although the range is from 6 months old to 20 years old, meaning they are of school age (including college). The average age so far in 2018 is 4 years old, but also with a broad age range through the teen years. If there was a change in vaccine doses just for a particular age group, why would we see the wide range of children affected?

Hypothesis #1, Theory 1- The flu shot and a *Guillain-Barre like Syndrome*

Then I asked myself, **what vaccine would have common dosing across all age demographics and be given late summer/early fall? It was the flu shot of course**. It is recommended starting at age 6 months and annually thereafter. The flu "season" officially starts on October 1st every year. Infants and toddlers typically get them a month or two before the flu season. Since, children and teens would most likely be given their flu shot along with any vaccines that needed to be given prior to starting the school year, they would most likely get them sometime between June and September. This timeline would fit perfectly with the extreme spike during the months of August, September and October, with the peak month of September.

The next thing I looked at was the similarities with AFM and ***Guillain-Barre Syndrome***. Guillain-Barre is a rare, but well known and established serious complication of the flu shot. Here is an article from the ***National Vaccine Information Center*** about the connection.
https://www.nvic.org/vaccines-and-diseases/influenza/vaccine-injury.aspx

What is Guillain-Barre?

According to MayoClinic.org-
Guillain-Barre (gee-YAH-buh-RAY) syndrome is a rare disorder in which **your body's immune system attacks your nerves**. Weakness and tingling in your extremities are usually the first symptoms.

These sensations can quickly spread, **eventually paralyzing your whole body**. In its most severe form Guillain-Barre syndrome is a medical emergency. Most people with the condition must be hospitalized to receive treatment.

The exact cause of Guillain-Barre syndrome is unknown. But it is often preceded by an infectious illness such as a respiratory infection or the stomach flu. ***(Me: as well as the well-established flu vaccine connection)***

There's no known cure for Guillain-Barre syndrome, but several treatments can ease symptoms and reduce the duration of the illness. **Most people recover from Guillain-Barre syndrome, though some may experience lingering effects from it, such as weakness, numbness or fatigue**.

Symptoms

Guillain-Barre syndrome often begins with tingling and weakness starting in your feet and legs and spreading to your upper body and arms. In about half of people with the disorder, symptoms begin in the arms or face. As Guillain-Barre syndrome progresses, muscle weakness can evolve into paralysis.

Signs and symptoms of Guillain-Barre syndrome may include:

- Prickling, pins and needles sensations in your fingers, toes, ankles or wrists
- Weakness in your legs that spreads to your upper body
- Unsteady walking or inability to walk or climb stairs
- Difficulty with eye or facial movements, including speaking, chewing or swallowing
- Severe pain that may feel achy or cramplike and may be worse at night
- Difficulty with bladder control or bowel function
- Rapid heart rate
- Low or high blood pressure
- Difficulty breathing

People with Guillain-Barre syndrome usually experience their most significant weakness within two to four weeks after symptoms begin.

Types
Once thought to be a single disorder, Guillain-Barre syndrome is **now known to occur in several forms**.

The main types are:

- **Acute inflammatory demyelinating polyradiculoneuropathy (AIDP),** the most common form in the U.S. The most common sign of AIDP is muscle weakness that starts in the lower part of your body and spreads upward.
- **Miller Fisher syndrome (MFS),** in which paralysis starts in the eyes. MFS is also associated with unsteady gait. MFS occurs in about 5 percent of people with Guillain-Barre syndrome in the U.S. but is more common in Asia.
- **Acute motor axonal neuropathy (AMAN) and acute motor-sensory axonal neuropathy (AMSAN)** are less common in the U.S. But AMAN and AMSAN are more frequent in China, Japan and Mexico.

https://www.mayoclinic.org/diseases-conditions/guillain-barre-syndrome/symptoms-causes/syc-20362793

When you look at the symptoms and variations of the different neurological subtypes, what is to say that AFM is not just another manifestation of Guillain-Barre Syndrome? Compare the symptoms to the symptoms of AFM a couple of pages ago. There are some very close similarities. Now I admit that this observation is just a hypothesis and that I have no proof of the connection, but it does sound very plausible.

Even though the Influenza vaccine is most commonly associated, other vaccines that have been shown to trigger Guillain-Barre Syndrome include:

- Hepatitis A or Hepatitis B Vaccines
- Gardasil or HPV Vaccine
- Tetanus Shot, Tdap, or DtaP
- Menactra (MCV4) Vaccine

Hypothesis #1, Theory 2- Contaminated vaccine ingredients involving other vaccines

The other thing that came to mind, is **I wonder if vaccine manufacturers are outsourcing the supply of some of their vaccine ingredients to China?** In other words, **was there a change in production, ingredients, or sources for those vaccine ingredients around the 2013-2014 time frame? Have the lot numbers of one or more of the vaccines that children receive changed from stockpiles that were drawn from prior to 2014 that would indicate new "batches" were put into circulation that year**? Drug ingredients are increasingly being sourced from China, which has already led to injuries and deaths due to contamination from the poorly regulated facilities over there. I don't know if the vaccine manufacturers started sourcing some of the chemicals or other ingredients from China or not, but it should be looked into. Since the spikes in occurrence seem to be happening every other year, is there a manufacturing cycle or change that has occurred every other year?

Hypothesis #2- An environmental toxin

Remember the discussion you just read about on the polio epidemic as it relates to the DDT, BHC, lead and arsenic issue? Has another neurotoxin been introduced into our products of the environment that is triggering this reaction in susceptible individuals? If so, why is it just affecting children, adolescents and teens? If it were an environmental neurotoxin, it should affect all ages, unless of course it was a product that only these age groups were exposed to. And, what exposure would occur in the summer months? I know in rural communities, herbicides like roundup are used on "Roundup ready" crops before harvest, which occurs at the end of summer. Again though, if that were the case why are only young people affected and not farm hands working the fields?

There certainly are a lot of unanswered questions. But all leads including vaccine have to be explored!

THE ELUSIVE HIV VACCINE

I could report about all the failures in the attempt to develop an HIV vaccine, but not only would that be a long chapter, but it also would shine the light on many of our government officials that have spent vast amounts of money and made their careers in the quest for an HIV vaccine. Instead, I would like to give

you just one example from a paper published in March 2021 that demonstrates the absurd amount of U.S. taxpayer money thrown at this issue to interests around the globe.

While it might be honorable to continue to try to develop a vaccine against HIV, take a look at the latest failed project paid for my you and I through Dr. Fauci's ***National Institute of Allergy and Infectious Diseases (NAIAD)***. The incredible thing I noticed were the number of collaborators on this project. It is the most I have seen in all my years of looking at studies. Just scroll down and check it out!

NEW - Two Randomized Trials of Neutralizing Antibodies to Prevent HIV-1 Acquisition

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All that to say….

Conclusions: VRC01 did not prevent overall HIV-1 acquisition more effectively than placebo, but analyses of VRC01-sensitive HIV-1 isolates provided proof-of-concept that bnAb prophylaxis can be effective. (Supported by the ***National Institute of Allergy and Infectious Diseases***; HVTN 704/HPTN 085 and HVTN 703/HPTN 081 ClinicalTrials.gov numbers, NCT02716675 and NCT02568215.).

HEALTH BENEFITS OF CHILDHOOD INFECTIOUS DISEASES LATER IN LIFE

Febrile infectious childhood diseases (FICDs) reduce the risk of cancer

A study in the journal ***Medical Hypotheses*** titled, **Febrile infectious childhood diseases in the history of cancer patients and matched controls**, found that persons that had natural childhood infections with measles, mumps, rubella, pertussis, scarlet-fever and chickenpox had lower rates of cancer later in life. https://www.ncbi.nlm.nih.gov/pubmed/9824838

From the Abstract:
"The present study was designed to investigate the hypothesis that **febrile infectious childhood diseases (FICDs)** are associated with a lower cancer risk in adulthood…except for breast cancer"

"The study consistently revealed a **lower cancer risk for patients with a history of FICD**. **The strongest associations** were found between patients with non-breast cancers and rubella respectively chickenpox. **A strong association was also found** with the overall number of FICD both 'classical' (measles, mumps, rubella, pertussis, scarlet-fever and chickenpox) and 'other'."

"The number of FICD decreased the cancer risk, in particular for non-breast cancers."

Cancer journal confirms that exposures to childhood infectious diseases are associated with lowered rates of several cancers

Another study in the journal ***Cancer Detection and Prevention*** titled, **Acute infections as a means of cancer prevention: opposing effects to chronic infections?**, confirms the association with the acquisition of childhood infectious diseases and lower cancer rates later in life. https://www.ncbi.nlm.nih.gov/pubmed/?term=16490323

"PURPOSE: Epidemiological studies have found an inverse association between acute infections and cancer development. In this paper, we review the evidence examining this potentially antagonistic relationship."

"METHODS: In addition to a review of the historical literature, we examined the recent epidemiological evidence on the relationship between acute infections and subsequent cancer development in adult life. We also discuss the impact of chronic infections on tumor development and the influence of the immune system in this process."

"RESULTS: Exposures to febrile infectious childhood diseases were associated with subsequently reduced risks for melanoma, ovary, and multiple cancers combined, significant in the latter two groups. Epidemiological studies on common acute infections in adults and subsequent cancer development found these infections to be associated with reduced risks for meningioma, glioma, melanoma and multiple cancers combined, significantly for the latter three groups. Overall, risk reduction increased with the frequency of infections, with febrile infections affording the greatest protection."

Exposure to germs early in life are protective against many inflammatory diseases

A study published in ***Science*** titled, **Microbial Exposure During Early Life Has Persistent Effects on Natural Killer T Cell Function**, underscores the importance of the immune system being stimulated and strengthened by early exposure to microbes. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3437652/

The Abstract:
"**Exposure to microbes during early childhood is associated with protection from immune-mediated diseases such as inflammatory bowel disease (IBD) and asthma**. Here, we show that in germ-free (GF) mice, **invariant natural killer T (iNKT) cells** accumulate in the colonic lamina propria and lung, **resulting in increased morbidity** in models of IBD and allergic asthma as compared with that of specific pathogen-free mice. This was associated with increased intestinal and pulmonary expression of the chemokine ligand CXCL16, which was associated with increased mucosal iNKT cells. Colonization of neonatal—but not adult—GF mice with a conventional microbiota protected the animals from mucosal iNKT accumulation and related pathology. **These results indicate that age-sensitive contact with commensal microbes is critical for establishing mucosal iNKT cell tolerance to later environmental exposures**."
(In other words, early exposure in life is essential to provide protection from environmental exposures later in life).

Other health benefits of acquiring childhood infectious diseases and the dangers of vaccine mediated immune alterations in the development of autoimmune disease

The long term pitfalls of the shortsighted childhood vaccine programs are summarized in a good article published on December 13, 2018 on **Robert F. Kennedy Jr.'s *Children's Health Defense*** web site which can be read here… https://childrenshealthdefense.org/news/vaccine-vs-disease-trade-offs-cheating-childrens-immune-systems/

Isn't it ironic that the exact childhood infections that we are being told by Big Pharma must be eradicated, seem to be protective against so many things! And when you think about it, by inducing a higher rate of other illness and diseases the pharmaceutical industry is creating a whole population of sick people to peddle other medications to. What a brilliant and lucrative business model!

Here's a crazy revelation! The measles virus may become one of the most effective tools we have in the fight with cancer

An article published on ***cybermedlife.eu*** titled, **Measles is a natural cancer killer**, discusses a case study published by Mayo Clinic in which a woman's golf ball sized brain tumor was eradicated in just 36 hours. Since it is short, I decided to include it in its entirety.

The article leads with the following statement…
"**Health authorities may want to think twice about eradicating measles: researchers are discovering that the virus can fight cancer, and in one case dissolved a golf ball-sized tumor in just 36 hours**.

The virus makes cancer cells join together and explode, explains Mayo Clinic researcher Dr Angela Dispenzieri. It also stimulates the immune system to detect any recurring cancer cells and 'mops them up'.

Although it's been recognised for a long time that measles and other viruses are natural cancer fighters—it's known as virotherapy—the dose seems to be an important factor. Dispenzieri and her Mayo colleagues engineered, or genetically modified, the measles virus strain, and gave it in a dose strong enough to vaccinate 10 million people to a woman with end-stage multiple myeloma.

Virotherapy was a last-resort therapy as the 49-year-old woman had endured every type of chemotherapy and two stem cell transplants without success.

A response was immediate. Within five minutes, the doctors say she developed a splitting headache and a temperature of 105 degrees F. before she started vomiting and shaking. A tumor the size of a golf ball had disappeared inside 36 hours, and all signs of cancer had disappeared from her body within two weeks.

"I think we succeeded because we pushed the dose higher than others have pushed it," said Mayo researcher Dr Stephen Russell. "The amount of virus that's in the bloodstream really is the driver of how much gets into the tumors."

Researchers at University College London agree that virotherapy could be a promising way forward in the fight against cancer. In a study titled 'Measles to the Rescue', the researchers say that "virotherapeutic agents are likely to become serious contenders in cancer treatment", and that the vaccine strain of measles virus holds special hope."

(Sources: Mayo Clinic Proceedings, 2014; 789: 926-33; Viruses, 2016; 8: 294)

HEALTH OF VACCINATED vs. UNVACCINATED CHILDREN

For many years, vaccine educated people and organizations have been asking that the CDC, pharmaceutical companies and other governmental agencies involved with vaccine policy, do comparison studies looking at the frequency of doctor's visits, hospitalizations and health outcomes of children that have been vaccinated and those that have not been vaccinated. To date they have all refused to conduct such studies. Thankfully and finally, over the last 4 years studies are being done by outstanding independent researchers NOT affiliated or supported by any of the agencies just mentioned. No conflicts of interest. No industry bias. Here we look at some of those studies.

A landmark study comparing the health of vaccinated to unvaccinated children, shows superior health outcomes in the non-vaccinated group

A study comparing health of vaccinated children to unvaccinated children has been something that people concerned with the risks of vaccines have been asking the pharmaceutical industry and the CDC to do for many years. That plea has fallen on deaf ears. The fact that they have refused to do so, speaks volumes about what they fear will happen. Well, finally someone else has done such a study. This 2017 study was released April 24, 2017 the ***Journal of Translational*** **Sciences** titled, **Pilot comparative study on the health of vaccinated and unvaccinated 6- to 12-year-old U.S. children.** The study consisted of 666 children of which 261 (38%), were unvaccinated. The children were all between 6 and 12 years of age. Of the vaccinated group, some were considered "partially" vaccinated. Of the vaccinated group, 208 were partially and 197 fully vaccinated. Fully vaccinated is according to the full CDC schedule. Partially is anything less.

https://www.researchgate.net/publication/317086531_Pilot_comparative_study_on_the_health_of_vaccinated_and_unvaccinated_6-to_12-year-old_US_children

This whole study deserves to be bold and red. To save your eyes the strain I'll just leave it as is. 😊 **Please read it in its entirety**

Acute Illness:

"Vaccinated children, combining the partially and fully vaccinated, were significantly less likely than the unvaccinated to have had chickenpox (7.9% vs. 25.3%), and whooping cough (pertussis) (2.5% vs. 8.4%),, and less likely, but not significantly so, to have had rubella (0.3% vs. 1.9%). However, the vaccinated were significantly more likely than the unvaccinated to have been diagnosed with otitis media (19.8% vs. 5.8%) and pneumonia (6.4% vs. 1.2%). No significant differences were seen with regard to hepatitis A or B, high fever in the past 6 months, measles, mumps, meningitis (viral or bacterial), influenza, or rotavirus." (Table 2)

Chronic Illness:

"Vaccinated children were significantly more likely than the unvaccinated to have been diagnosed with the following: allergic rhinitis (10.4% vs. 0.4%), other allergies (22.2% vs. 6.9%), eczema/atopic dermatitis (9.5% vs. 3.6%), a learning disability (5.7% vs. 1.2%), ADHD (4.7% vs. 1.0%), ASD (4.7% vs. 1.0%), any neurodevelopmental disorder (i.e., learning disability, ADHD or Autism Spectrum Disorder-ASD) (10.5% vs. 3.1%) and any chronic illness (44.0% vs. 25.0%). No significant differences were observed with regard to cancer, chronic fatigue, conduct disorder, Crohn's disease, depression, Types 1 or 2 diabetes, encephalopathy, epilepsy, hearing loss, high blood pressure, inflammatory bowel disease, juvenile rheumatoid arthritis, obesity, seizures, Tourette's syndrome, or services received under the Individuals with Disabilities Education Act." (Table 3)

Bear in mind that this study only looked at children between the ages of 6 and 12. The likelihood of these last criteria of chronic illness showing up before age 13 is small. It would be interesting to re-evaluate those children in 10 years.

Use of medication and health services:

"The vaccinated (combining the partially and fully vaccinated) were significantly more likely than the unvaccinated to use medication for allergies (20.0% vs. 1.2%), to have used antibiotics in the past 12 months (30.8% vs. 15.4%), and to have used fever medications at least once (90.7% vs. 67.8%). The vaccinated were also more likely to have seen a doctor for a routine checkup in the past 12 months (57.6% vs. 37.2%), visited a dentist during the past year (89.4% vs. 80.5%), visited a doctor or clinic due to illness in the past year (36.0% vs. 16.0%), been fitted with ventilation ear tubes (3.0% vs. 0.4%), and spent one or more nights in a hospital (19.8% vs. 12.3%) (Table 6)."

"With regard to acute and chronic conditions, vaccinated children were significantly less likely than the unvaccinated to have had chickenpox and pertussis but, contrary to expectation, were significantly more likely to have been diagnosed with otitis media, pneumonia, allergic rhinitis, eczema, and NDD. The vaccinated were also more likely to have used antibiotics, allergy and fever medications; to have been fitted with ventilation ear tubes; visited a doctor for a health issue in the previous year, and been hospitalized. The reason for hospitalization and the age of the child at the time were not determined, but the latter finding appears consistent with a study of 38,801 reports to the VAERS of infants who were hospitalized or had died after receiving vaccinations. The study reported a linear relationship between the number of vaccine doses administered at one time and the rate of hospitalization and death; moreover, the younger the infant at the time of vaccination, the higher was the rate of hospitalization and death [55]. The hospitalization rate increased from 11% for 2 vaccine doses to 23.5% for 8 doses ($r^2 = 0.91$), while the case fatality rate increased significantly from 3.6% for those receiving from 1-4 doses to 5.4 % for those receiving from 5-8 doses."

In addition, Children that were born prematurely and vaccinated were 6.6 times more likely to develop a neurodevelopmental disorder, whereas pre-term birth in non-vaccinated was not.

Did the partially vaccinated group fall somewhere in between the health of the unvaccinated and vaccinated groups as one might expect? Yes, somewhere midway to near the fully vaccinated group's incidence of the illnesses surveyed.

"In support of the possibility that the number of vaccinations received could be implicated in risks of associated chronic illness, a comparison of unvaccinated, partially and fully vaccinated children in the present study showed that the partially vaccinated had increased but intermediate odds of chronic disease, between those of unvaccinated and fully vaccinated children, specifically for allergic rhinitis, ADHD, eczema, a learning disability, and Neuro Developmental Disorder as a whole."

With regard to just the neurodevelopmental aspect of the vaccine controversy (because autism and neurodevelopmental issues dominate the public discourse about the safety of vaccinations), and to put the percentages found in what may be an easier to understand format…

- Term birth with vaccination was associated with a 2.7-fold (270%), increase in the odds of neurodevelopmental disorders compared to unvaccinated full-term babies
- Preterm birth with vaccination was associated with a 5.4-fold (540%), increase in the odds of neurodevelopmental disorders compared to the odds of neurodevelopmental disorders given term birth and vaccination
- Preterm birth with vaccination was associated with a 12.3-fold (1,230 %), increased odds of neurodevelopmental disorders compared to preterm birth without vaccination

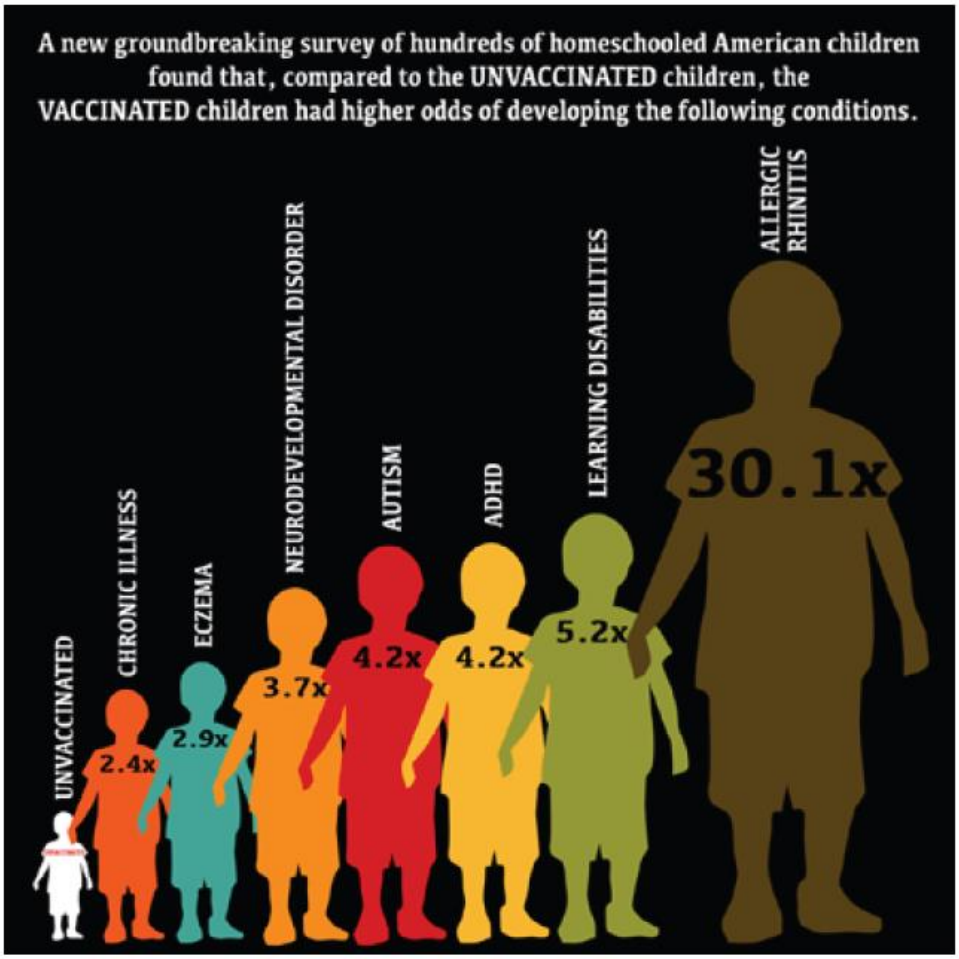
This is the study that the pharmaceutical industry and the CDC had previously refused to do! Those questioning the safety of vaccines have been pleading for industry and government to do a study such as this comparing vaccinated versus nonvaccinated children and looking at subsequent health issues that later develop in those populations. Every thinking person has to wonder as to the motivation for their omission of this critical scientific inquiry.

Less doctor visits equal health care cost savings

One of the factors often citing by those promoting vaccination is the health care savings costs of reducing the doctor visits of the childhood illnesses they are designed to prevent.

This study shows the opposite effect, in that the costs associated with doctor visits medication costs and hospitalizations from complications due to vaccination may far outweigh the financial savings that is often cited. In this and other studies, vaccination is associated with higher rates of pneumonia and Acute Otitis Media (AOM), also referred to as middle ear infection. Just in the case of AOM for example, "The odds of otitis media were almost four-fold higher among the vaccinated and the odds of myringotomy with tube placement were eight-fold higher than those of unvaccinated children. Acute otitis media is responsible for up to 30 million office visits each year and the most common reason for prescribing antibiotics. "Pediatric AOM is a significant concern in terms of healthcare utilization in the U.S., accounting for $2.88 billion in annual health care costs." If we were to consider the additional costs associated with complications associated with vaccination such as pneumonia, allergies, asthma, eczema, neurodevelopmental disorders and hospitalization as cited in this article, the costs would far exceed any cost savings that may be associated with reduction of the illnesses that vaccines are designed to prevent.

This is an instance where a graphic can help us appreciate the differences in chronic illness between the vaccinated and the unvaccinated children. The graphic on the next page courtesy of CMSRI.org shows it nicely.



Source: Graphic courtesy CMSRI.org, in reference to Mawson AR, Ray BD, Bhuiyan AR, Jacob B. Pilot comparative study on the health of vaccinated and unvaccinated 6- to 12-year-old U.S. children. *J Transl Sci* 3.

Interestingly, this article became a victim of selective bias in publishing as we have seen with some other studies throughout this document that dare to question the vaccine status quo. It was originally submitted for publication to ***Frontiers***, according to an article in ***Healthcare in America's website*** dated February 22, 2017 by James Grundvig, https://healthcareinamerica.us/censored-study-of-vaccinated-vs-unvaccinated-sees-daylight-4be6f3a03c1c

"Frontiers Journal received the study on September 17, 2016. After a two-month peer review process, published it on November 21 for its "68,000 on board editors" from institutions around the world (www.frontiersin.org), with the National Institute of Health (NIH) and Harvard University being the top two providing the science editors."

"**Over the course of four days, more than 80,000 views of the study found it important enough to read, going "viral" according to one familiar with its release**. Then on November 28, the bottom fell out when *Frontiers* scrapped the publication. In one week, it went from being accepted, published, and then retracted. The abstract can still be found online."

"**The paper, however, wasn't retracted; it was "unaccepted,"** according to Mawson via email. That means *Frontiers* didn't retract it, since it was never officially published. What's left for a study after its accepted, reviewed 80,000 times in less than 100 hours? . . . Censorship."

""Mawson's pilot study needs to be expanded and conducted by the highly respected international, independent public health organization the Cochrane Collaboration," said Kevin Barry, president of the non-profit organization, First Freedoms. "The CDC cannot be trusted to conduct a vaccinated vs. unvaccinated study honestly."

NEW - Another vaxxed vs. unvaxxed study shows that unvaccinated children are healthier

Those of us who want to know the truth owe a debt of gratitude to Brian S. Hooker and Neil Z. Miller for doing the important work of this study.

Published in ***Sage Open Medicine*** May 27, 2020 and titled, **Analysis of health outcomes in vaccinated and unvaccinated children: Developmental delays, asthma, ear infections and gastrointestinal disorders**, this study found significant health outcome differences between vaccinated and unvaccinated children. https://journals.sagepub.com/doi/10.1177/2050312120925344

These tables tell the story of the comparisons very nicely… The Odds ratio is the multiplier of the number of times greater for that health condition in the vaccinated group. For example, for asthma the vaccinated group had a 4.49 times (449%) greater prevalence than the unvaccinated group.

Table 4. Vaccinated versus unvaccinated (during the first year of life), stratified based on medical practice, gender and year of birth (child ⩾ 3 years of age).

Diagnosis	Vaccinated Cases/total	Unvaccinated Cases/total	Odds ratio (95% CI)	*p*-value
Developmental delay	153/1407 (10.9%)	34/630 (5.4%)	2.18 (1.47–3.24)	0.0001
Asthma	67/1412 (4.7%)	7/629 (1.1%)	4.49 (2.04–9.88)	0.0002
Ear infection	324/1116 (29.0%)	104/533 (19.5%)	2.13 (1.63–2.78)	<0.0001
Gastrointestinal disorder	55/1382 (4.0%)	18/619 (2.9%)	1.47 (0.84–2.57)	0.17
Head injury	93/1398 (6.7%)	31/627 (4.9%)	1.26 (0.82–1.94)	0.29

CI: confidence interval.

For the next table (Table 7), subjects were separated into quartiles based on the number of vaccine doses received within the first year of life (plus 15 days) calculated based on the distribution among the sample with a median of nine vaccine doses. The first quartile included children who received 1–5 vaccine doses (*n* = 353), the second included children who received 6–10 vaccine doses (*n* = 390), the third included children who received 11–12 vaccine doses (*n* = 417) and the fourth included children who received 13–21 vaccine doses (*n* = 254). Diagnoses for conditions within this analysis were considered only if they were made after each child's first birthday (plus 15 days). This analysis was limited to vaccine doses received in the first year of life to capture a significant portion of the diagnoses that may occur early in life, including ear infections and gastrointestinal disorders.

Table 7. Quartile analysis, vaccinated versus unvaccinated (during the first year of life), stratified based on medical practice, year of birth and gender (child ⩾ 3 years of age).

Diagnosis	Quartile 1 1–5 vaccines (95% CI)	Quartile 2 6–10 vaccines (95% CI)	Quartile 3 11–12 vaccines (95% CI)	Quartile 4 13–21 vaccines (95% CI)
Developmental delay	1.36 (0.53–3.48)	2.54 (1.30–4.96)	3.22 (1.70–6.09)	2.42 (1.17–4.99)
Asthma	1.94 (0.59–6.40)	6.48 (2.64–15.9)	3.66 (1.42–9.46)	4.62 (1.68–12.7)
Ear infection	1.43 (0.98–2.07)	2.48 (1.72–3.60)	2.26 (1.53–3.33)	2.81 (1.80–4.40)
Gastrointestinal disorder	0.49 (0.19–1.31)	1.61 (0.68–3.84)	3.77 (1.65–8.59)	4.03 (1.57–10.3)
Head injury	0.68 (0.32–1.44)	1.56 (0.93–2.62)	1.12 (0.65–1.94)	1.37 (0.73–2.56)

CI: confidence interval.

Discussion

Within this study, the number of vaccines received and vaccination status early in life are related to different acute and chronic conditions. The strongest relationships observed for vaccination status were for asthma, developmental delays and ear infections (Table 4).

NEW - A November 2020 study reveals incredible differences in the health difference between vaccinated and unvaccinated children

A study published in the International Journal of Research and Public Health by James Lyons-Weiler and Paul Thomas MD titled, **Relative Incidence of Office Visits and Cumulative Rates of Billed Diagnoses Along the Axis of Vaccination**, categorizes the illnesses that vaccinated and unvaccinated children saw doctors for at office visits during their first nine and a half years of life. It is a peer-reviewed study that shows unequivocally that unvaccinated children are healthier than unvaccinated children.

https://www.ar25.org/sites/default/files/ijerph-17-08674-v3.pdf

The large graph on the next page shows visually in a dramatic way, the differences in rates of doctor visits for various health problems. The vertical axis on the left is the number of office visits. The horizontal axis is the number of days of life.

The far right of the horizontal (X) axis represents 3,500 days (9.6 years) of age.

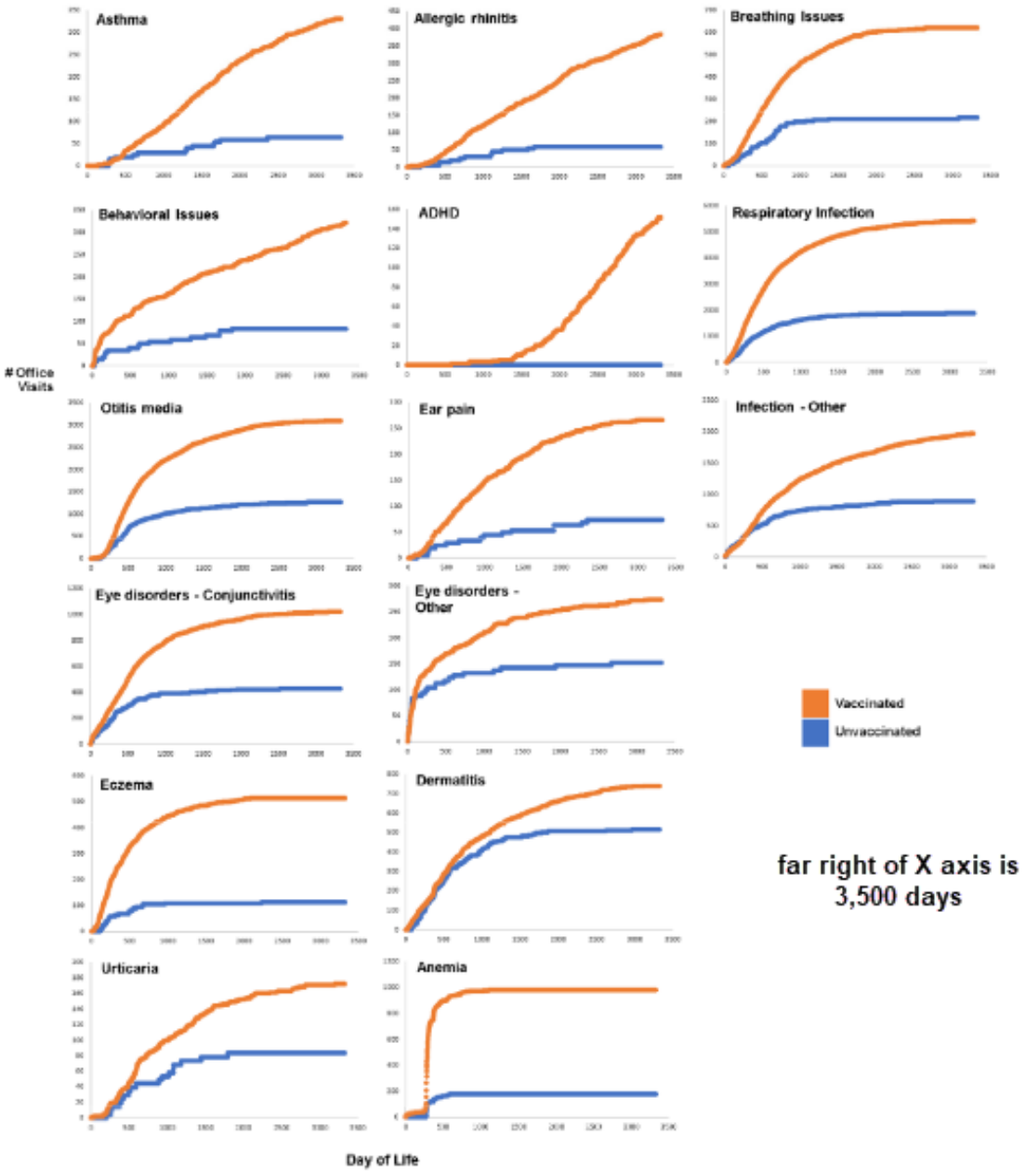


Figure 5. Analysis 5. Cumulative office visits in the vaccinated (orange) vs. unvaccinated (blue) patients born into the practice: the clarity of the age-specific differences in the health fates of individuals who are vaccinated (2763) compared to the 561 unvaccinated in patients born into the practice over ten years is most strikingly clear in this comparison of the cumulative numbers of diagnoses in the two patient groups. The number of office visits for the unvaccinated is adjusted by a sample size multiplier factor (4.9) to the expected value as if the number of unvaccinated in the study was the same as the number of vaccinated.

The importance of maintaining the right to exercise exemptions

Personal Exemptions-

These have been the first to come under attack. This exemption is based on a person's right to decide what they will consent to. This is paramount to our freedoms as Americans. If we allow the government to force any medical procedure on us or our children, where will it stop? As you have seen in this document, there are forces that have put profits ahead of safety, power ahead of freedom, "cooked up" and biased science, ahead of unbiased/unadulterated science and coercion ahead of due process and personal choice. For the government to do the bidding of an industry like the pharmaceutical industry, goes against everything that our founders established. The argument that vaccines are for the greater good of society is a non-starter, because as ***1200 Studies*** has proven, the science is far from settled. In fact, it's not even close! To take away our personal right to the sanctity of ours and our children's bodies, based on what we have seen in this eBook is not only wrong, it is criminal. Most states have already lost this option.

Religious Exemptions-

These is the next one to go in our ever-increasing dictatorial progression. As has been clearly demonstrated in ***1200 Studies***, people of faith have a sincere and moral argument against vaccines and particularly the ones that contain DNA from aborted fetuses. Regardless of official positions of any church denomination, the decision about one's conscious is between them and their God. If it is based on the sanctity of life, and that life begins at conception, and that all life is precious because we are image bearers of God; there is no other position one can take. Many religions have valid reasons for refusing vaccine based on the teachings and value systems of their faith. They all have a right to exercise their faith based on our freedom of religion. The founders left England in part, because the state was dictating what they could practice and believe regarding their faith. In our *Declaration of Independence* and *Bill of Rights*, they were adamant that the state would never have the right to do that in the United States of America. "We the people" need to fight to keep that right!

Medical Exemptions-

This is the last protection to stand after personal and religious exemptions are stripped away. This is where the battle lines are currently being drawn in several states.

In many states, parents have lost personal belief exemptions. In many states, parents have lost religious exemptions. In the current climate of stripping rights of parents, to make health care decisions for their own children, the last right many have is the right to a medical exemption. Even that is under attack. Doctors that write medical exemptions are under attack. Their livelihood is being threatened. Their practices are being destroyed. Well-meaning doctors, acting in the best interest of their patents are suffering for doing the right thing and trying to protect them from harm. The "state" has decided what is right for every child, not the parent who knows them best. Not the doctor that knows their health status best. "Big Brother" the state, is deciding to force parents of children that are at high risk to play Russian Roulette with their child's lives. When will the insanity end?

Valid reasons for medical exemptions

Some individuals have a limited capacity to detoxify due to genetic or functional reasons

To underscore this truth, I want to report on the tragic death of a child that died as the result of a genetic defect that prevented her from being able to eliminate the drug Fluoxetine from her system.

The article published in the year 2000 and from ***The Journal of Child and Adolescent Psychopharmacology*** is titled, **Fluoxetine-related death in a child with cytochrome P-450 2D6 genetic deficiency.** https://www.ncbi.nlm.nih.gov/pubmed/10755579

From the Abstract:
The clinical course of a 9-year-old diagnosed with attention-deficit hyperactivity disorder, obsessive-compulsive disorder, and Tourette's disorder and treated with a combination of methylphenidate, clonidine, and fluoxetine is described. The patient experienced over a 10-month period, **signs and symptoms suggestive of metabolic toxicity marked by bouts of gastrointestinal distress, low-grade fever, incoordination, and disorientation**. **Generalized seizures were observed, and the patient lapsed into status epilepticus followed by cardiac arrest and subsequently expired. At autopsy, blood, brain, and other tissue concentrations of fluoxetine and norfluoxetine were several-fold higher than expected based on literature reports for overdose situations**. The medical examiner's report indicated death caused by fluoxetine toxicity. As the child's adoptive parents controlled medication access, they were investigated by social welfare agencies. **Further genetic testing of autopsy tissue revealed the presence of a gene defect at the cytochrome P450 CYP2D locus, which results in poor metabolism of fluoxetine. As a result of this and other evidence, the investigation of the adoptive parents was terminated. This is the first report of a fluoxetine-related death in a child with a confirmed genetic polymorphism of the CYP2D6 gene that results in impaired drug metabolism. Issues relevant to child and adolescent psychopharmacology arising from this case are discussed.**

This so tragic on many levels. The child had obvious signs that were consistent with metabolic problems, including attention-deficit hyperactivity disorder, obsessive-compulsive disorder, and Tourette's

disorder. To start with, children that have that kind of profile should be investigated for functional deficiencies whether nutritional, biochemical, metabolic or genetic. Secondly, after starting on the regimen of medication, she experienced a significant deterioration in her health with the onset of numerous new symptoms, essentially "red flags" that something was wrong. The sad thing is that that these liver polymorphisms (or defects), have been known for over 30 years. This case occurred nearly 20 years ago. Do you think that in day-to-day practice, we are any closer to recognizing and testing for these kinds of genetic polymorphisms or functionally driven metabolic deficiencies? The discouraging answer is NO.

This is a prime example of a case of preventable death. Of all the severe and life-threatening adverse reactions to drugs including vaccines, the vast majority are preventable. We need to start looking at each individual as their own biologically unique web of complex and unique interactions, rather than treating each person the same as the previous one, or the next one. That has been the status quo for too long. These tests are available. It's time that clinicians use them, especially in cases where a person exhibits warning signs such as this 9-year-old girl did.

This Cytochrome P-450 liver detoxification pathway is not the only example of "faulty" biochemistry that people exhibit. Many people have methylation defects, folate pathway defects, glutathione conjugation or glutathione peroxidase defects, phase 2 liver detoxification pathway defects (i.e. sulfation, glucaronidation, etc), just to name a few. For a more information on detoxification issues and ways to test for them, see this link… https://www.greatplainslaboratory.com/gpl-blog-source/2016/6/6/your-bodys-detoxification-pathways

I recently heard the testimony of a mother that has a child who had reacted to his first vaccines. When she told the doctor, he said "oh that is normal". She was hesitant but took him back for his next well-baby check-up and was given his next round of vaccines. The boy had a much more serious bout of fever, seizures and listlessness that lasted longer than the first time. The mother called the doctor and was told not to worry, that those kinds of reactions are "normal". She felt incredibly guilty for going against her intuition the second time as her son suffered a series of serious reactions. When it came for the child's next "wellness visit", the doctor once again pressured the mother to get the next scheduled round of vaccines. The mother described being completely torn as to what to do. She said that little voice in her head kept telling her to stand her ground, but she eventually succumbed to the pressure from the doctor and his staff. This time after taking her child home, he spiked a high fever, screamed uncontrollably for days and had repetitive seizures. After that, her child was never the same. He lost the ability to communicate, lost eye contact, became listless, lost motor skills and became a "shell" of what he was. That became his permanent state. Today many years later, that mother lives with the guilt of those decisions and a child that will never marry, never get a higher education, never hold a meaningful job, never be able to care for himself.

Why is that story important? Because there are thousands of similar stories that mothers and fathers of vaccine damaged children have to share. Lives destroyed, families devastated relationally and economically, marriages blown-up and a society that will not acknowledge what happened to them and what they are still going through. **INVISIBLE**. That is how so many of them feel.

Now circling back to exemptions. That is exactly why parents must be able to maintain the options for these exemptions!

Here are some of the reactions the FDA vaccine package inserts list. If a child has experienced one of these reactions (especially the more serious ones), their body is essentially crying out that it can't tolerate the vaccine and its ingredients properly and that there is a problem. A child that has one of the more significant reactions, is more likely to have another and possibly even more serious one.
Who in their right mind would push for ADDING more chemical stress on a system that is exhibiting such warning signs? Pediatricians that ignore these warning signs should be sued for malpractice if that child suffers damage.

The following is from the ***Immunity Education Group*** (with some definitions added by me). These are based on CDC information and FDA vaccine package inserts:

CDC contraindications for vaccine injection:

- Anaphylaxis *(fife-threatening allergy)*
- Encephalopathy *(coma, reduced consciousness}*
- Anaphylactic allergy to egg/yeast
- Severe immunodeficiency *(ex. cancer, organ transplant)*
- Intussusception *{only for Rotavirus vaccine)*

Vaccine reactions (according to FDA package inserts), NOT included in CDC contraindications:

- Encephalitis (brain swelling)
- Guillain-Barre syndrome (the immune system attacks the nerves)
- Seizures
- Brachial neuritis (numbness in the upper extremity)
- Fever over 105 degrees
- Stevens-Johnson syndrome (a reaction in the skin and mucous membranes causing a purplish rash that can progress to a life-threatening condition)
- Stroke
- Hypotonic, unresponsive episodes
- Severe nerve dysfunction
- Vasculitis (blood vessel inflammation)
- Spinal cord paralysis
- Coma
- Pulmonary Embolism (blood clot in the lungs)
- Systemic lupus Erythematosus (an autoimmune disease)
- Severe nerve paralysis
- Moderate to severe allergic reactions
- Angioneurotic edema (swelling and fluid under the skin)

- Limb paralysis
- Apnea (not breathing)
- Cyanosis (turning blue)
- Swollen lymph nodes
- Cellulitis (inflammation of the skin)
- Hypotonia (loss of muscle tone; listlessness)
- Spinal cord inflammation
- Pneumonia
- Thrombocytopenia purpura (the immune system attacks platelets, the blood cells that help clotting)
- Worsening of multiple sclerosis symptoms
- Rapid heart rate or palpitations
- Wheezing or asthma attacks
- Edema
- Hair loss
- Vasovagal syncopy (fainting on standing)
- Vertigo (feels like the world is spinning around you)
- Chronic tinnitus (ringing in the ears)
- Facial nerve paralysis
- Inflammatory bowel disease
- inflammation of the pancreas
- Permanent arthritis
- Acute disseminated encephalomyelitis (brain and spinal cord inflammation}
- Optic nerve inflammation
- Kawasaki disease (blood vessels throughout the body become inflamed)
- Multiple nerve inflammation and dysfunction
- Onset of multiple sclerosis
- Henoch-Schonlein purpura (a very severe immune reaction that involves the skin and kidneys)
- Bloody stools
- Panniculitis (inflammation of the subcutaneous)
- Nerve deafness in the ear
- Severe eye inflammation that can permanently affect vision
- Abscess at the injection site
- Testicular pain and swelling
- Subacute sclerosing panencephalitis (chronic progressive brain inflammation, often caused by the measles vaccine
- Ataxia {balance problems with difficulty walking)
- Pneumonitis (a severe inflammatory reaction in the lungs}
- Extensive swelling of the injected limb and nearby joints
- Bacterial skin and tissue infections
- Difficulty swallowing
- Tremors
- Autoimmune arthritis

- Thyroiditis (inflammation of the thyroid)
- Blood clots in the limbs

If a person receiving a vaccine exhibit these side effects, how rational is it to roll the dice again? Or if they react to one or two vaccines in a visit, does it make sense to schedule them for a hexavalent (6 dose vaccine the next time? Or add a couple more for 8 or 9 doses in a visit? This sounds ludicrous, but unfortunately it happens all the time.

Valid reasons for religious exemptions

I was aked to do a blog for a site on the religious exemption topic. I thought I would in this eBook so that those that have similar convictions can use it as a template in the formulation of their own appeals for religious exemption status. It covers many of the key and legitimate concerns for people of faith. You can find it in the COVID-19 vaccine section titled **People with religious convictions need to know that certain COVID-19 vaccines may be contaminated with DNA from aborted fetuses.**

Are children in third-world countries considered less important by big pharma?

A paralytic epidemic of individuals in India, after receiving the oral polio vaccine undistinguishable from polio and twice as deadly

An article published in the ***Indian Journal of Medical Ethics*** in 2012 titled, **Polio programme: let us declare victory and move on**, describes an epidemic of what is called non-polio acute flaccid paralysis (NPAFP), that correlates directly and proportionally with the use of the oral polio vaccine. There were 47,500 cases occurring in 2011 alone! The sad fact is, that while affluent countries have moved on to "safer" inactivated forms of the polio vaccine, children in many third world countries have been subjected to using the left-over stock of the live oral version. That begs the question, aren't the lives of children in poorer countries just as valuable as our children?

From the abstract:

"It was hoped that following polio eradication, immunisation could be stopped. However the synthesis of polio virus in 2002, made eradication impossible. It is argued that getting poor countries to expend their scarce resources on an impossible dream over the last 10 years was unethical. Furthermore, while India has been polio-free for a year, there has been a huge increase in non-polio acute flaccid paralysis (NPAFP). In 2011, there were an extra **47,500 new cases** of NPAFP. Clinically indistinguishable from polio paralysis **but twice as deadly**, the incidence of NPAFP was directly proportional to doses of oral polio received. Though this data was collected within the polio surveillance system, **it was not investigated**.

The principle of primum-non-nocere *(First to do no harm)* was violated. The authors suggest that the huge bill of US $8 billion spent on the programme, is a small sum to pay if the world learns to be wary of such vertical programmes in the future."

Children in Third World Countries often get old stockpiles of unsafe vaccines

Comments by Joseph Mercola D.O.

"The problem is that, while the oral vaccine has reined in wild polio, persons recently vaccinated with **the live attenuated oral polio vaccine can shed vaccine strain virus in their body fluids for weeks** and, in some cases, **both the recently vaccinated and close contacts of the recently vaccinated can come down with vaccine strain polio**. Poor sanitation, including open sewage in underdeveloped countries, where drinking water is too often also used for bathing and disposal of human waste, can make it easy for vaccine strain polio virus to be transmitted."

"While most affluent nations now rely on inactivated, injectable poliovirus vaccine (IPV), many third-world countries still use an oral polio vaccine because it's much simpler to administer drops in the mouth rather than injecting a vaccine into a child. However, because the oral polio vaccine is made from live attenuated polio viruses, it carries a risk of *causing* vaccine strain polio in populations, especially among those, who are immune compromised, malnourished or suffering from serious health problems."

Oxford University scientists fail to properly notify parents whose children received a TB vaccine, as part of a clinical trial that caused the deaths of 5 out of 6 primates the vaccine was tested on

The unethical actions were uncovered by the ***British Medical Journal*** investigation that was published in January of 2018 titled, **Oxford TB vaccine study calls into question selective use of animal data**. The investigation revealed a terrible case of callous and unethical behavior by vaccine research scientists. An earlier trial beginning in 2006, caused the deaths of 5 out of 6 primates that the vaccine was tested on. This information was omitted during the initial application process for human trials and was not disclosed to the parents of the nearly 1,500 children that received the vaccine in 2009.
https://www.bmj.com/content/360/bmj.j5845

From the Abstract:

"In July 2009, researchers began a clinical trial in infants in South Africa, testing the newest hope for an improved vaccine against tuberculosis.1 Nearly 2800 infants took part. Their parents consented on the basis of information that included the statement that the trial vaccine, MVA85A, "has been tested in animals and was shown to be safe and effective."

"Similar statements had been used to obtain funding and ethical and regulatory approval for the trial. In one funding application, for example, the researchers said that the MVA85A booster had been shown to be more protective than BCG alone in four animal models."

"Information given to ethics committees, regulators, and trial investigators said that protective efficacy studies had been carried out in four animal models—mice, guinea pigs, cattle, and monkeys. They reported "evidence of protection" against *Mycobacterium tuberculosis* when MVA85A was given as a booster to BCG."

"However, an investigation by *The BMJ* has unearthed concerns about how the researchers, from Oxford University, used the results of animal studies selectively to gain funding and approval for human trials, publicly relying on claims that animal studies had shown the new vaccine to be protective while privately playing down or dismissing unsupportive experiments as "failed" or irrelevant. Disappointment at the apparent failure of animal models to predict the outcome of human trials has, in turn, led major funders of TB research to rethink their funding priorities, with allegations that this has slowed progress in the entire field."

A 2017 article in the ***Telegraph News*** titled, **Oxford University scientists gave babies trial TB vaccine 'that did not work on monkeys'**, gave more details on the controversy.
https://www.telegraph.co.uk/news/2017/09/03/oxford-university-scientists-gave-babies-trial-tb-vaccine-did/

Portions from the article:
"Oxford University is embroiled in an ethics row after scientists were accused of questionable conduct over a controversial trial of a new vaccine on African babies."

Professor Peter Beverley, a former senior academic at the university, complained that scientists planned to test a new tuberculosis vaccine on more than a thousand infants without sharing data suggesting that monkeys given the immunisation had appeared to "die rapidly".

Certainly here in this experiment there was no evidence whatsoever that this is an effective booster vaccine," Prof Beverley said."

He claimed the information was not given to regulators when an application to do the trial was initially submitted.

In the monkey study, five out of six of the animals infected with TB who were given the experimental vaccine had become "very unwell" and had to be put down.

An information sheet given to families in South Africa participating in the trial said the vaccine had been tested on animals and humans and was "safe and effective" in animals.

Professor Jimmy Volmink, Dean of the Faculty of Medicine and Health Sciences at Stellenbosch University, told The Telegraph the information sheet did not appear to reflect the evidence from the monkey study, which was "not right".

He said people affected by tuberculosis were often poor and "not very highly educated", making it particularly important that they were given "clear, understandable information."

Almost 1,500 babies in South Africa received the new jab and parents were paid in the region of £10 for taking part.

The South African regulator which approved the trial admitted to this newspaper that the information sheet given to parents "could be construed as misleading", raising questions about whether families were sufficiently informed.

South African Medicines Control Council, which was one of the regulators who approved the trial, said that a "large body of data" – apart from the monkey experiment and which included previous human trials – was considered as part of the approval process.

They also said that the monkey experiment was "not a trial of the vaccine in monkeys" and that "there was no suggestion that the vaccine was unsafe in the monkeys or that it had caused disease or death"

However, when asked about the information sheet that was given to parents, the regulator said, "In retrospect **the information on efficacy achieved in the animal studies could be construed as misleading**", although the "evidence of safety in the previous human studies was fairly reported"."

Doctors bonused for vaccine compliance

Doctors are incentivized to maximize immunization compliance in their patients

Financial incentive often clouds judgment and justifies action.

This link is but just one example of how insurance plans will incentivize doctors for immunization compliance http://www.whale.to/c/2016-BCN-BCBSM-Incentive-Program-Booklet.pdf. You can see on page 16 of their 2016 plan booklet, that Blue Cross Blue Shield pays doctors $400 as an "incentive" (as they call it), for each "Combo 10" (which is a series of 10 vaccines), that they provide children in their practice. This of course is in addition to any other fees that the doctor collects for that office visit. At $400 per child, that adds up. By vaccinating only 100 children, the doctor pockets an additional $40,000 bonus. Not bad. Isn't that a conflict of interest? It makes you wonder what their true motive is.

Financial incentives abound, not only for doctors but medical "associations" and trade groups that promote vaccine compliance and talking points

An excellent article on ***Children's Health Defense*** web site dated July 23, 2019 titled, **The Pharmaceutical Industries Front Men,** exposes the money trail that entices those willing to do the bidding of vaccine manufacturers. Those include trade organizations, vaccine front groups, medical journals, and pediatricians. https://childrenshealthdefense.org/news/the-pharmaceutical-industrys-front-men/ *(Reference links are contained in the article online)*

Some excerpts from the article:
"Thus, the American Academy of Pediatrics (AAP), one of the most notorious vaccine industry front groups, receives funding from all four manufacturers of childhood vaccines in the U.S. (Merck, Pfizer, Sanofi, GlaxoSmithKline). The AAP also gets substantial funding from the Centers for Disease Control and Prevention (CDC)—more than $20 million since 2009—over a third of which is explicitly vaccine-related. Two other front groups that routinely propagate misleading information about vaccine safety are the Immunization Action Coalition (IAC) and Every Child by Two (ECBT). A 2017 analysis in *The BMJ* showed that—far from being credible and independent sources of information—these outfits, like AAP, receive significant funding from vaccine manufacturers and the CDC, with a third of ECBT's annual funding coming from the CDC. With industry and CDC funding in hand, these front groups can guarantee vaccine makers' ability "to influence policy without having to stand on the front lines."

"Physicians' complacency about vaccines begins in medical school, where doctors are taught that vaccines are "wonderful" but learn nothing about vaccine ingredients, risks, effects on brain and immune system function or any other aspects critical to understanding vaccine safety and effectiveness. Once in practice, pediatric well-child visits ensure a steady stream of repeat customers and revenue. The CDC advises practices to administer vaccines at about half of the visits through the adolescent years, with 11 visits recommended by the AAP over a child's first 30 months (and annually thereafter). Various financial incentive programs also encourage pediatricians and family doctors to follow the CDC vaccine schedule, including insurers who give bonus payments to practice groups who achieve specified vaccination targets."

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"The tendency of pay-for-performance to "dangle money" before doctors has side effects. It turns the intrinsic professional and moral obligation of doing the best thing for the patient into a market transaction governed by price."

The TWO MOST IMPORTANT QUESTIONS one should always ask are…

There are two questions I always ask myself, when considering the truth behind statements and the corresponding motivations:

What does this person or organization stand to gain by my accepting their claims?
What does this person or organization stand to lose if I don't accept their claims?

- When I look at the groups and individuals that stand to gain the most by ensuring 100% compliance with and expansion of vaccination programs (Big Pharma, Legislators supported by Big Pharma, Media supported by advertising by Big Pharma and promoting access to those drugs from doctors who also benefit) and I ask those two questions, it certainly becomes obvious to me. **By far the overarching incentive in each link of the chain is money**. **Since it is well documented, that there are nearly 300 different vaccines currently in the pipeline and that the goal of the pharmaceutical industry is to mandate that every man woman and child be compliant with every single vaccine that they can come up with. Now, I will concede that there will be some well-meaning individuals in each of those groups. But as I just mentioned, it is their responsibility to do their due diligence and not to blindly follow the powers that be**.

- When I look at parents concerned over the welfare of their children making a decision as to what to allow somebody to inject into their bodies, and I ask myself those two questions, it also becomes obvious to me. **The parents are looking out for what they believe to be in the best interest of their child.** There is certainly no monetary incentive on the part of the parents. Most parents blindly trust the doctors, media and pharmaceutical companies who have a lot to gain. But if they don't buy into what they are told, all of those special interest groups also have A LOT to lose! So, there is a lot at stake between the swing from their gain and their loss. For families, there is so much more at stake in the health of their children. When you see vaccine injured children and the horrible and tragic consequences to the lives of those families, it is heart wrenching! It is an extremely difficult dilemma, so it's no wonder that so many are struggling over this issue.

What is the "End Game" of the pharmaceutical companies?

Currently there are 80 vaccines licensed for use in the United States

The FDA's website lists all of the vaccines that are licensed for use in the U.S. Of those 80, 24 are influenza (flu) vaccines.
https://www.fda.gov/BiologicsBloodVaccines/Vaccines/ApprovedProducts/ucm093833.htm

Nearly 300 new vaccines in the pipeline- And you can roll up your sleeves adults, they're coming for you too!

In a 2013 report presented by ***America's Biopharmaceutical Research Companies*** titled, **Nearly 300 Vaccines Are in Development; Research Focuses on Prevention and Treatment**, sheds light on a very dark prospect facing all Americans.
http://phrmadocs.phrma.org/sites/default/files/pdf/Vaccines_2013.pdf

There is a movement within our public health policymakers that would require ALL men, women and children to be fully compliant with their vaccine schedule to be eligible for the right to a driver's license and other government issued privileges. And with nearly 300 new vaccines in the pipeline and more to come, you had better be willing to subjugate your rights, roll up your sleeve and let them inject you with whatever potion they deem is for the "greater good" of humanity, if you want those civic privileges.

According to the Government's Healthy People 2020 initiative, the goal is to dramatically increase adult vaccination rates

According to ***the Adult Vaccine Access Coalition's website***, "According to the CDC, only 38 percent of adults (age 18 and older) received a flu shot in 2010-11 **while the Healthy People 2020 objective is 70 percent**. Similarly, 62 percent of adults over 65 and only 20 percent of high risk adults between 19 and 64 have received a pneumococcal vaccine **while Healthy People 2020 vaccine rate objectives are 90 and 60 percent, respectively.** Vaccination rates for other preventable conditions, including tetanus, diphtheria, pertussis, and zoster (shingles), among others, **also remain well below target levels**."
https://www.adultvaccinesnow.org/our-mission/

"AVAC seeks to achieve success that parallels childhood immunization levels when it comes to immunizations among adults." https://www.adultvaccinesnow.org/about/

The supporting organizations that are listed on their website is a long list of a variety of groups and organizations. From the about page: "AVAC is made up of a diverse group of health care providers, **vaccine makers**, pharmacies, public health organizations, patient and consumer groups. Together, we will strengthen and enhance access to and utilization of adult immunizations." It becomes obvious when looking at that list that many of those groups will benefit financially by increasing adult vaccine compliance.

Considering the goals of government's Healthy People 2020 program and the financial incentives of many medical groups and pharmaceutical companies and the fact that there are nearly 300 vaccines in the pipeline, adults had better get ready to get in line. As vaccine mandates for children take hold (and adults are complicit in that), you can bet that they are going to take aim at adults of all ages next. How would you like to have to roll up your sleeve and get a 7 or 8 vaccine combo when you want to renew you driver's license, or get a passport, or travel across state lines? Think that is far-fetched? Think again! Once Pandora's Box is open it is going to be extremely difficult to close it again.

Argentina passes law requiring adults comply with full vaccine mandates to enjoy privileges like a driver's license, passport and more

An article titled **Argentina's New Vaccine Law is a Blueprint for American Real ID**, and posted January 25th, 2019 on **The Vaccine Reaction** describes how over-reaching vaccine mandates are already happening in countries that have already lost many of the freedoms we enjoy and may be serving as a blueprint for things to come here in the U.S. unless people wake up, get educated and start thinking for themselves. https://thevaccinereaction.org/2019/01/argentinas-new-vaccine-law-is-a-blueprint-for-american-real-id/

From the article:

"In mid-December of 2018 Argentina unanimously passed its vaccine law through both chambers of congress **without debate**, **political discussion and seeing just one negative vote against it**. Learning nothing from the ongoing Colombian HPV issues, the new Argentinian law **forces their *entire* 20 vaccine schedule upon its population of both children and adults**. Using nearly identical talking points as seen in Colombia, the Argentinian bill's author Dr. Pablo Yedlin boasted on Twitter, **"They [vaccines] are free, they are your right and your obligation""**

"The law is perhaps the most overarching example seen to date of how invasive a government can become by forcing a medical intervention [vaccines] with questionable safety profiles onto its people. The recently approved law indicates **"certification of compliance with the National Vaccination Calendar must be required" including for passports, driver's licenses and National Identity Documents (DNI)."**

The evidence suggests vaccines contribute to numerous chronic illnesses, which provides an endless stream of patients for other drug "therapies"

People with autoimmune, neurological, hormonal, emotional and behavioral issues are a huge market for the pharmaceutical industry. Many of these conditions are very chronic and debilitating. They often lead to the need for lifelong treatment and management. This creates consumers for life and is the perfect scenario for the pharmaceutical industry.

Instead of looking for ways to improve the safety and efficacy of their products, vaccine manufacturers are developing "better" marketing strategies to convince more people to comply

A 2016 article in ***Vaccine*** titled, **Changes in childhood immunization decisions in the United States: Results from 2012 & 2014 National Parental Surveys**, discusses trends in vaccine compliance and ways to monitor trends and increase compliance. This is just one of many like articles that have emerged over the past few years. **It is obvious that as more people become aware of the shortcomings and potential risks of vaccines, the goal of big pharma and the government is to become better marketers, instead of creating a product that is safe, effective and everyone would want to benefit from.**

From the article: "These findings suggest that more effort is warranted **to counter persistent vaccine hesitancy**, particularly at the local level. Longitudinal monitoring of immunization attitudes is also warranted to evaluate temporal shifts over time and geographically."

An attempt to silence the vaccine backlash

There is a coordinated attempt to silence any dialog or discourse that disagrees with the vaccine paradigm and claims of its minions. No matter what the scientific evidence or the volume of dissenting science (as presented herein), the powers that be are determined to win this battle and protect their shareholders bottom line, regardless of the damaged lives that are left in the wake of this juggernaut.

As reported on July 02, 2019 by ***Science Daily*** in an article titled, **Top global public health scientists launch new challenge to anti-vaxxers**, the well scripted hit piece takes aim at any that would question the mantra of the vaccine model. **I will highlight the key words or "code"** that permeates any articles, news reports or other media "reporting". (I've made the words with negative connotations yellow and

the ones positive to their cause green). Pay close attention when you hear stories like these reported and you will notice a mesmerizing hum of hypnotizing Zen like mantra, designed to brain-wash the masses. And I'd have to admit, they are doing a pretty darn good job of it!
https://www.sciencedaily.com/releases/2019/07/190702112659.htm

From the Article:
"Search engines and social media organizations must do more to prevent the spread of inaccurate information on childhood vaccination, and governments must better support mandatory immunization programs, says an international group of leading public health scientists in a statement published in the *Journal of Health Communication*." (Notice they use the term "inaccurate information").

This is so typical of the linguistic battle that is being waged against those that would dare question the status quo, no matter what evidence they present. This is nothing but a P.R. campaign designed silence any public debate and to discredit all opposition to the well-oiled machine Big Pharma has put in place.

"The Salzburg Statement on Vaccination Acceptance lays down several recommendations to combat the global fall in vaccination rates fuelled by a powerful worldwide 'anti-vax' movement. The statement, which pledges to "support the development of new, effective and fact-based communications programs" to help parents, community and government leaders make appropriate decisions on childhood immunization, has already been endorsed by more than 60 public health leaders from the Americas, Europe, Asia, Africa and Australia."

"It calls upon major search engines and social media organisations to better monitor the vaccine information they provide so that they can improve the identification of disproven or inaccurate false claims about vaccine safety -- just as they do for sexually explicit, violent and threatening messages." **REALLY!!!**

"At the same time, advocacy groups, educators and health professionals should join forces to correct misleading vaccine information and disseminate reliable, accurate information via mass and social media and through trusted sources at all levels of society, including celebrities, faith-based leaders and parents."

"Governments and policymakers should support laws that limit exemptions from mandatory vaccinations and treat childhood vaccination like other essential services such as police, firefighters and public sanitation, the statement also says."

The article goes on, but I think you get the point.

The Salzburg Statement on Vaccination Acceptance. *Journal of Health Communication*, 2019; 1 DOI: 10.1080/10810730.2019.1622611

The anti-vaccine discourse has reached dangerous new levels

The discourse against persons that question the safety of vaccination has gone to a whole new level of hysteria, uncivil and unconstitutional level

The ***Boston Herald*** Takes Cyberbullying to a Whole New Level

In what has been called a "**scalding anti-anti-vax op-ed**," the ***Boston Herald's*** May 8 report on the Minnesota measles outbreak concluded with the following statement:

"These are the facts: Vaccines don't cause autism. Measles can kill. And lying to vulnerable people about the health and safety of their children ought to be a hanging offense."

This obnoxious paragraph led to hundreds of angry comments, at least one of which pointed out the hanging threat was an open violation of Massachusetts' 2014 law against cyberbullying. Others rightfully suggested that if lying to the public about health was a hanging offense, then many high-ranking health officials, researchers and drug manufacturers would earn a place at the front of the line.

As extreme as the Boston Herald's comment is, it's not the first-time mandatory vaccination proponents have made callous calls for violent action against those questioning vaccine safety. As noted by The ***Vaccine Reaction***, published by the ***National Vaccine Information Center (NVIC)***:

"In March … Scientific American published an article by Peter Hotez, M.D,. of Texas Children's Hospital, also inciting violence against people who do not agree with current government vaccine policies. Dr. Hotez stated: ***'An American antivaccine movement is building and we need to take steps now to snuff it out.'***

In 2015, USA Today published a column by Alex Berezow advocating ***that 'anti-vax' parents should be imprisoned.*** *At the time, that seemed to be a draconian proposal, but certainly less so compared to today's calls for execution."*

References:

- Journal of the American Board of Family Medicine July-August 2014; 27(4): 458-464
- Boston Herald May 8, 2017
- Massachusetts Law about Bullying and Cyberbullying
- Massachusetts Section 11H
- The Vaccine Reaction May 11, 2017

Jailed for refusing to vaccine a child?

Sounds very un-American. Well in October 2017, a mother in Michigan was jailed for five days, for refusing to vaccinate her son. This is not acceptable. When the state has the ability to dictate what a

parent must inject in their child's body is the day that we have lost our most precious freedom, the right to the sanctity of our child's or our own body.

From the article:
"In her fight against vaccinations, Bredow was jailed and lost primary custody of her son, then discovered that he was immunized against her wishes."
https://www.washingtonpost.com/news/to-your-health/wp/2017/10/12/a-mother-was-jailed-for-refusing-to-vaccinate-her-son-now-shes-outraged-hes-been-immunized/?noredirect=on&utm_term=.e2a01cbeb4c2

Vaccine mandates and removal of personal, religious and even many appropriate medical exemptions, including persecution of doctors that provide them is on the rise

All around the country, battle lines are being drawn between those that believe that the state should have the right to dictate what we must allow to be injected into our bodies and those of our children, and those that believe that our bodies are our personal domain and it is up to the individual to decide what they allow to be injected into their own and their children's bodies.

Medical Freedom is the rally cry of those that feel that freedom to choose must be maintained by the individual.

- When the vaccine manufacturers have immunity from being held accountable for making products that are inferior to their claims and have the real potential to harm, maim and kill those subjected to them, there MUST be a right to opt out!
- When long term, legitimate, real placebo (saline solution) safety studies have never been done, there MUST be a right to opt out!!
- When conflicts of interest, bias and financial gain are the norm in the research supporting vaccine industry claims and the have infiltrated the government agencies that are supposed to be regulating and watching out for the public welfare, there MUST be the right to opt out!!!
- As long as vaccines contain toxins that according to many hundreds of studies performed by thousands of medical and scientific researchers can cause injury, chronic life-long debilitating conditions and death in the unidentified, unsuspecting and unlucky ones that react to them, there MUST be a right to opt out!!!!
- All Americans need to push back against the tyranny that would force them to participate in the largest human experiment ever constructed against their will, an overt violation of the Nuremberg Code. The Nazis got away with such forced human experimentation, we have to stand and resist a repeat of that kind of coercion and forced mandates here in the United States of America. For those that want to participate, that should be their prerogative. For those that don't, they must be given the choice to opt out!!!!!

With nearly 300 vaccines in the pipeline and dozens more added annually, there will be no end to the multiplication of the required mandates if Big Pharma has their way. Profits and further shareholder investment and returns is the only name of the game. The financial gain is massive on the front end and astronomical on the back end, with the epidemics of chronic diseases ready made for additional pharmacological intervention. An ever-growing market in human lives for polypharmacy is and will continue to be the norm for aging adults, as they circle the drain, spiraling downward towards a sickly demise.

Europe is currently experiencing a backlash against mandatory vaccination-

In an article by Jefferey Jaxen titled, **FLASHPOINT: France Attempts Forced Vaccination on Unwilling Population** and posted July 14, 2017 on www.greenmedinfo.com , reveals the same old conflict of interest issues, with officials being on the payroll of vaccine manufacturers forcing unwilling people to roll up their sleeves in order to provide a nice return for their benefactors.

Here are excerpts from the article:+

"Headlines were recently made announcing that the French government plans to make 11 vaccines compulsory for children, adding to the three-shot combination already mandatory (*diphtheria, tetanus, and polio****). Under the new jurisdiction, parents would be forced to follow the vaccination schedule.***

With the recent announcement, newly appointed Minister of Health Agnès Buzyn is making no secret that she will aggressively push a vaccine agenda upon the French people.

In February 2017 the Conseil d'Etat, France's highest administrative court, ruled in favor of the parental right to decide when it comes to vaccinations. Since France only offers the mandatory DTP vaccine in one shot, the French court gave the Ministry of Health six months to find a solution to parents who would like the shots separate while also striking down arguments on the alleged risks of non-compulsory vaccinations associated with the three mandatory vaccinations.

Instead of working towards a solution, Buzyn's Ministry of Health decided to double down and announce a new 11-shot forced vaccine schedule for French children starting in 2018. The move, like those happening simultaneously in Italy, Poland and other European countries, appears to be leveraging media fear and hype over the increase in measles cases.

Documents obtained highlighting conflicts of interest show Buzyn was directly compensated for various activities by the pharmaceutical laboratory Genzyme, now a subsidiary of Sanofi, from 1998 to 2011. In addition, between 2005 and 2011 she was also paid by the laboratories Bristol Meyers-Squibb and Novartis. The two laboratories together with Pierre Fabre and Schering-Plow (a subsidiary of Merck) also financed the Robert Debré association headed by Agnès Buzyn.

Judging by past indicators, Buzyn will face an increasing headwind from the French population during this vaccine push. In 2015 the largest survey on confidence in immunization to date was conducted interviewing more than 65,000 people. As the researchers reported, 41% of respondents in France

disagreed with the assertion that vaccines are safe. The number of 41% was reached before the CDC whistleblower revelations became widespread, before the success of the ***film Vaxxed: From Cover-Up to Catastrophe***, and before tens of thousands of Italians began marching in the streets. The skepticism isn't just coming from the general population; a quarter of French health practitioners aren't confident about the efficacy and risk of vaccines, either.

Some of the hesitancy over the past decade in France can be attributed to the French government's mishandling of the 2009 H1N1 (swine flu) scam. At the time the H1N1 scare, based on false reporting and statistical manipulation, was billed as a pandemic. Through investigations by ***Sharyl Attkisson, Jon Rappoport*** and others the false narrative was dismantled. That was not before the French government bought double the doses of vaccines, 94 million shots costing nearly a billion euros, for its population**. In addition, the French government depleted the trust of its people by attempting to make the poorly tested thimerosal-containing vaccine mandatory for all its citizens over 3 months of age for a pandemic that didn't exist. In 2014 swine flu manufacturer GlaxoSmithKline eventually paid out £60 million to those who were injured by the shot.**

Prior to France's announcement, Italy had proclaimed a similar authoritarian-like vaccine scheme one month before. Italy's vaccine decree followed the same rules as California's Senate Bill 277 with the extra additions of hefty fines and mandatory reporting to the Juvenile Court for the potential suspension of parental authority on uncomplying parents. **Italy's population has since taken to the streets over the past weeks in a sustained, multi-city protest of their government's forced vaccination decree**."
(The article goes on to say that there were as many as 70,000 people that had taken to the streets in protesting its attempt toward mandating vaccination).

A 113-year-old Supreme Court Case decided due to extreme conditions, inappropriately used by some today to push the vaccine agenda

A 1905 Supreme Court decision is often cited as the reason the government has the power to subjugate an individual's right to what goes into their own body. The case ***Jacobson v. Massachusetts*** decided that **a Massachusetts pastor, Henning Jacobson could be forced to be vaccinated a second time against smallpox or face a fine, incarceration or both**. **The pastor from Sweden and his son had experienced severe adverse vaccine reactions previously to a smallpox vaccination**. The case pitted the state's right to mandate vaccination in cases of emergency versus an individual's right to decide his or her own fate under the 14th Amendment right to liberty and equal protection under the law.

In the trial, the judges unbelievably said the following regarding the common belief that the vaccine is safe: ""A common belief, like common knowledge, **does not require evidence to establish its existence**, but may be acted upon without proof by the legislature and the courts. The fact that the belief is not universal is not controlling, for there is scarcely any belief that is accepted by everyone. The possibility that the belief may be wrong, and that science may yet show it to be wrong, is not conclusive...for what the people believe is for the common welfare must be accepted as tending to promote the common welfare, **whether it does in fact or not**." ----- ***Huh????*** *(Emphasis mine).*

In other words, belief in something even without evidence to support it is justified. Whether it really does promote the common good or not doesn't matter. Well, that perfectly describes the vaccine industry and the unquestioned common belief of doctors, politicians and the media.

More from the article: ""In 2005, professors of law and bioethics at Boston University wrote about how *Jacobson v Massachusetts* is no longer relevant. They said that, "***Jacobson* was decided in 1905, when infectious diseases were the leading cause of death**," and when *"Few weapons existed to combat epidemics.... Preserving the public's health in the 21st century requires preserving respect for personal liberty...Public health programs that are based on force are a relic of the 19th century; 21st-century public health depends on good science, good communication, and trust in public health officials to tell the truth.""*

"**How we can we trust public health officials who think that some children are expendable for the rest? *Jacobson v. Massachusetts* is a Supreme Court decision that allows government to commit human rights abuses."**

Remember, the Nuremberg Trial gave birth to the Nuremberg Code in 1947, which gave birth to Informed Consent. "The next year, basic human rights that include autonomy and freedom of thought, conscience and religious belief were affirmed in the ***Universal Declaration of Human Rights***. Ever since, informed consent to medical risk taking has been the central ethical principle guiding the ethical practice of modern medicine. **Except that public health officials and doctors giving vaccines in America today don't want to respect that ethical principle**."

Don't let big pharma deny you and your children these rights in the name of huge profits!

"**Educate your legislators about the importance of protecting human rights in vaccine laws. Browse NVIC.org for more information and create a free account at** NVICAdvocacy.org **today to learn more about what you can do and how to get involved."**

To read the complete article, visit the National Vaccine Information Center's (NVIC) website here:
https://www.nvic.org/nvic-vaccine-news/november-2016/forced-vaccination-the-tragic-legacy.aspx

Suppression of Science for the Promotion of Profit

For a great summary regarding the suppression of science for the promotion of profit, read this short five-page excerpt from Mary Holland's book titled, Vaccine Epidemic.

http://vaxxedthemovie.com/wp-content/uploads/2017/04/The-Suppression-of-Science-by-Dr.-Andrew-Wakefield.pdf

This is just scratching the surface

These articles are just the tip of the iceberg. If you had several days to read them all, I could provide dozens more. To suggest that vaccines are completely safe is simply a lie. In fact, if you are like me and like to leave no stone unturned, you may want to investigate some of the resources I have included at the end of this document.

Suppression of the facts for corporate profit

There are many corporate executives from the media, from the pharmaceutical industry, from the political world that have turned a blind eye to evidence that has been presented to them. They are putting their own professional interest and pocketbooks ahead of the truth at a real and extreme cost to children and families, our military personnel, our intellectual capacity to churn out scientists, inventors and business innovators. The fear of losing advertising dollars or donations from big pharma has caused the suppression of truth and their own conscious.

Speaking of profits, how much do the top 4 vaccine manufacturers make per year?

Global vaccine revenues (IN BILLIONS) of just the top 4 players

	2016	2023 Projection
Merck & Co	6.750	7.545
Glaxo Smith Kline	6.219	8.657
Pfizer	6.071	7.133
Sanofi	5.568	6.825
Total	24.608	30.16

Source: https://www.statista.com/statistics/314562/leading-global-pharmaceutical-companies-by-vaccine-revenue/

What percentage of the revenue comes from vaccines?

This article published on the web site revenuesandprofits.com titled, **How Merck Makes Money? Understanding Merck Business Model**, gives a 2015 overview of their business model and the percentage dedicated to different fractions of the health care market.
https://revenuesandprofits.com/merck-makes-money-understanding-merck-business-model/

By scrolling down the page, you will see a colored pie chart showing the percentages and revenues derived from each segment. The vaccine component accounted for over $5.3 billion dollars and 13% of their overall business segments revenue. This website has similar data for other manufacturers as well.

Total Revenues for the top pharmaceutical Companies, based on 2017 numbers

Pfizer- $52.5 billion

Merck- $40.1 billion

Eli Lilly $22.9 billion

Bristol Myers Squibb- $20.8 billion

https://www.dcatvci.org/5451-pharma-and-the-fortune-5500-where-do-companies-rank

So, what would happen if large numbers of people decided not to get vaccines?

Let's face it, that is the question that is fundamental to this whole debate. All of the fear mongering and hysteria is designed to do just that, create a fear that all of these horrible infectious diseases will come back and kill thousands of our children. And, anyone that won't get in line with this way of thinking threatens my child! With the narrative that they have built up, it is easy to see why it is so easy to make people who are skeptical of vaccines the villains.

So, what would happen if a larger number of people opted out of the vaccine program? To answer that question, you have to take a rational, logical, fact-based approach and leave all of the whipped-up emotion out of it. Again, it boils down to this. We all need to be healthy skeptics about anything we hear. We need to think for ourselves and not just believe what we are told to believe. Take the time to fact check. Your health and the health of your children, grandchildren and beyond depend on it!

The following is from *Immunity Education Group* and does an excellent job of addressing this question…

Currently in the United States, most vaccine-preventable diseases are at an all-time low. But is that *only* because most people vaccinate? If too many stopped vaccinating, let's say 25% or even 50%, would diseases return? And if diseases increased significantly, what would the fatality and complication rate in our country be?

Diseases that would NOT increase

Let's first look at the ones which would *not* increase if there was a widespread decrease in vaccination:

Four of the 16 vaccine-preventable diseases are <u>not communicable</u> <u>through casual person-to-person contact</u>; therefore, lower vaccination rates cannot put vaccinated or immunocompromised people at any increased risk:

1. **Tetanus** is not contagious at all
2. **Hepatitis B** only spreads through sexual contact, the sharing of IV drug needles, or mixing of infected blood, <u>not</u> casual contact
3. **HPV** also spreads only through sexual contact, and therefore is not communicable in a casual manner
4. **Meningococcus (**meningitis) is carried asymptomatically in the nasal passages of about 1 in 10 people; it is often a person's own germ which flares up into symptomatic infection. And once sick, it doesn't spread through casual contact

Five of the 16 vaccines only protect the individual receiving the vaccine; <u>they do not keep the disease from spreading to other people:</u>

1. **Polio**: the injected polio vaccine only prevents internal neurological symptoms in the person who is vaccinated, it does *not* prevent the transmission of the disease in the population
2. **Pertussis**: the acellular pertussis vaccine may help prevent individual cases during young childhood, but wears off quickly and does not prevent transmission of the disease within the population; for example, in 2014, 90% of California children who caught pertussis were already vaccinated
3. **Flu**: the influenza vaccine does not prevent wide-spread yearly circulation of the flu; the vaccine can only provide limited individual protection
4. **Diphtheria**: the diphtheria vaccine prevents the disease toxin from causing individual disease, it does not prevent germ transmission from person to person
5. **Tetanus**: this vaccine only protects the individual who receives it

Three of the 16 diseases have so many strains that vaccination does little to reduce the prevalence of the disease; in fact, it increases other strains not covered by the vaccine:

1. **Pneumococcus**: there are more than 80 strains of pneumococcal bacteria, and the vaccine only contains 13 strains
2. **Flu**: several different strains of influenza circulate every year, and the vaccine only covers a few of them. Since the vaccine is based on an estimation months in advance, it often fails to match the strains that do circulate
3. **HPV**: there are about 100 strains of HPV, and the vaccine only protects against 2, 4, or 9, depending on the brand

While vaccines for the above diseases may reduce the chance of an individual catching a disease if exposed, a decline in vaccination rates would not result in an increase spread of these nine diseases to vaccinated or immunocompromised people.

Diseases that might increase, but are generally mild in virtually all cases

Vaccines have helped lower the prevalence of certain common childhood diseases and can prevent symptoms in some individuals who receive them. The incidence of these particular diseases *might* increase if vaccination rates declined significantly, but just how deadly would these diseases be in the United States? Looking back at the fatality and complication rates before vaccines were introduced gives us a picture of what we could expect:

Measles

In the several years preceding the introduction of measles vaccine in 1963, almost every child caught measles and developed lifetime immunity. The death rate from measles in the U.S. in the 1950's and early 1960's was 1 in 500,000 people in the population. Out of those who caught the illness, the fatality rate was 1 death in every 10,000 cases. (Today, the media often report a falsely elevated fatality rate of 1 in 500 cases. Such fatality rates are calculated by the CDC using only *reported* cases of measles that are severe enough to seek medical care during limited outbreaks, not the total actual cases in a population.)

Mumps

Prior to the vaccine in 1967, about 1 in 1000 people caught mumps and acquired lifetime immunity, and fatalities were rare: about 1 in every 5000 *reported* cases. Like measles, most cases were so mild they went unreported. Complications like infertility in adult males and hearing loss were also uncommon (1 in 7700 and 1 in 20,000 of those who caught the disease). In the population as a whole, 1 in almost 4 million people died from mumps.

Rubella

Widespread use of the rubella vaccine began in 1969. At that time, the fatality rate from this relatively harmless illness was 1 person per 9 million in the population. The reason for the vaccine is that in pregnant women who caught the disease, the infection caused birth defects in about 1 in 20,000 births.

Chicken pox
Like measles, almost every child would catch chicken pox, and the fatality rate was about 1 in every 60,000 cases. In the population as a whole, 1 in 2.3 million Americans died of complications from chicken pox every year. Introduction of the vaccine in 1995 has helped reduce the illness, but it remains harmless for virtually every child who does catch it.

Hib disease
Before the vaccine for Hib was introduced in 1985, about one in 2 million people in the U.S. population died annually from this illness. Including permanent harm from the meningitis disease, like brain damage or deafness, this risk was about 1 in 600,000 in the population.

Rotavirus
This mild illness had an extremely low death rate prior to the vaccine being introduced in 2006 (about 1 in 10 million in the U.S. population).

Polio
Even though the injected polio vaccine does not prevent transmission between people (see above), and the illness therefore would not increase if more people opted out of the vaccine, it is useful to know the statistics of this disease to understand what could happen if it did return. Before widespread use of the vaccine in 1955, the fatality or permanent paralysis rate from the disease in the U.S. population was 1 in 100,000 people. 95% of people who caught it had no symptoms and 4% had minor fever and upset stomach. Only about 1% suffered neurological complications, and about half of these fully recovered with physical therapy.

There Is NO Risk That Warrants Mandatory Vaccination

So, what would *actually* happen if a significant number of people opted out of certain vaccines? First, more than half of our 16 vaccines don't even prevent the spread of diseases through every-day casual contact. Second, based on the above data from today and from the pre-vaccine era in the United States, the risk of fatalities and complications IF certain contagious diseases came back is low. To put this into historical perspective, the risk of dying from or being permanently harmed by any of these diseases in the years before vaccines was lower than the risk of being struck by lightning in your lifetime (1 in 12,000). In fact, the flu, an illness which we all deal with every year despite vaccination, actually causes more fatalities than any other vaccine-preventable disease, both now and in the years right before each vaccine was introduced.

Perhaps more importantly, the number of unvaccinated children would have to be significantly high to trigger a resurgence of contagious diseases in our population. **Currently, according to the CDC, less than 1% of U.S. children are completely unvaccinated**. For this reason, the risk of large disease outbreaks is NOT a realistic threat to Americans. And in the event of an outbreak, instead of mandatory vaccination

for everyone, quarantine and targeted vaccination (if necessary) is a more effective, appropriate, and adequate response that safeguards public health.

Sources:

CDC: Reported Cases and Deaths from Vaccine Preventable Diseases, United States, 1950-2011.

Vital Statistics Rates in the United States 1940-1960 – Online database

California Department of Public Health Statistics, 2014

CDC National Immunization Survey, 2014

http://immunityeducationgroup.org/happen-many-people-stopped-vaccinating/

They also have some good infographics to check out here…
http://immunityeducationgroup.org/infographics/

In light of that I just covered regarding the end game of the pharmaceutical industry being mandatory child and adult vaccinations, removal of exemptions, health freedom and the autonomy ovder one's own body…..it's time to cover the COVID-19 Vaccines!

THE COVID-19 VACCINES

The COVID-19 Vaccines section has its own Table of Contents with active links that re-direct to each topic covered.

The first section on the COVID-19 vaccines was added May 22nd, 2021 and revised with each subsequent update. You can stay up to date on the latest breaking news about the COVID-19 shots by subscribing to my monthly 1200 Studies Newsletter. It can be accessed at https://wellnessdoc.com.

Also, consider perusing my site at for other new and important free health related information.

In addition, you will find my investigative reports revealing the real data, the real science and the unbiased expert opinions on the various aspects of the pandemic and pandemic responses used to manipulate behavior of the population through then media. Those include topics on:

- The real risks of becoming seriously ill or dying from COVID-19
- The completely faulty PCR testing "case" pandemic
- The suppression of safe and effective early treatment medications for the virus
- The origins of the virus
- Sweden the control group for the world
- Long term immunity from the infection
- Nutrition based prevention and treatment adjuncts

Find those and more here: https://www.wellnessdoc.com/ebooks-and-publications/

INTRODUCTION

The COVID-19 vaccines are a brand-new gene therapy technology that have never before been tested or used in the human population. The clinical trials have been cut short to get them to market in about 15% of the time typically required for new "vaccines." You will learn in this section, why I have placed the "scare quotes" around the word vaccines. Because these products have been rushed to market, there is NO long-term safety data on them. And, as you will see they are causing a terrifying and unprecedented number of reported serious adverse reactions and deaths in the history of vaccines

The pressure is on

There has never been a more orchestrated and aggressive push to get everyone vaccinated for anything in history. Yet, there are many questions:

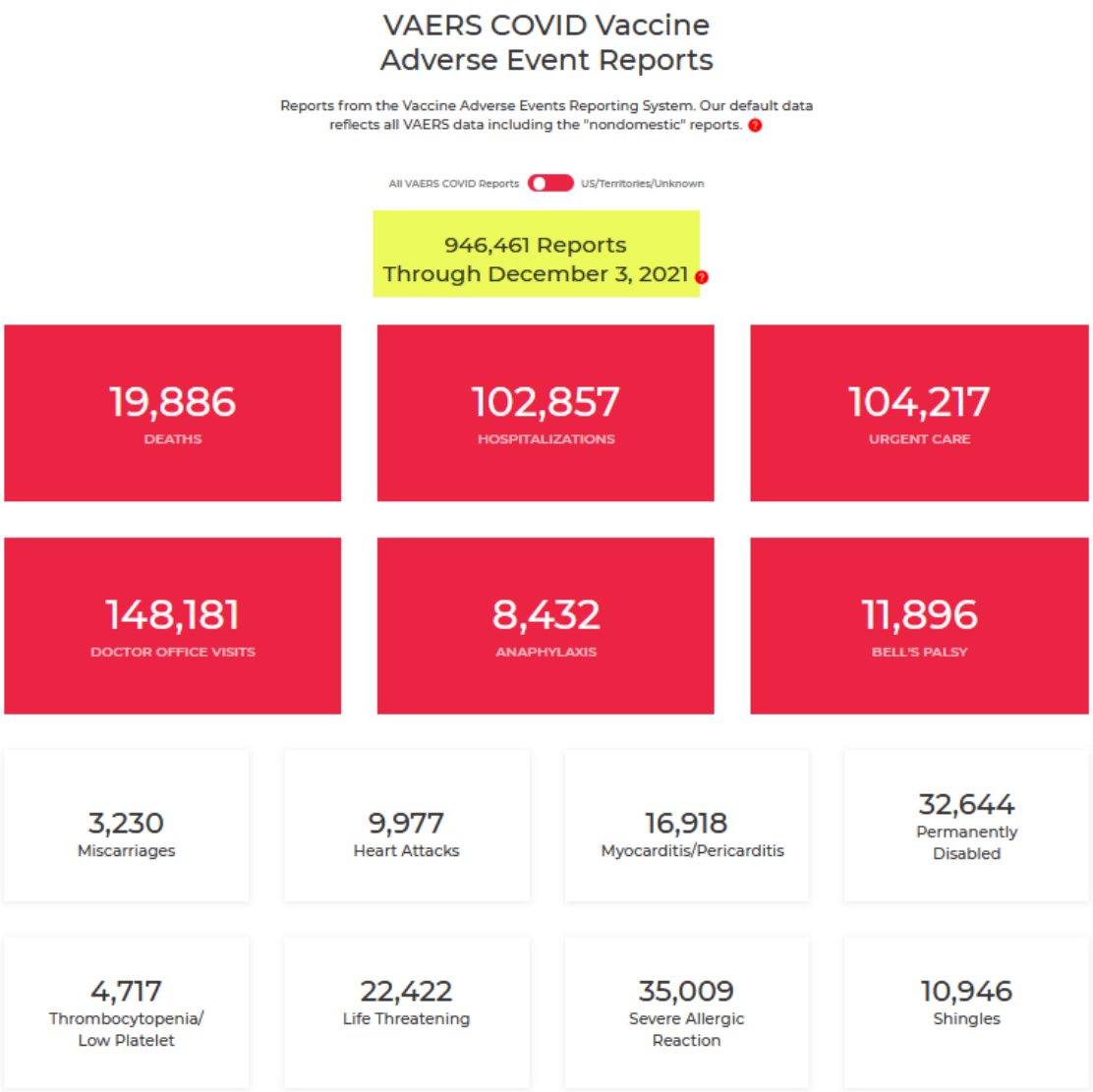
- **Is this massive effort warranted?**
- **Are these even vaccines?**
- **Do they stop infections and transmission? Because if they don't, what's the point?**
- **Are they safe?**
- **How much control over people's lives should the government have?**
- **How much control over people's live should the private sector have?**

- **Why should children and young people who are at nearly zero risk from COVID-19 need to get the vaccines?**
- **Why would the government push the vaccines on people that have already had COVID-19 and now have robust and lasting immunity?**
- **How much are we being lied to?**

These any many more questions are at the center of the mass vaccination program we are witnessing right now. How it will play out will be determined by how successful Big Tech is at suppressing any information that doesn't follow the party line, how much money the government throws into upselling every American into getting the shots and how many people are drinking the Kool-Aid after being terrorized by the pharma controlled mainstream media for nearlt two years and counting.

All I know for sure is that we are currently witnessing the largest mass casualty event from vaccination in history, and the media and government are silent. As of December 3rd, 2021 less than a year into the vaccination program, 19,886 deaths have been reported to the Vaccine Event Reporting System (VAERS). That number of reported deaths is approximately 200% of the total number of deaths as compared to deaths reported in all of the previous 30 years since the inception of VAERS, from ALL vaccines combined!!!

As you navigate further into this section of the eBook, you will see a rapidly escalating number of casualties reported to the CDC VAERS database. As of the December 3rd, 2021 VAERS update when this edition of the eBook was released, there have been 946,461 reported injuries broken out in various categories of adverse events from myocarditis, thrombosis, heart attack, miscarriages and many more, in addition to the 19,886 deaths. Contrast this to the 1976-1977 Swine Flu outbreak in which the vaccine was pulled after just 30 deaths. You will see evidence that the numbers reported below are just the tip of the iceberg and that there is a massive cover-up in progress.



And, importantly as reported on earlier in the eBook VAERS is a passive system. Nearly all consumers and many if not most doctors do not even know it exists. Historically, it has been shown that less than 1% of the adverse reactions to vaccines are ever reported. Think about that for a minute. Add two zeros to the end of each of those numbers and it may be more representative of the actual numbers. You quickly realize that the 19,886 deaths become 1,988,600 deaths! 102,857 hospitalizations become 10,285,700 and so on. Even if only 10% percent of adverse reactions and deaths have been reported and you add one zero to that baseline, that is astronomical! Think under-reporting is a myth? Check out this next story.

Vaccine adverse reactions have been proven to be grossly under-reported

The less than 1% number was derived from the ***Harvard Pilgrim Health Care*** medical system in a study funded by the CDC. It was performed between 12/01/2007 -09/30/2010. The report from the study was titled, **Electronic Support for Public Health–*Vaccine Adverse Event Reporting System (ESP: VAERS)***

https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf

The Purpose of the Study:

"This research project was funded to improve the quality of vaccination programs by improving the quality of physician adverse vaccine event detection and reporting to the national Vaccine Adverse Event Reporting System (VAERS)...

"The CDC's Public Health Information Network Messaging System (PHIN-MS) software was installed within the facilities so that the approved reports could be securely transferred to VAERS as electronic

messages in an interoperable health data exchange format using Health Level 7 (HL7)."

Results from the study:

"Preliminary data were collected from June 2006 through October 2009 on 715,000 patients, and 1.4 million doses (of 45 different vaccines) were given to 376,452 individuals. Of these doses, 35,570 possible reactions (2.6 percent of vaccinations) were identified. This is an average of 890 possible events, an average of 1.3 events per clinician, per month. These data were presented at the 2009 AMIA conference."

Dividing 1.4 million doses between 376,452 people is an average of 3.72 doses per person. And, if there were 35,570 reactions in 1.4 million doses given, that is one adverse reaction for every 39.4 doses. Perhaps what is most striking here is that if each person reacting experienced on adverse reaction only, of the 376,452 individuals vaccinated, nearly 10% experienced a possible reaction!

"Adverse events from drugs and vaccines are common, but underreported. Although 25% of ambulatory patients experience an adverse drug event, less than 0.3% of all adverse drug events and 1-13% of serious events are reported to the Food and Drug Administration (FDA). Likewise, fewer than 1% of vaccine adverse events are reported. Low reporting rates preclude or slow the identification of "problem" drugs and vaccines that endanger public health."

In addition, ESP: VAERS investigators participated on a panel to explore the perspective of clinicians, electronic health record (EHR) vendors, the pharmaceutical industry, and the FDA towards systems that use proactive, automated adverse event reporting." (Since in the end, this improved automated reporting system was stymied and went nowhere, one has to wonder what influence the pharma reps on the panel had on that).

Here's the kicker. After spending nearly 3 years and a million dollars, the CDC went dark on the program. Was it because the surveillance system would significantly increase the reporting of vaccine adverse reactions?

The last statement from the Results section of the article says it all…

"Unfortunately, there was never an opportunity to perform system performance assessments because the necessary CDC contacts were no longer available and the CDC consultants responsible for receiving data were no longer responsive to our multiple requests to proceed with testing and evaluation."

One has to wonder what is stopping the automation of the vaccine adverse reporting system from being implemented. This report suggested that its implementation would be easy to accomplish. That was in 2010. It is now 2021 and nothing has been done to accomplish this vital information system. And lives hang in the balance. And in May of 2021, I can absolutely say without doubt in my mind that many lives are being lost every day without ever being reported to the **VAERS** system.

Before we launch into the COVID-19 vaccines, I want to answer some of the questions I posed about 3 pages ago. To thoroughly answer all those questions and provide all the evidence I have would take hundreds of additional pages. So, instead I will provide a basic sampling of the evidence supporting the position here, and then refer those that would like to dive deeper into the pool of science and proof, you may visit https://www.wellnessdoc.com/ebooks-and-publications/ and check out the eBooks I have available there. If you aren't familiar with the misuse of the PCR test throughout this experience and the way

it was used to drive the fear, the false narratives and the policy decisions, check out my eBook on that topic there.

These are key points for consideration:

- **It is important to establish that the combined known and unknown RISKS of the vaccine is much greater than the risk of serious disease and death from COVID-19 for the vast majority of people.**

- **In addition, according to CDC estimates, most people have had the infection and now have lasting and robust immunity, therefore will not gain additional benefit from the vaccine. And in fact, some medical experts believe that getting the vaccine if a person has had COVID may be detrimental or potentially dangerous. More about that in this next section.**

- **Asymptomatic spread, one of the drivers of the fear and control campaigns is a rare event.**

- **Part is due to the fact that they vaccines have not been able to demonstrate that they can prevent infection or transmission to others, therefore having little if anything to contribute to reaching herd immunity or ending the pandemic as is promoted widely.**

- **Also, there is zero long-term safety data on these gene therapy biologics, not to mention the catastrophic mass casualties that we are already seeing as just discussed.**

- **And finally, in this section on the COVID-19 vaccines, you will see that these are not vaccines in the traditional sense of the definition. They are classified as Gene Therapy, which is more of a treatment for the illness than a preventative measure.**

Before considering risk, it is important to look at the manipulation of the death statistics

Minnesota State Senator and medical doctor Scott Jensen M.D. has been all over the alt media and even Fox News sharing about this very disturbing issue. Dr. Jensen has even taught medical coding, so he has expertise in this area. Dr. Jensen said in his 40 years of practice, he had never been "coached" or "massaged" to fill out death forms in a way that way completely uncharacteristic of all previous norms. He was interviewed by well-known motivational and inspirational guru **Tony Robbins** about this situation earlier in the pandemic. You can see that interview here: https://www.youtube.com/watch?v=1CZzdSzUZLE

Another footnote on deaths: We don't know what the actual number of deaths due to COVID-19 are, but all indicators are that it is GROSSLY inflated. Former Senator Jensen has done a forensic audit of deaths in Minnesota and found that they are 40% inflated due to incorrect assignment of cause of death on the death certificates. Think about the implications of this on our national reported totals. https://www.washingtonexaminer.com/news/coronavirus-death-certificates-minnesota-inflated

And this does not even take into consideration the high rate of false positives of the PCR test! That is a whole additional category of people that died and were assigned to have died of COVID-19 on the death certificates. These may have appeared to be a legitimate COVID-19 death because they may have presented with similar symptoms of another respiratory illness like influenza, influenza like illness, pneumonia, acute respiratory distress syndrome, etc. (thus would pass the test the Minnesota team used). If they pulled a positive COVID test but weren't tested for all the other pathogens…and the COVID test was truly a FALSE positive which again is common (estimated at 30%-90% depending on the source), that death is not a true COVID-19 death. How many of those were mislabeled? We may never know the number but suffice to say it would be a huge number!

Another great short article detailing what has happened and how it has distorted our COVID-19 response can be found here. https://theoutriderjournal.com/cdcs-covid-19-deaths-and-case-counting-procedures-illegal-and-compromised-data-research-shows/

James Lyons Weiler who is the Editor in Chief of the ***Institute for Pure and Applied Knowledge (IPAK)*** has released an important and very detailed paper on the whole debacle titled, COVID-19 Data Collection, Comorbidity & Federal Law: A Historical Retrospective. That can be accessed here. https://www.publichealthpolicyjournal.com/ethics-in-science-and-technololgy

Incidentally, Dr. Jensen is running for Governor of Minnesota! He is a stauch supporter of medical freedom and has expressed opinions that line up with the ***Great Barrington***

Declaration through out the pandemic. If you are not familiar with it, please take some time and check it out! As of the end of January, they have had 871,093 people, 15,091 medical and public health scientists and 44,541 medical practitioners sign on in support of their declaration. You can visit their website here: https://gbdeclaration.org/

In addition, they are working on another project called Collateral Global. The GBD authors – Professors Gupta, Kuldorff, and Bhattacharya - have teamed up with additional academics, researchers, and subject matter experts to cultivate a better understanding of the global impact of COVID-19 restrictions.

What are your risks of dying from COVID-19?

If you contract the virus, your age and what co-morbidities you have are the most likely determinates of that question. HOWEVER, as you will see in this section, for the vast majority of people the risk from COVID-19 in no way justifies the HUGELY OUT OF PROPORTION sales and pressure campaigns of the vaccines! Especially when THERE IS SIGNIFICANT RISK from the vaccines, which is being suppressed like nothing I have ever seen before. You will see PLENTY of that evidence here.

Advanced age is a risk factor

What is the risk of dying from COVID-19 in a given number of people of an age range, WITHOUT taking into consideration any comorbidities? The CDC data below dated August 08, 2020, is the latest reported on the Infection Fatality Rate (IFR) for COVID-19.

For the older crowd there is increased risk. But how much more risk? And, how does that relate to the risk from the seasonal flu? The annual flu was a concern every year, but we never locked the nations of the world down over it. I am also going to show your risk based on the level and number of comorbidities shown to make COVID-19 more serious and potentially fatal.

Let's first take a look from 30,000 feet at the relative risk for people under a certain age according to CDC statistics reported June 7th, 2020:

- People under 45 years of age **account for only 2.5% of ALL COVID-19 deaths!**
- People under 55 **only account for 7.3%** of all COVID-19 deaths.

- People under 65 account for 19.27% of all COVID-19 deaths.
- **People 65 and over account for 80.73% of all COVID-19 deaths.** (65-74 = 20.77%, 75-84 = 26.64%, 85+ = 33.32%)

Next let's look at death rates by age groups and the numbers I prefer to look at, the **survivability** numbers. That means, what is my chance of surviving if a given number of people in my age group are infected with COVID-19? I am hoping that this will help to put it in another context for you and allow you to compare survival rates with fatality rates for your age category.

Age	SURVIVAL rates	Death rates	What does that mean in practical terms?
0-19:	99.997%	0.003%	If 34,000 people were infected, 1 would die
20-49:	99.98%	0.02%	If 5,000 people were infected, 1 would die
50-69:	99.5%	0.5%	If 200 people were infected, 1 would die
70+:	94.6%	5.4%	If 20 people were infected, 1 would die

https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html **as of September 2020.**

Now remember and THIS IS KEY…These numbers are for all people across the board. If you lead a healthy lifestyle and don't have any co-morbidities, your risk with be dramatically less. Conversely, the more co-morbidities you have, the greater your risk as compared to these averages.

Let this sink in a minute

A CDC page titled, COVID-19 Hospitalization and Death by Age, compares risk of different age groups. The rate of death from COVID-19 in those 85 and older is 630 times (63,000 percent) greater than 18-29-year-olds. And it is approximately 5,670 times (567,000 percent) higher than children aged 0-4 and 10,080 times (1,008,000 percent) higher than youth aged 5-17!

https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-age.html

If you are over the age of 70 and certainly if older than 85, there is cause for genuine concern. But there is also cause for genuine concern in those age groups with the seasonal flu or pneumonia. And consider that nationwide 40% of deaths have occurred in nursing and long-term care facilities. In some states those deaths are higher, ranging as high as 82% of deaths as is the case in New Hampshire **earlier in the**

pandemic. https://www.kff.org/coronavirus-covid-19/issue-brief/state-data-and-policy-actions-to-address-coronavirus/#long-term-care-cases-deaths

A BIG reason why elderly people are more at risk

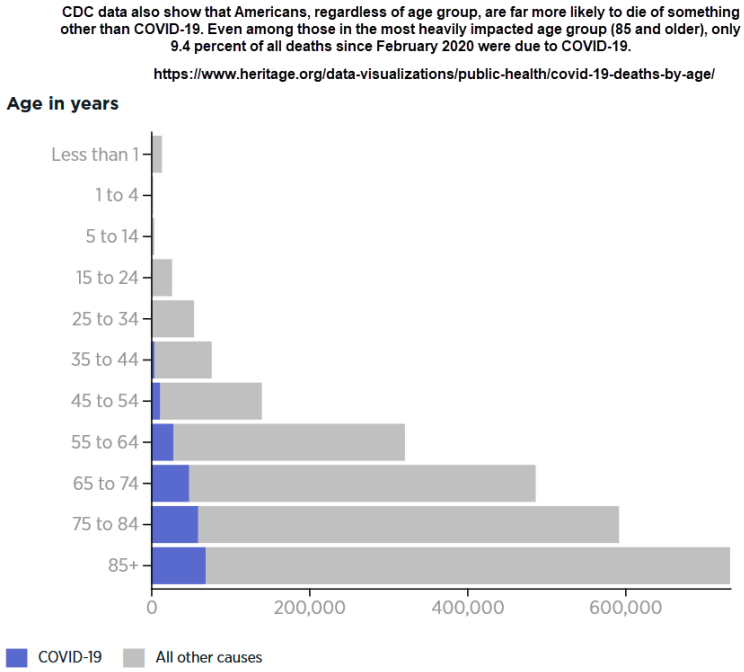
One of the KEY reasons is that elderly prople have lower vitamin D levels. There are now a multitude of studies showing that Vitamin D is protective from all viral respiratory infections INCLUCING COVID-19! Elderly people do not absorb Vitamin D very well from their diet, thewy typlically don't spend much time in the sun with enough surface area of their bodies exposed to sunlight and often do not supplement. Take the long-term care and nursing homes for example. If they would simply test all residents for Vitamin D deficiency and individualize the supplementation levels into the optimal range, we would have not lost as many of our elder loved ones to seasonal flu/pneumonia and COVID-19 as we have.

Another visual perspective

So, think about the risk in these terms. If you are 40 years old, had contracted COVID-19, picture yourself in a crowd of 5,000 people ALL WITH COVID-19. That's a lot of people! As shown above, the statistics from the CDC indicate that only one of those 5,000 people would perish from COVID-19. If you're looking over that sea of people, there would be only 1 that would die from it. What are the chances that 1 death would be you? It's very unlikely that it is actually 1 in 5,000. It could be more, or it could be less. I'll cover that in a minute.

If you are 18 years old and have COVID-19, you can picture yourself in a major league baseball stadium, packed with only children and teens ALL with COVID-19 infections like you. Statistically, only 1 of those 34,000 young people would die from COVID-19. And that child very likely would have had some underlying health condition that made them more susceptible to adverse effects from the disease.

One thing to consider when speaking of the very elderly dying from COVID-19, is that the average life expectancy in the U.S. is 79 years and people are much more likely to die of something else rather than COVID-19. The following graphic displays that fact and also shows the proportion of the COVID-19 deaths in the U.S. based on age ranges.



Compared to the seasonal flu

How do the previously mentioned fatality statistics compare to a "normal" flu season? Influenza accounts for about 10% of all flu-and-pneumonia-combined deaths each year and pneumonia about 90% (the CDC now combines these 2 categories of deaths together in one category as Influenza & Pneumonia). The Case Fatality Rate (CFR) for the average flu season is 0.1%. That means that 1 in 1,000 people diagnosed with the flu/pneumonia will die from it. In a more lethal flu season 1 in 500 people may die from influenza or pneumonia. Compare that to the different age sorted categories above and you will see that statistically the flu is more dangerous to young and middle-aged people than the other seasonal respiratory infections that make up the Influenza & Pneumonia group. For COVID-19, approximately 81% of the deaths are in people age 65 and older, which is almost identical to the seasonal flu.
https://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_04.pdf

According to an article written by **Anthony Fauci**, the Director of the ***National Institute of Allergy and Infectious Diseases (NIAID)*** and **Robert Redfield** the Head of the ***CDC*** published in ***the New England Journal of Medicine*** March 26, 2020, the fatality rate may be similar to a severe seasonal flu.

From the publication:

"If one assumes that the number of asymptomatic or minimally symptomatic cases is several times as high as the number of reported cases, the case fatality rate may be considerably less than 1%. This suggests that the overall clinical consequences of Covid-19 may ultimately be more akin to those of a severe seasonal influenza (which has a case fatality rate of

approximately 0.1%) or a pandemic influenza (similar to those in 1957 and 1968) rather than a disease similar to SARS or MERS, which have had case fatality rates of 9 to 10% and 36%, respectively." https://www.nejm.org/doi/full/10.1056/NEJMe2002387

My Note: The asymptomatic case estimates range between 40% and 60%. These people never see a doctor and are never diagnosed with COVID-19. Based on the studies I have seen; I believe that they are closer to the 60% number if T-Cell immunity and dormant B-cell levels from previous coronavirus specific common cold infections are taken into consideration. The lower range of 40% the CDC cites is based on antibody testing of general populations and don't consider the T-cell and dormant B-cell immunity just mentioned (more details on this below). And importantly, the higher the percentage of asymptomatic "immune" people in the population, the lower the Infection Fatality Rate becomes because there are fewer "hosts" for the virus to infect.

More recently, an article titled **CDC: COVID-19 Death Rate Far Lower Than Previously Thought**, reports on the latest CDC projections. https://www.thenewamerican.com/usnews/health-care/item/35799-cdc-covid-19-death-rate-far-lower-than-previously-thought

From the article:

"The federal government is finally admitting what many observers have suspected all along: The average American's chances of dying from COVID-19 are extremely small. The Centers for Disease Control and Prevention's (CDC) latest best estimate of the death rate for individuals with COVID-19 symptoms is just 0.26 percent, slightly higher than that of the seasonal flu." (That 0.26% number is for all age groups and includes the high percentage of Americans with co-morbidities combined).

Lifestyle and co-morbidities as risk factors for death from COVID-19

A large study looking at 160 countries through August 31, 2020 and published November 19, 2020 in the journal ***Frontiers in Public Health*** titled, **Covid-19 Mortality: A Matter of Vulnerability Among Nations Facing Limited Margins of Adaptation**, tested major indices from five domains (demography, public health, economy, politics, environment) and their potential associations with Covid-19 mortality during the first 8 months of 2020. Some very interesting and insightful conclusions were made, including the first bullet point on lockdowns. Lockdowns have destroyed businesses, lives, families and economies, increased mental health problems, suicides, domestic and child abuse and deaths from despair, but it appears have not saved lives.

From the article:

- Stringency of the measures settled to fight pandemia, including lockdown, did not appear to be linked with death rate.

- Countries that already experienced a stagnation or regression of life expectancy, with high income and NCD rates, had the highest price to pay. This burden was not alleviated by more stringent public decisions. Inherent factors have predetermined the Covid-19 mortality: understanding them may improve prevention strategies by increasing population resilience through better physical fitness and immunity. **NCD stands for metabolic and non-communicable diseases, which are represented by chronic diseases such as cardiovascular, respiratory and kidney disease, diabetes, obesity, cancer, autoimmune disease, etc. This makes the United States, which has some of the highest percentage of these diseases in the world vulnerable to higher rates of mortality than some of the Asian countries and those with healthier and more active lifestyles.*

https://www.frontiersin.org/articles/10.3389/fpubh.2020.604339/full

Each person must consider this crucial calculation-

Back to our 40-year-old. How healthy are you compared to the other 4,999 people in that group of 5,000?

This consideration will either give you a better than a 1 in 5,000 chance of survival, or a chance worse than that. The determining factor, is the degree you suffer from the following…

Sixty percent of adults suffer from at least one chronic disease. Forty percent have two or more.

This is undoubtably one of the key reasons why COVID-19 has hit countries like the U.S., that have high rates of chronic disease harder. The average number of co-morbidities a person that has died from COVID-19 had has recently been increased from 2.6 to 4 by the CDC.

These are the 4 most significant risk factors for severe outcome from COVID-19 and the percentage of American adults in that age group that have them: (**Circle each one that you have been diagnosed with.)**

1. **Hypertension-** (45% of adults have it) https://www.cdc.gov/bloodpressure/facts.htm (47.91 of fatal cases) https://pubmed.ncbi.nlm.nih.gov/32573311/
2. **Diabetes-** (16% of adults have diabetes and 42% have pre-diabetes) https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf

(24.9% of fatal COVID-19 cases) https://pubmed.ncbi.nlm.nih.gov/32573311/

3. **Obesity-** (42% of adults are obese) https://www.cdc.gov/nchs/data/databriefs/db360-h.pdf
   (3X risk of hospitalization and increased risk of death)
   https://www.cdc.gov/obesity/data/obesity-and-covid-19.html (11.3% of fatal COVID-19 cases)

4. **Respiratory diseases-**
   (10.9% of fatal cases) https://pubmed.ncbi.nlm.nih.gov/32573311/

Numbers 5- 8 are also significant risk factors. Circle the ones that pertain to you.

5. **Kidney disease**
6. **Smoking**
7. Being **immunocompromised**
8. **Non-Caucasian ethnicity**- One established reason is that those with darker pigmented skin have lower levels of Vitamin D, which is a risk factor for severe COVID-19.

   The following groups have increased risk of death from COVID-19 as compared to Caucasian and Asian Americans: African American (2.1X), Hispanic Americans (1.1X), Native Americans (1.4X). These ethnic groups also have higher rates of obesity, diabetes, cardiovascular disease than Caucasian and Asian Americans.

   The risk of being **hospitalized** from COVID-19 is much higher for Black (4.7X), Hispanic (4.6X), Asian (1.3X) and Native Americans (5.3X) as compared to Caucasian Americans. https://www.cdc.gov/coronavirus/2019-ncov/downloads/covid-data/hospitalization-death-by-race-ethnicity.pdf

How many comorbidities and risk factors did you circle?

The greater number of comorbidities, the greater your risk. The lower your number of comorbidities, the lower your risk. If you don't have any of those comorbidities, your risk goes way down.

For more on the increased risks from various diseases and risk factors visit https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html#obesity

Back to the 40-year-old in the crowd of 5,000 infected with SARS-CoV-2 severe enough to have developed the illness we call COVID-19. Since the prevalence of hypertension, diabetes and obesity are so high in the U.S., the numbers of people with one or more comorbidities in that

crowd of 5,000 is probably greater than two-thirds of that crowd. Since their risk of experiencing a more severe case or death is so much greater than our healthy 40-year-old, it would essentially mean that the risk of death to the healthy person would be significantly less than the average risk the CDC stats specify. One may suppose that they may have around a 1 in 10,000 chance rather than a 1 in 5,000 chance of dying, because the odds of dying would be more likely in the unhealthiest of the unhealthy. This last example is not based on hard data but an estimate, simply to make the point that relatively healthy people, especially those under 70 years old have a much lower risk of death than the overall risk the CDC lists for their particular age group. And the younger the age demographic that we consider, the lower the risk becomes exponentially.

Risk of dying from COVID-19 compared to other risks we all assume daily

How does a 1 in 5,000 or 1 in 10,000 risk of COVID-19 compare with other risks we don't even think about?

Lifetime odds of dying from:

- accidental drug poisoning- 1 in71
- opioids legal or illegal- 1 in 98
- a car accident- 1 in 106
- an assault by someone using a forearm- 1 in 298
- being hit by a car as a pedestrian- 1 in 541
- from exposure to smoke fire and flames- 1 in 1,399
- a fall down steps- 1 in 1,657
- Drowning after falling into a swimming pool- 1 in 5,573

The Insurance Information Institute- 2017 statistics
https://www.iii.org/fact-statistic/facts-statistics-mortality-risk

Children are at extremely low risk! We must resist the pressure to force the vaccines on them

We know that less than 1% of all COVID-19 deaths have been in children under the age of 18. Yet, that demographic makes up 22.2% of the U.S. population (a relatively large percentage). That just underscores how rare deaths in children are!

There are 74 million children in the United States. As of May 2021, 282 had died "involving

Covid." Two hundred eighty-two in 74 million is a rate of 0.00038%. While many more children have certainly had the SARS-CoV-2 virus than contracted COVID-19, CDC estimated that 22.2 million children aged 5-17 have had COVID-19 and 127 had died, at the May 12, 2021 meeting of the ***Advisory Committee on Immunization Practices (ACIP)***, or 0.00057%.[44] Available evidence strongly suggests that the vaccine ismuch more dangerous to children than the disease.

44. Helen Branswell, *CDC advisory group gives green light to Pfizer's Covid vaccine for adolscents*," STAT (May 12, 2021), https://www.statnews.com/2021/05/12/cdc-advisory-groupgives-green-light-to-pfizers-covid-vaccine-for-adolescents/ .

Based on the studies and data that I have been looking at, there appear to be at least 4 main reasons why most cases are either asymptomatic or very mild upper respiratory symptoms:

1. **Young children have been "primed" by other coronaviruses** and their immune systems have been trained to recognize the commonality with SARS-CoV-2. I have covered this phenomenon of cross recognition and reactivity by the immune system to various coronaviruses based on the large percentage of common DNA/RNA structure in previous issues. There are at least 4 versions of coronavirus family members that are part of the wider spectrum of viruses that cause the common cold. Exposure to and infection from these viruses afford a degree of protection to SARS-CoV-2. That occurs largely from T-cell immunity.

2. **Children have a greater number of Natural Killer (NK) Cells** patrolling their body. NK cells are cytotoxic lymphocytes representing powerful immune forces that act like the rapid response team, working to destroy infected cells even without an antibody response. They play important roles in both the Innate and the Adaptive arms of the immune system.

3. **Children have a better trained immune system in general.** Their exposure to many different microbes (bacteria, viruses, fungi, yeast, etc.), have prepared their immune systems for a robust immune response. That's why you want your kids playing outside in the dirt and mud. It's all immune system training.

4. **Children have less ACE-2 receptors-** This is the binding site on our cells for the SARS-CoV-2 virus. These are the gates to the castle so to speak, that when opened allow the virus to penetrate the cell where once inside they can replicate.

ACE-2 stands for Angiotensin-Converting Enzyme 2. Angiotensin-converting enzyme 2 is a zinc containing metalloenzyme located on the surface of endothelial and other cells. They are abundant in the epithelial cells of the mucous membranes of the nose, mouth, eyes,

nasopharynx and lungs. It is also present in cells of many other organs and tissues. That is why those tissues are the target tissues for SARS-CoV-2.

Children do NOT pose a risk to other children or adults

The evidence is plentiful from around the globe. In countries that have allowed children into classrooms during 2020, there has been little if any evidence of increased risk of transmission between children or from children to teachers. In addition, here are a couple of the many studies to support that children do not pose a significant risk to others.

Association between living with children and outcomes from COVID-19: an OpenSAFELY cohort study of 12 million adults in England, published on ***medRxiv*-** November 02, 2020
https://www.medrxiv.org/content/10.1101/2020.11.01.20222315v1

Findings:

Among 9,157,814 adults ≤65 years, living with children 0-11 years was not associated with increased risks of recorded SARS-CoV-2 infection, COVID-19 related hospital or ICU admission but was associated with reduced risk of COVID-19 death (HR 0.75, 95%CI 0.62-0.92). Living with children aged 12-18 years was associated with a small increased risk of recorded SARS-CoV-2 infection (HR 1.08, 95%CI 1.03- 1.13), but not associated with other COVID-19 outcomes. Living with children of any age was also associated with lower risk of dying from non-COVID-19 causes. Among 2,567,671 adults >65 years there was no association between living with children and outcomes related to SARS-CoV-2. We observed no consistent changes in risk following school closure.

Interpretation:

"For adults living with children there is no evidence of an increased risk of severe COVID-19 outcomes. These findings have implications for determining the benefit-harm balance of children attending school in the COVID-19 pandemic."

Another study published in the **August 2020** issue of the journal ***Pediatrics*** titled, **COVID-19 Transmission and Children: The Child is Not to Blame**, makes a pretty strong case that while children can be infected with COVID-19, they typically are either non-symptomatic or mildly symptomatic and are rarely spreaders. There seems to be a sliding scale with regard to that potential for transmission. It seems that when looking at this potential for children in the teen years, there seems to be a greater the tendency to transmit the infection to others.

From the article:

"Coronavirus disease (COVID-19) presents arguably the greatest public health crisis in living memory. One surprising aspect of this pandemic is that children appear to be infected by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes COVID-19, far less frequently than adults and, when infected, typically have mild symptoms."

https://pediatrics.aappublications.org/content/146/2/e2020004879.long

Most people that have had COVID-19 have a robust and lasting immunity. And many others have immunity from previous coronavirus infections.

Your risk of death drops even more when you consider that you may never contract COVID-19.

Current research is demonstrating that a decent percentage of the population has some immunity to coronaviruses because of previous common cold infections people have had. Coronaviruses make up about 15-20 percent of infections that we call the common cold. Since SARS-CoV-2 is a "cousin" of the common cold coronaviruses and share many of the same protein antigens that our immune system recognizes, therefore signaling our immune system through T-cell and Innate immunity to seek and destroy the virus. T-cells, thwart infections in two different ways. Helper T cells stimulate B-cells and other immune defenders into action, whereas killer T-cells target and destroy infected cells. The severity of disease can depend on the strength of these T cell and overall Innate Immune responses. I have seen the growing body of scientific evidence regarding this phenomenon since the start of the pandemic. The bottom line is, even though SARS-CoV-2 in a "novel" (new) virus, it isn't entirely novel and our immune systems have already met it's cousins.

In a ***Science Magazine*** article published May 14, 2020 titled **T cells found in COVID-19 patients 'bode well' for long-term immunity**, researchers analyzed blood from 68 **uninfected** people and found that 34% hosted helper T cells that recognized SARS-CoV-2. The La Jolla team detected this cross-reactivity in about half of stored blood samples collected between 2015 and 2018, well before the current pandemic began. The researchers think these cells were likely triggered by past infection with one of the four human coronaviruses that cause colds; proteins in these viruses resemble those of SARS-CoV-2. The results suggest "one reason that a large chunk of the population may be able to deal with the virus is that we may have some small residual immunity from our exposure to common cold viruses," says viral immunologist Steven Varga of the University of Iowa.

This is just one of numerous articles that have been published confirming this activity of "dormant" immune cells primed from other coronavirus infections that rise to the occasion against SARS-CoV-2. This is also another reason why many top scientists feel it will not be necessary for a majority of the population to be infected and develop antibodies or get a vaccine to boost antibodies before we reach herd immunity, and the virus dwindles.
In another paper released May 27th, 2020 in the journal ***BioRxiv*** and titled **Different pattern of pre-existing SARS-COV-2 specific T cell immunity in SARS-recovered and uninfected individuals**, investigators found that people that had the SARS outbreak in 2003 have immune resistance to the latest SARS-CoV-2 virus. https://pubmed.ncbi.nlm.nih.gov/32668444/

From the Abstract:

"**Memory T cells induced by previous infections can influence the course of new viral infections**. Little is known about the pattern of SARS-CoV-2 specific pre-existing memory T cells in human. Here, we first studied T cell responses to structural (nucleocapsid protein, NP) and non-structural (NSP-7 and NSP13 of ORF1) regions of SARS-CoV-2 in convalescent from COVID-19 (n=24). In all of them we demonstrated the presence of CD4 and CD8 T cells recognizing multiple regions of the NP protein. **We then show that SARS-recovered patients (n=23), 17 years after the 2003 outbreak, still possess long-lasting memory T cells reactive to SARS-NP, which displayed robust cross-reactivity to SARS-CoV-2 NP**."

Interestingly, they also found cellular immunity in COVID-19 patients that were never infected by the 2003 SARS-CoV-1 virus and believe that it is from exposure to the other common coronaviruses. This is similar to what I reported on last month from ***Science Magazine***. https://www.sciencemag.org/news/2020/05/t-cells-found-covid-19-patients-bode-well-long-term-immunity?#

An article about the May 27th study published on ***The Science Times*** online June 12th, 2020 and titled, **Some Forms of Common Cold May Give COVID-19 Immunity Lasting up to 17 Years, New Research Suggests** reported the following:

"Immunology experts recently released a paper suggesting that coronavirus immunity might be possible through a different genetic pattern of SARS, or the common cold. They claim that this possible immunity may last up to 17 years.

Coronavirus related symptoms that mimic the common cold, called betacoronavirus, may either have immunity or be infected by a milder form of the virus. Betacoronaviruses, specifically OC43 and HKU1, are the cause of common colds as well as severe chest infections, leaving the young and elderly in critical conditions.

The beta virus has similar genetic features with its SARS family, such as COVID-19 and Middle East Respiratory Syndrome (MERS). If an individual had been previously exposed to the common cold, the body develops memory T cells, which become a defense system when a similar infection enters the body, resulting in immunity.

T cells, a type of white blood cell, is a prominent part of the immune system, adjusting the body to respond to specific attacking pathogens. Because of their ability to create lasting shields against viruses, they are called 'memory cells.'

Professor Antonio Bertoletti, an immunologist from the Duke-NUS Medical School in Singapore, and his team have new findings on the function of T cells amidst the global pandemic. They discovered that patients who survived the SARS lung virus in 2003 had immune responses to COVID-19 antibodies.

Helper T Cells

'These findings demonstrate that virus-specific memory T cells induced by betacoronavirus infection are long-lasting, which supports the notion that COVID-19 patients would develop long-term T cell immunity,' said the team. 'Our findings also raise the intriguing possibility that infection with related viruses can also protect from or modify the pathology caused by SARS-Cov-2 [the strain of coronavirus that causes COVID-19].'

Four blood samples were taken from coronavirus patients who had recovered, 23 who has SARS, and 18 individuals who had exposed to neither deadly viruses.

What surprised Bertoletti's team was that 50% of unexposed patients had defensive T-cells which could defend their immune system against the betacoronaviruses SARS **and COVID-19**. Most likely, **the scientists concluded, their immunity developed memory cells from obtaining common colds caused by betacoronavirus or other unknown pathogens**.
https://www.sciencetimes.com/articles/26038/20200612/common-cold-give-covid-19-immunity-lasting-up-17-years.htm

One more study published in the journal ***Cell*** titled, **Targets of T Cell Responses to SARS-CoV-2 Coronavirus in Humans with COVID-19 Disease and Unexposed Individuals**, reports encouraging data about our immune system's cross reactivity from common coronavirus infections and SARS-CoV-2. Blood samples were collected from blood banks where donors had provided the between the years 2015-2018. Those samples that were never exposed to SARS-CoV-2 showed that 40-60% of those samples demonstrated a high degree of immune reactivity to the "novel" virus that causes COVID-19.

From the introduction:

"Estimations of immunity are also central to epidemiological model calibration of future social distancing pandemic control measures (Kissler et al., 2020). Such projections are dramatically different depending on whether SARS-CoV-2 infection creates substantial immunity, and whether any cross-reactive immunity exists between SARS-CoV-2 and circulating seasonal "common cold" human coronaviruses."

"Based on data from SARS patients in 2003–2004 (caused by SARS-CoV, the most closely related human betacoronavirus to SARS-CoV-2), and based on the fact that most acute viral infections result in development of protective immunity (Sallusto et al., 2010), a likely possibility has been that substantial $CD4^+$ T cell, $CD8^+$ T cell, and neutralizing antibody responses develop to SARS-CoV-2, and all contribute to clearance of the acute infection, and, as a corollary, some of the T and B cells are retained long term (i.e., multiple years) as immunological memory and protective immunity against SARS-CoV-2 infection (Guo et al., 2020b, Li et al., 2008)."

Results:

"Importantly, we utilized the exact same series of experimental techniques with blood samples from healthy control donors (PBMCs collected in the 2015–2018 time frame), and substantial cross-reactive coronavirus T cell memory was observed."

"Importantly, we detected SARS-CoV-2-reactive $CD4^+$ T cells in ~40%–60% of unexposed individuals, suggesting cross-reactive T cell recognition between circulating "common cold" coronaviruses and SARS-CoV-2."

"Given the severity of the ongoing COVID-19 pandemic, it has been modeled that any degree of cross-protective coronavirus immunity in the population could have a very substantial impact on the overall course of the pandemic, and the dynamics of the epidemiology for years to come (Kissler et al., 2020)."

https://www.cell.com/cell/fulltext/S0092-8674(20)30610-3

Have the vaccines contributed to the fall in cases?

This is the multi-billion-dollar question. The timing of the release of the vaccine was almost perfect to take advantage of the appearance that they would be effective. But there are at least three problems with I see with that assumption. Here are the key factors I see at play.

1. The timing of the release and increase of population vaccination coverage correlated closely with the normal decrease in respiratory viral patterns due to seasonality. The question is would the cases, hospitalizations and deaths have decreased at the same rate without any vaccines? You will see examples from other countries that haven't had the vaccine uptake we have and their rates of mortality has fallen to the same extent.

2. The CDC has predicted that 8 times more people than have tested PCR positive have had the infection. As of the release of this update, the CDC says that there have been nearly 34 million cases of COVID-19 in the U.S. Take their 8 times that have been infected without being tested and therefore not considered cases. That number would suggest that 272 million have had the infection. That is 82 percent of the population of 332 million. Since then, the CDC has revised that to around 4 times the number of known infections. Even so, with predictions ranging from 70-90% to reach herd immunity, we have to be there or very close by now.

   That 8X ratio is according to an article posted online November 27th titled **Estimated Incidence of Coronavirus Disease 2019 (COVID-19) Illness and Hospitalization—United States, February–September 2020**

   "The CDC researchers estimated that about 52.9 million Americans had been infected in the U.S. by the end of September". The number of confirmed COVID-19 cases was only 6.9 million up to that time. That is about an 8 to 1 ratio of those that have it and either don't know it or have very mild symptoms and never get a test to those that do test positive. (PCR testing inaccuracy as we have seen is a whole other issue!) https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1780/6000389

3. The WHO, CDC and numerous credible scientific experts have admitted the fact that the "Vaccines" do NOT prevent infection and do NOT prevent transmission. Therefore, there is no way that they could be responsible for falling cases. (see my next story to find out why I've used the scare quotes). They MAY reduce symptoms is all that they have been able to demonstrate. But to what extent?

World renowned vaccine developers are warning that continuing mass vaccination with a "leaky" vaccine that cannot stop infection or transmission is a colossal error. They say that these vaccines will drive the development of escape mutant variants that will lead to an increasing level of hospitalizations and death in the fully vaccinated population. We are already seeing this occurring, as the trends have moved sharply in that direction over the last six months. This is blatantly obvious in countries that launched their vaccination programs the

earliest and the fastest and have vaccinated the largest percentages of their population. I have been reporting this using government data from several countries such as Israel, the U.K., Iceland, Gibraltar and many more.

If you want to read more about these concerns, you can also follow the Twitter accounts of Geert Vanden Bossche, a former top level vaccine developer working for ***GAVI, the Global Alliance for Vaccines and Immunization***, and Dr. Robert Malone, the inventor of the messenger RNA technology being used in the Pfizer and Moderna products.

Freedom to choose

Whether you are in favor of the vaccines or not, there is a monumental decision you need to make. And some critically important questions you need to ask yourself:

- **Are we going to remain a free people?**
- **Who will get to decide what we are required to have injected into our bodies in order to participate in society?**
- **What happens when they add many new products they deem are for the benefit of society?**

THE BOTTOM LINE IS…once the precident is set, it will be next to impossible to go back and reel in that authority. Stand firm for freedom to decide for ourselves and our children. Demand the right to keep the sanctity of our own bodies!

The remaining questions posed earlier will be addressed in the remainder of this section on the COVID-19 vaccines

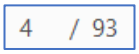
A Chronology of the COVID-19 Vaccines- From the Clinical Trials to their Epic Failure.

You may notice that this portion on the COVID-19 vaccines is quite massive. It contains many charts and graphs that I've included to make your understanding and enjoyment of the topics much better.

And as the title would indicate, it is a chronological history of the valid issues and concerns over the of development, deployment, contrasting evidence to the public narratives and of the suppressed data and research regarding the serious problems that have occurred.

Tips for easy navigating

Like the prior sections of this eBook, it is not necessarily meant to be read cover-to-cover (although you could if you have the time). It is really meant to be used as an information and reference tool. Scan the table of contents and click on the link to the topics that interest you.

To return to the previous page click on the  **(previous view) button on the toolbar (Adobe Acrobat). If you don't see it, right click on the tool bar…go to navigation tools drop-down and select it and it will appear on your toolbar. Each time you click it, it will take you to the previous page you were on even if that page was 60 pages back. If you read 3 pages after navigating from the table of contents and want to return back there, click it 3 times. Another way to return to the table of content page (other than scrolling), is to change the page displayed on the left in this window on the toolbar to the page your navigated from in the table of contents** 

and hit the enter key. Hope that helps make your experience better 😊

Using Adobe Acrobat, you can also do key word and phrase searching.

For ease of navigation, I have provided a series of Table of Contents links that will help you navigate directly to the section identified by that link.

COVID-19 Vaccines Table of Contents with active links directly to that topic

- What are the vaccines designed to do? And, what does “effective” really mean in the percentage of effectiveness rates touted by the press releases and repeated ad nauseum by the media?

- A look at some of the top COVID-19 vaccine candidates

- Moderna and Pfizer/BionTech vaccines turn cells in the human body into vaccine making machines- It is risky and untested in long-term trials

- Another leading vaccine candidate the AstraZeneca/Oxford vaccine draws scrutiny

- Concerns over the Johnson & Johnson vaccine

- Major issues with all of them

- Trials were designed to use chemical cocktails instead of inert saline placebos in the control (placebo) groups

- Clinical trials fraught with even more problems and adverse reactions

- Other vaccine adverse reactions and long-term concerns

- Many prestigious scientists and doctors call for a halt to the approval due to serious safety concerns around immune enhancement, infertility and brain injury

- Erasing the placebo group

- Pharma insiders are the foxes watching the henhouse in the vaccine clinical trials

- People with religious convictions need to know that certain COVID-19 vaccines may be contaminated with DNA from aborted fetuses

- Victims of vaccine injury will not be compensated as makers will be free of liability in most if not all countries including the U.S. You're on your own.

- Who really "needs" the vaccine? As of the time of this writing, the vaccine manufacturers are losing market share FAST and this is why.

- Conflicts of interest and personal financial gain drive decision making for vaccine development

- Now that the vaccines have been rolled out to elderly and long-term care facilities, unusually high rates of deaths are being reported in elderly nursing home residents after they receive the shots

- Status of Vaccine Adverse Event Reporting System (VAERS) reported injuries and deaths from COVID-19 vaccines

- The technology for tracking vaccine recipients and monitoring their biological processes is ready for implementation

- Then there's the permanent body I.D. systems and tracking that Gate's wants to mandate along with vaccines

- Another kind of biometric monitoring advanced by Bill Gates and Microsoft- As this technology evolves, will vaccines be the delivery system?

- Alternatives to a vaccine- Prophylaxis and early effective treatment options

- Repurposed inexpensive drugs as a first line of defense

- Natural Alternative Options

April 11th, 2021 update

- Associate Editor Peter Doshi of the British Medical Journal questions the "effectiveness" claims of the Pfizer and Moderna vaccines

- Dr. Doshi had previously questioned the "end points" of the trials as not addressing the most important aspects for a successful vaccine, including protecting the elderly

- Now that the vaccines have been rolled out to elderly and long-term care facilities, unusually high rates of deaths are being reported in elderly nursing home residents after they receive the shots

- Concerns over the Johnson & Johnson's vaccine

- New concerns over the Moderna and Pfizer mRNA vaccines

- Polyethylene Glycol (PEG) is suspected in severe anaphylactic reactions and deaths from the COVID-19 vaccines

- Another reason why natural immunity and acquired immunity from getting COVID-19 is better than the vaccine

- Shockingly, Anthony Fauci knows that injected vaccines do not interrupt infection or transmission. This is a striking admission!

- What are the latest Infection Fatality Rates for different age groups in the U.S.?

- World renowned vaccine scientist warns of a global catastrophe from the vaccine program

- A brilliant evolutionary biologist and scientist lays out the most likely scenario for the COVID-19 vaccines to result in an epidemic of future illness in vaccinees and risk of autoimmune disease

- A new study showcases the advantage of natural infection over vaccine immunity with regard to SARS-CoV-2 variant strains

- Urgent letter from doctors and scientists to the European Medicines Agency over COVID-19 Vaccine concerns

- New research points to link between AstraZeneca Vaccine and blood clots

- A data breach reveals confidential emails showing that the spike protein RNA in the mRNA vaccines may not be as advertised

- Pfizer revises ultra-cold storage guidance for Covid-19 jab to refrigerator temperatures- This raises suspicions

- Is the death rate from the vaccines higher than from COVID-19?

- First lawsuit challenging mandatory vaccines

- AstraZeneca Vaccine linked to blood clots leading to deaths and severe injury

- Bill Gates says a third shot may now be needed

- Personal anecdotes of serious and fatal reactions

May 1st 2021 Update

- Latest VAERS COVID vaccine injury reports and the incredibly high real-world numbers

- The U.S. government funded a Harvard study that found that less than 1% of adverse reactions to vaccines are reported

- The Spike Protein as the progenitor of the epidemic of thrombotic events occurring post-vaccination around the globe
- Have the vaccines contributed to the fall in cases?
- Are they really vaccines? See what the government filed documents say
- What about herd immunity? Where are we at?
- How much are the vaccines responsible for the drop in COVID-19 deaths in the U.S.?
- More concerns over the blood clotting issues from the COVID-19 vaccines
- Deep vein thrombosis after Pfizer vaccine
- Study shows the spike protein cause damage to the Blood-Brain-Barrier (BBB) and resultant brain inflammation
- Tiny country of Gibraltar sees unexpected increase in deaths in elderly population after vaccination with COVID-19 vaccines

July 1st, 2021 Update

- What percentage of the children under 18 in the U.S. have died from COVID-19?
- The CDC's weekly cause of death tally shows a consistent uptick in an "unspecified" category since the start of administration of the COVID-19 vaccine
- Explosive new report blows the lid off of the claims of efficacy and safety of the COVID-19 vaccines
- Notice of liability for harm served on all members of the European Parliament

- COVID vaccines for children- We had better think again! A letter from a consortium of U.K. medical specialists calling for a halt
- Cases of myocarditis making the news are just the tip of the iceberg. FDA adding warning labels
- Myocarditis is much more serious than the CDC and the media have been portraying
- Not only are the vaccines risky, but the vaccinated don't appear to be as protected as the unvaccinated against variants
- Speaking of variants, is the Delta Variant the scary boogieman that people are being told it is?
- Since Delta IS the Indian Variant and India was hit hard this spring, shouldn't we be concerned?
- How about the mainstream media's sensationalized reporting? Is there any basis for it? Let's look at how they've handled previous variants.
- Inventor of Messenger RNA (mRNA) technology used by Pfizer and Moderna drops a bombshell about the COVID-19 vaccines in a must watch interview
- Another outstanding interview with Dr. Malone was done on the Highwire by Del Bigtree.
- What are medical professionals saying about the adverse effects of the vaccines?
- An international coalition of doctors and scientists warn governments and regulatory agencies of the dangers of the COVID-19 vaccines
- New study in the New England Journal of Medicine looking at risks of COVID-19 shots in pregnancy is under fire for glaring flaws that mis-represent the conclusion
- Tweet by HHS promoting COVID-19 vaccines in women who want to become pregnant
- COVID-19 vaccines may also have detrimental effects to the male reproductive system
- COVID-19 vaccines may have negative and risky immune effects for people that have previously had COVID-19
- At least some of the mainstream media is finally catching on

- Blatant misinformation from the World Health Organization (but then, who is really surprised?)

- WHO changes their position against vaccinating children in another embarrassing about-face after external pressure

August 1st 2021 Update

- Latest VAERS update as of August 13th, 2021- A catastrophic number of casualties

- Study shows that spike protein from the SARS-CoV-2 virus or from the spike protein generating vaccines damage heart tissue in unexpected ways

- Known harms of the spike protein

- The lies are so blatant, can we ever believe our CDC and media again?

- Yet, pharma is ready to capitalize on the lack of durability of their products

- Fact checked false information. The unvaccinated are 99% of hospitalizations and deaths

- Another twist in the skewing of the numbers

- The CDC isn't counting vaccinated people that get tests outside the hospital as positive cases. No wonder the numbers are lop-sided

- Public health experts blaming low vaccination rates for delta variant's spread, but much of the published data are blaming the vaccines for pushing the virus to mutate or "escape" the vaccines

- Yet our "health" officials continue to use misinformation to accuse those sharing accurate data and science of spreading misinformation

- Notice the fear mongering is once again about case numbers and not deaths? How many people are dying from COVID-19 now as compared to other times of the pandemic?

- This study details another mechanism for clotting caused by the COVID-19 vaccines other than the spike protein toxin that they force your cells to make

September 1st, 2021 Update

- Current VAERS reported COVID-19 vaccine injuries and deaths in the U.S.
- Percentage of people reporting injuries and deaths after COVID-19 vaccines
- What about the European Union? What is the reported casualty count there?
- There has been a simultaneous name change (rebranding) of all the top COVID-19 vaccines
- The approval of the Pfizer vaccine may be the most scandalous thing the FDA has ever done (and that's saying a lot)
- The official narrative we had been hearing of COVID-19 is now a disease of the unvaccinated, is falling apart as data coming in from around the world contradicts the CDC's claims
- In many countries, the mass vaccination programs have been associated with spikes in deaths immediately following the start and now deaths in fully vaccinated appear to be rising higher than in the unvaccinated
- How are some of the countries with the lowest vaccination rates doing?
- Percentages of cases in the vaxxed versus the unvaxxed segments of the population. Here are the reasons why the reported narrative is wrong
- Breaking News on immunity conferred by infection with SARS-CoV-2! New data out of Israel shows conclusively that COVID recovered people have a remarkably smaller chance of reinfection than fully vaccinated people
- Medical Freedom should be non-negotiable
- Breakthrough cases are significantly under-reported by the CDC
- Ireland also seeing an uptick of seriously ill, fully vaccinated individuals
- Why is the virus evading the vaccines? These next two stories will shed some light on that. But you will never hear this from the mainstream media
- Vaccine developer and expert Geert Vander Bossche posts a dire new warning about continuing the mass vaccination program

- An article from the pre-COVID era describes how viruses and bacteria are driven to mutate under pressure from vaccines and antibiotics
- The virus is evading the vaccines. This is called vaccine escape and the variants are called escape mutants (sounds like something out of a sci-fi movie, doesn't it?) Why is that happening?
- A new study reveals information that may be a clue that Antibody Dependent Enhancement may be in play with the rising hospitalizations and deaths in vaccinated individuals
- A reminder from this article I ran in last month's newsletter about the concerns many scientists and bioethicists have about informing people about the real risk of ADE
- A study in the Journal of Infection rings the alarm bells about Antibody Dependent Enhancement from the COVID-19 vaccines
- A perspective on why the spike protein was a bad choice for the shots (other than the fact that the spike protein acts as a toxin in the body)
- Vaccine researcher admits 'big mistake,' says spike protein is dangerous 'toxin'
- Other valuable resources from Dr. Palmer:
    - eBook *1200 Studies- Truth will Prevail*
    - *Monthly 1200 Studies COVID-19 newsletter*
    - Other COVID-19 topic eBooks

October 1st, 2021 Update

- U.K. regulators admit that there has been four times the number of deaths reported from the COVID-19 vaccines in 8 months than all vaccines combined in the last 20 years

- The mRNA vaccines use technology the suppresses the immune system so the lipid nanoparticles can get through the body's defenses to deliver the payload to our cells. What are the frightening prospects of that?

- Reports of rapidly growing cancers are on the rise in COVID-19 vaccinated individuals and this doctor has a plausible theory as to why that is happening

- Another dire warning about continuing the mass vaccination program from vaccine developer Dr. Geert Vanden Bossche

- Perhaps this series of September 13th Tweets by Dr. Vanden Bossche sums up the vaccinated vs unvaccinated debate most succinctly

- Vermont, the highest vaccinated state in the U.S. has skyrocketing cases, hospitalizations and deaths

- Three states with the highest vaccination rates also have some of the highest hospitalizations for COVID-19

- The first report of mass breakthrough cases in the U.S. came in July 2021

- Fauci's predictions on the success of the vaccines was, well let's just say it, 180 degrees wrong

- How can we tell what will happen in the near future with the effectiveness of the vaccines, cases, hospitalizations and deaths in the U.S. if we keep going?

- So, how is Israel doing with breakthrough cases?

- Let's look at how the "vaccine effectiveness" number can be deceptive

- A comparison of deaths in Sweden with triple vaxxed Israel

- An urgent appeal to the European Medicines Agency to stop the vaccination program and launch a large-scale independent investigation into the injuries and deaths caused by the vaccines

- I recommend sharing this excellent rapid drawing video discussing the risks of the COVID-19 vaccines

- Naturally acquired immunity from SARS-CoV-2 infection continues to be ignored in the push to vaccinate everyone, despite the overwhelming scientific evidence

- Our federal health agencies have been corrupted by the financial influence of the drug industry

- The risk of Antibody Dependent Enhancement (ADE) is increased by the COVID-19 vaccines according to a study in the Journal of Infection

- If you are a physician or scientist, consider signing on to the Rome Physician's Declaration. It asserts that radical changes must be made in the way public health agencies have interfered with doctors ability to practice medicine

- Calculate your risk of hospitalization and death from COVID-19

- Speaking of risk from COVID-19, a new CDC funded study looks at over a half million people to determine the highest risk factors for hospitalization and death

- How do the different states compare in COVID-19 death rates?

- A look at the estimated percentage of the population that have been infected by SARS-CoV-2 in the various U.S. states

- We are starting to see the bravado of forcing healthcare and emergency medical responders to be vaccinated begin to crumble

November 1st, 2021 Update

- The nonsensical policies of pretending that vaccines that can't prevent infection or transmission to participate in society just became all the more ridiculous
- Massive study across 68 countries and nearly 3,000 counties in the U.S. finds that high vaccination levels of the population seem to correlate with higher infection transmission and case rates
- A report from a hospital in Israel showing 39 of 42 cases in an outbreak were in people that were fully vaccinated
- New study from Sweden shows how rapidly the three leading vaccines against COVID-19 decrease in effectiveness
- Is it even possible to reach herd immunity with the vaccines? Many experts from the most vaccinated countries don't seem to think so
- The mRNA vaccines may inhibit the innate immune system which could reduce effectiveness against viral infection and lead to increased risk of cancer
- Introducing the two scientists being touted as heroes for helping mRNA evade the body's immune system. But will history remember them as villains?
- A contemporary study describes how this same mechanism used in the Pfizer vaccine negatively impacts the body's innate immune response
- A 2021 study explains how the mRNA vaccines are designed to escape the innate immune system
- A disturbing trend for vaccinated individuals noted from Public Health England's updates- Cases, hospitalizations and deaths rising in the fully vaccinated
- Public Health England numbers continuing to deteriorate month by month for the vaccinated
- Israeli hospital outbreak, with 39 of 41 people being fully vaccinated and highly masked
- Why is the virus evading the vaccines so rapidly and efficiently?
- The U.K. continues its downhill slide for the vaccinated

- More statistics on the failure of the vaccines
- The state of Illinois is 68% fully vaccinated, but transmission rates are high across the state
- Waterford Ireland has the highest vaccination rate in the country and also an out-of-control COVID-19 surge
- Singapore, a country then has fully vaccinated 80% of their population is experiencing soaring case rates
- Despite the tidal wave of evidence against the safety and effectiveness of the COVID-19 shots, the FDA plan to move forward with full approval of 5-11 year-olds. Here are 10 reasons why that is a terrible idea.
- Guidance for obtaining religious exemptions
- Do the adenovirus vaccines like J & J and AstraZeneca integrate into DNA of the person getting the shots?
- There is a lack of correlation between percentage of population vaccinated and rates of COVID-19 across a broad swath of countries
- Is the approval of Pfizer's vaccines a bait and switch, when the version that will not be available until sometime next year was the one FDA approved and the original one being used until then is still under EUA?
- It appears that the spike protein toxin may circulate up to four months after injection with the mRNA shots
- Speaking of vaccine effectiveness, if greater than 60% of people who are vaccinated have already had COVID and have natural immunity isn't that going to make the vaccine look more effective than it really is?

December 1st, 2021 Update

- Study concludes that mRNA vaccines cause inflammation of the endothelium and vascular changes that may explain the various types of cardiovascular complications after vaccination

- **Study finds no need for children to be vaccinated against COVID-19 and shocking finds that at least 5 times as many people over 65 die from the vaccines than from COVID.**

- **Study shows another mechanism for the way that the spike protein alone causes cardiovascular damage**

- **Pfizer under-reported the number of deaths in the vaccinated cohort in their clinical trial. The numbers extrapolated to all vaccinated individuals is massive**

- **What about the most vulnerable to COVID-19, the elderly?**

- **Now that we have seen how miniscule the risk from COVID-19 is for children and teens, how about the risk from the vaccines?**

- **Brilliant presentation by Steve Kirsch at the October VRBPAC Meeting October 26th, 2021 on considering the COVID-19 shots for 5-11 year old children**

- **Does the vaccine efficacy study from Sweden I highlighted last month disclose an increased rise in deaths after the vaccines?**

- **Increase in all-cause deaths in the UK by vaccination status shows significant increase after the second dose**

- **Reporting of vaccine effectiveness uses a deceptive tactic to make it sound better than it really is**

- **More trouble for the credibility of the vaccine trials as a whistleblower's accounts including emails, documents and recordings of violations are disclosed in a *British Medical Journal* Investigative Report**

- **Why is the FDA trying to hide the Pfizer trial data from the public for 55 years?**

- In typical fashion, the people on the committee deciding whether children are exposed to these shots and parent's right to protect their children's bodily autonomy all have ties to Big Pharma

- An attorney's op-ed in the Wall Street Journal explains why it is illegal to mandate these shots on children

- Article exposes false narratives about the origins of SARS-CoV-2 variants and the failure of Dr. Fauci and his cohorts to allow doctors to treat patients early

- The latest variant fear-porn, the omicron variant. Is there a reason for concern?

- Just in time for the new variant, Pfizer to the rescue with a new vaccine. Couldn't have seen that one coming!

- Vermont, with the highest vaccination rate in the country is reeling from all-time high cases, hospitalizations and deaths, especially in the fully vaccinated

- Now consider West Virginia, the state with the lowest vaccination rate in the country

- Israeli news reporting serious concerns about the trends in rise of vaccinated hospitalizations and deaths

- Several studies warning of enhanced or fatal disease in animals vaccinated for SARS-CoV-1 when later exposed to the wild virus, may be what we are seeing now in highly vaccinated countries

- Portugal, the 4th most highly vaccinated country in the world and having delivered over 900,000 booster shots is seeing a large uptick in cases and new restrictions.

- Gibraltar, the most highly vaccinated country in the world at 121% has been seeing an uptick in cases as of late

- **Shocking graph shows CDC data of obscure cause of death diagnosis code titled "Symptoms signs and abnormal clinical and laboratory findings not elsewhere classified", cross-referenced and following COVID-19 vaccine doses administered**

- **New England Journal of Medicine reports on a mechanism for spike protein driven antibody reaction that may lead to adverse reactions including immune-suppression, myocarditis and autoimmune disease…a possible explanation for some vaccine caused reactions and disease**

- **CDC's reporting system VAERS -"Red Box" casualty counts month by month**

- **Other valuable resources from Dr. Palmer**

Vaccine trials shortcut the typical 4 to 6 year process for vaccine development, leaving the public as the long-term risk group

I have several serious concerns about the experimental COVID-19 vaccines. There are multiple issues with skipping important steps and taking shortcuts in the way they are doing the safety studies, not to mention that the recipients of the vaccine are younger, very healthy people in the early stages of the clinical trials. There is inadequate time to ascertain the potential delayed adverse reactions that may occur, especially in all the high-risk groups. Yet, they plan on rolling it out to the most vulnerable groups first. They and the rest of the public become the experimental group for which long-term effects will be determined going forward. Without full disclosure to each person of the fact that they are part of a biologic (drug) experiment, in fact the largest human experiment in history, it clearly violates the ***Nuremberg Code***. **The first principle of the *Nuremberg Code* clearly states, "The voluntary consent of the human subject is absolutely essential".** This is followed by an explicit clarification of all the associated requirements, making it extremely difficult for research principle investigators to twist it's meaning. http://www.ushmm.org/research/doctors/Nuremberg_Code.htm"

Immune Enhancement has plagued past attempts to make a coronavirus vaccine

Also, the reason that they have never been able to produce a coronavirus vaccine in the past despite numerous efforts, is that the vaccine caused a phenomenon called Immune Enhancement or sometimes called Pathogenic Priming. That is where the animals in the study developed a severe immune reaction similar to cytokine storm when later challenged with the wild virus. They suffered various pathological responses including severe lung damage. Those studies never proceeded to human trials as a result. This time Moderna skipped animal trials altogether. The AstraZeneca (Oxford) trial tested their vaccine on macaque monkeys and all of them got sick when later challenged with the wild virus. The Daily Mail reported: *"In the latest animal trials of the vaccine carried out on rhesus macaques, all six of the participating monkeys went on to catch the coronavirus. "Dr William Haseltine, a former **Harvard Medical School** professor, revealed the monkeys who received the vaccine had the same amount of virus in their noses as the three non-vaccinated monkeys in the trial. This suggests the treatment, which has already received in the region of £90 million in government investment, may not halt the spread of the deadly disease."*

It is feared that the greatest number of deaths will not occur for some time to come in those that are vaccinated with the COVID-19 "vaccines"

Many scientists and researchers warn that the potential for ***Antibody Dependent Enhancement (ADE)***, AKA ***Pathogenic Priming*** as well as other autoimmune and immune dysregulation effects from the vaccines can lead to a large number of delayed deaths from the vaccines.

In these excerpts from an article on the ***Children's Health Defense*** website, the concerns over ADE are expressed.

From the article

In the development of vaccines against coronaviruses like SARS-COV-1 and MERS in the early 2000's, researchers found evidence of a serious problem. Teams of U.S. and foreign scientists vaccinated animals with the four most promising vaccines. At first, the experiment seemed successful as all the animals developed a robust antibody response to coronavirus. However, when the scientists exposed the vaccinated animals to the wild virus, the results were horrifying. Vaccinated animals suffered hyper-immune responses including inflammation throughout their bodies, especially in their lungs.

This issue is well known. Early in the COVID-19 scenario, Dr. Peter Hotez, of ***Baylor College of Medicine***, testified before Congress about the dangers of accelerating coronavirus vaccine development, saying "(The) unique safety problem of coronavirus vaccines" was discovered 50 years ago while developing the Respiratory Syncytial Virus (RSV) vaccine."

He went to register that this "'paradoxical immune enhancement phenomenon' means vaccinated people may still develop the disease, get sicker and die."

Researchers had seen this same "enhanced immune response" during human testing of the failed RSV vaccine tests in the 1950s. The vaccines not only failed to prevent infection; 80% of the children infected required hospitalization, and two children challenged with the RSV died (see Openshaw, 2005). In April of 2020, Hotez told CNN, "If there is immune enhancement in animals, that's a showstopper."

In this video footage, Offit, Hotez and even Fauci (in an unguarded moment), warn that any new coronavirus vaccine could trigger lethal immune reactions, "vaccine enhancement," when

vaccinated people come in contact with the wild virus. Instead of proceeding with caution, Fauci made the reckless choice to fast track vaccines, partially funded by Gates, without critical animal studies before moving into human clinical trials that could provide early warning of runaway immune responses.

Gates (in this video) is so worried about the danger of adverse events that he says vaccines shouldn't be distributed until governments agree to indemnify against lawsuits. On Feb. 4, according to the Centers for Disease Control and Prevention (CDC) website, there were only 11 active CV cases in the U.S., yet the U.S. quietly pushed through federal regulations giving coronavirus vaccine makers full immunity from liability.

End of excerpts

https://childrenshealthdefense.org/defender/pfizer-covid-vaccine-trial-pathogenic-priming/

Here is a study from the Journal *Human Vaccines and Immunotherapeutics* that demonstrated this very deadly phenomenon

Immunization with inactivated Middle East Respiratory Syndrome coronavirus vaccine leads to lung immunopathology on challenge with live virus

This study from the journal ***Human Vaccines and Immunotherapeutics*** 2016 demonstrates the biggest concern and main reason why attempts to make a coronavirus vaccine have previously failed. That is the phenomenon of immune enhancement or sometimes called pathogenic priming. This is where vaccinated subjects later when exposed to the wild virus develop an over reactive immune response leading to a hyper-inflammatory pathological condition. This can lead to severe and even fatal results.

The abstract:

"To determine if a hypersensitive-type lung pathology might occur when mice were given an inactivated MERS-CoV vaccine and challenged with infectious virus as was seen with SARS-CoV vaccines, we prepared and vaccinated mice with an inactivated MERS-CoV vaccine. Neutralizing antibody was induced by vaccine with and without adjuvant and lung virus was reduced in vaccinated mice after challenge. Lung mononuclear infiltrates occurred in all groups after virus

challenge but with increased infiltrates that contained eosinophils and increases in the eosinophil promoting IL-5 and IL-13 cytokines **only in the vaccine groups**. **Inactivated MERS-CoV vaccine appears to carry a hypersensitive-type lung pathology risk from MERS-CoV infection that is similar to that found with inactivated SARS-CoV vaccines from SARS-CoV infection**." https://pubmed.ncbi.nlm.nih.gov/27269431/

Elderly people may be at even greater risk for danger from Pathogenic Priming or Adverse Immune Enhancement

According to a December 10th, 2020 article in the ***Children's Health Defense*** e-publication called ***the Defender*** titled, **Pfizer COVID Vaccine Trial Shows Alarming Evidence of Pathogenic Priming in Older Adults,** concerns are raised about pathogenic priming and how older adults may fare from these vaccines.

https://childrenshealthdefense.org/defender/pfizer-covid-vaccine-trial-pathogenic-priming/

From the article:

In the development of vaccines against coronaviruses like SARS-COV-1 and MERS in the early 2000's, researchers found evidence of a serious problem. Teams of U.S. and foreign scientists vaccinated animals with the four most promising vaccines. At first, the experiment seemed successful as all the animals developed a robust antibody response to coronavirus. However, when the scientists exposed the vaccinated animals to the wild virus, the results were horrifying. Vaccinated animals suffered hyper-immune responses including inflammation throughout their bodies, especially in their lungs.

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Gates (in this video) is so worried about the danger of adverse events that he says vaccines shouldn't be distributed until governments agree to indemnify against lawsuits. On Feb. 4, according to the Centers for Disease Control and Prevention (CDC) website, there were only 11 active CV cases in the U.S., yet the U.S. quietly pushed through federal regulations giving coronavirus vaccine makers full immunity from liability.

My comment: Now that's a problem. While as mentioned above, the AstraZeneca trials did incorporate some primate animal testing, the Moderna and Pfizer vaccines did not. In my opinion that was a mistake from a safety standpoint.

The article goes on to say: The Vaccines and Related Biological Products Advisory Committee Briefing Document on the Pfizer-BioNTech COVID-19 vaccine contains disturbing indications that might be a safety signal on pathogenic priming, **especially in older adults.** (**My comment:** this is consistent with previous failed attempts to develop a coronavirus vaccine, where the older animals were the ones most likely to suffer severe reactions from pathogenic priming).

The clinical trials found a 10-fold increase of serious adverse events in older adults after the second dose, compared to 3.6-fold for those under 55

Among the 18-55 year-old participants, there were 370 solicited **serious adverse events (SSAEs)** in the vaccinated group and 73 in the unvaccinated. **Of the vaccinated, 18% experienced SSAEs; in the placebo group, only 3% did, implying that SSAEs can be expected at a rate five times greater in the vaccinated compared to the unvaccinated.**

These included severe fatigue, headache, chills, vomiting, diarrhea, muscle and joint pain. Whether these conditions represent instances of pathogenic priming, identifying individuals who are now at higher risk of serious morbidity and mortality if they become infected with SARS-CoV-2 is unknown, but given past studies, seems likely.

In the over 55 group, which was a smaller group, there were 60 SSAEs in the vaccinated group and 24 in the unvaccinated. **Of the vaccinated, 6.5% experienced SAEs, compared to 1.4% in the unvaccinated, implying a 4.46% increased risk overall of SSAEs due to vaccination**.

However, in the older group, the vaccinated group was 10 times more likely to have a SSAE upon receipt of the second vaccine dose than the first dose compared to the 1:1 ratio in the unvaccinated. In the younger group, the vaccinated were only 3.61 times more likely to have second-dose SSAEs than the age-matched placebo group, which had about as many SSAEs in the first and second dose.

End of excerpts:

Four big concerns I have are:

1. One very important thing to consider is that, while Phase 3 trials did include older individuals, they chose relatively healthy people. That is in no way representative of the general population of the elderly in the U.S.

2. We may not know what the extent of pathogenic priming reactions will be in the people getting the vaccine, until they are challenged by coming in contact with the wild virus in the future.

3. This "priming' of the immune system by the vaccine may lead to development of autoimmune disease in the future. Because these vaccine trials have been so short lived in humans, around 90 days rather than 4 to 6 years or longer as is typically the case, we may not know for many months or even a few years what the fallout may be regarding autoimmune disease.

4. Currently 1 in 6 Americans has one or more autoimmune diseases. We know from many previous studies, that people with autoimmune disease and their offspring, are more likely to suffer adverse reactions from vaccines. How will individuals with current autoimmune disease do after exposure to the COVID-19 vaccines?

Shocking statements about vaccinating the elderly, by the associate director of the *Immunization Action Coalition*, a vaccine advocacy group

"Since they haven't been studied in people in those populations, we don't know how well the vaccine will work for them," says Dr. Kelly Moore, associate director of the Immunization Action Coalition, a group that supports frontline workers who will be tasked with administering COVID-19 vaccines.

We know that most vaccines don't work nearly as well in a frail elderly person as they would in someone who is fit and vigorous, even if they happen to be the same age."

Dr. Moore went on to admit that there is no way to truly know if COVID-19 vaccines will benefit the elderly in any way **because those at the highest risk were not included in the test groups.**

"There's a question about the direct benefit of the vaccine, if given to people who live in those facilities, because we haven't studied how well it works in that group yet."

So much for science. At the same time, anyone who dies following vaccination for COVID-19 probably died from something else, according to Dr. Moore, especially if they were already nearing the end of their lives.

"One of the things we want to make sure people understand is that they should not be unnecessarily alarmed if there are reports, once we start vaccinating, of someone or multiple people dying within a day or two of their vaccination who are residents of a long-term care facility," Dr. Moore contends.

"That would be something we would expect, as a normal occurrence, because people die frequently in nursing homes."

https://www.naturalnews.com/2020-12-11-cnn-reveals-vaccinating-elderly-covid19-kill-them.html

My comments: If that's the case Dr. Moore, why didn't we hear these cautionary words from her or health officials when people in nursing homes started dying "from COVID-19"? In those cases, it was always COVID that killed them. But all that aside, her admission that they don't know what will happen when they start mass immunization of the frail and most elderly is VERY concerning. Of course, we haven't taken the time to test these vaccines on that population, so everyone's grandmother and grandfather living in these facilities will become the test subjects. But of course, if they die shortly after, "it couldn't have been from the vaccine" (I say sarcastically).

Keep this story in mind until you read this STATUS UPDATE story about deaths in elderly later in this document

A top expert in the field of respiratory diseases is an outspoken critic of the rush to the vaccines

Dr. Michael Yeadon, former VP and ***Chief Scientific Officer with Pfizer*** is also an outspoken critic of the rushed experimental vaccine being promoted to the public as safe and anything but

experimental. This is a scathing series of Tweets Dr. Yeadon directed at Matt Hancock, the ***U.K. Secretary of State for Health and Social Care.***

Dear Mr. Hancock,

I have a degree in biochemistry and toxicology and a research based PhD in pharmacology. I had spent 32 years working in pharmaceutical R&D, mostly in new medicines for disorders of lung and skin. I was a VP at Pfizer and CEO of a biotech I founded Ziarco – acquired by Novartis). I'm knowledgeable about new medicine R&D.

I have read the consultation document. I've rarely been as shocked and upset.

All vaccines against the SARS-CoV-2 virus are by definition novel. No candidate vaccine has been in development for more than a few months.

If any such vaccine is approved for use under any circumstances that are not EXPLICITLY experimental, I believe that recipients are being misled to a criminal extent.

This is because there are precisely zero human volunteers for whom there could possibly be more than a few months past-dose safety information.

My concern does not arise because I have negative views about vaccines (I don't).

Instead, it's the very principle that politicians seem ready to waive that new medical interventions at this, incomplete state of development- should not be made available to subjects on anything other than an explicitly experimental basis. That is my concern.

And the reason for that concern is that it is not known what the safety profile will be, six months or a year or longer after dosing.

You have literally no data on this & neither does anyone else.

It isn't that I'm saying that unacceptable adverse effects will emerge after longer intervals after dosing. No: it is that you have no idea what will happen yet, despite this, you'll be creating the impression that you do.

Several of the vaccine candidates utilized novel technology which has not previously been used to create vaccines. There is therefore no long-term safety data which can be pointed to in support of the notion that it's reasonable to expedite development and to waive absent safety information on this occasion.

I am suspicious of the motives of those proposing expedited use in the wider human population. We now understand who is at particularly elevated risk of morbidity and mortality from acquiring this virus. Volunteers from these groups only should be provided detailed

information about risk / benefit, including the sole point I make here. Only if informed consent is given should any EXPERIMENTAL vaccine be used.

I don't trust you. You have not been straightforward and have behaved appallingly throughout this crisis. You're still doing it now, misleading about infection risk from young children. Why should I believe you in relation to experimental vaccines?

Dr. Michael Yeadon

WOW! This section should be copied and pasted into emails and social media posts and sent to everyone you know. Here is a long-time pharma scientist, former Chief Scientific Officer with Pfizer ripping a top U.K. health official and laying out the risks of the coming vaccines, plain and simple.

Dr. Yeadon has a very impressive bio.

Dr. Yeadon is an Allergy & Respiratory Therapeutic Area expert, developed out of deep knowledge of biology & therapeutics and is an innovative drug discoverer with 23y in the pharmaceutical industry. He trained as a biochemist and pharmacologist, obtaining his PhD from the University of Surrey (UK) in 1988 on the CNS and peripheral pharmacology of opioids on respiration. Dr Yeadon then worked at the Wellcome Research Labs with Salvador Moncada with a research focus on airway hyper-responsiveness and effects of pollutants including ozone and working in drug discovery of 5-LO, COX, PAF, NO and lung inflammation. With colleagues, he was the first to detect exhaled NO in animals and later to induce NOS in lung via allergic triggers. **Joining Pfizer in 1995, he was responsible for the growth and portfolio delivery of the Allergy & Respiratory pipeline within the company. During his tenure at Pfizer, Dr Yeadon was responsible for target selection and the progress into humans of new molecules, leading teams of up to 200 staff across all disciplines and won an Achievement Award for productivity in 2008**. Under his leadership the research unit invented oral and inhaled NCEs which delivered multiple positive clinical proofs of concept in asthma, allergic rhinitis and COPD. He led productive collaborations such as with Rigel Pharmaceuticals (SYK inhibitors) and was involved in the licensing of Spiriva® and acquisition of the Meridica (inhaler device) company. **Dr Yeadon has published over 40 original research articles and now consults and partners with a number of biotechnology companies. Before working with Apellis, Dr Yeadon was VP and Chief Scientific Officer (Allergy & Respiratory Research) with Pfizer.**

A large percentage of doctors and nurses are hesitant to take the vaccines

A Washington Post article titled, **Doctors and nurses want more data before championing vaccines to end the pandemic**, conveys the skepticism expressed by a large percentage of doctors and nurses, a group that typically buys in to the idea of vaccines.

From the article:

A report released November 19th by the University of California at Los Angeles researchers said that 66 percent of Los Angeles health-care workers who responded to an online questionnaire (not a randomized sample) said they would delay taking a vaccine. The American Nurses Association, a national professional organization, said one-third of its members do not intend to take the vaccine, and an additional third are undecided.
https://www.medrxiv.org/content/10.1101/2020.11.18.20234468v1

"These mRNA vaccinations have never been approved before, so there is no reliable track record of safety. We should expect to set the bar higher for safety," said Jeffrey A. Hirschfield, a pediatrician in St. Petersburg, Fla., who has discussed his reservations on Twitter. "It typically takes five to 10 years to successfully develop and vet vaccine candidates, especially those relying on new technologies."

Marie Ritacco, a longtime nurse at St. Vincent Hospital in Worcester, Mass., and vice president of a state nurses union, said many nurses will continue to rely on personal protective equipment and strict anti-infection procedures rather than be in the first wave of health-care workers receiving coronavirus vaccine.

https://www.msn.com/en-us/news/us/doctors-and-nurses-want-more-data-before-championing-vaccines-to-end-the-pandemic/ar-BB1becTK

We now know that PCR Testing is a disaster

One of the biggest problems about the reports of success with the vaccines is the reliance on PCR testing for positivity, for which PCR testing is now shown to be highly inaccurate

Because the vaccine studies have used PCR testing to determine if someone is COVID-19 positive and as the next section will show you, it is estimated that the error rate in PCR testing

may be as high as 50%, that makes their conclusions about effectiveness of their vaccines in the trials using this method null and void. A PCR test alone according to the experts I will present, cannot be used to diagnose COVID-19. In addition, the false positive rate at 30% and 70% of those testing positive being unable to transmit the virus to others makes this whole testing methodology a disaster.

Other reasons that this is so very important to understand is that we have shut down nations of the world, destroying lives, permanently closing tens of thousands of small businesses and potentially killing millions of people in the process over positive case numbers. Now we are facing mandated experimental vaccines, for a virus that for people under 60 years of age is no more serious than the seasonal respiratory viruses and pneumonia we have been encountering and dealing with successfully with minimal risk throughout our lifetimes.

This could be a very long section, because there is so much controversy now about the high false positive rate of PCR tests, so to keep it as simple as possible I will include a section out of my last newsletter, a couple other stories and some references and resources for those that want to dive deeper into this aspect.

To bypass this section on PCR testing and go to the next section click **HERE**

To read my detailed and evidence based ebooks on the PCR testing debacle, the failure of lockdowns, the ineffectiveness and harms from facemasks, Nutrients for viral prevention and treatment and more….go to https://www.wellnessdoc.com/ebooks-and-publications/

The many problems with PCR testing

Labs performing PCR testing are running too many cycles resulting in false positives and a better way to do things

For context in this discussion, it is important to remember that there is a distinct difference between infection and disease.

Infection is the replication of the SARS-CoV-2 virus in the body. Infection may or may not cause symptoms (disease) in the body. A large percentage of people contracting SARS-CoV-2, never develop symptoms (COVID-19).

COVID-19 (the disease) is when the infection causes symptoms. The symptoms can range from barely noticeable, to life threatening ones.

In an interview with Michael Mina MD, PhD from the ***Centers for Communicable Diseases at Harvard University*** and a proponent of at-home rapid testing that will tell if a person is infectious with COVID-19, he presented these graphs showing the exponential increase in viral titers, quickly followed by a rapid decline as the immune system does its job. Many people remain sick (with symptoms) after the virus is disabled because of the immune system and inflammatory chain of events the virus has set in motion in the body.

Dr. Mina is a very credible expert and has a very impressive bio. He is an Assistant Professor of **Epidemiology** at ***Harvard T. H. Chan School of Public Health*** and a core member of the ***Center for Communicable Disease Dynamics (CCDD)***. He is additionally an Assistant Professor in **Immunology** and **Infectious Diseases** at HSPH and Associate Medical Director in Clinical **Microbiology** (molecular diagnostics) in the ***Department of Pathology at Brigham and Women's Hospital, Harvard Medical School***.

Dr. Mina stated that 70% of the COVID-19 PCR positive tests are in people that are no longer infectious! Read that again and let that sink in.

Think about this. As of December 14th, 16,545,000 people in the U.S. have been "confirmed" COVID positive by PCR testing. If 70% of those people are incapable of infecting anyone else, it means that 11,581,500 people have been quarantined for 14 days unnecessarily, unable to work or go to school and made to worry about any human contact with family or friends. As you will see, Dr. Mina has a better solution for testing.

As a side note, the CDC estimates that the number of Americans that have had COVID-19 is 8 times what have tested positive with PCR testing. That makes the total around 130 million. That is about 40% of the population! It is also estimated that around 50% of people have few if any symptoms. For the remaining 50%, the symptoms can range from mild-moderate to severe and even death in some cases.

THE LYNCHPIN OF WHAT IS WRONG WITH PCR TESTING AND THE RESULTING CALAMATIES IT IS CAUSING

You can see from the graph below, the Ct (Cycle Threshold) scale reflects the highest viral load associated with the lowest Ct numbers. Let me explain. When the lab runs the test, it runs these "cycles" to see if genetic material from the SARS-CoV-2 virus is present. **With each cycle run there is a huge amount of amplification applied to see if the next cycle can catch any of the specific genetic code. If large amounts of virus are present, it requires fewer cycles to identify it. The more cycles run before finding evidence of the virus, the lower the viral load in the sample and less likely the person can infect others. The problem arises when cycles above 30 are run. It may pick up fragments of genetic material from SARS-CoV-2, but none of those pieces would be able to infect another person. Yet, the test comes up positive! And labs are instructed to run up to 40 cycles with these sample which gives an erroneous FALSE positive. Hence Dr. Mina's assertion is that up to 70% of "positives" are people unable to transmit to others and are not infectious to others!** And they are told to quarantine unnecessarily. Fortunately, Dr. Mina has a great solution that I'll discuss below.

Dr. Mina has explained in other interviews, that the people who are transmitting the disease have Ct Values that are less than 30, with the vast majority of transmitters are less than 25 on the scale. Remember, the lower the number, the higher and the more contagious the infection.

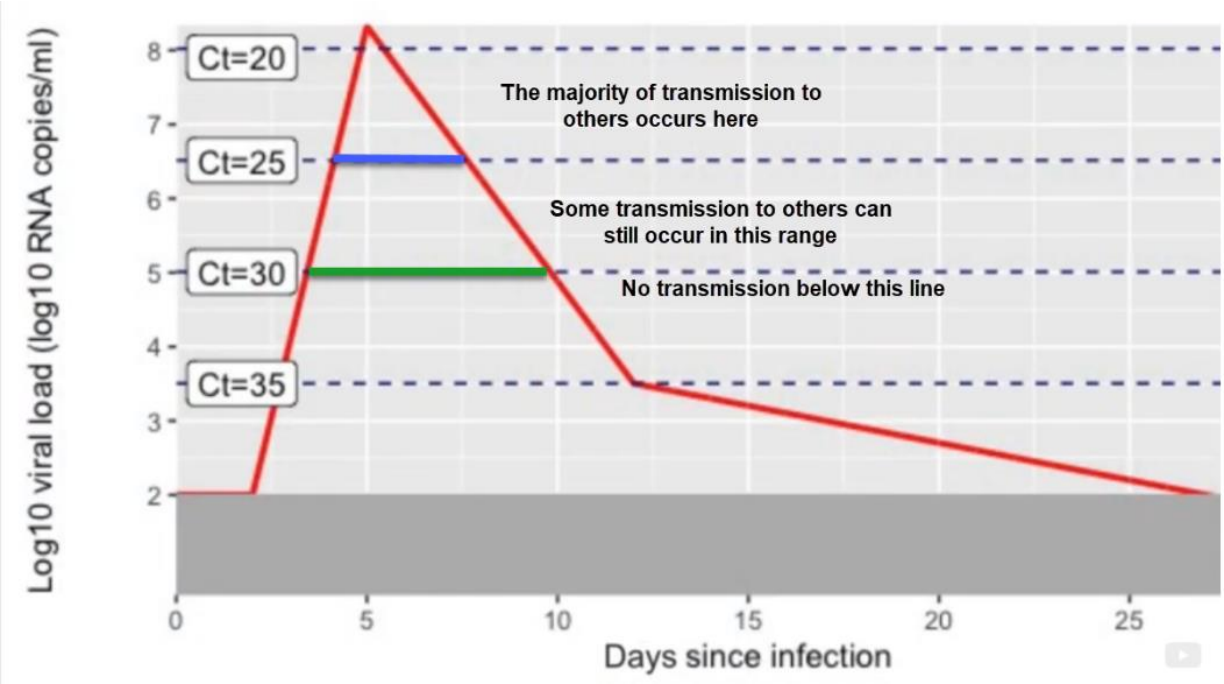
Continued next page…

A visual representation of the viral explosion and decline

The red line represents the amount of viable virus in the body, sometimes called “viral load”. You can see that ability to transmit the virus to others occurs primarily between days 3 and 10. According to Dr. Mina, the vast majority of people capable of transmitting the virus to others are above the purple line.

There are a small percentage of people that are between the green and purple lines that can be transmitting, but this is the exception and not the rule.

People with levels below the green line cannot transmit the virus to others.



As you can see, the viral levels increase rapidly from about day 3 until day 5. The immune system (if working properly) gains the upper hand and the viral levels then drop precipitously. Imagine running Ct up to 40 or more, amplifying the sample exponentially in order to trigger a “positive” as most labs have done during the pandemic and you can understand why the rates of false positives are so high.

As you will see in a few pages, people that are infected and never develop symptoms are not infecting others. Looking at the graph above, these are most likely people that if tested have viral loads below the green line. They have such strong innate immune response (natural killer cells, etc.), that their immune system prevents the exponential growth of the virus. Children are great examples. They have very robust innate immune response capabilities. That innate immune response can be optimized with a preventative strategy. That's not to say that everyone that does this will avoid symptoms. But, in doing so they stand a much better chance of experiencing a milder case. Check out the strategy I have posted on my web site for an example of such an approach **HERE**.

Many people are being quarantined for no reason-

If someone gets a PCR test on day 6, has to wait 3-4 days to get the results and is at day 10 post infection, they are no longer able to infect others. But what is the protocol being used? They are told to quarantine for 14 days when there is NO reason for them to do that at that point, since the only reason to quarantine an infected person is to prevent the spread to others. The same thing is true for the majority of people that test positive (and not a false positive, but that's a whole other issue that happens quite often as you will see). **Again, according to Dr Mina 70% of people that test positive are not able to transmit the infection to others.**

The test that Dr. Mina has been working tirelessly to promote could be revolutionary in the whole COVID narrative.

"Paper antibody tests", is the term used for simplicity for this new type of test. This is paper coated with monoclonal antibodies that can detect antigens. They are not detecting RNA like the PCR Test, but just antigens.

This test has several benefits:

- It is a home test
- It only costs about $1 per test
- The results return in about a minute
- It identifies if you are contagious

So, the whole point is that people will be positive on the RT-PCR Test, because it is so sensitive, that it can detect fragments of virus which can turn the test positive, even when the person is

no longer at risk for transmitting the disease. Therefore, with our current approach, we have no idea when a person tests positive for COVID-19 with the RT-PCR Test, if they are capable of infecting others. Whereas this paper test for antigens will. This could be revolutionary, because we could now know whether a person can go back to work of school after testing positive for COVID-19. This approach is how we can safely get society fully open!

A family could purchase a box of the test strips and test each family member twice a week. If negative, go about your business. If positive, stay home and treat accordingly. Then continue to test twice weekly until you return a negative test. That may only take 4-8 days. At that point you could return to work, school, the gym and social activities, knowing full well that you are not going to put anyone else at risk.

Unfortunately, these paper tests have been hung up in bureaucratic red tape. An incredible amount of investment and effort has gone into the PCR development and distribution.

Here is a video that explains PCR testing, Cycle Thresholds (Ct) and explains the deficiencies of this testing paradigm.

https://www.youtube.com/watch?v=S_1Z8cSXI-Q

PCR testing has had flaws from the start

A November 6th report from NPR.org titled, **CDC Report: Officials Knew Coronavirus Test Was Flawed But Released It Anyway**, reveals that the test was released when it was shown that it would fail a third of the time.

Highlights from the article:

The FDA had required a particular protocol be followed when designing the test, and the lab didn't seem to be using the correct one, it said. "The first round of [quality control] for final kit release used an 'incorrect' testing procedure," it said. "Later in the timeline, detection of a 33 percent kit failure" using the correct quality control protocols "did not result in a kit recall or a performance alert."

The FDA had required a particular protocol be followed when designing the test, and the lab didn't seem to be using the correct one, it said. "The first round of [quality control] for final kit release used an 'incorrect' testing procedure," it said. "Later in the timeline, detection of a 33

percent kit failure" using the correct quality control protocols "did not result in a kit recall or a performance alert."

HHS officials said there was nothing intrinsically wrong with the test Lindstrom's lab built but had Lindstrom been at the infectious disease lab longer, he might have pulled a MERS test out of the freezer and used that as the template for a coronavirus test instead because it had more in common with a respiratory virus than influenza did.

Because the respiratory disease lab had fewer entrenched systems than Lindstrom's previous lab, the review also found that basic mistakes were made. "The absence or failure of document control to ensure the use of a single verified correct test quality control procedure matching [Emergency Use Authorization] procedure," the review said, "resulted in deficiencies."

Wroblewski agreed. "The thing that hangs me up most is probably the 33% and not recalling or not immediately going to remanufacture or something at that point," she said, "because 33% is clearly a lot."

Compounding the problem, officials said, was the fact that the CDC had not established specific benchmarks for the test. There was not, for example, an agency directive that said the test needed to be correct some specific percentage of the time before it could be released.

Because there was no benchmark set for acceptance, it became Lindstrom's call. He appears to have decided either that the last quality control test was wrong or that the 33% failure rate was acceptable, officials said.

Posts by former Pfizer science executive criticize PCR test false positive rate inaccuracies

Dr. Yeadon is on record saying that the current "epidemic" of positive cases is much overblown and inaccurate. He believes that under controlled laboratory conditions, the PCR accuracy is much better. But in the commercialization and supply chain of mass testing, such as the world has never seen, the false positive rates are amplifying the numbers significantly.

An article titled, **COVID-19: Do We Have a Coronavirus Pandemic, or a PCR Test Pandemic?** echoes Dr. Yeadon's concerns.

From the article:

Will the huge rollout of COVID tests help end the pandemic—or assure that it will never end?

We have had pseudo-epidemics before. In 2006, much of Dartmouth-Hitchcock Medical Center was shut down, and 1,000 employees were furloughed or quarantined, because whooping cough was thought to be spreading like wildfire based on 142 positive PCR tests.

The employees also had cultures taken, and a couple weeks later not a single one had a positive culture for the slow-growing bacteria, *Bordetella pertussis*. There had simply been an outbreak of some other ordinary respiratory disease, not the dreaded whooping cough. Gina Kolata wrote in *The New York Times*: "Faith in Quick Test Leads to Epidemic That Wasn't."

It is not so easy to culture a virus, and cultures of SARS-CoV-2 are not routinely done. Unlike in previous epidemics (SARS-CoV-1, H1N1 influenza, Ebola, or Zika), World Health Organization (WHO) guidance has no requirement or recommendation for a confirmatory test in COVID-19. *(isn't that strange?)*

Having great-sounding numbers, say a specificity of 99 percent, is not enough. For all tests, the predictive value of a positive test depends on the prevalence of disease. If most of the persons tested are free of disease, a positive test may be more likely to be a false than a true positive. This could at least partially explain the reports of large numbers of asymptomatic carriers of SARS-CoV-2.

Failure to recognize the problem of false positives has consequences—such as possible quarantining of uninfected with infected individuals.

The CDC limits the primers and probes that may be used for PCR testing. For the viral sequences that may be used for viral surveillance and research, the CDC posts this disclaimer on its website,

cdc.gov: “Every effort has been made to assure the accuracy of the sequences, but CDC cannot provide any warranty regarding their accuracy.”

End of excerpts

https://aapsonline.org/covid-19-do-we-have-a-coronavirus-pandemic-or-a-pcr-test-pandemic/

Many of these issues have been known by the FDA for months. Yet the media and those pushing the agenda of raging out-of-control disease are once again M.I.A. from doing their job.

The statement about the majority of people testing positive without symptoms is verified The Office of National Statistics in the UK which has found that only 22% are showing any symptoms of COVID-19 when the test says that they have it.
https://www.diabetes.co.uk/news/2020/jul/majority-of-people-with-a-positive-covid-19-test-are-symptom-free.html

CEO of a major PCR testing company, also an esteemed pathologist calls what is going on “the greatest hoax ever perpetuated on an unsuspecting public”

Mercola.com published an article on December 9th, 2020 exposing the fallacies of PCR testing and the catastrophic consequences it has caused for the world.

According to Dr. Roger Hodkinson, one of Canada’s top pathologists and an expert in virology, the COVID-19 pandemic is the “greatest hoax ever perpetrated on an unsuspecting public.” Hodkinson made these blunt statements during a zoom conference with an Alberta Community and Public Services Committee (see video in link below).

Hodkinson is the CEO of Western Medical Assessments, a biotech company that manufactures COVID-19 PCR tests, so “I might know a little bit about all this,” he said, adding that the entire situation represents “politics playing medicine,” which is “a very dangerous game.”[1]

He stressed that PCR tests simply cannot diagnose infection and mass testing should therefore cease immediately. He also pointed out that social distancing is useless as the virus “is spread by aerosols which travel 30 meters or so.”

https://articles.mercola.com/sites/articles/archive/2020/12/09/coronavirus-hoax.aspx

And one last criticism from one of the most highly respected and acclaimed researchers in the world, Tom Jefferson.

Tom Jefferson is a British epidemiologist, based in Rome, Italy, who works for the Cochrane Collaboration. Jefferson is an author and editor of the Cochrane Collaboration's acute respiratory infections group, as well as part of four other Cochrane groups. He is also a founding member of the Brighton Collaboration. He is also an advisor to the Italian National Agency for Regional Health Services.

The article published in the ***Daily Mail*** December 12th, 2020.

Some excerpts

The PCR verdict cannot tell these individuals whether they need to self-isolate or whether they might need treatment – the things that really matter to them and society.

In some cases, for example, viral RNA might be present in such very low quantities that an individual is not at all infectious and poses zero danger. In other cases, the swabs might pick up RNA which is so old it is completely dead, as people continue shedding material from the virus up to 80 days after the initial infection.

As Newcastle University's Professor Allyson Pollock said recently, the PCR tests were never designed to be used across entire populations. The manufacturer's instructions, she says, make it clear that they are no more than a tool to help with diagnosis and they are 'not to be used on healthy people with no symptoms'.

All precision has been sacrificed and instead we are blundering through – imprisoning people in their homes, further crippling the economy long after the infection has vanished.

This is why we must treat the Government's daily tally of cases – often in five figures – with a huge dose of salt. And why we must restrict the reporting of positive coronavirus diagnoses to those who are infectious to others. These are the people who matter in a pandemic.

We must reach agreed laboratory standards for how swabs are processed so that one result can be meaningfully compared with another. And we must bring this indiscriminate regime of mass tests to a halt, concentrating instead on those who have good reason to believe they have the virus.

The alternative is yet more agonising muddle and delay. More needless damage to lives and livelihoods, more pointless suffering.

https://www.dailymail.co.uk/health/article-9046363/DR-TOM-JEFFERSON-fear-mania-mass-Covid-testing-hugely-expensive-blunder.html

A better way to ensure PCR accuracy

And a solution to the problem with PCR accuracy… a paper by Dr. Sin Hang Lee M.D.

CDC Coronavirus Test Kits Generate *30% False Positive and 20% False Negative Results* - Connecticut Pathologist's Newly Published Findings Confirm

https://www.businesswire.com/news/home/20200717005397/en/CDC-Coronavirus-Test-Kits-Generate-30-False

It looks to me that the title of that article would indicate that the PCR test results are wrong 50% of the time! Yet we are making crushing policy decisions based on highly inaccurate data.

Some takeaways from the abstract:

Currently, molecular tests for SARS-CoV-2 infection are primarily based on reverse transcription-quantitative polymerase chain reaction (RT-qPCR) on cell-free fluid samples of respiratory tract specimens. These tests measure the rate of fluorescent signal accumulation as a surrogate for direct DNA sequence determination and are known to generate false-negative and false-positive results. The author has developed a routine protocol to test the cellular components of respiratory tract specimens instead of cell-free fluids only and to use conventional nested RT-PCR to amplify the target nucleic acid for high detection sensitivity. A 398-bp heminested PCR amplicon is used as the template for direct DNA sequencing to ensure no false-positive test results.

Using this protocol to re-test 20 reference samples prepared by the Connecticut State Department of Public Health, the author found 2 positives among 10 samples classified as negative by RT-qPCR assays. One of these two positive samples contained a mutant with a novel single nucleotide insertion in the N gene and a wild-type parental SARS-CoV-2. Of the 10 samples classified as positive by RT-qPCR assays, only 7 (7/10) were confirmed to contain SARS-CoV-2 by heminested PCR and DNA sequencing of a 398-bp amplicon of the N gene.

Routine sequencing of a 398-bp PCR amplicon can categorize any isolate into one of 6 clades of SARS-CoV-2 strains known to circulate in the United States. The author proposes that extremely

accurate routine laboratory tests for SARS-CoV-2 be implemented as businesses attempt to return to normal operation in order to avoid raising false alarms of a re-emerging outbreak. False-positive laboratory test reports can easily create unnecessary panic resulting in negative impacts on local economies.

End of excerpts

You can access his paper here: http://www.int-soc-clin-geriat.com/info/wp-content/uploads/2020/03/Dr.-Lees-paper-on-testing-for-SARS-CoV-2.pdf

Based on a lie?

On November 27th, 2020, **twenty-two renowned international scientists** petitioned for the retraction of the original study showing PCR testing to be a credible source of identifying infection from SARS-CoV-2. They contend that there are 10 fatal flaws in the study leading to extreme false positives and the results and reliance on this study **according to the authors have led to "worldwide misdiagnosis of infections attributed to SARS-CoV-2 and associated with the disease COVID-19. We are confronted with stringent lockdowns which have destroyed many people's lives and livelihoods, limited access to education and these imposed restrictions by governments around the world are a direct attack on people's basic rights and their personal freedoms, resulting in collateral damage for entire economies on a global scale".**

Some of them included the former head of research of Pfizer Dr. Michael Yeadon, the geneticist Kevin McKernan (the main initiator of the Human Genome Project), who holds several patents in the field of PCR diagnostics, the molecular geneticist Dr. Pieter Borger, PhD, the specialist for infectious diseases and preventive medicine Dr. Fabio Franchi, the microbiologist and immunologist Prof. emerit. Dr. Makoto Ohashi and the cell biologist Prof. Dr. Ulrike Kämmerer.

https://cormandrostenreview.com/report/

The paper goes on to detail the flaws and serious errors in the study that invalidate the results. The study that has raised these criticisms is titled "**Detection of 2019 novel coronavirus (2019-nCoV) by real-time RT-PCR**."

At the end of the day, I believe that the paper home tests promoted by Dr. Michael Mina are the real answer. They are fast, inexpensive, can be administered at home and give real time

results about whether a person is contagious or not. That approach would prevent unnecessary quarantine, allow life, business and society to resume and allow us to focus on safeguarding the elderly and those with serious comorbidities, the only people really threatened by COVID-19.

Here are other examples of the problems with PCR testing.

From the FDA: **Risk of Inaccurate Results with Thermo Fisher Scientific TaqPath COVID-19 Combo Kit - Letter to Clinical Laboratory Staff and Health Care Providers.**

https://www.fda.gov/medical-devices/letters-health-care-providers/risk-inaccurate-results-thermo-fisher-scientific-taqpath-covid-19-combo-kit-letter-clinical?

And this: **False Positive Results with BD SARS-CoV-2 Reagents for the BD Max System - Letter to Clinical Laboratory Staff and Health Care Providers**

https://www.fda.gov/medical-devices/letters-health-care-providers/false-positive-results-bd-sars-cov-2-reagents-bd-max-system-letter-clinical-laboratory-staff-and

The mRNA vaccines are an experimental project and have never been used in humans before

Mary Holland, vice chair and general counsel for ***Children's Health Defense*** said the following: "New vaccine technology will likely mean new kinds of vaccine injuries. Because there's never been a licensed mRNA vaccine before, we really don't know what injuries are going to look like."

What exactly is mRNA technology? *Fast Company* describes it this way:

"Like other vaccines, mRNA vaccines work by training the immune system to recognize a threat like a virus and begin producing antibodies to protect itself. But while traditional vaccines often use inactivated doses of the organisms that cause disease, mRNA vaccines are designed to make the body produce those proteins itself. Messenger RNA — a molecule that contains instructions for cells to make DNA — is injected into cells. In the case of COVID-19, mRNA vaccines provide instructions for cells to start producing the 'spike' protein of the new coronavirus, the protein that helps the virus get into cells. On its own, the spike protein isn't

harmful. But it triggers the immune system to begin a defensive response. As Bill Gates, who has supported companies like Moderna and BioNTech through the Gates Foundation, has described it, '**you essentially turn your body into its own manufacturing unit.'**"
https://www.fastcompany.com/90573488/how-pfizers-covid-19-vaccine-works-mrna

Watch the Chief Medical Officer of the ***Moderna*** mRNA vaccine explain how their vaccine is **"hacking the software of life"**. https://www.instagram.com/p/CIJWGzunJgo/?igshid=bq8150epb69b

I don't know about you, but it seems that whenever pharma starts bio-hacking the natural processes of the human body something bad happens. Again, new technology never been used in a vaccine before, rushed to market, shortcutting trials and already producing millions of doses, applying for emergency use authorization (because it is still in experimental stages)….WHAT CAN POSSIBLY GO WRONG!

The mRNA technology uses a lipid nanoparticle (LNP) incorporating PEG and is suspected in severe anaphylactic reactions in two UK healthcare workers

An ingredient called **Polyethylene Glycol (PEG)** is suspected as the culprit. PEG is used in the envelope that encloses the mRNA and is highly reactogenic in people that are sensitive to the chemical.

When Robert F. Kennedy found out about the controversial ingredient three moths prior, he warned the FDA in a letter about the potential dangers of putting it in the experimental COVID-19 vaccines. In a December 12th article by Lyn Redwood of ***Children's Health Defense***, an ingredient in the Moderna and Pfizer vaccines can lead to life-threatening reactions.

According to the article:

A mass vaccination campaign that targeted frontline workers to receive the vaccine began on Dec. 8. Within 24 hours of launching the campaign, MHRA acknowledged two reports of anaphylaxis and one report of a possible allergic reaction.

Reuters reported late yesterday afternoon that an investigation into the anaphylactic reactions by MHRA has identified polyethylene glycol, or PEG, as the likely culprit.

Moderna, Pfizer/BioNTech and Arcturus Therapeutics COVID vaccines all utilize a never-before-approved messenger RNA (mRNA) technology, an experimental approach designed to turn the

body's cells into viral protein-making factories. This technology involves the use of lipid nanoparticles (LNPs) that encapsulate the mRNA to protect them from degradation and promote cellular uptake.

The LNP formulations in the three COVID-19 mRNA vaccines are "PEGylated," meaning that the vaccine nanoparticles are coated with a synthetic, non-degradable and increasingly controversial PEG.

COVID mRNA vaccines are not the only vehicle for PEG involvement in COVID-19 vaccine production. Researchers at Germany's Max Planck Institute report developing a process for COVID-19 vaccine production to purify virus particles at "high yield." The process involves adding PEG to a virus-containing liquid and passing the liquid through membranes.

On Sept. 25, Robert F. Kennedy, Jr., chairman and chief legal counsel for Children's Health Defense (CHD), notified the Steven Hahn, director of the U.S. Food and Drug Administration (FDA), Dr. Peter Marks director of FDA's Center for Biologics Evaluation and Research and Anthony Fauci, director of the National Institute for Allergy and Infectious Diseases, of the serious and possibly life-threatening anaphylactic potential of PEG.

You can see the letter by going to the link to the article below.

An extensive review of PEG therapeutics, published in 2013, documented adverse effects of PEGylation and questioned the wisdom behind the continued use of PEG in drug development. The authors concluded that "the accumulating evidence documenting the detrimental effects of PEG on drug delivery make it imperative that scientists in this field break their dependence on PEGylation."

More evidence and links to studies about these concerns can be found in the article on CHD's web site.

https://childrenshealthdefense.org/defender/pfizer-covid-vaccine-reaction-fda-peg/

A major concern is that the public is unwittingly becoming part of the clinical trials and the largest human experiment in history

Is there proof of that? Yes! When are the clinical trials set to be completed? See below. (of course it now looks like they will try get full approval sooner).

The Moderna Trial is due to complete October 27, 2022. WHAT? Nearly 2 years from now? Yes. See the screen captures below from the clinicaltrials.gov website. That just confirms that the public is part of the clinical trials! With tens of millions of doses rolling off production lines now, are they going to inform each recipient of their participation in this experiment by informed consent, or just proceed without notification and consent?

https://clinicaltrials.gov/ct2/show/NCT04470427?term=Moderna&cond=covid-19&draw=2&rank=1

Detailed Description:
Please access www.modernatx.com/cove-study for additional information, such as Study Overview, Participation, Site Locations along with contact numbers for each location for the study.

Study Design Go to

Study Type :	Interventional (Clinical Trial)
Estimated Enrollment :	30000 participants
Allocation:	Randomized
Intervention Model:	Parallel Assignment
Masking:	Quadruple (Participant, Care Provider, Investigator, Outcomes Assessor)
Primary Purpose:	Prevention
Official Title:	A Phase 3, Randomized, Stratified, Observer-Blind, Placebo-Controlled Study to Evaluate the Efficacy, Safety, and Immunogenicity of mRNA-1273 **SARS-CoV-2** Vaccine in Adults Aged 18 Years and Older
Actual Study Start Date :	July 27, 2020
Estimated Primary Completion Date :	October 27, 2022
Estimated Study Completion Date :	October 27, 2022

https://clinicaltrials.gov/ct2/show/NCT04470427?term=Moderna&cond=covid-19&draw=2&rank=1

For the Pfizer/ BionTech vaccine, the trial is not scheduled to be completed until January 29th 2023.

https://www.clinicaltrials.gov/ct2/show/NCT04368728

Condition or disease	Intervention/treatment	Phase
SARS-CoV-2 Infection	Biological: BNT162b1	Phase 2
COVID-19	Biological: BNT162b2	Phase 3
	Other: Placebo	

Study Design Go to

Study Type :	Interventional (Clinical Trial)
Estimated Enrollment :	43998 participants
Allocation:	Randomized
Intervention Model:	Parallel Assignment
Masking:	Triple (Participant, Care Provider, Investigator)
Primary Purpose:	Prevention
Official Title:	A PHASE 1/2/3, PLACEBO-CONTROLLED, RANDOMIZED, OBSERVER-BLIND, DOSE-FINDING STUDY TO EVALUATE THE SAFETY, TOLERABILITY, IMMUNOGENICITY, AND EFFICACY OF SARS-COV-2 RNA VACCINE CANDIDATES AGAINST COVID-19 IN HEALTHY INDIVIDUALS
Actual Study Start Date :	April 29, 2020
Estimated Primary Completion Date :	August 1, 2021
Estimated Study Completion Date :	January 29, 2023

https://www.clinicaltrials.gov/ct2/show/NCT04368728

So as you can see, the public rollout comes about 2 years BEFORE the completion of the clinical trials! You are part of the experiment. Yet, the odd thing is that they only plan on following the vaccinated group a very brief period of time (see next section).

Go back and read the first paragraph of this paper again for emphasis regarding the Nuremberg violations of experimenting on an unknowing person without their consent. After you do and then read this, realize that if you are injured now or later from the vaccine, you have NO RECOURSE. The government and drug companies have been given complete immunity (pun intended) from legal action. So, all that to say, unless you get full informed consent of all the possible risks including autoimmune disease, cancer and a litany of other serious complications including death and then sign off on the fact that you understand that you are a willing participant in an experiment with an experimental product (vaccine), your rights have been violated under the Nuremberg Code. In addition, if you are not informed of all the possible risks associated with receiving the vaccine, accepting and signing off on those risks you have not been given the right to full informed consent that is required legally and ethically for every medical procedure, even the ones that are low risk or benign.

Follow-up periods for Phase 3 clinical trials are not nearly long enough

How long would it be reasonable to follow subjects of a vaccine trial after they are injected to see if they suffered any adverse effects? Is 2 weeks long enough? Is 1 month long enough? Is 6 months? 12 months? Well with emergency use authorization being given after only 3 months of Phase 3 trial data, do you feel comfortable becoming part of the experiment?

You may be interested to know that if you are vaccinated in the trial and don't drop out, they only follow you for adverse effects for the following period.

- **Pfizer/BionTech**- 1 month after second dose and 6 months for serious adverse events.
- **Moderna**- with **Solicited Local and Systemic Adverse Reactions** (ARs) [Time Frame: Up to Day 8 (7 days after first dose) and up to Day 36 (7 days after second dose) **Unsolicited AEs** [Time Frame: Up to Day 57 (28 days after each dose)
- **AstraZeneca/Oxford**- 1 month after second dose and 6 months for serious adverse events.

Another caveat is, that the FDA doesn't consider certain side effects serious, so they will only be tracked for 1 month. These include, but are not limited to alopecia, autoimmune disease, lupus erythematosus, vasculitis, Bell's Palsy, hypotonia, migraine, myelitis, neuropathy, seizures, mental disorders, rhinitis, and vertigo. The ironic thing is that many of these take months or years to even show up.

In both the case of Pfizer and AstraZeneca, they plan on tracking effectiveness for 2 years, so why not track adverse health effects for the same period also?

Thanks to the ***Informed Consent Action Network*** https://icandecide.org for providing this information.

According to Clinicaltrials.gov, if someone withdraws from the studies due to "Adverse Events (AEs) or Medically Attended AEs (MAAEs) Leading to Withdrawal [Time Frame: Up to Day 759 (2 years after second dose)]".

https://www.clinicaltrials.gov/ct2/show/NCT04470427

In other words, then they will track them for 2 years if they drop out. Why not if they stay in?

What are the vaccines designed to do? And, what does "effective" really mean in the percentage of effectiveness rates touted by the press releases and repeated ad nauseum by the media?

An October 22nd article titled, **Coronavirus Vaccine Trials Underway May Not Tell if the Shots Save Lives of COVID-19 Patients: British Medical Journal Expert**, highlights shortcomings of the COVID-19 vaccines, as expressed by one of the world's foremost medical experts.

From the article:

What most people do not realize is that the vaccines are not even designed to prevent COVID-19. What? None of the vaccines are designed to actually prevent infection. The primary measure of success is whether or not the vaccine results in fewer symptoms when you're infected with SARS-CoV-2. And the bar is set so low, that the proforma for the vaccines consider a 50% rate in decreasing symptoms a success.

Writing in the ***British Medical Journal*** (***BMJ)***, **Associate Editor Peter Doshi**, said that several COVID-19 vaccine trials are now in their most advanced (phase 3) stage, but expressed reservations about what will it mean exactly when a vaccine is declared "effective"?

From the letter:

Many may assume that successful phase 3 studies will mean we have a proven way of keeping people from getting very sick and dying from COVID-19. And a robust way to interrupt viral transmission. Yet the current phase 3 trials are not actually set up to prove either, Doshi said. "None of the trials currently underway are designed to detect a reduction in any serious outcome such as hospitalisations, intensive care use, or deaths. Nor are the vaccines being studied to determine whether they can interrupt transmission of the virus," he wrote.

He explained that all ongoing phase 3 trials for which details have been released are evaluating mild, not severe, disease—and they will be able to report final results once around 150 participants develop symptoms.

But Doshi raised another important issue—that few or perhaps none of the current vaccine trials appear to be designed to find out whether there is a benefit in the elderly, despite their obvious vulnerability to COVID-19.

If the frail elderly is not enrolled into vaccine trials in sufficient numbers to determine whether there is a reduction in cases in this population, "there can be little basis for assuming any benefit against hospitalisation or mortality," he warned.

Follow-up:

Dr. Doshi released another opinion letter January 4th, 2021 highly critical of how the Pfizer and Moderna trials determined their rates of “effectiveness”. The letter titled **Peter Doshi: Pfizer and Moderna’s “95% effective” vaccines—we need more details and the raw data**, reported that because of exclusionary data the actual effectiveness (and remember that only means reduction of COVID-19 symptoms), should have been reported as between 19% and 29%! In other words, the numbers had to be manipulated to get to the approximately 95% effectiveness that was reported. Remember Peter Doshi is the ***Associate Editor of the British Medical Journal (BMJ)*** and is a highly credible scientifically qualified source to analyze the data and comment on it.

From his letter:

“Suspected covid-19”

All attention has focused on the dramatic efficacy results: Pfizer reported 170 PCR confirmed covid-19 cases, split 8 to 162 between vaccine and placebo groups. But these numbers were dwarfed by a category of disease called "suspected covid-19"—those with symptomatic covid-19 that were not PCR confirmed. According to FDA's report on Pfizer's vaccine, there were "3410 total cases of suspected, but unconfirmed covid-19 in the overall study population, 1594 occurred in the vaccine group vs. 1816 in the placebo group."

With 20 times more suspected than confirmed cases, this category of disease cannot be ignored simply because there was no positive PCR test result. Indeed this makes it all the more urgent to understand. A rough estimate of vaccine efficacy against developing covid-19 symptoms, with or without a positive PCR test result, would be a relative risk reduction of 19% (see footnote)—far below the 50% effectiveness threshold for authorization set by regulators. Even after removing cases occurring within 7 days of vaccination (409 on Pfizer's vaccine vs. 287 on placebo), which should include the majority of symptoms due to short-term vaccine reactogenicity, vaccine efficacy remains low: 29% (see footnote).

However, if confirmed covid-19 is on average more severe than suspected covid-19, we must still keep in mind that at the end of the day, it is not average clinical severity that matters, it's the incidence of severe disease that affects hospital admissions. With 20 times more suspected covid-19 than confirmed covid-19, and trials not designed to assess whether the vaccines can interrupt viral transmission, an analysis of severe disease irrespective of etiologic agent—namely, rates of hospitalizations, ICU cases, and deaths amongst trial participants—seems warranted, and is the only way to assess the vaccines' real ability to take the edge off the pandemic.

There is a clear need for data to answer these questions, but Pfizer's 92-page report didn't mention the 3410 "suspected covid-19" cases. Nor did its publication in the *New England Journal of Medicine*. Nor did any of the reports on Moderna's vaccine. The only source that appears to have reported it is FDA's review of Pfizer's vaccine.

The 371 individuals excluded from Pfizer vaccine efficacy analysis

Another reason we need more data is to analyse an unexplained detail found in a table of FDA's review of Pfizer's vaccine: 371 individuals excluded from the efficacy analysis for "important protocol deviations on or prior to 7 days after Dose 2." What is concerning is the imbalance between randomized groups in the number of these excluded individuals: 311 from the vaccine group vs 60 on placebo. (In contrast, in Moderna's trial, there were just 36 participants excluded from the efficacy analysis for "major protocol deviation"—12 vaccine group vs 24 placebo group.)

What were these protocol deviations in Pfizer's study, and why were there five times more participants excluded in the vaccine group? The FDA report doesn't say, and these exclusions are difficult to even spot in Pfizer's report and journal publication.

We need the raw data

Addressing the many open questions about these trials requires access to the raw trial data. But no company seems to have shared data with any third party at this point.

Pfizer says it is making data available "upon request, and subject to review." This stops far short of making data publicly available, but at least leaves the door open. How open is unclear, since the study protocol says Pfizer will only start making data available **24 months after study completion**. ***(My emphasis and comment: and the study isn't scheduled to be completed until January 29th, 2023. That makes the release of the raw data January 29th, 2025! This is absurd with an experimental rushed to market product).***

Moderna's data sharing statement states data "may be available upon request once the trial is complete." This translates to sometime in mid-to-late 2022, as follow-up is planned for 2 years.

Things may be no different for the Oxford/AstraZeneca vaccine which has pledged patient-level data "when the trial is complete." And the ClinicalTrials.gov entry for the Russian Sputnik V vaccine says there are no plans to share individual participant data.

Footnote: Calculations in this article are as follows: 19% = 1 – (8+1594)/(162+1816); 29% = 1 – (8 + 1594 – 409)/(162 + 1816 – 287). I ignored denominators as they are similar between groups.

End of excerpts: Follow the link below to read the rest of the article

https://blogs.bmj.com/bmj/2021/01/04/peter-doshi-pfizer-and-modernas-95-effective-vaccines-we-need-more-details-and-the-raw-data/

On 5 February 2021 he published a clarification to this piece. It is available here. It basically addressed some criticisms of his calculations which he defended aptly.

For those that want to see more evidence of the "fuzzy math" used to determine the "effectiveness" and the risks of the mRNA vaccines you can read this excellent article…

https://everlyreport.com/what-you-need-to-know-about-the-covid-vaccine/

"Significantly noticeable" side effects in the trials

A December 1st ***CNBC*** article cited a 10-15% rate of "significantly noticeable" side effects from the Pfizer and Moderna vaccines in their Phase 3 trials. https://www.cnbc.com/2020/12/01/trump-covid-vaccine-czar-says-side-effects-significantly-noticeable-in-10percent-to-15percent-of-recipients.html

Some key points:

- President Trump's coronavirus vaccine czar said Pfizer's and Moderna's Covid-19 vaccines are safe, with only 10% to 15% of volunteers reporting "significantly noticeable" side effects.

- The side effects can last up to a day and a half, said Dr. Moncef Slaoui, who is leading the Trump administration's Covid-19 vaccine program Operation Warp Speed.

The obvious and immediate side effects from the vaccine include (and sound very similar to what mild to moderate COVID patients are experiencing)**:**

- Fever (and typically higher in the vaccinated group vs. people with COVID-19)
- Severe headache (both fever and severe headache are related to brain swelling after vaccination)
- Muscle aches
- Chills
- Day long exhaustion

Dr. Moncef Slaoui, who is leading the Trump administration's Covid-19 vaccine program Operation Warp Speed also said…

"The longer, more important kind of adverse events such as some autoimmune disease or others have not been reported in a different way between the placebo group and the vaccine group in these two trials, which is very reassuring," he told The Washington Post. "I always make sure we say that [while] we know the short term and I'm going to call it midterm effects of the vaccine is now well understood, the very long-term safety is not yet understood by definition."

End of excerpts

The vaccine's immediate side effects can be worse than people suffer from mild to moderate COVID-19

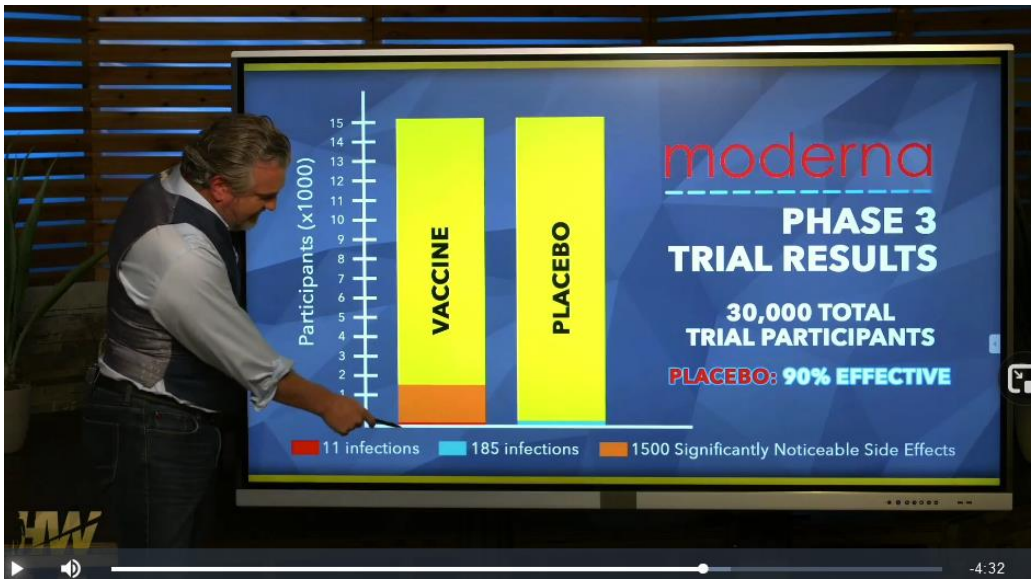
Well, that quote from Dr. Slaoui is a real smoke screen. Autoimmune disease, cancer or other chronic metabolic diseases take much longer to rear their ugly head, typically months or even years, not just the short 2 to 3 months since participants were injected. And, I would have to assume that someone like Dr. Slaoui should know that. So, the comment must just be window dressing meant to make the public more "comfortable" with the vaccines.

People need to ask themselves if that is worth taking the risk of serious adverse vaccine reactions and potential long-term health consequences. On a recent episode of the ***Highwire***, Del Bigtree showed a graphic example of how the people in the vaccine trials suffered more symptoms from the vaccines than symptoms suffered by the placebo group. Later in this document, you will see excerpts from a ***New York Post*** article showcasing examples from vaccine trial participants describing how severe the side effects can become.

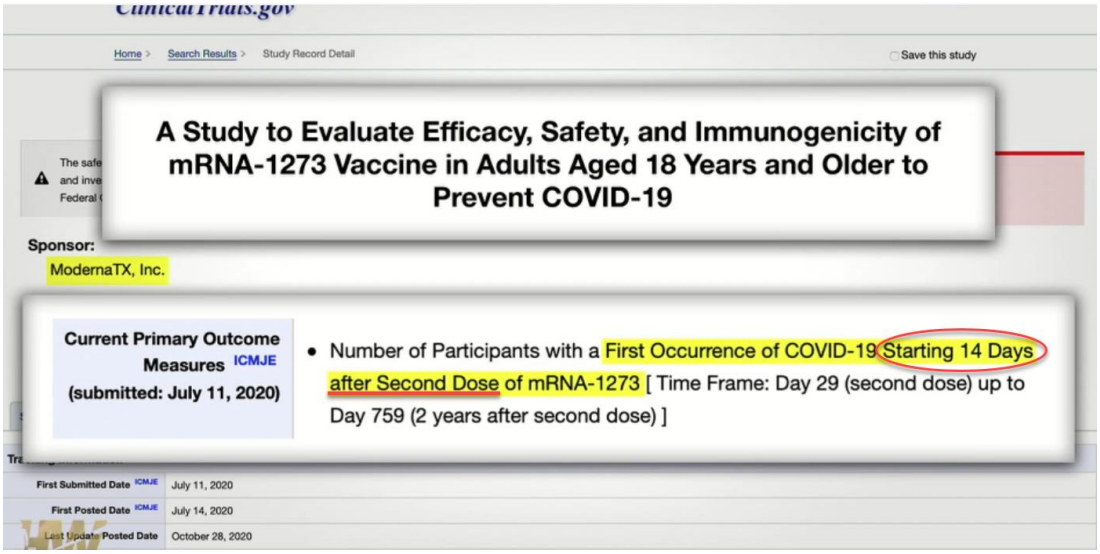
In the graphic below looking at the Moderna vaccine and using the 10-15% range of people experiencing significant side effects, Del shows that if just 10% (1,500 of 15,000 getting the shots) experienced those types of symptoms, the number of people experiencing those significant side effects from the vaccine would far exceed the 185 out of the 15,000 in the placebo group that did not get the vaccine and developed symptoms of COVID-19. Also, as we now know from the experts on PCT testing, the tests are false positives 30% of the time, so out of the 185 positives, there may have been only 125 true COVID-19 positives. Also consider that in the total population, it is estimated that approximately, 50% of people have zero to minimal symptoms from COVID-19. That could mean that out of the approximately 125 that truly had the infection, around 60 would most likely have little or no symptoms.

To make the differences even greater, we could use the higher range (15%) of the estimated number experiencing significant side effects from the vaccine which would be 2,250 people. That would be around 60 or so people having significant symptoms from COVID-19 and 2,250 people in the vaccinated group. Which odds would you take? And considering the risk factors for COVID-19, advanced age and if you have significant co-morbidities would need to be considered.

This is a screen capture from the episode "How Effective is the COVID-19 vaccine".
https://thehighwire.com/videos/how-effective-is-the-covid-19-vaccine/



So, in looking at the graphic above and considering the percentage of vaccinated subjects experiencing side effects, the unvaccinated group (placebo) fared much better than the vaccinated group, with at least 90% fewer people having symptoms. Why don't all these people with symptoms show up in the data? Because as Del points out so brilliantly in this same video clip as above, they don't start monitoring for symptoms (including adverse effects from the vaccine), until 14 days AFTER the second shot. See what I've circled and underlined in the screenshot below.



https://thehighwire.com/videos/how-effective-is-the-covid-19-vaccine/

And, as you will see in this next section, reducing symptoms was the primary endpoint and expectation for the vaccine in the first place. So with that being the case, the vaccine is actually a miserable failure with regard to its stated purpose and the expectations! Don't believe me? Listen to what Anthony Fauci has recently said in this next segment.

Lowering the bar for expectations for the vaccines

In an article posted on ***the Blaze.com*** October 27th, titled, **Fauci says early COVID vaccines will prevent symptoms, not block disease — and may be only 50% to 60% effective**, the bar for the definition of success is definitely being set extremely low.

From the article:

Dr. Anthony Fauci says that early COVID-19 vaccines will likely only prevent symptoms — not stop transmission. He also pointed out that such vaccines may only be 50% or 60% effective.

What are the details?

According to a report from ***Yahoo! Finance***, Fauci, director of the ***National Institute of Allergy and Infectious Diseases***, cautioned that early vaccines are simply aimed at preventing or reducing symptoms of coronavirus infection.

"If the vaccine allows you to prevent initial infection, that would be great," he said in remarks. "[But] the primary endpoint [is] to prevent clinically recognizable disease."

My comment: It is shocking to me that preventing infection with SARS-CoV-2 is not a criterion for success in these vaccine trials. The vaccine trials are not even designed to see if the vaccine will reduce hospitalizations or death. If the vaccine cannot reduce infection, hospitalization or death, then it cannot end the pandemic, which means everyone who takes the vaccine thinking it will help to "save grandma" or to "do their part" to protect others, will be doing so in vain.

My questions are:

Safe with limited short-term trials? Trials that never tested subjects that are at high risk for COVID-19. Elderly people and those with serious comorbidities have not been tested. What happens when millions of those people become that arm of the trial? Will the cure be worse than the disease?

What is the point? The vaccines WON'T or aren't designed to prevent transmission, reduce cases, reduce hospitalizations, reduce ICU bed utilization, ventilators or deaths. So really what is the point? For a person to assume short and long-term risk of adverse health consequences from an experimental "Warp Speed" vaccine, for a 50% chance it may reduce their symptoms to some degree, is ludicrous. After all, it is estimated that 50% or more of people that contract COVID-19 experience very mild or no symptoms at all. Therefore, why would younger healthy people who have extremely low risk from COVID-19 need a vaccine at all?

Not only that, but I have more than 2 dozen studies that show good Vitamin D status is protective from respiratory viral infections, including COVID-19. They show that symptoms are much milder, and it reduces the chances of severe of fatal cases. In addition, other studies since the start of the pandemic have found similar results in people with adequate Zinc levels. By being proactive with these and other immune supporting nutrients a person can achieve results similar to what the vaccines are reported to do, without the risk of short or long-term adverse reactions.

You can go to my website and see an article I wrote about Vitamin D and respiratory infectious diseases including COVID-19 with over two dozen references and links to the published research. Read that **HERE**

A look at some of the top COVID-19 vaccine candidates

Moderna's mRNA 1273 Vaccine

When it comes to **the Moderna vaccine**, Dr. Fauci's favored horse in the race, this is what ***ICAN's* legal update** dated August 25th, 2020 had to say.

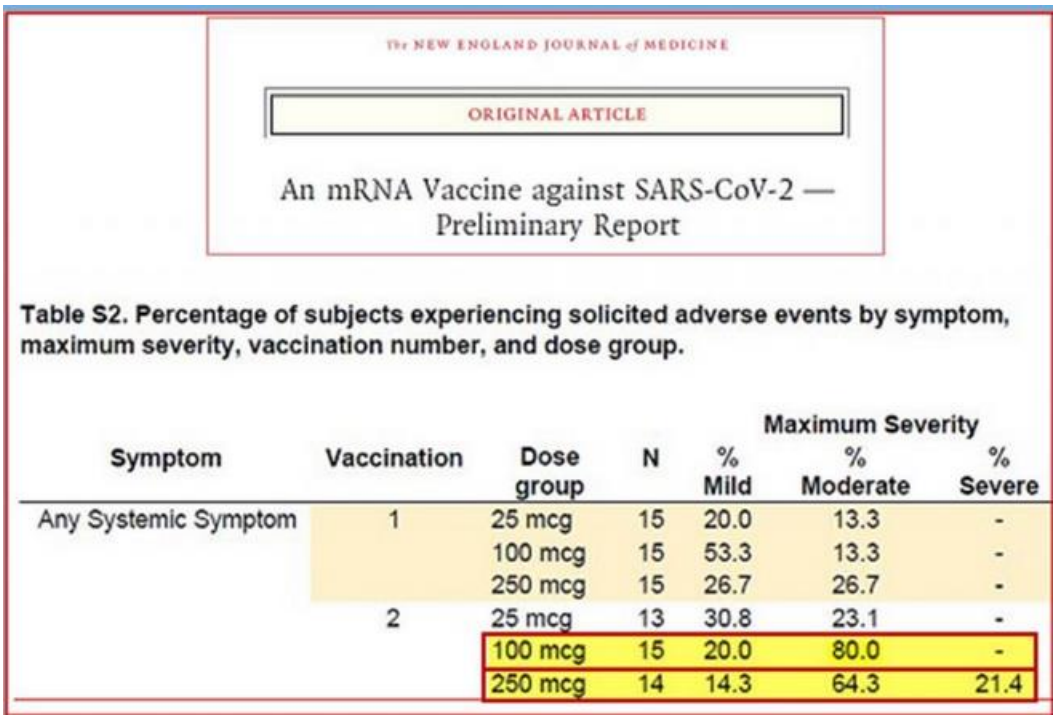
"The NIH and Moderna have rigged the clinical trial of their COVID-19 vaccine, mRNA-1273, to avoid capturing adverse reactions that occur more than 28 days after injecting this experimental vaccine. ICAN's legal team has filed an emergency petition to stop this unethical conduct."

"**Their trick is to only capture adverse reactions that occur more than 28 days after injection *if* the participant withdraws from the clinical trial.** This is nonsensical, since there is little for a participant to withdraw from after getting two doses during the first 28 days of the clinical trial. Once a participant has received both doses, if anything, a participant would have an incentive to remain part of the follow-up check-ups to address any adverse effects." Link to the Clinical Trials.gov where the trial details are outlined
https://www.clinicaltrials.gov/ct2/show/NCT04470427?term=mrna-1273&draw=2&rank=1

"There could be many autoimmune, neurological and chronic health disorders which have a major impact on the quality of life that this experimental vaccine could cause. All of which may only arise more than 28 days after the injection. But yet, as long as the participant does not withdraw from the clinical trial, these will nonsensically be ignored as if they did not occur. This is unethical and renders vacuous any claim of safety for this product based on this trial." To date they have not received a satisfactory response to their petition.

Phase 1 trial

A report in the ***New England Journal of Medicine*** released July 14th, 2020 titled, **<u>An mRNA Vaccine against SARS-Co-V-2 – Preliminary Report</u>**, reveals a high percentage of side effects in Moderna's Phase 1 Vaccine Trial, although the authors and the media did their best to sugar coat it.



The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

An mRNA Vaccine against SARS-CoV-2 — Preliminary Report

Table S2. Percentage of subjects experiencing solicited adverse events by symptom, maximum severity, vaccination number, and dose group.

Symptom	Vaccination	Dose group	N	Maximum Severity % Mild	% Moderate	% Severe
Any Systemic Symptom	1	25 mcg	15	20.0	13.3	-
		100 mcg	15	53.3	13.3	-
		250 mcg	15	26.7	26.7	-
	2	25 mcg	13	30.8	23.1	-
		100 mcg	15	20.0	80.0	-
		250 mcg	14	14.3	64.3	21.4

As you can see, 100% of recipients had adverse effects from the 100-mcg dose, with 80% of those being moderate symptoms. **And 100% of the recipients of the 25- mcg dose had adverse effects with 64.3% being moderate and 21.4% experiencing severe reactions.**

As expected, the announcement came shortly afterward that the trial **was successful**, and they were ready to move on to the next phase…Warp speed ahead Scotty!

Pfizer/BionTech

With regard to another vaccine candidate, Pfizer and BioNTech have also rigged the clinical trial of their COVID-19 vaccine, BNT162b, to avoid capturing many potential life-altering adverse reactions that may occur from this experimental vaccine. ***ICAN's*** legal team again filed an emergency petition to stop this unethical conduct as announced in their **Legal Update** dated August 25, 2020. The following is from that update.

The **study design** for the clinical trial for **BNT162b** provides that -- **despite reviewing efficacy for at least 2 years -- it will only capture "adverse events" for 1 month and "serious adverse events" for only 6 months after each dose.**

The adverse events captured beyond a month after injection should not be limited to "serious adverse events," since there are many autoimmune, neurological, and chronic health disorders which have a major impact on the quality of life, yet are **categorized by the FDA** as "adverse reactions" and *not* categorized as "serious adverse reactions." To wit, there are a myriad of post-licensure adverse reactions reported by consumers and physicians and are also listed in the **package inserts** for one or more vaccines that any individual living with would categorize as "serious"; yet the FDA, under its current guidelines, may not. These include, but are not limited to: alopecia, autoimmune disease, lupus erythematosus, vasculitis, Bell's Palsy, hypotonia, migraine, myelitis, neuropathy, seizures, mental disorders, rhinitis, and vertigo.

These artificial limitations are unethical and make any claim of safety for this product based on this trial specious at best.

ICAN's legal team filed a **citizen petition** and an **emergency stay petition** demanding that the clinical trial design for this vaccine be updated to require that all adverse reactions for the entire period of the clinical trial be tracked. These petitions also demand that the number of participants in this trial be increased and that they be tested before and after injection for any T-cells to SARS-CoV-2. ICAN intends to take further legal action if its rational and sensible requests are not met.

Shipping and storage of the Pfizer/Biontech vaccine presents a huge challenge.

The vaccine must be stored at -70 degrees Celsius, which is -94 degrees Fahrenheit. There will undoubtably be problems and times when those temperatures will not be maintained. What

happens then? If it goes unnoticed will it render the vaccine simply ineffective, or will it become harmful to the person receiving it? These are real challenges and potential dangers or consequences that will be playing out in real time to real people.

A major flaw in the study design

The Phase 3 trial of the vaccine only required a person to have 1 symptom of COVID-19. No positive PCR test. Not multiple symptoms…one. The problem with that is there are many symptoms that COVID-19 has in common with the common cold, other respiratory viruses and influenza. Without confirmation that the people they say contracted COVID-19 in the study, it invalidates the results. Nothing in the media about this though. Crickets…

If you read Pfizer's and Moderna's press releases and other clinical trial information, you'll see that they have left out some really crucial information. For example:[5]

- They don't say how many cycles they used for the PCR tests they gave to count COVID-19 cases, which is crucial for determining the accuracy of those tests (amplifying and running cycles over 30 to 33 only catches fragments of the virus after infection)
- They don't say whether the "cases" had symptoms or not
- They don't mention anything about hospitalizations or deaths, meaning there is no indication it prevents either
- There is no indication about how long the vaccine lasts if it truly is effective and protective. Some indications suggest you might need to take this vaccine every three to six months in order for it to be effective

Moderna and Pfizer/BionTech vaccines turn cells in the human body into vaccine making machines- It is risky and untested in long-term trials

mRNA technology has NEVER been used in vaccines. Is a rushed to market, abbreviated safety process vaccine pushed on the public as the long-term phase of the trials a good idea? Here is more on the nature of what they will do to your cells.

According to a ***Bloomberg Report***, "The coronavirus vaccines from Moderna Inc., in Cambridge, Mass., and its German rival BioNTech SE propose to immunize people in a radically different way: by harnessing human cells to become miniature vaccine factories in their own right.

Instead of virus proteins, the vaccines contain genetic instructions that prompt the body to produce them. Those instructions are carried via messenger RNA, or mRNA."

"Moderna's mRNA-1273 consists of a strand of mRNA that tells the body to produce the spike protein the coronavirus uses to latch onto human cells. The strand is like one side of a zipper; the "teeth" are a sequence of chemical letters that cells read to produce the 1,273 amino acids that make up the spike protein. If the vaccine works as intended, the body will start producing the proteins soon after injection, prompting the immune system to react and build up protective antibodies against them."

According to some experts looking into this technology, if this genetic material recombines with our DNA, in essence we will become Genetically Modified Organisms (GMOs). I'm not 100% convinced of this yet, but if that were the case, just like you can never get the toothpaste back in the tube, how will you undo the splicing of this foreign genetic material from your own unique DNA code?

End of Bloomberg report-

Another leading vaccine candidate the AstraZeneca/Oxford vaccine draws scrutiny

In the same Legal Update August 25, 2020, ICAN's legal team reported the following:

AstraZeneca and the University of Oxford have also rigged the clinical trial of their COVID-19 vaccine, **ChAdox1 nCoV-19**, to avoid capturing many potential life-altering adverse reactions that may occur from this experimental vaccine. ICAN's legal team once again filed an emergency petition to stop this unethical conduct.

Unlike the clinical trials for Moderna and Pfizer's vaccines for COVID-19, which are occurring in the United States, the current clinical trial for AstraZeneca's COVID-19 vaccine is not under the direct authority of the FDA, since this clinical trial is not occurring in the United States.

News **reports** have indicated that AstraZeneca will be starting a new clinical trial in the United States for its COVID-19 vaccine that presumably will include a placebo control group. In the meantime, its current clinical trial occurring outside the United States persists in **using a MenACWY vaccine as a control**. As if that were not enough to rig this trial's safety results, the **study design** for their vaccine, ChAdox1 nCoV-19, like the design of Pfizer's vaccine, provides

that, despite reviewing efficacy for at least 2 years, **it will only capture "adverse events" for 1 month and "serious adverse events" for only 6 months after each dose.**

Therefore, ICAN's legal team has also filed a **citizen petition** and an **emergency stay petition** demanding that the clinical trial design for this vaccine be updated to require that all adverse reactions for the entire period of the clinical trial be tracked against a placebo control group. These petitions also demand that the number of participants in this trial be increased and that they be tested before and after injection for any T-cells to SARS-CoV-2. ICAN intends to take further legal action if its rational and sensible requests are not met.

Just as the pharmaceutical companies will never rest when it comes to promoting and selling their vaccine products, we will never rest in exposing the truth regarding these products.

AstraZeneca's vaccine has multiple issues with their clinical trials

There are 3 arms to the Phase 3 trial. One in the USA, one in the UK and one in Brazil.

IMPORTANT: In the trial, some people got the vaccine and some got the "placebo" in the form of a meningococcal vaccine, NOT an inert substance like saline.

The USA arm of the trial was paused after subjects has serious side effects and one subject in the Brazil trial died. In the UK arm (3,000 people), they accidentally gave ½ dose as the first dose and a full dose as the second dose, 28 days apart. In the Brazil arm (9,000) people, they got a full dose both times. As it turned out, the participants that got the ½ dose followed by the full dose got better results that the people that got two full doses.

Now here is where things get even more convoluted. In reporting the results, they mixed all three arms of the trial and "averaged" the results. This is highly unusual and has drawn scrutiny from experts around the world.

Adverse reactions

At least two cases of transverse myelitis (severe inflammation of the spinal cord) has been documented in AstraZeneca's trial, and the company temporarily halted its trial in September 2020.

Concerns over the genetically modified virus technology

The AstraZeneca Vaccine has the same recombinant technology as the Johnson & Johnson Vaccine described below. Recombinant in this case means that DNA is combined in a lab from two different viruses into a hybrid organism (genetically modified organism- GMO), that would not normally be found in nature. Read on about the Johnson & Johnson Vaccine to see why that is such a concern by many scientists.

Concerns over the Johnson & Johnson vaccine

This vaccine is similar to the AstraZeneca/Oxford vaccine. They are referred by some scientists as a "Frankenstein" vaccine. The reason is that it uses another virus, a chimpanzee adenovirus as the carrier for the section of the SARS-CoV-2 virus spike protein DNA, which is "spliced" into the adenovirus. It is a hybrid of sorts, part this and part that (hence the Frankenstein label). J & J's and AstraZeneca are both called recombinant Adenovirus vector vaccines. Adenoviruses are viruses that are part of the common cold spectrum of viruses, just like coronaviruses are. Like the Pfizer and Moderna rRNA vaccines, these vaccines are a departure from the traditional vaccine platform.

Johnson & Johnson's vaccine consists of a ***replication-incompetent (genetically modified) recombinant adenovirus type 26 virus***, with the section of the SARS-CoV-2 spike protein spliced in. It also contains the following ingredients: citric acid monohydrate, trisodium citrate dihydrate, ethanol, 2-hydroxypropyl-β-cyclodextrin (HBCD), ***polysorbate 80***, sodium chloride, sodium hydroxide, and hydrochloric acid. The adenovirus is also grown in the ***PER.C6® aborted fetal cell line***.

The reason I have highlighted those 3 ingredients, is because they have proven to be problematic in other vaccines.

1. **A replication-incompetent (genetically modified) recombinant adenovirus type 26 virus** is concerning because it uses the prior mentioned technology where a virus is made incapable of replicating (Adenovirus) and the gene sequences from another virus (in this case the SARS-CoV-2 spike protein are inserted into the modified Adenovirus. There is historical context to make this a major concern. In 2015 a vaccine against Dengue Fever was developed by Sanofi Pasteur and rolled out on children in the Philippines. In that case it was a Yellow Fever Virus that had gene sequences of the Dengue Virus spliced into it. This experiment on children in the Philippines went horribly wrong resulting in criminal charges brought against researchers, health officials and Sanofi Pasteur.

   The following excerpt is from an April 24th, 2019 article published in ***ScienceMag*** titled **Dengue vaccine fiasco leads to criminal charges for researcher in the Philippines.** https://www.sciencemag.org/news/2019/04/dengue-vaccine-fiasco-leads-criminal-charges-researcher-philippines

Dengvaxia consists of an attenuated yellow fever virus that expresses genes of each of the four types of dengue virus. The Philippine FDA greenlighted the vaccine in December 2015, based on research funded by Sanofi Pasteur in which Capeding played an important role. For example, she was the first author on a 2014 paper in *The Lancet* detailing a study among more than 10,000 children in five Asian countries that showed Dengvaxia worked and had a good safety profile. In April 2016, the Philippine government launched a $67 million public school–based immunization program for Dengvaxia.

That alarmed some scientists, because the dengue virus is peculiar: A first infection is rarely fatal, but a second one with a different virus type can lead to much more serious disease, because of what is called antibody-dependent enhancement (ADE), in which the immune response to the first virus amplifies the effect of the second type. Scott Halstead, a retired dengue expert formerly at the Uniformed Services University of the Health Sciences in Bethesda, Maryland, argued that dengue vaccines could have the same effect, and warned that Dengvaxia should not be given to children never infected with dengue. But a vaccine panel at the World Health Organization (WHO) concluded in 2016 that Dengvaxia was safe for children aged 9 and older.

Halstead's concerns proved valid. In November 2017, Sanofi Pasteur announced that the vaccine could indeed exacerbate cases of dengue in children never previously infected, and the Philippines halted the campaign immediately. (WHO now recommends the vaccine be used only after a test to be sure children have had at least one brush with dengue.)

End of excerpts

Many in the science world are concerned that the ADE or sometimes called Pathogenic Priming may not have been solely a result of the vaccine being given to children that had not had a prior infection, but that the vaccine platform (ie. The genetically modified organism created by recombinant virus splicing) may be what triggers this reaction in certain susceptible individuals. Couple that with the history of the failed prior attempts to create a coronavirus vaccine leading to termination of the trials after animal studies as a result of the numbers of animals that developed ADE and became severely ill and many dying.

2. **The PER.C6 cell line** is derived from human embryonic retinal cells, originally from the retinal tissue of an 18-week-old fetus aborted in 1985. Notoriously, DNA from the

aborted fetus is present in vaccines and biologics where the viruses were grown on these cells. The FDA allows for 100,000,000 bits and strands of human DNA per dose. That is problematic, because as Dr. Theresa Deisher has warned can cause insertion into the recipient's DNA of this other human DNA (called homologous recombination) and lead to development of autoimmunity and other chronic health issues. Not to mention that it is abhorrent for many persons of faith to have human DNA from a fetus that was aborted for this purpose to be injected into their own body and potentially become part of their own DNA.

If you didn't catch it, you can read about more about aborted fetal cell lines, Dr. Deisher's work in this area as well as the many problems with Polysorbate 80 earlier in this eBook.

3. **Polysorbate 80** has been shown to cause allergic and even anaphylactic reactions in some people. It also has been shown to disrupt the blood-brain-barrier and aid in transport of drugs, chemicals and nanoparticles, even mercury and aluminum into the brain.

As a footnote, in October 2020 Johnson & Johnson paused its trial due to an undisclosed "unexplained illness" in one of its participants. This illness has not been disclosed publicly.

The phase 3 trial recipients have commonly experienced side effects very similar to the Pfizer and Moderna vaccine recipients. Those include fever, chills, headaches, body aches, joint pain, fatigue, basically the same symptoms as many people in the low risk category experience from COVID-19 itself.

See more in the next section on the J & J vaccine.

Major issues with all of them

A September 23rd article in Forbes did a good job of comparing the 4 top vaccine candidates and discussing some of the shortcomings.

The article is titled, **Covid-19 Vaccine Protocols Reveal That Trials Are Designed To Succeed.**

Here are some highlights from that article:

Moderna, Pfizer, AstraZeneca, and Johnson & Johnson are leading candidates for the completion of a Covid-19 vaccine likely to be released in the coming months. These companies have published their vaccine trial protocols. This unusually transparent action during a major drug trial deserves praise, close inspection of the protocols raises surprising concerns. These trials seem designed to prove their vaccines work, even if the measured effects are minimal.

What would a normal vaccine trial look like?

Prevention of infection must be a critical endpoint. Any vaccine trial should include regular antigen testing every three days to test contagiousness to pick up early signs of infection and PCR testing once a week to confirm infection by SARS-CoV-2 test the ability of the vaccines to stave off infection. Prevention of infection is *not* a criterion for success for any of these vaccines. In fact, their endpoints all require confirmed infections and all those they will include in the analysis for success, the only difference being the severity of symptoms between the vaccinated and unvaccinated. Measuring differences amongst only those infected by SARS-CoV-2 underscores the implicit conclusion that the vaccines are not expected to prevent infection, only modify symptoms of those infected.

We all expect an effective vaccine to prevent serious illness if infected. Three of the vaccine protocols—Moderna, Pfizer, and AstraZeneca—do *not* require that their vaccine prevent serious disease only that they prevent moderate symptoms which may be as mild as cough, or headache.

Vaccine efficacy is typically proved by large clinical trials over several years. The pharmaceutical companies intend to do trials ranging from thirty thousand to sixty thousand participants. This scale of study would be sufficient for testing vaccine efficacy. The first surprise found upon a closer reading of the protocols reveals that each study intends to complete interim and primary analyses that at most include 164 (Infected- *my addition*) participants.

These companies likely intend to apply for an emergency use authorization (EUA) from the Food and Drug Administration (FDA) with just their limited preliminary results.

Interim analysis success requires a seventy percent efficacy. The vaccine or placebo will be given to thousands of people in each trial. For Moderna, the initial interim analysis will be based on the results of infection of only 53 people. The judgment reached in interim analysis is dependent upon the difference in the number of people with symptoms, which may be mild, in the vaccinated group versus the unvaccinated group.

Moderna's success margin is for 13 or less of those 53 to develop symptoms compared to 40 or more in their control group. For Johnson & Johnson, their interim analysis includes 77 vaccine recipients, with a success margin of 18 or less developing symptoms compared to 59 in the

control group. For AstraZeneca, their interim analysis includes 50 vaccine recipients, with a success margin of 12 or less developing symptoms compared to 19 in the 25 person control group. Pfizer is even smaller in its success requirements. Their initial group includes 32 vaccine recipients, with a success margin of 7 or less developing symptoms compared to 25 in the control group.

The second surprise from these protocols is how mild the requirements for contracted Covid-19 symptoms are. A careful reading reveals that the minimum qualification for a case of Covid-19 is a positive PCR test and one or two mild symptoms. These include headache, fever, cough, or mild nausea. This is far from adequate. These vaccine trials are testing to prevent common cold symptoms.

These trials certainly do not give assurance that the vaccine will protect from the serious consequences of Covid-19. Johnson & Johnson is the only trial that requires the inclusion of severe Covid-19 cases, at least 5 for the 75 participant interim analysis.

One of the more immediate questions a trial needs to answer is whether a vaccine prevents infection. If someone takes this vaccine, are they far less likely to become infected with the virus? These trials all clearly focus on eliminating symptoms of Covid-19, and not infections themselves. Asymptomatic infection is listed as a secondary objective in these trials when they should be of critical importance.

It appears that all the pharmaceutical companies assume that the vaccine will never prevent infection. Their criteria for approval is the difference in symptoms between an infected control group and an infected vaccine group. They do not measure the difference between infection and noninfection as a primary motivation.

A greater concern for the millions of older people and those with preexisting conditions is whether these trials test the vaccine's ability to prevent severe illness and death. Again we find that severe illness and death are only secondary objectives in these trials. None list the prevention of death and hospitalization as a critically important barrier.

If total infections, hospitalizations, and death are going to be ignored in the preliminary trials of the vaccines, then there must be phase four testing* to monitor their safety and efficacy. This would be long term massive scale monitoring of the vaccine. There must be an indication that the authorized vaccines are reducing infection, hospitalization, and death, or else they will not be able to stop this pandemic.

End of excerpts

https://www.forbes.com/sites/williamhaseltine/2020/09/23/covid-19-vaccine-protocols-reveal-that-trials-are-designed-to-succeed

***My comment: There will be Phase 4 testing. That is the phase where the vaccines are given to millions of people and then we see what happens over the next few years.**

Trials were designed to use chemical cocktails instead of inert saline placebos in the control (placebo) groups

The majority of the 100 or so vaccine candidates being produced around the world have decided to use other vaccines or injections with an aluminum adjuvant along with different chemicals for their "placebo" injections that controls would get. This summer after learning that Moderna was planning on using another vaccine as the "placebo", once again ICAN filed a petition to the FDA demanding that the plan be modified to include a true saline placebo. As a result of ICAN's efforts, Moderna agreed to use a saline placebo.

And, as the previous section reported, the AstraZeneca vaccine trial in Great Britain called for using a meningococcal vaccine as the "placebo" instead of an inert substance like saline. Why would that be? For previous vaccines, there has never been a saline placebo used in safety studies. The obvious reason why that would be is to hide the differences between the adverse symptoms developed in the vaccine group and the "placebo" group. If they both develop similar adverse events, it can be said that there were no significant differences between the two groups. Anyone doubting what I am saying can view the package inserts for the CDC vaccine schedule and check it out for themselves.

Clinical trials fraught with even more problems and adverse reactions

As Robert F. Kennedy has said on many occasions, we are finally getting to see how the sausage is made, referring to the very public process that the COVID-19 vaccines trials are being subjected to. Seeing and hearing reports along the way is a unique opportunity. Normally vaccine trials are done under a veil of secrecy, outside of public scrutiny and the results are reported in the package inserts after approval and release to market. In the trials so far, there have been multiple instances in adverse reactions and injuries from the vaccines.

According to a ***New York Post*** article on October 6th, 2020, some participants in the vaccine trials have had significant side effects.

From the article:

“If this proves to work, people are going to have to toughen up,” one of the Moderna participants, a North Carolina woman in her 50s who declined to be identified, told the outlet.

“The first dose is no big deal. And then the second dose will definitely put you down for the day for sure. … You will need to take a day off after the second dose.”

She said she didn’t experience a fever but had a bad migraine that left her exhausted and struggling to focus, the outlet reported. But the next day, she woke up feeling better after taking Excedrin.

While she was uncomfortable, the side effects outweigh the risks of becoming infected with the virus, she said.

“My hope is that this works but also that the communication [on side effects] is good,” she said, adding that Moderna may need to tell people to take a day off after a second dose.

Meanwhile, a Maryland participant in his 20s said he came down with a high fever after receiving the shot.

“I wasn’t sure if I needed to go to the hospital or not because 104 is pretty high,” he told CNBC. “But other than that, it’s been fine.”

Luke Hutchison, a 44-year-old from Utah, also participated in the Moderna trials and felt out of sorts for a couple of days after being administered his first shot on Aug. 18, the outlet reported.

But just hours after receiving the second dose on Sept. 15, he became bedridden with shakes, chills, a terrible headache and shortness of breath, the outlet reported. For five hours, his temperature was above 100 degrees.

Hutchinson compared the ordeal — which lasted for 12 hours — to “full-on Covid-like symptoms” on Twitter.

“I’m obviously an isolated case, but since all indications point to this vaccine being approved, I feel like people should know that the side effects may be severe, especially after the second shot,” he wrote.

Pfizer trial participants have reported similar symptoms.

One of the participants said he suffered intense flu-like symptoms after his second injection that left him shaking so hard, he cracked part of his tooth.

“It hurt to even just lay in my bedsheet,” he told CNBC.

https://nypost.com/2020/10/06/covid-19-vaccine-trial-participants-report-aches-fevers-and-chills/

Other vaccine adverse reactions and long-term concerns

In addition to all the concerns expressed earlier in this article, what other concerns are there?

How many will become casualties of the vaccine? Bill Gates expects 700,000 victims will suffer adverse side effects from COVID-19 Vaccines

In an article published online in Germany reveals what Bill Gates is anticipating with regards to collateral damage from the COVID-19 vaccines. The truth is, based on other attempts at developing coronavirus vaccines and the clinical trials so far, it may be far worse than that.

https://kenfm.de/bill-gates-predicts-700000-victims-from-corona-vaccination/

From the article:

In an interview with ***CNBC***, Gates says that for one out of every 10,000 people, permanent vaccination damage would occur, and he expects 700,000 victims.

Towards the end of the short CNBC interview Bill Gates says:

"We have … you know … one in ten thousand … ah … side effects. That's … you know … way more. Seven hundred thousand … ah … you know … people who will suffer from that. So, really understanding the safety at gigantic scale across all age ranges – you know – pregnant, male, female, undernourished and existing comorbidities. It's very, very hard and that actual decision of ‚OK, let's go and give this vaccine to the entire world'… ah … governments will have to be involved because there will be some risk and indemnification needed before that … ah … can be decided on."

You can see that Gates interview here: https://d33wjekvz3zs1a.cloudfront.net/wp-content/uploads/2020/05/Gates-700000-Dead.mp4?_=1

That is a real problem, because there most certainly will be long-term health consequences to certain people from the vaccine

Autoimmune diseases

A study published March 31, 2020 in ***Autoimmunity Reviews*** titled, **Corona (COVID-19) time musings: Our involvement in COVID-19 pathogenesis, diagnosis, treatment and vaccine planning**, sounds the alarm about serious concerns over the rush to a vaccine for SARS-CoV-2. https://pubmed.ncbi.nlm.nih.gov/32268212/

From the article:

"We all are expecting the vaccine production trials to materialize quickly. We believe that once the vaccine found to be effective (most probably on a theoretical basis) it will be distributed to millions or billions of people. We believe that this vaccine will be approved through an expedited process thus not necessarily enabling surveillance due to the shortness of time thus eventual side effects of the vaccine could not be evaluated. The amino acid sequences of the virus like in other viruses, might have a cross-reaction with the human body sequences [28–31]. Therefore, one of the side effects of giving a MASS vaccine could be emergence of autoimmune diseases especially in individuals who are genetically prone for autoimmunity [28–31]. Actually, the coronavirus was reported to induce retinal autoimmune disease in an experimental model [32]."

A May 2020 publication in the journal ***Clinical Immunology*** titled, **Potential antigenic cross-reactivity between SARS-CoV-2 and human tissue with a possible link to an increase in autoimmune diseases.** They talk about other instances where vaccines have cause autoimmune disease manifestations. They express concerns that without adequate long-term research on the new COVID-19 vaccine and its propensity to trigger autoimmune disease that we could cause a "monumental cost on humanity in the form of another epidemic, this time a rising tide of increased autoimmune diseases and the years of suffering that come with them." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7246018/

From the study:

"At the moment, scientists are frantically trying to develop either a definitive cure, neutralizing antibodies, or a vaccine to protect us from contracting the disease in the first place, and they want it right now. **We must consider that finding a vaccine for a disease may normally take years.** There are reasons for all the precautions involved in developing a vaccine, not the least of which are unwanted side-effects. **In light of the information discussed above about the cross-reactivity of the SARS-CoV-2 proteins with human tissues and the possibility of either inducing autoimmunity, exacerbating already unhealthy conditions, or otherwise resulting in unforeseen consequences, it would only be prudent to do more extensive research regarding the autoimmune-inducing capacity of the SARS-CoV-2 antigens. The promotion and**

implementation of such an aggressive "immune passport" program worldwide in the absence of thorough and meticulous safety studies may exact a monumental cost on humanity in the form of another epidemic, this time a rising tide of increased autoimmune diseases and the years of suffering that come with them."

Many prestigious scientists and doctors call for a halt to the approval due to serious safety concerns around immune enhancement, infertility and brain injury

On December 1, 2020, the ex-Pfizer head of respiratory research Dr. Michael Yeadon and the lung specialist and former head of the public health department Dr. Wolfgang Wodarg filed an application with the EMA, the European Medicine Agency responsible for EU-wide drug approval, for the immediate suspension of all SARS CoV 2 vaccine studies, in particular the BioNtech/Pfizer study on BNT162b (EudraCT number 2020-002641-42).

Dr. Wodarg and Dr. Yeadon demand that the studies – for the protection of the life and health of the volunteers – should not be continued until a study design is available that is suitable to address the significant safety concerns expressed by an increasing number of renowned scientists against the vaccine and the study design.

On the one hand, the petitioners demand that, due to the known lack of accuracy of the PCR test in a serious study, a so-called Sanger sequencing must be used. This is the only way to make reliable statements on the effectiveness of a vaccine against Covid-19. On the basis of the many different PCR tests of highly varying quality, neither the risk of disease nor a possible vaccine benefit can be determined with the necessary certainty, which is why testing the vaccine on humans is unethical per se.

Furthermore, they demand that it must be excluded, e.g. by means of animal experiments, that risks already known from previous studies, which partly originate from the nature of the corona viruses, can be realized.

The concerns are directed in particular to the following points:

- The formation of so-called "non-neutralizing antibodies" can lead to an exaggerated immune reaction, especially when the test person is confronted with the real, "wild" virus after vaccination. This so-called **antibody-dependent enhancement ADE** *(AKA Adverse Immune Enhancement or Pathogenic Priming),* has long been known from experiments with corona vaccines in cats, for example. In the course of these studies all cats **that initially tolerated the vaccination well died after catching the wild virus.**

- The vaccinations are expected to produce antibodies against spike proteins of SARS-CoV-2. However, **spike proteins also contain syncytin-homologous proteins**, which are essential for the formation of the placenta in mammals such as humans. **It must be absolutely ruled out that a vaccine against SARS-CoV-2 could trigger an immune reaction against syncytin-1, as otherwise infertility of indefinite duration could result in vaccinated women.**

- The mRNA vaccines from BioNTech/Pfizer contain polyethylene glycol (PEG). **70% of people develop antibodies against this substance – this means that many people can develop allergic, potentially fatal reactions to the vaccination.**

- The much too **short duration of the study** does not allow a realistic estimation of the late effects. As in the narcolepsy cases after the swine flu vaccination, **millions of healthy people would be exposed to an unacceptable risk** if an emergency approval were to be granted and the possibility of observing the late effects of the vaccination were to follow. Nevertheless, BioNTech/Pfizer apparently submitted an application for emergency approval on December 1, 2020.

https://2020news.de/en/dr-wodarg-and-dr-yeadon-request-a-stop-of-all-corona-vaccination-studies-and-call-for-co-signing-the-petition/

Vaccines in pregnancy

In addition to the fertility concerns discussed above, there are legitimate concerns regarding vaccinating pregnant women. The vaccines frequently cause immune activation and inflammation as they are designed to stimulate (aggravate) the immune system. The common symptoms of redness, swelling, pain, headache and fever after vaccination are a result of immune activation and inflammation. To intentionally induce this puts the fetus at risk. The following article is the latest of dozens of articles published over the last few years that expose this risk. You can view many more on this topic in my eBook found at https://1200studies.com .

This recent article published December 23rd, 2020 titled, **Maternal immune activation induces sustained changes in fetal microglia motility**, describes the mechanism of how maternal (mother's) strong immune activation and inflammation increase the risk of developmental and social disorders and schizophrenia. This occurs by increasing inflammation in the cells of the fetal brain's immune system called microglia. This can lead to long lasting alterations in behavior and development, especially in genetically susceptible individuals.

From the study

The above findings showed that maternal inflammation affects the fetal microglia during the embryonic stage, resulting in alterations in microglial process motility that begin at the embryonic stage and remain in the developmental stage, or even the adolescent stage. Moreover, these research results demonstrate the possibility of a connection between changes in microglial process motility and deficits in social behavior that

are characteristic of developmental disorders and schizophrenia.

https://medicalxpress.com/news/2020-12-maternal-immune-sustained-fetal-microglia.html

Potential for causing neurodegenerative diseases

A January 2021 research article published in ***Microbiology and Infectious Diseases*** titled, **COVID-19 RNA Based Vaccines and the Risk of Prion Disease**, serious concerns about the mRNA vaccines causing reactions that can lead to the development of ALS (Lou Gehrig's Disease), Alzheimer's and other neurological degenerative diseases. If true, with hundreds of millions of people being vaccinated with these vaccines this could lead to a catastrophic increase in these diseases over the next decade or two.

From the article:

Development of new vaccine technology has been plagued with problems in the past. The current RNA based SARS-CoV-2 vaccines were approved in the US using an emergency order without extensive long term safety testing. In this paper the Pfizer COVID-19 vaccine was evaluated for the potential to induce prion-based disease in vaccine recipients. The RNA sequence of the vaccine as well as the spike protein target interaction were analyzed for the potential to convert intracellular RNA binding proteins TAR DNA binding protein (TDP-43) and Fused in Sarcoma (FUS) into their pathologic prion conformations.

In the current paper the concern is raised that the RNA based COVID vaccines have the potential to cause more disease than the epidemic of COVID-19. This paper focuses on a novel potential adverse event mechanism causing prion disease which could be even more common and debilitating than the viral infection the vaccine is designed to prevent. While this paper focuses on one potential adverse event there are multiple other potential fatal adverse events as discussed below.

The results indicate that the vaccine RNA has specific sequences that may induce TDP-43 and FUS to fold into their pathologic prion confirmations. In the current analysis a total of sixteen UG tandem repeats (ΨGΨG)

were identified and additional UG (ΨG) rich sequences were identified. Two GGΨA sequences were found.

Furthermore, the spike protein, created by the translation of the vaccine RNA, binds angiotensin converting enzyme 2 (ACE2), a zinc containing enzyme. This interaction has the potential to increase intracellular zinc. Zinc ions have been shown to cause the transformation of TDP-43 to its pathologic prion configuration. The folding of TDP-43 and FUS into their pathologic prion confirmations is known to cause ALS, front temporal lobar degeneration, Alzheimer's disease and other neurological degenerative diseases. The enclosed finding as well as additional potential risks leads the author to believe that regulatory approval of the RNA based vaccines for SARS-CoV-2 was premature and that the vaccine may cause much more harm than benefit.

https://scivisionpub.com/pdfs/covid19-rna-based-vaccines-and-the-risk-of-prion-disease-1503.pdf

It appears that the spike protein formed from the vaccine can cross into the brain

Much concern regarding these vaccines is how our body's immune system may react to the spike protein from the "vaccine" after being manufactured (copied) by our own cells. An article in the prestigious journal ***Nature Neuroscience*** December 16th, 2020 titled, **The S1 protein of SARS-CoV-2 crosses the blood–brain barrier in mice** raises some very serious and concerning questions.

First my commentary:

This is the mRNA "vaccine" design…. Once the spike protein from the "vaccine" is taken up by our cells and then duplicated or manufactured inside our cells by our cell machinery, it is expressed to the surface of the cell and starts a chain reaction within our immune system. The main goal is to force our immune system to make antibodies to the spike protein. But it also causes our immune system to mount an attack on that cell thinking it is infected with the virus itself. When Killer T-cells and other immune cells destroy the spike protein making factory (our cell), a large amount of spike proteins and protein fragments are released. This is where things can really go wrong as supported by this study. As it shows (although it is a mouse model), these spike proteins and even fragments of the spike protein can cross into the brain where the brain's immune system called microglia would have to mount an attack against these foreign

proteins. When that happens, inflammation inside the brain increases as does oxidative stress. This can lead to adverse effects on the health and well-being of the brain and potentially contribute to neurodegenerative diseases of the brain.

From the study:

"The results from this study show that I-S1 *(injected S1 segment of the spike protein)* from two different commercial sources readily crosses the mouse BBB *(Blood Brain Barrier)*, at least when injected intravenously. I-S1 was taken up by all 11 brain regions examined. Such widespread entry into brain of I-S1 could explain the diverse effects of S1 and/or SARS-CoV-2 such as encephalitis, respiratory difficulties and anosmia *(loss of smell)*. S1 is the SARS-CoV-2 protein that initially binds to cell-surface receptors, setting the stage for viral internalization".

"For transport across the BBB, viral binding proteins often behave similarly to the virus itself. For example, interactions (including binding and transport) between the HIV-1 glycoprotein gp120 and the BBB are similar to those for the complete virus. Additionally, many if not most viral proteins themselves can be biologically highly active; for example, gp120 is highly toxic. Coronavirus spike proteins are often cleaved from the virus by host cell proteases. Once cleaved, coronavirus spike S1 and S2 subunits are not held covalently by disulfide bonds and so S1 could be shed from virions. It is possible that during infection by SARS-CoV-2, shed S1 is available to cross the BBB, triggering responses in the brain itself, without necessarily involving crossing of intact virus particles. Thus, determining whether S1 crosses the BBB is important for understanding whether SARS-CoV-2 and S1 itself could induce responses in the brain".

https://www.nature.com/articles/s41593-020-00771-8

Spike protein introduced into and replicated by our cells from the mRNA vaccines are released into circulation when those cells are later destroyed by our immune system may cause widespread damage

Dr. J. Patrick Whelan M.D., PhD, with degrees in medicine, biochemistry and rheumatology warned the FDA in December that mRNA vaccines could cause microvascular injury to the brain, heart, liver and kidneys in ways not assessed in safety trials. That warning was ignored by the FDA.

This is from an article by Lyn Redwood of Children's Health Defense in a February 10th, 2021 article that she wrote titled, **Could Spike Protein in Moderna, Pfizer Vaccines Cause Blood Clots, Brain Inflammation and Heart Attacks?**

From the article:

"The most likely culprit that has been identified is the COVID-19 spike protein released from the outer shell of the virus into circulation. Research cited below has documented that the viral spike protein is able to initiate a cascade of events that triggers damage to distant organs in COVID-19 patients."

"Worryingly, several studies have found that the spike proteins alone have the capacity to cause widespread injury throughout the body, without any evidence of virus."

"What makes this finding so disturbing is that the COVID-19 mRNA vaccines manufactured by Moderna and Pfizer and currently being administered throughout the U.S. program our cells to manufacture this same coronavirus spike protein as a way to trigger our bodies to produce antibodies to the virus.

According to Whelan's letter to the FDA, the "Pfizer/BioNTech vaccine is composed of an mRNA that produces a membrane-anchored full-length spike protein.""

To read the full article with links to references go here:
https://childrenshealthdefense.org/defender/moderna-pfizer-vaccines-blood-clots-brain-inflammation-heart-attacks/

Erasing the placebo group

One of the tactics vaccine manufacturers use in their clinical trials is to vaccinate all the subjects in the control or placebo arm as soon as their short 30-day or 60-day follow-up period is complete. And this is one that they are planning on using with the COVID-19 vaccine candidates. That may not be so unscrupulous if the safety studies lasted for 5 years or more like required by the FDA for most drugs. But what about when the subjects are only followed for 4- and 5-days post injection as with the two Hepatitis B vaccines Recombivax HB and Energerix B? What about when the subjects are only followed 60 days like with Varivax chicken pox vaccine? They've done the same thing with the HPV vaccine Gardasil and many others. And now, they are going to do it with the COVID-19 vaccines.

Now why in the world would they do that? They say it would be "unethical" not to vaccinate the control group. Is that the real reason, or is it the fact that nobody will ever be able to look at the health problems they develop 5, 10 or 20 years down the road and compare them to the vaccinated subjects? How many of each group developed cancer, autoimmune disorders,

infertility, neurological disorders, allergies, mental and emotional conditions, etc.? If it would have been significantly less in the placebo group, no one will ever know. They conveniently eliminate or erase the control group for any future comparison or scrutiny.

Pharma insiders are the foxes watching the henhouse in the vaccine clinical trials

espite numerous statements by Anthony Fauci and Alex Azar among others that the oversight committee for the vaccine clinical trials consist of scientists independent of pharma influence. Well it appears that is not the case. This bias and conflict of interest puts all Americans at risk. ***The Informed Consent Action Network (ICAN)***, through its attorneys, headed by Aaron Siri, has therefore sent a demand letter to the Director of ***HHS***, Director of ***NIAID***, Director of the ***FDA's*** CBER, the White House Coronavirus Task Force, and POTUS. You can see that letter here: https://www.icandecide.org/wp-content/uploads/2020/10/Conflicted-Members-on-DSMBs-for-COVID-19-Vaccines-Final.pdf

There are four potential COVID-19 vaccines that are currently in Phase III clinical trials in the United States. The clinical trials for three of these experimental vaccines – the ones to be sold by AstraZeneca, Moderna, and Johnson & Johnson – are being overseen by a DSMB created by Dr. Fauci's National Institute of Allergy and Infectious Diseases (the **NIAID DSMB**). The clinical trial for Pfizer's experimental vaccine is being overseen by a different DSMB (the **Pfizer DSMB**).

The members of these DSMBs were selected in secret. They meet in secret. Their identities are supposed to remain a secret. This veil of secrecy has held with the exception of two members. The identity of the chairperson of the NIAID DSMB, Dr. Richard Whitley, was mistakenly revealed by his university in an announcement that has been scrubbed from its website. As for the Pfizer DSMB, made up of five individuals, one of its members, Dr. Kathryn Edwards, was apparently mistakenly revealed in a CBS article.

Selecting these individuals could only occur by turning a blind eye to their extremely troubling and blatant conflicts with pharmaceutical companies. For example, ICAN's investigation has revealed that one or both of these two doctors have been, among other things, consultants for Gilead Science, AstraZeneca, GlaxoSmithKline, Merck, Sanofi, Sequirus, La Roche, Allergan, Moderna, and Novartis; advisors to Merck, Bionet, GSK, and Pfizer; paid speakers for Connaught, Lederle-Praxis, Wyeth Lederle, Glaxo, and Novartis; paid millions of dollars from these companies; and, on the tab of these companies, wined-and-dined to hundreds of meals and taken dozens of trips to exotic destinations. Meaning, they have had duties to these companies as consultants and advisors, have been personally financially supported by them, and have been their mouthpieces to the public.

Only those wearing blinders could give Dr. Whitley and Dr. Edwards the label "independent." To head the "independent" DSMB, Dr. Fauci could have selected from a sea of potential scientists, many of whom have never consulted for a pharmaceutical company, were never on a pharmaceutical company speakers' bureau, and have not had hundreds of meals and dozens of exotic trips paid for by pharmaceutical companies. Instead he chose Dr. Whitely as its head. Dr. Fauci makes a mockery of the term "independent" and calls into serious question his judgment and objectivity.

ICAN, through its attorneys, headed by Aaron Siri, has therefore sent a demand letter to the Director of HHS, Director of NIAID, Director of the FDA's CBER, the White House Coronavirus Task Force, and POTUS. This letter lays out in detail: the conflicts of interest that Dr. Whitley and Dr. Edwards have with pharmaceutical companies; the litany of lies told by Dr. Fauci and other public health officials regarding the supposed independence of the DSMBs; and demands that they "**remove any member of the NIAID DSMB, including Dr. Whitley, who has ever been a consultant, has been on a speakers' bureau, or has had meals or travel paid for by any pharmaceutical company**."

You can read the full demand letter here.

In a response from the ***FDA***, the ***Informed Consent Action Network (ICAN)*** says that they have declined to make any changes to the people overseeing the process, despite their conflicts of interest.

From an ***ICAN Legal Update*** dated November 30th, 2020…

The Director of the FDA's Center for Biologics Evaluation and Research, Dr. Peter Marks, has now responded in a letter that fails to address any of these conflicts, conceding the existence of these conflicts. It also fails to provide any vow that the FDA will replace these individuals with those that are actually independent of pharmaceutical companies. This response should send shivers down the spine of anyone considering the process by which the safety and efficacy of any COVID-19 vaccine will be evaluated.

People with religious convictions need to know that certain COVID-19 vaccines may be contaminated with DNA from aborted fetuses

Here is some background on the ethical questions surrounding the use of vaccines that contain DNA from aborted babies.

As of June 2020, thirty-three of the FDA approved vaccines on the market contain DNA fragments from various cell lines originating from aborted fetuses, where the virus is grown in the cell cultures derived from the tissues of those fetuses. Several of the COVID-19 vaccines have either used fetal cell lines in the development and/or production of the "vaccines" (gene therapy agents). To see a list of all the vaccines that contain DNA from aborted fetuses and ethical alternatives, see this PDF:
https://cogforlife.org/wp-content/uploads/vaccineListOrigFormat.pdf

And we are not talking about insignificant numbers of this human DNA in vaccines. In vaccines, the FDA allows 100,000,000 (yes one hundred million) bits and strands of human DNA per dose.

As a person with very strong Christian faith and conviction, I feel that the human DNA from aborted fetal cell lines used in the MMR and many of the other vaccines, violate the sanctity of human life. I believe that human life begins at conception and the science is incontrovertible on that. Abortion is clearly the termination of a human life. As such, I am strongly opposed to abortion and the sale of aborted babies or their body parts. This would most certainly be an abomination in God's eyes. And horrifically, in many cases these babies were intentionally delivered alive before being killed for their tissues. And for each baby used, there were dozens of ones that were not used as they did not make a good match for what the "scientists" were looking for.

In addition to all of that, I believe that my body is the Temple of the Holy Spirit. Vaccines contain many other ingredients in addition to the residual human DNA from the aborted babies that are in direct conflict the with the way I have chosen to honor my body as Scripture makes clear we should.

In addition to the obvious reason for a person of faith to decline having that DNA injected into their body, there is also concern among many scientists that these DNA fragments can combine with the recipient's DNA in a process called homologous recombination and that the resultant inflammatory reaction may lead to autoimmune responses and other downstream effects of the alteration of the recipients DNA including triggering inflammation in the brain leading to regressive autism in genetically susceptible children. There is such evidence showing that when human DNA was incorporated into vaccines, there was a significant uptick in the rate of autism. This sharp increase became referred to as a "hockey stick" appearance.

A 2014 article published in the **Journal of Public Health and Epidemiology** titled, **Impact of environmental factors on the prevalence of autistic disorder after 1979**, produces convincing evidence of the effects of human fetal cell lines on the "change point" where the incidence of autism rose sharply in the late 1980s. https://academicjournals.org/journal/JPHE/article-full-text-pdf/C98151247042

One explanation as to why boys are affected with autism implicates human DNA found in vaccines comes from an article from the ***Journal Immunotoxicology*** published in 2011 and titled, **Theoretical Aspects of Autism**. The article clearly shows that It's not just the mercury that puts children at risk from vaccines. There is human DNA and retroviruses found in childhood vaccines. This article discusses many plausible explanations for the rise in autism as a result of various vaccine related factors, including this quote: "The human DNA from the vaccine can be randomly inserted into the recipient's genes by homologous recombination, a process that occurs spontaneously only within a species. Hot spots for DNA insertion are found on the X chromosome in eight autism-associated genes involved in nerve cell synapse formation, central nervous system development, and mitochondrial function (Deisher, 2010). This could provide some explanation of why autism is predominantly a disease of boys. Taken together, these data support the hypothesis that residual human DNA in some vaccines might cause autism." http://www.tandfonline.com/doi/full/10.3109/1547691X.2010.545086

Dr. Theresa Deisher has been a very vocal critic of the use of fetal cell lines that contaminate vaccines with human DNA. Dr. Deisher is highly qualified to make speak to this issue. She obtained her PhD in Molecular and Cellular Physiology from Stanford University and has spent over 20 years in commercial biotechnology and an inventor on 23 issued US patents in the biotechnology field. https://www.soundchoice.org/

It is crucial that we fight for the right to oppose vaccines based on religious exemptions. This is under attack all around the country. It is a right based on medical freedom that we can't allow to be taken away from us.

For more extensive information on these cell lines, the vaccines containing them and contaminated with fetal DNA, and the potential health risks associated with them download my eBook **1200 Studies- Truth Will Prevail** at https://1200studies.com

The leading vaccines that have been verified to involve the use of aborted fetal tissue are the following:

- Moderna/NIAID
- Johnson & Johnson
- AstraZeneca/Oxford
- Pfizer/BionTech (used HEK-293 cells in testing, but not in the product)

See details on these and all other COVID-19 vaccines here: https://cogforlife.org/wp-content/uploads/CovidCompareMoralImmoral.pdf

You can find more information about the bioethics of aborted fetal tissue nd medical products at ***Children of God for Life (COG)***- https://cogforlife.org/

Their web site describes them as ***"The Pro-Life World Leader in the Campaign for Ethical Vaccines, Medicines and Consumer Products".***

Victims of vaccine injury will not be compensated as makers will be free of liability in most if not all countries including the U.S. You're on your own.

This is just like childhood vaccine manufacturers are exempt from product liability and injuries they cause. This is thanks to the 1986 ***National Childhood Vaccine Injury Act*** (**NCVIA**). This has been a disaster, because it has prevented families from being justly compensated for egregious vaccine reaction injuries, including permanent disability and death. They put in place the ***National Vaccine Injury Compensation Program*** (**NVICP**), but the difficulty the process presents and the extreme limitations it puts on awards, makes it unfair and unjust. Not only that, but vaccine manufacturers have become emboldened since 1986 to cut corners in their safety studies and bring vaccines to market without adequate testing. The fact that not a single vaccine on the CDC Childhood immunization schedule has ever been tested against a saline (inert) placebo in the control group tells you all you need to know. You can look at any vaccine package insert and verify that this is true.

The COVID-19 vaccines will provide a liability free environment for vaccine manufacturers as well. The liability free environment in the U.S. will be provided by the 2005 ***P.R.E.P Act***.

This description off of the ***U.S. Department of Health and Human Services*** web site says it all.

"The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the Secretary of the Department of Health and Human Services (Secretary) to issue a declaration (PREP Act declaration) ***that provides immunity from liability (except for willful misconduct) for claims of loss caused, arising out of, relating to, or resulting from administration or use of countermeasures to diseases****, threats and conditions determined by the Secretary to constitute a present, or credible risk of a future public health* ***emergency to entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of***

such countermeasures. A PREP Act declaration is specifically for the purpose of providing immunity from liability, and is different from, and not dependent on, other emergency declarations."

https://www.phe.gov/Preparedness/legal/prepact/Pages/default.aspx

In other countries, drug makers are creating similar protection agreements as they move toward a rollout of their vaccines.

Who really "needs" the vaccine? As of the time of this writing, the vaccine manufacturers are losing market share FAST and this is why.

What would that mean to the "success" of the investment made by our government in the development of COVID-19 vaccines and Operation Warp Speed? Will it be pushed on the American public because it has become too big to fail? How will that impact our individual rights and sovereignty of our own bodies? These are all questions that we the people need to ponder BEFORE they lose these freedoms that we all hold dear to us. As we are told that everyone" needs the new vaccines, what is the TRUTH?

The first truth is, that as of mid-February, there have been over 28 million confirmed cases. Based on the CDC's formula for estimating the total number of people that have had the infection of 8 times confirmed cases (includes asymptomatic and mild cases never tested), that number is around approximately 224 million Americans. That is about 67% of the population!

That 8X ratio is according to an article posted online November 27th titled "The CDC researchers estimated that about 52.9 million Americans had been infected in the US by the end of September". The number of confirmed COVID-19 cases was only 6.9 million up to that time. That is about an 8 to 1 ratio of those that have it and either don't know it or have very mild symptoms and never get a test to those that do test positive. (PCR testing inaccuracy as we have seen is a whole other issue!)

https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1780/6000389

And at the fever pitch rate that new cases are being reported (pun intended), some estimates are that we will reach herd immunity even without the vaccines in the next few weeks. Every day that goes by more lost market share for the vaccines and their shareholders.

And here is why. Even if you have had COVID-19, the official narrative is that you should still get your vaccine shots. After all, our government and pharma have collaborated on producing billions of doses of these vaccines. And again, I am not telling you not to. BUT the science shows

that immunity develops after infection and the immune response is lasting. While some studies are showing that antibody levels drop a certain percentage in the weeks and months after infection, THIS IS NORMAL! And everyone that has studied immunology knows this. Once the threat is gone, the immune system doesn't maintain a level of "red alert". Antibody levels drop, but memory cells remain inactive. Then once the virus shows up again, they jump into action and crank out antibodies against the virus. And, because of the "maturing" of those cells the response is more robust than even during the first infection. In addition to the antibody response, the T-Cell response also has been shown to last for many years from previous coronavirus infections including SARS-CoV-1. There is no reason to believe that the same won't be true with SARS-CoV-2. And lastly, because natural immunity is always more lasting and effective against the wild virus because it covers the whole virus not just a small section like the spike protein, it will always superior. If the mutations we are seeing in various corners of the world and those to come affect the spike protein, the vaccines will be even less effective than natural immunity.

The second truth is that young people can develop better immunity from contracting the virus and producing their own natural antibodies and t-cell immunity from the wild virus. The younger the individual, the more robust their Innate Immune response, which acts as the first line of defense against viral pathogens and consists of Cytotoxic T-Cells, Natural Killer Cells, lymphocytes, neutrophils, macrophages and other key players. That is a huge part of the reason most young people are barely affected by the virus.

Young people age 0-19 have a 99.997% survival rate. People 20-49 have a 99.98% survival rate. And even people age 50-69 have a 99.5% survival rate.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html

Age	**SURVIVAL rates**	**Death rates**	**What does that mean in practical terms?**
0-19:	99.997%	0.003%	If 34,000 people were infected, 1 would die
20-49:	99.98%	0.02%	If 5,000 people were infected, 1 would die
50-69:	99.5%	0.5%	If 200 people were infected, 1 would die
70+:	94.6%	5.4%	If 20 people were infected, 1 would die

https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html

Co-morbidities are a major consideration in addition to age

Sixty percent of adults suffer from at least one chronic disease. Forty percent have two or more.

This is undoubtably one of the key reasons why COVID-19 has hit countries like the U.S., that have high rates of chronic disease harder. The average person that has died from COVID-19 has 2.6 comorbidities per CDC.

These are the 4 most significant risk factors for severe outcome from COVID-19 and the percentage of American adults in that age group that have them:

9. **Hypertension-** (45% of adults have it) https://www.cdc.gov/bloodpressure/facts.htm (47.91 of fatal cases) https://pubmed.ncbi.nlm.nih.gov/32573311/
10. **Diabetes-** (16% of adults have diabetes and 42% have pre-diabetes) https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf

    (24.9% of fatal COVID-19 cases) https://pubmed.ncbi.nlm.nih.gov/32573311/
11. **Obesity-** (42% of adults are obese) https://www.cdc.gov/nchs/data/databriefs/db360-h.pdf (3X risk of hospitalization and increased risk of death) https://www.cdc.gov/obesity/data/obesity-and-covid-19.html (11.3% of fatal COVID-19 cases)
12. **Respiratory diseases-**
    (10.9% of fatal cases) https://pubmed.ncbi.nlm.nih.gov/32573311/

Numbers 5- 8 are also significant risk factors. Circle the ones that pertain to you.

13. **Kidney disease**
14. **Smoking**
15. Being **immunocompromised**
16. **Non-Caucasian ethnicity**- One established reason is that those with darker pigmented skin have lower levels of Vitamin D, which is a risk factor for severe COVID-19.

    The following groups have increased risk of <u>death</u> from COVID-19 as compared to Caucasian and Asian Americans: African American (2.1X), Hispanic Americans (1.1X),

Native Americans (1.4X). These ethnic groups also have higher rates of obesity, diabetes, cardiovascular disease than Caucasian and Asian Americans.

The risk of being **hospitalized** from COVID-19 is much higher for Black (4.7X), Hispanic (4.6X), Asian (1.3X) and Native Americans (5.3X) as compared to Caucasian Americans. https://www.cdc.gov/coronavirus/2019-ncov/downloads/covid-data/hospitalization-death-by-race-ethnicity.pdf

Continued next page…

Consider this table showing of how low risk this disease is for 99.99% of young people…

10/5/20 update on C19 among students on campus since August, from 50 U.S. universities: Despite ~70,000 "+ C19 tests" near absence of reported C19 hospitalizations, & zero reported deaths*

University	Reported C19+, "Cases" (N)*	Reported Hospitalizations (N)**	Reported C19 Deaths (N)***
(1) U of Alabama sys	2861	0	0
(2) U of Georgia	3363	0	0
(3) U of Kentucky	2005	0	0
(4) Ohio State U	2987	0	0
(5) U of Dayton	1284	0	0
(6) Miami U of OH	1614	0	0
(7) Illinois State U	1358	0	0
(8) U of Iowa	2005	0	0
(9) Missouri State U	1017	0	0
(10) U of Kansas	1000	0	0
(11) Kansas State U	811	0	0
(12) Penn State U	2426	0	0
(13) U of Wisconsin	2967	1	0
(14) U of Miami	474	0	0
(15) U of S Carolina	2367	0	0
(16) U of Arizona	2338	0	0
(17) Notre Dame U	752	0	0
(18) Temple University	488	0	0
(19) James Madison U	1522	0	0
(20) Texas Tech U	1544	0	0
(21) U of Texas	1015	0	0
(22) Texas Christian U	1161	0	0
(23) Texas A & M U (incl staff)	1613	0	0
(24) U of Illinois	2566	1	0
(25) Iowa State U	1078	0	0
(26) East Carolina U	1240	0	0
(27) U of N Carolina	1146	0	0
(28) N Carolina State U	1089	0	0
(29) Auburn U	1938	0	0
(30) Arizona State U	1852	0	0
(31) San Diego State U	1106	1	0
(32) Ball State U	1015	0	0
(33) U of N. Dakota	771	0	0
(34) U of Cent Florida	1074	0	0
(35) U of Florida	853	0	0
(36) Oklahoma State U	1158	0	0
(37) SUNY-Oneonta	703	0	0
(38) U of Missouri	1630	0	0
(39) SUNY-Buffalo	444	0	0
(40) U of Michigan	573	0	0
(41) Michigan St (incl staff)	1395	0	0
(42) U of Nebraska (incl staff)	826	0	0
(43) U of Tenn sys	779	0	0
(44) Florida St U	1448	0	0
(45) Indiana U (incl staff)	1719	0	0
(46) U of Arkansas (incl staff)	1611	0	0
(47) Louisiana St U	947	0	0
(48) U of Louisville	543	0	0
(49) Arkansas St U (incl staff)	540	0	0
(50) Liberty U	428	0	0
Totals (N)	69,444	3**	0

Out of 69,444 cases of college students and staff, there were only 3 hospitalizations and ZERO deaths! Instead many schools freak when a few cases are reported, threatening shutdowns, quarantines and remote learning. This is completely insane! This is a great example of why we should not be myopic on "cases". Rather, we need to focus on hospitalizations, ICU bed availablility and deaths.

And these were college age students and staff of various ages. As mentioned above, the group younger than these people are at even lower risk from COVID-19. Even so, I'm sure the pressure will be on to vaccinate all of these extremely low-risk age groups based on the "do it for the greater good" flawed premise.

The third truth is, that several studies have shown that 30-40% of the population have T-Cell immunity from previous coronavirus infections. There are 4 human coronaviruses that make up about 15-20% of the "common colds" people get. Since they are a very similar cousin to SARS-CoV-2, people that have developed T-cell and Memory B-Cell immunity to those, exhibit a cross-reactivity to the SARS-CoV-2 virus. Cytotoxic T-cells and the Innate Arm of the immune system are almost never discussed yet play a powerful role in immune protection. There are several articles that could be cited, but here is a good one that also shows that the immunity should be long-term:

https://www.sciencemag.org/news/2020/05/t-cells-found-covid-19-patients-bode-well-long-term-immunity?#

Even more lost market share! The bottom line is, from a logical and scientific perspective only a small certain percentage of people if any should be recommended these experimental vaccines, as more questions are being raised daily about their safety and efficacy. But do you think pharma or their agents will limit their "marketing" to the groups that are the exceptions to those I've listed above? I don't know about you, but at this point I haven't heard any mention about any Americans that they don't feel require the vaccine. Just the full-court-press. Not surprising. One thing for certain, the only way they had a shot at selling these vaccines was a "warp speed" approach and masking, social distancing and lockdowns to try to slow the spread through the healthy population. Brilliant strategy if you think about it.

Elderly people are at risk

A CDC page titled, COVID-19 Hospitalization and Death by Age, compares risk of different age groups. The rate of death from COVID-19 in those 85 and older is 630 times (63,000 percent)

greater than 18-29-year-olds. And, it is approximately 5,670 times (567,000 percent) higher than children aged 0-4 and 10,080 times (1,008,000 percent) higher than youth aged 5-17!

https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-age.html

If you are over the age of 70 and certainly if older than 85, there is cause for genuine concern. But there is also cause for genuine concern in those age groups with the seasonal flu or pneumonia. And, consider that nationwide 40% of deaths have occurred in nursing and long-term care facilities. In some states those deaths are higher, ranging as high as 82% of deaths as is the case in New Hampshire. https://www.kff.org/coronavirus-covid-19/issue-brief/state-data-and-policy-actions-to-address-coronavirus/#long-term-care-cases-deaths

Each person should have the right to decide if they want to assume the risk of the illness or the risks of the vaccine. But certainly, healthy people without health co-morbidities from all those age groups are low risk from COVID-19. How many will choose the vaccines? Once again, more lost market share.

Conflicts of interest and personal financial gain drive decision making for vaccine development

The Informed Consent Action Network can now officially confirm that officials within the ***National Institute of Health (NIH)*** who are working to develop a vaccine for novel coronavirus (COVID-19), stand to personally earn millions of dollars from sales of this vaccine. The following is from one of their recent Legal Updates.

When government officials will profit from the sale of a product, there is cause for concern regarding their licensure and promotion of that product.

The first vaccine for COVID-19 to begin trials in the United States is **mRNA-1273**. This experimental vaccine was developed by Dr. Anthony Fauci's ***National Institute of Allergy and Infectious Disease (NIAID)***, which is part of the ***NIH***, along with a biotech company, Moderna Inc., the company that will sell this product to the public.

To receive a share of the profit from the sale of mRNA-1273, the inventors of this product within NIAID would submit an **Employee Invention Report** to the NIH Office of Technology Transfer. Each inventor stands to receive a personal payment of up to **$150k annually** from the

sales of mRNA-1273. NIAID also stands to earn **millions of dollars** in revenue from the sale of mRNA-1273 in addition to what its inventors within NIAID earn personally.

Moderna will pay a license fee to NIAID (or its parent agency) to use its patents related to mRNA-1273 and a portion of those fees are then paid directly to the **inventors** within NIAID who developed those patents.

There are **two patents** for which the following six individuals in NIAID appear to be listed as inventors which relate to development of mRNA-1273:

- Barney Graham, Deputy Director, NIAID Vaccine Research Center
- Kizzmekia Shanta Corbett, Scientific Lead, NIAID's Coronavirus Vaccine Program
- Michael Gordon Joyce, NIAID
- Hadi Yassine, NIAID
- Masaru Kanekiyo, NIAID
- Olubukola Abiona, NIAID

To confirm these findings, ICAN had its legal team, headed by Aaron Siri, obtain directly from NIH copies of the Employee Invention Reports submitted by NIAID officials with regard to the COVID-19 vaccine. NIH has now produced those **reports** which confirm that the above individuals are indeed listed as inventors. Hence, these individuals within Dr. Fauci's NIAID, and their **heirs**, will each potentially earn millions of dollars personally from sales of mRNA-1273 over the next twenty years. NIAID also stands to earn millions annually from the sale of this vaccine.

Given the potentially significant personal financial interests of individuals within NIAID, it may not be surprising that NIAID used taxpayer dollars to sponsor, assume responsibility for, and perform the first **clinical trial** of this vaccine. There is a clear conflict in having NIAID, whose employees stand to potentially earn millions of dollars from this vaccine, overseeing and conducting the clinical trial for mRNA-1273. This clinical trial information is what NIAID's sister agency, the FDA, will then rely upon to license the mRNA-1732 for public use.

NIAID's parent department, HHS, has also awarded **$483 million** to accelerate development of mRNA-1273, including to "fund the development of mRNA-1273 to FDA licensure and manufacturing process scale-up to enable large-scale production in 2020 [before licensure is granted]." The U.S. Government has also already reached a **$1.5 billion** deal to purchase 100 million doses of mRNA-1273. HHS has even granted those developing and selling this product, including NIAID and Moderna, **broad immunity** from liability for injuries caused by this product.

Dr. Fauci has been tirelessly promoting the mRNA-1273 vaccine that will potentially make individuals in his agency millionaires and will drive millions more dollars into his agency. It

should not be permissible that the federal department responsible for testing and licensing a product would include individuals who stand to earn millions of dollars from selling that product. It creates conflicts of interest that can cloud the vision of the most clear-eyed individuals.

Now that the vaccines have been rolled out to elderly and long-term care facilities, unusually high rates of deaths are being reported in elderly nursing home residents after they receive the shots

As of mid-February, reports from all over the globe have been coming in that are raising serious cause for concern over the elderly and frail getting the COVID-19 vaccines.

A CNA whistleblower from a nursing facility posted a video of himself expressing concerns over what he was seeing. The video went viral in a short amount of time before being censored and taken down. It is still being shared on various alternative platforms and by individuals. The story on this particular site is titled, **CNA Nursing Home Whistleblower: Seniors Are DYING LIKE FLIES After COVID Injections! SPEAK OUT!!!**

From the article:

James (he gives his last name in the video) is a CNA (Certified Nursing Assistant), and he recorded this video as a whistleblower because he could not keep silent any longer.

James reports that in 2020 **very few residents in the nursing home where he works got sick with COVID, and none of them died during the entire year of 2020**.

However, shortly after administering the Pfizer experimental mRNA injections, 14 died within two weeks, and he reports that many others are near death.

The video is long (47 minutes), and it is clear that James is suffering from emotional stress, and he admits that he has nothing to gain from going public, and that he will probably lose his job for doing so. But he makes it very clear that these were patients he knew and cared for (he is also a "lay pastor"), and that after being injected with the mRNA shot, residents who used to walk on their own can no longer walk. Residents who used to carry on an intelligent conversation with him could no longer talk. And now they are dying. "They're dropping like flies."

His superiors are explaining the deaths as being caused by a COVID19 "super-spreader." However, the residents who refused to take the injections, are not sick, according to James.

James makes it very clear that as a Christian, he cannot live with his conscience anymore, and that he can no longer remain silent. He is not anti-vaccine, but just sharing what he knows is true, regarding the people he has cared for in his profession for over 10 years now.

https://medicalkidnap.com/2021/01/26/cna-nursing-home-whistleblower-seniors-are-dying-like-flies-after-covid-injections-speak-out/

Once you read the article and watch the video if you choose, scroll down on that same web page and view many other stories coming in from different countries.

Norway halts vaccine rollout in the elderly due to deaths after vaccines

A January 16th article on Bloomberg.com titled **Norway Raises Concern Over Vaccine Jabs for the Elderly**, reports on the increased deaths in the elderly and frail after the Pfizer shots.

From the article:

Until Friday, the vaccine produced by Pfizer and BioNTech SE was the only one available in Norway, and "all deaths are thus linked to this vaccine," the Norwegian Medicines Agency said in a written response to Bloomberg on Saturday.

"There are 13 deaths that have been assessed, and we are aware of another 16 deaths that are currently being assessed," the agency said. All the reported deaths related to "elderly people with serious basic disorders," it said. "Most people have experienced the expected side effects of the vaccine, such as nausea and vomiting, fever, local reactions at the injection site, and worsening of their underlying condition."

The findings have prompted Norway to suggest that Covid-19 vaccines may be too risky for the very old and terminally ill, the most cautious statement yet from a European health authority.

The Norwegian Institute of Public Health judges that "for those with the most severe frailty, even relatively mild vaccine side effects can have serious consequences. For those who have a very short remaining life span anyway, the benefit of the vaccine may be marginal or irrelevant."

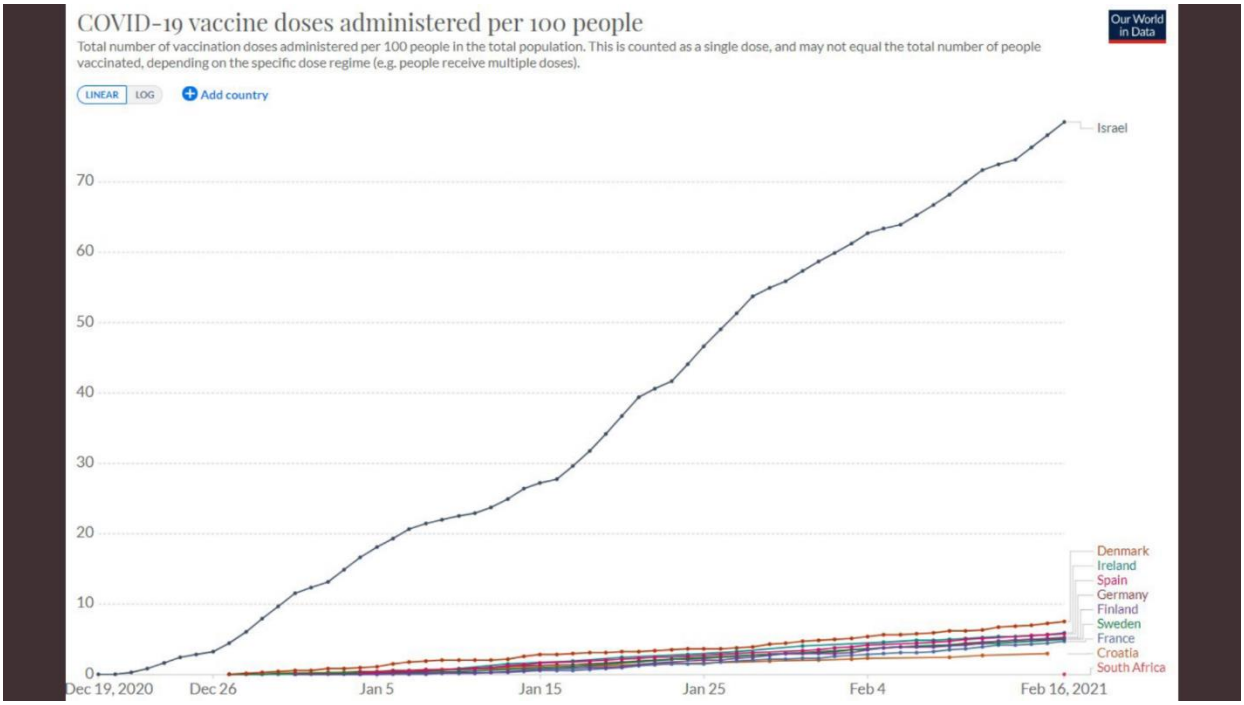
https://www.bloomberg.com/news/articles/2021-01-16/norway-vaccine-fatalities-among-people-75-and-older-rise-to-29

Spain halts vaccine in nursing home after 46 residents die shortly after the first Pfizer shot

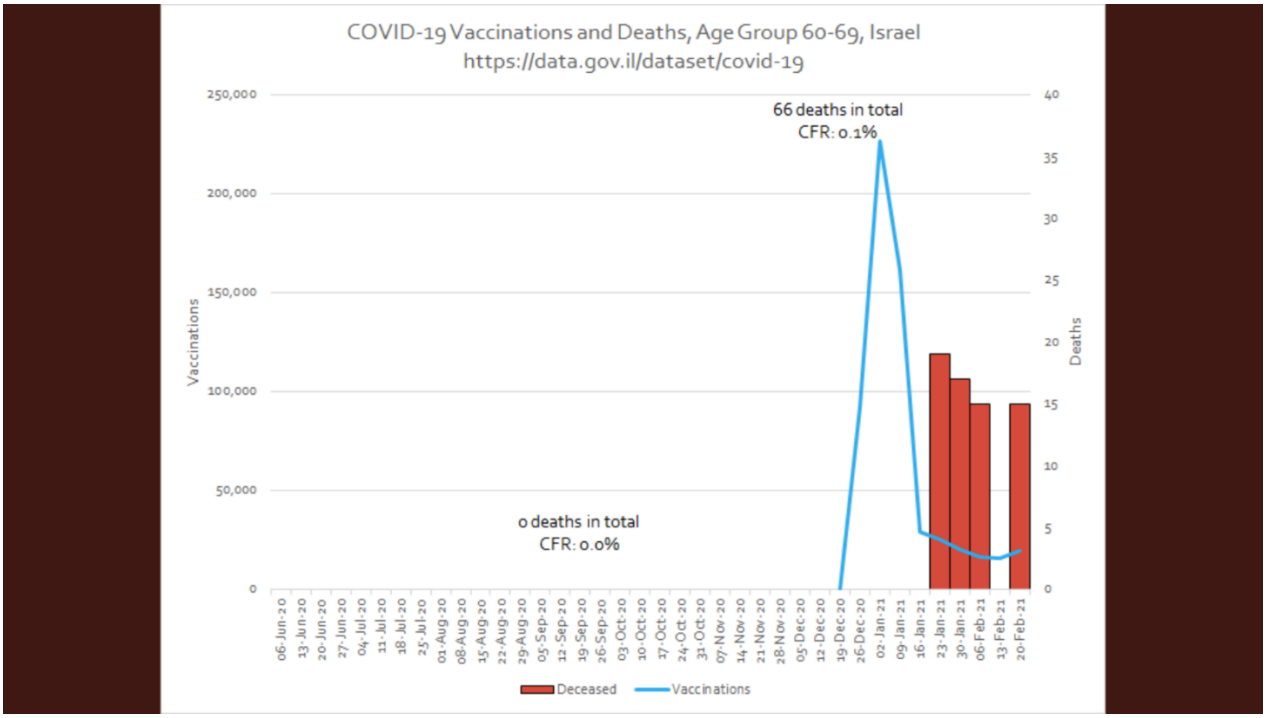
Considering that the total population of the nursing home was only 145, this is an extremely high number. The residents were vaccinated in early January. In mid-February it was reported that another 28 residents and 12 staff members have tested positive for COVID-19.

https://europerenaissance.com/2021/02/19/spain-second-pfizer-shots-halted-after-46-nursing-home-residents-die-after-the-first-shot/

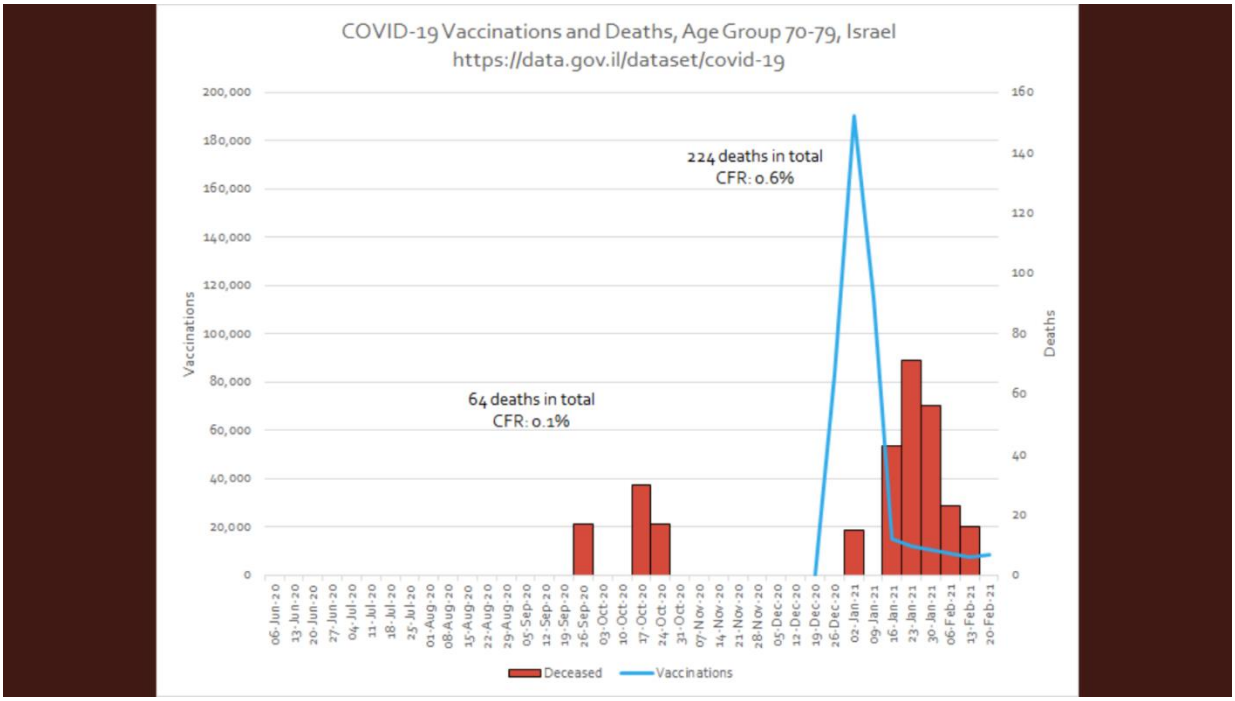
Israel has the highest rate of COVID-19 vaccine distribution in the world, but it seems to correlate with a large increase in deaths in their elderly



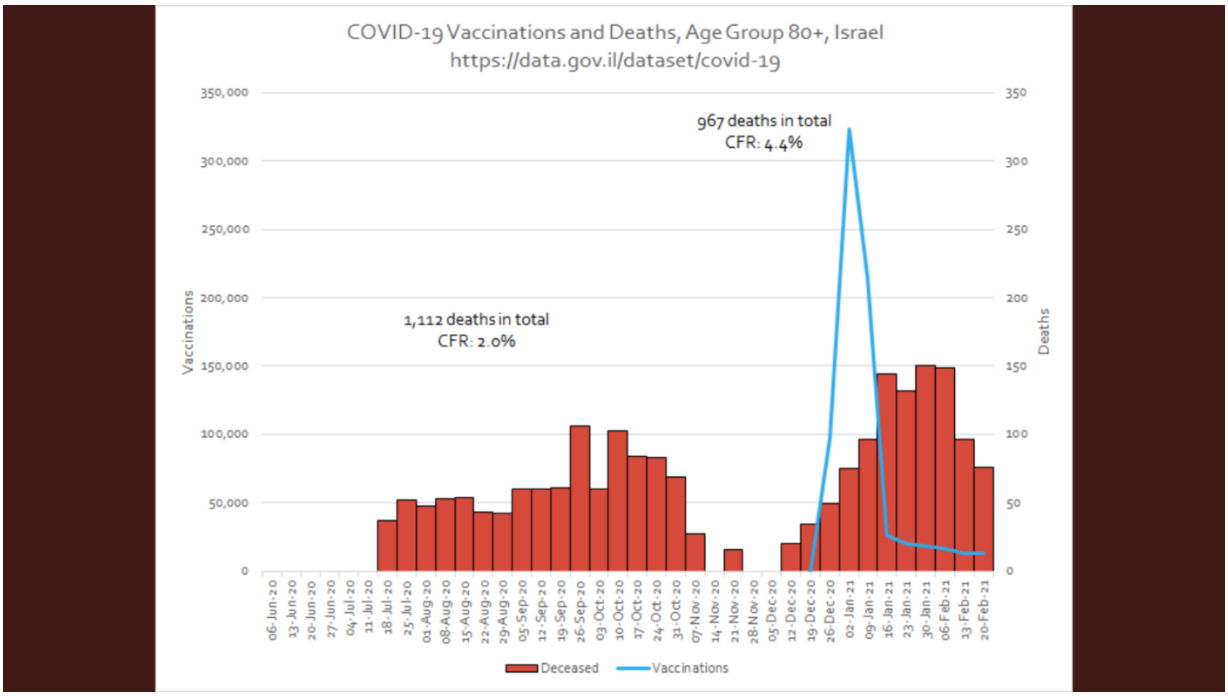
Deaths in the 60 to 69 year-old age group- Vaccination campaign is the blue line



Deaths in the 70 to 79 year-old age group- Vaccination campaign is the blue line



Deaths in the 80+ year-old age group- Vaccination campaign is the blue line



The big question is, does the large increase in deaths relate to various side effects from the vaccines that aren't tolerated by the frail and elderly, or is it the Antibody Dependent Enhancement (AKA Pathogenic Priming) scenario that so many of the world's health experts were warning about as described earlier in this paper. Either way, if you extrapolate these findings on a much larger scale in a country like the United States who are lagging far behind Israel in vaccination coverage, it should sent up major red flags that would call for further investigation before we see potentially catastrophic results here with our elderly population.

Status of Vaccine Adverse Event Reporting System (VAERS) reported injuries and deaths from COVID-19 vaccines

As of February 12th, 2021, there have been 15,923 reports of injuries and 929 deaths reported to the ***Vaccine Adverse Event Reporting System (VAERS)***. https://www.openvaers.com/covid-data

VAERS is a PASSIVE reporting system, meaning that vaccine reactions are not required to be reported. It is completely voluntary and the person that has received the vaccine would have to

know that it even exists and if they do how to report. This presents a problem of extreme under-reporting as verified by a U.S. government funded ***Harvard Pilgrim Health*** study that determined that less than 1% of all adverse vaccine reactions are reported to VAERS. https://www.ncbi.nlm.nih.gov/pubmed/?term=26060294. As of today, I have not seen a single Public Service Announcement (PSA) telling people about VAERS and that they should report any side effects from the shots. That sounds like common sense, but of course would raise concerns in the minds of the public about the possibility of adverse reactions and conflict with the public narrative. After all, they have been told ad nauseum that they are safe.

The technology for tracking vaccine recipients and monitoring their biological processes is ready for implementation

In a revealing article on Mercola.com, Whitney Webb an investigative journalist discusses the Sci-Fi reality that the biotech industries and globalists have for the human population. I'm going to devote a bit of content space to this article because it is very alarming. The rest of the article can be found here. https://articles.mercola.com/sites/articles/archive/2020/11/01/operation-warp-speed.aspx

From the article:

In this interview, investigative journalist ***Whitney Webb***, who does both independent work and collaborations with ***The Last American Vagabond***, discusses the little-known details of **Operation Warp Speed**, a joint operation between **U.S. Health and Human Services (HHS) and the Department of Defense** to produce a fast-tracked COVID-19 vaccine and other therapeutics.

As you may have noticed by now, ***Google***, ***YouTube***, ***Facebook***, ***Twitter*** and a host of other platforms are censoring information relating to COVID-19 in general and vaccine information in particular. Many commentators who touch on these issues have been deplatformed altogether, so information on these crucial topics are getting harder to come by.

"We're at a point where the line between Silicon Valley and the national security state has become so blurred, you really can't distinguish where one begins and where the other ends," Webb says. This in large part helps explain how and why big tech is getting away with such blatant censorship as deplatforming of individuals who discuss issues the mainstream media refuse to touch.

“You can definitely make the argument that it’s state censorship to a degree,” she says. “I think it's quite telling that a lot of these companies, from the very beginning of their existence, had some sort of funding from U.S. intelligence.”

Operation Warp Speed

As noted by Webb, you’d expect Operation Warp Speed, being a government program, to be governed by some federal regulatory agency like the Food and Drug Administration or the Centers for Disease Control and Prevention, or even the HHS, but no. It’s almost entirely funded and operated by the CIA and the U.S. military. Webb explains:

“When Operation Warp Speed was announced … it was essentially sold to the public as a joint operation between HHS and the Department of Defense. So, the military was involved from the beginning. But oddly enough, last month, a lot of information about Warp Speed started to come to light.

A company called Palantir was given the contract to come up with the vaccine allocation strategy and determine the critical populations each vaccine should be distributed to. Palantir, founded by Peter Thiel, was initially funded by QTL, the CIA's venture capital arm.

The CIA was its only client for the first three years of its existence. At present, Palantir is a contractor to 17 U.S. intelligence agencies and also the U.S. military. The company is also in charge of COVID-19 data under the auspices of the HHS. Hospitals must now report their COVID-19 data to Palantir or lose their Medicaid and Medicare funding. Palantir is also involved in things like predictive policing.

“There are a lot of things in Warp Speed that are concerning. One of the things I read about recently is that Google and Oracle, two large tech companies that have longstanding ties to the CIA, are going to be involved in what they describe as a pharmacovigilance surveillance system, or what was more recently referred to by the head of Warp Speed as an incredibly precise tracking system, whereby everyone who receives one of these vaccines will be tracked and surveilled, not just to make sure that they get a second dose ...

... but also to see what happens to people's physiology, because they admit that every single one of these vaccine candidates … has never been brought to market or licensed by the government before,” Webb says.

Pharmacovigilance Surveillance

According to Webb, the plan is to monitor vaccine recipients for 24 months after the first dose. The question is, how do you monitor such a large population? One way would be to employ biosensors that collect and send biological metrics automatically.

Monsef Salafi, a long-time head of GlaxoSmithKline's vaccine division, who is now part of Warp Speed, is a leading proponent of bioelectronic medicine, the use of injectable or implantable technology for the purpose of treating nerve conditions. The MIT Technology review has referred to it as hacking the nervous system. But it also allows you to monitor the physiology of the human body from the inside.

The vaccine coordinator for Operation Warp Speed is Matt Hepburn, a former program manager for DARPA, where he oversaw the development of ProfusA,[1] an implantable biosensor that allows a person's physiology to be examined at a distance via smartphone connectivity. ProfusA is also backed by Google, the largest data mining company in the world. Salafi is also invested in a company called Galvani Bioelectronics, which was cofounded by a Google subsidiary.

"So, you have Google being contracted to monitor this pharmacovigilance surveillance system that aims to monitor the physiology and the human body for two years," Webb says.

"And then you have the ties to the ProfusA project, which oddly enough is supposed to work inside the human body for 24 months — the exact window they've said will be used to monitor people after the first [vaccine] dose."

Guinea Pigs 'R Us

In short, rather than doing long-term safety studies on both animals and humans beforehand, what's being put into place is a "safety study" after the fact, where vaccine recipients are monitored for side effects. Unfortunately, Warp Speed, being shrouded in secrecy, has not released details about what biological parameters would actually be monitored and surveilled.

As noted by Webb: *"It really doesn't make sense, if you think about it, for something that … is funded by American taxpayers to produce a medical countermeasure or a vaccine [during] peace time, is being run by the military under extreme secrecy with a lot of involvement of intelligence contractors, or intelligence agencies themselves.*

A lot of the same initiatives proposed under that original program after 9/11 have essentially been resurrected, with updated technology, under the guise of combating COVID-19."

Later in the article Webb discusses ways that HHS is partnering with technology companies to create predictive models that will supposedly predict outbreaks before they occur in certain geographic regions. This will allow the government to shut down cities and communities even before any signs of outbreak. This is potentially ripe for abuse and very difficult for independent sources to verify and could lead to population control under the guise of "health measures".

Then there's the permanent body I.D. systems and tracking that Gate's wants to mandate along with vaccines

An article in ***Scientific American*** titled, **Invisible Ink Could Reveal whether Kids Have Been Vaccinated**, reveals that the M.I.T. researcher's project was funded by the Bill and Melinda Gates Foundation (surprise, surprise). And, "came about because of a direct request from Microsoft founder and philanthropist Bill Gates himself…"
https://www.scientificamerican.com/article/invisible-ink-could-reveal-whether-kids-have-been-vaccinated/

From the article:

"The research, conducted by M.I.T. bioengineers Robert Langer and Ana Jaklenec and their colleagues, uses a patch of tiny needles called microneedles to provide an effective vaccination without a teeth-clenching jab. Microneedles are embedded in a Band-Aid-like device that is placed on the skin; a skilled nurse or technician is not required. Vaccines delivered with microneedles also may not need to be refrigerated, reducing both the cost and difficulty of delivery, Langer and Jaklenec say."

"Along with the vaccine, a child would be injected with a bit of dye that is invisible to the naked eye but easily seen with a special cell-phone filter, combined with an app that shines near-infrared light onto the skin. The dye would be expected to last up to five years, according to tests on pig and rat skin and human skin in a dish."

"Delivering the dye required the researchers to find something that was safe and would last long enough to be useful. "That's really the biggest challenge that we overcame in the project," Jaklenec says, adding that the team tested a number of off-the-shelf dyes that could be used in the body but could not find any that endured when exposed to sunlight. The team ended up using a technology called quantum dots, tiny semiconducting crystals that reflect light and were originally developed to label cells during research."

In a related 2019 article titled, **Bill Gates, MIT Develop New 'Tattoo ID' to Check For Vaccinations**, other nefarious plans for biometric I.D.s as a means of population management is discussed. https://21stcenturywire.com/2019/12/23/bill-gates-develops-new-id-tattoo-to-check-for-vaccinations/

From the article:

"Could this technology be utilized by governments as an exclusionary tool, or as a mechanism for social engineering? Certainly he potential is there to streamline these two methods of 'people management.' Currently the US government is quietly implementing the REAL ID Act which now requires Americans to hold a biometric ID in order to travel on airplanes. US lawmakers have been pushing for this from the 1980s, when former Attorney General William French Smith had proposed to implement a 'perfectly harmless national ID system' for which another cabinet minister at the time also proposed to 'tattoo a number on each American's forearm.' To some, this may seem like the stuff of science fiction, and yet it's been openly discussed by government for decades."

And that leads us to the Bill Gates' Microchip patent

Another kind of biometric monitoring advanced by Bill Gates and Microsoft- As this technology evolves, will vaccines be the delivery system?

I covered the microchip technology invented and patented by Bill Gates and Microsoft in my June ***1200 Studies Update Newsletter***, where I've been covering the many behind the scenes stories related to COVID-19 that you will never hear from the mainstream media. Gates is the driving force behind world vaccination projects and with the United States having pulled out of the World Health Organization, Gates is now is the top funder of the W.H.O. along with China. And with provocative comments like, **"Normalcy only returns when we've largely vaccinated the entire global population."** And what better opportunity will the people working to find a system to harvest raw biometric data from everyone than this Orwellian new order we find ourselves in.

An article titled, **Bill Gates, Vaccinations, Microchips, And Patent 060606**, published on ***Orientalreview.org*** April 29, 2020 reveals what the future of microchipping humans to track their location, retrieve biometric data and exchange cryptocurrency.
https://orientalreview.org/2020/04/29/bill-gates-vaccinations-microchips-and-patent-060606/

From the article:

The case described below relates to an officially documented fact, although there is something rather biblical about it. **Patent WO/2020/060606** was registered on 26 March 2020. The patent application was filed by Microsoft Technology Licensing, LLC, headed by Bill Gates, back on 20 June 2019, and, on 22 April 2020, the patent was granted international status. The title of the patent is "Cryptocurrency system using body activity data".

So, what is this invention that the people at Microsoft decided to patent? The abstract of the patent application online states: "Human body activity associated with a task provided to a user may be used in a mining process of a cryptocurrency system. A server may provide a task to a device of a user which is communicatively coupled to the server. A sensor communicatively coupled to or comprised in the device of the user may sense body activity of the user. Body activity data may be generated based on the sensed body activity of the user. The cryptocurrency system communicatively coupled to the device of the user may verify if the body activity data satisfies one or more conditions set by the cryptocurrency system, and award cryptocurrency to the user whose body activity data is verified."

In other words, a chip will be inserted into the body that monitors a person's daily physical activity in return for cryptocurrency. If conditions are met, then the person receives certain bonuses that can be spent on something.

A detailed description of the "invention" **provides 28 concepts for how the device could be used.**

"Microsoft's involvement is interesting. And why has the patent been given the code number 060606? Is it a coincidence or the deliberate choice of what is referred to in the ***Book of Revelation*** as the number of the "mark of the beast"?

Alternatives to a vaccine- Prophylaxis and early effective treatment options

In these last sections, I will present some options for prophylaxis and early treatment with two medications and some natural alternatives like Vitamin D. Have you ever heard a public service announcement, or our health officials promote Vitamin D? I do believe Dr. Fauci did mention he takes Vitamin D one time, but that was it. But when you see the evidence on having optimal

Vitamin D levels in a link to an article on my web site, you may be outraged as I am that it isn't front page news.

Once again, I want to reiterate, that I am not saying you should not take the vaccine. Listen to and study what the people promoting them are saying. Then look at other sources of information like I have provided you. Then based on a risk vs. reward analysis, decide what is in your best interest and the best interest of your family members.

Ultimately if you decide to not take the vaccine, I have a strategy to recommend that will help you optimize your immune system's function and bolster your defenses.

Repurposed inexpensive drugs as a first line of defense

Disclaimer: *As a chiropractic physician, I do not prescribe medications and I do not tell people not to take their medications. I am simply acting as a journalist and reporting what is being reported and what the peer reviewed studies have shown. Each person must decide for themselves, with consultation from the medical provider what would be in their best interest. Even though these medications have been proven very safe over decades of use, like with any drug it may not be recommended for a very small subset of people with certain risk factors.*

There are two drugs that have been getting a lot of attention as a first line medication against COVID-19. Those are:

- **Hydroxychloroquine (HCQ) WITH ZINC-** HCQ acts as a Zinc ionophore helping Zinc to get into the cells where it can interfere with replication of the SARS-CoV-2 virus. It costs about $30 for a course of treatment. It is sometimes prescribed with Azithromycin as a prevention against secondary bacterial infection.

- **Ivermectin-** Costs about $80 for a course of treatment. Ivermectin acts both as an anti-viral and an anti-inflammatory drug. This makes it effective early in care and later as well. The anti-inflammatory aspect may lend itself well to patients after the viral replication phase in helping to control an over-reactive immune response.

Both of these medications are very inexpensive and have been used world-wide for decades, mostly for malaria and parasites with very good safety profiles. And both have very powerful

antiviral effects. HCQ is also used by millions of people in the U.S. for autoimmune disease. HCQ has been on the W.H.O.'s list of essential medications for many years.

Both of these drugs are best used early in the illness as they interfere with viral replication and can impact the exponential growth of the virus, giving the immune system a better chance of getting the upper hand. Ivermectin has also shown promise with intermediate and even some later stage illness partly because of its anti-inflammatory properties, which mitigates the hyper-immune response sometimes called a cytokine storm that occurs in some patients.

Unfortunately however, these drugs that could be a game changer according to thousands of physicians and clinics all over the world have been undermined in countries where pharma has powerful influence, including the U.S. Some recent studies looking at HCQ have been designed to fail, either omitting Zinc which is the key ingredient for success, using near lethal doses on patients that are 4-6 times what clinics are using, or using it in patients with severe advanced COVID-19 disease which is not the target population it works for. Many of the studies and reports in medical journals have been authored by people with ties to companies making competing drugs like Gilead Sciences, the makers of Remdesivir (which costs about $3,000 for a course of treatment). This is blatant bias and conflicts of interest. Medical journals allowing these "hit pieces" should be ashamed of themselves and they should be retracted.

Doctors using HCQ with amazing success, report that it is more effective in keeping people out of the hospital by helping them get better quickly early on. It is obvious that these drugs are being sabotaged by people and groups with deep ties to pharma. Some state pharmacy boards have even restricted dispensing of HCQ prescribed by physicians for COVID-19. And why would they do that? Many speculate that it is to promote the expensive antiviral treatments (i.e., Remdesivir), those drugs in development and of course, the vaccines. All you usually have to do when asking the why question in circumstances like this, is follow the money trail. It is awful to think that these actions would be intentional, as restricting their use and availability may have contributed to the deaths of hundreds of thousands of people world-wide, while we have waited for the vaccines which is where the big money lies. Fortunately for people in countries that aren't so dominated by pharma, they are using these drugs with incredible success.

More on Hydroxychloroquine (and don't forget the Zinc)

Here is the website for ***America's Frontline Doctors***. They are the group that held a press conference several weeks ago on the steps of the ***Supreme Court of the United States***. The video reached about 18 million views in 6 hours before being taken down by YouTube, the arbiter of the "truth" as they or their handlers see it. It is a great resource on HCQ.
https://www.americasfrontlinedoctors.com/

This is an AMAZING resource! It features 206 studies, 140 of which are peer-reviewed on HCQ https://c19study.com/ They estimate that over 813,000 lives have been lost (at the time of writing this article) by not using HCQ in early treatment.

Here is a site that shows many studies and the efficacy of HCQ.

https://www.sciencedirect.com/journal/international-journal-of-antimicrobial-agents/special-issue/10V3JMBH9GZ

More on Ivermectin

Here is a recently released report from a consortium of doctors that have been successfully using and studying **Ivermectin**. The group is called the ***FRONT LINE COVID-19 CRITICAL CARE ALLIANCE*** and is made up of critical care physicians https://covid19criticalcare.com/wp-content/uploads/2020/11/FLCCC-Ivermectin-in-the-prophylaxis-and-treatment-of-COVID-19.pdf

Watch Dr. Pierre Kory's passionate testimony about the effectiveness of Ivermectin on December 8, 2020, at the U.S. Senate Committee on Homeland Security and Governmental Affairs.

https://www.youtube.com/watch?v=YgOAaLmoa68&feature=emb_logo

Another great source is Dr. Paul Marik's Math + Protocol

Dr. Paul Merik is board certified in Internal Medicine, Critical Care Medicine, Neurocritical Care and Nutrition Science. Dr Marik is currently Professor of Medicine and Chief of Pulmonary and Critical Care Medicine, Eastern Virginia Medical School in Norfolk, Virginia. Dr Marik has written over 400 peer reviewed journal articles, 50 book chapters and authored four critical care books.

His website and protocol can be accessed here: https://covid19criticalcare.com/math-hospital-treatment/pdf-translations/

Natural Alternative Options

Maintaining optimal levels of Vitamin D is one of the most important things anyone can do to prevent getting COVID-19 (the disease) and if you do get it to reduce the chances of a severe outcome. Numerous studies verify the benefits against viral respiratory infections, including many recent studies on the benefits with COVID-19. You can read all about that and see dozens of references in my article on my website at https://www.wellnessdoc.com/vitamin-d-status-as-it-relates-to-covid-19-complications-and-death/

There are many other nutritional compounds that also support healthy immune function and protect against viral illness. Check out my Viral Prevention and Treatment strategies page at https://www.wellnessdoc.com/nutritional-viral-prevention-and-treatment-products/

and also general tips here https://www.wellnessdoc.com/10-effective-ways-to-prevent-and-treat-viral-infections/

Download a compilation of my *Nutrient of the Month* segments covering nutritional compounds that have shown protective anti-viral properties

HERE

Delicious Immune Boosting Drink

For prevention (prophylaxis) of viral illness, you may want to try an **immune/detox drink** that I have been making for myself and my family over the last few months. It combines several nutrients that I have covered in my ***Nutrient of the Month*** columns of my monthly newsletter over the past few months.

I like to use orange flavored Emergen-C. With the vanilla whey, it makes it taste like an orange dreamsicle. 😉

In a glass of water, add:

- 1 Pack Super Orange Emergen-C (or similar powdered Vitamin C, mineral ascorbate formula)
- 1 Zinc capsule (30 mg)
- 1 Quercetin capsule (500 mg)
- 1 NAC- capsule (500 mg)
- 1 Selenium capsule (200 mg)
- 3 grams powdered glutamine
- 1 scoop vanilla whey protein (I use cold filtered, non-hydrolyzed)

Mix with a wire whip or blender

In addition to all of the other immune modulating effects of these nutrient listed in my previous issues, they can act directly in the efforts against viral pathogens in the following ways.

- The Quercetin (a Zinc ionophore like HCQ) and Zinc act together to deliver Zinc into your cells and inhibit viral replication (not just COVID-19, but all viruses).
- The NAC, Selenium, Glutamine and undenatured Whey Protein help your body make Glutathione, the "Master Antioxidant" and detoxifier.
- The Vitamin C increases activity and effectiveness of the Innate Arm of the immune system, including Natural Killer Cells, Neutrophils, Lymphocytes and Macrophages.

I also make sure that myself and my family maintain Vitamin D levels between 60 and 80 ng/mL. If you haven't had your Vitamin D levels tested, you can order an at home test kit for just $70, postage included from and back to the lab. Order that here: https://lp.constantcontactpages.com/sh/qHdiKdW/vitaminD

If you don't have access to high quality nutritional supplements and would like help with finding the above products, you can visit my store at Wellnessdoc.com **HERE**.

Agree to the consent disclaimer and then follow the links to ***Nutridyn's*** web site through my portal. There you would sign up as a new customer (upper right of the page). After that, you can peruse the product categories and excellent products they carry.

IMPORTANT: If you contract COVID-19 and are in the high-risk categories and/or if the illness is progressing beyond mild to moderate symptoms including low oxygen levels (which you can monitor with a home pulse oximeter), **seek medical attention**, as there are medical options that can help to prevent the illness from progressing to a severe level.

Update April 11th, 2021

Associate Editor Peter Doshi of the British Medical Journal questions the "effectiveness" claims of the Pfizer and Moderna vaccines

Dr. Peter Doshi, Associate Editor of the ***BMJ*** released this opinion letter highly critical of the "effectiveness" claims the public have been hearing ad nauseum. The letter was published on January 4th, 2021. The letter titled **Peter Doshi: Pfizer and Moderna's "95% effective" vaccines—we need more details and the raw data**, reported that because of exclusionary data the actual effectiveness (and remember that only means reduction of COVID-19 symptoms), should have been reported as between 19% and 29%! In other words, the numbers had to be manipulated to get to the approximately 95% effectiveness that was reported. Remember Peter Doshi is the ***Associate Editor of the British Medical Journal (BMJ)*** and is a highly credible scientifically qualified source to analyze the data and comment on it.

From his letter:

"Suspected covid-19"

All attention has focused on the dramatic efficacy results: Pfizer reported 170 PCR confirmed covid-19 cases, split 8 to 162 between vaccine and placebo groups. But these numbers were dwarfed by a category of disease called "suspected covid-19"—those with symptomatic covid-19 that were not PCR confirmed. According to FDA's report on Pfizer's vaccine, there were "3410 total cases of suspected, but unconfirmed covid-19 in the overall study population, 1594 occurred in the vaccine group vs. 1816 in the placebo group."

With 20 times more suspected than confirmed cases, this category of disease cannot be ignored simply because there was no positive PCR test result. Indeed this makes it all the more urgent to understand. A rough estimate of vaccine efficacy against developing covid-19 symptoms, with or without a positive PCR test result, would be a relative risk reduction of 19% (see footnote)—far below the 50% effectiveness threshold for authorization set by regulators. Even after removing cases occurring within 7 days of vaccination (409 on Pfizer's vaccine vs. 287 on placebo), which should include the majority of symptoms due to short-term vaccine reactogenicity, vaccine efficacy remains low: 29% (see footnote).

However, if confirmed covid-19 is on average more severe than suspected covid-19, we must still keep in mind that at the end of the day, it is not average clinical severity that matters, it's the incidence of severe disease that affects hospital admissions. With 20 times more suspected covid-19 than confirmed covid-19, and trials not designed to assess whether the vaccines can interrupt viral transmission, an analysis of severe disease irrespective of etiologic agent—namely, rates of hospitalizations, ICU cases, and deaths amongst trial participants—seems warranted, and is the only way to assess the vaccines' real ability to take the edge off the pandemic.

There is a clear need for data to answer these questions, but Pfizer's 92-page report didn't mention the 3410 "suspected covid-19" cases. Nor did its publication in the *New England Journal of Medicine*. Nor did any of the reports on Moderna's vaccine. The only source that appears to have reported it is FDA's review of Pfizer's vaccine.

The 371 individuals excluded from Pfizer vaccine efficacy analysis

Another reason we need more data is to analyse an unexplained detail found in a table of FDA's review of Pfizer's vaccine: 371 individuals excluded from the efficacy analysis for "important protocol deviations on or prior to 7 days after Dose 2." What is concerning is the imbalance between randomized groups in the number of these excluded individuals: 311 from the vaccine group vs 60 on placebo. (In contrast, in Moderna's trial, there were just 36 participants excluded from the efficacy analysis for "major protocol deviation"—12 vaccine group vs 24 placebo group.)

What were these protocol deviations in Pfizer's study, and why were there five times more participants excluded in the vaccine group? The FDA report doesn't say, and these exclusions are difficult to even spot in Pfizer's report and journal publication.

We need the raw data

Addressing the many open questions about these trials requires access to the raw trial data. But no company seems to have shared data with any third party at this point.

Pfizer says it is making data available "upon request, and subject to review." This stops far short of making data publicly available, but at least leaves the door open. How open is unclear, since the study protocol says Pfizer will only start making data available **24 months after study completion**. ***(My emphasis and comment: and the study isn't scheduled to be completed until January 29th, 2023. That makes the release of the raw data January 29th, 2025! This is absurd with an experimental rushed to market product).***

Moderna's data sharing statement states data "may be available upon request once the trial is complete." This translates to sometime in mid-to-late 2022, as follow-up is planned for 2 years.

Things may be no different for the Oxford/AstraZeneca vaccine which has pledged patient-level data "when the trial is complete." And the ClinicalTrials.gov entry for the Russian Sputnik V vaccine says there are no plans to share individual participant data.

Footnote

Calculations in this article are as follows: 19% = 1 – (8+1594)/(162+1816); 29% = 1 – (8 + 1594 – 409)/(162 + 1816 – 287). I ignored denominators as they are similar between groups.

End of excerpts: Follow the link below to read the fell letter

https://blogs.bmj.com/bmj/2021/01/04/peter-doshi-pfizer-and-modernas-95-effective-vaccines-we-need-more-details-and-the-raw-data/

On 5 February 2021 he published a clarification to this piece. It is available here. It basically addressed some criticisms of his calculations which he defended aptly.

For those that want to see more evidence of the "fuzzy math" used to determine the "effectiveness" and the risks of the mRNA vaccines you can read this excellent article…

https://everlyreport.com/what-you-need-to-know-about-the-covid-vaccine/

Dr. Doshi had previously questioned the "end points" of the trials as not addressing the most important aspects for a successful vaccine, including protecting the elderly

Dr. Peter Doshi , Associate Editor for the BMJ released a letter on October 22nd article titled, **Coronavirus Vaccine Trials Underway May Not Tell if the Shots Save Lives of COVID-19**

Patients: British Medical Journal Expert. In that letter, he questioned the end points of the Moderna and Pfizer vaccine trails stating "None of the trials currently underway are designed to detect a reduction in any serious outcome such as hospitalisations, intensive care use, or deaths. Nor are the vaccines being studied to determine whether they can interrupt transmission of the virus."

He explained that all ongoing phase 3 trials for which details have been released are evaluating mild, not severe, disease—and they will be able to report final results once around 150 participants develop symptoms.

But Doshi raised another important issue—that few or perhaps none of the current vaccine trials appear to be designed to find out whether there is a benefit in the elderly, despite their obvious vulnerability to COVID-19.

If the frail elderly is not enrolled into vaccine trials in sufficient numbers to determine whether there is a reduction in cases in this population, "there can be little basis for assuming any benefit against hospitalisation or mortality," he warned. **My comment:** And this is something that as you will see in the next section, is playing out in a terrible way.

End of excerpts:

You can read the full letter here:

https://weather.com/en-IN/india/coronavirus/news/2020-10-22-vaccine-trials-may-not-tell-they-save-lives-of-covid-19-patients

Now that the vaccines have been rolled out to elderly and long-term care facilities, unusually high rates of deaths are being reported in elderly nursing home residents after they receive the shots

As of mid-February, reports from all over the globe have been coming in that are raising serious cause for concern over the elderly and frail getting the COVID-19 vaccines.

A CNA whistleblower from a nursing facility posted a video of himself expressing concerns over what he was seeing. The video went viral in a short amount of time before being censored and taken down. It is still being shared on various alternative platforms and by individuals. The story on this particular site is titled, **CNA Nursing Home Whistleblower: Seniors Are DYING LIKE FLIES After COVID Injections! SPEAK OUT!!!**

From the article:

James (he gives his last name in the video) is a CNA (Certified Nursing Assistant), and he recorded this video as a whistleblower because he could not keep silent any longer.

James reports that in 2020 **very few residents in the nursing home where he works got sick with COVID, and none of them died during the entire year of 2020**.

However, shortly after administering the Pfizer experimental mRNA injections, 14 died within two weeks, and he reports that many others are near death.

The video is long (47 minutes), and it is clear that James is suffering from emotional stress, and he admits that he has nothing to gain from going public, and that he will probably lose his job for doing so. But he makes it very clear that these were patients he knew and cared for (he is also a "lay pastor"), and that after being injected with the mRNA shot, residents who used to walk on their own can no longer walk. Residents who used to carry on an intelligent conversation with him could no longer talk. And now they are dying. "They're dropping like flies."

His superiors are explaining the deaths as being caused by a COVID19 "super-spreader." However, the residents who refused to take the injections, are not sick, according to James.

James makes it very clear that as a Christian, he cannot live with his conscience anymore, and that he can no longer remain silent. He is not anti-vaccine, but just sharing what he knows is true, regarding the people he has cared for in his profession for over 10 years now.

https://medicalkidnap.com/2021/01/26/cna-nursing-home-whistleblower-seniors-are-dying-like-flies-after-covid-injections-speak-out/

Once you read the article and watch the video if you choose, scroll down on that same web page and view the other stories coming in from different countries.

Norway halts vaccine rollout in the elderly due to deaths after vaccines

A January 16th article on Bloomberg.com titled **Norway Raises Concern Over Vaccine Jabs for the Elderly**, reports on the increased deaths in the elderly and frail after the Pfizer shots.

From the article:

Until Friday, the vaccine produced by Pfizer and BioNTech SE was the only one available in Norway, and "all deaths are thus linked to this vaccine," the Norwegian Medicines Agency said in a written response to Bloomberg on Saturday.

"There are 13 deaths that have been assessed, and we are aware of another 16 deaths that are currently being assessed," the agency said. All the reported deaths related to "elderly people with serious basic disorders," it said. "Most people have experienced the expected side effects of the vaccine, such as nausea and vomiting, fever, local reactions at the injection site, and worsening of their underlying condition."

The findings have prompted Norway to suggest that Covid-19 vaccines may be too risky for the very old and terminally ill, the most cautious statement yet from a European health authority.

The Norwegian Institute of Public Health judges that "for those with the most severe frailty, even relatively mild vaccine side effects can have serious consequences. For those who have a very short remaining life span anyway, the benefit of the vaccine may be marginal or irrelevant."

https://www.bloomberg.com/news/articles/2021-01-16/norway-vaccine-fatalities-among-people-75-and-older-rise-to-29

Spain halts vaccine in nursing home after 46 residents die shortly after the first Pfizer shot

Considering that the total population of the nursing home was only 145, this is an extremely high number. The residents were vaccinated in early January. In mid-February it was reported that another 28 residents and 12 staff members have tested positive for COVID-19.

https://europerenaissance.com/2021/02/19/spain-second-pfizer-shots-halted-after-46-nursing-home-residents-die-after-the-first-shot/

Concerns over the Johnson & Johnson's vaccine

This vaccine is similar to the AstraZeneca/Oxford vaccine. They are referred by some scientists as a "Frankenstein" vaccine. The reason is that it uses another virus, a chimpanzee adenovirus as the carrier for the section of the SARS-CoV-2 virus spike protein DNA, which is "spliced" into the adenovirus. It is a hybrid of sorts, part this and part that (hence the Frankenstein label). J & J's and AstraZeneca are both called recombinant Adenovirus vector vaccines. Adenoviruses are viruses that are part of the common cold spectrum of viruses, just like coronaviruses are. Like

the Pfizer and Moderna rRNA vaccines, these vaccines are a departure from the traditional vaccine platform.

Johnson & Johnson's vaccine consists of a ***replication-incompetent (genetically modified) recombinant adenovirus type 26 virus***, with the section of the SARS-CoV-2 spike protein spliced in. It also contains the following ingredients: citric acid monohydrate, trisodium citrate dihydrate, ethanol, 2-hydroxypropyl-β-cyclodextrin (HBCD), ***polysorbate 80***, sodium chloride, sodium hydroxide, and hydrochloric acid. The adenovirus is also grown in the ***PER.C6® aborted fetal cell line***.

The reason I have highlighted those 3 ingredients, is because they have proven to be problematic in other vaccines.

1. **A replication-incompetent (genetically modified) recombinant adenovirus type 26 virus** is concerning because it uses the prior mentioned technology where a virus is made incapable of replicating (Adenovirus) and the gene sequences from another virus (in this case the SARS-CoV-2 spike protein are inserted into the modified Adenovirus. There is historical context to make this a major concern. In 2015 a vaccine against Dengue Fever was developed by Sanofi Pasteur and rolled out on children in the Philippines. In that case it was a Yellow Fever Virus that had gene sequences of the Dengue Virus spliced into it. This experiment on children in the Philippines went horribly wrong resulting in criminal charges brought against researchers, health officials and Sanofi Pasteur.

   The following excerpt is from an April 24th, 2019 article published in ***ScienceMag*** titled **Dengue vaccine fiasco leads to criminal charges for researcher in the Philippines.** https://www.sciencemag.org/news/2019/04/dengue-vaccine-fiasco-leads-criminal-charges-researcher-philippines

   Dengvaxia consists of an attenuated yellow fever virus that expresses genes of each of the four types of dengue virus. The Philippine FDA greenlighted the vaccine in December 2015, based on research funded by Sanofi Pasteur in which Capeding played an important role. For example, she was the first author on a 2014 paper in *The Lancet* detailing a study among more than 10,000 children in five Asian countries that showed Dengvaxia worked and had a good safety profile. In April 2016, the Philippine government launched a $67 million public school–based immunization program for Dengvaxia.

That alarmed some scientists, because the dengue virus is peculiar: A first infection is rarely fatal, but a second one with a different virus type can lead to much more serious disease, because of what is called antibody-dependent enhancement (ADE), in which the immune response to the first virus amplifies the effect of the second type. Scott Halstead, a retired dengue expert formerly at the Uniformed Services University of the Health Sciences in Bethesda, Maryland, argued that dengue vaccines could have the same effect, and warned that Dengvaxia should not be given to children never infected with dengue. But a vaccine panel at the World Health Organization (WHO) concluded in 2016 that Dengvaxia was safe for children aged 9 and older.

Halstead's concerns proved valid. In November 2017, Sanofi Pasteur announced that the vaccine could indeed exacerbate cases of dengue in children never previously infected, and the Philippines halted the campaign immediately. (WHO now recommends the vaccine be used only after a test to be sure children have had at least one brush with dengue.)

End of excerpts

Many in the science world are concerned that the ADE or sometimes called Pathogenic Priming may not have been solely a result of the vaccine being given to children that had not had a prior infection, but that the vaccine platform (ie. The genetically modified organism created by recombinant virus splicing) may be what triggers this reaction in certain susceptible individuals. Couple that with the history of the failed prior attempts to create a coronavirus vaccine leading to termination of the trials after animal studies as a result of the numbers of animals that developed ADE and became severely ill and many dying.

2. **The PER.C6 cell line** is derived from human embryonic retinal cells, originally from the retinal tissue of an 18-week-old fetus aborted in 1985. Notoriously, DNA from the aborted fetus is present in vaccines and biologics where the viruses were grown on these cells. The FDA allows for 100,000,000 bits and strands of human DNA per dose. That is problematic, because as Dr. Theresa Deisher has warned can cause insertion into the recipient’s DNA of this other human DNA (called homologous recombination) and lead to development of autoimmunity and other chronic health issues. Not to mention that it is abhorrent for many persons of faith to have human DNA from a fetus that was aborted for this purpose to be injected into their own body and potentially become part of their own DNA.

You can read about more about aborted fetal cell lines, Dr. Deisher's work in this area as well as the many problems with Polysorbate 80 in my eBook available at https://1200studies.com.

3. **Polysorbate 80** has been shown to cause allergic and even anaphylactic reactions in some people. It also has been shown to disrupt the blood-brain-barrier and aid in transport of drugs, chemicals and nanoparticles, even mercury and aluminum into the brain.

As a footnote, in October 2020 Johnson & Johnson paused its trial due to an undisclosed "unexplained illness" in one of its participants. This illness has not been disclosed publicly.

The AstraZeneca/Oxford vaccine has the same genetically modified virus technology

The AstraZeneca Vaccine has the same recombinant technology as the Johnson & Johnson Vaccine described below. Recombinant in this case means that DNA is combined in a lab from two different viruses into a hybrid organism (genetically modified organism- GMO), that would not normally be found in nature. Read on about the Johnson & Johnson Vaccine to see why that is such a concern by many scientists.

Johnson & Johnson's Vaccine hits a snag as multiple people suffer adverse effects at various vaccine sites

North Carolina paused two vaccine sites April 8th, as 18 people suffered reactions and four were hospitalized. In Colorado Wednesday, eleven people had adverse reactions and two were hospitalized. , Iowa and Georgia also reported adverse reactions.

In an article written by Megan Redshaw and released on ***Children's Health Defense*** website April 9th, the following was reported….In response to the recent reports of site closings, the vaccine maker said in a statement, "there is no greater priority than the safety and well-being of the people we serve. When we receive reports of adverse events in individuals receiving our medicines and vaccines, we collect necessary information and carefully assess the events."

As ***The Defender***, ***Children's Health Defense*** publication reported in March, J&J has a criminal track record involving safety concerns with numerous products. The company has paid billions of dollars in fines and punitive damages related to fraud and other dubious practices for its role in the opioid crisis, for failure to warn that Risperdal — an antipsychotic drug produced by the company — could lead to breast growth in boys and for its asbestos-tainted baby powder associated with cancer, which the company knew about for almost 50 years and failed to disclose.

On Wednesday, EU regulators confirmed a "possible link" between AstraZeneca and blood clots resulting in suspension of AstraZeneca's vaccine in younger populations in many European countries, and guidance in the UK that the vaccine not be used in people under 30.

The European Medicines Agency said Wednesday during a press conference it is also looking carefully at the J&J vaccine, as three cases of blood clots associated with low platelets, similar to the cases reported after AstraZeneca vaccines, have been reported, as well as one instance of thrombosis in a clinical trial.

End of excerpts

New concerns over the Moderna and Pfizer mRNA vaccines

Spike protein introduced into and replicated by our cells from the mRNA vaccines are released into circulation when those cells are later destroyed by our immune system may cause widespread damage

Dr. J. Patrick Whelan M.D., PhD, with degrees in medicine, biochemistry and rheumatology warned the FDA in December that mRNA vaccines could cause microvascular injury to the brain, heart, liver and kidneys in ways not assessed in safety trials. That warning was ignored by the FDA.

This is from an article by Lyn Redwood of Children's Health Defense in a February 10th, 2021 article that she wrote titled, **Could Spike Protein in Moderna, Pfizer Vaccines Cause Blood Clots, Brain Inflammation and Heart Attacks?**

From the article:

"The most likely culprit that has been identified is the COVID-19 spike protein released from the outer shell of the virus into circulation. Research cited below has documented that the viral

spike protein is able to initiate a cascade of events that triggers damage to distant organs in COVID-19 patients."

"Worryingly, several studies have found that the spike proteins alone have the capacity to cause widespread injury throughout the body, without any evidence of virus."

"What makes this finding so disturbing is that the COVID-19 mRNA vaccines manufactured by Moderna and Pfizer and currently being administered throughout the U.S. program our cells to manufacture this same coronavirus spike protein as a way to trigger our bodies to produce antibodies to the virus.

According to Whelan's letter to the FDA, the "Pfizer/BioNTech vaccine is composed of an mRNA that produces a membrane-anchored full-length spike protein.""

To read the full article with links to references go here:
https://childrenshealthdefense.org/defender/moderna-pfizer-vaccines-blood-clots-brain-inflammation-heart-attacks/

Polyethylene Glycol (PEG) is suspected in severe anaphylactic reactions and deaths from the COVID-19 vaccines

The mRNA vaccines from Pfizer/BioNTech and Moderna contain polyethylene glycol (PEG). The mRNA is packaged into lipid and Polyethylene Glycol (PEG) nanoparticles. **70% of people develop antibodies against this substance – this means that many people can develop allergic, potentially fatal reactions to the vaccination.**

There have been many reports of severe reactions thought to be attributed to the PEG in the vaccines. Another concern revolves around the easy uptake by the brain of this lipophilic (easily absorbed by fatty tissue) molecule, potentially causing brain inflammation due to activation of the brain's microglia (immune cells). The brain is composed of around 60% fat, making a lipid nanoparticle easily absorbed.

There are 3 articles of interest I came across in the last month…

1. **Polyethylene glycol as a cause of anaphylaxis** from the Journal ***Allergy, Asthma & Clinical Immunology.*** https://pubmed.ncbi.nlm.nih.gov/27999603/

Conclusion: Potential life-threatening hypersensitivity reactions to hidden molecules like macrogol may be underdiagnosed. Cases of immediate-type PEG hypersensitivity were reported with increasing frequency. The awareness regarding the allergenic potential of PEG should be raised and a proper product labelling is crucial to prevent PEG mediated hypersensitivity.

2. **Analysis of Pre-existing IgG and IgM Antibodies against Polyethylene Glycol (PEG) in the General Population** from the journal ***Analytical Chemistry.***
https://pubmed.ncbi.nlm.nih.gov/27804292/

From the study: The widespread prevalence of pre-existing anti- PEG Ab, coupled with high Ab levels in a subset of the population, underscores the potential importance of screening patients for anti-PEG Ab levels prior to administration of therapeutics containing PEG.

Now we all know that isn't happening before the administration of the vaccines!

3. **Physician Awareness of Immune Responses to Polyethylene Glycol-Drug Conjugates** from ***Clinical and Translational Science***. https://pubmed.ncbi.nlm.nih.gov/29383836/

This article reinforces that doctors have a poor level of awareness of the scope of the risk of allergic reactions to PEG. This is especially concerning since we are seeing a large uptick in allergic reactions from the COVID-19 vaccines, some fatal. Doctors need to know that this risk exists, how to recognize it and report them to the VAERS system when they occur.

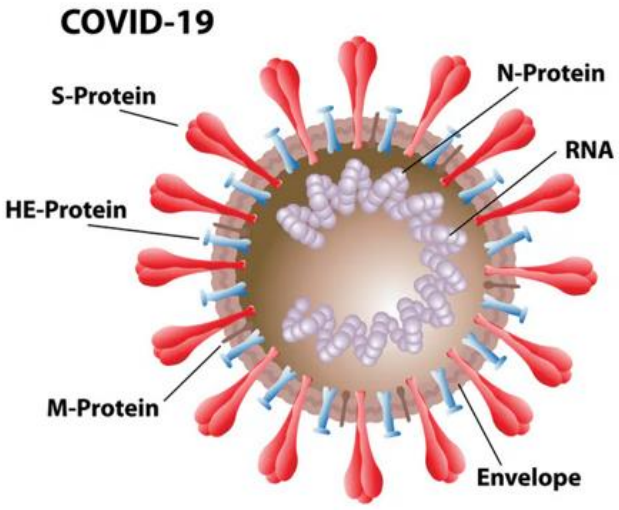
4. **COVID-19 vaccine-associated anaphylaxis: A statement of the World Allergy Organization Anaphylaxis Committee** from the ***World Allergy Organization Journal***
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7857113/pdf/main.pdf

This article is very interesting in that it covers various aspects of allergy and anaphylaxis, suggesting that these reactions may be due to more than the PEG in the Messenger RNA vaccines. It's covers the role that PEG plays in anaphylaxis, but it also suggests a possible reaction to the mRNA itself or other components. It also gives a table of indicators that

would suggest caution or avoidance of vaccination in certain individuals. Because of the credibility and reputation of this organization, these recommendations may be used to help protect and then individuals right to avoid the potential for serious adverse reactions.

Another reason why natural immunity and acquired immunity from getting COVID-19 is better than the vaccine

The graphic below is from an article in ***Discover Magazine*** titled, **COVID Vaccines Focus on the Spike Protein – But Here's Another Target**. One detail I would like to point out is that the virus is not called COVID-19. COVID-19 is the illness caused by the virus which is called SARS-CoV-2.



As you can see, there are 5 proteins that form the overall structure of the virus.

1. The Spike protein (S)
2. The Nucleocapsid protein (N)
3. The Envelope protein (E)
4. The Membrane protein (M)
5. The Hemagglutinin protein (HE)

https://www.discovermagazine.com/health/covid-vaccines-focus-on-the-spike-protein-but-heres-another-target

The COVID-19 vaccine model of "immunity"

All the vaccine candidates that have been developed and now introduced into the market concentrate on introducing the Spike protein to our immune system. This is the portion of the virus that "docks" with the ACE-2 receptors on our cell membrane. This then starts the process of entry for the virus into our cells where it can use our cell as a host to replicate. This fragment of the spike protein that is introduced into our body by the vaccines causes our immune system to recognize that particular DNA or RNA specific to the Spike protein and produces antibodies that recognize the spike protein when a person is later exposed to the wild virus. This then tells other parts of the immune system to respond to the threat.

The body's model of immunity

Unlike the limited recognition by our immune system of only one of the five SARS-CoV-2 proteins, an infection with the wild virus triggers immune recognition of all 5 of the viral proteins, essentially the total virus. Why is this important? It is because as the virus mutates as they always do (and we certainly have been hearing a lot about that lately), some of those mutations may happen with the Spike protein. This results in the antibodies that are trained to recognize the original Spike protein DNA sequences from the vaccine not recognizing the mutated form that is now in circulation. And therefore, an immune response would not be triggered. Of course, as pharma would like you to believe, you could always get the next version of the vaccine where they have "fine-tuned" it. And on and on and on just like the flu shot. But maybe that was the plan all along. The people working in vaccine development are certainly smart enough (one would think anyway) to know this would happen. Once again, natural immunity trumps vaccinology every time.

Shockingly, Anthony Fauci knows that injected vaccines do not interrupt infection or transmission. This is a striking admission!

In an article authored by Dr. Fauci published January 19th, 2021 titled **SARS-CoV-2 Vaccines: Much Accomplished, Much to Learn,** a startling revelation came to light. This is a screen capture of the journal page with our "illustrious" Dr. Fauci listed as an author.

The following is a quote from the article…

Given that recent polling suggests that only 40% to 60% of people in the United States are currently planning to get vaccinated, it is conceivable that without some impact on transmission, the virus will continue to circulate, infect, and cause serious disease in certain segments of the unvaccinated population. Administration of parenterally administered vaccines alone typically does not result in potent mucosal immunity that might interrupt infection or transmission (9). https://pubmed.ncbi.nlm.nih.gov/33460347/

That reference (#9) is to an article published in ***Frontiers in Immunology***, November 2020 and titled **Mucosal Immunity in COVID-19: A Neglected but Critical Aspect of SARS-CoV-2 Infection.**

In that article it states the following, essentially saying that the injectable vaccines are not going to be effective and suggesting nasal spray vaccines and other delivery methods. Get ready for the next wave of vaccine delivery systems:

"Almost all efforts at vaccine development against COVID-19 focus on systemic injection, which predominantly induces circulatory IgG antibodies and, potentially, cytotoxic T cells (18). These routes are poorly effective at generating mucosal immune responses, which can only be induced by mucosal routes of immunization, including through the NALT in the URT *(NALT is Nasopharynx-Associated Lymphoid Tissue and URT is Upper Respiratory Tract).* Mucosal immune responses are partly compartmentalized, as the distribution of the responses depends

on the actual route of induction (7, 19). For example, the enteric route predominantly generates responses in the gastro-intestinal tract, whereas the nasal route predominantly

generates responses in the respiratory tract and salivary glands (7)".

"Finally we expect that efforts in vaccine development aimed at inducing mucosal immune responses and memory cells, especially in the URT, would yield benefits not seen with conventional parenteral *(injectable)* routes of vaccine administration. Intranasal vaccines are already available against influenza and others are under development (30, 38). The advantages, in addition to needle-free administration, include the generation

of both mucosal (SIgA) and circulating (IgG and IgA) antibodies, as well as T-cell responses. As discussed above, such responses might achieve desirable results not obtained with systemic immunization routes."

https://www.frontiersin.org/articles/10.3389/fimmu.2020.611337/full

Ironically, the ACE-2 receptors of mucosal cells are the way SARS-CoV-2 infects humans. Therefore, mucosal immunity is a critical aspect to defending against the virus. So, essentially what this paper authored by Fauci is saying, is that injected vaccines are not going to trigger mucosal immunity effectively. Why isn't this being communicated to the public?

I have one simple question. Why is Anthony Fauci and the government agencies he is involved with pushing experimental vaccines that he knows are most likely not going to be effective and preventing infection or transmission and marketing it with language (i.e. 95% "effective"), which leaves people with the impression that it will help us to end the pandemic, knowing full well that is not true?

Now people of the world are Guinea Pigs for the world's largest ever human experiment and a very dangerous one at that, because of the novel technology never before used in humans in a rushed-to-market vaccine that was developed in 10% of the time normally required to safety test a new vaccine. Am I the only one this infuriates?

What are the latest Infection Fatality Rates for different age groups in the U.S.?

Updated on CDC site 03-19-21

Table 1. Parameter Values that vary among the five COVID-19 Pandemic Planning Scenarios. The scenarios are intended to advance public health preparedness and planning. They are **not** predictions or estimates of the expected impact of COVID-19.

Parameter	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5: Current Best Estimate
R_0*	2.0		4.0		2.5
Infection fatality ratio (Estimated number of deaths per 1,000,000 infections)†	0–17 years old: 6 18–49 years old: 150 50–64 years old: 1,800 65+ years old: 26,000		0–17 years old: 80 18–49 years old: 1,700 50–64 years old: 20,000 65+ years old: 270,000		0–17 years old: 20 18–49 years old: 500 50–64 years old: 6,000 65+ years old: 90,000
Percent of infections that are asymptomatic§	15%	70%	15%	70%	30%
Infectiousness of asymptomatic individuals relative to symptomatic¶	25%	100%	25%	100%	75%
Percentage of transmission occurring prior to symptom onset**	30%	70%	30%	70%	50%

https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html

Later in this newsletter we will compare these death rates from COVID-19 to the reported and also the more likely death rates from the vaccines…Stay tuned!

World renowned vaccine scientist warns of a global catastrophe from the vaccine program

First, I would like to present this scientist/researcher's credentials

Geert Vanden Bossche, PhD, DVM

GSK biologicals:

- Senior Project Leader of Adolescent Vaccine Projects
- New Biotech Vaccine Development and QC-QA Manager
- Head of Adjuvant Technologies and Alternative Deliveries, R&D

Novartis vaccines and diagnostics:

- Director, Research Program Leader and Head of Adjuvants

Solvay Biologicals:

- Global Project Director Influenza Vaccines

Bill and Melinda Gates Foundation:

- Senior Program Officer, Global Health, Vaccine Discovery

Global Alliance for Vaccines and Immunization (GAVI)

- Program Manager

Univac

- Chief Innovation and Scientific Officer

German Center for Infection Research (DZIF)

- Head of the Vaccine Development Office

VARECO

- Managing Director

https://www.bitchute.com/video/BGtSE3OfO2wv/ Starts at 56:30

Here are the opening sections of his letter:

Geert Vanden Bossche, DMV, PhD, *independent virologist and vaccine expert, formerly employed at*

GAVI and The Bill & Melinda Gates Foundation.

To all authorities, scientists and experts around the world, to whom this concerns: the entire world

population.

I am all but an antivaxxer. As a scientist I do not usually appeal to any platform of this kind to make a stand on vaccine-related topics. As a dedicated virologist and vaccine expert I only make an exceptionwhen health authorities allow vaccines to be administered in ways that threaten public health, most certainly when scientific evidence is being ignored. The present extremely critical situation forces me to spread this emergency call. As the unprecedented extent of human intervention in the Covid-19- pandemic is now at risk of resulting in a global catastrophe without equal, this call cannot sound loudly and strongly enough.

As stated, I am not against vaccination. On the contrary, I can assure you that each of the current vaccines have been designed, developed and manufactured by brilliant and competent scientists.

However, this type of prophylactic vaccines are completely inappropriate, and even highly dangerous, when used in mass vaccination campaigns during a viral pandemic. Vaccinologists, scientists and clinicians are blinded by the positive short-term effects in individual patents, but don't seem to bother about the disastrous consequences for global health. Unless I am scientifically proven wrong, it is difficult to understand how current human interventions will prevent circulating variants from turning into a wild monster.

Racing against the clock, I am completing my scientific manuscript, the publication of which is,

unfortunately, likely to come too late given the ever increasing threat from rapidly spreading, highly

infectious variants. This is why I decided to already post a summary of my findings as well as my keynote speech at the recent *Vaccine Summit* in Ohio on LinkedIn. Last Monday, I provided international health organizations, including the WHO, with my analysis of the current pandemic as based on scientifically informed insights in the immune biology of Covid-19. Given the level of emergency, I urged them to consider my concerns and to initiate a debate on the detrimental consequences of further 'viral immune escape'. For those who are no experts in this field, I am attaching below a more accessible and comprehensible version of the science behind this insidious phenomenon.

You can read the entire letter here:

https://mcusercontent.com/92561d6dedb66a43fe9a6548f/files/bead7203-0798-4ac8-abe2-076208015556/Public_health_emergency_of_international_concert_Geert_Vanden_Bossche.01.pdf

Typically, as viruses mutate, they may become more contagious, but less virulent (deadly). That may still hold true with SARS-CoV-2, at least to the non-vaccinated. But what about the vaccinated? Whether Dr. Vanden Bossche's predictions come true of not remain to be seen, but they do highlight one of the very possible risks that have been seen with other vaccination programs (measles and pertussis to name a couple) and one that is not beyond the realm of possibility with the rush vaccination efforts during this pandemic.

A brilliant evolutionary biologist and scientist lays out the most likely scenario for the COVID-19 vaccines to result in an epidemic of future illness in vaccinees and risk of autoimmune disease

James Lyons-Weiler PhD, CEO and Director of ***IPAK, the Institute for Pure and Applied Knowledge***

is a brilliant critical thinker. And his background makes him a perfect voice of reason that the scientific community had better listen to.

In an opinion piece March 17, 2021, he lays out the mechanisms for a likely autoimmune epidemic in COVID-19 vaccine recipients in the coming months and years. He also makes a case for natural immunity being superior to partial (vaccine derived) immunity. It can be a little technical, but for you science nerds like me (and you know who you are), you're going to love and appreciate it!

Here goes:

I've been doing a deep dive into the immunology of COVID19 scientific literature for weeks now, and it seems someone somewhere has proposed nearly every possible ill effect of the virus on the immune system. Few have bothered to transfer that concern over fully to vaccine effects.

We've all suspected **antigenic shift** and **antigenic drift** from all of the pediatric vaccines for quite some time.

Original antigenic sin has been known to be a problem with fixed vaccines - specifically w/influenza - since the 1950s. Andy (Wakefield) published a beautiful write-up on MMR vaccine failure; we know the mumps portion is failing because the vaccine lineage is older than anyone born after 1961.

The deal w/SARS-CoV-2, is that everything is happening on a massive scale at an accelerated pace: new variants are emerging due to RNA virus evolution - but they are increasing in frequency (proliferating) on an adaptive landscape specifically because of flattening, not truncating, the curve (in descending order of importance, i.e., size of selection coefficient, my guesstimate):

(1) **viremia** being allowed to increase in infected people (denial of early treatment) because new mutations occur in people

(2) **test escape** (increased survival and transmission of viruses due to non-isolation of people infected w/variants that escape the test)

(3) **immunological escape** (survival and transmission of viruses that can escape our immune responses

(4) **migration** (heterogeneity in public health response (maintenance of all variants at different frequencies somewhere in the globe))

(5) genetic drift

All of the above interact and are not competing.

In the meantime, allopathy has written itself another permission slip to skip Antibody Dependent Enhancement (ADE) in COVID19 - with highly questionable reliance on "authority" that absolutely misrepresents ADE (it's illness of infected immune cells, but allopathy does not want to make that part well known because the answer is antivirals, which compete w/vaccines.

https://www.medpagetoday.com/special-reports/exclusives/91648?xid=nl_mpt_DHE_2021-03-17

This completely ignores the pathogenic priming of people toward autoimmunity.

Definition of epitope: a molecular region on the surface of an antigen capable of eliciting an immune response and of combining with the specific antibody produced by such a response.

As an evolutionary biologist, my focus is on **pathoimmunogenic EPITOPES,** not vaccine, not virus. **EPITOPES**.

The pathoimmunogenic epitopes cause disease when introduced to the human body **via infection or vaccine**.

Real-world contemporary example

Let's call the spike protein in the current vaccines **spike2019.**

Due to original antigenic sin, a partial immune response to viral epitopes in the spike protein only will cause people to mount an ineffective immune response to the virus when it evolves new spike protein epitope variants. These people will not have long-term adaptive immunity to the other pathoimmunogenic epitopes from the virus, and thus they will experience a new immune response - **as if they have not been vaccinated.**

So, we will see full-blown COVID-19 in some vaccinees regardless of their immunity to spike2019 epitopes (antigenic shifting).

Some of these people will have the same baseline rate of morbidity and mortality as anyone else... but will fail to seek care because they are vaccinated - they will not receive early treatment and thus morbidity and mortality will be higher.

Some **non-immune vaccinees** (who will not mount an adequate immune response to spike2020+ epitopes) will also have had occult infection (subclinical COVID19) before, during or after their vaccination.

Some of these non-immune vaccinees people are at full risk of ADE and autoimmunity from infection following secondary infection.

Why? Because we're keeping the virus around so long, because public health failed to truncate the curve. Failed early testing.

So, at this point, pathogenic priming is all-important (validated by Harvard scientists, very much recognized in the scientific literature) because autoimmunity from exposure to viral immunopathogenic epitopes is important and non-immune vaccinees are sitting ducks for it.

Natural immunity brings about a wide repertoire of responses to all of the immunogenic epitopes (diverse IgG, diverse memory B-cells, diverse T-cells).

People who have broad, lasting immunity can feel safer in a world w/COVID-19.

We need studies of the antibody responses to non-spike immunogenic epitopes... titres against spike2019 won't prove immunity for anyone for the reasons outlined above.

What about "Recurrent Infection"?

Some articles that show Spike proteins DID contribute to ADE and that "recurrent infection" can occur (likely due to new variants). I would not call it "recurrent infection"; I would call it "new infection by a non-vaccine-targeted lineage of SARS-CoV-2."

Also, here is some info on **immune escape.**

Their fabled, magical belief in "protection" from vaccines is going to be shattered by COVID-19, and it's going to be a wake-up call to those who wanted the vaccine so badly. They won't be able to keep up via updates to the vaccine, it's just not possible. Recall what's going on w/HPV vaccination - type replacement - it's the same thing.

https://www.sciencedirect.com/science/article/pii/S0163445321000438

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7749790/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3187504/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7115648/

https://www.sciencedirect.com/science/article/pii/S0163445321000104

https://www.sciencedirect.com/science/article/pii/S0163445321000438

They can try to deny ADE, but once chronic illness due to vaccination (as outlined below) is in full swing, there will be no denying it. THUS, they will require 100% vaccination to disallow any control group.

Risks vs "benefits" of the COVID-19 vaccines- JLW

(1) The vaccines can only be expected to provide protection against severe COVID19 and death for viruses that have the same spike protein epitopes against which people have been vaccinated. It's wishful thinking to expect cross-protection.

(2) The vaccines do not confer immunity from antibodies from any of the other viral epitopes; thus, when evolutionary pressure (antigenic shifting) makes the SARS-CoV-2 vaccines obsolete, those who believe they immune will be fully vulnerable to infection from SARS-CoV-20, 21, 22 etc. Only those who had prior COVID-19 INFECTION will be immune; the vaccine does not deserve ANY credit for immunity due to SARS-CoV-2 infection. To attribute immunity to SVCV2 vaccines is a form of "stolen valor". Objectivity dictates that we assay vaccinees and non-vaccinees for non-spike protein antibody immunity so proper scientific understanding of human immunity against SARS-CoV-2 can be procured.

(3) The total "benefit" of the SVCV2 vaccination program MUST include the full assessment, over one human lifetime, to the contribution of the vaccine-induced autoimmunity due to unsafe (immunopathological) epitopes - and a strategic misjudgment in vaccine formulation. The vaccines should have been multi-epitope with unsafe (autoimmunogenic) epitopes removed.

Given all of the above, and given that diseases of unknown origin have been on the increase since 1976 when the 1st national vaccination program against a respiratory virus was started (see https://jameslyonsweiler.com/2018/01/31/diseases-with-unknown-etiology-trace-back-to-mass-vaccination-against-influenza-in-1976/ for the compelling finding), I cannot in good faith promote the currently available vaccines.

The actual risk to benefit equation is undefined. Thus, choice. Thus, no mandate. Thus, more science on vaccinated vs. unvaccinated.

Here, for example, is an example of a SARS-CoV-1 autoimmunity induced in vaccinated animals.

Glycan arrays lead to the discovery of autoimmunogenic activity of SARS-CoV

https://journals.physiology.org/doi/pdf/10.1152/physiolgenomics.00102.2004

Which patients do worse from COVID-19 and thus potentially from the vaccines? JLW

We're not questioning basic principles of immunology. We're just taking in ALL of the information - the good and bad of it. As any science should.

My concern is reliance on unwarranted over-generalizations based on immunogenicity, ignoring pathimmunogenicity.

You're all about risk of vaccination given a certain condition (residual viral material).

But check this out, for example

"Patients that tested positive for auto-antibodies had a significantly more severe prognosis than other patients did: 6 of 15 patients (40%) with auto-antibodies died due to COVID-19 complications during hospitalization, whereas only 1 of 18 patients (5.5%) who did not have auto-antibodies died (P=0.03)." https://pubmed.ncbi.nlm.nih.gov/32989903/

To me, this meant that those who have prior autoreactogenic immune systems do poorly.

We should focus on finding out what causes people to have Th2-skew and pro-autoreactogenic immune systems.

We see these features of poor immune health in highly vaccinated populations, esp. w/Aluminum.

Animal studies routinely use aluminum hydroxide to induce autoimmunity in animals. I've consumed all of that literature - the doses overlap per body weight up to year 2.

If so many people didn't have autoimmunity, would COVID-19 be much less of a threat?

Again, a determination of full cost/benefit of vaccine calculation requires full, unbiased accounting of the costs.

Denialism (by the public health oligarchy) in the name of "vaccine efficacy" has prevented objective analysis. Even IOM/NAS was rigged to prevent vaccine hesitancy. An utter waste of time, at great expense to our nation's health.

Here's more evidence that people w/autoreactogenic immune systems are at higher risk and are walking into a storm - unlike most people -

Latent rheumatic, thyroid and phospholipid autoimmunity in hospitalized patients with COVID-19 Juan-Manuel Anaya 1 , Diana M Monsalve 1 , Man

https://pubmed.ncbi.nlm.nih.gov/33681751/

Thank you Dr. Lyons-Weiler for a very insightful discussion and hopefully a wake-up call for the perpetrators of the mass vaccination program experiment before it's too late.

A new study showcases the advantage of natural infection over vaccine immunity with regard to SARS-CoV-2 variant strains

As a great follow up on the previous discussion on natural immunity, a new pre-print study titled **Memory B cell repertoire for recognition of evolving SARS-CoV-2 spike** highlights the effectiveness of long-term capabilities, diversity and flexibility of memory immune function.

From the abstract:

Memory B cell reserves can generate protective antibodies against repeated SARS-CoV-2 infections, but with an unknown reach from original infection to antigenically drifted variants.

The results furnish a global atlas of the S-specific memory B cell repertoire and illustrate properties conferring robustness against emerging SARS-CoV-2 variants.

More from the study:

(PC = Plasma Cells, GC = Lymphoid tissue Germinal Centers, ABs = Antibodies and SHM = gene Somatic Hyper-Mutation)

Both PC-derived secreted antibody and memory B cells supply immune memory to prevent repeat infection, but with non-redundant roles. Secreted antibodies can prophylactically thwart pathogen invasion with fixed recognition capability, while memory B cells harbor expanded pathogen recognition capacity and can differentiate quickly into PCs to contribute dynamically to the secreted antibody repertoire (*4*). Moreover, memory B cells retain plasticity to adapt to viral variants through GC re-entry and SHM-mediated evolution (*5*).

In a comprehensive competition analysis of 152 monoclonal antibodies (mAbs) from 19 subjects for binding with trimeric S ectodomain, we have identified 7 recurrently targeted competition groups -- three for antibodies with epitopes on the receptor-binding domain (RBD), two for epitopes on the N-terminal domain (NTD), and two for S2 epitopes. We show that these groups represent the major practical antibody footprints, with rare antibodies outside them.

Discussion:

Our results illustrate the landscape of memory B cell coverage of the SARS-CoV-2 S glycoprotein in convalescent donors. Unlike the terminally differentiated plasma cells that determine the profile of serum antibodies, memory B cells will clonally expand upon re-exposure to antigen, some differentiating into fresh antibody secreting cells and others re-entering germinal centers and undergoing further SHM-mediated diversification and affinity maturation. These outcomes offer a layer of flexibility for adaptation to drifted or related viral strains, if available secreted antibodies fail to prevent initial infection. Loss of protection against overt or severe disease is not an inevitable consequence of a waning serum antibody titer. This atlas of B cell memory therefore maps systematically a crucial component of the long-term immune response to SARS-CoV-2 infection.

Complementary recognition of non-overlapping viral targets by non-competing antibodies in the repertoire can reduce the likelihood of viral escape (*41*). Our data suggest an additional mechanism for preventing viral escape: competing antibodies may help retain recognition of a rapidly evolving antigen by their differential sensitivity to specific mutations. The potential dynamic reach of otherwise redundant mAb recognition, illustrated by selective retention of affinity for the UK variant by some antibodies within a cluster but not by others, may give selective advantage to immune mechanisms that yield multiple competing antibodies to critical epitopes, as those that retain adequate affinity can then re-activate, expand, and potentially undergo further affinity maturation. The emergence of strains that may have gained selective advantage by escape from neutralization emphasizes the importance of determining whether the level of retained affinity for the S protein by some antibodies in the immunodominant clusters influences protection from clinical disease.

https://europepmc.org/article/MED/33758863

Urgent letter from doctors and scientists to the European Medicines Agency over COVID-19 Vaccine concerns

An article titled, **Urgent Open Letter from Doctors and Scientists to the European Medicines Agency regarding COVID-19 Vaccine Safety Concerns**, was published on the ***Doctors for Covid Ethics*** site.

The letter in its entirety:

Emer Cooke, Executive Director, European Medicines Agency, Amsterdam, The Netherlands

28 February 2021

Dear Sirs/Mesdames,

FOR THE URGENT PERSONAL ATTENTION OF: EMER COOKE, EXECUTIVE DIRECTOR OF THE EUROPEAN MEDICINES AGENCY

As physicians and scientists, we are supportive in principle of the use of new medical interventions which are appropriately developed and deployed, having obtained informed consent from the patient. This stance encompasses vaccines in the same way as therapeutics.

We note that a wide range of side effects is being reported following vaccination of previously healthy younger individuals with the gene-based COVID-19 vaccines. Moreover, there have been numerous media reports from around the world of care homes being struck by COVID-19 within days of vaccination of residents. While we recognise that these occurrences might, every one of them, have been unfortunate coincidences, we are concerned that there has been and there continues to be inadequate scrutiny of the possible causes of illness or death under these circumstances, and especially so in the absence of post-mortems examinations.

In particular, we question whether cardinal issues regarding the safety of the vaccines were adequately addressed prior to their approval by the European Medicines Agency (EMA).

As a matter of great urgency, we herewith request that the EMA provide us with responses to the following issues:

1. Following intramuscular injection, it must be expected that the gene-based vaccines will reach the bloodstream and disseminate throughout the body [1]. We request evidence that this

possibility was excluded in pre-clinical animal models with all three vaccines prior to their approval for use in humans by the EMA.

2. If such evidence is not available, it must be expected that the vaccines will remain entrapped in the circulation and be taken up by endothelial cells. There is reason to assume that this will happen particularly at sites of slow blood flow, i.e. in small vessels and capillaries [2]. We request evidence that this probability was excluded in pre-clinical animal models with all three vaccines prior to their approval for use in humans by the EMA.

3. If such evidence is not available, it must be expected that during expression of the vaccines' nucleic acids, peptides derived from the spike protein will be presented via the MHC I — pathway at the luminal surface of the cells. Many healthy individuals have CD8-lymphocytes that recognize such peptides, which may be due to prior COVID infection, but also to cross-reactions with other types of Coronavirus [3; 4] [5]. We must assume that these lymphocytes will mount an attack on the respective cells. We request evidence that this probability was excluded in pre-clinical animal models with all three vaccines prior to their approval for use in humans by the EMA.

4. If such evidence is not available, it must be expected that endothelial damage with subsequent triggering of blood coagulation via platelet activation will ensue at countless sites throughout the body. We request evidence that this probability was excluded in pre-clinical animal models with all three vaccines prior to their approval for use in humans by the EMA.

5. If such evidence is not available, it must be expected that this will lead to a drop in platelet counts, appearance of D-dimers in the blood, and to myriad ischaemic lesions throughout the body including in the brain, spinal cord and heart. Bleeding disorders might occur in the wake of this novel type of DIC-syndrome including, amongst other possibilities, profuse bleedings and haemorrhagic stroke. We request evidence that all these possibilities were excluded in pre-clinical animal models with all three vaccines prior to their approval for use in humans by the EMA.

6. The SARS-CoV-2 spike protein binds to the ACE2 receptor on platelets, which results in their activation [6]. Thrombocytopenia has been reported in severe cases of SARS-CoV-2 infection [7]. Thrombocytopenia has also been reported in vaccinated individuals [8]. We request evidence that the potential danger of platelet activation that would also lead to disseminated intravascular coagulation (DIC) was excluded with all three vaccines prior to their approval for use in humans by the EMA.

7. The sweeping across the globe of SARS-CoV-2 created a pandemic of illness associated with many deaths. However, by the time of consideration for approval of the vaccines, the health systems of most countries were no longer under imminent threat of being overwhelmed because a growing proportion of the world had already been infected and the worst of the pandemic had already abated. Consequently, we demand conclusive evidence that an actual emergency existed at the time of the EMA granting Conditional Marketing Authorisation to the manufacturers of all three vaccines, to justify their approval for use in humans by the EMA, purportedly because of such an emergency.

Should all such evidence not be available, we demand that approval for use of the gene-based vaccines be withdrawn until all the above issues have been properly addressed by the exercise of due diligence by the EMA.

There are serious concerns, including but not confined to those outlined above, that the approval of the COVID-19 vaccines by the EMA was premature and reckless, and that the administration of the vaccines constituted and still does constitute "human experimentation", which was and still is in violation of the Nuremberg Code.

In view of the urgency of the situation, we request that you reply to this email within seven days and address all our concerns substantively. Should you choose not to comply with this reasonable request, we will make this letter public.

https://doctors4covidethics.medium.com/urgent-open-letter-from-doctors-and-scientists-to-the-european-medicines-agency-regarding-covid-19-f6e17c311595

The letter also provides a list of references to studies supporting their concerns and a list of the doctors and scientists that have generated the letter.

New research points to link between AstraZeneca Vaccine and blood clots

Researchers in Norway and Germany say they've identified antibodies that provoke immune reactions leading to the type of cerebral blood clots experienced by some people who received AstraZeneca's COVID vaccine.

A March 22nd article posted on ***Children's Health Defense*** by Megan Redshaw reveals the mechanisms of the suspected connection between the rash of fatalities and strokes and the AstraZeneca Vaccine.

Researchers at the Greifswald teaching hospital in northern Germany said Friday they've discovered how the AstraZeneca COVID vaccine could cause blood clots that could lead to rare thrombosis in the brain, public broadcaster Norddeutscher Rundfunk reported.

The researchers found that AstraZeneca's vaccine activates blood platelets, or thrombocytes, which typically only happens in the body when a wound is healing — when the blood coagulates as the wound closes. In some patients, the vaccination activated a mechanism that caused blood clots to form in the brain.

The German research team did not release detailed data but planned to submit their findings to The Lancet.

While researchers were studying cases in Germany, a team led by Pål Andre Holme, chief physician at Oslo University Hospital, was investigating three cases of post-vaccination blood clots in Norway that occurred in healthcare workers under the age of 50.

Holme told the Norwegian newspaper VG he's confident they've identified antibodies triggered by the vaccine that caused an overreaction of the immune system leading to blood clots.

"Our theory is that this is a strong immune response that most likely comes after the vaccine," Holme said. "There is no other thing than the vaccine that can explain this immune response," Holme said.

The European Medicines Agency (EMA) investigated the reports of blood clot-related injuries and deaths and concluded that AstraZeneca's vaccine was not associated with an overall risk of blood clots in those vaccinated.

My comment: Of course they didn't!

See the rest of the article with all the links here:

https://childrenshealthdefense.org/defender/link-astrazeneca-vaccine-blood-clots/?itm_term=home

*Late March 30th update: Germany halts distribution of AstraZeneca vaccine in people under 60 years of age due to blood clots in the brain known as sinus vein

thrombosis. At least thirty-one people have now suffered these effects in Germany.

A data breach reveals confidential emails showing that the spike protein RNA in the mRNA vaccines may not be as advertised

In an investigation published in the BMJ on March 10th, 2021 titled **The EMA covid-19 data leak, and what it tells us about mRNA instability**, reveals that between 55-78% of the mRNA in the Pfizer vaccine is not the DNA/protein sequences they are intended to be. This could have vast implications as it relates to the possibility of causing autoimmune disease in the people receiving the vaccine. If the degraded protein sequences are similar to proteins in the host tissues of the people receiving the vaccine, the person's immune system may mount a persistent attack against those tissues.

From the article:

As it conducted its analysis of the Pfizer-BioNTech covid-19 vaccine in December, the European Medicines Agency (EMA) was the victim of a cyberattack.1 More than 40 megabytes of classified information from the agency's review were published on the dark web, and several journalists—including from *The BMJ*—and academics worldwide were sent copies of the leaks. They came from anonymous email accounts and most efforts to interact with the senders were unsuccessful. None of the senders revealed their identity, and the EMA says it is pursuing a criminal investigation.

The BMJ has reviewed the documents, which show that regulators had major concerns over unexpectedly low quantities of intact mRNA in batches of the vaccine developed for commercial production.

EMA scientists tasked with ensuring manufacturing quality—the chemistry, manufacturing, and control aspects of Pfizer's submission to the EMA—worried about "truncated and modified mRNA species present in the finished product." Among the many files leaked to *The BMJ*, an email dated 23 November by a high ranking EMA official outlined a raft of issues. In short, commercial manufacturing was not producing vaccines to the specifications expected, and regulators were unsure of the implications. EMA responded by filing two "major objections" with Pfizer, along with a host of other questions it wanted addressed.

The email identified “a significant difference in % RNA integrity/truncated species” between the clinical batches and proposed commercial batches—from around 78% to 55%. The root cause was unknown and the impact of this loss of RNA integrity on safety and efficacy of the vaccine was “yet to be defined,” the email said. suffers from contain “a significant difference in % RNA integrity/truncated species”.

RNA instability is one of the biggest hurdles for researchers developing nucleic acid based vaccines. It is the primary reason for the technology’s stringent cold chain requirements and has been addressed by encapsulating the mRNA in lipid nanoparticles (box).

“The complete, intact mRNA molecule is essential to its potency as a vaccine,” professor of biopharmaceutics Daan J.A. Crommelin and colleagues wrote in a review article in *The Journal of Pharmaceutical Sciences* late last year. “Even a minor degradation reaction, anywhere along a mRNA strand, can severely slow or stop proper translation performance of that strand and thus result in the incomplete expression of the target antigen.”6

AN IMPORTANT SECTION AT THE END OF THE ARTICLE:

Lipid nanoparticles—where do they go and what do they do?

Conceived three decades ago, RNA based therapeutics11 have long inspired imaginations for their theoretical potential to transform cells of the body into “an on-demand drug factory.”12 But despite heavy investment by the biotech industry, bench-to-bedside translation was constantly hindered by the fragility of mRNA.

Over the years, researchers attempted to resolve intrinsic instability by encapsulating mRNA in nanocarriers made of polymers, lipids, or inorganic materials. Lipid nanoparticles (LNPs) were chosen by Moderna, Pfizer-BioNTech, CureVac, and Imperial College London for their covid-19 vaccines. This has attracted the attention of specialists in the field of pharmaceutical biotechnology, some of whom have raised concerns about further unknowns.

In a rapid response posted on bmj.com, JW Ulm, a gene therapy specialist who has published on tissue targeting of therapeutic vectors,13 raised concerns about the biodistribution of LNPs: “At present, relatively little has been reported on the tissue localisation of the LNPs used to encase the SARS-CoV-2 spike protein-encoding messenger RNA, and it is vital to have more specific information on precisely where the liposomal

nanoparticles are going after injection."14 It is an unknown that Ulm worries could have implications for vaccine safety.

End of excerpts

A concern about this revelation from a scientist that specializes in immunoreactivity.

"On a good day at the vaccine plant, as much as 30% of the mRNA in the vaccine can be "truncated and modified" due to instability. 45% on a bad day. That means instead of producing the target spike protein, this mRNA will direct the cell to produce RANDOMLY modified proteins with RANDOMLY modified peptides that can have high homology to ANY protein/peptide. These randomly modified proteins can have peptides that have high homology to self-proteins, food proteins, aeroallergen proteins, etc. The result is the immune system could be trained to attack self-proteins (autoimmunity), food proteins (food allergy), aeroallergen (asthma) etc." Quote from Vinu Arumugham

Final thoughts

Not only does this article expose defects in the final product that raise concerns over host autoimmune reactions, but what how does that huge deficiency affect the efficacy of the vaccine, when the person's cells make the wrong proteins to be displayed to the immune system? The only possible answer is that the effectiveness can't be nearly as expected. And lastly, the unknowns over the Lipid Nanoparticles (LNPs). Is it prudent to test these "unknowns" on much of the world's population? What could possibly go wrong!!!?

Pfizer revises ultra-cold storage guidance for Covid-19 jab to refrigerator temperatures- This raises suspicions

Considering the previous report, isn't it ironic that Pfizer has now announced that its vaccine does not need to be stored at the ultra-cold temperatures previously recommended. The article is titled, **Pfizer revises ultra-cold storage guidance for Covid-19 jab, says vaccine is stable at refrigerator temperatures**, and was published on RT.com.

Given the original rationale for the ultra-cold storage as the fact that the mRNA is unstable at "warmer" temperatures. Based on the previous report, the mRNA appears to be very unstable even in the manufacturing process. So, if the final product is left with an unacceptably high level of degraded and incomplete mRNA already, does it make any sense that they are now promoting a storage temperature that they were convinced from the outset was necessary to maintain stability?

https://www.rt.com/news/516069-pfizer-covid19-vaccine-refrigerator-cold/

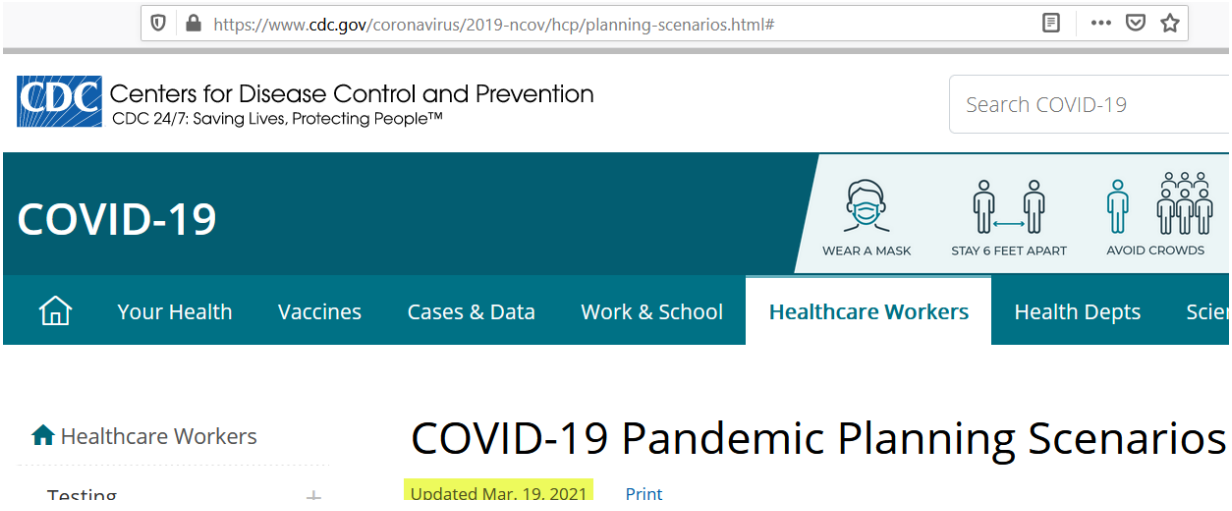
Is the death rate from the vaccines higher than from COVID-19?

On its face, that sounds like a ludicrous and highly improbable possibility but consider this.

According to a January 2021 article published in the ***Annals of Internal Medicine*** titled, **Infection Fatality Ratios for COVID-19 Among Non-institutionalized Persons 12 and Older: Results of a Random-Sample Prevalence Study**, the infection Fatality Rate (IFR) for persons under age 40 is just 0.01% or 1 in 10,000.

https://www.acpjournals.org/doi/10.7326/M20-5352

So, how does that compare to the IFR estimates in different age demographics according to the CDC's statistics as of March 19th 2021?



https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html#

The SUMMARY of most likely scenario according to the CDC March 19th, 2021:

-In the 0-17 year-old age group, the Infection Fatality Rate is 0.002% (20 deaths per million infections, or 1 death in every 50,000 infections)

-In the 18-49 year-old age group it is 0.05% (500 deaths per million infections, or 1 death in every 2,000 infections)

-In the 50-64 year-old age group it is 0.6% (6,000 deaths per million infections, or 1 death in every 167 infections)

-In the 65+ age group it is 9% (90,000 deaths per million infections, or 1 death in every 11 infections). The CDC previously reported in June 2020, that people 65 and over account for 80.73% of all COVID-19 deaths.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html

Footnote: We have to keep in mind the significant over-reporting of what consists of a COVID-19 death. But let's set that aside for now and compare suspected vaccination deaths to what the CDC has been considering COVID-19 deaths.

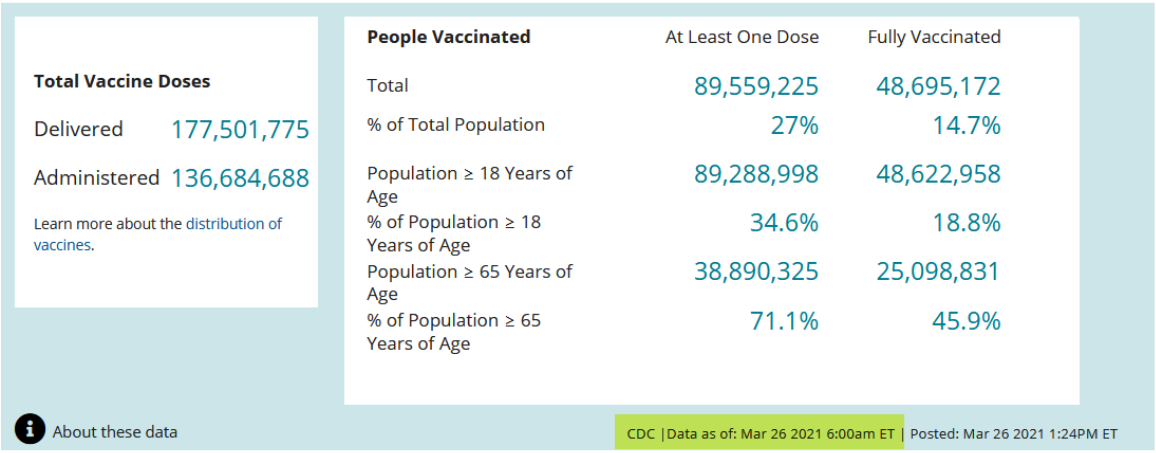
So, what is the death rate for those getting the vaccine? We have no way to now for sure, but we can play out different scenarios based on what we know so far.

As seen in the screen capture below, as of March 26th, there have been 48,695,172 people FULLY vaccinated in the U.S.

COVID-19 Vaccinations in the United States

Overall US COVID-19 Vaccine | Deliveries and Administration; Maps, charts, and data provided by CDC, updated daily by 8 pm ET†

Represents all vaccine partners including jurisdictional partner clinics, retail pharmacies, long-term care facilities, Federal Emergency Management Agency and Health Resources and Services Administration partner sites, and federal entity facilities.



Total Vaccine Doses

Delivered 177,501,775

Administered 136,684,688

Learn more about the distribution of vaccines.

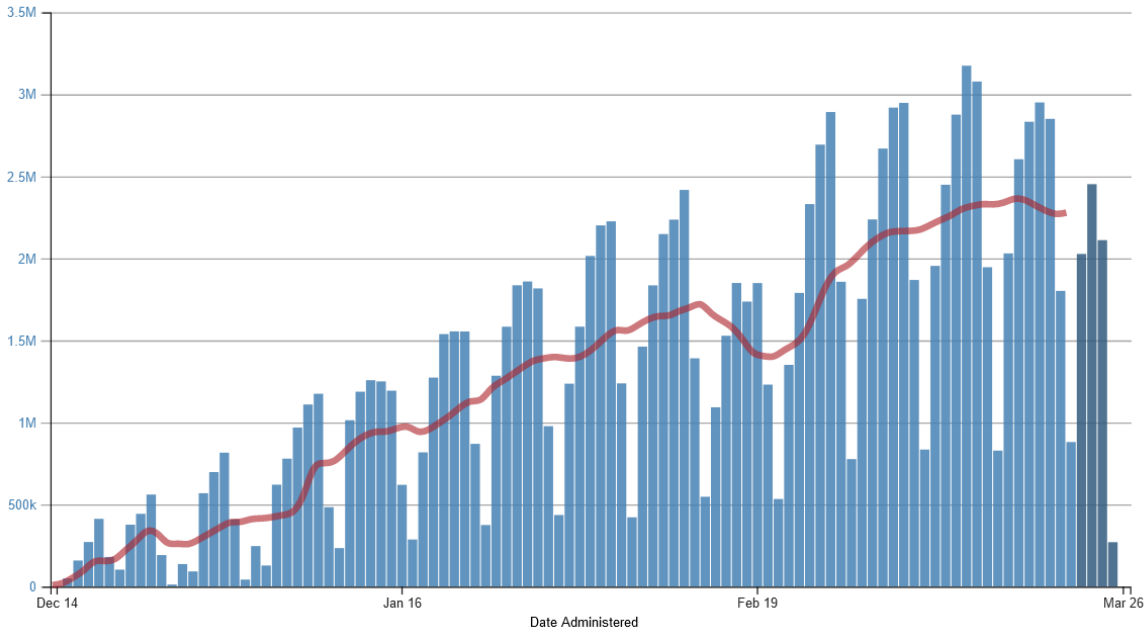
People Vaccinated	At Least One Dose	Fully Vaccinated
Total	89,559,225	48,695,172
% of Total Population	27%	14.7%
Population ≥ 18 Years of Age	89,288,998	48,622,958
% of Population ≥ 18 Years of Age	34.6%	18.8%
Population ≥ 65 Years of Age	38,890,325	25,098,831
% of Population ≥ 65 Years of Age	71.1%	45.9%

https://covid.cdc.gov/covid-data-tracker/#vaccinations

Since the latest reported VAERS death totals were as of March 19th, and this chart was through March 25th, I had to back out the doses given from March 19th through March 25th. This is how I did that. I used the data from the CDC's web site shown in the chart below. It is an interactive chart, so I could see how many doses were given each day. Since both the Pfizer and Moderna vaccines require 2-doses to be fully vaccinated I cut the number of doses to back out from the total in half.

https://covid.cdc.gov/covid-data-tracker/#vaccination-trends

Daily Count of Total Doses Administered and Reported to the CDC by Date Administered, United States



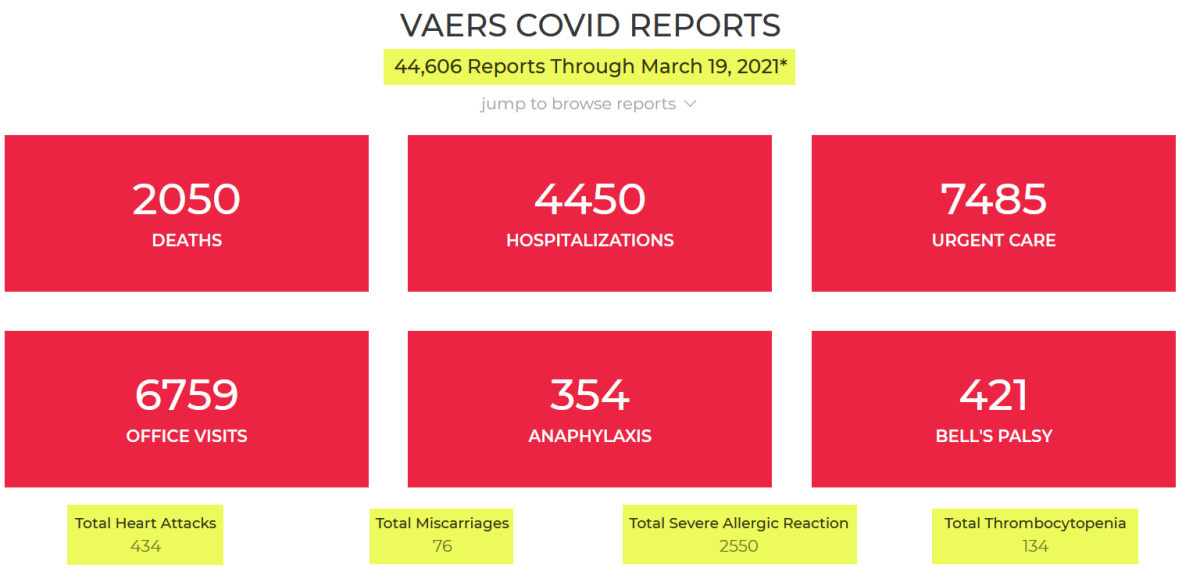
My calculation resulted in 14,123,487 doses March 19th (last VAERS death total available) through the 25th, the last full day reported for vaccines doses administered. Since I am calculating the number of people fully vaccinated and Pfizer and Moderna require 2 doses, I will divide the 14,123,487 does by 2. That equals another 7,061,744 fewer people fully vaccinated by March 19th than the reported numbers for March 26th. That means approximately 41,633,428 people were fully vaccinated by March 19th.

I am using old data here to make a point

Deaths reported to the Vaccine Adverse Event Reporting System (VAERS)

There had been 2,050 VAERS reported deaths **as of March 19th, 2021.**

Note: This is <u>not</u> the latest data but was the data I used to make the calculations below. Now that the reported deaths (as of April 2nd, 2021) are 2,342, it makes the death by vaccine numbers that much higher. And the concerning thing is, this number will continue to climb weekly until the vaccinations stop.



Now the calculations

Dividing 2,050 (deaths) by 41,633,428 (fully vaccinated individuals) equals a 0.0049% mortality (death) rate from the vaccines.

It is critical to consider that there has been every attempt possible to deny that any deaths were related to the vaccine and people are afraid to even go there, because they will be ridiculed and accused of giving the "anti-vaxxers" ammunition to push back against the vaccines. Even the many cases of deaths in reportedly healthy people have been roundly denied without any investigative efforts. With all that going on, the reported deaths may actually be less than 1% of the actual deaths.

So, taking 1% reporting as has been shown to be accurate according to the ***CDC funded Harvard Pilgrim Health Study***, discussed previously in this newsletter, the actual death rate would be 100 times higher and calculates to 0.49% (take 0.0049% and move 2 decimal places to the right). That will calculate to 204,000 deaths. As strange and ironic as it sounds, that is one death in every 204 fully vaccinated people (204 X 204,000 = 41,616,000 or 41,616,000 / 204,000 = 204). Compare that number to the 50-64 year-old age group in the CDC table of 1 death in every 167 people infected with SARS-CoV-2.

It's doubtful, but let's consider that maybe as high as 10% of deaths are being reported to VAERS. That would mean that as of March 19th, there would have been 20,500 deaths from the vaccines rather than the 2,050 that have been reported. **With 41,633,428 people fully vaccinated, that would be a death rate of 0.049% or one person in 2,041 fully vaccinated**

people. So the notion that death as a consequence of the vaccines is a one-in-a-million as many like to parrot is ridiculous.

So once again. **If only 10% of the deaths from the vaccines are being reported to VAERS**, compare that death rate from the vaccines spread across all age groups at 0.049% to the CDC's data for the following age groups:

- **The 0-17 year-old age group-** The risk of death from the vaccines is approximately 25 times higher than from the infection itself! (0.002% to 0.49%). Now we don't know what the death rate in those under 17 will be from the vaccines, because thank God they haven't started vaccinating them YET, but they intend to. And it is unconscionable that they are even considering risking the short-term, the long-term and the potential risk of fatality in an age group with such low mortality from the disease. But that's the upside-down world we live in right now. And all driven by pharma's insatiable profit hungry motives.

- **The 18-49 year-old age group-** The risk of death from the vaccines is approximately 10 times higher from the vaccines than from the infection! (0.49% to 0.5%)

- **The 50-64 year-old age group-** The risk of death is nearly the same from the vaccines as compared to the infection. (.49% to .6%)

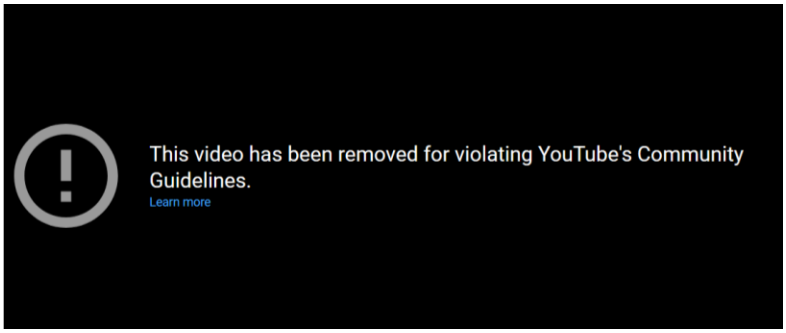
And remember, according to the ***Annals of Internal Medicine*** article above, the Infection Fatality Rate for the under 40 age group is only 0.01%. So according to their statistics the risk of death from the vaccines are nearly 5 times higher!

And to reiterate, one thing we have to keep in mind as we speculate as to the number of deaths and other serious adverse reaction reporting is that there is intense pressure from medical providers, the media and those in government that are highly invested in seeing that the vaccination program rolls on unencumbered by pesky reports like these. After all, if any causation is attributed to the vaccine for any of these reactions and deaths, it would "fuel the fires of vaccine hesitancy." And for heaven's sake, we wouldn't want truth and informed decision-making to get in the way!

Other interesting comparisons can be made looking at the number of adverse events reported through VAERS as of March 19th, 2021. As seen above, there were 44,606 reports registered. If that represents 1% of thew actual adverse reactions, the real number would be 4,460,600. With 41,633,428 people fully vaccinated, 4,460,600 AEs represents 11% of all vaccinated individuals. "One in a million" huh?

First lawsuit challenging mandatory vaccines

You could have seen the video here: https://www.youtube.com/watch?v=t3P9CYGq9M4 , but the arbiters of truth have taken it down.



AstraZeneca Vaccine linked to blood clots leading to deaths and severe injury

A March 16th article appeared on ***theBusinessInsider.com*** titled, **Sweden joins Germany, France, and 15 other countries in suspending AstraZeneca's vaccine over possible side effects.**

he article reported the following:

Multiple countries have paused the use of AstraZeneca's COVID-19 vaccine as a precaution while investigators look into cases of blood clots among vaccinated people.

Austrian authorities said March 7 that a 49-year-old woman had died as a result of severe coagulation disorder after taking the shot, and that a 35-year-old had developed blood clots in the lungs, but was recovering. Both had received vaccines from the same batch, the authorities said.

Danish authorities said on March 10 that one person who had clots after receiving the vaccine had died.

The European Medicines Agency (EMA) on the same day noted one death in a person with multiple blood clots after receiving the shots, and one person who had been hospitalized from a blood clot in their lung. It didn't specifically say whether these were the same as the two incidents reported in Austria.

The EMA noted two other "thrombotic events" in people who had received the vaccines, without giving details.

And on Sunday, the Dutch said there had been six new reports of clotting and thrombocytopenia — low platelet count — in adults under 50 in Denmark and Norway over that weekend.

https://www.businessinsider.com/astrazeneca-covid-vaccine-countries-suspend-denmark-thailand-batch-blood-clots-2021-3?op=1

In a related April 6th story published on ***Reuter's*** titled **Clear link between AstraZeneca vaccine and rare blood clots in brain, EMA official tells paper**, it appears that the connection between the vaccine and these adverse events is becoming clearer.

From the story:

There is a link between AstraZeneca's COVID-19 vaccine and very rare blood clots in the brain but the possible causes are still unknown, a senior official for the European Medicines Agency (EMA) said in an interview published on Tuesday.

"In my opinion, we can now say it, it is clear that there is an association (of the brain blood clots) with the vaccine. However, we still do not know what causes this reaction," Marco Cavaleri, chair of the vaccine evaulation team at the EMA, told Italian daily Il Messagero.

A high proportion among the reported cases affected young and middle-aged women but that did not lead EMA to conclude this cohort was particularly at risk from AstraZeneca's shot.

European investigators have put forward one theory that the vaccine triggers an unusual antibody in some rare cases; others are trying to understand whether the cases are linked with birth control pills.

The AstraZeneca vaccine is based on a modified chimpanzee adenovirus vector, ChAdOx1, developed at Oxford University, and is one of several adenovirus-vector COVID-19 vaccines. The current vaccine rollout represents the first use of viral vector vaccines on such a global scale.

https://www.reuters.com/article/us-health-coronavirus-astrazeneca-vaccin-idUSKBN2BT1ER

One more story was published in ***MedScape*** on April 1st, 2021 titled **AstraZeneca COVID Vaccine: Clotting Disorder Mechanism Revealed?**

From the story:

Use of the vaccine has been suspended for individuals younger than 55 or 60 years in several European countries and in Canada after reports of a prothrombotic disorder and thrombocytopenia, mainly in younger individuals.

Now, more information on the prothrombotic disorder has become available. The vaccine appears to be linked to a condition that clinically resembles heparin-induced thrombocytopenia (HIT) and that occurs mainly in younger women.

They found that serum from four patients who were tested showed platelet-activating antibodies directed against platelet factor 4 (PF4), similar to what is seen in HIT.

They are proposing naming the condition "vaccine-induced prothrombotic immune thrombocytopenia (VIPIT)" to avoid confusion with HIT.

"Vaccinated people should be aware of the remote possibility of these very rare types of blood clots occurring. If they have symptoms suggestive of clotting problems as described in the product information, they should seek immediate medical attention and inform healthcare professionals of their recent vaccination."

https://www.medscape.com/viewarticle/948560

Bill Gates says a third shot may now be needed

"Doctor" Gates is at it again. In a ***CBS News*** article, he says that the new variants may require his buddies in the vax industry to try to stay one step ahead of the virus. I guess he is setting us up for the eventual pitch that the public will "need" regular injections, maybe something similar to the low effectiveness "crap shoot" that is the annual flu shot campaign. And you can bet the shareholders for these companies are salivating at the idea.

The February 17th, 2021 article was titled, **Third shot may be needed to combat new coronavirus variants, Bill Gates says.**

And, in case you care what Gates had to say, here are some choice quotes:

"The discussion now is do we just need to get a super high coverage of the current vaccine, or do we need a third dose that's just the same, or do we need a modified vaccine?" Gates told "CBS Evening News" anchor and managing editor Norah O'Donnell.

"All five of the companies that have U.S. vaccines are looking at making that modification and adding that in so that people who've already had two shots might need to get a third shot," he said. "I think it's reasonably likely that we will have a tuned vaccine just to make absolutely sure that as these variants hit the U.S. that they're not escaping from vaccine protection."

If the coronavirus is not eradicated, he said, additional shots may be necessary in the future. "Probably not yearly, but as long as it's out there, we want as many Americans as possible not to be spreading it to each other," he said.

End of excerpts:

https://www.cbsnews.com/news/covid-vaccine-variants-third-shot-bill-gates/

Obviously, Bill is one of the few people that haven't heard that the vaccines have not been shown to prevent infection and transmission. His comment either shows his ignorance, or a pathological desire to deceive the public.

When will it end?

If you think the third shot is the end of the PUSH (pun intended) for ongoing vaccines, you are sadly mistaken. The real question is, are you willing to line up for you annual or semi-annual "booster" for this just like the flu vaccine? And consider, if you are pro-vaccine passports you will be regretting that decision later when they inevitably roll out all kinds of other new vaccines. And don't say I didn't tell you so.

Personal anecdotes of serious and fatal reactions:

In my close circle of friends, I have been told of three instances, one critical, one fatal reaction and one miscarriage.

1. The person that died from the vaccine was an elderly man with dementia living in a care home. He was otherwise doing well prior to the vaccine. After the shot he lapsed into confusion to the point of "being incoherent" and had extreme difficulty breathing as my friend (his daughter) related to me. Shortly thereafter he developed fluid in his lungs and had to have them drained three times. Sadly, he passed away shortly thereafter.

2. The other person was an ex-firefighter, 61 years old who was a health and fitness fanatic in great shape. He was not intending to get the vaccine, but the only reason he got the

vaccine was to travel to Nepal to climb up to "Base Camp" on Everest with a group of firefighters. They were doing that trip to bring about awareness of the high rates of cancer in the firefighter community. Again, this man had been training for this expedition and was incredibly fit. After receiving his first vaccine, he suffered a reaction that has left him fighting for his life in the hospital. Both lungs have "collapsed" according to my friend who is a retired fellow fire fighter. He is waiting on a double lung transplant.

3. The third is someone that was 7 months pregnant and chose to get the vaccine. After being vaccinated she lost the baby. Prior to the vaccine she was having no complications and her pregnancy was progressing normally.

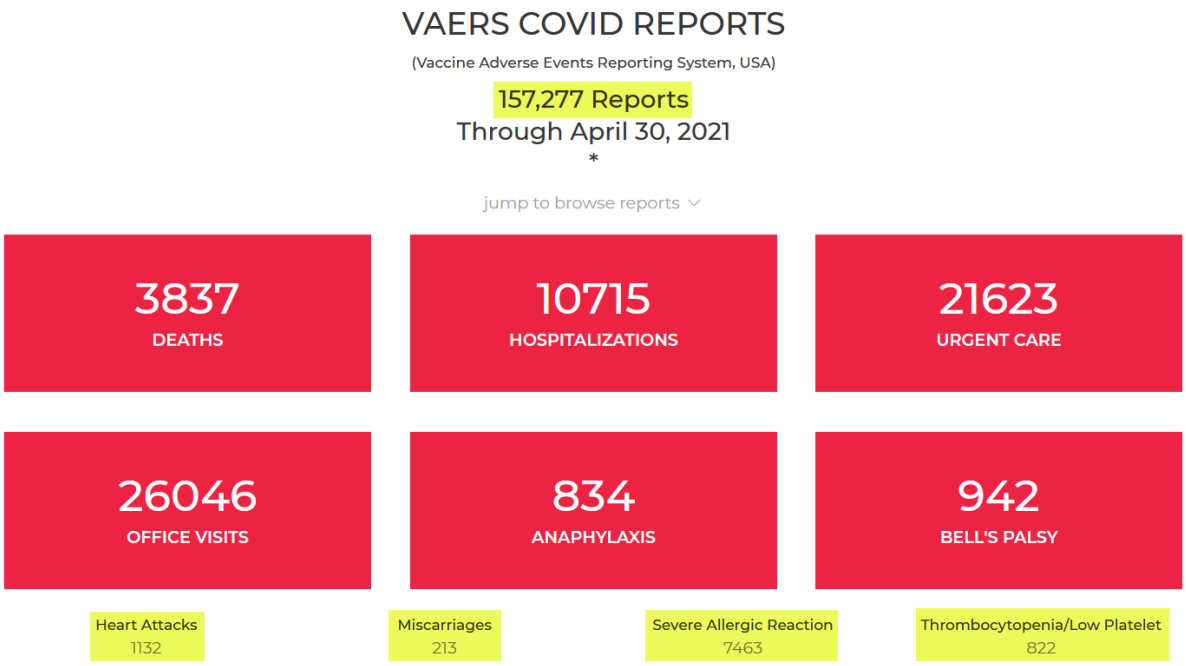
These are three events that were completely preventable. The shocking and maddening thing is that this is happening all over our country and the world, yet the media is silent. Doctors are either afraid or unwilling to report them because of being criticized for doing the right thing, or in some warped and twisted way not wanting to contribute to "vaccine hesitancy."

On one last note: The Federal Government has just pledged to spend 3 BILLION dollars to convince people to get the vaccines. And the marketing campaigns are everywhere you look. If you've seen celebrities peddling them lately, guess what? Yes, YOU are paying them and the media to convince YOU to get the shots. Isn't that a messed-up proposition to say the least? They've pledged billions of dollars to pharma to produce these gene therapy biologicals. Now they are paying billions to promote them and by golly, they are going to get their money's worth!

May 1st Update

Latest VAERS COVID vaccine injury reports and the incredibly high real-world numbers

VAERS, the ***Vaccine Adverse Event Reporting System*** is a voluntary (passive) reporting system. There are no requirements to report, and most people have no idea it even exists. Therefore, the number of adverse events from vaccines are grossly under-reported as you will see below.



The CDC funded a Harvard study that found that less than 1% of adverse reactions to vaccines are reported

More about that in a second. But imagine if this is true, you would ADD two zeros to each of the above numbers, i.e., 224,900 deaths! Some say that with serious reactions like deaths it may be higher reporting. If instead of <1%, what if only 10% were reported. You would then add one zero to the reported deaths and the actual number would be 22,490 thus far. The next logical question would have to be, “how many is too many?”

Here's the proof of the <1% reporting claim

Harvard Pilgrim Health Care performed the study between 12/01/2007 -09/30/2010. The report was titled, **Electronic Support for Public Health–Vaccine Adverse Event Reporting System (ESP: VAERS)**

https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf

The Purpose of the Study:

"This research project was funded to improve the quality of vaccination programs by improving the quality of physician adverse vaccine event detection and reporting to the national Vaccine Adverse Event Reporting System (VAERS)...

"The CDC's Public Health Information Network Messaging System (PHIN-MS) software was installed within the facilities so that the approved reports could be securely transferred to VAERS as electronic

messages in an interoperable health data exchange format using Health Level 7 (HL7)."

Results from the study:

"Preliminary data were collected from June 2006 through October 2009 on 715,000 patients, and 1.4 million doses (of 45 different vaccines) were given to 376,452 individuals. Of these doses, 35,570 possible reactions (2.6 percent of vaccinations) were identified. This is an average of 890 possible events, an average of 1.3 events per clinician, per month. These data were presented at the 2009 AMIA conference."

Dividing 1.4 million doses between 376,452 people is an average of 3.72 doses per person. And, if there were 35,570 reactions in 1.4 million doses given, that is one adverse reaction for every 39.4 doses. Perhaps what is most striking here is that if each person reacting experienced on adverse reaction only, of the 376,452 individuals vaccinated, nearly 10% experienced a possible reaction!

"Adverse events from drugs and vaccines are common, but underreported. Although 25% of ambulatory patients experience an adverse drug event, less than 0.3% of all adverse drug events and 1-13% of serious events are reported to the Food and Drug Administration (FDA). Likewise, fewer than 1% of vaccine adverse events are reported. Low reporting rates preclude or slow the identification of "problem" drugs and vaccines that endanger public health."

In addition, ESP: VAERS investigators participated on a panel to explore the perspective of clinicians, electronic health record (EHR) vendors, the pharmaceutical industry, and the FDA towards systems that use proactive, automated adverse event reporting." (Since in the end, this improved automated reporting system was stymied and went nowhere, one has to wonder what influence the pharma reps on the panel had on that).

Here's the kicker. After spending nearly 3 years and a million dollars, the CDC went dark on the program. Was it because the surveillance system would significantly increase the reporting of vaccine adverse reactions?

The last statement from the Results section of the article says it all…

“Unfortunately, there was never an opportunity to perform system performance assessments because the necessary CDC contacts were no longer available and the CDC consultants responsible for receiving data were no longer responsive to our multiple requests to proceed with testing and evaluation.”

One has to wonder what is stopping the automation of the vaccine adverse reporting system from being implemented. This report suggested that its implementation would be easy to accomplish. That was in 2010. It is now 2018 and nothing has been done to accomplish this vital information system. And lives hang in the balance.

The Spike Protein as the progenitor of the epidemic of thrombotic events occurring post-vaccination around the globe

In the first part of this newsletter, I am going to concentrate on the clotting issue that many top experts now believe is leading to the unprecedented number of cases of severe injury and death happening around the world post COVID-19 “vaccines”. I personally know of three people that this has happened to as relayed to me from my closest circle of friends. This is just one of the many potential mechanisms of injury, but I believe is an important one to take a deeper dive into.

I’ve used scare quotes around the word vaccine, because as many of you reading this know, these are not vaccines in the traditional sense. The top four products are actually gene modifying technologies that introduce the spike protein into our cells either by a lipid nanoparticle encapsulating it (Moderna and Pfizer) or a viral vector with the spike protein spliced into an adenovirus (Johnson and Johnson and AstraZeneca). These two methods are the delivery mechanism to get the spike protein inside our cells. Once inside our cells, the ribosomes within the cell then manufacture or make copies of the spike protein sequences. These then are presented on the surface of the cell as they “bud” through the exterior layers and are eventually released into our circulation. Aside from that method of release into our body, our immune system upon recognizing these budding viral proteins mount an attack on the cell, eventually essentially blowing up the cell. When that happens all of the manufactured spike proteins are released into circulation to travel throughout the body and wreak havoc.

It has often been said as these novel technologies were being produced, that they will turn our cells into vaccine making factories. This ability of the spike proteins produced by our own cells as a result of the programming or “hacking the software of life” as Tal Zacs, Moderna’s Chief Scientific Officer is quoted as saying about their mRNA vaccine technology in a ***Ted Talk*** is a risky proposition, especially when attempts to make vaccines in the past were never able to

make it past animal trials due to the lethality of the vaccines.
https://www.ted.com/talks/tal_zaks_the_disease_eradicating_potential_of_gene_editing

As I said months ago when I first saw this video…"Hacking the software of life? What could possible go wrong!"

As this release of spike protein happens throughout the body in the hours and days after a person receives the vaccine, some people have an exaggerated reaction to this exposure to the spike protein and develop this clotting phenomenon in the small blood vessels of organs, leading to severe complications and death. As I've studied this, I have heard experts express concern and reservation about how this is then treated in the hospital, as they say that the traditional way of treating these clotting disorders with blood thinners may actually make matters worse.

We are really in unchartered territory here. And that is why you don't shortcut long-term safety studies for vaccines, especially new and experimental technologies. This is especially true for a virus that has a world-wide infection survival rate of 99.95% for people under 70 years of age.

https://www.marktaliano.net/publication-bulletin-of-the-world-health-organization-infection-fatality-rate-of-covid-19-john-p-a-ioannidis/

A prime example of the dangers of the spike protein

This March 8th, 2021 pre-print study titled **SARS-CoV-2 spike protein S1 induces fibrin(ogen) resistant to**

fibrinolysis: Implications for microclot formation in COVID-19, is a wake-up call for the need for an intensive INDEPENDENT investigation to the injuries and deaths post COVID vaccines all around the world. This is something that I have been suspicious about and have reported on in previous newsletters.

The spike protein is thought to be the triggering mechanism for the thrombotic (clotting) disorders seen in the microvasculature of the body in some patients with COVID-19. After this section I will show one of the mechanisms for how that happens.

But first, I think it is important to read some very relevant sections of this study. I've included a good portion of the study because I believe it is a powerful wake up call for the world and the use of these experimental products.

***PPP stands for Platelet Poor Plasma.**

ABSTRACT

Severe acute respiratory syndrome coronavirus 2 (SARS-Cov-2) -induced infection, the cause of coronavirus disease 2019 (COVID-19), is characterized by unprecedented clinical pathologies. One of the most important pathologies, is hypercoagulation and microclots in the lungs of patients. Here we study the effect of isolated SARS-CoV-2 spike protein S1 subunit as potential inflammagen *sui generis*. Using scanning electron and fluorescence microscopy as well as mass spectrometry, we investigate the potential of this inflammagen

to interact with platelets and fibrin(ogen) directly to cause blood hypercoagulation. Using platelet poor plasma (PPP), we show that spike protein may interfere with blood flow. Mass spectrometry also showed that when spike protein S1 is added to healthy PPP, it results in structural changes to β and γ fibrin(ogen), complement 3, and prothrombin. These proteins were substantially resistant to trypsinization, in the presence of spike protein S1. Here we suggest that, in part, the presence of spike protein in circulation may contribute to the hypercoagulation in COVID-19 positive patients and may cause substantial impairment of fibrinolysis. Such lytic impairment may result in the persistent large microclots we have noted here and previously in plasma samples of COVID-19 patients. This observation may have important clinical relevance in the treatment of hypercoagulability in COVID-19 patients.

From the study:

Spike protein, can however be shed, and it has been detected in various organs, including the urinary tract (George et al., 2021). S1 proteins can also cross the blood-brain-barrier (Rhea et al., 2021). Free S1 particles may also play a role in the pathogenesis of the disease (Letarov et al., 2020, Buzhdygan et al., 2020). Free spike

protein can potentially be released due to spontaneous "firing" of the S protein trimers on the surface of virions, and infected cells liberates free receptor binding domain-containing S1 particles (Letarov et al., 2020).

Here we study the effect of isolated SARS-CoV-2 spike protein S1 subunit as potential proinflammatory

inflammagen *sui generis*. We investigate the potential of this inflammagen to directly interact with platelets and fibrin(ogen) to cause fibrin(ogen) protein changes and blood

hypercoagulation. We also determine if the spike protein may interfere with blood flow, by comparing naïve healthy PPP samples, with and without added spike protein, to PPP samples from COVID-19 positive patients (before treatment). We conclude that the spike protein may have pathological effects directly, without being taken up by cells.

Discussion:

In this laboratory analysis, we provide evidence that spike protein does indeed play a major role in hypercoagulability seen in COVID-19 patients. It causes anomalous clotting in both purified fluorescent fibrinogen and in PPP, where the nature of the clots were shown to be amyloid (ThT as our amyloid dye of choice). An interesting observation was that these dense deposits were noted both in smears exposed to spike protein, and when thrombin was added. The addition of thrombin causes purified (Alexa Fluor™488) fibrinogen to polymerize into fibrin networks. Typically, these networks are netlike (Figure 3A). In the presence of spike protein, the structure changed to form dense clot deposits (Figure 3B). These deposits were seen in our fluorescent fibrin(ogen) model and PPP from healthy individuals exposed to spike protein. In healthy PPP exposed to spike protein, followed by incubation with ThT, there was a significant increase in anomalous clots with an amyloid nature, (Figure 4D), when compared to the health PPP. Spike protein also caused major ultrastructural changes in WB (as viewed with the SEM), where platelet hyperactivation were noted (Figure 6C and D). Increased in spontaneously formed fibrin network, as well as anomalous clot formation were also observed in SEM micrographs (Figure 6E - H). Interestingly, extensive spontaneous fibrin network formation was noted, without the addition of thrombin. This is in line with results that were recently published, where we showed similar ultrastructure in blood smears form COVID-19 positive patients. In these patient's platelet hyperactivation, anomalous clotting with amyloid signal and spontaneous fibrin fibre formation were also

observed (Pretorius et al., 2020, Venter et al., 2020).

Figure 4: Representative fluorescence micrographs of platelet poor plasma (PPP) from healthy individuals after addition of ThT (green fluorescent signal). **A)** PPP smear. **B)** PPP with spike protein. **C)** PPP with thrombin to create extensive fibrin clot; **D)** PPP exposed to spike protein followed by addition of thrombin. Final spike protein concentration was 1ng.mL^{-1}.

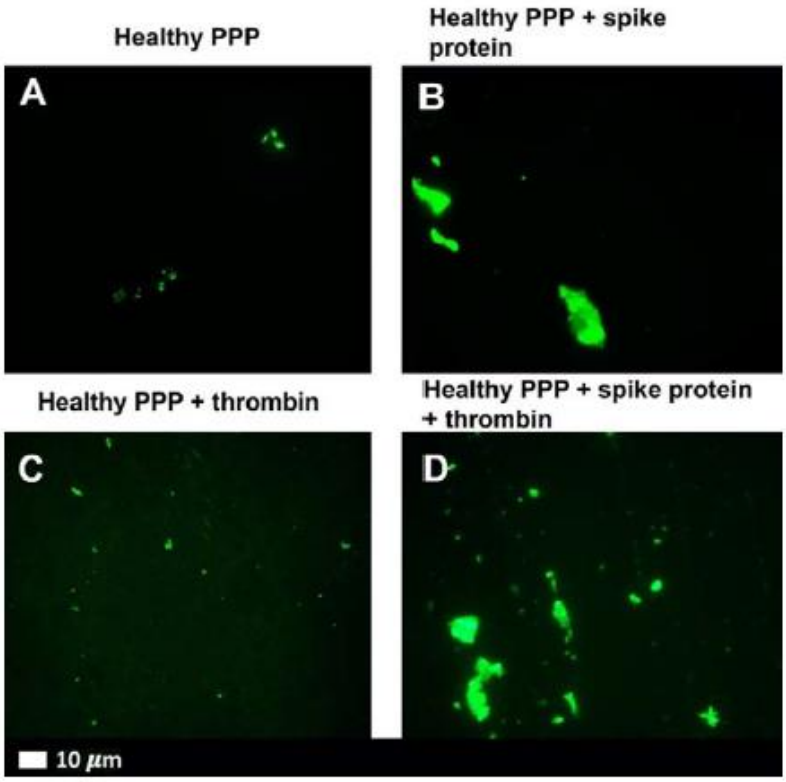


Figure 5A: Fluorescence microscopy micrographs of representative naïve whole blood (WB), where platelets were incubated with fluorescent marker, CD62P-PE. **B)** WB after exposure to spike protein. The white arrows point to hyperactivated activated platelets.

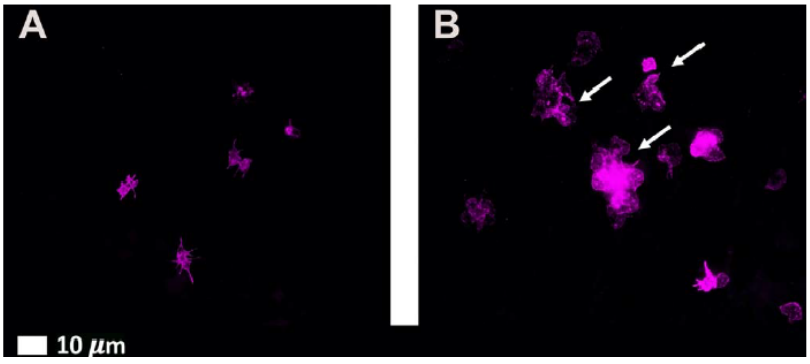


Figure 6A to H: Representative scanning electron micrographs of healthy control whole blood (WB), with and without spike protein. **A and B)** Healthy WB smears, with arrow indicating normal erythrocyte ultrastructure. **C to H)** Healthy WB exposed to spike protein (1 $ng.mL^{-1}$ final concentration), with **C and D**) indicating the activated platelets (arrow), **E and F**) showing the spontaneously formed fibrin network and **G and H**) the anomalous deposits that is amyloid in nature (arrows) (Scale bars: E: 20µm; A: 10µm; F and G: 5µm; H: 2µm; C: 1µm; B and D: 500nm).

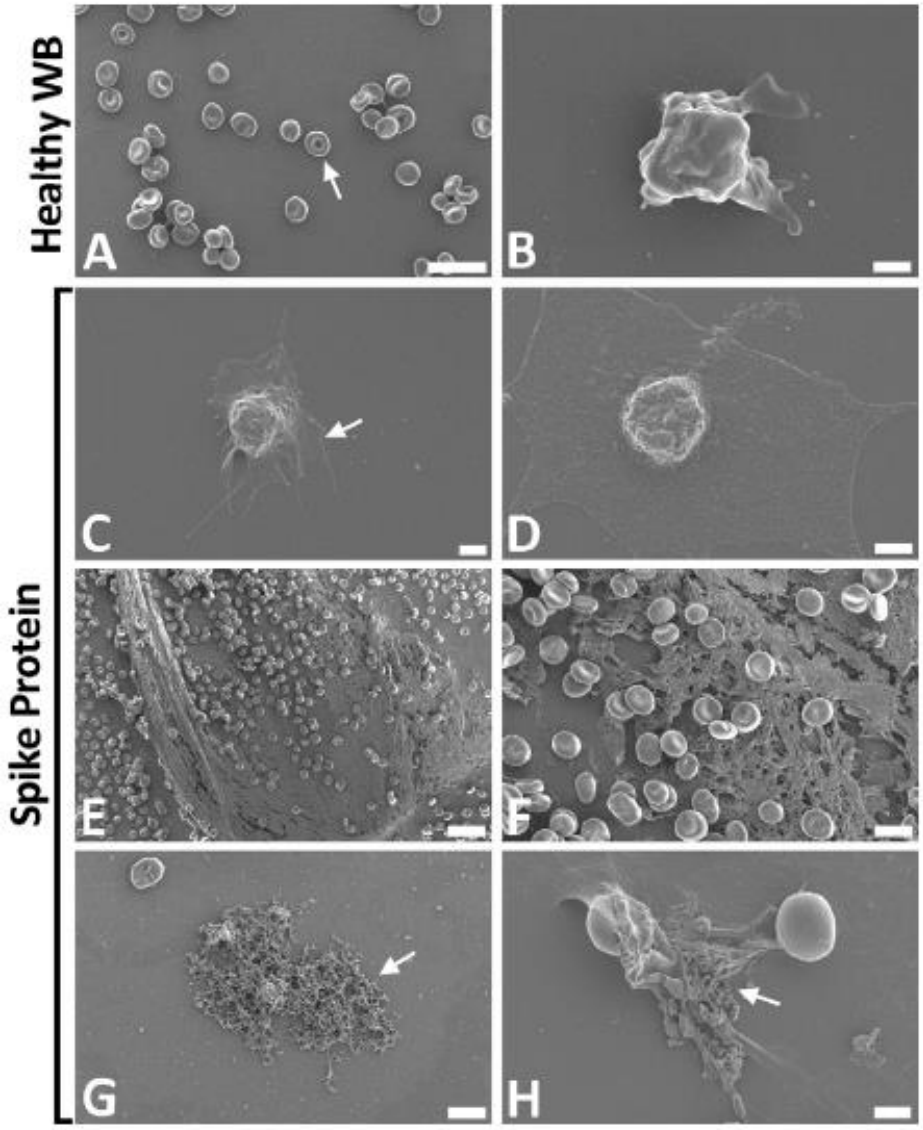
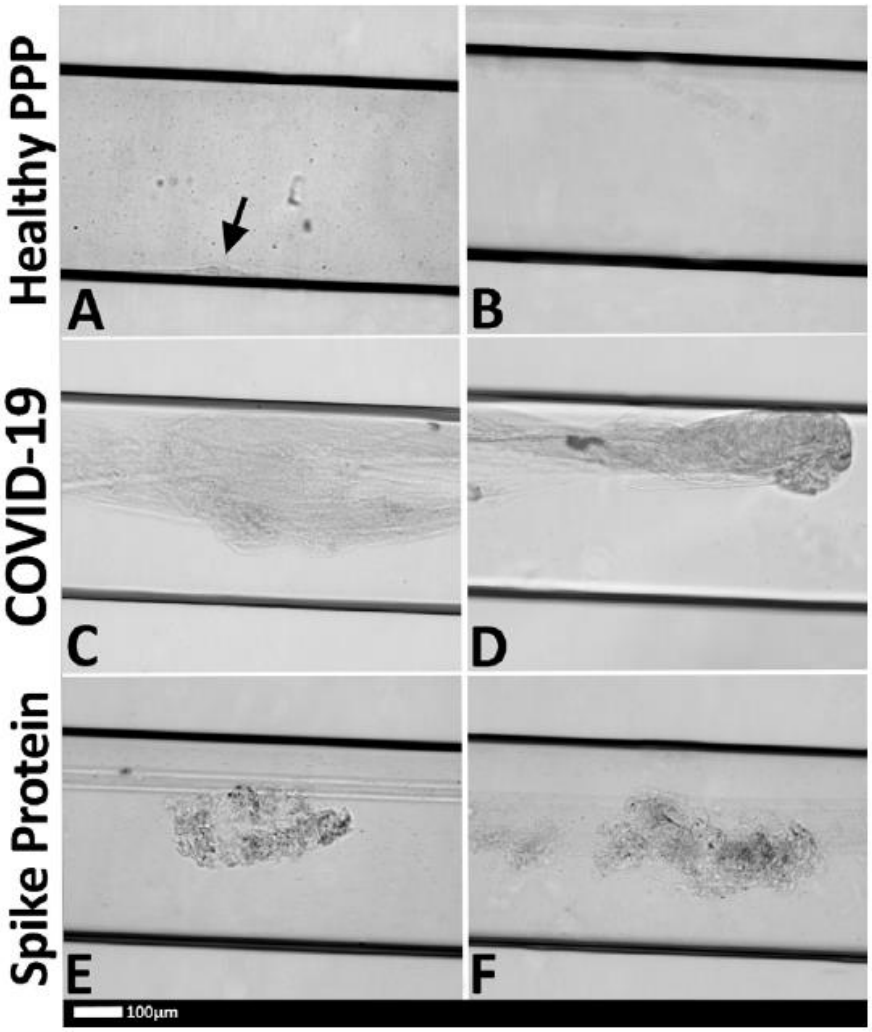


Figure 7: Representative micrographs of PPP clots in the microfluidic chambers (black horizontal lines are the outlines of the chambers) that were coated with thrombin. **A)** Healthy PPP clot, with small clot formation (arrow), with **B)** no clot formed in the healthy PPP sample; C **and D)** examples of clots from COVID-19 PPP samples and **E and F)** healthy PPP clot with spike protein.



The clots that were observed in the healthy PPP with added spike protein, were of particular interest as they demonstrated a bridge between healthy PPP clots and COVID-19 clots. As described in the results, the healthy PPP clots were relatively small and orderly, while COVID-19 PPP clots were large, disorderly masses that formed rapidly and disrupted PPP flow in the channel. The healthy PPP clots with added spike protein, were a combination of the two, demonstrating disorderly clumped clot areas, co-existing with laminar fibrous PPP

clots (which were larger than the healthy PPP clots). This intermediate state may arise from a number of factors, including the interaction of other biological actors which were absent from

the flow setup and the time of exposure to spike protein. Further investigations would be beneficial for understanding the clotting mechanisms that are altered in the presence of spike protein.

The Conclusion:

Scanning electron- and fluorescence microscopy revealed large dense anomalous and amyloid masses in whole blood and PPP of healthy individuals where spike protein was added to the samples. Mass spectrometry confirmed that when spike protein was added to PPP, it interacts with plasma proteins, resulting in fibrin(ogen), prothrombin and other proteins linked to coagulation, to become substantially resistant to trypsinization, resulting in less fragments. Flow analysis confirmed that microclots may impair blood flow. Here we suggest that, in part, the presence of spike protein in circulation may contribute to the hypercoagulation in COVID-19 positive patients and may cause severe impairment of fibrinolysis. Such lytic impairment may be the direct cause of the large microclots we have noted here in SEM and fluorescence microscopy, and previously in plasma samples of COVID-19 patients (Pretorius et al., 2020, Venter et al., 2020).

End of excerpts

Questions remain that contradict the efficacy claims for the vaccines

Dr. Peter Doshi, Associate Editor of the ***British Medical Journal (BMJ)*** released an opinion letter highly critical of the "effectiveness" claims the public have been hearing ad nauseum. The letter was published on January 4th, 2021. The letter titled **Peter Doshi: Pfizer and Moderna's "95% effective" vaccines—we need more details and the raw data**, reported that because of exclusionary data the actual effectiveness (and remember that only means reduction of COVID-19 symptoms), should have been reported as between 19% and 29%! In other words, the numbers had to be manipulated to get to the approximately 95% effectiveness that was reported. Peter Doshi is a highly credible scientifically qualified source to analyze the data and comment on it.

One of the issues Dr. Doshi had with Pfizer's reporting of the clinical data was the following…

"Another reason we need more data is to analyse an unexplained detail found in a table of FDA's review of Pfizer's vaccine: 371 individuals excluded from the efficacy analysis for "important protocol deviations on or prior to 7 days after Dose 2." What is concerning is the

imbalance between randomized groups in the number of these excluded individuals: 311 from the vaccine group vs 60 on placebo." This could obviously skew the numbers in favor of the vaccinated group to make the efficacy look better than it was.

Another issue was exclusion of "suspected" COVID-19 cases.

"All attention has focused on the dramatic efficacy results: Pfizer reported 170 PCR confirmed covid-19 cases, split 8 to 162 between vaccine and placebo groups. But these numbers were dwarfed by a category of disease called "suspected covid-19"—those with symptomatic covid-19 that were not PCR confirmed. According to FDA's report on Pfizer's vaccine, there were "3410 total cases of suspected, but unconfirmed covid-19 in the overall study population, 1594 occurred in the vaccine group vs. 1816 in the placebo group."

"With 20 times more suspected than confirmed cases, this category of disease cannot be ignored simply because there was no positive PCR test result. Indeed this makes it all the more urgent to understand. A rough estimate of vaccine efficacy against developing covid-19 symptoms, with or without a positive PCR test result, would be a relative risk reduction of 19% (see footnote)—far below the 50% effectiveness threshold for authorization set by regulators. Even after removing cases occurring within 7 days of vaccination (409 on Pfizer's vaccine vs. 287 on placebo), which should include the majority of symptoms due to short-term vaccine reactogenicity, vaccine efficacy remains low: 29%."

https://blogs.bmj.com/bmj/2021/01/04/peter-doshi-pfizer-and-modernas-95-effective-vaccines-we-need-more-details-and-the-raw-data/

Are they really vaccines? See what the government filed documents say

We are continually told that the COVID-19 shots are vaccines. But are they really?

It appears from the following documents that they are really "Gene Therapy". It makes sense when you hear Dr. Fauci and others say that they may reduce symptoms of clinical disease. In essence, they are a treatment and to not prevent infection as would be the traditional role of a vaccine.

See next page….

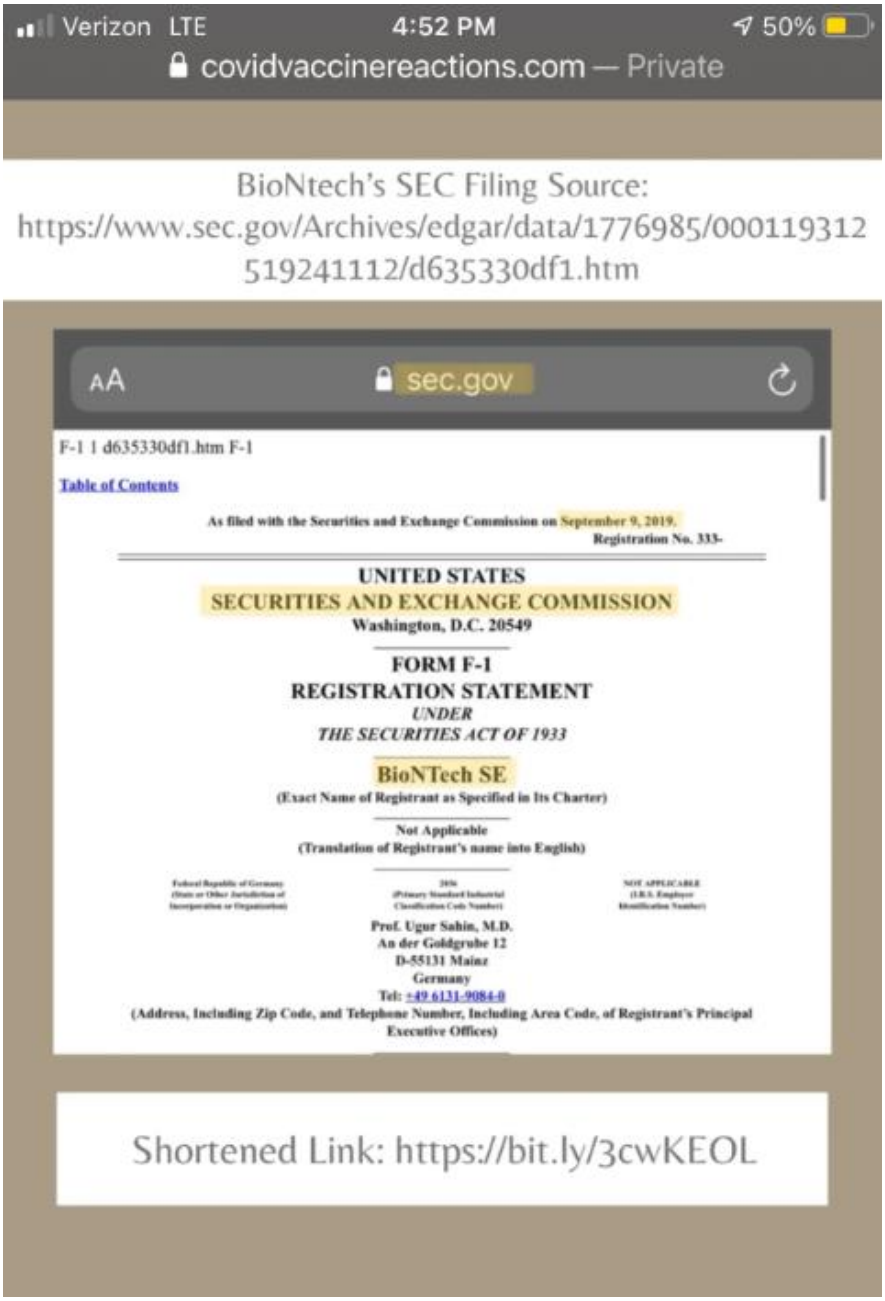

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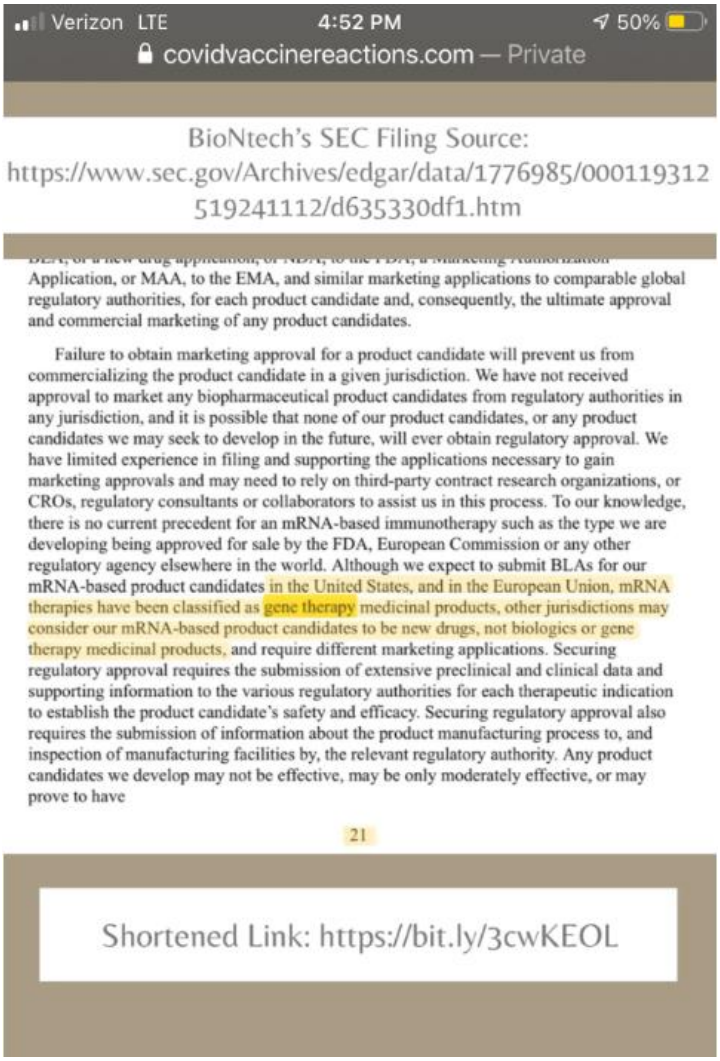
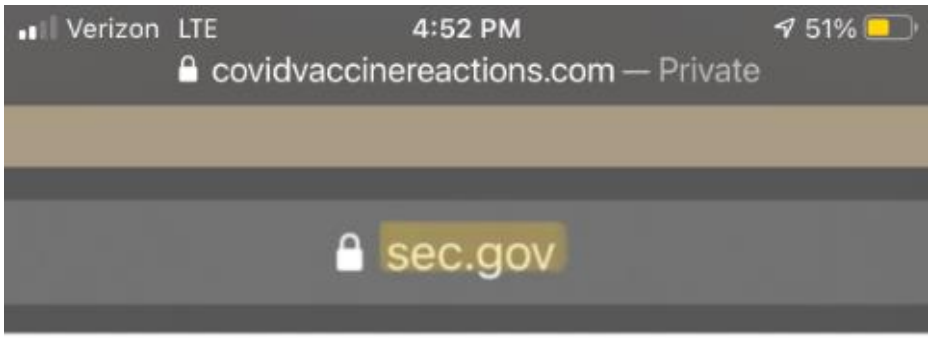
Table of Contents
As filed with the Securities and Exchange Commission on September 9, 2019.
Registration No. 333-
UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM F-1
REGISTRATION STATEMENT
UNDER
THE SECURITIES ACT OF 1933
BioNTech SE
(Exact Name of Registrant as Specified in Its Charter)
Not Applicable
(Translation of Registrant's name into English)
Federal Republic of Germany
2836
NOT APPLICABLE
Prof. Ugur Sahin, M.D.
An der Goldgrube 12
D-55131 Mainz
Germany
Tel: +49 6131-9084-0
(Address, Including Zip Code, and Telephone Number, Including Area Code, of Registrant's Principal Executive Offices)
Shortened Link: https://bit.ly/3cwKEOL



ENLARGED

CROs, regulatory consultants or collaborators to assist us in this process. To our knowledge, there is no current precedent for an mRNA-based immunotherapy such as the type we are developing being approved for sale by the FDA, European Commission or any other regulatory agency elsewhere in the world. Although we expect to submit BLAs for our mRNA-based product candidates in the United States, and in the European Union, mRNA therapies have been classified as gene therapy medicinal products, other jurisdictions may consider our mRNA-based product candidates to be new drugs, not biologics or gene therapy medicinal products, and require different marketing applications. Securing regulatory approval requires the submission of extensive preclinical and clinical data and supporting information to the various regulatory authorities for each therapeutic indication to establish the product candidate's safety and efficacy. Securing regulatory approval also requires the submission of information about the product manufacturing process to, and inspection of manufacturing facilities by, the relevant regulatory authority. Any product candidates we develop may not be effective, may be only moderately effective, or may prove to have



UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

FORM 10-Q

REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT
For the quarterly period ended June 30, 2020
OR
REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT
For the transition period from _ to _
Commission File Number: 001-38753

moderna

Moderna, Inc.
(Exact Name of Registrant as Specified in Its Charter)

Delaware	81-3467528
(State or Other Jurisdiction of Incorporation or Organization)	(IRS Employer Identification No.)
200 Technology Square Cambridge, Massachusetts	02139
(Address of Principal Executive Offices)	(Zip Code)

(617) 714-6500
(Registrant's Telephone Number, Including Area Code)

Shortened Link: https://bit.ly/2NitVGl

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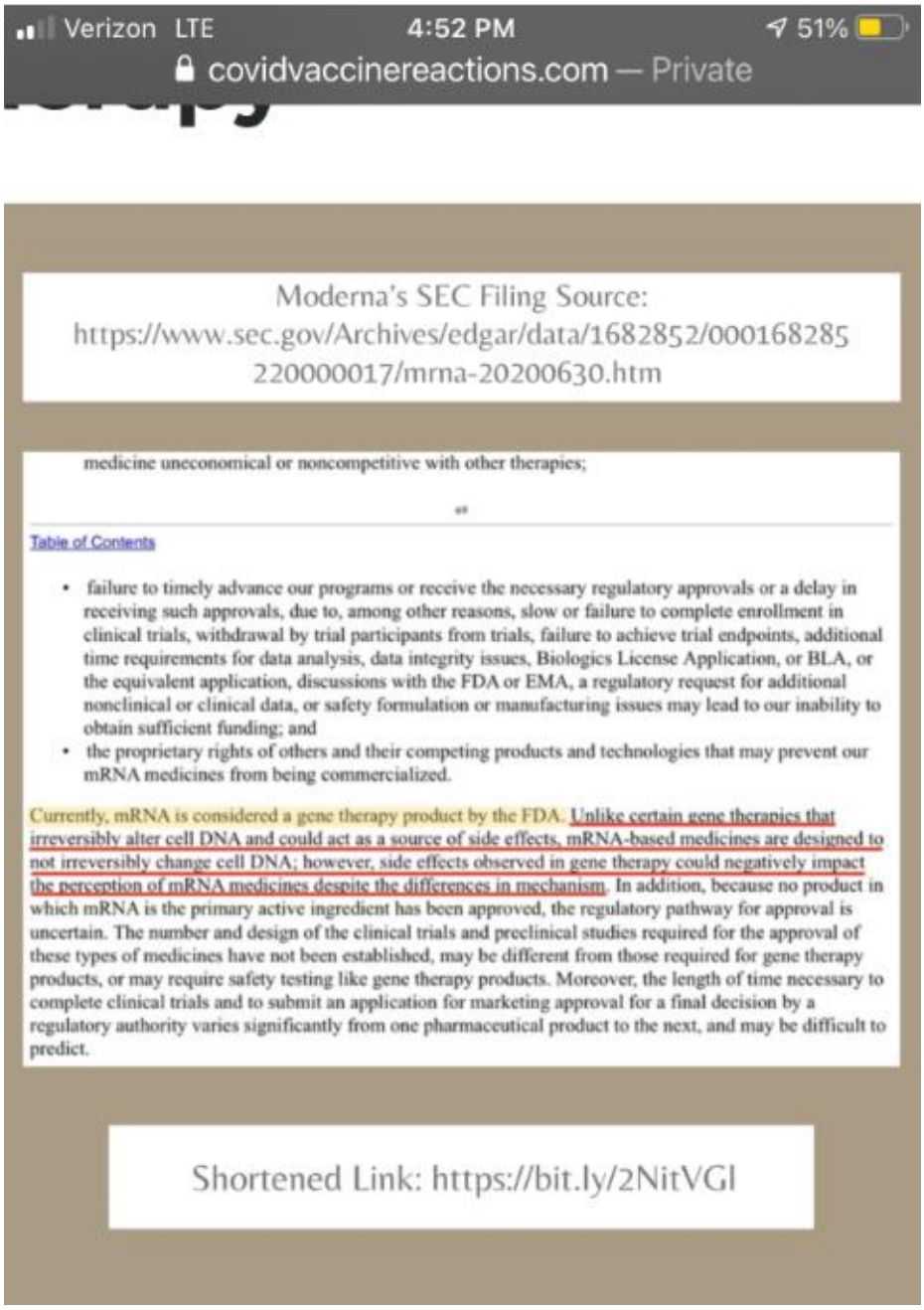

ENLARGED

Currently, mRNA is considered a gene therapy product by the FDA. Unlike certain gene therapies that irreversibly alter cell DNA and could act as a source of side effects, mRNA-based medicines are designed to not irreversibly change cell DNA; however, side effects observed in gene therapy could negatively impact the perception of mRNA medicines despite the differences in mechanism. In addition, because no product in which mRNA is the primary active ingredient has been approved, the regulatory pathway for approval is uncertain. The number and design of the clinical trials and preclinical studies required for the approval of

From the FDA's website

What is Gene Therapy?

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Human gene therapy seeks to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use [1].

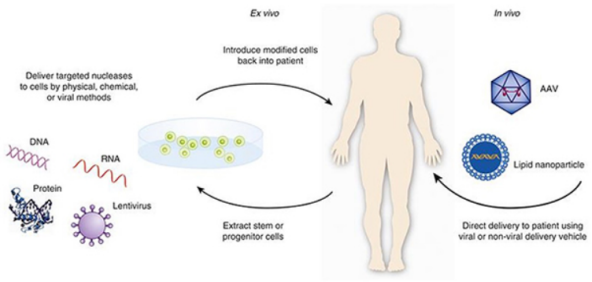
Gene therapy is a technique that modifies a person's genes to treat or cure disease. Gene therapies can work by several mechanisms:

- Replacing a disease-causing gene with a healthy copy of the gene
- Inactivating a disease-causing gene that is not functioning properly
- Introducing a new or modified gene into the body to help treat a disease

Gene therapy products are being studied to treat diseases including cancer, genetic diseases, and infectious diseases.

There are a variety of types of gene therapy products, including:

- **Plasmid DNA:** Circular DNA molecules can be genetically engineered to carry therapeutic genes into human cells.
- **Viral vectors:** Viruses have a natural ability to deliver genetic material into cells, and therefore some gene therapy products are derived from viruses. Once viruses have been modified to remove their ability to cause infectious disease, these modified viruses can be used as vectors (vehicles) to carry therapeutic genes into human cells.
- **Bacterial vectors:** Bacteria can be modified to prevent them from causing infectious disease and then used as vectors (vehicles) to carry therapeutic genes into human tissues.
- **Human gene editing technology:** The goals of gene editing are to disrupt harmful genes or to repair mutated genes.
- **Patient-derived cellular gene therapy products:** Cells are removed from the patient, genetically modified (often using a viral vector) and then returned to the patient.



Gene therapy products are biological products regulated by the FDA's Center for Biologics Evaluation and Research (CBER). Clinical studies in humans require the submission of an investigational new drug application (IND) prior to initiating clinical studies in the United States. Marketing a gene therapy product requires submission and approval of a biologics license application (BLA).

1 Long Term Follow-Up After Administration of Human Gene Therapy Products; Guidance for Industry, January 2020

So, why not call them what they are?

Here are some obvious reasons I can think of:

1. ***It is very likely that experimental gene therapy technology would not be able to be authorized for emergency use*** under the **Emergency Use Authorization (EUA)** Rule? But certainly "vaccines" could. Sleight of hand?

2. Another reason could be that ***the public would be much more likely to comply with a new "vaccine" than a new gene therapy technology***. Then the question becomes…Was that decision made to "save more lives" or to sell more product?

3. ***By calling them vaccines rather than gene therapy, they can get the buy-in of the public on the false narrative that these "vaccines" are necessary to reach herd immunity*.** The truth is, if they don't prevent infection and allow a vaccinated person that gets infected to transmit to others, they can't possibly help us get to herd immunity.

What about herd immunity? Where are we at?

The good new however is, that the U.S. is most likely at or very close to herd immunity. This is due to the number of people that have had the SARS-CoV-2 infection and not due to the vaccine. Let's assume that the 33 million PCR positive infections are really true infections and take the CDC's 8X figure of people that have had the infection and were never tested and considered in that 33 million positives number and add them to the 33 million number. It would mean that 91% of the population has had the infection. Now, I have to say that because the PCR test has a notoriously high level of false positives, there may have only been a fraction of those 33 million positive cases that truly had the infection. Let's assume that 70% of those 33 million were really infected with SARS-CoV-2, that would be 23,100,000 people infected. Eight times that number of untested infections would be another 184,800,000 infections. Added to the 23,100,000 PCR confirmed cases would total 207,900,000 total people that have been infected. Compared to 330 million people in the U.S. population, that equates to 63% of the population.

The R-naught (R_0) number discussed below is the effective **Reproduction Number** of a virus or contagion. The number is the estimated number of people on average that will be infected by a person with the infection. For example, if one person infects 10 other people, the R-naught number is 10. If they infect 4 people, the R-naught number is 4. The higher the number, the more contagious the pathogen. Measles for example has been estimated to have an R-naught number somewhere between 12 and 18. Influenza depending on the strain is thought to be between 1.0 and 2. The common cold between 2 and 3. For an outbreak to subside, the (R_0) number must drop below 1.

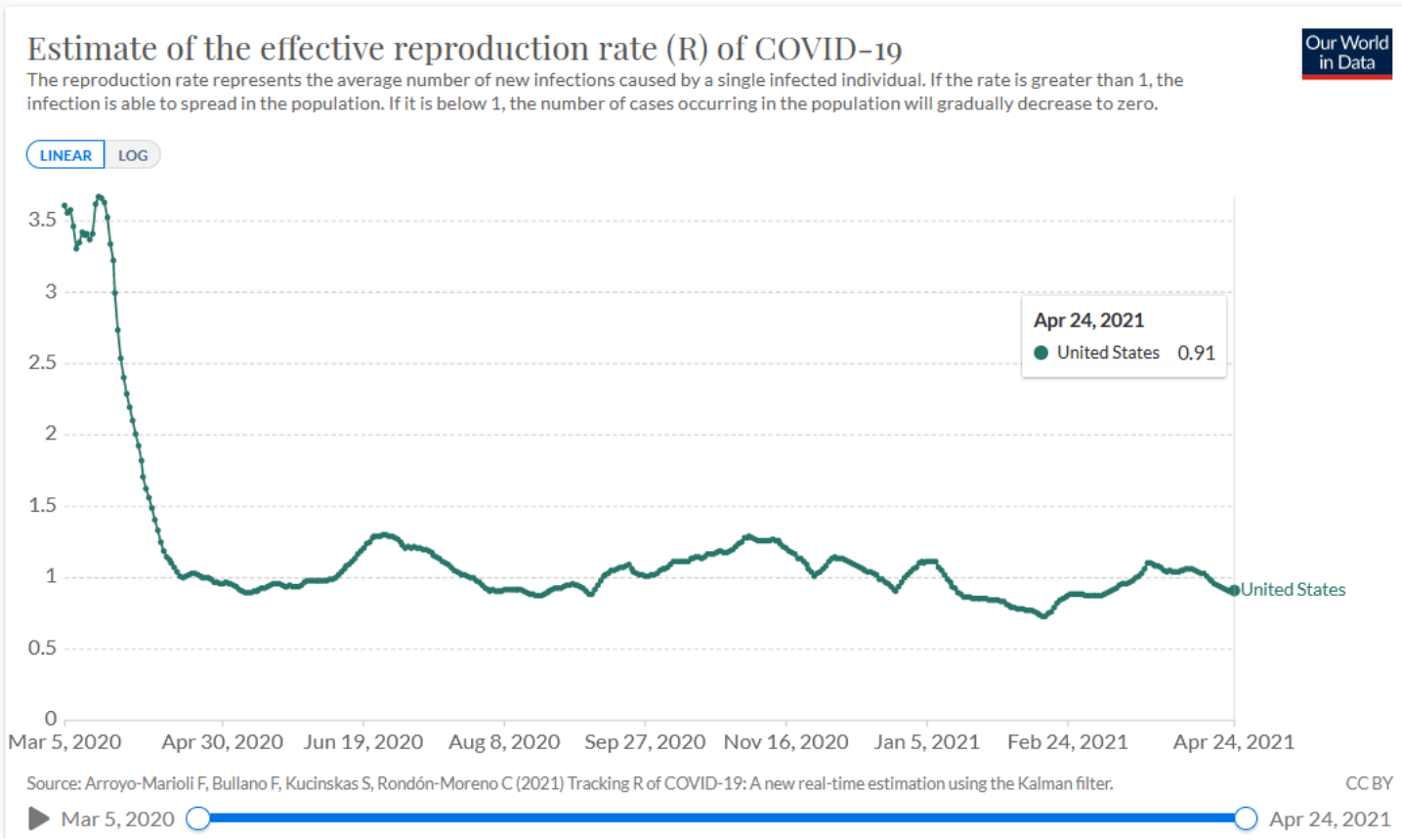
- **Herd immunity** is calculated by the following formula. 1 minus 1/the R-naught #, times 100 to get the percentage of the population that would need immunity to provide protection for the remainder of the population. The R-naught for SARS-CoV-2 has been estimated at between 2.0 and 2.5 especially earlier in the pandemic (although as the virus burns out it becomes lower and lower). For calculation, let's take the higher estimate of 2.5…..1 divided by 2.5 = 0.4. So, 1 minus 0.4 = 0.6. 0.6 times 100 = 60%. With a population of 330 million, that would mean that **198,000,000** people would need to have had the infection to protect the other 132 million people. Taking the lower hypothetical from above that **207,900,000** people have been infected, it would mean that we are over the number required to achieve herd immunity at a 60% coverage. Now there are certain things that have to be taken into consideration for this estimate to be accurate.

    - Is the CDC's estimate of 8X number of infections over PCR confirmed cases accurate? https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1780/6000389

    - What is the real number of CASES of COVID-19? Meaning how many people have really had the DISEASE COVID-19, not just had the infection and never developed the disease? Of the 32 million "cases" meaning positive PCR, how many of those were false positives and really influenza or other seasonal respiratory viruses. As we've seen in the beginning this issue of ***1200 Studies Newsletter*** as well as the last few issues, the flu is virtually gone this year. But where did it go?

  Regardless of those specifics, suffice to say we are moving in the right direction and must be getting very close to population (herd) immunity. And this next graph makes the prospects even better!

Based on this graph from the ***Our World in Data COVID-19 Data Explorer*** the R-naught number for the U.S. is lower than previously projected. That is very good news with respect to herd immunity! (https://ourworldindata.org),

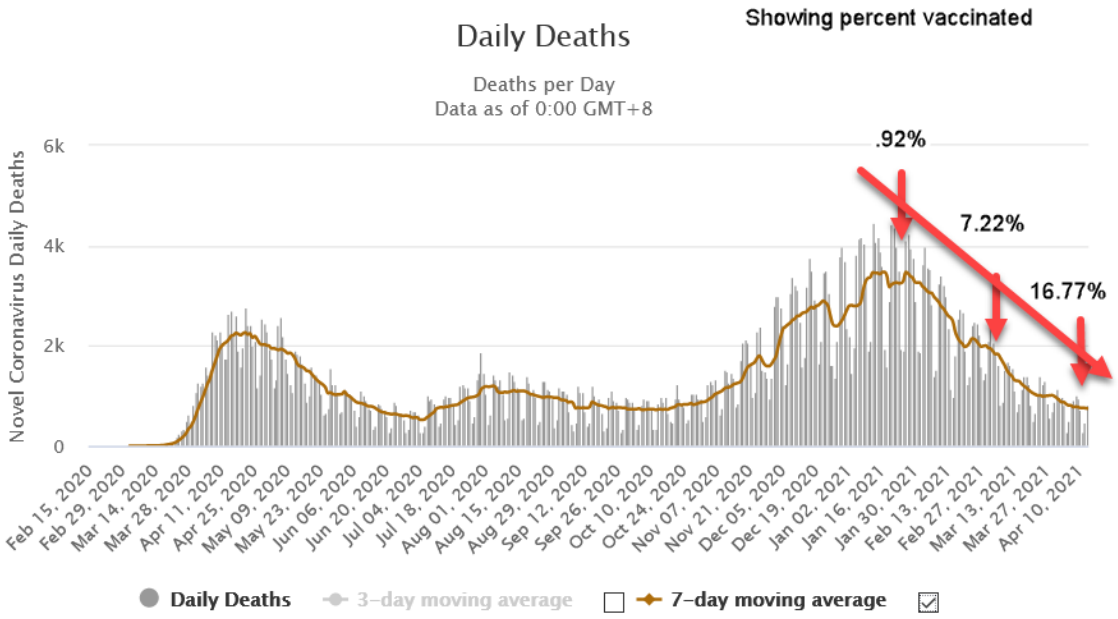


As of April 24th, the R-naught or Reproduction Rate of SARS-CoV-2 in the U.S. is under 1 at 0.91. That is a great sign and could be another indicator that we are reaching herd immunity.

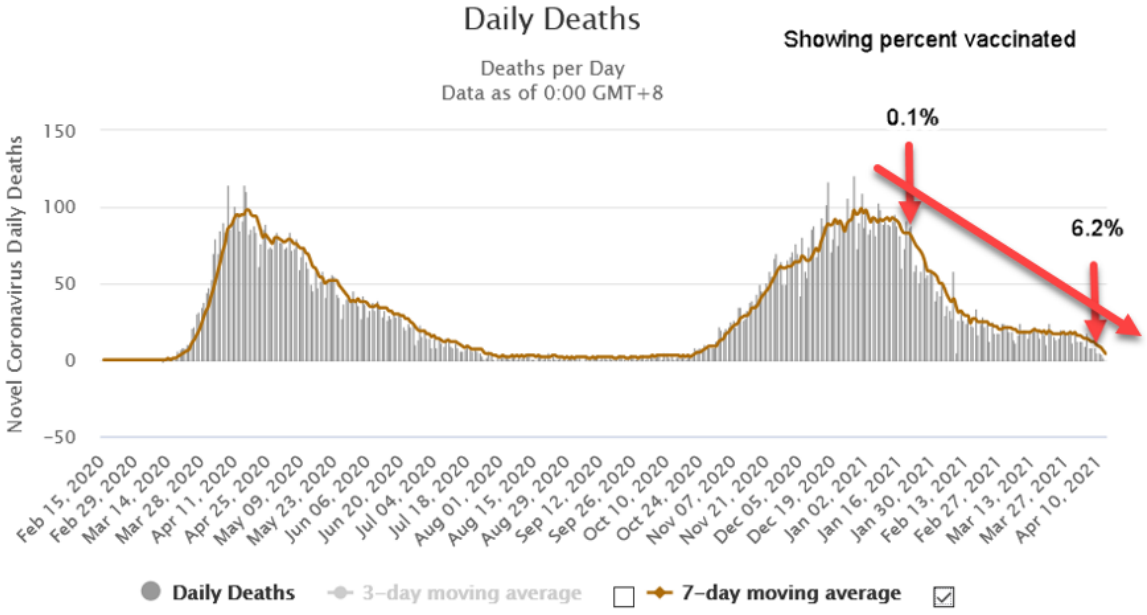
How much are the vaccines responsible for the drop in COVID-19 deaths?

As of April 8th, the U.S. has 16.77% of the population fully vaccinated. Compared to Sweden at only 6.2%.

Daily New Deaths in the United States



Daily New Deaths in Sweden



Very similar downward trajectory in the 7-day moving average of deaths, right?

Since Sweden, a country that never locked down and destroyed business and their economy, kept their kids in school and didn't inflict a huge emotional toll on their population is experiencing the same success in their death rates as the U.S. even without vaccine coverage that would explain that drop in mortality, there is no reason to believe the narrative about gene therapy treatments helping to end the pandemic.

More concerns over the blood clotting issues from the COVID-19 vaccines

An April 13th article in Natural News by Mike Adams titled **Vaccine antibodies CAUSE blood clots in the brain, lungs and heart… FDA calls halt to J&J vaccine as deaths accelerate** raises serious concerns over the large numbers of clotting issues seen not just with the Johnson and Johnson vaccine, but the other mRNA vaccines as well.

From the article:

In the wake of accelerating deaths from vaccine-induced blood clots, the FDA has now called a nationwide halt to the Johnson & Johnson covid-19 vaccine.

In truth, **all covid-19 vaccines cause deadly blood clots** for the simple reason that **spike protein structures are biologically active** and lead to blood coagulation (clotting) inside the body. These blood clots travel to the brain, heart, lungs and other organs, causing strokes, heart attacks (rapper DMX was killed this way), pulmonary embolisms (blood clots in the lungs) and other similar causes of death, none of which are officially listed as "vaccine" deaths.

The fact that mRNA vaccines hijack the body's cells to generate spike proteins which cause blood clotting is an open admission that **mRNA vaccines are death shots** — a form of vaccine euthanasia. And people who are foolish enough to take these vaccine shots are signing up for "vaccine suicide" as part of a global depopulation agenda.

Even worse, none of the vaccines actually do anything useful to reduce deaths from covid. As Dr. Richard Fleming recently told ***the War Room*** broadcast, the vaccine efficacy data from Pfizer, Moderna and Johnson & Johnson, "all show their vaccines make zero difference in stopping covid." From that article:

Fleming warned the effects could take a year and half to show in humans.

Fleming, who in the 1990s discovered inflammation causes cardiovascular disease, said man-made spike proteins in the vaccines also cause inflammation. The Johnson & Johnson vaccine was pulled for its link to blood clots in women.

The vaccines have "no statistically significant benefit," Fleming said, but cause "inflammation and blood clotting, Lewy bodies [associated with dementia], Mad Cow disease, and nothing to benefit."

Fleming said the Biden regime should call for immediate reevaluation of "whether there's any demonstrated efficacy" of the vaccines, "because there's not."

"Secondly, what are the potential consequences of having already vaccinated a substantial number of individuals in this country?" Fleming said.

In today's ***Situation Update podcast***, I cover the blood clotting problems with the vaccine, revealing why so many people are already dying from an experimental intervention the government lied about and insisted was safe:

Brighteon.com/b3132a4a-a952-43a4-8475-7372b91a8690

Deep vein thrombosis after Pfizer vaccine

An article published in Internal and Energency Medicine March 9th, 2021 titled **Deep vein thrombosis (DVT) occurring shortly after the second dose of mRNA SARS-CoV-2 vaccine**, describes a case of a 66 year-old woman who developed the blood clots after her second dose of vaccine.

From the report:

Venous thromboembolic (VTE) complications have been consistently reported to be increased in SARS-CoV-2 infection, most probably as the results of a thrombophilic state secondary to inflammation and immunethrombosis.

A 66-year-old woman received the first dose of mRNA Covid-19 vaccine (BNT162b2, Comirnaty, Pfizer/BioNTech) subcutaneously on January 4th, 2021, without any reported clinical problem; she was scheduled for the second dose on January 25th. Her medical history was unremarkable except for post-trauma left leg neuropathy. She never had previous thrombotic events; she had one successful delivery. Her body mass index was 23 kg/m2; she did not smoke or had no allergic problems; she intermittently took painkillers for the neuropathy. On January 26th, 24 h after the second vaccine dose, she received acetaminophen for persistent fever with chills, fatigue, malaise, and muscle pain. On January 27th, 48 h after the second vaccine dose,

persistent fever was still present, and acute right calf pain appeared in the absence of trauma. On January 28th, she was admitted for evaluation at the emergency room because of persistent pain and inability to walk. Physical examination was unremarkable except for mild edema in the right calf. Blood tests (Blood count, INR, PTT, fibrinogen, renal and hepatic function) were normal, as notably was the D-dimer measurement. A Color-Doppler ultrasound scan revealed the presence of deep vein thrombosis involving the right peroneal vein and extending up to the popliteal vein, without signs of venous insufficiency. Thrombophilia screening was otherwise negative except for the presence of heterozygous FV Leiden mutation. The patient started apixaban 10 mg bid for 1 week, followed by 5 mg bid, with rapid symptoms resolution.

End of excerpts

This report follows many such reports coming in from all over the world and was the reason two dozen European countries called a pause to the AstraZeneca vaccine.

Another report in the ***British Medical Journal (BMJ)*** published April 14th, 2021 titled
Thrombosis after covid-19 vaccination

From the report:

During March, however, concerns were raised over possible thromboses after immunisation with the AstraZeneca vaccine. One of the first official reports from the European Medicines Agency, on 10 March, noted four cases of thrombosis in people immunised with a single batch of the vaccine in Austria, including at least two severe cases and one death.3 The batch was withdrawn from use. The following day reports emerged of a death in Denmark and the country suspended use of the vaccine to allow time for investigation. Several other countries followed suit.4

Subsequently, the focus of attention narrowed from thrombosis in general to cerebral venous sinus thrombosis (CVST), a rare condition with a background incidence of about 15 cases per million people each year according to recent studies from Australia and the Netherlands.5 CVST is a rare cause of stroke that generally affects younger adults and women more than men. Important risk factors are pregnancy and hormonal contraception.5

Proving cause and effect is never easy, especially for rare events. Chance clusters of rare events occur quite commonly in observations or analyses of large groups.6 Nevertheless, the balance of evidence was clearly shifting at the beginning of April. Increased reporting of CVST in the UK as well as in Europe, along with the almost total absence of cases after immunisation with Pfizer or Moderna vaccines were strong indicators that this may be a real association. That

many of those affected also had thrombocytopenia, which is not normally found in CVST, was an additional pointer that this was not a random association.

Both European and UK medicines regulators reported their conclusions on 7 April.[7] From the EMA briefing we learnt that other blood clots associated with thrombocytopenia were also being reported following the AstraZeneca vaccine, including arterial thromboses and splanchnic vein thrombosis.[8] The EMA compared the clinical picture to a similar heparin induced thrombocytopenia,[9] and two recently published case series have confirmed this similarity.[10][11] All patients in each series had high levels of antibodies against antigenic complexes of platelet factor 4 (PF4), as seen in heparin induced thrombocytopenia. None of the patients had received heparin.[10][11] Further studies in two patients confirmed PF4 dependent platelet activation.[10] The authors coined the term vaccine induced immune thrombotic thrombocytopenia for this condition. Potential treatment options include high dose immunoglobulins and certain non-heparin anticoagulants.[10]

The UK's Medicines and Healthcare Products Regulatory Agency had received 79 reports of thrombosis associated with low platelets by 31 March, of which 44 were CVST.[12] Of these 79 cases, 51 (13 fatal) were in women and 28 (six fatal) in men. So far all of the UK cases have occurred after the first dose. The risk was higher in the younger age groups, starting at 1.1 serious harm events for 100 000 immunised people among those aged 20-29 years and falling to 0.2/100 000 in those aged 60-69. For comparison, in women taking hormonal contraceptives the risk of thrombosis is about 60/100 000 person years and risk of fatal pulmonary embolism is about 1/100 000.[13][14] In most adult age groups, the benefits of the AstraZeneca vaccine far outweigh the risks. The exception is the 20-29 year age group, for which the risk-benefit equation is more finely balanced when community transmission is low.

https://www.bmj.com/content/373/bmj.n958

A response to that article is VERY revealing

In an April 14th, 2021 ***BMJ*** **Rapid Response** to the **Thrombosis after covid-19 vaccination** article**,** much more important information about the increasing awareness of these events by physicians is discussed.

The title of the response is:

CoViD-19 post-vaccine menorrhagia, metrorrhagia or postmenopausal bleeding and potential risk of vaccine-induced thrombocytopenia in women

Dear Editor,

Many women across the world after receiving CoViD vaccines are complaining of irregularities in their menstrual bleeding; some experiencing heavy menstrual bleeding (menorrhagia), some bleeding before their periods were due or bleeding frequently (metrorrhagia/polymenorrhea), whereas some are complaining of postmenopausal bleeding.

As of 5th April 2021, there have been ~958 cases of post-vaccination menstrual irregularities, including vaginal haemorrhages, that were recorded in MHRA's adverse event reports. There were twice more cases of menstrual irregularities with CoViD Vaccine AstraZeneca than Pfizer (643 vs 315 respectively) [1]. It is anticipated that the actual numbers of cases are much higher than the numbers recorded in the pharmacovigilance systems as many women in different cultural context may have felt uncomfortable to talk about it, may not have thought that it was vaccine-related, or may have not been encouraged by their clinicians to make an official report into the adverse events reporting system.

There have been recent reports of haemorrhage, blood clots and thrombocytopenia following administration of CoViD-19 vaccines that have raised concerns over the safety of genetic vaccines for people with pre-existing coagulation disorders or those on certain medications. Regulatory bodies have also issued warnings to the patients and healthcare professionals to be vigilant and seek prompt medical assistance if they experienced typical symptoms of cerebral venous sinus thrombosis (CVST), a potentially fatal clot in the brain [2,3].

European Medicines Agency has also revised the summary of product characteristics and listed thrombocytopenia (very low platelets) as a 'common' side effect (i.e., 1 in 100 to 1 in 10) of Vaxzevria, i.e., the CoViD vaccine AstraZeneca [4]. The pharmacovigilance data also suggests that thrombocytopenia is also a frequent observation followed by mRNA CoViD vaccines such as Pfizer or Moderna.

The 'heavy menstrual bleeding' has been previously reported in females with underlying platelets disorders [5]. It is plausible that the vaccine-induced thrombocytopenia may be an explanation for the recent incidences of heavy menstrual bleeding experienced by women in different countries after the CoViD-19 vaccination. The significant loss of blood in many women may lead to severe anaemia, further exacerbate thrombocytopenia, and therefore may significantly increase the risk of haemorrhages and clots.

Clinicians and front-line healthcare workers are advised to encourage women to report heavy menstrual bleeding or other extraordinary bleeding events post-vaccination formally into the vaccine adverse events reporting system and seek prompt medical advice. Public health agencies and regulatory authorities are also requested to investigate these incidences and issue

further warnings, as this can, possibly be an early sign of potentially fatal vaccine-induced prothrombotic thrombocytopenia leading to rare CVST events in younger women. There may be some women with pre-existing conditions or those on certain medications that may be at increased risk of experiencing post-vaccination severe adverse events and early warnings will help saving lives.

https://www.bmj.com/content/373/bmj.n958/rr-2

References:

[1] https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-...
[2] https://doi.org/10.1186/s40545-021-00315-w
[3] https://www.ema.europa.eu/en/news/covid-19-vaccine-astrazeneca-benefits-...
[4] https://www.ema.europa.eu/en/documents/product-information/vaxzevria-pre...
[5] https://www.sciencedirect.com/science/article/pii/S1083318816001637

Study shows the spike protein cause damage to the Blood-Brain-Barrier (BBB) and resultant brain inflammation

These findings have implications for the COVID-19 vaccines as they prompt our cells to make spike protein. Those manufactured spike proteins could migrate to the brain and trigger a cascade of events that may result in neurovascular injury, microthrombi (clots) and brain damage.

The study published December 2020 in the journal ***Neurobiology of Disease*** and titled **The SARS-CoV-2 spike protein alters barrier function in 2D static and 3D microfluidic in-vitro models of the human blood–brain barrier**, reveals a possible mechanism for the brain pathology caused by the SARS-CoV-2 Spike Protein.

From the Abstract:

As researchers across the globe have focused their attention on understanding SARS-CoV-2, the picture that is emerging is that of a virus that has serious effects on the vasculature in multiple organ systems including the cerebral vasculature. Observed effects on the central nervous system include neurological symptoms (headache, nausea, dizziness), fatal microclot formation and in rare cases encephalitis. However, our understanding of how the virus causes these mild

to severe neurological symptoms and how the cerebral vasculature is impacted remains unclear. Thus, the results presented in this report explored whether deleterious outcomes from the SARS-CoV-2 viral spike protein on primary human brain microvascular endothelial cells (hBMVECs) could be observed. The spike protein, which plays a key role in receptor recognition, is formed by the S1 subunit containing a receptor binding domain (RBD) and the S2 subunit. First, using postmortem brain tissue, we show that the angiotensin converting enzyme 2 or ACE2 (a known binding target for the SARS-CoV-2 spike protein), is ubiquitously expressed throughout various vessel calibers in the frontal cortex. Moreover, ACE2 expression was upregulated in cases of hypertension and dementia.

Introduction of spike proteins to *invitro* models of the blood-brain barrier (BBB) showed significant changes to barrier properties. Key to our findings is the demonstration that S1 promotes loss of barrier integrity in an advanced 3D microfluidic model of the human BBB, a platform that more closely resembles the physiological conditions at this CNS interface. Evidence provided suggests that the SARS-CoV-2 spike proteins trigger a pro-inflammatory response on brain endothelial cells that may contribute to an altered state of BBB function. Together, these results are the first to show the direct impact that the SARS-CoV-2 spike protein could have on brain endothelial cells; thereby offering a plausible explanation for the neurological consequences seen in COVID-19 patients.

From the Discussion:

SARS-CoV-2 can induce microclots formation in the vasculature of periphery tissues and within the vessels of the CNS. In fact, Bryce et al.[32] found that 6 out of 20 cases had microthrombi and acute infarction in the brain. Here we report the evident breakdown of the BBB by SARS-CoV-2 spike protein, thus offering a possible avenue for counteracting the consequences of acute ischemic stroke observed in COVID-19 patients younger than 50 years old. However, future studies should place focus on interrogating the connection between virus-mediated barrier disruption and coagulation to determine the unique cerebrovascular mechanisms responsible for heightening the risk of strokes in COVID-19 patients.

Taking together our data of elevated MMP3, CCL5, CXCL10 and CAMs, we can speculate that SARS-CoV-2 is a potentially neuroinvasive virus as it turns on the machinery to facilitate the migration of infected immune cells as “Trojan horses” into the brain parenchyma.

To our knowledge, this is the first reported evaluation that examined the effects of the SARS-CoV-2 spike protein on the BBB. Our findings provide insight into the continued theme that this novel coronavirus triggers responses at the endothelium. Specifically, in regard to the brain endothelium, the SARS-CoV-2 spike protein induced destabilization of the BBB, promoted a pro-inflammatory status but did not appear to alter cell viability acutely. Dysfunction of the barrier offers a plausible explanation to the observed neurological complications seen in COVID-19.

Lastly, the opening of the BBB, hints at the possible means in which the SARS-CoV-2 pathogen could also neuroinvade.

End of excerpts

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7547916/

Tiny country of Gibraltar sees unexpected increase in deaths in elderly population after vaccination with COVID-19 vaccines

In an article by Lance D. Johnson and published on Dr Eddy Bettermann MD's website titled, **Elderly population suddenly dying off for unexplained reasons, and it's no longer coded as covid-19**, the sudden deaths in the elderly of Gibraltar immediately after the vaccination program began is called the worst loss of life there in over 100 years.

Around the world, medical authorities are seeing a spike in elderly deaths, after covid-19 vaccination. Gibraltar, a nation located at the southern tip of Spain, is suffering from an unexplained surge in elderly deaths. In the second week of January, a subset of the elderly population suddenly started to die off. The new wave of unexplained elderly deaths is occurring at nearly three times the magnitude of covid-19 deaths that were recorded during 2020.

The new, unexplained surge in elderly deaths is occurring approximately forty times faster when compared to the overall timeline of covid-19 deaths that occurred since a pandemic was first declared. This surge in elderly deaths occurred after 5,847 doses of experimental mRNA injections were administered to the citizens of Gibraltar. In just one week, 17 percent of the country's population had been inoculated with the first dose of Pfizer's mRNA experiment.

Before the vaccine experiment began, the covid-19 related death toll accounted for ten people. After the vaccine rollout, the total number of deaths had skyrocketed to forty-five people. In the first eight days of the vaccination program, thirty-five seniors suddenly passed away.

After the first week of vaccination, Chief Minister Fabian Picardo said, "This is now the worst loss of life of Gibraltarians in over 100 years. Even in war, we have never lost so many in such a short time."

Vaccine-induced deaths to be blamed on new "covid-variant"

In 2020, medical examiners would have easily labeled these sudden deaths as covid-19, but now these deaths are somehow unexplained, with no definitive cause. Before the covid-19 vaccines were unleashed, seniors died of covid-19. Now seniors are dying of natural causes again, right after being vaccinated. It won't be long before a surge in elderly deaths around the world is blamed on a new variant of SARS-CoV-2, with medical authorities calling for new

vaccines, more doses, and mRNA updates. Isn't it suspicious that a deadly covid-variant became headline news suddenly after the vaccine rollout?

Norway deaths

Gibraltar isn't the only nation to report on the sudden spike in senior deaths. In Norway, twenty-nine senior citizens suddenly passed away in the first two weeks after the first dose of the vaccine. In the hours after vaccination, and sometimes minutes after, these seniors shared similar side effects, including but not limited to: persistent malaise and extreme exhaustion; severe allergic, including anaphylactic, reactions; multi-system inflammatory syndrome; psychological disturbances; seizures; convulsions; and paralysis, including Bell's Palsy. The Norwegian Medicines Agency declared that "all deaths are linked to this [Pfizer's] vaccine" because it was the only intervention that preceded the sudden elderly deaths.

https://dreddymd.com/2021/02/18/elderly-population-suddenly-dying-off-for-unexplained-reasons-and-its-no-longer-coded-as-covid-19/

That story coincides with a ***Mercola.com*** article titled, **Seniors Dying After COVID Vaccine Labeled as Natural Causes**. I want you to catch the irony in that title. Throughout the COVID-19 pandemic, nearly all elderly deaths, no matter what the actual cause of death were being called a COVID death. Now, after people are vaccinated and die suddenly and unexpectedly, the deaths are all being called "natural" or "unexplained."

From the article:

Around the world, reports are pouring in of people dying shortly after receiving the COVID-19 vaccine. In many cases, they die suddenly within hours of getting the shot. In others, death occurs within the span of a couple of weeks.

One notable case is baseball legend Hank Aaron, 86, who died January 22, 2021, 17 days after publicly getting vaccinated for COVID-19.[1,2] He said at the time that he hoped other Blacks would follow his lead and get their vaccines too.

According to news reports, he died "peacefully in his sleep" and no cause of death had been announced. Aaron was famous for being the home-run king of baseball, and broke Babe Ruth's record when he hit homerun No. 715; he had hit 755 by the time he retired from the sport.

My comment: *Hank Aaron had been used by the media-pharmaceutical complex to promote that people get vaccinated with the experimental COVID-19 vaccines. As a role model for millions and especially the African American community, Aaron's endorsement carried a lot of weight. He was quoted as saying… "It makes me feel wonderful. I don't have any qualms about it at all … I feel quite proud of myself for doing something like this … It's just a small thing that can help zillions of people in this country."*

He was filmed getting his first dose as he encouraged minorities to join in and get the life-saving vaccine. He didn't make it to the next appointment for his second dose because he suddenly died "in his sleep" seventeen days after getting the first dose.

Vaccine Rollout Coincides with Outbreak

Other areas are also reporting "outbreaks" of COVID-19, resulting in increased death tolls, after the rollout of vaccinations. Case in point: In Auburn, New York, a COVID-19 outbreak began December 21, 2020, in a ***Cayuga County nursing home.***[8,9] Before this outbreak, no one in the nursing home had died from COVID-19.

The next day, December 22, they started vaccinating residents and staff. The first death was reported December 29, 2020. Between December 22, 2020, and January 9, 2021, 193 residents (80%) received the vaccine, as did 113 staff members.

As of January 9, 2021, 137 residents had been infected and 24 had died. Forty-seven staff members had also tested positive for SARS-CoV-2 and one was on life-support.

Considering we're also seeing cases in which healthy young and middle-aged individuals die within days of receiving the vaccine, it's not inconceivable that the vaccine might have something to do with these dramatic rises in deaths among the elderly in various parts of the world. In fact, I'd expect it.

End of excerpts

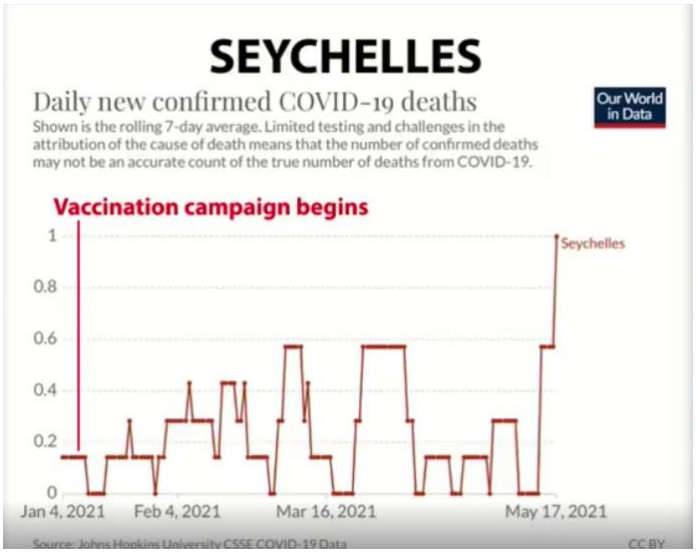
https://articles.mercola.com/sites/articles/archive/2021/02/02/covid-vaccine-death-seniors.aspx

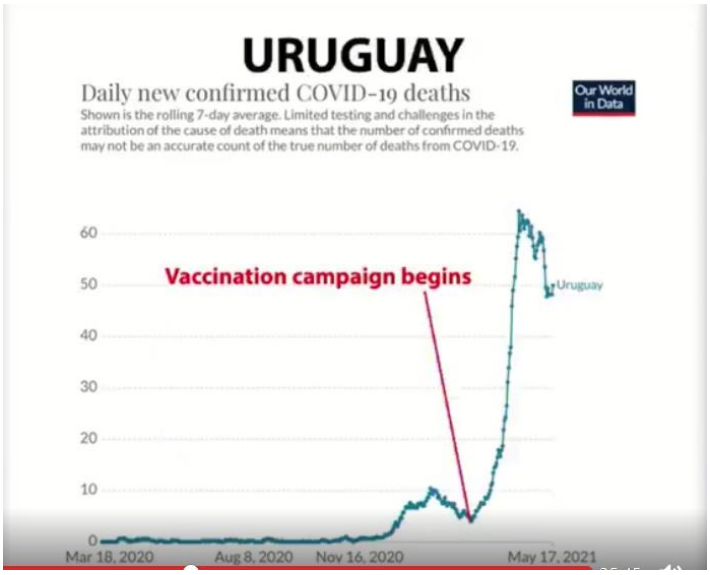
Update July 04th, 2021

18 countries deaths spike after vaccine campaigns begin- See the Graphs

In each of these graphs, look at where the mass vaccination campaigns started and then see what happened with the death rates shortly thereafter. Then ask yourself. Are the vaccines really safe and effective?

Get ready to have your mind blown!





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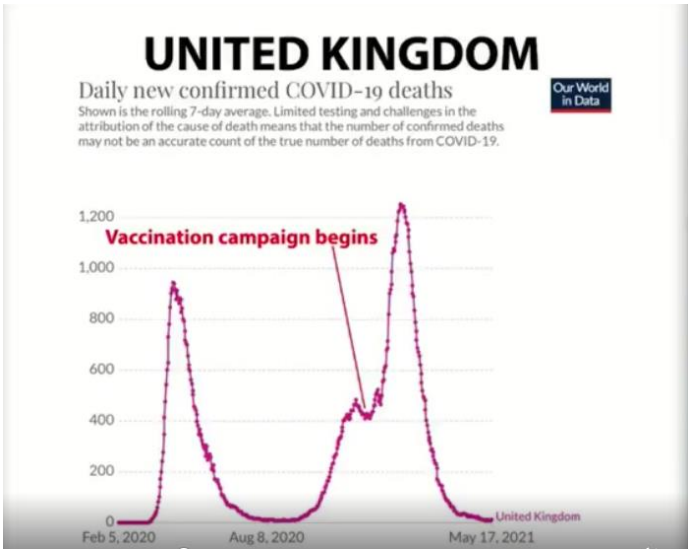
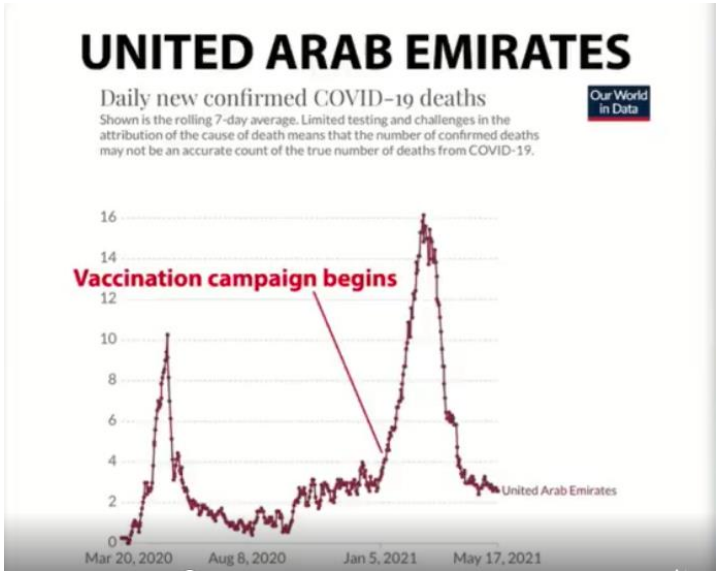
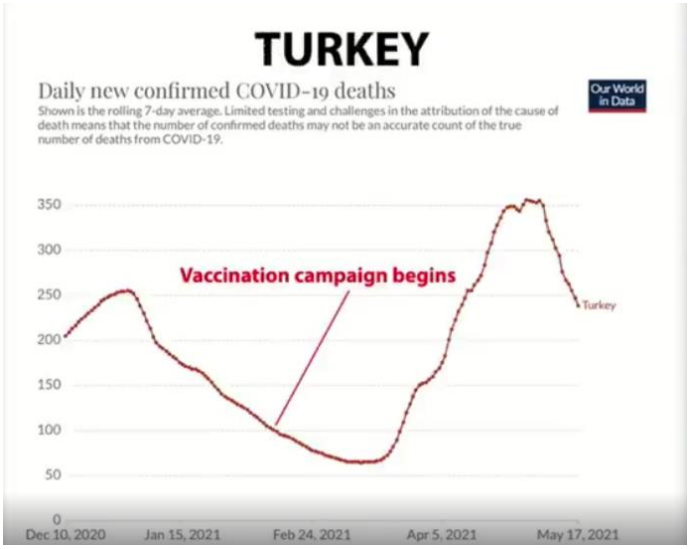
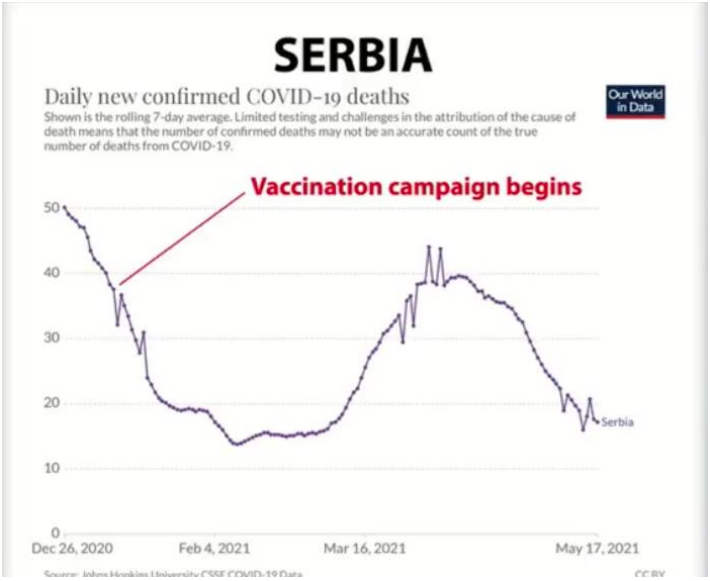
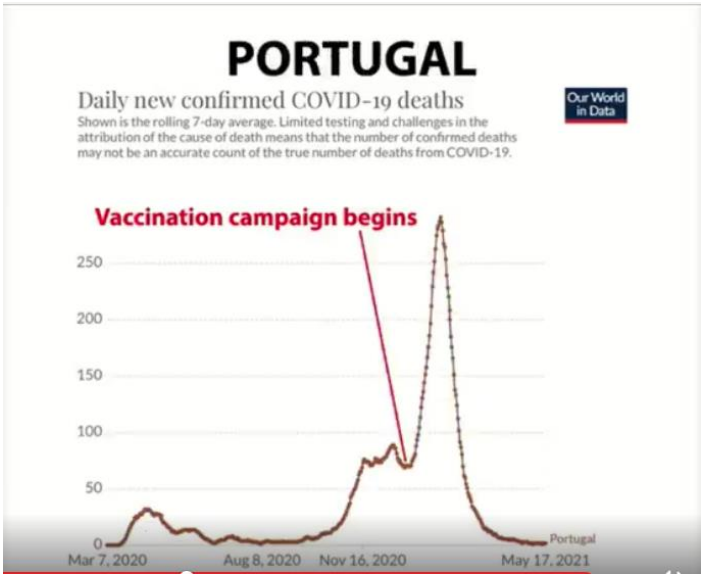

UNITED KINGDOM
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
1,200
1,000
800
600
400
200
0
United Kingdom
Feb 5, 2020
Aug 8, 2020
May 17, 2021

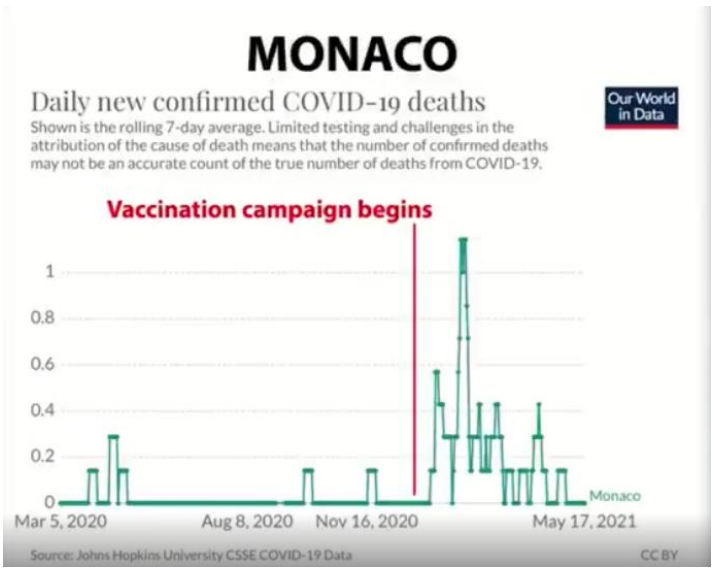

UNITED ARAB EMIRATES
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
16
14
12
10
8
6
4
2
0
United Arab Emirates
Mar 20, 2020
Aug 8, 2020
Jan 5, 2021
May 17, 2021

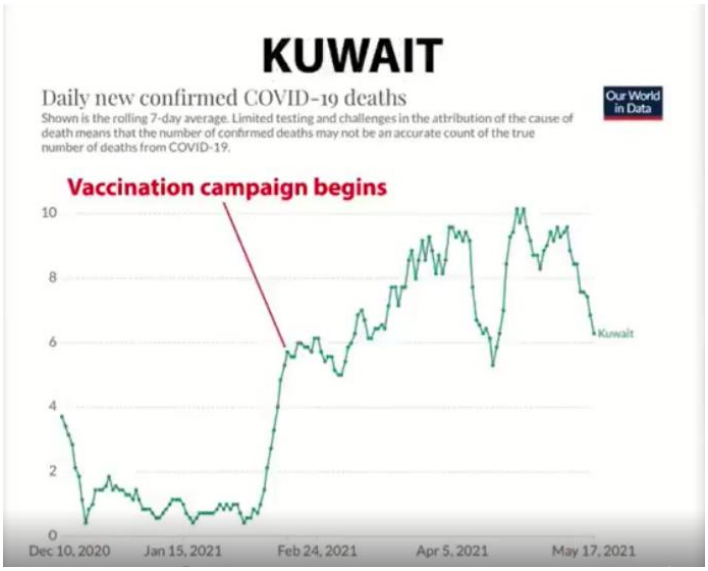

TURKEY
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
350
300
250
200
150
100
50
0
Turkey
Dec 10, 2020
Jan 15, 2021
Feb 24, 2021
Apr 5, 2021
May 17, 2021

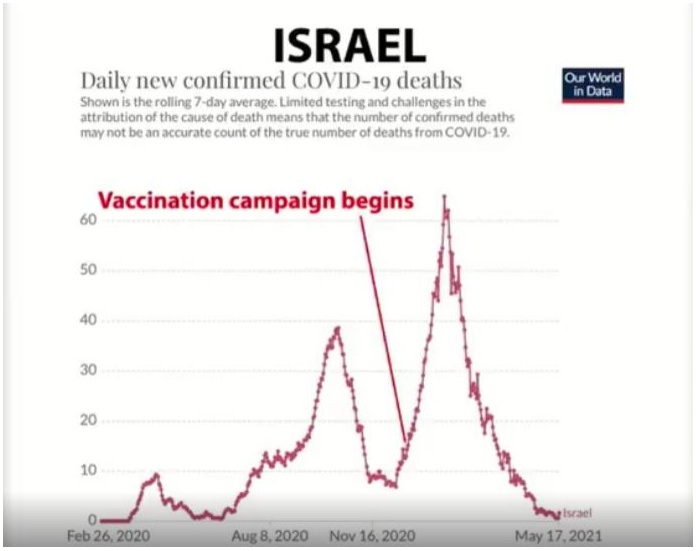

SERBIA
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
50
40
30
20
10
0
Serbia
Dec 26, 2020
Feb 4, 2021
Mar 16, 2021
May 17, 2021

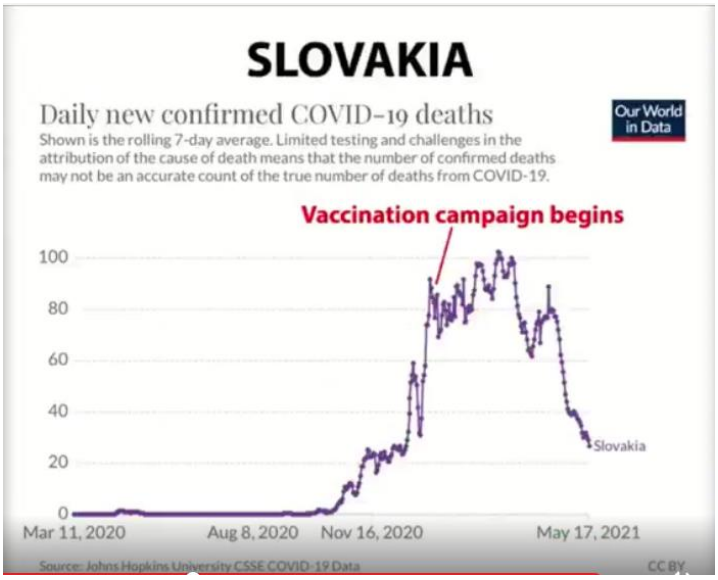

PORTUGAL
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
250
200
150
100
50
0
Portugal
Mar 7, 2020
Aug 8, 2020
Nov 16, 2020
May 17, 2021

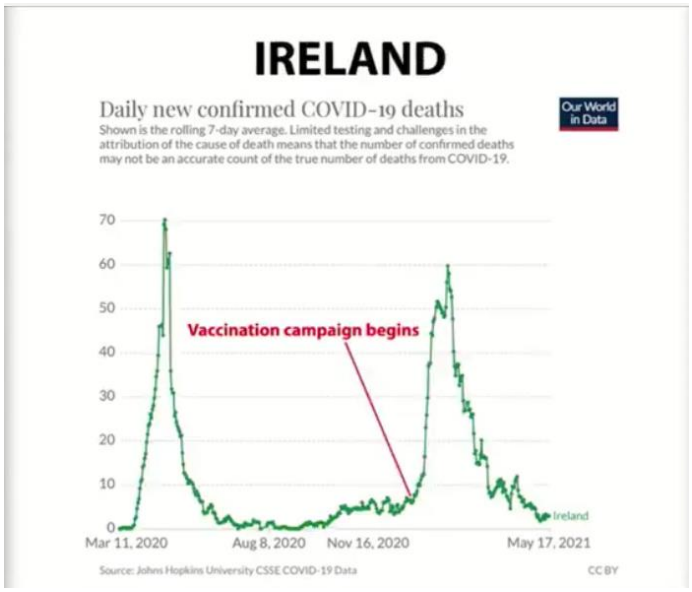

NORTH MACEDONIA
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
40
30
20
10
0
North Macedonia
Mar 11, 2020
Aug 8, 2020
Nov 16, 2020
May 17, 2021

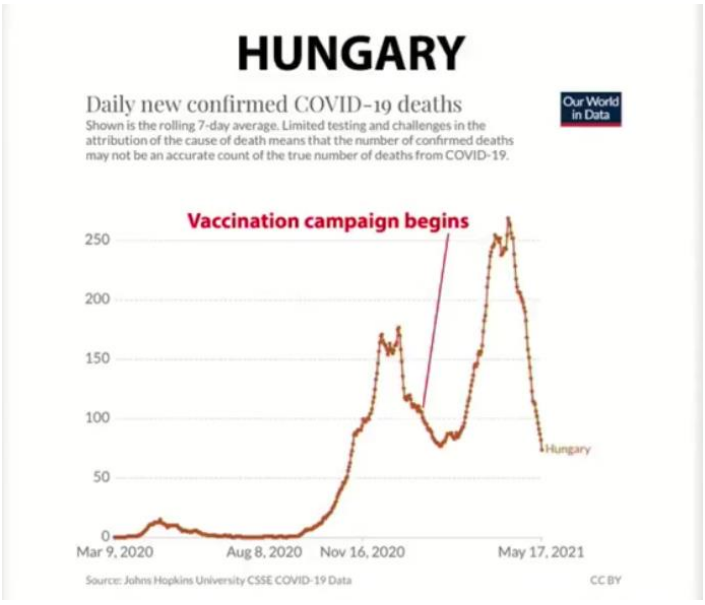

MONACO
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
1
0.8
0.6
0.4
0.2
0
Monaco
Mar 5, 2020
Aug 8, 2020
Nov 16, 2020
May 17, 2021
Source: Johns Hopkins University CSSE COVID-19 Data
CC BY

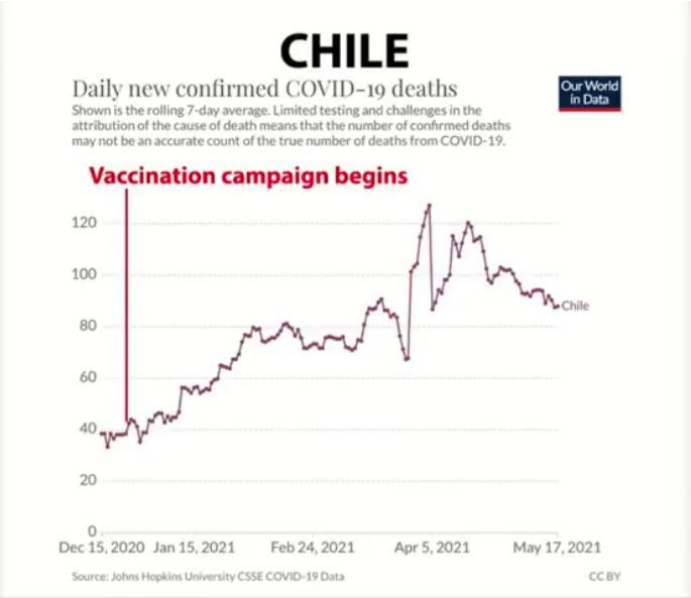

KUWAIT
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
10
8
6
4
2
0
Kuwait
Dec 10, 2020
Jan 15, 2021
Feb 24, 2021
Apr 5, 2021
May 17, 2021

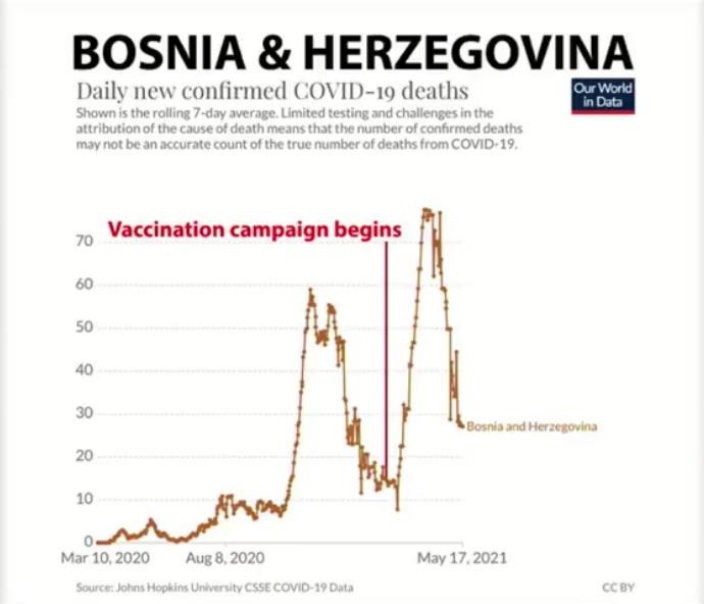

ISRAEL
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
60
50
40
30
20
10
0
Israel
Feb 26, 2020
Aug 8, 2020
Nov 16, 2020
May 17, 2021

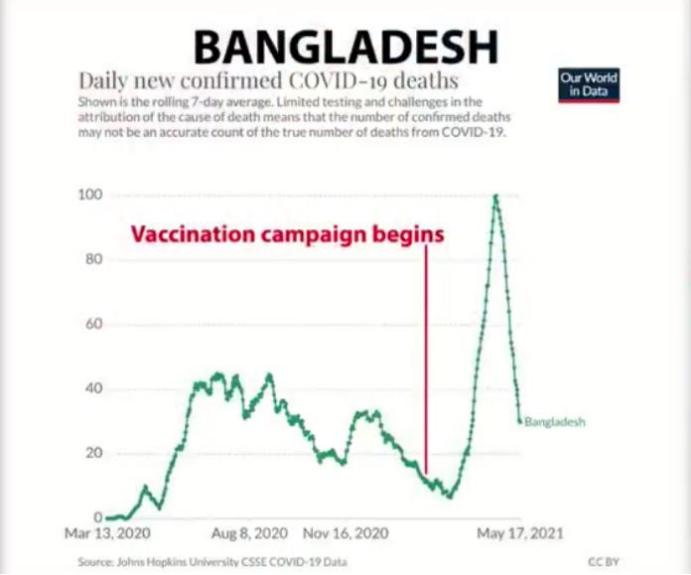

SLOVAKIA
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
100
80
60
40
20
0
Slovakia
Mar 11, 2020
Aug 8, 2020
Nov 16, 2020
May 17, 2021
Source: Johns Hopkins University CSSE COVID-19 Data
CC BY


IRELAND
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
70
60
50
40
30
20
10
0
Ireland
Mar 11, 2020
Aug 8, 2020
Nov 16, 2020
May 17, 2021
Source: Johns Hopkins University CSSE COVID-19 Data
CC BY

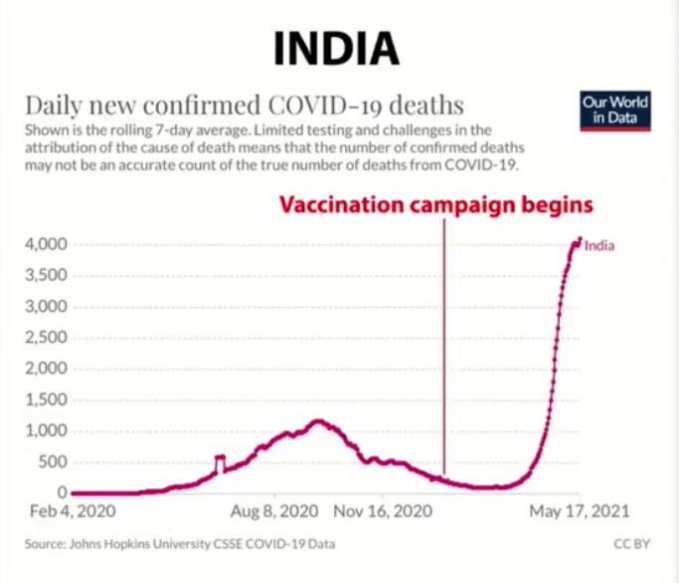

HUNGARY
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
250
200
150
100
50
0
Hungary
Mar 9, 2020
Aug 8, 2020
Nov 16, 2020
May 17, 2021
Source: Johns Hopkins University CSSE COVID-19 Data
CC BY


CHILE
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
120
100
80
60
40
20
0
Chile
Dec 15, 2020
Jan 15, 2021
Feb 24, 2021
Apr 5, 2021
May 17, 2021
Source: Johns Hopkins University CSSE COVID-19 Data
CC BY


BOSNIA & HERZEGOVINA
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
70
60
50
40
30
20
10
0
Bosnia and Herzegovina
Mar 10, 2020
Aug 8, 2020
May 17, 2021
Source: Johns Hopkins University CSSE COVID-19 Data
CC BY


BANGLADESH
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
100
Vaccination campaign begins
80
60
40
20
0
Bangladesh
Mar 13, 2020
Aug 8, 2020
Nov 16, 2020
May 17, 2021
Source: Johns Hopkins University CSSE COVID-19 Data
CC BY


CZECHIA
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
200
150
100
50
0
Czechia
Vaccination campaign begins
Mar 6, 2020
Aug 8, 2020
Nov 16, 2020
May 17, 2021



More concerns of Antibody Dependent Enhancement

It is feared that the greatest number of deaths will not occur for some time to come in those that are vaccinated with the COVID-19 "vaccines"

Many scientists and researchers warn that the potential for ***Antibody Dependent Enhancement (ADE)***, AKA ***Pathogenic Priming*** as well as other autoimmune and immune dysregulation effects from the vaccines can lead to a large number of delayed deaths from the vaccines.

In these excerpts from an article on the ***Children's Health Defense*** website, the concerns over ADE are expressed.

From the article

In the development of vaccines against coronaviruses like SARS-COV-1 and MERS in the early 2000's, researchers found evidence of a serious problem. Teams of U.S. and foreign scientists vaccinated animals with the four most promising vaccines. At first, the experiment seemed successful as all the animals developed a robust antibody response to coronavirus. However, when the scientists exposed the vaccinated animals to the wild virus, the results were horrifying. Vaccinated animals suffered hyper-immune responses including inflammation throughout their bodies, especially in their lungs.

This issue is well known. Early in the COVID-19 scenario, Dr. Peter Hotez, of ***Baylor College of Medicine***, testified before Congress about the dangers of accelerating coronavirus vaccine development, saying "(The)

unique safety problem of coronavirus vaccines" was discovered 50 years ago while developing the Respiratory Syncytial Virus (RSV) vaccine."

He went to register that this "'paradoxical immune enhancement phenomenon' means vaccinated people may still develop the disease, get sicker and die."

Researchers had seen this same "enhanced immune response" during human testing of the failed RSV vaccine tests in the 1950s. The vaccines not only failed to prevent infection; 80% of the children infected required hospitalization, and two children challenged with the RSV died (see Openshaw, 2005). In April of 2020, Hotez told CNN, "If there is immune enhancement in animals, that's a showstopper."

In this video footage, Offit, Hotez and even Fauci (in an unguarded moment), warn that any new coronavirus vaccine could trigger lethal immune reactions, "vaccine enhancement," when vaccinated people come in contact with the wild virus. Instead of proceeding with caution, Fauci made the reckless choice to fast track vaccines, partially funded by Gates, without critical animal studies before moving into human clinical trials that could provide early warning of runaway immune responses.

Gates (in this video) is so worried about the danger of adverse events that he says vaccines shouldn't be distributed until governments agree to indemnify against lawsuits. On Feb. 4, according to the Centers for Disease Control and Prevention (CDC) website, there were only 11 active CV cases in the U.S., yet the U.S. quietly pushed through federal regulations giving coronavirus vaccine makers full immunity from liability.

End of excerpts

https://childrenshealthdefense.org/defender/pfizer-covid-vaccine-trial-pathogenic-priming/

Here is a study from the Journal *Human Vaccines and Immunotherapeutics* that demonstrated this very deadly phenomenon

Immunization with inactivated Middle East Respiratory Syndrome coronavirus vaccine leads to lung immunopathology on challenge with live virus

This study from the journal ***Human Vaccines and Immunotherapeutics*** 2016 demonstrates the biggest concern and main reason why attempts to make a coronavirus vaccine have previously failed. That is the phenomenon of immune enhancement or sometimes called pathogenic priming. This is where vaccinated subjects later when exposed to the wild virus develop an over reactive immune response leading to a hyper-inflammatory pathological condition. This can lead to severe and even fatal results.

The abstract:

"To determine if a hypersensitive-type lung pathology might occur when mice were given an inactivated MERS-CoV vaccine and challenged with infectious virus as was seen with SARS-CoV vaccines, we prepared and vaccinated mice with an inactivated MERS-CoV vaccine. Neutralizing antibody was induced by vaccine with and without adjuvant and lung virus was reduced in vaccinated mice after challenge. Lung mononuclear infiltrates occurred in all groups after virus challenge but with increased infiltrates that contained eosinophils and increases in the eosinophil promoting IL-5 and IL-13 cytokines **only in the vaccine groups**. **Inactivated MERS-CoV vaccine appears to carry a hypersensitive-type lung pathology risk from MERS-CoV infection that is similar to that found with inactivated SARS-CoV vaccines from SARS-CoV infection**."
https://pubmed.ncbi.nlm.nih.gov/27269431/

An excellent paper by Dr. James Lyons-Weiler published April 2020 in the ***Journal of Translational Autoimmunity*** titled, **Pathogenic priming likely contributes to serious and critical illness and mortality in COVID-19 via autoimmunity** raises the concerns about pathogenic priming and future development of autoimmunity as a consequence of COVID-19 reinfection or vaccine administration.

My comment: Now 8 months after this paper was released, we know that as true reinfection is extremely rare. And, based on studies looking at both humoral and innate immunity it is very promising as to long-term immunity after infection. We will certainly know more in 2-3 years.

From the article

SARS-CoV-2 has some unexplained pathogenic features that might be related to the table of putative pathogenic priming peptides. Exposure to these specific peptides - via either infection or vaccination - might prime patients for increased risk of enhanced pathogenicity during future exposure due either to future pandemic or outbreaks or via universal vaccination programs. While the mechanisms pathogenesis of COVID-19 are still poorly understood, the morbidity and mortality of SARS has been extensively studied. Thus, the involvement of pathogenic priming in reinfection by COVID-19 is a theoretical possibility; of course no vaccine

against SARS-CoV-2 has yet been tested in animals and therefore we do not yet know if pathogenic priming is in fact expected. Such studies should be undertaken before use of any vaccine against SARS-CoV-2 is used in humans.

https://pubmed.ncbi.nlm.nih.gov/32292901/

My comment: And as we all know, the mRNA vaccines that are now being injected into the public, have skipped this very important step of sufficient animal studies looking at the very possible risk of pathogenic priming.

A very important consideration in the discussion regarding kids and these experimental products

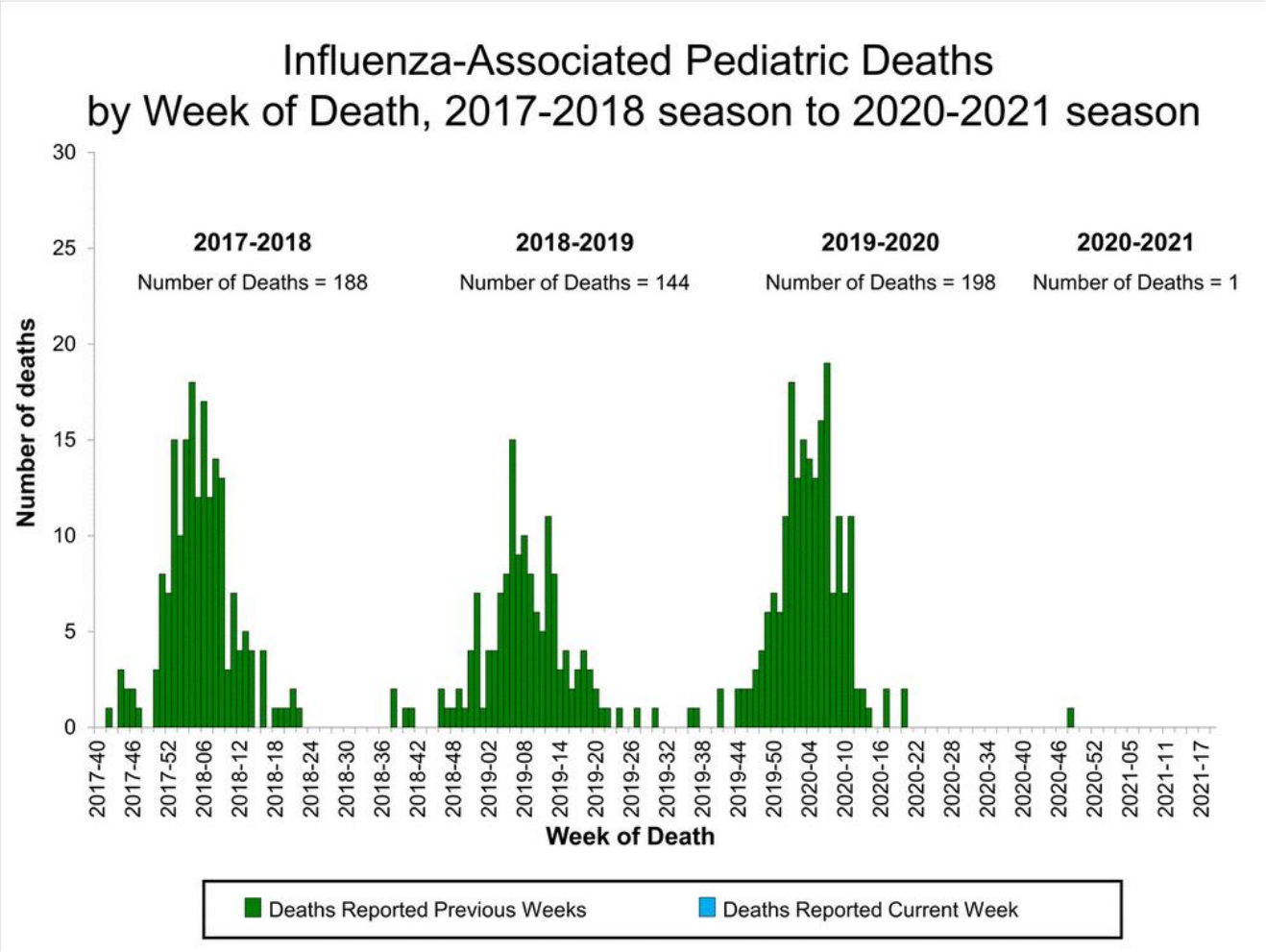
The survival rate for COVID-19 in children is 99.998%

This is critical to understand. COVID-19 appears by all measures to be less deadly to children than the seasonal flu. And, during the 2020-2021 flu season it appears that the flu was almost non-existent, dominated by the SARS-CoV-2 virus. Even so, deaths in children were very low.

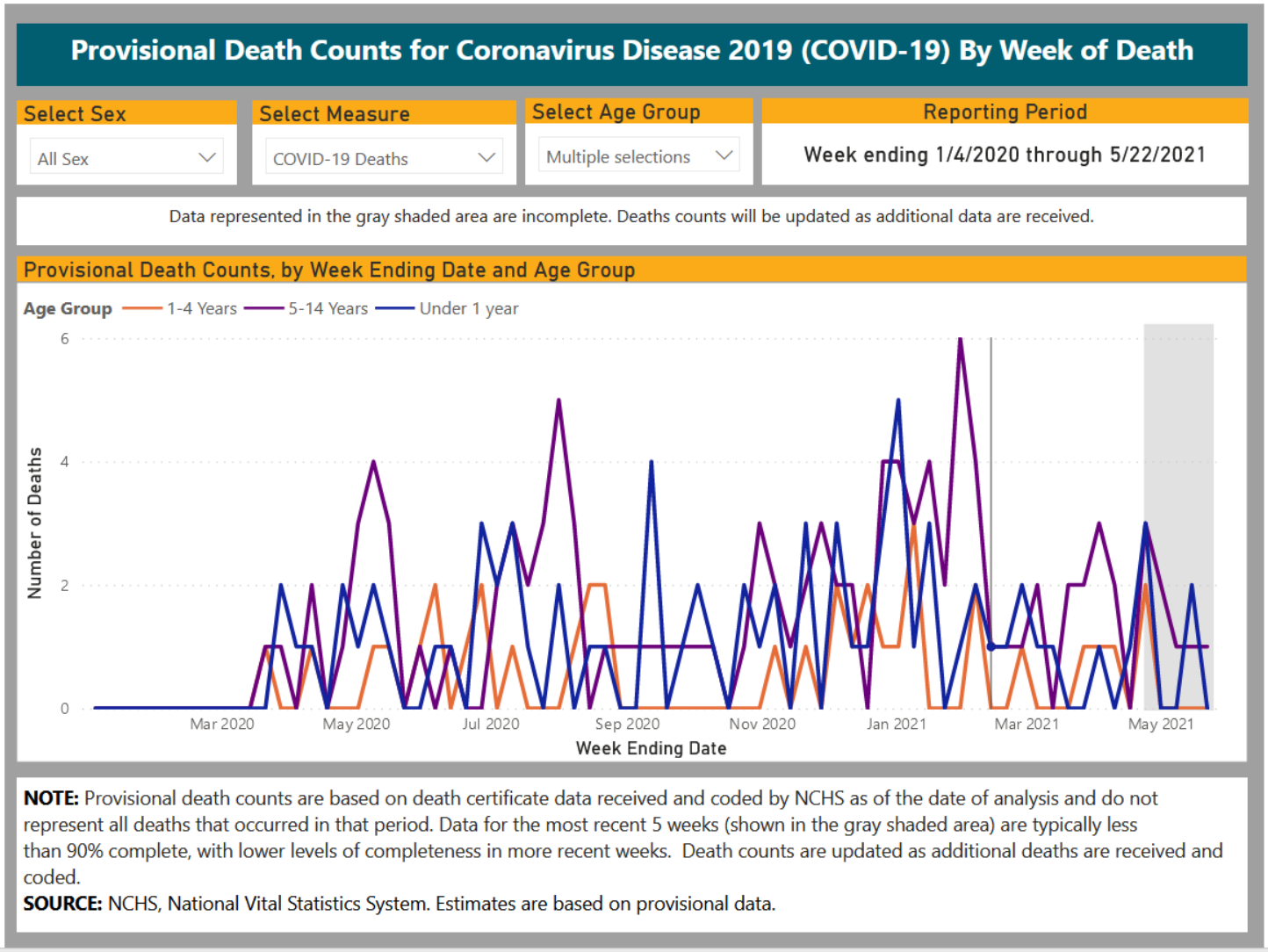
The number of pediatric deaths from the flu have dropped 99.5% this year

Looking at the chart below it is obvious that just like all flu cases and deaths, pediatric deaths from the flu are at an all-time low. Why is that? Some would claim that it is because of the masks and social distancing. Well, if that were the case, how do you explain the surge of COVID-19 cases and deaths this past winter? If the masks and distancing were effective against the flu, they certainly would have been effective against the SARS-CoV-2 virus. But that just wasn't the case. As I have previously covered in many stories backed by evidence from many studies, masks have been ineffective at stopping this virus, just like they have been proven ineffective against influenza and other respiratory viruses over the last 40 years. It could be argued that lockdowns and severely restricting movement of people could slow the spread of an outbreak as has been shown in various areas of the world throughout the pandemic, but that policy is simply not sustainable and creates massive collateral damage in society. Once those areas eventually opened up the virus spread as it would have in the absence of lockdowns.

Looking at the chart below is a graphic reminder of how dominant viruses will increase mortality in populations that are susceptible to respiratory viruses, as we have seen with SARS Co V2. As with the very elderly and sickly who normally succumb to influenza and influenza like illnesses every winter season, pediatric deaths will show a similar phenomenon. Those children with underlying conditions that make them susceptible to severe outcomes or death from any pathogenic respiratory virus will be more susceptible to the dominant strain or strains during any given season. Had SARS-CoV-2 never arrived on the scene, we most likely would have seen flu related death numbers in children similar to the previous seasons.



To reinforce the point that the masks and distancing have not been the X-factor with controlling flu related deaths this past winter in children, take a look at this chart showing the pediatric deaths throughout the pandemic. As you can see, the highest numbers of deaths "with COVID" occurred this past January and February, exactly when we would normally see the flu deaths peak in children as demonstrated by the graph above. But note for reference that the numbers of deaths displayed on the Y-axis on the left peak out at 6 deaths in the age 5-14 age group, so we are not talking about large numbers of children.



https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm#SexAndAge

In total, the CDC says that there have been 300 pediatric deaths in children "involving COVID" as of May 26th, 2021. But remember that involves 2 full respiratory seasons and 7 months of COVID spread in between. If you average the 3 prior flu seasons in the flu death chart on the previous page, you will get an average of 177 deaths per flu season in the pediatric population. One would expect approximately 354 flu deaths in children over the course of 2 flu seasons, which is less than what have occurred during COVID. Another argument I would make is that we have caused a population wide immunosuppression in our children by forcing them to wear masks at school and in public. Numerous studies have shown the immunosuppressive effects of face coverings worn consistently. Not only that, but the lack of social connection, propagation of fear and paranoia, and decreased amounts of outdoor activities and exercise would have all contributed to an increase in

susceptibility to viral illness in the pediatric population, resulting in a higher number of severe cases and deaths than would have occurred otherwise.

In summary:

- **"Flu" cases and deaths parallel the same seasonal pattern as we have seen with COVID.** (other than the summer surge we saw in areas that did not have a strong initial surge back in March and April of 2020 due to lockdowns and other factors. Remember, you can't hide from a virus. You simply delay the inevitable)

- **Despite masks and social distancing, we saw the same spikes during this past winter from COVID that we would typically see during the usual flu season.**

- **COVID-19 is less lethal to children than the seasonal flu.**

***As a side note.** The CDC also reported in the link above that there have been a total of 44,788 pediatric deaths during the same time period. That means that deaths involving COVID in the pediatric population account for just 0.67% of all deaths in children.
https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm#SexAndAge

Yet, we are acting like unless we vaccinate all of them with the experimental "vaccines", they will be at risk. It is ridiculous, especially due to the fact that in addition to an incredibly low risk of severe complications and death in children, a very large percentage of their population have had COVID-19 and recovered. That means they cannot get it again and will serve as a buffer for the other children that have not contracted COVID-19. Injecting a child that has had COVID-19 and recovered, especially in light of their low risk and unknowns of the effects short and long-term in children should be medical malpractice. Not only that, but to not even suggest that children should be tested for antibodies and T-cell immunity before vaccinating them is another example of the UNscientific approach we are following in nearly every area of this whole fiasco. Considering all of those variables it is complete insanity in my opinion to move forward with these experimental products that have no long-term safety record and could very well pose a higher risk of short- and long-term adverse effects in children than the virus itself.

July 1st, 2021 Update

What percentage of the children under 18 in the U.S. have died from COVID-19?

When we are talking about giving a new, never before tested in children experimental gene therapy biologic technology, we really need to ask the question…"How dangerous is COVID-19 to children anyway?"

One calculation that can be looked at is the percentage of all children under the age of 18 in the U.S. that have died from COVID-19 according to the CDC. I have borrowed this from ***Children's Health Defense*** Citizen Petition you will read in this document, but it bears repeating over and over.

There are 74 million children in the United States. That is 74,000,000 in numeric form. So far, 282 have died "involving Covid." Two hundred eighty-two in 74 million is a rate of 0.00038%. While many children may not have been exposed to COVID, CDC estimated that 22.2 million children aged 5-17 had had COVID and 127 had died, at the May 12, 2021 meeting of the ***Advisory Committee on Immunization Practices (ACIP),*** or 0.00057%.44 Available evidence strongly suggests that the vaccine is much more dangerous to children than the disease.

It's an abomination that we are going to subject children in this country with an unknown health risk when they are about as close to zero risk from COVID as it can get. And don't give me the "we have to vaccinate the kids to get to herd immunity" BULL S_ _ _. They are grasping at straws and they know it. Kids do not readily spread the infections and even more pertinent is that you cannot reach herd immunity with a product that cannot prevent infection OR stop transmission. So, once again stop the B.S.! Ask doctors and nurses in the field what they are seeing now. A high percentage of people testing positive and showing up at hospitals now have been vaccinated. Many reports estimate as high as 60%. You will see reports of that in this issue. It's time to stop the charade. Leave the kids alone.

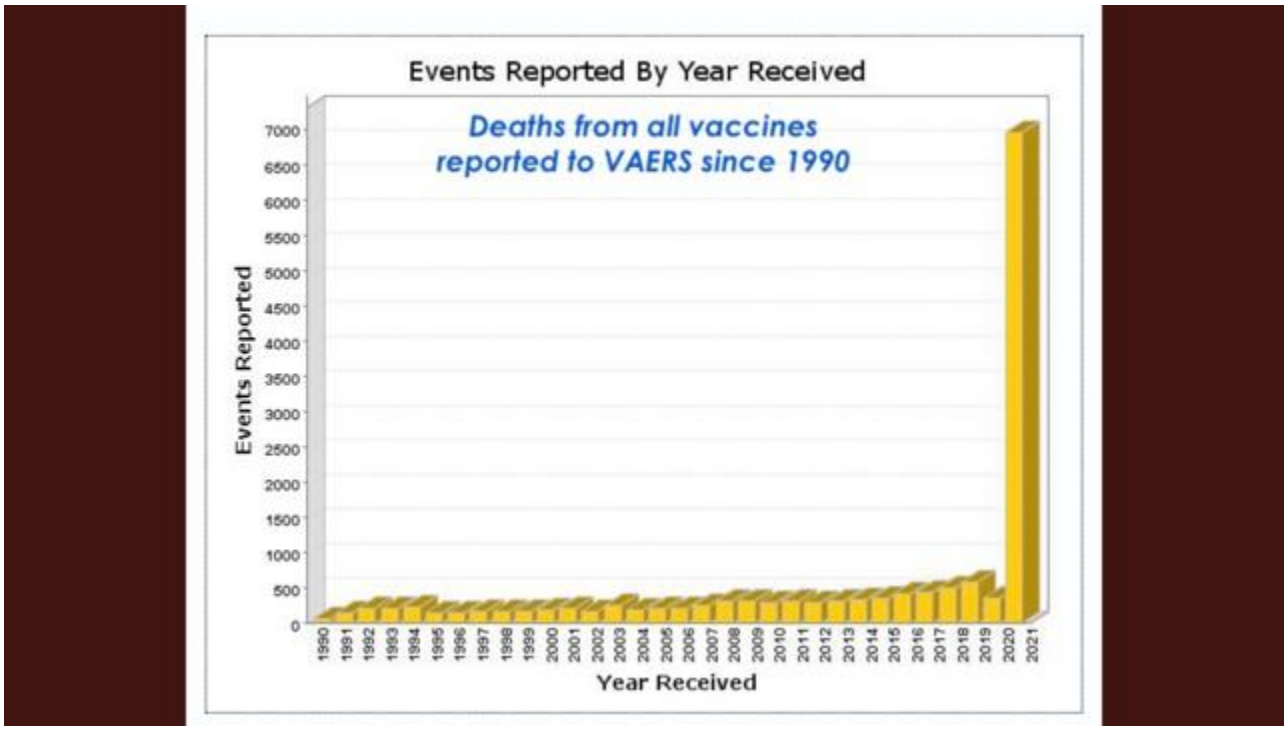
I would encourage you to support the legal challenges underway by the team at the ***Informed Consent Action Network (ICAN), by Robet F. Kennedy Jr. with his legal team at Children's Health Defense*** and with ***America's Frontline Doctors headed up by doctor and attorney Simon Gold M.D.*** to stop the madness of moving forward with vaccinating children, adolescents and teens. We are already seeing an unacceptable toll of injuries and fatalities just in the small numbers that have been vaccinated thus far.

Despite the under-reporting of deaths and serious adverse reactions to the COVID-19 vaccines, our public health authorities and public health agencies remain silent and even ignore the pleas of the many injured people. Senator Ron Johnson of Wisconsin held a press conference earlier this week and invited some of the

victims to tell their stories because they have been ignored. https://informedchoicewa.org/news/senator-ron-johnson-milwaukee-news-conference-covid-19-vax-injuries/

Unfortunately, this is not unprecedented as tens of thousands of families have been ignored by our federal government after they or their children have been injured throughout the years. I have chronicled and investigated the science being vaccine injury and reported it in my eBook titled, 1200 Studies- Truth Will Prevail. It is now over 900 pages in length and contains excerpts from over 1,500 studies that contradict the public narrative about the safety and effectiveness of vaccines. It is available online at https://1200studies.com

Check out this graph on this page to see how the death rates from the COVID-19 vaccines (as of first of July 2021) compared to all the other vaccines combined for the last 30 years.



The CDC's weekly cause of death tally shows a consistent uptick in an "unspecified" category since the start of administration of the COVID-19 vaccine

The CDC maintains a database called the **Weekly Provisional Counts of Deaths by State and Select Causes, 2020-2021.** It shows the cause of death in columns for each week. There is one column that is listed as

“Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)”. That column has seen an unprecedented increase since the start of the COVID-19 vaccination program that began on December 14th, 2020.

The large table on the next page shows the R00-R99 category from January 2020 and the increase after the COVID-19 vaccine program began December 14th 2021. (You can increase the magnification of the page to read it easier).

https://data.cdc.gov/NCHS/Weekly-Provisional-Counts-of-Deaths-by-State-and-S/muzy-jte6

Jurisdictio	MMWR	MMV	Week Ending	All Cause	Natural Ca	Septicer	Malignant	Diabetes n	Alzheimer	Influenza a	Chronic lo	Other dise	Nephritis,	Symptoms, signs and abnormal c	Diseases	Cerebrova	COVID-19 (UC	COVID-19 (UC
United Sta	2020	1	1/4/2020	60,173	55,014	844	11,566	1,830	2,536	1,560	3,502	1,068	1,094	639	14,202	3,109	0	0
United Sta	2020	2	1/11/2020	60,735	55,754	863	11,960	1,943	2,566	1,529	3,709	1,036	1,092	651	13,912	3,189	1	1
United Sta	2020	3	1/18/2020	59,364	54,522	831	11,705	1,820	2,490	1,484	3,526	993	1,121	620	13,592	3,258	3	2
United Sta	2020	4	1/25/2020	59,171	54,407	830	11,882	1,865	2,517	1,488	3,403	979	1,107	646	13,612	3,185	2	1
United Sta	2020	5	2/1/2020	58,833	54,004	813	11,963	1,828	2,480	1,412	3,314	981	1,074	624	13,467	3,084	1	0
United Sta	2020	6	2/8/2020	59,482	54,412	809	11,709	1,957	2,515	1,464	3,413	974	1,136	604	14,004	3,057	3	2
United Sta	2020	7	2/15/2020	58,812	53,969	794	11,814	1,845	2,537	1,514	3,479	978	1,070	623	13,639	3,087	2	0
United Sta	2020	8	2/22/2020	58,912	53,989	782	11,783	1,880	2,515	1,462	3,454	968	1,058	618	13,628	3,083	6	6
United Sta	2020	9	2/29/2020	59,342	54,322	820	11,790	1,830	2,519	1,507	3,460	1,011	1,092	688	13,715	3,127	9	9
United Sta	2020	10	3/7/2020	59,694	54,391	815	11,712	1,867	2,511	1,610	3,471	1,003	1,071	667	13,688	3,096	37	33
United Sta	2020	11	3/14/2020	58,672	53,531	759	11,571	1,743	2,445	1,641	3,390	993	1,078	649	13,442	3,167	58	54
United Sta	2020	12	3/21/2020	59,218	54,306	843	11,735	1,835	2,515	1,742	3,384	1,022	1,105	626	13,200	3,069	584	546
United Sta	2020	13	3/28/2020	63,046	58,258	851	11,784	2,046	2,749	1,789	3,520	1,064	1,027	648	13,722	3,067	3,203	3,024
United Sta	2020	14	4/4/2020	72,295	67,451	954	11,597	2,301	2,871	1,856	3,537	1,029	1,037	704	14,956	3,165	10,116	9,619
United Sta	2020	15	4/11/2020	79,092	74,008	836	11,552	2,358	2,964	1,628	3,441	1,020	1,119	677	15,768	3,192	16,302	15,488
United Sta	2020	16	4/18/2020	76,807	71,896	751	11,209	2,271	2,900	1,245	3,196	916	1,099	676	14,578	3,205	17,183	16,276
United Sta	2020	17	4/25/2020	73,910	68,749	739	11,363	2,086	2,804	1,147	2,995	889	987	689	13,875	3,059	15,545	14,647
United Sta	2020	18	5/2/2020	69,320	63,942	741	11,099	1,935	2,727	1,013	2,930	852	961	563	13,009	3,042	13,212	12,429
United Sta	2020	19	5/9/2020	66,811	61,190	722	11,018	1,971	2,498	865	2,807	858	937	617	13,167	2,855	11,229	10,454
United Sta	2020	20	5/16/2020	64,478	58,996	681	11,268	1,968	2,432	863	2,771	786	976	590	12,740	2,962	9,223	8,478
United Sta	2020	21	5/23/2020	61,628	56,021	715	11,118	1,835	2,417	806	2,678	744	919	596	12,782	2,827	7,243	6,588
United Sta	2020	22	5/30/2020	59,692	54,021	653	10,905	1,814	2,261	754	2,634	761	893	610	12,462	2,855	6,170	5,585
United Sta	2020	23	6/6/2020	58,918	52,951	733	11,084	1,728	2,302	701	2,565	780	905	576	12,480	2,791	5,053	4,515
United Sta	2020	24	6/13/2020	58,033	52,295	694	11,131	1,741	2,327	700	2,502	737	924	610	12,411	2,843	4,229	3,726
United Sta	2020	25	6/20/2020	57,997	52,220	686	11,159	1,792	2,362	756	2,563	762	932	634	12,406	2,925	3,845	3,351
United Sta	2020	26	6/27/2020	58,506	52,654	721	11,360	1,768	2,289	723	2,538	775	952	600	12,513	2,962	3,839	3,327
United Sta	2020	27	7/4/2020	59,840	53,830	686	11,298	1,931	2,362	656	2,625	780	986	624	12,878	2,835	4,548	4,047
United Sta	2020	28	7/11/2020	61,939	55,854	767	11,329	1,956	2,471	741	2,615	753	916	698	13,022	2,921	5,783	5,232
United Sta	2020	29	7/18/2020	63,169	57,160	711	11,376	1,889	2,501	767	2,646	712	985	702	12,867	2,984	7,190	6,524
United Sta	2020	30	7/25/2020	64,246	58,399	687	11,558	1,956	2,510	782	2,560	732	969	702	12,928	2,913	8,238	7,519
United Sta	2020	31	8/1/2020	64,229	58,289	693	11,512	1,989	2,502	759	2,737	782	961	659	12,826	2,991	8,300	7,606
United Sta	2020	32	8/8/2020	63,716	57,849	786	11,530	1,798	2,435	782	2,594	730	910	705	12,817	3,036	7,863	7,176
United Sta	2020	33	8/15/2020	63,641	57,770	740	11,702	1,895	2,528	756	2,657	798	968	682	12,841	2,950	7,257	6,557
United Sta	2020	34	8/22/2020	62,578	56,631	738	11,519	1,935	2,567	697	2,644	784	967	664	12,768	2,933	6,379	5,747
United Sta	2020	35	8/29/2020	61,101	55,354	728	11,575	1,882	2,430	680	2,560	747	984	657	12,473	2,992	5,741	5,142
United Sta	2020	36	9/5/2020	60,241	54,269	704	11,376	1,838	2,506	737	2,553	801	929	611	12,508	2,864	5,010	4,424
United Sta	2020	37	9/12/2020	59,660	53,970	698	11,468	1,894	2,330	681	2,560	748	928	657	12,350	3,046	4,624	4,078
United Sta	2020	38	9/19/2020	59,732	54,164	751	11,628	1,860	2,373	718	2,519	779	920	680	12,688	2,949	4,269	3,759
United Sta	2020	39	9/26/2020	60,610	55,080	769	11,864	1,843	2,500	724	2,672	790	923	627	12,706	3,079	4,298	3,786
United Sta	2020	40	10/3/2020	59,803	54,142	724	11,424	1,896	2,414	763	2,578	719	945	708	12,653	2,885	4,241	3,694
United Sta	2020	41	10/10/2020	61,778	55,978	759	11,829	1,895	2,516	725	2,615	800	959	690	12,800	3,125	4,817	4,272
United Sta	2020	42	10/17/2020	60,638	55,243	777	11,321	1,845	2,538	724	2,598	814	1,023	675	12,571	3,038	5,193	4,587
United Sta	2020	43	10/24/2020	62,207	56,903	732	11,677	1,838	2,572	766	2,700	796	944	673	12,869	3,082	5,988	5,320
United Sta	2020	44	10/31/2020	63,420	58,099	703	11,529	1,941	2,460	795	2,570	831	923	638	13,154	3,103	7,015	6,248
United Sta	2020	45	11/7/2020	67,599	61,791	771	11,809	1,963	2,664	802	2,898	814	1,028	740	13,675	3,160	8,753	7,837
United Sta	2020	46	11/14/2020	68,815	63,251	796	11,740	2,024	2,735	849	2,751	859	1,023	672	13,453	3,174	10,638	9,572
United Sta	2020	47	11/21/2020	71,662	66,277	824	11,634	2,119	2,657	833	2,818	858	1,032	753	13,628	3,215	13,352	12,062
United Sta	2020	48	11/28/2020	73,286	67,950	777	11,392	2,153	2,774	810	2,755	863	1,043	769	13,545	3,127	15,608	14,120
United Sta	2020	49	12/5/2020	77,406	72,018	851	11,353	2,216	2,846	919	2,834	902	1,034	797	14,295	3,312	18,546	16,836
United Sta	2020	50	12/12/2020	81,980	76,458	835	11,902	2,298	2,935	953	3,032	973	1,088	816	14,549	3,482	20,908	19,050
United Sta	2020	51	12/19/2020	82,916	77,581	842	11,782	2,351	3,059	949	2,947	921	1,022	Health care workers get 1st shots 838	14,749	3,466	22,301	20,393
United Sta	2020	52	12/26/2020	84,324	78,756	860	11,692	2,329	2,979	979	2,861	924	1,124	896	14,825	3,388	23,343	21,319
United Sta	2020	53	1/2/2021	86,842	81,049	896	11,672	2,439	3,066	1,019	3,055	904	1,108	874	15,208	3,502	24,767	22,649
United Sta	2021	1	1/9/2021	86,421	80,864	856	11,282	2,345	2,937	1,031	2,942	938	1,148	986	14,947	3,356	25,737	23,692
United Sta	2021	2	1/16/2021	86,243	80,775	821	11,736	2,415	2,954	999	2,898	948	1,226	1,039	14,764	3,501	25,286	23,132
United Sta	2021	3	1/23/2021	82,465	77,190	831	11,434	2,172	2,888	923	2,782	892	1,180	1,036	14,371	3,411	23,241	21,225
United Sta	2021	4	1/30/2021	78,718	73,511	782	11,641	2,153	2,641	914	2,769	950	1,168	1,061	14,132	3,272	20,133	18,232
United Sta	2021	5	2/6/2021	74,326	68,940	804	11,291	2,021	2,499	827	2,791	902	1,104	1,180	13,993	3,225	16,461	14,741
United Sta	2021	6	2/13/2021	69,060	63,984	804	11,152	1,998	2,309	837	2,565	869	1,078	1,150	13,443	3,271	12,954	11,501
United Sta	2021	7	2/20/2021	67,255	62,224	796	11,051	2,211	2,424	850	2,615	830	1,034	1,214	13,698	3,072	10,399	9,149
United Sta	2021	8	2/27/2021	64,646	59,453	848	11,276	1,910	2,409	773	2,543	863	1,040	1,219	13,113	3,115	8,308	7,220
United Sta	2021	9	3/6/2021	61,565	56,474	763	11,036	1,887	2,234	812	2,493	786	1,040	1,293	12,771	3,074	6,498	5,580
United Sta	2021	10	3/13/2021	59,790	54,922	812	11,044	1,829	2,213	748	2,542	828	981	1,441	12,619	2,999	5,549	4,664
United Sta	2021	11	3/20/2021	58,230	53,306	736	10,943	1,876	2,111	726	2,459	814	945	1,676	12,134	2,961	4,786	4,018
United Sta	2021	12	3/27/2021	58,416	53,685	694	10,969	1,791	2,147	664	2,576	813	979	1,802	12,438	3,002	4,357	3,694
United Sta	2021	13	4/3/2021	56,152	51,649	664	10,637	1,816	1,970	659	2,389	812	963	2,091	11,764	2,826	4,090	3,440
United Sta	2021	14	4/10/2021	58,148	53,404	673	11,075	1,756	2,076	700	2,477	740	984	2,377	12,112	2,924	4,177	3,543
United Sta	2021	15	4/17/2021	56,129	51,906	639	10,862	1,653	1,878	645	2,345	729	919	2,384	11,844	2,951	4,304	3,671
United Sta	2021	16	4/24/2021	57,200	53,084	691	11,047	1,739	1,949	658	2,437	822	931	2,596	11,975	2,933	4,419	3,805
United Sta	2021	17	5/1/2021	56,286	52,500	678	10,997	1,718	2,024	631	2,451	784	942	2,717	11,697	2,791	3,997	3,460
United Sta	2021	18	5/8/2021	54,695	51,111	649	10,666	1,655	1,979	642	2,390	781	834	3,046	11,327	2,786	3,754	3,239
United Sta	2021	19	5/15/2021	53,739	50,492	631	10,734	1,632	1,884	617	2,319	770	888	3,134	10,979	2,755	3,457	2,980
United Sta	2021	20	5/22/2021	52,895	49,726	637	10,720	1,446	1,992	584	2,369	804	871	3,252	10,687	2,700	2,943	2,509
United Sta	2021	21	5/29/2021	49,172	46,498	612	10,041	1,455	1,792	567	2,224	716	849	3,166	10,243	2,589	2,389	2,000
United Sta	2021	22	6/5/2021	44,698	42,399	533	9,441	1,221	1,675	489	2,030	636	759	3,143	9,277	2,324	1,828	1,567
United Sta	2021	23	6/12/2021	32,665	31,470	362	7,020	926	1,392	377	1,574	483	550	2,491	6,908	1,761	1,151	952
														48,102				
Alabama	2020	1	1/4/2020	1,082	1,009	15	196	25	54	28	86	13	25	25	268	81	0	0
Alabama	2020	2	1/11/2020	1,127	1,060	25	197	17	41	27	72	20	23	34	274	68	0	0

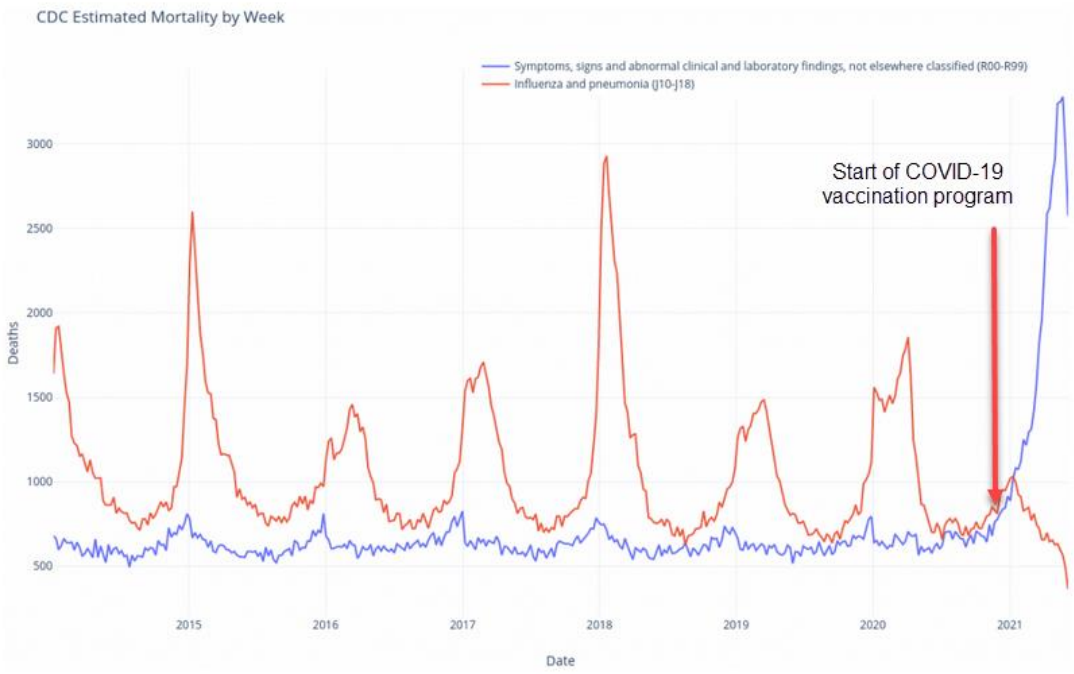
https://data.cdc.gov/NCHS/Weekly-Provisional-Counts-of-Deaths-by-State-and-S/muzy-jte6

The total of 48,102 at the bottom of that column is the total of deaths classified with that code from the onset of the mass vaccination program. The average baseline weekly amount for that code BEFORE the vax program is 660.88 (661). Backing out 661 per week since the start of the vax program accounts for 17,186 of the 48,102 deaths categorized with that code since the program started. Subtracting 17,186 from 48,102 leaves 30,916 deaths over the baseline. This is speculation, but it could explain the vaccine deaths where cause of death after the vaccines was never determined (i.e., heart attack, brain aneurism, etc.). As has been widely reported, many people that have passed away after getting the shots never have an autopsy to determine the cause of death. Is it possible that this is a category where they are showing up?

Check out this next graphic. (I've added the arrow showing the date of the start of the vax program)

*The print is small, but the orange is the influenza and pneumonia deaths, and the blue is the R00-R99 code.

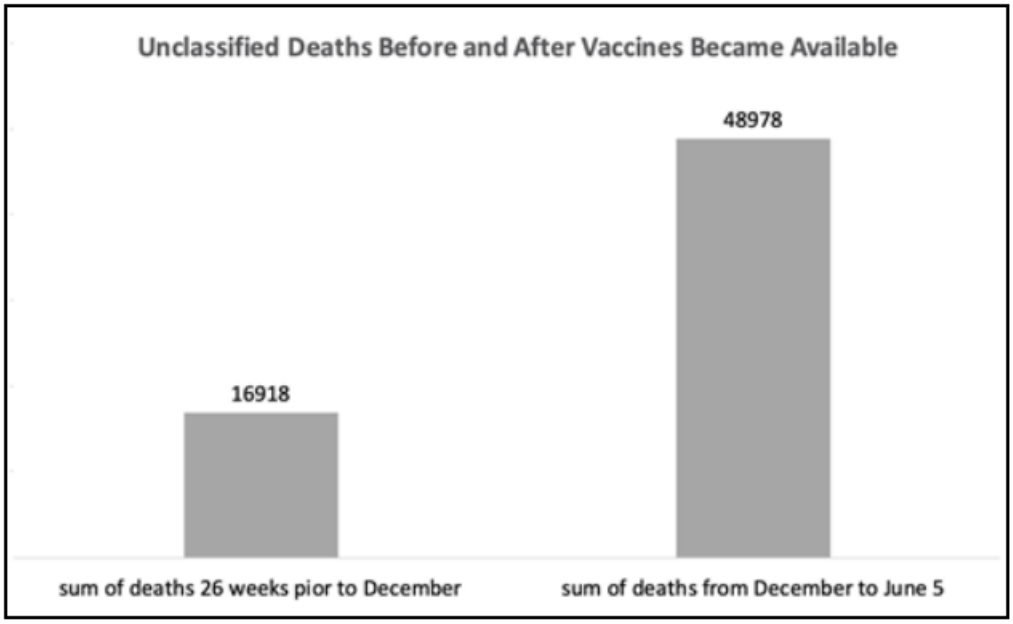
(Addition June 16, 2021) To really make it clear how well outside of normal this is, we look at historic CDC data we can see a dramatic spike in the R00-R94 codes – from 2014 through today June 2021.



(Addition June 22, 2021) It's important to note the R00-R99 codes will adjust later, i.e. re-attributed to COVID-19 or diseases of heart deaths. I do a bit of an analysis into that topic in a follow up article, Changes in the CDC Counts of Deaths by State and Select Cause. Yes, the R00-R99 are increasing over time. This is counter intuitive as the rate should be decreasing as there are fewer cases of COVID-19. In addition, it appears there are an increasing number of R00-R99 deaths being re-attributed to diseases of heart (see follow up article). That being said, it is still early and the data is unclear until the numbers stabilize in the next 6-8 weeks (at time of writing).

https://austingwalters.com/covid19-vaccine-risks/

If values prior to December (left bar in Graph 3) are subtracted from values December to June (right bar in Graph 3), the number of excess "unclassified" deaths is 32,060. This is comparable to Steve Kirsch's difference of 25,800 (My calculation may be higher because I downloaded the data a few days after Kirsch posted the video).



Graph3: Total "unclassified" deaths before and after vaccine availability. Death rates were provided the CDC's "Weekly Provisional Counts of Deaths by State and Select Causes."

https://www.americanthinker.com/blog/2021/06/what_is_the_true_number_of_vaccinerelated_deaths.html

Explosive new report blows the lid off of the claims of efficacy and safety of the COVID-19 vaccines

A June 24th, 2021 article published in the journal ***Vaccine*** titled, **The Safety of COVID-19 Vaccinations—We Should Rethink the Policy**, reveals devastating statistics on the COVID-19 vaccines. It finds greater than a 1 in 25,000 death rate and that between 200 and 700 people would need to be vaccinated to prevent one person from getting COVID-19. As bad as the numbers are in this study, it must be recognized that like the VAERS system here in the U.S., the number of adverse reactions and deaths are likely grossly under-reported.

Abstract

Background: COVID-19 vaccines have had expedited reviews without sufficient safety data. We wanted to compare risks and benefits.

Method: We calculated the number needed to vaccinate (NNTV) from a large Israeli field study to prevent one death. We accessed the Adverse Drug Reactions (ADR) database of the European Medicines Agency and of the Dutch National Register (lareb.nl) to extract the number of cases reporting severe side effects and the number of cases with fatal side effects.

Result: The NNTV is between 200–700 to prevent one case of COVID-19 for them RNA vaccine marketed by Pfizer, while the NNTV to prevent one death is between 9000 and 50,000 (95% confidence interval), with 16,000 as a point estimate. The number of cases experiencing adverse reactions has been reported to be 700 per 100,000 vaccinations. Currently, we see 16 serious side effects per 100,000 vaccinations, and the number of fatal side effects is at 4.11/100,000 vaccinations. For three deaths prevented by vaccination we have to accept two inflicted by vaccination.

Conclusions: This lack of clear benefit should cause governments to rethink their vaccination policy.

From the article

Table 1. Risk differences and number needed to vaccinate (NNTV) to prevent one infection, one case of symptomatic illness, and one death from COVID-19. Data from Dagan et al. [6], $N = 596{,}618$ in each group.

	Documented Infection		Symptomatic Illness		Death from COVID-19	
Period	Risk Difference (No./1000 Persons) (95% CI)	NNTV (95% CI)	Risk Difference (No./1000 Persons) (95% CI)	NNTV (95% CI)	Risk Difference (No./1000 Persons) (95% CI)	NNTV (95% CI)
14–20 days after first dose	2.06 (1.70–2.40)	486 (417–589)	1.54 (1.28–1.80)	650 (556–782)	0.03 (0.01–0.07)	33,334 (14,286–100,000)
21–27 days after first dose	2.31 (1.96–2.69)	433 (372–511)	1.34 (1.09–1.62)	747 (618–918)	0.06 (0.02–0.11)	16,667 (9091–50,000)
7 days after second dose to end of follow-up	8.58 (6.22–11.18)	117 (90–161)	4.61 (3.29–6.53)	217 (154–304)	NA	NA

Data taken from Table 2 in Dagan et al.'s work. NNTV = 1/risk difference.

Table 2. Number needed to vaccinate (NNTV) calculated from pivotal phase 3 regulatory trials of the SARS-CoV2 mRNA vaccines of Moderna, BioNTech/Pfizer, and Sputnik (the vector vaccine of Astra-Zeneca is not contained here, as the study [9] was active-controlled and not placebo-controlled).

Vaccine	*N* Participants Vaccine Group	*N* Participants Placebo Group	CoV2 Positive End of Trial Vaccine Group	CoV2 Positive End of Trial Placebo Group	Absolute Risk Difference (ARD)	Number Needed to Vaccinate 1/ARR
Moderna [5] $	15,181(14,550 *)	15,170 (14,598 *)	19 (0.13%) [1]	269 (1.77%) [1]	0.0165	61
Comirnaty (BioNTech/Pfizer) [4] $	18,860	18,846	8 (0.042%) [2]	162 (0.86%) [2]	0.00817	123
Sputnik V [7] §	14,964	4902	13 (0.087%) **,[3]	47 (1%) **,[3]	0.0091	110

* Modified intention to treat-population—basis for calculation; ** taken from the publication because of slightly different case numbers; $ outcome was a symptomatic COVID-19 case; § outcome was a confirmed infection by PCR-test; [1] after 6 weeks; [2] after 4 weeks; [3] after 3 weeks.

Table 3. Individual case safety reports for the most widely distributed COVID-19 vaccines according to the Dutch side effects register (www.lareb.nl/coronameldingen (accessed on 29 May 2021)), the absolute numbers per vaccine, and standardization per 100,000 vaccinations.

	General Number of Reports (1)	Serious Side Effects (1)	Deaths (2)	Number of Vaccinations According to (3)	Number of Vaccinations According to ECDC (4)
Comirnaty (Pfizer)	21,321	864	280	5,946,031	6,004,808
Moderna	6390	114	35	531,449	540,862
Vaxzevria (AstraZeneca)	29,865	411	31	1,837,407	1,852,996
Janssen	2596	7	-	142,069	143,525
Unknown	129	15	5	-	540
Total	60,301	1.411	351	8,456,956	8,542,731
Per 100,000 vaccinations according to Dutch data	**713.03**	**16.68**	**4.15**		
Per 100,000 vaccinations according to ECDC	**705.87**	**16.52**	**4.11**		

(1) https://www.lareb.nl/coronameldingen. (2) https://www.lareb.nl/pages/update-van-bijwerkingen. (3) https://coronadashboard.rijksoverheid.nl/landelijk/vaccinaties. (4) https://www.ecdc.europa.eu/en/publications-data/data-covid-19-vaccination-eu-eea. All sites accessed on 27 May 2021. The Dutch government reported two numbers; we took the calculated amounts.

Thus, we need to accept that around 16 cases will develop severe adverse reactions from COVID-19 vaccines per 100,000 vaccinations delivered, and approximately four people will die from the consequences of being vaccinated per 100,000 vaccinations de-livered. Adopting the point estimate of NNTV = 16,000 (95% CI, 9000–50,000) to prevent one COVID-19-related death, for every six (95% CI, 2–11) deaths prevented by vaccination,

we may incur four deaths as a consequence of or associated with the vaccination. Simply put: As we prevent three deaths by vaccinating, we incur two deaths.

The risk–benefit ratio looks better if we accept the stronger effect sizes from the phase3 trials. Using Cunningham's estimate of NNTV = 12,300, which stems from a non-peer reviewed comment, we arrived at eight deaths prevented per 100,000 vaccinations and, in the best case, 33 deaths prevented by 100,000 vaccinations. Thus, in the optimum case, we risk four deaths to prevent 33 deaths, a risk–benefit ratio of 1:8. The risk–benefit ratio in terms of deaths prevented and deaths incurred thus ranges from 2:3 to 1:8, although real-life data also support ratios as high as 2:1, i.e., twice as high a risk of death from the vaccination compared to COVID-19, within the 95% confidence limit.

A recent experimental study showed that the SARS-CoV2 spike protein is sufficient to produce endothelial damage [23]. This provides a potential causal rationale for the most serious and most frequent side effects, namely, vascular problems such as thrombotic events. The vector-based COVID-19 vaccines can produce soluble spike proteins, which multiply the potential damage sites [24]. The spike protein also contains domains that may bind to cholinergic receptors, thereby compromising the cholinergic anti-inflammatory pathways, enhancing inflammatory processes [25]. A recent review listed several other potential side effects of COVID-19 mRNA vaccines that may also emerge later than in the observation periods covered here [26].

Is this a few or many? This is difficult to say, and the answer is dependent on one's view of how severe the pandemic is and whether the common assumption that there is hardly any innate immunological defense or cross-reactional immunity is true. Some argue that we can assume cross-reactivity of antibodies to conventional coronaviruses in 30–50%of the population [13–16]. This might explain why children and younger people are rarely afflicted by SARS-CoV2 [17–19]. An innate immune reaction is difficult to gauge. Thus, low seroprevalence figures [20–22] may not only reflect a lack of herd immunity, but also a mix of undetected cross-reactivity of antibodies to other coronaviruses, as well as clearing of infection by innate immunity.

However, one should consider the simple legal fact that a death associated with a vaccination is different in kind and legal status from a death suffered as a consequence of an incidental infection.

End of excerpts

https://www.mdpi.com/2076-393X/9/7/693/htm

Notice of liability for harm served on all members of the European Parliament

NOTICE OF LIABILITY

May 18, 2021

This Notice of Liability has been SERVED to you personally.

You may be held personally liable for harm and death caused by LEGISLATION, which is designed to coerce widespread acceptance of EXPERIMENTAL VACCINATION OF CHILDREN. If you take further action supporting such LEGISLATION, and if you take no steps to mitigate your past actions supporting such LEGISLATION, you may be held personally liable for resulting harm and death.

Severe illness and death in children and young adults caused by SARS-CoV-2 is extremely rare. It is absurd to claim that any measure can or will protect against a danger that does not exist. The claims that these experimental vaccinations induce production of protective antibodies are fundamentally flawed. Antibodies in the blood cannot prevent entry of air-borne viruses into cells of the lower respiratory tract. Secretory IgA antibodies are also known to be unable to efficiently prevent viral pneumonia. Severe adverse effects occur at high frequency following application of all gene-based agents. Children have already joined the tragic list of victims.

Attached as appendices and as integral parts of this Notice of Liability are the documents: Urgent Open Letter from Doctors and Scientists to the European Medicines Agency Regarding COVID-19 Vaccine Safety Concerns; Reply from the European Medicines Agency to Doctors for Covid Ethics; Doctors and Scientists Accuse Medical Regulator of Downplaying COVID-19 Vaccine Dangers; Rebuttal Letter to European Medicines Agency from Doctors for Covid Ethics; Doctors for Covid Ethics Signatories; COVID Vaccines: Necessity, Efficacy and Safety.

Furthermore, you may be held personally responsible for supporting CRIMES AGAINST HUMANITY, defined as acts that are purposely committed as part of a widespread or systematic policy, directed against civilians, committed in furtherance of state policy.

Please respond to this NOTICE OF LIABILITY within 14 days from the DATE OF SERVICE to:

DOCTORS FOR COVID ETHICS *Doctors4CovidEthics@protonmail.com*

Cc: Rechtsanwaltskanzlei Dr. Reiner Fuellmich

Appendices

1. **Urgent Open Letter from Doctors and Scientists to the European Medicines Agency Regarding COVID-19 Vaccine Safety Concerns**

2. **Reply from the European Medicines Agency to Doctors for Covid Ethics**

3. **Doctors and Scientists Accuse Medical Regulator of Downplaying COVID-19 Vaccine Dangers**

4. **Rebuttal Letter to European Medicines Agency from Doctors for Covid Ethics**

5. **Doctors and Scientists Write to the European Medicines Agency, Warning of COVID-19 Vaccine Dangers for a Third Time**

6. **Doctors for Covid Ethics Signatories**

7. **COVID Vaccines: Necessity, Efficacy and Safety**

Doctors for Covid Ethics

We are doctors and scientists from 30 countries, seeking to uphold medical ethics, patient safety and human rights in response to COVID-19. t: @Drs4CovidEthics

https://doctors4covidethics.medium.com/notice-of-liability-for-harm-and-death-to-children-served-on-all-members-of-the-european-parliament-fe42ffdbf400

COVID vaccines for children- We had better think again! A letter from a consortium of U.K. medical specialists calling for a halt

COVID-19 child vaccination: safety and ethical concerns

May 20, 2021

An open letter from UK doctors to Dr June Raine, Chief Executive, MHRA

Lead signatory Dr Ros Jones- Retired Consultant Paediatrician

We wish to notify you of our grave concerns regarding all proposals to administer COVID-19 vaccines to children. Recently leaked Government documents suggested that a COVID-19 vaccine rollout in children over 12 years old is already planned for September 2021, and the possibility of children as young as 5 years old being vaccinated in the summer in a worst-case scenario.[1]

We have been deeply disturbed to hear several Government and SAGE representatives calling in the media for the COVID-19 vaccine rollout to be "turning to children as fast as we can".[2] Teaching materials circulated to London schools contain emotionally loaded questions and inaccuracies[3]. In addition, there has been disturbing language used by teaching union leaders, implying that coercion of children to accept the COVID-19 vaccines through peer pressure in schools was to be encouraged, despite the fact that coercion to accept a medical treatment is against UK and International Laws and Declarations.[4] Rhetoric such as this is irresponsible and unethical, and encourages the public to demand the vaccination of minors with a product still at the research stage and about which no medium- or long-term effects are known, against a disease which presents no material risk to them. A summary of our reasons is given below and a more detailed fully referenced explanation is available.[5]

Risks and benefits in medical treatments

Vaccines, like any other medical treatment, come with varied risks and benefits. Therefore, we must consider each product, individually, on its merits, and specifically for which patients or sections of the population is the risk/benefit ratio acceptable. For COVID-19 vaccines, the potential benefits are clear for the elderly and vulnerable, however, for children, the balance of benefit and risk would be quite different. We are raising these concerns as part of an informed debate, which is a vital part of the proper, scientific process. We must ensure that there is no repeat of any past tragedies which have occurred especially when vaccines are rushed to market. For example, the swine flu vaccine, Pandemrix, rolled out following the pandemic of 2010, resulted in over one thousand cases of narcolepsy, a devastating brain injury, in children and teenagers, before being

withdrawn.[6] Dengvaxia, a new vaccine against Dengue, was also rolled out to children ahead of the full trial outcomes, and 19 children died of possible antibody dependent enhancement (ADE) before the vaccine was withdrawn.[7] We must not risk a repeat of this with the COVID-19 vaccines, which would not only impact on the children and families affected, but would also have a hugely damaging effect on vaccination uptake in general.

No medical intervention should be introduced on a 'one size fits all' basis, but instead should be fully assessed for suitability according to the characteristics of the age cohort and of the individuals concerned, weighing up the risk versus benefit profile for each cohort and the individuals within a group. This approach was outlined last October, by the head of the Government Vaccine Task Force, Kate Bingham, who said "We just need to vaccinate everyone at risk. There's going to be no vaccination of people under 18. It's an adult-only vaccine, for people over 50, focusing on health workers and care home workers and the vulnerable."[8]

Children do not need vaccination for their own protection

Healthy children are at almost no risk from COVID-19, with risk of death as low as 1 in 2.5 million[9]. No previously healthy child under the age of 15 died during the pandemic in the UK and admissions to hospital or intensive care are exceedingly rare[10] with most children having no or very mild symptoms. Although Long-Covid has been cited as a reason for vaccinating children, there is little hard data. It appears less common and much shorter-lived than in adults and none of the vaccine trials have studied this outcome[11 12]. The inflammatory condition, PIMS, was listed as a potential adverse effect in the Oxford AstraZeneca children's trial[13]. Naturally acquired immunity will give broader and better lasting immunity than vaccination[14]. Indeed, many children will already be immune[15]. Individual children at very high risk can already receive vaccination on compassionate grounds[16].

Children do not need vaccination to support herd immunity

Already, two thirds of the adult population have received at least one dose of a COVID-19 vaccine[17]. Models that assume vaccination of children is required to reach herd immunity have failed to account for the proportion who had immunity prior to March 2020 and those who have acquired it naturally[18]. Recent modelling suggested that the UK had achieved the required herd immunity threshold on 12 April 2021.[19]

Children do not transmit SARS-CoV-2 as readily as adults, moreover adults living or working with young children are at lower risk of severe COVID-19[20]. Schools have not been shown to be the focus on spread to the community, teachers have a lower risk of COVID-19 than other working age adults[21].

Short-term safety concerns

As of 13th May, the MHRA[22] has received a total of 224,544 adverse events, including 1,145 deaths in association with SARS-CoV-2 vaccines. Reports of strokes due to cerebral venous thromboses were initially in low numbers but as awareness increased, many more reports led to the conclusion that AstraZeneca vaccine should not be used for adults under 40 years of age and this unpredicted finding has also led to the suspension of the Oxford AstraZeneca children's trial.

Similar events have been noted with Pfizer & Moderna vaccines on the US adverse reporting system (VAERS)[23] and it is likely that this is a class effect related to production of spike protein. New UK guidelines on managing Vaccine-Induced Thrombotic Thrombocytopenia (VITT)[24] include all COVID-19 vaccines in their advice. The possibility of further unexpected safety issues cannot be ruled out. In Israel, where the vaccines have been widely rolled out to young people and teenagers, the Pfizer vaccine has been linked to several cases of myocarditis in young men[25] and concerns have been raised about reports of altered menstrual cycles and abnormal bleeding in young women following the vaccine.[26]

Most concerning with regard to possible vaccination of children, is that there have now been a number of deaths associated with vaccination reported to VAERS in the US, despite the vaccines only being given to children within trials and a very recent rollout to 16-17 year olds[27].

Long-term safety concerns

All Phase 3 COVID-19 vaccine trials are ongoing and not due to conclude until late 2022/early 2023. The vaccines are, therefore, currently experimental with only limited short-term and no long-term adult safety data available. In addition, many are using a completely new mRNA vaccine technology, which has never previously been approved for use in humans[28]. The mRNA is effectively a pro-drug and it is not known how much spike protein any individual will produce. Potential late-onset effects can take months or years to become apparent. The limited children's trials undertaken to date are totally underpowered to rule out uncommon but severe side effects.

Children have a lifetime ahead of them, and their immunological and neurological systems are still in development, making them potentially more vulnerable to adverse effects than adults. A number of specific concerns have been raised already, including autoimmune disease and possible effects on placentation and fertility.[29] A recently published paper raised the possibility that mRNA COVID-19 vaccines could trigger prion-based, neurodegenerative disease[30]. All potential risks, known and unknown, must be balanced against risks of COVID-19 itself, so a very different benefit/risk balance will apply to children than to adults.

Conclusion

There is important wisdom in the Hippocratic Oath which states, "First do no harm". All medical interventions carry a risk of harm, so we have a duty to act with caution and proportionality. This is particularly the case when considering mass intervention in a healthy population, in which situation there must be firm evidence of benefits far greater than harms. The current, available evidence clearly shows that the risk versus benefit calculation does NOT support administering rushed and experimental COVID-19 vaccines to children, who have virtually no risk from COVID-19, yet face known and unknown risks from the vaccines. The Declaration of the Rights of the Child states that, "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection".[31] As adults we have a duty of care to protect children from unnecessary and foreseeable harm.

We conclude that it is irresponsible, unethical and indeed, unnecessary, to include children under 18 years in the national COVID-19 vaccine rollout. Clinical trials in children also pose huge ethical dilemmas, in light of the

lack of potential benefit to trial participants and the unknown risks. The end of the current Phase 3 trials should be awaited as well as several years of safety data in adults, to rule out, or quantify, all potential adverse effects.

We call upon our governments and the regulators not to repeat mistakes from history, and to reject the calls to vaccinate children against COVID-19. Extreme caution has been exercised over many aspects of the pandemic, but surely now is the most important time to exercise true caution – we must not be the generation of adults that, through unnecessary haste and fear, risks the health of children.

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Endnotes

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Cases of myocarditis making the news are just the tip of the iceberg. FDA adding warning labels

FDA Notice:

Today, the FDA is announcing revisions to the patient and provider fact sheets for the Moderna and Pfizer-BioNTech COVID-19 vaccines regarding the suggested increased risks of myocarditis (inflammation of the heart muscle) and pericarditis (inflammation of the tissue surrounding the heart) following vaccination. For each vaccine, the Fact Sheet for Healthcare Providers Administering Vaccine (Vaccination Providers) has been revised to include a warning about myocarditis and pericarditis and the Fact Sheet for Recipients and Caregivers has been revised to include information about myocarditis and pericarditis. … The warning in the Fact Sheets for Healthcare Providers Administering Vaccines notes that **reports of adverse events suggest increased risks of myocarditis and pericarditis, particularly following the second dose and with onset of symptoms within a few days after vaccination.** Additionally, the Fact Sheets for Recipients and Caregivers for these vaccines **note that vaccine recipients should seek medical attention right away if they have chest pain, shortness of breath, or feelings of having a fast-beating, fluttering, or pounding heart after vaccination."**

See: https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-june-25-2021

Myocarditis is much more serious than the CDC and the media have been portraying

In an excellent ***Highwire*** interview by Del Bigtree of Dr. Roger Hodkinson, a highly credentialled Canadian pathologist. Dr. Hodkinson makes it clear that the potential damage to the heart can be not only life-threatening, but life-altering for a lifetime.

Dr. Hodkinson is the former President of the ***Alberta Society of Laboratory Physicians***, holds two different fellowships, is the CEO of a large laboratory specializing in infectious and viral diseases, has held many local and national public positions in Canadian Medicine. He talks extensively on the myocarditis problem that is impacting so many young people after the COVID-19 vaccines. He speaks to the ridiculous downplaying of the severe nature of myocarditis and the lasting consequences that these young people may face in the future.

Here is the link. https://thehighwire.com/videos/episode-220-dirty-deeds/ If you want to go directly to the interview, fast forward to the interview go to the 1 hour and 5-minute mark.

Not only are the vaccines risky, but the vaccinated don't appear to be as protected as the unvaccinated against variants

A May 29th article in ***the Telegraph*** titled, **Fully vaccinated people who catch Covid variants may pass virus on, study finds**, pulls back the curtain on the effectiveness of the COVID-19 vaccines against variants. It also appears to suggest that people who have been vaccinated can still carry high viral loads making them infectious to others.

Study shows post-jab cases more likely to be infected with virus strains that have emerged in recent months

By Anne Gulland, Global Health Security Deputy Editor 29 May 2021 • 6:00pm

Fully vaccinated people infected with Covid variants may be likely to pass the virus on, researchers have said.

No vaccine is 100 per cent effective, and while the number of people who contract Covid after vaccination – known as post-vaccine breakthrough cases – is tiny, a growing number of studies show that these cases are more likely to be infected with variants that have emerged in recent months.

Researchers at the University of Washington in the United States sequenced samples from 20 health workers who went on to contract Covid after receiving both doses of either the Pfizer or Moderna vaccine.

The study showed that all 20 were infected with variants of concern that have been driving second waves of Covid in many parts of the world – eight had the UK variant, one the South African variant, 10 had one of the two California variants and one had the Brazilian variant.

The researchers then compared the samples collected from this group with samples collected from 5,174 non-vaccinated individuals who had Covid.

While everyone in the vaccinated group had a variant of concern, only 67 per cent of non-vaccinated individuals did. **The study also showed that the vaccinated individuals infected with Covid had high viral loads.**

Dr Pavitra Roychoudhury, the lead author of the study, said the "prevailing understanding" was that while vaccine breakthrough cases would occur, they would be mild.

"But in contrast to that, what we saw among our 20 samples was that a number of them actually had quite robust viral loads. That was concerning in the sense that there was definitely enough virus to sequence, and potentially there might be enough virus to transmit," she said.

None of the 20 patients studied were hospitalised and it is not known whether they passed the disease to others, said Dr Roychoudhury.

A recent study by the US Centers for Disease Control and Prevention also showed that vaccinated individuals who contracted the disease were also likely to be infected with variants.

Data released earlier this week showed that, as of April 30, there were 10,262 cases of post-vaccination infection among the 101 million people that had been fully vaccinated.

My comment: It is certain that there have many more cases than that. Because the vaccines may reduce the symptoms of COVID-19, it is likely that most people that contract it after being vaccinated have mild to moderate symptoms and may never go to be tested.

Some 555 of these 10,000 samples were sequenced and researchers found that 356 were identified as variants of concern. Of these, more than half were the UK variant, 33 per cent were one of the two California variants, eight per cent were the Brazilian variant and four per cent were the South African variant.

Dr Roychoudhury said the finding of high viral loads showed that it was important to monitor breakthrough cases and highlighted the importance of continuing self-isolation.

She added that monitoring breakthrough cases would help vaccine manufacturers who are currently looking at booster shots, saying: "It can help us identify a potential redesign of the booster shots and improve them."

However, Dr Roychoudhury said the findings of her study did not indicate that the current vaccines were not effective.

"A lot of the antibody responses are pretty broad. The vaccines are not designed to be super specific so they will be able to target the variants," she said. She added that, as more people are vaccinated, the number of vaccination breakthrough cases is likely to come down as infection levels reduce in the wider population.

End of excerpts

https://www.telegraph.co.uk/global-health/science-and-disease/fully-vaccinated-people-catch-covid-variants-may-pass-virus/

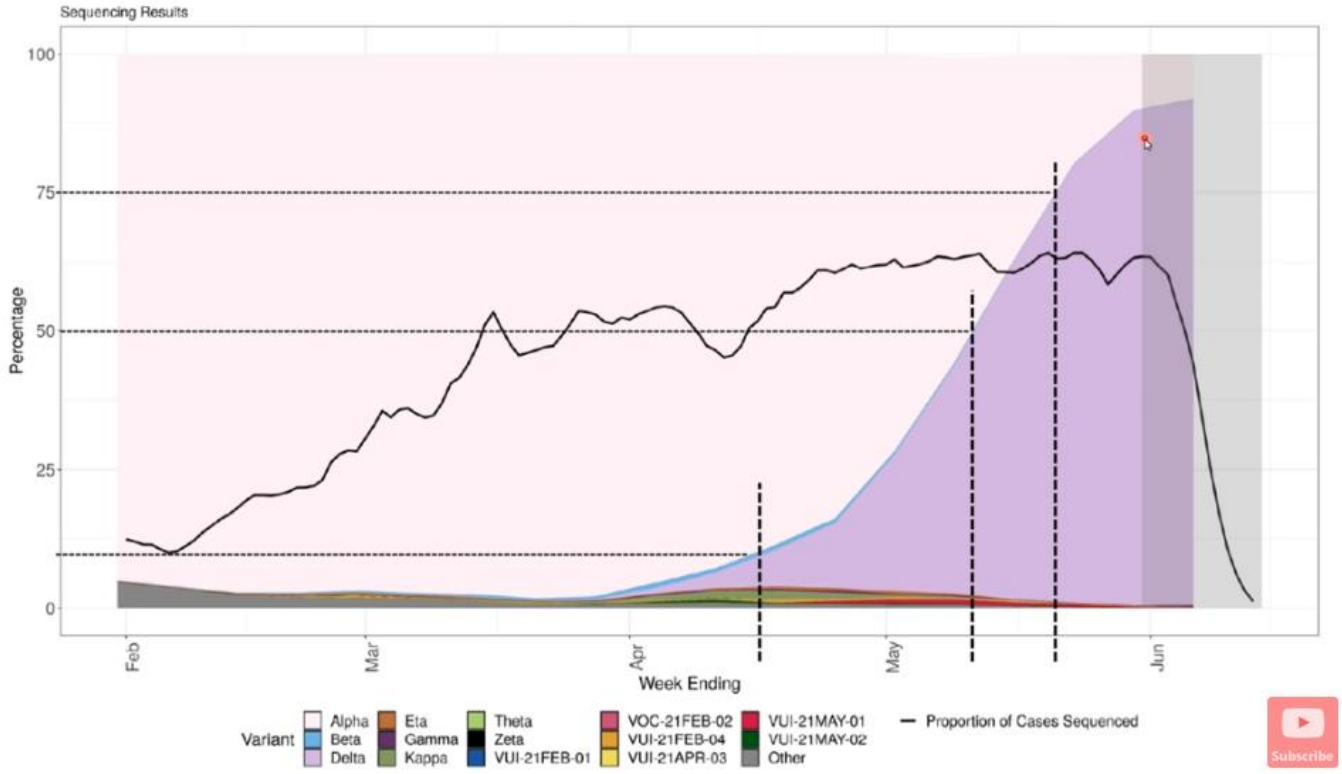
Speaking of variants, is the Delta Variant the scary boogieman that people are being told it is?

In mid-June, the UK announced another 30 days of lockdowns- (at least)

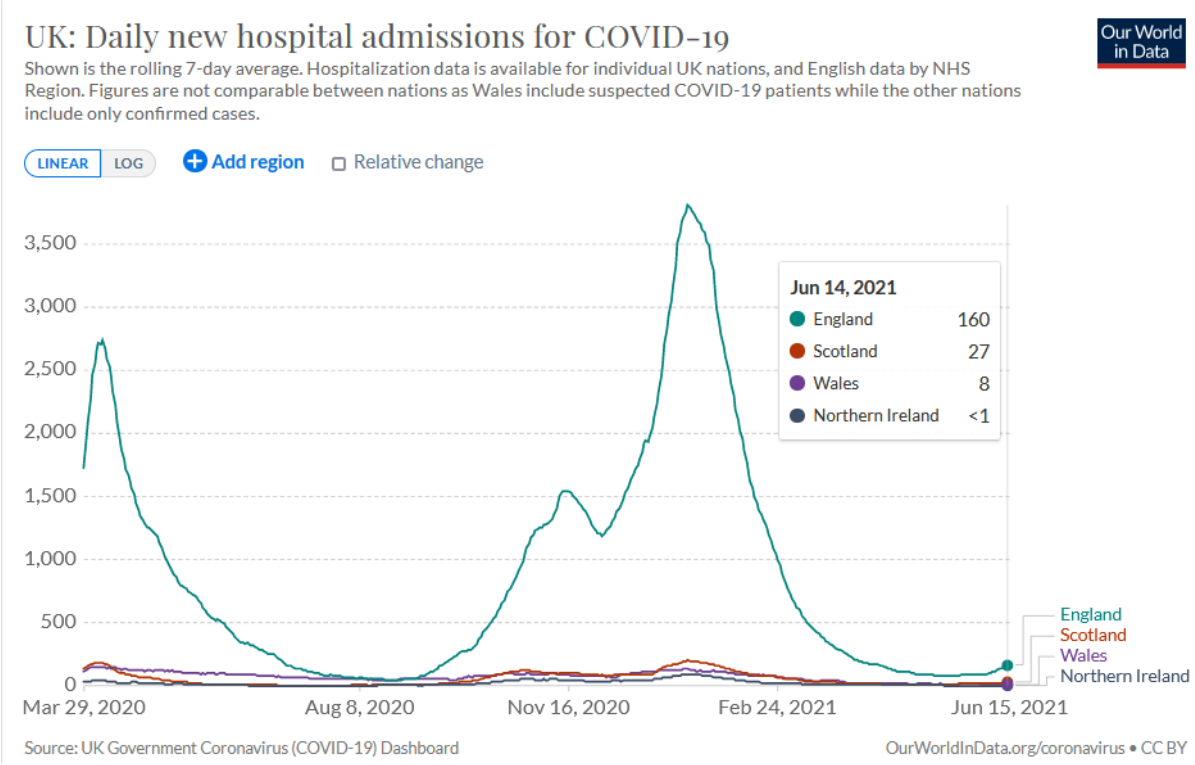
See news publication headlines next page…

The purple is the Delta Variant, which as you can see has taken over >90% of the cases.

Figure 3. Variant prevalence for all England available sequenced cases from 1 February 2021 as of 14 June 2021 (excluding 48 cases where the specimen date was unknown). (Find accessible data used in this graph in underlying data).

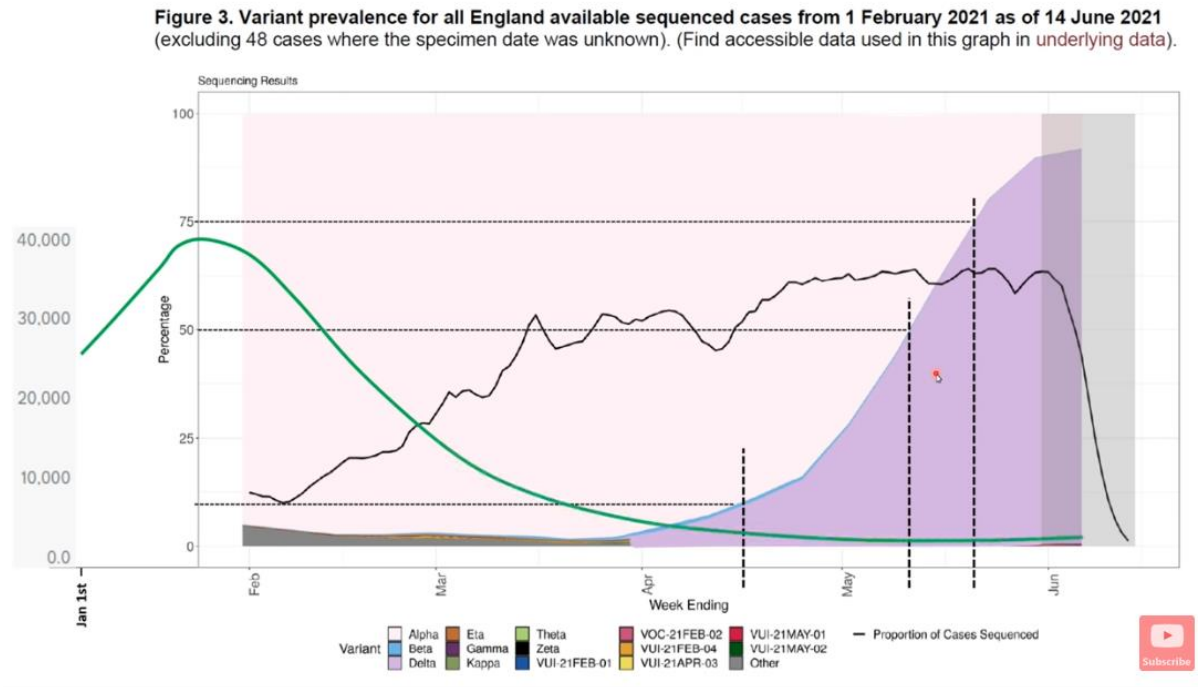


But what are the real-world effects on hospitalizations and deaths? Here is a graph looking at that…

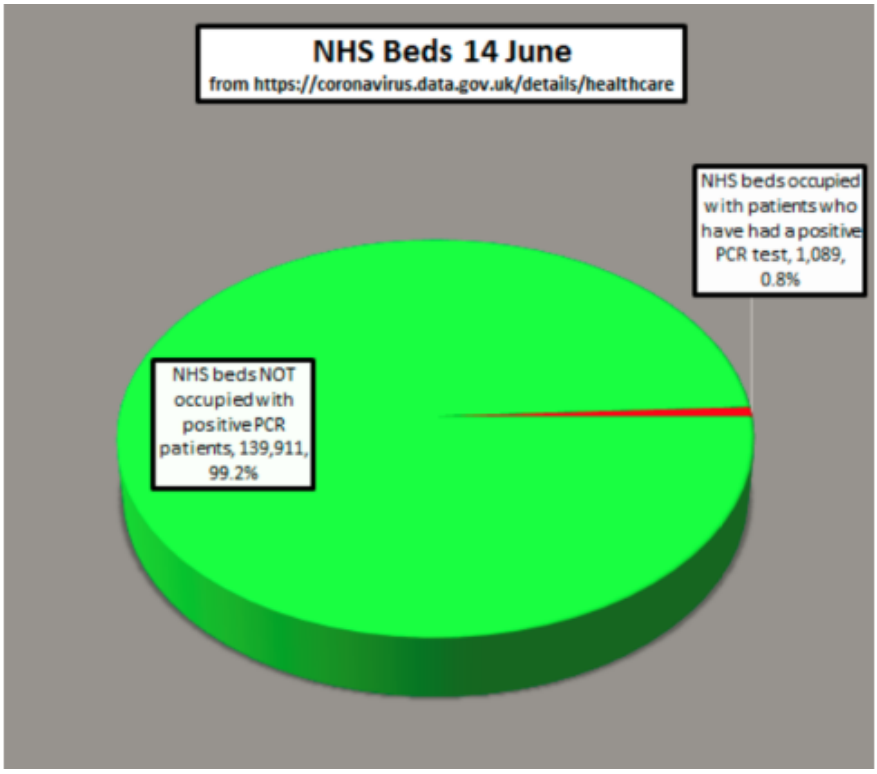


As you can see, zilch, nada, nothing to be panicked about.

And here the green line representing the hospitalizations is superimposed on the graph showing the dominant Delta Variant.



Here is another look at the availability of hospital beds across the U.K. as of June 14th when the decision to announce another 30 days of lockdown "due to the Delta Variant."



My understanding is that throughout the natural evolution of virus mutation, they become more contagious but less virulent and that is what the Delta Variant is demonstrating. And the vaccines are driving the virus to shapeshift or evolve into variants and more high amplification cycle PCR testing driven cases, which are then being co-opted by the profiteers that want to peddle more fear and compliance with the narrative to keep this going as long as possible.

Case in point. The UK locking down for at least another 30 days under the guise of the Delta Variant which has had no impact on the health care system. Welcome to totalitarianism!

Credit to Ivor Cummins, AKA the Fat Emperor Podcast for much of this information.

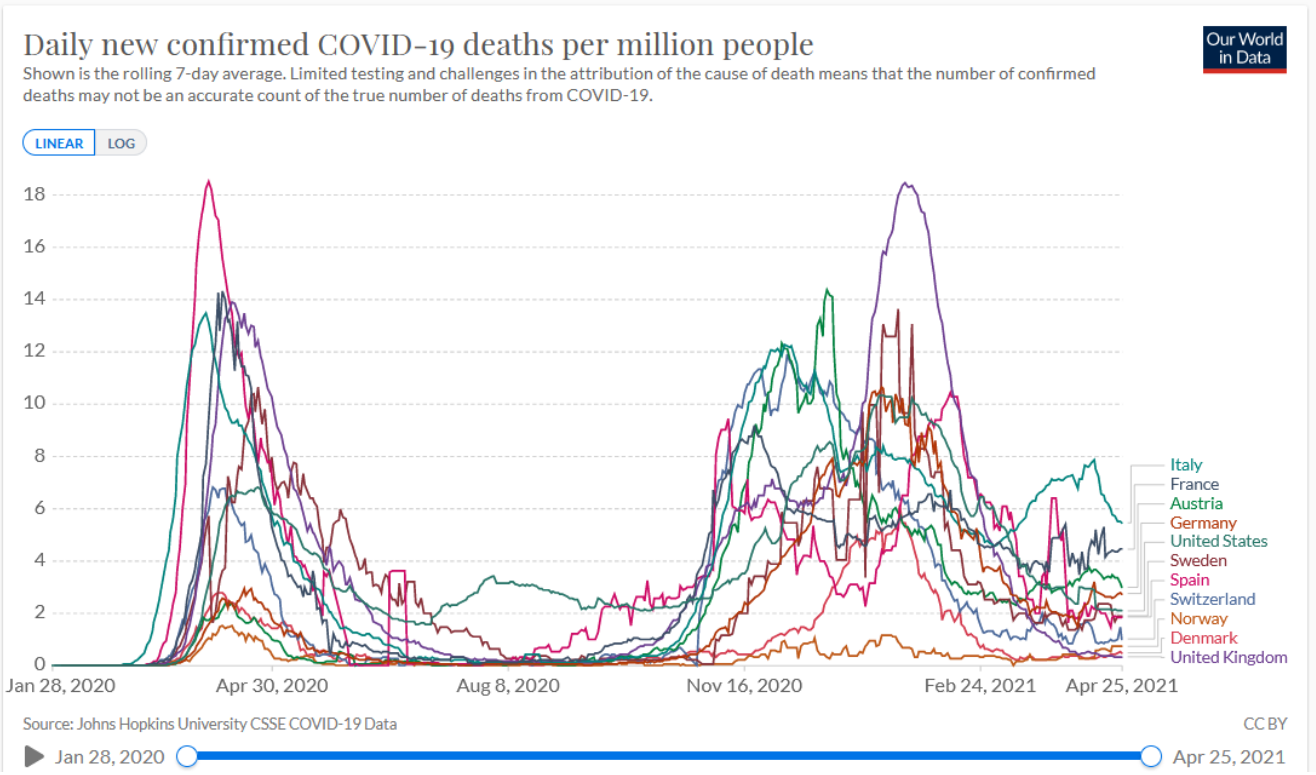
https://www.youtube.com/watch?v=TtOu7jx3snQ

Although the Delta Variant may be a nothing burger when it comes to increasing severe COVID-19 and deaths, there is one strain we should all be on the lookout for.

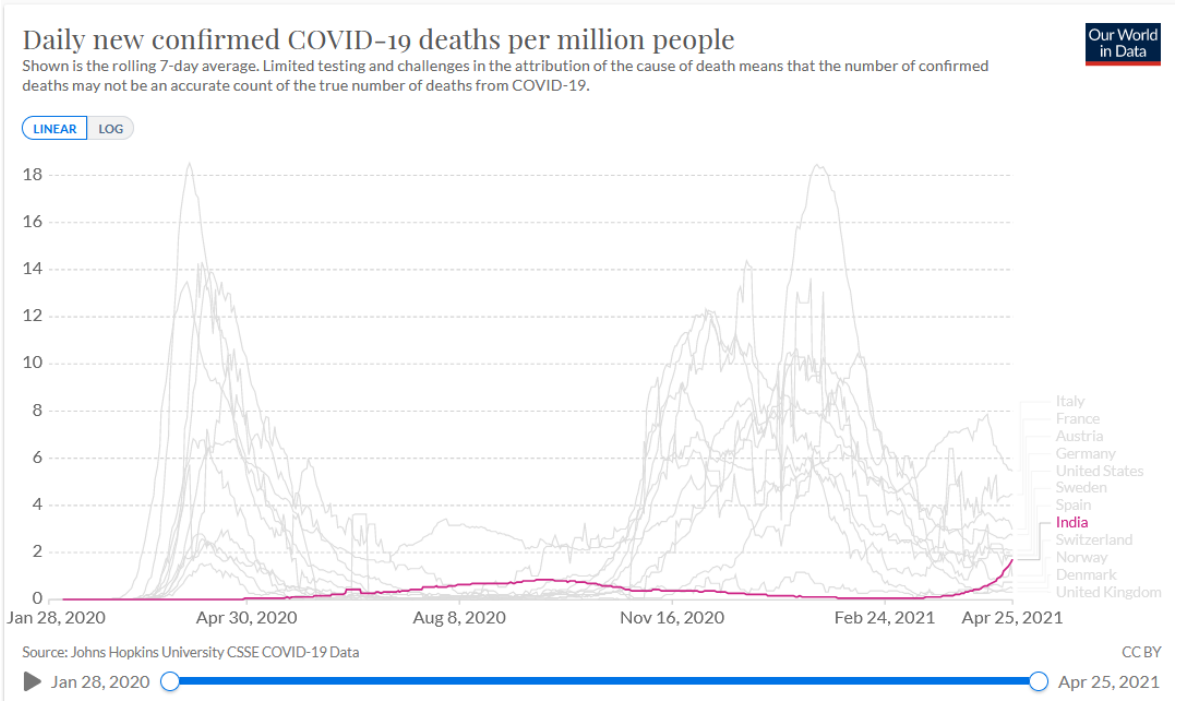
Since Delta IS the Indian Variant and India was hit hard this spring, shouldn't we be concerned?

Not so fast. I reported in the May issue, the reasons why India was hit hard is that they had managed to avoid endemic spread previously.

I showed the graph on the next page showing the deaths per 1 million people in many major European countries and the U.S.



Then I showed India superimposed over the other countries.



As you can clearly see, India has skated through the pandemic almost unscathed compared to most of the rest of the world. But, as has been said many times, you cannot hide from a virus. And earlier this year India was seeing an uptick. BUT, does the evidence you can see above with your very own eyes support the

sensationalized headlines, hysteria and graphic displays of apocalyptic proportions we saw in the media? It appeared as the western nations were calming down, the media had found another way to scare the people they have been traumatizing in the developed world for a year now into more fear. And, as the alt-media reporting shows that fewer people are buying into the vaccine plan, you can certainly expect more of the same fear mongering from pharma's marketing puppets. And now the Delta Variant. Wait until you see what I have

And a post from someone on the ground in India during the hysteria created over it in the west.

Gagan Si 32 minutes ago (edited)

Reporting from the ground here:

The situation is mainly tense in Delhi. All arrangements made by the state government last year just disappeared weeks before the pandemic. Nobody is asking where did all those beds go! Those stadiums, hotels etc that were set up as "Covid facilities" have all just disappeared.
We are a population of 1.4 Billion (Europe x 2 , US x 4, UK x 15).
Objectively speaking, the COVID patient load is tiny and manageable, but there are signs posted outside the hospitals in Delhi - "No beds, No oxygen, No admission". But why? A city of 22 Million people cannot handle 1000 patients a day??
Where the hell did all that preparation go?

Not saying the situation is not serious. People have died and died unnecessarily. But the images being shown on TV are so so exaggerated and misleading. The Australian media is describing it as "Apocalypse"! Really? 3 million people die of heart attacks in India.
There are weddings happening in my hometown (200kms from Delhi).

Temples, churches and mosques opened up to full capacity last year in late September. Why would it take 6 months for a wave to build up?
All in all, the fear machine is firing on all cylinders, but not asking any questions of the government

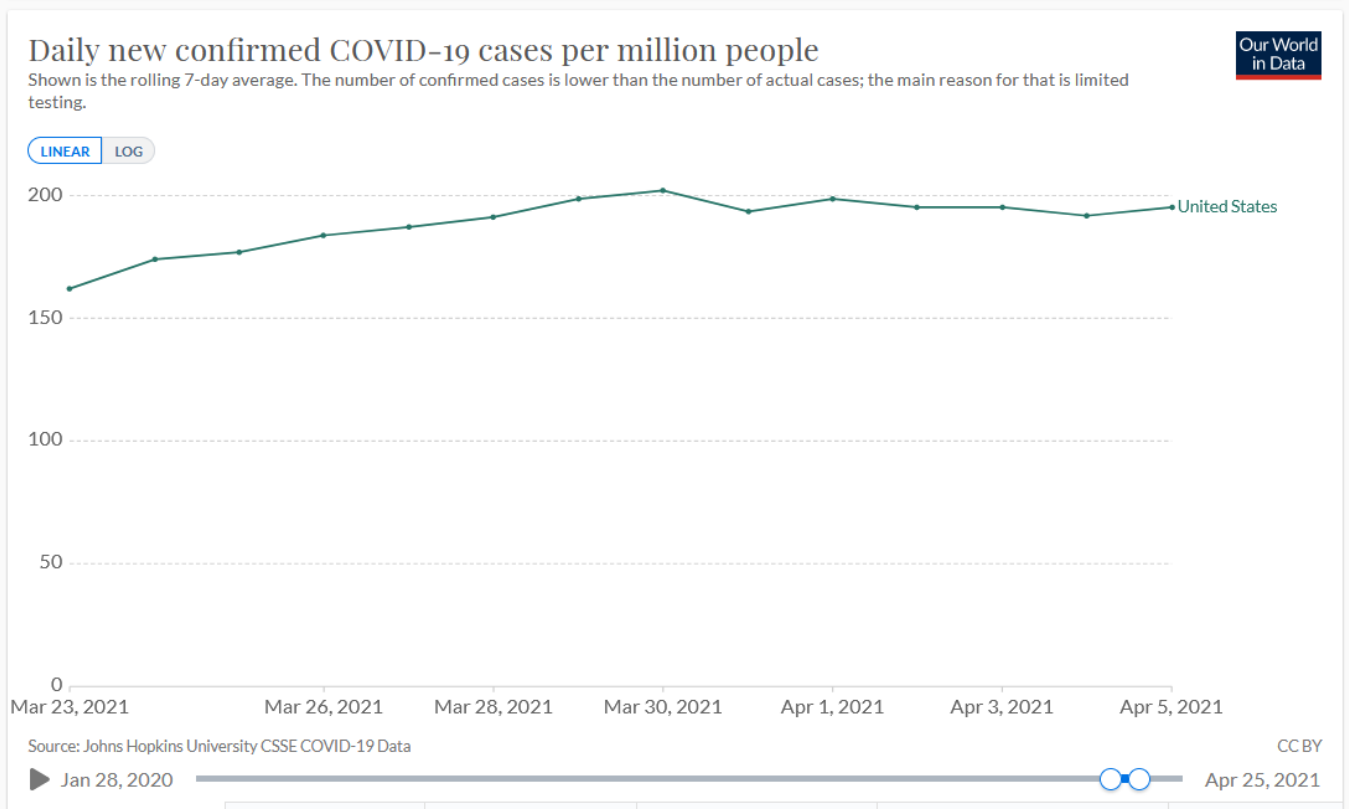
How about the mainstream media's sensationalized reporting? Is there any basis for it? Let's look at how they've handled previous variants.

We have seen this play before. A couple of months ago, ***ABC Good Morning America*** video report (see the link below). They reported on a "double mutant variant"….."this as COVID cases across the country climb. And fears of a fourth wave are growing."….."The nation's daily case average up nearly 20% in the last 2-weeks. Experts fearing the spread of variants will only accelerate it. Like in Massachusetts, where are more cases of the Brazilian Variant than anywhere else in the country." Pretty scary right?

https://abcnews.go.com/International/india-sees-alarming-rate-growth-covid-19-cases/story?id=76874838

But what does the data really look like?

Here is the 2-week period that they reported on with the near "20% rise in cases." There was a slight uptick, bet followed by a flattening. You would never get that from the way they reported it.



At the same time death rates plummeted across the U.S. Now as the Delta variant becomes more predominant in many countries around the world, we are seeing the same trend, more cases mostly mild and fewer hospitalizations and deaths. But none of that matters, because fear sells vaccines.

Inventor of Messenger RNA (mRNA) technology used by Pfizer and Moderna drops a bombshell about the COVID-19 vaccines in a must watch interview

In an amazing interview on the ***Dark Horse Podcast***, **Dr. Robert Malone** the creator of mRNA vaccine technology, said the COVID vaccine lipid nanoparticles which transport the spike protein into people's cells so that they can then kick out copies of the spike protein at high levels leave the injection site in large amounts and accumulate in organs and tissues. The two areas that these particles accumulate are especially in the ovaries by multiple factors, followed by the bone marrow, a very concerning revelation (others as well).

Here are some of Dr. Malone's credentials.

Dr. Malone is the discoverer of in-vitro and in-vivo RNA transfection and the inventor of mRNA vaccines, while he was at the Salk Institute in 1988. His research was continued at Vical in 1989, where the first in-vivo mammalian experiments were designed by him. The mRNA, constructs, reagents were developed at the Salk institute and Vical by Dr. Malone. The initial patent disclosures were written by Dr. Malone in 1988-1989. **Dr. Malone was also an inventor of DNA vaccines in 1988 and 1989**. **This work results in over 10 patents and numerous publications, yielding about 7000 citations for this work. Dr. Malone has extensive research and development experience in the areas of pre-clinical discovery research, clinical trials, vaccines, gene therapy, bio-defense, and immunology. He has over twenty years of management and leadership experience in academia, pharmaceutical and biotechnology industries, as well as in governmental and non-governmental organizations.**

Dr. Malone specializes in clinical research, medical affairs, regulatory affairs, project management, proposal management (large grants and contracts), vaccines and biodefense. This includes writing, developing, reviewing and managing vaccine, bio-threat and biologics clinical trials and clinical development strategies. **He has been involved in developing, designing, and providing oversight of approximately forty phase 1 clinical trials and twenty phase 2 clinical trials, as well as five phase 3 clinical trials. He has served as medical director/medical monitor on approximately forty phase 1 clinical trials, and on twenty phase 2 clinical trials, including those run at vaccine-focused Clinical Research Organizations**. His proposal development work has yielded clients billions of dollars.

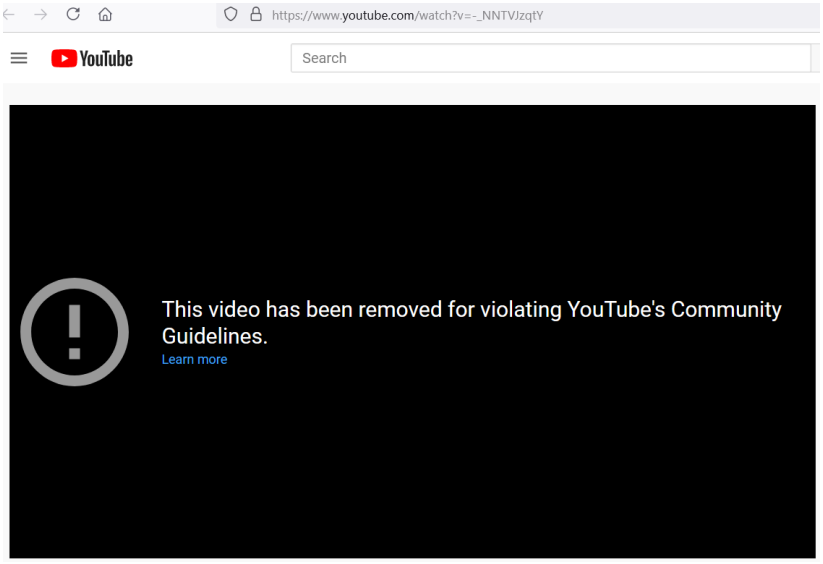
Scientifically trained at UC Davis, UC San Diego, and at the Salk Institute Molecular Biology and Virology laboratories, **Dr. Malone is an internationally recognized scientist (virology, immunology, molecular biology) and is known as one of the original inventors of mRNA vaccination and DNA Vaccination. His discoveries in mRNA non viral delivery systems are considered the key to the current COVID-19 vaccine strategies. Dr. Malone holds numerous fundamental domestic and foreign patents in the fields of gene delivery, delivery formulations, and vaccines.**

He received his medical training at Northwestern University (MD) and Harvard University (Clinical Research Post Graduate) medical school, and in Pathology at UC Davis.

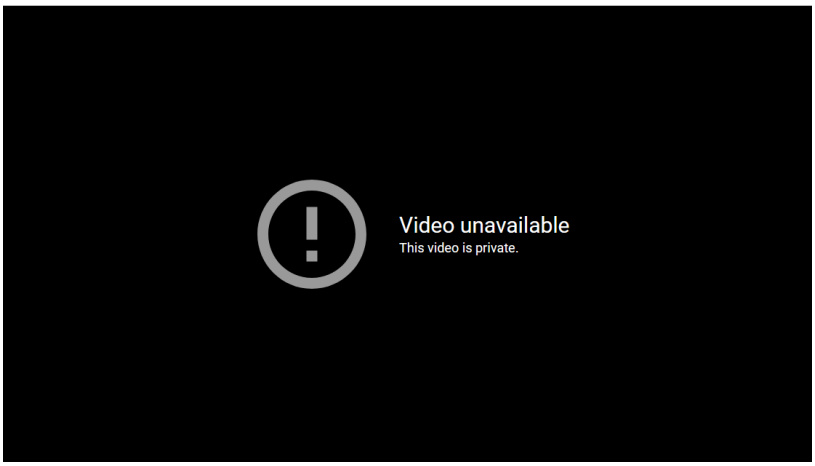
Dr. Malone has close to 100 peer-reviewed publications and published abstracts and has over 11,477 citations of his peer reviewed publications, as verified by Google Scholar. His google scholar ranking is "outstanding" for impact factors. **He has been an invited speaker at over 50 conferences, has chaired numerous conferences and he has sat on or served as chairperson on numerous NIAID and DoD study sections.**

See next page…

Then following the link from ***Children's Health Defense*** website resulted in this from YouTube.



Interestingly, You Tube must have felt uneasy about censoring the inventor of the technology and have changed the censor flag to say this.



Since then, I have been able to access this critical section on YouTube here: https://www.youtube.com/watch?v=Du2wm5nhTXY

Thankfully, there are platforms that allow debate and free speech, and you can see that part of the interview here and it IS A MUST WATCH! https://www.bitchute.com/video/ZXIz7NCD7tnm/

Another backup link

https://odysee.com/@BretWeinstein:f/how-to-save-the-world,-in-three easy:0?r=FuWwFotRbicqY9GHyWBqDdTNNHpaTgC9 The 15 minutes I am referring to is from to

Details…

In case you don't have the time to watch the interview, the following is an excellent article by Megan Redshaw from ***The Defender*** publication of the ***Children's Health Defense.***

On June 10, Dr. Robert Malone, creator of mRNA vaccine technology, joined evolutionary biologist Bret Weinstein, Ph.D., for a 3-hour conversation on the "Dark Horse Podcast" to discuss multiple safety concerns related to the Pfizer and Moderna vaccines.

In this short outtake (this link now censored as I showed by the graphics above) from the full podcast, Malone, Weinstein and tech entrepreneur Steve Kirsch touch on the implications of the controversial Japanese Pfizer biodistribution study. The study was made public earlier this month by Dr. Byram Bridle, a viral immunologist.

They also discuss the lack of proper animal studies for the new mRNA vaccines, and the theory, espoused by virologist Geert Vanden Bossche, Ph.D., that mass vaccination with the mRNA vaccines could produce ever more transmissible and potentially deadly variants.

As The Defender reported June 3, Bridle received a copy of a Japanese biodistribution study — which had been kept from the public — as a result of a freedom of information request made to the Japanese government for Pfizer data.

Prior to the study's disclosure, the public was led to believe by regulators and vaccine developers that the spike protein produced by mRNA COVID vaccines stayed in the shoulder where it was injected and was not biologically active — even though regulators around the world had a copy of the study which showed otherwise.

The biodistribution study obtained by Bridle showed lipid nanoparticles from the vaccine did not stay in the deltoid muscle where they were injected as the vaccine's developers claimed would happen, but circulated throughout the body and accumulated in large concentrations in organs and tissues, including the spleen, bone marrow, liver, adrenal glands and — in "quite high concentrations" — in the ovaries.

The mRNA — or messenger RNA — is what tells the body to manufacture the spike protein. The lipid nanoparticles are like the "boxes" the mRNA is shipped in, according to Malone. "If you find lipid nanoparticles in an organ or tissue, that tells you the drug got to that location," Malone explained.

According to the data in the Japanese study, lipid nanoparticles were found in the whole blood circulating throughout the body within four hours, and then settled in large concentrations in the ovaries, bone marrow and lymph nodes.

Malone said there needed to be monitoring of vaccine recipients for leukemia and lymphomas as there were concentrations of lipid nanoparticles in the bone marrow and lymph nodes. But those signals often don't show up for six months to three or nine years down the road, he said.

Usually, signals like this are picked up in animal studies and long-term clinical trials, but this didn't happen with mRNA vaccines, Malone said.

Malone said there are two adverse event signals that are becoming apparent to the U.S. Food and Drug Administration (FDA). One of them is thrombocytopenia — not having enough platelets, which are manufactured in the bone marrow. The other is reactivation of latent viruses.

Malone found the ovarian signal perplexing because there is no accumulation in the testes.

Malone said the original data packages contained this biodistribution information. "This data has been out there a long time" within the protected, non-disclosed, purview of the regulators across the world, he said.

According to Malone, the FDA knew the COVID spike protein was biologically active and could travel from the injection site and cause adverse events, and that the spike protein, if biologically active, is very dangerous.

In fact, Malone was one of many scientists to warn the FDA about the dangers of the free spike protein.

Malone suggested autoimmune issues may be related to free-circulating spike protein which developers assured would not happen. To pick up autoimmune issues, a 2- to 3- year follow-up period in phase 3 patients would be required to monitor for potential autoimmune consequences from vaccines — but that monitoring didn't happen with the Pfizer and Moderna vaccines.

Pfizer and Moderna also didn't conduct proper animal studies, Weinstein said. What the animal models give us is a signal that alerts us to what we need to follow up on in humans.

Weinstein said:

"We've got very alarming short-term stuff. We've got short-term stuff that is alarming on the basis of where we find these lipids, where we find the spike proteins — those things are reasons for concern because it wasn't supposed to be this way. We've also got an alarming signal in terms of the hazards and deaths or the harms and the deaths that are reported in the system and there are reasons to think they are dramatic under-reports."

Vaden Bossche got it right

One of the potential harms from the vaccines, Weinstein said, was made famous by Vanden Bossche, a vaccinologist who worked with GSK Biologicals, Novartis Vaccines, Solvay Biologicals, Bill & Melinda Gates Foundation's Global Health Discovery team in Seattle, and Global Alliance for Vaccines and Immunization in Geneva.

Earlier this year, Vanden Bossche put out a call to the World Health Organization, supported by a 12-page document, that described the "uncontrollable monster" that a global mass vaccination campaign could potentially unleash.

Vanden Bossche said a combination of lockdowns, and extreme selection pressure on the virus induced by the intense global mass vaccination program, might diminish the number of cases, hospitalizations and deaths in

the short-term, but ultimately, will induce the creation of more mutants of concern. This is what Vanden Bossche calls “immune escape” (i.e. incomplete sterilization of the virus by the human immune system, even following vaccine administration).

Immune escape will in turn trigger vaccine companies to further refine vaccines that will add, not reduce, the selection pressure, producing ever more transmissible and potentially deadly variants.

The selection pressure will cause greater convergence in mutations that affect the critical spike protein of the virus that is responsible for breaking through the mucosal surfaces of our airways, the route used by the virus to enter the human body.

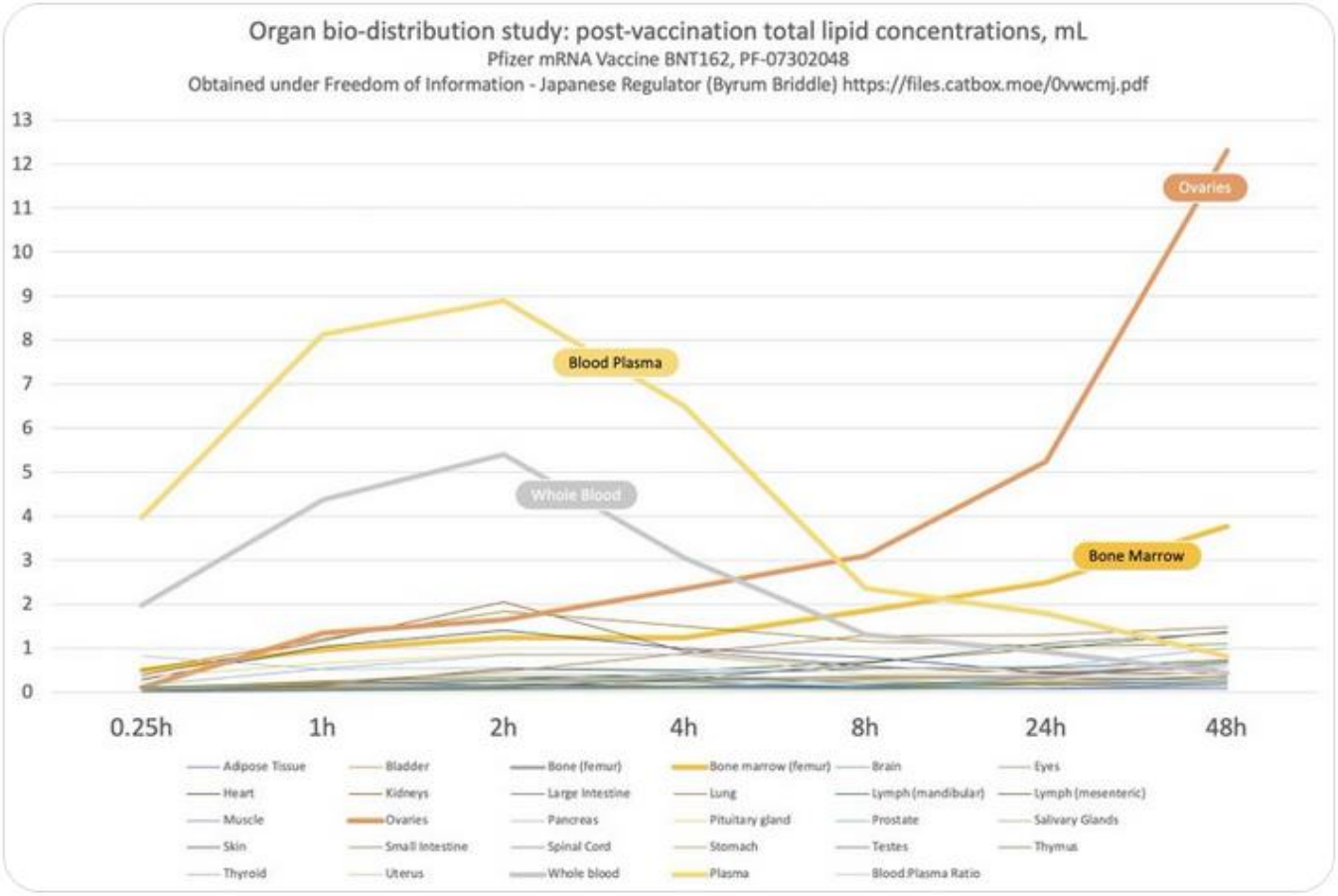
The virus will effectively outsmart the highly specific antigen-based vaccines being used and tweaked, depending on the circulating variants. All of this could lead to a hockey stick-like increase in serious and potentially lethal cases — in effect, an out-of-control pandemic.

Malone said:

“Vanden Bossche’s concern is not theoretical. It is real and we have the data. We’re stuck with this virus or its downstream variants pretty much for the rest of our lives and it’s going to become more like the flu. We will have continuing evolution and circulation of variants, and that is an escape.”

My comment: This is another highly respected and qualified scientist that warns that we have made a grave mistake by forcing evolutionary mutational pressure on a virus by mass vaccinating for it during the middle of an outbreak.

Graphs from the Japanese Biodistribution study on the next page…



2.6.5.5B. PHARMACOKINETICS: ORGAN DISTRIBUTION CONTINUED

Test Article: [^{3}H]-Labelled LNP-mRNA formulation containing ALC-0315 and ALC-0159
Report Number: 185350

Sample	Total Lipid concentration (µg lipid equivalent/g [or mL]) (males and females combined)							% of Administered Dose (males and females combined)						
	0.25 h	1 h	2 h	4 h	8 h	24 h	48 h	0.25 h	1 h	2 h	4 h	8 h	24 h	48 h
Lymph node (mandibular)	0.064	0.189	0.290	0.408	0.534	0.554	0.727	--	--	--	--	--	--	--
Lymph node (mesenteric)	0.050	0.146	0.530	0.489	0.689	0.985	1.37	--	--	--	--	--	--	--
Muscle	0.021	0.061	0.084	0.103	0.096	0.095	0.192	--	--	--	--	--	--	--
Ovaries (females)	0.104	1.34	1.64	2.34	3.09	5.24	12.3	0.001	0.009	0.008	0.016	0.025	0.037	0.095
Pancreas	0.081	0.207	0.414	0.380	0.294	0.358	0.599	0.003	0.007	0.014	0.015	0.015	0.011	0.019
Pituitary gland	0.339	0.645	0.868	0.854	0.405	0.478	0.694	0.000	0.001	0.001	0.001	0.000	0.000	0.001
Prostate	0.061	0.091	0.128	0.157	0.150	0.183	0.170	0.001	0.001	0.002	0.003	0.003	0.004	0.003

This second table shows some other organs with high biodistribution that are not included in the graph above.

Continued next page…

Sample	Mean total lipid concentration (μg lipid equivalent/g (or mL) (males and females combined)							% of administered dose (males and females combined)						
	0.25 h	1 h	2 h	4 h	8 h	24 h	48 h	0.25 h	1 h	2 h	4 h	8 h	24 h	48 h
Adipose tissue	0.057	0.100	0.126	0.128	0.093	0.084	0.181	--	--	--	--	--	--	--
Adrenal glands	0.271	1.48	2.72	2.89	6.80	13.8	18.2	0.001	0.007	0.010	0.015	0.035	0.066	0.106
Bladder	0.041	0.130	0.146	0.167	0.148	0.247	0.365	0.000	0.001	0.001	0.001	0.001	0.002	0.002
Bone (femur)	0.091	0.195	0.266	0.276	0.340	0.342	0.687	--	--	--	--	--	--	--
Bone marrow (femur)	0.479	0.960	1.24	1.24	1.84	2.49	3.77	--	--	--	--	--	--	--
Brain	0.045	0.100	0.138	0.115	0.073	0.069	0.068	0.007	0.013	0.020	0.016	0.011	0.010	0.009
Eyes	0.010	0.035	0.052	0.067	0.059	0.091	0.112	0.000	0.001	0.001	0.002	0.002	0.002	0.003
Heart	0.282	1.03	1.40	0.987	0.790	0.451	0.546	0.018	0.056	0.084	0.060	0.042	0.027	0.030
Injection site	128	394	311	338	213	195	165	19.9	52.6	31.6	28.4	21.9	29.1	24.6
Kidneys	0.391	1.16	2.05	0.924	0.590	0.426	0.425	0.050	0.124	0.211	0.109	0.075	0.054	0.057
Large intestine	0.013	0.048	0.093	0.287	0.649	1.10	1.34	0.008	0.025	0.065	0.192	0.405	0.692	0.762
Liver	0.737	4.63	11.0	16.5	26.5	19.2	24.3	0.602	2.87	7.33	11.9	18.1	15.4	16.2
Lung	0.492	1.21	1.83	1.50	1.15	1.04	1.09	0.052	0.101	0.178	0.169	0.122	0.101	0.101

See the links to these tables in the biodistribution link above from the ***Children's Health Defense*** article. It will take you to the study which is in Japanese, however the tables are in English.

WOW! This is not only unexpected as Dr. Malone said, it in-and-of itself should be sufficient reason to stop the vaccine program immediately. As mentioned in the interview, these biodistribution studies are typically done in animals prior to testing on humans and this was never done in the United States. And as Dr. Michael Yeadon has said, toxicology studies on the spike protein these gene therapy agents instruct our cells to make were never done before the Emergency Use Authorizations were given. Now, unleashed on millions soon to be billions of people in the world we are learning a very bitter lesson; you cannot shortcut safety steps in the scientific method.

Another outstanding interview with Dr. Malone was done on the Highwire by Del Bigtree.

Del does a great job of discussing the many concerns that Dr. Malone has about the COVID-19 vaccines and the ethical issues surrounding the way they are being promoted, including the bribery, coercion, threatened segregation and loss of human rights surrounding the freedom of choice. One of the most revealing interview you will see on this topic by someone who checks all the credibility and expertise boxes.

https://thehighwire.com/videos/mrna-vaccine-inventor-calls-for-stop-of-covid-vax/

To view that whole ***Highwire*** episode click here… https://thehighwire.com/watch/#latest-episodes

What are medical professionals saying about the adverse effects of the vaccines?

Medscape is a popular web site that offers medical advice on just about any topic you could imagine. It is considered quite mainstream in the medical world. As of June 22nd, 2021, they have had 644 comments and the vast majority of them relate personal stories and stories of what they are seeing in the field. With this many doctors, nurses and other health care professionals relating these first-hand accounts, why aren't our regulatory agencies taking notice and acting on these dangerous vaccines?

One of the physicians weighing in is Dr. Peter McCullough who has been very visible and expressing his frustrations with the suppression of early, inexpensive and effective treatments for COVID-19 like hydroxychloroquine and zinc, Ivermectin, Budesonide and others. He has also been critical of the expedited vaccines and the shortcuts that have occurred in the safety trials. Here is what he had to say on the Medscape blog.

Dr. Peter McCullough| Cardiology, General 3 days ago

June 12, 2021, Multiple medical authorities have called for termination of the COVID-19 mass vaccination program due to safety concerns and the lack of independent critical event, data safety monitoring, and human ethics committees:

1) Bruno et al, 57 authors from 17 countries indicate the program should be halted unless safety mechanisms are immediately installed and risk mitigation initiated. https://www.authorea.com/users/414448/articles/522499-sars-cov-2-mass-vaccination-urgent-questions-on-vaccine-safety-that-demand-answers-from-international-health-agencies-regulatory-authorities-governments-and-vaccine-developers

2) Lawrie et al, Evidence Based Medicine Consultancy calls upon the MHRA to terminate the COVID-19 vaccination program "vaccines not safe for human use". https://drive.google.com/file/d/1pH0Y3jvHtgaEwcDR9QGTB2f90IaPbcRW/view

3) McCullough PA, calls for halt of vaccination of < 30 year olds for no clinical benefit and safety concerns. https://rumble.com/vif52d-evidence-builds-for-early-treatment-natural-immunity-and-pause-on-vaccinati.html

4) Wastila, et al, letter to FDA calling for non-approval of COVID-19 vaccines based on safety concerns. https://www.regulations.gov/commenton/FDA-2021-P-0521-0001

Based on VAERS as of May 28, 2021, there were 5,165 deaths reported and over 17,619 hospitalizations reported. By comparison, from July 1, 1997, until December 31, 2013, VAERS received 666 adult death reports for all vaccines.[1]

[1]Pedro L. Moro, Jorge Arana, Mria Cano, Paige Lewis, and Tom T. Shimabukuro, Deaths Reported to the Vaccine Adverse Event Reporting System, United States, 1997-2013, VACCINES, CID 2015:61 (September 2015).

Log on and sample what others are saying (if Medscape hasn't taken it down yet).

https://www.medscape.com/sites/public/covid-19/vaccine-insights/how-concerned-are-you-about-vaccine-related-adverse-events

An international coalition of doctors and scientists warn governments and regulatory agencies of the dangers of the COVID-19 vaccines

An article published May 24th, 2021 on ***Authorea*** titled **SARS-CoV-2 mass vaccination: Urgent questions on vaccine safety that demand answers from international health agencies, regulatory authorities, governments and vaccine developers**, serves as a wake-up call and urges an immediate pause followed by "opening an urgent pluralistic, critical, and scientifically-based dialogue on SARS-CoV-2 vaccination among scientists, medical doctors, international health agencies, regulatory authorities, governments, and vaccine developers" to address the many concerns about the vaccines and policies surrounding their promotion and use.

Abstract

Since the start of the COVID-19 outbreak, the race for testing new platforms designed to confer immunity against SARS-CoV-2, has been rampant and unprecedented, leading to conditional emergency authorization of various vaccines. Despite progress on early multidrug therapy for COVID-19 patients, the current mandate is to immunize the world population as quickly as possible. The lack of thorough testing in animals prior to clinical trials, and authorization based on safety data generated during trials that lasted less than 3.5 months, raise questions regarding vaccine safety. The recently identified role of SARS-CoV-2 Spike glycoprotein for inducing endothelial damage characteristic of COVID-19, even in absence of infection, is extremely relevant given that most of the authorized vaccines induce endogenous production of Spike. Given the high rate of occurrence of adverse effects that have been reported to date, as well as the potential for vaccine-driven disease enhancement, Th2-immunopathology, autoimmunity, and immune evasion, there is a need for a better understanding of the benefits and risks of mass vaccination, particularly in groups excluded from clinical trials. Despite calls for caution, the risks of SARS-CoV-2 vaccination have been minimized or ignored by health organizations and government authorities. As for any investigational biomedical program, data safety monitoring boards (DSMB) and event adjudication committees (EAC), should be enacting risk mitigation. If DSMBs and EACs do not do so, we will call for a pause in mass vaccination. If DSMBs and EACs do not exist, then vaccination should be halted immediately, in particular for demographic groups at highest risk of vaccine-associated death or serious adverse effects, during such time as it takes to assemble these boards and commence critical and independent assessments. We urge for pluralistic dialogue in the context of health policies, emphasizing critical questions that require urgent answers, particularly if we wish to avoid a global erosion of public confidence in science and public health

Discussion

The risks outlined here are a major obstacle to continuing global SARS-CoV-2 vaccination. Evidence on the safety of all SARS-CoV-2 vaccines is needed before exposing more people to the risk of these experiments, since releasing a candidate vaccine without time to fully understand the resulting impact on health could lead to an exacerbation of the current global crisis [41]. Risk-stratification of vaccine recipients is essential. According to the UK government, people below 60 years of age have an extremely low risk of dying fromCOVID-19[1]. However, according to ***Eudravigillance***, most of the serious adverse effects following SARS-CoV-2 vaccination occur in people aged 18-64. Of particular concern is the planned vaccination schedule for children aged 6 years and older in the United States and the UK. Dr. Anthony Fauci recently anticipated that teenagers across the country will be vaccinated in the autumn and younger children in early 2022, and the UK is awaiting trial results to commence vaccination of 11 million children under 18. There is a lack of scientific justification for subjecting healthy children to experimental vaccines, given that the Centers for Disease Control and Prevention estimates that they have a 99.997% survival rate if infected with SARS-CoV-2. Not only is COVID-19 irrelevant as a threat to this age group, but there is no reliable evidence to support vaccine efficacy or effectiveness in this population or to rule out harmful side effects of these experimental vaccines. In this sense, when physicians advise patients on the elective administration of COVID-19 vaccination, there is a great need to better understand the benefits and risk of administration, particularly in understudied groups.

In conclusion, in the context of the rushed emergency-use-authorization of SARS-CoV-2 vaccines, and the current gaps in our understanding of their safety, the following questions must be raised:

*Is it known whether cross-reactive antibodies from previous coronavirus infections or vaccine-induced antibodies may influence the risk of unintended pathogenesis following vaccination with COVID-19?

*Has the specific risk of ADE, immunopathology, autoimmunity, and serious adverse reactions been clearly disclosed to vaccine recipients to meet the medical ethics standard of patient understanding for informed consent? If not, what are the reasons, and how could it be implemented?

*What is the rationale for administering the vaccine to every individual when the risk of dying fromCOVID-19 is not equal across age groups and clinical conditions and when the phase 3 trials excluded the elderly, children and frequent specific conditions?

*What are the legal rights of patients if they are harmed by a SARS-CoV-2 vaccine? Who will cover the costs of medical treatment? If claims were to be settled with public money, has the public been made aware that the vaccine manufacturers have been granted immunity, and their responsibility to compensate those harmed by the vaccine has been transferred to the tax-payers?

If vaccination programs worldwide do not institute independent data safety monitoring boards (DSMB), event adjudication committees (EAC), and enact risk mitigation, we will call for a pause in the mass vaccination program. If DSMBs and EACs do not exist currently, as would be imperative for any investigational biomedical program, then vaccination should be immediately halted for those demographic groups at highest risk of vaccine-associated death or serious adverse effects, during the time it takes to assemble these boards and committees and commence their assessments.

In the context of these concerns, we propose opening an urgent pluralistic, critical, and scientifically-based dialogue on SARS-CoV-2 vaccination among scientists, medical doctors, international health agencies,

regulatory authorities, governments, and vaccine developers. This is the only way to bridge the current gap between scientific evidence and public health policy regarding the SARS-CoV-2 vaccines. We are convinced that humanity deserves a deeper understanding of the risks than what is currently touted as the official position. An open scientific dialogue is urgent and indispensable to avoid erosion of public confidence in science and public health and to ensure that the WHO and national health authorities protect the interests of humanity during the current pandemic. Returning public health policy to evidence-based medicine, relying on a careful evaluation of the relevant scientific research, is urgent. It is imperative to follow the science.

https://www.authorea.com/users/414448/articles/522499-sars-cov-2-mass-vaccination-urgent-questions-on-vaccine-safety-that-demand-answers-from-international-health-agencies-regulatory-authorities-governments-and-vaccine-developers

This paper has 41 references.

Speaking of dangers…Check out the next story!

New study in the New England Journal of Medicine looking at risks of COVID-19 shots in pregnancy is under fire for glaring flaws that mis-represent the conclusion

A June 17th study published in the ***New England Journal of Medicine*** titled, **Preliminary Findings of mRNA Covid-19 Vaccine Safety in Pregnant Persons** concluded that there were no safety signals related to spontaneous abortions in women getting the COVID-19 vaccines. But stop the press! An independent analysis of the data found some glaring flaws that completely change the narrative that the study authors were apparently attempting to provide.

There were some interesting findings and statements throughout the study that leads me to believe they recognized some of the issues with their conclusion which says this

From the Conclusion

"Preliminary findings did not show obvious safety signals among pregnant persons who received mRNA Covid-19 vaccines."

They did say that further follow-up with larger cohorts are needed especially in women vaccinated earlier in pregnancy, but they did make a couple very large and critically important miscalculations in the data that was reported.

Here are some those interesting sections from the study.

Among 827 participants who had a completed pregnancy, the pregnancy resulted in a live birth

in 712 (86.1%), in a spontaneous abortion in 104 (12.6%), in stillbirth in 1 (0.1%), and in other outcomes (induced abortion and ectopic pregnancy) in 10 (1.2%). A total of 96 of 104 spontaneous abortions (92.3%)

occurred before 13 weeks of gestation (Table 4), and 700 of 712 pregnancies that resulted in a live birth (98.3%) were among persons who received their first eligible vaccine dose in the third trimester.

https://www.nejm.org/doi/full/10.1056/NEJMoa2104983

In a letter to the editor, it was pointed out that there are at least two glaring flaws in this study.

1. The range used population wide stillbirths used a higher end range that represented clinically-unrecognized pregnancies, which does not reflect the clinically-recognized pregnancies of this cohort and should be removed according to the authors.
2. The intent of the study was to evaluate the COVID-19 vaccines for adverse pregnancy events including spontaneous abortion (death prior to 20 weeks gestation), or still birth (death between 21 weeks and full term). It is well documented that the fetus is most susceptible to toxins and spontaneous abortion if the mother is vaccinated or exposed to other toxins in the first trimester of pregnancy. The number of vaccinated women in the study by the authors also included women who were vaccinated in the last trimester of pregnancy.

After the authors of the letter to the editor adjusted for the above variables of using the rate of fetal deaths in **known pregnancies** and removed those who were vaccinated in the third trimester of their pregnancy from the cohort, they came up with a **greater than 82% rate of spontaneous abortion** in those vaccinated in the first trimester!

Here is the Letter to the Editor

Letter to Editor – Comment on “mRNA Covid-19 Vaccine Safety in Pregnant Persons”, Shimabukuro et al. (NEJM Apr 2021)

TO THE EDITOR

The article by Shimabukuro et al. 2021 presents preliminary safety results of coronavirus 2019 mRNA vaccines used in pregnant women from the V-Safe Registry.1 These findings are of particular importance, as pregnant women were excluded from the phase III trials assessing mRNA vaccines.

In table 4, the authors report a rate of spontaneous abortions <20 weeks (SA) of 12.5% (104 abortions/827 completed pregnancies). However, this rate should be based on the number of women who were at risk of an SA due to vaccine receipt and should exclude the 700 women who were vaccinated in their third-trimester

(104/127 = 82%). We acknowledge this rate will likely decrease as the pregnancies of women who were vaccinated <20 weeks complete but believe the rate will be higher than 12.5%. However, given the importance of these findings we feel it important to report these rates accurately. Additionally, the authors indicate that the rate of SAs in the published literature is between 10% and 26%.3-5 However, the upper cited rate includes clinically-unrecognized pregnancies,3 which does not reflect the clinically-recognized pregnancies of this cohort and should be removed.

NOTE: I'm going to insert the table from the study itself prior to the table the authors of this letter provide to make it easier to see the contrast from what the study authors showed as compared to the authors of the letter to the editor. See them on the next page…

Table 4. Pregnancy Loss and Neonatal Outcomes in Published Studies and V-safe Pregnancy Registry Participants.

Participant-Reported Outcome	Published Incidence*	V-safe Pregnancy Registry†
	%	*no./total no. (%)*
Pregnancy loss among participants with a completed pregnancy		
Spontaneous abortion: <20 wk[15-17]	10–26	104/827 (12.6)‡
Stillbirth: ≥ 20 wk[18-20]	<1	1/725 (0.1)§
Neonatal outcome among live-born infants		
Preterm birth: <37 wk[21,22]	8–15	60/636 (9.4)¶
Small size for gestational age[23,24]‖	3.5	23/724 (3.2)
Congenital anomalies[25]**	3	16/724 (2.2)
Neonatal death[26]††	<1	0/724

From the Letter to the Editor on the next page…

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Neonatal death[26]††	<1	0/724

* The populations from which these rates are derived are not matched to the current study population for age, race and ethnic group, or other demographic and clinical factors.

† Data on pregnancy loss are based on 827 participants in the v-safe pregnancy registry who received an mRNA Covid-19 vaccine (BNT162b2 [Pfizer–BioNTech] or mRNA-1273 [Moderna]) from December 14, 2020, to February 28, 2021, and who reported a completed pregnancy.

A total of 700 participants (84.6%) received their first eligible dose in the third trimester. Data on neonatal outcomes are based on 724 live-born infants, including 12 sets of multiples.

‡ A total of 96 of 104 spontaneous abortions (92.3%) occurred before 13 weeks of gestation.

§ The denominator includes live-born infants and stillbirths.

¶ The denominator includes only participants vaccinated before 37 weeks of gestation.

‖ Small size for gestational age indicates a birthweight below the 10th percentile for gestational age and infant sex ac- cording to INTERGROWTH-21st growth standards (http://intergrowth21.ndog.ox.ac.uk). These standards draw from an international sample including both low-income and high-income countries but exclude children with coexisting conditions and malnutrition. They can be used as a standard for healthy children growing under optimal conditions.

Letter to Editor – Comment on "mRNA Covid-19 Vaccine Safety in Pregnant Persons", Shimabukuro et al. (NEJM Apr 2021)

** Values include only major congenital anomalies in accordance with the Metropolitan Atlanta Congenital Defects Pro- gram 6-Digit Code Defect List (www.cdc.gov/ncbddd/birthdefects/macdp.html); all pregnancies

with major congeni- tal anomalies were exposed to Covid-19 vaccines only in the third trimester of pregnancy (i.e., well after the period of organogenesis).

†† Neonatal death indicates death within the first 28 days after delivery.

Kind Regards,

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No potential conflict of interest relevant to this letter was reported.

1. Shimabukuro TT, Kim SY, Myers TR, Moro PL, Oduyebo T, Panagiotakopoulos L, Marquez PL, Olson CK, Liu R, Chang KT. Preliminary Findings of mRNA Covid-19 Vaccine Safety in Pregnant Persons. *New England Journal of Medicine* 2021.

2. Devis P, Knuttinen MG. Deep venous thrombosis in pregnancy: incidence, pathogenesis and endovascular management. *Cardiovascular diagnosis and therapy* 2017;7:S309.

3. Dugas C, Slane VH. Miscarriage. *StatPearls [Internet]* 2020.

4. Obstetricians ACo, Gynecologists. ACOG practice bulletin no. 200: Early pregnancy loss. *Obstetrics and gynecology* 2018;132:e197-e207.

5. Medicine PCotASfR. Evaluation and treatment of recurrent pregnancy loss: a committee opinion. *Fertility and sterility* 2012;98:1103-11.

https://www.skirsch.com/covid/Vaccine_safety_in_preg_NEJM_May_28_2021.pdf

Another beef I have with this study, is with the title. See if you can pick it out.

Preliminary Findings of mRNA Covid-19 Vaccine Safety in Pregnant Persons

You may have different feelings about this, but I am so sick of the woke culture. To use the term “pregnant persons” rather than women is an obvious surrender to wokeness. This is particularly egregious coming from one of the top medical journals in the world, whose authors and peer reviewers ought to know the biological difference between men and women with regard to the capability of childbirth. Until someone can demonstrate to me that men are having children by natural means, this is completely ridiculous! I'll probably get cancelled for this biological truth. That is just another sign of the sick and twisted times we live in.

IMPORTANT UPDATE: As of Tuesday June 29th, the NEJM has removed this letter to the editor. Another example of scientific censorship? What normally happens if there is disagreement by some in the scientific

community or the journal regarding the content or conclusions of a letter to the editor, other doctors or researchers will write their response to that letter and give their arguments against what the writer or writers of the letter to the editor have said. That is healthy scientific debate. But apparently those days are long gone.

BREAKING NEWS as of July 1st: (I had to squeeze this in prior to releasing this newsletter)

A story in ***Science*** on Sciencemag.org titled, **Scientists quit journal board, protesting 'grossly irresponsible' study claiming COVID-19 vaccines kill**, reports on an exodus from the editorial board of the journal ***Vaccine***.

From the story

Several reputed virologists and vaccinologists have resigned as editors of the journal ***Vaccine*** to protest its 24 June publication of a **peer-reviewed article** that misuses data to conclude that "for three deaths prevented by [COVID-19] vaccination, we have to accept two inflicted by vaccination."

Since Friday, at least six scientists have resigned positions as associate or section editors with *Vaccines*, including Florian Krammer, a virologist at the Icahn School of Medicine at Mount Sinai, and Katie Ewer, an immunologist at the Jenner Institute at the University of Oxford who was on the team that developed the Oxford-AstraZeneca COVID-19 vaccine.

https://www.sciencemag.org/news/2021/07/scientists-quit-journal-board-protesting-grossly-irresponsible-study-claiming-covid-19

My comment: Isn't it interesting that Katie Ewer, a developer of the AstraZeneca vaccine was one of the editors jumping ship. So, the narrative is that they resigned in protest of the article saying it "misuses" data, but is it really that, or is it that they are upset that the journal had the integrity to publish the results and expose the dangers of the vaccine? It will be interesting to continue to follow this story.

Considering the risk found in pregnant woman as demonstrated by this story, look at how these shots are being marketed to women wanting to get pregnant…

Tweet by HHS promoting COVID-19 vaccines in women who want to become pregnant

Health and Human Services (HHS) has put out a video June 8th in a Tweet designed to encourage women desiring or planning to get pregnant containing some false and deceptive statements. The person speaking in the video is Sara Whetstone M.D. https://twitter.com/hhsgov/status/1402340632807415809?s=11

This is the full script, which I will take point by point.

1. "We don't have any data that suggests that COVID-19 vaccines affects fertility."

This is debatable as many world-renowned scientists and medical specialists have come forward expressing legitimate concerns and asking for a pause in vaccinations until these concerns can be addressed. In addition, we have seen many adverse wide-ranging effects to menstrual cycles of women who have been vaccinated. And aside from all that, reading that statement again is the exact point that people advocating for safe vaccines are making. WE DON'T HAVE ANY DATA about short, moderate or long-range effects of these experimental vaccines on fertility. We now know thanks to a Japanese study discussed in this newsletter, that the Lipid nanoparticles that carry the spike protein used by our cells to manufacture trillions of copies of spike protein accumulate in the ovaries in quantities several times greater than any other organ or tissue. The inventor of mRNA technology that is being used by the Pfizer ND Moderna vaccines expressed grave concerns about this very issue. You would have been able to see it on YouTube initially, but this is what I found when I first tried.

2. "It's not a live vaccine."

This statement is a non-relevant statement, so in essence a distraction. No, it is not a live vaccine. It is an engineered spike protein never used in humans before, in a delivery system that has never been used in humans before. And, with very short trials in limited numbers and demographics before unleashing it on the public. So, their statement that is not a live vaccine is basically saying "why worry?"

3. "The sort of proteins that are used in the vaccine do not alter anyone's DNA or genetic material."

That is still up for debate, but one thing that isn't, is that they do instruct your cells to manufacture a genetically modified spike protein that has now shown in several studies to act as a toxin in the body and is now thought to be responsible for the catastrophic numbers of casualties in vaccinated people.

4. "So, we don't have any evidence that makes us worry that this vaccine could affect fertility."

Could that be because these vaccines weren't studied as they should have been and tested in a small number of women who were then followed for two to three years to see if they were able to conceive as compared to the rest of the population? And, based on the previous report it would be logical to suggest that the possibility exists.

5. "And we know, we have lots of vaccines in the past, that we give out, you know, to people that desire to get pregnant as a way to protect them in pregnancy."

The only two vaccines that the CDC recommends in pregnant women are the flu vaccine and the T-dap. What she means by "lots of vaccines" I'm not exactly sure. And even these two vaccines have been shown in many studies to be problematic. Download and read my **1200 Studies- Truth Will Prevail** (https://1200studies.com) and you will see extensive evidence to support that statement.

6. "So, in general, we think that vaccines are safe prior to pregnancy. And in some cases, we encourage people to get vaccinated before pregnancy for certain viruses."

"We think"? That's reassuring. Especially considering the findings in the Japanese Pfizer biodistribution study as discussed by the inventor of messenger RNA technology Dr. Robert Malone. See that story in this newsletter.

COVID-19 vaccines may also have detrimental effects to the male reproductive system

A study published in the ***World Journal of Men's Health*** November 2020 titled, **Histopathology and Ultrastructural Findings of Fatal COVID-19 Infections on Testis** presents some very concerning findings.

Conclusion from the abstract

The novel COVID-19 has an affinity for ACE-2 receptors. Since ACE-2 receptor expression is high in the testes,

we hypothesized that COVID-19 is prevalent in testes tissue of infected patients. This study suggests the male reproductive tract, specifically the testes, may be targets of COVID-19 infection. We found an inverse association between ACE-2 receptor levels and spermatogenesis, suggesting a possible mechanism of how COVID-19 can cause infertility.

From the study

As our understanding of the virus grew, it became apparent that the virus additionally affects other organs of the human body, such as the liver, kidneys, and gastrointestinal tract. There is a male preponderance for the virus and early studies showed worse disease severity and duration in men compared to women. This preponderance has resulted in an increased incidence of the disease and morbidity rate in men that is double that of women [2]. The 2005 SARS-CoV virus, a respiratory virus part of the same family as the SARS-CoV-2 virus, was also investigated regarding its effects on testes tissue. Xu et al [3] found that all six patients who died of SARS-CoV displayed widespread germ cell destruction with few to no spermatozoon, thickened seminiferous tubule basement membranes, as well as lymphocyte and macrophage infiltration. They suggested orchitis is a complication of SARS-CoV.

Pathological studies have shown that the primary target organ of COVID-19 is the lungs. It is believed that this is due to an increased expression of angiotensin- converting enzyme 2 (ACE-2) receptors in lung tissue, of which COVID-19 has a high affinity of binding and subsequent entry [8-10]. Studies have shown the potential risk of COVID-19 impacting and damaging other organs that express ACE-2 receptors, including the heart, kidneys, bladder, oral cavity, esophagus, and ileum [9,11,12]. Interestingly, the ACE-2 receptor is widely expressed in the testes [13]. It has been found that in prior to viral entry *via* ACE-2 the SARS-CoV-2 viral spike proteins must be primed *via* the transmembrane protease, serine 2 (TMPRSS2). Androgens *via* the androgen receptor are the only known transcription promoters for the TMPRSS2 gene [14,15]. Since both ACE-2 as well as TMPRSS2 have been shown to be expressed in testis tissue, *via* single-cell and single nucleus

RNA-seq studies, we believe the high androgen environment of the testes will allow for viral entry [16].

In addition, multiple studies have reported that the use of renin-angiotensin system inhibitors has neither

been shown to confer any protective effects, nor impact testing positive rates or mortality [17-19].

Additionally, it has been shown that viruses, such as human immunodeficiency virus, hepatitis B virus, and mumps, can cross the blood-testis barrier and cause viral orchitis resulting in infertility and cancer [20]. In this study we hypothesized that the SARS-CoV-2 virus can be present in the testis and impact spermatogenesis. We also evaluated the association between ACE-2 receptor levels and impact on spermatogenesis.

The presence of SARS-CoV-2 viral particles in the testicular tissue fills a fundamental gap in knowledge of the affected organs and possible sequalae of COVID-19 in men. The findings of this study could be the first step in discovering impacts to fertility or the possibility of sexual transmission of the virus. On the basis of these preliminary findings, we believe that COVID-19 can penetrate the blood-testis barrier and enter the testis in some men. Presence of the virus can still be identified in the testis after patients have seroconverted. ACE-2 receptor density in testis tissue may be a factor influencing the extent of damage to cells responsible for spermatogenesis, with higher ACE-2 expression possibly leading to poorer spermatogenesis. However, further experiments are needed to validate this association. The relationship between possible visual viral particles on TEM and leukocyte infiltration suggests the COVID-19 virus may enter the testis and potentially cause orchitis. Further studies need to be undertaken to better understand the effects of this virus on reproductive organs.

Since the vaccines trigger our cells to make the spike protein and as the story I reported in this newsletter about the Japanese biodistribution study showed, these nanoparticles travel throughout the body. They seem to have a greater affinity for then ovaries than the testis, but what about the billions of free spike proteins released by the cells which have also been shown to travel throughout the body? Since the testis have high levels of ACE-2 receptors (the target for the spike protein) and TMPRSS2 expression as discussed above, it is reasonable to be concerned about the vaccine's effect on male reproduction. Since hundreds of millions of males are now experimental test subjects, I guess we will see in two to three years.

https://pubmed.ncbi.nlm.nih.gov/33151050/

COVID-19 vaccines may have negative and risky immune effects for people that have previously had COVID-19

A February 2021 study from Italy and published on ***medRxiv*** as a preprint titled, **A cautionary note on recall vaccination in ex-COVID-19 subjects** warns of some disastrous unintended consequences to the vaccines.

From the Abstract

Here, we tested the antibody response developed after the first dose of the mRNA-based vaccine encoding the SARS-CoV-2 full-length spike protein (BNT162b2) in 124 healthcare professionals of which 57 had a previous history of COVID-19 (ExCOVID). Post-vaccine antibodies in ExCOVID individuals increase exponentially within 7-15 days after the first dose compared to naïve subjects (p<0.0001). We developed a multivariate Linear Regression (LR) model with l2 regularization to predict the IgG response for SARS-COV-2 vaccine. We

found that the antibody response of ExCOVID patients depends on the IgG pre-vaccine titer and on the symptoms that they developed during the disorder, with anosmia/dysgeusia and gastrointestinal disorders being the most significantly positively correlated in the LR. Thus, one vaccine dose is sufficient to induce a good antibody response in ExCOVID subjects. **On the contrary, a second dose might switch-off the immune response due to antigen exhaustion, which occurs in response to several viruses or drive the development of low-affinity antibodies for SARS-CoV-2 which may foster an antibody dependent enhancement (ADE) reaction when re-exposed to the virus. These results question whether a second shot in ExCOVID subjects is indeed required and suggest to post-pone it while monitoring antibody response longevity.**

https://www.medrxiv.org/content/10.1101/2021.02.01.21250923v1

At least some of the mainstream media is finally catching on

For quite some time, we have seen excellent monologs and interviews by Tucker Carlson and Laura Ingraham from Fox News covering various stories about the pandemic public health response, recently the origins of the virus and bringing to light the risks of the COVID shots. Add the Wall Street Journal to the list of honest journalism.

Recently they have reported on the lab origins…

The Science Suggests a Wuhan Lab Leak - The Covid-19 pathogen has a genetic footprint that has never been observed in a natural coronavirus.

https://www.wsj.com/articles/the-science-suggests-a-wuhan-lab-leak-11622995184

and now this from the WSJ…

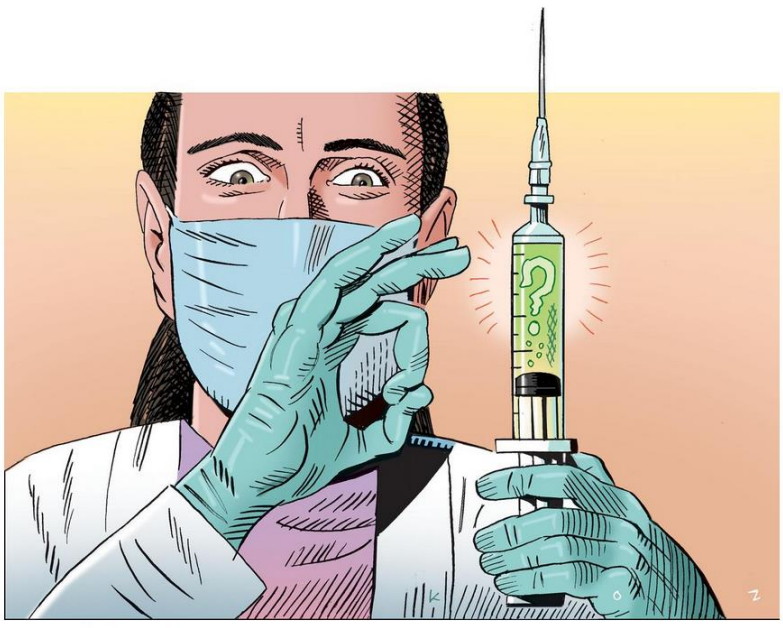


ILLUSTRATION: MARTIN KOZLOWSKI

The op-ed featured in the WSJ June 22nd, 2021 titled **Are Covid Vaccines Riskier Than Advertised?** - **There are concerning trends on blood clots and low platelets, not that the authorities will tell you** was submitted by

Joseph Ladapo, M.D., Ph.D., associate professor of medicine at ***UCLA's David Geffen School of Medicine***, and Harvey Risch, M.D., Ph.D., a professor of epidemiology at ***Yale School of Public Health*** wrote while "some scientists have raised concerns that the safety risks of Covid-19 vaccines have been underestimated … the politics of vaccination has relegated their concerns to the outskirts of scientific thinking."

In discussing the numbers of adverse reports after the vaccines, they said that they felt that "The true number of cases is almost certainly higher. This tendency of underreporting is consistent with our clinical experience."

In addition, they said "The implication is that the risks of a COVID-19 vaccine may outweigh the benefits for certain low-risk populations, such as children, young adults and people who have recovered from COVID-19. This is especially true in regions with low levels of community spread, since the likelihood of illness depends on exposure risk. And while you would never know it from listening to public health officials, not a single published study has demonstrated that patients with a prior infection benefit from COVID-19 vaccination. That this isn't readily acknowledged by the CDC or Anthony Fauci is an indication of how deeply entangled pandemic politics is in science."

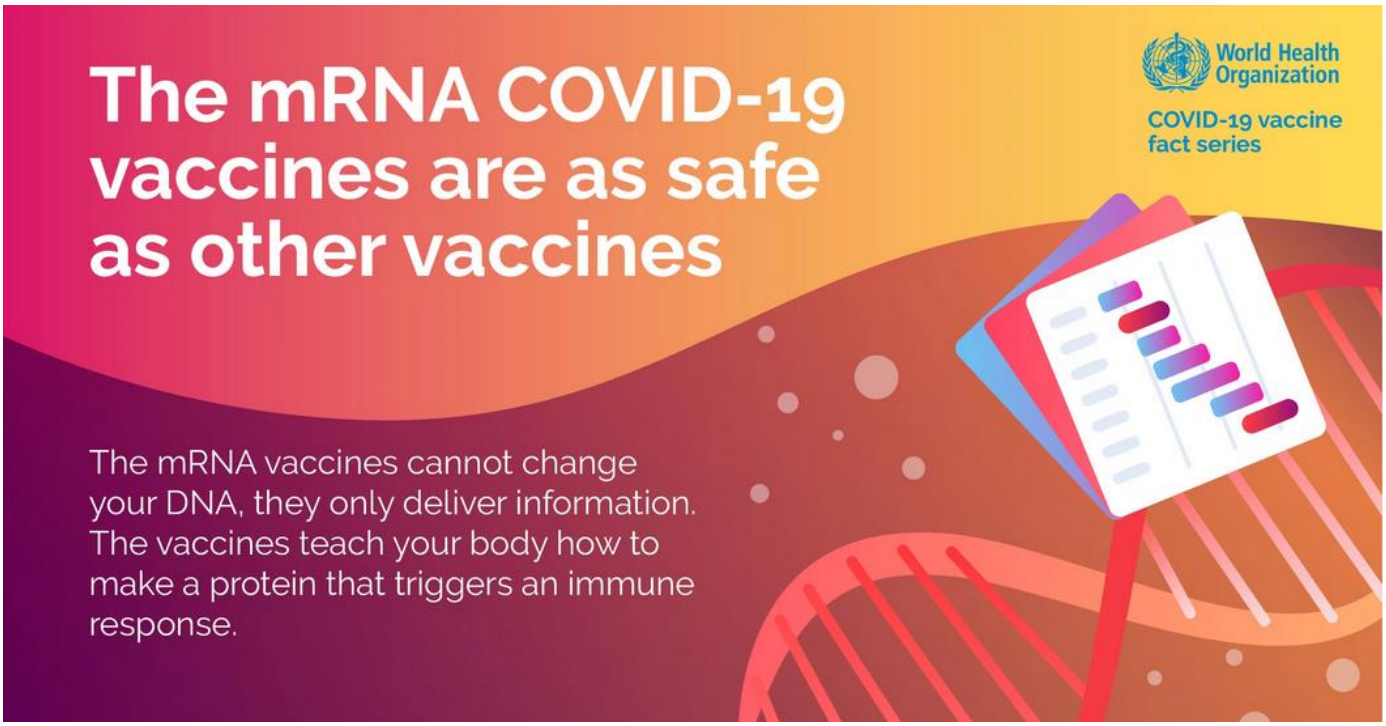
"Analyses to confirm or dismiss these findings should be performed using large data sets of health-insurance companies and healthcare organizations. The CDC and FDA are surely aware of these data patterns, yet neither agency has acknowledged the trend."

https://www.wsj.com/articles/are-covid-vaccines-riskier-than-advertised-11624381749

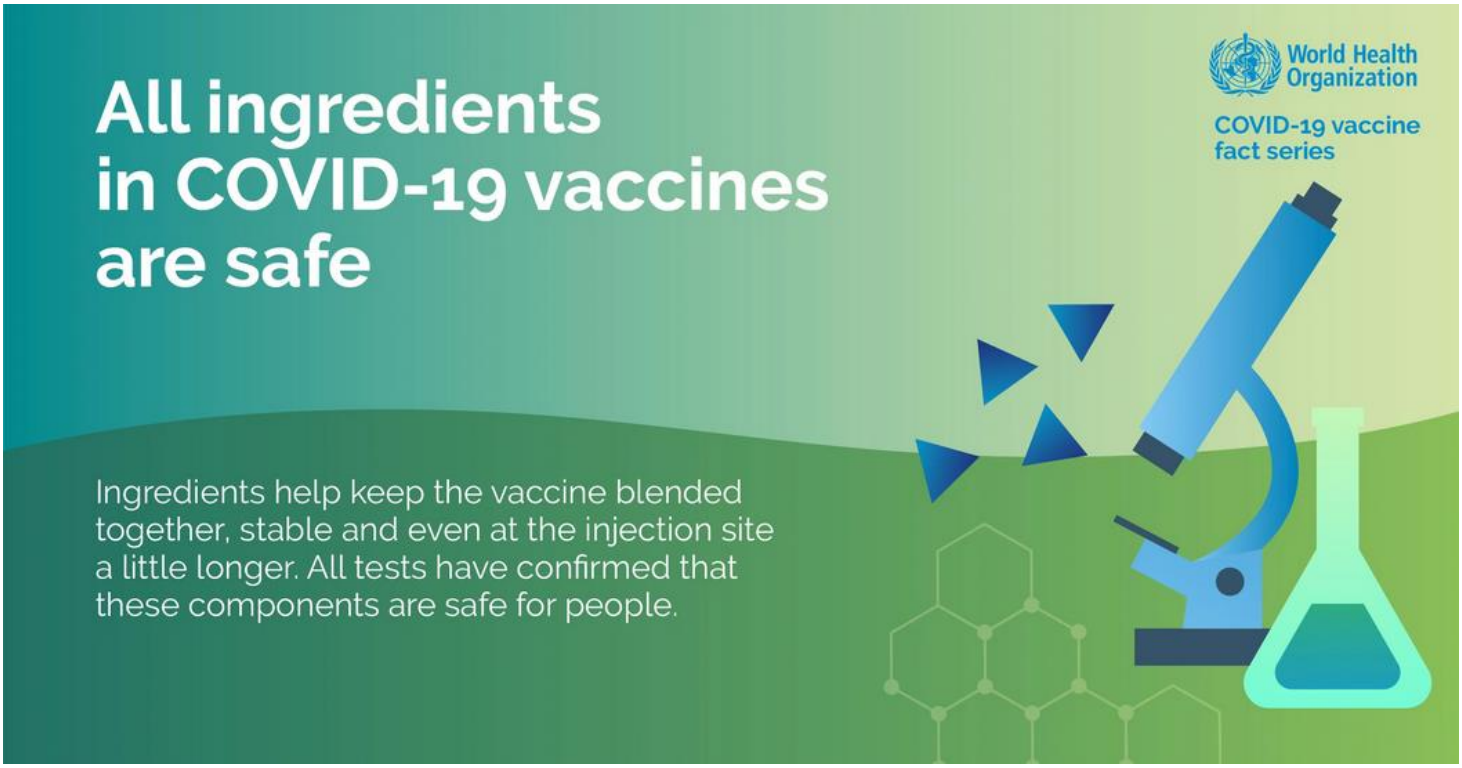
Blatant misinformation from the World Health Organization (but then, who is really surprised?)

In a series of infographics on the COVID vaccines found on the World Health organization's website, I found seven of the nine to contain blatant misinformation.

See if you can pick them out yourself in the next few pages….



As safe as other vaccines? Just check the VAERS reports (which we know are highly under-reported) and read the MedScape medical professional comments from the link found in this newsletter. Then tell me what you think about this egregious statement.

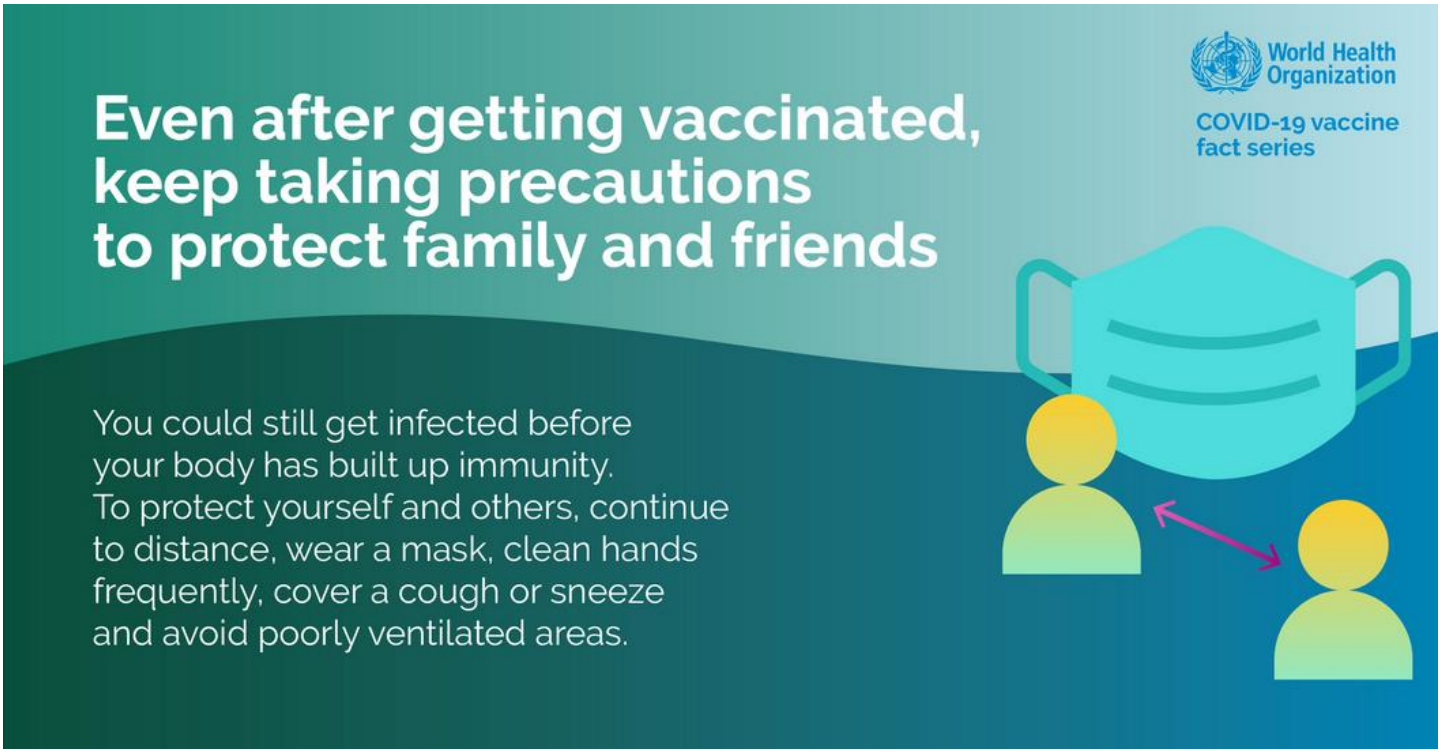


See my comment above. In addition, the Pfizer biodistribution study from Japan that I report on in this newsletter clearly shows that these ingredients distribute throughout the human body and do not stay at or near the injection site.

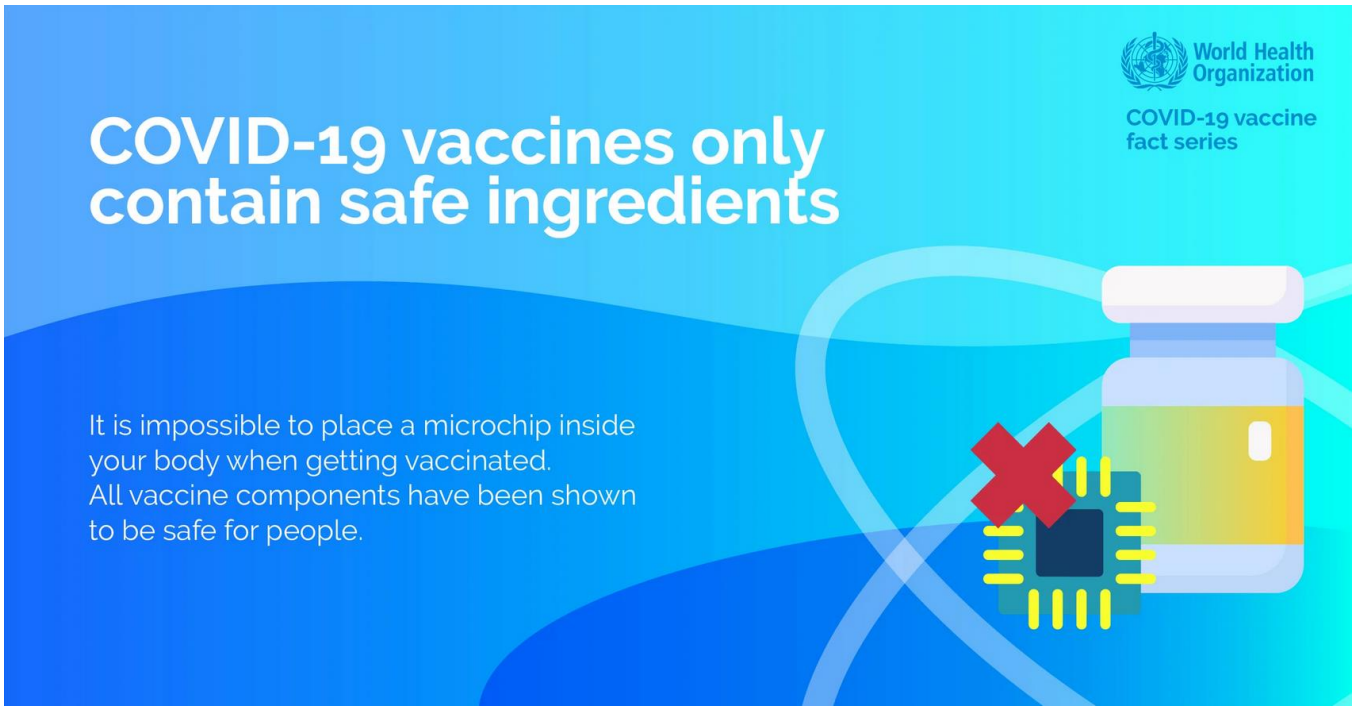
The statement above is a joke! We know from numerous studies many of which I've covered in previous newsletters and some of them in this newsletter, that natural immunity is far superior to vaccine immunity. Those who have been vaccinated are at far greater risk of becoming infected by mutant strains. This is becoming clearly evident all around the world. One of the key reasons is that their immune system only recognizes the spike protein. Once mutations occur in the spike protein it reduces the immune system's ability to recognize it and mount an attack. Whereas natural infection trains the immune system to recognize the whole virus in all of the proteins not just the single S1 protein. In all of this is withstanding the fact that 99.8 percent of the people under the age of 60 have very little risk of death from this virus, especially those who do not have co-morbidities. For them the risk is far lower. That is definitely a risk reward part of the equation that leans towards more risk from the vaccine and one that those individuals need to make without force or coercion.

Continued next page…

Serious side effects are rare? Really? For those of you that have been reading my monthly newsletters, you know this is a boldface lie. And looking at the statistics posted this month, recognizing that they may represent only 1% of the total numbers will quickly make you realize the magnitude of this lie. The same thing is being reported throughout the European reporting system.



This statement infers that you can't get infected after your body builds up immunity post-vaccination. Making a reassuring statement like that which is untrue, is a deceptive lie. Once again, many reports are that as high as 60 to 70% of COVID-19 infections and hospitalizations are now in vaccinated people.



To continue to repeat this lie is truly nauseating. Many people have the risk of severe anaphylaxis and death from the polyethylene glycol in the Pfizer and Moderna vaccines. The spike protein in the vaccines force the body to make, what are now being recognized as a toxin and its actions in many people are leading to serious illness, hospitalizations, and death (this includes the Johnson and Johnson and AstraZeneca vaccines). The spike protein that begins that cascade of events in the body, is in the vaccine lipid nanoparticles. Therefore, the spike proteins which are an incredibly dangerous toxin in the body, is an unsafe ingredient in the vaccine. Dr. Michael Yeadon the former vice president of Pfizer respiratory division, clearly states this in the interview that I've posted the link for in this newsletter. Additionally, Dr. Robert Malone the inventor of the messenger RNA (mRNA) technology echoed the same concerns, including the fact that researchers developing the vaccines did not expect the lipid nanoparticles carrying the spike protein to be so widely distributed throughout the body. That distribution appears to be greatest in the ovaries, but also high in the liver, adrenals and bone marrow. This is an incredibly disturbing revelation.

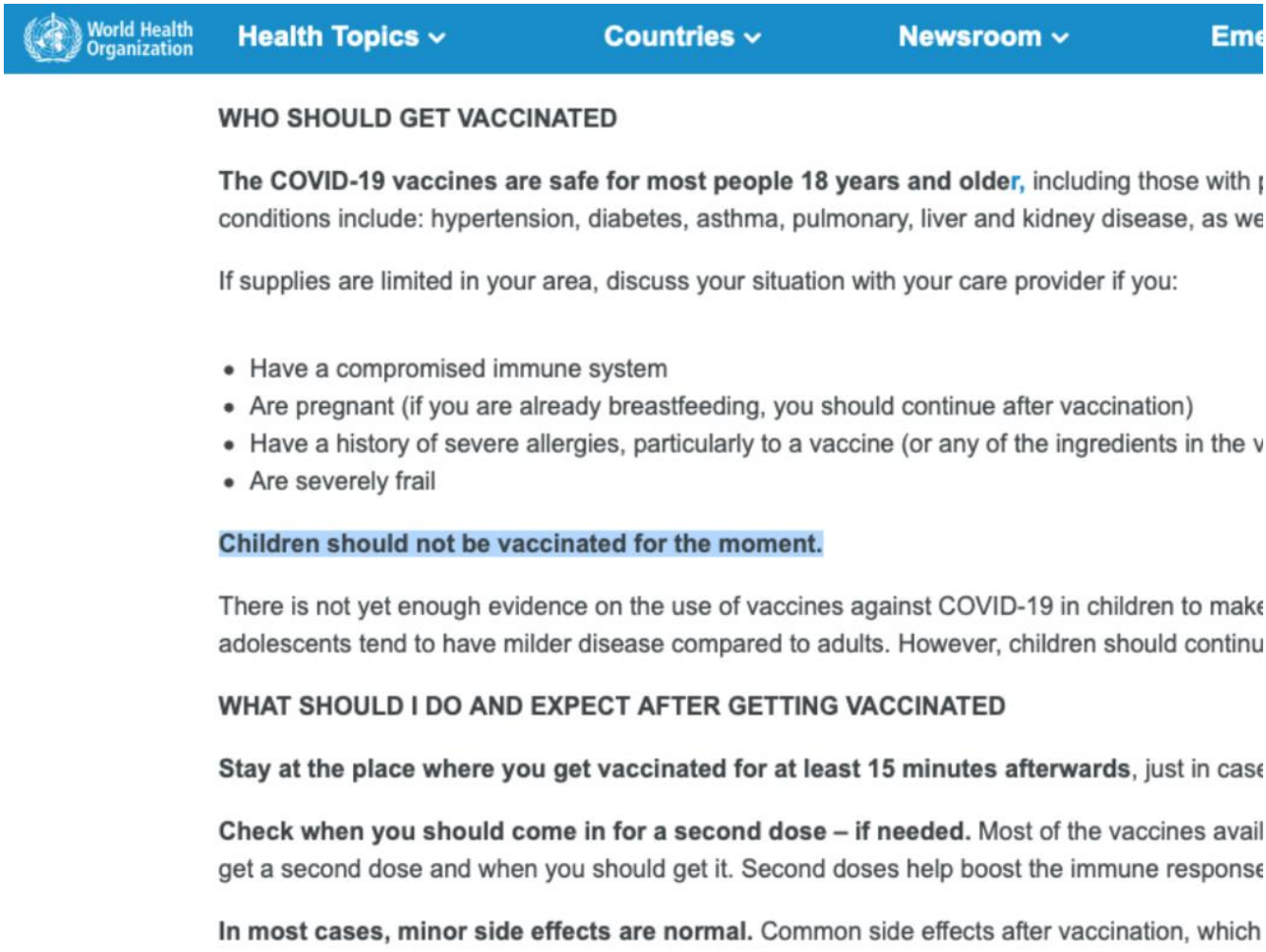
Link to WHO graphics
https://www.who.int/emergencies/diseases/novel-coronavirus-2019/covid-19-vaccines/advice

The tragic thing is that our own CDC and FDA parrot many if these same claims on their websites and official communications.

And as the lies from the W.H.O. pile up, the next story exposes just another level of dishonesty.

WHO changes their position against vaccinating children in another embarrassing about-face after external pressure

This is a post from the ***World Health Organization*** website a week ago.


World Health Organization Health Topics Countries Newsroom Eme

WHO SHOULD GET VACCINATED

The COVID-19 vaccines are safe for most people 18 years and older, including those with
conditions include: hypertension, diabetes, asthma, pulmonary, liver and kidney disease, as we

If supplies are limited in your area, discuss your situation with your care provider if you:

- Have a compromised immune system
- Are pregnant (if you are already breastfeeding, you should continue after vaccination)
- Have a history of severe allergies, particularly to a vaccine (or any of the ingredients in the v
- Are severely frail

Children should not be vaccinated for the moment.

There is not yet enough evidence on the use of vaccines against COVID-19 in children to make
adolescents tend to have milder disease compared to adults. However, children should continu

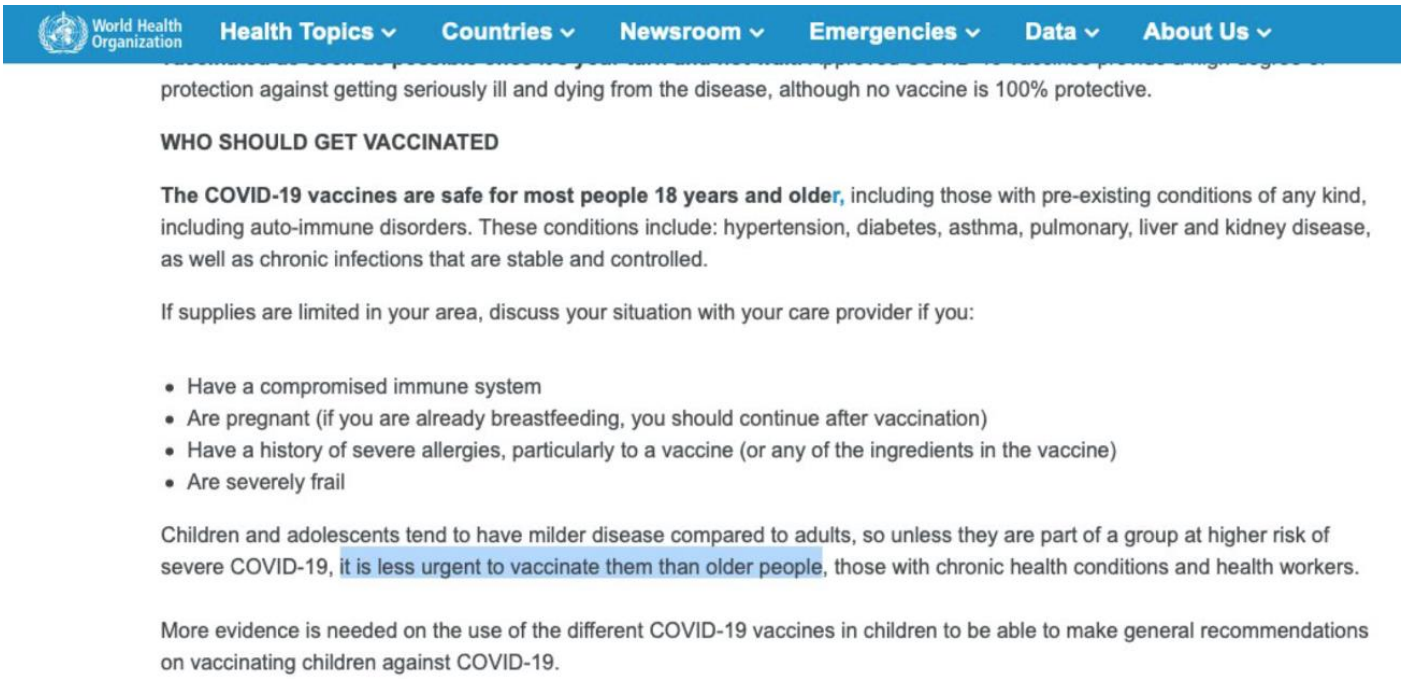
WHAT SHOULD I DO AND EXPECT AFTER GETTING VACCINATED

Stay at the place where you get vaccinated for at least 15 minutes afterwards, just in case

Check when you should come in for a second dose – if needed. Most of the vaccines avail
get a second dose and when you should get it. Second doses help boost the immune response

In most cases, minor side effects are normal. Common side effects after vaccination, which

Then overnight after I'm sure they were reamed out by big pharma and WHO knows who (pun intended) in our government this…



World Health Organization | Health Topics | Countries | Newsroom | Emergencies | Data | About Us

protection against getting seriously ill and dying from the disease, although no vaccine is 100% protective.

WHO SHOULD GET VACCINATED

The COVID-19 vaccines are safe for most people 18 years and older, including those with pre-existing conditions of any kind, including auto-immune disorders. These conditions include: hypertension, diabetes, asthma, pulmonary, liver and kidney disease, as well as chronic infections that are stable and controlled.

If supplies are limited in your area, discuss your situation with your care provider if you:

- Have a compromised immune system
- Are pregnant (if you are already breastfeeding, you should continue after vaccination)
- Have a history of severe allergies, particularly to a vaccine (or any of the ingredients in the vaccine)
- Are severely frail

Children and adolescents tend to have milder disease compared to adults, so unless they are part of a group at higher risk of severe COVID-19, it is less urgent to vaccinate them than older people, those with chronic health conditions and health workers.

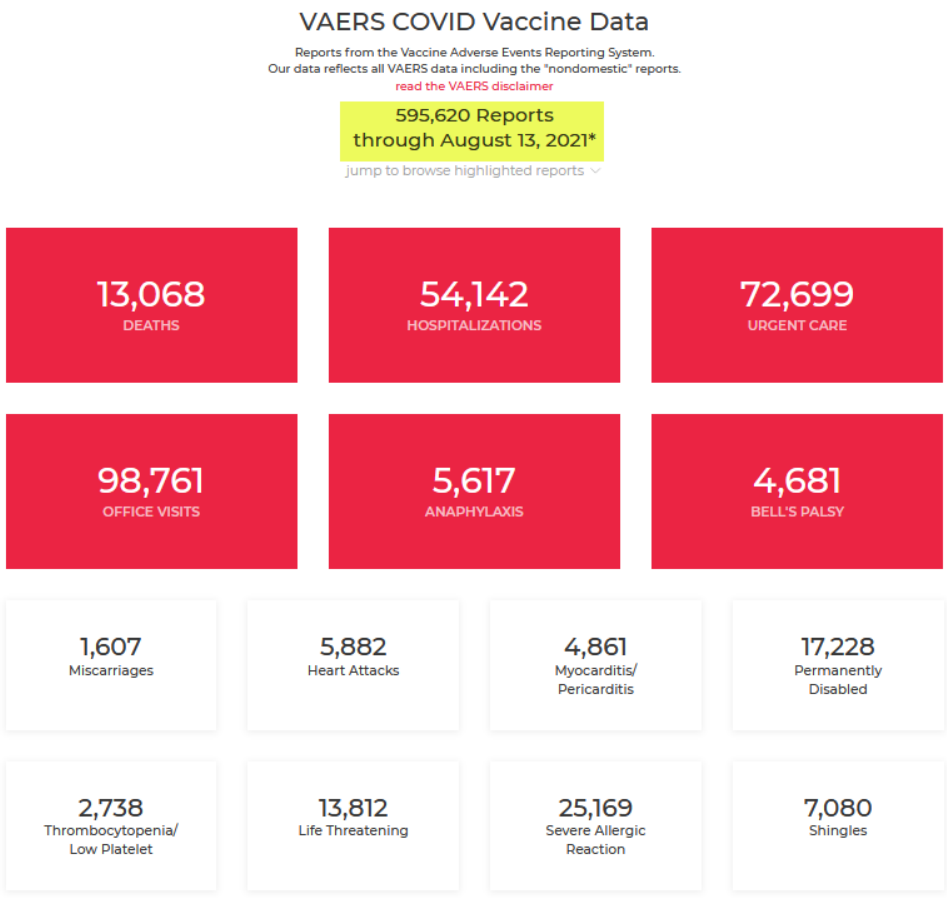
More evidence is needed on the use of the different COVID-19 vaccines in children to be able to make general recommendations on vaccinating children against COVID-19.

Not only does this once again spotlight the inconsistencies from and unreliability of WHO, but the way that they act as pawns for the people that pull their purse-strings.

Continued next page…

August 01, 2021 update

Latest VAERS update as of August 13th, 2021- A catastrophic number of casualties



Study shows that spike protein from the SARS-CoV-2 virus or from the spike protein generating vaccines damage heart tissue in unexpected ways

The study is a June 2021 pre-print release on ***BioRxiv*** titled, **Selectively expressing SARS-CoV-2 Spike protein S1 subunit in cardiomyocytes induces cardiac hypertrophy in mice.**

This study shows at least in mice, that the spike protein induces inflammation of the cardiomyocytes (heart muscle cells) independently of the ACE-2 binding action. This seems to go a long way in explaining the wide array of cardiac symptoms including myocarditis after the COVID-19 injections. As you will read, the spike

protein does not interact with murine (mouse) ACE-2, therefore they know that this is a separate and distinct reaction from the ACE-2 binding which it is most known for.

Abstract

Cardiac injury is common in hospitalized COVID-19 patients and portends poorer prognosis and higher mortality. To better understand how SARS-CoV-2 (CoV-2) damages the heart, it is critical to elucidate the biology of CoV-2 encoded proteins, each of which may play multiple pathological roles. For example, CoV-2 Spike glycoprotein (CoV-2-S) not only engages ACE2 to mediate virus infection, but also directly impairs endothelial function and can trigger innate immune responses in cultured murine macrophages. Here we tested the hypothesis that CoV-2-S damages the heart by activating cardiomyocyte (CM) innate immune responses. HCoV-NL63 is another human coronavirus with a Spike protein (NL63-S) that also engages ACE2 for virus entry but is known to only cause moderate respiratory symptoms. We found that CoV-2-S and not NL63-S interacted with Toll-like receptor 4 (TLR4), a crucial pattern recognition receptor that responsible for detecting pathogen and initiating innate immune responses. Our data show that the S1 subunit of CoV-2-S (CoV-2-S1) interacts with the extracellular leucine rich repeats-containing domain of TLR4 and activates NF-kB. To investigate the possible pathological role of CoV-2-S1 in the heart, we generated a construct that expresses membrane-localized CoV-2-S1 (S1-TM). AAV9-mediated, selective expression of the S1-TM in CMs caused heart dysfunction, induced hypertrophic remodeling, and elicited cardiac inflammation. Since CoV-2-S does not interact with murine ACE2, our study presents a novel ACE2-independent pathological role of CoV-2-S, and suggests that the circulating CoV-2-S1 is a TLR4-recognizable alarmin that may harm the CMs by triggering their innate immune responses

https://www.biorxiv.org/content/10.1101/2021.06.20.448993v1

Known harms of the spike protein

Here are four studies that demonstrate that the spike protein that the COVID shots that force our cells to make are toxins and have multiple deleterious effects in the body.

A recent experimental study showed that the SARS-CoV2 spike protein is sufficient to produce endothelial damage [see reference 23 below]. This provides a potential causal rationale for the most serious and most frequent side effects, namely, vascular problems such as thrombotic events. The vector-based COVID-19 vaccines can produce soluble spike proteins, which multiply the potential damage sites [reference 24]. The spike protein also contains domains that may bind to cholinergic receptors, thereby compromising the cholinergic anti-inflammatory pathways, enhancing inflammatory processes [reference 25]. A recent review listed several other potential side effects of COVID-19 mRNA vaccines that may also emerge later than in the observation periods covered here [reference 26].

23. Lei, Y.; Zhang, J.; Schiavon Cara, R.; He, M.; Chen, L.; Shen, H.; Zhang, Y.; Yin, Q.; Cho, Y.; Andrade, L.; et al. SARS-CoV-2 Spike Protein Impairs Endothelial Function via Downregulation of ACE 2. Circ. Res. **2021**, 128, 1323–1326. [CrossRef] [PubMed]

24. Kowarz, E.; Krutzke, L.; Reis, J.; Bracharz, S.; Kochanek, S.; Marschalek, R. "Vaccine-Induced COVID-19 Mimicry" Syndrome: Splice reactions within the SARS-CoV-2 Spike open reading frame result in Spike protein variants that may cause thromboembolic events in patients immunized with vector-based vaccines (non-peer reviewed preprint). Res. Sq. **2021**. [CrossRef]

25. Farsalinos, K.; Eliopoulos, E.; Leonidas, D.D.; Papadopoulos, G.E.; Tzartos, S.; Poulas, K. Nicotinic Cholinergic System and COVID-19: In Silico Identification of an Interaction between SARS-CoV-2 and Nicotinic Receptors with Potential Therapeutic Targeting Implications. Int. J. Mol. Sci. **2020**, 21, 5807. [CrossRef] [PubMed]

26. Seneff, S.; Nigh, G. Worse than the disease? Reviewing some possible unintended consequences of the mRNA vaccines against COVID-19. Int. J. Vaccine Theory Pract. Res. **2021**, 2, 38–79.

The lies are so blatant, can we ever believe our CDC and media again?

The talking points about 99% of the cases and 99% of the hospitalizations and "it is now a pandemic of the unvaccinated is being regurgitated 24/7. But is it true? It appears that we are now having to rely on outside governments and their published data to understand what is really happening with regard to cases, hospitalizations and deaths in the vaxxed vs the unvaxxed. I've already given other examples in this newsletter, but it warrants more evidence because the pharma-controlled messaging is in full court press mode.

One of the countries whose data completely contradicts our CDC and media reporting is the country of Israel. Israel is a very interesting case study because they made a deal with Pfizer to use their vaccine exclusively in their country. This makes their population a very interesting case study.

Continued next page…

This table shows the confirmed cases of COVID-19 from July 4th through July 10th in people who have been fully vaccinated as compared to unvaccinated. As can be clearly seen the vast majority of cases are in people who have been fully vaccinated. This runs completely contrary to what we are being told here in the US.

Israel Confirmed Cases, July 4th – July 10th, Vaccinated* vs. Unvaccinated**

Age Group	Cases, Vaccinated	Cases, Unvaccinated	Percent of Cases Vaccinated	Percent of Population*** Vaccinated
20-29	217	61	78%	77%
30-39	248	84	75%	82%
40-49	356	54	87%	85%
50-59	237	26	90%	89%
60-69	227	14	94%	91%
70-79	143	12	92%	95%
80-89	42	6	88%	91%
קבוצת גיל	נדבקים מחוסנים	נדבקים לא מחוסנים	אחוז נדבקים מחוסנים	אחוז מחוסנים באוכלוסיה

ישראל, מקרי קורונה מאומתים, 4 ביולי עד 10 ביולי, מחוסנים לעומת לא מחוסנים

Source: Israel Ministry of Health Dashboard
https://datadashboard.health.gov.il/COVID-19/general
** Vaccinated – 2 shots.*
*** Unvaccinated – No shots.*
**** Excluding population with 1 shot.*

*****Thanks to my friend Mark for that graphic. You can follow Mark's podcast on ***YouTube*** at **Coffee with MarkZ**

According to a ***Jerusalem Post*** article July 17th titled, **More than 1,000 Israelis test positive for COVID,**

their Prime Minister Bennett is quoted as saying the "vaccine is 'significantly less' effective against the Delta variant".

From the article: At the moment, around 60% of the patients in serious conditions have been vaccinated. Moreover, according to Hebrew University researchers who advise the government, around 90% of newly infected people over the age of 50 are fully vaccinated.

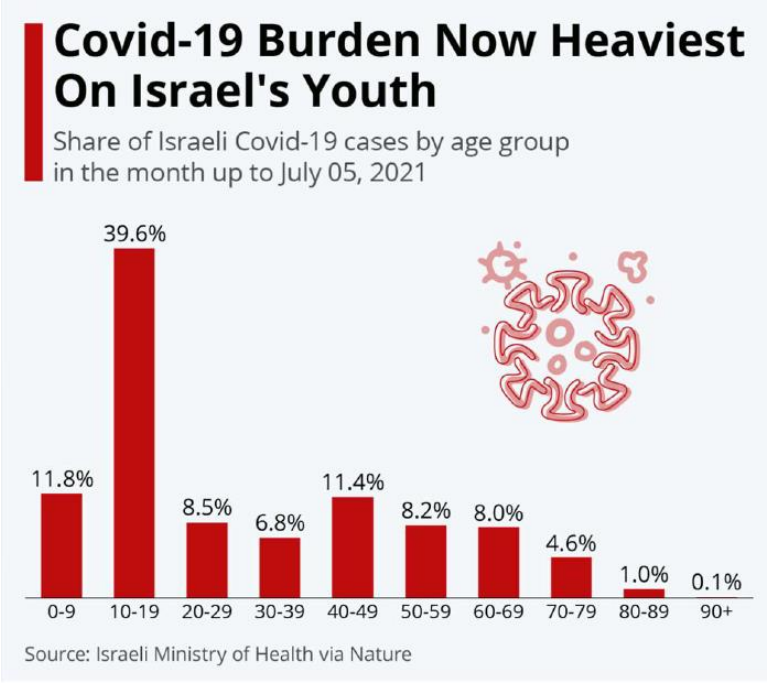
The article also said the following: "The reproduction rate (R), the number of people a sick person infects, stood at 1.37 – meaning that Covid-19 is spreading again." Parts of my brain perked up when I read this. A reproduction number (R0 for R-naught) above 1 means that there is spread of a pathogen as each infected person is expected would infect on average 1.37 people in this case. An R0 below 1 means the spread of the virus is in decline. When I read this, parts of my brain perked up. The estimated (R0) for SARS-CoV-2 has been around 2.5 throughout most of the pandemic. That is very close to the common cold, influenza and influenza like viruses. So, a current rate of 1.37 is a much slower rate of spread. Yet we are all being told that the Delta Variant is so much more contagious. If that were true, the R0 number would be much higher than the 2.5 rate

of the original Wuhan version. As an example of a very contagious virus is the measles virus. It is estimated to have an R0 number of between 16 and 18. Regardless, things don't add up.

https://www.jpost.com/breaking-news/for-first-time-since-march-855-new-coronavirus-cases-in-israel-674084

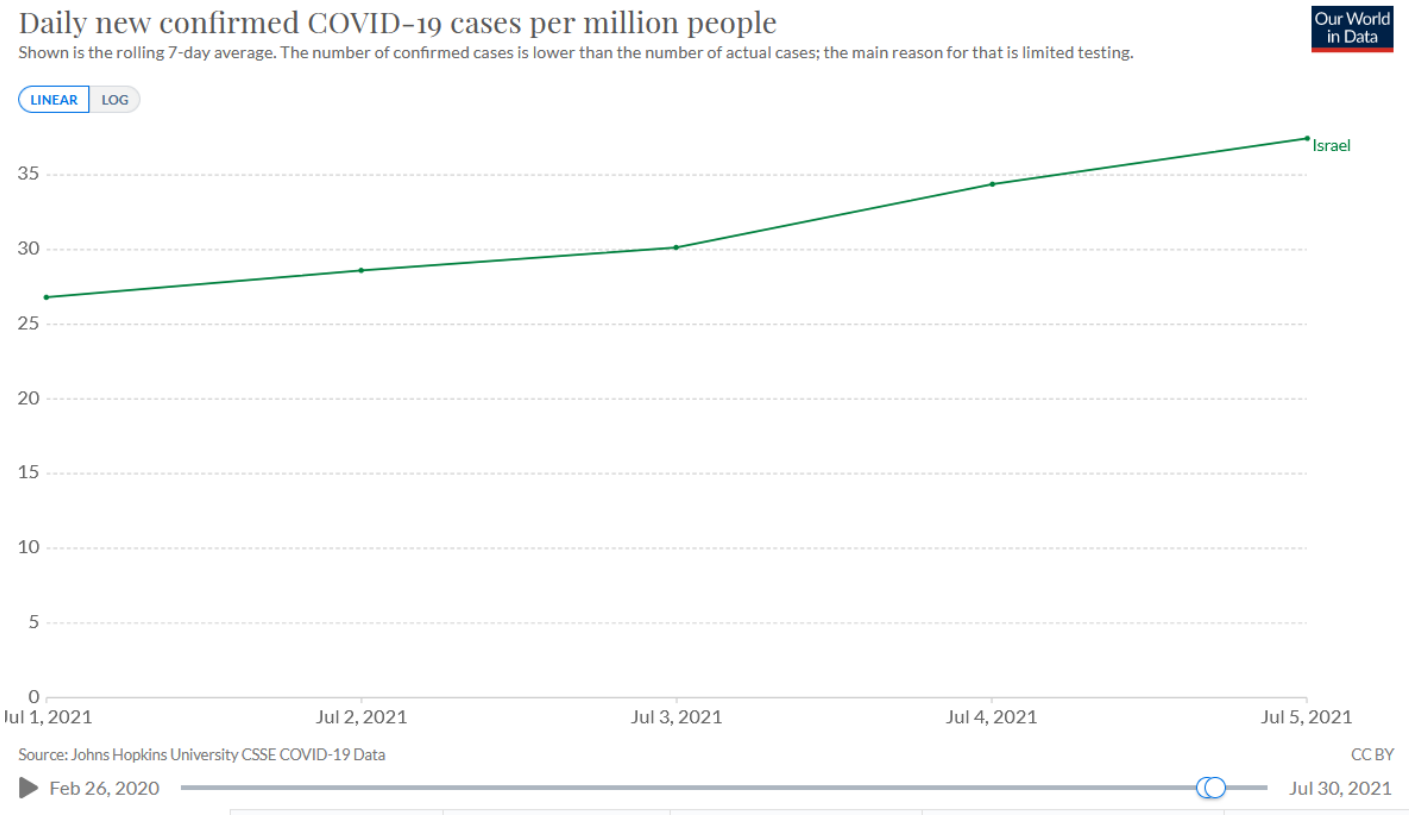
What about an increased number of cases in young people as we are hearing about?

This graph looking at the data from Israel is an example of typing something that doesn't need to be hyped.



Look at that headline on that graphic and then let's demolish it. So, 39.6% looks like a big number in the 10–19 year-old age group right? Not so fast. Notice the graph says that these numbers are for the month of July up until July 5th. That means these numbers represent five days in the first week of July. So, I did a little checking. I asked myself how many total cases were there in the increase of cases from July 1st to July 5th? That came out to 94 total cases. So that 39.6% figure represents only 37 cases. With such a low number of cases many factors could skew those numbers. Did they happen to be doing more testing with middle and high school children that particular week for example? Regardless, this is making something look like a BIG problem in the way it is portrayed, when is absolutely not.

This next graph is from ***Our World in Data*** showing the number of cases from July 1st to July 5th, 2020. On the left side representing July 1st there were 26.79 cases per million population. Population of Israel is 8.8 million. So that represents 236 cases. On the far right the graft reaches 37.45 cases per million people. Multiply that times 8.8 million and you get 330. So, the increase in the number of cases between July 1st & July 5th was only 94 (less than 20 per day).

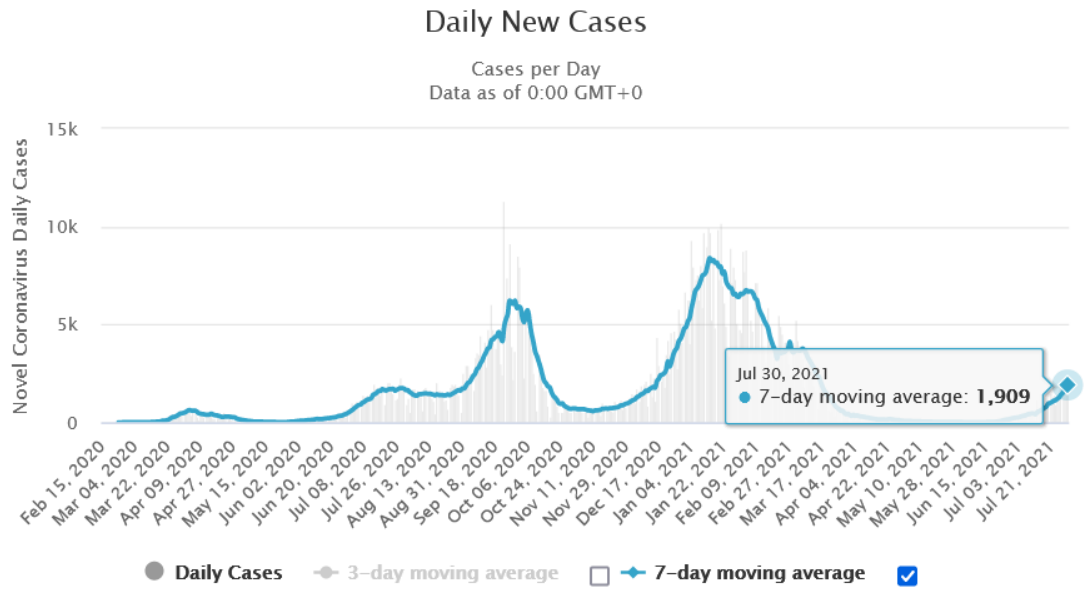


The reality is that young people are still doing extremely well against this virus and it is not only irrational to use scare tactics like this in reporting, it is corrupt and disingenuous. We will talk a lot more about all of that kind of reporting and behavior in this issue of 1200 Studies newsletter.

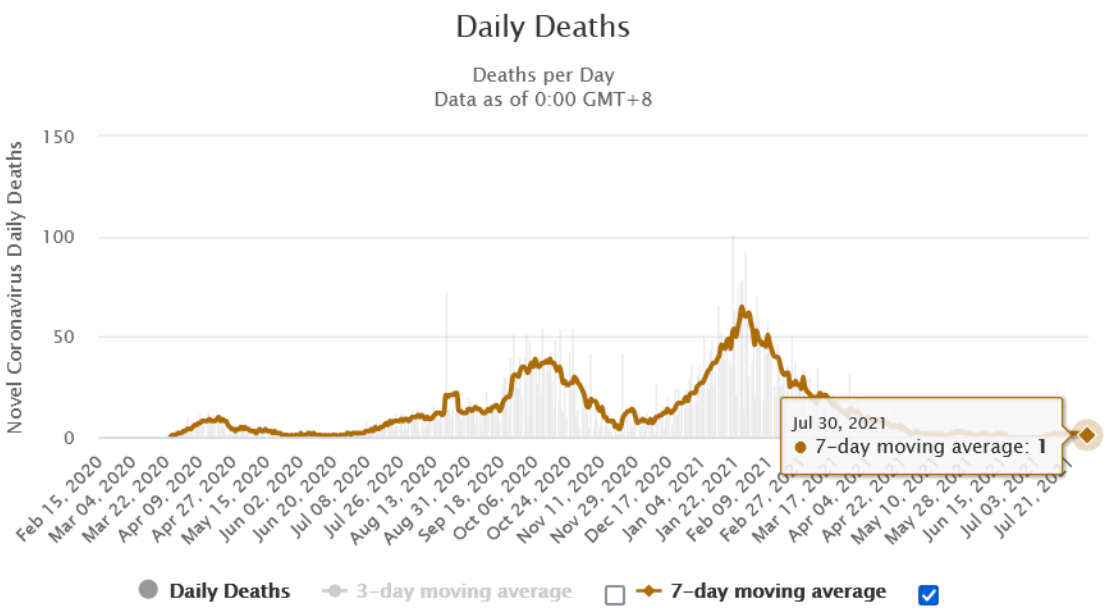
On the next page…As an example of the non-story that the image showing cases by age is presenting, let's look at what is really happening with case and death rates in Israel?

Here are the numbers for Cases and Deaths as of July 15th in Israel. Cases are up slightly, but deaths are flatlined (pun intended).

Daily New Cases in Israel



Daily New Deaths in Israel



That is a seven-day moving average of ONE death per day. As you can see, really nothing going on! The fearmongering with taking things like using that graph out of context is outrageous. If young people get the infection and recover (which 99.998% of them will), it helps us get to herd immunity faster. And in addition,

they will be less susceptible to future variants. What is important is the real-world impact on hospitalizations and deaths? Because most young people hardly know they are infected, and if they do it typically runs its course like a cold or flu.

One more point I just can't let go before we move on. If you take that 7-day average of one death per day and divide it into by the 7-day average number of cases, you get a **Case Fatality Rate (CFR)** of 0.00052. That is a CFR of 0.05%. That is INCREDIBLY LOW!!!

Yet, pharma is ready to capitalize on the lack of durability of their products

Then you have this article from Forbes. It shows that pharma is already looking to capitalize on the fact that they have made a crappy product that doesn't provide lasting protection.

https://www.forbes.com/sites/jonathanponciano/2021/07/11/declining-vaccine-efficacy-particularly-among-older-individuals-prompting-pfizers-emergency-booster-request-former-fda-chief-says/

And here in the U.S. **Pfizer to ask US regulators to authorize booster of its COVID-19 vaccine.**
https://www.israelnationalnews.com/News/News.aspx/309537

Fact checked false information. The unvaccinated are 99% of hospitalizations and deaths

As another example of the false narrative that nearly all deaths are in unvaccinated people, this is from the report from England discussed above. It is a table showing that 43% of deaths associated with the Delta Variant from February 1st, 2021 through June 14th, 2021 are in fully vaccinated people (see highlighted part).

Continued next page due to size of the graphic…

SARS-CoV-2 variants of concern and variants under investigation

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001359/Variants_of_Concern_VOC_Technical_Briefing_16.pdf

Table 4. Attendance to emergency care and deaths by vaccination status among Delta confirmed cases (sequencing and genotyping) in England, 1 February 2021 to 14 June 2021.

	Total	Cases with specimen date in past 28 days*	Unlinked	Unvaccinated	<21 days post dose 1	≥21 days post dose 1	≥14 days post dose 2
Delta cases since 1 Feb 2021 ¥	60,624	53,177	7,461	35,521	4,094	9,461	4,087
Cases with an A&E visit§ (excluding cases with the same specimen and attendance dates)‡	1,555	NA	14	1,038	116	285	102
Cases with an A&E visit§ (including cases with the same specimen and attendance dates)	2,176	NA	24	1,446	155	378	173
Cases where presentation to A&E resulted in overnight inpatient admission§ (excluding cases with the same specimen and admission dates)‡	488	NA	7	324	30	87	40
Cases where presentation to A&E resulted in overnight inpatient admission§ (including cases with the same specimen and admission dates)	806	NA	10	527	50	135	84
Deaths^	73	NA	2	34	1	10	26 43%

Data sources: Emergency care attendance and admissions from Emergency Care Dataset (ECDS), deaths from PHE daily death data series (deaths within 28 days)

And an article from Israel titled, **Natural infection vs vaccination: Which gives more protection?**

Shows statistics that natural infection is better for future protection than the vaccines. The study it reports on states that 40% of infections in the latest wave starting in May are in people vaccinated versus less than 1% in the people that have already had COVID and recovered. Another win for natural immunity!

From the article

Coronavirus patients who recovered from the virus were far less likely to become infected during the latest wave of the pandemic than people who were vaccinated against COVID, according to numbers presented to the Israeli Health Ministry.

Health Ministry data on the wave of COVID outbreaks which began this May show that Israelis with immunity from natural infection were far less likely to become infected again in comparison to Israelis who only had immunity via vaccination.

More than 7,700 new cases of the virus have been detected during the most recent wave starting in May, but just 72 of the confirmed cases were reported in people who were known to have been infected previously – that is, less than 1% of the new cases.

Roughly 40% of new cases – or more than 3,000 patients – involved people who had been infected despite being vaccinated.

With a total of 835,792 Israelis known to have recovered from the virus, the 72 instances of reinfection amount to 0.0086% of people who were already infected with COVID.

By contrast, Israelis who were vaccinated were 6.72 times more likely to get infected after the shot than after natural infection, with over 3,000 of the 5,193,499, or 0.0578%, of Israelis who were vaccinated getting infected in the latest wave.

https://www.israelnationalnews.com/News/News.aspx/309762

Another twist in the skewing of the numbers

An article published in ***The Hill*** July 7th, 2021, titled **Top health expert says vaccinated people are spreading delta variant** reveals several things including what the subtitle says, **"The CDC currently does not require vaccinated individuals to undergo regular testing"**. One is that a key reason why cases in unvaccinated seem to be climbing at a higher rate proportionally, is that the CDC is recommending the vaccinated people NOT be tested regularly. We all have heard of school or workplace situations where unvaccinated people have to be tested twice a week or some interval, but vaccinated people are not. The article even states that vaccinated individuals can still get the virus and spread the virus. I have been reporting on that from before the vaccinations began. So, this non-sensical recommendation by the CDC is contributing the spread of the virus and increase in COVID-19 cases, hospitalizations and ultimately many deaths.

From the article

Some experts, however, warn that vaccinated individuals may still be capable of contracting and transmitting COVID-19.

Speaking to Insider, Christopher Murray, the director of the **Institute for Health Metrics and Evaluation (IHME)**, said that not testing vaccinated people — as **the U.S. Centers for Disease Control and Prevention (CDC)** recommends — may be overlooking some transmission.

"We actually have states where hospitalizations are going up more than cases," Murray said, adding that **"we're probably missing a bunch of transmission in vaccinated individuals."** (bold emphasis mine)

My comment: Dah! It's all making sense now. I was asking myself, why are the vaccines failing in other countries leading to high percentages of cases and people being admitted to hospitals, even dying from COVID being in vaccinated individuals, yet we are being told that 99% of people here in the U.S. being admitted to hospitals and dying are unvaccinated. Well, if you don't test the vaccinated when they come to the hospital, you would get very skewed numbers! So the next question is, why would they not test the vaccinated? The

CDC knows that the vaccines don't protect against infection or transmission. So why in the world wouldn't they want to know what percent of vaccinated individuals are represented in cases, hospitalization numbers and deaths? Is it because it would reveal the false narrative that the vaccines are going to "help us get back to normal"? Is it because it would encourage vaccine hesitancy? Is it because it would expose the lies that have been told to the public ad nauseum about the vaccine's effectiveness? (See my article from my June newsletter on the Actual Risk Reduction (ARR) and Number Needed to Vaccinate (NNV) to benefit one person). Regardless of the reason, it shows either the corruption or the incompetency of the CDC. Neither bode well for encouraging the trust of the American people.

https://thehill.com/changing-america/well-being/longevity/561994-top-health-expert-says-vaccinated-people-are-spreading

The CDC isn't counting vaccinated people that get tests outside the hospital as positive cases. No wonder the numbers are lop-sided.

In addition to the prior story, as of May 2021, the CDC decided not to track breakthrough cases in people that have been vaccinated unless they are hospitalized or have died.

How does this make any sense? Unless you are trying to make the vaccines APPEAR more effective than they are.

The article is titled, **CDC narrows monitoring of breakthrough COVID-19 cases** and was written by Mackenzie Bean from ***BeckersHospitalReview.com***- Published Monday, May 10th, 2021

The CDC changed how it tracks breakthrough COVID-19 cases among fully vaccinated Americans this month, spurring concerns from scientists about the potential for inadequate data, reports *Bloomberg*.

The agency switched from monitoring all reported breakthrough cases to only ones that result in hospitalization or death as of May 1, Tom Clark, MD, head of the vaccine evaluation unit for the CDC's vaccine task force, told Bloomberg. The CDC's goal is to improve the quality of data collected for severe cases that have the greatest clinical and public health importance.

Some scientists have said the change may mean missing out on data needed to understand why and how breakthrough cases happen.

"We shouldn't be narrowing the focus, we should be broadening and develop a systematic plan," Eric Topol, director of the Scripps Research Translational Institute in La Jolla, Calif., told *Bloomberg*.

The CDC opted to change its strategy after finding few concerning patterns in the current data, Dr. Clark said. He added that the agency is also planning future vaccine research to compare disease severity and the frequency of variant infections among vaccinated and unvaccinated participants.

As of April 26, there have been 9,245 reports of breakthrough cases among more than 95 million Americans vaccinated, according to the CDC.

End of article

https://www.beckershospitalreview.com/public-health/cdc-narrows-monitoring-of-breakthrough-covid-19-cases.html

Public health experts blaming low vaccination rates for delta variant's spread, but much of the published data are blaming the vaccines for pushing the virus to mutate or "escape" the vaccines.

To further expand on the false narrative of the Delta Variant is being driven by the unvaccinated, ***Natural News*** added details to this story in their July 14th, 2021 article titled, **Fully vaccinated Americans are SPREADING covid's delta variant, health expert warns.**

From the article

To Murray, ***(that is Christopher Murray from IHME as referenced above)***, transmission among the vaccinated population explains why states with high vaccination rates like Washington, New York, Illinois and California are seeing a surge in coronavirus cases.

According to CDC data, the prevalence of the delta variant in the U.S. has doubled since late June and early July, when it made up 26 percent of new cases. Now it makes up nearly 52 percent of all recent infections.

The delta variant has been detected in all 50 states. Along with the four aforementioned states, the variant is also spiking in states like Missouri, Kansas, Iowa, Connecticut and Arkansas. Health experts claim without evidence that the low vaccination rate of some of these states is responsible for the recent surge in cases.

"We're already starting to see places with low vaccination rates starting to have relatively big spikes from the delta variant," said Dr. Ashish Jha, dean of the Brown University School of Public Health.

But Connecticut is the fourth most vaccinated state in the country, with 73.3 percent of its adult residents fully vaccinated. Both Iowa and Kansas also have more than 50 percent of their adult residents fully vaccinated. Missouri and Arkansas have fully vaccinated adult populations of over 40 percent.

Similar situations can be found in other settings with high vaccination rates. Los Angeles County and New York City are experiencing surges in coronavirus cases. Over 60 percent of residents aged 16 and up in Los Angeles County are fully vaccinated. Nearly 67 percent of all adults in New York are fully vaccinated as well.

https://www.naturalnews.com/2021-07-14-fully-vaccinated-americans-spreading-coronavirus-delta-variant.html

This is a list of just some of the highly credible sources that have stated publicly that they feel the virus is mutating because of vaccine pressure.

Dr. Robert Malone- One of the original inventors of the Messenger RNA technology

Dr. Geert Vandenbossche- Senior Program Officer of ***Global Alliance for Vaccines and Immunization (GAVI),*** Global Project Director Influenza Vaccines ***Bill and Melinda Gates Foundation***

Dr. Michael Yeadon- former Chief Scientific Officer (Allergy & Respiratory Research) with **Pfizer.**

Dr. Peter McCullough- Vice Chief of Medicine at ***Baylor University Medical Center***, Dallas. He has 1000 publications and > 500 citations in the ***National Library of Medicine.***

And the list goes on and on…

And here is a couple quotes from an article that Geert Vanden Bossch has posted on his website…

…mass vaccination promotes natural selection of increasingly vaccine immunity (VI)-escaping variants in the vaccinated part of the population. Taken together, mass vaccination conducted on a background of high infectivity rates enables more infectious, increasingly VI-escaping variants to expand in prevalence. This evolution inevitably results in inclining morbidity rates in both, the non-vaccinated and vaccinated population and precipitates the emergence of circulating viral variants that will eventually fully resist vaccine-mediated immunity (VMI). This is why mass vaccination campaigns should not be conducted during a pandemic of a highly mutable virus, let alone during a pandemic of more infectious variants (unless transmission-blocking vaccines are used!). It is critical to understand that a rapid decline in viral infectivity rates that is not achieved by natural infection but merely results from expedited mass vaccination campaigns will only *delay* abrupt propagation of emerging, fully vaccine-resistant viral variants and hence, only delay the occurrence of a high wave of morbidity and mortality.

This is to say that mass vaccination campaigns conducted during a pandemic of more infectious variants will precipitate resistance of more infectious Sars-Cov-2 variants to S-based Covid-19 vaccines.

Last but not least, it must be emphasized that those calling themselves 'experts' while pretending that this pandemic is 'a pandemic among the non-vaccinated' are devoid of any scientific insight in the evolutionary dynamics of Sars-CoV-2 as currently shaped by a combination of high viral infectivity and vaccine coverage rates. Neither the vaccinated (who merely believed the vaccine would protect them from Covid-19 disease) nor the non-vaccinated (who simply believe there is no need for them to take the vaccine in order to stay protected) are to be blamed for the escalation of this pandemic. **Mass vaccination is the one and only culprit.** *(Emphasis mine)*

Note: A copy of this letter has been sent to WHO, NIH, CDC, the Bill & Melinda Gates Foundation, GAVI, CEPI, FDA, EMEA and to R&D leaders from Pfizer, Moderna, Astra-Zeneca, J&J, Novavax and GSK

End of excerpts

https://www.geertvandenbossche.org/post/a-last-word-of-caution-to-all-those-pretending-the-covid-19-pandemic-is-toning-down

Yet our "health" officials continue to use misinformation to accuse those sharing accurate data and science of spreading misinformation

Does your head hurt yet? The word misinformation has been so overused that it has literally become synonymous to "opposing information". You know the saying when you point your finger at someone else, you have three fingers pointing right back at you. And as Jesus said in the Sermon on the Mount, "You hypocrite, first take the log out of your own eye, and then you will see clearly to take the speck out of your brother's eye."

So, with the last stories in mind clearly showing government data and what out officials are telling us, consider this next article titled, Surgeon General Declares War on COVID 'Misinformation'.

From the article

Dr. Vivek Murthy, the U.S. Surgeon General, says COVID-19 "misinformation is an urgent threat to public health."

Murthy, in his first surgeon general's advisory, said that "health misinformation" continues to put "lives at risk" and prolong the pandemic, NPR is reporting.

He called for a war against the "health misinformation." "COVID has really brought into sharp focus the full extent of damage that health misinformation is doing," Murthy told NPR.

Surgeon general's advisories are reserved for significant public health challenges that demand immediate attention.

As Surgeon General, my job is to help people stay safe and healthy, and without limiting the spread of health misinformation, American lives are at risk ... tackling this challenge will require an all-of-society approach, but it is critical for the long-term health of our nation."

End of excerpts

https://www.newsmax.com/us/murthy-covid-advisory-misinformation/2021/07/15/id/1028753/

European countries with the lowest vaccination rates appear to be faring the best

This is a Tweet from July 16th showing ***Our World in Data*** and ***Johns Hopkins*** data.

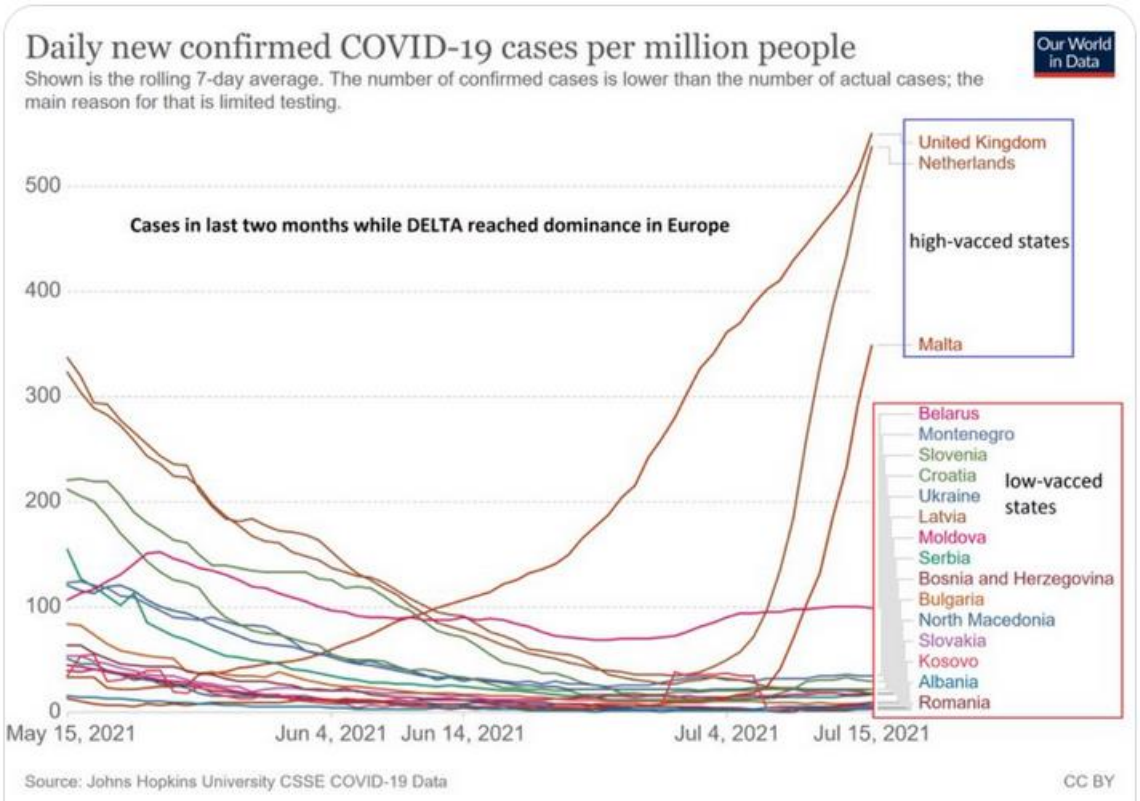
Corona Realism 🟢
@holmenkollin

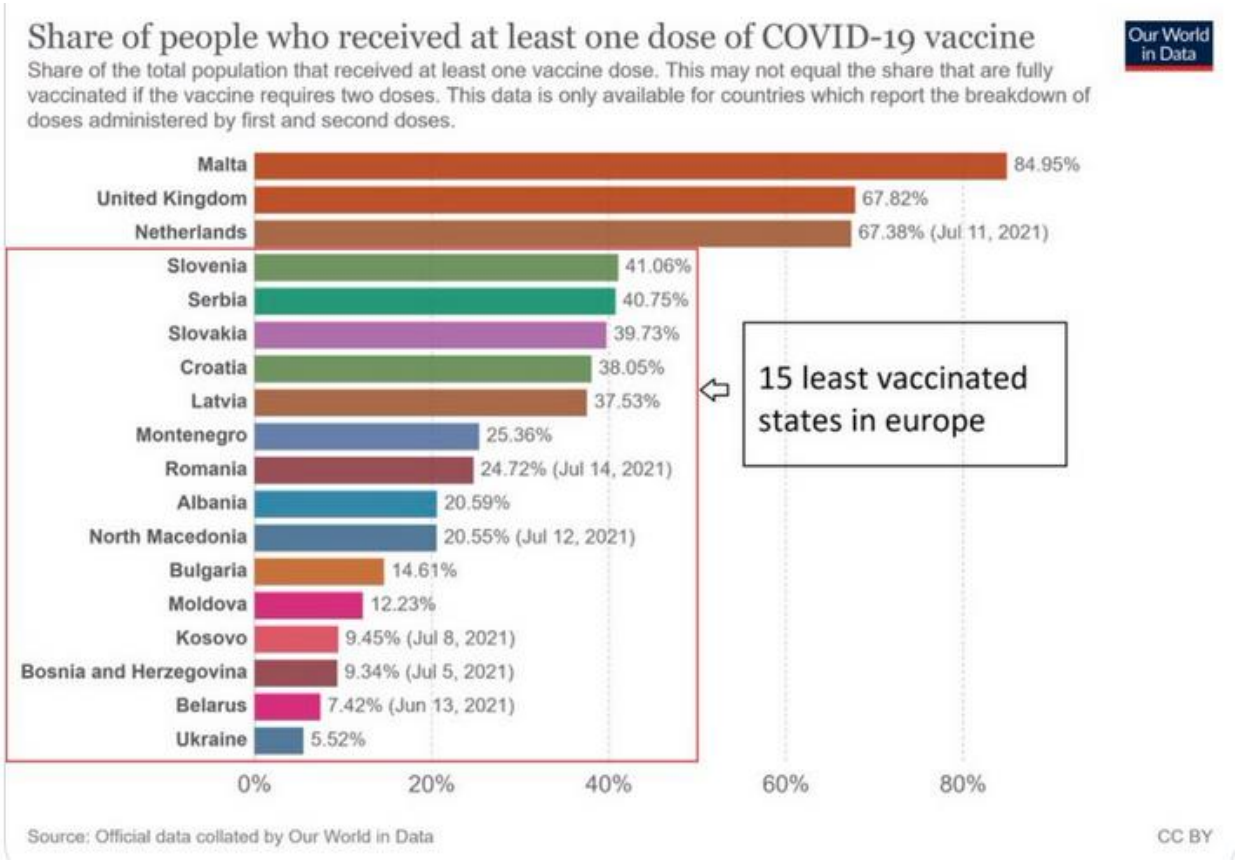
Something really odd is going on:

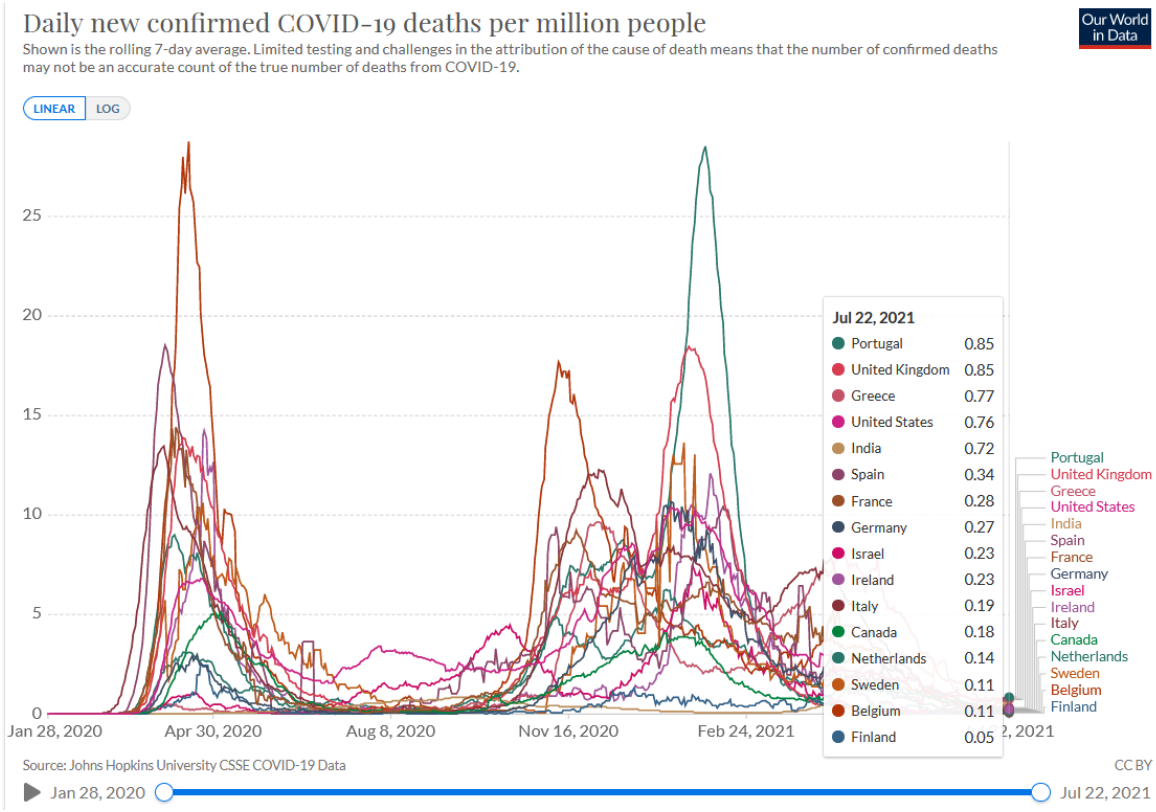
In Europe we are seeing surges at many places where most of the population has already been vaccinated.

At the same time, the 15 least vaccinated countries don't seem to face any problem.

At some point, denying this problem will get painful.




Share of people who received at least one dose of COVID-19 vaccine
Share of the total population that received at least one vaccine dose. This may not equal the share that are fully vaccinated if the vaccine requires two doses. This data is only available for countries which report the breakdown of doses administered by first and second doses.
Our World in Data
Malta 84.95%
United Kingdom 67.82%
Netherlands 67.38% (Jul 11, 2021)
Slovenia 41.06%
Serbia 40.75%
Slovakia 39.73%
Croatia 38.05%
Latvia 37.53%
Montenegro 25.36%
Romania 24.72% (Jul 14, 2021)
Albania 20.59%
North Macedonia 20.55% (Jul 12, 2021)
Bulgaria 14.61%
Moldova 12.23%
Kosovo 9.45% (Jul 8, 2021)
Bosnia and Herzegovina 9.34% (Jul 5, 2021)
Belarus 7.42% (Jun 13, 2021)
Ukraine 5.52%
15 least vaccinated states in europe
0% 20% 40% 60% 80%
Source: Official data collated by Our World in Data
CC BY


Daily new confirmed COVID-19 deaths per million people
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
LINEAR LOG
25
20
15
10
5
0
Jan 28, 2020 Apr 30, 2020 Aug 8, 2020 Nov 16, 2020 Feb 24, 2021
Jul 22, 2021
Portugal 0.85
United Kingdom 0.85
Greece 0.77
United States 0.76
India 0.72
Spain 0.34
France 0.28
Germany 0.27
Israel 0.23
Ireland 0.23
Italy 0.19
Canada 0.18
Netherlands 0.14
Sweden 0.11
Belgium 0.11
Finland 0.05
Source: Johns Hopkins University CSSE COVID-19 Data
CC BY
Jan 28, 2020
Jul 22, 2021

Notice the fear mongering is once again about case numbers and not deaths? How many people are dying from COVID-19 now as compared to other times of the pandemic?

On the graph above, you can see through the list of countries with the highest mortality rates in order and see the lines converging down near the baseline on the far right as of July 22nd, 2021. When you look at the course of the whole pandemic and you see the huge fluctuations in spikes, you can really get an appreciation for where we are now in comparison. The levels of deaths per million population as of the end of July are almost negligible as compared to nearly every other part of the pandemic.

Back to the denial and censorship of official government published data that doesn't fit the narrative spoon fed to the public. I guess we are at the point where official government data posted on its own website, peer-reviewed studies published in scientific journals and top experts from universities like Harvard, Stanford and Oxford becomes misinformation because it doesn't fit the talking points that are designed to keep the people in fear and make them do whatever the government decides is in their best interest. What happened to the America I grew up in, where people were allowed to think critically, have differing viewpoints, debate those viewpoints and express their sincerely held beliefs, evidence-based facts and published research results without fear of reprisal from the government or the tech giants that they recently revealed they are coaching about what should be considered "misinformation"?

This study details another mechanism for clotting caused by the COVID-19 vaccines other than the spike protein toxin that they force your cells to make

A peer-reviewed study in ***Nature*** published July 7th, 2021, titled **Antibody epitopes in vaccine-induced immune thrombotic thrombocytopenia**, sheds light on one of the mechanisms for which COVID-19 vaccines can cause blood clotting in the body (the thrombo part of the name). In a previous newsletter topic, I presented a study that showed how the spike protein itself can contribute to clotting disorders. In this case it's not the spike protein itself but an antibody reaction that develop against the spike protein in the vaccine cross-react with Platelet Factor IV (PF4) by combining with it and causing the activation of platelets, clumping of the platelets and thus the clotting disorder. As a result, prostaglandins and clotting factors are released. Inflammation occurs, monocytes (white blood cells) rush in and platelets begin aggregating and clumping together. Ironically, this clumping of platelets throughout the body produces a net reduction of overall platelets circulating freely in the body and thus can also contribute to bleeding disorders in that way (the cytopenia part of the name). The Platelet Factor IV complexes also begin to clump together.

In this case the AstraZeneca adenovirus vector vaccine was evaluated. This is the same type of vaccine as the Johnson & Johnson's vaccine. Because the reaction was cross-reactivity by the antibodies produced against the spike protein in the vaccine, the same thing mechanism could potentially happen with Pfizer or Moderna's M RNA vaccines.

A key element of this is study, is that they found that the antibodies can produced between 5 and 90 days after the shot, with a peak at 30-45 days. The occurrence of the clotting seems to be highest at 14-40 days with a mean of 28 days. So oftentimes people equate a vaccine adverse reaction as something that happens within 24 to 48 hours after an injection. This is not the case with this mechanism. The blood clots can form up to four weeks after the shot. This is critically important to realize when considering if these injuries are related to the vaccine itself.

The abstract

Vaccine-induced immune thrombotic thrombocytopenia (VITT) is a rare adverse effect of COVID-19 adenoviral vector vaccines1–3. VITT resembles heparin-induced thrombocytopenia (HIT) as it is associated with platelet-activating antibodies against platelet factor 4 (PF4)4; however, patients with VITT develop thrombocytopenia and thrombosis without heparin exposure. The objective of this study was to determine the binding site on PF4 of antibodies from patients with VITT. Using alanine scanning mutagenesis5, we determined the binding of VITT anti-PF4 antibodies (n=5) was restricted to 8 surface amino acids, all of which were located within the heparin binding site on PF4, and the binding was inhibited by heparin. In contrast, HIT sampled (n=10) bound to amino acids corresponding to 2 different sites on PF4. Using biolayer interferometry, we demonstrated VITT anti-PF4 antibodies had a stronger binding response against PF4 and PF4/heparin complexes than HIT antibodies; albeit, with similar dissociation rates. Our data indicates VITT antibodies can mimic the effect of heparin by binding to a similar site on PF4, allowing PF4 tetramers to cluster and form immune complexes, which in turn causes Fcγ receptor IIa (FcγRIIa; also known as CD32a)-dependent platelet activation. These results provide an explanation for VITT-antibody-induced platelet activation that could contribute to thrombosis.

Concluding remarks

In this report, we show that anti-PF4 antibodies in patients with VITT can induce platelet activation through Fc γ RIIa receptors in the presence of PF4, without heparin. However, other serum factors could also contribute to platelet activation. Previous studies found that antibodies from patients with VITT were able to activate platelets and cause platelet aggregation in the presence of adenoviral particles in a dose-dependent

manner1,23,24. Thus, it is possible that platelet activation caused by anti-PF4 antibodies in patients with VITT is not the only factor that leads to the development of thrombotic events. HIT is also propagated by various

pro-thrombotic mechanisms that could also be important in VITT, including Fc-receptor polymorphisms25, monocyte activation and tissue factor production26, and the generation of procoagulant microparticles10.

This study offers an explanation for VITT-mediated platelet activation. The patients with VITT in our study exhibited similar antibody characteristics to one another and their antibodies bound PF4 at the same site as

heparin. VITT antibodies form immune complexes without the addition of heparin or other co-factors, and activate platelets and potentially other cells through Fc γ RIIa receptors, which, in turn, could initiate coagulation at multiple points to cause thrombocytopaenia and thrombosis.

End of excerpts

For the science geeks like me, you can see a well-done video about this mechanism by Dr. Mobeen Syed (Dr. Been of Dr Been Medical Lectures) here: https://www.youtube.com/watch?v=WsRgRP1Oou0

The epitopes of the spike protein can trigger an autoimmune reaction that will target Platelet Factor IV, there are legitimate concerns about the same happening to other proteins in the body

To look at this topic I turned to a paper by ***Vinu Arumugham*** from January 2020, prior to the pandemic. His paper is titled, **Analyzing 23000+ epitopes covering 82 autoimmune diseases in the Immune Epitope Database, 57% have only one and 78% have up to two amino acid residue differences compared to animal, fungal or plant peptides present in vaccines; an unmistakable signature of the role of vaccines in their etiologies.**

One reason I feel it is important to explore this risk is that many experts in the various fields of medicine and different scientific disciplines have expressed concerns about the COVID-19 vaccines increasing the risk of autoimmunity later in the body. One particular reason for concern, is that we have also seen that these genetically engineered spike proteins in the vaccines do not always make it through the manufacturing process intact. A significant percentage of those spike proteins end up being pieces or fragments of the complete spike protein. More about this in this issue. That greatly increases the risk of these fragments matching some of the proteins within our bodies and potentially triggering an autoimmune reaction.

First, I think a definition of epitope would be in order. This definition is from ***Pacific Immunology's*** website.

What is an Epitope?

An epitope refers to the specific target against which an individual antibody binds.

When an antibody binds to a protein, it isn't binding to the entire full-length protein. Instead, it is binding to a to a segment of that protein known as an epitope. In general, an epitope is approximately five or six amino acids in length. So, a typical full-length protein sequence actually contains many different epitopes against which antibodies can bind.

And, for any given protein sequence, one will typically find that multiple unique antibodies will recognize the protein. Each of these antibodies binds to a specific epitope located on that protein.

Abstract from Vinu's paper

The ***National Institute of Allergy and Infectious Diseases (NIAID)*** sponsors the Immune Epitope Data Base (IEDB). IEDB contains epitopes identified from the medical literature and organized by diseases and categories of diseases. All epitopes (23000+) associated with 82 autoimmune diseases in humans were analyzed.

The role of animal, plant, fungal proteins contained in vaccines in the etiology of autoimmune diseases have been described in humans and animals. BLASTP was used to analyze IEDB derived epitopes for sequence alignment to animal, plant, fungal (APF) proteins present in vaccines and biologics. Specifically, the search was performed against bovine, chicken, porcine, guinea pig, African green monkey, Chinese hamster, murine, peanut, soy, wheat, corn, sesame and *Saccharomyces cerevisiae* proteomes.

The results show that 57% of epitopes differed by exactly one amino acid residue from an APF peptide. 78% of the epitopes differed by up to two amino acid residues from an APF peptide. The rest of the epitopes were either identical or differed by more than two amino acid residues.

A majority of IEDB epitopes analyzed were 9-mer peptides. Comparing randomly selected 9-mer human peptides with APF proteomes, the probability of single amino acid residue difference (SAARD) outcomes was derived. This was used to estimate the probability that actual IEDB SAARD alignments to APF peptides were merely a chance outcome. The estimates show that the probability that the observed IEDB alignments to APF being merely a chance outcome are vanishingly small. So the results make it absolutely clear that APF proteins in vaccines cause all these autoimmune diseases.

Introduction

Vaccines contain thousands of residual animal, plant and fungal (APF) proteins from the manufacturing process (1–6). 293 chicken proteins were identified in the influenza vaccine (7), for example. Actin and

vimentin proteins were detected in the Priorix Tetra vaccine (8). Immunization with homologous xenogeneic antigens resulting in autoimmune diseases has been known for at least 40 years (9). Vaccines that contain bovine proteins caused autoimmunity in dogs (10). We previously described the immunological mechanism involved in autoimmunity induction by immunization with homologous xenogeneic antigens (11).

End of excerpts

His paper goes through a number of complex calculations and interpretations that are way above my knowledge or skills to interpret. And even though this paper does not specifically address the COVID-19 vaccines, the theory and mechanisms of which of the ways that the body can misinterpret sequences of amino acids or proteins as foreign have been well established for many years. If his assertions are right regarding other vaccines with proteins injected into the body and I have no reason to doubt that they are as I have read other papers by him and found him to make use of sound scientific analysis and to be a credible researcher, it further supports the worries of many other scientists from around the world expressing similar concerns.

America's Frontline Doctors files a motion for preliminary injunction against continuation of the COVID-19 shots

On July 19th, 2021, ***America's Frontline Doctors*** filed a **PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION** in U.S. Federal Court for the Northern District of Alabama in an effort to halt the COVID-19 vaccination program. I have read the full 67 pages and am extremely impressed with the comprehensive nature of and evidence-based substantiation for their request. I am not going to include the whole document here but would like to highlight some of the key components for you. I have pasted sections 1-6 in here so you can get a good idea of the great case they are making. And if you are a freedom and Constitutional loving and supporting American, trust me when I say you are going to love the job they did! Please consider donating to their efforts.

References cited are given at the end of this topic.

TABLE OF CONTENTS

(1) 21 U.S.C. § 360bbb–3(b)(1)(C): There is No Emergency

On February 4, 2020, the Department of Health and Human Services ("DHHS") Secretary declared, pursuant to § 360bbb–3(b)(1)(C), that SARS-CoV-2 created a "public health emergency." This initial emergency declaration has been renewed repeatedly and remains in force today. The emergency declaration is the necessary legal predicate for the issuance of the Vaccine EUAs, which have allowed the mass use of the Vaccines by the American public, even before the completion of the standard regimen of clinical trials and FDA approval.

The emergency declaration and its multiple renewals are illegal, since in fact there is no underlying emergency. Assuming the accuracy of Defendants' COVID-19 death data, SARS-CoV-2 has an overall survivability rate of 99.8% globally, which increases to 99.97% for persons under the age of 70, on a par with the seasonal flu. However, Defendants' data is deliberately inflated. On March 24, 2020, DHHS changed the rules applicable to coroners and others responsible for producing death certificates and making "cause of death" determinations — **exclusively for COVID-19**. The rule change states: "COVID-19 should be reported on the death certificate for all decedents where the disease caused *or is assumed to have caused or contributed* to death." In fact, DHHS statistics show that 95% of deaths classed as "COVID-19 deaths" involve an average of four additional co-morbidities. The CDC knew "…the rules for coding and selection of the underlying cause of death are expected to result in COVID-19 being the underlying cause more often than not."

Similarly, the actual number of COVID-19 "cases" is far lower than the reported number. DHHS authorized the emergency use of the polymerase chain reaction ("PCR") test as a diagnostic tool for COVID-19, with disastrous consequences. The PCR tests are themselves experimental products, authorized by the FDA under separate EUAs. PCR test manufacturers use disclaimers like this in their product manuals: "[t]he FDA has not determined that the test is safe or effective for the detection of SARS-Co-V-2." Manufacturer inserts furnished with PCR test products include disclaimers stating that the PCR tests should NOT be used to diagnose

COVID-19. This is consistent with the warning issued by the Nobel Prize winning inventor of the PCR test that such tests are not appropriate for diagnosing disease.

The way in which the PCR tests are administered guaranties an unacceptably high number of false positive results. Cycle Threshold Value ("CT value") is essentially the number of times that a sample (usually from a

nasal swab) is magnified or amplified before a fragment of viral RNA is detected. The CT Value is exponential, and so a 40-cycle threshold means that the sample is magnified around a trillion times. The higher the CT Value, the less likely the detected fragment of viral RNA is intact, alive and infectious.5

Virtually all scientists, including Dr. Fauci, agree that any PCR test run at a CT value of 35-cycles or greater is useless. Dr. Fauci has stated (emphasis below added):

> ***What is now evolving into a bit of a standard is that if you get a cycle threshold of 35 or more that the chances of it being replication competent are miniscule****…We have patients, and it is very frustrating for the patients as well as for the physicians…somebody comes in and they repeat their PCR and it's like 37 cycle threshold…you can almost never culture virus from a 37 threshold cycle. So I think if somebody does come in with 37, 38, even 36, you gotta say, you know, it's dead nucleotides, period. In other words, it is not a COVID-19 infection.6*

A study funded by the French government showed that even at 35-cycles, the false positivity rate is as high as 97%. Despite this, a majority of the PCR tests for COVID-19 deployed under EUAs in the United States are run at 35-45 cycles in accordance with manufacturer instructions. Under the EUAs issued by the FDA, there is no flexibility to depart from the manufacturer's instructions and change the way in which the test is administered or interpreted. The chart below shows that all major PCR tests in use in the United States are run at cycles of up to 35 or higher.

Manufacturer	Manufacturer's Recommended Cycle Threshold
Xiamen Zeesan SARS-CoV-2 Test Kit (Real-time PCR)	45 cycles
Opti Sars CoV-2 RT-PCR Test	45 cycles
Quest SARS-CoV-2rRT-PCR Test	40 cycles
CDC 2019-Novel Coronavirus Real Time (RT-PCR Diagnostic Panel) Test	40 cycles
Wren Labs COVID-19 PCR Test	38 cycles
LabCorp COVID-19 RT-PCR Test	35 cycles

Further, the Defendants and their counterparts in state governments used the specter of "asymptomatic spread" — the notion that fundamentally healthy people could cause COVID-19 in others — to justify the purported emergency. But there is *no credible scientific evidence* that demonstrates that the phenomenon of "asymptomatic spread" is real. On the contrary, on June 7, 2020, Dr. Maria Von Kerkhov, head of the WHO's Emerging Diseases and Zoonosis Unit, told a press conference that from the known research, asymptomatic spread was "very rare." "From the data we have, it still seems to be rare that an asymptomatic person actually transmits onward to a secondary individual." She added for emphasis: "it's very rare." Researchers from Southern Medical University in Guangzhou, China, published a study in August 2020 concluding that asymptomatic transmission of COVID-19 is *almost non-existent*. "Asymptomatic cases were least likely to

infect their close contacts," the researchers found. A more recent study involving nearly 10 million residents of Wuhan, China found that there were no — zero — positive COVID-19 tests amongst 1,174 *close contacts* of asymptomatic cases, *indicating the complete absence of asymptomatic transmission*.

On September 9, 2020, Dr. Fauci was forced to admit in an official press conference:

> *Even if there is some asymptomatic transmission, in all the history of respiratory borne viruses of any type, asymptomatic transmission has never been the driver of outbreaks. The driver of outbreaks is always a symptomatic person, even if there is a rare a symptomatic person that might transmit, an epidemic is not driv en by asymptomatic carriers. Even if there is a rare a symptomatic person that might transmit, an epidemic is not driven by asymptomatic carriers [7].*

(2) § 360bbb–3(c)(1): There is in Fact no Serious or Life-Threatening Disease or Condition

Once an emergency has been declared and while it remains in force, the DHHS Secretary can issue and maintain EUAs "**only if**" (emphasis added) certain criteria are met. One of these criteria is that there is in fact (not simply perceived, projected or declared) "a serious or life threatening disease or condition." For the reasons set forth above in the prior section, SARS-CoV-2 and COVID-19 do not constitute a "serious or life threatening disease or condition" within the meaning of the statute. It also bears noting that the legal purpose of an emergency declaration is to bypass checks and balances typically required under law due to a crisis and that the use of such a declaration for such an arbitrary purpose could undermine the balance of power between the various branches of government.

(3) § 360bbb–3(c)(2)(A): The Vaccines Do Not Diagnose, Treat or Prevent SARS-CoV-2 or COVID-19

The DHHS Secretary can issue and maintain the Vaccine EUAs "**only if**" they are "effective" in diagnosing, treating or preventing a disease or condition.

Centers for Disease Control and Prevention ("CDC") data shows that the Vaccines are not effective in treating or preventing SARS-CoV-2 or COVID-19. Deaths from COVID-19 in those who have received the recommended dosages of the Vaccines increased from 160 as of April 30, 2021 to 535 as of June 1, 2021. Further, a total of 10,262 SARS-CoV-2 "breakthrough infections" of those who have already received the full recommended dosage of the Vaccines were reported to the CDC from 46 states and territories between January 1, 2021 and April 30, 2021.

In studying the effectiveness of a medical intervention in randomized controlled trials (often called the gold standard of study design), the most useful way to present results is in terms of Absolute Risk Reduction ("ARR"). ARR compares the impact of treatment by comparing the outcomes of the treated group and the untreated group. In other words, if 20 out of 100 untreated individuals had a negative outcome, and 10 out of 100 treated individuals had a negative outcome, the ARR would be 10% (20 - 10 = 10). **According to a study published by the NIH, the ARR for the Pfizer Vaccine is a mere 0.7%, and the ARR for the Moderna Vaccine is only 1.1%.**

From the ARR, one can calculate the Number Needed to Vaccinate ("NNV"), which signifies the number of people that must be injected before even one person benefits from the vaccine. The NNV for the Pfizer Vaccine is 119, meaning that 119 people must be injected in order to observe the reduction of a COVID-19 case in one person. The reputed journal the *Lancet* reports data indicating that the NNV may be as high as 217.

There are several factors that reduce any purported benefit of the COVID-19 Vaccines. First, it is important to note that the Vaccines were only shown to reduce symptoms – not block transmission. For over a year now, these Defendants and state-level public health authorities have told the American public that SARS-CoV-2 can be spread by people who have none of the symptoms of COVID-19, therefore Americans must mask themselves, and submit to innumerable lockdowns and restrictions, even though they are not manifestly sick. If that is the case, and these officials were not lying to the public, and asymptomatic spread is real, then what is the benefit of a vaccine that merely reduces symptoms? There isn't any.

Secondly, it appears that these Defendants either did lie about asymptomatic spread, or were simply wrong about the science. The theory of asymptomatic transmission — used as the justification for the lockdown and masking of the healthy — was based *solely* upon mathematical modeling. This theory had no actual study participants, and no peer review. The authors made the unfounded assumption that asymptomatic persons were "75% as infectious" as symptomatic persons. But in the real world, healthy false positives turned out to be merely healthy, and were never shown to be "asymptomatic" carriers of anything. Studies have shown that PCR test-positive asymptomatic individuals do not induce clinical COVID-19 disease, not even in a family member with whom they share a home and extended proximity. An enormous study of nearly ten million people in Wuhan, China showed that asymptomatic individuals testing positive for COVID-19 **never** infected others. Since asymptomatic individuals do not spread COVID-19, they do not need to be vaccinated.

(4) § 360bbb–3(c)(2)(B): The Known and Potential Risks of the Vaccine Outweigh their Known and Potential Benefits

The DHHS Secretary can issue and maintain the Vaccine EUAs "**only if**" (emphasis added) the known and potential risks of each Vaccine are outweighed by its known and potential benefits.

The typical vaccine development process takes between 10 and 15 years, and consists of the following sequential stages: research and discovery (2 to 10 years), pre-clinical animal studies (1 to 5 years), clinical human trials in four phases (typically 5 years). Phase 1 of the clinical human trials consists of healthy individuals and is focused on safety. Phase 2 consists of additional safety and dose-ranging in healthy volunteers, with the addition of a control group. Phase 3 evaluates efficacy, safety and immune response in a larger volunteer group, and requires two sequential randomized controlled trials. Phase 4 is a larger scale investigation into longer-term safety. Vaccine developers must follow this process in order to be able to generate the data the FDA needs in order to assess the safety and effectiveness of a vaccine candidate.

This 10-15 year testing process has been abandoned for purposes of the Vaccines. The first human-to-human transmission of the SARS-CoV-2 virus was not confirmed until January 20, 2020, and less than a year later both mRNA Vaccines had EUAs and for the first time in history this novel mRNA technology was being injected into millions of human beings. As of June 7, 2021, 138 million Americans, representing 42% of the population, have been fully vaccinated.

All of the stages of testing have been compressed in time, abbreviated in substance, and are overlapping, which dramatically increases the risks of the Vaccines. Plaintiffs' investigation indicates that Moderna and Pfizer designed their Vaccines in only two days. It appears that pharmaceutical companies did not independently verify the genome sequence that China released on January 11, 2020. It appears that the Vaccines were studied for only 56 days in macaques, and 28 days in mice, and then animal studies were halted. It appears that the pharmaceutical companies discarded their control groups receiving placebos, squandering the opportunity to learn about the rate of long-term complications, how long protection against the disease lasts and how well the Vaccines inhibit transmission. A number of studies were deemed unnecessary and not performed prior to administration in human subjects, including single dose toxicity, toxicokinetic, genotoxicity, carcinogenicity, prenatal and postnatal development, offspring, local tolerance, teratogenic and postnatal toxicity and fertility. The American public has not been properly informed of these dramatic departures from the standard testing process, and the risks they generate.

Plaintiff America's Frontline Doctors' ("AFLDS") medico-legal researchers have analyzed the accumulated COVID-19 Vaccine risk data, and report as follows:

Migration of the SARS-CoV-2 "Spike Protein" in the Body

The SARS-CoV-2 has a spike protein on its surface. The spike protein is what allows the virus to infect other bodies. It is clear that the spike protein is not a simple, passive structure. The spike protein is a "pathogenic protein" and a toxin that causes damage. The spike protein is itself biologically active, even without the virus. It is "fusogenic" and consequently binds more tightly to our cells, causing harm. If the purified spike protein is injected into the blood of research animals, it causes profound damage to their cardiovascular system, and crosses the blood-brain barrier to cause neurological damage. If the Vaccines were like traditional *bona fide* vaccines, and did not leave the immediate site of vaccination, typically the shoulder muscle, beyond the local draining lymph node, then the damage that the spike protein could cause might be limited.

However, the Vaccines were authorized without any studies demonstrating where the spike proteins traveled in the body following vaccination, how long they remain active and what effect they have. A group of international scientists has recently obtained the "biodistribution study" for the mRNA Vaccines from Japanese regulators. The study reveals that unlike traditional vaccines, this spike protein enters the bloodstream and circulates throughout the body over several days post-vaccination. It accumulates in a number of tissues, such as the spleen, bone marrow, liver, adrenal glands and ovaries. It fuses with receptors on our blood platelets, and also with cells lining our blood vessels. It can cause platelets to clump leading to clotting, bleeding and heart inflammation. It can also cross the blood-brain barrier and cause brain damage. It

can be transferred to infants through breast milk. The VAERS system includes reports of infants suckling from vaccinated mothers experiencing bleeding disorders in the gastrointestinal tract.

Increased Risk of Death from Vaccines

The government operated VAERS database is intended to function as an "early warning" system for potential health risks caused by vaccines. It is broadcasting a red alert. Of the 262,000 total accumulated reports in VAERS, only 1772 are not related to COVID-19. The database indicates that the total reported vaccine deaths in the first quarter of 2021 represents a 12,000% to 25,000% increase in vaccine deaths, year-on-year. In ten years (2009-2019) there were 1529 vaccine deaths, whereas in the first quarter of 2021 there have been over 4,000. Further, 99% of all reported vaccine deaths in 2021 are caused by the COVID-19 Vaccines, only 1% being caused by the numerous other vaccines reported in the system. It is estimated that VAERS only captures 1% to at best 10% of all vaccine adverse events.

Reproductive Health

The mRNA Vaccines induce our cells to manufacture (virus-free) "spike proteins." The "spike proteins" are in the same family as the naturally occurring syncytin-1 and syncytin-2 reproductive proteins in sperm, ova and placenta. Antibodies raised against the spike protein might interact with the naturally occurring syncytin proteins, adversely affecting multiple steps in human reproduction. The manufacturers did not provide data on this subject despite knowing about the spike protein's similarity to syncytin proteins for more than one year. There are now a very high number of pregnancy losses in VAERS. A study recently published in the New England Journal of Medicine, "Preliminary Findings of mRNA COVID-19 Vaccine Safety in Pregnant Persons," exposes that pregnant women receiving Vaccines during their first or second trimesters suffer an 82% spontaneous abortion rate, killing 4 out of 5 unborn babies. There are worldwide reports of irregular vaginal bleeding without clear explanation. Scientists are concerned that the Vaccines pose a substantial risk to a woman's reproductive system. This increased risk of sterility stems from an increased concentration of the spike proteins in various parts of the reproductive system after vaccination. Not enough is known to determine the risk of sterility, but it is beyond question that the risk is increased.

A leaked Pfizer document (excerpted below) exposes that Pfizer Vaccine nanoparticles accumulate in the ovaries at an extraordinarily high rate, in concentrations orders of magnitude higher than in other tissues. Billions of aggressive spike proteins are accumulating in very delicate ovarian tissues, the one place in the human body where females carry a finite number of fertile eggs.

Continued next page…

2.6.5.5B. PHARMACOKINETICS: ORGAN DISTRIBUTION CONTINUED **Test Article: [**

Sample	Total Lipid concentration (µg lipid equivalent/g [or mL]) (males and females combined)							%
	0.25 h	1 h	2 h	4 h	8 h	24 h	48 h	0.25 h
Lymph node (mandibular)	0.064	0.189	0.290	0.408	0.534	0.554	0.727	--
Lymph node (mesenteric)	0.050	0.146	0.530	0.489	0.689	0.985	1.37	--
Muscle	0.021	0.061	0.084	0.103	0.096	0.095	0.192	--
Ovaries (females)	0.104	1.34	1.64	2.34	3.09	5.24	12.3	0.001
Pancreas	0.081	0.207	0.414	0.380	0.294	0.358	0.599	0.003
Pituitary gland	0.339	0.645	0.868	0.854	0.405	0.478	0.694	0.000
Prostate (males)	0.061	0.091	0.128	0.157	0.150	0.183	0.170	0.001
Salivary glands	0.084	0.193	0.255	0.220	0.135	0.170	0.264	0.003
Skin	0.013	0.208	0.159	0.145	0.119	0.157	0.253	--
Small intestine	0.030	0.221	0.476	0.879	1.28	1.30	1.47	0.024
Spinal cord	0.043	0.097	0.169	0.250	0.106	0.085	0.112	0.001
Spleen	0.334	2.47	7.73	10.3	22.1	20.1	23.4	0.013
Stomach	0.017	0.065	0.115	0.144	0.268	0.152	0.215	0.006
Testes (males)	0.031	0.042	0.079	0.129	0.146	0.304	0.320	0.007
Thymus	0.088	0.243	0.340	0.335	0.196	0.207	0.331	0.004
Thyroid	0.155	0.536	0.842	0.851	0.544	0.578	1.00	0.000
Uterus (females)	0.043	0.203	0.305	0.140	0.287	0.289	0.456	0.002
Whole blood	1.97	4.37	5.40	3.05	1.31	0.909	0.420	--
Plasma	3.97	8.13	8.90	6.50	2.36	1.78	0.805	--
Blood:Plasma ratio[a]	0.815	0.515	0.550	0.510	0.555	0.530	0.540	--

Each baby girl is born with the total number of eggs she will ever have in her entire life. Those eggs are stored in the ovaries, and one egg is released each month of a normal menstrual cycle. When there are no more eggs, a woman stops menstruating. The reproductive system is arguably the most delicate hormonal and organ balance of all our systems. The slightest deviation in any direction results in infertility. Even in 2021, doctors and scientists do not know all the variables that cause infertility.

There is evidence to support that the Vaccines could cause permanent autoimmune rejection of the placenta. Placental inflammation resulting in stillbirths mid-pregnancy (second trimester) is seen with COVID-19 and with other similar coronaviruses. There is a case report of a woman with a normally developing pregnancy who lost the otherwise healthy baby at five months during acute COVID-19. The mother's side of the placenta was very inflamed. This "infection of the maternal side of the placenta inducing acute or chronic placental insufficiency resulting in miscarriage or fetal growth restriction was observed in 40% of pregnant women with

similar coronaviruses." The mRNA Vaccines may instigate a similar reaction as the SARS-CoV-2 virus. There is a component in the vaccine that could cause the same autoimmune rejection of the placenta, but indefinitely. Getting COVID-19 has been associated with a high risk of mid-pregnancy miscarriage because the placenta fails. The mRNA Vaccines may have precisely the same effect, however, not for just the few weeks of being sick, but forever. Repeated pregnancies would keep failing in mid-pregnancy.

On December 1, 2020, a former Pfizer Vice President and allergy and respiratory researcher, Dr. Michael Yeadon, filed an application with the European Medicines Agency, responsible for approving drugs in the European Union, seeking the immediate suspension of all SARS-CoV-2 Vaccines, citing *inter alia* the risk to pregnancies. As of April 26, 2021, the VAERS database contains over 3,000 reports of failed pregnancies associated with the Vaccines.

Vascular Disease

Salk Institute for Biological Studies researchers in collaboration with the University of San Diego, published in the journal *Circulation Research* that the spike proteins themselves

damage vascular cells, causing strokes and many other vascular problems. All of the Vaccines are causing clotting disorders (coagulopathy) in all ages. The spike proteins are known to cause clotting that the body cannot fix, such as brain thrombosis and thrombocytopenia.

None of these risks has been adequately studied in trials, or properly disclosed to healthcare professionals or Vaccine subjects.

Autoimmune Disease

The spike proteins are perceived to be foreign by the human immune system, initiating an immune response to fight them. While that is the intended therapeutic principle, it is also the case that any cell expressing spike proteins becomes a target for destruction by our own immune system. This is an autoimmune disorder and can affect virtually any organ in the body. It is likely that some proportion of spike protein will become permanently fused to long-lived human proteins and this will prime the body for prolonged autoimmune diseases. Autoimmune diseases can take years to show symptoms and many scientists are alarmed at giving young people such a trigger for possible autoimmune disease.

Neurological Damage

The brain is completely unique in structure and function, and therefore it requires an environment that is insulated against the rest of the body's functioning. The blood-brain-barrier exists so the brain can function without disruption from the rest of the body. This is a complex, multi-layered system, using several mechanisms that keep nearly all bodily functions away from the brain. Three such systems include: very tight junctions between the cells lining the blood vessels, very specific proteins that go between, and unique enzymes that alter substances that do go through the cells. Working together, the blood-brain-barrier prevents almost everything from getting in. Breaching it is generally incompatible with life.

Most unfortunately, the COVID-19 Vaccines — unlike any other vaccine ever deployed — are able to breach this barrier through various routes, including through the nerve structure in the nasal passages and through the blood vessel walls. The resulting damage begins in the arterial wall, extends to the supporting tissue outside the arteries in the brain, and from there to the actual brain nerve cells inside. The Vaccines are programmed to produce the S1 subunit of the spike protein in every cell in every Vaccine recipient, but it is this subunit that causes the brain damage and neurologic symptoms. Elderly persons are at increased risk for this brain damage.

COVID-19 patients typically have neurological symptoms including headache and loss of smell and taste, as well as brain fog, impaired consciousness, and stroke. Researchers have published a paper in the *Journal of Neurological Sciences* correlating the severity of the pulmonary distress in COVID-19 with viral spread to the brain stem, suggesting direct brain damage, not just a secondary cytokine effect. It has been shown recently by Dr. William Banks, professor of Internal Medicine at University of Washington School of Medicine, that the S1 subunit of the spike protein — the part of the SARS-CoV-2 virus that produces the COVID-19 disease and is in the Vaccines — can cross the blood brain barrier. This is even more concerning, given the high number of ACE2 receptors in the brain (the ACE2 receptor is that portion of the cell that allows the spike protein to connect to human tissue). Mice injected with the S1 subunit of the spike protein developed direct damage to the perivascular tissue. In humans, viral spike protein was detected in the brain tissues of COVID-19 patients, but not in the brain tissues of the controls. Spike protein produces endothelial damage.

There are an excessive number of brain hemorrhages associated with COVID-19, and the mechanism suggests that it is the spike protein that is responsible. The federal government's VAERS database shows a dramatic increase in adverse event reporting of neurological damage following injection with the Vaccine.

Year	**Dementia** (reports following injection with Vaccine)	**Brain Bleeding** (reports following injection with Vaccine)
2000	4	7
2010	0	17
2015	0	17
2018	21	31
2019	11	17
2020	12 → (43)	4 → (11)
2021	17 → (251)	0 → (258)

While the full impact of these Vaccines crossing the blood-brain barrier is unknown, they clearly put vaccinated individuals at a substantially increased risk of hemorrhage, neurological damage, and brain damage as demonstrated by the increased instances of such reporting in the VAERS system.

Effect on the Young

The Vaccines are more deadly or harmful to the young than the virus, and that is excluding the unknown future effects on fertility, clotting, and autoimmune disease. Those under the age of 18 face statistically zero chance of death from SARS-CoV-2 according to data published by the CDC, but there are reports of heart inflammation — both myocarditis (inflammation of the heart muscle) and pericarditis (inflammation of the lining outside the heart) — in young men, and at least one documented fatal heart attack of a healthy 15-year old boy in Colorado two days after receiving the Pfizer Vaccine.8 The CDC has admitted that "[s]ince April 2021, increased cases of myocarditis and pericarditis have been reported in the United States after the mRNA COVID-19 vaccination (Pfizer-BioNTech and Mederna), particularly in adolescents and young adults."

The Vaccines induce the cells of the recipient to manufacture trillions of spike proteins with the pathology described above. Because immune responses in the young and healthy are more vigorous than those in the old, paradoxically, the vaccines may thereby induce, in the very people least in need of assistance, a very strong immune response, including those which can damage their own cells and tissues, including by stimulating blood coagulation.

See also infra Section II.B.

Chronic Disease

Healthy children whose birthright is decades of healthy life will instead face premature death or decades of chronic disease. We cannot say what percentage will be affected with antibody dependent enhancement, neurological disorders, autoimmune disease and reproductive problems, but it is a virtual certainty that this will occur.

Antibody Dependent Enhancement

Antibody Dependent Enhancement ("ADE") occurs when SARS-CoV-2 antibodies, created by a Vaccine, instead of protecting the vaccinated person, cause a more severe or lethal case of the COVID-19 disease when the person is later exposed to SARS-CoV-2 in the wild.9 The vaccine *amplifies* the infection rather than *preventing* damage. It may only be seen after months or years of use in populations around the world.

This paradoxical reaction has been seen in other vaccines and animal trials. One well-documented example is with the Dengue fever vaccine, which resulted in avoidable deaths. Dengue fever has caused 100-400 million infections, 500,000 hospitalizations, and a 2.5% fatality rate annually worldwide. It is a leading cause of death in children in Asian and Latin American countries. Despite over 50 years of active research, a Dengue vaccine still has not gained widespread approval in large part due to the phenomenon of ADE. Vaccine manufacturer Sanofi Pharmaceutical spent 20 years and nearly $2 billion to develop the Dengue vaccine and published their results in the *New England Journal of Medicine*, which was quickly endorsed by the World Health Organization. Vigilant scientists clearly warned about the danger from ADE, which the Philippines ignored when it administered the vaccine to hundreds of thousands of children in 2016. Later, when these children were exposed in the wild, many became severely ill and 600 children died. The former head of the Dengue

department of the Research Institute for Tropical Medicine (RITM) was indicted in 2019 by the Phillipines Department of Justice for "reckless imprudence resulting [in] homicide," because he "facilitated, with undue haste," Dengvaxia's approval and its rollout among Philippine schoolchildren.

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ADE has been observed in the coronavirus setting. The original SARS-CoV-1 caused an epidemic in 2003. This virus is a coronavirus that is reported to be 78% similar to the currentSARS-CoV-2 virus that causes the disease COVID-19. Scientists attempted to create a vaccine. Of approximately 35 vaccine candidates, the best four were trialed in ferrets. The vaccines appeared to work in the ferrets. However, when those vaccinated ferrets were challenged bySARS-CoV-1 in the wild, they became very ill and died due to what we would term a sudden severe cytokine storm. The reputed journals *Science*, *Nature* and *Journal of Infectious Diseases* have all documented ADE risks in relation to the development of experimental COVID-19vaccines. The application filed by Dr. Yeadon with the European Medicines Agency on December 1, 2020 also mentioned the risk from ADE. ADE is discovered during long-term animal studies, to which the Vaccines have not been subjected.

Vaccine-Driven Disease Enhancement in the Previously Infected- *See infra* section II. C.

More Virulent Strains

Scientists are concerned that universal inoculation may create more virulent strains. This has been observed with Marek's Disease in chickens.11 A large number of chickens not at risk of death were vaccinated, and now all chickens must be vaccinated or they will die from a virus that was nonlethal prior to widespread vaccination. The current policy to pursue universal vaccination regardless of risk may exert the same evolutionary pressure toward more highly virulent strains.

Blood Supply

Presently, the vaccinated are permitted to donate their spike protein laden blood into the blood supply, which projects all of the risks discussed *supra* onto the general population of unvaccinated blood donees.

Scientists and healthcare professionals all over the world are sounding the alarm and frantically appealing to the FDA to halt the Vaccines. They have made innumerable public statements. Fifty-seven top scientists and doctors from Central and South America are calling for an immediate end to all Vaccine COVID-19 programs. Other physician-scientist groups have made similar calls, among them: Canadian Physicians, Israeli People's

Committee, Frontline COVID-19 Critical Care Alliance, World Doctors Alliance, Doctors 4 Covid Ethics, and Plaintiff America's Frontline Doctors. These are healthcare professionals in the field who are seeing the catastrophic and deadly results of the rushed Vaccines, and reputed professors of science and medicine, including the physician with the greatest number of COVID-19 scientific citations worldwide. They accuse the government of deviating from long-standing policy to protect the public. In the past, government has halted vaccine trials based on a tiny fraction — far less than 1% — of the number of unexplained deaths already recorded. The scientists all agree that the spike protein (produced by the Vaccines) *causes disease even without the virus*, which has motivated them to lend their imprimatur to, and risk their reputation and standing on, these public objections.

(5) § 360bbb–3(c)(3): There Are Adequate, Approved and Available Alternatives to the Vaccines

The DHHS Secretary can issue and maintain the Vaccine EUAs "**only if**" (emphasis added) there is no adequate, approved and available alternative to the Vaccines.

There are numerous alternative safe and effective treatments for COVID-19. These alternatives are supported by over 300 studies, including randomized controlled studies. Tens of thousands of physicians have publicly attested, and many have testified under oath, as to the safety and efficacy of the alternatives. Globally and in the United States, treatments such as Ivermectin, Budesonide, Dexamethasone, convalescent plasma and monoclonal antibodies, Vitamin D, Zinc, Azithromycin, Hydroxychloroquine, Colchicine and Remdesivir are being used to great effect, and they are far safer than the COVID-19 Vaccines.12

Doctors from the Smith Center for Infectious Diseases and Urban Health and the Saint Barnabas Medical Center have published an *Observational Study on 255 Mechanically Ventilated COVID Patients at the Beginning of the USA Pandemic*, which states: "Causal modeling establishes that weight-adjusted HCQ [Hydroxychloroquine] and AZM [Azithromycin] therapy improves survival by over 100%."13

Observational studies in Delhi and Mexico City show dramatic reductions in COVID-19 case and death counts following the mass distribution of Ivermectin. These results align with those of a study in Argentina, in which 800 healthcare professionals received Ivermectin, while another 400 did not. Of the 800, not a single person contracted COVID-19, while more than half of the control group did contract it. Dr. Pierre Kory, a lung specialist who has treated more COVID-19 patients than most doctors, representing a group of some of the most highly published physicians in the world, with over 2,000 peer reviewed publications among them, testified before the U.S. Senate in December 2020.14 He testified that based on 9 months of review of scientific data from 30 studies, Ivermectin obliterates transmission of the SARS-CoV-2 virus and is a powerful prophylactic (if you take it, you will not contract COVID-19). Four large randomized controlled trials totaling over 1500 patients demonstrate that Ivermectin is safe and effective as a prophylaxis. In early outpatient treatment, three randomized controlled trials and multiple observational studies show that Ivermectin reduces the need for hospitalization and death in statistically significant numbers. In inpatient treatment, four randomized controlled trials show that Ivermectin prevents death in a statistically significant, large magnitude. Ivermectin won the Nobel Prize in Medicine in 2015 for its impacts on global health.15

Inexplicably, the Defendants never formed or assigned a task force to research and review existing alternatives for preventing and treating COVID-19. Instead, the Defendants and others set about censoring both concerns about the Vaccines, and information about safe and effective alternatives.

(6) § 360bbb–3(e)(1)(A)(i) and (ii): Healthcare Professionals and Vaccine Candidates are Not Adequately Informed

Once an EUA has been issued, § 360bbb–3(e) mandates that the DHHS Secretary "shall [ ] establish" conditions "designed to ensure" that both healthcare professionals and Vaccine candidates receive certain minimum required information that is necessary in order to make voluntary, informed consent possible. The required disclosures that the DHHS Secretary are designed to ensure include inter alia (i) that the Vaccines are only authorized for emergency use and not FDA approved, (ii) the significant known and potential risks of the Vaccines, (iii) available alternatives to the Vaccines, (iv) the option to accept or refuse the Vaccines.

The Vaccines are Not Approved by the FDA, but Merely Authorized for Emergency Use

Defendants have failed to educate the American public that the FDA has not actually "approved" the Vaccines, and that the DHHS Secretary has *not* in fact determined that the Vaccines are "safe and effective," and on the contrary has merely determined, in accordance with the proverbial "weasel language" of the EUA statute, that "**it is reasonable to believe**" that the Vaccines "**may be**" effective and that the benefits outweigh the risks. Instead of being so educated, the public is barraged with unqualified "safe and effective" messaging from all levels of federal and state government, the private sector and the media. They hear from no higher authority than the President himself that: "The bottom line is this: I promise you they are safe. They are safe. And even more importantly, they're extremely effective. If you're vaccinated, you are protected."

The public are also unaware of the serious financial conflicts-of-interest that burden Dr. Fauci, the National Institute of Allergies and Infectious Diseases, and the Vaccines and Related Biological Products Advisory Committee which advises and consults Defendants with respect to the Vaccine EUAs, as outlined in the Complaint (ECF 10, ¶¶ 250-256). Without the information

regarding conflicts-of interest, the public cannot assess for themselves the reliability and objectivity of the analysis underpinning the EUAs.

The Significant Known and Potential Risks of the Vaccines

Perhaps the first step in understanding the potential risks of the Vaccines is to understand exactly what they are, and what they are not. The CDC defines a "vaccine" as: "A product that stimulates a person's immune system to produce immunity to a specific disease, protecting the person from that disease. Vaccines are usually administered through needle injections, but can also be administered by mouth or sprayed into the nose."16 The CDC defines "immunity" as: "Protection from an infectious disease. If you are immune to a disease, you can be exposed to it without becoming infected."17

However, the “Pfizer-BioNTech COVID-19 Vaccine” and the “Moderna COVID-19 Vaccine” do not meet the CDC’s own definitions. They do not stimulate the body to produce immunity from a disease. They are a synthetic fragment of nucleic acid embedded in a fat carrier that is introduced into human cells, not for the purpose of inducing immunity from infection with the SARS-CoV-2 virus, and not to block further transmission of the virus, but in order to lessen the symptoms of COVID-19. No published, peer-reviewed studies prove that the “Pfizer-BioNTech COVID-19 Vaccine” and the “Moderna COVID-19 Vaccine” confer immunity or stop transmission.

Further, the “Pfizer-BioNTech COVID-19 Vaccine” and the “Moderna COVID-19 Vaccine” are not “vaccines” within the common, lay understanding of the public. Since vaccines were first discovered in 1796 by Dr. Edward Jenner, who used cowpox to inoculate humans against smallpox, and called the process “vaccination” (from the Latin term *vaca* for cow), the public has had an entrenched understanding that a vaccine is a microorganism, either alive but weakened, or dead, that is introduced into the human body in order to trigger the production of antibodies that confer immunity from the targeted disease, and also prevent its transmission to others. The public are accustomed to these traditional vaccines and understand them.

The public are fundamentally uninformed about the gene therapy technology behind the “Pfizer-BioNTech COVID-19 Vaccine” and the “Moderna COVID-19 Vaccine.” Referring to the “mRNA technology” in its Vaccine, Moderna admits the “novel and unprecedented nature of this new class of medicines” in its Securities and Exchange Commission filings.18 Further, it admits that the FDA classes its Vaccine as a form of “gene therapy.” No dead or attenuated virus is used in the “Pfizer-BioNTech COVID-19 Vaccine” and the “Moderna COVID-19 Vaccine.” Rather, instructions, via a piece of lab-created genetic code (the mRNA) are injected into your body that tell your body how to make a certain “spike protein” that is purportedly useful in attacking the SARS-CoV-2 virus.

By referring to the “Pfizer-BioNTech COVID-19 Vaccine” and the “Moderna COVID-19 Vaccine” as “vaccines,” and by allowing others to do the same, the Defendants knowingly seduce and mislead the public, short-circuit independent, critical evaluation and decision-making by the consumers of these products, and vitiate their informed consent to this novel technology which is being deployed in the unsuspecting human population for the first time in history.

Meanwhile, the federal government is orchestrating a nationwide media campaign funded with $1 billion — not to ensure that the Defendants meet their statutory disclosure obligations, but solely to promote the purported benefits of the Vaccines. Simultaneously, the Associated Press, Agence France Press, British Broadcasting Corporation, CBC/Radio-Canada, European Broadcasting Union (EBU), Facebook, Financial Times, First Draft, Google/YouTube, The Hindu Times, Microsoft, Reuters, Reuters Institute for the Study of Journalism, Twitter, The Washington Post and The New York Times all participate in the “Trusted News Initiative” which has agreed to not allow any news critical of the Vaccines.

Individual physicians are being censored on social media platforms (e.g., Twitter, Facebook, Instagram, TikTok), the modern day “public square.” Plaintiff AFLDS has recorded innumerable instances of social media deleting scientific content posted by AFLDS members that runs counter to the prevailing Vaccine narrative,

and then banning them from the platform altogether as users. Facebook has blocked the streaming of entire events at which AFLDS Founder Dr. Simone Gold has been an invited guest, prior to her uttering a word. Other doctors have been banned for posting or tweeting screenshots of government database VAERS.

The censorship also extends to medical journals. In an unprecedented move, the four founding topic editors for the *Frontiers in Pharmacology* journal all resigned together due to their collective inability to publish peer reviewed scientific data on various drugs for prophylaxis and treatment of COVID-19.

Dr. Philippe Douste-Blazy, a cardiology physician, former France Health Minister, 2017 candidate for Director of the WHO and former Under-Secretary-General of the United Nations, described the censorship in chilling detail:

The Lancet boss said "Now we are not going to be able to, basically, if this continues, publish any more clinical research data, because the pharmaceutical companies are so financially powerful today and are able to use such methodologies, as to have us accept papers which are apparently, methodologically perfect but in reality, which manage to conclude what they want to conclude." … one of the greatest subjects never anyone could have believed … I have been doing research for 20 years in my life. I never thought the boss of The Lancet could say that. And the boss of the New England Journal of Medicine too. He even said it was "criminal" — the word was used by him. That is, if you will, when there is an outbreak like the COVID-19, in reality, there are people … us, we see "mortality" when you are a doctor or yourself, you see "suffering." And there are people who see "dollars" — that's it.

In many instances, highly publicized attacks on early treatment alternatives seem to be done in bad faith. For example, one study on Hydroxychloroquine overdosed study participants by administering a multiple of the standard prescribed dose, and then reported the resulting deaths as though they were not a result of the overdose, but from the medication itself administered in the proper dosages. The twenty-seven physician-scientist authors of the study were civilly indicted and criminally investigated, and still the Journal of the American Medical Association has not retracted the article.19

The Available Alternatives to the Vaccines

Information regarding available alternatives to the Vaccines has been suppressed and censored equally with information regarding the risks of the Vaccines, as aforesaid.

The Option to Accept or Refuse the Vaccines

The idea of using fear to manipulate the public is not new, and is a strategy frequently deployed in public health. In June 2020, three American public health professionals, concerned about the psychological effects of the continued use of fear-based appeals to the public in order to motivate compliance with extreme COVID-19 countermeasures, authored a piece for the journal Health Education and Behavior calling for an end to the fear-mongering. In doing so, they acknowledged that fear has become an accepted public health strategy, and that it is being deployed aggressively in the United States in response to COVID-19:

"… behavior change can result by increasing people's perceived severity and perceived susceptibility of a health issue through heightened risk appraisal coupled by raising their self-efficacy and response-efficacy about a behavioral solution. In this model, fear is used as the trigger to increase perceived susceptibility and severity."

In 1956, Dr. Alfred Biderman, a research social psychologist employed by the U.S. Air Force, published his study on techniques employed by communist captors to induce individual compliance from Air Force prisoners of war during the Korean War. The study was at the time and to some extent remains the core source for capture resistance training for the armed forces. The chart below compares the techniques used by North Korean communists with the fear-based messaging and COVID-19 countermeasures to which the American population has been subjected over the last year.

"COMMUNIST COERCIVE METHODS FOR ELICITING INDIVIDUAL COMPLIANCE".*
The Biderman Report of 1956 and COVID-19

Chart of Coercion	COVID-19
Isolation • Deprives individual of social support of his ability to resist • Makes individual dependent upon the captor • Individual develops an intense concern with self.	***Isolation*** • Social distancing • Isolation from loved ones, massive job loss • Solitary confinement semi-isolation • Quarantines, containment camps
Monopolization of Perception • Fixes all attention upon immediate predicament; • Frustrates all actions not consistent with compliance • Eliminates stimuli competing with those controlled by the captor	***Monopolization of perception*** • Restrict movement • Create monotony, boredom • Prevent gathering, meetings, concerts, sports • Dominate all media the 24/7, censor information
Induced Debility and Exhaustion • Weakens mental and physical ability to resist • People …become worn out by tension and fear	***Induced debility*** • Forced to stay at home, all media is negative • not permitted to exercise or socialize
Threats • Cultivates anxiety and despair • Gives demands and consequences for non compliance	***Threats and Intimidation*** • Threaten to close business, levy fines • Predict extension of quarantine, force vaccines • Create containment camps
Occasional Indulgences • Provides motivation for compliance • Hinders adjustment to deprivation. • Creates hope for change, reduces resistance • This keeps people unsure of what is happening.	***Occasional Indulgences*** • Allow reopening of some stores, services • Let restaurants open but only at a certain capacity • Increase more people allowed to gather • Follow concessions with tougher rules
Demonstrate Omnipotence • Demonstrates futility of resistance • Shows who is in charge • Provides positive motivation for compliance	***Demonstrate Ominpotence*** • Shut down entire economies across the world • Create money out of nowhere, force dependency • Develop *total* surveillance with nanochips and 5G
Degradation • Makes resistance seem worse than compliance • Creates feelings of helplessness. • Creates fear of freedom, dependence upon captors	***Humiliation or Degradation techniques*** • Shame people who refuse masks, don't distance • Make people stand on circles and between lines • Make people stand outside and wait in queues • Sanitation stations in every shop
Enforcing trivial demands • Develops habit of compliance • Demands made are illogical and contradictory • Rules on compliance may change • Reinforces who is in control	***Enforcing trivial demands*** • Family members must stand apart • Masks in home and even when having sex • Random limits on people allowed to be together • Sanitizers to be used over and over in a day

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The Chart of Coercion above is drawn from the Biderman Report on communist brainwashing techniques used by the Chinese and North Koreans on captured American servicemen to make them psychological as well as physical prisoners. Dr. Alfred D. Biderman M.A. and presented his Report at the New York Acadamy of Medicine Nov 13, 1956. Compare right column with your experience this year.

After a year of sustained psychological manipulation, the population is now weakened, frightened, desperate for a return of their freedoms, prosperity and normal lives, and especially vulnerable to pressure to take the Vaccine. The lockdowns and shutdowns, the myriad rules and regulations, the confusing and self-contradictory controls, the enforced docility, and the consequent demoralization, anxiety and helplessness are typical of authoritarian and totalitarian conditions. This degree of systemic and purposeful coercion means that Americans cannot give truly free and voluntary informed consent to the Vaccines.

At the same time, the population is being subjected to an aggressive, coordinated media campaign promoting the Vaccines funded by the federal government with $1 billion. The media campaign is reinforced by a system of coercive rewards and penalties designed to induce vaccination. The federal government is offering a range of its own incentives, including free childcare. The Ohio Governor rewarded those Ohio residents accepting the Vaccines by allowing them to enter into the "Vaxamillion" lottery with a total $5 million prize and the chance to win a fully funded college education, while barring entry for residents who decline the Vaccines. In New York, metro stations offer free passes to those receiving the Vaccine in the station. West Virginia is running a lottery exclusively for the vaccinated with free custom guns, trucks and lifetime hunting and fishing licenses, a free college education, and cash payments of $1.5 million and $600,000 as the prizes. Previously, the state offered a $100 savings bond for each injection with a Vaccine. New Mexican residents accepting the Vaccines will be entered into weekly drawings to take home a $250,000 prize, and those fully vaccinated by early August could win the grand prize of $5 million. In Oregon, the vaccinated can win $1 million, or one of 36 separate $10,000 prizes through the state's "Take Your Shot" campaign. Other state and local governments are partnering with fast food chains to offer free pizza, ice cream, hamburgers and other foods to the vaccinated. Many people are desperate following the last year of economic destruction and deprivation of basic freedoms, and they are especially vulnerable to this coercion.

The penalties take many forms, among them:

• Using guilt and shame to make unvaccinated children and adults feel badly about themselves for refusing the Vaccines.

• Threatening the unvaccinated with false fears and anxieties about COVID-19, especially children who are at no risk statistically.

• Removing the rights of those who are unvaccinated, including: o Being prohibited from working

o Being prohibited from attending school or college

o Being limited in the ability to travel in buses, trains and planes

o Being prohibited from traveling outside the United States

o Being excluded from public and private events, such as performing arts venues.

Most recently, the President has announced an aggressive campaign to visit the homes of the unvaccinated, not for the purpose of ensuring that they have all of the information they might need in order to make fully

informed, voluntary decisions about the Vaccines (the information required by § 360bbb–3(e)(1)(A)(i) and (ii)), but instead for the purpose of pressuring them to be injected with the Vaccine so that the Administration can reach its goal of having 70% of the American population vaccinated. He said: "Now we need to go to community by community, neighborhood by neighborhood, and oftentimes, door to door — literally knocking on doors — to get help to the remaining people protected from the virus."20 The White House press secretary referred to the door-knockers who would enter our communities to pressure us to accept the Vaccines using the language of war, as "strike forces." Then, after Dr. Fauci stated his opinion in mainstream media news outlets that "at the local level . . . there should be more mandates, there really should be", the press secretary announced that the Biden Administration would support state and local Vaccine mandates.[21]

A study recently published in the International Journal of Clinical Practice, "Informed Consent Disclosure to Vaccine Trial Subjects of Risk ofCOVID-19 Vaccines Worsening Clinical Disease,"[22]concludes:

> *COVID-19 vaccines designed to elicit neutralizing antibodies may sensitise vaccine recipients to more severe disease than if they were not vaccinated. Vaccines for SARS, MERS and RSV have never been approved, and the data generated in the development and testing of these vaccines suggest a serious mechanistic concern: that vaccines designed empirically using the traditional approach (consisting of the unmodified or minimally modified coronavirus viral spike to elicit neutralising antibodies), be they composed of protein, viral vector, DNA or RNA and irrespective of delivery method, may worsen COVID-19 disease via antibody-dependent enhancement(ADE).* ***This risk is sufficiently obscured in clinical trial protocols and consent forms for ongoingCOVID-19 vaccine trials that adequate patient comprehension of this risk is unlikely to occur, obviating truly informed consent by subjects in these trials.***
>
> (emphasis added).

Plaintiffs' expert Dr. Lee Merritt is a fully licensed, board certified surgeon, and has been actively engaged in medical practice for over 35 years. As Chief of Staff, Chief of Surgery and Chief of Credentialing at a regional medical center, she participated in hospital administration and education with respect to *inter alia* informed consent. She states: "I have read the Complaint and Motion for Preliminary Injunction in the above captioned matter, specifically the allegations related to informed consent. I agree with the informed consent allegations contained in the Complaint and Motion for Preliminary Injunction" (*see* Declaration of Dr. Lee Merritt at Exhibit A). Dr. Merritt has provided an example of some of the language that she would recommend using for the purpose of obtaining voluntary, informed consent to the Vaccines.

The Injunction goes on to cover the VAERS and other reporting systems and monitoring of adverse events, immunity in people that have had SARS-CoV-2 infection or recovered from COVID-19, the reasons why children do not need to be vaccinated, whistleblower testimony about the deaths tally from the vaccines being 45,000 and then all of the laws and court decisions that have laid the groundwork for precedence with this injunction.

References listed in the sections I have presented.

1 Emergency Use Authorization ("EUA") issued December 11, 2020. *See* https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine.

2 EUA issued December 18, 2020. *See* https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/moderna-covid-19-vaccine.

3 EUA issued February 27, 2021. *See* https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/janssen-covid-19-vaccine.

4 For the sake of clarity of reference, Plaintiffs are using the names given to the Pfizer and Moderna EUA medical products by their manufacturers and the Defendants. However, Plaintiffs reject the highly misleading use of the term "vaccine" to describe the Pfizer and Moderna EUA medical products, since they are not vaccines within the settled meaning of the term and instead are more precisely described as a form of genetic manipulation.

5 https://www.oralhealthgroup.com/features/the-problems-with-the-covid-19-test-a-necessary-understanding/ (last visited July 15, 2021).

6 https://1027kearneymo.com/kpgz-news/2020/11/9/covid-tests-may-inflate-numbers-by-picking-up-dead-virus (last visited July 15, 2021).

7 https://www.statnews.com/2021/01/23/asymptomatic-infection-blunder-covid-19-spin-out-of-control/ (last visited July 15, 2021).

8 https://archive.is/mEBcV (last visited July 15, 2021).

9 https://www.nature.com/articles/s41564-020-00789-5 (last visited July 15, 2021).

10 https://trialsitenews.com/philippine-dengue-vaccine-criminal-indictments-includes-president-of-sanofi-pasteur-their-fda (last visited July 15, 2021).

11 https://en.wikipedia.org/wiki/Marek%27s_disease (last visited July 15, 2021).

12 *Numerous studies can be reviewed here: https://c19early.com (last visited June 7, 2021).*

13 https://www.medrxiv.org/content/10.1101/2021.05.28.21258012v1 (last visited July 15, 2021).

14 https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwji38elkuPxAhW eAp0JHZhzAeMQFnoECAIQAA&url=https%3A%2F%2Fwww.hsgac.senate.gov%2Fdownload%2Fkory12-08-2020&usg=AOvVaw3z2a7PpDLWgyfSrp3miF1y (last visited July 15, 2021).

15 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4692067/ (last visited July 15, 2021).

16 *See* https://www.cdc.gov/vaccines/vac-gen/imz-basics.htm (last visited July 9, 2021).

17 *Id.*

18 *See* www.sec.gov/Archives/edgar/data/1682852/000168285220000017/mrna-20200630.htm (last visited July 6, 2021).

19 https://www.medrxiv.org/content/medrxiv/early/2020/04/16/2020.04.07.20056424.full.pdf (last visited July 15, 2021).

20 See “Biden admin launching door-to-door push to vaccinate Americans, sparks major backlash,” https://www.foxnews.com/media/biden-admin-door-to-door-coronavirus-vaccines (last visited July 15, 2021).

21*See* “Biden will back local vaccine mandates,” https://thehill.com/changing-america/well-being/prevention-cures/562622-biden-will-back-local-vaccine-mandates (last visited July 15, 2021).

22*See*https://onlinelibrary.wiley.com/doi/epdf/10.1111/ijcp.13795 (last visited July 17, 2021).

A great explanation of what we may be beginning to see and what many scientists have been warning about regarding the failure of the vaccines and possible devastation to come

I recently ran across an excellent article titled **Is a Coronavirus Vaccine a Ticking Time Bomb?** that really articulates the problem that may be beginning to happen according to some the top scientists and vaccine experts. And I pray this is not the case. If what we may be beginning to see happening with mutating strains of the virus, the vaccine failing, an increase in serious COVID-19 illness and deaths in some vaccinated individuals, is related to this phenomenon, we may be in big trouble, especially those that have been vaccinated. This article was written in August of 2020, almost exactly a year ago. This is the problem that has been predicted by Geert Vanden Bossche, Dr. Michael Yeadon, and many others. The phenomenon I am referring to is the problem of Antibody Dependent Enhancement (ADE). I hope that this article written by Dr. Doug Corrigan, a PhD in biochemistry and molecular biology which really hit the nail on the head will help you understand the game of Russian Roulette that we are playing with the population of the world. And one thing that I didn’t completely understand at first, but is a critical point, is that the resulting ADE and illness a person may suffer as a result, may not show up for many weeks or months after they have been vaccinated.

So, I decided to publish the entire article here in my newsletter. I feel that it is definitely worth the four pages it occupies. You can see the link to Dr. Corrigan’s web site at the end. He has written some very interesting articles that you’ll find there as well.

The article starting on the next page…

Will a vaccine to SARS-CoV-2 actually make the problem worse? Although not a certainty, all of the current data says that this prospect is a real possibility that needs to be paid careful attention to. If you stay with me, I’ll explain why.

First, let’s set aside the debate surrounding the topic of whether vaccines work and the negative health consequences due to the components of the vaccine. No matter where you stand on the vaccine issue, I’m not asking anyone to capitulate on this point. I’m just asking that this issue be set aside, because in this instance this argument is completely irrelevant. Even without bringing any other issue into the vaccine debate, a

coronavirus vaccine is a highly dangerous undertaking due to a peculiar trojan horse mechanism known as Antibody Dependent Enhancement (ADE). Regardless of someone's conviction about vaccines, this point needs to be acknowledged. In the remaining portion of this article, I'm going to explain how ADE works and the future perils it may bring.

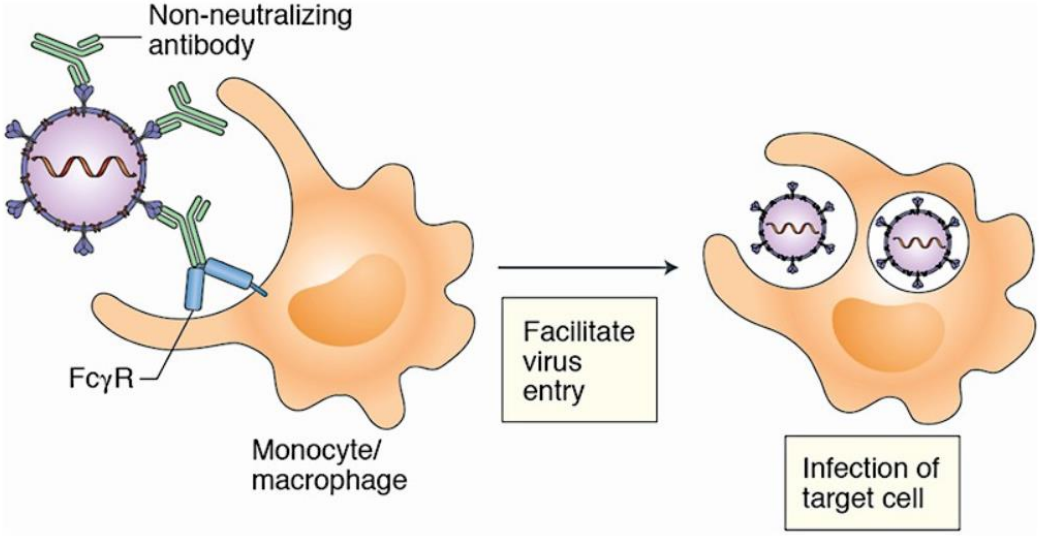
For a vaccine to work, our immune system needs to be stimulated to produce a neutralizing antibody, as opposed to a non-neutralizing antibody. A neutralizing antibody is one that can recognize and bind to some region ('epitope') of the virus, and that subsequently results in the virus either not entering or replicating in your cells.

A non-neutralizing antibody is one that can bind to the virus, but for some reason, the antibody fails to neutralize the infectivity of the virus. This can occur, for example, if the antibody doesn't bind tightly enough to the virus, or the percentage of the surface area of the virus covered by the antibody is too low, or the concentration of the antibody is not high enough. Basically, there is some type of generic binding of the antibody to the virus, but it fails to neutralize the virus.

In some viruses, if a person harbors a non-neutralizing antibody to the virus, a subsequent infection by the virus can cause that person to elicit a more severe reaction to the virus due to the presence of the non-neutralizing antibody. This is not true for all viruses, only particular ones. This is called Antibody Dependent Enhancement (ADE), and is a common problem with Dengue Virus, Ebola Virus, HIV, RSV, and the family of coronaviruses. In fact, this problem of ADE is a major reason why many previous vaccine trials for other coronaviruses failed. Major safety concerns were observed in animal models. If ADE occurs in an individual, their response to the virus can be worse than their response if they had never developed an antibody in the first place.

An antibody can be rendered a non-neutralizing antibody simply because it doesn't bind to the right portion of the virus to neutralize it, or the antibody binds too weakly to the virus. This can also occur if a neutralizing antibody's concentration falls over time and is now no longer of sufficient concentration to cause neutralization of the virus. In addition, a neutralizing antibody can subsequently transition to non-neutralizing antibody when encountering a different strain of the virus.

What does ADE entail? The exact mechanism of ADE in SARS is not known, but the leading theory is described as follows: In certain viruses, the binding of a non-neutralizing antibody to the virus can direct the virus to enter and infect your immune cells. This occurs through a receptor called FcγRII. FcγRII is expressed on the outside of many tissues of our body, and in particular, in monocyte derived macrophages, which are a type of white blood cell. In other words, the presence of the non-neutralizing antibody now directs the virus to infect cells of your immune system, and these viruses are then able to replicate in these cells and wreak havoc on your immune response. One end of the antibody grabs onto the virus, and the other end of the antibody grabs onto an immune cell. Essentially, the non-neutralizing antibody enables the virus to hitch a ride to infect immune cells. You can see this in this picture.



This can cause a hyperinflammatory response, a cytokine storm, and a generally dysregulation of the immune system that allows the virus to cause more damage to our lungs and other organs of our body. In addition, new cell types throughout our body are now susceptible to viral infection due to the additional viral entry pathway facilitated by the FcγRII receptor, which is expressed on many different cell types.

What this means is that you can be given a vaccine, which causes your immune system to produce an antibody to the vaccine, and then when your body is actually challenged with the real pathogen, the infection is much worse than if you had not been vaccinated.

Again, this is not seen in all viruses, or even in all strains of a given virus, and there is a great deal that scientists don't understand about the complete set of factors that dictate when and if ADE may occur. It's quite likely that genetic factors as well as the health status of the individual may play a role on modulating this response. That being said, there are many studies (in the reference section below) that demonstrate that ADE is a persistent problem with coronaviruses in general, and in particular, with SARS-related viruses. Less is known, of course, with respect to SARS-CoV-2, but the genetic and structural similarities between the SARS-CoV-2 and the other coronaviruses strongly suggests that this risk is real.

ADE has proven to be a serious challenge with coronavirus vaccines, and this is the primary reason many have failed in early in-vitro or animal trials. For example, rhesus macaques who were vaccinated with the Spike protein of the SARS-CoV virus demonstrated severe acute lung injury when challenged with SARS-CoV, while monkeys who were not vaccinated did not. Similarly, mice who were immunized with one of four different SARS-CoV vaccines showed histopathological changes in the lungs with eosinophil infiltration after being challenged with SARS-CoV virus. This did not occur in the controls that had not been vaccinated. A similar problem occurred in the development of a vaccine for FIPV, which is a feline coronavirus.

For a vaccine to work, vaccine developers will need to find a way to circumvent the ADE problem. This will require a very novel solution, and it may not be achievable, or at the very least, predictable. In addition, the

vaccine must not induce ADE in subsequent strains of SARS-CoV-2 that emerge over time, or to other endemic coronaviruses that circulate every year and cause the common cold.

A major trigger for ADE is viral mutation. Changes to the amino acid sequence of the Spike Protein (which is the protein on the virus that facilitates entry into our cells via the ACE2 receptor) can cause antigenic drift. What this means is that an antibody that was once neutralizing can become a non-neutralizing antibody because the antigen has slightly changed. Therefore, mutations in the Spike protein that naturally occur with coronaviruses could presumably result in ADE. Since these future strains are not predictable, it is impossible to predict if ADE will become a problem at a future date.

This inherent unpredictability problem is highlighted in the following scenario: A coronavirus vaccine may not be dangerous initially. If the initial testing looks positive, mass vaccination efforts would presumably be administered to a large portion of the population. In the first year or two, it may appear that there is no real safety issue, and over time, a greater percentage of the world population will be vaccinated due to this perceived "safety". During this interim period, the virus is busy mutating. Eventually, the antibodies that vaccinated individuals have floating around in their bloodstream are now rendered non-neutralizing because they fail to bind to the virus with the same affinity due to the structural change resulting from the mutation. Declining concentrations of the antibody over time would also contribute to this shift towards non-neutralization. When these previously vaccinate people are infected with this different strain of SARS-CoV-2, they could experience a much more severe reaction to the virus.

Ironically, in this scenario, this vaccine made the virus more pathogenic rather than less pathogenic. This is not something that vaccine producers would be able predict or test for with any level of real confidence at the outset, and it would only become evident at a later time.

If and when this does occur, who will be liable?

Does this vaccine industry know about this problem? The answer is yes, they do.

Quoting a Nature Biotechnology news article published on June 5th, 2020: ""It's important to talk about it [ADE]," says Gregory Glenn, president of R&D at Novavax, which launched its COVID-19 vaccine trial in May. But "we can't be overly cautious. People are dying. So we need to be aggressive here.""

And from the same article:

"ADE "is a genuine concern," says virologist Kevin Gilligan, a senior consultant with Biologics Consulting, who advises thorough safety studies. "Because if the gun is jumped, and a vaccine is widely distributed that is disease enhancing, that would be worse than actually not doing any vaccination at all."" The vaccine industry is aware of this problem. The degree to which they are taking it seriously, is another question.

While many vaccine developers are aware of the problem, some of them are approaching the problem with more Laissez-faire attitude. They see this problem as "theoretical," and not guaranteed, with the idea that animal trials should rule out the potential of ADE in humans.

As a side note, it is not ethical to conduct "challenge" studies in humans. However, challenge studies are conducted in animals. In other words, a clinical trial for a vaccine does not include administering the vaccine to a person, and then exposing this person to the virus post-vaccination to monitor their reaction. In clinical trials, humans are only given the vaccine, they are not "challenged" with the virus afterward. In animal studies, they do conduct a challenge test to observe how the animals respond to being infected with the actual virus after being vaccinated.

Will conducting animal studies solve the issue and remove the risk?

Not at all.

Anne De Groot, CEO of EpiVax argues that testing for vaccine safety in primates does not guarantee safety in humans, mainly because primates express different major histocompatibility complex (MHC) molecules, which alters epitope presentation and the immune response. Animals and humans are similar, but they are also very different. In addition, as pointed out above, the development of different viral strains in subsequent years could present a major problem not noticeable during the initial safety trials in either humans or animals.

What about unvaccinated people who are naturally infected with the virus and develop antibodies? Could these people experience ADE to a future strain of SARS-CoV-2?

The ADE response is actually much more complicated than the picture I outlined above. There are other competing and non-competing factors in our immune system that contribute to the ADE response, many of which are not fully understood. Part of that equation is a variety of different types of T-cells that modulate this response, and these T-Cells respond to other portions (epitopes) of the virus. In a vaccine, our body is normally presented with a small part of the virus (like the Spike protein), or a modified (attenuated or dead) virus which is more benign. A vaccine does not expose the entirety of our immune system to the actual virus.

These types of vaccines will only elicit antibodies that recognize the portion of the virus which is present in the vaccine. The other portions of the virus are not represented in the antibody pool. In this scenario, it is much more likely that the vaccine-induced antibodies can be rendered as non-neutralizing antibodies, because the entire virus is not coated in antibodies, only the portion that was used to develop the vaccine.

In a real infection, our immune system is exposed to every nook and cranny of the entire virus, and as such, our immune system develops a panacea of antibodies that recognize different portions of the virus and, therefore, coat more of the virus and neutralize it. In addition, our immune system develops T-Cell responses to hundreds of different peptide epitopes across the virus; whereas in the vaccine the plethora of these T-Cell responses are absent. Researchers are already aware that the T-Cell response plays a cooperative role in either the development of, or absence of, the ADE response.

Based on these differences and the skewed immunological response which is inherent with vaccines, I believe that the risk of ADE is an order of magnitude greater in a vaccine-primed immune system rather than a virus-primed immune system. This will certainly become more apparent as COVID-19 progresses over the years, but

the burden of proof rests on the shoulders of the vaccine industry to demonstrate that ADE will not rear its ugly head in the near term or the far term. Once a vaccine is administered and people develop antibodies to some misrepresentation of the virus, it cannot be reversed. Again, this is a problem that could manifest itself at a later date.

Although this article focused on the problem of ADE, it is not the only pathway or mechanism that could present a problem for people being infected after vaccination. Another pathway is governed by Th2 immunopathology, in which a defective T-cell response initiates an allergic inflammation reaction. A second pathway is based on the development of faulty antibodies that form immune complexes, which then activate the complement system a consequently damage the airways. These pathways are also potential risks for SARS-CoV-2.

Right now, the fatality rate of the virus is estimated to be approximately 0.26%, and this number seems to be dropping as the virus is naturally attenuating itself through the population. It would be a great shame to vaccinate the entire population against a virus with this low of a fatality rate, especially considering the considerable risk presented by ADE. I believe this risk of developing ADE in a vaccinated individual will be much greater than 0.26%, and, therefore, the vaccine stands to make the problem worse, not better. It would be the biggest blunder of the century to see the fatality rate of this virus increase in the years to come because of our sloppy, haphazard, rushed efforts to develop a vaccine with such a low threshold of safety testing and the prospect of ADE lurking in the shadows. I would hope (and this is a big hope), that this vaccine WILL NOT BE MANDATORY.

Hopefully, you now know a little more about the topic of Antibody Dependent Enhancement, and the real, unpredictable dangers of a coronavirus vaccine. In the end, your health should be your decision, not some bureaucrat's that doesn't know the first thing about molecular biology.

End of article- References for his article can be found after the article on his web site

https://sciencewithdrdoug.com/2020/08/01/is-a-coronavirus-vaccine-a-ticking-time-bomb/

Reputable scientific journal published study expressing concerns about Antibody Dependent Enhancement

On the heels of the previous article, a study was published in ***Nature Microbiology*** in October 2020 titled, **Antibody-dependent enhancement and SARS-CoV-2 vaccines and therapies.** That study covers many of the same concerns.

From the introduction

Antibody-based drugs and vaccines against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) are being expedited through preclinical and clinical development. Data from the study of SARS-Co-V and other respiratory viruses suggest that anti-SARS-CoV-2 antibodies could exacerbate COVID-19 through antibody-

dependent enhancement (ADE). Previous respiratory syncytial virus and dengue virus vaccine studies revealed human clinical safety risks related to ADE, resulting in failed vaccine trials. Here, we describe key ADE mechanisms and discuss mitigation strategies for SARS-CoV-2 vaccines and therapies in development.

Risk of ADE for SARS-CoV-2 vaccines

Evidence for vaccine-induced ADE in animal models of SARS-CoV is conflicting, and raises potential safety concerns. Liu et al. found that while macaques immunized with a modified vaccinia Ankara viral vector expressing the SARS-CoV S protein had reduced viral replication after challenge, anti-S IgG also enhanced pulmonary infiltration of inflammatory macrophages and resulted in more severe lung injury compared to unvaccinated animals. They further showed that the presence of anti-S IgG prior to viral clearance skewed the wound-healing response of macrophages into a pro-inflammatory response. In another study, Wang et al. immunized macaques with four B-cell peptide epitopes of the SARS-CoV S protein and demonstrated that while three peptides elicited antibodies that protected macaques from viral challenge, one of the peptide vaccines induced antibodies that enhanced infection in vitro and resulted in more severe lung pathology in vivo.

Conclusion

ADE has been observed in SARS, MERS and other human respiratory virus infections including RSV and measles, which suggests a real risk of ADE for SARS-CoV-2 vaccines and antibody-based interventions. However, clinical data has not yet fully established a role for ADE in human COVID-19 pathology. Steps to reduce the risks of ADE from immunotherapies include the induction or delivery of high doses of potent neutralizing antibodies, rather than lower concentrations of non-neutralizing antibodies that would be more likely to cause ADE. Going forwards, it will be crucial to evaluate animal and clinical datasets for signs of ADE, and to balance ADE-related safety risks against intervention efficacy if clinical ADE is observed. Ongoing animal and human clinical studies will provide important insights into the mechanisms of ADE in COVID-19. Such evidence is sorely needed to ensure product safety in the large-scale medical interventions that are likely required to reduce the global burden of COVID-19.

End of excerpts

https://www.nature.com/articles/s41564-020-00789-5

My comments: one thing of great concern regarding ADE with these vaccines is that they are beginning to show that the neutralizing antibody levels drop rapidly one recent study showing that happens within 10 weeks after vaccination. If you lose the neutralizing antibodies and all you have left are the binding (non-neutralizing) antibodies the risk of ADE goes up substantially when that person is later challenged with the wild virus.

This next story demonstrates that concern.

Scientists finding the neutralizing antibodies drop quickly after vaccination and "breakthrough" cases are epidemic

A July 27th, 2021 article from the ***Guardian*** titled **UK scientists back Covid boosters as study finds post-jab falls in antibodies**, provides insights into the waning of the important neutralizing antibodies shortly after vaccination.

From the article

The UCL Virus Watch study found that antibodies generated by two doses of the Oxford/AstraZeneca and Pfizer/BioNTech vaccines started to wane as early as six weeks after the second shot, in some cases falling more than 50% over 10 weeks.

The UCL team analysed blood from 605 vaccinated people mostly in their 50s and 60s. They found that antibody levels varied widely between patients, but a double dose of Pfizer/BioNTech tended to produce far more antibodies against the coronavirus than two shots of the Oxford/AstraZeneca vaccine.

Three to six weeks after full vaccination with Pfizer, antibody levels typically stood at about 7,500 units per millilitre (ml), but more than halved to 3,320 units per ml after 10 weeks. For AstraZeneca, antibody levels peaked at about 1,200 units per ml and typically fell to 190 units per ml after 10 weeks. Since publishing the results in a letter to the Lancet, the researchers have seen the same trend in a further 4,500 participants in the study.

"We know levels of antibodies start high and drop substantially," said Prof Rob Aldridge, an infectious disease epidemiologist at University College London. "We're concerned that if they carry on dropping at the rate we've seen, the protective effects of the vaccines will start to drop too, and the big question is, when is that going to happen?"

End of excerpts

https://www.theguardian.com/world/2021/jul/22/uk-scientists-back-covid-boosters-as-study-finds-post-jab-falls-in-antibodies

My comment: While this is true that antibody levels drop after natural infection and after vaccines, as I have reported in other issues of my newsletter, the antibody levels do not seem to drop this rapidly after natural infection and they remain at decent levels at least 8 months after the infection. And, other published research shows that after natural infection from COVID-19, there is a strong population of resident memory cells in the bone marrow that are ready to activate and kick out robust levels of antibodies when future exposure to the virus occurs. I just haven't seen evidence that vaccines produce memory cells to a significant degree or that are as robust or durable as seen after natural infection.

Another concerning article

Another article preview in ***Nature,*** published online and titled **Reduced sensitivity of SARS-CoV-2 variant Delta to antibody neutralization**, raises concerns about the Delta Variant being resistant to neutralizing antibodies from the vaccines, thus its ability to "escape" the vaccine's protection.

The abstract

The SARS-CoV-2 B.1.617 lineage was identified in October 2020 in India[1-5]. It has since then become dominant in some indian regions and UK and further spread to many countries[6]. The lineage includes three main subtypes (B1.617.1, B.1.617.2 and B.1.617.3), harbouring diverse Spike mutations in the N-terminal domain (NTD) and the receptor binding domain (RBD) which may increase their immune evasion potential. B.1.617.2, also termed variant Delta, is believed to spread faster than other variants. Here, we isolated an infectious Delta strain from a traveller returning from India. We examined its sensitivity to monoclonal antibodies (mAbs) and to antibodies present in sera from COVID-19 convalescent individuals or vaccine recipients, in comparison to other viral strains. Variant Delta was resistant to neutralization by some anti-NTD and anti-RBD mAbs including Bamlanivimab, which were impaired in binding to the Spike. Sera from convalescent patients collected up to 12 months post symptoms were 4 fold less potent against variant Delta, relative to variant Alpha (B.1.1.7). Sera from individuals having received one dose of Pfizer or AstraZeneca vaccines barely inhibited variant Delta. Administration of two doses generated a neutralizing response in 95% of individuals, with titers 3 to 5 fold lower against Delta than Alpha. Thus, variant Delta spread is associated with an escape to antibodies targeting non-RBD and RBD Spike epitopes.

https://pubmed.ncbi.nlm.nih.gov/34237773/

Another…

The ***Times*** of Israel reports that the vaccine quickly wanes after 4 to 5 months. The article is titled, **HMO: Early vaccinees are twice as likely to catch COVID as later recipients**

From the article…

People vaccinated before late February are twice as likely to catch the coronavirus than other inoculated Israelis, according to new research.

"We looked at tens of thousands of people tested in the month of June, alongside data on how long had passed since their second shot, and found that those vaccinated early were more likely to test positive," Dr. Yotam Shenhar, who headed the research, told The Times of Israel.

"This definitely reinforces the argument for giving a third vaccine dose to the elderly."

The report, published by the healthcare provider Leumit, comes on the heels of other Israeli studies that suggest a decreasing vaccine effectiveness, partly as a result of the Delta variant and partly because of the passage of time.

Data released by the Health Ministry on Thursday suggested that people vaccinated in January were said to have just 16% protection against infection now, while in those vaccinated in April the effectiveness was at 75%.

“Now we see vaccination effectiveness drops, so it seems we definitely need to think about a third vaccine,” he said. “We have started already by giving the immunocompromised, but in my assessment we need to consider giving third shots to everyone over 70 or 80. We shouldn’t wait long; we need to make a decision fast.”

In his study, the apparent waning effect in immunity was felt across all ages. For all age groups, early vaccinators were 1.95 times more likely to be confirmed coronavirus positive. Among those aged 60-plus, early vaccinators are twice as likely to get infected. For those aged 40-59 early vaccinators are 2.1 times more vulnerable, and among under 39s they are 1.6 more likely to catch the coronavirus.

“In a previous analysis we showed that as time passes since the vaccine, the level of antibodies drops at a rate of about 40% per month. This new study builds a clearer picture of the effect seen in the months after vaccination,” said Shenhar.

Israel has seen a dramatic rise in recent COVID-19 infections, with the daily caseload rising from several dozen to over 1,400 in recent days.

End of excerpts

https://www.timesofisrael.com/hmo-those-who-inoculated-early-twice-as-likely-to-catch-covid-as-later-adopters/

One more bombshell report. This time from the CDC…

A CDC, yes CDC report shows 74% of people infected in a Massachusetts outbreak we're fully vaccinated

This July 30th ***CNBC*** article titled, **CDC study shows 74% of people infected in Massachusetts Covid outbreak were fully vaccinated**, is another of the explosive stories we are seeing all over media this past week about the fact that breakthrough infections are commonplace and not rare as we have been told to believe ad nauseum. Apparently that dam is breaking and now a flood of stories are coming out. BUT, even though they can no longer claim that infections are “rare” if you've been vaccinated, or that you can't transmit to others, of course they're still putting a spin on these latest “revelations”. And the spin is that at least if you're vaccinated your illness will not be as severe, will not land you in the hospital, and make you much less likely to die. Well,

we have already seen from reporting earlier in this newsletter that that is absolutely not the case. But trust me that they will hang on to that narrative as long as they possibly can in order to continue to push the vaccines. Which honestly is the exact opposite thing of what we should be doing as discussed earlier in this newsletter according to many of the scientists and vaccine experts in the world. This will just continue to push the evolutionary mutations in the virus and could eventually create a monster that even natural immunity may be significantly challenged by. It would be like not recognizing that indiscriminately pushing antibiotics on everybody that has a sniffle will eventually create superbugs that no antibiotic will be able to defeat. Oh wait, the medical profession has been doing that for decades and antibiotic resistant infections now kill well over 100,000 people a year in the U.S. Have we not learned anything from prior mistakes?

From the article

About three-fourths of people infected in a Massachusetts Covid-19 outbreak were fully vaccinated against the coronavirus with four of them ending up in the hospital, according to new data published Friday by the Centers for Disease Control and Prevention.

The new data, published in the U.S. agency's Morbidity and Mortality Weekly Report, also found that fully vaccinated people who get infected carry as much of the virus in their nose as unvaccinated people, and could spread it to other individuals.

"This finding is concerning and was a pivotal discovery leading to CDC's updated mask recommendation," CDC Director Dr. Rochelle Walensky said in a statement. "The masking recommendation was updated to ensure the vaccinated public would not unknowingly transmit virus to others, including their unvaccinated or immunocompromised loved ones." **My comment:** As if masks will make a difference. That notion has been dispelled by dozens of studies over the years including in 2020, many of which I have on my website (https://wellnessdoc.com). Yet, they continue to promote an unscientific, disproven and harmful policy like the zealots they are.

Article continued…

On Tuesday, the CDC reversed course on its prior guidance and recommended fully vaccinated Americans who live in areas with high Covid infection rates resume wearing face masks indoors. The guidelines cover about two-thirds of the U.S. population, according to a CNBC analysis.

End of excerpts

https://www.cnbc.com/2021/07/30/cdc-study-shows-74percent-of-people-infected-in-massachusetts-covid-outbreak-were-fully-vaccinated.html

One more from the CDC…

The Dirty little secret that vaccinated people can get infected or spread the virus is finally out of the bag

To build on all the other examples I have in this newsletter regarding the previously perpetrated misinformation campaign comes a new story as reported by ***NBC News*** in an article online July 30th, 2020 titled, **CDC warns in internal document that 'war has changed' with the coronavirus.**

From the article

The Centers for Disease Control and Prevention has issued a stern warning about the delta variant of the coronavirus: "Acknowledge the war has changed." Now, it says even vaccinated people are able to readily spread the virus.

That is part of the message from a recent internal presentation prepared by the CDC detailing findings, some of which are considered preliminary, on the dangers posed by the delta variant, which has already led to a spike in cases in the United States. The document, obtained Friday by NBC News and first published by The Washington Post, explains the scientific background behind the agency's change in mask guidance earlier this week.

It concludes that the delta variant is "highly contagious, likely to be more severe" and that "breakthrough infections may be as transmissible as unvaccinated cases."

Researchers have been focusing on viral load — a term for just how much of the virus is present in infected peoples' bodies — which can affect transmissibility and severity. Infections with the delta variant lead to higher levels of virus in the body, even in breakthrough cases in fully vaccinated individuals, the document said. Virus levels can be as high in breakthrough cases as in unvaccinated people, even if vaccinated people don't get nearly as sick. **My comment:** *This myth over lower severity is dispelled by many other stories in this issue.*

What's more, these higher levels also persist for longer than was seen with previous strains, meaning an infected person is likely contagious for longer.

End of excerpts

https://www.nbcnews.com/science/science-news/cdc-warns-internal-document-war-has-changed-coronavirus-n1275478

Once again, this really proves that we are playing with fire by continuing to push these ineffective vaccines.

A report from the UK dispels the narrative that disease is always less severe in the vaccinated, as it is reported that 87% of deaths are in the fully vaccinated

The July 29th article in ***The Daily Expose*** titled, **EXCLUSIVE – Covid-19 deaths are rising and official data shows 87% of the people who have died were Vaccinated**, shows how data is often reported in such a way as to hide the real impact of the true numbers. It also shows that the further we go down the road since the vaccinations have started, a very disturbing trend is becoming apparent. Serious illness and deaths in the fully vaccinated appeared to be rising overtime. This could be a foreshadowing of what the many experts we have reported on over the months preceding have been warning about, and that is Antibody Dependent Enhancement (ADE) in vaccinated individuals. This is not unexpected as this phenomenon is one of the reasons why previous attempts to make coronavirus vaccines Have never made it past the animal trials. Unfortunately, due to the warp speed efforts of pushing this vaccine on the public as quickly as possible the proper animal trials were never done. That would have required vaccinating the animals and then waiting until the immunity begins to wane before exposing them to the wild virus again. Had they done that, they may very well have found that a high percentage of those animals not only got sick but died. This could have saved countless lives that now stand to be lost since millions of humans have replaced that portion of the clinical trials.

From the article

Public Heath Scotland (PHS) have released a weekly report on Covid-19 statistics covering data on testing, vaccinations, hospitalisations and deaths. We've been studying the reports by the week and recently told you how the report released on the 23rd June 2021 announced that 5,522 people had died within 28 days of having a Covid-19 vaccine in Scotland.

A few weeks ago we noticed that Public Health Scotland were being very clever with the way they were presenting the data, in what seems to be an attempt to hide a shocking statistic in regards to Covid-19 deaths and the Covid-19 vaccine. Unfortunately for PHS, they weren't quite clever enough, as their latest report has allowed us to uncover the shocking statistic that they were attempting to hide.

Public Health Scotland have been presenting data on cases, hospitalisations, and deaths by vaccination status. However, we noticed that they were particularly clever in the way they were presenting the data on deaths.

The data on both cases and hospitalisations has been presented with a total for each week within the last 4 weeks prior to the date of the report.

For instance, table 15 of their 28th July report on the number of alleged Covid-19 positive cases is presented as follows –

See the next page…

Overall results of COVID-19 cases and hospitalisations, and deaths by vaccination status

COVID-19 cases by vaccination status

Table 15: Number of COVID-19 positive cases individuals by week and vaccination status, 26 June 2021 to 23 July 2021

	No. of COVID-19 cases / No. of people eligible for COVID-19 vaccination or vaccinated (%)		
Week	Unvaccinated	1 Dose	2 Doses
26 June 2021 - 02 July 2021	14,457 / 1,436,957 (1.006%)	4,082 / 908,273 (0.449%)	4,360 / 2,553,943 (0.171%)
03 July 2021 - 09 July 2021	11,128 / 1,303,773 (0.854%)	3,601 / 933,904 (0.386%)	4,386 / 2,661,496 (0.165%)
10 July 2021 - 16 July 2021	7,554 / 1,185,784 (0.637%)	3,180 / 970,834 (0.328%)	3,716 / 2,742,555 (0.135%)
17 July 2021 - 23 July 2021	4,937 / 1,072,563 (0.460%)	2,373 / 973,507 (0.244%)	3,023 / 2,853,103 (0.106%)

Vaccination status is determined as at the date of PCR specimen date according to the definitions described above. The data displayed within the greyed-out section (3 days) are considered preliminary and are subject to change as more data is updated.

The above clearly shows that the majority of positive cases of Covid-19 between 26th June and 23rd July have been people who weren't vaccinated, accounting for 57% of all cases. However, in the most recent week, between 17th July and 23rd July we can see that the tables have turned and those who've had the Covid-19 vaccine account for 52% of positive cases.

Table 16 of PHS 28th July report is also presented in the same fashion, showing weekly totals within the past four weeks on the number of Covid-19 related hospital admissions –

Table 16: Number of COVID-19 related acute hospital admissions by week and vaccination status, 26 June 2021 to 23 July 2021

	No. of COVID-19 related acute hospitalisations / No. of people eligible for COVID-19 vaccination or vaccinated (%)		
Week	Unvaccinated	1 Dose	2 Doses
26 June 2021 - 02 July 2021	163 / 1,436,957 (0.011%)	42 / 908,273 (0.005%)	139 / 2,553,943 (0.005%)
03 July 2021 - 09 July 2021	266 / 1,303,773 (0.020%)	43 / 933,904 (0.005%)	228 / 2,661,496 (0.009%)
10 July 2021 - 16 July 2021	238 / 1,185,784 (0.020%)	46 / 970,834 (0.005%)	229 / 2,742,555 (0.008%)
17 July 2021 - 23 July 2021	197 / 1,072,563 (0.018%)	37 / 973,507 (0.004%)	167 / 2,853,103 (0.006%)

Vaccination status is determined as at the date of positive PCR test according to the definitions described above. The data displayed within the greyed-out section (1 week) are considered preliminary and are subject to change as more data is updated.

The above shows a slightly different story though to what we have seen in terms of confirmed cases. That's because the majority of hospital admissions have been people who have been vaccinated, accounting for 50.8% of all admissions. What's interesting about this is the number of admissions against the number of alleged positive cases.

From the 26th June to the 23rd July 2021, PHS claim that 38,067 positive cases of Covid-19 were confirmed in the unvaccinated population. However, within the same time frame just 15,485 positive cases of Covid-19 were confirmed in the fully vaccinated population.

However, of the unvaccinated population, 863 people have been hospitalised in the same time frame. Whereas of the fully vaccinated population, 763 people have been hospitalised in the same time frame.

This means that just 2.3% of confirmed Covid-19 cases in the unvaccinated population have resulted in hospitalisation. Whereas 5% of confirmed Covid-19 cases in the fully vaccinated population have resulted in hospitalisation. There is a slight flaw to this analysis in respect of there will be a lag between a confirmed case and hospitalisation, but even so this clearly shows that the jabs are not quite doing what they claim to do "on the tin".

The Covid-19 vaccines were only allegedly proven to reduce the risk of hospitalisation and death, however the methods used to prove this are highly questionable. Therefore to measure the effectiveness of the vaccines in the real world we shouldn't be looking at how many people have been hospitalised or died due to Covid-19 against the number of people vaccinated or not vaccinated. We should be looking at how many people have been hospitalised or died due to Covid-19 against the number of people allegedly infected with Covid-19 by their vaccination status.

Using that measure against the above data we can clearly see the fully vaccinated have got a problem, because it looks like if they are infected with Covid-19 they are much more likely to be hospitalised than if they were not vaccinated.

But we're afraid the data shows that being hospitalised is the least of their worries, even if Public Health Scotland have tried their hardest to conceal it.

Tracking data from December 29th, the onset of the vaccination program- This notation and the bolding below are mine to make it easier to see the category differences better.

- As of the **8th July**, 2,962 deaths were in the **unvaccinated** population. As of the **15th July**, 2,967 deaths were in the **unvaccinated** population. This is **an increase of 5.**

- As of the **8th July**, 257 deaths were people who'd had just **one dose** of a Covid-19 vaccine, however they may have had two doses due to PHS adding them to the one dose figures if their second dose was

less than 14 days prior to their death. As of the **15th July**, 262 people who'd had just one dose of a Covid-19 vaccine had died of Covid-19. This is **an increase of 5.**

- As of the **8th July**, 64 deaths were in the **fully vaccinated population**. As of the **15th July**, 92 deaths were in the fully **vaccinated population**. This is **an increase of 28**.

This means that people who've been vaccinated against Covid-19 account for 87% of the deaths in the third wave of deaths in Scotland that have just begun. The fully vaccinated account for 74% of the deaths that have only just begun to occur again, those who'd had a single dose account for 13% of the deaths, and the unvaccinated account for just 13% of the deaths. This is despite the fact the fully vaccinated account for just 23% of the cases seen in the previous four weeks.

By unpicking the data that Public Health Scotland have cleverly attempted to hide we have proven that you are more likely to be hospitalised and more likely to die if you are infected with Covid-19 after being vaccinated.

Antibody-dependent enhancement occurs when the antibodies generated during an immune response recognise and bind to a pathogen, but they are unable to prevent infection. Instead, these antibodies act as a "Trojan horse," allowing the pathogen to get into cells and exacerbate the immune response.

We were warned this is what the Covid-19 vaccines would cause based on the evidence produced in previous decades, the data we've just uncovered shows that the public should have heeded those warnings.

End of excerpts

https://dailyexpose.co.uk/2021/07/29/87-percent-covid-deaths-are-vaccinated-people/

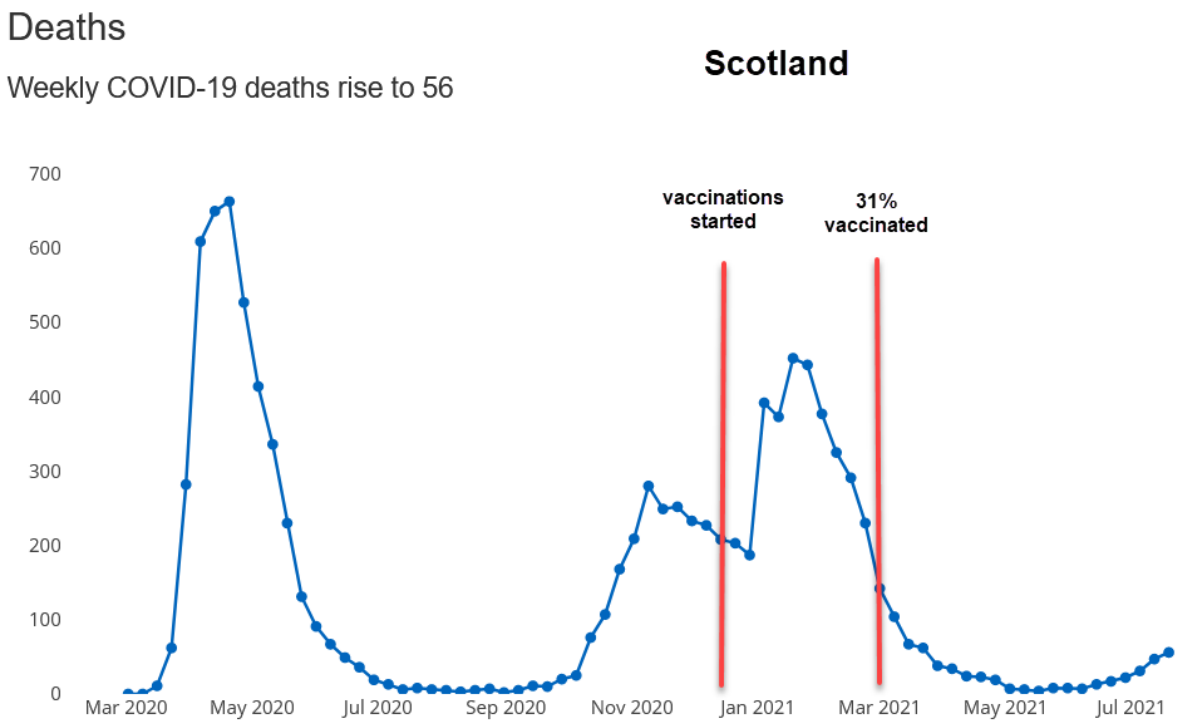
This is an example of how statistics can be deceptive.

Table 17: Number of confirmed COVID-19 related deaths by vaccination status at time of the most recent PCR positive specimen date, 29 December 2020 to 08 July 2021

Age group	Unvaccinated	1 Dose	2 Doses	Total
< 40	21	1	0	**22**
40-49	55	1	1	**57**
50-59	184	5	1	**190**
60-69	412	13	5	**430**
70-79	765	43	26	**834**
80+	1,525	194	31	**1,750**
Total	**2,962**	**257**	**64**	**3,283**

Vaccination status is determined as at the most recent PCR positive specimen date according to the definitions described above.

Looking at this chart, on face value it would appear that the unvaccinated represent a far higher percentage of deaths due to COVID-19 than the vaccinated. But that chart accounts for all COVID deaths since December 29th when only 1.9% of the population was vaccinated. Therefore 98% were unvaccinated. Thus nearly 100% of deaths accumulating during that time period were all in unvaccinated people. By January 27th only 9% had been vaccinated (91% unvaxxed) and by March 3rd, only 31% had been vaccinated (69% unvaxxed). In addition, as you will see from the graph below, there was a wave of deaths from COVID in January and February like many other places in the world because of the seasonality of this virus. With such a low percentage of the population being vaccinated at that point it would make sense that the vast majority of deaths would be in the unvaccinated regardless of the "protection" the vaccine may or may not provide.



So back to the table above this graph. It's no surprise that the majority of deaths are in the unvaccinated because of what I just discussed. What is concerning is the trend over the last 30 days. And this seems to be the trend in many countries including the United States. This is something we're going to have to keep a close eye on in the coming weeks and months. And in the meantime, as many health experts not tied with pharma or the government are recommending, I believe we should halt the vaccine program and start a serious debate and unbiased assessment about the risks of continuing to vaccinate masses of people in the middle of a pandemic with a vaccine that does not stop infection or transmission. Once again as I have said hundreds of times, if the vaccine will not prevent infection or transmission how in the world will it ever help us get to herd immunity? This is an especially daunting question considering the vaccines also appear to be weakening a person's innate immune system and overriding the body's nonspecific antibodies which help protect us from a variety of pathogenic viruses we are exposed to.

Don’t take my word for it, I urge you to watch and share the segment where Del Bigtree shows important segments of the interview with Geert Vanden Bossche discussing these very same concerns. You can see that here at the 46-minute mark to the 60 minute mark…
https://thehighwire.com/watch/

One last comment about that graph above. In a previous newsletter I showed approximately 30 countries that had a spike in deaths immediately following the institution of their mass vaccination programs. If you look at when this program started and that spike of deaths during January and early February, it looks suspiciously like all of the other countries.

Mixed messaging abounds from the CDC, leading Tucker Carlson to coin a new acronym for CDC

And here's an example…

The absurdity that the CDC and media continue to push the pandemic of the unvaccinated narrative and then this happens….

Dr. Rochelle Wolensky, Director of the CDC in an interview on New Day CNN July 28th, 2021

"I do want to sort of comment, that in some fully vaccinated venues, if they are unmasked and if there are a few people that are transmitting there as a fully vaccinated person, it is possible to pick up disease in those settings we've seen that in some of our outbreaks investigations this summer which is why overall it's so very critical to just get the huge amount of disease in some of these areas down."

You can see this video during the ***Jaxon Report*** on the ***Highwire,*** Episode 226 titled **Ahead of the Curve**.

See that here: https://thehighwire.com/watch/

One expert thinks the vaccines were doomed to fail from the beginning and boosters are not the answer

In a July 14th article posted on his website titled **Not Covid-19 vaccine-mediated but naturally acquired immunity enables herd immunity**, Dr. Geert Vanden Bossche made a case for the superiority of natural immunity and why the vaccines as developed and used during the pandemic were doomed to fail.

He stated the following:

Overall conclusion: From the very beginning of the mass vaccination program, it should have been clear that because of the intrinsic limitations of S-based Covid-19 vaccines and their deployment in mass vaccination campaigns in the midst of a pandemic, herd immunity was simply the last thing this mass vaccination program could possibly achieve and that moving this program forward would fulfill all the conditions for driving S-directed viral immune escape to eventually result in full resistance of Sars-CoV-2 to the Covid-19 vaccines. Boosting vaccinal Abs with 2nd generation vaccines is not going to solve the issue of immune escape, even if the immunization with 'updated' vaccines would be repeated by 6-month intervals. This is because 2nd generation vaccines will primarily recall S-specific Abs elicited by the first generation vaccines (due to 'antigenic sin') and not be effective against recombinations of Sars-CoV-2 variants, which are highly likely to occur as a result of co-infection, especially in the most vulnerable (see previous critical opinion article: 'Why is the ongoing mass vaccination experiment driving a rapid evolutionary response of SARS-CoV-2?').

https://www.geertvandenbossche.org/post/not-covid-19-vaccine-mediated-but-naturally-acquired-immunity-enables-herd-immunity

Pfizer makes record profits thanks to the boost from its COVID-19 vaccine

Imagine what will happen now as the duration of the vaccine is waning, and boosters will be recommended every 6 months or so.

Mothers pass antibodies produced in response to the COVID-19 vaccines to their babies through breastmilk

Since the incident I reported on in the last topic relating to the truncated mRNA in the batches of the Pfizer vaccine is fresh in your mind, I thought I would follow with this next story.

The authors of this report are excited about the results because think that it is a good idea for mothers to pass antibodies to the engineered spike protein on to their infants through the breastmilk, because they believe that this will help to protect their infants from SARS-CoV-2. At the end of this topic, I will share with you a concern I have in the form of a hypothesis that could play out as a long-term risk for the child.

The research letter was published in the ***Journal of the American Medical Association*** May 18th, 2021. It was titled **Specific antibodies in breast milk after COVID-19 vaccination of breastfeeding women**.

From the article

Results |Eighty-four women completed the study, providing 504 breast milk samples. Women were a mean (SD) age of 34 (4) years and infants 10.32 (7.3) months (Table).

Mean levels of anti–SARS-CoV-2-specific IgA antibodies in the breast milk increased rapidly and were significantly elevated at 2 weeks after the first vaccine (2.05 ratio; $P < .001$), when 61.8% of samples tested positive, increasing to 86.1% at week 4 (1 week after the second vaccine). Mean levels remained elevated for the duration of follow-up, and at week six, 65.7% of samples tested positive. Anti–SARSCoV-2-specific IgG antibodies remained low for the first 3 weeks, with an increase at week 4 (20.5 U/mL; $P = .004$), when 91.7% of samples tested positive, increasing to 97% at weeks 5 and 6 (Figure).

No mother or infant experienced any serious adverse event during the study period. Forty-seven women (55.9%) reported a vaccine-related adverse event after the first vaccine dose **and 52 (61.9%) after the second vaccine dose,** with local pain being the most common complaint (Table). **Four infants developed fever during the study period 7, 12, 15, and 20 days after maternal vaccination. All had symptoms of upper respiratory**

tract infection including cough and congestion, which resolved without treatment except for 1 infant who was admitted for neonatal fever evaluation due to his age and was treated with antibiotics pending culture results.

Table. Maternal and Infant Characteristics

	No. (%)
Study participants, No.	84
Maternal features	
Maternal age, mean (SD), y	34 (4)
No. of children, mean (SD)	2.36 (0.98)
Chronic diseases	22 (26.2)
Gestational diabetes	3 (3.6)
First vaccine adverse effects	47 (55.9)
Local pain	40 (47.6)
Fatigue	8 (9.5)
Fever	0
Other	12 (14.3)
Second vaccine adverse effects	52 (61.9)
Local pain	34 (40.5)
Fatigue	28 (33.3)
Fever	10 (11.9)
Other	22 (26.2)
Infant related features	
Vaginal delivery mode	78 (92.9)
Infant age at time of first maternal vaccine, mean (SD), mo	10.32 (7.31)
Birth week, mean (SD)	39.01 (1.95)
Birth weight, mean (SD), g	3175.27 (502.33)
Exclusive breastfeeding	35 (41.6)

End of excerpts

https://pubmed.ncbi.nlm.nih.gov/33843975/

My comments:

Sixty-two percent of the women suffered adverse events from the second dose of the vaccine. Twenty-two were listed as “other” side effects. I looked for a supplemental table that would show all of the adverse events so that I could see what other kinds of side effects the women were getting. We were told that none of them had serious side effects, but then why don't they publish all of the side effects? This is suspect.

Also, one of the four infants that developed upper respiratory infections was hospital sized and started on antibiotics pending a culture. I thought it strange that they didn't publish the results of that culture. If those lab results came back with that infant having COVID-19, that have a devastating impact on the outcome of the study. I would think if the culture would have come back with something other than that, they would have made that known to prevent this kind of speculation. This is also suspect. In addition, if you look at the bottom

of the table only 35 of the 84 women were exclusively breastfeeding. With four children developing upper respiratory infections, it would be very interesting to know whether the children that developed these infections were part of the group of babies that were exclusively breastfed or not.

One last observation. The conclusion that none of the infants had suffered adverse reactions to he these antibodies is premature. And here is where my hypothetical comes in. The report did not reveal whether a long-term follow-up study is to be continued with these infants, but because of the experimental nature of this biological that their mother had taken it would certainly be a great idea. We know from the report I shared about the denaturing of the synthetic messenger RNA resulting in truncated (shortened) pieces of the spike protein in the Pfizer vaccines that was discovered during the computer hacking incident of the ***European Medicines Agency*** covered in this issue. A HUGE concern with that is the bits and pieces that are injected into the body will also be copied by the ribosomes of the cells and the body will spit out billions of those copies. If those random Yeah amino acid sequences happen to match one or more of your body's own proteins, it could be setting you up for a variety of autoimmune diseases.

Informed consent is the hallmark of ethical responsibility for all medical procedures and medications. Yet, for vaccines it has always been sorely lacking.

In a March 2021 article published in ***Perspective- Infectious Diseases*** titled **Informed consent disclosure two vaccine trial subjects of risk of COVID-19 vaccines worsening clinical disease**, authors are critical of the lack of patient informed consent revolving around COVID-19 vaccines the risk of causing Antibody Dependent Enhancement (ADE), or what is sometimes called Pathogenic Priming. The section I have pasted here goes through a nice history of why many top scientists and medical experts have been terrified about the prospect of this developing in some people. In fact, as I have reported in previous issues of this newsletter, there have been thousands of reports world-wide of incidents of previously uninfected people developing severe COVID-19, with many dying after they have had their shots. These have been roundly dismissed as unfortunate coincidences.

From the article-

Results of the study: COVID-19 vaccines designed to elicit neutralizing antibodies may sensitise vaccine recipients to more severe disease than if they were not vaccinated. Vaccines for SARS, MERS and RSV have never been approved, and the data generated in the development and testing of these vaccines suggest a

serious mechanistic concern: that vaccines designed empirically using the traditional approach (consisting of the unmodified or minimally modified coronavirus viral spike to elicit neutralising antibodies), be they composed of protein, viral vector, DNA or RNA and irrespective of delivery method, may worsen COVID-19 disease via antibody-dependent enhancement (ADE). This risk is sufficiently obscured in clinical trial protocols and consent forms for ongoing COVID-19 vaccine trials that adequate patient comprehension of this risk is unlikely to occur, obviating truly informed consent by subjects in these trials.

Conclusions drawn from the study and clinical implications: The specific and significant COVID-19 risk of ADE should have been and should be prominently and independently disclosed to research subjects currently in vaccine trials, as well as those being recruited for the trials and future patients after vaccine approval, in order to meet the medical ethics standard of patient comprehension for informed consent.

Vaccine-elicited enhancement of disease was also observed with the SARS and MERS viruses and with feline

coronavirus, which are closely related to SARS-CoV-2, the causative pathogen of COVID-19 disease. The immune mechanisms of this enhancement have invariably involved antibodies, from direct antibody-dependent enhancement, to immune complex formation by antibodies, albeit accompanied by various coordinated cellular responses, such as Th2 T-cell skewing.2-7 Notably, both neutralizing and non-neutralising antibodies have been implicated. A recent study revealed IgG-mediated acute lung injury in vivo in macaques

infected with SARS that correlated with a vaccine-elicited, neutralizing antibody response.8 Inflammation and tissue damage in the lung in this animal model recapitulated the inflammation and tissue damage in the lungs of SARS-infected patients who succumbed to the disease. The time course was also similar, with the worst damage occurring in delayed fashion in synchrony with ramping up of the immune response. Remarkably, neutralising antibodies controlled the virus in the animal, but then would precipitate a severe, tissue damaging, inflammatory response in the lung. This is a similar profile to immune complex-mediated disease seen with RSV vaccines in the past, wherein vaccinees succumbed to fatal enhanced RSV disease because of the formation of antibody-virus immune complexes that precipitated harmful, inflammatory immune responses. It is also similar to the clinical course of COVID-19 patients, in whom severe COVID-19 disease is associated with the development of anti-SARSCoV- 2 serum antibodies,[9] with titres correlating directly with the severity of disease.[10] Conversely, subjects who recover quickly may have low or no anti-SARS-CoV-2 serum antibodies.[11]

End of excerpts

https://pubmed.ncbi.nlm.nih.gov/33113270/

Once again, we see the strategy to erase the placebo group

There was a May 18th, 2021 feature article in the ***British Medical Journal*** by Peter Doshi, senior editor titled **COVID-19 vaccines: in the rush for regulatory approval do we need more data?** One of these significant points the article makes is as I have predicted earlier, vaccine makers are allowing people that were in the control group, meaning those not getting the vaccines (instead the placebo) to now get the vaccines. This practice essentially erases the placebo group making it impossible to follow up with their health months and years down the road. This would be critical in order to compare the kinds of illnesses they develop to the groups that received the vaccines. This is a sleight of hand that vaccine manufacturers have done with virtually every other vaccine they have developed. It is a way of hiding adverse changes in health outcomes down the road in those receiving the vaccines.

From the article

The BMJ asked Moderna, Pfizer, and Janssen (Johnson and Johnson) what proportion of trial participants were now formally unblinded, and how many originally allocated to placebo have now received a vaccine. Pfizer declined to say, but Moderna announced that "as of April 13, all placebo participants have been offered the Moderna covid-19 vaccine and 98% of those have received the vaccine."2 In other words, the trial is unblinded, and the placebo group no longer exists.

Janssen told *The BMJ*: "Wedo not have specific figures on how many of our study participants have received a vaccine at this time." But the company confirmed it was implementing an amended protocol across all countries to unblind all participants in its two phase III trials, the earlier of which passed the median of two month follow-up mark in January.

How the FDA will weigh the loss of blinding and placebo-controlled follow-up is unclear, but just months ago the agency said these trial properties were vital.

End of excerpts

https://www.bmj.com/content/bmj/373/bmj.n1244.full.pdf

My comment: How can the FDA which considered these protocols "vital" allow these for-profit companies to get away with this and still consider full approval? If these companies did not behave in the best interest of

investigators to track long term safety and therefore put the public at risk, how can they be rewarded for bad behavior? Is this just another example of the good old boys club protecting the interests of their buddies?

Update from India, the original home of the Delta Variant

Interestingly, the percentages of the Indian population with COVID antibodies is high.

Two-thirds of Indians have coronavirus antibodies, survey shows

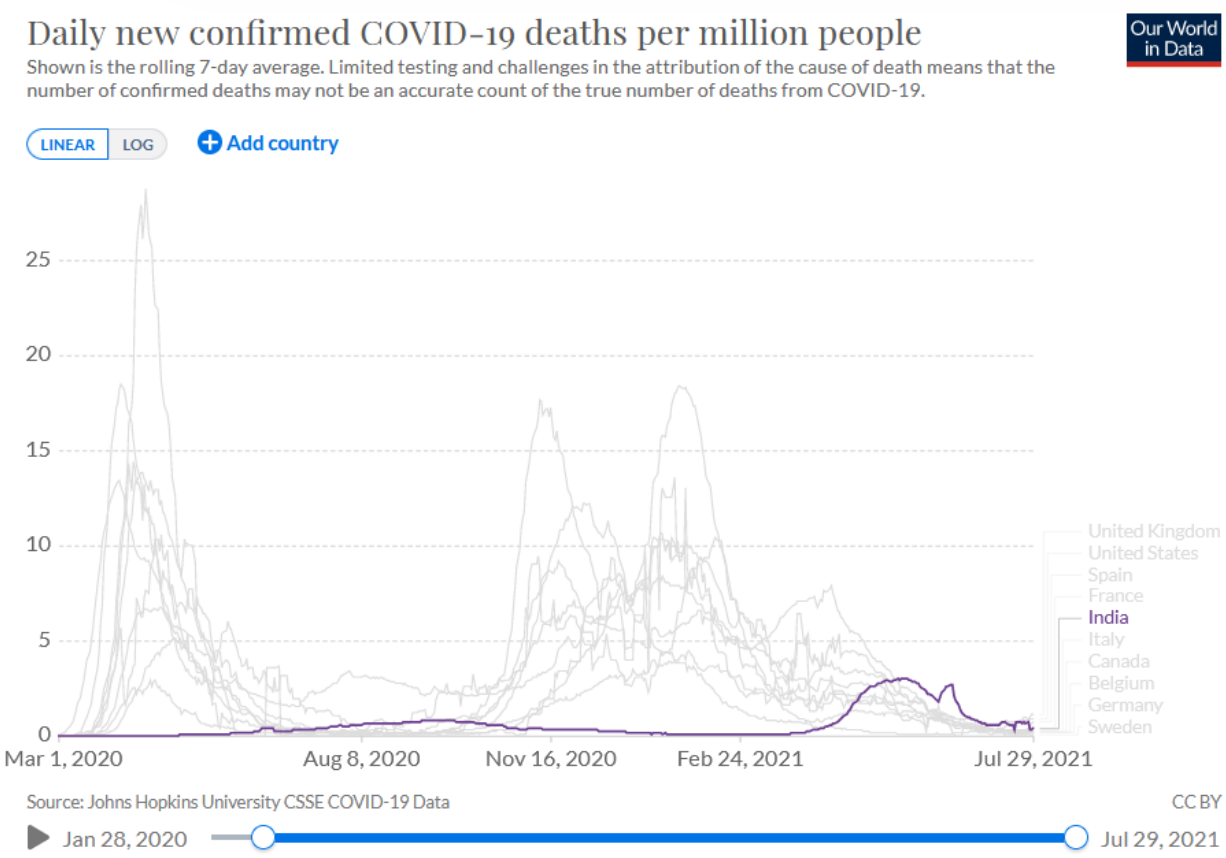
July 20, 2021 (Reuters) - Two-thirds of India's population have antibodies against the coronavirus, according to data released on Tuesday from a survey of 29,000 people across the nation conducted in June and July.

The fourth national blood serum survey which tests for antibodies, known as a sero survey, included 8,691 children aged 6-17 years for the first time. Half of them were seropositive.

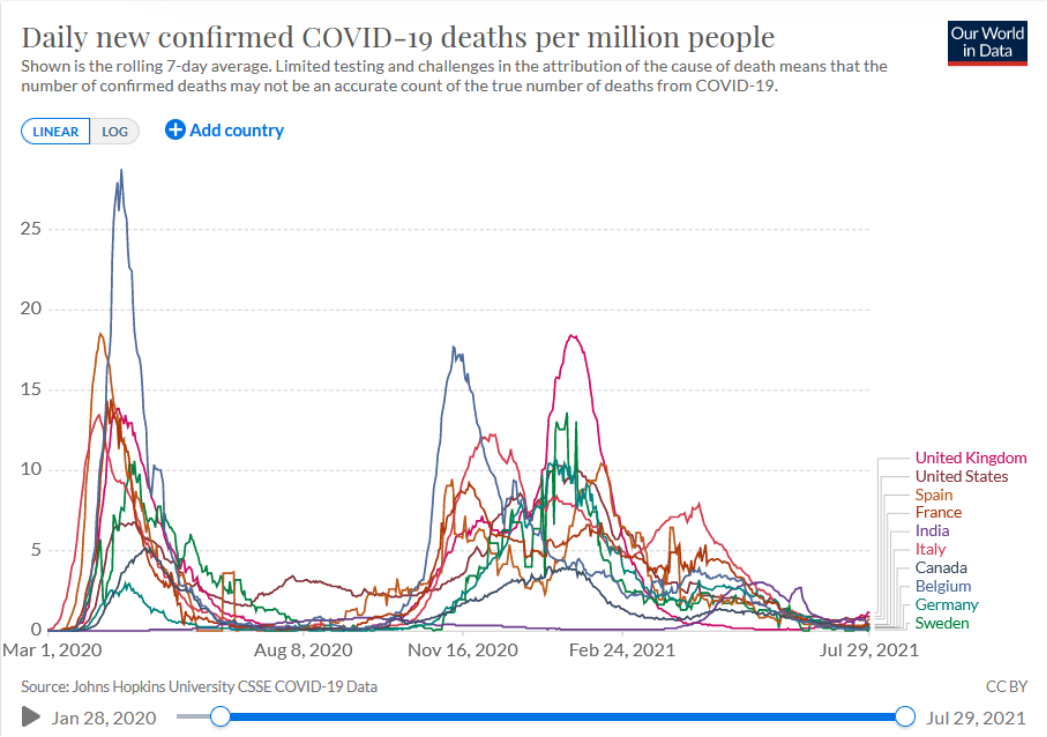
The survey showed 67.6% of adults were seropositive, while more than 62% of adults were unvaccinated. As of July, just over 8% of eligible adult Indians had received two vaccine doses.

The study also surveyed 7,252 healthcare workers and found 85% had antibodies, with one in 10 unvaccinated.

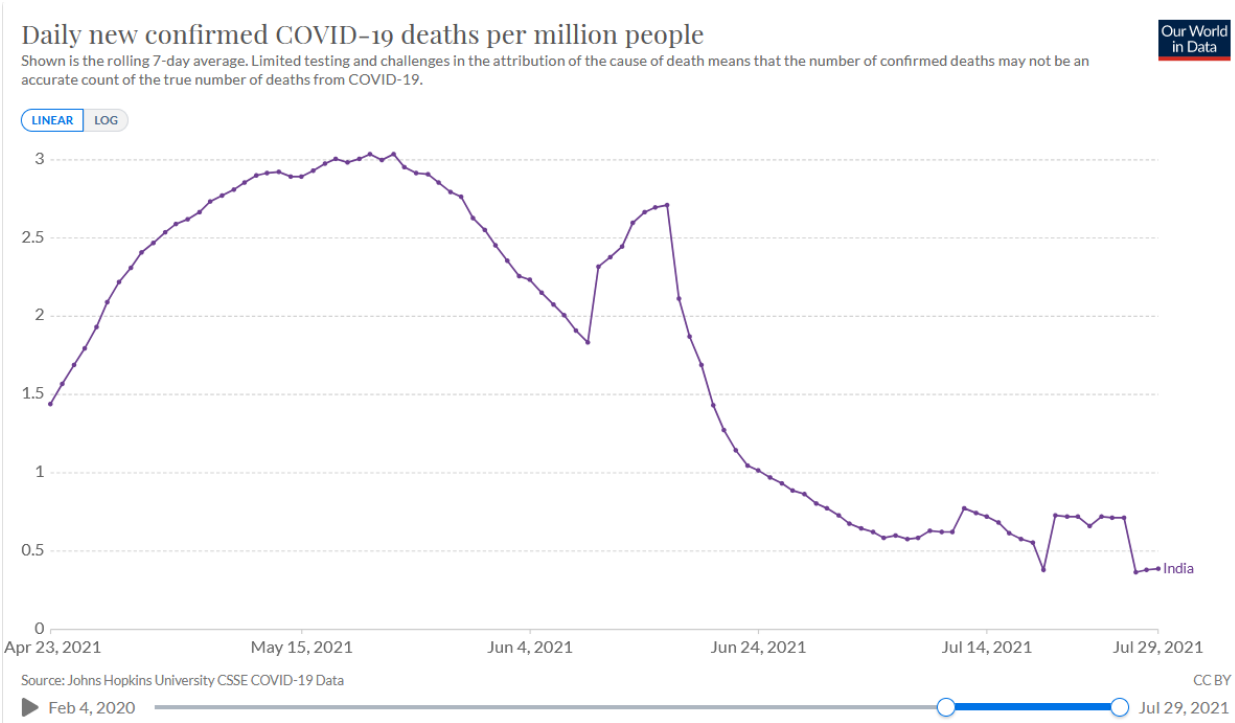
https://www.reuters.com/world/india/india-govt-survey-shows-two-thirds-have-coronavirus-antibodies-2021-07-20/



How does that compare to the U.S. and some European countries?



Expanding the Indian graph, focusing on April 23rd to July 29th shows the dramatic decrease in deaths.



As can be seen, although Delta is contagious and deadly to some people, the pandemic seems to have waned there even though only 7% of the country's population have been vaccinated as of July 30th, 2021. And keep in mind as reported earlier in this story, it is estimated that two thirds of India's population have had the SARS-CoV-2 infection and are now immune.

"A Pandemic of the Unvaccinated"- What is the TRUTH?

The latest reports that 99% of all COVID-19 deaths are in unvaccinated people in the U.S. is an absurd lie. And that's not the only lie we have been told. There is an abundance of them. Here are just some of them and the proof as to their fallacy.

1. **The vaccines are failing-** The U.S. would have to be an anomaly compared to other nations. Israel the country with the highest vaccination rates in the world reports that people that were vaccinated in January have already lost a good portion of their protection according to ***Pfizer Chief Scientific Officer*** Mikael Dolsten. "The Pfizer vaccine is highly active against the Delta variant," Dolsten said in an interview, according to *Reuters*. But after six months, he said, "there likely is the risk of reinfection as antibodies, as predicted, wane."

   In addition, England reports that **43% of their hospitalizations and deaths are in fully vaccinated people** as this table clearly shows. The report from ***Public Health England*** is titled**, SARS-CoV-2 variants of concern and variants under investigation in England** and was published June 25th, 2021.

See the table on the next page…

SARS-CoV-2 variants of concern and variants under investigation

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001359/Variants_of_Concern_VOC_Technical_Briefing_16.pdf

Table 4. Attendance to emergency care and deaths by vaccination status among Delta confirmed cases (sequencing and genotyping) in England, 1 February 2021 to 14 June 2021.

	Total	Cases with specimen date in past 28 days*	Unlinked	Unvaccinated	<21 days post dose 1	≥21 days post dose 1	≥14 days post dose 2
Delta cases since 1 Feb 2021 ¥	60,624	53,177	7,461	35,521	4,094	9,461	4,087
Cases with an A&E visit§ (excluding cases with the same specimen and attendance dates)‡	1,555	NA	14	1,038	116	285	102
Cases with an A&E visit§ (including cases with the same specimen and attendance dates)	2,176	NA	24	1,446	155	378	173
Cases where presentation to A&E resulted in overnight inpatient admission§ (excluding cases with the same specimen and admission dates)‡	488	NA	7	324	30	87	40
Cases where presentation to A&E resulted in overnight inpatient admission§ (including cases with the same specimen and admission dates)	806	NA	10	527	50	135	84
Deaths^	73	NA	2	34	1	10	26 43%

Data sources: Emergency care attendance and admissions from Emergency Care Dataset (ECDS), deaths from PHE daily death data series (deaths within 28 days)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001359/Variants_of_Concern_VOC_Technical_Briefing_16.pdf

And from Israel, the data on people testing positive for COVID is looking even worse for the vaccines.

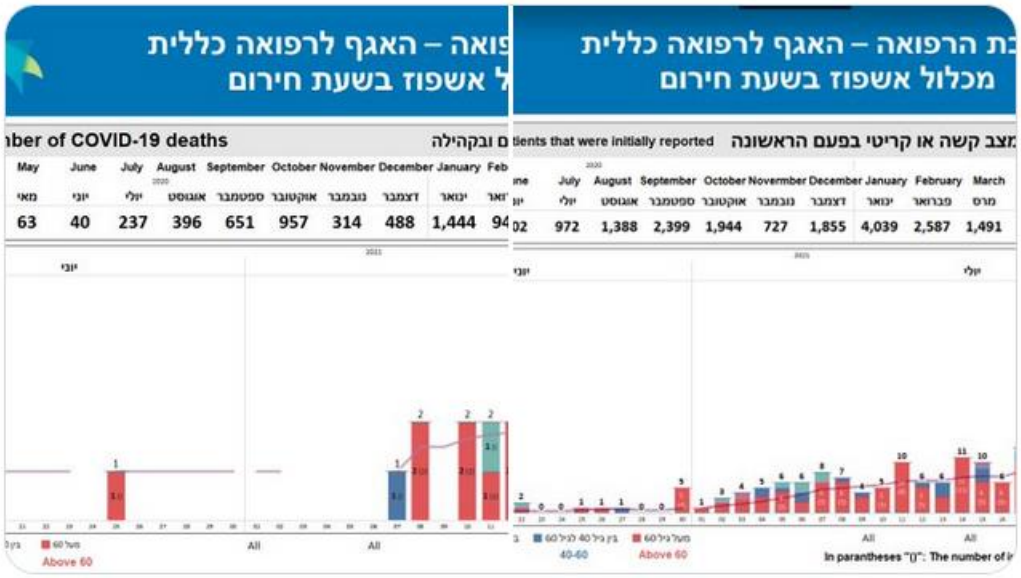
Israel Confirmed Cases, July 4th – July 10th, Vaccinated* vs. Unvaccinated**				
Age Group	Cases, Vaccinated	Cases, Unvaccinated	Percent of Cases Vaccinated	Percent of Population*** Vaccinated
20-29	217	61	78%	77%
30-39	248	84	75%	82%
40-49	356	54	87%	85%
50-59	237	26	90%	89%
60-69	227	14	94%	91%
70-79	143	12	92%	95%
80-89	42	6	88%	91%
קבוצת גיל	נדבקים מחוסנים	נדבקים לא מחוסנים	אחוז נדבקים מחוסנים	אחוז מחוסנים באוכלוסיה
ישראל, מקרי קורונה מאומתים, 4 ביולי עד 10 ביולי, מחוסנים לעומת לא מחוסנים				

Source: Israel Ministry of Health Dashboard
https://datadashboard.health.gov.il/COVID-19/general
* *Vaccinated – 2 shots.*
** *Unvaccinated – No shots.*
*** *Excluding population with 1 shot.*

A July 29th, 2021 Tweet by a person that I have been following who is reporting on Israeli health data and someone that I have noticed is being followed by many credible and well known scientists, is reporting some shocking statistics. And thankfully he can interpret Hebrew.

Ran Israeli @RanIsraeli · Jul 29

New update from the Israeli MoH:
The number of deaths in July - Age 60+:
25 deaths=Fully vaxxed.
6 deaths=Not fully vaxxed.
The number of initially reported severe/critical patients - Age 60+ :
182=Fully vaxxed.
46=Not fully vaxxed.
govextra.gov.il/ministry-of-he...
drive.google.com/file/d/1n7ng6G...



How does that contrast to what we are hearing from our media and CDC?

As more proof that they are realizing the vaccines are failing, as ***Forbes*** reports, Pfizer has already petitioned the FDA to authorize a third dose for the fall to try to help keep vaccinated people protected. This is also happening in Israel, the U.K and other countries around the world.

https://www.forbes.com/sites/jonathanponciano/2021/07/11/declining-vaccine-efficacy-particularly-among-older-individuals-prompting-pfizers-emergency-booster-request-former-fda-chief-says/

2. **The Delta variant may be more contagious than the original alpha version, but it is also less deadly-** This is the normal evolution of a virus. As they evolve, they become more contagious but less virulent (lethal). This is Virology 101. So, the media and the agencies promoting the vaccines focus on cases rather than the effects those cases are having on people in the way of hospitalizations and deaths. These are the metrics that matter. If people are getting typical cold or flu symptoms, but never progress in severity to require medical care what is the big deal? They get it, get over it and develop natural immunity to it in the future. How exaggerated are their claims? I went to the CDC's own website showing rates of hospitalizations in the U.S. and found that the current rates for all ages are at the lowest since the beginning of the pandemic.

   You can see the CDC graph for yourself here: https://gis.cdc.gov/grasp/COVIDNet/COVID19_3.html

   You can see the data from the aforementioned report from ***Public Health England*** titled**, SARS-CoV-2 variants of concern and variants under investigation in England** on page 8 showing that the Delta is far less deadly than the Alpha (UK) virus and other variants.

   https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001359/Variants_of_Concern_VOC_Technical_Briefing_16.pdf

Table 2. Number of confirmed (sequencing) and probable (genotyping) cases by variant as of 14 June 2021

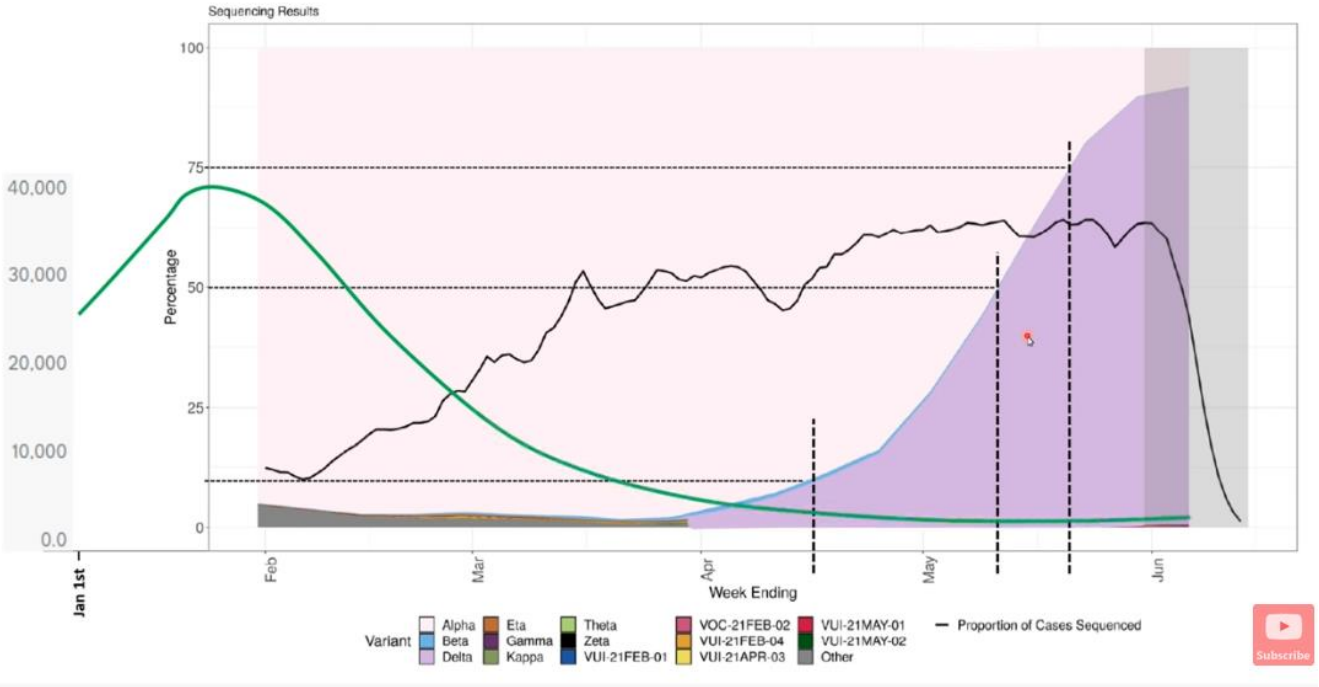
Variant	Confirmed (sequencing) case number	Probable (genotyping) case number*	Total case number	Case Proportion*	Deaths	Case Fatality	Cases with 28 day follow up	Deaths among those with 28 day follow up	Case Fatality among those with 28 day follow up
Alpha	218,332	5,689	224,021	77.9%	4,259	1.9% (1.8 to 2.0%)	217,228	4,252	2.0% (1.9 to 2.0%)
Beta	871	55	926	0.3%	13	1.4% (0.7 to 2.4%)	858	13	1.5% (0.8 to 2.6%)
Delta	31,132	29,523	60,655	21.1%	73	0.1% (0.1 to 0.2%)	5,762	17	0.3% (0.2 to 0.5%)
Eta	441	0	441	0.2%	12	2.7% (1.4 to 4.7%)	428	12	2.8% (1.5 to 4.8%)
Gamma	170	42	212	0.1%	0	0.0% (0.0 to 1.7%)	155	0	0.0% (0.0 to 2.4%)
Kappa	422	0	422	0.1%	1	0.2% (0.0 to 1.3%)	404	1	0.2% (0.0 to 1.4%)
Theta	7	0	7	0.0%	0	0.0% (0.0 to 41.0%)	5	0	0.0% (0.0 to 52.2%)

Compare the Delta (Indian) Variant statistics to the Alpha (UK), Beta (South African) or Eta Variants and you will see that it is far less lethal. But you would never know that by listening to the hysterical “misinformation media”.

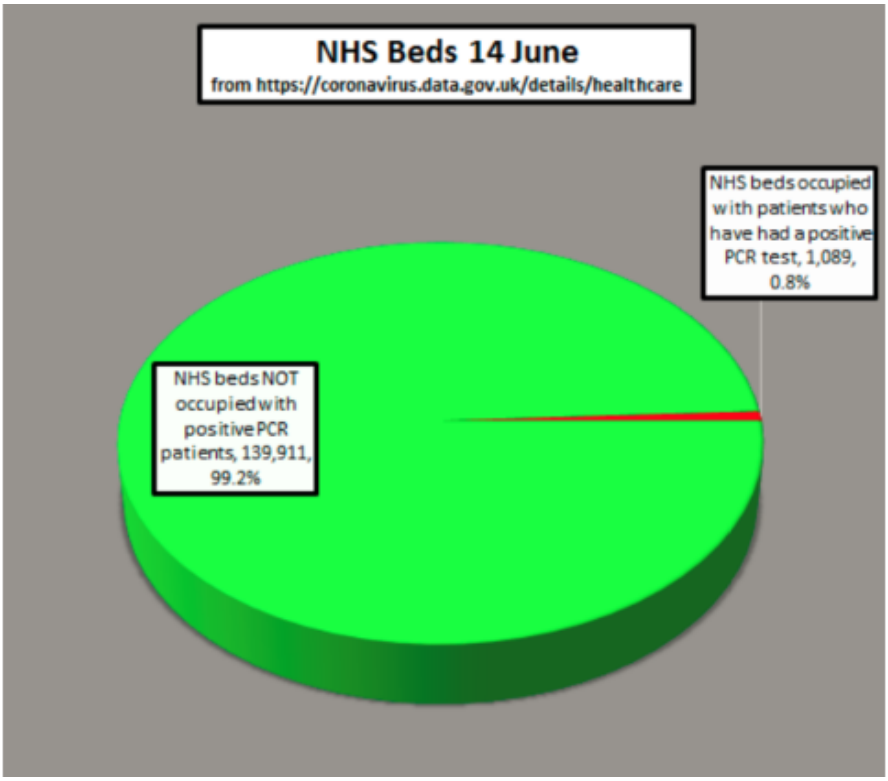
Want more evidence of the disconnect with what we hear in the media in the U.S. and what they are experiencing elsewhere?

A picture is worth a thousand words as they say…This graph shows the dominant Delta Variant in the UK as of a month ago at over 90% of cases. And the green line is representing the rate of hospitalizations over time superimposed on the graph.

Figure 3. Variant prevalence for all England available sequenced cases from 1 February 2021 as of 14 June 2021
(excluding 48 cases where the specimen date was unknown). (Find accessible data used in this graph in underlying data).



Here is another look at the availability of hospital beds across the U.K. as of June 14th when the decision to announce another 30 days of lockdown "due to the Delta Variant."



3. **Natural infection is far superior to the vaccines**- I have posted at least two dozen studies since May 2020 that show this to be true. Recently in Israel, the following report came from their national health data. The article in ***Israel National News*** titled, **Natural infection vs vaccination: Which gives more protection?** found that **nearly 40% of new COVID patients were vaccinated - compared to just 1% who had been infected previously.** https://www.israelnationalnews.com/News/News.aspx/309762

For more evidence on the lasting immunity after infection see my eBook covering that at https://www.wellnessdoc.com/ebooks-and-publications/

4. **They are playing with the numbers-** An article published in ***The Hill*** July 7th, 2021, titled **Top health expert says vaccinated people are spreading delta variant** reveals several things including what the subtitle says, **"The CDC currently does not require vaccinated individuals to undergo regular testing"**.

From the article: Speaking to Insider, Christopher Murray, the director of the ***Institute for Health Metrics and Evaluation***, said that not testing vaccinated people — as the U.S. Centers for Disease Control and Prevention (CDC) recommends — may be overlooking some transmission.

"We actually have states where hospitalizations are going up more than cases," Murray said, adding that "we're probably missing a bunch of transmission in vaccinated individuals." (bold emphasis mine)

My comment: Dah! It's all making sense now. I was asking myself, why are the vaccines failing in other countries leading to high percentages of cases and people being admitted to hospitals, even dying from COVID being in vaccinated individuals, yet we are being told that 99% of people here in the U.S. being admitted to hospitals and dying are unvaccinated. Well, if you don't test the vaccinated when they come to the hospital, you would get very skewed numbers! So the next question is, why would they not test the vaccinated? The CDC knows that the vaccines don't protect against infection or transmission. So why in the world wouldn't they want to know what percent of vaccinated individuals are represented in cases, hospitalization numbers and deaths? Is it because it would reveal the false narrative that the vaccines are going to "help us get back to normal"? Is it because it would encourage vaccine hesitancy? Is it because it would expose the lies that have been told to the public ad nauseum about the vaccine's effectiveness? (See my article from my June newsletter on the Actual Risk Reduction (ARR) and Number Needed to Vaccinate (NNV) to benefit one person). Regardless of the reason, it shows either the corruption or the incompetency of the CDC. Neither bode well for encouraging the trust of the American people.

https://thehill.com/changing-america/well-being/longevity/561994-top-health-expert-says-vaccinated-people-are-spreading

5. **Why the panic and the desperation? Who is left that "needs" to be vaccinated?**
   All we hear these days is that 50% of the population in unvaccinated. The shrill screams, sense of urgency and desperation is palpable.

What is the truth? And is the remaining 50% of the population vulnerable to COVID-19 (the disease)? According to CDC estimates, the number of people that have had COVID is approximately 8X the number of known confirmed cases. https://academic.oup.com/cid/article/72/12/e1010/6000389

As of July 17, 2021, there have been 35 million PCR "**confirmed"** cases of COVID-19 in the U.S. Using the CDC's own data and their 8X estimate, that means that approximately 280 million Americans (84%) of the 335 million Americans have had the SARS-CoV-2 infection that will confer to them strong immunity from future infection. Even if that number were just 6X, that would be 210 million people

(63%). And based on the 2 dozen or so studies that I have accumulated, that means that they will have a robust and lasting defense against future infection and developing COVID-19, the disease. An immunity that is proving to be much more lasting than the "vaccines". That is because the immune system builds a response to all of the viral proteins, not just the spike protein as with the vaccines. Therefore, when there are natural mutations, especially with the spike protein, the immune system trained from natural infection to recognize other sequences of the virus will still be effective. And reinfections are so rare after someone has had the infection, that there are less than a hundred documented and confirmed cases of over 190 million cases worldwide. Could it be that a large percentage of those 50% holdouts, are in people that have read the science and know that the risk of an experimental vaccine is not worth taking when they are already protected?

And to further the notion that people that have had the infection and recovered need the vaccines flies in the face of all the science that has reported on it thus far, the article from ***Israel National News*** I have included above is a good example of that point. In fact, many experts like Dr. Hooman Noorchashm MD an immunologist have pointed out that it is a **highly risky** practice to vaccinate those that have had it and recovered. https://www.newswars.com/doctors-issue-dire-warnings-about-covid-19-vaccine-dangers/

Getting the vaccines if you had COVID can be dangerous

Here is another reference to an article titled, Self-Reported Real-World Safety and Reactogenicity of COVID-19 Vaccines: A Vaccine Recipient Survey, that showed that people that have had the infection prior to vaccination had a 56% greater risk of more severe reactions leading to hospital care after the vaccines.

In conclusion

This extensive survey of over 2000 recipients of COVID-19 vaccines confirmed the findings of recent randomised controlled trials (RCTs) demonstrating that COVID-19 vaccines are generally safe with limited severe side effects. Moreover, it linked previous COVID-19 illnesses with an increased incidence of vaccination side effects. It also demonstrated that mRNA vaccines caused milder, less frequent systemic side effects but more local reactions *(than the adenovirus vector vaccines).* These findings will need to be validated in clinical studies, preferably randomized controlled trials including patients from multiple groups. (Emphasis mine)

https://pubmed.ncbi.nlm.nih.gov/33803014

In summary, other than a small percentage of adults that haven't had the infection or the vaccine, and those that have done their homework about vaccine risks and have a high vaccine risk awareness I.Q.

(especially when considering fast-tracked, protocol short-cut experimental gene therapy shots), that only leaves the children. Yes the children, our future and our treasure. And pharma has their sights on them, licking their chops with dollar signs in their eyes. I'll get to them shortly, but first let's consider another reason they are using the full-court-press.

So, once again why the desperation in the words and actions of public officials? I believe that there are many forces at work here, but I have a theory about one of them.

The Federal Government has spent tens of billions of dollars investing in the vaccines and the vaccine program. The product they have purchased has a shelf life. They just can't let their investment spoil on the shelf. In fact, one of the reasons that messenger RNA technology has been slow to come to market, is because messenger RNA degrades so rapidly as will be discussed in a ***British Medical Journal Investigation*** I will share with you now. This is one of the reasons they had the extreme cold protocols (-90 degrees F.) for shipping and storage of their products. As we know they have relaxed those policies which the rationale for has never been adequately explained. Regardless, this very likely means that the vaccines will have to be used much more rapidly. Not only that but as I reported in an earlier issue of this newsletter, it was discovered in the UK because of a hacking incident that uncovered emails discussing about an assessment of the quality of the messenger RNA in the vaccine lots and revealed that a significant percentage of messenger RNA proteins sequences did not match the protein sequences of the engineered spike protein as designed. They were truncated or just sections of the spike.

Here is that story as I reported it….

In an investigation published in the ***BMJ*** on March 10th, 2021 titled, **The EMA covid-19 data leak, and what it tells us about mRNA instability**, reveals that between 55-78% of the mRNA in the Pfizer vaccine is not the DNA/protein sequences they are intended to be. This could have vast implications as it relates to the possibility of causing autoimmune disease in the people receiving the vaccine. If the degraded protein sequences are similar to proteins in the host tissues of the people receiving the vaccine, the person's immune system may mount a persistent attack against those tissues.

From the article:

As it conducted its analysis of the Pfizer-BioNTech covid-19 vaccine in December, the European Medicines Agency (EMA) was the victim of a cyberattack.1 More than 40 megabytes of classified information from the agency's review were published on the dark web, and several journalists—including from *the BMJ*—and academics worldwide were sent copies of the leaks. They came from

anonymous email accounts and most efforts to interact with the senders were unsuccessful. None of the senders revealed their identity, and the EMA says it is pursuing a criminal investigation.

The BMJ has reviewed the documents, which show that regulators had major concerns over unexpectedly low quantities of intact mRNA in batches of the vaccine developed for commercial production.

EMA scientists tasked with ensuring manufacturing quality—the chemistry, manufacturing, and control aspects of Pfizer's submission to the EMA—worried about "truncated and modified mRNA species present in the finished product." Among the many files leaked to *The BMJ*, an email dated 23 November by a high ranking EMA official outlined a raft of issues. In short, commercial manufacturing was not producing vaccines to the specifications expected, and regulators were unsure of the implications. EMA responded by filing two "major objections" with Pfizer, along with a host of other questions it wanted addressed.

The email identified "a significant difference in % RNA integrity/truncated species" between the clinical batches and proposed commercial batches—from around 78% to 55%. The root cause was unknown and the impact of this loss of RNA integrity on safety and efficacy of the vaccine was "yet to be defined," the email said. suffers from contain "a significant difference in % RNA integrity/truncated species".

RNA instability is one of the biggest hurdles for researchers developing nucleic acid based vaccines. It is the primary reason for the technology's stringent cold chain requirements and has been addressed by encapsulating the mRNA in lipid nanoparticles (box).

"The complete, intact mRNA molecule is essential to its potency as a vaccine," professor of biopharmaceutics Daan J.A. Crommelin and colleagues wrote in a review article in *The Journal of Pharmaceutical Sciences* late last year. "Even a minor degradation reaction, anywhere along a mRNA strand, can severely slow or stop proper translation performance of that strand and thus result in the incomplete expression of the target antigen."6

AN IMPORTANT SECTION AT THE END OF THE ARTICLE:

Lipid nanoparticles—where do they go and what do they do?

Conceived three decades ago, RNA based therapeutics11 have long inspired imaginations for their theoretical potential to transform cells of the body into "an on-demand drug factory."12 But despite heavy investment by the biotech industry, bench-to-bedside translation was constantly hindered by the fragility of mRNA.

Over the years, researchers attempted to resolve intrinsic instability by encapsulating mRNA in nanocarriers made of polymers, lipids, or inorganic materials. Lipid nanoparticles (LNPs) were chosen

by Moderna, Pfizer-BioNTech, CureVac, and Imperial College London for their covid-19 vaccines. This has attracted the attention of specialists in the field of pharmaceutical biotechnology, some of whom have raised concerns about further unknowns.

In a rapid response posted on bmj.com, JW Ulm, a gene therapy specialist who has published on tissue targeting of therapeutic vectors,13 raised concerns about the biodistribution of LNPs: “At present, relatively little has been reported on the tissue localisation of the LNPs used to encase the SARS-CoV-2 spike protein-encoding messenger RNA, and it is vital to have more specific information on precisely where the liposomal nanoparticles are going after injection.”14 It is an unknown that Ulm worries could have implications for vaccine safety.

End of excerpts

https://www.bmj.com/content/372/bmj.n627

And now to the kids. The icing on the cake for pharma.

6. **Risks to children-** What is the risk to children from the virus? And does it warrant experimenting on them with an agent that has no long-term safety data on and a questionable risk benefit profile in the short-term?

As recently reported in a study using data through ***Public Health England (PHE)*** titled, **Deaths in Children and Young People in England following SARS-CoV-2 infection during the first pandemic year: a national study using linked mandatory child death reporting data**, the risk of death to healthy children is statistically zero. It used data from March 1st, 2020, through February 28th, 2021, a total of one year. They used detailed clinical data in the ***National Child Mortality Database (NCMD)***, a comprehensive and unique mandatory national dataset of deaths <18 years of age, to review the contribution of SARS-CoV-2 to death.

Out of over 12 million children under 18 years of age, it was estimated that there were 469,282 that were infected in that years’ time. Of that there were only 25 deaths due to COVID-19. That is an Infection Fatality Rate (IFR) of just 0.005%. That is one child dying per 20,000 infected. If you factor out the children that had serious co-morbidities, **only 6 healthy children died and the IFR becomes 0.001% or 1 death in approximately 78,000 total infections.** When comparing those deaths to the entire population of children and young people under the age of 18 (12,023,568 children), it is **1 death for every 2 million children.** Now any death in a child is tragic and in a utopian world none would die. But the reality is that in the same one year that this study evaluated, 3,105 children under age 18 died from all causes in England.

https://www.medrxiv.org/content/10.1101/2021.07.07.21259779v1

Study finds that zero children without underlying health conditions have died from COVID in the U.S.

Recently a team led by Dr. Marty Makary is a medical expert and professor at the ***Johns Hopkins School of Medicine, Bloomberg School of Public Health***, and ***Carey Business School*** discovered that ZERO children died from COVID-19 in the U.S. that did not have any pre-existing health conditions.

Dr. Makary authored a July 19th ***Wall Street Journal*** article titled **The Flimsy Evidence Behind the CDC's Push to Vaccinate Children**, in which he wrote about their findings.

From the article

A tremendous number of government and private policies affecting kids are based on one number: 335. That is how many children under 18 have died with a Covid diagnosis code in their record, according to the Centers for Disease Control and Prevention. Yet the CDC, which has 21,000 employees, hasn't researched each death to find out whether Covid caused it or if it involved a pre-existing medical condition.

Without these data, the CDC Advisory Committee on Immunization Practices decided in May that the benefits of two-dose vaccination outweigh the risks for all kids 12 to 15. I've written hundreds of peer-reviewed medical studies, and I can think of no journal editor who would accept the claim that 335 deaths resulted from a virus without data to indicate if the virus was incidental or causal, and without an analysis of relevant risk factors such as obesity.

My research team at Johns Hopkins worked with the nonprofit FAIR Health to analyze approximately 48,000 children under 18 diagnosed with Covid in health-insurance data from April to August 2020. **Our report found a mortality rate of zero among children without a pre-existing medical condition such as leukemia.** If that trend holds, it has significant implications for healthy kids and whether they need two vaccine doses. The National Education Association has been debating whether to urge schools to require vaccination before returning to school in person. How can they or anyone debate the issue without the right data?

Meanwhile, we've already seen inflated Covid death numbers in the U.S. revised downward. Last month Alameda County, Calif., reduced its Covid death toll by 25% after state public-health officials insisted that deaths be attributed to Covid only if the virus was a direct or contributing factor.

Organizations and politicians who are eager to get every living American vaccinated are following the CDC without understanding the limitations of the methodology. CDC Director Rochelle Walensky

claimed that vaccinating a million adolescent kids would prevent 200 hospitalizations and one death over four months. But the agency's Covid adolescent hospitalization report, like its death count, doesn't distinguish on the website whether a child is hospitalized *for* Covid or *with* Covid. The subsequent Morbidity and Mortality Weekly Report of that analysis revealed that 45.7% "were hospitalized for reasons that might not have been primarily related" to Covid-19.

End of excerpts

https://www.wsj.com/articles/cdc-covid-19-coronavirus-vaccine-side-effects-hospitalization-kids-11626706868

Risk comparison-

According to the ***National Safety Council***, the odds of dying in a car crash in 2019 (which is a one-year period) was 1 in 8,393. The odds of them dying in a car crash over the course of 1 year is nearly 10 times greater than the risk when comparing to the number of children that had the infection. When comparing to the entire population under age 18, the risk of dying in a car accident is 239 times greater (23,900%) than dying of COVID-19. My goodness folks, life is not without risk. If you are going to strap your child in a car and drive them around, you are putting them at far greater risk than the risk of them dying from COVID-19.

https://injuryfacts.nsc.org/all-injuries/preventable-death-overview/odds-of-dying/data-details/

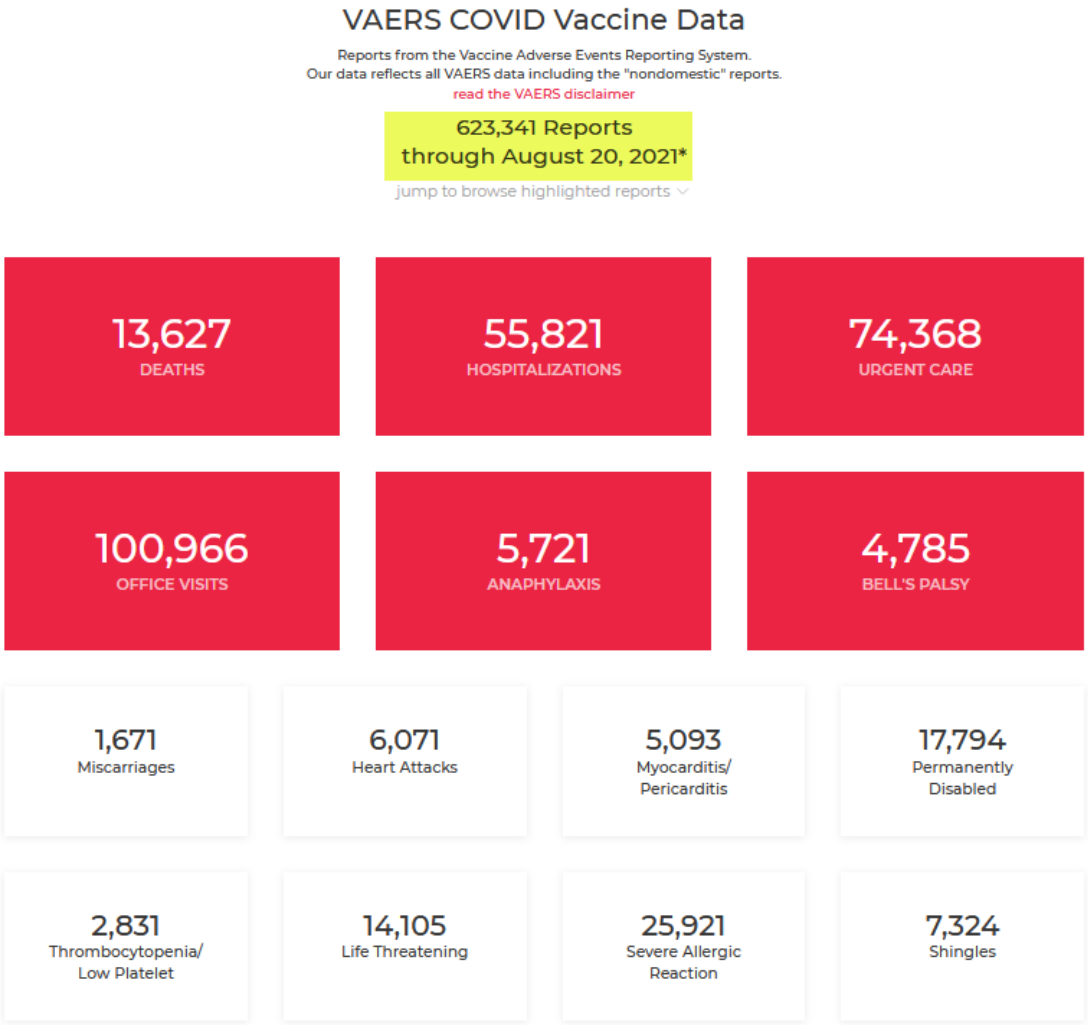
Not only that, but it has been proven time and time again that children are not vectors for spreading the virus, because we all know that one of the sales pitches is we need to vaccinate the children to protect grandma and grandpa. First of all, why don't we do a survey of all of the grandmas and grandpas in this country and ask them if they feel it is worth the risk to vaccinate their grandkids with this experimental shot to protect them from their grandkids. I would bet the results would fall heavily on the "leave 'em alone" side.

To consider vaccinating children, especially healthy children with these experimental products that are causing serious side effects in an alarming number of young people is horrific. I pray that the people in charge of making these decisions will leave their own competing financial and professional interests behind and do the right thing for our children.

September 1st, 2021 update

Current VAERS reported COVID-19 vaccine injuries and deaths in the U.S.

The death reports after COVID-19 vaccines have now exceeded the total number of deaths from ALL VACCINES COMBINED since the system was started 30 years ago!



https://www.openvaers.com/covid-data

Percentage of people reporting injuries and deaths after COVID-19 vaccines

As of August 20th, the estimates are that there were 168 million people fully vaccinated in the U.S. That is 168,000,000 or 51% of the population. As shown above, there have been nearly 623,000 injuries reported after the shots. Dividing the injuries into the number of people fully vaccinated, it works out to 1 injury every 270 people, or 0.37% of those getting the shots. Considering the 13,627 reported deaths to VAERS (if accurate), would mean that 1 person in every 12,328 people that are fully vaccinated die with suspicious enough circumstances for a doctor or close relative to believe that their death was as a result of the vaccine.

According to a search of VAERS records, a portion of those reported deaths are from people outside of the U.S. If this is true, it is puzzling why the CDC's reporting system would allow this, since this system is supposed to be specific for the U.S. But let's assume that is true. That reported number is 6,128 deaths as of August 20th, 2021. Using that conservative figure, that still means that there is 1 reported death for every 27,415 fully vaccinated people. Even using this most conservative number, if there were a drug on the market that was killing one out of every 27,415 people that took it, it would be immediately pulled from the market! And if you don't think the VAERS figures are conservative, read this next section.

Key Point

As reported many times before, but important for any new readers that are not aware of the extreme under-reporting of adverse events to the VAERS system. For those that have seen this information feel free to scroll on past.

The U.S. government funded a Harvard study that found that less than 1% of adverse reactions to vaccines are reported to VAERS

More about that in a second. But imagine if this is true, you would ADD two zeros to each of the above numbers, i.e., 1,194,000 deaths! Some say that with serious reactions like deaths it may be higher reporting. If instead of <1%, what if only 10% were reported. You would then add one zero to the reported deaths and the actual number would be 119,400 thus far. The next logical question would have to be, "how many is too many?"

And as we all know by now, the vaccine makers are completely liability free for any damages caused by their products. You assume ALL risk and costs for damages.

Here's the proof of the <1% reporting claim

Harvard Pilgrim Health Care performed the study between 12/01/2007 -09/30/2010. The report was titled, **Electronic Support for Public Health–Vaccine Adverse Event Reporting System (ESP: VAERS)**

https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf

The Purpose of the Study:

"This research project was funded to improve the quality of vaccination programs by improving the quality of physician adverse vaccine event detection and reporting to the national Vaccine Adverse Event Reporting System (VAERS)...

"The CDC's Public Health Information Network Messaging System (PHIN-MS) software was installed within the facilities so that the approved reports could be securely transferred to VAERS as electronic

messages in an interoperable health data exchange format using Health Level 7 (HL7)."

Results from the study:

"Preliminary data were collected from June 2006 through October 2009 on 715,000 patients, and 1.4 million doses (of 45 different vaccines) were given to 376,452 individuals. Of these doses, 35,570 possible reactions (2.6 percent of vaccinations) were identified. This is an average of 890 possible events, an average of 1.3 events per clinician, per month. These data were presented at the 2009 AMIA conference."

Dividing 1.4 million doses between 376,452 people is an average of 3.72 doses per person. And, if there were 35,570 reactions in 1.4 million doses given, that is one adverse reaction for every 39.4 doses. Perhaps what is most striking here is that if each person reacting experienced on adverse reaction only, of the 376,452 individuals vaccinated, nearly 10% experienced a possible reaction!

"Adverse events from drugs and vaccines are common but underreported. Although 25% of ambulatory patients experience an adverse drug event, less than 0.3% of all adverse drug events and 1-13% of serious events are reported to the Food and Drug Administration (FDA). **Likewise, fewer than 1% of vaccine adverse events are reported.** Low reporting rates preclude or slow the identification of "problem" drugs and vaccines that endanger public health."

Despite the under-reporting of deaths and serious adverse reactions to the COVID-19 vaccines, our public health authorities and public health agencies remain silent and even ignore the pleas of the many injured

people. Senator Ron Johnson of Wisconsin held a press conference earlier this week and invited some of the victims to tell their stories because they have been ignored. https://informedchoicewa.org/news/senator-ron-johnson-milwaukee-news-conference-covid-19-vax-injuries/

Unfortunately, this is not unprecedented as tens of thousands of families have been ignored by our federal government after they or their children have been injured throughout the years. I have chronicled and investigated the science being vaccine injury and reported it in my eBook titled, 1200 Studies- Truth Will Prevail. It is now over 900 pages in length and contains excerpts from over 1,500 studies that contradict the public narrative about the safety and effectiveness of vaccines. It is available online at https://1200studies.com

What about the European Union? What is the reported casualty count there?

The database (https://www.adrreports.eu/en/index.html), which covers the 27 countries of the ***European Union*** is similar to the U.S. ***VAERS*** Database. Also, like VAERS the reported deaths and injury are likely significantly understated (As has been previously reported, a 2010 study funded by the ***CDC*** and conducted by ***Harvard***, found that <1% of vaccine adverse reactions are reported to VAERS). And. as you read this consider that there are about 50 countries that are considered a part of Europe. So, these numbers may only reflect around half or slightly more of the total REPORTED injuries and deaths across Europe.

The title of an article published in ***GlobalResearch.org*** on August 3rd 2021, sums up the magnitude of the problem across the pond. The title of the article is **20,595 Dead 1.9 Million Injured (50% Serious) Reported in European Union's Database of Adverse Drug Reactions for COVID-19 Shots.** From the total of injuries recorded, half of them (968,870) are **serious** injuries.

https://www.globalresearch.ca/20595-dead-1-9-million-injured-50-serious-reported-european-union-database-adverse-drug-reactions-covid-19-shots/5751904

Relevant facts

- The current population of all of the countries in the E.U. combined is 447,794,691 (2020 Census data as reported by the World Bank). https://data.worldbank.org/indicator/SP.POP.TOTL?locations=EU

- According to ***Our World in Data***, the percentage of people fully vaccinated in countries of the ***European Union*** is 49% as of July 31st, 2021, (the date the data for injuries and deaths were updated). 49% of the total vaccinated population means that 219,419,399 people are considered fully vaccinated. https://ourworldindata.org/coronavirus

So, now let's do some simple math.

- For round numbers, there have been 1 million REPORTED **serious adverse reactions** to the vaccines in the E.U. as of July 31st, 2021. With 220 million people fully vaccinated, that means that **1 person in every 220 people are having a serious adverse reaction** to the vaccines. How can that be called "safe" as we keep hearing? Name any drug on the market. If it was causing a serious adverse reaction in 1 out of every 220 people taking it, it would be pulled from the market immediately and a full investigation would be launched to figure out what went wrong and who the responsible parties were!

- How about deaths? With 21,000 REPORTED **deaths**, that calculates to **1 death in every 10,449 people that are fully vaccinated**. Once again, if there were a drug on the market that was killing one out of every 10,449 people that took it, it would be immediately pulled from the market!

The scenario is most likely far worse

And remember these are just reported serious injuries and deaths. Just like our own ***VAERS*** system, the ***EudraVigilance*** system in the EU is most certainly also very underreported. And I know that this is purely speculation, but it's not out of the realm of possibility. Imagine **if the reported numbers were just 10% of the actual numbers. That would mean that there would be 1 serious vaccine injury in every 22 vaccinated persons and 1 death in every 1,045 vaccinated people!**

From the article
From the total of injuries recorded, half of them (968,870) are **serious** injuries.

*"**Seriousness** provides information on the suspected undesirable effect; it can be classified as 'serious' if it corresponds to a medical occurrence that results in **death**, is life-threatening, requires inpatient hospitalisation, results in another medically important condition, or prolongation of existing hospitalisation, results in persistent or significant disability or incapacity, or is a congenital anomaly/birth defect."*

Here is the summary data through July 31, 2021.

**I have broken out the 4 different vaccines total injuries from the article. In the article, the injuries and deaths from the vaccines are listed by category and type of injury.*

From the article: A *Health Impact News* subscriber in Europe ran the reports for each of the four COVID-19 shots we are including here. This subscriber has volunteered to do this, and it is a lot of work to tabulate each reaction with injuries and fatalities, since there is no place on the EudraVigilance system we have found that tabulates all the results. Since we have started publishing this, others from Europe have also calculated the numbers and confirmed the totals. **If you want to see that in detail, you can click on the link at the bottom of this section.*

- **Total reactions** for the experimental mRNA vaccine **Tozinameran** (code **BNT162b2**, **Comirnaty**) from **BioNTech/ Pfizer: 9,868 deaths** and **767,225** injuries to 31/07/2021

- **Total reactions** for the experimental mRNA vaccine **mRNA-1273 (CX-024414) from Moderna: 5,460 deaths** and **212,474 injuries** to 31/07/2021

- **Total reactions** for the experimental **vaccine AZD1222/VAXZEVRIA (CHADOX1 NCOV-19) from Oxford/ AstraZeneca**: **4,534 deaths** and **923,749 injuries** to 31/07/2021

- **Total reactions** for the experimental **COVID-19 vaccine JANSSEN (AD26.COV2.S) from Johnson & Johnson**: **733 deaths** and **57,159 injuries** to 31/07/2021

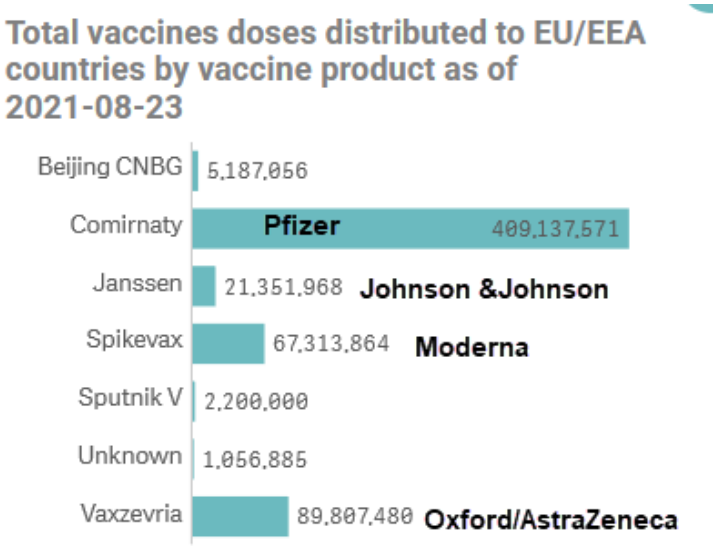
EudraVigilance - European database of suspected adverse drug reaction reports

EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

Last Update: Jul 31, 2021	Reported Cases	Fatalities	% fatalities to cases	All Multiple Symptoms	Serious injuries	% serious to ALL
Oxford/AstraZeneca	346 881	4 534	1,31%	923 749	496 693	53,77%
Pfizer-BioNTech	327 665	9 868	3,01%	767 225	336 609	43,87%
Moderna	84 587	5 460	6,45%	212 474	116 849	54,99%
Janssen	19 915	733	3,68%	57 159	18 719	32,75%
Total:	**779 048**	**20 595**	2,64%	**1 960 607**	**968 870**	49,42%

***Note (This is my comment):** The number of injuries and deaths reported for each vaccine most likely does not reflect the comparison of the different vaccines for risk of injury, because it may reflect the number of doses of those vaccines administered. The Pfizer (now called the Camirnaty shot), is by far the most used one (see the graph below). https://www.globalresearch.ca/20595-dead-1-9-million-injured-50-serious-reported-european-union-database-adverse-drug-reactions-covid-19-shots/5751904

There has been a simultaneous name change (rebranding) of all the top COVID-19 vaccines



All this, yet the FDA has now fully approved Pfizer's shot. Was that done aboveboard and what data did they rely on to make their determination?

The approval of the Pfizer vaccine may be the most scandalous thing the FDA has ever done (and that's saying a lot)

Let's get straight to the point…

1. The extent of the data the FDA relied on for their determination was only up to March 13th, 2021 and the Delta variant (vaccine resistant) wasn't established until months later. Therefore, the vaccine the FDA approved was for the original Wuhan strain, which is gone from the scene now. Therefore, the vaccine is largely ineffective against the present-day radically different virus.

2. By the March 13th data endpoint that the FDA relied on, there was only 6-months of data for a trial that isn't designed for completion until January 29th, 2023.

3. Only 7% of trial participants ever reached 6-months of "blinded" follow-up. Therefore, there is no safety or efficacy data available past 6-months (since March 13th).

4. The FDA skipped the usual step of referring the matter to either the ***Vaccines and Related Biological Products Advisory Committee (VRBPAC)*** or the ***Advisory Committee on Immunization Practices (ACIP)*** committees.

5. The FDA IGNORED the only vaccine safety monitoring system we have, which is the CDC's own ***Vaccine Adverse Event Reporting System (VAERS).***

Point 1 (con't)- That was before the Delta variant came on the scene here in the U.S. It was first identified sometime in March but didn't become the dominant variant until several weeks later. Why is that important? It is because the Delta variant has developed several mutations (*see below) of the spike protein which allow it to evade the vaccine induced immune response to the original Wuhan spike protein configuration.

According to the CDC, Delta and its subtypes display spike protein mutations T19R, (V70F), T95I, G142D, E156-, F157-, R158G, (A222V*), (W258L*), (K417N*), L452R, T478K, D614G, P681R, and D950N.

As you will see in this issue of my newsletter, the percentages of patients hospitalized and succumbing to COVID-19 is has shifted predominantly to fully vaccinated people in many of the most highly vaccinated countries in the world as the vaccine is failing. **There are two main reasons for that.**

Number one- the number of antibodies drop off quickly after vaccination. A ***University College London*** study found that antibodies generated by two doses of the Oxford/AstraZeneca and Pfizer/BioNTech vaccines started to wane **as early as six weeks after the second shot, in some cases falling more than 50% over 10 weeks.** https://www.theguardian.com/world/2021/jul/22/uk-scientists-back-covid-boosters-as-study-finds-post-jab-falls-in-antibodies

And it takes 2-weeks after the second shot for the body to reach maximum antibody protection. That means **within 4-weeks** after that point, the antibodies are already declining. And by 8-weeks after a person is considered fully protected, the "protection" has already diminished by 50%. Why wasn't that brought to the attention of the regulators when Pfizer applied for the ***Emergency Use Authorization (EUA)*** in December of 2020? The FDA had set a bar of 50% effectiveness to even approve a vaccine under EUA. There is a very good chance that this product would not have even met that bar in the first place if this evidence had been fully disclosed.

Number two- The previously mentioned issue of vaccine escape by the Delta variant. A Forbes article Julu 23rd (**a month before FDA approval**) reported that the ***Health Ministry of Israel*** had determined that the Pfizer vaccine's effectiveness had dropped to 39%. And we have just approved it? Don't the folks at the FDA read the data coming in from countries that are slightly ahead of us in the rollout of the vaccines and where the Delta variant became prevalent before it was here? Wouldn't that be a good way to predict what may occur here? I guess that would make too much logical and strategic sense and we can't have

that now, can we? Or, could it be that the FDA rushed the approval knowing that if they waited any longer, the efficacy of the Pfizer vaccine would fall so drastically that it wouldn't even reach the minimum 50% effectiveness bar that they set last fall for the Emergency Use Authorization?

Regardless, the good news is natural immunity following infection with SARS-CoV-2 affords MUCH better and lasting protection than the vaccines. More about that later in this newsletter, as a brand-new study out of Israel proves that point.

Point 2- See Point 3

Point 3- With only six months of data and allowing the unblinding of the trial subjects before the end of the six-month period, that brings the data and validity of it into question. Not only that but as I've reported in previous issues against the FDA's original recommendations Pfizer was allowed to offer vaccines to the control group. This essentially wipes out or erases the placebo group making it impossible to follow them and track for long term adverse effects from the vaccine. This seems to be a concerted effort to undermine the ability to identify any safety signals or long-term adverse effects in the population. This in and of itself should disqualify the clinical trial altogether.

Point 4- This is an essential step which allows for public comment on the approval process. This would accommodate for not just lay people, but doctors and scientists to face the committee and comment regarding their concerns, giving them the chance to ask pointed and direct questions of the committee. This is part of the democratic process. But, as we have seen with so many things related to COVID-19, scientific debate and discussion has been censored and those that offer alternative scientific positions are cancelled. It is obvious that the powers-that-be considered this too risky, especially in light of the vaccine failures that are being seen all around the world and the astronomical numbers of adverse reactions and deaths being reported. Refer to Point 5.

Point 5- With well over 600,000 adverse events including 56,000 hospitalizations, 74,000 urgent care visits and over 13,000 deaths reported from the vaccines, how can this possibly be ignored?! That number of deaths is more than have been reported by all 70 vaccines combined over the last 30 years. As you will also see in this issue, there have been 2-million adverse injury reports from the vaccines in the 27 countries of the ***European Union***, with half of them considered serious. In addition to that, there have been over 20,000 deaths reported. An interesting note about that is, that the Pfizer vaccine represents the vast number of doses given to citizens of those countries. You just saw that a few pages ago.

Peter Doshi, Associate Editor of the ***British Medical Journal (BMJ)*** makes many of these points in an excellent Opinion Letter to the BMY dated August 23rd, 2021, and titled **Does the FDA think these data justify the first full approval of a covid-19 vaccine?**

https://blogs.bmj.com/bmj/2021/08/23/does-the-fda-think-these-data-justify-the-first-full-approval-of-a-covid-19-vaccine/

The official narrative we had been hearing of COVID-19 is now a disease of the unvaccinated, is falling apart as data coming in from around the world contradicts the CDC's claims

A new report from ***Public Health England*** dated August 15th, 2021, and titled, **SARS-CoV-2 variants of concern and variants under investigation in England Technical briefing 21**, reveals a disturbing trend, at least for vaccinated people over 50.

The following table is from pages 22 & 23. It covers the time period from February 1st, 2021 to August 15th, 2021.

Table 5. Attendance to emergency care and deaths of sequenced and genotyped Delta cases in England by vaccination status (1 February 2021 to 15 August 2021)

Variant	Age group (years)**	Total	Cases with specimen date in past 28 days	Unlinked	<21 days post dose 1	≥21 days post dose 1	≥14 days post dose 2	Unvac-cinated
Delta cases	<50	337,834	106,718	35,397	25,965	57,688	40,544	178,240
	≥50	48,264	20,295	4,242	228	6,075	32,828	4,891
	All cases	386,735	127,091	40,273	26,194	63,763	73,372	183,133
Cases with an emergency care visit§ (exclusion‡)	<50	11,195	N/A	88	886	1,581	1,161	7,479
	≥50	2,952	N/A	18	19	372	1,803	740
	All cases	14,147	N/A	106	905	1,953	2,964	8,219
Cases with an emergency care visit§ (inclusion#)	<50	14,676	N/A	154	1,111	1,926	1,447	10,038
	≥50	5,098	N/A	36	43	574	2,956	1,489
	All cases	19,774	N/A	190	1,154	2,500	4,403	11,527
Cases where presentation to emergency care resulted in overnight inpatient admission§ ((exclusion‡)	<50	2,538	N/A	41	144	267	246	1,840
	≥50	1,593	N/A	11	13	149	990	430
	All cases	4,131	N/A	52	157	416	1,236	2,270
Cases where presentation to emergency care resulted in overnight inpatient admission§ (inclusion#)	<50	4,112	N/A	71	229	402	366	3,044
	≥50	3,173	N/A	28	31	287	1,838	989
	All cases	7,285	N/A	99	260	689	2,204	4,033
Deaths within 28 days of positive specimen date	<50	113	N/A	3	6	5	27	72
	≥50	1,076	N/A	13	8	85	652	318
	All cases	1,189	N/A	16	14	90	679	390

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1012644/Technical_Briefing_21.pdf

On the surface, this may look like the vaxxed have the advantage as they have fewer numbers of PCR positive cases. The greater concern is in the hospitalizations and deaths which is what I have been saying all along, as this is what stresses the capacity of the healthcare system.

Deaths

- The deaths in the vaxxed (679) out of 73,372 positive cases **(.93%)** represents 64% of total deaths.
- The deaths in the unvaxxed (390) out of 183,133 positive cases **(.21%)** is 36% of total deaths *(see highlighted numbers in the table above).*
- In the vaxxed group, that calculates to 1 death in every 108 cases.
- In the unvaxxed it works out to be 1 death in every 470 cases.

That ratio is approximately 4.4 times higher in the vaxxed than the unvaxxed.

Hospitalization

Check out the percentage of vaxxed vs. unvaxxed that presented to the E.R. **and resulted in overnight in-patient admission**.

For those under age 50, the rate is higher in the unvaxxed vs. vaxxed (1.7% vs. 0.5% of PCR cases).

The over 50-age group. In that cohort, there were 989 in the unvaxxed group and 1,838 in the vaxxed group. **That means that 2.5% of the vaxxed cases had to be admitted to the hospital for an overnight stay. This compares to just 0.54% in the unvaxxed cohort.**

This trend that we are seeing in highly vaccinated countries of the vaccinated becoming less and less protected and more and more sick as time goes on is very concerning, in this case especially with older individuals. This could be caused in part by the rapid decline of the antibodies conferred by the vaccines. But if that were the case, why would the unvaccinated older individuals, which have no vaccine caused SARS spike protein generated antibodies be doing so much better with regard to serious illness and deaths? This could point to an even

more concerning issue for vaccinated individuals. It could be a signal for Antibody Dependent Enhancement (ADE) occurring in vaccinated individuals. As I reported nearly a year ago, ADE discovered in animal trials during attempts to develop coronavirus vaccines nearly 20 years ago affected the older animals at a rate nearly 10 times higher.

Children's Health Defense also reported on this phenomenon specifically with the Pfizer vaccine (and before the vaccines were authorized under the EUA)

According to a December 10th, 2020 article in the ***Children's Health Defense*** e-publication called ***the Defender*** titled, **Pfizer COVID Vaccine Trial Shows Alarming Evidence of Pathogenic Priming in Older Adults,** concerns are raised about pathogenic priming and how older adults may fare from these vaccines.

https://childrenshealthdefense.org/defender/pfizer-covid-vaccine-trial-pathogenic-priming/

The article goes on to say: The Vaccines and Related Biological Products Advisory Committee Briefing Document on the Pfizer-BioNTech COVID-19 vaccine contains disturbing indications that might be a safety signal on pathogenic priming, **especially in older adults.** (**My comment:** this is consistent with previous failed attempts to develop a coronavirus vaccine, where the older animals were the ones most likely to suffer severe reactions from pathogenic priming).

Even as of June the trend of vaccinated getting reinfected, hospitalized and even dying is accelerating!

Now the even more concerning part for vaccinated people. I had the section below in my newsletter last month. It was from ***Public Health England's*** Technical Report document that was dated June 25th. The percentage of deaths in the vaccinated was 43% at that time. The range of dates covering that report was from February 1st, 2021, through June 14th, 2021. Now, as just reported a couple pages earlier, that has increased to 64%. And it's not just a 20% increase in the matter of 60 days. Recall that these statistics run from February 1st, 2021. That means that in the short span of the last 60 days, the increase in percentage of deaths in vaccinated individuals has been enough to skew the whole six months of reporting up 20%.

As it appears like the severity of disease is escalating in vaccinated people, could be the feared ***ADE, Antibody Dependent Enhancement***. Or that the vaccines are interfering with the non-specific antibodies and innate arm of the immune system, in essence undermining the body's first line of defenses. Both of these possibilities were predicted by many credible doctors and scientists.

From my July newsletter

"A Pandemic of the Unvaccinated"- What is the TRUTH?

The latest reports that 99% of all COVID-19 deaths are in unvaccinated people in the U.S. is an absurd lie. And that's not the only lie we have been told. There is an abundance of them. Here are just some of them and the proof as to their fallacy.

1. **The vaccines are failing-** The U.S. would have to be an anomaly compared to other nations. Israel the country with the highest vaccination rates in the world reports that people that were vaccinated in January have already lost a good portion of their protection according to ***Pfizer Chief Scientific Officer*** Mikael Dolsten. "The Pfizer vaccine is highly active against the Delta variant," Dolsten said in an interview, according to *Reuters*. But after six months, he said, "there likely is the risk of reinfection as antibodies, as predicted, wane."

   In addition to all of that, England reports that **43% of their hospitalizations and deaths are in fully vaccinated people** as this table clearly shows. The report from ***Public Health England*** is titled**, SARS-CoV-2 variants of concern and variants under investigation in England** and was published June 25th, 2021.

SARS-CoV-2 variants of concern and variants under investigation

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001359/Variants_of_Concern_VOC_Technical_Briefing_16.pdf

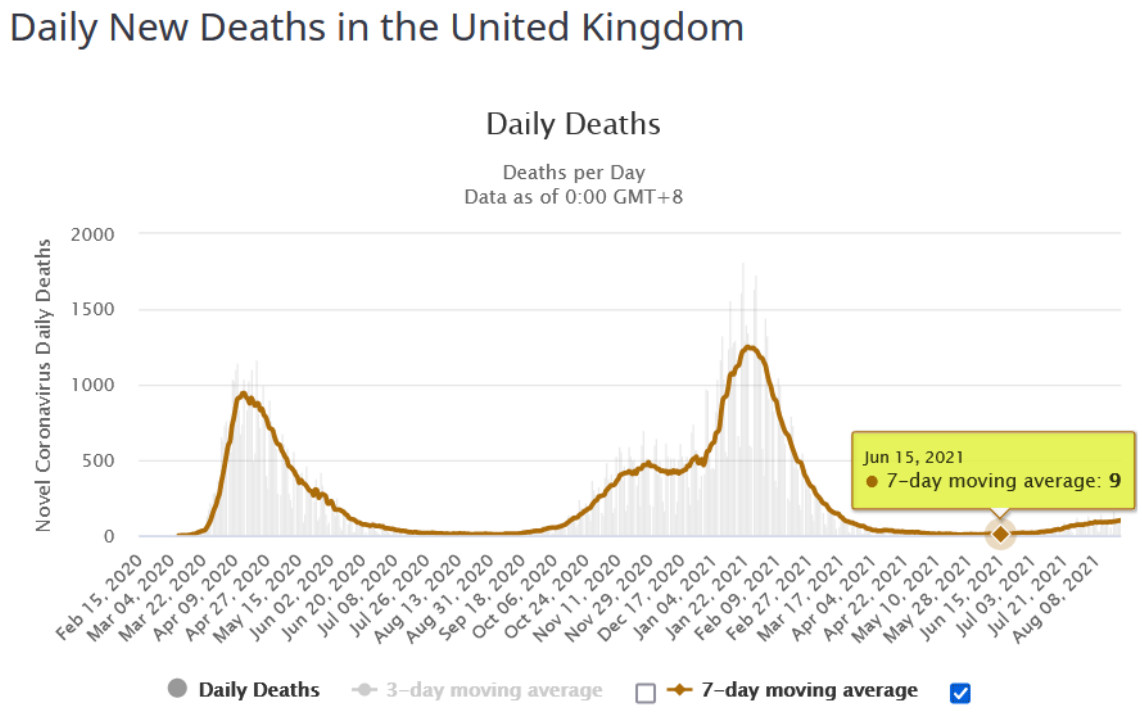
Table 4. Attendance to emergency care and deaths by vaccination status among Delta confirmed cases (sequencing and genotyping) in England, 1 February 2021 to 14 June 2021.

	Total	Cases with specimen date in past 28 days*	Unlinked	Unvaccinated	<21 days post dose 1	≥21 days post dose 1	≥14 days post dose 2
Delta cases since 1 Feb 2021 ¥	60,624	53,177	7,461	35,521	4,094	9,461	4,087
Cases with an A&E visit§ (excluding cases with the same specimen and attendance dates)‡	1,555	NA	14	1,038	116	285	102
Cases with an A&E visit§ (including cases with the same specimen and attendance dates)	2,176	NA	24	1,446	155	378	173
Cases where presentation to A&E resulted in overnight inpatient admission§ (excluding cases with the same specimen and admission dates)‡	488	NA	7	324	30	87	40
Cases where presentation to A&E resulted in overnight inpatient admission§ (including cases with the same specimen and admission dates)	806	NA	10	527	50	135	84
Deaths^	73	NA	2	34	1	10	26 43%

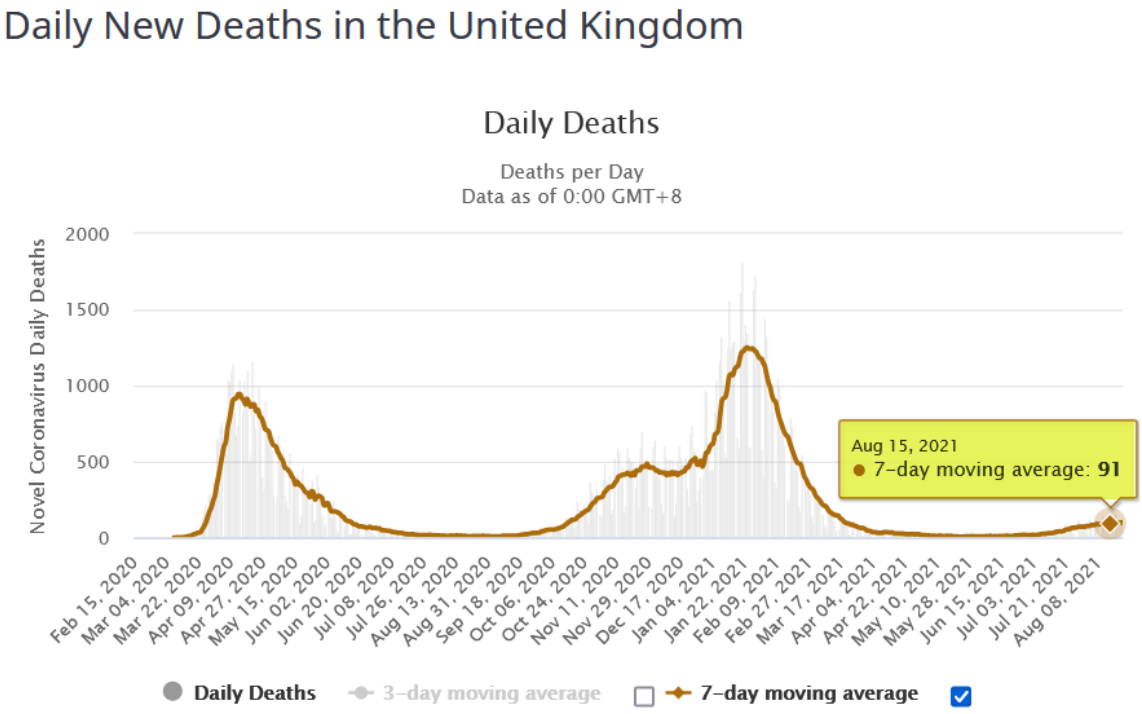
Data sources: Emergency care attendance and admissions from Emergency Care Dataset (ECDS), deaths from PHE daily death data series (deaths within 28 days)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001359/Variants_of_Concern_VOC_Technical_Briefing_16.pdf

This was the 7-day average of deaths at that time in the UK on June 14th



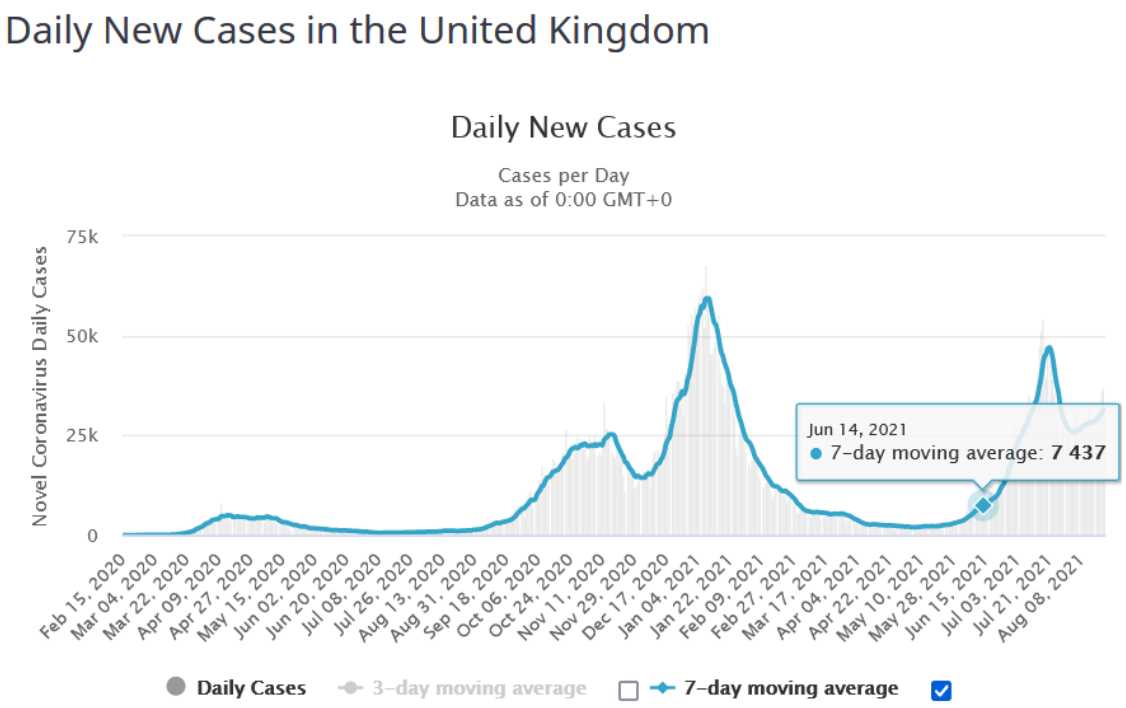
This was the 7-day average for deaths in the UK on August 15th, the date of the PHE report.



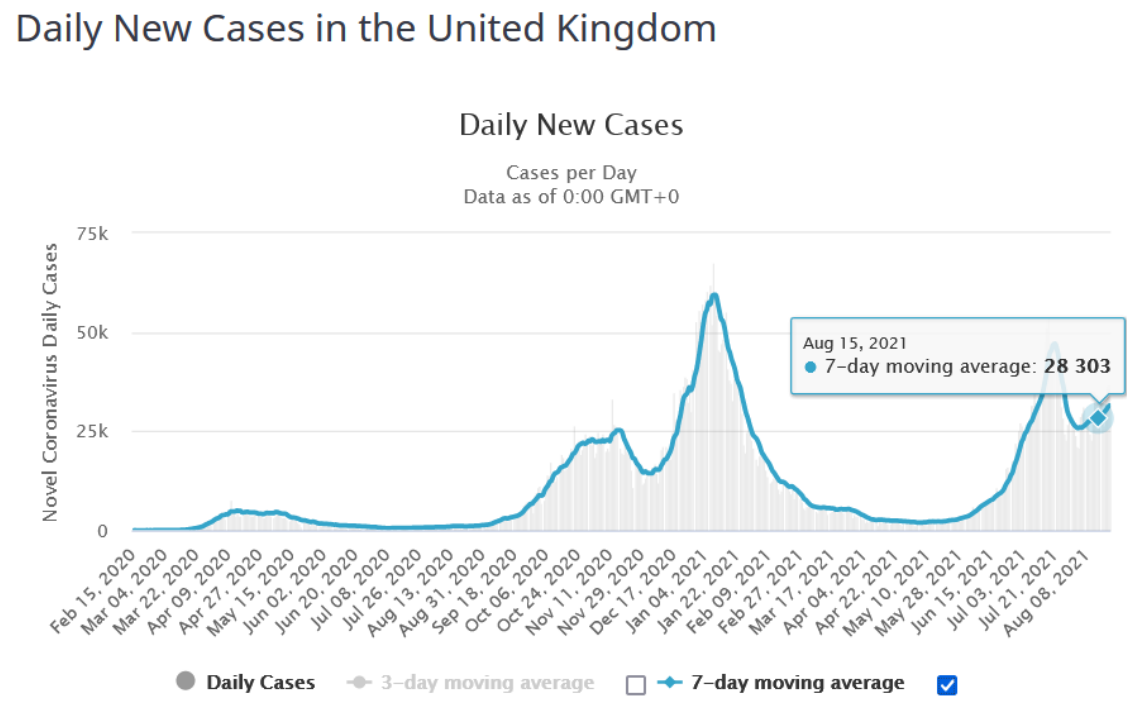
As you can see, the 7-day average for daily deaths is 10-fold higher as of August 15th (91) as compared to June 14th (9).

Case comparison for June 14th and August 15th

June 14th



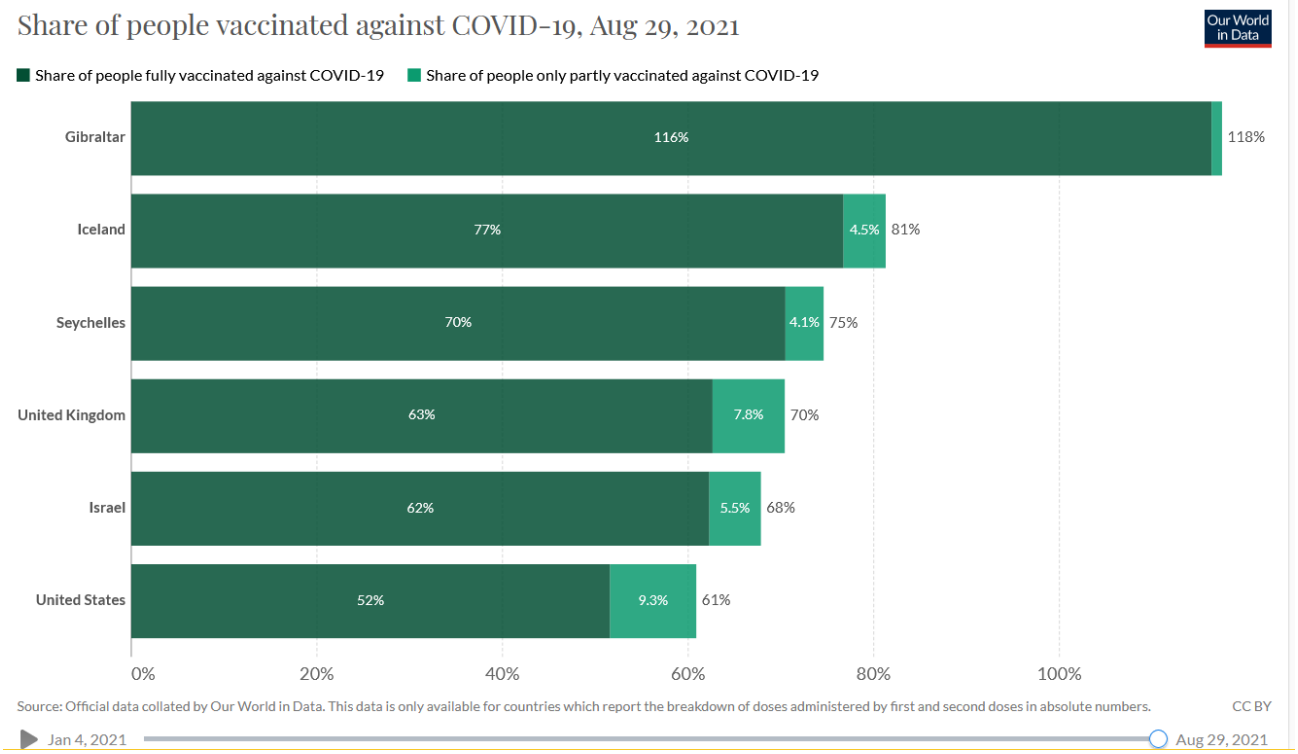
August 15th



https://www.worldometers.info/coronavirus/country/uk/

In many countries, the mass vaccination programs have been associated with spikes in deaths immediately following the start and now deaths in fully vaccinated appear to be rising higher than in the unvaccinated

This is a graph showing some of the countries with the highest vaccination rates in the world



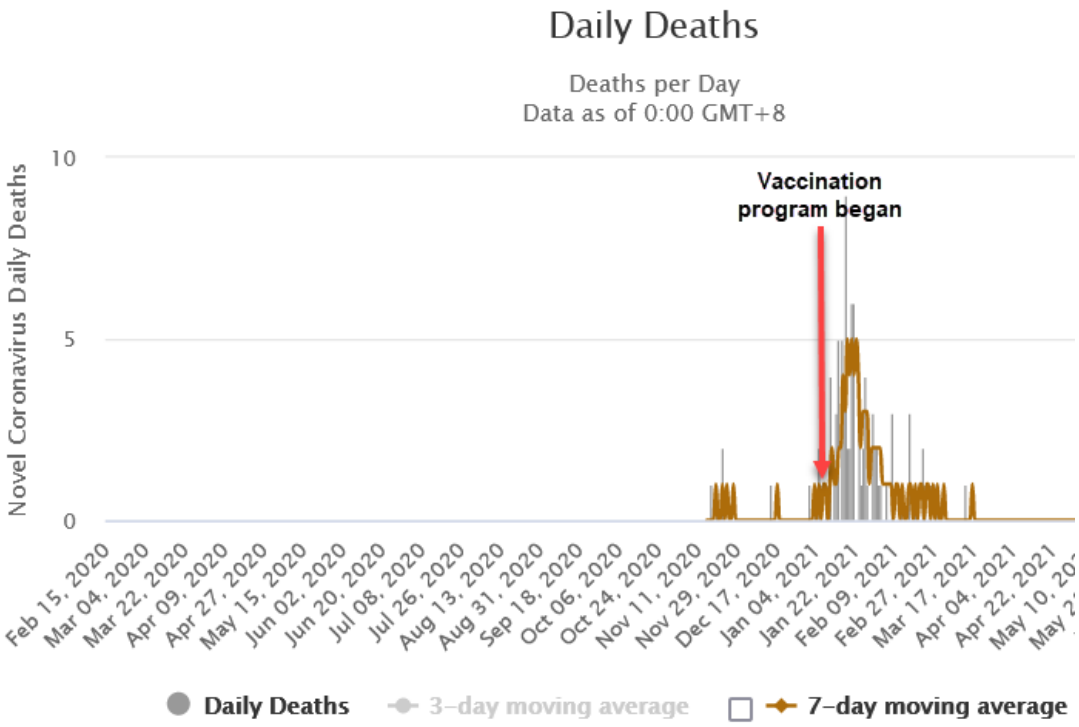
Gibraltar's 116% vaccination rate is apparently because they have a large workforce that comes in from out of the country. That workforce is also required to be vaccinated.

Gibraltar

In an article by Lance D. Johnson and published on Dr Eddy Bettermann MD's website titled, **Elderly population suddenly dying off for unexplained reasons, and it's no longer coded as covid-19**, the sudden deaths in the elderly of Gibraltar immediately after the vaccination program began is called the "worst loss of life there in over 100 years". *(Gibraltar has a population of 33,680).*

From the article

Around the world, medical authorities are seeing a spike in elderly deaths, after covid-19 vaccination. Gibraltar, a nation located at the southern tip of Spain is suffering from an unexplained surge in elderly deaths. In the second week of January, a subset of the elderly population suddenly started to die off *(see the graph below)*. The new wave of unexplained elderly deaths is occurring at nearly three times the magnitude of covid-19 deaths that were recorded during 2020.



My comment: If you have been reading my newsletters, you would have seen other reports from dozens of countries around the world showing spikes in deaths related to “COVID” shortly after the mass vaccine rollouts.

Continued from the article

The new, unexplained surge in elderly deaths is occurring approximately forty times faster when compared to the overall timeline of covid-19 deaths that occurred since a pandemic was first declared. This surge in elderly deaths occurred after 5,847 doses of experimental mRNA injections were administered to the citizens of Gibraltar. In just one week, 17 percent of the country’s population had been inoculated with the first dose of Pfizer’s mRNA experiment.

Before the vaccine experiment began, the covid-19 related death toll accounted for ten people. After the vaccine rollout, the total number of deaths had skyrocketed to forty-five people. In the first eight days of the vaccination program, thirty-five seniors suddenly passed away.

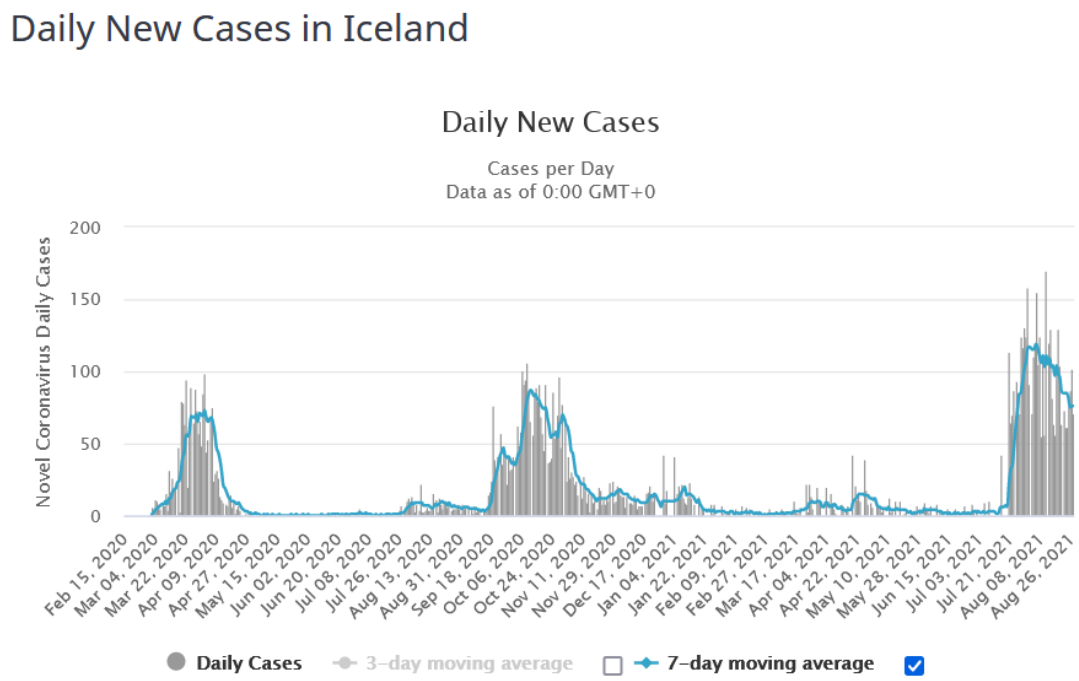
After the first week of vaccination, Chief Minister Fabian Picardo said, “This is now the worst loss of life of Gibraltarians in over 100 years. Even in war, we have never lost so many in such a short time.”

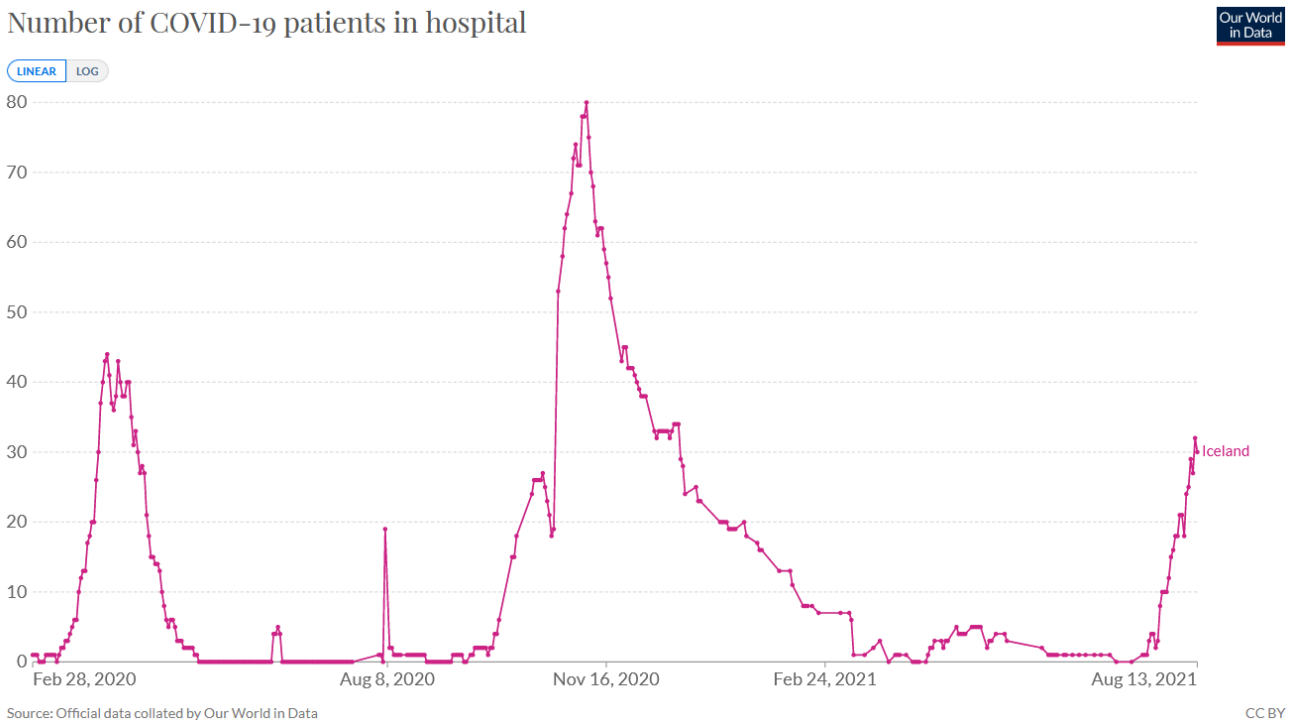
Vaccine-induced deaths to be blamed on new “covid-variant”

In 2020, medical examiners would have easily labeled these sudden deaths as covid-19, but now these deaths are somehow unexplained, with no definitive cause. Before the covid-19 vaccines were unleashed, seniors died of covid-19. Now seniors are dying of natural causes again, right after being vaccinated. It won’t be long before a surge in elderly deaths around the world is blamed on a new variant of SARS-CoV-2, with medical authorities calling for new vaccines, more doses, and mRNA updates. Isn’t it suspicious that a deadly covid-variant became headline news suddenly after the vaccine rollout? https://dreddymd.com/2021/02/18/elderly-population-suddenly-dying-off-for-unexplained-reasons-and-its-no-longer-coded-as-covid-19/

Iceland

Iceland is second on our list with 77% of the population fully vaccinated. Iceland is a small country both is size and from a population perspective. The population of Iceland is 344,000. At 75% of their population fully vaccinated, they rank among the highest in the world. So what do their cases and hospitalizations look like currently.

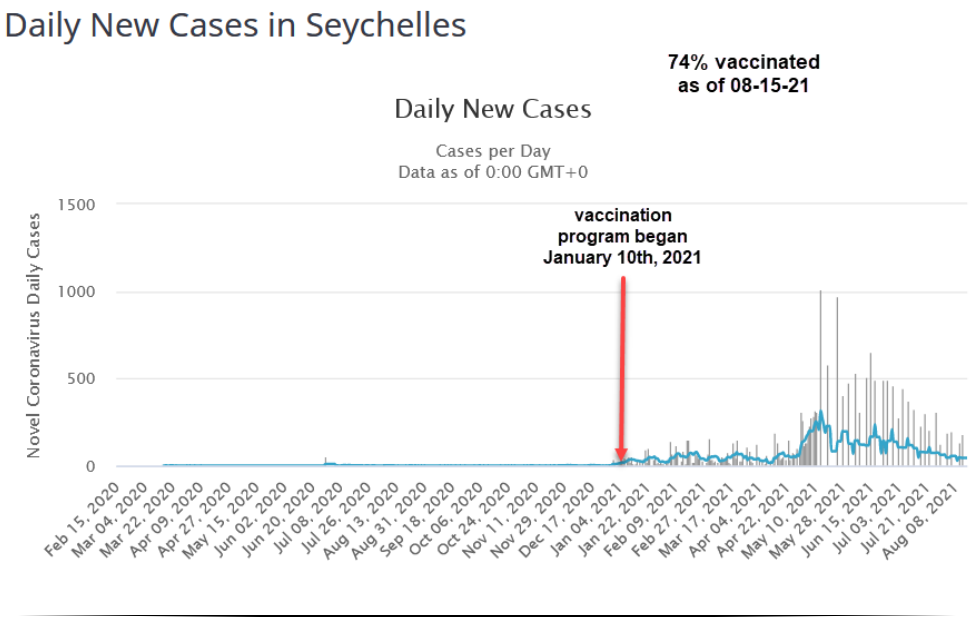




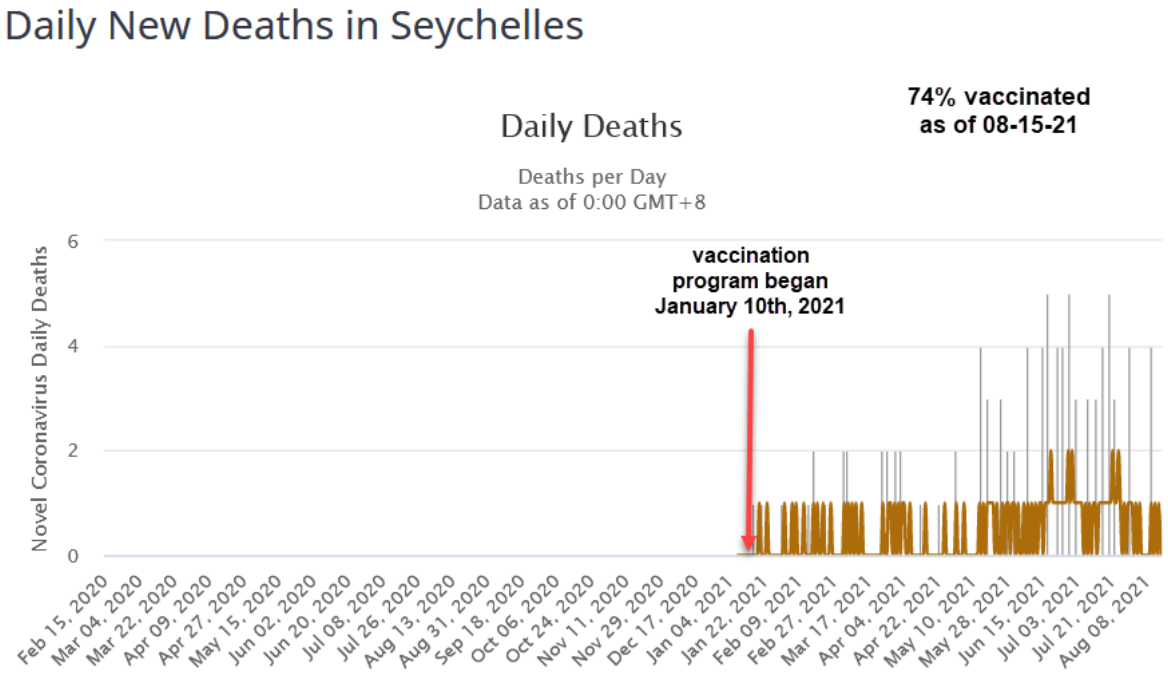
Seychelles

Seychelles is third on our list with 70% of the population of 98,000 fully vaccinated. Seychelles is a small island nation in the Indian Ocean. According to Wikipedia, Seychelles launched its mass vaccination campaign on 10 January, initially with 50.000 doses of Sinopharm's BBIBP-CorV vaccine donated by the United Arab Emirates. The UAE has since donated 20.000 more doses of a different vaccine to Seychelles.

Check out this graph that shows what happened then…



That marginal increase in cases is somewhat interesting but look at what happened to the COVID death rates!



Bear in mind that Seychelles is a very small nation, so these numbers of people are not large. But the changepoint is unmistakable as they appeared to have been doing just fine with next to zero cases and deaths up to that point.

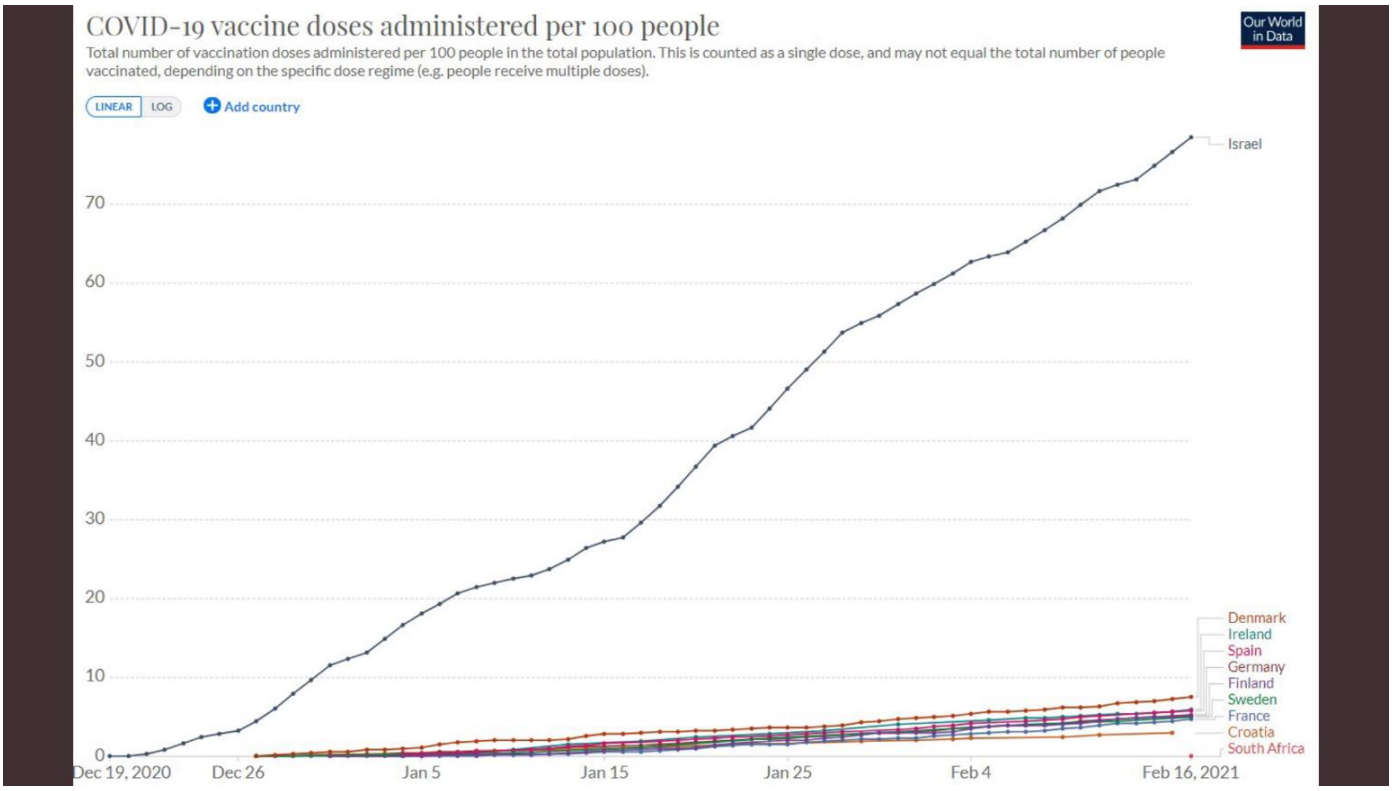
The United Kingdom

I have already covered the U.K. earlier in. As you read there, the script has also flipped with the percentage of those being hospitalized and dying from COVID-19 is increasingly shifting to the vaccinated, especially in those over 50-years of age.

Israel

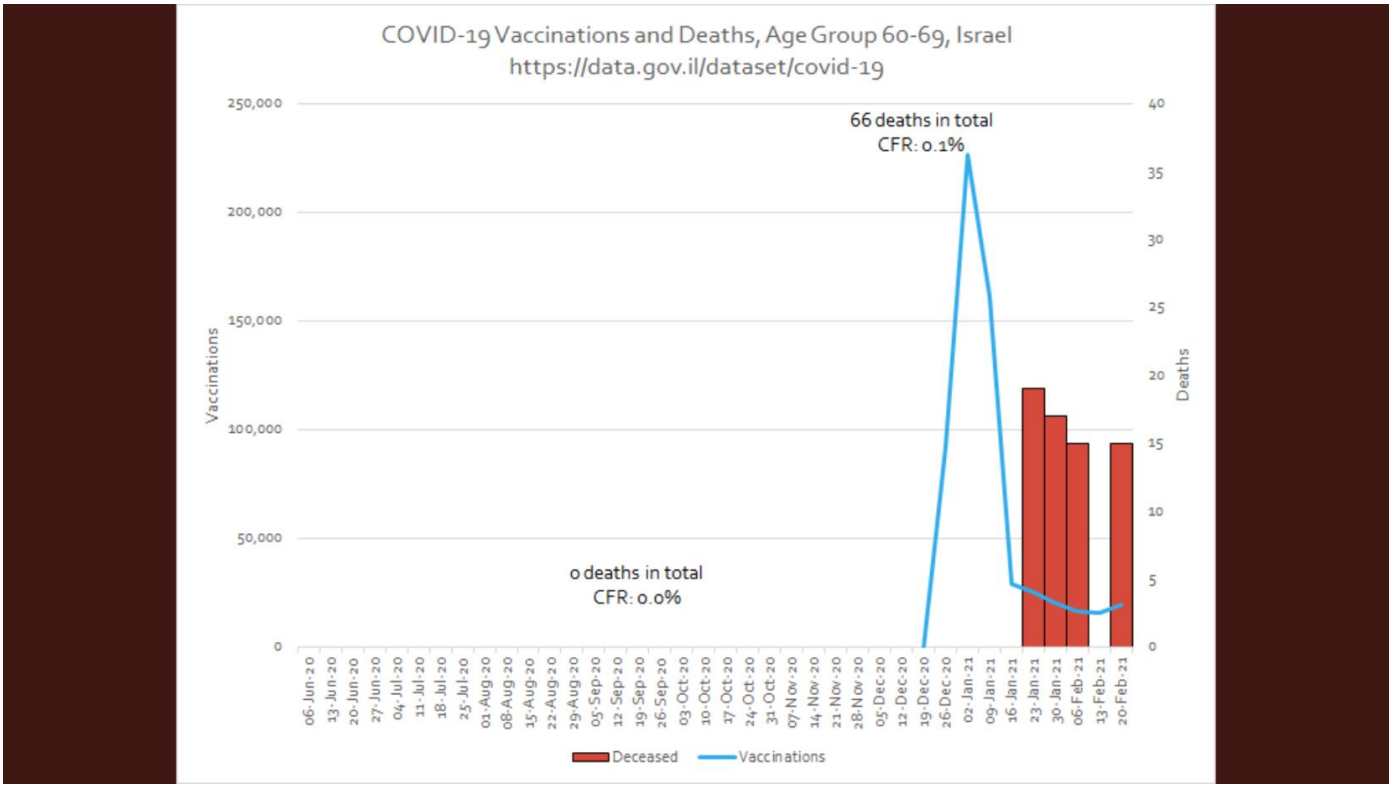
Let's look first at what happened in Israel after the rollout of their mass vaccination program.

As you can see from this next graph, as of mid-February, Israel had the highest rate of COVID-19 vaccine distribution in the world by far. But as you will see in the subsequent graphs, it seemed to correlate with a large increase in deaths in their elderly after they got the vaccines!

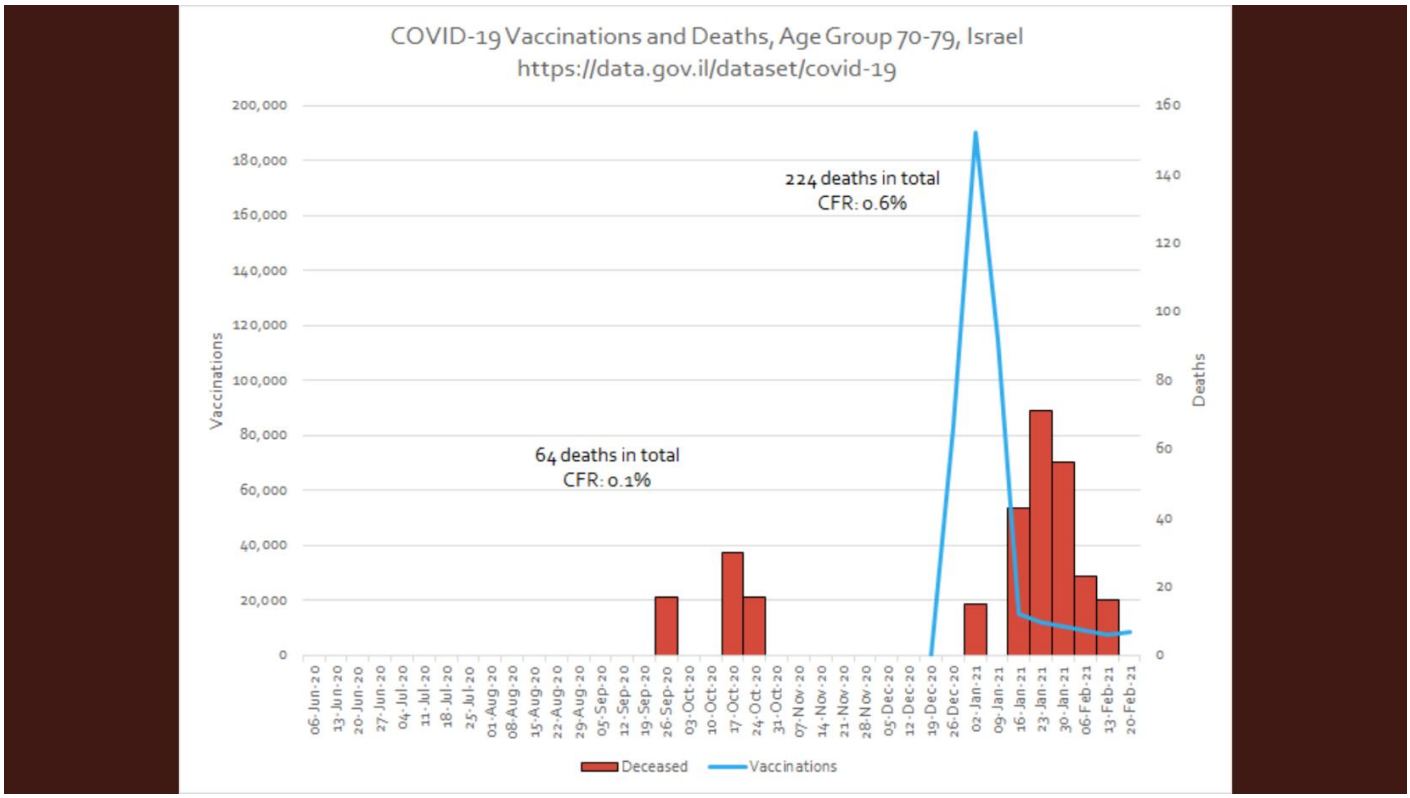


See the next page…

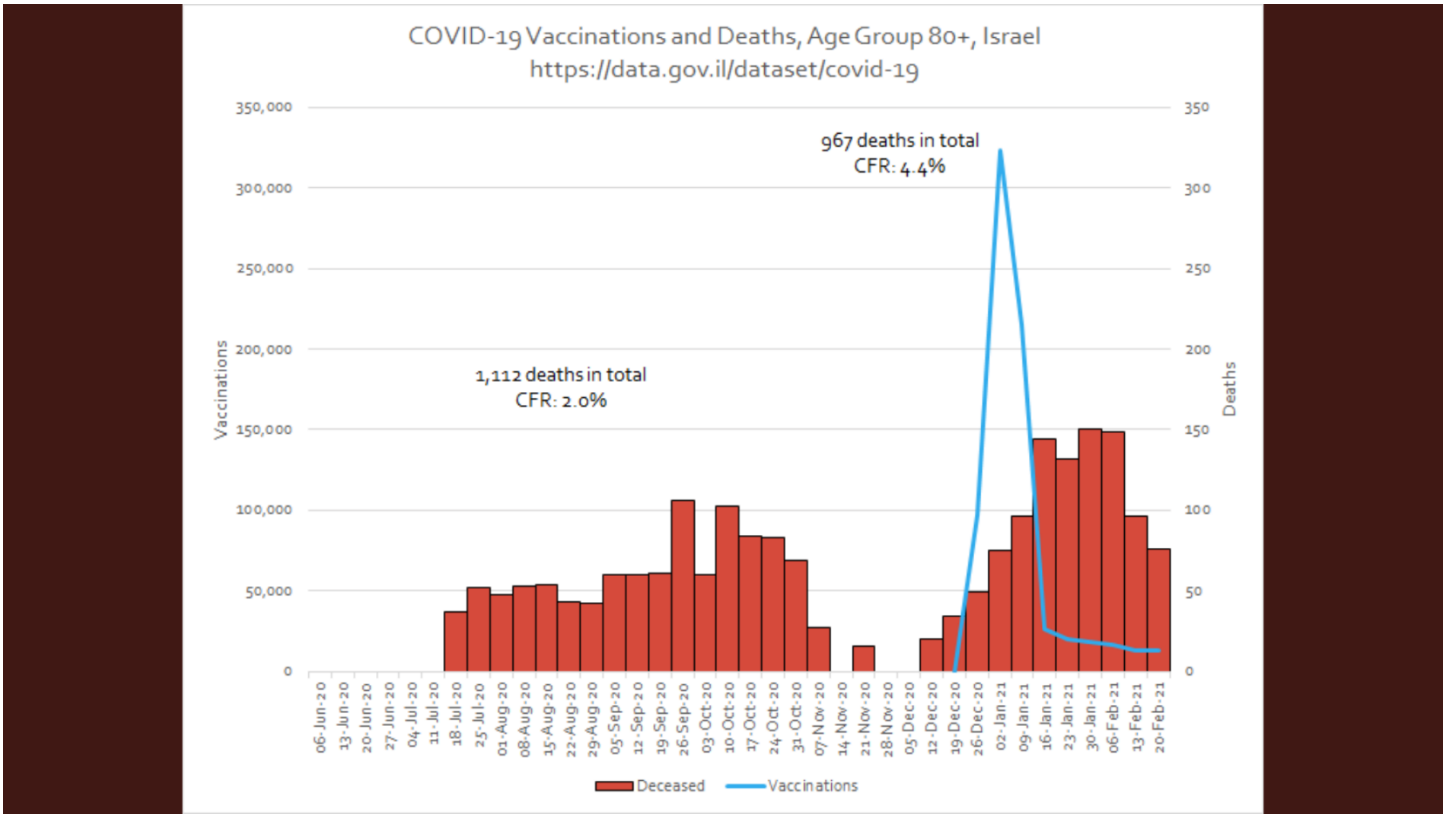
Deaths in the 60- to 69-year-old age group- Vaccination campaign is the blue line



Deaths in the 70- to 79-year-old age group- Vaccination campaign is the blue line



Deaths in the 80+ year-old age group- Vaccination campaign is the blue line



The big question is, does the large increase in deaths relate to various side effects from the vaccines that aren't tolerated by the frail and elderly, or is it the Antibody Dependent Enhancement (AKA Pathogenic Priming) scenario that so many of the world's health experts were warning about as described earlier in this paper. Either way, if you extrapolate these findings on a much larger scale in a country like the United States who are lagging far behind Israel in vaccination coverage, it should send up major red flags that would call for further investigation before we see potentially catastrophic results here with our elderly population.

So, how is Israel doing now?

As an example, and this ***Forbes*** article was dated July 23rd, yet the title of the article could not be used if it were written 4 weeks later, because as you will see, the percentage of those hospitalized and dying of COVID-19 are fully vaccinated.

Title: <u>Pfizer Shot Just 39% Effective Against Delta Infection, But Largely Prevents Severe Illness, Israel Study Suggests</u>.

From the article

Recent data from Israel's health ministry suggests Pfizer's Covid-19 vaccine is far less effective at preventing infection and symptomatic illness with the Delta variant than with previous strains of coronavirus, a finding that conflicts with other research indicating high levels of protection against the contagious variant as countries around the world struggle to contain new waves of infection.

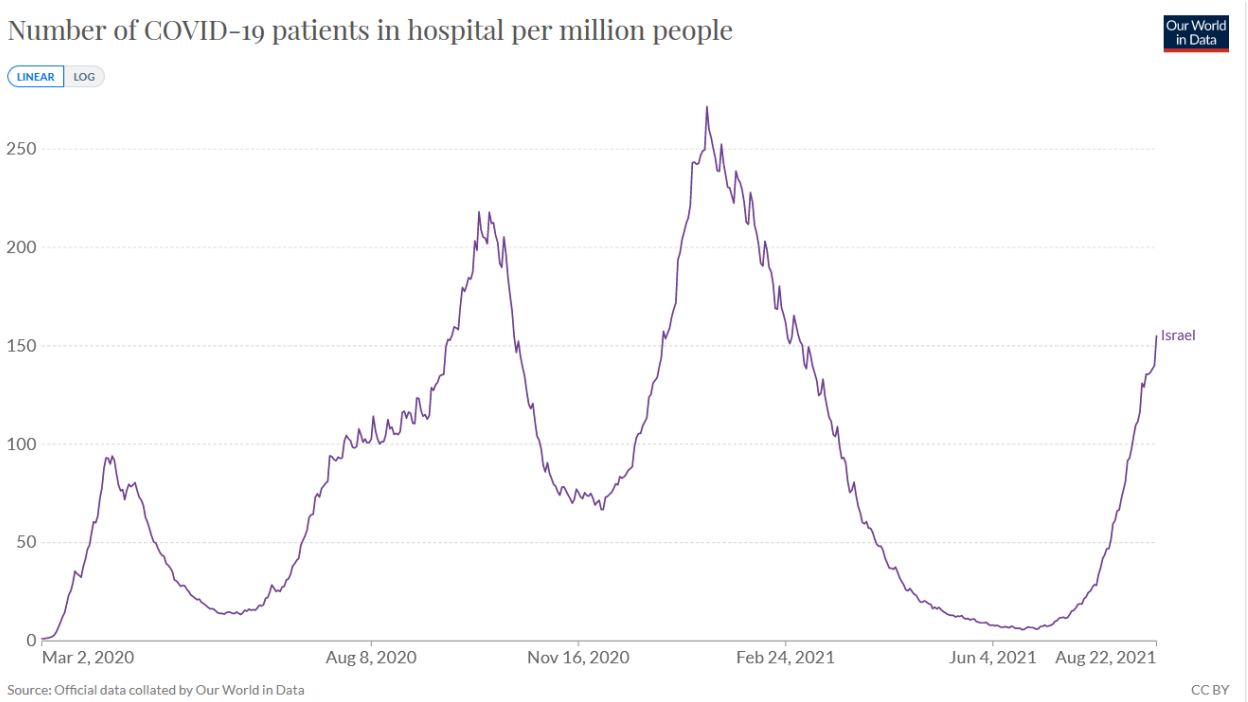
A full course of the Pfizer-BioNTech vaccine was just 39% effective at preventing infections and 41% effective at preventing symptomatic infections caused by the Delta Covid-19 variant, according to Israel's health ministry, **down from early estimates of 64% two weeks ago.** (Emphasis mine)

The figures, based on data from an unspecified number of people between June 20 and July 17, are significantly lower than previous estimates of the vaccine's efficacy against other variants, which initial clinical trials found to be 95%. And remember as reported in an earlier newsletter, the 95% is relative risk reduction.

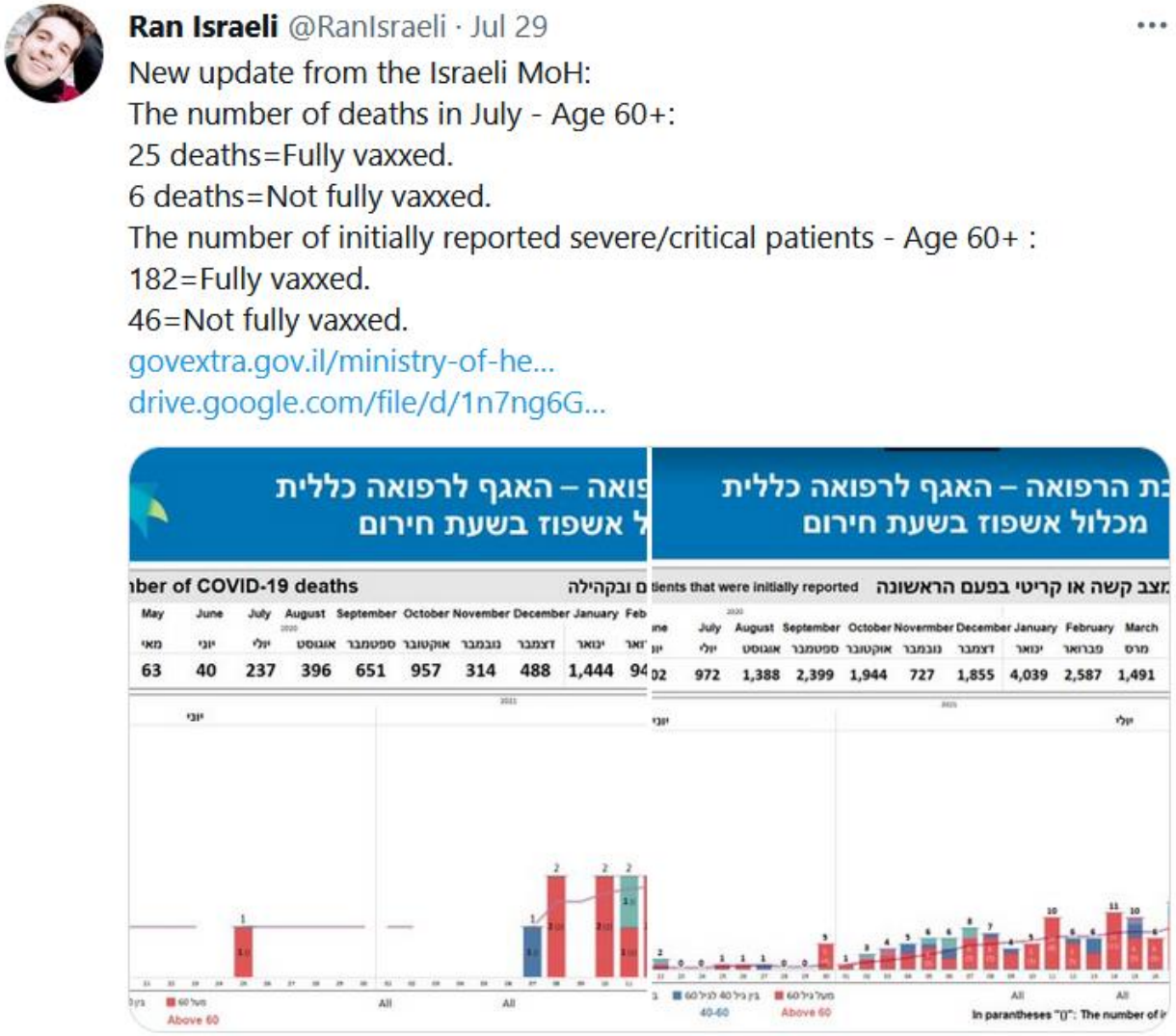
End of excerpts

https://www.forbes.com/sites/roberthart/2021/07/23/pfizer-shot-just-39-effective-against-delta-infection-but-largely-prevents-severe-illness-israel-study-suggests/?sh=666f825584f1

Health Ministry Data- (sorry it's in Hebrew). https://www.gov.il/BlobFolder/reports/vaccine-efficacy-safety-follow-up-committee/he/files_publications_corona_two-dose-vaccination-data.pdf



This is a July 29th Tweet by a person that I have been following who is reporting on Israeli health data and someone that I have noticed is being followed by many credible and well-known scientists, is reporting some shocking statistics. And thankfully he can interpret Hebrew.



Ran Israeli @RanIsraeli · Jul 29

New update from the Israeli MoH:
The number of deaths in July - Age 60+:
25 deaths=Fully vaxxed.
6 deaths=Not fully vaxxed.
The number of initially reported severe/critical patients - Age 60+ :
182=Fully vaxxed.
46=Not fully vaxxed.
govextra.gov.il/ministry-of-he...
drive.google.com/file/d/1n7ng6G...

On August 24th, the Daily Beast published an article titled, **Ultra-Vaxxed Israel's Crisis Is a Dire Warning to America**. The article reveals the rapidly escalating increase of infections, hospitalizations and deaths in fully vaccinated individuals.

From the article

In June, there were several days with zero new COVID infections in Israel.

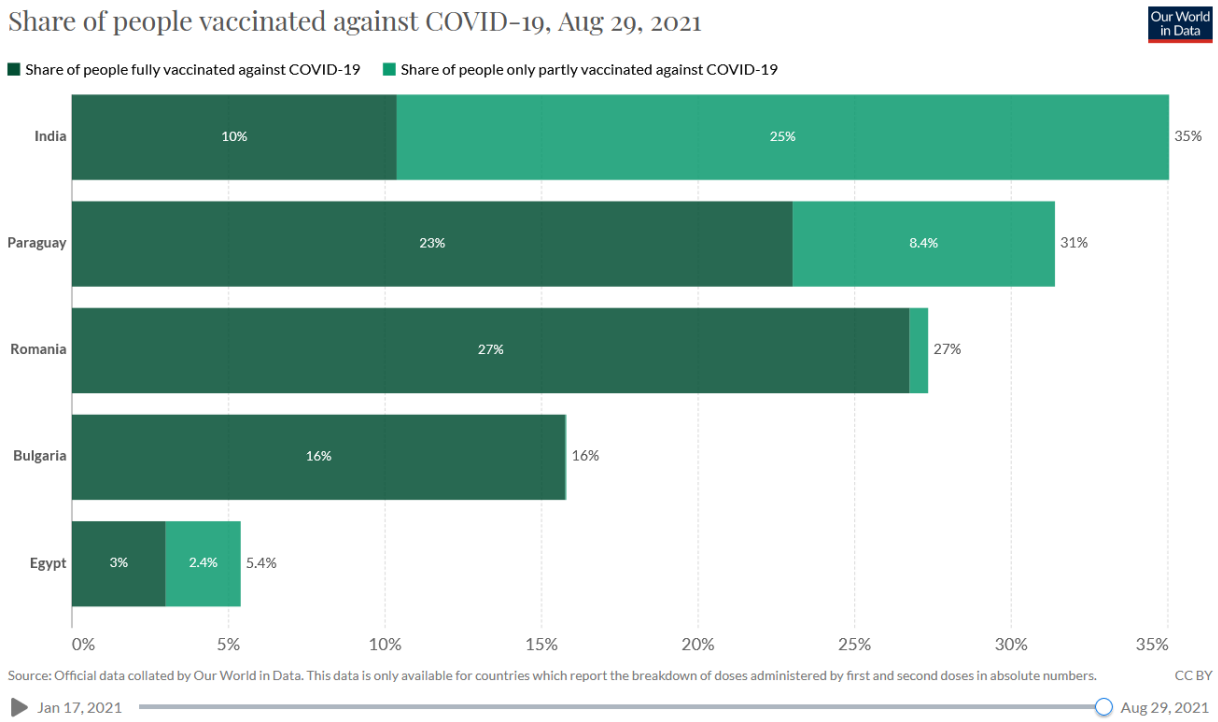
Fast forward two months later: Israel reported 9,831 new diagnosed cases on Tuesday, a hairbreadth away from the worst daily figure ever recorded in the country—10,000—at the peak of the third wave. More than 350 people have died of the disease in the first three weeks of August. In a Sunday press conference, the directors of seven public hospitals announced that they could no longer admit any coronavirus patients. With 670 COVID-19 patients requiring critical care, their wards are overflowing and staff are at breaking point. "I don't want to frighten you," coronavirus czar Dr. Salman Zarka told the Israeli parliament this week. "But this is the data. Unfortunately, the numbers don't lie."

https://www.thedailybeast.com/ultra-vaccinated-israels-debacle-is-a-dire-warning-to-america

How does that the information coming out of all those highly vaccinated countries contrast to what we are hearing from our media and CDC?

How are some of the countries with the lowest vaccination rates doing?

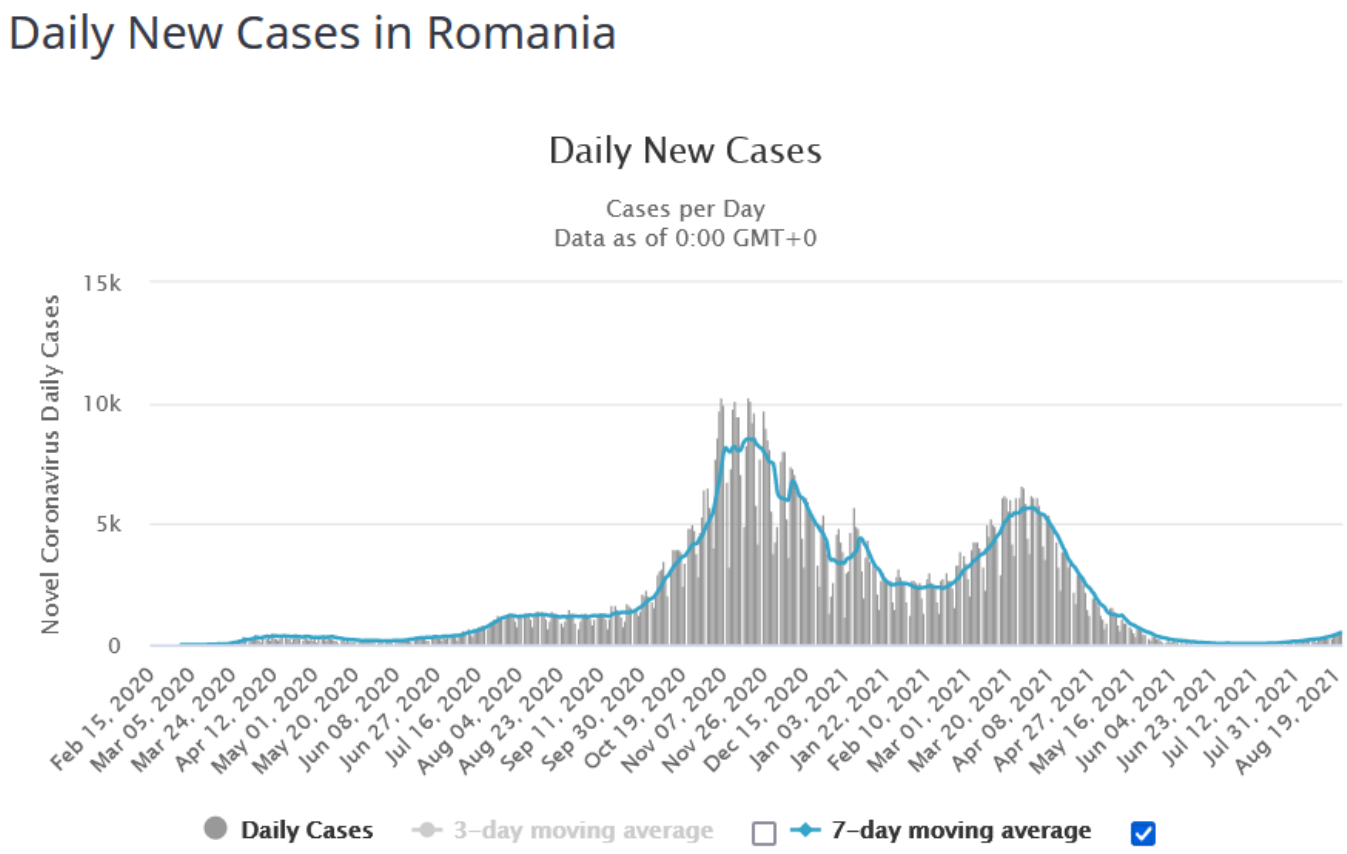
Let's now consider how some of the countries with the lowest vaccination rates are doing with regard to cases and deaths. If the prevailing narrative that the CDC has been pushing through the media is true, we would expect those countries to be having run away cases and deaths.



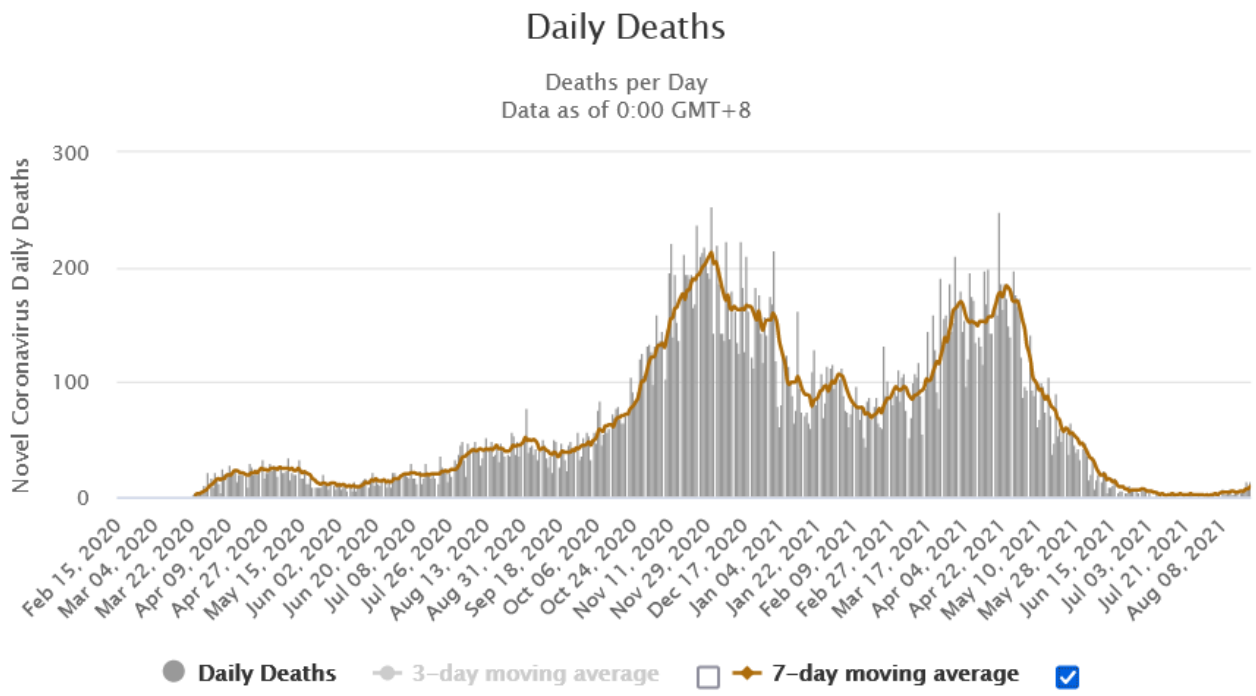
So, let's look at these five countries starting with the one that has the most fully vaccinated people at 27% and finishing with the one that is the least fully vaccinated at 3%.

Romania

As of August 29th, just 27% of the population is fully vaccinated.



Daily New Deaths in Romania

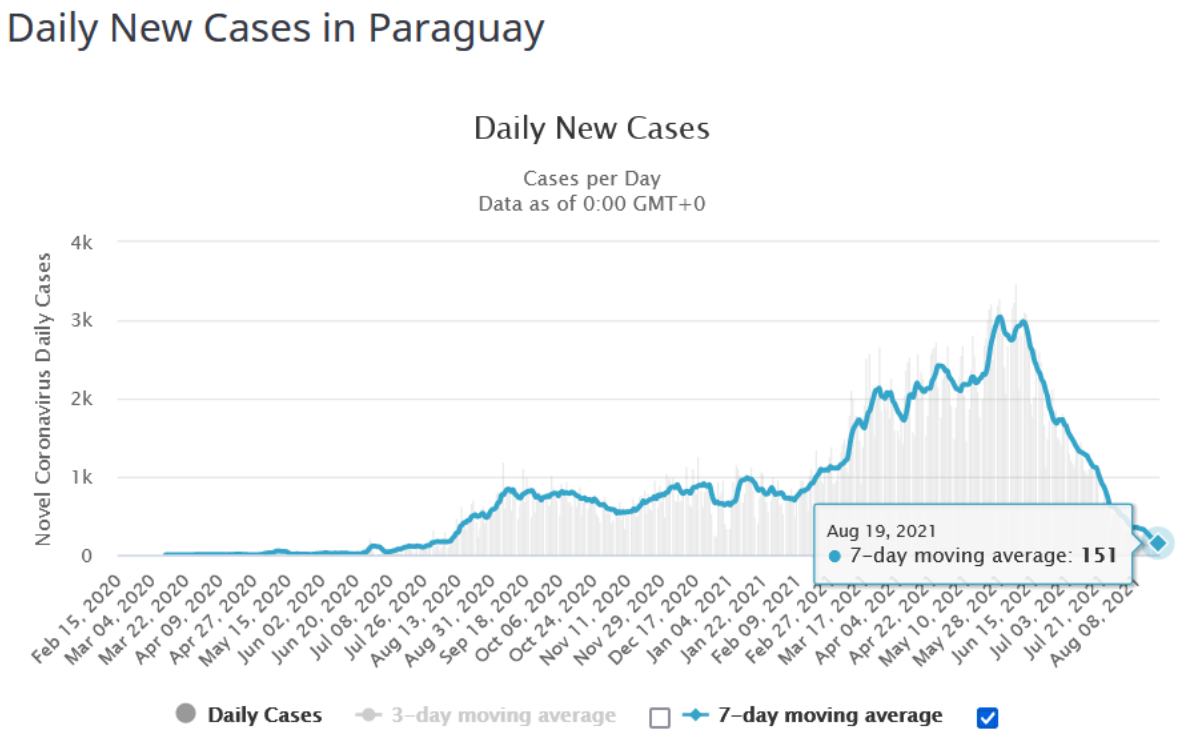


All with only one fourth of the population fully vaccinated they are doing just fine. This could be a case of decrease due to seasonality, or are they possibly nearing natural herd immunity?

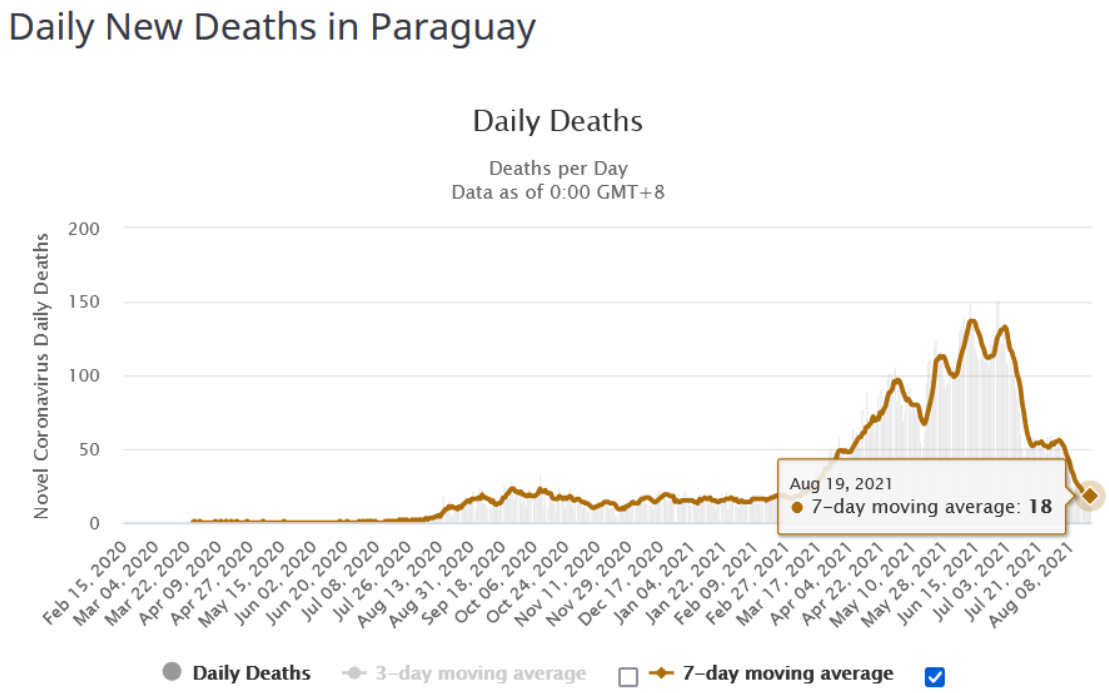
Paraguay next page…

Paraguay

As of August 17th, 2021, Paraguay only had 23% of their population fully vaccinated. They had about a 90-day surge in cases in April through June, but now those are dropping precipitously.



The same thing seems to have happened with deaths



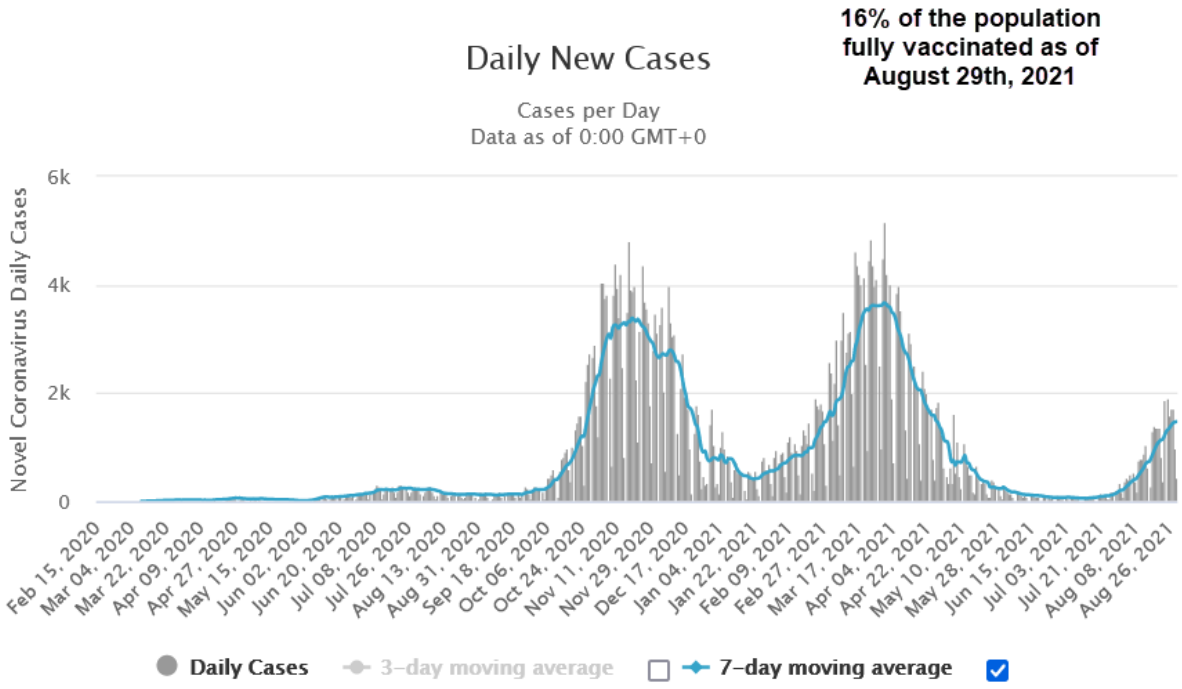
While you can see that Paraguay had a rise in cases and deaths just like so many countries around the world despite vaccination rates, the rates of both have dropped precipitously. This is what happens with viral outbreaks. They have rises and falls based on many factors including seasonality, percentage of the population that have contracted the illness and recovered giving them immunity. Paraguay is a country in South America located in the southern hemisphere. Because it is in the southern hemisphere, they have just passed the middle of their winter. As you can see, they had their spikes in April, May and June, which would be equivalent to our October, November and December which is when cases, hospitalizations and deaths tend to ramp up here in the U.S. And that is the typical respiratory viral season pattern in the northern hemisphere. Sometimes it starts a little later and ends later, but generally these surges run their course in about 90-120 days.

Please scroll to the next page. I am attempting to keep each country's data on a single page.

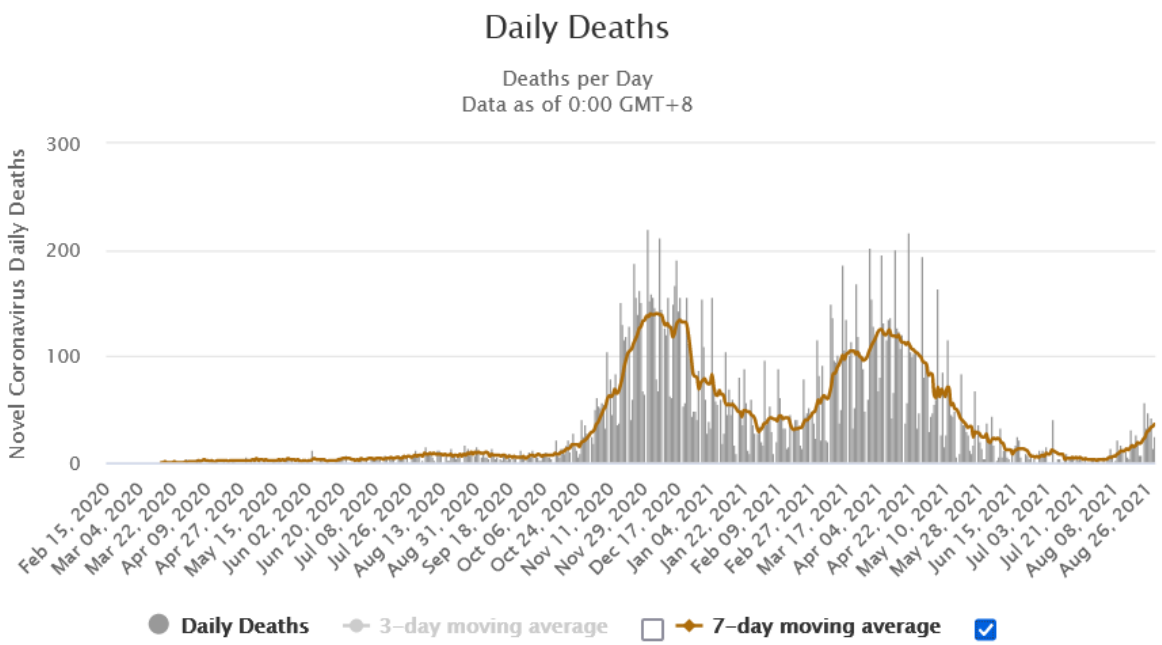
Bulgaria

Just 16% of the population Was fully vaccinated as of August 29th.

Daily New Cases in Bulgaria



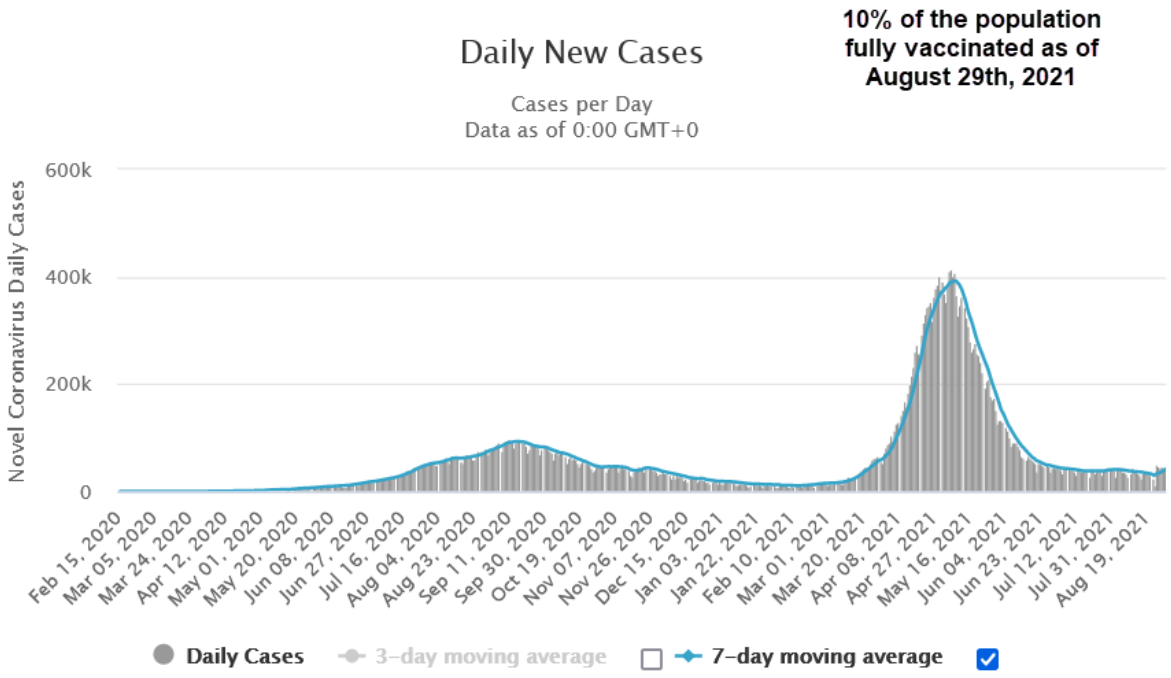
Daily New Deaths in Bulgaria



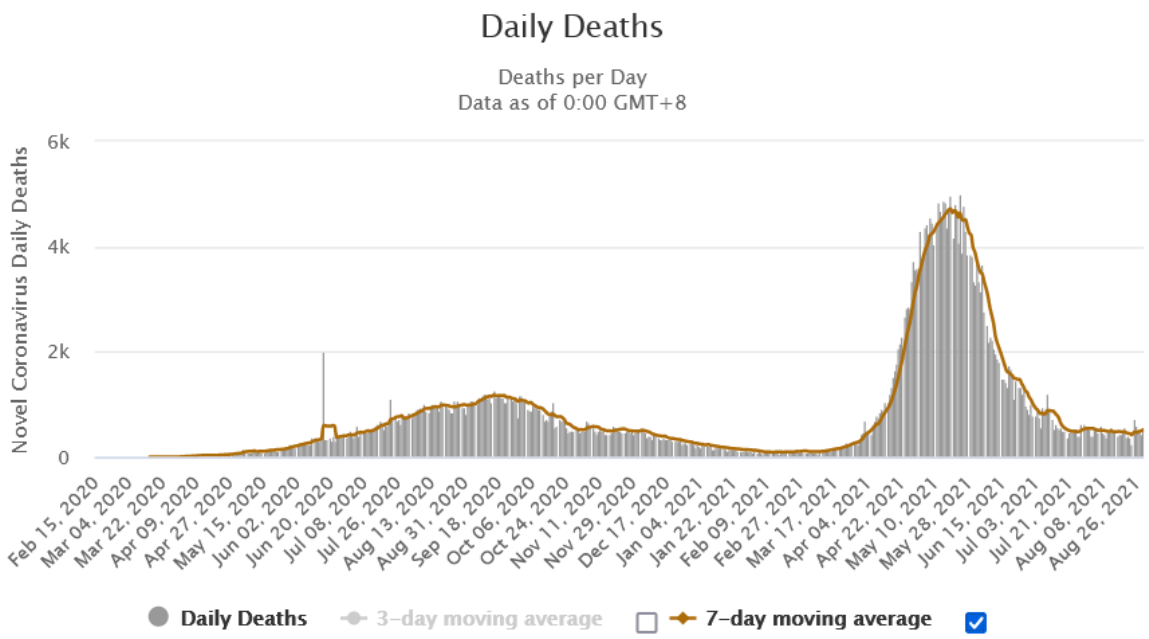
India

Just 10% of the 1.35 billion people in India have been fully vaccinated. So, how are they doing?

Daily New Cases in India



Daily New Deaths in India

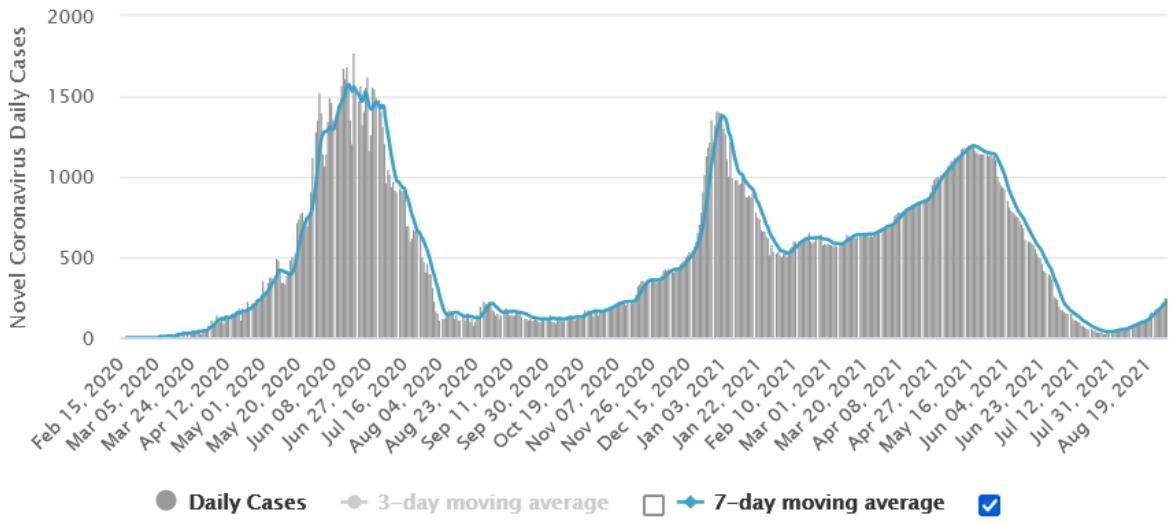


Egypt

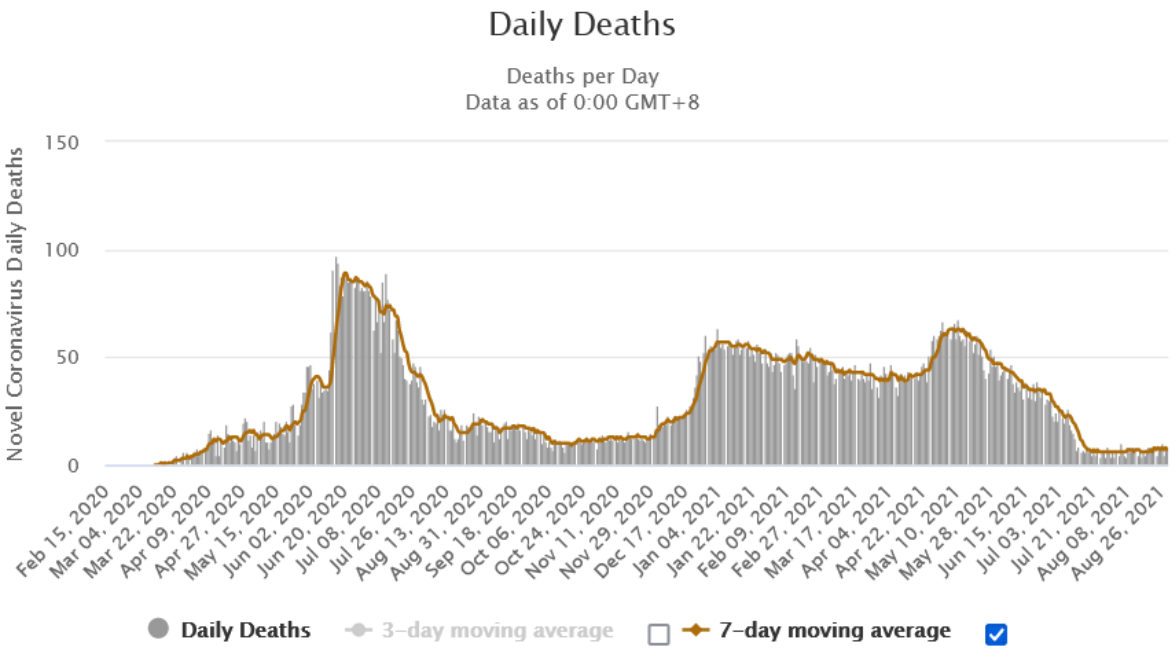
Only 3% of the population is fully vaccinated in Egypt.

Daily New Cases in Egypt

3% of the population fully vaccinated as of August 29th, 2021



Daily New Deaths in Egypt



In looking at these countries, they all seem to be doing extremely well. In fact, when you compare these countries to the most highly vaccinated countries I showed you, it becomes readily apparent that these countries with lower rates of the population vaccinated are doing much better. That sure seems like a paradoxical position compared to what the WHO, CDC, NHS and other public "health" agencies pushing these experimental shots would lead us to believe. Raw data is hard to argue with however.

Percentages of cases in the vaxxed versus the unvaxxed segments of the population. Here are the reasons why the reported narrative is wrong

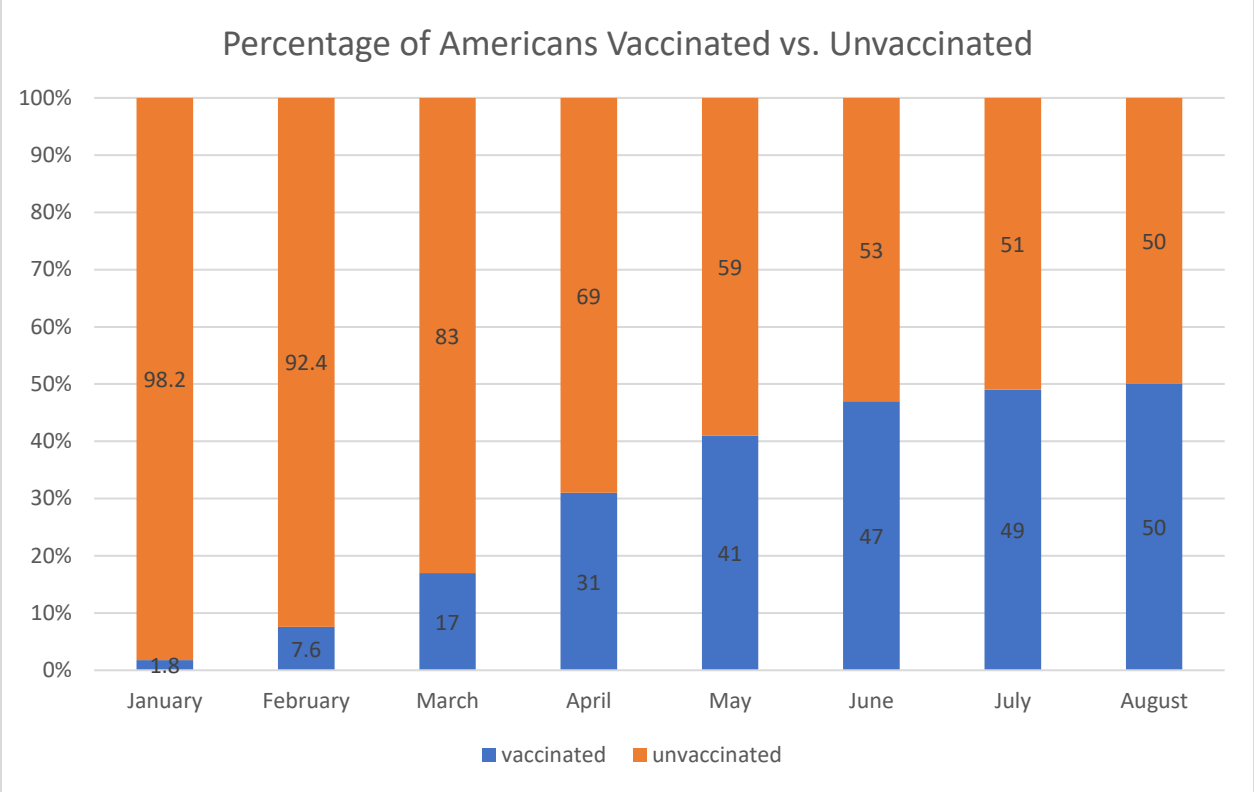
We have all heard reports over the last few months, that the majority of cases are people who are unvaccinated. What is the truth? Last month I covered the statistics coming from Israel and the U.K. showing that the numbers of cases, hospitalizations and deaths have been steadily increasing in the fully vaccinated as the vaccines are failing, especially against the Delta and other variants.

Reason number one…

But for now, one important consideration that must be made is the percentage of the population that have been vaccinated versus unvaccinated at the various points in time since the start of the mass vaccination program. Consider the chart below and this premise. If the exact same percentage of the population that was vaxxed and unvaxxed tested PCR positive for the SARS-CoV-2 virus (*which they call "cases"), the higher numbers would be in the unvaccinated earlier in the campaign by far, simply because there were far fewer people that had been fully vaccinated.

Infections without the manifestation of the symptoms of COVID-19 are not and should not be called "cases". See the commentary on cases near the beginning of this issue…but I digress.

Looking at the chart below, it is obvious that the number of "cases" would be much higher in the unvaccinated as compared to the vaccinated even if the percentages of each group contracting the virus were the same.



The total percentage of unvaccinated vs. vaccinated average over the entire 8 months of this graph is 70% unvaccinated vs. 30% vaccinated. So, as you can see simply by sheer numbers, the unvaccinated would naturally appear like they are affected to a greater degree.

A second reason…

A second reason the numbers are skewed is that **the CDC stopped counting positive cases in the vaccinated portion of the population on May 1st, 2021, unless they were hospitalized or died.** To my knowledge no one has been able to justify this disparate change in counting. If you are going to bother to continue counting the unvaccinated individuals in case counts, why not the vaccinated? By all appearances, it would be to change the narrative that the unvaccinated are the ones that are to blame for the spread of the pandemic. If someone can challenge that assumption rational and logically, have at it.

Proof of the change in policy
From the CDC web page titled, **COVID-19 Vaccine Breakthrough Case Investigation and Reporting**.

"As of May 1, 2021, CDC transitioned from monitoring all reported vaccine breakthrough cases to focus on identifying and investigating only hospitalized or fatal cases due to any cause. This shift will help maximize the quality of the data collected on cases of greatest clinical and public health importance."

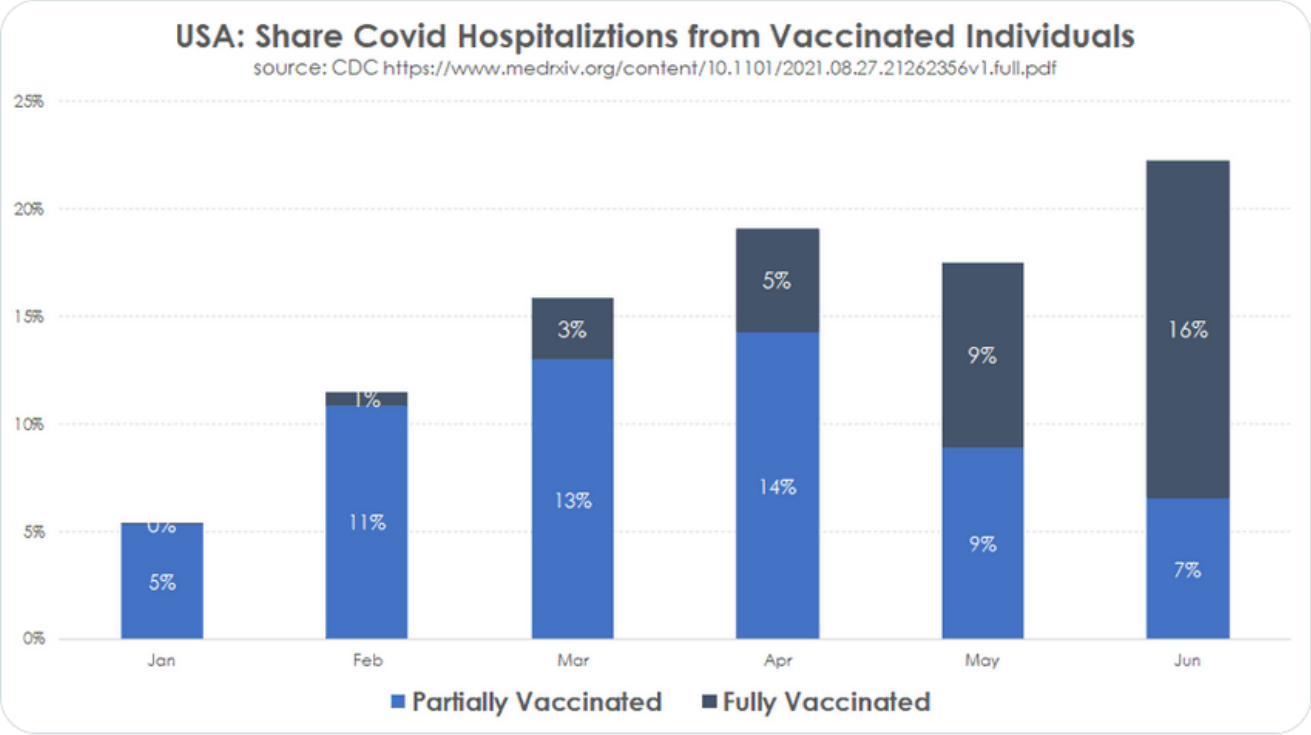
https://www.cdc.gov/vaccines/covid-19/health-departments/breakthrough-cases.html

You don’t have to be a statistician to realize that this will skew the case numbers heavily in the direction of the unvaccinated, because the vast majority (probably 99%) of PCR positive cases never reach the doors of the hospital and even fewer become fatalities. Also, isn’t it interesting that their decision came as Delta Variant cases began to surge here in the U.S., and after the trend abroad where Delta hit sooner and was exposing the glaring truth that Delta was defeating the protection of the vaccines? Coincidence?

Reason number three…

Because sometimes they just lie…

Here is data from a ***CDC*** sponsored study looking at data through June 2021. If you'll notice, from March through June the percentage of fully vaccinated people being hospitalized has consistently nearly doubled each month. While I couldn't find the data for July in August, one could extrapolate that if this trend continues, July may be nearly 30% fully vaccinated and August at around 55 percent fully vaccinated. This is really not a stretch because it is the trend that we are seeing from countries all over the world. And, I have been hearing from healthcare personnel working in hospitals for many weeks now that they are seeing an increasing number of vaccinated people sick enough to be hospitalized. Yet, even as of this month the headlines have been running with the narrative that 99% of the people hospitalized are unvaccinated. These people need to be exposed for the fools that they are! They are lying to the public as yet another disinformation campaign tactic to increase vaccination levels, which if you



Breaking News on immunity conferred by infection with SARS-CoV-2! New data out of Israel shows conclusively that COVID recovered people have a remarkably smaller chance of reinfection than fully vaccinated people

The study is a pre-print updated August 25th, 2021 and is titled, **Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections.**

Spoiler alert: At the end of the study, researchers found that vaccinated people were 13 times more likely to be infected and 27 times *(2,700%)* more likely to have symptomatic infections as a matched cohort that was previously infected with the Delta variant.

From the study
"This is the largest real-world observational study comparing natural immunity, gained through previous SARS-CoV-2 infection, to vaccine-induced immunity, afforded by the BNT162b2 mRNA vaccine. Our large cohort, enabled by Israel's rapid rollout of the mass-vaccination campaign, allowed us to investigate the risk for additional infection – either a breakthrough infection in vaccinated individuals or reinfection in previously infected ones – over a longer period than thus far described."

"Our analysis demonstrates that SARS-CoV-2-naïve vaccinees had a 13.06-fold increased risk for breakthrough infection with the Delta variant compared to those previously infected, when the first event (infection or vaccination) occurred during January and February of 2021. The increased risk was significant for a symptomatic disease as well."

Conclusions:

This study demonstrated that natural immunity confers longer-lasting and stronger protection against infection, symptomatic disease and hospitalization caused by the Delta variant of SARS-CoV-2, compared to the BNT162b2 two-dose vaccine-induced immunity.

End of excerpts

This is certainly not a surprise, even to Dr. Fauci who has been playing down the lasting and robust immunity conferred to those that have had and recovered from the SARS-CoV-2 infection. And, I have presented at least a couple dozen studies in my monthly newsletters since the start of the outbreak showing the same. Unfortunately, this information doesn't sell vaccines, so it doesn't get air time.

If you would like to get all of that information from my previous newsletters on natural immunity, you can order my eBook titled, **Long-term or Prior Immunity from COVID-19** for just $4.95 **HERE**.

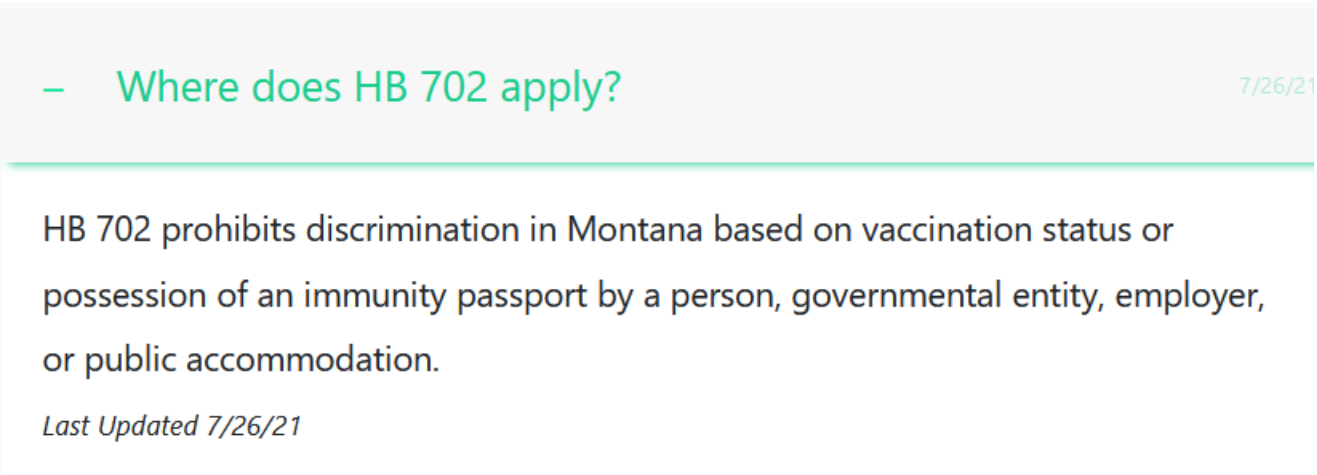
Medical Freedom should be non-negotiable

Medical freedom is not only ensured in our Bill of Rights, but the ***Nuremberg Convention*** which the United States and many other countries of the civilized world signed onto guarantees the right to body autonomy and the freedom to decline any medical intervention. And such intervention cannot be forced, required or made necessary through coercion, which is exactly what we are seeing today.

Montana is the first state to ban vaccine mandates

While Florida and Arizona and other conservative run states have banned vaccine mandates by colleges and state universities, Montana becomes the first state to ban them across the board.

From the Montana Department of Health website.



https://erd.dli.mt.gov/human-rights/human-rights-laws/employment-discrimination/hb-702

An August 20th, article in Fortune online titled, **Montana becomes the first U.S. state to ban vaccine requirements for employees**, portrays the struggle between those that think it is the right and constitutional thing to do and those that think it the worst kind of public health policy.
https://fortune.com/2021/08/20/montana-first-us-state-to-ban-covid-vaccine-requirements-employees/

From the article
While many large companies across the U.S. have announced that COVID-19 vaccines will be required for their employees to return to work in-person, there is one state where such requirements are banned: Montana.

Under a new law passed by the state's Republican-controlled Legislature earlier this year, requiring vaccines as a condition for employment is deemed "discrimination" and a violation of the state's human rights laws.

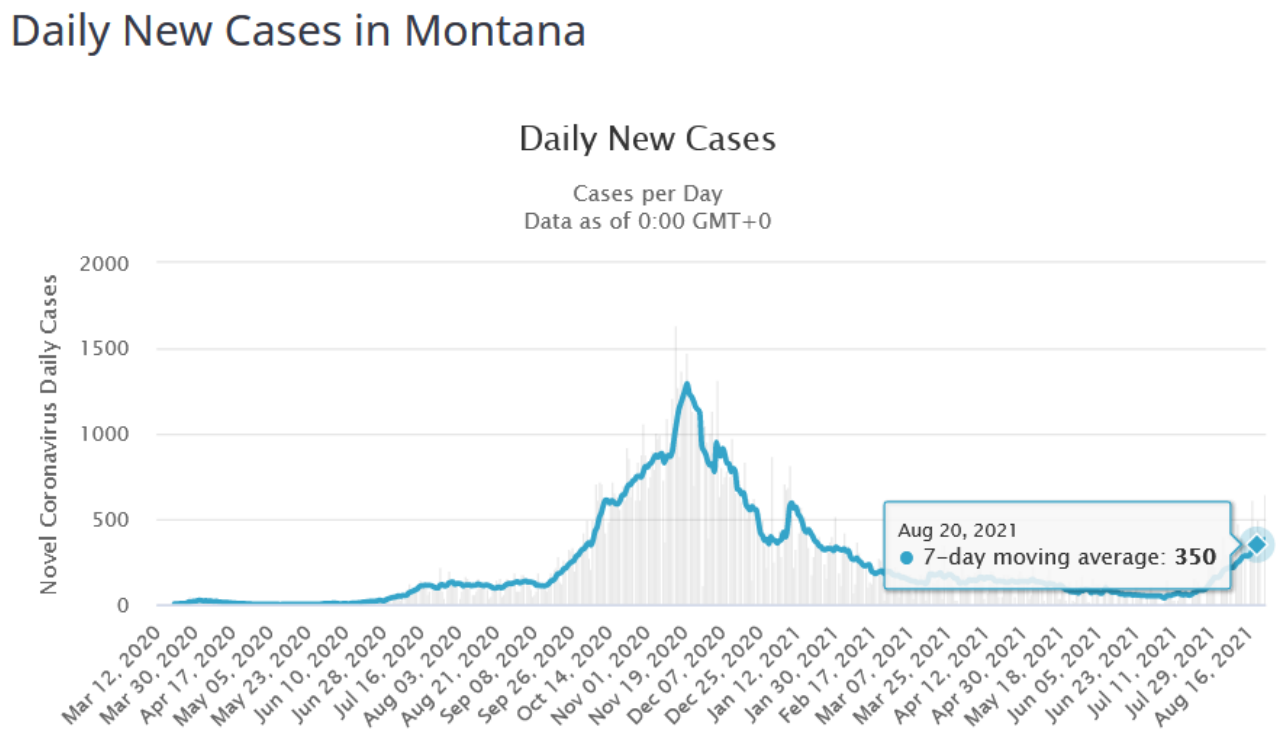
Montana is the only state in the U.S. with a law like this for private employers, said Hemi Tewarson, executive director of the National Academy for State Health Policy.

The law has raised concern among employers across the state **as Montana struggles with a rise in COVID-19 cases that is once again straining the state's health care system.** *(keeping this last statement in mind)…*

End of excerpts

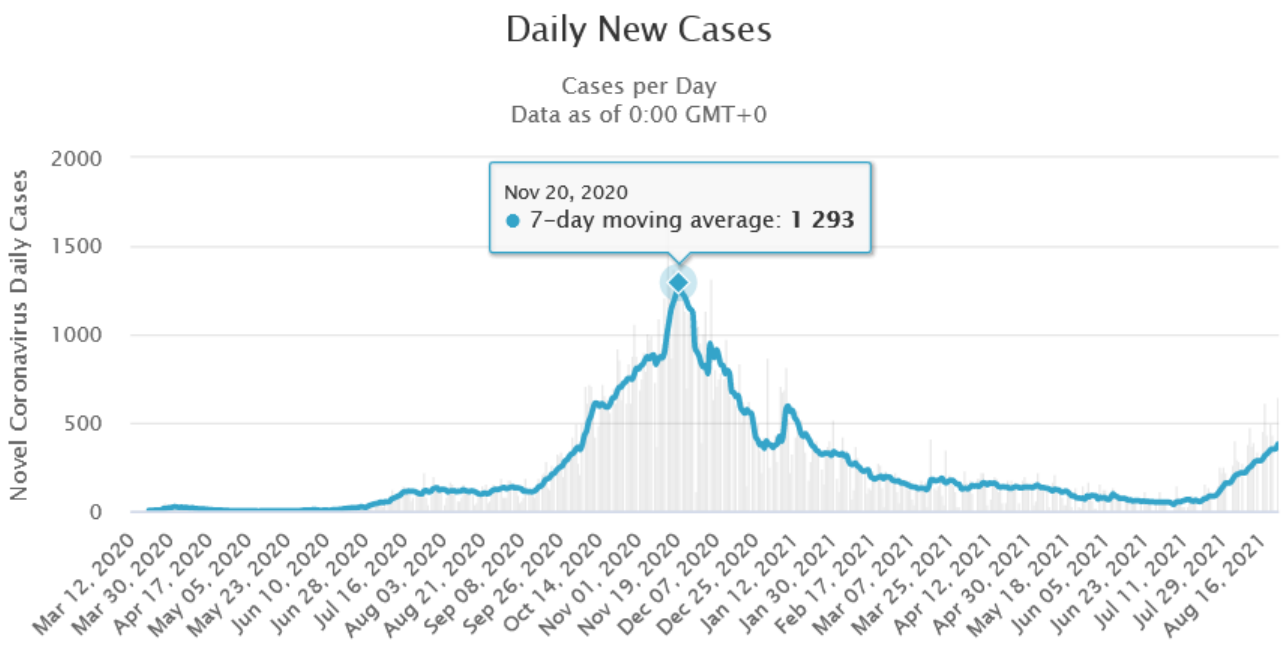
WAIT! Hold the press. Let's look at just how strained the state's health care system really was at the time that this comment was made.

Because I deal in raw data and facts, nor hyperbole and fearmongering let's take a look.



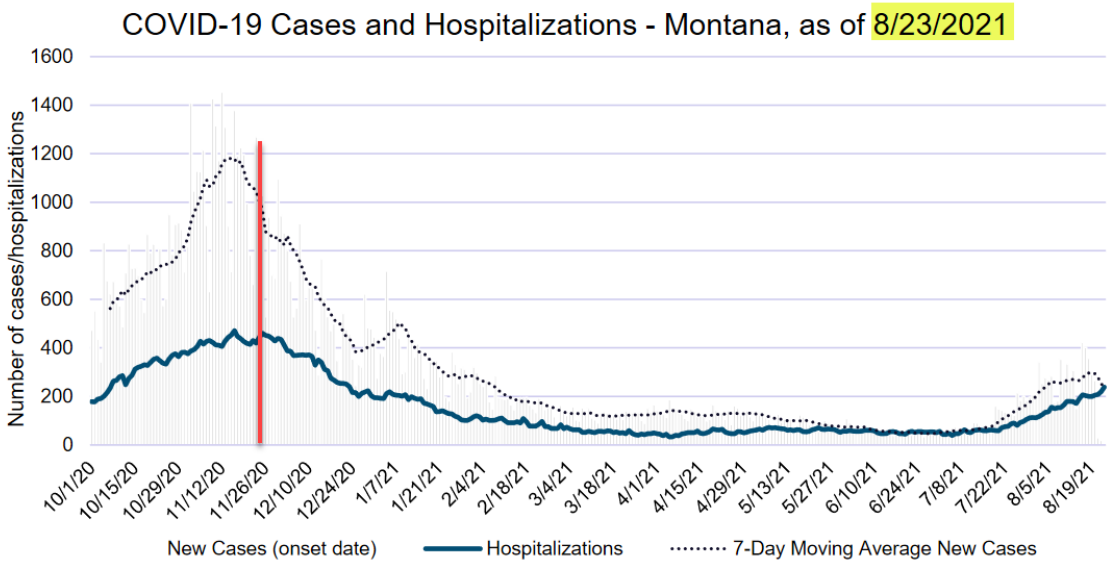
https://www.worldometers.info/coronavirus/usa/montana/

So, the seven-day moving average on August 20th was 350 daily new cases. How does that compare to Montana at its peak of the outbreak which occurred November 20th, 2020.



As you can see the 7-day average number of daily cases is approximately 25% of what it was at the peak. That doesn't sound like much of a strain on the system. Remember we're not talking about hospitalizations or deaths, merely positive PCR tests. Hospitalizations is what really puts the strain on the system.

The number of those PCR positives that are being hospitalized is the more important metric to track.



https://dphhs.mt.gov/assets/publichealth/CDEpi/DiseasesAtoZ/2019-nCoV/Reports/HospitalReport08232021.pdf

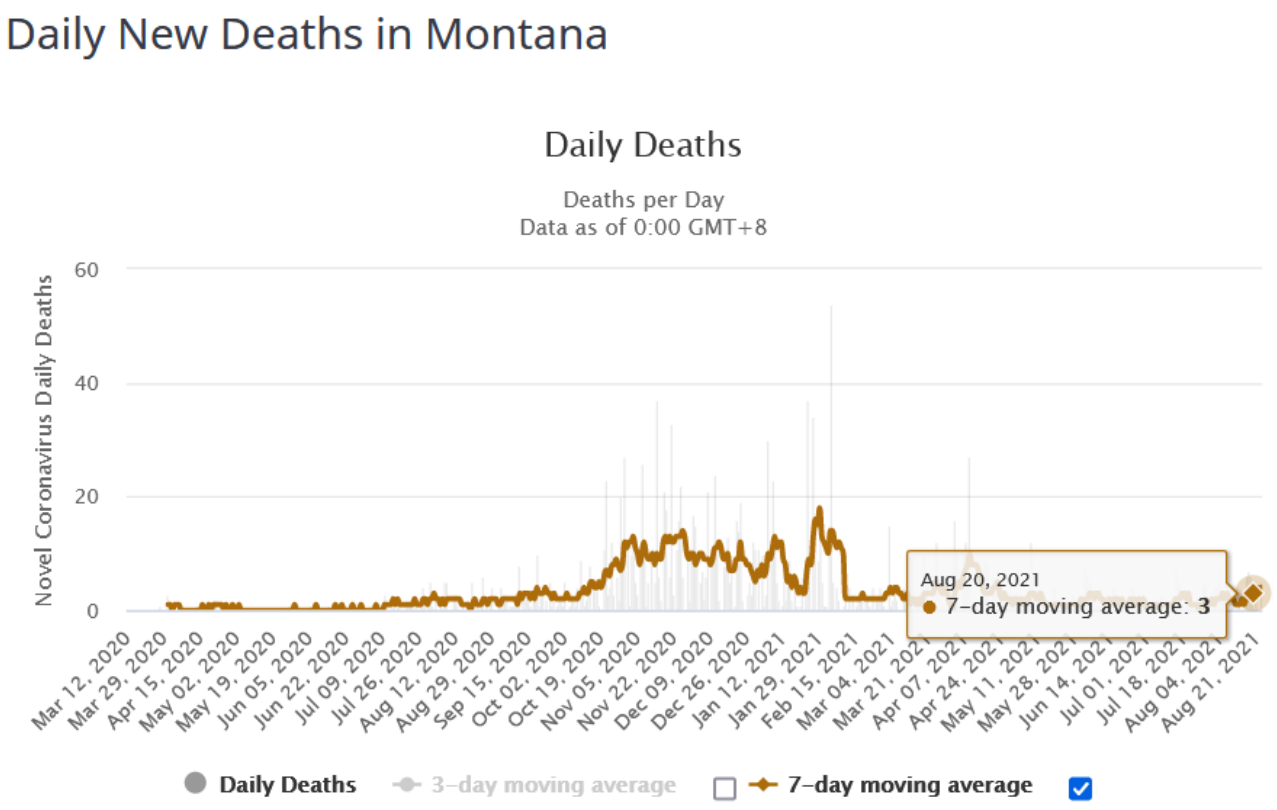
The red line represents November 20th, 2020, when the number of PCR positives reached its peak.

Notice from the table below, that only 5% of cases ever needed to go to the hospital.

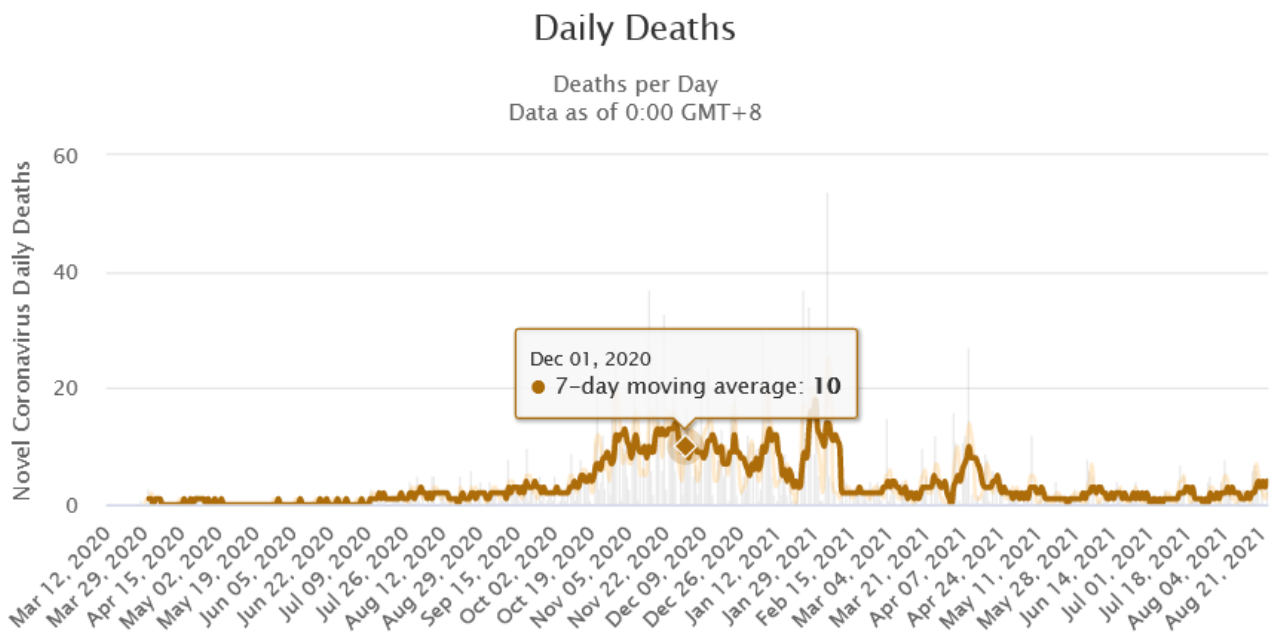
Montana as of August 23rd, 2021

Hospitalization Status	Number of Cases (percent of total)
Ever hospitalized	6201 (5%)
Never hospitalized	117473 (95%)
Total	123674

This first graph represents the seven-day moving average (3 deaths) on August 20th, the date of the article.



The seven-day moving average was only three deaths per day on August 20th, 2021. So, what was it at the peak back in November when the cases hit their all-time peak? I'm going to use December 1st as the number of deaths because that is approximately 10 days later from when the number of cases peaked. There is typically a 10-to-14-day lag time between a case being diagnosed and death in the most severe cases.



In this case, the average daily deaths were approximately a third on August 20th 2021, compared to what they were on December 1st 2020, at the case peak of the pandemic.

In summary, it appears that the number of hospitalizations are approximately 50% of what they were at the peak late last fall. Obviously, some areas of the state would be higher than that and some lower than that. But I wouldn't exactly call that a strain on the healthcare system. A lot depends on where things go from here, but hopefully we will see a downhill progression like we are seeing in many areas. And for reference, the cases are nearly one forth and the deaths are about a third of what they were at the peak.

Let's hope that more states follow suit in protecting a person's individual medical freedoms and right to have autonomy over one's own body without coercion, force, mandate or threat of penalty. This is a clear violation of the ***Nuremberg Code***. As I have described in this newsletter, the narrative about the unvaccinated spreading COVID-19 and causing the variants is exactly opposite of what is true and what our scientific knowledge about vaccine escape mutants and inappropriate antibiotic use driving antibiotic resistant strains of bacteria have taught us. Of course, it took medicine decades to catch onto how the inappropriate and indiscriminate use of antibiotics causes super germs. And it wouldn't be a stretch to say that a significant percentage of medical doctors still prescribe antibiotics for viral conditions, making the problem even worse. Currently over 100,000 people a year die of antibiotic resistant infections in the U.S. alone. This is a medically caused situation that puts any person entering a hospital at extreme risk. It's unfortunate that we see history repeating itself with these gene therapies being utilized during this pandemic, and we see the definition of insanity playing out before our very eyes. Coming at the public with boosters of the same ineffective vaccines that do not control infection or transmission and very likely are driving the creation of escape variants, is the epitome of doing the same thing over and over and over and expecting a different result.

Breakthrough cases are significantly under-reported by the CDC

It is become obvious to anybody who is digging into the data that the CDC is significantly underreporting the number of breakthrough cases of COVID-19. The question is why?

There are a few different potential reasons.

As I reported earlier in this issue, as of March 1st the CDC stopped counting COVID positive cases in vaccinated individuals. The only exception are for those who are hospitalized or die. Why would they do that?

https://www.cdc.gov/vaccines/covid-19/health-departments/breakthrough-cases.html

Here is more detail on how that is affecting the reported cases (and possibly even hospitalizations and deaths).

An ***NBC News*** investigation found that the CDC was under counting by a magnitude of more than 20 times. NBC contacted various states for their numbers of breakthrough cases. They were able to obtain numbers from 38 states. At the time of the NBC investigation, the CDC was reporting only 6,587 breakthrough cases in the U.S. The NBC investigation found that there were more than 125,000 breakthrough cases and 1,400 of them died. The fact that they were only able to get data from 75% of the states means that maybe over 31,000 cases unaccounted for, bringing the total number of cases to nearly 160,000. **That means that the CDC was only reporting on approximately 4% of the total breakthrough cases** (and that's assuming all the states are doing a good job of counting them).

The title of the story was, **Breakthrough Covid cases: Data shows how many vaccinated Americans have tested positive.**

From the story (bold, italics and highlights are mine)

During the **Face the nation** interview, Fauci adhered to the CDC's position — that breakthrough infections are happening only in a small proportion of fully vaccinated people — while Alroy-Preis said **Israel is seeing breakthrough infections occurring in 50% of those who test positive for COVID.**

Despite mounting evidence COVID vaccine protection is waning over time, Fauci told "Face the Nation":

"…the predominant message is that if you are vaccinated and you get a breakthrough infection … you're much, much more protected against getting infected than an unvaccinated [person] who is completely vulnerable."

The Centers for Disease Control and Prevention reported 3,907 hospitalizations and 750 deaths in people fully vaccinated against COVID with an FDA-authorized vaccine as of June 21.

The CDC's latest breakthrough numbers, as of July 25, show 6,587 fully vaccinated people with COVID breakthrough cases. Of those, 6,239 people were hospitalized and 1,263 people died. *(isn't it interesting that according to the CDC, nearly 100% of the vaccinated people who got COVID were hospitalized and nearly a fourth of them died?).*

In May, the CDC revised its guidance for reporting breakthrough cases, stating it would count only those cases that result in hospitalization or death. Previously, the agency had included in its breakthrough count anyone who tested positive for COVID.

According to the CDC, the surveillance system for breakthrough cases is passive and relies on voluntary reporting from state health departments, which may not be complete.

In addition, some breakthrough cases will not be identified due to lack of testing. This is particularly true in instances of asymptomatic or mild illness, the CDC said.

NBC News investigated breakthrough cases not reported by CDC

NBC News contacted health agencies in 50 states and the District of Columbia to collect information on breakthrough cases, citing a lack of comprehensive data available from the CDC.

Data collected from 38 states showed more than 125,000 fully vaccinated Americans tested positive for COVID, and 1,400 died.

This conflicts with the CDC's data published July 26. Research by NBC News indicates the number who have been hospitalized or died passed 7,300 in just 30 states providing data. *(Therefore that number could be over 10,000 as 40% of the states were not reporting).*

The total number of breakthrough cases is likely higher than 125,683, as nine states, including Pennsylvania and Missouri, did not provide information, while 11 states did not provide death and hospitalization totals. Four states gave death and hospitalization numbers, but not total cases.

In addition, vaccinated adults who had breakthrough cases but showed no symptoms could be missing from the data altogether, officials told NBC.

End of excerpts- https://www.nbcnews.com/health/health-news/breakthrough-covid-cases-least-125-000-fully-vaccinated-americans-have-n1275500

Ireland also seeing an uptick of seriously ill, fully vaccinated individuals

Last month I reported from other countries that the rates of cases, hospitalizations and deaths in fully vaccinated cases were rises at accelerating rates. Now this from Ireland.

An August 22nd article in the ***Independent.ie*** from Dublin Ireland titled, **St Vincent's at capacity as 'worried unwell' add to the workload woes- Emergency chief braced for new wave of hospital Covid cases as schools and colleges prepare to reopen**, stated the following:

St Vincent's hospital in Dublin is admitting a "worrying" number of double-vaccinated patients for treatment for Covid-19, emergency department head Professor John Ryan has said.

He emphasised that just because people are double-jabbed does not mean they are immune to the virus. "Right now, we're seeing a significant number of breakthrough cases," he said.

Why is the virus evading the vaccines? These next two stories will shed some light on that. But you will never hear this from the mainstream media.

Vaccine developer and expert Geert Vander Bossche posts a dire new warning about continuing the mass vaccination program

Dr. Vanden Bossche whom I mentioned earlier in this newsletter, posted the following on August 16th 2021 titled, **How remaining in the dark and turning in vicious circles inevitably leads to erroneous decisions.**

Conducting mass vaccination campaigns on a background of high infection rates generates optimal conditions for breeding even more infectious Sars-CoV-2 variants. The combination of massive, spike-directed immune pressure combined with high infectious pressure rapidly allows these variants to reproduce more effectively such as to outcompete previously circulating variants/ strains. Mass vaccination, therefore, promotes viral evolution towards more infectious variants. The resulting enhancement of viral infectious pressure makes it more likely for everyone, including healthy, unvaccinated people to come in contact with the virus, especially in times where infection prevention measures are loosened. To the extent that high infection rates cause people to become re-exposed shortly after a previous asymptomatic infection, their innate Sars-CoV-binding antibodies (Abs) will be suppressed by short-lived, poorly functional anti-spike Abs, known to not be responsible for preventing the infection from becoming symptomatic. It is precisely the suppression of these broadly protective innate Abs that makes previously asymptomatically infected individuals more susceptible to disease. It is also precisely this phenomenon that explains why a first wave of a natural pandemic is followed by a second wave in younger age groups. The even bigger amplitude of that second wave merely reflects the

overwhelming contribution of a population's innate immunity to its overall immune protective capacity. So, this is why we're now seeing more and more disease in younger age groups, and even children, although they were perfectly protected during previous waves. Extending mass vaccination campaigns to these younger age groups is the most irresponsible public health proposal (decision?) ever as

1. it results in turning a huge cohort of naturally protected people into subjects who will soon become much more vulnerable because the virus is now becoming increasingly resistant to vaccinal Abs (which, despite poor functionality, are still able to suppress broadly protective innate Abs).

2. it further augments pressure on viral infectiousness (i.e., on spike protein, which happens to be the target of all C-19 vaccines!) and, therefore, will only contribute to expediting viral evolution towards enhanced infectiousness (and eventually full resistance to anti-S Abs). As already mentioned, the higher viral infectivity rates grow, the more the incredibly precious innate immune capacity of the population gets eroded and the faster vaccine-mediated protection will wane as a result of enhanced evolution of the virus towards S-Ab-directed resistance. In the meantime – and for as long the C-19 vaccines protect against disease – mass vaccination is turning healthy people into asymptomatic breeding grounds and spreaders of evolving, more infectious variants, which is quite the opposite effect of what mass vaccination was supposed to do (i.e., to generate herd immunity). We only *begin* to see the early consequences of waning vaccine protection, erosion of innate immunity and fulminant expansion of steadily evolving, more infectious variants.

This is to say that it is the complete lack of understanding of why morbidity rates are now increasing in younger age groups that now prompts short-sighted experts and politicians, who typically have no long-term antennae, to advocate for mass vaccination of younger age groups and children. As they obviously lack any kind of insight into the evolutionary dynamics of a pandemic and how those are driven by the interplay between viral infectious pressure and host immune pressure in the population, they don't understand that mass vaccination of the younger age groups is only throwing fuel to the devastating fire of a self-amplifying vicious circle. I challenge any expert, regardless of reputation or qualifications, to invalidate or oppose my arguments in a public debate on a mainstream broadcasting channel. If that debate doesn't take place, it should be very straightforward for youngsters, parents, guardians, or even the children themselves, to draw their own conclusions and decide what is best for themselves or the children.

If we could only have politicians and short-sighted 'experts' hanging this sheet over their bed, we might finally be in a position where we could start cleaning up some of the mess they have made and put an end to all of the completely unacceptable and needless animosity it caused between the vaccinated and the unvaccinated. Time has come to turn all this chaos into a constructive effort that is finally driven by 'Science' and 'Solidarity'!

https://www.geertvandenbossche.org/post/how-remaining-in-the-dark-and-turning-in-vicious-circles-inevitably-leads-to-erroneous-decisions

We can only pray that there will be leaders in government and public health that will understand what is happening and demand that the scientific community (at least those that haven't yet been paid off by pharma), come together and debate these concerns openly and freely. I know that is a grandiose wish considering the totalitarian-like control over any free speech, much less scientific debate that has been imposed on our nation and much of the world.

Who is Geert Vander Bossche and is he qualified to make these statements? I certainly believe so. Here are some of the positions that he has held.

- Geert Vanden Bossche received his DVM from the University of Ghent, Belgium, and his PhD degree in Virology from the University of Hohenheim, Germany.

- He held adjunct faculty appointments at universities in Belgium and Germany.

- After his career in Academia, Geert joined several vaccine companies (GSK Biologicals, Novartis Vaccines, Solvay Biologicals) to serve various roles in vaccine R&D as well as in late vaccine development.

- Geert then moved on to join the Bill & Melinda Gates Foundation's Global Health Discovery team in Seattle (USA) as Senior Program Officer.

- He then worked with the Global Alliance for Vaccines and Immunization (GAVI) in Geneva as Senior Ebola Program Manager. At GAVI he tracked efforts to develop an Ebola vaccine. He also represented GAVI in fora with other partners, including WHO, to review progress on the fight against Ebola and to build plans for global pandemic preparedness. Back in 2015, Geert scrutinized and questioned the safety of the Ebola vaccine that was used in ring vaccination trials conducted by WHO in Guinea. His critical scientific analysis and report on the data published by WHO in the Lancet in 2015 was sent to all international health and regulatory authorities involved in the Ebola vaccination program.

- After working for GAVI, Geert joined the German Center for Infection Research in Cologne as Head of the Vaccine Development Office.

- He is at present primarily serving as a Biotech/ Vaccine consultant while also conducting his own research on Natural Killer cell-based vaccines.

An article from the pre-COVID era describes how viruses and bacteria are driven to mutate under pressure from vaccines and antibiotics

The article posted May 10th, 2018 on ***QuantumMagazine.org*** is titled, **Vaccines Are Pushing Pathogens to Evolve.** Just as indiscriminate or inappropriate antibiotics breed resistant bacterial mutations, vaccines can incite viral mutations (variants) that outpace the vaccines and enable diseases to escape their control.

From the article
Andrew Read, a disease ecologist who directs the Pennsylvania State University Center for Infectious Disease Dynamics wrote a **paper** titled, **Imperfect Vaccination Can Enhance the Transmission of Highly Virulent Pathogens**.

In a 2015 paper in *PLOS Biology*, Read and his colleagues vaccinated 100 chickens, leaving 100 others unvaccinated. They then infected all the birds with strains of Marek's that varied in how virulent — as in how dangerous and infectious — they were. The team found that, over the course of their lives, the unvaccinated birds shed far more of the least virulent strains into the environment, whereas the vaccinated birds shed far more of the most virulent strains. The findings suggest that the Marek's vaccine encourages more dangerous viruses to proliferate. This increased virulence might then give the viruses the means to overcome birds' vaccine-primed immune responses and sicken vaccinated flocks.
https://www.quantamagazine.org/how-vaccines-can-drive-pathogens-to-evolve-20180510/

The abstract from Dr. Read's 2015 paper in *PLOS Biology*
Could some vaccines drive the evolution of more virulent pathogens? Conventional wisdom is that natural selection will remove highly lethal pathogens if host death greatly reduces transmission. Vaccines that keep hosts alive but still allow transmission could thus allow very virulent strains to circulate in a population. Here we show experimentally that immunization of chickens against Marek's disease virus enhances the fitness of more virulent strains, making it possible for hyperpathogenic strains to transmit. Immunity elicited by direct vaccination or by maternal vaccination prolongs host survival but does not prevent infection, viral replication or transmission, thus extending the infectious periods of strains otherwise too lethal to persist. Our data show that anti-disease vaccines that do not prevent transmission can create conditions that promote the emergence of pathogen strains that cause more severe disease in unvaccinated hosts.
https://journals.plos.org/plosbiology/article?id=10.1371/journal.pbio.1002198

The virus is evading the vaccines. This is called vaccine escape and the variants are called escape mutants (sounds like something out of a sci-fi movie, doesn't it?) Why is that happening?

It is happening because the virus is mutating to evade the antibodies created by the vaccine's strategy of stimulating the body to produce specific antibodies against the genetically engineered spike protein of the real virus. The vaccine version of the spike protein that the shots cause our bodies to manufacture by the billions, becomes recognized by our immune system by the exact amino acid sequences in that spike protein, just a very small part of the virus. If those sequences along that spike protein are changed (called mutations), the antibodies produced by the vaccine will not recognize the new patterns of amino acid sequences of the new mutated strain (variant). Therefore, the effectiveness of the vaccines are reduced.

A 2017 study published in the Journal of Autoimmunity titled, **Original antigenic sin: A comprehensive review**, describes how the process called ***Original Antigenic Sin (OAS)*** occurs and the ramifications of that.

The abstract- (bolded sections by me)

The concept of "original antigenic sin" was first proposed by Thomas Francis, Jr. in 1960. This phenomenon has the potential to rewrite what we understand about how the immune system responds to infections and its mechanistic implications on how vaccines should be designed. Antigenic sin has been demonstrated to occur in several infectious diseases in both animals and humans, including human influenza infection and dengue fever. The basis of "original antigenic sin" requires immunological memory, and our immune system ability to autocorrect.

In the context of viral infections, it is expected that if we are exposed to a native strain of a pathogen, we should be able to mount a secondary immune response on subsequent exposure to the same pathogen. "Original antigenic sin" will not contradict this well-established immunological process, **as long as the subsequent infectious antigen is identical to the original one**. But "original antigenic sin" implies that **when the epitope varies slightly, then the immune system relies on memory of the earlier infection, rather than mount another primary or secondary response to the new epitope which would allow faster and stronger responses**. **The result is that the immunological response may be inadequate against the new strain, because the immune system does not adapt and instead relies on its memory to mount a response.**

In the case of vaccines, if we only immunize to a single strain or epitope, and if that strain/epitope changes over time, then the immune system is unable to mount an accurate secondary response.

In addition, depending of the first viral exposure the secondary immune response **can result in an *antibody-dependent enhancement** of the disease or at the opposite, it could induce ***anergy**. Both of them triggering loss of pathogen control and inducing aberrant clinical consequences.

End of abstract

***Definitions**

Antibody Dependent Enhancement (ADE)- AKA disease enhancement. It is a phenomenon in which binding of a virus to suboptimal antibodies enhances its entry into host cells, followed by its replication and leading to an

intensified inflammatory response and disease progression in the body. This is the phenomenon that has plagued every other attempt to make a corona virus vaccine in the last 30 years. It is the main reason why those vaccines never made it past the animal studies into humans. The animals appeared to develop a healthy antibody response which was encouraging to researchers. But later when those animals were challenged by the wild virus they developed an out of control immune reaction leading to death in a large number of those affected animals.

Anergy- Passivity or diminished responsiveness to specific antigens.

A new study reveals information that may be a clue that Antibody Dependent Enhancement may be in play with the rising hospitalizations and deaths in vaccinated individuals

A ***bioRxiv*** preprint posted August 23rd, 2021 titled, **The SARS-CoV-2 Delta variant is poised to acquire complete resistance to wild-type spike vaccines,** reveals the failure of the Pfizer vaccine with the Delta variant and describes what is happening which fits the exact scenario in which **Antibody Dependent Enhancement (ADE),** AKA Pathogenic Priming develops. Keep that in mind as you read the **Key points from the study** below.

But first some background…

- Neutralizing antibodies (Nab) are those that bind to the virus at the active site it uses to bind to the cell (the spike protein binding domain), which prevents it from entering or infecting a cell. This prevents the virus from replicating inside the cell and releasing thousands of new viruses.
- Binding antibodies (AKA non-neutralizing antibodies or (n-NAb), are unable to prevent infection. They can bind to the virus but not to the spike protein binding domain. They bind to the envelop protein of other protein (of which 29 have been identified in the SARS-CoV-2 virus). Paradoxically, that can then actually help the virus enter to infect a cell. They are sometimes referred to as Disease Enhancing Antibodies.
- It is believed that ADE develops when the neutralizing antibodies are insufficient to neutralize the virus. This allows the binding antibodies to bind to the virus which can help the virus get into the cell.
- The mRNA vaccines have been shown to be poor at producing neutralizing antibodies from the first shot. In the first shot they produce more binding than neutralizing antibodies. Hence the need for the 2-dose regimen.
- If the neutralizing antibodies "wane" or decrease over time and much more than the non-neutralizing antibodies, which is what is happening within 4-6 months after the mRNA vaccines (beginning at just 6 weeks), a real problem of enhanced infectivity can occur in the vaccinated. We are already seeing that the levels of virus in the nasopharynx of vaccinated individuals can be dozens of times higher than

when unvaccinated people become infected. This can then cause an over-reaction by the immune system which goes into hyperdrive and cause runaway inflammation leading to tissue and organ damage.

Key points from the study- (Red comments by me)

- **Here, we found that the Delta variant completely escaped from anti-N-terminal domain (NTD) neutralizing antibodies, while increasing responsiveness to anti-NTD infectivity-enhancing antibodies.** (exactly as I described above)

- Although Pfizer-BioNTech BNT162b2-immune sera neutralized the Delta variant, when four common mutations were introduced into the receptor binding domain (RBD) of the Delta variant (Delta 4+), some BNT162b2-immune sera **lost neutralizing activity and enhanced the infectivity.**

- **Unique mutations in the Delta NTD were involved** in the enhanced infectivity by the BNT162b2-immune sera. (That is why natural immunity is far superior. It isn't just focused on one very small part of the virus)

- **Given the fact that a Delta variant with three similar RBD mutations has already emerged according to the GISAID database, it is necessary to develop vaccines that protect against such complete breakthrough variants.** (Like the old adage says, "If your only tool is a hammer, everything starts looking like a nail")

https://www.biorxiv.org/content/10.1101/2021.08.22.457114v1

Now of course their solution is another vaccine, but they obviously haven't learned a thing. By the time they could develop and roll out a new version of the vaccine, there most likely would be new mutations that would evade the new vaccine from the start. Even if that didn't happen, the vaccines would drive development of new mutations just like the current version has done. You know what doing the same thing over and over and expecting a different result is called don't you? It's the definition of insanity.

A reminder from this article I ran in last month's newsletter about the concerns many scientists and bioethicists have about informing people about the real risk of ADE

In a March 2021 article **FUNDED by the *NIH*** (Tony Fauci's group) and published in ***Perspective- Infectious Diseases*** titled **Informed consent disclosure two vaccine trial subjects of risk of COVID-19 vaccines worsening clinical disease**, authors are critical of the lack of patient informed consent revolving around

COVID-19 vaccines the risk of causing Antibody Dependent Enhancement (ADE), or what is sometimes called Pathogenic Priming. The section I have pasted here goes through a nice history of why many top scientists and medical experts have been terrified about the prospect of this developing in some people. In fact, as I have reported in previous issues of this newsletter, there have been thousands of reports world-wide of incidents of previously uninfected people developing severe COVID-19, with many dying after they have had their shots. These have been roundly dismissed as unfortunate coincidences.

From the article-

Results of the study: COVID-19 vaccines designed to elicit neutralizing antibodies may sensitise vaccine recipients to more severe disease than if they were not vaccinated. Vaccines for SARS, MERS and RSV have never been approved, and the data generated in the development and testing of these vaccines suggest a serious mechanistic concern: that vaccines designed empirically using the traditional approach (consisting of the unmodified or minimally modified coronavirus viral spike to elicit neutralising antibodies), be they composed of protein, viral vector, DNA or RNA and irrespective of delivery method, may worsen COVID-19 disease via antibody-dependent enhancement (ADE). This risk is sufficiently obscured in clinical trial protocols and consent forms for ongoing COVID-19 vaccine trials that adequate patient comprehension of this risk is unlikely to occur, obviating truly informed consent by subjects in these trials.

Conclusions drawn from the study and clinical implications: The specific and significant COVID-19 risk of ADE should have been and should be prominently and independently disclosed to research subjects currently in vaccine trials, as well as those being recruited for the trials and future patients after vaccine approval, in order to meet the medical ethics standard of patient comprehension for informed consent.

End of story

https://pubmed.ncbi.nlm.nih.gov/33113270/

Is informed consent about ADE happening? Based on all have heard and found out, the answer is categorically NO. And they want these shots mandated without giving people the truth about ADE and all the other known and potential risks? It's absurd.

A study in the *Journal of Infection* rings the alarm bells about Antibody Dependent Enhancement from the COVID-19 vaccines

The study is from the ***Journal of Infection*** dated August 9th, 2021 titled, **Infection-enhancing anti-SARS-CoV-2 antibodies recognize both the original Wuhan/D614G strain and Delta variants. A potential risk for mass**

vaccination? It has some very concerning things to say that may explain the rise in severe cases and deaths from the Delta Variant that we are seeing in fully vaccinated people.

From the article- (emphasis and comments in italics are mine)

Since the Covid-19 pandemic is now dominated with Delta variants, we analyzed the interaction of facilitating antibodies with the NTD of these variants. Using molecular modeling approaches, we show that **enhancing antibodies have a higher affinity for Delta variants than for Wuhan/D614G NTDs.** *(Enhancing antibodies help facilitate the virus into the cells increasing infectivity)*

As the NTD is also targeted by neutralizing antibodies, **our data suggest that the balance between neutralizing and facilitating antibodies in vaccinated individuals is in favor of neutralization for the original Wuhan/D614G strain**. **However, in the case of the Delta variant, neutralizing antibodies have a decreased affinity for the spike protein, whereas facilitating antibodies display a strikingly increased affinity. Thus, ADE may be a concern for people receiving vaccines based on the original Wuhan strain spike sequence (either mRNA or viral vectors).** *(Neutralizing antibodies are the ones that you want, which will bind to the spike protein of the virus and prevent it from infecting the cell. In this case with the Delta variant, it says that the neutralizing antibodies have a decreased affinity for the spike protein. That is NOT a good thing).*

Since our data indicate that **Delta variants are especially well recognized by infection enhancing antibodies** targeting the NTD, the possibility of ADE should be further investigated as **it may represent a potential risk for mass vaccination during the current Delta variant pandemic.** *(Once again, especially well recognized by infection enhancing antibodies in NOT a good thing).*

End of excerpts

https://pubmed.ncbi.nlm.nih.gov/34384810/

A perspective on why the spike protein was a bad choice for the shots (other than the fact that the spike protein acts as a toxin in the body).

A paper published pre-vaccine development in April 2020 describes the proposed target spike protein for vaccine development.

The paper titled, **Computers and viral diseases. Preliminary bioinformatics studies on the design of a synthetic vaccine and a preventative peptidomimetic antagonist against the SARS-CoV-2 (2019-nCoV, COVID-19) coronavirus**, describes it this way…

1.4. Coronavirus spike protein as therapeutic target

More specifically focus is on the Class I fusion protein of the coronaviruses which is a glycoprotein known as the spike protein (S) that protrudes extensively from the virus envelope surface. It is responsible for binding to the receptor on the host cell as well as mediating the fusion of host and viral membranes [4]. S, most frequently referred to as the "spike protein" or "spike glycoprotein" below, is synthesized as a single-chain precursor of approximately 1300 amino acids and forms a trimer of 3 S proteins on folding. The trimeric SARS coronavirus (SAR-S-CoV) spike glycoprotein consists of three S1–S2 heterodimers and binds the cellular receptor angiotensin-converting enzyme 2 (ACE2). It mediates fusion of the viral and cellular membranes through a pre-to post fusion conformation transition. Airway protease cleavage site along the amino acid sequence of SARS-CoV S glycoprotein have been identified.

My comment: The 1,300 amino acid chain mentioned is where the mutations that affect the effectiveness of the vaccines occur diminishing the effectiveness of the vaccines and driving the development of new variants.

Vaccine researcher admits 'big mistake,' says spike protein is dangerous 'toxin'

May 31, 2021 (LifeSiteNews) — New research shows that the coronavirus spike protein from

COVID-19 vaccination unexpectedly enters the bloodstream, which is a plausible explanation for thousands of reported side-effects from blood clots and heart disease to brain damage and reproductive issues, a Canadian cancer vaccine researcher said last week.

"We made a big mistake. We didn't realize it until now," said Byram Bridle, a viral immunologist and associate professor at University of Guelph, Ontario, in an interview with Alex Pierson last Thursday, in which he warned listeners that his message was "scary."

"We thought the spike protein was a great target antigen, we never knew the spike protein itself was a toxin and was a pathogenic protein. So by vaccinating people we are inadvertently inoculating them with a toxin," Bridle said on the show, which is not easily found in a Google search but went viral on the internet this weekend.

Bridle, a vaccine researcher who was awarded a $230,000 government grant last year for research on COVID vaccine development, said that he and a group of international scientists filed a request for information from the Japanese regulatory agency to get access to what's called the "biodistribution study."

"It's the first time ever scientists have been privy to seeing where these messenger RNA [mRNA] vaccines go after vaccination," said Bridle. "Is it a safe assumption that it stays in the shoulder

muscle? The short answer is: absolutely not. It's very disconcerting."

Vaccine researchers had assumed that novel mRNA COVID vaccines would behave like "traditional" vaccines and the vaccine spike protein — responsible for infection and its most severe symptoms — would remain mostly in the vaccination site at the shoulder muscle. Instead, the Japanese data showed that the infamous spike protein of the coronavirus gets into the blood where it circulates for several days post-vaccination and then accumulated in organs and tissues including the spleen, bone marrow, the liver, adrenal glands, and in "quite high concentrations" in the ovaries.

"We have known for a long time that the spike protein is a pathogenic protein. It is a toxin. It can cause damage in our body if it gets into circulation," Bridle said.

FDA warned of spike protein danger

Pediatric rheumatologist J. Patrick Whelan had warned a vaccine advisory committee of the Food and Drug Administration of the potential for the spike protein in COVID vaccines to cause microvascular damage causing damage to the liver, heart, and brain in "ways that were not assessed in the safety trials."

While Whelan did not dispute the value of a coronavirus vaccine that worked to stop transmission of the disease (which no COVID vaccine in circulation has been demonstrated to do), he said, "it would be vastly worse if hundreds of millions of people were to suffer long-lasting or even permanent damage to their brain or heart microvasculature as a result of failing to appreciate in the short-term an unintended effect of full-length spike protein-based vaccines on other organs."
Vaccine-associated spike protein in blood circulation could explain myriad reported adverse events from COVID vaccines, including the 4,000 deaths to date, and nearly 15,000 hospitalizations, reported to the U.S. government's Vaccine Adverse Event Reporting System (VAERS) as of May 21, 2021. Because it is a passive reporting system, these reports are likely only the tip of an iceberg of adverse events since a Harvard Pilgrim Healthcare study found that less than one percent of side-effects that physicians should report in patients following vaccination are in fact reported to VAERS.
See more of the full article here: https://www.lifesitenews.com/news/vaccine-researcher-admits-big-mistake-says-spike-protein-is-dangerous-toxin/

The following is a follow-up post from ***LifeSiteNews.com*** dated June 1st, 2021

A focus of the statement was the risk to children and teens who are the target of the latest vaccine marketing strategies, including in Canada.

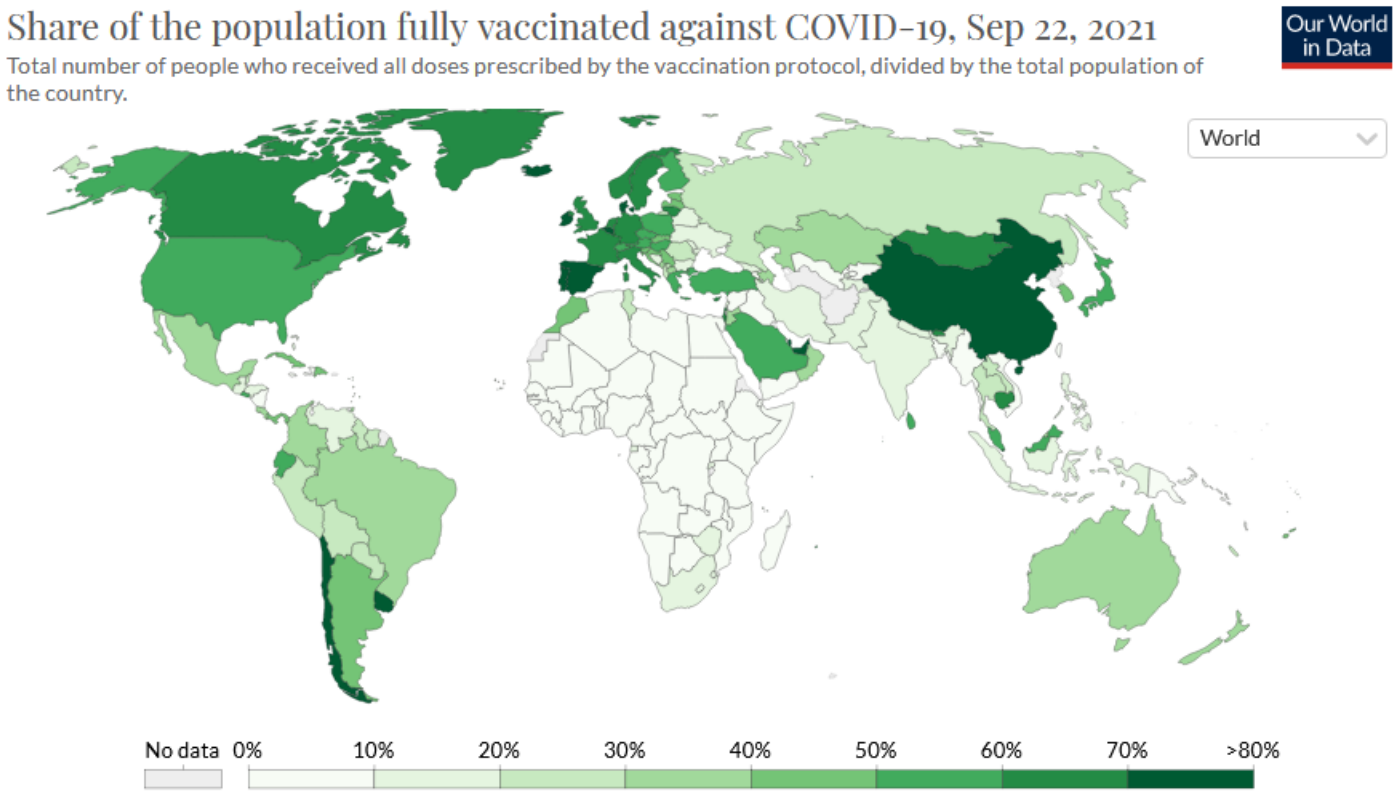
As of May 28, 2021, there have been 259,308 confirmed cases of SARS-CoV-2 infections in Canadians 19 years and under. Of these, 0.048% were hospitalized, but only 0.004% died, according to the CCCA statement. “Seasonal influenza is associated with more severe illness than COVID-19.”

Given the small number of young research subjects in Pfizer’s vaccine trials and the limited duration of clinical trials, the CCCA said questions about the spike protein and another vaccine protein must be answered before children and teens are vaccinated, including whether the vaccine spike protein crosses the blood-brain barrier, whether the vaccine spike protein interferes with semen production or ovulation, and whether the vaccine spike protein crosses the placenta and impacts a developing baby or is in breast milk.

LifeSiteNews sent the Public Health Agency of Canada the statement of CCCA and asked for a response to Bridle’s concerns. The agency responded that it was working on the questions but did not send answers before publication time.

Pfizer, Moderna, and Johnson & Johnson did not respond to questions about Bridle’s concerns. Pfizer did not respond to questions about how long the company was aware of its research data that the Japanese agency had released, showing spike protein in organs and tissue of vaccinated individuals.

October 01, 2021 update



U.K. regulators admit that there has been four times the number of deaths reported from the COVID-19 vaccines in 8 months than all vaccines combined in the last 20 years

The ***Medicine and Healthcare Products Regulatory Agency*** for the just the ***United Kingdom*** has responded to a Freedom of Information Request and revealed that there have been 404 deaths reported from all vaccines in the UK since 2001.
https://theexpose.uk/wp-content/uploads/2021/09/FOI-21-907-Response-1.pdf (see page 3)

Since the onset of the COVID-19 vaccine program in the UK, there have been the following deaths reported associated with these different vaccines.

AstraZeneca/Oxford- 1,083
Pfizer- 534
Moderna- 17
Total = 1,634

https://rightsfreedoms.wordpress.com/2021/09/28/uk-medicine-regulator-confirms-there-have-been-four-times-as-many-deaths-due-to-the-covid-19-vaccines-in-8-months-than-deaths-due-to-all-other-vaccines-combined-in-20-years/

The mRNA vaccines use technology the suppresses the immune system so the lipid nanoparticles can get through the body's defenses to deliver the payload to our cells. What are the frightening prospects of that?

An excellent article published September 12th, 2021 on ***UKColumn.org*** tiled, **Stabilising the Code**, does a fantastic job of explaining how the developers of the mRNA vaccines were able to suppress the body's innate immune system to keep it from destroying the lipid nanoparticles before they can deliver their payload, the genetically engineered spike protein into the cells of the injected person. The unintended consequences of doing this may be profound however!

This discovery was adopted in the mRNA technology used in Covid vaccines, in order that the foreign vaccine mRNA could enter cells without being destroyed. Below is the mRNA code from the Pfizer vaccine demonstrating the modified Uridine nucleoside by denoting it as **Ψ** (modified) instead of its natural form U (Uridine). To be precise: every Uridine (U) has been replaced by 1-methyl-3'-pseudouridylyl (Ψ).

Sequence / Séquence / Secuencia

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GAGAAΨAAAC ΨAGΨAΨΨCΨΨ CΨGGΨCCCCA CAGACΨCAGA GAGAACCCGC   50
CACCAΨGΨΨC GΨGΨΨCCΨGG ΨGCΨGCΨGCC ΨCΨGGΨGΨCC AGCCAGΨGΨG  100
ΨGAACCΨGAC CACCAGAACA CAGCΨGCCΨC CAGCCΨACAC CAACAGCΨΨΨ  150
ACCAGAGGCG ΨGΨACΨACCC CGACAAGGΨG ΨΨCAGAΨCCA GCGΨGCΨGCA  200
CΨCΨACCCAG GACCΨGΨΨCC ΨGCCΨΨΨCΨΨ CAGCAACGΨG ACCΨGGΨΨCC  250
ACGCCAΨCCA CGΨGΨCCGGC ACCAAΨGGCA CCAAGAGAΨΨ CGACAACCCC  300
GΨGCΨGCCCΨ ΨCAACGACGG GGΨGΨACΨΨΨ GCCAGCACCG AGAAGΨCCAA  350
CAΨCAΨCAGA GGCΨGGAΨCΨ ΨCGGCACCAC ACΨGGACAGC AAGACCCAGA  400
GCCΨGCΨGAΨ CGΨGAACAAC GCCACCAACG ΨGGΨCAΨCAA AGΨGΨGCGAG  450
ΨΨCCAGΨΨCΨ GCAACGACCC CΨΨCCΨGGGC GΨCΨACΨACC ACAAGAACAA  500
CAAGAGCΨGG AΨGGAAAGCG AGΨΨCCGGGΨ GΨACAGCAGC GCCAACAACΨ  550
GCACCΨΨCGA GΨACGΨGΨCC CAGCCΨΨΨCC ΨGAΨGGACCΨ GGAAGGCAAG  600
CAGGGCAACΨ ΨCAAGAACCΨ GCGCGAGΨΨC GΨGΨΨΨAAGA ACAΨCGACGG  650
CΨACΨΨCAAG AΨCΨACAGCA AGCACACCCC ΨAΨCAACCΨC GΨGCGGGAΨC  700
ΨGCCΨCAGGG CΨΨCΨCΨGCΨ CΨGGAACCCC ΨGGΨGGAΨCΨ GCCCAΨCGGC  750
AΨCAACAΨCA CCCGGΨΨΨCA GACACΨGCΨG GCCCΨGCACA GAAGCΨACCΨ  800
GACACCΨGGC GAΨAGCAGCA GCGGAΨGGAC AGCΨGGΨGCC GCCGCΨΨACΨ  850
AΨGΨGGGCΨA CCΨGCAGCCΨ AGAACCΨΨCC ΨGCΨGAAGΨA CAACGAGAAC  900
GGCACCAΨCA CCGACGCCGΨ GGAΨΨGΨGCΨ CΨGGAΨCCΨC ΨGAGCGAGAC  950
AAAGΨGCACC CΨGAAGΨCCΨ ΨCACCGΨGGA AAAGGGCAΨC ΨACCAGACCA 1000
GCAACΨΨCCG GGΨGCAGCCC ACCGAAΨCCA ΨCGΨGCGGΨΨ CCCCAAΨAΨC 1050
ACCAAΨCΨGΨ GCCCCΨΨCGG CGAGGΨGΨΨC AAΨGCCACCA GAΨΨCGCCΨC 1100
ΨGΨGΨACGCC ΨGGAACCGGA AGCGGAΨCAG CAAΨΨGCGΨG GCCGACΨACΨ 1150
CCGΨGCΨGΨA CAACΨCCGCC AGCΨΨCAGCA CCΨΨCAAGΨG CΨACGGCGΨG 1200
ΨCCCCΨACCA AGCΨGAACGA CCΨGΨGCΨΨC ACAAACGΨGΨ ACGCCGACAG 1250
CΨΨCGΨGAΨC CGGGGAGAΨG AAGΨGCGGCA GAΨΨGCCCCΨ GGACAGACAG 1300
GCAAGAΨCGC CGACΨACAAC ΨACAAGCΨGC CCGACGACΨΨ CACCGGCΨGΨ 1350
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By modifying the Uridine in the Pfizer vaccine mRNA code, the foreign mRNA is able to bypass part of the body's first line of defense — the Innate Immune System.

The body possesses two broad parts to its immune system: innate and specific. The innate is the first to go into action against foreign invaders, including foreign mRNA from a vaccine.

How does that simple removal of one letter of code from mRNA achieve that?
It does so by affecting Toll Like Receptors (TLR): the alarm signal of the Innate Immune System.
The key TLRs affected are TLR 3, TLR 7 and TLR 8. They act as sentries, whose job is to recognise foreign invaders by way of their form or patterns; a bit like an aircraft spotter in World War II. If the wrong type of shape is recognised in the sky then alarm bells sound and anti-aircraft fire kicks in. In the case of TLRs, the immune system gets activated.

What if you could by-pass those spotters? No alarms, no immune system response; and your payload, foreign mRNA in this example, gets through safely. Then your drug/vaccine has a much greater chance of working.
At that point in the original experiments to discover how to *turn off* toll-like receptors (and subsequently in the design of the vaccines), the question should have been asked: *but what would be the consequences of switching off that important early warning system?*

If that question was raised it appears to have fallen on deaf ears and not been answered until, possibly, now.
Aberrant immune response

The BNT162b2 mRNA vaccine against SARS-CoV-2 reprograms both adaptive and innate immune responses

F. Konstantin Föhse, Büsranur Geckin, Gijs J. Overheul, Josephine van de Maat, Gizem Kilic, Ozlem Bulut, Helga Dijkstra, Heidi Lemmers, S. Andrei Sarlea, Maartje Reijnders, Jacobien Hoogerwerf, Jaap ten Oever, Elles Simonetti, Frank L. van de Veerdonk, Leo A.B. Joosten, Bart L. Haagmans, Reinout van Crevel, Yang Li, Ronald P. van Rij, Corine GeurtsvanKessel, Marien I. de Jonge, Jorge Domínguez-Andrés, Mihai G. Netea

doi: https://doi.org/10.1101/2021.05.03.21256520

Dominguez-Andres et al addressed that question May 6th 2021.

They state:
Certain vaccines such as Bacillus Calmette-Guérin (BCG) and the measles, mumps, and rubella (MMR) vaccine also induce long term functional reprogramming of cells of the innate immune system. (Netea et al., 2020). This biological process is also termed trained immunity when it involves increased responsiveness, or **innate immune tolerance** when it is characterized by decreased cytokine production (Ifrim et al., 2014). Although these effects have been proven mainly for live attenuated vaccines, we sought to investigate whether the BNT162b2 [Pfizer] vaccine might also induce effects on innate immune responses against different viral, bacterial and fungal stimuli. [Emphasis added].

Their answer?

The BNT162b2 vaccine also modulated the production of inflammatory cytokines by innate immune cells upon stimulation with both specific (SARS-CoV-2) and non-specific (viral, fungal and bacterial) stimuli. **The response of innate immune cells to TLR4 and TLR7/8 ligands was lower after BNT162b2 vaccination.** [Emphasis added].

They continue:
[W]e observed a significant reduction in the production if IFN-α secreted after stimulation with poly I:C and R848 after the administration of the second dose of the vaccine (Figure 1H, 1I). **This may hamper the initial innate immune response against the virus**, as defects in TLR7 have been shown to result in and increased susceptibility to COVID-19 in young males (Van Der Made et al., 2020). **These results collectively demonstrate that the effects of the BNT162b2 vaccine go beyond the adaptive immune system and can also modulate innate immune responses.** [Emphasis added].

Three concerns are raised by the above.

1. The ability of the immune system to fight viruses has been diminished; specifically, the ability to fight SARS-CoV-2 may be affected;
2. Vaccine-induced innate immune tolerance may affect other vaccines; and finally
3. What other parts of the immune system may be affected.

If this story intrigues you, I highly recommend that you read the entire article. There are several different references that support the concerns over the alteration of the immune system by these experimental biological products.

https://www.ukcolumn.org/article/stabilising-the-code

Also, Del Bigtree and Jefferey Jaxon of the ***Highwire*** did a great story on this during ***the Jaxon Report*** of **Episode 234- Rise of the Resistance**
https://thehighwire.com/videos/episode-234-rise-of-the-resistance/

Reports of rapidly growing cancers are on the rise in COVID-19 vaccinated individuals and this doctor has a plausible theory as to why that is happening

Lifesite news posted an article on September 13th 2021 titled, **Idaho doctor reports a '20 times increase' of cancer in vaccinated patients.**

The article
'Post-vaccine, what we are seeing is a drop in your killer T-cells, in your CD8 cells," said Dr. Ryan Cole.

"Since January 1, in the laboratory, I'm seeing a 20 times increase of endometrial cancers over what I see on an annual basis," reported Dr. Cole in the video clip shared on Twitter.

"I'm not exaggerating at all because I look at my numbers year over year, I'm like 'Gosh, I've never seen this many endometrial cancers before'," he continued.

Explaining his findings at the March 18 event, Cole told Idahoans that the vaccines seem to be causing serious autoimmune issues, in a way he described as a "reverse HIV" response.

Cole explained that two types of cells are required for adequate immune system function: "Helper T-cells," also called "CD4 cells," and "killer T-cells," often known as "CD8 cells."

According to Cole, in patients with HIV, there is a massive suppression of "helper T-cells" which cause immune system functions to plummet, and leave the patient susceptible to a variety of illnesses.

Similarly, Cole describes, "post-vaccine, what we are seeing is a drop in your killer T-cells, in your CD8 cells," "And what do CD8 cells do? They keep all other viruses in check," he continued.
Much like HIV causes immune system disruption by suppressing CD4 "helper" cells, the same thing happens when CD8 "killer" cells are suppressed. In Dr. Cole's expert view, this is what seems to be the case with the COVID-19 jabs.

Cole goes on to state that as a result of this vaccine-induced "killer T-cell" suppression, he is seeing an "uptick" of not only endometrial cancer, but also melanomas, as well as herpes, shingles, mono, and a "huge uptick" in HPV when "looking at the cervical biopsies of women."

This is not the first time the COVID-19 vaccines have been linked to serious issues regarding women's health.

According to a German research study, polyethylene glycol, an ingredient found in the Pfizer and Moderna jabs, has been found to pose a "potential toxicity risk" to women's ovaries.

Dr. Michael Yeadon, a former vice president at Pfizer, has cited the German study as a possible explanation for the large number of menstrual irregularities and miscarriages being reported by vaccinated women.
Yeadon warns young women to avoid the vaccine for, in his expert opinion as a toxicologist, the shots will likely impede a woman's ability to get pregnant and carry a baby to term.

Dr. Cole states in his video that, not only are melanomas showing up more frequently, like endometrial cancers, the melanomas are also developing more rapidly, and are more severe in younger people, than he has ever previously witnessed.

“Most concerning of all, there is a pattern of these types of immune cells in the body keeping cancer in check,” stated the doctor.

“I’m seeing invasive melanomas in younger patients; normally we catch those early, and they are thin melanomas, [but] I’m seeing thick melanomas skyrocketing in the last month or two,” he added.

Cole came into prominence in January of 2021 when the Idaho government put in place an effort called “Capitol Clarity,” with the stated goal of keeping Idahoans informed about the facts surrounding COVID-19. Capitol Clarity has since hosted Dr. Ryan Cole multiple times to provide information to the public about vaccine safety and COVID-19 measures more broadly.

The videos of Dr. Cole at these events, which were originally posted on YouTube, have since been deleted by the Google owned video platform in a continual effort of censorship by Big Tech.

“You’re not being told the truth,” said Yeadon “Thinking about this, I try to imagine that I was speaking to my own young adult daughters, for whom I would be very concerned if they got these vaccines.”

https://www.lifesitenews.com/news/idaho-doctor-reports-a-20-times-increase-of-cancer-in-vaccinated-patients/

Another dire warning about continuing the mass vaccination program from vaccine developer Dr. Geert Vanden Bossche

His article is titled **The Last Post**

From the article
Who’s wrong, who’s right?

These are the key points one has to understand to be able to capture the never-ending discussion on whether or not mass vaccination campaigns work.

1. Pandemics are by definition not static but dynamic events
2. Pandemics have both detrimental and beneficial effects (e.g., waves of morbidity & death and generation of herd immunity, respectively) that are phased in time
3. Pandemic waves hit populations of different age groups at different points in time
4. Normally (I should say: ‘naturally’), a pandemic starts with some bad news (a number of lives are lost) and ends with plenty of good news (all of the population protected by herd immunity)

Other segments…

…Likewise, mass vaccination campaigns may have a beneficial short-time effect in that they reduce viral spread and protect vulnerable people from disease (e.g., elderly people and those with underlying disease), but will eventually drive the propagation of more infectious variants. Dominant circulation of the latter will lead to a resurgence of viral infectious pressure, thereby eroding the innate immune defense of the unvaccinated (i.e., mostly younger age groups including children) and thus making them more susceptible to contracting Covid-19 disease. This already explains why mass vaccination campaigns conducted in the middle of a pandemic will only cause Sars-CoV-2 to engender more disease and claim more human lives. Because of this mass vaccination program, waves of morbidity will continue for much longer, as more (recovery from) disease cases will be required to compensate for the erosion of the population's innate immunity and, therefore, to make up for the latter's deficient contribution to HI.

…There should be no doubt that non-transmission-blocking vaccines (i.e., so-called 'leaky' or 'imperfect' vaccines) can never ever control a pandemic, even though they may temporarily protect against disease. Only temporarily? Yes, indeed. Given the globally increasing immune pressure and concomitant infectious viral pressure, genomic epidemiologists have no doubt that this pandemic roller coaster will not stop before it takes us over the cliff into the abyss of *complete viral resistance to anti-spike (S) antibodies*. That is where all runaway trains of the *different ongoing pandemics of highly infectious variants* will be coming together and converge into a big whirl where they can no longer be distinguished from one another. The first stages of this evolution is what we now begin to see in countries which have already massively vaccinated their population (e.g., Israel). There is no doubt that other countries like the United Kingdom and the United States will soon go down the same path. Due to increasing resistance to neutralizing anti-S antibodies (Abs), these countries are now even beginning to shift from a primarily beneficial (i.e., less susceptible to severe disease) to a primarily detrimental effect (more susceptible to severe disease) in the vaccinated as compared to the unvaccinated (https://www.gov.uk/government/publications/investigation-of-novel-sars-cov-2-variant-variant-of-concern-20201201).

…Conclusively, mass vaccination campaigns during a pandemic of highly infectious variants fail to control viral transmission. Instead of contributing to building HI, they dramatically delay natural establishment of HI (Vanden Bossche, August 2021). This is why *the ongoing universal vaccination campaigns are absolutely detrimental to public and global health*.

End of excerpts

https://www.geertvandenbossche.org/post/the-last-post

Perhaps this series of September 13th Tweets by Dr. Vanden Bossche sums up the vaccinated vs unvaccinated debate most succinctly

"This time, in a nutshell: All unvaccinated people who're susceptible to C-19 disease (because of re-exposure shortly after primary infection due to high infectious pressure, or if otherwise immune suppressed, or if immunosenescent) and all vaccinees contribute to the ongoing explosive expansion of more infectious and increasingly anti-spike-Ab-resistant immune escape variants."

"However, ALL of the unvaccinated but not vaccinated (= still predominantly asymptomatically infected) contribute to herd immunity, either by virtue of naturally acquired immunity (i.e., those who were susceptible and recovered from C-19 disease) or by preventing or abrogating infection by ANY Sars-CoV-2 variant (i.e., all the unvaccinated who're not susceptible to C-19 disease for lack of immune suppression of their multispecific innate immune effectors)."

"We, therefore, have to rely on the unvaccinated to prevent dominant, highly infectious variants from rapidly evolving towards full resistance to the vaccines. We need, therefore, more unvaccinated people to protect the vaccinees."

"Hence, it's imperative that we make love (=> baby boom to replenish reservoir of unvaccinated!) and no war (=> STOP mass vaccination). When presenting with first signs & symptoms, ALL MUST have free access to immune-strengthening supplements (mostly sufficient for the young & previously healthy) and early multidrug treatment (mostly required for the vulnerable & elderly). We're in this TOGETHER and, once again, I am BEGGING the WHO to give me a chance to explain all of the above."

In case you are new to this newsletter or are not familiar with Dr. Vanden Bossche's qualifications, here they are…

Who is Geert Vander Bossche and is he qualified to make these statements? I certainly believe so. Here are some of the positions that he has held.

- Geert Vanden Bossche received his DVM from the University of Ghent, Belgium, and his PhD degree in Virology from the University of Hohenheim, Germany.
- He held adjunct faculty appointments at universities in Belgium and Germany.
- After his career in Academia, Geert joined several vaccine companies (GSK Biologicals, Novartis Vaccines, Solvay Biologicals) to serve various roles in vaccine R&D as well as in late vaccine development.
- Geert then moved on to join the Bill & Melinda Gates Foundation's Global Health Discovery team in Seattle

(USA) as Senior Program Officer.

- He then worked with the Global Alliance for Vaccines and Immunization (GAVI) in Geneva as Senior Ebola Program Manager. At GAVI he tracked efforts to develop an Ebola vaccine. He also represented GAVI in fora with other partners, including WHO, to review progress on the fight against Ebola and to build plans for global pandemic preparedness. Back in 2015, Geert scrutinized and questioned the safety of the Ebola vaccine that was used in ring vaccination trials conducted by WHO in Guinea. His critical scientific analysis and report on the data published by WHO in the Lancet in 2015 was sent to all international health and regulatory authorities involved in the Ebola vaccination program.

- After working for GAVI, Geert joined the German Center for Infection Research in Cologne as Head of the Vaccine Development Office.

- He is at present primarily serving as a Biotech/ Vaccine consultant while also conducting his own research on Natural Killer cell-based vaccines.

If you are trying to explain the concepts Dr. Vanden Bossche is concerned about in a simpler way to someone else, perhaps this may help. It is my response to a post I saw on Facebook.

I saw a post the other day that said the people who have not gotten the V are the reason for development of the variants.

I have another opinion shared by Geert Vanden Bossche, a lifetime V developer formerly working for GAVI (the Global Alliance for Vaccines and Immunizations) and the Gates Foundation. He says that because the V's are leaky, Meaning that they don't prevent a person from getting infected or being able to spread it, that the V'inated are the depots for encouraging the virus to mutate. Think about it like giving an antibiotic that isn't quite strong enough to kill a type of bacteria. That bacteria will mutate to get stronger and be more resistant to that antibiotic. Same principle can happen with V's for viruses.

If the V was completely effective against a person becoming infected or transmitting the virus to others, it would be a completely different story. We now know that isn't the case. And to continue the insanity of increasing V'ination rates and perpetuating this problem even further, we will be creating even more resistant strains. This is one of the reasons why so many of the mutations in the Delta variant are along the spike protein, the very single component these V's force the body to manufacture.

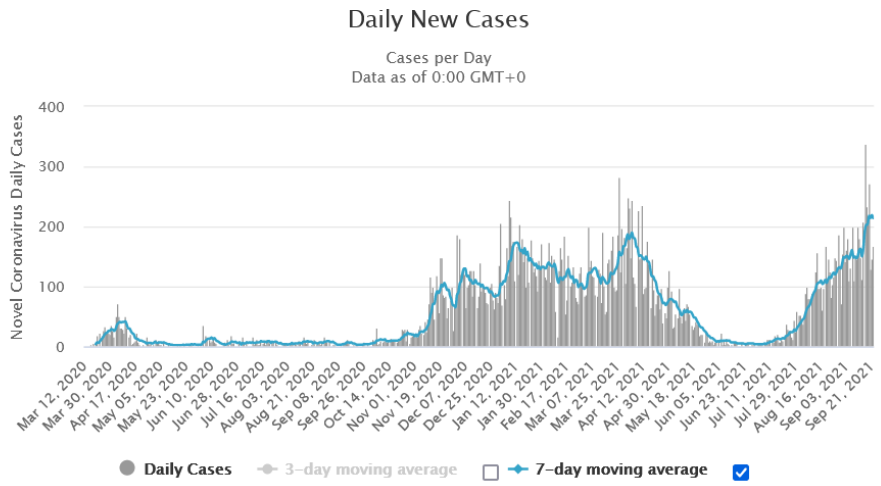
Unfortunately, it took the medical profession decades to learn this lesson with the indiscriminate use of antibiotics. And it's the reason we have not been able to keep up with bacterial mutations and the creation of these bacterial "super germ" variants. Now, well over 100,000 people a year die in the U.S. from antibiotic resistant infections.

You can go to Dr Vanden Bossche's website and read his dire warnings to the world about this. His website is https://geertvandenbossche.org.

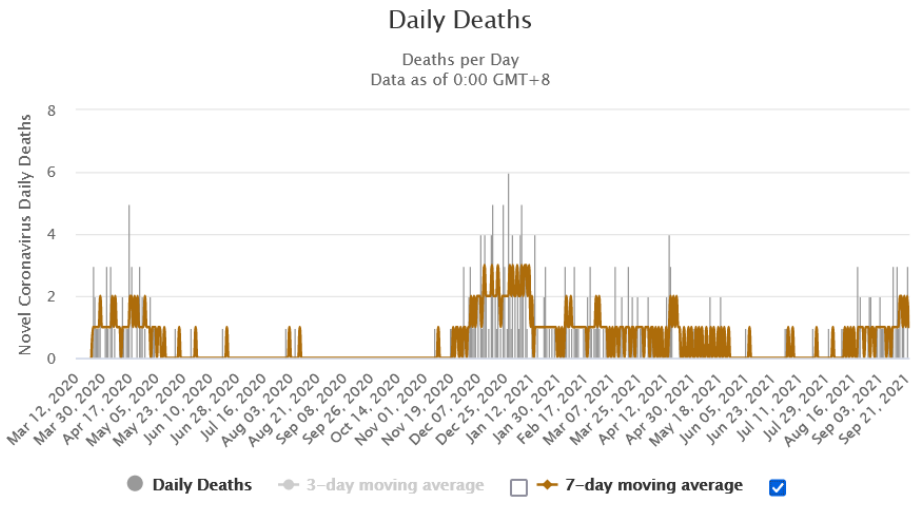
Vermont, the highest vaccinated state in the U.S. has skyrocketing cases, hospitalizations and deaths

Vermont is not a very populace state at approximately 620,000 persons, so the total numbers are not large. But that doesn't change the correlation of the rates of vaccination and the numbers. As of September 25th, 2021, 69.2% of the state's population has been fully vaccinated.

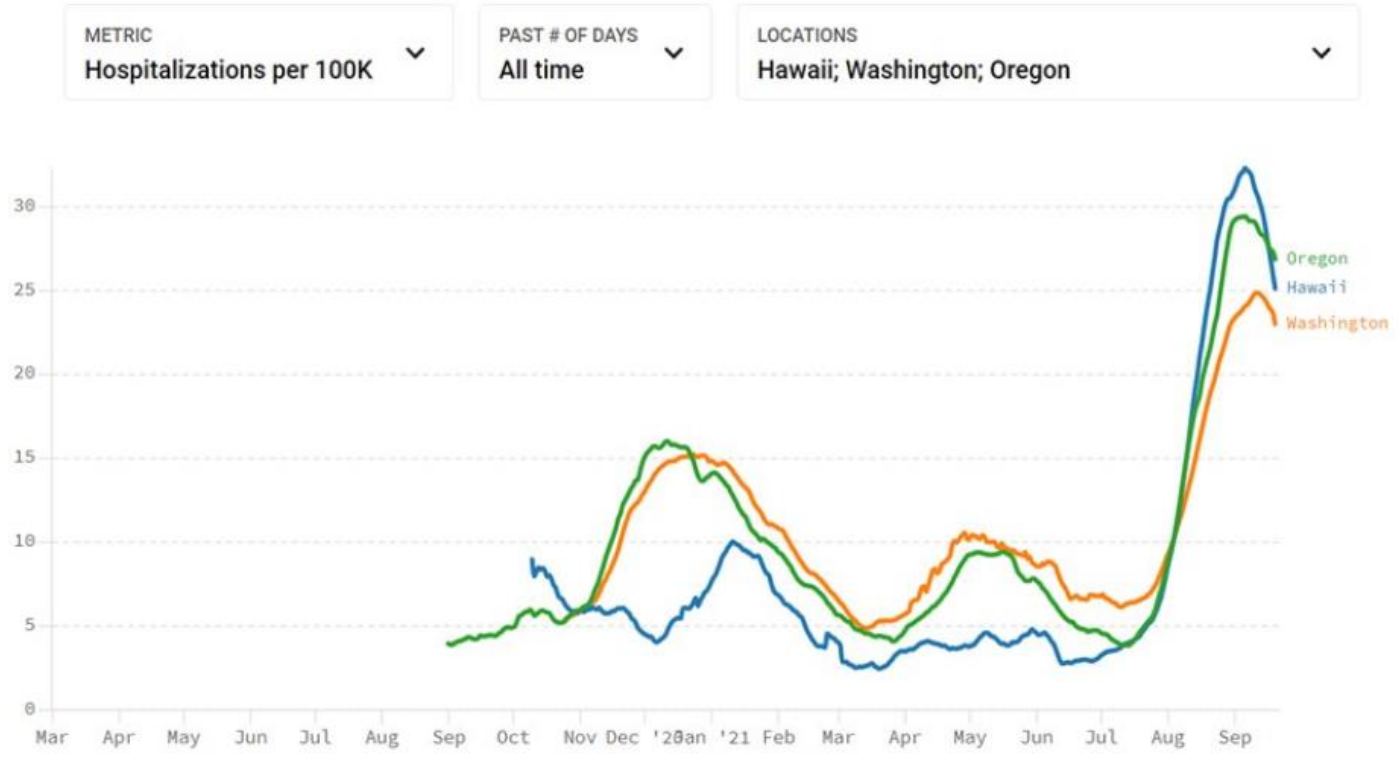
Daily New Cases in Vermont



Daily New Deaths in Vermont



Three states with the highest vaccination rates also have some of the highest hospitalizations for COVID-19



The first report of mass breakthrough cases in the U.S. came in July 2021

The first mainstream media coverage of mass breakthrough cases came in July 2021 from Massachusetts by way of a CDC report titled, **Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021**

From the report (emphasis mine)
Among the 469 cases in Massachusetts residents, 346 **(74%) occurred in persons who were fully vaccinated**; of these, 301 (87%) were male, with a median age of 42 years. Vaccine products received by persons experiencing breakthrough infections were Pfizer-BioNTech (159; 46%), Moderna (131; 38%), and Janssen (56; 16%); among fully vaccinated persons in the Massachusetts general population, 56% had received Pfizer-BioNTech, 38% had received Moderna, and 7% had received Janssen vaccine products. **Among persons with breakthrough infection, 274 (79%) reported signs or symptoms, with the most common being cough, headache, sore throat, myalgia, and fever. Among fully vaccinated symptomatic persons, the median interval from completion of ≥14 days after the final vaccine dose to symptom onset was 86 days (range = 6–178 days).** Among persons with breakthrough infection, four (1.2%) were hospitalized, and no deaths were

reported. **Real-time RT-PCR Ct values in specimens from 127 fully vaccinated patients (median = 22.77) were similar to those among 84 patients who were unvaccinated, not fully vaccinated, or whose vaccination status was unknown (median = 21.54)** (Figure 2).

These results clearly show an abject failure of the vaccines.

- Three-quarters of the individuals in the outbreak we're fully vaccinated.
- The average time of breakthrough infection was less than three months from the point at which the person was fully vaccinated.
- Eight out of ten people who were fully vaccinated experienced a variety of symptoms from the infection.
- And the level of viral load in the vaccinated individuals was nearly identical to that of the unvaccinated positive cases.

https://www.cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm?s_cid=mm7031e2_w

Fauci's predictions on the success of the vaccines was, well let's just say it, 180 degrees wrong

Just how badly did vaccine failure surprise Fauci?

This badly: on May 20 (May!) he said the US might be able to eliminate Sars-Cov-2 entirely. Three months later he was begging for boosters double-quick. True story.

Alex Berenson

Sep 16

From his SubStack Unreported truths

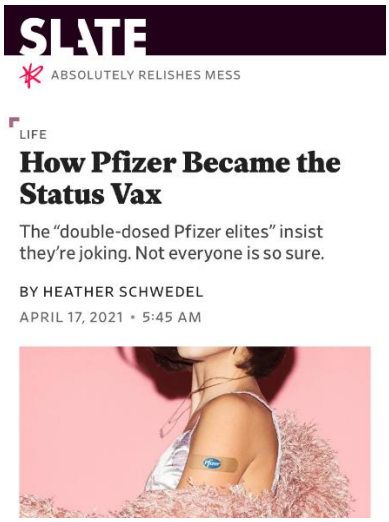
Let's go to the videotape!

On May 20, Dr. Anthony S. Fauci (People's Sexiest Man Alive for 12 straight years) took time from his busy day for an interview the Washington Post.

Beyond its cringe-inducing title - “Coronavirus: Leadership During Crisis” - the interview is noteworthy because it came at the moment of peak overconfidence in the mRNA vaccines.

Sars-Cov-2 had basically disappeared in Israel, which was the first country to begin a mass mRNA vaccination campaign. With about 80 percent of adults vaccinated, new cases were down 99.5 percent from their January peak *and still falling.* Deaths had dropped nearly as much.

On Twitter and off, the word “miracle” was getting thrown around a lot. Slate and the Atlantic had turned their attention to the vitally important question of which vaccine was the coolest (Pfizer! Pfizer was the coolest!)


SLATE

ABSOLUTELY RELISHES MESS

LIFE

How Pfizer Became the Status Vax

The “double-dosed Pfizer elites” insist they’re joking. Not everyone is so sure.

BY HEATHER SCHWEDEL

APRIL 17, 2021 • 5:45 AM

And the only thing standing in the way of herrrrd immunity were the mouth-breathing Trump fans (and some African-Americans who remembered Tuskegee, but no one blamed them) who refused to submit to the miracle.

No matter, though. The vaccines were that good! How good? Dr. Fauci can speak for himself:
Q: Vaccinations are rising, but is there a concern about a resurgence in the latter part of the year as the weather gets colder? And how much of this hinges upon what our understanding is of how long these vaccines are effective?

DR. FAUCI: Well, I don't think we should be that concerned right now about how long they're effective. **I think they will be effective long enough that we will get to the point where we are not going to be necessarily worrying about a surge…**[as] highly effective as these vaccines are and you get a substantial proportion of the population vaccinated, **the chances of there being a surge are extraordinarily low**.

But what about boosters, Dr. F.? Boosters? Boosters? We don’t need no stinking boosters!

Q: One thing that you've talked about is that people might need a booster shot within a year or so of being vaccinated. What is the timeline right now for when people might need to start getting that?

A: …I really don't think it's accurate to say that we will need boosters X number of months from now. We may not need it for quite a while… Will this be a situation **where over the years, we may need intermittent boosts?** Again, you want to be prepared for that, Yasmeen, but you don't know definitely if we'll need it…-
But Fauci wasn't done with his answer. He had a prediction to make.

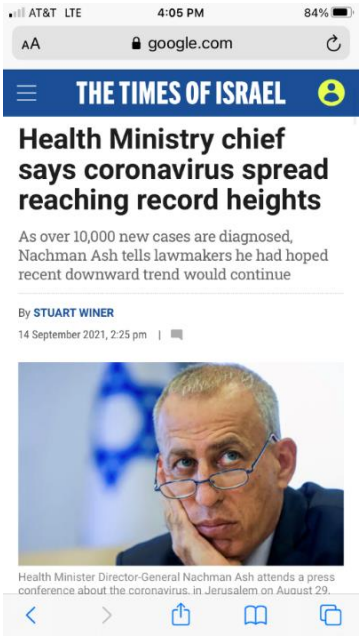
A: When you have an infectious disease and you want to, in essence, address it appropriately, there are three possibilities. One, you could eradicate it. That's a very high bar because we've only eradicated one human infectious disease in our entire history, and that is smallpox, with a highly successful vaccination campaign. The next thing is you can eliminate, and you generally do that by having certain countries, usually with good vaccination programs, essentially eliminate the presence of a particular pathogen in society. We've done that with polio in the United States. We've done that with measles in the United States and other developed nations.

So, that's called elimination, and the other is control. You have a very, very low level in the community, not enough to be a public health issue but enough to know that you haven't completely eliminated it. We don't know where we're going to be with SARS-CoV-2 and with COVID-19. **I would hope it would be much closer to elimination than just control.** That's going to depend entirely on the success, which I believe we're going in the right direction, of the vaccine program…

Elimination?

Control?

At this point I think we'd all settle for zero efficacy, zero long-term side effects.
Of course, the vaccine fanatics (including the ones in the White House) will note that the United States didn't duplicate Israel's success at vaccinating nearly its entire adult population. Lucky us.



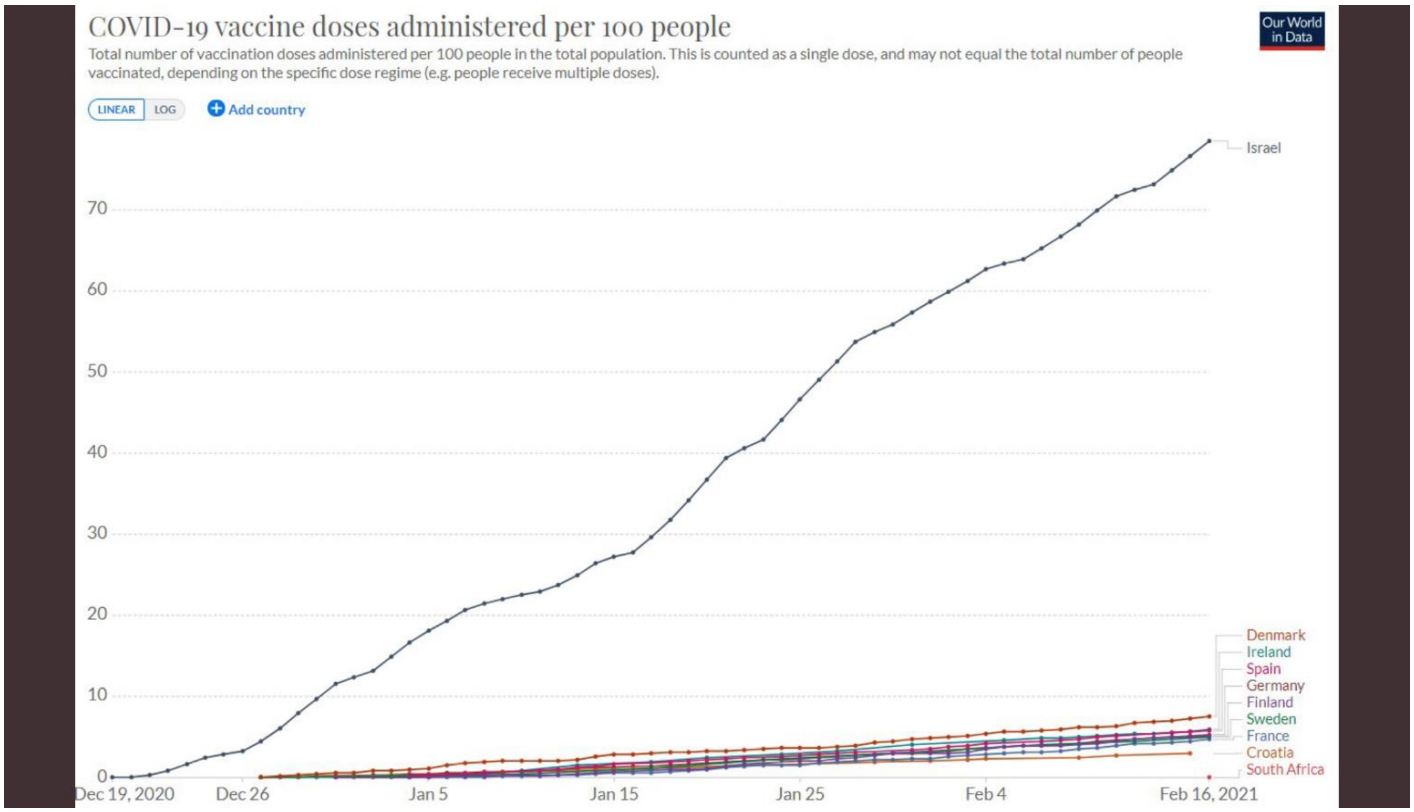
I'm a terrible Jew today, I shouldn't be working (and I usually on Yom Kippur), but under the circumstances I hope whoever is in charge gives me a pass. Also my temple won't let me go to services in-person since I'm not vaccinated, because science!
Anyway the Haftarah from Isaiah is what really matters.
Hope you're having an easy fast.

SOURCE: https://www.washingtonpost.com/washington-post-live/2021/05/20/coronavirus-leadership-during-crisis-with-anthony-s-fauci/

How can we tell what will happen in the near future with the effectiveness of the vaccines, cases, hospitalizations and deaths in the U.S. if we keep going?

We watch Israel. One of the highest vaccinated countries in the entire world. And one that right out of the gate was the world's leader by far in the percentage of their population vaccinated. In case you didn't see this in an earlier newsletter, this is what that looked like as of February 16th, 2021.

See next page…



Pfizer's vice president and chief scientist, Dr. Philip Dormitzer appeared on a zoom call speaking to Israeli scientists recently.

Here is some of what he had to say.

“Early in the pandemic, we'd established a relationship with the Israeli Ministry of Health where they used exclusively the Pfizer vaccine and they monitored it very closely. So, we had sort of a laboratory where we could could see the effect. They immunized a very high proportion of their population very early. So, it's been a way that we could almost look ahead. What we see happening in Israel, happens again in the U.S. a couple of months later.”

This of course is not playing very well with many people in Israel. To hear the vice president of the company making the experimental agent intended by your own government to be injected into the entire population, communicate his perception of Israel as a “laboratory” (essentially an experiment), to learn what is going to happen in the United States two months later has to bring back horrific connotations to many who suffered or had relatives who suffered and were murdered during the Holocaust.

You can see the video here… https://www.youtube.com/watch?v=rUIGgYT6L8Y&t=139s

Yet, the reality of what he is saying is true. Much of what we have seen over the last nine months here in the U.S. has been precluded by what has happened in the weeks and months prior in Israel. Therefore, wouldn't you think that our federal health officials who are supposed to be intelligent people, would look at what's happened in Israel with the out-of-control cases, hospitalizations and deaths in fully vaccinated people and change course here? Up to the writing of this newsletter, we haven't seen much else except full speed ahead and punish those that are hesitant to get the shots with loss of their careers and often social ostracizing. That is until recently. While Israel has gone all-in with the booster shots and is already talking about a fourth, the FDA may be pumping the breaks by not recommending them for the general population….yet. Whether that is a form of virtue signaling made to look as though they are finally following the data and the science, or if they really are realizing that with Delta and some other variants and the obvious capability of this virus to shape-shift and morph like Houdini to escape vaccine protection, there needs to be a different approach.

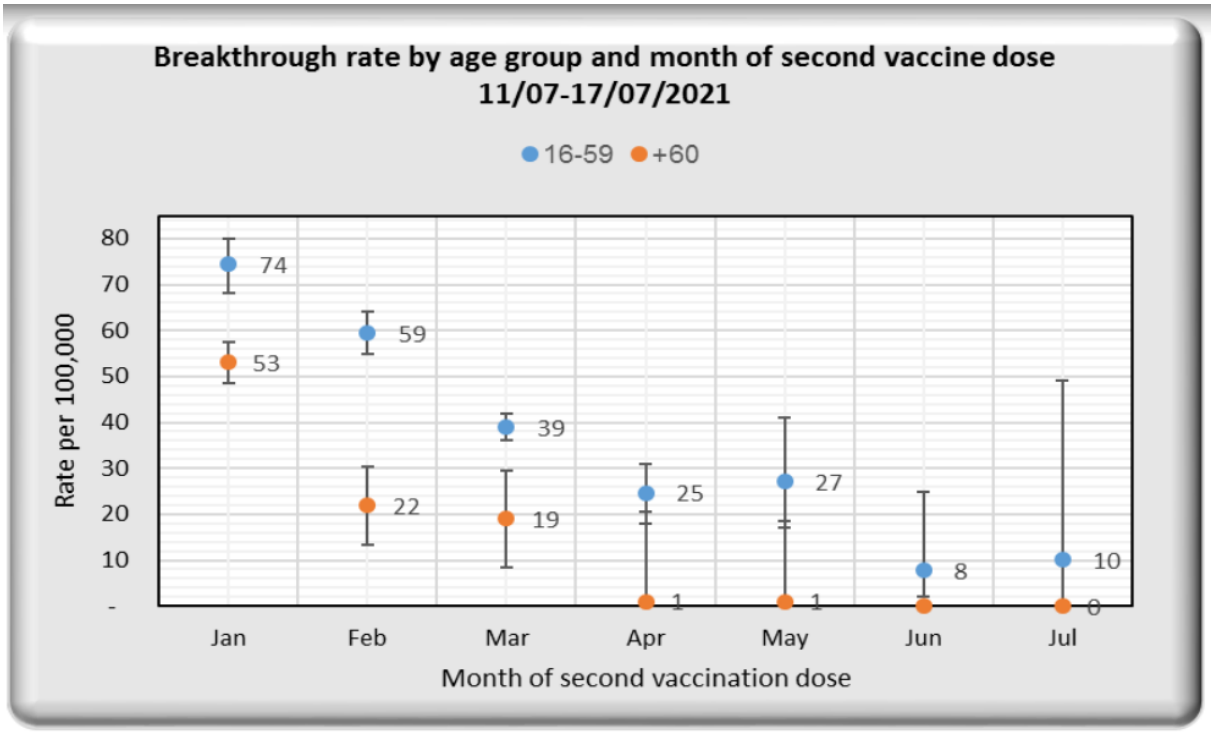
Hopefully that approach will be the one that I and thousands of other physicians and scientists have been advocating for nearly a year and a half now. And that is **EARLY** treatment with the widely available, non-patented, inexpensive, and safe medications like Hydroxychloroquine with Zinc, Ivermectin and Budesonide among others. And, making sure that Vitamin D levels are optimized and immune building lifestyle habits like a healthy diet, nutritional supplementation, exercise, quality sleep and addressing emotional health are at the forefront of everyone's mind.

Hopefully, the time of telling people to hunker down or go back home and come back to the hospital when they are turning blue will be a thing of the past soon. Early treatment to prevent viral replication is the key. Unfortunately, recently I have had a very sick relative and a friend that were still both told to go back home and stay there until they get so bad that they are having difficulty breathing or their oxygen levels dropped below 90. Even when EMS was called for one of them, her oxygen levels were not quite low enough, so the paramedic said that they didn't recommend that she go because the hospitals are trying to save room for the worst cases (even though they weren't over-run. Now, that may be ok if they would have been given a referral for an outpatient visit with a doctor who could have determined what treatment would have been best for them at the time and started intervention. But no other options were offered.

See how Israel is doing now on the next page…

So, how is Israel doing with breakthrough cases?

The graph below is from the ***Israeli Ministry of Health*** and shows the rates of breakthrough cases in people that had their second shot in various months throughout the first half of 2021.



As can be seen, people aged 16-59 that had their second shot in January are exhibiting breakthrough cases at the rate of 74 per 100,000 people. People 60+ at the rate of 53/100,000.

As you move to the right on the horizontal (x) axis, the rate of breakthrough infections drops. In other words, if you have had your second shot in June or July you have a much lower risk of breakthrough infection (so far).

As a point of reference, the vaccination campaign in Israel launched like it was shot out of a cannon on December 19th, 2020. By mid-February 2021, approximately 80% of the population had been vaccinated. This was the most aggressive mass vaccination campaign of any country in the world. The nice thing about that is, that this allows us to get an idea of how lasting the relative risk reduction effectiveness of the vaccines is. That would have been much harder to track if the vaccination campaign were more of a gradual rollout. But, as can be seen in the graph above, the vaccine effectiveness starts to diminish after approximately 2 months and really drops off at about month 4.

An unknown is how the Israeli government is tracking breakthrough infections. As I reported last month, as of May 1st, 2021, the CDC is not tracking breakthrough infections for vaccinated individuals unless they are hospitalized.

The table below, shows the vaccine efficacy as measured in Relative Risk Reduction (RRR). As I've mentioned in a previous newsletter, the relative risk reduction is he's somewhat deceptive measure of effectiveness.

More on that on the next page…

Data from June 20, 2021 through July 17, 2021

Outcome	20/06-17/07		
	VE	Lower CI	Upper CI
SARS-CoV-2 cases	39.0%	9.0	59.0
Symptomatic COVID-19*	40.5%	8.7	61.2
COVID-19 hospitalization	88.0%	78.9	93.2
Severe COVID-19**	91.4%	82.5	95.7

* Fever and/or respiratory symptoms on epidemiologic investigation
** Including severe, critical and deceased COVID-19 (Severe – respiratory rate > 30/minute, oxygen saturation < 94%, and/or PaO2/FiO2 < 300; Critical – invasive mechanical ventilation, shock or major organ failure)

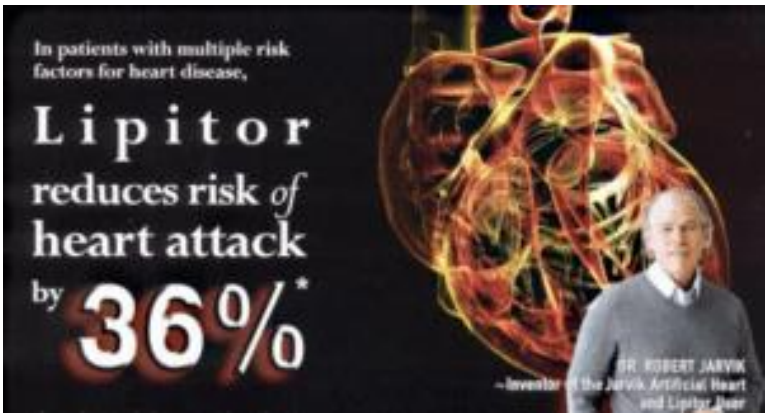
https://www.gov.il/BlobFolder/reports/vaccine-efficacy-safety-follow-up-committee/he/files_publications_corona_two-dose-vaccination-data.pdf

***VE = Vaccine efficacy. Bear in mind that this is referring to the relative risk reduction (RRR) as we discuss it in this next section.**

Let's look at how the "vaccine effectiveness" number can be deceptive

Vaccine efficacy is generally reported as a relative risk reduction (RRR). It uses the relative risk (RR)—ie, the ratio of attack rates with and without a vaccine—which is expressed as 1–RR. **Ranking by reported efficacy gives relative risk reductions of 95% for the Pfizer–BioNTech, 94% for the Moderna–NIH, 90% for the Gamaleya, 67% for the J&J, and 67% for the AstraZeneca–Oxford vaccines.** However, RRR should be seen against the background risk of being infected and becoming ill with COVID-19, which varies between populations and over time. **Although the RRR considers only participants who could benefit from the vaccine, the absolute risk reduction (ARR), which is the difference between attack rates with and without a vaccine, considers the whole population. ARRs tend to be ignored because they give a much less impressive effect size than RRRs: 1·3% for the AstraZeneca–Oxford, 1·2% for the Moderna–NIH, 1·2% for the J&J, 0·93% for the Gamaleya, and 0·84% for the Pfizer–BioNTech vaccines.**

***Here's a classic example*:** This Pfizer ad makes it look like taking their drug, Lipitor, will reduce your chances of having a heart attack by a whopping 36%. But that's the relative risk reduction. It tends to exaggerate the benefit. (That's why you'll often see relative numbers featured in advertisements.)



This 36% number comes from a randomized trial called ASCOT-LLA published in The ***Lancet*** in 2003. It showed that 1.9% of people taking Lipitor suffered a heart attack, while 3.0% of the placebo group had one. The *relative risk reduction*, or RRR, is the ratio of the two risks and is calculated by subtracting the Lipitor heart attack rate (1.9) from the placebo group rate (3.0) and dividing the difference (1.1) by the placebo group rate (3.0). This equals 36%.

But the ***absolute risk reduction*, or ARR**, is calculated by simply subtracting the two risks, so 3.0% – 1.9% = 1.1%.

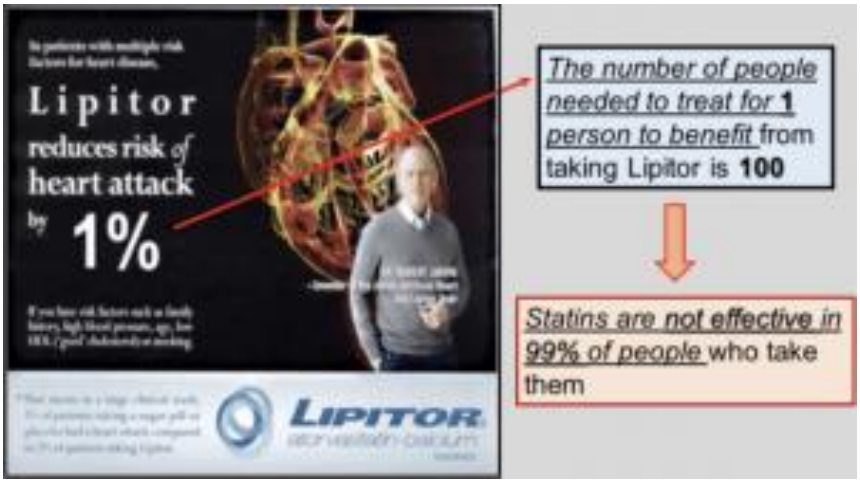
In reality, Lipitor reduced the risk of heart attack from 3% to about 2%, and this 1% difference is the number that people care about. But the Lipitor ad is more interested in promoting than informing, which is why it describes this difference as a "36%" reduction rather than a more helpful and accurate 1% reduction.

A much more important calculation would be the number of people needing to get the vaccine or treatment, also called the NNT or Number Needed to Treat in order to protect one person. Let's take a look at that.

To calculate the NNT, you first have to find out the absolute risk reduction, or ARR. That's the amount that your risk is reduced by the treatment compared with people who didn't get it.
The ARR is not a number most people are used to seeing. Studies, news reports, and other media messages are much more likely to focus on a different number, known as the "relative risk reduction," or RRR, that can be misleading.

So, let's calculate the NNT using the ARR of 1%, and see how it reframes the drug's benefits in a more user-friendly way. The NNT is simply the inverse of the ARR; it can be calculated by taking 100 and dividing it by the ARR (1).

100/ 1 = 100



How NNT helps

This means that 99 people need to take the drug, pay for it, run the risk of side effects, and stand no chance of benefit. Of course, no one knows going in who will be that lucky 1 out of 100 who does benefit.
This is the power of NNT. It gives a sense of scale to discussions regarding potential harms and benefits. In the Lipitor example, if all you read about was the relative risk reduction of 36% highlighted in headlines and advertisements (a likely scenario), your response might be: *"Wow! I can cut my risk of a heart attack by over one-third!"*

But if you were lucky enough to read some thoughtful news coverage that included the absolute risk reduction of just 1% you might think: *"Hmm, that's a far cry from 36%. I'm going to ask my doctor what she thinks."*

And if you were armed with the NNT number of 100 — realizing you probably won't be that lucky one person out of 100 who actually benefits from the drug — you might not hesitate to say: *"I don't like those odds at all; especially given the costs and risks."*

Originally, the NNT for the Pfizer Vaccine was calculated at 119. That means that 119 people would have needed to be vaccinated in order for one person to benefit. This is a graph from the study that I reported previously.

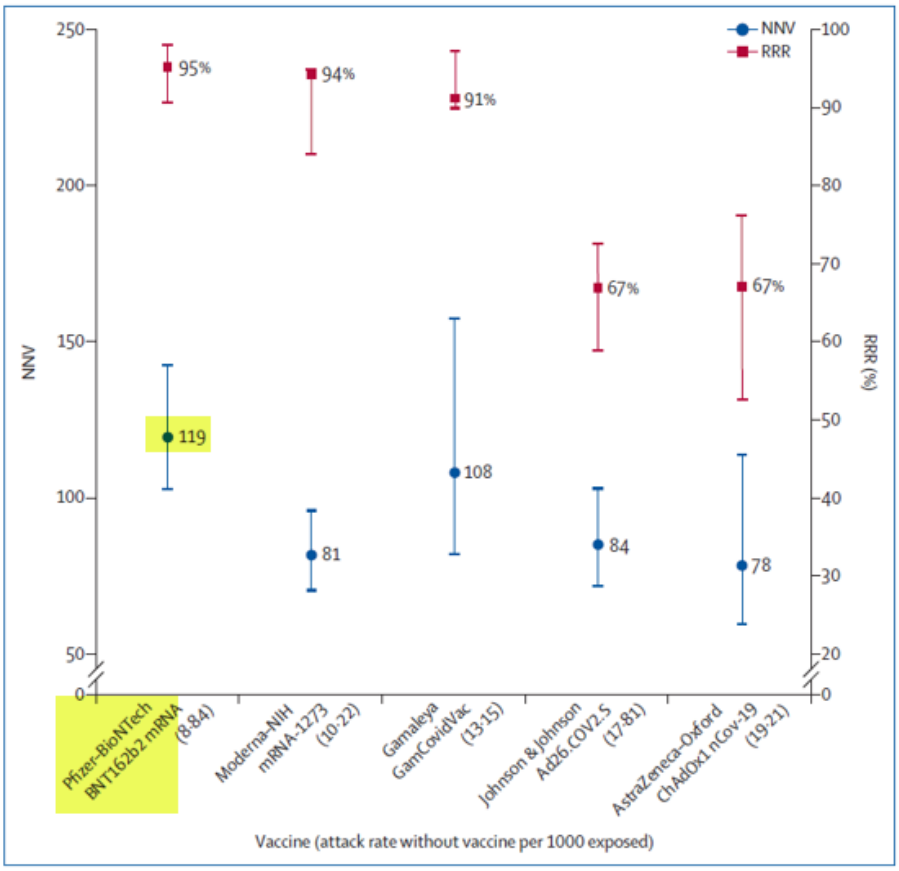


Figure: **RRR and NNV with 95% CI ranked by attack rate in the unvaccinated (placebo) group for five COVID-19 vaccines**
The lower the NNV and the higher the RRR, the better the vaccine efficacy. Details are in the appendix (p 3). RRR=relative risk reduction. NNV=numbers needed to vaccinate. NIH=US National Institutes of Health.

https://www.thelancet.com/journals/lanmic/article/PIIS2666-5247(21)00069-0/fulltext

As you can see, the Relative Risk Reduction (RRR) at 95% sounds much more impressive than the Number Needed to Vaccinate (NNV) at 119 people vaccinated for one to benefit.

The NNV of 119 was for the clinical trial. What has that number been estimated to be for the Pfizer "experiment" in the Israeli population?

The only reported indication of vaccine effectiveness is the Israeli mass vaccination campaign using the Pfizer–BioNTech product. Although the design and methodology are radically different from the randomised trial, Dagan and colleagues report an RRR of 94%, which is essentially the same as the RRR of the phase 3 trial (95%) but with an ARR of 0·46%, which translates into an NNV of 217 (when the ARR was 0·84% and the NNV was 119 in the phase 3 trial). This means in a real-life setting, 1·8 times more subjects might need to be vaccinated to prevent one more case of COVID-19 than predicted in the corresponding clinical trial.

These are excerpts from the Dagan study cited above explaining why the clinical trial results may look better than once the vaccines are rolled out to the general population.…

Mass vaccination campaigns using newly approved vaccines against the severe acute respiratory syndrome coronavirus (SARS-CoV-2)1,2 are beginning in many parts of the world. Randomized clinical trials of mRNA-based vaccines reported efficacies for preventing coronavirus 2019 (Covid-19) in the range of 94%2 to 95%.1

Although randomized clinical trials are considered the “gold standard” for evaluating intervention effects, they have notable limitations of sample size and subgroup analysis, restrictive inclusion criteria, and a highly controlled setting that may not be replicated in a mass vaccine rollout. For example, the phase 3 trial of the BNT162b2 mRNA vaccine against Covid-19 included 21,720 persons who were randomly assigned to the vaccinated group, which permitted estimates of vaccine efficacy in only a small number of subpopulations.1 Moreover, patients with chronic diseases were included only if the conditions were deemed stable by the investigators.3

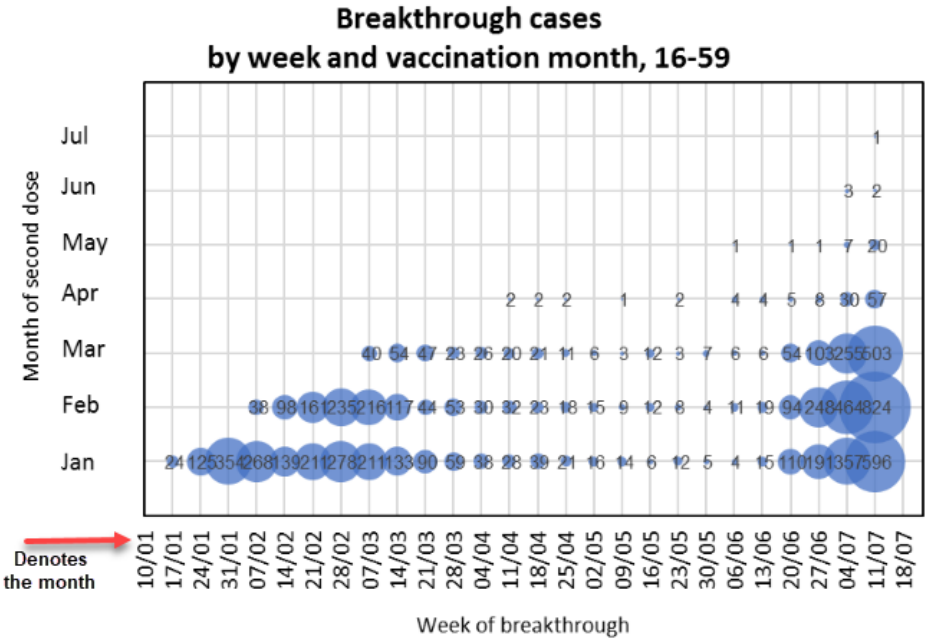
End of excerpts

It’s important to point out that these decisions are personal, and different people may make different decisions about treatment based on the same information. Furthermore, different people have different baseline risk profiles and different risk tolerance. This means clinical decisions should not be based on NNT alone. It’s just one piece of information that needs to be interpreted in a clinical context and under medical supervision.

One last thing worth looking at regarding the Israeli data, is the number of breakthrough infections early in the vaccination campaign.

See the graph next page…

Breakthrough cases

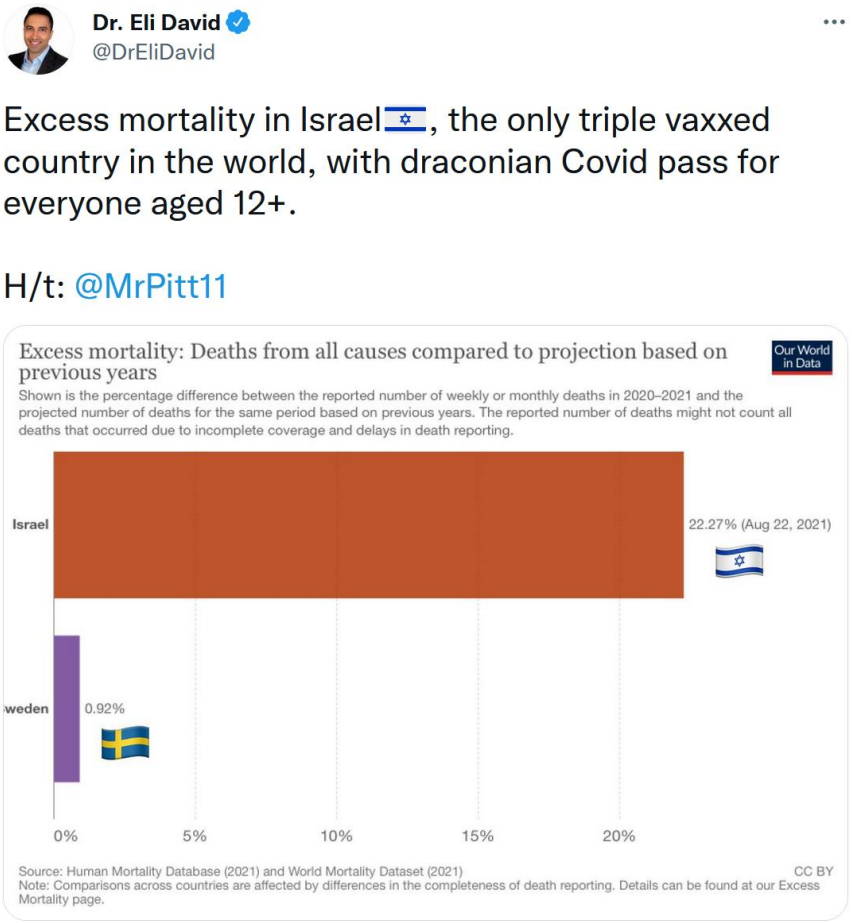


The first shot typically doesn't produce ample levels of neutralizing antibodies, but instead produces more non neutralizing antibodies. It's the neutralizing antibodies that are the most important to prevent infection. The second shot appears to produce more of the neutralizing antibodies to the spike protein. That is why the CDC does not deem a person fully vaccinated until 14 days after their second shot. So that may be six weeks after their first injection. There is some fuzzy math that can tend to go on with regard to these details. The question is, are all of the people that were infected earlier on in the campaign considered unvaccinated or vaccinated with breakthrough infections. It appears from the Israeli data that they are considering people contracting early infections as breakthrough infections. It's my understanding that the CDC here in the US is not categorizing them that way, but as unvaccinated people becoming infected. This is important because categorizing people that get infected within the first six weeks of the trial as unvaccinated pumps up the numbers of infections in the unvaccinated subjects. It also reduces the amount of time that the fully vaccinated subjects are part of the trial, making it obvious that they would have less time as “fully vaccinated” to catch the virus. If the trial period is only 90 days long and for the first half of that 90 days, the vaccinated subjects are considered unvaccinated, it's obvious to see how the numbers would be skewed to make it look like the unvaccinated subjects had more infections.

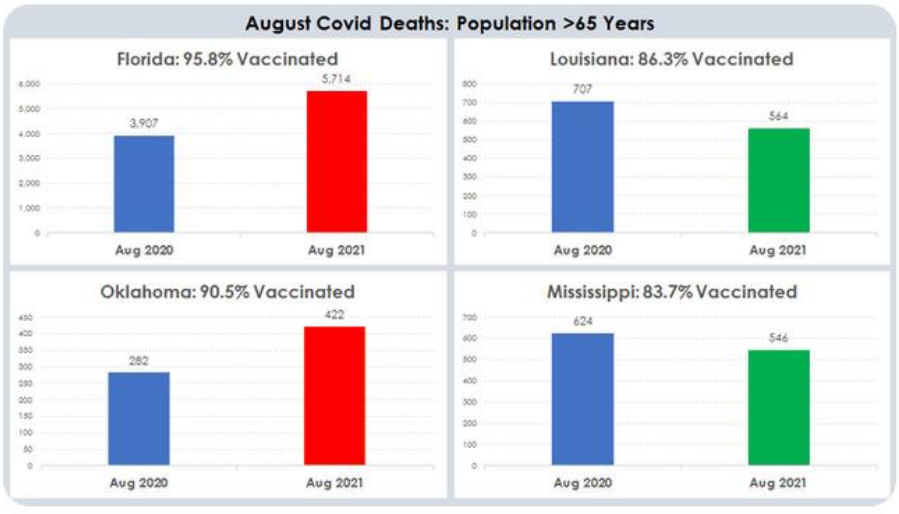
Scroll to next page…

A comparison of deaths in Sweden with triple vaxxed Israel

It appears that this graph is for August 2021 compared to previous years all-cause mortality. What may have made the difference? Israel launched it's 3rd shot booster program on July 31st, 2021.



Another interesting comparison of the month of August 2020 to August 2021 in higher and lower vaccinated states in those over 65 years of age.



In urgent appeal to the European Medicines Agency to stop the vaccination program and launch a large-scale independent investigation into the injuries and deaths caused by the vaccines

An urgent report by the ***Evidence-Based Consultancy Medicine Ltd*** June 9th, 2021, calls for action to mitigate the damage caused by the COVID-19 vaccines.

We are sharing this preliminary report due to the urgent need to communicate information that should lead to cessation of the vaccination roll out while a full investigation is conducted. According to the recent paper by Seneff and Nigh (1), potential acute and long-term pathologies include:

- Pathogenic priming, multisystem inflammatory disease and autoimmunity
- Allergic reactions and anaphylaxis
- Antibody dependent enhancement

The
- Activation of latent viral infections
- Neurodegeneration and prion diseases
- Emergence of novel variants of SARSCoV2
- Integration of the spike protein gene into the human DNA

The nature and variety of ADRs reported to the Yellow Card System are consistent with the potential pathologies described in this paper and supported by other recent scientific papers on vaccine-induced harms, which are mediated through the vaccine spike protein product (2,3). It is now apparent that these products in the blood stream are toxic to humans. An immediate halt to the vaccination programme is required whilst a full and independent safety analysis is undertaken to investigate the full extent of the harms, which the UK Yellow Card data suggest include thromboembolism, multisystem inflammatory disease, immune suppression, autoimmunity and anaphylaxis, as well as Antibody Dependent Enhancement (ADE).
Due to the need for expedience, we have not detailed all ADRs in this preliminary report. The existing Yellow Card data covering just under a five-month period indicate that the extent of morbidity and mortality associated with the COVID-19 vaccines is unprecedented. Age and gender specific data, as well as the time from vaccination, are required to further our analysis of these data and we have sent Freedom of Information Requests (FOIRs) to the MHRA in this regard.

In addition, urgent independent expert evaluation and discussion is required to assess whether the novel vaccines may be causing gene mutations among recipients, as suggested by the occurrence of usually extremely rare genetic disorders, such as Paroxysmal Extreme Pain Disorder (PEPD). In addition to the 11 cases of PEPD on the Yellow Card system, there are currently 12 reports of this extremely rare condition on the WHO's Vigiaccess.org database and 10 on the European Medicines Agency's (EUDRA) pharmacovigilance database. Are these ADRs occurring in babies of vaccinated pregnant women, or spuriously among vaccinated

adults? This question needs urgent attention.

As pharmacovigilance data are known to be substantially under-reported, we recommend that the MHRA urgently publicises these ADR data and assists people with their ADR reporting, to facilitate full elucidation and clarification of the extent of the problem.

The MHRA now has more than enough evidence on the Yellow Card system to declare the COVID-19 vaccines unsafe for use in humans. Preparation should be made to scale up humanitarian efforts to assist those harmed by the COVID-19 vaccines and to anticipate and ameliorate medium to longer term effects. As the mechanism for harms from the vaccines appears to be similar to COVID-19 itself, this includes engaging with numerous international doctors and scientists with expertise in successfully treating COVID-19.
(Highlighted by me)

https://ebmcsquared.org/wp-content/uploads/2021/08/Urgent-Preliminary-Report-of-Yellow-Card-Data-9-6-2021.pdf

In a follow-up report issued August 9th, 2021, summarizing data through June 30th, 2021, ***The Evidence-Based Medicine Consultancy LTD*** did a fabulous job of pointing out the data and concerns. If you want to dig deeper into what they have found I would highly recommend that you take the time to read this report. This report is found by scrolling about halfway down the web page at this link… https://ebmcsquared.org/urgent-preliminary-report-of-yellow-card-data

The following is an urgent appeal to take immediate actions.

As noted in the CHM's Expert Working Group report on COVID-19 vaccine safety surveillance (1), **MHRA has statutory responsibility for undertaking post-authorisation safety monitoring in the UK.** We ask the MHRA **to take action as follows, in line with its statutory obligation to minimize risk to individuals,** pending full investigation of vaccine safety and efficacy **and re-assessment of risk-benefit ratios** by MHRA/CHM/CHM EAGs and independent experts using real world empirical evidence and assuming use of known effective treatment protocols:

• **Suspend the COVID-19 vaccines immediately in all children** so plans to vaccinate children aged 12 & over are cancelled, incl. imminent plans in those at higher risk of COVID-19, who would be most vulnerable to vaccine side-effects, and plans in 16-17 year olds.

• **Suspend** the use of COVID-19 vaccines in all adults

• **Suspend enrolment** in trials in UK of COVID-19 vaccines

• **Communicate to healthcare workers and vaccine recipients** the potential risk of Guillain-Barré Syndrome with the AstraZeneca COVID-19 vaccine and that 'Vaccinated persons need to seek immediate medical attention if they develop weakness and paralysis in the extremities, possibly progressing to the chest and face, after vaccination, as these could be signs of Guillain-Barré Syndrome'.

• **Communicate to healthcare workers and vaccine recipients** known treatment protocols for COVID-19 (acute and long) and for post-vaccination side-effects, including Covid Vaccination (CoVAC) Syndrome, so that people can receive timely care. We have collated health guidance from international clinical expert groups on managing these conditions, which we can share with you for distribution.

• **Postpone** any EUA assessment of booster vaccinations

• **Conduct a comprehensive overhaul** of the UK's Yellow Card system

I recommend sharing this excellent rapid drawing video discussing the risks of the COVID-19 vaccines

https://rumble.com/vkjkcu-dont-get-jabbed-be-informed.html

Also consider sharing a free download of an article I wrote regarding the risks from COVID to children compared to the risks of the vaccines for children and pregnant women. You can access that document here: https://www.wellnessdoc.com/the-risk-vs-reward-of-the-covid-19-vaccines-for-children/

Naturally acquired immunity from SARS-CoV-2 infection continues to be ignored in the push to vaccinate everyone, despite the overwhelming scientific evidence

Watch this 6-minute video from October 1st, 2021, where Rand Paul torches HHS Sec. Becerra on the reluctance to acknowledge naturally acquired immunity and the forced mandates of the vaccines.

https://www.youtube.com/watch?v=ml1W0k0yaJk

I have covered at least 2 dozen studies in my newsletter over the last 17 months that show strong, resilient, and lasting immunity to reinfection from SARS-CoV-2 in people that have previously been infected. If you

would like to check out those studies, you can download my eBook on Natural Immunity after SARS-CoV-2 infection here: https://www.wellnessdoc.com/ebooks-and-publications/

In addition, Rand Paul mentions the recent Israeli study that was a massive study looking at 800,000 Israelis and concluded that those with natural immunity had superior protection form infection and symptoms of COVID-19 disease.

The study is a pre-print updated August 25th, 2021 and is titled, **Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections.**

Spoiler alert: At the end of the study, researchers found that vaccinated people were 13 times more likely to be infected and 27 times *(2,700%)* more likely to have symptomatic infections as a matched cohort that was previously infected with the Delta variant.

From the study
"This is the largest real-world observational study comparing natural immunity, gained through previous SARS-CoV-2 infection, to vaccine-induced immunity, afforded by the BNT162b2 mRNA vaccine. Our large cohort, enabled by Israel's rapid rollout of the mass-vaccination campaign, allowed us to investigate the risk for additional infection – either a breakthrough infection in vaccinated individuals or reinfection in previously infected ones – over a longer period than thus far described."

"Our analysis demonstrates that SARS-CoV-2-naïve vaccinees had a 13.06-fold increased risk for breakthrough infection with the Delta variant compared to those previously infected, when the first event (infection or vaccination) occurred during January and February of 2021. The increased risk was significant for a symptomatic disease as well."

Conclusions:
This study demonstrated that natural immunity confers longer-lasting and stronger protection against infection, symptomatic disease and hospitalization caused by the Delta variant of SARS-CoV-2, compared to the BNT162b2 two-dose vaccine-induced immunity.

https://www.medrxiv.org/content/10.1101/2021.08.24.21262415v1

Our federal health agencies have been corrupted by the financial influence of the drug industry

In an excellent article by Dr. Mercola, including a video by Russell Brand, the glaring conflicts of interest within the FDA are revealed. Unfortunately, Dr. Mercola has been forced to remove his content after 48 hours of

posting. You can watch the video here if you would like. The video has been seen nearly 900,000 times in the first 10 days of posting. https://www.youtube.com/watch?v=7fQ6JklHjBc&t=1s

From the article/video

Take the U.S. Food and Drug Administration, for example. In years past, the FDA was funded entirely by U.S. taxpayers. Today, nearly 45% of its annual budget comes from user fees paid by the drug companies that seek approval for a given product, Brand says. This transition from public to corporate funding has had a significant impact on how the agency operates, and it's clearly not in the public's best interest.

Brand cites data showing the FDA has gone from a drug approval rate of 38% in 2005 to 61% in 2018. In situations where a drug is aimed at a disease where few medication options already exist, 89% of new drug applications are approved on the first try.

Has drug development simply gotten that much better? Probably not. The fact is that drug companies view the FDA's user fees as payment for service rendered, and that service includes approval. They're not paying for the FDA to turn them down.

Why FDA and Big Pharma Have a Trust Problem

In response to the COVID-19 pandemic, the FDA issued emergency use authorizations for completely novel types of "vaccine" in a matter of weeks. While some applaud this speediness, it's worth remembering that as speedy approvals have increased with other drugs, so have the number found to be harmful after the fact. Data cited by Brand show that 21% of FDA approved medications ultimately had to be removed from the market or be given a black box warning. Essentially, if you're taking a newly approved drug, the chances that this drug will be found to be extremely dangerous is 1 in 5, which is hardly encouraging!

A 2017 Yale study[1] (https://news.yale.edu/2017/05/09/new-safety-concerns-identified-1-3-fda-approved-drugs) found the situation is even more dire than that, showing nearly 1 in 3 FDA approved drugs ends up having new safety issues detected in the years following approval.

The FDA is also allowing drug makers to profit at the expense of public health by allowing them to "claim success in trials based on proxy measurements instead of clinical outcomes like survival rates or cures, which take more time to evaluate," Caroline Chen notes in a June 2018 ProPublica article.[2]
https://www.propublica.org/article/fda-repays-industry-by-rushing-risky-drugs-to-market

FDA Advisers Receive Payouts to Approve Drugs

In addition to that, "pay-later conflicts of interest" are widespread, according to an investigation by the journal Science.[3] https://www.science.org/news/2018/07/hidden-conflicts-pharma-payments-fda-advisers-after-drug-approvals-spark-ethical This is when doctors who advise the FDA or sit on drug panels that are in charge of drug approval are paid by drug makers AFTER the approval is a done deal.

Science examined 107 physician FDA advisers who voted on drug approvals. Of those, 40 ended up receiving more than $10,000 in post hoc earnings from the drug company whose drug they voted to approve; 26 of them got more than $100,000 and six were paid more than $1 million. FDA advisers who help drug makers gain approval also reap rewards in other ways. As noted by Science:[4]

"The FDA says its rules, along with federal laws, stop employees from improperly cashing in on their government service. But Science found that employees at the agency often reap later rewards — jobs or consulting work — from the makers of the drugs …

A 2016 study found that 15 of the 26 employees who left the agency later worked or consulted for the biopharmaceutical industry. Of the more than $24 million in personal payments or research support from industry to the 16 top-earning advisers, 93% came from the makers of drugs those advisers previously reviewed."

FDA Has Already Lost Most of Its Credibility

As argued by Brand, the data is rather unequivocal. It tells us corruption is rampant and the FDA has completely abandoned its charter to ensure public health and safety. It's really just there to give the appearance that someone is looking out for public health, while in actuality it's a venue through which drug makers are enabled to profit from unsafe and unproven drugs.

The sad reality is that while FDA approval used to mean something, today it has basically lost all meaning. Just because a drug is FDA-approved doesn't mean it's been proven safe and effective.

Again and again, drugs are found to have serious safety issues in the years after their approval. As a result, drug companies are allowed to benefit while public health is sacrificed, which is precisely the situation that the FDA was created to prevent.

End of excerpts

The risk of Antibody Dependent Enhancement (ADE) is increased by the COVID-19 vaccines according to a study in the Journal of Infection

This article appeared in the ***Journal of Infection*** August 16th 2021 and was titled, **Infection-enhancing anti-SARS-CoV-2 antibodies recognize both the original Wuhan/D614G strain and Delta variants. A potential risk for mass vaccination?**

The abstract- (My comments in red)

Antibody dependent enhancement (ADE) of infection is a safety concern for vaccine strategies. In a recent publication, Li et al. (Cell 184 :4203–4219, 2021) have reported that infection-enhancing antibodies (meaning

they make the infection worse) directed against the N-terminal domain (NTD) of the SARS-CoV-2 spike protein facilitate virus infection in vitro, but not in vivo. However, this study was performed with the original Wuhan/D614G strain. Since the Covid-19 pandemic is now dominated with Delta variants, we analyzed the interaction of facilitating antibodies with the NTD of these variants. Using molecular modeling approaches, we show that enhancing antibodies have a higher affinity for Delta variants than for Wuhan/D614G NTDs these enhancing antibodies making the infection worse are more evident against Delta than the original strain). We show that enhancing antibodies reinforce the binding of the spike trimer to the host cell membrane by clamping the NTD to lipid raft microdomains. This stabilizing mechanism may facilitate the conformational change that induces the demasking of the receptor binding domain. As the NTD is also targeted by neutralizing antibodies, our data suggest that the balance between neutralizing and facilitating antibodies in vaccinated individuals is in favor of neutralization for the original Wuhan/D614G strain (that is what you want is the neutralizing antibodies and they were more active against the original strain). However, in the case of the Delta variant, neutralizing antibodies have a decreased affinity for the spike protein (once again, not good), whereas facilitating antibodies display a strikingly increased affinity (again, really bad). Thus, ADE may be a concern for people receiving vaccines based on the original Wuhan strain spike sequence (either mRNA or viral vectors) This is all of the vaccines currently in use). Under these circumstances, second generation vaccines with spike protein formulations lacking structurally-conserved ADE-related epitopes should be considered.

The top diagram is showing that the vaccines against the original Wuhan SARS-CoV-2 virus show stronger neutralization and lighter or less risk of ADE against that strain.

The lower diagram shows that those same vaccines have a much have a lighter or weaker neutralization effect and a much heavier or stronger risk of ADE with the Delta Variant.

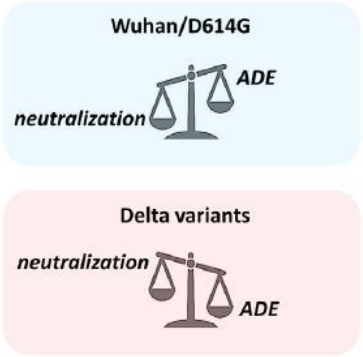


Fig. 2. Neutralization vs ADE balance according to SARS-CoV-2 strains.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8351274/

If you are a physician or scientist, consider signing on to the Rome Physician's Declaration. It asserts that radical changes must be made in the way public health agencies have interfered with doctors ability to practice medicine

Read about it here: https://globalcovidsummit.org/news/welcome-to-the-global-covid-summit

Sign the document here: https://doctorsandscientistsdeclaration.org/

Calculate your risk of hospitalization and death from COVID-19

QCovid. The risk calculator

QCovid® has been developed using the ***University of Oxford*** hosted QResearch database which has anonymised data from primary care, hospitals, COVID-19 test results and death registries. This was used to determine which factors were associated with poor outcomes during the first wave of COVID-19 and create a risk prediction model - QCovid® - that provides a weighted, cumulative calculation of absolute risk using the variables associated with poor COVID-19 outcomes. The factors incorporated in the model include age, ethnicity, level of deprivation, obesity, whether someone lived in residential care or was homeless, and a range of existing medical conditions, such as cardiovascular disease, diabetes, respiratory disease and cancer.

This model was then tested in two independent sets of data, one from January to April 2020 and one from May 2020 to June 2020, to find out whether it accurately predicted severe outcomes due to COVID-19 during the first wave of the pandemic in England.

The research, published in the BMJ, showed that the model performed well in predicting severe outcomes due to COVID-19 (death and hospitalisation).

Go here to calculate your risk- https://www.qcovid.org/Calculation

This is my risk calculation

The risk table

The table shows the absolute risk of catching and dying COVID-19 over a 90-day period based on data from the first peak of the pandemic. There is a comparison with the risk for a person of the same age and sex but with no risk factors. The relative risk is the absolute risk divided by this average risk.

	Absolute risk (a)		Absolute risk with no risk factors (b)		Relative risk (a/b)
COVID associated death	0.0228%	**1 in 4386**	0.0227%	**1 in 4405**	1.0044
COVID associated hospital admission	0.1029%	**1 in 972**	0.101%	**1 in 990**	1.0188

KEY POINT: One very important thing to consider when looking at this risk analysis, is that it doesn't take into consideration vitamin D status or many other health and lifestyle factors. The other important consideration is that the absolute and relative risk of you being hospitalized or dying from COVID in this method is that it uses statistics from the very deficient treatment system that has been in place whereby people were sent home to sicken in place without treatment. Using the "shunned" early treatment medications upon contracting the infection, could reduce your chance of hospitalization and death by a tremendous amount according to hundreds of studies from around the world. So, just know that depending on your particular lifestyle, nutritional status, overall health picture and advanced preparation for what to do if you get sick, can reduce your risk considerably.

Speaking of risk from COVID-19, a new CDC funded study looks at over a half million people to determine the highest risk factors for hospitalization and death

A July 1st, 2021 study posted on the ***CDC's*** website titled, **Underlying Medical Conditions and Severe Illness Among 540,667 Adults Hospitalized With COVID-19, March 2020–March 2021**, identified risk factors that had been identified before and also some new surprises.

The abstract

Introduction

Severe COVID-19 illness in adults has been linked to underlying medical conditions. This study identified frequent underlying conditions and their attributable risk of severe COVID-19 illness.

Methods

We used data from more than 800 US hospitals in the Premier Healthcare Database Special COVID-19 Release (PHD-SR) to describe hospitalized patients aged 18 years or older with COVID-19 from March 2020 through March 2021. We used multivariable generalized linear models to estimate adjusted risk of intensive care unit admission, invasive mechanical ventilation, and death associated with frequent conditions and total number of conditions.

Results

Among 4,899,447 hospitalized adults in PHD-SR, 540,667 (11.0%) were patients with COVID-19, of whom 94.9% had at least 1 underlying medical condition. Essential hypertension (50.4%), disorders of lipid metabolism (49.4%), and obesity (33.0%) were the most common. The strongest risk factors for death were obesity (adjusted risk ratio [aRR] = 1.30; 95% CI, 1.27–1.33), anxiety and fear-related disorders (aRR = 1.28; 95% CI, 1.25–1.31), and diabetes with complication (aRR = 1.26; 95% CI, 1.24–1.28), as well as the total number of conditions, with aRRs of death ranging from 1.53 (95% CI, 1.41–1.67) for patients with 1 condition to 3.82 (95% CI, 3.45–4.23) for patients with more than 10 conditions (compared with patients with no conditions).

Conclusion

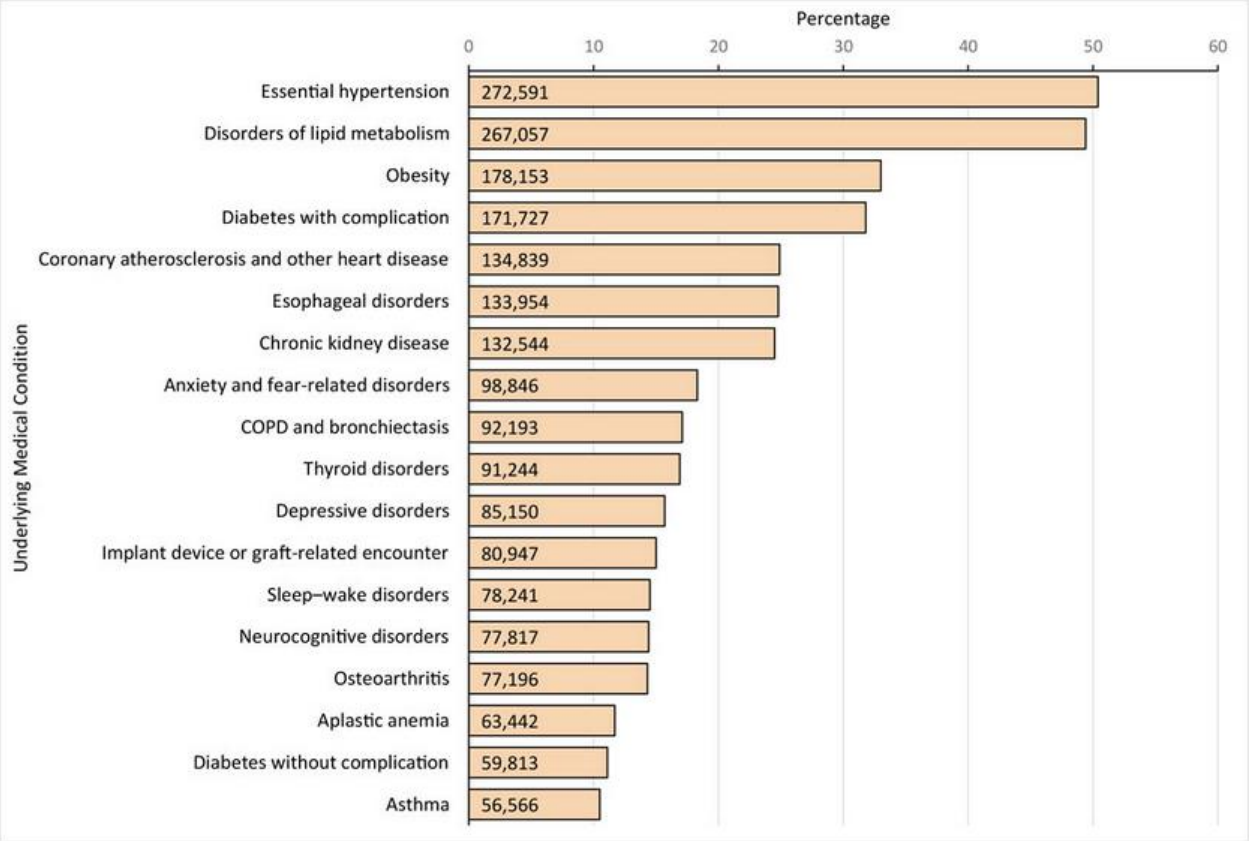
Certain underlying conditions and the number of conditions were associated with severe COVID-19 illness. Hypertension and disorders of lipid metabolism were the most frequent, whereas obesity, diabetes with complication, and anxiety disorders were the strongest risk factors for severe COVID-19 illness. Careful evaluation and management of underlying conditions among patients with COVID-19 can help stratify risk for severe illness.

See the graph on the next page…

From the study

Figure 1.

Prevalence of the most frequent underlying medical conditions in a sample of adults hospitalized with COVID-19 in Premier Healthcare Database



Relative risk of death in the full model was:

- 30% higher with obesity
- 28% higher with anxiety and fear-related disorders
- 26% higher with diabetes with complication
- 21% higher with Chronic Kidney Disease (CKD)
- 18% higher with neurocognitive disorders including dementia and Alzheimer's disease
- 18% higher with chronic obstructive pulmonary disease and bronchiectasis

- 17% higher with aplastic anemia including anemia in CKD
- 14% higher with coronary atherosclerosis and other heart disease

Age-stratified analysis showed that the number of frequent underlying medical conditions (present in ≥10.0% of patients) was higher with older age. The most frequent conditions were obesity, diabetes, and essential hypertension among patients younger than 65, and disorders of lipid metabolism, essential hypertension, diabetes, and coronary atherosclerosis among patients aged 65 or older. Among patients aged 18 to 39, essential hypertension was associated with a 26% higher risk of death (95% CI, 10%–44%), 25% higher risk of IMV (95% CI, 17%–35%), and an 11% higher risk of ICU admission (95% CI, 7%–15%). In the same age group, asthma was frequent and was associated with a 9% (95% CI, 5%–13%) higher risk of ICU admission but was not significantly associated with higher risk of IMV or death. Other specified status (CCSR category indicating a need for specific medical support, such as a wheelchair or renal dialysis) was a frequent category among patients aged 40 to 64 and 65 or older and was associated with a 7% (1%–13%) and 4% (1%–6%) higher risk of death, respectively.

We found a dose–response association between the total number of underlying medical conditions and risk of severe COVID-19 illness…

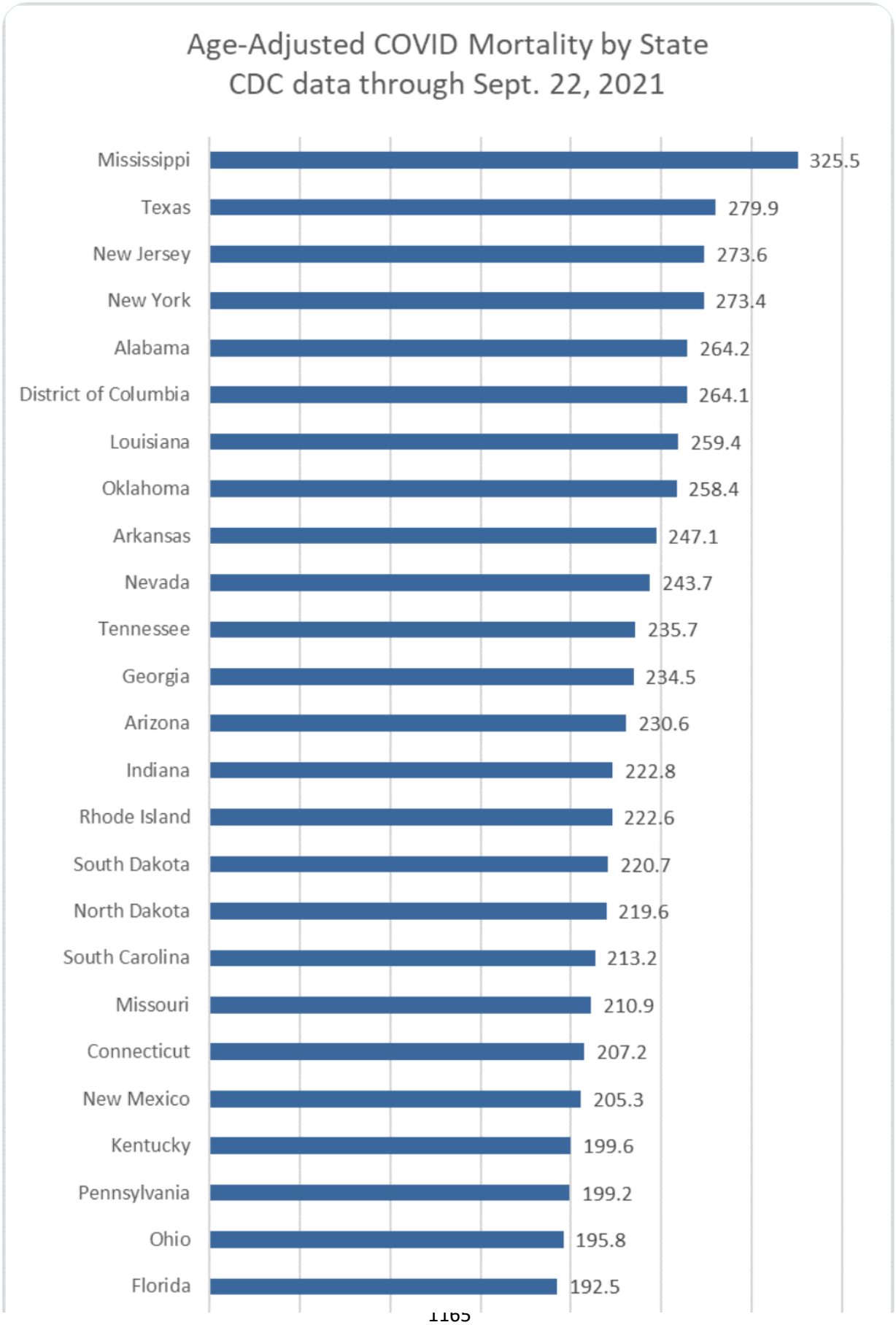
Compared with patients with no documented underlying medical conditions, patients' risk of death was

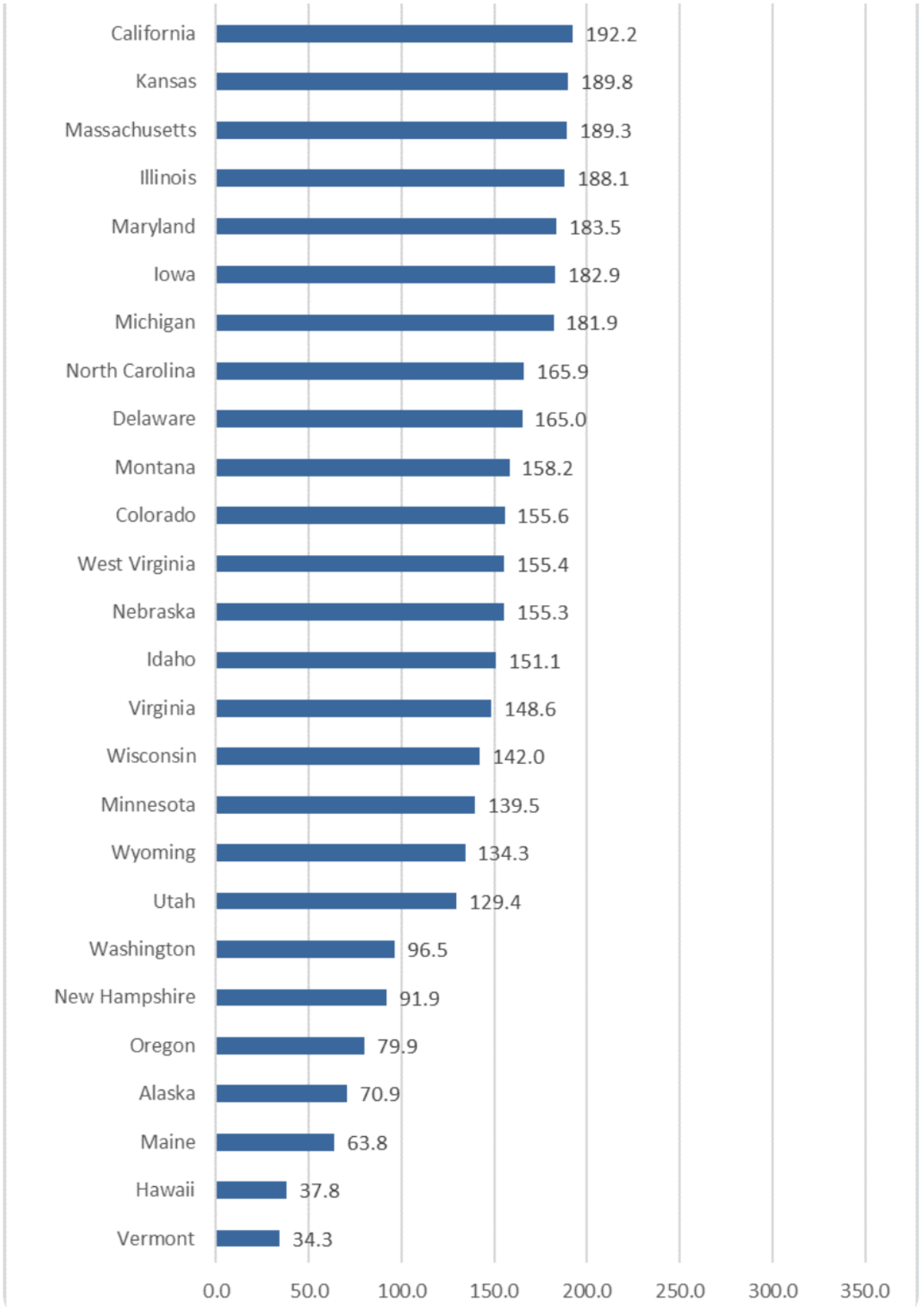
- 1.53 times (95% CI, 1.41–1.67) as high if they had 1 condition,
- 2.55 times (95% CI, 2.32–2.80) as high if they had 2 to 5 conditions,
- 3.29 times (95% CI, 2.98–3.63) as high if they had 6 to 10 conditions,
- 3.82 times (95% CI, 3.45–4.23) as high if they had more than 10 conditions.

https://www.cdc.gov/pcd/issues/2021/21_0123.htm

How do the different states compare in COVID-19 death rates?

Scroll to next page due to image size…

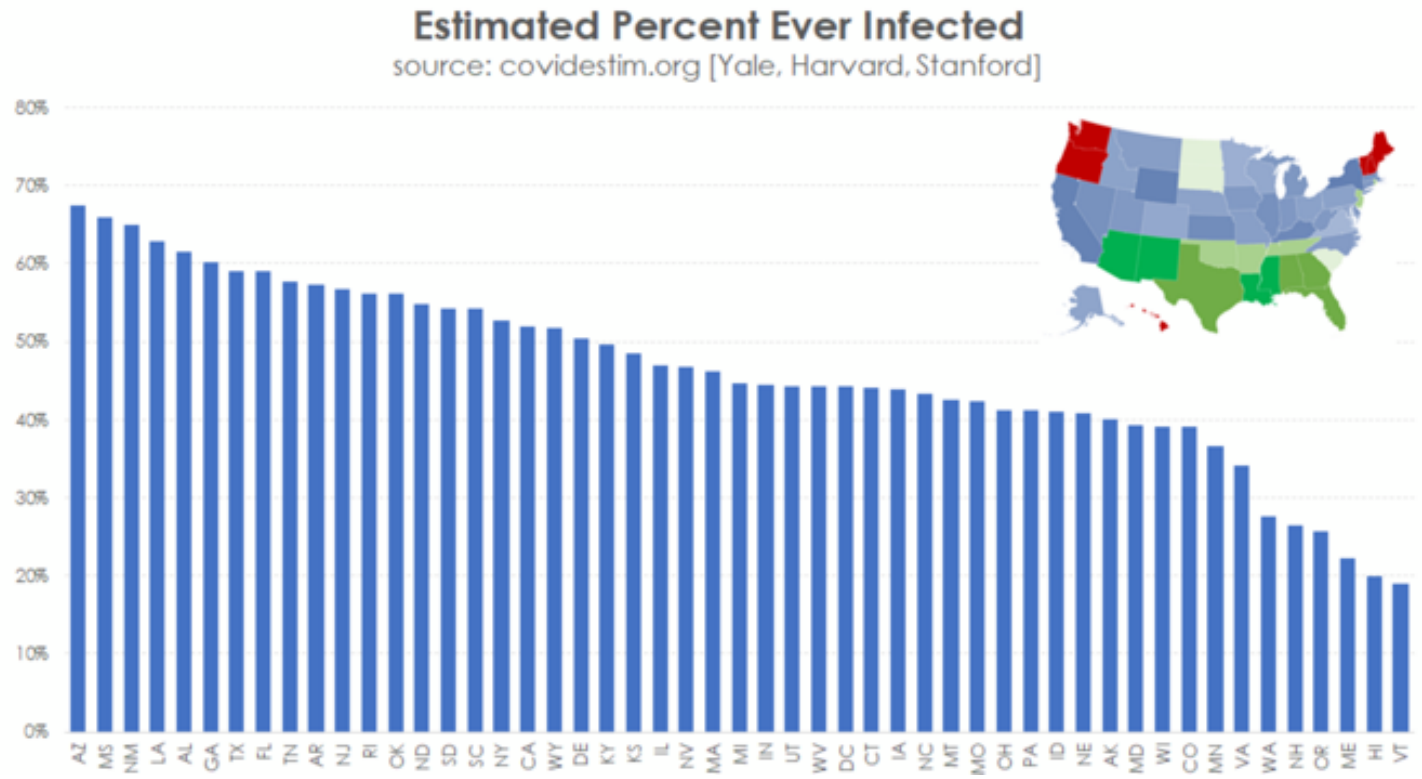

Age-Adjusted COVID Mortality by State
CDC data through Sept. 22, 2021
Mississippi 325.5
Texas 279.9
New Jersey 273.6
New York 273.4
Alabama 264.2
District of Columbia 264.1
Louisiana 259.4
Oklahoma 258.4
Arkansas 247.1
Nevada 243.7
Tennessee 235.7
Georgia 234.5
Arizona 230.6
Indiana 222.8
Rhode Island 222.6
South Dakota 220.7
North Dakota 219.6
South Carolina 213.2
Missouri 210.9
Connecticut 207.2
New Mexico 205.3
Kentucky 199.6
Pennsylvania 199.2
Ohio 195.8
Florida 192.5


California 192.2
Kansas 189.8
Massachusetts 189.3
Illinois 188.1
Maryland 183.5
Iowa 182.9
Michigan 181.9
North Carolina 165.9
Delaware 165.0
Montana 158.2
Colorado 155.6
West Virginia 155.4
Nebraska 155.3
Idaho 151.1
Virginia 148.6
Wisconsin 142.0
Minnesota 139.5
Wyoming 134.3
Utah 129.4
Washington 96.5
New Hampshire 91.9
Oregon 79.9
Alaska 70.9
Maine 63.8
Hawaii 37.8
Vermont 34.3
0.0 50.0 100.0 150.0 200.0 250.0 300.0 350.0

A look at the estimated percentage of the population that have been infected by SARS-CoV-2 in the various U.S. states

There are so many variables that may come into play with regard to the amount that the virus has moved through the population in different states. One could be the stringency of the public health measures such as lockdowns. I have shown in multiple instances throughout the last 18 months of doing my monthly newsletter that lockdowns while they may delay the spread of the virus, they do not stop the inevitable population infectivity or change the outcomes related to mortality or morbidity. Yet they do have very damaging effects economically, societally, emotionally and with negative health outcomes from all other diseases suffering delayed diagnosis and treatment. Other variables with regard to spread could relate to the demographics of population movement or population density.

The obvious benefit of a high percentage of the population having been infected is the benefit of herd immunity. It's becoming more and more apparent as the vaccines fail due to viral escape, that natural immunity from recovered infection is going to give us the best possibility to develop herd immunity and a pathway forward back to normalcy. While this virus may remain in some capacity as endemic along with the many other viruses we encounter, natural immunity gives a person the widest array of protection as the virus continues to evolve and mutate.



We are starting to see the bravado of forcing healthcare and emergency medical responders to be vaccinated begin to crumble

An article appearing on ktvz.com website titled, **Jefferson County commissioners declare state of emergency, call on state to scrap vaccine mandate,** Describes the concern over the coming shortages of health care workers and emergency responders due to the vaccine mandates.

From the article
"The Board of Commissioners requests that the state of Oregon immediately withdraw its vaccine mandate to prevent further exhaustion and departure of providers of core public services, including first responders, health care providers, educators and related staff, emergency service providers and public safety providers, that are essential for the safety and well-being of Oregonians living in, visiting and traveling through Jefferson County," the resolution concluded.

"By doing this declaration, we are setting the stage for requesting state and/or federal assistance to assist local resources and capabilities. In rural counties all over the state, we are faced with the possibility of not being able to provide adequate Public Safety service. We do not want to lose any of our service providers, and it is extremely hard to find replacements in rural Oregon should there be no alternatives.

End of excerpts

Hopefully this is the start of towns cities and municipalities coming to their senses and realizing that forcing an experimental product with no long term safety data, a risk profile that has shown hundreds of thousands of vaccine injuries in the United states alone and is proving to be increasingly ineffective against the delta variant to be a ludicrous proposition.

https://ktvz.com/news/2021/09/15/jefferson-county-commissioners-declare-state-of-emergency-call-on-state-to-scrap-vaccine-mandate/

Now unfortunately, this story does not appear to be the case in all parts of the country. Led by Joe Biden's edicts, states cities municipalities and private companies are forcing valuable and loyal employees out of their jobs. Many of these people have naturally acquired immunity, which is far better than the vaccines can provide. Many have legitimate medical concerns over getting the shots and many have religious objections. And many don't want to risk the known short-term potential well documented harms and the unknown long-term potential harms of taking an experimental product. And yes, the vaccines are still experimental as the clinical trials are not scheduled to be completed until the end of 2022 and early 2023 for Pfizer and

Moderna. Stay tuned as I am hoping that we will see a flurry of class-action lawsuits being unleashed against these unconstitutional, human rights violations.

November 1st, 2021

The nonsensical policies of pretending that vaccines that can't prevent infection or transmission to participate in society just became all the more ridiculous

In a medRvix pre-print article dated, August 24th, 2021 titled, **Shedding of Infectious SARS-CoV-2 Despite Vaccination**, what we already knew became even more obvious. And, that is that fully vaccinated people incubate virus at as high and even higher levels than people that are not vaccinated. Watch for this study to be shadow banned or retracted. They excluded people who are either only partially vaccinated, or for whom vaccination status was unknown from the study.

The Abstract

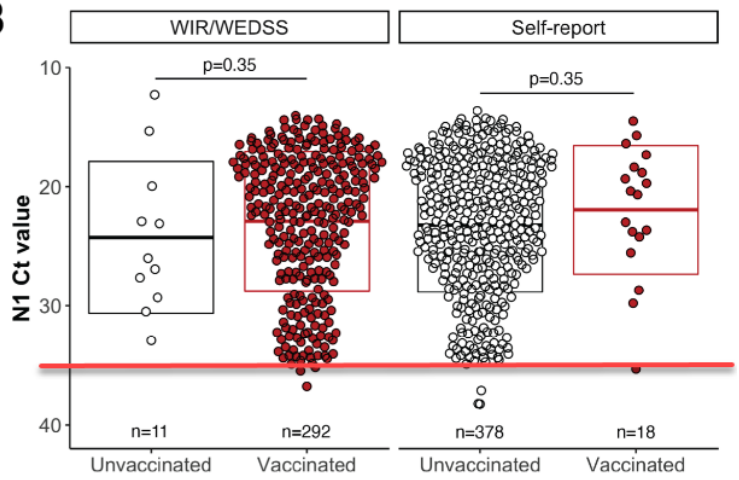
The SARS-CoV-2 Delta variant might cause high viral loads, is highly transmissible, and contains mutations that confer partial immune escape. Outbreak investigations suggest that vaccinated persons can spread Delta. We compared RT-PCR cycle threshold (Ct) data from 699 swab specimens collected in Wisconsin 29 June through 31 July 2021 and tested with a qualitative assay by a single contract laboratory. Specimens came from residents of 36 counties, most in southern and southeastern Wisconsin, and 81% of cases were not associated with an outbreak. **During this time, estimated prevalence of Delta variants in Wisconsin increased from 69% to over 95%. Vaccination status was determined via self-reporting and state immunization records. (Supplemental Figure 1).**

Supplemental figure 1

A

Vaccinated per WIR or WEDSS	Vaccinated per self-report: Yes	Vaccinated per self-report: No
Yes	124	33
No	0	8

B



My comments: **The red horizontal wine was added by me.** If you look at the Ct value on the vertical axis on the left, you will see that the line intersects at about 35 cycles. We have discussed the many faults of the PCR testing numerous times over the last 18 months. As you can see in the diagram there was little if any positives that were triggered beyond the 35-cycle threshold. Yet, our CDC directed labs to run 42 as many as 45 amplification cycles on samples. Keep in mind, that the higher the number of amplification cycle thresholds run before triggering a positive test, the less likely that person has any viable infectious virus. As I have shown in previous issues of the newsletter by presenting various studies, it becomes very difficult to be able to culture virus after 28 to 30 amplification cycles.

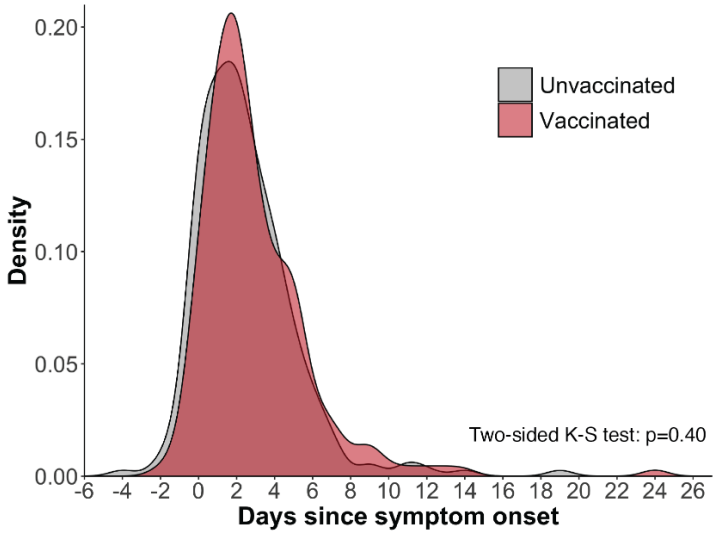
Back to the study:

Low Ct values were detected in vaccinated people regardless of symptoms at the time of testing.

My comment: that they could pick up the virus at low CT levels means that the person Had a high viral load and was very infectious.

(**Figure 1C**). Ct values <25 were detected in 7 of 24 unvaccinated (29%; CI: 13-51%) and 9 of 11 fully vaccinated asymptomatic individuals (82%; CI: 48-97%), and 158 of 232 unvaccinated (68%, CI: 62-74%) and 156 of 225 fully vaccinated (69%; CI: 63-75%) symptomatic individuals. Time from symptom onset to testing did not vary by vaccination status (p=0.40; **Supplemental Figure 2**). Infectious virus was detected in the sole specimen tested from an asymptomatic fully vaccinated individual. Although few asymptomatic individuals were sampled, these results indicate that even asymptomatic, fully vaccinated people might shed infectious virus.

Supplemental figure 2



Supplemental figure 2. Density distributions of unvaccinated and vaccinated specimen collection dates by day since symptom onset. Day 0 on the x-axis denotes self-reported day of symptom onset. Negative values for days indicate specimen collection prior to symptom onset. Symptom onset data were available for n=263 unvaccinated cases and n=232 vaccinated cases.

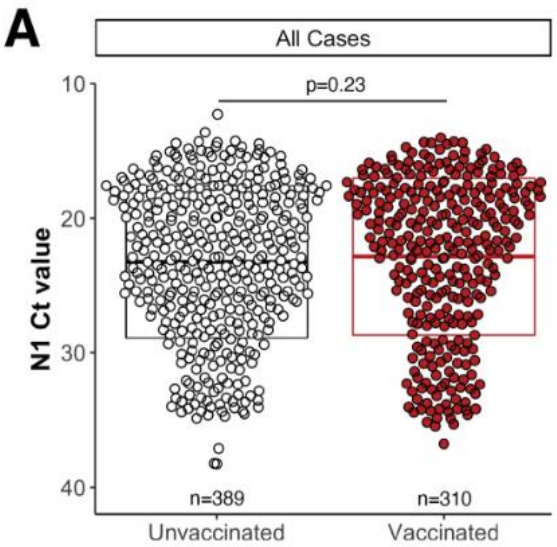
Combined with other studies 2–5, these data indicate that vaccinated and unvaccinated individuals infected with the Delta variant might transmit infection. Importantly, we show that infectious SARS-CoV-2 is frequently found even in vaccinated persons when specimen Ct values are low. The inclusion of viruses from Pango lineages B.1.617.2, AY.2, and AY.3, and multiple counties without a linking outbreak, indicate that Delta-lineage SARS-CoV-2 can achieve low Ct values consistent with transmissibility in fully vaccinated individuals across a range of settings. Vaccinated and unvaccinated persons should get tested when symptomatic or after close contact with someone with suspected or confirmed COVID-19. Continued adherence to non-pharmaceutical interventions during periods of high community transmission to mitigate spread of COVID-19 remain important for both vaccinated and unvaccinated individuals.

Figure 1. Individuals infected with SARS-CoV-2 despite full vaccination have low Ct values and shed infectious virus.

1, A. Ct values for SARS-CoV-2-positive specimens grouped by vaccination status.

We observed low Ct values (<25) in 212 of 310 fully vaccinated (68%; Figure 1A) and 246 of 389 (63%) unvaccinated individuals.

Figure 1, A

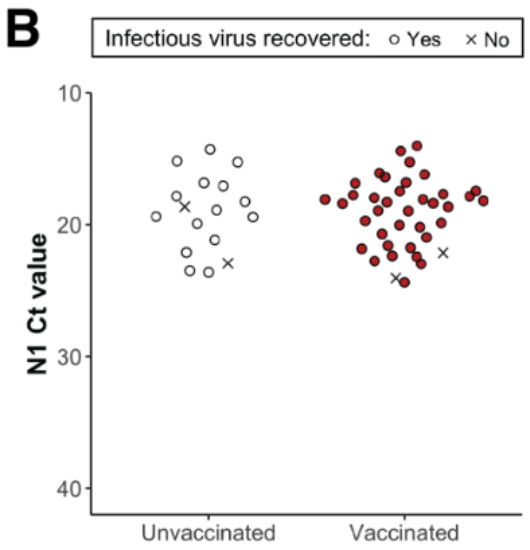


1, B. Infectiousness was determined for a subset of N1 Ct-matched specimens with Ct <25 by inoculation onto Vero E6 TMPRSS2 cells and determining presence of cytopathic effects (CPE) after 5 days in culture. Specimens were selected by N1 Ct-matching between fully vaccinated and not fully vaccinated persons, then

specimens from persons with unknown vaccination status were excluded from the analysis. Circles indicate presence of CPE; 'X' indicates no CPE detected.

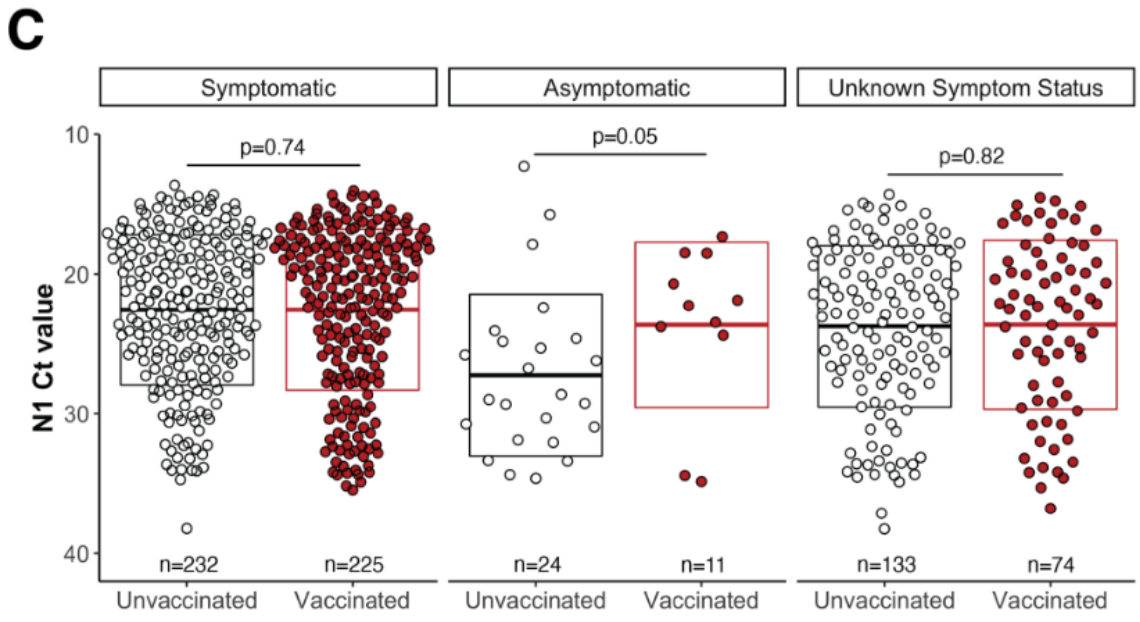
Testing a subset of low-Ct samples revealed infectious SARS-CoV-2 in 15 of 17 specimens (88%) from unvaccinated individuals and 37 of 39 (95%) from vaccinated people.

Figure 1, B



1, C. N1 Ct values for SARS-CoV-2-positive specimens grouped by vaccination status for individuals who were symptomatic or asymptomatic, or those whose symptom status was not determined, at the time of testing.

Figure 1, C



https://www.medrxiv.org/content/10.1101/2021.07.31.21261387v4.full.pdf

Let's consider the implications of this study in the real world. This next story seems to corroborate the findings of this study and should be the death nail to vaccine mandates worldwide.

Massive study across 68 countries and nearly 3,000 counties in the U.S. finds that high vaccination levels of the population seem to correlate with higher infection transmission and case rates

A study published September 30th, 2021, in the ***European Journal of Epidemiology*** titled, **Increases in COVID-19 are unrelated to levels of vaccination across 68 countries and 2947 counties in the United States**, exposes the lie that the vaccination program is working and that these gene therapy prophylactics will be able to move the needle on ending the pandemic.

Findings

At the country-level, there appears to be no discernable relationship between percentage of population fully vaccinated and new COVID-19 cases in the last 7 days (Fig. 1). In fact, the trend line suggests a marginally positive association such that countries with higher percentage of population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days. The lack of a meaningful association between percentage population fully vaccinated and new COVID-19 cases is further exemplified, for instance, by comparison of Iceland and Portugal. Both countries have over 75% of their population fully vaccinated and have more COVID-19 cases per 1 million people than countries such as Vietnam and South Africa that have around 10% of their population fully vaccinated.

Across the US counties too, the median new COVID-19 cases per 100,000 people in the last 7 days is largely similar across the categories of percent population fully vaccinated (Fig. 2). Notably there is also substantial county variation in new COVID-19 cases *within* categories of percentage population fully vaccinated. There also appears to be no significant signaling of COVID-19 cases decreasing with higher percentages of population fully vaccinated (Fig. 3).

Of the top 5 counties that have the highest percentage of population fully vaccinated (99.9–84.3%), the US Centers for Disease Control and Prevention (CDC) identifies 4 of them as “High” Transmission counties. Chattahoochee (Georgia), McKinley (New Mexico), and Arecibo (Puerto Rico) counties have above 90% of their population fully vaccinated with all three being classified as “High” transmission.

Conversely, of the 57 counties that have been classified as “low” transmission counties by the CDC, 26.3% (15) have percentage of population fully vaccinated below 20%. Since full immunity from the vaccine is believed to take about 2 weeks after the second dose, we conducted sensitivity analyses by using a 1-month lag on the percentage population fully vaccinated for countries and US counties. The above findings of no discernable association between COVID-19 cases and levels of fully vaccinated was also observed when we considered a 1-month lag on the levels of fully vaccinated (Supplementary Figure 1, Supplementary Figure 2).

In summary, even as efforts should be made to encourage populations to get vaccinated it should be done so with humility and respect. Stigmatizing populations can do more harm than good. Importantly, other non-pharmacological prevention efforts (e.g., the importance of basic public health hygiene with regards to maintaining safe distance or handwashing, promoting better frequent and cheaper forms of testing) needs to be renewed in order to strike the balance of learning to live with COVID-19 in the same manner we continue to live a 100 years later with various seasonal alterations of the 1918 Influenza virus.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8481107/

My comment: There are a couple of very important things missing from the last summary paragraph. It would be nice to see these journals discuss the role of optimizing vitamin D levels in the population, as well as promoting the early use of antiviral treatments that are proving to be so very valuable in preventing hospitalizations and deaths. Those would include hydroxychloroquine with zinc, Ivermectin and Budesonide used appropriately. There is literally well over 100 studies now that show tremendous benefit with these medications used as early treatment for COVID-19.

That leads me to this next story and pharma’s attempt to cash in on that early treatment market.

A report from a hospital in Israel showing 39 of 42 cases in an outbreak were in people that were fully vaccinated

A report published September 26th, 2021, in the ***Euro Surveillance*** the European communicable disease bulletin, **Nosocomial outbreak caused by the SARS-CoV-2 Delta variant in a highly vaccinated population, Israel, July 2021**

The abstract

A nosocomial outbreak of SARS-CoV-2 Delta variant infected 42 patients, staff and family members; 39 were fully vaccinated. The attack rate was 10.6% (16/151) among exposed staff and reached 23.7% (23/97) among exposed patients in a highly vaccinated population, 16–26 weeks after vaccination (median: 25 weeks). All cases were linked and traced to one patient. Several transmissions occurred between individuals wearing face masks. Fourteen of 23 patients became severely sick or died, raising a question about possible waning immunity. https://pubmed.ncbi.nlm.nih.gov/34596015/

New study from Sweden shows how rapidly the three leading vaccines against COVID-19 decrease in effectiveness

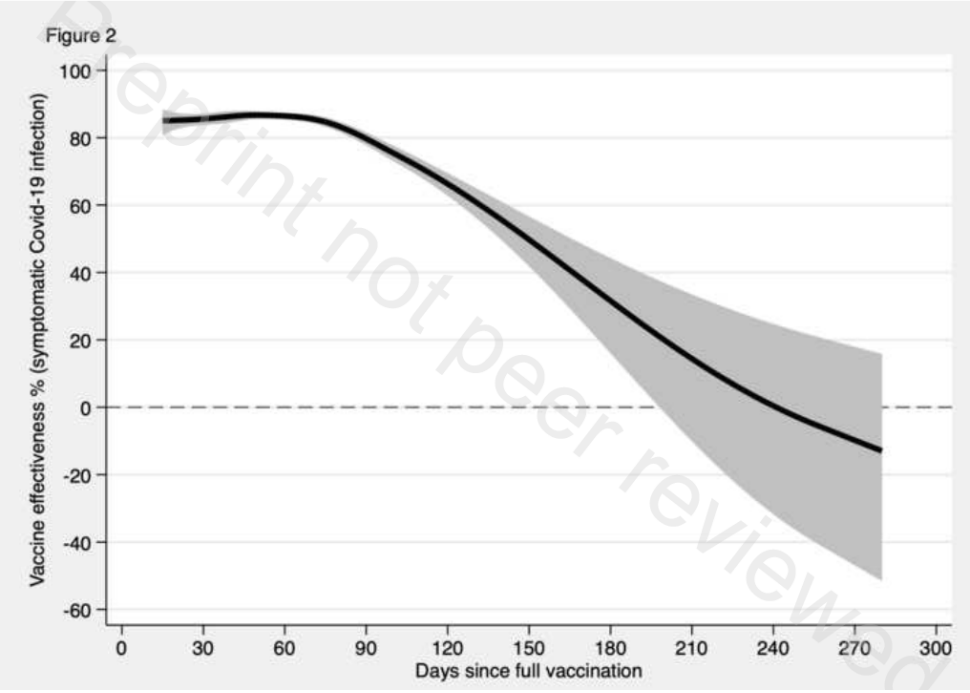
The study is a preprint posted October 25th 2021 titled, **Effectiveness of COVID-19 vaccination against risk of symptomatic infection, hospitalization, and death up to nine months: a Swedish total population cohort study.** The findings mirror other studies and reports from all over the world showing the dramatic decline in effectiveness of the vaccines within a few months.

Findings of vaccine effectiveness against infection:

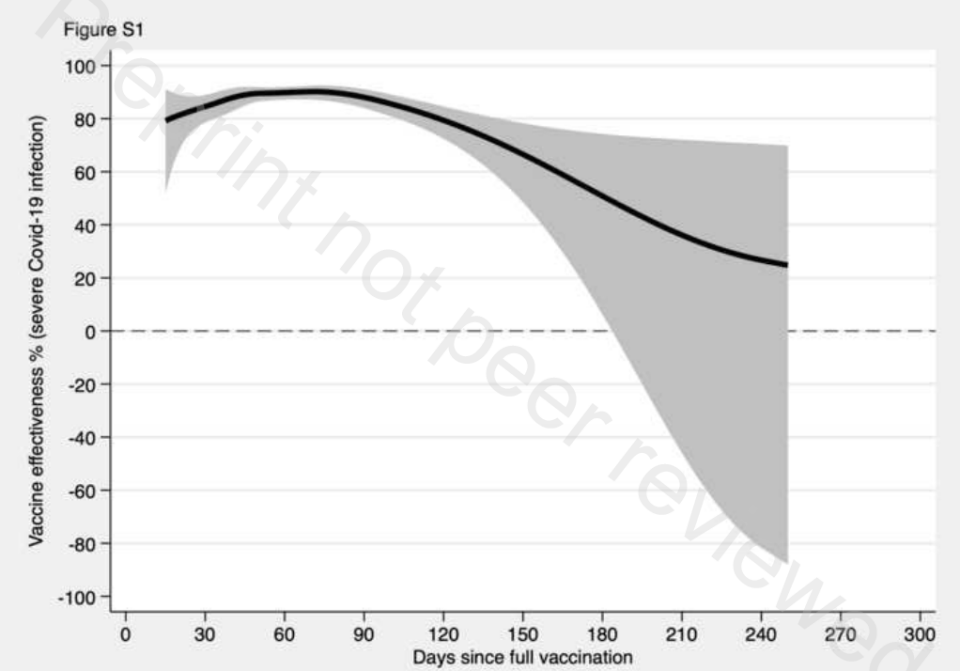
- Pfizer waned progressively from 92% at day 15-30 to 47%, and from day 211 and onwards no effectiveness could be detected.
- Moderna waned to 59% from day 181 and onwards.
- AstraZeneca's effectiveness was generally lower and waned faster, with no effectiveness detected from day 121 and onwards.

As You can see, vaccine effectiveness decreases below zero at about nine months.

Figure 2. Adjusted vaccine effectiveness (any vaccine) against symptomatic Covid-19 infection among 842,974 vaccinated individuals matched to equally number of unvaccinated individuals through 9 months of follow-up. To model the association between vaccine effectiveness during follow-up, restricted cubic splines were used with 5 degrees of freedom



Supplemental Figure 1. Adjusted vaccine effectiveness (any vaccine) against Covid-19 hospitalization or death among 842,974 vaccinated individuals matched to equally number of unvaccinated individuals through 9 months of follow-up. To model the association between vaccine effectiveness during follow-up, restricted cubic splines were used with 5 degrees of



"Overall, vaccine effectiveness was lower and waned faster among men and older individuals.
For the outcome severe Covid-19, effectiveness waned from 89% at day 15-30 to 42% from day 181 and onwards, with sensitivity analyses showing notable waning among men, older frail individuals, and individuals with comorbidities."

https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3949410

My comments:

1. In looking at the graphs above you can see the dark line representing the average decrease flanked by a shaded gray area that tends to widen as time goes on. That represents the full spectrum of individuals studied participating in the study. Look at how far below the zero line that shaded area goes in both graphs. That means that the vaccine effectiveness is in the negative, meaning that in that percentage of the population, the vaccine is making people more susceptible to contracting COVID-19, becoming hospitalized and dying. The quote below the second graph describes those individuals that are most likely to fall within that negative shaded area. Could this represent cases of severe disease and deaths due to Antibody Dependent Enhancement (ADE)? Concerns over the potential for ADE have been worrying experts in the medical and scientific community since prior to the release of the vaccines. The development of ADE in animals in clinical trials of vaccine development after the SARS-CoV-1 outbreak in 2002-2003 is what prevented those vaccines from ever making it to human trials. It was simply too risky. The omission of animal trials in the rush to get the COVID-19 vaccines to market is in my opinion a huge mistake. With the increase over time of COVID related hospitalizations and

deaths in vaccinated individuals around the world, we may be seeing the predicted outcome of those shortcuts becoming realized.

2. Some people may look at the graph above and say that even some protection against hospitalization and death is worth taking the vaccine. What those people don't realize or in some may choose to ignore, is that optimal levels of vitamin D will do the same thing with zero risk of side effects. This has been shown in dozens of studies that I have posted on my web site HERE. Plus many other benefits of optimizing vitamin D in overall health. The other thing that will reduce hospitalizations and death significantly, (as studies have shown up to an 85% reduction), are the early treatment medications I have presented repeatedly over the last 18 months.

Is it even possible to reach herd immunity with the vaccines? Many experts from the most vaccinated countries don't seem to think so

White House spokespersons and public health officials continue to tell the American people that the vaccines have the capability of ending the pandemic. This rationale has been used to justify the mandates and now to justify going after extremely low risk children with these experimental gene therapy products. So, what do some of the experts around the world who have seen first-hand the vaccine's inability to slow the pandemic feel about this overly optimistic viewpoint. Jefferey Jaxen, the ***Highwire's*** investigative journalist wrote an editorial piece that contained a couple of those stunning admissions.

Sir Andrew Pollard, a professor of pediatric infection and immunity at the ***University of Oxford*** and the Director of the ***Oxford Vaccine Group*** has now admitted that in the light of the vaccine failure, any chance of reaching herd immunity as a result of high vaccination levels is virtually impossible. He even called the idea mythical. Pollard was quoted as saying "We don't have anything that will stop transmission, so I think we are in a situation here with this current variant where herd immunity is not a possibility because it still infects vaccinated individuals."

Iceland's Chief Epidemiologist Þórólfur echoed Pollard's views for his own country as Iceland's visir.is website reports:

"… it is disappointing that herd immunity has not been achieved with vaccination." He says that only one other way is able to achieve herd immunity, to allow the virus to spread through the community.

"We really cannot do anything else," says Þórólfur when asked whether the nation of 70 to 80 [percent] must be allowed to become infected to achieve herd immunity.

Even our CDC's very own Rochelle Walensky has had to publicly admit that the vaccines do not stop infection or transmission. Therefore, the notion that they could contribute to stopping the spread of the virus is irrational.

The mRNA vaccines may inhibit the innate immune system which could reduce effectiveness against viral infection and lead to increased risk of cancer

Last month I covered a story about Dr. Ryan Cole, an Idaho Pathologist that reported that he and many colleagues are seeing an explosion of new and recurrent cancers in vaccinated people. It also discussed the possible mechanisms for how this may be possible.

Here is a short excerpt from that article. I though it would add context for this month's story.
Explaining his findings at the March 18 event, Cole told Idahoans that the vaccines seem to be causing serious autoimmune issues, in a way he described as a "reverse HIV" response.

Cole explained that two types of cells are required for adequate immune system function: "Helper T-cells," also called "CD4 cells," and "killer T-cells," often known as "CD8 cells."

According to Cole, in patients with HIV, there is a massive suppression of "helper T-cells" which cause immune system functions to plummet, and leave the patient susceptible to a variety of illnesses.

Similarly, Cole describes, "post-vaccine, what we are seeing is a drop in your killer T-cells, in your CD8 cells," "And what do CD8 cells do? They keep all other viruses in check," he continued.

Much like HIV causes immune system disruption by suppressing CD4 "helper" cells, the same thing happens when CD8 "killer" cells are suppressed. In Dr. Cole's expert view, this is what seems to be the case with the COVID-19 jabs.

Cole goes on to state that as a result of this vaccine-induced "killer T-cell" suppression, he is seeing an "uptick" of not only endometrial cancer, but also melanomas, as well as herpes, shingles, mono, and a "huge uptick" in HPV when "looking at the cervical biopsies of women."

https://www.lifesitenews.com/news/idaho-doctor-reports-a-20-times-increase-of-cancer-in-vaccinated-patients/

If you want to see a great and revealing interview with Dr. Cole about this very topic, check out ***The Highwire.com*** **Episode 234- Rise of the Resistance** https://thehighwire.com/**videos/is-there-a-covid-vaccine-cancer-connection/**

Introducing the two scientists being touted as heroes for helping mRNA evade the body's immune system. But will history remember them as villains?

Drs. Drew Weissman and Katalin Kariko from the University of Pennsylvania discovered a way of sneaking lipid nanoparticles past the immune system's defense are being heralded in the scientific community as heroes. Some are even calling for the award of a Nobel Prize for discovering how to uncouple the immune system's first line of attack so the carrier molecules can get to their intended targets.

But…Will there be unintended consequences like unchecked cancer?

Their 2005 study published in the journal *Immunity*

- **Suppression of RNA recognition by Toll-Like Receptors: the impact of nucleoside modification and the evolutionary origin of RNA-**

From the summary

DNA and RNA stimulate the mammalian innate immune system through activation of toll like receptors (TLRs).

We show that RNA signals through human TLR 3, TLR 7, and TRL 8, but incorporation of modified nucleosides M5C, M6A, M5U, S2U, or pseudouridine ablates activity. Dendritic cells exposed to such modified RNA express significantly less cytokines and activation markers than those treated with unmodified RNA. We conclude that nucleoside modifications suppress the potential of RNA to activate dendritic cells.

https://pubmed.ncbi.nlm.nih.gov/16111635/

My comment: Dendritic cells are a key player in the immune system. Dendritic cells are antigen-presenting cells. Their main function is to process antigen material and present it on the cell surface to the T cells of the immune system. They act as messengers between the innate and the adaptive immune systems as they can differentiate into various cells that can attack invading organisms or cancer.

This study identified ways to modify RNA in such a way as to trick the immune system and reduce the immune system's response to the foreign RNA. On one hand, it sounds like a good idea to the people developing drugs and biologics wanting to use lipid nanoparticles and genetically modified RNA strands as therapeutics. But on the other hand, like has happened so many times in science and medicine, the unintended consequences can have dire results.

A contemporary study describes how this same mechanism used in the Pfizer vaccine negatively impacts the body's innate immune response

Now, on to another study that presents concerns about the vaccines interfering with the innate immune system. The article is a medRxiv preprint titled, **The BNT162b2 mRNA vaccine against SARS-CoV-2 reprograms both adaptive and innate immune responses.**

From the summary

Interestingly, however, the BNT162b2 vaccine also modulated the production of inflammatory cytokines by innate immune cells upon stimulation with both specific (SARS-CoV-2) and non-specific (viral, fungal and bacterial) stimuli. The response of innate immune cells to TLR4 and TLR7/8 ligands was lower after BNT162b2 vaccination, while fungi-induced cytokine responses were stronger. In conclusion, the mRNA BNT162b2 vaccine induces complex functional reprogramming of innate immune responses, which should be considered in the development and use of this new class of vaccines.

….**inhibition of innate immune responses may diminish anti-viral responses. Type I interferons also play a central role in the pathogenesis and response against viral infections, including COVID-19** (Hadjadj et al., 2020). With this in mind, we also assessed the production of IFN-α by immune cells of the volunteers after vaccination. Although the concentrations of IFN-α were below the detection limit of the assay for most of the stimuli, **we observed a significant reduction in the production if IFN-α secreted after stimulation with poly I:C and R848 after the administration of the second dose of the vaccine** (Figure 1H, 1I). **This may hamper the initial innate immune response against the virus, as defects in TLR7 have been shown to result in and increased susceptibility to COVID-19 in young males** (Van Der Made et al., 2020). These results collectively demonstrate that the effects of the BNT162b2 vaccine go beyond the adaptive immune system and can also modulate innate immune responses.

The effect of the BNT162b2 vaccination on innate immune responses may also indicate a potential to interfere with the responses to other vaccinations, as known for other vaccines to be as 'vaccine interference' (Lum et al., 2010; Nolan et al., 2008; Vajo, Tamas, Sinka, & Jankovics, 2010). Future studies are therefore needed to investigate this possibility, especially the potential interaction with the influenza vaccine: **in the coming years (including the autumn of 2021) COVID-19 vaccination programs will probably overlap with the seasonal Influenza vaccination, so it is crucial to perform additional studies to elucidate the potential interactions and effects of the COVID-19 vaccines with the current vaccination schedules, especially for immunosuppressed and elderly individuals.**

https://www.medrxiv.org/content/10.1101/2021.05.03.21256520v1.full.pdf

A couple key takeaways are, that the vaccines appear to:

Reduce production of Type 1 Interferon, a crucial compound produced by immune cells that are a first line of defense against viral infection, as it regulates an immune response by activating multiple cell types, including dendritic cells, cytotoxic T cells, and natural killer cells. Reduction of Type 1 Interferon and also derail an important part of the immune system's control over cancer (see #1 and #2 below).

#1. **Interferon-alpha and cancer: mechanisms of action and new perspectives of clinical use** - ***Journal Biochimie-*** 2007

From the study

Early studies in mouse tumor models showed the importance of host immune mechanisms in the generation of a long-lasting antitumor response after treatment of the animals with IFN-alpha/beta. Subsequently, an ensemble of studies based on the use of genetically modified tumor cells expressing specific IFN molecules provided important information on the host-mediated antitumor mechanisms induced by the local production of IFN-alpha. Of note, several studies have then underscored new immunomodulatory effects of IFN-alpha, including activities on T cells and dendritic cells, which may lead to IFN-induced antitumor immunity. In addition, recent reports on new immune correlates in cancer patients responding to IFN-alpha represent additional evidence on the importance of the interactions of IFN-alpha with the immune system for the generation of a durable antitumor response.

https://pubmed.ncbi.nlm.nih.gov/17532550/

#2. **Interferons α and β in cancer: therapeutic opportunities from new insights** - ***Nature Reviews Drug Discovery-*** 2019

The abstract- (I have added the bolded words)

Over the past decade, preclinical and clinical research have confirmed the essential role of interferons for effective host immunological responses to malignant cells. Type I interferons (IFNα and IFNβ) directly regulate transcription of >100 downstream genes, which results in a myriad of direct (on cancer cells) and indirect (through immune effector cells and vasculature) effects on the tumour. New insights into endogenous (**interferon made by the immune system)** and exogenous **(from the outside)** activation of type I interferons in the tumour and its microenvironment have given impetus to drug discovery and patient evaluation of interferon-directed strategies. When combined with prior observations or with other effective modalities for cancer treatment, modulation of the interferon system could contribute to further reductions in cancer morbidity and mortality.

https://pubmed.ncbi.nlm.nih.gov/30679806/

A 2021 study explains how the mRNA vaccines are designed to escape the innate immune system

A 2021 study published in the ***International Journal of Biological Sciences*** titled, **mRNA vaccines for COVID-19: what, why and how** describes mechanisms that are designed into the vaccines to help them illude the body's immune system.

From the article

RNA degradation

mRNA vaccines took the vaccine development stage by storm mainly due to their rapid development and versatility of design. However, as described above there are two significant intrinsic limitations of mRNA as a vaccine: 1) the instability of mRNA molecules **and 2) the activation of the innate immune response.** Appropriate purification of IVT-synthesized mRNA is critical to avoid the cellular immune response against the exogenous mRNA and maximize the protein yield. **Moreover, the incorporation of chemically modified nucleosides such as pseudouridine and 1-methylpseudouridine allows mRNA molecules to escape the recognition by TLR7 and -8 as well as other innate immune sensors** [62, 111]. Surprisingly, pseudouridine in mRNA molecules enhances the translation efficiency from ssRNA by reducing the PKR activity [112]. Moreover, pseudouridine-modified mRNA can be translated in primary dendritic cells **and even in mice by evading innate immune surveillance** and increasing the protein yield

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8071766/

This next story may reflect a trend of gradual immune compromise in vaccinated people as time goes on.

A disturbing trend for vaccinated individuals noted from Public Health England's updates- Cases, hospitalizations and deaths rising in the fully vaccinated

A series of articles posted on ***The Expose*** paint a dire picture for the health of the immune systems in those that are vaccinated with the experimental COVID-19 gene therapy products.

I will only show a few of the charts in an effort to conserve space for this newsletter. The links are provided if you would like to look at everything in more detail.

The first article posted October 10th, 2021 titled, **A comparison of official Government reports suggest the Fully Vaccinated are developing Acquired Immunodeficiency Syndrome**, shows ***Public Health England*** charts which reflect a decline in vaccinated individuals protection. This is something that I have been reporting on over the last several months from Public Health England. But in these articles, they have cleverly strung together the various charts in sequence allowing us to see the changes from month to month.

From the article

The 5 PHE tables below from their excellent Vaccine Surveillance Report, separated by 4 weeks, clearly show the progressive damage that the vaccines are doing to the immune system's response.

People aged 40-69 have already lost 40% of their immune system capability and are losing it progressively at 3.3% to 6.4% per week.

My comment: In all fairness, I am not sure if this trend is due to a gradual decline in the immune systems of people that have had the vaccines, the fact that the antibody protection from the vaccines wane as time goes on, antibody dependent enhancement in those who are vaccinated, or that the vaccines are driving further mutations in the spike and hence the development of variance that are escaping whatever vaccine protection there may be left..., or a combination of the above.

I am going to show you the first table (weeks 32-35) and the last (weeks 36-39) in the article. They have added the far-right column to the *PHE* table from their report.

Table 2. COVID-19 cases by vaccination status…

Cases reported by specimen date between week 32 and week 35 2021 –
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1016465/Vaccine_surveillance_report_-_week_36.pdf

Age group	Total Cases	Vax Status unknown	Unvaccinated	1 dose 1-20 days before specimen date	1 dose ≥21 days before specimen date	2nd dose ≥14 days before specimen date	Rates per 100k in double vaxxed (V)	Rates per 100k in unvaxxed (U)	Immune system boost or degradation % (U-V)/U when positive (pfizer's formula) (U-V)/V when negative
Under 18	167,832	15,901	141,676	8,132	1,368	757	476.0	1,192.9	+60.1% (excludes 12-15)
18-29	176,392	19,529	53,187	4,598	66,545	32,533	711.1	1,520.8	+53.2%
30-39	113,373	12,452	33,986	1,497	22,434	43,004	782.2	1,143.9	+31.6%
40-49	97,881	8,930	15,106	496	6,000	67,349	1,116.2	880.4	-21.1%
50-59	84,488	6,868	7,552	168	2,248	67,652	962.0	729.7	-24.1%
60-69	45,252	3,657	2,650	54	772	38,119	672.3	487.5	-27.5%
70-79	25,499	2,034	910	12	273	22,270	480.5	367.5	-23.5%
80+	12,011	1,124	545	9	246	10,087	391.1	427.4	+8.5%

Cases reported by specimen date between week 36 and week 39 2021 – https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1023849/Vaccine_surveillance_report_-_week_40.pdf

Age group	Total Cases	Vax status unknown	Unvaccinated	1 dose 1-20 days before specimen date	1 dose ≥21 days before specimen date	2nd dose ≥14 days before specimen date	Rates per 100k in double vaxxed (V)	Rates per 100k in unvaxxed (U)	Immune system boost or degradation % (U-V)/U when positive (pfizer's formula) (U-V)/V when negative	Weekly Decline
Under 18	305,428	20,967	272,981	4,073	5,898	609	278.8	2,325.7	+88.0% (includes 135k 12-15 cases)	+4.3%
18-29	67,820	8,556	23,440	1,119	12,593	22,112	409.6	688.1	+40.5%	-4.3%
30-39	81,532	7,534	21,449	690	7,468	44,391	763.6	738.4	-3.3%	-11.4%
40-49	101,094	6,839	11,662	297	3,653	78,643	1,291.8	690.2	-46.6%	-6.9%
50-59	70,731	4,668	5,144	88	1,464	59,366	839.5	502.5	-40.1%	-5.7%
60-69	36,953	2,585	1,798	26	546	31,998	563.1	332.9	-40.9%	-2.1%
70-79	22,142	1,367	693	6	207	19,869	428.9	281.4	-34.4%	-3.6%
80+	10,581	863	403	4	199	9,106	354.4	319.5	-9.8%	-2.5%

Weekly Decline in doubly vaccinated immune system performance compared to unvaccinated people…

Age group	Week36 Decline	Week37 Decline	Week38 Decline	Week39 Decline	Week40 Position	Average Weekly Decline	Weeks before total immune system failure (100% degradation)
18-29	-2.5%	-1.9%	-4.0%	-4.3%	+40.5%	-3.2%	**44** weeks (140.5/3.2)
30-39	-6.0%	-7.0%	-10.5%	-11.4%	-3.3%	-8.7%	**12** weeks (96.7/8.7)
40-49	-5.2%	-5.3%	-8.1%	-6.9%	-46.6%	-6.4%	**9** weeks (53.4/6.4)
50-59	-4.0%	-2.4%	-3.9%	-5.7%	-40.1%	-4.0%	**15** weeks (59.9/4)
60-69	-4.2%	-2.9%	-4.2%	-2.1%	-40.9%	-3.35%	**18** weeks (59.1/3.35)
70-79	-4.1%	+0.7%	-3.9%	-3.6%	-34.4%	-2.7%	**25** weeks (65.6/2.7)
80+	-5.6%	-7.1%	-3.1%	-2.5%	-9.8%	-4.6%	**20** weeks (90.2/4.6)

https://theexpose.uk/2021/10/10/comparison-reports-proves-vaccinated-developing-ade/

The second article titled, **It gets worse – A comparison of official Government reports suggest the Fully Vaccinated are developing Acquired Immunodeficiency Syndrome much faster than anticipated** reflects an update posted approximately a week later and adds another dimension to the analysis.

From the article

A Vaccine efficacy of **50%** means that doubly vaxxed people are 50% more protected from Covid than unvaxxed people. It means that the delta case rate in the vaxxed is half the delta case rate in the unvaxxed.
A Vaccine efficacy of **-50%** means that unvaxxed people are 50% more protected from Covid than doubly vaxxed people. It means that the delta case rate in the vaxxed is double the delta case rate in the unvaxxed.
A Vaccine efficacy of **0%** means that doubly vaccinated people are 0% more protected from Covid than

unvaxxed people. It means that the delta case rate in the vaxxed equals the delta case rate in the unvaxxed. It means the vaccines have lost all their effectiveness.

Age group	Week35 Vax Efficacy	Week36 Vax Efficacy	Week37 Vax Efficacy	Week38 Vax Efficacy	Week39 Vax Efficacy	Week40 Vax Efficacy
18-29	+53.2%	+50.7%	+48.8%	+44.8%	+40.5%	+33.5%
30-39	+31.6%	+25.6%	+18.6%	+8.1%	-3.3%	-13.8%
40-49	-21.1%	-26.3%	-31.6%	-39.7%	-46.6%	-52.2%
50-59	-24.1%	-28.1%	-30.5%	-34.4%	-40.1%	-45.8%
60-69	-27.5%	-31.7%	-34.6%	-38.8%	-40.9%	-46.7%
70-79	-23.5%	-27.6%	-26.9%	-30.8%	-34.4%	-44.0%
80+	+8.5%	+2.9%	-4.2%	-7.3%	-9.8%	-18.1%

https://theexpose.uk/2021/10/15/its-worse-than-we-thought-fully-covid-vaccinated-ade/

Public Health England numbers continuing to deteriorate month by month for the vaccinated

Representing September 06th through October 02nd 2021

COVID-19 vaccine surveillance report – week 40

Table 2. COVID-19 cases by vaccination status between week 36 and week 39 2021

Rates higher in all vaccinated age groups over 30

Cases reported by specimen date between week 36 and week 39 2021	Total	Unlinked*	Not vaccinated	Received one dose (1-20 days before specimen date)	Received one dose, ≥21 days before specimen date	Second dose ≥14 days before specimen date	Rates among persons vaccinated with 2 doses (per 100,000)	Rates among persons not vaccinated (per 100,000)
Under 18	305,428	20,967	272,981	4,973	5,898	609	278.8	2,325.7
18-29	67,820	8,556	23,440	1,119	12,593	22,112	409.6	688.1
30-39	81,532	7,534	21,449	690	7,468	44,391	763.6	738.4
40-49	101,094	6,839	11,662	297	3,653	78,643	1,281.8	690.2
50-59	70,731	4,668	5,144	89	1,464	59,366	839.5	502.5
60-69	36,953	2,585	1,798	26	546	31,998	563.1	332.9
70-79	22,142	1,367	693	6	207	19,869	428.9	281.4
80+	10,581	869	403	4	199	9,106	354.4	319.5

I've been reporting on this in previous newsletters since June. Every month the numbers continue to be skewed higher in the vaccinated group.

Scroll to next page…

And this is the latest report, ***Public Health England's*** Technical Briefing week number 43, looking at the emergency room visits resulting in person being admitted.

Table 3. COVID-19 cases presenting to emergency care (within 28 days of a positive specimen) resulting in an overnight inpatient admission by vaccination status between week 39 and week 42 2021

Cases presenting to emergency care (within 28 days of a positive test) resulting in overnight inpatient admission, by specimen date between week 39 and week 42 2021	Total	Unlinked*	Not vaccinated	Received one dose (1-20 days before specimen date)	Received one dose, ≥21 days before specimen date	Second dose ≥14 days before specimen date[1]
Under 18	633	17	592	12	11	1
18-29	324	8	212	2	28	74
30-39	708	10	446	2	47	203
40-49	991	14	495	5	40	437
50-59	1,139	13	447	1	46	632
60-69	1,177	12	288	3	33	841
70-79	1,642	1	195	3	34	1,409
≥80	1,724	2	157	0	38	1,527

And the death rates in the vaccinated and the unvaccinated. Shocking, especially for those over 60 years of age.

Death within 60 days of positive COVID-19 test by date of death between week 39 and week 42 2021	Total**	Unlinked*	Not vaccinated	Received one dose (1-20 days before specimen date)	Received one dose, ≥21 days before specimen date	Second dose ≥14 days before specimen date[1]
Under 18	5	0	4	1	0	0
18-29	19	1	11	0	0	7
30-39	42	1	27	0	2	12
40-49	100	3	55	0	6	36
50-59	224	3	100	0	9	112
60-69	490	4	143	0	23	320
70-79	904	4	121	0	27	752
≥80	1,717	5	167	0	53	1,492

Israeli hospital outbreak, with 39 of 41 people being fully vaccinated and highly masked

A study titled, **Nosocomial outbreak caused by the SARS-CoV-2 Delta variant in a highly vaccinated population, Israel, July 2021**, shows just how much vaccines and masking are failing.

It describes a SARS-CoV-2 outbreak among 42 patients in a hospital setting of which “39 were fully vaccinated,” the “index case was … fully vaccinated,” “all transmission between patients and staff occurred between masked and vaccinated individuals, as experienced in an outbreak from Finland,” and that this “outbreak exemplifies the high transmissibility of the SARS-CoV-2 Delta variant among twice vaccinated and masked individuals.”

The abstract

A nosocomial outbreak of SARS-CoV-2 Delta variant infected 42 patients, staff and family members; 39 were fully vaccinated. The attack rate was 10.6% (16/151) among exposed staff and reached 23.7% (23/97) among exposed patients in a highly vaccinated population, 16–26 weeks after vaccination (median: 25 weeks). All cases were linked and traced to one patient. Several transmissions occurred between individuals wearing face masks. Fourteen of 23 patients became severely sick or died, raising a question about possible waning immunity.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8485578/

Why is the virus evading the vaccines so rapidly and efficiently?

An October 25th 2021 article published in ***Nature Cellular and Molecular Immunology*** titled, **The spike protein of SARS-CoV-2 variant A.30 is heavily mutated and evades vaccine induced antibodies with high efficiency**, does a good job of explaining why the vaccines are failing so miserably.

***Note:** ChAdOx1 nCoV-19 is the AstraZeneca/Oxford vaccine. BNT162b2 is the Pfizer vaccine.

From the article

Compared to the S protein of SARS-CoV-2 B.1, which circulated in the early phase of the pandemic, the S protein of the A.30 variant contains 10 amino acid substitutions and five deletions. All deletions along with four substitutions are found in the N-terminal domain of the surface unit S1, which harbors an antigenic supersite that is targeted by most neutralizing antibodies not directed against the receptor-binding domain (RBD). In addition, three mutations are located inside the RBD, which binds to the cellular receptor ACE2 and constitutes the main target of neutralizing antibodies. Two of these mutations, T478R and E484K, are located close to the ACE2 binding site, and E484K is known to reduce susceptibility to antibody-mediated neutralization. Finally, two mutations are located close to the S1/S2 cleavage site, and one mutation is found in the transmembrane unit S2, which facilitates fusion of the viral envelope with cellular membranes.

In summary, A.30 exhibits a cell line preference not observed for other viral variants and efficiently evades neutralization by antibodies elicited by ChAdOx1 nCoV-19 or BNT162b2 vaccination. SARS-CoV-2 entry into cell lines depends on S protein activation by the cellular proteases cathepsin L or TMPRSS2, and activation by the latter is thought to support viral spread in the lung.

Collectively, our results suggest that the SARS-CoV-2 variant A.30 can evade control by vaccine-induced antibodies and might show an increased capacity to enter cells in a cathepsin L-dependent manner, which might particularly aid in the extrapulmonary spread. As a consequence, the potential spread of the A.30 variant warrants close monitoring and rapid installment of countermeasures.
https://www.nature.com/articles/s41423-021-00779-5

Breakthrough infections transmit as efficiently as unvaccinated infections

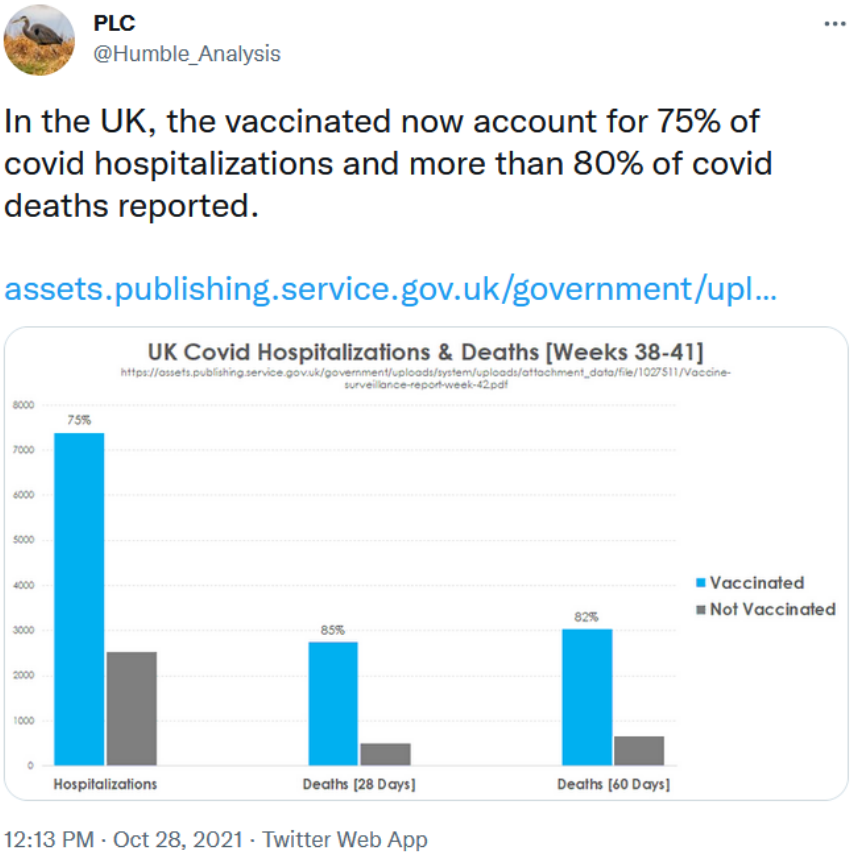
An article posted on a ***medRxiv preprint*** August 25th, 2021, titled, **Predominance of antibody-resistant SARS-CoV-2 variants in vaccine breakthrough cases from the San Francisco Bay Area, California**,

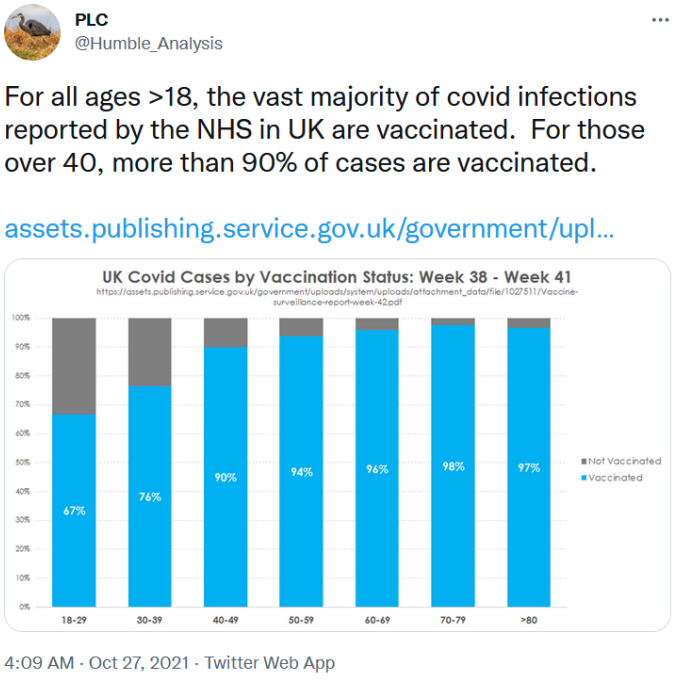
The abstract

Associations between vaccine breakthrough cases and infection by SARS coronavirus 2 (SARS-CoV-2) variants have remained largely unexplored. Here we analyzed SARS-CoV-2 whole-genome sequences and viral loads from 1,373 persons with COVID-19 from the San Francisco Bay Area from February 1 to June 30, 2021, of which 125 (9.1%) were vaccine breakthrough infections. **Fully vaccinated were more likely than unvaccinated persons to be infected by variants carrying mutations associated with decreased antibody neutralization (L452R, L452Q, E484K, and/or F490S) (78% versus 48%, p = 1.96e-08), but not by those associated with increased infectivity (L452R and/or N501Y) (85% versus 77%, p = 0.092)**. **Differences in viral loads were non-significant between unvaccinated and fully vaccinated persons overall (p = 0.99) and according to lineage (p = 0.09 – 0.78). Viral loads were significantly higher in symptomatic as compared to asymptomatic vaccine breakthrough cases (p < 0.0001), and symptomatic vaccine breakthrough infections had similar viral loads to unvaccinated infections (p = 0.64)**. In 5 cases with available longitudinal samples for serologic analyses, vaccine breakthrough infections were found to be associated with low or undetectable neutralizing antibody levels attributable to immunocompromised state or infection by an antibody-resistant lineage. **These findings suggest that vaccine breakthrough cases are preferentially caused by circulating antibody-resistant SARS-CoV-2 variants, and that symptomatic breakthrough infections may potentially transmit COVID-19 as efficiently as unvaccinated infections, regardless of the infecting lineage.**

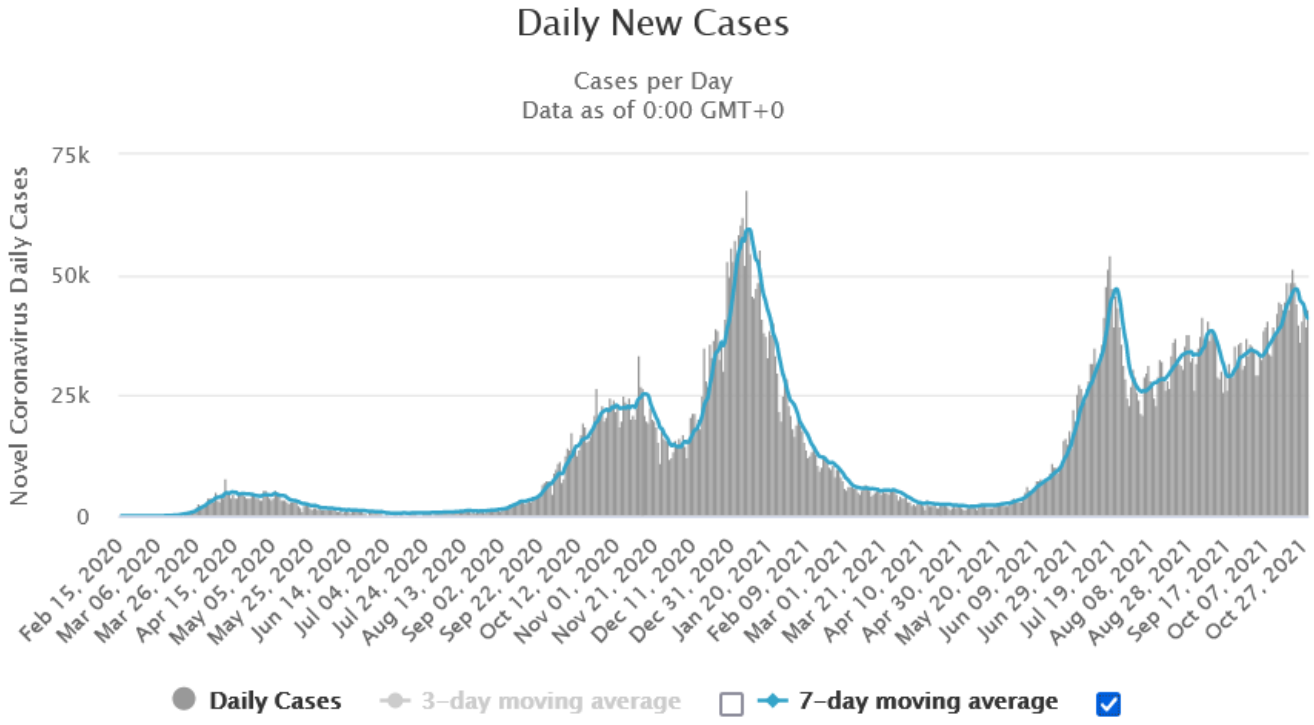
My comment: To me this clearly says that vaccinated individuals have no advantage when it comes to protection against infection, level of viral load and therefore also transmissibility. Not only that, but vaccinated persons were more likely (78% vs. 48%) to be infected by variants containing mutations. Well, this makes perfect sense, because the virus even though it is not an intelligent organism (if it is actually an organism- See my article of the month), microbes have learned how to evolve to survive over millennia. And this virus has learned how to beat the vaccine induced antibody production. That's what organisms do. A perfect example is with antibiotic resistant bacteria. This is a health crisis around the world because of the indiscriminate use of antibiotics unnecessarily or inappropriately. In the United States alone, there are over 100,000 people who die due to hospital acquired antibiotic resistant infections.

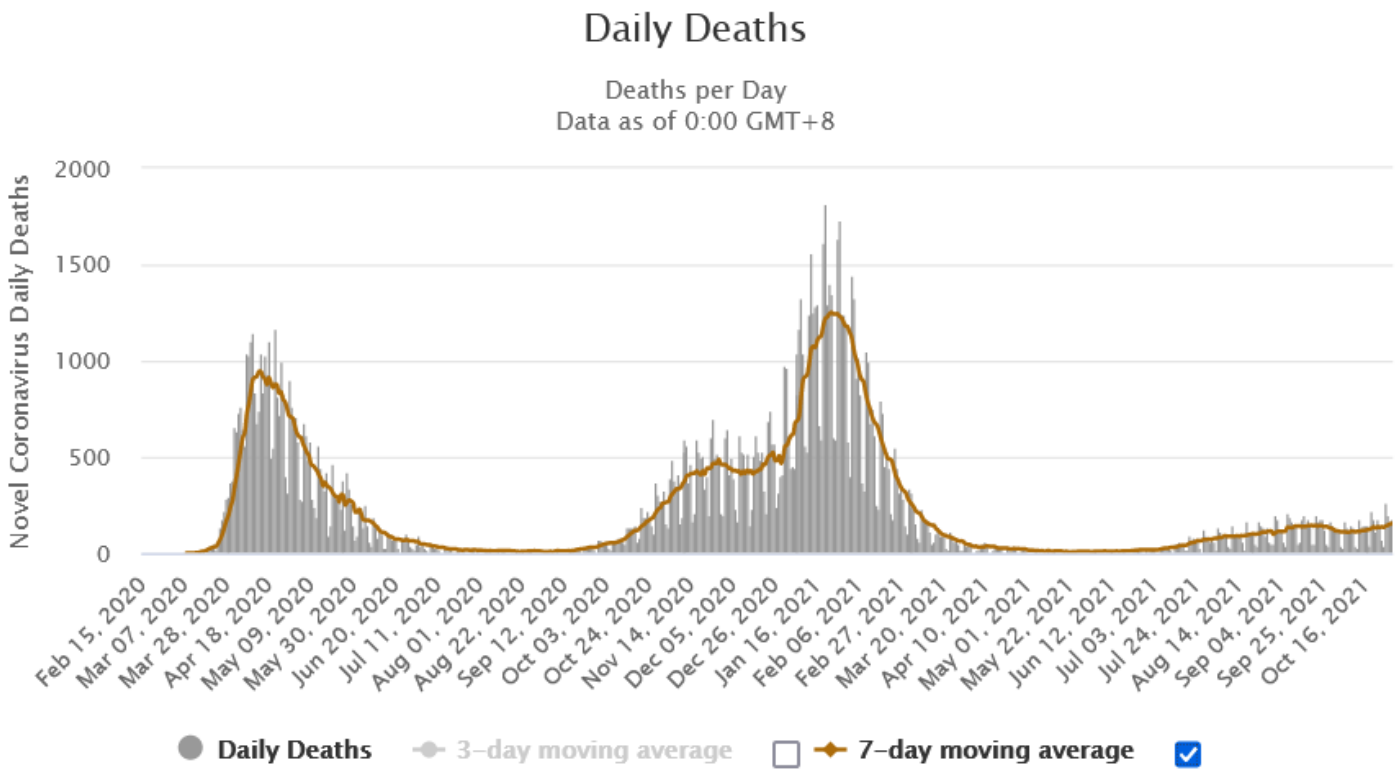
The U.K. continues its downhill slide for the vaccinated





Daily New Cases in the United Kingdom



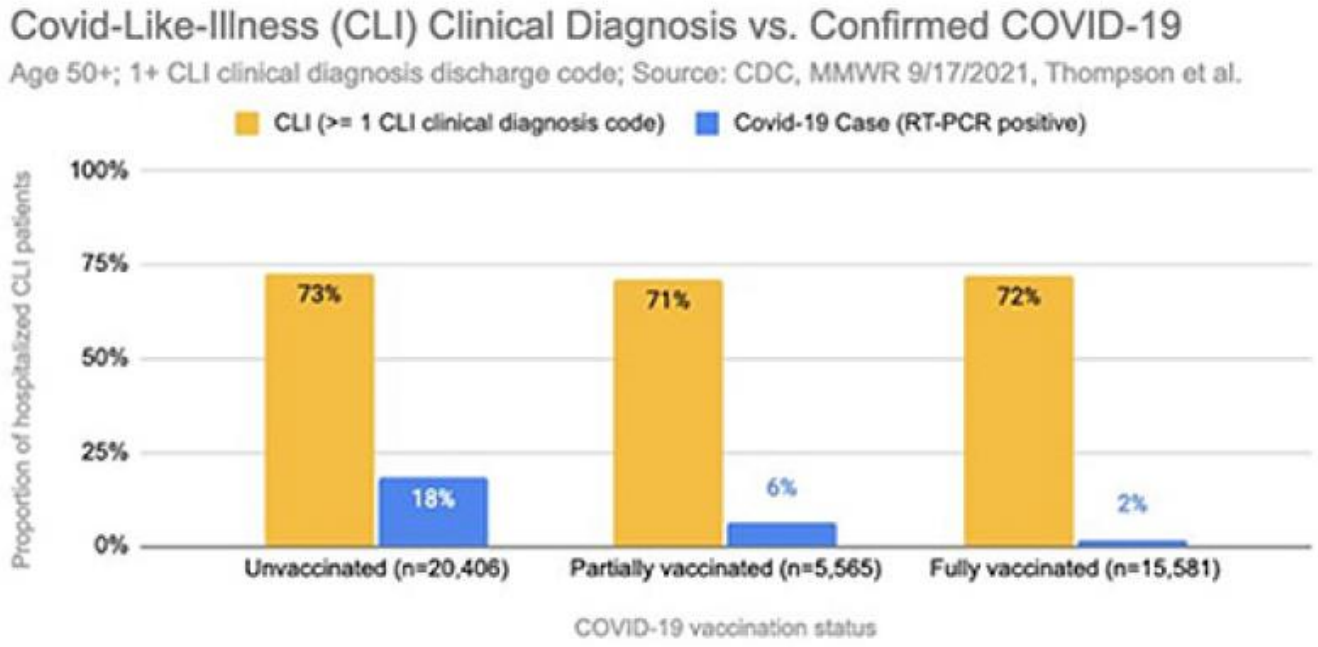


More statistics on the failure of the vaccines

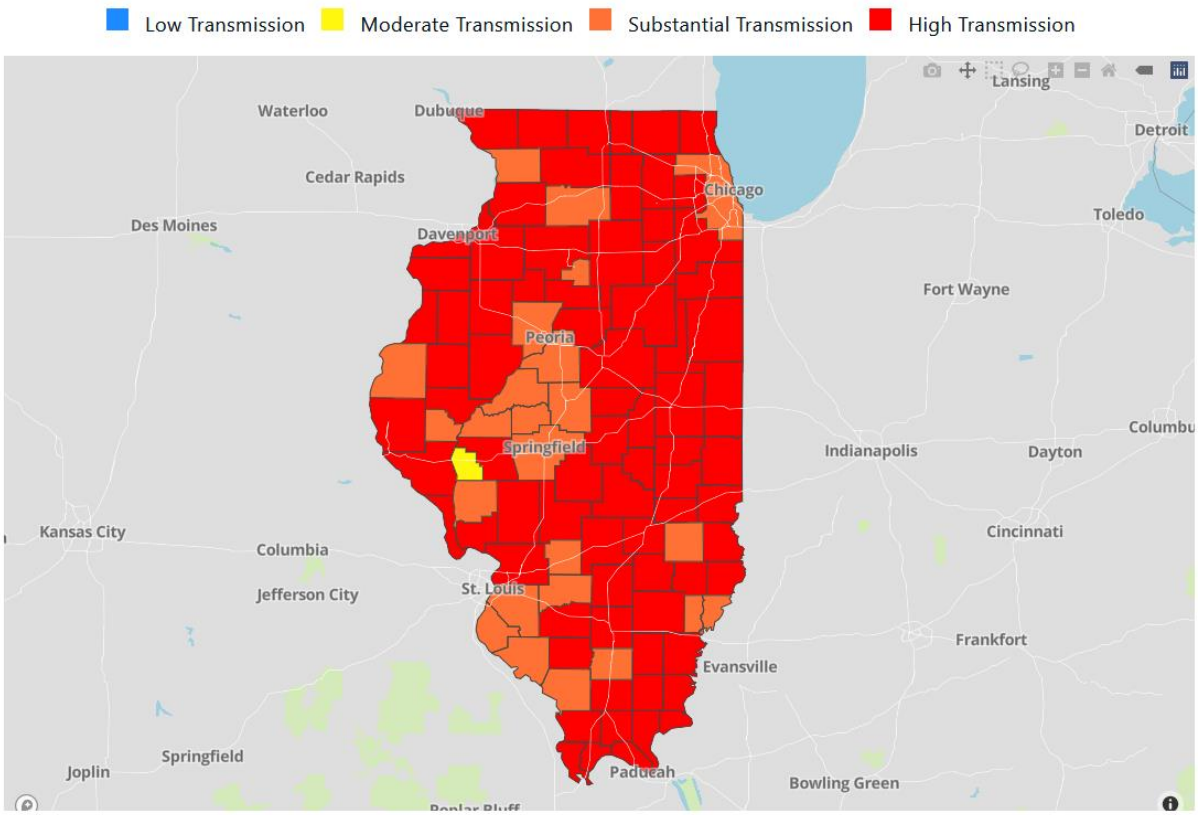
An article published by ***Dr. Mercola*** titled, **Are the COVID Shots Working?**, highlights some lowlights of the statistics comparing case numbers and degree of illness of vaccinated vs. unvaccinated individuals.

STORY AT-A-GLANCE

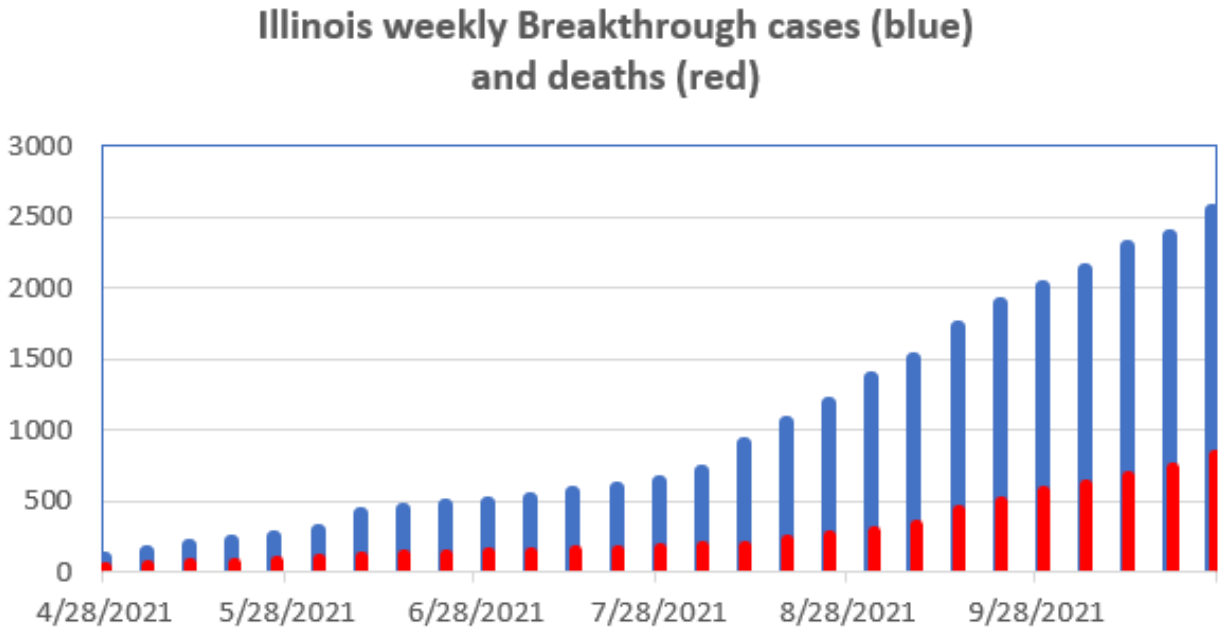
- A recent report details a SARS-CoV-2 Delta outbreak in an Israeli hospital where 238 out of 248 (96%) of the exposed patients and staff had been fully vaccinated with Pfizer's mRNA vaccine
- Of the 238 fully vaccinated individuals, 39 (16%) were infected, as were three of the 10unvaccinated individuals who got exposed
- While all of the sickened staff recovered, five infected patients died and nine turned into severe or critical cases. All of the dead and severe/critical cases were fully vaccinated. Two unvaccinated patients that got infected only had mild illness
- This outbreak tells us that the COVID shots cannot create herd immunity. It also suggests vaccinated people may be more prone to serious and lethal infection than the unvaccinated
- Of 41,552 hospitalized patients in the U.S., 73% of the unvaccinated, 71% of the partially vaccinated and 72% of the fully vaccinated received a diagnosis of COVID-like illness (CLI) between January 1, 2021, and June 22, 2021



The state of Illinois is 68% fully vaccinated, but transmission rates are high across the state



Data from this map is provided by the Centers for Disease control **data source is available here**. Data Last Updated 10/28/2021



Illinois reported that 77% of the deaths the week of October 20th were fully vaccinated (91 out of 117).
https://dph.illinois.gov/covid19/vaccine/vaccine-breakthrough.html

Waterford Ireland has the highest vaccination rate in the country and also an out-of-control COVID-19 surge

An article titled, **Covid is surging in Waterford, Ireland where 99.7 percent of adults are Fully Vaccinated** appeared in ***Citizen Free Press*** October 17th, 2021.

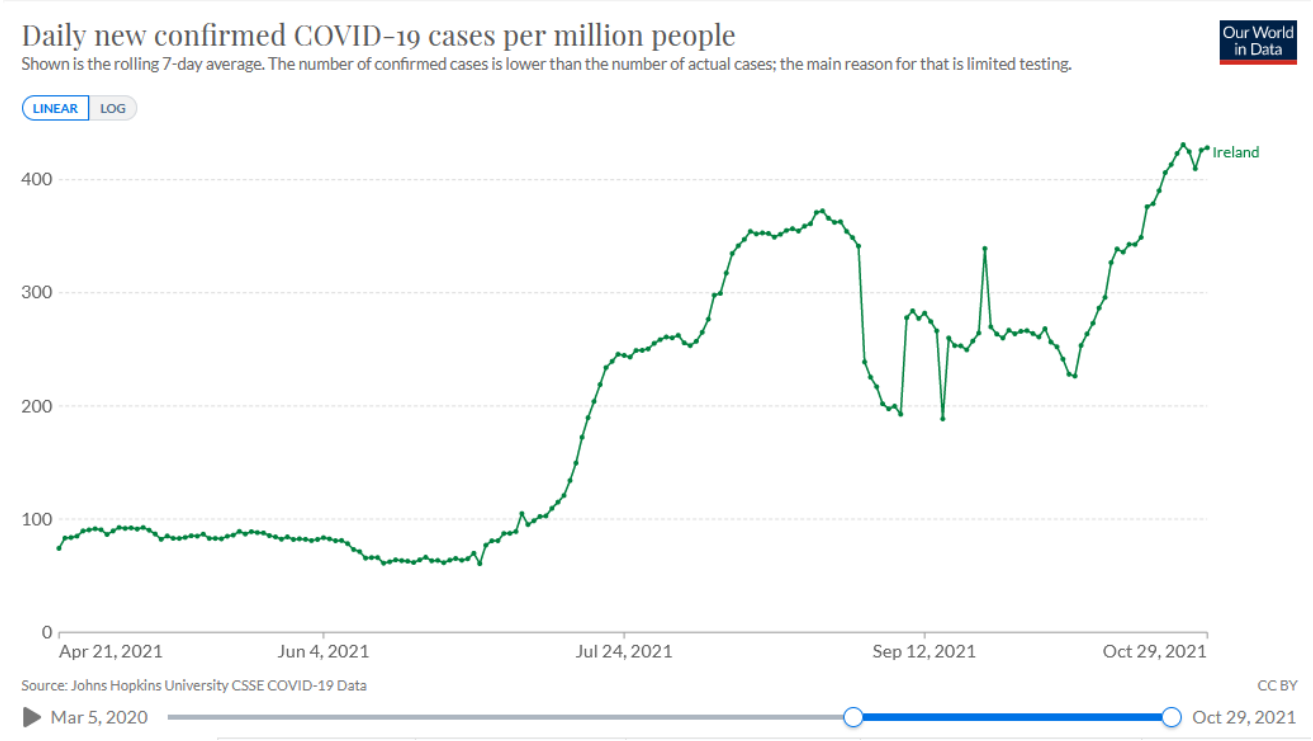
From the article
Waterford, once the crown jewel of Ireland's Vaccination program, now has the highest rate of infection in the country. For the first time since March, the number of patients in hospital with Covid in Ireland is over 400. This in a country where 92% of adults have been Vaccinated against the CCP Virus.

It's worse for County Waterford where almost every single person over the age of 18 has been double jabbed and yet case numbers are surging with more than 700 new cases documented in the last 2 weeks.

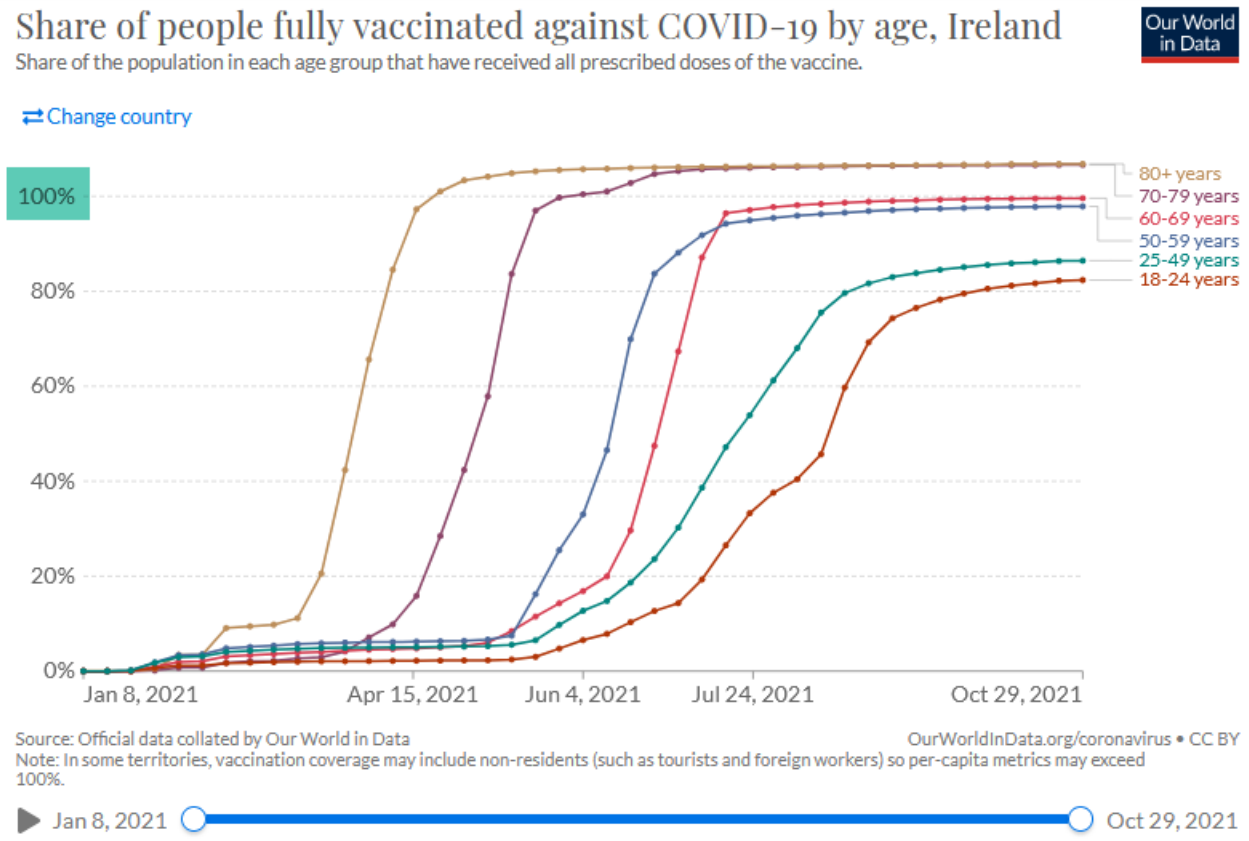
The number of vaccinated patients in ICU now is almost as high as the entire number of Covid patients in ICU a year ago. HSE chief clinical officer Dr Colm Henry admitted the figures were "higher than we would like" but added they would be even higher but for the impact of vaccination.

https://citizenfreepress.com/column-3/covid-is-surging-in-waterford-ireland-where-99-7-percent-are-double-vaccinated/

Daily cases on the rise in Ireland next page…

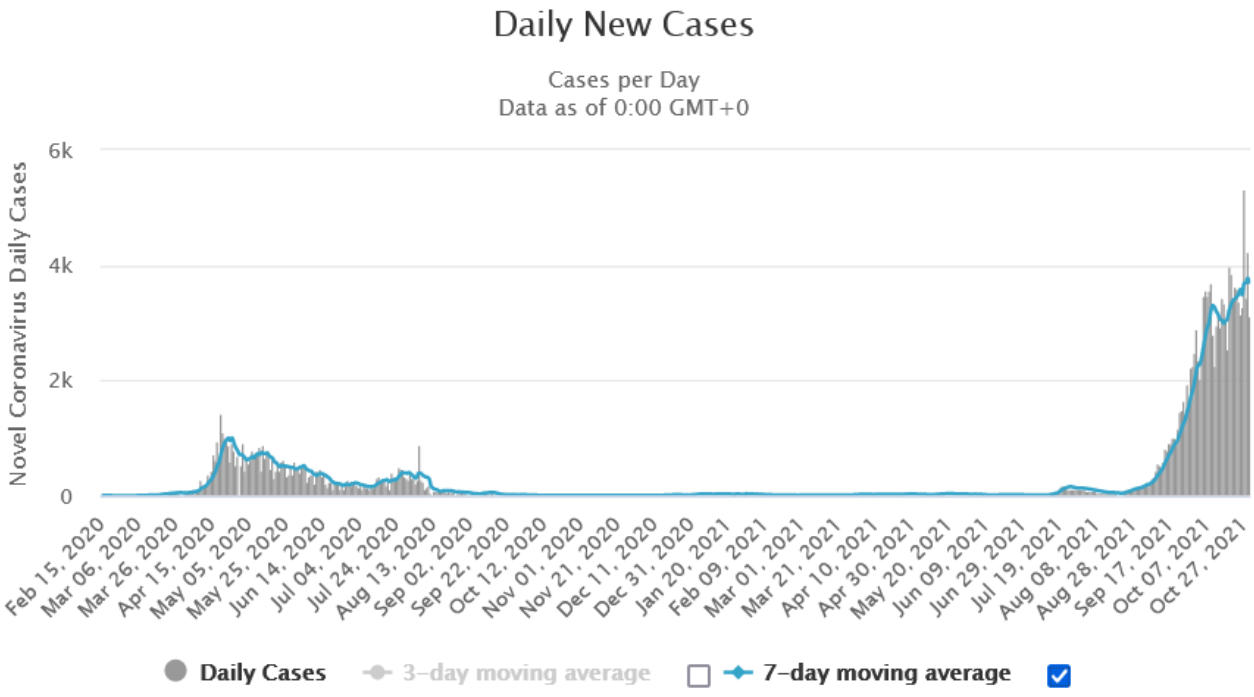


Yet nearly 100% of the population over the age of 50 are vaccinated

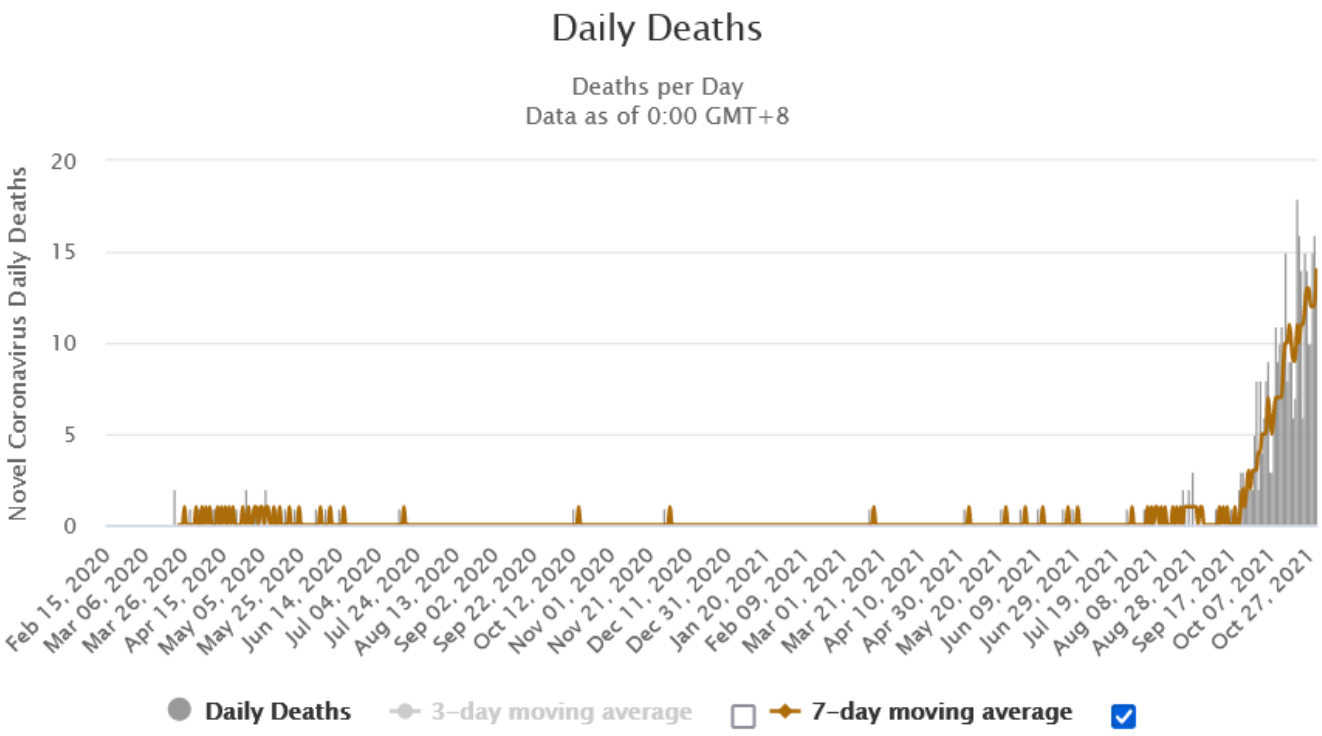


Singapore, a country then has fully vaccinated 80% of their population is experiencing soaring case rates

Daily New Cases in Singapore



Daily New Deaths in Singapore



Despite the tidal wave of evidence against the safety and effectiveness of the COVID-19 shots, the FDA plan to move forward with full approval of 5-11 year-olds. Here are 10 reasons why that is a terrible idea.

In an article published in ***The Defender*** on the ***Children's Health defense*** website by Toby Rogers, ten very good reasons are laid out as to why approving these "vaccines" for children would be a terrible idea. (And I could think of at least 10 more, many of which I have laid out in my free download about the risk of COVID to children versus the risks of the vaccines. You can download that **HERE**.

From the article- I'm just giving you a teaser here, only the 10 reasons without the details. But the devil's in the details as they say. I highly recommend reading the whole excellent article.

1. COVID-19 rates in children ages 5 to 11 are so low that there were ZERO cases of severe COVID-19 and ZERO cases of death from COVID in either the treatment (n= 1,518) or control group (n= 750).
2. Pfizer's clinical trial in kids was intentionally undersized to hide harm.
3. Pfizer only enrolled 'participants 5-11 years of age without evidence of prior SARS-CoV-2 infection.'
4. **Did Pfizer LOSE CONTACT with 4.9% of their clinical trial participants?**
5. **The follow-up period was intentionally too short.**

6. **The risk-benefit model created by the FDA only looks at one known harm from the Pfizer mRNA shot — myocarditis.**
7. **Pfizer intentionally wipes out the control group as soon as they can by vaccinating all of the kids who initially got the placebo.**
8. **Given all of the above, how on earth did the FDA claim any benefits at all from this shot?**
9. **The FDA model only assesses the benefits of vaccine protection in a six-month period after the completion of two doses**.
10. **The FDA/Pfizer play fast and loose with their estimates of myocarditis**.

https://childrenshealthdefense.org/defender/fda-risk-benefit-analysis-pfizer-children-covid-vaccine/

Guidance for obtaining religious exemptions

Here is an example of an email that I have been sending people that are wanting to apply for a religious exemption. I'm not presenting this the be all/end all, but I'm hoping that it can give some ideas and guidance in the process.

I think that it is to a person's advantage if they don't belong to a particular denomination like the Catholic Church or the episcopalian church, etc., unless they have come out against the COVID-19 vaccines. That is because many of those official church denominations have come out in support of vaccines in the past and in some cases this vaccine in particular, stating that it does not violate their religious "code" or church doctrine, or because the vaccine is for "the greater good". That is unfortunate because that is really going to work against people of those faiths and denominations who stand on Biblical principles and have a sincerely held religious belief that it would be wrong for them to violate. This is especially egregious because of the use of aborted fetal tissue in the manufacture and production of many vaccines including these COVID-19 gene therapy products. Depending on the fetal cell line, dozens of babies were sacrificed to find the perfect match to use tissue from their organs that can be grown in perpetuity and used in the production of vaccines. Even more tragically the vaccines that use fetal cell lines could be produced using other methodology in animal tissues. But much more on that in a minute.

I've heard some commentators and even attorneys on podcasts say that you don't need to even tell them what's your religion is. They say that you can just say that "it's between me and God", and that they cannot ask you or confront you about that, because that would be subjecting you to a religious test which goes against the Bill of Rights. However, if you defend yourself using your constitutional position, it is possible that it may lead to a more confrontational issue with an employer. Unfortunately, it would be difficult to predict if one would get that pushback and each employee should measure that themselves based on their own personal knowledge of the makeup of and history with management or administration. If you know someone that has been successful in their religious exemption appeal, it may be helpful to ask them what position they took and how they constructed it.

Unfortunately, there just doesn't seem to be 100% clear cut consensus on how to approach this issue. These principles may apply for many different religions, but because I am not familiar with the core beliefs of any other than Christianity, I will comment on what I know and believe. For a person that is a non-denominational Christ follower or lives their life on the basis of Scripture as their final authority on all matters of conscience and morality, I would take the approach that you must hold to your firmly held religious beliefs. And then if they push for an explanation further, I recommend that you say that you view your body as the ***Temple of the Holy Spirit*** (as Scripture clearly states in 1 Cor 6:19), and taking the shot would defile it. That may induce questions from them like, do you take other vaccines? Or what is it about these vaccines that you oppose as compared to other vaccines you have taken in the past? You may then have to argue the use of aborted fetal tissue in the development and production of the vaccines. If you have taken other vaccines that may have contained components grown in fetal tissue in the past, but was unaware of that fact, you could then also say that you were not aware that other vaccines taken in the past used aborted babies and contained their DNA in those shots. Further, knowing that now, I am in complete objection to having them injected into my body because it would violate my sincerely held religious beliefs.

More on fetal Cell lines used in the making of the vaccines

There is an obvious moral dilemma for people of faith that don't support the use of abortion to produce medical products or having them injected into their bodies. Importantly and of additional concern is that when vaccines are produced by growing the virus or bacteria in aborted fetal tissue, there are DNA strands that make it through in the manufacturing process. There are in fact hundreds of thousands of DNA fragments that are allowed by the FDA in every dose. So, that human DNA is injected into your body and potentially may combine with your own DNA in a process called homologous recombination. There is a scientist named Theresa Deisher that has done extensive research and writing about this. I have a section of my eBook ***1200 Studies- Truth Will Prevail*** on this found on https://wellnessdoc.com . I know that's probably too much information, but for making decisions about other vaccines for children or yourself that would definitely be a consideration.

A couple points that might clarify the objection to the use of aborted fetal cells. Pfizer and Moderna did not use the HEK293 fetal cells in production, but did in the research, testing and development phase. J & J used the PER.C6 in the production. Therefore, you would have to say that your sincerely held religious beliefs would prohibit using any product that used an aborted baby in any phase of the making of the product. **ALTHOUGH…**The second week of October ***Project Veritas*** came out with a video showing emails from top officials at Pfizer talking about the use of fetal tissue in their vaccines and their desire to cover it up from the public. https://www.projectveritas.com/news/pfizer-leaks-whistleblower-goes-on-record-reveals-internal-emails-from-chief/

The source for the information below is ***Children of God for Life***. It is a great website on this topic, and I've used it as a source for many of my articles in the past. https://cogforlife.org/

Moderna

Fetal cell line: The **HEK293** cell line (info here) originated from a healthy aborted child in the 1970s, age unknown.

Did Moderna use the HEK293 fetal cell line in research? Yes, they did in the research and development of the vaccine.

- In March 2020, researchers explained in *Science* journal that they expressed the 2019-nCoV spike in the prefusion conformation using HEK293 cells. That means they made the spike protein so they could study it, and they used HEK293 cells as the medium to express it in.
- In this preliminary report from July 2020, researchers explain in the supplementary appendix that ACE-2-overexpressing 293T cells were used in a neutralization assay to detect the presence of antibodies, a test to make sure the vaccine works as it should.
- This August 2020 preclinical trial report in *Nature* journal also explains that researchers transfected HEK293 cells to test expression. That means they added the vaccine in each step of development to the cells to see if they produced the protein as expected. This is the *in vitro* (in the lab) mRNA expression test.
- This U.S. patent for the *in vivo* (in the body) production of proteins explains a similar test, including testing the mRNA encapsulated in the lipid for delivery into the body. Again, they needed to see if the vaccine was stable and worked as expected.

Pfizer

Fetal cell line: The **HEK293** cell line (info here) originated from a healthy aborted child in the 1970s, age unknown.

Did Pfizer/BioNTech use the HEK293 fetal cell line in research? Yes, they did in the research and development of the vaccine, similar to the way Moderna (above) did. They used the HEK293 cell line for testing the vaccine. And as mentioned above, the Project Veritas video seem to reveal that they may also have been used in the manufacturing process as a result of their scheming to prevent the public from finding out how these fetal cell lines were used.

- In September 2020, researchers explained that they used HEK293 in a neutralization assay to detect the presence of antibodies, a test to make sure the vaccine works as it should, and they transfected HEK293 cells to test expression. That means they added the vaccine in each step of development to the cells to see if they produced the protein as expected. This is the *in vitro* (in the lab) mRNA expression test.
- This U.S. patent describes how they made RNA molecules encoding fusion proteins (like the spike protein) and tested them in development. They used a variety of cell lines, HEK293 among them, but do not specifify which cell line they used for the COVID-19 vaccine. Again, they needed to see if the vaccine was stable and worked as expected.

J & J

Fetal cell line: AdVac® technology uses **PER.C6®** cell line (info here) originating from a healthy 18-week-old aborted child.

Did Johnson & Johnson use the PER.C6 fetal cell line in research and production? Yes, they did in the research and development of the vaccine, as explained in this scientific report from July 2020 in *Nature* journal and in this scientific report from September 2020 also in *Nature* journal. To propagate the virus in the PER.C6 cells means to grow it in them. They will need to do this in ongoing manufacturing.

Another consideration is ***Title VII of the Civil Rights Act of 1964***. This comes into play in employment discrimination. Title VII makes it unlawful for public or private employers, employment agencies, licensing agencies, and unions to refuse to hire, to fire, or otherwise discriminate against any individual in compensation or the terms or conditions of his/her employment based on certain protected classes. It further prohibits harassment in the workplace based on those same protected classes.
Under Title VII, employment discrimination or harassment based on any of the following protected categories is unlawful:

- Color
- **Creed/Religion**
- Gender (Sex)
- National Origin
- Pregnancy (included in Sex Discrimination)
- Race

How did we even get to this ridiculous point of absurdity?

This whole scenario should never have come to this point for anybody, because nobody should ever be forced to take a medicine or medical product that they don't feel they want or need. Also, the infection survival rate for people under age 60 is 99.73%. The infection survival rate for people under the age of 30 is 99.986%. And for children and teens under the age of 20, the survival rate is 99.9973%. Individuals should be allowed to do their own risk reward stratification. And based upon their level of health and age, they should be able to do a calculation as to whether the risk of the side effects from the vaccines is worth the benefit for them. Besides that, the vaccines are failing on such a massive scale in countries that are slightly ahead of us on their vaccination programs, signifying that it will only continue to get worse here in the U.S. The Pfizer vaccine has been found to only be 39% effective in Israel according to data as August 2021 and has continued to decline since then. That is in part because of the waning of the antibodies, but also the variants like Delta are defeating the vaccine by mutating along points of the spike protein, which is the only thing that vaccinated people's antibodies are trained to identify. And moreover, the antibodies produced from the vaccines are trained to identify the spike from the original virus. Now, because of the mutations in these variants especially along the spike protein changing its configuration, the antibodies are becoming increasingly ineffective.

In addition, immunity for people who have recovered from the infection is so much more durable and robust than what the vaccines have been shown to provide. The immune system recognizes the totality of the virus, which is 29 different protein sequences rather than just the one protein sequence of the spike protein. It's literally criminal that the CDC is not recognizing that scientific fact showing the long-term and effectiveness of natural immunity (no longer disputable with nearly 3 dozen studies that I am aware of). And yet, the coercion of forcing people through the use of mandates they dictate by using businesses and entities to do their dirty work for them.

In addition:

This is a link to an article that has some great ideas and suggestions in it. The article also has some recommendations as to what you should and should not put on the form requesting the religious exemption. https://thenewamerican.com/covid-vaccine-mandates-if-i-dont-want-the-jab-what-are-my-options/. Remember, these are all only suggestions. Ultimately you have to decide what your particular employer is looking for and how best to address it.

The **Informed Consent Action Network (ICAN)**- Help with university exemptions
This link https://www.icandecide.org/covid-19-vaccine-exemptions/ will take you to information regarding religious and medical exemptions for select universities' COVID-19 vaccination requirements. The list was taken from the Siri & Glimstad LLP website. They cannot guarantee the accuracy of this information as this was last updated on June 23, 2021.

Also, ***America's Frontline Doctors*** has a whole legal team dedicated to medical freedom issues and especially surrounding the vaccine. You could probably find some good information there as well. https://americasfrontlinedoctors.org/ . I believe that they have some forms that you can use with your efforts with employers.

Do the adenovirus vaccines like J & J and AstraZeneca integrate into DNA of the person getting the shots?

A 2002 study published in ***Current Gene Therapy*** titled, **Adenovirus as an Integrating Vector** raises concerns about the effect they may have on the chromosomes of the recipient of the vaccine.

The Johnson and Johnson and the AstraZeneca-Oxford vaccines are adenovirus vector vaccines. They have taken an adenovirus and rendered it unable to replicate. They then splice the genetically modified spike protein from the SARS-CoV-2 virus into the adenovirus. The adenovirus gains access into the recipient's cells and then is replicated by the ribosomes (like little copy machines) inside the cell to be released, thus stimulating the immune system to create antibodies.

Abstract:
Recombinant adenoviral vectors have served as one of the most efficient gene delivery vehicles in vivo thus far. Multiply attenuated or completely gutless adenoviral vectors have been developed to achieve long-term gene expression in animal models by overcoming cellular immunity against de novo synthesized adenoviral proteins. However, since adenovirus lacks native integration machinery, the goal of gene therapy obtaining permanent expression cannot be realized with current adenoviral vector systems. **Recent studies have shown that replication-incompetent adenoviral vectors randomly integrate into host chromosomes at frequencies of 0.001-1% of infected cells.** To improve the integration frequencies of adenoviral vectors, a variety of hybrid vectors combining the highly efficient DNA delivery of adenovirus with the integrating machinery of retroviruses, adeno-associated viruses, and transposons, have been emerging. These hybrid vectors have shown promise, at least in in vitro systems. Furthermore, a denoviral vectors have shown potential as gene targeting vectors. These developments should eventually lead to more effective gene therapy vectors that can transduce a myriad of cell types stably in vivo.

https://pubmed.ncbi.nlm.nih.gov/12109211/

This study was from 2002. What I don't know is if they have fixed that glitch prior to the development of the most recent adenovirus virus vector vaccines.

There is a lack of correlation between percentage of population vaccinated and rates of COVID-19 across a broad swath of countries

This table is from a ***Dr. Mercola*** article titled, **Ivermectin vs. Merck's New Antiviral, Molnupiravir**

While the table does not have anything to do with the two medications, I thought it was a stark example of the lack of correlation between percentage of the population vaccinated and the percentage of the population that have had cases of COVID-19.

From the article
And yet, data show that the number of confirmed cases of COVID in countries where much of the population is unvaccinated is not higher than in countries where nearly100% have been given the jab. For example, as of October 13, 2021, according to the CNN COVID-19 vaccination tracker and the Johns Hopkins Coronavirus Resource Center

Country	Vaccination Rate	Infections	Population	% Population Infected
Portugal	86.4%	1,075,639	10,196,709	10.5%
United Arab Emirates	84.3%	737,890	9,890,402	7.4%
Spain	79%	4,977,448	46,754,778	10.6%
Ireland	74.6%	404,514	4,937,786	8.1%

United States	55.8%	44,455,949	331,002,651	13.4%
Russia	39.9%	7,687,559	145,934,462	5.2%
Romania	29%	1,365,788	19,237,691	7%
Indonesia	21.1%	4,228,552	273,523,615	1.5%
India	19.6%	33,985,920	1,380,004,385	2.4%
Vietnam	16.4%	843,281	97,338,579	0.86%
Bangladesh	11.1%	1,562,958	164,689,383	0.9%

Since this data was derived from Dr. Mercola's article comparing Ivermectin and Molnupiravir, I thought I would include the key takeaways that Dr. Mercola led that article with: ***(Emphasis mine)***

- One paper compared Merck's data on molnupiravir against peer-reviewed data on ivermectin and found ivermectin has a low side effect profile, costs less than molnupiravir and is more effective against SARS-CoV-2. ***(Ivermectin costs between $30 and $60 for a treatment series, whereas molnupiravir costs just over $700).***

- Clinical Trials data show Merck gathered 1,850 participants but released data on only762 in the non-hospitalized arm of the study. The study with hospitalized patients anticipated 1,300 participants, but enrolled 304 before terminating for "business reasons" ***(One can only imagine what "business reasons" is actually code for).***

- Merck has applied for emergency use authorization for molnupiravir against COVID-19. Some are excited about an antiviral that may be effective against the virus, but the exclusion criteria for participants in the study may mean few will qualify to take the drug. ***(Once again, an example of drug companies using certain exclusion criteria In their trials, such as accepting only extremely healthy people for a study that will determine whether a drug may be used in a population consisting of a high percentage of sick people, many with multiple comorbidities and many that are very elderly. But why should that be a surprise?).***

Doctor Mercola has come under so much fire and threats from our government, that he has conceded to delete his articles 48 hours after he posts them. Therefore, this article is no longer available on his website. Unfortunately, another victory for censorship and cancel culture.

Is the approval of Pfizer's vaccines a bait and switch, when the version that will not be available until sometime next year was the one FDA approved and the original one being used until then is still under EUA?

An article published on American Greatness titled, **Defense Department Pulls a Bait and Switch on Vaccines**

If a soldier goes to a military hospital or a private provider to receive an approved Pfizer COVID vaccine, he will be administered the unapproved Pfizer-BioNTech vaccine. Coerced, it's illegal.

Excerpts from the article

On August 24, Secretary of Defense Lloyd Austin issued a memo to senior Pentagon leadership announcing that he was implementing a mandatory COVID-19 vaccination policy for all military service members. The day before, the FDA had issued full authorization to Pfizer for their Comirnaty COVID-19 vaccine product (the nomenclature of which is meant to be a mashup of the words "COVID", "mRNA", and "community") . At first glance it would seem that the mandatory vaccination policy, while scientifically unsound and strategically foolish, was at least a policy being implemented according to both the letter of the directive and in accordance with the law. But a further examination of the facts and the manner in which this order is being implemented makes clear that the military's implementation of this order is illegal and highly unethical.

In the memo, Secretary Austin issued a directive and a promise, that "Mandatory vaccination against COVID-19 will only use COVID-19 vaccines that receive full licensure from the Food and Drug Administration (FDA), in accordance with FDA-approved labeling and guidance." The problem with this is that the Comirnaty vaccine product that was approved by the FDA is not available anywhere in the Military Health System. It is not even in production, according to the military's TRICARE healthcare providers. If a soldier goes to a military hospital or a private provider to receive an approved Pfizer COVID vaccine, he will be administered the unapproved Pfizer-BioNTech vaccine which is a vaccine that is not approved but has been administered under an Emergency Use Authorization (EUA). We are told that this is but a brand name difference, that the formulation is the same, and they can be used interchangeably. But as the FDA was approving the Comirnaty product, they were renewing the authorization for the Pfizer-BioNTech product. If it's just a matter of brand name, why issue an approval for one brand name and an EUA renewal for the other? This is because they are not actually the same.

According to the formulation comparison sheet, the Comirnaty vaccine product has a very different formulation than the Pfizer BioNTech product—on a per 30 µg dose basis for instance, it contains 25 percent more SARS-CoV-2 spike glycoprotein mRNA, 34 percent more polyethylene glycol, 1070 percent more potassium chloride, as well as an ingredient listed only as "Redacted Ingredient." That last item is alarming. Informed consent is required by both federal and international law under the Nuremberg Code. It is impossible to give informed consent to receive a medical ingredient that is shrouded in secrecy behind a *redacted* label.

There is a difference between Pfizer's BioNTech and Comirnaty products that may even be more profound: the legal one. According to the FDA's own vaccine fact sheet for the two Pfizer vaccines, "*The products are legally distinct . . .*". That legal distinction may mean that any service member who is coerced into taking the vaccine and suffers adverse effects—which is already happening, with case rates of vaccine-induced myocarditis soaring among service members—will have *no legal recourse* because the vaccine they took was only given Emergency Use Authorization, not full approval, which means that there is no legal liability whatsoever for Pfizer if and when vaccine injury occurs. Not only is the manufacturer not liable for damages

incurred, neither are governments or employers. And under the Public Readiness and Emergency Preparedness Act (PREP), their families would also be barred from legal recourse as well.

These facts were brought to my attention by a group of fighter pilots who are standing up to a corrupt military leadership who seek to impose a dangerous and unnecessary experimental gene therapy on them, taking no responsibility for their welfare or health care if and when this experimental therapy causes serious injury or death. They provided me with internal emails confirming that the FDA-approved Pfizer vaccine product is not available to anyone in the United States Military. From the director of a Military Treatment Facility:
Per the memo attached, On September 13, 2021, the National Library of Medicine within the National Institutes of Health (NIH), reported, '[a]t present, Pfizer does not plan to produce any product with these new [Comirnaty National Drug Codes] and labels over the next few months while EUA authorized product is still available and being made available for U.S. distribution.' Therefore, Pfizer has not made any Comirnaty. There is no expected date when we will receive Comirnaty.

Read the rest of the article here…. https://amgreatness.com/2021/10/19/defense-department-pulls-a-bait-and-switch-on-vaccines/

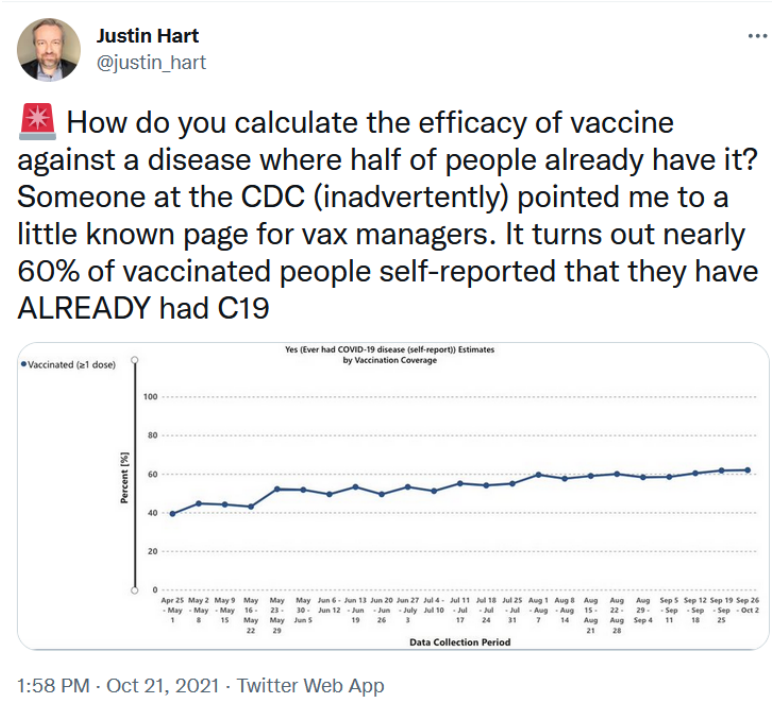
It appears that the spike protein toxin may circulate up to four months after injection with the mRNA shots

An October 15th 2021 article published in ***The Journal of Immunology*** titled, **Cutting edge: circulating exosomes with COVID spike protein are induced by BNT162b2 (Pfizer-BioNTech) vaccination prior to development of antibodies: a novel mechanism for immune activation by mRNA vaccines**, appears to reveal that the spike protein generated from the mRNA vaccines continue to circulate in the body far longer than the developers and many experts had believed.

The Abstract
Severe acute respiratory syndrome corona virus 2 (SARS-CoV-2) causes severe acute respiratory syndrome. mRNA vaccines directed at the SARS-CoV-2 spike protein resulted in development of Abs and protective immunity. To determine the mechanism, we analyzed the kinetics of induction of circulating exosomes with SARS-CoV-2 spike protein and Ab following vaccination of healthy individuals. Results demonstrated induction of circulating exosomes expressing spike protein on day 14 after vaccination followed by Abs 14 d after the second dose. Exosomes with spike protein, Abs to SARS-CoV-2 spike, and T cells secreting IFN-γ and TNF-α increased following the booster dose. Transmission electron microscopy of exosomes also demonstrated spike protein Ags on their surface. **Exosomes with spike protein and Abs decreased in parallel after four months.** These results demonstrate an important role of circulating exosomes with spike protein for effective immunization following mRNA-based vaccination. This is further documented by induction of humoral and cellular immune responses in mice immunized with exosomes carrying spike protein.
https://www.jimmunol.org/content/early/2021/10/11/jimmunol.2100637

Speaking of vaccine effectiveness, if greater than 60% of people who are vaccinated have already had COVID and have natural immunity isn't that going to make the vaccine look more effective than it really is?

Food for thought…



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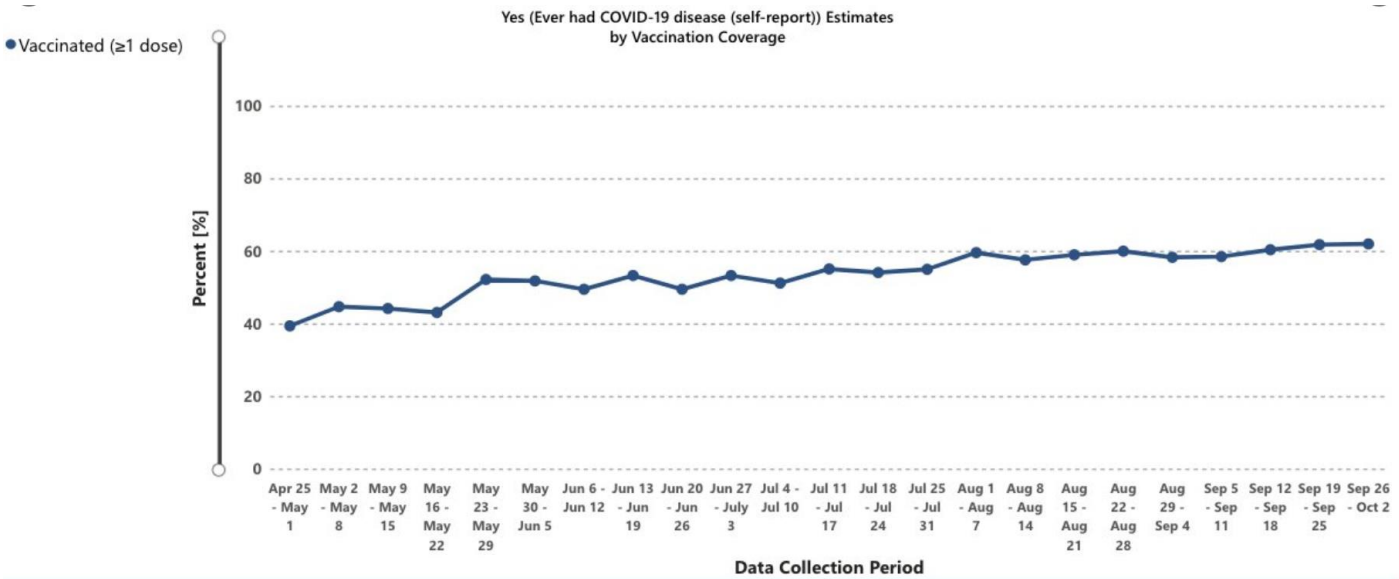


December 1st, 2021

Study concludes that mRNA vaccines cause inflammation of the endothelium and vascular changes that may explain the various types of cardiovascular complications after vaccination

An article published November 8th, 2021, in the ***American Heart Association Journal*** titled, **Abstract 10712: Mrna COVID Vaccines Dramatically Increase Endothelial Inflammatory Markers and ACS Risk as Measured by the PULS Cardiac Test: a Warning**, reveals just how common heart related problems can be after the mRNA COVID-19 vaccines**.** By Steven R Gundry. Dr. Gundry has reportedly published three hundred articles and registered several patents for medical devices. He was a Clinical Professor of Cardiothoracic Surgery at ***Loma Linda University School of Medicine***. He later started ***The International Heart & Lung Institute*** in Palm Springs, California.

Abstract- (emphasis mine)

Our group has been using the **PLUS Cardiac Test** (GD Biosciences, Inc, Irvine, CA) a clinically validated measurement of multiple protein biomarkers which **generates a score predicting the 5 yr risk (percentage chance) of a new Acute Coronary Syndrome (ACS).** The score is based on changes from the norm of multiple protein biomarkers including IL-16, a proinflammatory cytokine, soluble Fas, an inducer of apoptosis, and Hepatocyte Growth Factor (HGF) which serves as a marker for chemotaxis of T-cells into epithelium and cardiac tissue, among other markers. Elevation above the norm increases the PULS score, while decreases below the norm lowers the PULS score. The score has been measured every 3-6 months in our patient population for 8 years. Recently, with the advent of the mRNA COVID 19 vaccines (vac) by Moderna and Pfizer, dramatic changes in the PULS score became apparent in most patients. This report summarizes those results. **A total of 566 pts, aged 28 to 97, M:F ratio 1:1 seen in a preventive cardiology practice had a new PULS test drawn from 2 to 10 weeks following the 2nd COVID shot and was compared to the previous PULS score drawn 3 to 5 months previously pre- shot. Baseline IL-16 increased from 35=/-20 above the norm to 82 =/-75 above the norm post-vac; sFas increased from 22+/- 15 above the norm to 46=/-24 above the norm post-vac; HGF increased from 42+/-12 above the norm to 86+/-31 above the norm post-vac. These changes resulted in an increase of the PULS score from 11% 5 yr ACS risk to 25% 5 yr. ACS risk. At the time of this report, these changes persist for at least 2.5 months post second dose of vac. We conclude that the mRNA vacs dramatically increase inflammation on the endothelium and T cell infiltration of cardiac muscle and may account for the observations of increased thrombosis, cardiomyopathy, and other vascular events following vaccination.**

https://www.ahajournals.org/doi/abs/10.1161/circ.144.suppl_1.10712

Wow, this is astounding! This assessment predicts the 5-year risk of a new Acute Coronary Syndrome (ACS). To increase the risk from an average baseline of 11% to as much as 25% is a very significant risk. Let's read the last sentence of the abstract again.
"We conclude that the mRNA vacs dramatically increase inflammation on the endothelium and T cell infiltration of cardiac muscle and may account for the observations of increased thrombosis, cardiomyopathy, and other vascular events following vaccination."
The tsunami of thromboses, thrombocytopenia, myocarditis, pericarditis and heart related issues that we are already seeing may just be the tip of the iceberg of what's to come.

Study finds no need for children to be vaccinated against COVID-19 and shocking finds that at least 5 times as many people over 65 die from the vaccines than from COVID

A September 2021 article published in the journal ***Toxicology Reports*** titled, **Why are we vaccinating children against COVID-19?** is not only highly critical of the suggestion that children should be vaccinated against COVID-19, but it also suggests that at least 5 times more people over the age of 65 have died from the shots than from the disease itself (see my story in this issue on the country of Gibraltar as one example). The paper is also highly critical of the Pfizer clinical trials, pointing out various flaws, design deficiencies and erroneous findings. The paper has 127 references.

The abstract
This article examines issues related to COVID-19 inoculations for children. The bulk of the official COVID-19-attributed deaths per capita occur in the elderly with high comorbidities, and the COVID-19 attributed deaths per capita are negligible in children. The bulk of the normalized post-inoculation deaths also occur in the elderly with high comorbidities, while the normalized post-inoculation deaths are small, but not negligible, in children. Clinical trials for these inoculations were very short-term (a few months), had samples not representative of the total population, and for adolescents/children, had poor predictive power because of their small size. Further, the clinical trials did not address changes in biomarkers that could serve as early warning indicators of elevated predisposition to serious diseases. Most importantly, the clinical trials did not address long-term effects that, if serious, would be borne by children/adolescents for potentially decades. A novel *best-case scenario* cost-benefit analysis showed *very conservatively* that there are five times the number of deaths attributable to each inoculation vs those attributable to COVID-19 in the most vulnerable 65+ demographic. The risk of death from COVID-19 decreases drastically as age decreases, and the longer-term effects of the inoculations on lower age groups will increase their risk-benefit ratio, perhaps substantially.
The article is full of interesting and thoughtful analysis. I'm not sure that I would support every conclusion they make, but here are just a few of those…
A vaccine is legally defined as any substance designed to be administered to a human being for the prevention of one or more dis- eases [5]. For example, a January 2000 patent application that defined vaccines as "compositions or mixtures that when introduced into the circulatory system of an animal will evoke a

protective response to a pathogen." was rejected by the U.S. Patent Office because "The immune response produced by a vaccine must be more than merely some immune response but must be protective. As noted in the previous Office Action, the art recognizes the term "vaccine" to be a compound which prevents infection" [6]. In the remainder of this article, we use the term inoculated' rather than vaccinated, because the injected material in the present COVID-19 inoculations prevents neither viral infection nor transmission. Since its main function in practice appears to be symptom suppression, it is operationally a "treatment".

By the end of May 2021, the official CDC death count attributed to COVID-19 was approaching 600,000, as stated previously. This number has been disputed for many reasons. First, before COVID-19 testing began, or in the absence of testing, after it was available, the diagnosis of COVID-19 (in the USA) could be made by the presumption of the healthcare practitioner that COVID-19 existed [4,18]. Second, after testing began, the main diagnostic used was the RT-PCR test. This test was done at very high amplification cycles, ranging up to 45 [19–21]. In this range, very high numbers of false positives are possible [22]. Third, most deaths attributed to COVID-19 were elderly with high comorbidities [1,22]. As we showed in a previous study [22], attribution of death to one of many possible comorbidities or especially toxic exposures in combinations [23] is highly arbitrary and can be viewed as a political decision more than a medical decision. For over 5 % of these deaths, COVID-19 was the only cause mentioned on the death certificate. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death [24]. These deaths with comorbidities could equally have been ascribed to any of the comorbidities [22]. Thus, the actual number of COVID-19-based deaths in the USA may have been on the order of 35,000 or less, characteristic of a mild flu season.

Even the 35,000 deaths may be an overestimate. Comorbidities were based on the clinical definition of specific diseases, using threshold biomarker levels and relevant symptoms for the disease(s) of interest [25,26]. But many people have what are known as pre-clinical conditions. The biomarkers have not reached the threshold level for official disease diagnosis, but their abnormality reflects some degree of under- lying dysfunction. The immune system response (including pre-clinical conditions) to the COVID-19 viral trigger should not be expected to be the same as the response of a healthy immune system [27]. If pre-clinical conditions had been taken into account and coupled with the false positives as well, the CDC estimate of 94 % misdiagnosis would be substantially higher.

On the other hand, the inoculation landscape has become even more complex due to new circulating viral variants. Authorities recommend genomic surveillance and adaptation in order to be effective against new variants (different from the initial strain that was detected at the end of 2019). The efficacy data of Comirnaty against circulating viral variants are highlighted in a very recent study in Israel which showed that the protection offered by the Pfizer inoculant against variant B.1.351 (first identified in South Africa) is lower [112]. The results have not yet been submitted to the expertise of specialists. The study compared nearly 400 adults who were diagnosed with COVID-19 at least 14 days after receiving one or two doses of the inoculant to the same number of uninoculated people. It was found that B.1.351 represents approximately 1 % of the COVID-19 cases studied. **But among patients who received two doses of inoculant, the prevalence rate of the variant was eight times higher than in those not inoculated - 5.4 % compared to 0.7 %.** This suggests that

Comirnaty is less effective against variant B.1.351, compared to the original variant and variant B.1.1.7. The limitation of the study comes from the small number of adult people studied, but it is an alarm signal for a closer study of these cases. In addition, it seems that at present, the prevalence of this variant is low. On the other hand, in early April, Pfizer announced that according to the results of the Phase III study in the adult population, Comirnaty also demonstrated 100 % efficacy in the prevention of Covid-19 disease caused by SARS-CoV-2 variant B.1.351 (9 cases of Covid-19 were recorded, all in the placebo group, and after sequencing it was found that 6 had been determined by B.1.351) [117].

A2-b Ongoing Clinical Trials in the Pediatric Population

In a recent Phase III study performed in the pediatric population, Comirnaty (Pfizer) was tested on a group of 2,260 children, aged 12–15, years who had no previous clinical signs of SARS-CoV-2 infection. They were divided into two groups, one placebo (978 children) and the other with Comirnaty (1005 children). In the Comirnaty group, of the 1005 children in whom the serum was administered, none developed COVID-19 disease, compared with the placebo group in which 16 children in 978 had clinical signs of the disease. The Pfizer study showed that the children's immune response was comparable to the immune response in the 16–25 age group (measured by the level of antibodies against SARS-CoV-2). It could be concluded that in this study, Comirnaty was 100 % effective in preventing SARS-CoV-2 infection, although the actual rate could be between 75 % and 100 %. [63]. The results will be evaluated by the FDA and EMA. **(which they have since done)**

The predictive value (for mass inoculation results) of the Comirnaty trial for the children aged 12–15 years is questionable. There were 1005 children who were inoculated with Comirnaty. Using the rule of three in statistics, where to obtain a predictive result of 1/x with high confidence (e.g., 1 in a thousand), 3x participants are required for the test sample. For the Comirnaty test sample of 1005, an adverse event of about 1/340 could be detected with high confidence.

What does this mean in the real world? In the USA, there are approximately 4,000,000 children in each age year for adolescents. Thus, there are˜16,000,000 children in the 12–15 age band. A serious adverse event, including death, that occurred at a 1/800 rate would not be detectable with high confidence in a sample of 1005 people. Thus, the results of the trials for 1005 children would allow for 20,000 children to suffer a non-trial-detected serious adverse event, including death, when extrapolated to potential inoculation of all children in the 12–15 age group! Given that the risk of contracting COVID-19 with serious outcomes is negligible in this population, ***proceeding with mass inoculation of children 12–15 years old based on the trials that were conducted cannot be justified on any cost-benefit ratio findings***. (The authors had bolded this sentence.)

4. Discussion

Two issues arise from these results. First, where is the data justifying inoculation for children, much less most people under forty? It's not found on Fig. 1, where the most vulnerable are almost exclusively the elderly with

many comorbidities [83]. Yet, in the USA, Pfizer has been approved to inoculate children 12–17, and the goal is to accomplish this by the start of the school year in the Fall. As stated previously, there are plans to inoculate children as young as six months starting before the end of 2021.

What is the rush for a group at essentially zero risks? Given that the inoculations were tested only for a few months, only very short-term adverse effects could be obtained. It is questionable how well even these short-term effects obtained from the clinical trials reflect the short-term effects from the initial mass inoculation results reported in VAERS.

Figs. 1 and 2 reflect only these very short-term results. A number of researchers have suggested the possibility of severe longer-term autoimmune, Antibody-Dependent Enhancement, neurological, and other potentially serious effects, with lag periods ranging from months to years. If such effects do turn out to be real, the children are the ones who will have to bear the brunt of the suffering. There appear to be no benefits for the children and young adults from the inoculations and only Costs!

The second issue is why the deaths shown on Fig. 2 were not predicted by the clinical trials. We examined the Pfizer trial results (based on a few months of testing) and did not see how (potentially) hundreds of thousands of deaths could have been predicted from the trials' mortality results. Why this gap?

As we showed in the clinical trials section, 17.4 % of the Pfizer sample members were over 65, and 4.4 % were over 75. When the later phases of the trials started in late July 2020, the managers knew the COVID-19 age demographics affected from the July 2020 analog of Fig. 1. Rather than sampling from the age region most affected, they sampled mainly from the age region least affected! And even in the very limited sampling from the oldest groups, it is unclear whether they selected from those with the most serious comorbidities. Our impression is that the sickest were excluded from the trials, but were first in line for the inoculants.

It is becoming clear that the central ingredient of the injection, the recipe for the spike protein, will produce a product that can have three effects. Two of the three occur with the production of antibodies to the spike protein. These antibodies could allegedly offer protection against the virus (although with all the "breakthrough" cases reported, that is questionable), or could suppress serious symptoms to some extent. They could also cross-react with human tissue antigen, leading to potential autoimmune effects. The third occurs when the injected material enters the bloodstream and circulates widely, which is enabled by the highly vascular injection site and the use of the PEG-2000 coating.

This allows spike protein to be manufactured/expressed in endothelial cells at any location in the body, both activating platelets to cause clotting and causing vascular damage. It is difficult to believe this effect is unknown to the manufacturer, and in any case, has been demonstrated in myriad locations in the body using VAERS data. There appears to be modest benefit from the inoculations to the elderly population most at risk, no benefit to the younger population not at risk, and much potential for harm from the inoculations to both populations. It is unclear why this mass inoculation for all groups is being done, being allowed, and being promoted.

5. Overall conclusions

The people with myriad comorbidities in the age range where most deaths with COVID-19 occurred were in very poor health. Their deaths did not seem to increase all-cause mortality as shown in several studies. If they hadn't died with COVID-19, they probably would have died from the flu or many of the other comorbidities they had. We can't say for sure that many/most died from COVID-19 because of: 1) how the PCR tests were manipulated to give copious false positives and 2) how deaths were arbitrarily attributed to COVID-19 in the presence of myriad comorbidities.

The graphs presented in this paper indicate that the frail injection recipients receive minimal benefit from the inoculation. Their basic problem is a dysfunctional immune system, resulting in part or in whole from a lifetime of toxic exposures and toxic behaviors. They are susceptible to either the wild virus triggering the dysfunctional immune system into over-reacting or under-reacting, leading to poor outcomes or the injection doing the same.

This can be illustrated by the following analogy. A person stands in a bare metal enclosure. What happens when the person lights a match and drops it on the floor depends on what is on the floor. If the floor remains bare metal, the match burns for a few seconds until extinguished. If there is a sheet of paper on the floor under the match, the match and the paper will burn for a short time until both are extinguished. If, however, the floor is covered with ammonium nitrate and similar combustible/ explosive materials, a major explosion will result! For COVID-19, the wild virus is the match. The combustible materials are the toxic exposures and toxic behaviors. If there are no biomarker 'footprints' from toxic exposures and toxic behaviors, nothing happens. If there are significant biomarker 'footprints' from toxic exposures and toxic behaviors, bad outcomes result.

Adequate safety testing of the COVID-19 inoculations would have provided a distribution of the outcomes to be expected from 'lighting the match'. Since adequate testing was not performed, we have no idea how many combustible materials are on the floor, and what the expected outcomes will be from 'lighting the match'.

The injection goes two steps further than the wild virus because 1) it contains the instructions for making the spike protein, which several experiments are showing can cause vascular and other forms of damage, and 2) it bypasses many front-line defenses of the innate immune system to enter the bloodstream directly in part. Unlike the virus example, the injection ensures there will always be some combustible materials on the floor, even if there are no other toxic exposures or behaviors. In other words, the spike protein and the surrounding LNP are toxins with the potential to cause myriad short-, mid-, and long-term adverse health effects even in the absence of other contributing factors! Where and when these effects occur will depend on the biodistribution of the injected material. Pfizer's own biodistribution studies have shown the injected material can be found in myriad critical organs throughout the body, leading to the possibility of multi-organ failure. And these studies were from a single injection. Multiple injections and booster shots may have cumulative effects on organ distributions of inoculant!

The COVID-19 reported deaths are people who died **with** COVID-19, not necessarily **from** COVID-19. Likewise, the VAERS deaths are people who have died **following** inoculation, not necessarily **from** inoculation.

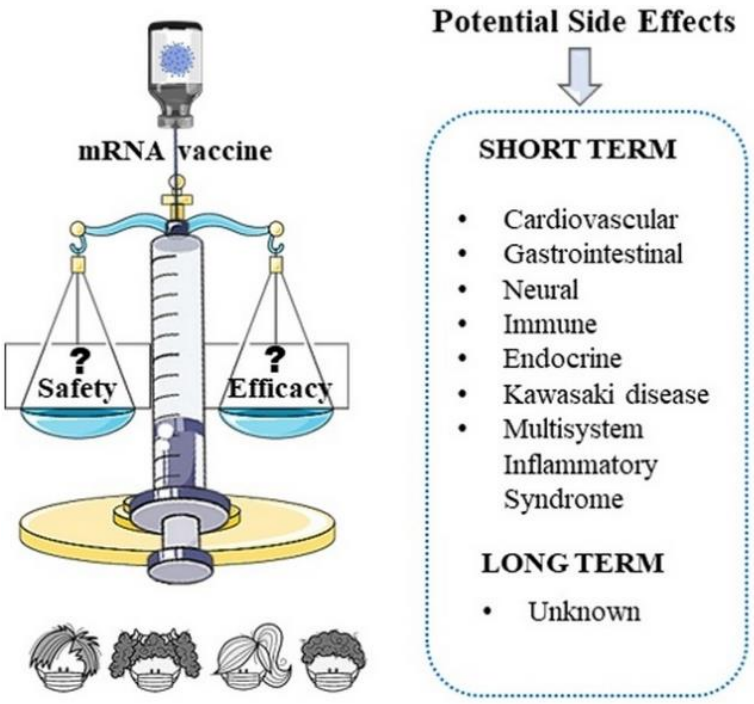
As stated before, CDC showed that 94 % of the reported deaths had multiple comorbidities, thereby reducing the CDC's numbers attributed strictly to COVID-19 to about 35,000 for all age groups. Given the number of high false positives from the high amplification cycle PCR tests, and the willingness of healthcare professionals to attribute death to COVID-19 in the absence of tests or sometimes even with negative PCR tests, this 35,000 number is probably highly inflated as well.

On the latter issue, both Virginia Stoner [85] and Jessica Rose [86] have shown independently that the deaths **following** inoculation are not coincidental and are **strongly related to** inoculation through strong clustering around the time of injection. Our independent analyses of the VAERS database reported in Appendix 1 confirmed these clustering findings.

Additionally, VAERS historically has under-reported adverse events by about two orders-of-magnitude, so COVID-19 inoculation deaths ***in the short-term*** could be in the hundreds of thousands for the USA for the period mid-December 2020 to the end of May 2021, potentially swamping the *real* COVID-19 deaths. Finally, the VAERS deaths reported so far are for the very short term. We have no idea what the death numbers will be in the intermediate and long-term; the clinical trials did not test for those.

The clinical trials used a non-representative younger and healthier sample to get EUA for the injection. Following EUA, the mass inoculations were administered to the very sick (and first responders) initially, and many died quite rapidly. However, because the elderly who died following COVID-19 inoculation were very frail with multiple comorbidities, their deaths could easily be attributed to causes other than the injection (as should have been the case for COVID-19 deaths as well).

Now the objective is the inoculation of the total USA population. Since many of these potential serious adverse effects have built-in lag times of at least six months or more, we won't know what they are until most of the population has been inoculated, and corrective action may be too late.



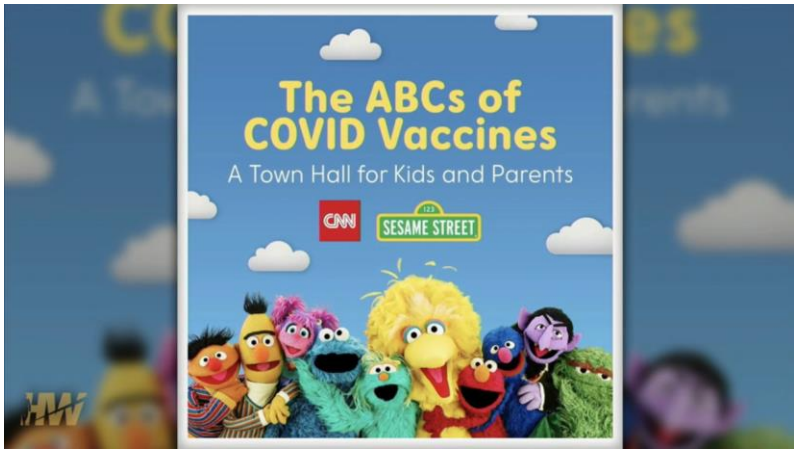
Note: ***Appendix A*** goes into great detail about the ***EXPECTED DEATHS IN 65+ DEMOGRAPHIC VS COVID-19 INOCULATION DEATHS.***

https://reader.elsevier.com/reader/sd/pii/S221475002100161X

End of excerpts

This picture pretty much sums it up nicely

Yet, this is kind of disgusting crap they are resorting to… (notice the Communist News Network CNN logo)



Study shows another mechanism for the way that the spike protein alone causes cardiovascular damage

A ***bioRxiv*** pre-print study titled, **The SARS-CoV-2 Spike protein disrupts human cardiac pericytes function through CD147-receptor-mediated signalling: a potential non-infective mechanism of COVID-19 microvascular disease** explores a fascinating mechanism for cardiovascular damage from the spike protein.

ABSTRACT

Severe coronavirus disease 2019 (COVID-19) manifests as a life-threatening microvascular syndrome. The severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) uses the Spike (S) protein to engage with its receptors and infect host cells. To date, it is still not known whether heart vascular pericytes (PCs) are infected by SARS-CoV-2, and if the S protein alone provokes PC dysfunction. Here, we aimed to investigate the effects of the S protein on primary human cardiac PC signalling and unction. Results show, for the first time, that cardiac PCs are not permissive to SARS-CoV-2 infection in vitro, whilst a recombinant S protein alone elicits functional alterations in PCs. This was documented as: increased migration, reduced ability to support endothelial cell (EC) network formation on Matrigel, secretion of pro-inflammatory molecules typically involved in the cytokine storm, and production of pro-apoptotic factors responsible for EC death. Next, adopting a blocking strategy against the S protein receptors angiotensin-converting enzyme 2 (ACE2) and CD147, we discovered that the S protein stimulates the phosphorylation/activation of the extracellular signal-regulated kinase 1/2 (ERK1/2) through the CD147 receptor, but not ACE2, in PCs. The neutralisation of CD147, either using a blocking antibody or mRNA silencing, reduced ERK1/2 activation and rescued PC function in the presence of the S protein. In conclusion, our findings suggest that circulating S protein prompts vascular PC dysfunction, potentially contributing to establishing microvascular injury in organs distant from the site of infection. This mechanism may have clinical and therapeutic implications.

From the study

Pericytes (PCs) are pleiotropic cells that wrap ECs. In the heart, they are abundantly associated with the coronary microvasculature. They support the integrity of coronary artery ECs (CAECs), participate in vascular remodelling and cardiac repair, and modulate inflammatory responses. Dysfunctional cardiac PCs were found in patients with severe myocardial disease. Dysfunctional PCs participate in adverse vascular phenomena; for instance, after a heart attack, persistently contracted PCs block the coronary microvascular circulation, thereby causing blood to clot.

Clinical perspective

- Severe COVID-19 manifests as a microvascular syndrome, but whether SARS-CoV-2 infects and damages heart vascular pericytes (PCs) remains unknown.
- We provide evidence that cardiac PCs are not infected by SARS-CoV-2. Importantly, we show that the recombinant S protein alone elicits cellular signalling through the CD147 receptor in cardiac PCs, thereby inducing cell dysfunction and microvascular disruption in vitro.
- This study suggests that soluble S protein can potentially propagate damage to organs distant from sites of infection, promoting microvascular injury. Blocking the CD147 receptor in patients may help protect the vasculature not only from infection, but also from the collateral damage caused by the S protein.

The S protein also activated or enhanced the production of pro-inflammatory cytokines by cardiac PCs. MCP1, IL-6, IL-1β and TNFα are typical components of the cytokine storm associated with respiratory failure and high mortality in COVID-19 patients. (38, 49) This pro-inflammatory secretome could produce harmful paracrine effects on the surrounding vascular cells, as our experiment on CAEC apoptosis suggests. This mechanism can propagate functional alterations even to those cell populations which may not be directly infected by the virus, ultimately contributing to vascular disruption.

Scroll to next page for large image…

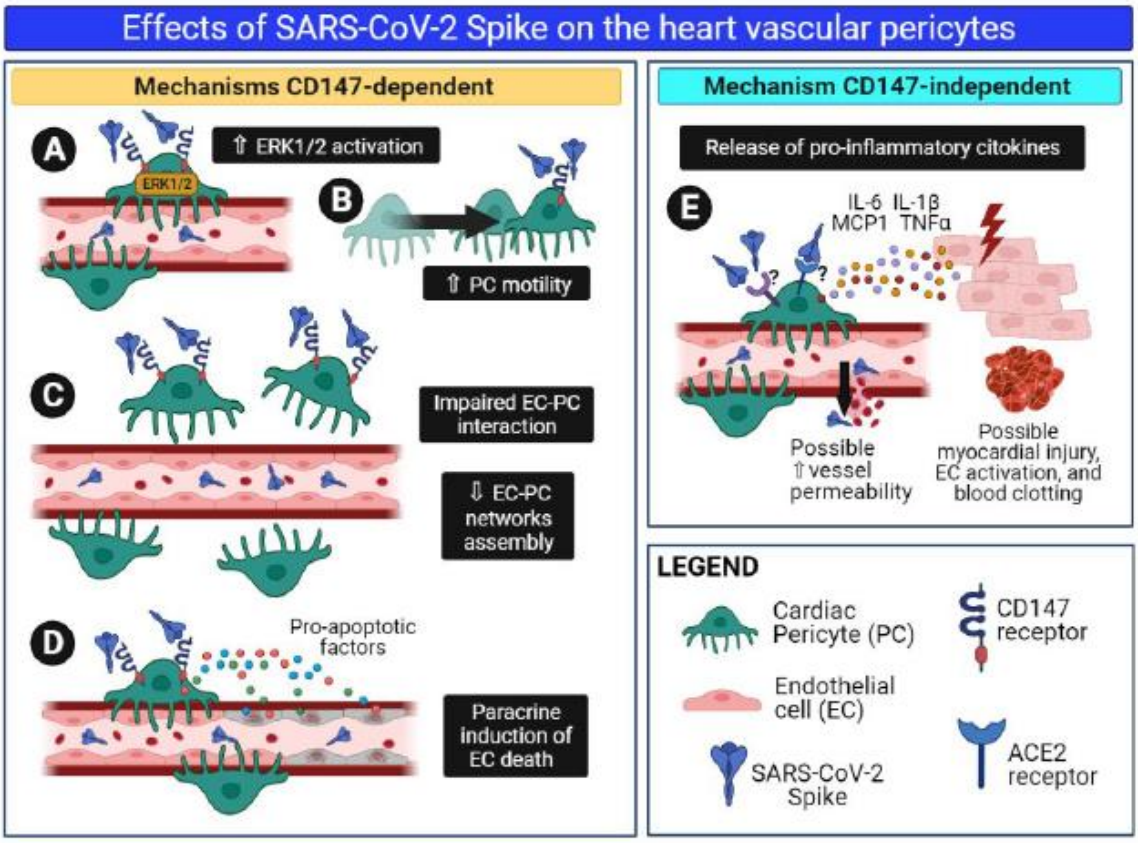


Figure 9. The SARS-CoV-2 S protein alters cardiac pericyte function. Schematic summary of the research. We hypothesize that in patients with acute COVID-19, S protein molecules are cleaved from the virus particle and released from the respiratory system into the bloodstream. Through the circulation, isolated S protein fragments reach all organs of the body, including the heart. Here, the interaction of the S protein with the CD147 receptor on cardiac PCs triggers the ERK1/2 signalling **(A)** and provokes PC dysfunction, including increased cell motility **(B)** and decreased angiogenic activity in cooperation with coronary ECs **(C)**. In addition, the S protein-CD147 interaction prompts cardiac PCs to release pro-apoptotic factors, which cause EC death **(D)**. Finally, through a mechanism CD147-independent, the S protein induces PCs to release pro-inflammatory cytokines, which include MCP-1, IL-6, IL-1β, and TNF-α **(E)**. These cytokines can damage neighbouring cardiomyocytes and activate ECs, potentially promoting blood to clot and increasing vascular permeability.

In conclusion, although more investigation being needed to definitively prove the harmful effects of the S protein on the heart PCs and associated microvasculature in vivo, this work suggests that fragments of the S protein may elicit vascular cell dysfunction through CD147, independently from the infection. This mechanism has the potential to spread cellular and organ injury beyond the infection sites and may have important clinical implications. For instance, in patients with disrupted endothelial barrier and increased vascular permeability due to underlying diseases, such as hypertension, diabetes, nd severe obesity, S protein molecules could easily spread to the PC compartment and cause, or exacerbate, microvascular injury. Blocking the CD147 receptor may help protect the vasculature of the most vulnerable patients from infection and the collateral damage caused by the S protein.

End of excerpts
https://www.biorxiv.org/content/10.1101/2020.12.21.423721v2

This could further explain why so many adverse cardiovascular events are being seen from the COVID-19 shots as this study clearly shows that the virus (infection) is not necessary to cause the damage, just the spike protein alone. And, that toxin is what the geniuses behind the development of the gene therapy that hundreds of millions of people are currently being injected with decided to force recipient's cells to make and distribute throughout people's bodies by the billions.

Pfizer under-reported the number of deaths in the vaccinated cohort in their clinical trial. The numbers extrapolated to all vaccinated individuals is massive

The six-month trial reporting date considered data up until March 13th, 2021. At that time Pfizer reported 15 deaths in the vaccinated group compared to 14 deaths in the placebo group.

"All cause mortality" is one of the most important data points to track in any drug or vaccine trial. By tracking all cause mortality over an extended period of time you can get an idea as to whether the intervention group has a higher risk of death from various causes over the course of months or years.

See the chart below on ALL-CAUSE MORTALITY that was originally reported from the Pfizer trial...

See large table next page…

Reported Cause of Death[a]	BNT162b2 (N=21,926) n	Placebo (N=21,921) n
Deaths	15	14
Acute respiratory failure	0	1
Aortic rupture	0	1
Arteriosclerosis	2	0
Biliary cancer metastatic	0	1
COVID-19	0	2
COVID-19 pneumonia	1	0
Cardiac arrest	4	1
Cardiac failure congestive	1	0
Cardiorespiratory arrest	1	1
Chronic obstructive pulmonary disease	1	0
Death	0	1
Dementia	0	1
Emphysematous cholecystitis	1	0
Hemorrhagic stroke	0	1
Hypertensive heart disease	1	0
Lung cancer metastatic	1	0
Metastases to liver	0	1
Missing	0	1
Multiple organ dysfunction syndrome	0	2
Myocardial infarction	0	2
Overdose	0	1
Pneumonia	0	2
Sepsis	1	0
Septic shock	1	0
Shigella sepsis	1	0
Unevaluable event	1	0

Table S4 | Causes of Death from Dose 1 to Unblinding (Safety Population, ≥16 Years Old). a. Multiple causes of death could be reported for each participant. There were no deaths among 12–15-year-old participants.

file:///C:/Users/drpal/AppData/Local/Temp/media-1-1.pdf

But in the ***Summary Basis for Regulatory Action*** released **on November 8th, 2021** explaining why it approved the Pfizer product on August 23rd, 2021. On page 23 of the summary, the following was reported…
"From Dose 1 through the March 13, 2021 data cutoff date, there were a total of 38 deaths, **21 in the COMIRNATY group and 17 in the placebo group**. None of the deaths were considered related to vaccination."
Why does this number conflict with what was reported in July as evidenced by the table above, considering the cut-off date for the data cited in both reports was March 13th, 2021? What changed? Where were the missing deaths? Wouldn't you think that would be THE most important metric to track?

How does that extrapolate to extra deaths in the entire vaccinated population?
The difference between 21 deaths and 17 deaths is 19% lower in the non-vaccinated. That doesn't sound like a big differential, but when you're comparing that number of deaths in that study population 2 what the potential difference in deaths would be for the general population it can be a significant difference. Currently there are 195,275,904 Americans fully vaccinated (59%) as of November 15th, 2021.
https://usafacts.org/visualizations/covid-vaccine-tracker-states/

Let's look at the math…

17/21 X 100 = 80.95% 100% – 80.95% = 19.05% lower in the unvaccinated group.
There were 21 deaths (all cause) in the vaccinated group- 21/21,720 people = 0.096%
There were 17 deaths (all cause) in the unvaccinated group- 17/21,728 people = 0.078%

Rounding the number of vaccinated Americans to 200 million.

- Multiply that by the rate of all-cause death in the vaccinated group 0.096% = 19,200,000

Taking the same number (200 million) unvaccinated to compare apples to apples…

- Multiply that by the rate of all-cause death in the unvaccinated group 0.078% = 15,600,000

Subtracting 15,600,000 from 19,200,000 = 3,600,000 (three million, six hundred thousand) more excess deaths in the vaccinated population than the same number of unvaccinated people. Now you can see how that difference of 4 people in that small number in the trial becomes HUGE when it is extrapolated to the real-world numbers. That is not saying that definitively 3.6 million people will have died from the vaccine by now, but it does beg the question, why would the all-cause deaths be so much higher in vaccinated people?

More questions
In another statement, a question remains…**Why were only 60% of the 2 groups participating in the trial followed for greater than 4 months?**

From the summary: (emphasis mine)
The population for the updated vaccine efficacy analysis per protocol included participants 16 years of age and older who had been enrolled from July 27, 2020 and followed for the development of COVID-19 during blinded placebo-controlled follow-up through March 13, 2021, representing up to ~6 months of follow-up after Dose 2.

Overall, 60.8% of participants in the COMIRNATY group and 58.7% of participants in the placebo group had ≥4 months of follow-up time after Dose 2 in the blinded placebo-controlled follow-up period. The overall VE against COVID-19 in participants without evidence of prior SARS-CoV-2 infection was 91.1% (95% CI: 88.8 to 93.1). The overall VE against COVID-19 in participants with or without evidence of prior SARS-CoV-2 infection was 90.9% (95% CI: 88.5 to 92.8). https://www.fda.gov/media/151733/download

From Pfizer's website about the Phase 3 clinical trial…

Who participated or was able to participate in the landmark Phase 3 study?

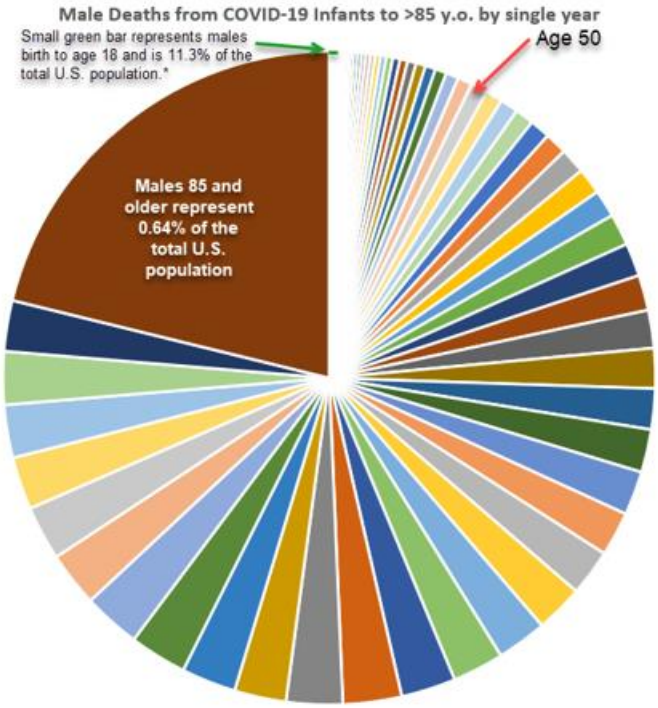
We enrolled 46,331 people in the trial, **with the majority of participants ranging from ages 16-56**. Additional trial populations included people as young as 12 years old and people with chronic, stable human immunodeficiency virus (HIV) (), Hepatitis C virus (HCV), or Hepatitis B virus (HBV) infections. We believe that doing so enabled more individuals who were at risk of COVID-19 disease to have the opportunity to participate in the study. As with the vaccine candidates we test in adult populations, we followed a careful, stepwise approach as we moved down to younger age groups.

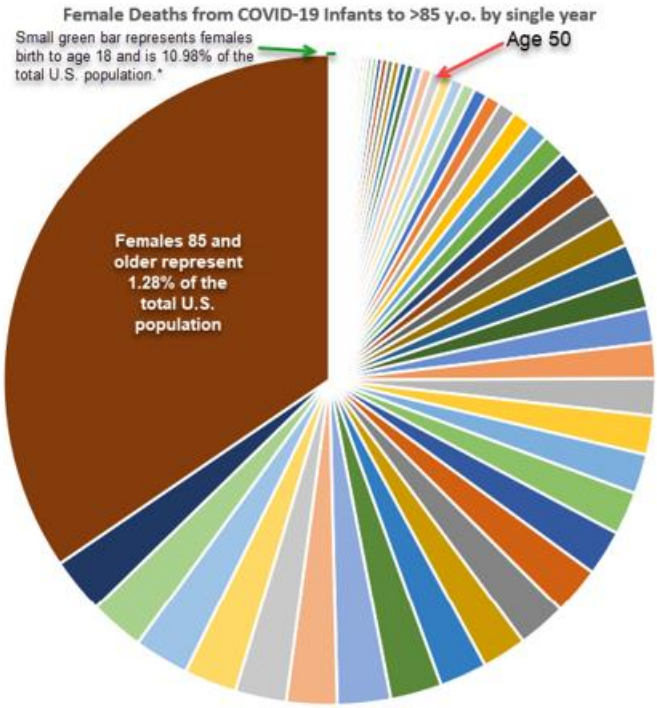
https://www.pfizer.com/science/coronavirus/vaccine/about-our-landmark-trial

What about the most vulnerable to COVID-19, the elderly?

As you can see from the portion I bolded in the last paragraph above, they didn't even test the vaccines in numbers that were proportional to the most vulnerable population, the elderly. Approximately 60% of the study subjects were younger than 57 years of age. As can be seen from the mortality (death from COVID-19) pie charts below which I highlighted in last month's newsletter, the deep brown largest piece of the pie for both males and females, represents the age demographic 85 years and older. Each slice after that large brown piece represents a single year of life. So, the first slice moving counterclockwise from the large deep brown piece is 84 years old, the second slice 83 years old, etc. Look at where I have marked the slice for age 50 and then just move 6 slices clockwise to that gray colored slice which represents age 56. Now consider the "majority" of the population in their clinical trial (16-56) was everything from that point counterclockwise to where the slices are so thin, they become invisible. Since the most vulnerable population is in excess of 70 years old, why wouldn't that demographic makeup the largest and most important part of the clinical trial? Since that population is by far the most impacted by the disease, wouldn't it make sense to see how effective the product was for them? And what the risks are for them? Unfortunately, as we've seen from the data since the release of the vaccines, the most elderly and frail are also at the greatest risk of death from the vaccines. Is it possible that they did not want to expose a larger percentage of the elderly test subjects that potential danger and risk a greater safety signal?

See the graph next page…





CDC data used: https://data.cdc.gov/resource/3apk-4u4f.csv

As of October 23rd, 2021…

Age 85 and over = 1.8% of the population yet accounts for 198,648 of the COVID-19 deaths.
Age birth to 18 = 22.3% of the population yet accounts for 558 of the COVID-19 deaths.

Co-morbidities

The other important consideration is that they chose people who were for the most part, healthy. That just does not represent the standard American. The United States has one of the highest rates of chronic disease in the world. Quite honestly, that is one of the main reasons why we have such a high mortality rate from COVID-19. Our rates of obesity, hypertension, diabetes, kidney disease and immunological deficiency diseases are some of the highest in the world. Since those individuals even if younger, are at greatest risk from COVID-19, wouldn't it have made perfect sense to select a representative population to test the vaccines on?
The trial reports said the following: “35% were obese (body mass index [the weight in kilograms divided by the square of the height in meters] of at least 30.0), and 21% had at least one coexisting condition.” If accurate, that is still short of the percentage of obese individuals in the U.S. The CDC’s website says that he US obesity prevalence was 42.4% in 2017 – 2018. https://www.cdc.gov/obesity/data/adult.html. In 2020, it is likely that it has increased from there. And, considering the statistics about weight gain during the lockdowns and gym closures. According to a CNBC article posted April 09, 2021, “42% of U.S. adults reported undesired weight gain due to Covid-19, according to a recent survey by the American Psychological Association. Average increase: 29 pounds.” When the Phase 3 trials were designed, it had become apparent that this trend was rising rapidly.

As far as the comment that the 21% of the study participants had at least "one coexisting condition", again that far undershoots both the national average for one chronic disease and 42% have more than one https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm . And consider the fact that the CDC now states that the average number of co-morbidities people that did not survive COVID-19 was four or more.

"Among 36,523 participants who had no evidence of existing or prior SARS-CoV-2 infection by the time of the immunizations…" There were 43,448 participants. That leaves 6,925 that have had COVID previously. I would like to know what group they went into. I could not find that information anywhere. If they were selected as part of the vaccine group, their natural immunity would certainly give them a major advantage against getting COVID during the trial.

Now that we have seen how minuscule the risk from COVID-19 is for children and teens, how about the risk from the vaccines?

Before I launch into this month's additions to the accumulating evidence that I have been providing over the last several months, I would like to make you aware of a free download I have on my web site. It looks at the risks from COVID-19 for children versus the risks of the vaccines. I just updated it the first part of November, so the data, the studies and the links have been updated. Download your copy here. Please feel free to share the link on social media. https://www.wellnessdoc.com/the-risk-vs-reward-of-the-covid-19-vaccines-for-children/

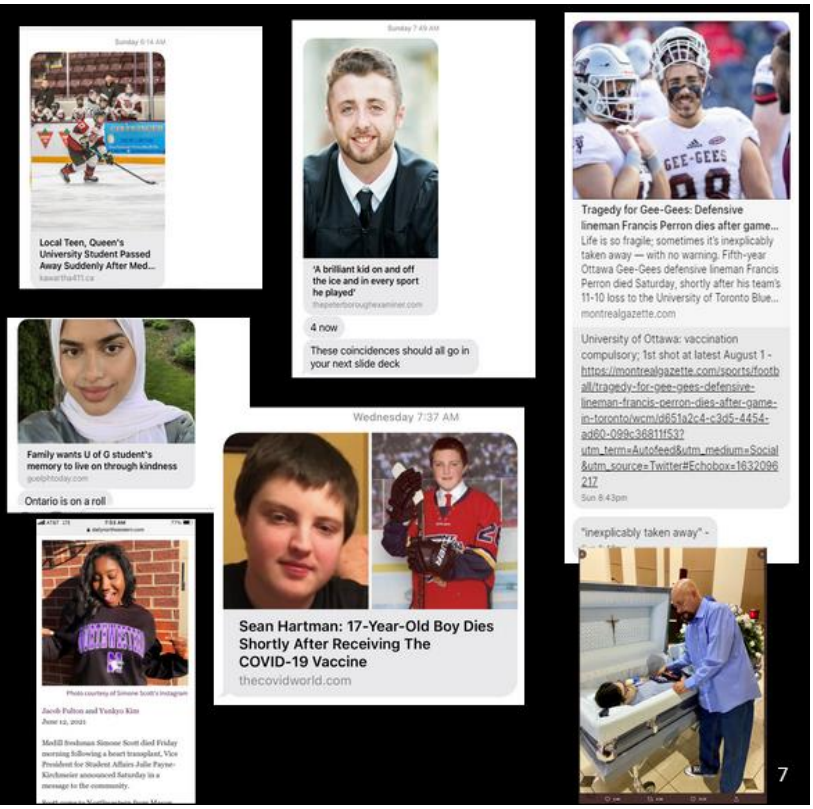
Brilliant presentation by Steve Kirsch at the October VRBPAC Meeting October 26th, 2021 on considering the COVID-19 shots for 5-11 year old children

Steve Kirsch is the Executive Director of the ***COVID-19 Early Treatment Fund***. His presentation was 191 slides long and he did a beautiful job of making his case for denying approval of these shots for children. Unfortunately, these meetings never give the presenters enough time to present that volume of information, but he really nailed it with the time he had. And his presentation covers a massive amount of critical information for doctors, politicians, adults and parents of children to consider before deciding to inject anyone with these experimental products.

Now, let's get to it. To start I want to show you some slides from a presentation that Steve Kirsch did on October 26th, 2021, at the VRBPAC meeting to consider recommendations for approving the shots for 5-11 year-olds. Steve is the Executive Director of the ***COVID-19 Early Treatment Fund***. His presentation is excellent and I thought I would share just a few select slides with you to give you a flavor of the work that he has done. I'll put a link to the presentation at the end so you can access it.

Why are kids **dropping like flies** right after getting vaccinated?

If they didn't die from the vaccine, then what killed all these kids?



7

Why did this 15 year-old die in his sleep?

Just 2 days after getting vaccinated.

VAERS ID: 1382906

Sonoma County Sheriff's Office
Mark Essick, Sheriff-Coroner
Coroner Investigations Unit
3336 Chanate Road, Santa Rosa, CA 95404
(707) 565-5070

DEATH INVESTIGATION SYNOPSIS REPORT

CORONER CASE #: 21-0000670

INCIDENT INFORMATION

LAW ENFORCEMENT AGENCY WITH JURISDICTION	REPRESENTATIVE TITLE AND NAME	AGENCY CR # ☐ N/A
Santa Rosa Police Department	Officer Jose Andrade #568	21-0006115

MANNER OF DEATH	DATE/TIME RECEIVED	
Undetermined	06/07/2021 14:35	

DECEDENT INFORMATION

DECEDENT'S NAME (FIRST, MIDDLE, LAST)	AGE	
[redacted]	15 yrs	

DEATH INFORMATION

PLACE OF DEATH (Facility Name or Address Location)	DATE OF DEATH	TIME OF DEATH
[redacted]	06/07/2021 [Found]	14:04 [Found]

SYNOPSIS

The decedent was found unresponsive in his bedroom after his mother was checking on his welfare long after he was supposed to wake in the morning. The decedent was pronounced dead at the scene due to obvious death. The decedent had been in good health with no medical history and had received his second Pfizer COVID-19 Vaccination approximately two days before his death.

The decedent's body was transported to the Sonoma County Morgue Facility, where he was registered for a postmortem examination by a forensic pathologist.

After extensive research, additional testing, and collaboration with numerous other entities, the cause of death was determined to be: **"STRESS CARDIOMYOPATHY WITH PERIVASCULAR CORONARY ARTERY INFLAMMATION (hours to days),** due to, **UNKNOWN ETIOLOGY IN SETTING OF RECENT PFIZER-BIONTECH COVID-19 VACCINATION (days)."** There were no other significant conditions contributing to the death listed.

Since the etiology of the stress cardiomyopathy with perivascular coronary artery inflammation was unknown but was in the setting of a recent Pfizer-Biontech Covid-19 vaccination, I mannered this death as "**UNDETERMINED**," which was consistent with the circumstances and cause.

10

How can a healthy 16-year-old boy die in the middle of his zoom math class?

He was fine 20 minutes before he died.

lifesitenews.com

Healthy 16-year-old boy dies during online class after second Pfizer jab: VAERS database - ...

How did you miss all these safety signals?

Doesn't this explain the deaths?

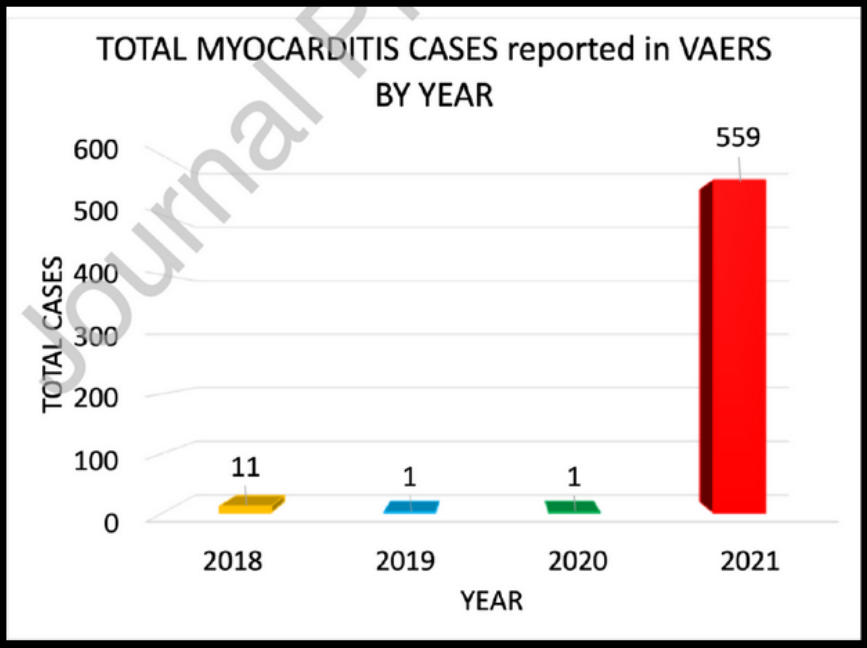
Note: this list is just a small subset of >1,000 symptoms that are elevated by these vaccines

Symptom	X factor
Pulmonary embolism	570
Thrombosis	360
Myocarditis	118
Ischaemic stroke	80
Deep vein thrombosis	72
Cardiac arrest	65
Aphasia	42
Blindness	32
Death	29
Haemorrhage intracranial	20

Increased VAERS reporting rate in 15-24 year olds vs. avg rate over 5 years computed from VAERS data on Oct 22, 2021 by Steve Kirsch

11

Is this what you mean by "slightly elevated" risk?



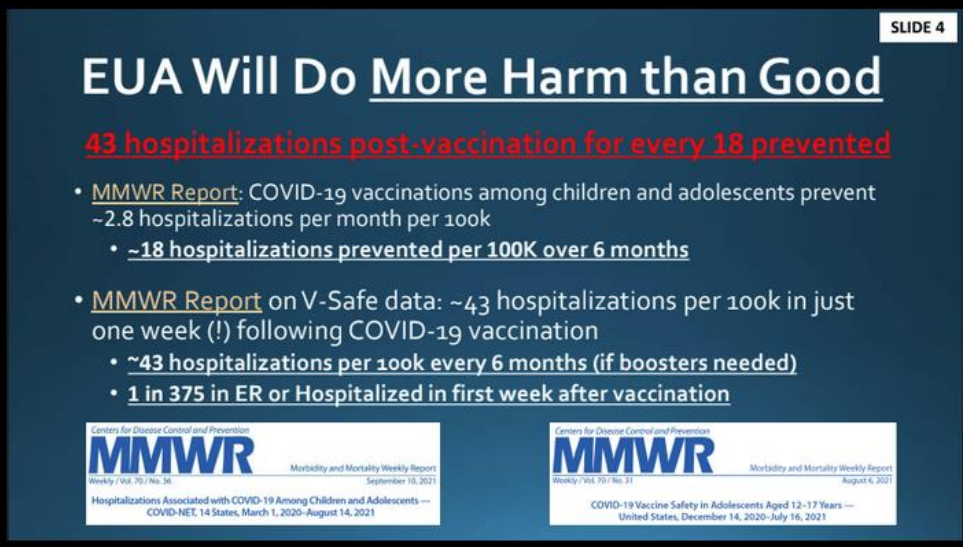
From the Rose paper

27

Guetzkow FDA presentation

We'll hospitalize more kids than we'll save from hospitalization.

Vaccines more dangerous to kids than COVID



https://tinyurl.com/HoldTheLineFDA

56

Do you find this recent UK headline troubling?

Children are up to 16 times more likely to die with Covid-19 if they've had the Covid Vaccine according to latest UK Health Security Agency report

by Daily Expose

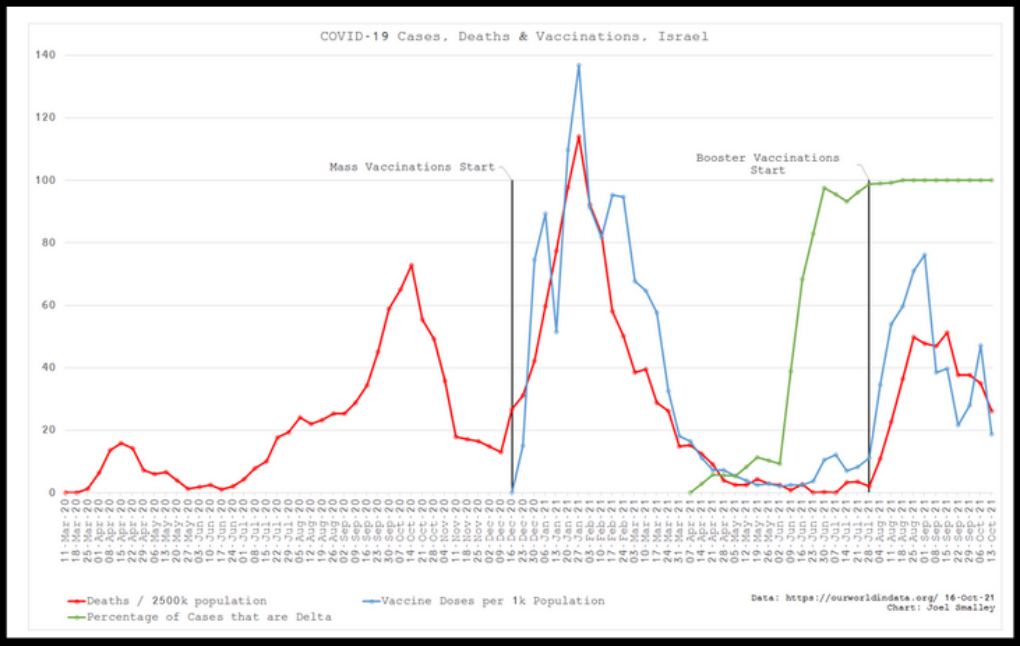
The latest report from the UK Health Security Agency shows that the Chief Medical Officer (CMO) for England's decision to recommend all children over the age of 12 should be vaccinated against Covid-19 was a huge mistake because the data shows children are 16 times more likely to die with Covid-19 if they have been [...]

Read more of this post

Source:
https://theexpose.uk/2021/10/22/children-up-to-16-times-more-likely-to-die-with-covid-19-if-vaccinated/

13

How come deaths in Israel go up when vaccinations go up? And go down when vaccinations go down?



15

Why won't anyone at CDC or FDA disclose the VAERS underreporting factor (URF) for this year?

How can you do a proper risk benefit analysis if you don't know the URF?

URF?

Reason: John Su at the CDC never calculated it. He will never calculate it because it would blow the narrative. But the outside committees and mainstream media never ask about it so it is OK.

16

Using a URF of 41 (calculated using the CDC methodology), we find over 300,000 excess deaths in VAERS.

If the vaccine didn't kill them, what did?

300,000

Excess deaths

17

That's just a small sample of the 193 slides in his presentation!

You can access his slide show here… https://docs.google.com/presentation/d/1qJRRFt7PkLTJSv0P-JKWP6YUB4Axa2gtROqpMJ9HkYY/edit#slide=id.gfa0a9bff83_0_599

Does the vaccine efficacy study from Sweden I highlighted last month disclose an increased rise in deaths after the vaccines?

The study is a preprint posted October 25th 2021 titled, **Effectiveness of COVID-19 vaccination against risk of symptomatic infection, hospitalization, and death up to nine months: a Swedish total population cohort study.** The findings mirror other studies and reports from all over the world showing the dramatic decline in effectiveness of the vaccines within a few months. But does it also unintentionally signal something else?

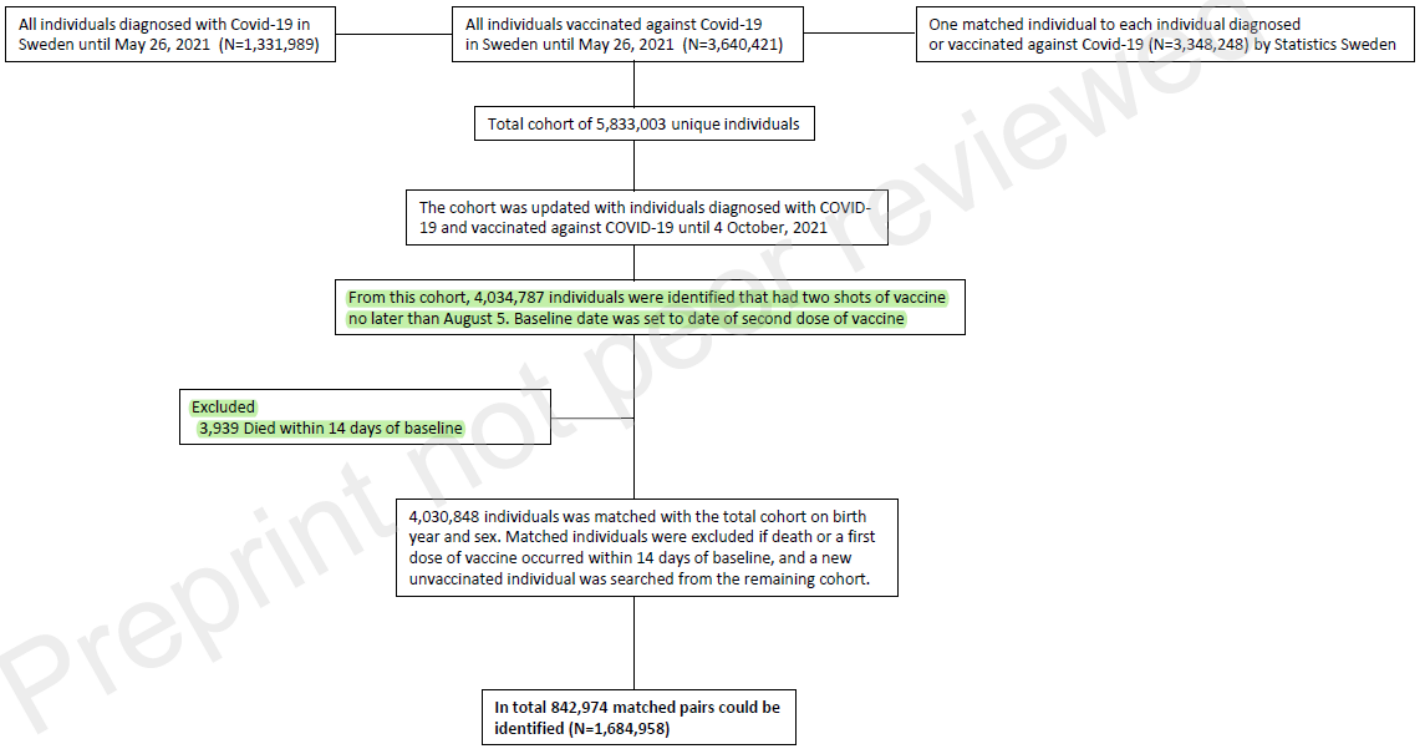
Alex Berenson's Substack
People appear to die at rates 20 percent or more above normal for weeks after receiving their second Covid vaccine dose, according to data from a huge Swedish study.

The figures are buried in a preprint paper on vaccine effectiveness released last month. The headline finding of the paper was that protection against Covid, including severe cases, plunged after six months.
The researchers did not explicitly examine deaths from all causes - which have risen since the summer in many countries that have highly vaccinated populations.

But on page 32 of the 34-page report, a chart shows that 3,939 of 4.03 million Swedes who received the second dose died less than two weeks later.

Continued next page…

Figure 1, page 32



Over a one-year period, that rate of death would translate into an annual mortality rate of about 2.5 percent a year - 1 person in 40 - almost *three times* the overall Swedish average. In a typical year, about 1 in 115 Swedes dies.

Of course, that huge gap does not account for an important confounding factor: younger people, who have a much lower risk of death, were less likely to be vaccinated.

But Sweden also provides detailed data on overall deaths nationally, making a crude baseline comparison possible.

That data shows that from an average of about 1,650 Swedes died every week between 2015 and 2019 between April 1 and early August, the period in which almost all of those 4 million Swedes in the study received their second dose. Death rates hardly varied over those years.
(SOURCE: https://www.scb.se/en/finding-statistics/statistics-by-subject-area/population/population-composition/population-statistics/)

In other words, during the spring and summer, Sweden normally has about 3,300 deaths every two weeks - not just in the people who received vaccines, but in all 10.6 million of its people.

So let's make an incredibly conservative assumption, one that strongly favors the vaccines. (The next couple paragraphs are a bit tricky, but I hope the payoff is worth taking the time to read and think through them.)

Assume that the group of people who received vaccines were so much older and unhealthier than those who didn't that they would have accounted for *every single death* in Sweden whether or not they were vaccinated. In other words, assume that even if the vaccines did not exist, every person in Sweden who died would have been part of that group of 4.03 million people the researchers tracked - while not one other person would have died.

In that case, those 4.03 million people "should" have about 3,300 deaths every two weeks. They CANNOT HAVE MORE - because all of Sweden does not have more.

But the vaccines do exist. Those 4.03 million people received them. And in the two weeks after receiving the second vaccine dose, as a group, the researchers reported they had not about 3,300 deaths, but 3,939. And 3,939 deaths is about 20 percent more deaths than "should" have occurred in those two post-vaccine weeks. Again, the 20 percent figure understates the real gap, because in the real world some deaths will occur in the 6.6 million unvaccinated people too, so the actual baseline number for the vaccinated group is not 3,300 deaths but somewhat lower.

Unfortunately, the researchers did not report any details on the deaths, so it is impossible to know if they are disproportionately cardiovascular. It is also impossible to know whether one particular vaccine was disproportionately linked to deaths. (Sweden used mostly the Pfizer mRNA vaccine, as well as some of AstraZeneca's DNA/AAV vaccine, which is not available in the United States, and a small amount of Moderna's mRNA vaccine.)

Of course, it is just possible the extra deaths are due to chance. Or that the handful of elderly Swedes who received vaccines in February and March accounted for a hugely disproportionate number of the post-vaccine deaths. (Because per-week Swedish death rates are higher in the winter, a large number of post-vaccine deaths in those months would somewhat reduce the strength of the signal, though it would still exist.) But the caveats aside, the Swedish figures offer a very large real-world dataset apparently showing a notable increase in all-cause mortality directly following Covid vaccination.

They are yet another piece of evidence in an increasingly worrying picture - alongside case and anecdotal reports, a known link to heart inflammation in young men, the updated Pfizer clinical trial data revealing a numerical imbalance in deaths in vaccinated people, and most importantly the general rise in all-cause mortality in many countries.

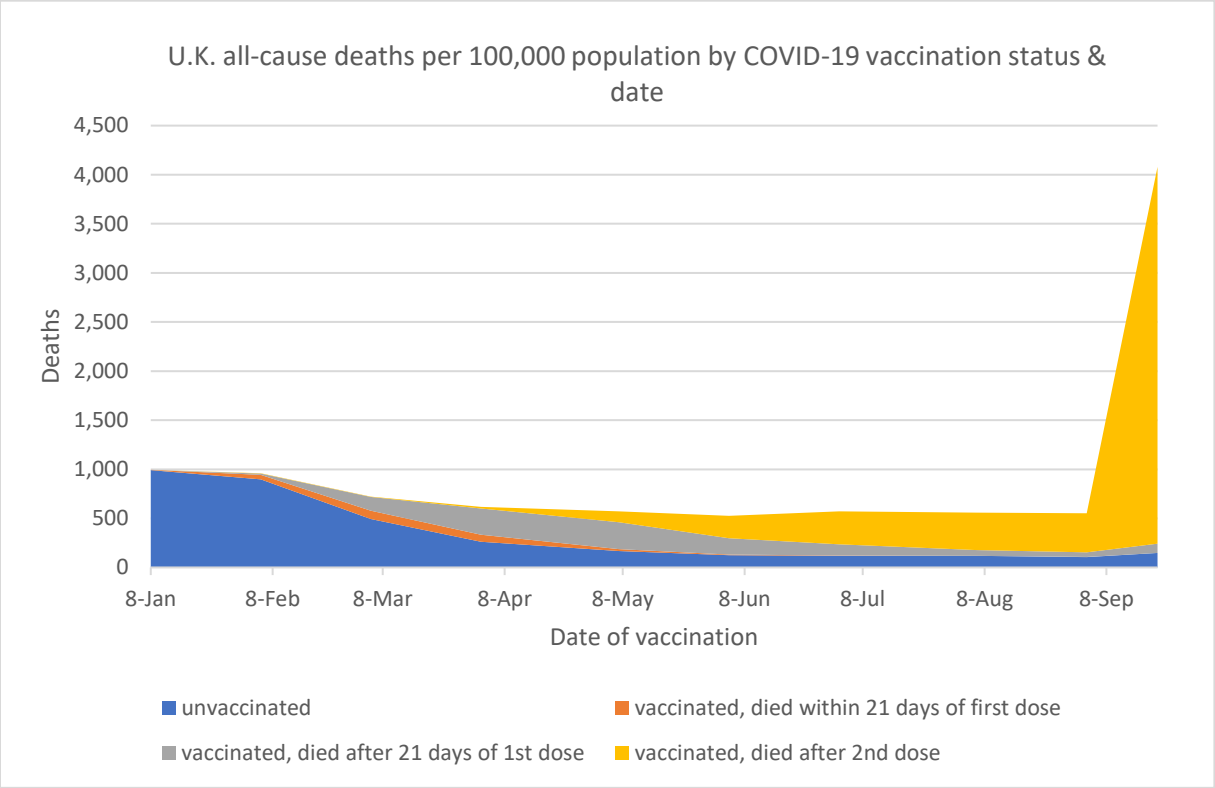
And all of these red flags come for vaccines that - if the Swedish data are correct - may actually raise the risk of Covid infection after about eight months. Yes, RAISE. See how that black line drops below the zero level on the top chart? That represents negative effectiveness, which is another way to say people who are vaccinated are MORE likely to be infected than those who aren't.

And, as the second chart shows, effectiveness against severe Covid infection is also spiraling towards zero.

Increase in all-cause deaths in the UK by vaccination status shows significant increase after the second dose

This data comes directly from the UK's Office for National Statistics (ONS). It shows a troubling trend of increasing all-cause mortality after people have had their second dose of the COVID-19 shots.

The data is described as… **Table 4: Weekly age-specific mortality rates by vaccination status for all deaths, per 100,000 people, England, deaths occurring between 2 January 2021 and 24 September 2021** [1,2,3,4,5,6,7,8]



https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsbyvaccinationstatusengland

***Percentages of population vaccinated for this next section** come from https://ourworldindata.org/covid-vaccinations and choosing only the UK.

As of the 10th of January, the UK only had 3% of their population partially vaccinated and 0.6% fully vaccinated. That is why at the beginning or left side of this graph you cannot see any color other than blue denoting the all-cause deaths in the unvaccinated population. Naturally 100% of all-cause deaths per 100,000 people would be in unvaccinated individuals.
On the above chart, May 15th, 2021, appears to be the point at which approximately the same number of all-cause deaths came from both the unvaccinated population and the population that was fully vaccinated. Yet only 29% of the population was fully vaccinated at that point.

A Dramatic shift in deaths in the vaccinated population

What is most concerning about the data coming out of the UK is that as time goes on, we see a dramatic acceleration of the number of all caused deaths in the vaccinated population. The graph above is a visual representation of that, **but what do the real numbers look like between August 6th and September 21st?**

What percentage of the population is fully vaccinated?

As of August 6th, 58% of the UK's population had been fully vaccinated. By September 24th, that number rose to 65%.

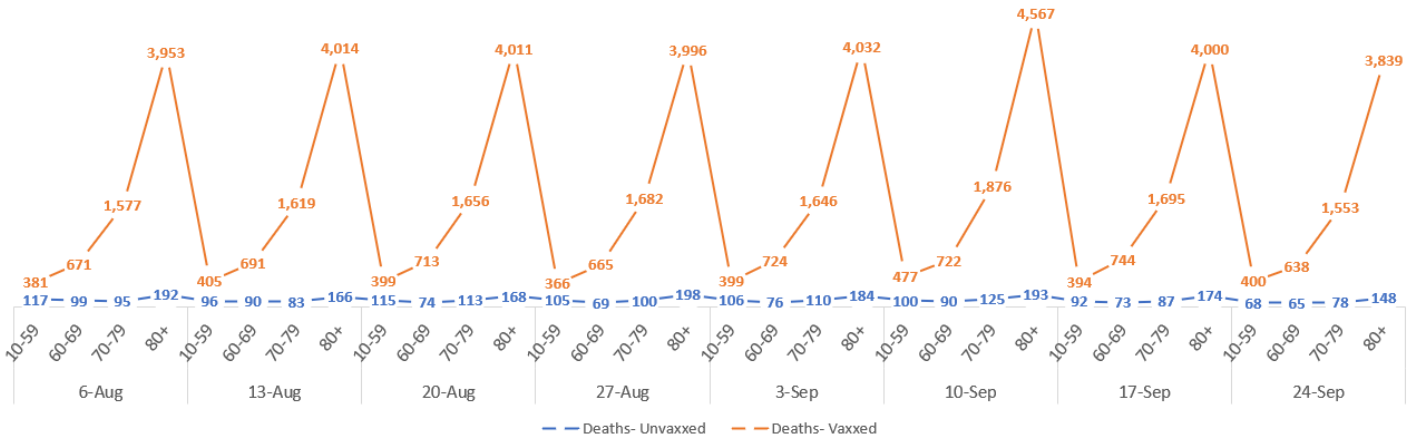
What is the difference in all-cause mortality of the vaxxed vs. unvaxxed during that period?

- The number of all cause deaths in the unvaccinated population between those dates was 3,649, or 6.27% of all-cause deaths.
- The number of all caused deaths in the fully vaccinated population between those dates was 54,505, or 93.73% of all-cause deaths.

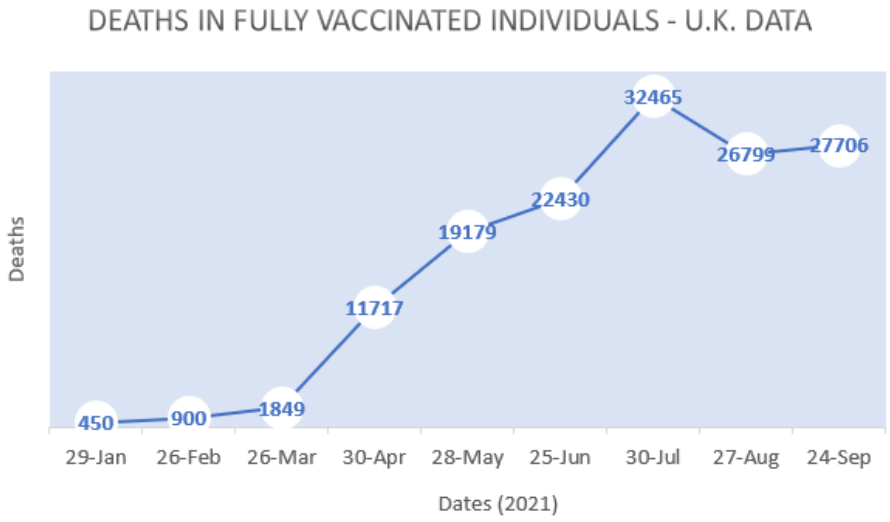
For the portion of the population that is fully vaccinated (at 68% as of November 28th, 2021), to represent nearly 94% of all deaths in the UK for all age groups is a safety signal that something is seriously wrong!

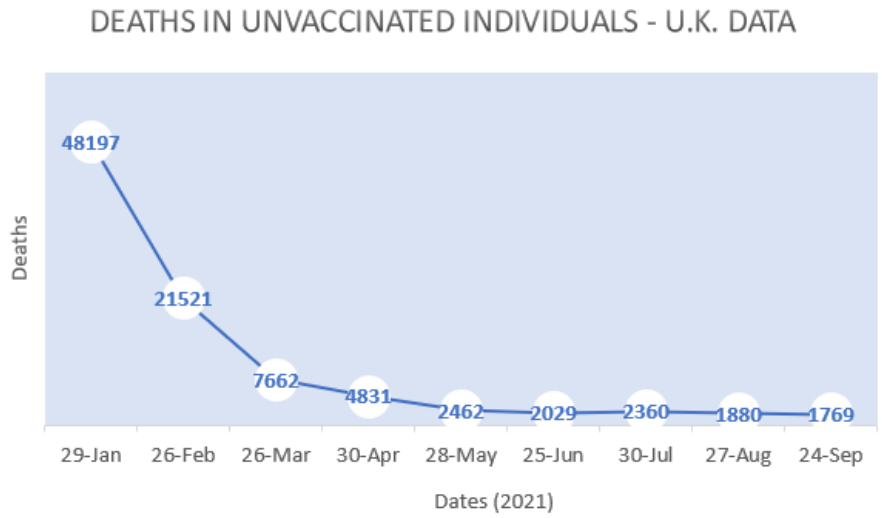
Another way to look at this of course is that unvaccinated people at around 32% of the population account for just over 6% of total deaths. And keep in mind that the countries where this is happening are one to two months ahead of the United States in their vaccine programs. Fortunately, the government of the United Kingdom is being forthright in their reporting. It gives countries like the United States the opportunity to change course, but only if the leadership observes the warning signs and does so. Think about it like two ships at sea traveling through a storm, with the ship in the rear charting the same course as the one ahead. And a distress signal being radioed by the one ahead that they have just hit a reef and run aground. The fate of that second ship is in the hands of the captain who must make a decision as to continue the same course or to deviate and avoid sure destruction. Will our government take the evasive action necessary to avoid a calamity?

A graphic example of what that looks like…



How does the data look when comparing vaccinated and unvaccinated individuals throughout 2021 up to September 24th, 2021?





Before releasing this month's issue, I decided to look at the very latest ***Public Health England Surveillance Report number 47***, reporting data between weeks 43 and 46.

This is a disclaimer that they have on the page. It attempts to rationalize the higher numbers for vaccinated individuals. This is what it says.

In the context of very high vaccine coverage in the population, even with a highly effective vaccine, it is expected that a large proportion of cases, hospitalisations and deaths would occur in vaccinated individuals, simply because a larger proportion of the population are vaccinated than unvaccinated and no vaccine is 100% effective. This is especially true because vaccination has been prioritised in individuals who are more susceptible or more at risk of severe disease. Individuals in risk groups may also be more at risk of hospitalisation or death due to non-COVID-19 causes, and thus may be hospitalised or die with COVID-19 rather than because of COVID-19.

Let's see if that explanation stands up.

I looked at table numbers 10a and 10b and crunched some numbers.

Public Health England Surveillance Report 0n COVID-19 deaths for week 47 by age & vax status

Death within 60 days post diagnosis						**Death within 28 days post diagnosis**			
	unvaxxed	**vaxxed**				**unvaxxed**	**vaxxed**		
Under 18	10	0				8	0		
18-29	9	5				9	2		
30-39	32	15				28	11		
40-49	62	61				51	46		
50-59	134	158				108	126		
60-69	181	452				154	380		
70-79	175	996				163	846		
80 and up	207	1787				187	1492		
	810	3474	Total =	4284		708	2903	Total =	3611
Percent of 4284	18.91	81.09			Percent of 3611	19.61	80.39		

It appears that about 81% of the deaths are in vaccinated individuals across all age demographics. With the percentage of the population hovering around 66 to 68% during this time frame, that is an inordinate percentage of the COVID-19 deaths occurring in the vaccinated. Isn't lowering chances of severe disease or death the default narrative that they went to when they had to finally admit that the shots don't stop infection or transmission? That you are still as likely to get infected if you are vaccinated? This should be the final nail

in the coffin of the "vaccine" program. But don't expect any of them to come clean on any of this any time soon.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1036047/Vaccine_surveillance_report_-_week_47.pdf

Here are the two tables for easy comparison to my spreadsheet…

Table 10. COVID-19 deaths (a) within 28 days and (b) within 60 days of positive specimen or with COVID-19 reported on death certificate, by vaccination status between week 43 and week 46 2021

Please note that corresponding rates by vaccination status can be found in Table 11.

(a)

Death within 28 days of positive COVID-19 test by date of death between week 43 and week 46 2021	Total**	Unlinked*	Not vaccinated	Received one dose (1-20 days before specimen date)	Received one dose, ≥21 days before specimen date	Second dose ≥14 days before specimen date[1]
	[These data should be interpreted with caution. See information below in footnote about the correct interpretation of these figures]					
Under 18	9	1	8	0	0	0
18-29	13	0	9	0	2	2
30-39	44	1	28	0	4	11
40-49	104	3	51	0	4	46
50-59	250	5	108	0	11	126
60-69	555	3	154	0	18	380
70-79	1025	6	163	1	9	846
≥80	1,726	7	187	5	35	1,492

*individuals whose NHS numbers were unavailable to link to the NIMS

** number of deaths of people who had had a positive test result for COVID-19 and either died within 60 days of the first positive

(b)

Death within 60 days of positive COVID-19 test by date of death between week 43 and week 46 2021	Total**	Unlinked*	Not vaccinated	Received one dose (1-20 days before specimen date)	Received one dose, ≥21 days before specimen date	Second dose ≥14 days before specimen date[1]
	[These data should be interpreted with caution. See information below in footnote about the correct interpretation of these figures]					
Under 18	12	1	10	0	1	0
18-29	16	0	9	0	2	5
30-39	52	1	32	0	4	15
40-49	132	4	62	0	5	61
50-59	312	6	134	0	14	158
60-69	658	5	181	0	20	452
70-79	1,195	7	175	1	16	996
≥80	2,054	7	207	6	47	1,787

*individuals whose NHS numbers were unavailable to link to the NIMS

** number of deaths of people who had had a positive test result for COVID-19 and either died within 60 days of the first positive test or have COVID-19 mentioned on their death certificate

Reporting of vaccine effectiveness uses a deceptive tactic to make it sound better than it really is

I have covered this topic in the past looking at the dishonest way that relative risk reduction (RRR) is used when describing the effectiveness of a drug or vaccine. By selectively choosing that metric and leaving out the absolute risk reduction (ARR) and number needed to treat or to vaccinate (NNT or NNV), it portrays a completely disingenuous and inflated appearance of benefit. I ran across the following article this month that discusses much of this again, plus adds some really great nuances to it.
The article written by investigative journalist and PhD Mary Anne Demasi and published on her site November 11th is titled, **COVID-19 vaccine benefits exaggerated say experts**.

In February, Federal Health Minister Greg Hunt boasted that AstraZeneca's COVID-19 vaccine offered "100% protection" against death in the primary analysis of phase III trials.

It was repeated by the CEO of AstraZeneca and uncritically reported by the mainstream media in what seemed to be an impressive achievement.

The published study in ***The Lancet***, however, revealed a more nuanced picture.

In the trial of 23,848 subjects across the UK, Brazil, and South Africa, there was **one death** in the placebo group and **no deaths** in the vaccinated group.

One less death out of a total of one, indeed, was a relative reduction of **100%** but the absolute reduction was **0.01%**. (1/11,724 – 0/12,021)

Similarly, in February the CDC director Rochelle Walensky co-authored a publication in JAMA, which stated unequivocally:

"Clinical trials have shown that the vaccines authorized for use in the US are highly effective against COVID-19 infection, severe illness, and death."

However, there were too few deaths recorded in the controlled trials at the time to arrive at such a conclusion.

The 6 month follow up data from the blinded Pfizer trial found there were **15 deaths** in the vaccine group and **14 deaths** in the placebo group. (see table S4)

Reported Cause of Death[a]	BNT162b2 (N=21,926) n	Placebo (N=21,921) n
Deaths	15	14
Acute respiratory failure	0	1
Aortic rupture	0	1
Arteriosclerosis	2	0
Biliary cancer metastatic	0	1
COVID-19	0	2
COVID-19 pneumonia	1	0
Cardiac arrest	4	1
Cardiac failure congestive	1	0
Cardiorespiratory arrest	1	1
Chronic obstructive pulmonary disease	1	0
Death	0	1
Dementia	0	1
Emphysematous cholecystitis	1	0
Hemorrhagic stroke	0	1
Hypertensive heart disease	1	0
Lung cancer metastatic	1	0
Metastases to liver	0	1
Missing	0	1
Multiple organ dysfunction syndrome	0	2
Myocardial infarction	0	2
Overdose	0	1
Pneumonia	0	2
Sepsis	1	0
Septic shock	1	0
Shigella sepsis	1	0
Unevaluable event	1	0

Table S4 | Causes of Death from Dose 1 to Unblinding (Safety Population, ≥16 Years Old). a. Multiple causes of death could be reported for each participant. There were no deaths among 12–15-year-old participants.

NOTE: In the open label phase, another 5 deaths occurred in the vaccine group (2 were in the original placebo group but swapped to the vaccine group after unblinding).

Last week, at a roundtable meeting in the US Capitol, Prof Peter Doshi, associate editor of *The BMJ* raised concerns about the statements made by the CDC director. *(**My comment:** That was the meeting/hearing I highlight in this issue, that Senator Ron Johnson from Wisconsin held to bring attention to the problem with COVID-19 vaccine injuries and deaths. In addition, the complete shunning of the people that have been injured or have died by our government agencies).*

"The trials did not show a reduction in deaths, even for Covid deaths. The evidence was flimsy," said Prof Doshi.

"Those who claimed the trials showed that the vaccines were highly effective in saving lives were wrong. The trials did not demonstrate this."

Prof Doshi was not passing judgement on the vaccines. Instead, he was critical of the way authorities had portrayed trial data to the public.

All the public announcements about the vaccines were initiated by the vaccine manufacturers in highly curated press releases, and it significantly shaped the public narrative, setting the stage for high expectations.

For example, Pfizer published a press release claiming the vaccine was "95% effective against COVID-19."

Several weeks later, the actual trial results were published in the *New England Journal of Medicine*.

- In the vaccine group, 8 out of 18,198 people had COVID-19 symptoms (0.04%)
- In the placebo group, 162 out of 18,325 people had COVID-19 symptoms (0.88%)

The vaccine reduced the baseline risk from 0.88% down to 0.04% after two months. That is, a 'relative risk reduction (RRR) of **95%** but an absolute risk reduction (ARR) of **0.84%**.

Hence, if someone's baseline risk of COVID-19 is very low to begin with (as it is for most people under 50 years), a 100% reduction in risk is trivial.

An editorial in *The Lancet* compared the RRR of each vaccine to the ARR:

Vaccine	Relative Risk Reduction (RRR)	Absolute Risk Reduction (ARR)
Pfizer	95%	0.84%
Moderna	91%	1.2%
AstraZeneca	67%	1.3%

Notably, when quoting the vaccine's harms, authorities will use the smaller percentage, ARR, presumably to minimise public concern about adverse events.

If authorities are using different metrics to convey the harms and benefits of a medical therapy, it is misleading the public.

Exaggerate the benefits?

It is well established that only quoting RRR without quoting the ARR, can inflate or exaggerate an intervention's effect size and clinical importance, as well as increase people's willingness to receive the treatment.

It has been referred to as the first "sin" against transparent communication by Gerd Gigerenzer, director of the Harding Centre for Risk Literacy at the Max Planck Institute. He says it can be used as "a deliberate tactic to manipulate or persuade people."

“Many physicians, patients, health journalists and politicians do not understand health statistics. This collective statistical illiteracy has resulted in serious consequences for health,” Gigerenzer says.
John Ioannidis, Professor at Stanford University and the most cited physician scientist, agrees.
“In my experience, innumeracy is widely prevalent,” says Prof Ioannidis.

“This is not happening just for vaccines. Over many decades, RRR has been the dominant way of communicating results of clinical trials. Almost always, RRR looks nicer than absolute risk reductions.”
When asked if there was any justification for misleading the public about the vaccine’s benefits to encourage uptake, Prof Ioannidis rejected the notion.

“I don't see how one can increase uptake by using misleading information. I am all in favour of increasing uptake, but this needs to use complete information, otherwise sooner or later incomplete information will lead to misunderstandings and will backfire,” says Ioannidis.

The way authorities have communicated risk to the public, is likely to have misled and distorted the public’s perception of the vaccine’s benefit and underplayed the harms.

This, in essence, is a violation of the ethical and legal obligations of informed consent.
End of article
https://maryannedemasi.com/publications/f/covid-19-vaccine-benefits-exaggerated-say-experts

Here’s a perfect example of how the media spin IS THE MISINFORMATION

More trouble for the credibility of the vaccine trials as a whistleblower's accounts including emails, documents and recordings of violations are disclosed in a *British Medical Journal* Investigative Report

A ***BMJ INVESTIGATION*** as reported by Paul D. Thacker titled, **Covid-19: Researcher blows the whistle on data integrity issues in Pfizer's vaccine trial**. Revelations of poor practices at a contract research company helping to carry out Pfizer's pivotal covid-19 vaccine trial raise questions about data integrity and regulatory oversight.

Excerpts from the article

In autumn 2020 Pfizer's chairman and chief executive, Albert Bourla, released an open letter to the billions of people around the world who were investing their hopes in a safe and effective covid-19 vaccine to end the pandemic. "As I've said before, we are operating at the speed of science," Bourla wrote, explaining to the public when they could expect a Pfizer vaccine to be authorised in the United States.1

But, for researchers who were testing Pfizer's vaccine at several sites in Texas during that autumn, speed may have come at the cost of data integrity and patient safety. A regional director who was employed at the research organisation Ventavia Research Group has told *The BMJ* that the company falsified data, unblinded patients, employed inadequately trained vaccinators, and was slow to follow up on adverse events reported in Pfizer's pivotal phase III trial. Staff who conducted quality control checks were overwhelmed by the volume of problems they were finding. After repeatedly notifying Ventavia of these problems, the regional director, Brook Jackson, emailed a complaint to the US Food and Drug Administration (FDA). Ventavia fired her later the same day. Jackson has provided *The BMJ* with dozens of internal company documents, photos, audio recordings, and emails.

In a recording of a meeting in late September2020 between Jackson and two directors a Ventavia executive can be heard explaining that the company wasn't able to quantify the types and number of errors they were finding when examining the trial paperwork for quality control. "In my mind, it's something new every day," a Ventavia executive says. "We know that it's significant."

Ventavia was not keeping up with data entry queries, shows an email sent by ICON, the contract research organisation with which Pfizer partnered on the trial. ICON reminded Ventavia in a September 2020 email: "The expectation for this study is that all queries are addressed within 24hrs." ICON then highlighted over 100 outstanding queries older than three days in yellow. Examples included two individuals for which "Subject has reported with Severe symptoms/reactions … Per protocol, subjects experiencing Grade 3 local reactions should be contacted. Please confirm if an UNPLANNED CONTACT was made and update the corresponding form as appropriate." According to the trial protocol a telephone contact should have occurred "to ascertain further details and determine whether a site visit is clinically indicated."

Worries over FDA inspection

Documents show that problems had been going on for weeks. In a list of "action items" circulated among Ventavia leaders in early August 2020, shortly after the trial began and before Jackson's hiring, a Ventavia executive identified three site staff members with whom to "Go over e-diary issue/falsifying data, etc." One of them was "verbally counseled for changing data and not noting late entry," a note indicates. At several points during the late September meeting Jackson and the Ventavia executives discussed the possibility of the FDA showing up for an inspection (box 1). "We're going to get some kind of letter of information at least, when the FDA gets here . . . know it," an executive stated. The next morning, 25 September 2020, Jackson called the FDA to warn about unsound practices in Pfizer's clinical trial at Ventavia. She then reported her concerns in an email to the agency. In the afternoon Ventavia fired Jackson—deemed "not a good fit," according to her separation letter. Jackson told *The BMJ* it was the first time she had been fired in her 20 year career in research.

Concerns raised

In her 25 September email to the FDA Jackson wrote that Ventavia had enrolled more than 1000 participants at three sites. The full trial (registered under NCT04368728) enrolled around 44 000 participants across 153 sites that included numerous commercial companies and academic centres.

She then listed a dozen concerns she had witnessed, including:

- Participants placed in a hallway after injection and not being monitored by clinical staff

- Lack of timely follow-up of patients who experienced adverse events
- Protocol deviations not being reported
- Vaccines not being stored at proper temperatures
- Mislabelled laboratory specimens, and
- Targeting of Ventavia staff for reporting these types of problems.

Within hours Jackson received an email from the FDA thanking her for her concerns and notifying her that the FDA could not comment on any investigation that might result. A few days later Jackson received a call from an FDA inspector to discuss her report but was told that no further information could be provided. She heard nothing further in relation to her report.

In Pfizer's briefing document submitted to an FDA advisory committee meeting held on 10 December 2020 to discuss Pfizer's application for emergency use authorisation of its covid-19 vaccine, the company made no mention of problems at the Ventavia site. The next day the FDA issued the authorisation of the vaccine.8

In August this year, after the full approval of Pfizer's vaccine, the FDA published a summary of its inspections of the company's pivotal trial. Nine of the trial's 153 sites were inspected. Ventavia's sites were not listed

among the nine, and no inspections of sites where adults were recruited took place in the eight months after the December 2020 emergency authorisation.

My comment: I had to red-light this section, because to me it shines a huge spotlight on the lack of oversight and quality control by the FDA. Mind you, this is the FDA's own summary admitting this lack of surveillance of what could arguably be the most important duty in the history of the agency. When a product is being rushed to market in 10% of the time it typically takes to run proper safety and efficacy trials, it should be incumbent of the "watchdog" of public health to step up and go above and beyond their usual lackluster performance. I say that because as I reported in a previous issue, the FDA has always been significant understaffed and biologics facilities under inspected. See the excerpts from that report after this story.

Also, in this BMJ investigation this section titled "Box 1" exposes exactly what I'm talking about…

Box 1: A history of lax oversight

When it comes to the FDA and clinical trials, Elizabeth Woeckner, president of Citizens for Responsible Care and Research Incorporated (CIRCARE),3 says the agency's oversight capacity is severely under-resourced. If the FDA receives a complaint about a clinical trial, she says the agency rarely has the staff available to show up and inspect. And sometimes oversight occurs too late.

In one example CIRCARE and the US consumer advocacy organisation Public Citizen, along with dozens of public health experts, filed a detailed complaint in July 2018 with the FDA about a clinical trial that failed to comply with regulations for the protection of human participants.4 Nine months later, in April 2019, an FDA investigator inspected the clinical site. In May this year the FDA sent the triallist a warning letter that substantiated many of the claims in the complaints. It said, "[I]t appears that you did not adhere to the applicable statutory requirements and FDA regulations governing the conduct of clinical investigations and the protection of human subjects."5

"There's just a complete lack of oversight of contract research organisations and independent clinical research facilities," says Jill Fisher, professor of social medicine at the University of North Carolina School of Medicine and author of *Medical Research for Hire: The Political Economy of Pharmaceutical Clinical Trials*. **Ventavia and the FDA**

A former Ventavia employee told *The BMJ* that the company was nervous and expecting a federal audit of its Pfizer vaccine trial.

"People working in clinical research are terrified of FDA audits," Jill Fisher told *The BMJ*, but added that the agency rarely does anything other than inspect paperwork, usually months after a trial has ended. "I don't know why they're so afraid of them," she said. But she said

she was surprised that the agency failed to inspect Ventavia after an employee had filed a complaint. “You would think if there’s a specific and credible complaint that they would have to investigate that,” Fisher said.

In 2007 the Department of Health and Human Services’ Office of the Inspector General released a report on FDA’s oversight of clinical trials conducted between 2000 and 2005. The report found that the FDA inspected only 1% of clinical trial sites.6 Inspections carried out by the FDA’s vaccines and branch have been decreasing in recent years, with just 50 conducted in the 2020 fiscal year.7

Other employees’ accounts

In recent months Jackson has reconnected with several former Ventavia employees who all left or were fired from the company. One of them was one of the officials who had taken part in the late September meeting. In a text message sent in June the former official apologised, saying that “everything that you complained about was spot on.”

Two former Ventavia employees spoke to *The BMJ* anonymously for fear of reprisal and loss of job prospects in the tightly knit research community. Both confirmed broad aspects of Jackson’s complaint. One said that she had worked on over four dozen clinical trials in her career, including many large trials, but had never experienced such a “helter skelter” work environment as with Ventavia on Pfizer’s trial.

“I’ve never had to do what they were asking me to do, ever,” she told *The BMJ*. “It just seemed like something a little different from normal—the things that were allowed and expected.”

She added that during her time at Ventavia the company expected a federal audit but that this never came.

After Jackson left the company problems persisted at Ventavia, this employee said. In several cases Ventavia lacked enough employees to swab all trial participants who reported covid-like symptoms, to test for infection. Laboratory confirmed symptomatic covid-19 was the trial’s primary endpoint, the employee noted. (An FDA review memorandum released in August this year states that across the full trial swabs were not taken from 477 people with suspected cases of symptomatic covid-19.)

“I don’t think it was good clean data,” the employee said of the data Ventavia generated for the Pfizer trial. “It’s a crazy mess.”

A second employee also described an environment at Ventavia unlike any she had experienced in her 20 years doing research. She told *The BMJ* that, shortly after Ventavia fired Jackson, Pfizer was notified of problems at Ventavia with the vaccine trial and that an audit took place.

Since Jackson reported problems with Ventavia to the FDA in September 2020, Pfizer has hired Ventavia as a research subcontractor on four other vaccine clinical trials (covid-19 vaccine in children and young adults, pregnant women, and a booster dose, as well an RSV vaccine trial; NCT04816643, NCT04754594, NCT04955626, NCT05035212). The advisory committee for the Centers for Disease Control and Prevention is set to discuss the covid-19 paediatric vaccine trial on 2 November.

End of excerpts

Excerpts from my previous report…

Case in point. Another concern now that we have witnessed the "***Operation Warp Speed***" production and rollout of these vaccines is, what kind of quality control has there been? An article in Vanity Fair brings serious questions to light about safety and health violations at the plants where vaccines and biologics are made. Apparently, the FDA has a team of only 14 inspectors that are responsible for inspecting 280 vaccine and biologics plants and manufacturing facilities. One of those inspectors has come forward with serious allegations of the lack of follow through on the part of the FDA after violations are brought to light.
The December 2nd, 2020, article by Katherine Eban is titled, **The COVID Vaccines Are Approaching. Is the FDA Ready to Inspect the Plants Where They're Made?** Some of the revelations in this article are truly shocking.
https://www.vanityfair.com/news/2020/12/fda-covid-vaccine-plant-inspectors
Watch an interview with Katherine Eban regarding the FDA whistleblower and these issues here…
https://video.kqed.org/video/whistleblower-says-fda-isn-t-properly-regulating-facilities-1607290063/

You will see in my eBook on starting on page 135, that independent analysis of vaccines has found they often contain potentially dangerous contaminants and may not contain the very things we are told are in them that are supposed to give them their effectiveness. With the unprecedented rollout of billions of doses of vaccines in record time, quality control that was apparently sorely lacking before, is likely much worse now. If safety has been sacrificed for speed, it could certainly put people's health and life at risk.

Why is the FDA trying to hide the Pfizer trial data from the public for 55 years?

Attorney Aaron Siri's Substack story shines light on the egregious and frankly unbelievable request by the FDA to bury the Pfizer trial data until 2176. This unprecedented effort begs the question. What in the world are they trying to hide?

The article…

FDA Asks Federal Judge to Grant it Until the Year 2076 to Fully Release Pfizer's COVID-19 Vaccine Data
The fed gov't shields Pfizer from liability. Gives it billions of dollars. Makes Americans take its product. But won't let you see the data supporting its safety/efficacy. Who does the gov't work for?

The FDA has asked a federal judge to make the public wait until the year 2076 to disclose all of the data and information it relied upon to license Pfizer's COVID-19 vaccine. That is not a typo. It wants 55 years to produce this information to the public.

As explained in a prior article, the FDA repeatedly promised "full transparency" with regard to Covid-19 vaccines, including reaffirming "the FDA's commitment to transparency" when licensing Pfizer's COVID-19 vaccine.

With that promise in mind, in August and immediately following approval of the vaccine, more than 30 academics, professors, and scientists from this country's most prestigious universities requested the data and information submitted to the FDA by Pfizer to license its COVID-19 vaccine.

The FDA's response? It produced nothing. So, in September, my firm filed a lawsuit against the FDA on behalf of this group to demand this information. To date, almost three months after it licensed Pfizer's vaccine, the FDA still has not released a single page. Not one.

Instead, two days ago, the FDA asked a federal judge to give it until 2076 to fully produce this information. The FDA asked the judge to let it produce the 329,000+ pages of documents Pfizer provided to the FDA to license its vaccine at the rate of 500 pages per month, which means its production would not be completed earlier than 2076. The FDA's promise of transparency is, to put it mildly, a pile of illusions.
It took the FDA precisely 108 days from when Pfizer started producing the records for licensure (on May 7, 2021) to when the FDA licensed the Pfizer vaccine (on August 23, 2021). Taking the FDA at its word, it conducted an intense, robust, thorough, and complete review and analysis of those documents in order to assure that the Pfizer vaccine was safe and effective for licensure. While it can conduct that intense review of Pfizer's documents in 108 days, it now asks for over 20,000 days to make these documents available to the public.

So, let's get this straight. The federal government shields Pfizer from liability. Gives it billions of dollars. Makes Americans take its product. But won't let you see the data supporting its product's safety and efficacy. Who does the government work for?

The lesson yet again is that civil and individual rights should never be contingent upon a medical procedure. Everyone who wants to get vaccinated and boosted should be free to do so. But nobody should be coerced by the government to partake in any medical procedure. Certainly not one where the government wants to hide the full information relied upon for its licensure until the year 2076!
End of article

In typical fashion, the people on the committee deciding whether children are exposed to these shots and parent's right to protect their children's bodily autonomy all have ties to Big Pharma

Children's Health Defense published an article on November 24th titled, **14 ACIP Members Who Voted to Jab Your Young Children — and Their Big Ties to Big Pharma**-

Subheading: On Nov. 2, members of the Centers for Disease Control and Prevention's vaccine advisory committee voted 14–0 to recommend Pfizer's pediatric COVID shot for children 5 –11 years old. Were their decisions driven by science and conscience — or their ties to drugmakers?

From the article
Neither the disgracefully unscientific vote nor CDC Director Rochelle Walensky's prompt endorsement came as a surprise. Though billed as "independent," the 14 ACIP members — like the 17 members of FDA's VRBPAC who voted the same way the previous week — have deep ties to pharma, with careers that hinge on promoting and rubber-stamping the United States' destructive one-size-fits-all vaccination agenda.

Describing the VRBPAC and ACIP meetings as "a total sham," Children's Health Defense President Mary Holland said, "Sadly, approval from these committees means nothing in terms of safety."

Political scientist Toby Rogers agreed, stating the ACIP meeting "was not a scientific review. It was banal bureaucrats announcing plans for a Blitzkrieg and the bought white coats were cheering them on."

With their vote to give young children the dangerous injections, ACIP members signaled that they, too, deserve to be shunned, along with the powerful institutions with which they are affiliated. The latter include the nation's top universities and leading pediatric hospitals.

The article goes on to list the various members and their pharmaceutical connections.

You can read the entire article here…
https://childrenshealthdefense.org/defender/cdc-acip-pfizer-pediatric-covid-vaccine-big-pharma/

An attorney's op-ed in the Wall Street Journal explains why it is illegal to mandate these shots on children

Despite the corruption in the approval process for these shots for kids, some solace maybe gained by the opinion given by this attorney about the legality of mandating these shots for children. Despite the unlawful

attempts that will come to require these shots for children entering school, parents need to push back and the legal system needs to uphold the law and prevent mandating these EUA experimental products.

The Opinion piece by Jenin Younes- Nov. 9, 2021

Now that the Food and Drug Administration has authorized the Pfizer -BioNTech vaccine for 5- to 11-year-olds, expect a wave of Covid-19 vaccine mandates for children. San Francisco announced last week that the city will require children in that age group to show proof of vaccination to enter restaurants, sporting events, swimming pools and more. New York's School of American Ballet informed parents via email on Nov. 4 that all students—the school enrolls children as young as 6—must receive a Covid vaccine by January.

While parents may choose to vaccinate their own children, these mandates are unethical and unlawful. Advocates of mandating Covid vaccines equate them with standard childhood shots against polio, chickenpox, TDaP (tetanus, diphtheria and pertussis) and MMR (measles, mumps and rubella). But those decades-old vaccines have gone through the full FDA testing regime. The Covid vaccine has received only emergency-use authorization for this age group, meaning its safety and efficacy have not yet been established to the FDA's satisfaction.

he Covid-19 vaccines are too new to have been studied for long-term effects. There are no studies of whether it is safe to vaccinate children who have recovered from Covid-19. Many states don't require vaccinating children against diseases they have already had, like measles or chickenpox, because they acquire natural immunity. Why should Covid be any different?

The emergency-use authorization of the Covid vaccine also creates a legal distinction. Federal law requires, among other things, that potential recipients of EUA products be informed "of the option to accept or refuse administration of the product, of the consequences, if any, of refusing administration of the product, and of the alternatives to the product that are available and of their benefits and risks."

Put plainly, this means that patients—in this case children—may not be forced, coerced or pressured into taking EUA products and are entitled by law to refuse them. Another statute authorizes the president to require members of the armed services to take EUA products, and President Biden has invoked this power to require Covid vaccination. No law authorizes such mandates outside the military. Conditioning access to education and participation in public life on treatment with an unapproved vaccine is the antithesis of free and informed consent and is therefore unlawful. Private institutions that force an EUA drug on children could face lawsuits.

A new statute permitting mandates for EUA products would be unconstitutional as well. Children have a right to bodily autonomy and to refuse unnecessary medical treatment, which their parents exercise on their behalf. The government can't conscript them as guinea pigs or vessels to protect adults. Young children face virtually no risk from Covid-19 and the mandates mainly serve to assuage adult fear. Young children rarely infect adults, who in any event have had access to vaccines for many months. And children pose no threat to anyone if they have natural immunity.

Children's rights and needs have taken a back seat during the past 18 months. Let's not make forced vaccination of young children, which is unconstitutional and illegal under federal law, the next way in which we disregard their interests to mollify adults' irrational fears.

Ms. Younes is litigation counsel at the New Civil Liberties Alliance.

Article exposes false narratives about the origins of SARS-CoV-2 variants and the failure of Dr. Fauci and his cohorts to allow doctors to treat patients early

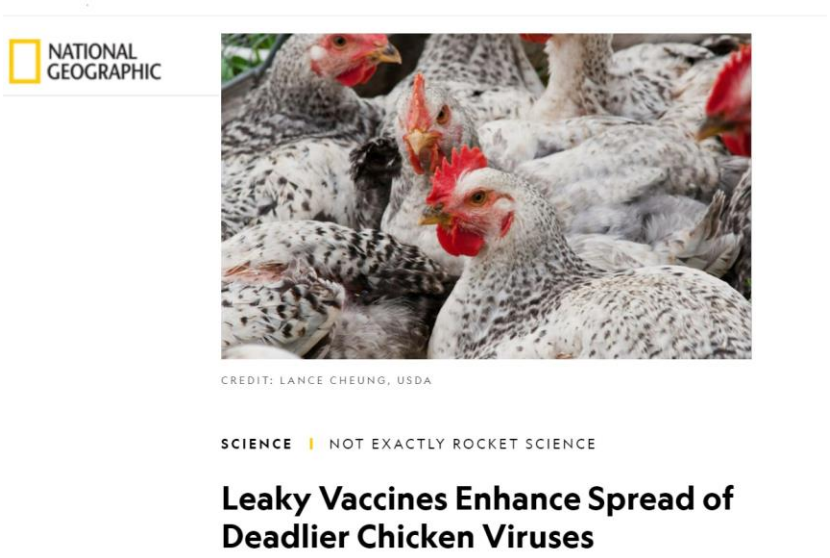
A Substack article by James Lyons Weiler published on November 19th, 2021, titled **Where Do New Variants REALLY Come From? Most Variants of Concern Pre-date the Vaccine and Could Not Have Come from "The Unvaccinated". So Where Does Science Say They Really Come From?** is an excellent explanation of some very important aspects of the COVID-19 narrative. It also appeals for people to rally around Dr. Paul Marik in his fight to preserve a doctor's right to treat patients based on their clinical judgment, training, experience and expertise. That is threatened in today's medical-corporate, non-individualized, one-size-fits-all, protocol-based medicine.
Consider subscribing to James Lyons Weiler's Substack at https://popularrationalism.substack.com

Article
The molecular clock is a wonderful tool. It allows us to put a date on the emergence of new species, or in the case of viruses, new viral lineages.

Luckily, we have the public record to tell us when variants were first detected. The Delta variant, for example, was first detected in late 2020, long before any COVID-19 vaccination program.
That did not stop vaccine zealots from launching a half-hearted attempt to blame the "Unvaccinated" as the source of new variants.

Since we know variants emerged before there were "Vaccinated" or "Unvaccinated" categories of people, the emergence and spread of new variants requires no special explanation. Evolution happens. But there are a few factors that are in place that are helping the emergence of new variants.

Factor 1. Leaky Vaccines
It is widely known from animal science that when a virus is widespread in a flock or herd, vaccinating during the outbreak against viruses can be disastrous. Due to high numbers of infected individuals with high viremia (blood levels of infectious virus), a lot of genetic diversity can exist. And the vaccine immunity can interact with virus in a process known as antibody-dependent enhancement, a form of pathogenic priming.
This factor is so well-known that National Geographic reports "Not Exactly Rocket Science".

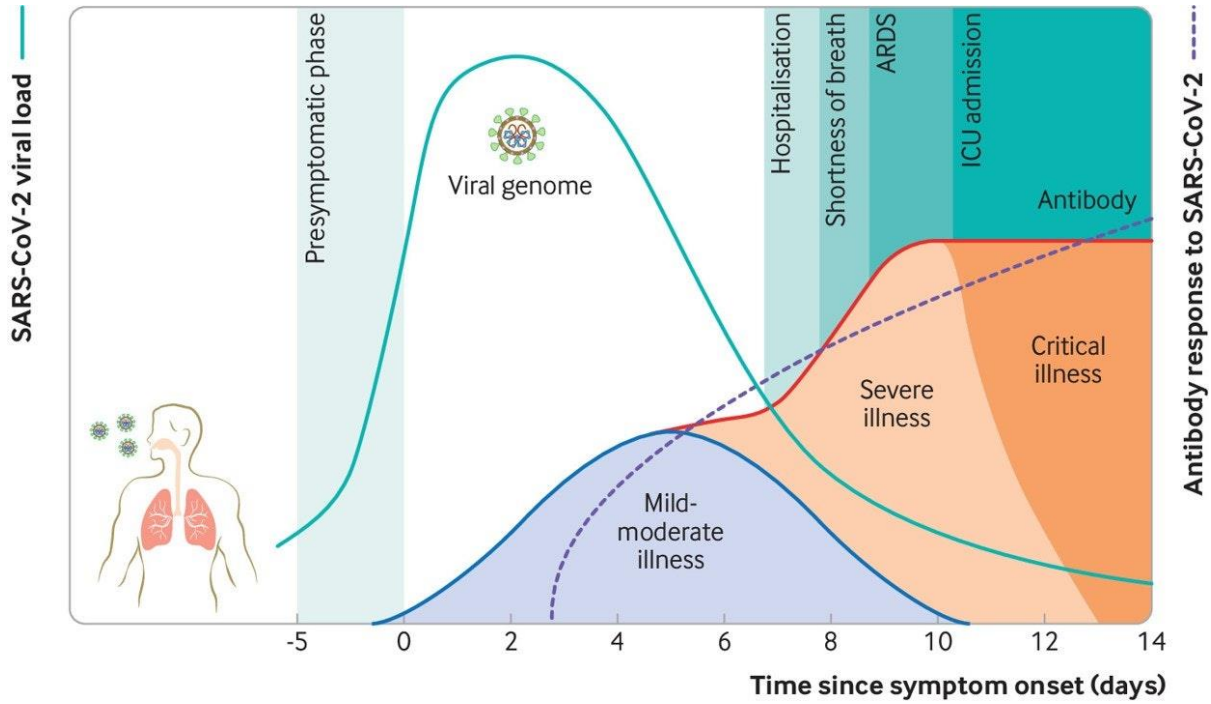


This was the factor that Nobel Laureate Luc Montagnier was referencing in the French documentary "Hold-Up" he said (about vaccinating during a pandemic):
"It's an enormous mistake, isn't it? A scientific error as well as a medical error. It is an unacceptable mistake."

He also said
"The history books will show that because it is the vaccination that is creating the variants".
and that many epidemiologists know this, but remain silent about the problem known as antibody-dependent enhancement.

Factor 2. Fauci Medicine
From the onset, CDC insisted that "PCR+ = 'COVID-19'". I (and others) have addressed the issue with the many flaws of using PCR as applied to the diagnosis of COVID-19 in many places. But the issue with "PCR+ = 'COVID-19'" became an even more serious problem when tied with the public health version of medical care for COVID-19, which is "Go Home and Isolate for 10 to 14 Until You're Sick Enough for Emergency Care".
This figure, from the BMJ, shows the timeline from infection to resolution or serious COVID-19:

My comment: I just love this next graph! It really provides a great snapshot of the phases of, infection, viral replication, progression of illness and the adaptive immune system's antibody response. It also clearly exposes the missed opportunity for early treatment and the tragic mistake of sending people home from the hospital without anti-viral medication, allowing the virus to incubate in their bodies unchecked often leading to a state of severe illness.



Under Fauci Medicine, patients who have mild COVID-19 and those who develop serious COVID-19 become in-home incubators of the SARS-CoV-2 virus.

To date, there have been 47.5 Million cases of COVID-19 reported to CDC. That means that **Fauci Medicine has allowed 1.2 Million Person-Years of viremia.**

Why do I say Fauci Medicine did this? Because of Factor 3.

Factor 3. Fauci Medicine Part 2.

The rest of Fauci Medicine, of course, is to send people home with no instructions on outpatient care. Dr. Paul Marik, one of the most ethical physicians in the US, is currently embattled in court for daring to actually practice medicine, daring to treat patients with COVID-19, and for daring to save lives.

He and other physicians who have provided the early effective treatments have also helped reduce viremia in COVID-19 infection - as well as the duration of illness. Both factors reduce the risk transmission.

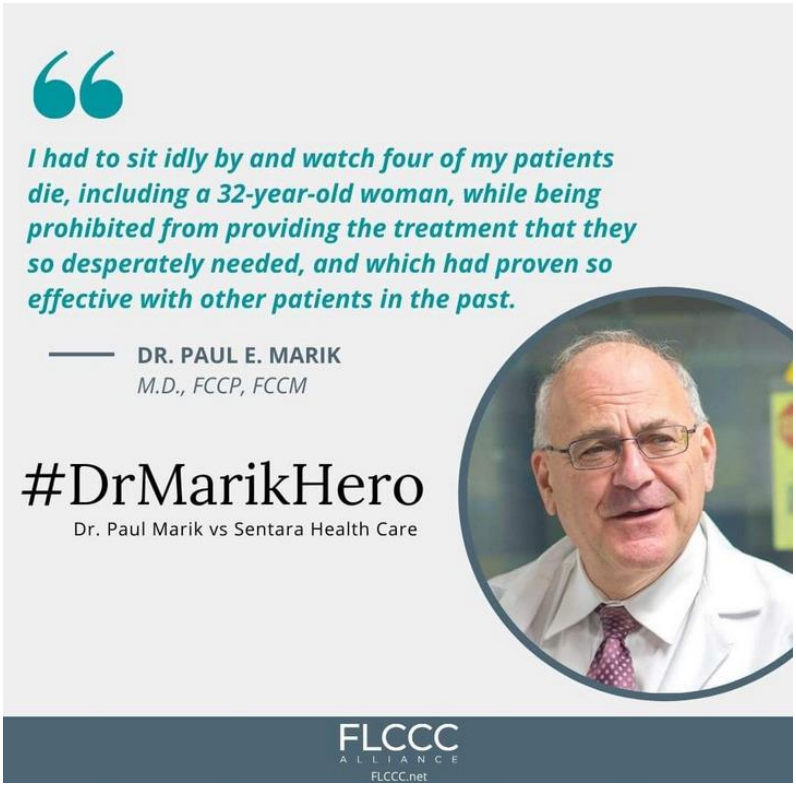
Fauci, by contrast, has destroyed public confidence in Science as well as awareness of the fact of the efficacy and safety of available early treatments.

The denial of early treatment and the millions of episodes of people incubating at home has led to variants. To the extent that the unvaccinated develop high viremia - well, if the disinformation campaign against early treatment had not been so pervasive, infiltrating each and every mainstream media channel, the unvaccinated no doubt would have had greater awareness - and access to- effective early treatments.

Usually my articles end with buttons to Subscribe. Today I'd like everyone to support Dr. Paul Marik via this petition - sent to me by Dr. Pierre Kory.

Your support of Dr. Marik will help ethical physicians everywhere to become free of the yoke of Fauci Medicine.

Click on the image below and share this article with #WeStandWithMarik and #DrMarikHero.
Let Doctors Be Doctors!



https://popularrationalism.substack.com/p/where-do-new-variants-really-come

A caveat to the origins of the variant… There has been evidence presented that the major variance of concern have originated in countries where there were major clinical trials for the various vaccines. The speculation is that the large numbers of vaccinees put selective pressure on the virus and caused it to mutate. There may be some validity to that theory.

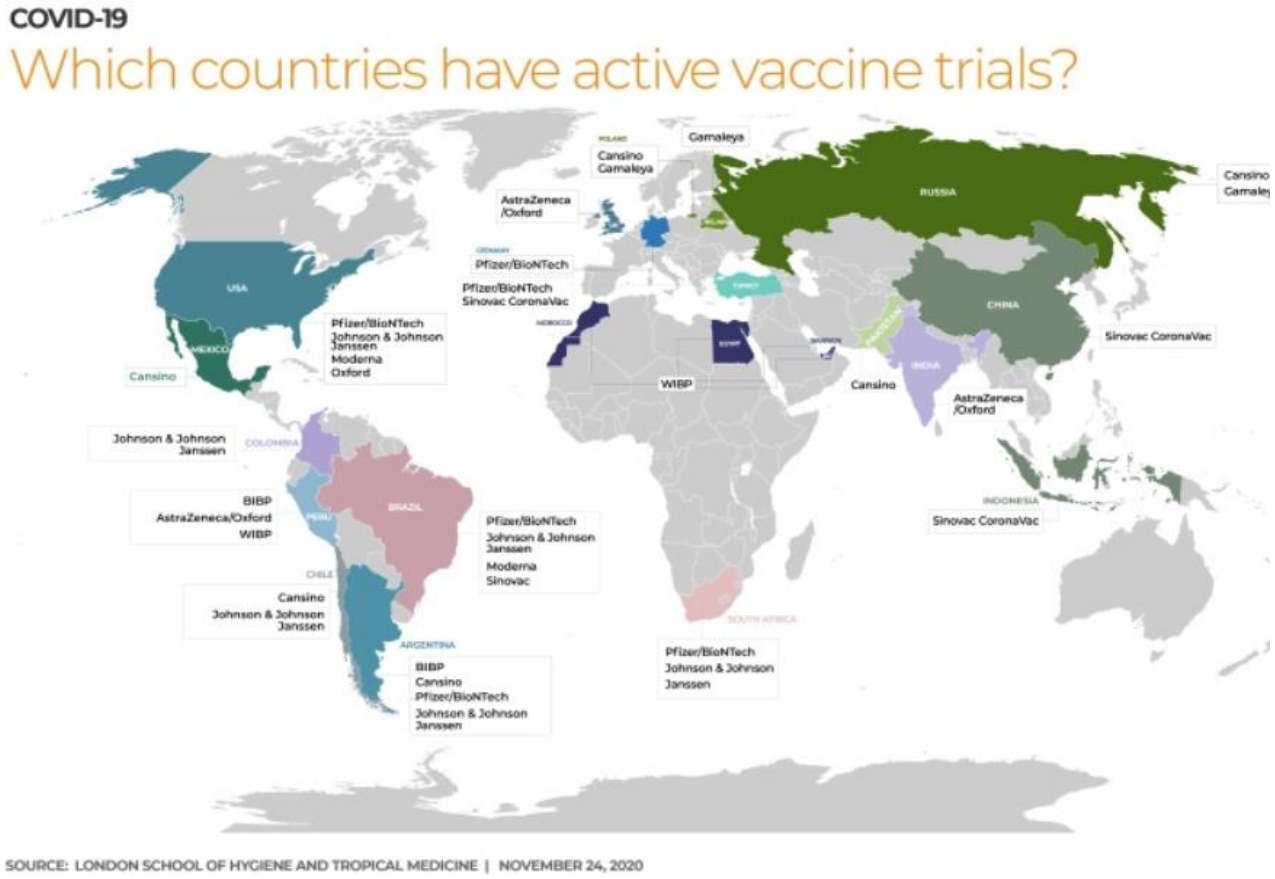
Here are some of the main variants that were first discovered in certain countries.

- The U.K. or Alpha variant (B.1.1.7)
- The South African or Beta variant (B.1.351)
- The Brazilian or Gamma variant (P.1)
- The United States variants (B.1.427 and B.1.429 or Epsilon, B.1.525 or Eta, B.1.526 or Iota)
- The Indian variants (B.1.617.1 or Kappa, B.1.617.2 or Delta)
- The Columbian or Mu variant (B.1.621)

- The Peru or Lambda variant (C.37)
- The Russian variant (AT.1)

https://pubmed.ncbi.nlm.nih.gov/34314723/
https://www.ecdc.europa.eu/en/covid-19/variants-concern

Here is a map of the countries that hosted vaccine trials.



It is incredibly ironic that these countries are all sites for the major COVID-19 vaccine clinical trials.

The latest variant fear-porn, the omicron variant. Is there a reason for concern?

Key points from a CNBC article titled, **A heavily mutated Covid variant emerges in southern Africa: Here's what we know so far**:

- The World Health Organization said a heavily mutated version of the virus that causes Covid-19 poses a possible increased risk of reinfection.
- The WHO named the strain omicron and labeled it a variant of concern.
- South African scientist Tulio de Oliveira said in a media briefing that the variant contains more than 30 mutations to the spike protein, the component of the virus that binds to cells.

A couple comments on these "key points"

- The worry about re-infection should be less for those that have had a previous SARS-CoV-2 infection and recovered. Natural immunity recognizes the whole virus and numerous protein sequences, not just the spike as with vaccine produced antibody recognition.
- If this version of the virus now has more than 30 mutations to the spike protein, the chances of vaccine escape are that much greater. The original vaccine is still geared for the original spike protein from the original Wuhan virus, making it more and more obsolete as the virus mutates away from that original strain.
- As viruses mutate, the norm is for them to become more transmissible but less lethal. However, if the viruses are mutating to escape the leaky "vaccines", the more we vaccinate the more they will be pushed to evade. As they are pushed in this way, the vaccinated will become increasingly at-risk for developing ***Antibody Dependent Enhancement (ADE)***, leading to more serious disease and deaths in those that have been on the vaccine merry-go-round that is the current and future game plan of the myopic approach we have seen throughout. This is already happening in the most highly vaccinated populations as highlighted in this and previous issues of this newsletter.

https://www.cnbc.com/2021/11/26/covid-variant-emerges-in-south-africa-heres-what-we-know-so-far.html

One possibility:

A consideration is, as these variants develop numerous mutations that are more and more different from the original Wuhan virus, the possibility exists they will become unstable and may disappear more quickly. This is common in highly mutated viruses. In the meantime, until we see plan on a 24/7 barrage of fear-mongering.

Another possibility:

As more mutations develop, many of them will occur on the spike protein (currently 30 mutations) and affect the receptor binding domain (RBD), which is how the virus attaches to our cells. This makes it unable to infect the cell.

Interestingly, the first 4 cases that were reported were all fully vaccinated.

The following are portions of a Tweet by the Highwire on November 25th, 2021.
One day before the WHO's VOC statement, the Government of Botswana's Presidential COVID-19 Task Force Coordinator Dr. K. Basupu released their statement regarding the variant detected in the country.

Notably, the statement read, "The four (4) cases were detected among travelers who tested SARS-COV-2 positive on routine pre travel testing." The statement went on to read "The preliminary report revealed that all four had been fully vaccinated for COVID-19."

The chairwoman of the South African Medical Association has described the travel restrictions imposed on the country as “hasty” and the reaction from other countries as “a storm in a teacup”.
Dr Angelique Coetzee told BBC News: “We think it is a premature decision that has been taken, I think it is a hasty decision.

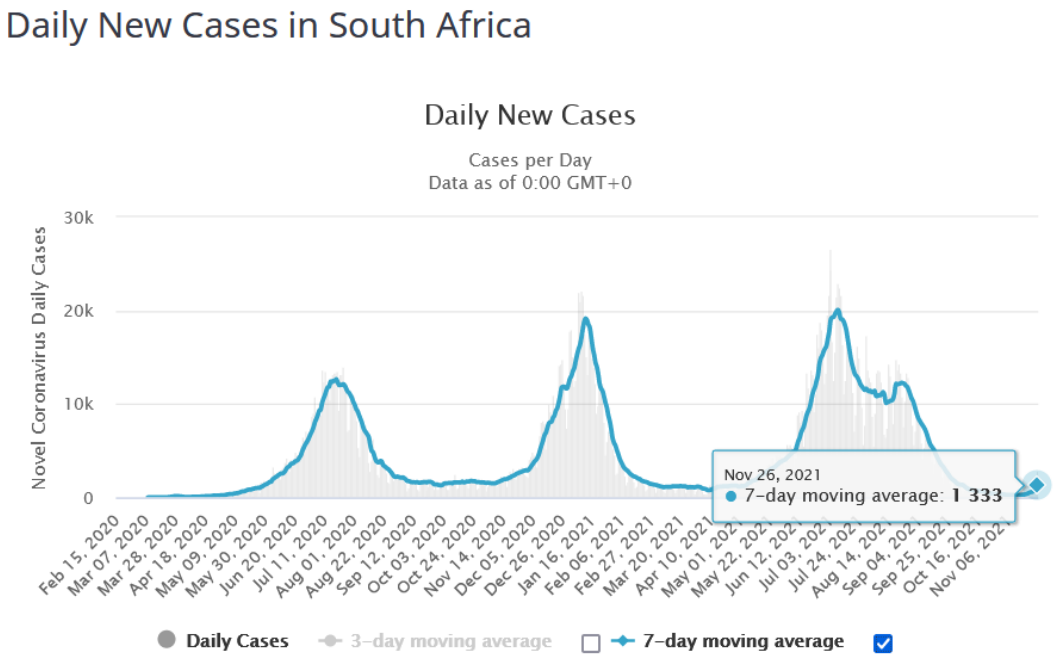
“I would understand if it was two weeks later and we know much more about this viral infection that is going around, or this mutation, but for now, it is like a storm in a teacup.

“We have only become aware of this viral mutation, or the new strain we are seeing, last week.”
She added: “From us as medical practitioners, we picked up, last week, the different clinical pictures, we looked at the advisory committees and so far what we have seen is very mild cases. [I’m] not sure why we are all up in arms.

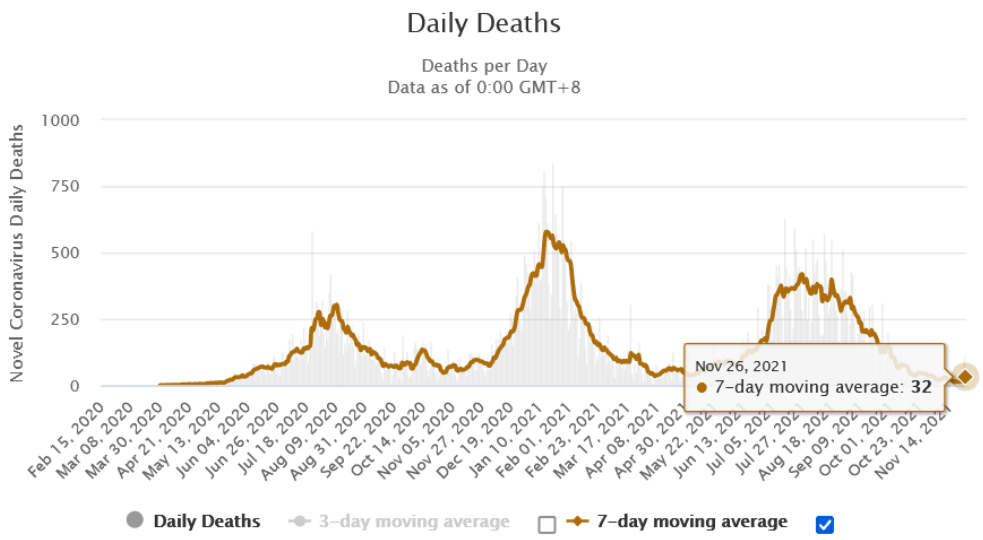
The new variant, reportedly having the most mutations so far of any variant, is also allegedly demonstrating “immune evasion and enhanced transmissibility” reports CNN. Could this be the exact scenario the likes of which Vaccinologist, Geert Vanden Bossche, Ph.D., D.V.M. and other top scientists have warned about? Watch the breaking new interview below as one of the world’s top vaccine experts warns of a COVID catastrophe.

https://thehighwire.com/news/developing-variant-of-concern-mutation-first-detected-in-4-vaccinated-people-says-govt/

This is what is currently happening in South Africa, where the variant has originated.



Daily New Deaths in South Africa



Just in time for the new variant, Pfizer to the rescue with a new vaccine. Couldn't have seen that one coming!

In a Yahoo article posted November 27th, 2021, titled, **Pfizer said an updated version of its COVID-19 vaccine will be 'ready in 100 days' if the new Omicron variant is resistant to its current vaccine**, the drugmaker generously says that it can make a new "vaccine" for the variant and make tens of billions of dollars, to bail out the world from their failed vaccine (which they have made an estimated $$$$$$$).

Key points from the article

- Pfizer said it can update its COVID-19 vaccine if the Omicron variant is found to be resistant to its current vaccine.
- The company said it can update its current vaccine within 100 days.
- Pfizer expects to know within two weeks whether the variant is resistant, a spokesperson told Reuters.
  My comment: Vegas odds are 100,000 to 1 for resistance.

https://news.yahoo.com/pfizer-said-updated-version-covid-153353672.html

Vermont, with the highest vaccination rate in the country is reeling from all-time high cases, hospitalizations and deaths, especially in the fully vaccinated

Vermont CDC Vaccine Scorecard

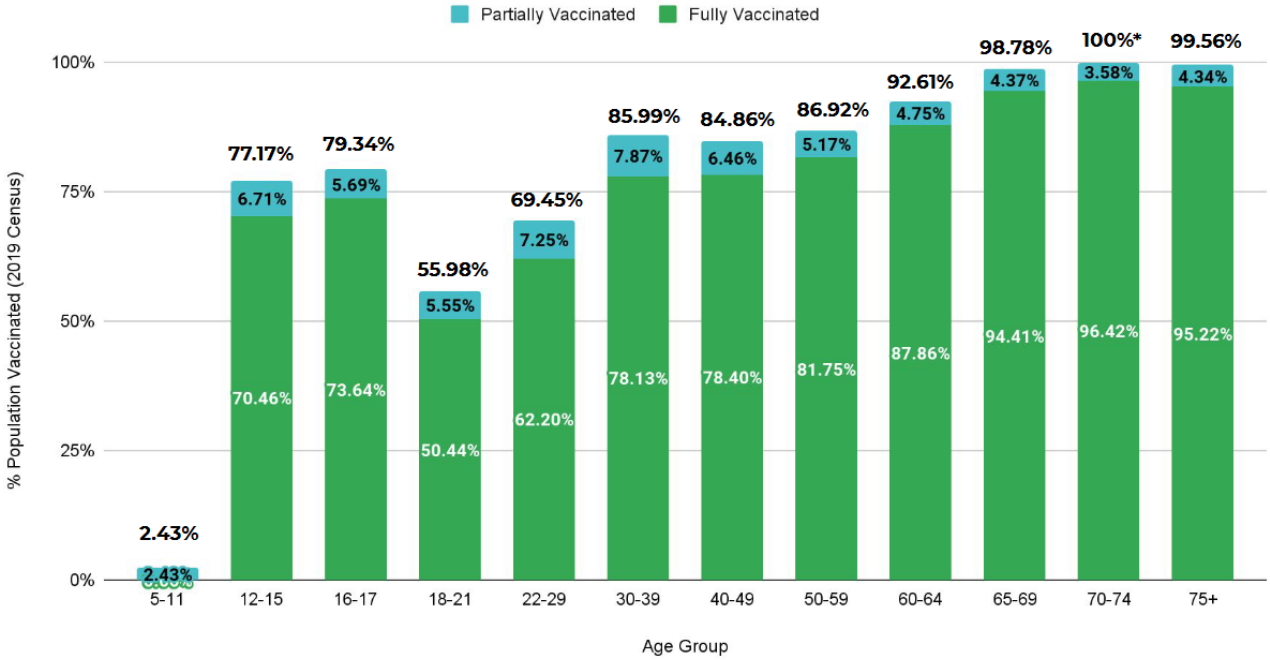
Metric	Figure	State Ranking
Doses Administered per 100K	163,427	1
% At Least 1 Dose (Eligible Population)	91.1%	5
% Fully Vaccinated (Eligible Population)	81.2%	3
% At Least 1 Dose (Full Population)	80.6%	2
% Fully Vaccinated (Full Population)	71.7%	1
% Fully Vaccinated (65 & Over)	97.9%	1

41

Source: CDC—November 9, 2021

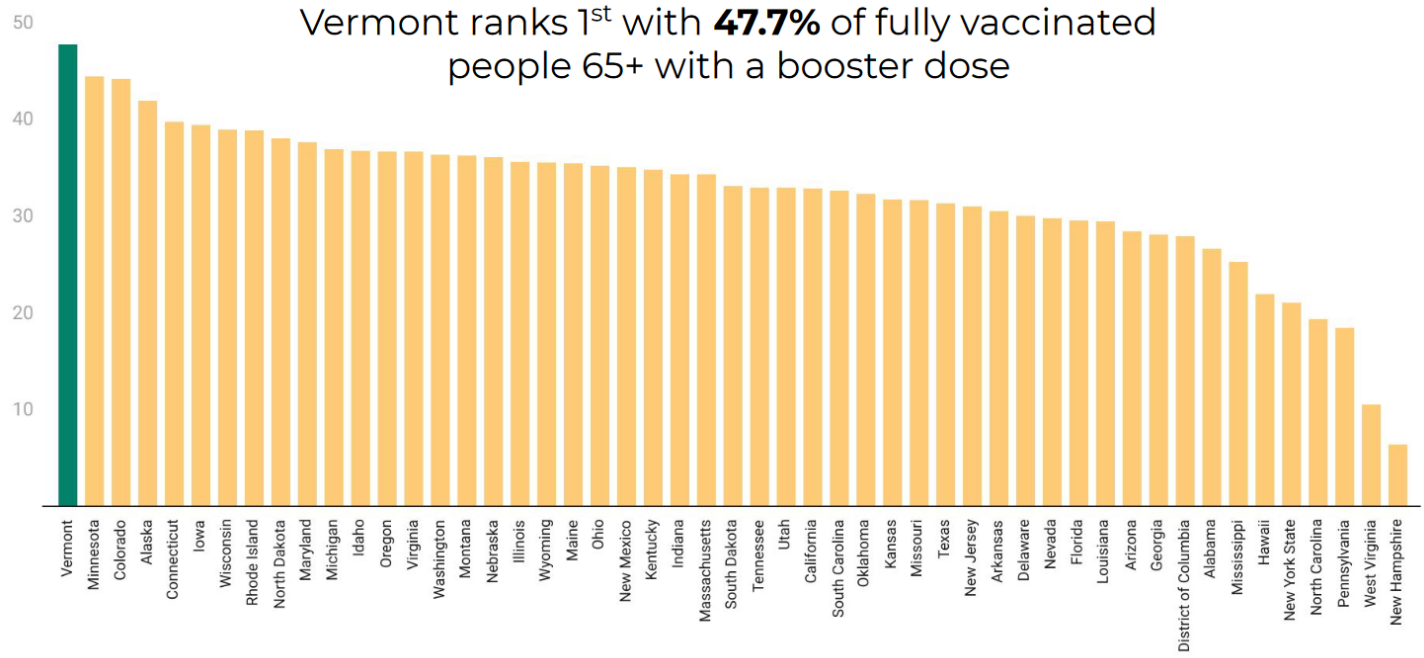
Vermont Vaccination Progress

By Age Band



Source: Vermont Dept. of Health—November 9, 2021; *based on 2019 census estimates; state data may differ from CDC reporting

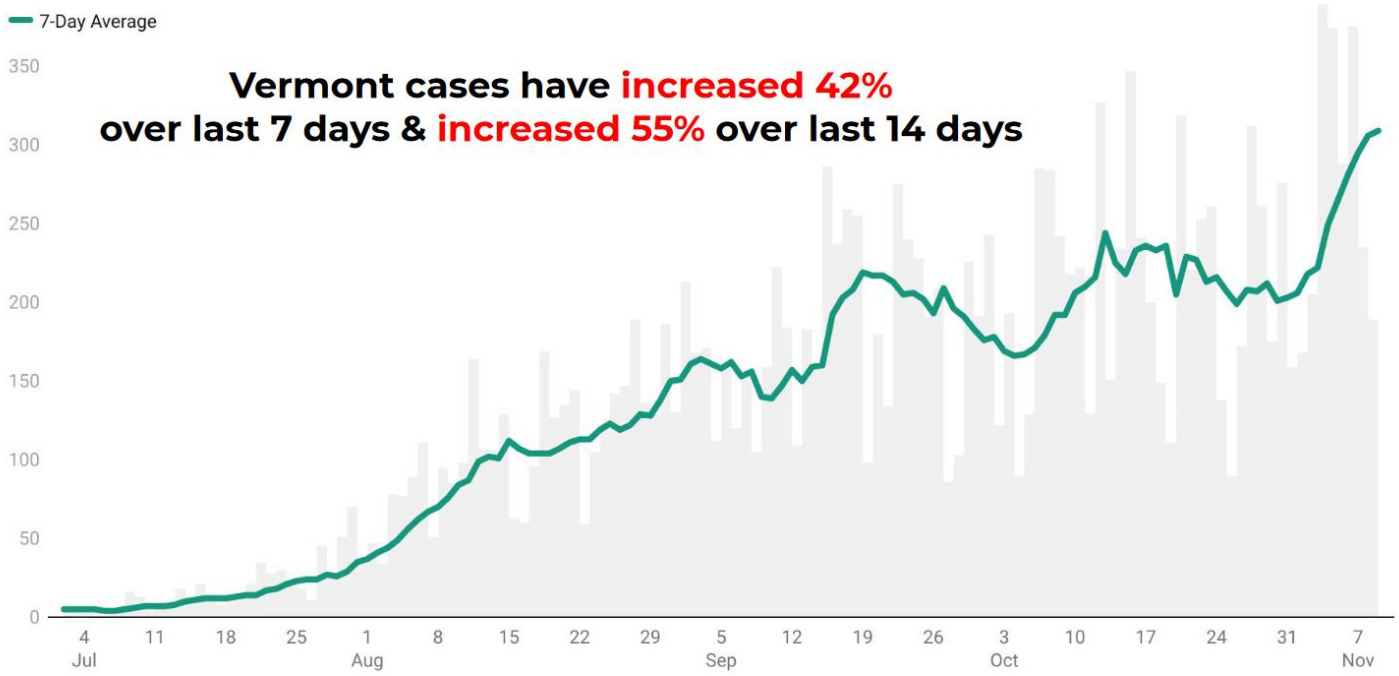
Percent of Fully Vaccinated People 65+ with Booster Dose



Source: CDC—November 9, 2021

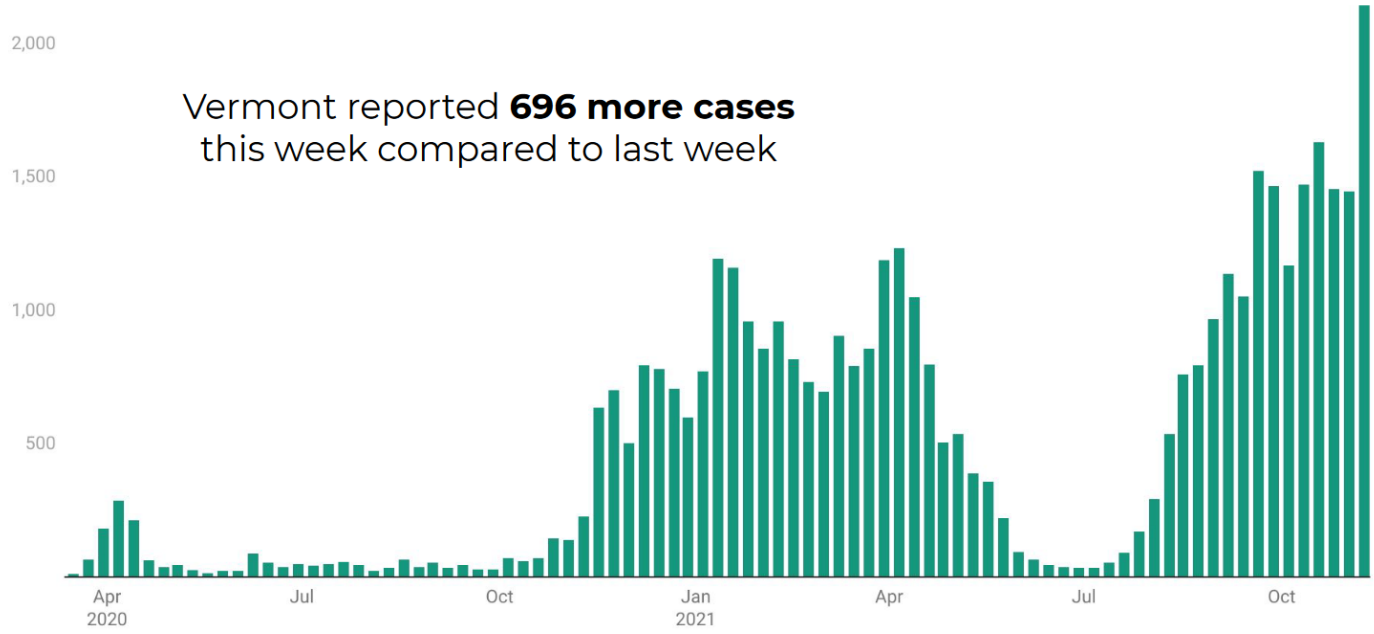
Now look at these graphs and tell me how effective you think these shots really are…

Vermont New COVID-19 Cases



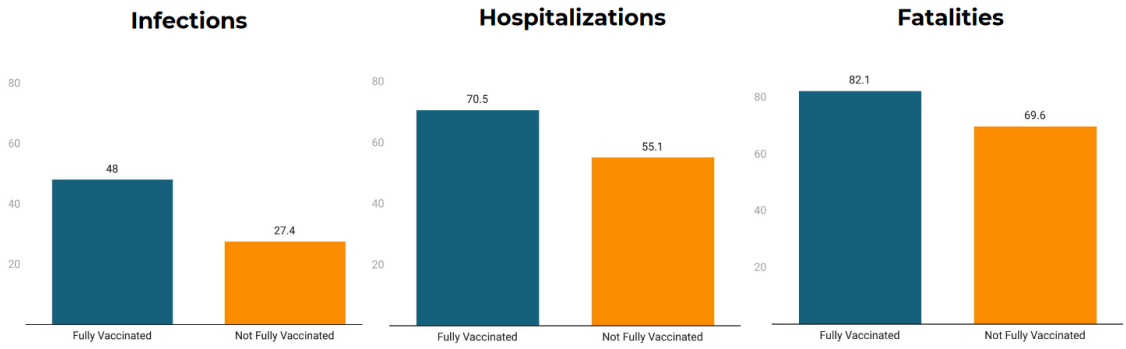
Source: Vermont Dept. of Health—November 9, 2021; created with Datawrapper

Vermont New Weekly COVID-19 Cases



Source: Vermont Dept. of Health—November 9, 2021; created with Datawrapper

Average Age of Covid-19 Outcomes by Vaccination Status (July-Present)



12

Source: VDH—Vaccination data from July 1 to November 6, 2021; created with Datawrapper

Trend lines

The not fully vaccinated admission rate has **decreased 15%** in the last 7 days

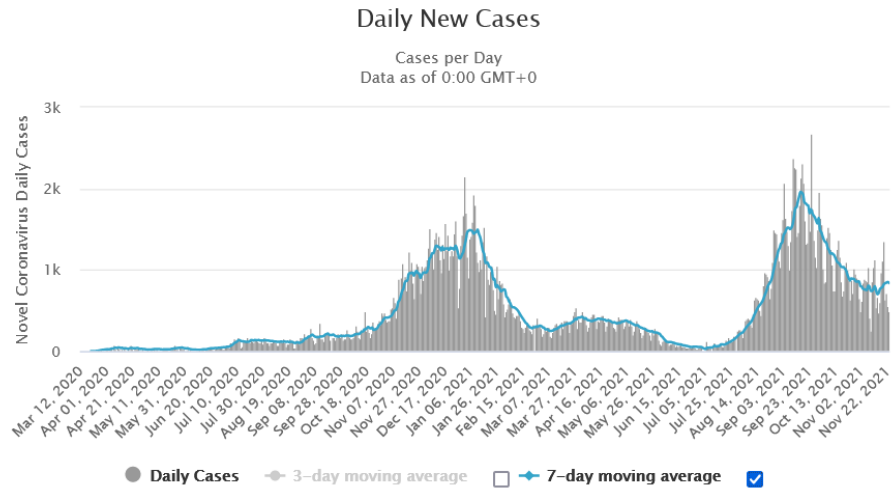
The fully vaccinated admission rate has **increased 8%** during the same period

https://dfr.vermont.gov/sites/finreg/files/doc_library/dfr-covid19-modeling-110921.pdf

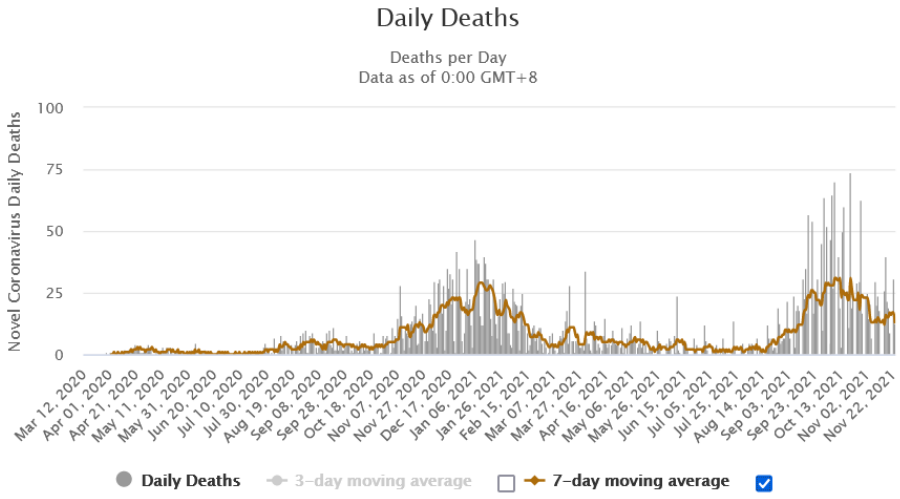
Now consider West Virginia, the state with the lowest vaccination rate in the country

West Virginia has the lowest vaccination rates in the country at 41.5% of their population fully vaccinated. Yet looking at these graphs you will see how cases and deaths are in decline over the last 30 days, in direct contrast to what we saw in Vermont in the previous section.

Daily New Cases in West Virginia



Daily New Deaths in West Virginia



Israeli news reporting serious concerns about the trends in rise of vaccinated hospitalizations and deaths

As reported previously, Israel is a couple of months ahead of the U.S. in the vaccine program. Even the CEO of Pfizer has said if you want to see what will happen in the U.S., look at Israel because they are about 2 months ahead with their program.

So, what is happening in Israel now? Israeli television reports are concerning. Here are some quotes from clips that were broadcast on Israeli television.
Israeli spokesperson… "In this wave we're seeing infection and illness in vaccinated individuals. We're seeing vaccinated individuals that are sick and arrive at the hospital in serious condition. And, we're seeing death as well. The increase in the seriously ill who have been vaccinated is an increase that we have seen over the last few days very significantly."
Broadcasters… "The almost vast majority of the deceased are vaccinated people that seemingly have gone through "immune-erosion" 83 dead in just the past month."
Interviewed patient in the hospital… "Between if I, as someone that has been vaccinated with two doses, got sick so, so badly, so what does it matter if you take the vaccines or not?"
Doctor… "Certainly it is starting to bother us."
Newscasters… "Meanwhile we are becoming aware of the fact that the Director General of the Sheba Hospital, Professor Yitzhak Kreiss. He was, if you recall, the third person to get vaccinated (in Israel), after the Prime Minister and Minister of Health. He has also become sick with COVID despite being vaccinated. Do you have a clear position Professor, regarding what they call the boost?"
Professor… "We must say decisively, even that there isn't any medical basis, as of today, for massive and bulk vaccination of the population with a third vaccine, with a booster. We really are not at the point in time that we need to vaccinate the bulk of the population with a third dose."
https://twitter.com/EliseiNicole/status/1461441345877389319

Several studies warning of enhanced or fatal disease in animals vaccinated for SARS-CoV-1 when later exposed to the wild virus, may be what we are seeing now in highly vaccinated countries

I would like to highlight one article and give citations for several others that had sounded the alarm bells over the last 15 years.

This first article is a 2012 one titled, **Immunization with SARS Coronavirus Vaccines Leads to Pulmonary Immunopathology on Challenge with the SARS Virus**.

The abstract- (emphasis mine)
Background: Severe acute respiratory syndrome (SARS) emerged in China in 2002 and spread to other countries before brought under control. Because of a concern for reemergence or a deliberate release of the SARS coronavirus, vaccine development was initiated. Evaluations of an inactivated whole virus vaccine in ferrets and nonhuman primates and a virus- like-particle vaccine in mice induced protection against infection but challenged animals exhibited an immunopathologic- type lung disease.

Design: Four candidate vaccines for humans with or without alum adjuvant were evaluated in a mouse model of SARS, a VLP vaccine, the vaccine given to ferrets and NHP, another whole virus vaccine and an rDNA-produced S protein. Balb/c or C57BL/6 mice were vaccinated IM on day 0 and 28 and sacrificed for serum antibody measurements or challenged with live virus on day 56. On day 58, challenged mice were sacrificed and lungs obtained for virus and histopathology.

Results: All vaccines induced serum neutralizing antibody with increasing dosages and/or alum significantly increasing responses. Significant reductions of SARS-CoV two days after challenge was seen for all vaccines and prior live SARS-CoV. **All mice exhibited histopathologic changes in lungs two days after challenge including all animals vaccinated** (Balb/C and C57BL/6) or given live virus, influenza vaccine, or PBS suggesting infection occurred in all. Histopathology seen in animals given one of the SARS-CoV vaccines was uniformly a Th2-type immunopathology with prominent eosinophil infiltration, confirmed with special eosinophil stains. The pathologic changes seen in all control groups lacked the eosinophil prominence.

Conclusions: These SARS-CoV vaccines all induced antibody and protection against infection with SARS-CoV. **However, challenge of mice given any of the vaccines led to occurrence of Th2-type immunopathology suggesting hypersensitivity to SARS-CoV components was induced. Caution in proceeding to application of a SARS-CoV vaccine in humans is indicated.**

https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0035421&type=printable

This is just one of many studies between the year 2000 and today showing either antibody dependent enhancement (ADE) or TH2 type immunopathology in animals after vaccinating for coronavirus disease. That is the reason clinical trials had never progressed to humans prior to the coronavirus pandemic we are currently experiencing. The clinical trials for these current vaccines omitted careful and important animal studies prior to human exposure. This is something that has been warned against in many of these prior attempts at creating a coronavirus vaccine.

One of the reasons that ADE can develop is that coronavirus vaccines cause two different types of antibodies to be produced.

Neutralizing antibodies- also referred to as immunoglobulin G (IgG) antibodies. These fight the infection by neutralizing the ability of the virus to gain entry into the cells.

Binding antibodies- also known as non-neutralizing antibodies that cannot prevent viral infection. Instead of preventing viral infection, binding antibodies can trigger an abnormal immune response known as "paradoxical immune enhancement." In this case, your immune system is working against itself and may actually enhance the ability of the virus to infect cells.

And as is the case with the COVID-19 vaccines, the first dose produces mostly binding antibodies and insufficient neutralizing antibodies. Thus, increasing the concern over future development of ADE when individuals that have been vaccinated are later exposed to the virus or a variant of the virus.

Other studies showing this phenomenon on ADE and Th2 immunopathology after vaccination for coronavirus disease:

Anti–spike IgG causes severe acute lung injury by skewing macrophage responses during acute SARS-CoV infection- ***JCL Insight*** 2019
https://insight.jci.org/articles/view/123158

Enhanced inflammation in New Zealand white rabbits when MERS-CoV reinfection occurs in the absence of neutralizing antibody- ***PLOS Pathogens*** 2017
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5574614/

Antibody Response and Disease Severity in Healthcare Worker MERS Survivors- ***Emerging Infectious Diseases*** 2016
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4880093/

Antibody-dependent SARS coronavirus infection is mediated by antibodies against spike proteins- ***Science Direct*** 2014
https://www.sciencedirect.com/science/article/pii/S0006291X14013321

Antibody-dependent infection of human macrophages by severe acute respiratory syndrome coronavirus- ***Virology Journal*** 2014
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4018502/

Immunization with SARS Coronavirus Vaccines Leads to Pulmonary Immunopathology on Challenge with the SARS-CoV-2 Virus- ***PLOS One*** 2012
https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0035421&type=printable

Neutralizing Antibody Response and SARS Severity- ***Emerging Infectious Diseases*** 2005
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3367364/

A summary of various studies on coronavirus vaccines that caused immunopathology is found on the next page…

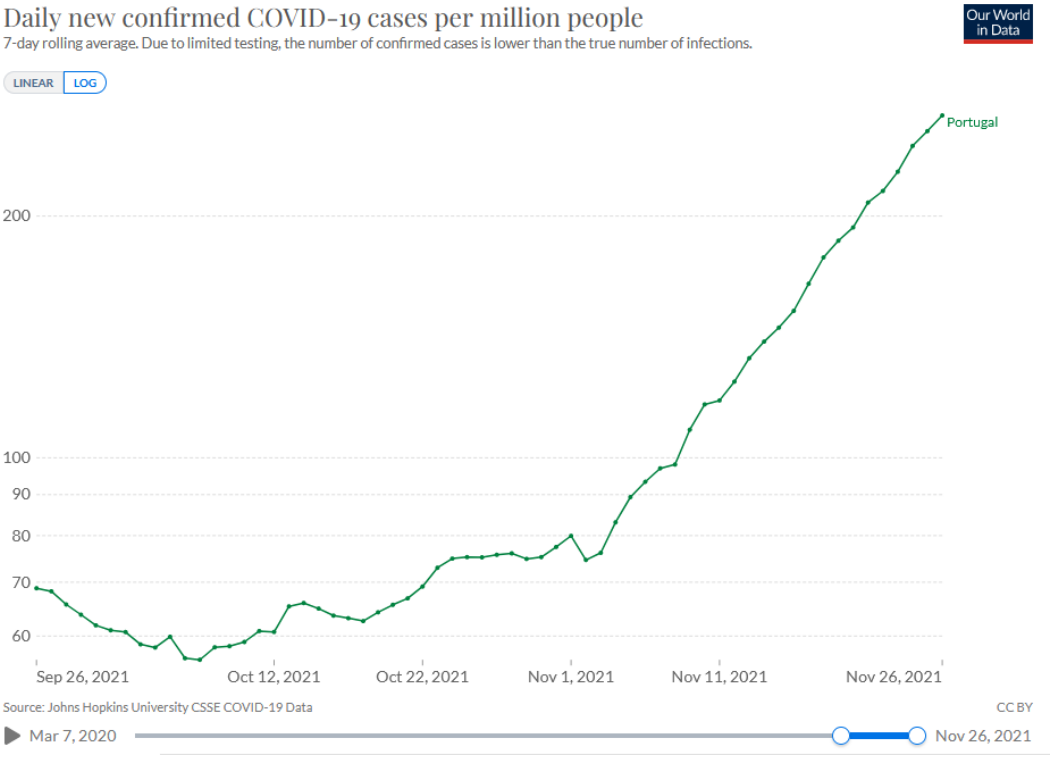
Coronavirus Vaccines.

Animal Model	Vaccine[1]	Protection[2]	Immunopathology[3]
Mice	Whole virus[tr]		
	w alum	Yes	Yes
	Whole virus[25,tr]		
	w alum	Yes	Yes
	wo alum	Yes	Yes
	VLP[17,tr]		
	w alum	Yes	Yes
	wo alum	Yes	Yes
	S Protein[tr]		
	w alum	Yes	Yes
	wo alum	Yes	Yes
	VEE Vector[15]		
	for N protein	No	Yes
	for S protein	Yes	No
	Vaccinia vector[18]		
	for N protein	No	Yes
	for S protein	Yes	?No
Ferrets	Whole virus[11]		
	w alum	Yes	Yes
Nonhuman Primate[4]	Whole virus[11]		
	w alum	Yes	Yes
Hamsters	Whole virus[22]		

Considering the upward trend of hospitalizations and deaths in countries that are most highly vaccinated, one would think that public health officials around the world would be concerned and called for a pause in the mass vaccination campaign. Unfortunately, as is often the case, when people are hyper-committed to and invested in a cause and the results are failing miserably, they are unwilling or even unable to see the obvious even if it smacked them right in the face. And in the meantime, the casualties pile up.

Portugal, the 4th most highly vaccinated country in the world and having delivered over 900,000 booster shots is seeing a large uptick in cases and new restrictions.

Portugal has vaccinated 89.04% of its population (https://ourworldindata.org/covid-vaccinations), as of November 15th, yet as the graph below shows, the cases have risen dramatically in the last 60 days.



Excerpts from Yahoo News article November 5th, 2021, titled, **Portugal returns to COVID restrictions despite high jab rate**…

LISBON, Portugal (AP) — Portugal is bringing back some tight pandemic restrictions, less than two months after scrapping most of them when the goal of vaccinating 86% of the population against COVID-19 was reached.

From Dec. 1, wearing a face mask will once again be mandatory in enclosed spaces; a digital certificate proving vaccination or recovery from the coronavirus must be shown to enter restaurants, cinemas and hotels; and even inoculated people must have a negative test to visit hospitals, elderly care homes, sports events and bars and discos.

The General Directorate for Health officially reported 3,150 new cases Thursday, with 691 people in hospital, 103 in intensive care units and 15 deaths. The number of patients requiring hospitalization was the highest since September.

End of excerpts

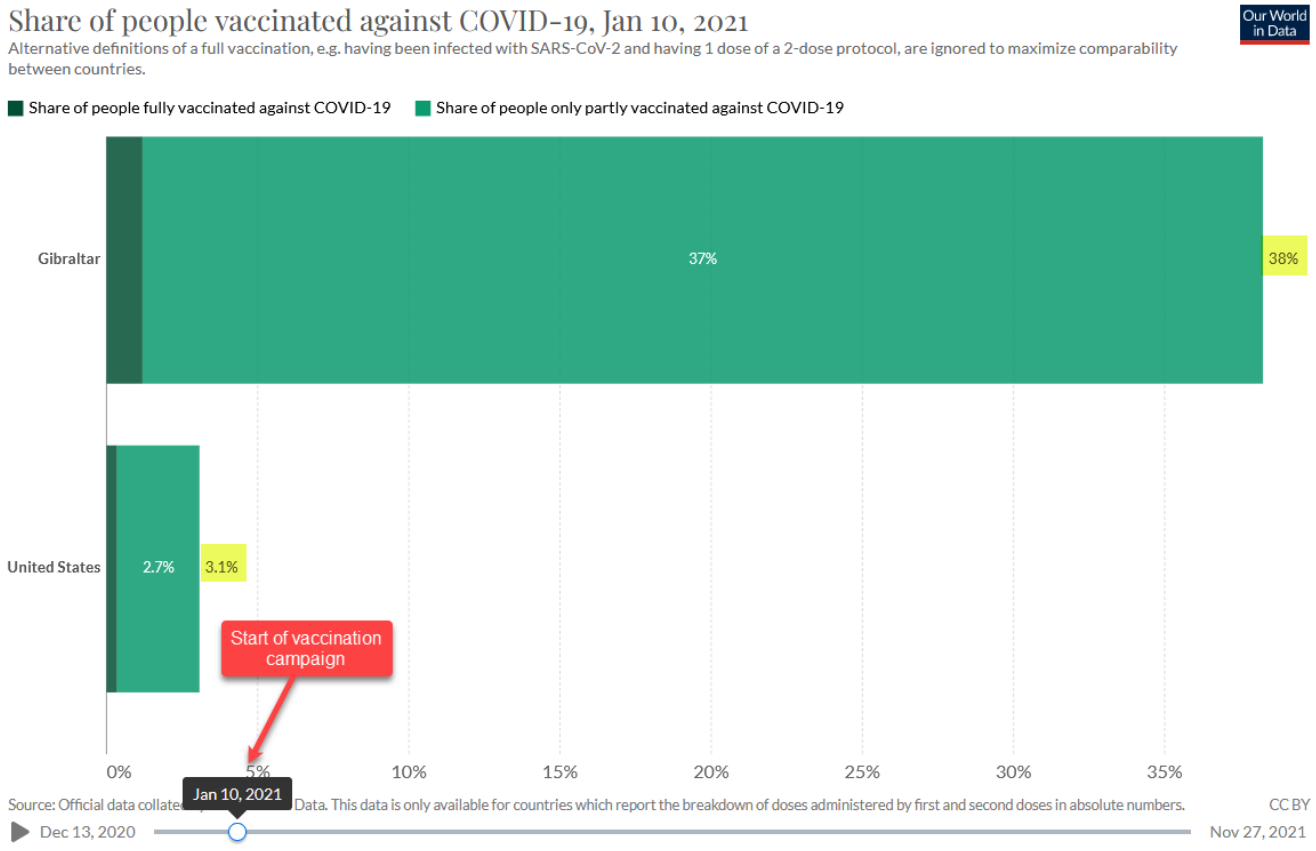
https://news.yahoo.com/portugal-returns-covid-restrictions-despite-182239913.html

Gibraltar, the most highly vaccinated country in the world at 121% has been seeing an uptick in cases as of late

Gibraltar is a tiny British Territory located at the southern tip of Spain with a population of 33,680. As a small nation, it has been easy for government officials to mass vaccinate the entire population rapidly. One of the things that accounts for the greater than 100% of the population vaccinated is that they have a substantial workforce that comes in from outside the country, and those individuals were immediately required to be fully vaccinated also.

Let's also not forget what happened when Gibraltar launched its COVID-19 vaccination campaign like it was shot out of a cannon…

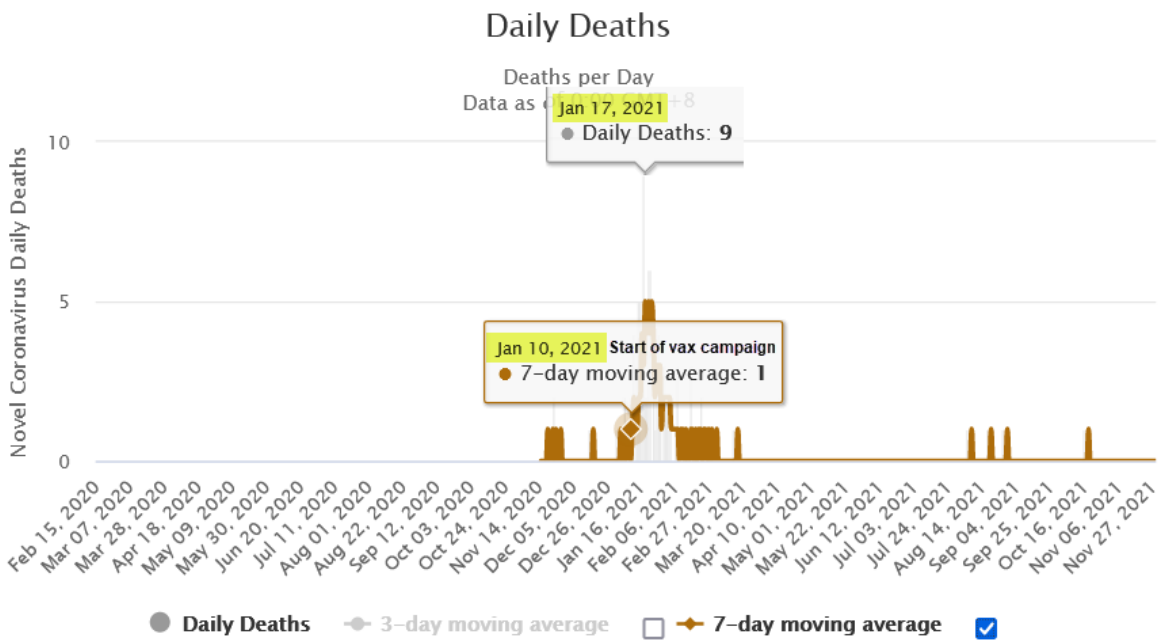
Very early into their COVID-19 vaccination campaign which started with the elderly, Gibraltar already had 38% of its population vaccinated with at least 1 shot. Contrast that to the U.S. with a mere 3.1% at the same point in time.



https://ourworldindata.org/covid-vaccinations

So, what happened to the death rate in Gibraltar at the point of their mass vaccination program? Bear in mind there had been only 10 deaths total in the 11 months prior to the launch of their COVID-19 vaccine campaign.

Daily New Deaths in Gibraltar



https://www.worldometers.info/coronavirus/country/gibraltar/

In an article by Lance D. Johnson and published on Dr Eddy Bettermann MD's website titled, **Elderly population suddenly dying off for unexplained reasons, and it's no longer coded as covid-19**, the sudden deaths in the elderly of Gibraltar immediately after the vaccination program began is called the worst loss of life there in over 100 years.

Around the world, medical authorities are seeing a spike in elderly deaths, after covid-19 vaccination. Gibraltar, a nation located at the southern tip of Spain, is suffering from an unexplained surge in elderly deaths. In the second week of January, a subset of the elderly population suddenly started to die off. The new wave of unexplained elderly deaths is occurring at nearly three times the magnitude of covid-19 deaths that were recorded during 2020.

The new, unexplained surge in elderly deaths is occurring approximately forty times faster when compared to the overall timeline of covid-19 deaths that occurred since a pandemic was first declared. This surge in elderly deaths occurred after 5,847 doses of experimental mRNA injections were administered to the citizens of Gibraltar. In just one week, 17 percent of the country's population had been inoculated with the first dose of Pfizer's mRNA experiment.

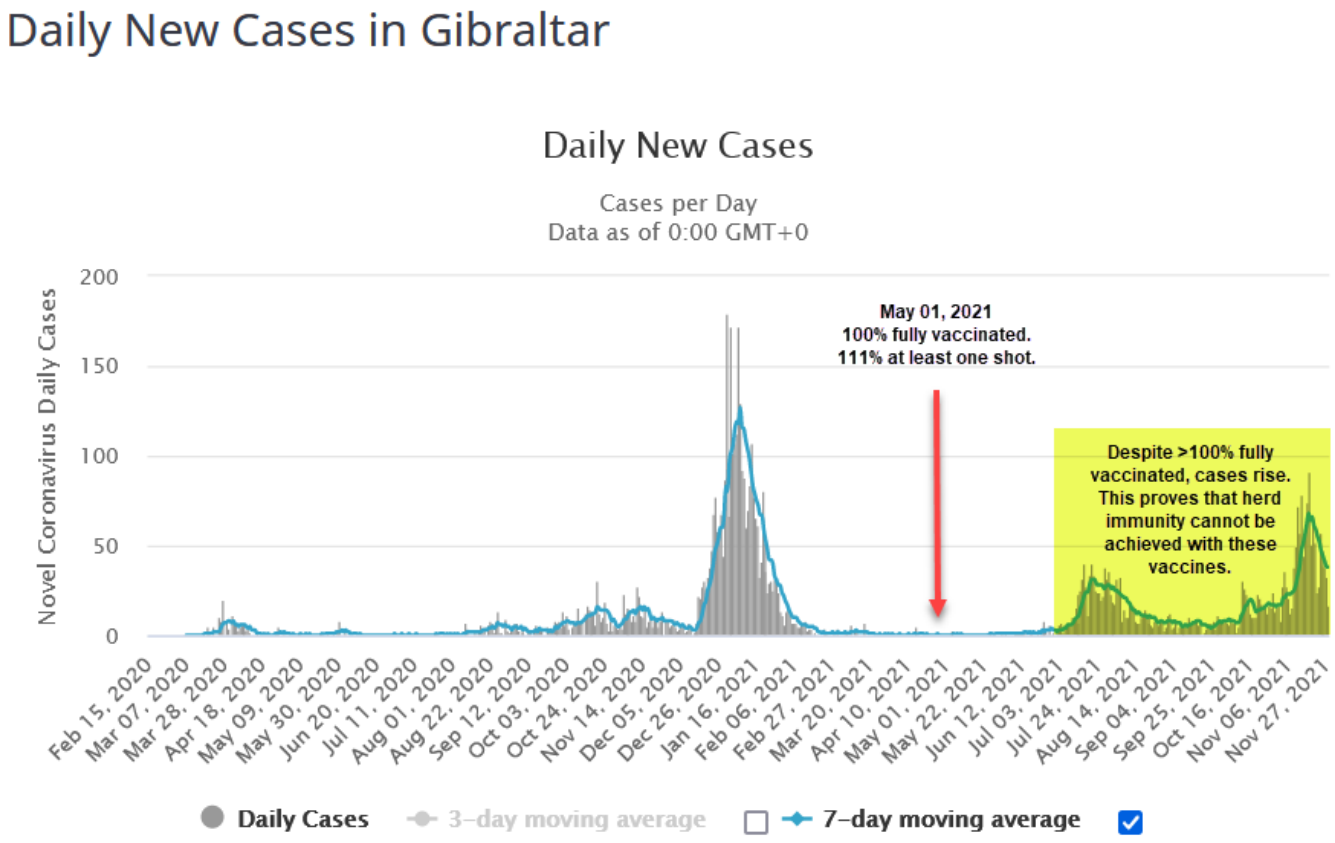
Before the vaccine experiment began, the covid-19 related death toll accounted for ten people. After the vaccine rollout, the total number of deaths had skyrocketed to forty-five people. In the first eight days of the vaccination program, thirty-five seniors suddenly passed away.

After the first week of vaccination, Chief Minister Fabian Picardo said, “This is now the worst loss of life of Gibraltarians in over 100 years. Even in war, we have never lost so many in such a short time.”

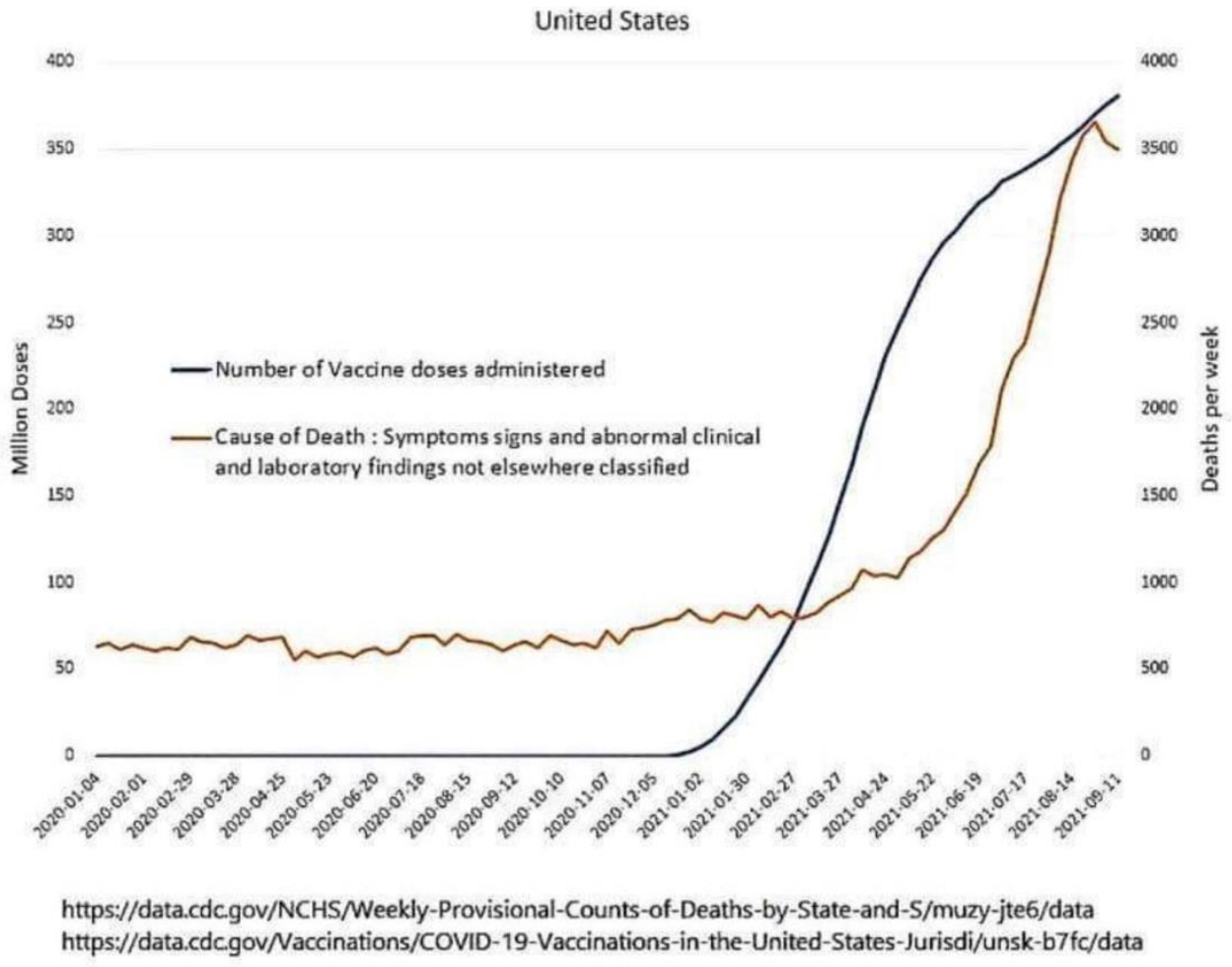
Gibraltar isn’t the only nation to report on the sudden spike in senior deaths. In Norway, twenty-nine senior citizens suddenly passed away in the first two weeks after the first dose of the vaccine. In the hours after vaccination, and sometimes minutes after, these seniors shared similar side effects, including but not limited to: persistent malaise and extreme exhaustion; severe allergic, including anaphylactic, reactions; multi-system inflammatory syndrome; psychological disturbances; seizures; convulsions; and paralysis, including Bell’s Palsy. The Norwegian Medicines Agency declared that “all deaths are linked to this [Pfizer’s] vaccine” because it was the only intervention that preceded the sudden elderly deaths.

https://dreddymd.com/2021/02/18/elderly-population-suddenly-dying-off-for-unexplained-reasons-and-its-no-longer-coded-as-covid-19/

The more recent state of affairs in Gibraltar



Shocking graph shows CDC U.S. data of obscure cause of death diagnosis code titled “Symptoms signs and abnormal clinical and laboratory findings not elsewhere classified”, cross-referenced and following COVID-19 vaccine doses administered



When deaths occur, there is no explanation as to cause and no autopsy is done, this is a code that is often utilized. It is sometimes called a “garbage can code”. The question is, why was there such a huge jump in the use of those codes following and tracking along with the rise in vaccination doses administered?

New England Journal of Medicine reports on a mechanism for spike protein driven antibody reaction that may lead to adverse reactions including immune-suppression, myocarditis and autoimmune disease…a possible explanation for some vaccine caused reactions and disease

An article published in the New England Journal of medicine on November 24th, 2021, titled **A Possible Role for Anti-idiotype Antibodies in SARS-CoV-2 Infection and Vaccination** proposes a mechanism by which infection or vaccine induced adverse reactions and long-term complications may occur. This may be one for those that like to geek-out on the science.

The article in its entirety

The development of multiple efficacious vaccines has been critical in the control of the pandemic, but their efficacy has been limited by the appearance of viral variants, and the vaccines can be associated with rare off-target or toxic effects, including allergic reactions, myocarditis, and immune-mediated thrombosis and thrombo-cytopenia in some healthy adults. Many of these phenomena are likely to be immune-mediated.3 How can we understand this diversity in immune responses in different persons?

One way of thinking about the complexity of the immune response is through the lens of anti-idiotype immune responses. The Network Hypothesis, formulated in 1974 by Niels Jerne, described a mechanism by which the antibody responses to an antigen themselves induced downstream antibody responses against the antigen-specific antibody.4 Every antibody that is induced and specific for an antigen (termed “Ab1” antibody) has immunogenic regions, particularly in their variable-region antigen-binding domains, that are unique as a result of genetic recombination of immunoglobulin variable, diversity, and joining (VDJ) genes; VDJ recombination results in new and therefore immunogenic amino acid sequences called idiotopes, which are then capable of inducing specific antibodies against Ab1 antibodies as a form of down-regulation. A simi-lar paradigm has been proposed for T cells. How-ever, these regulatory immune responses are also capable of doing much more. The paratopes, or antigen-binding domains, of some of the resulting anti-idiotype (or “Ab2”) antibodies that are specific for Ab1 can structurally resemble that of the original antigens themselves. Thus, the Ab2 antigen-binding region can potentially represent an exact mirror image of the initial targeted antigen in the Ab1 response, and Ab2 antibodies have even been examined for potential use as a surrogate for the antigen in vaccine studies. However, as a result of this mimicry, Ab2 anti-bodies also have the potential to bind the same receptor that the original antigen was targeting (Fig. 1). Ab2 antibodies binding to the original receptor on normal cells therefore have the potential to mediate profound effects on the cell that could result in pathologic changes, particularly in the long term — long after the original antigen itself has disappeared.

See large graphic on the next page…

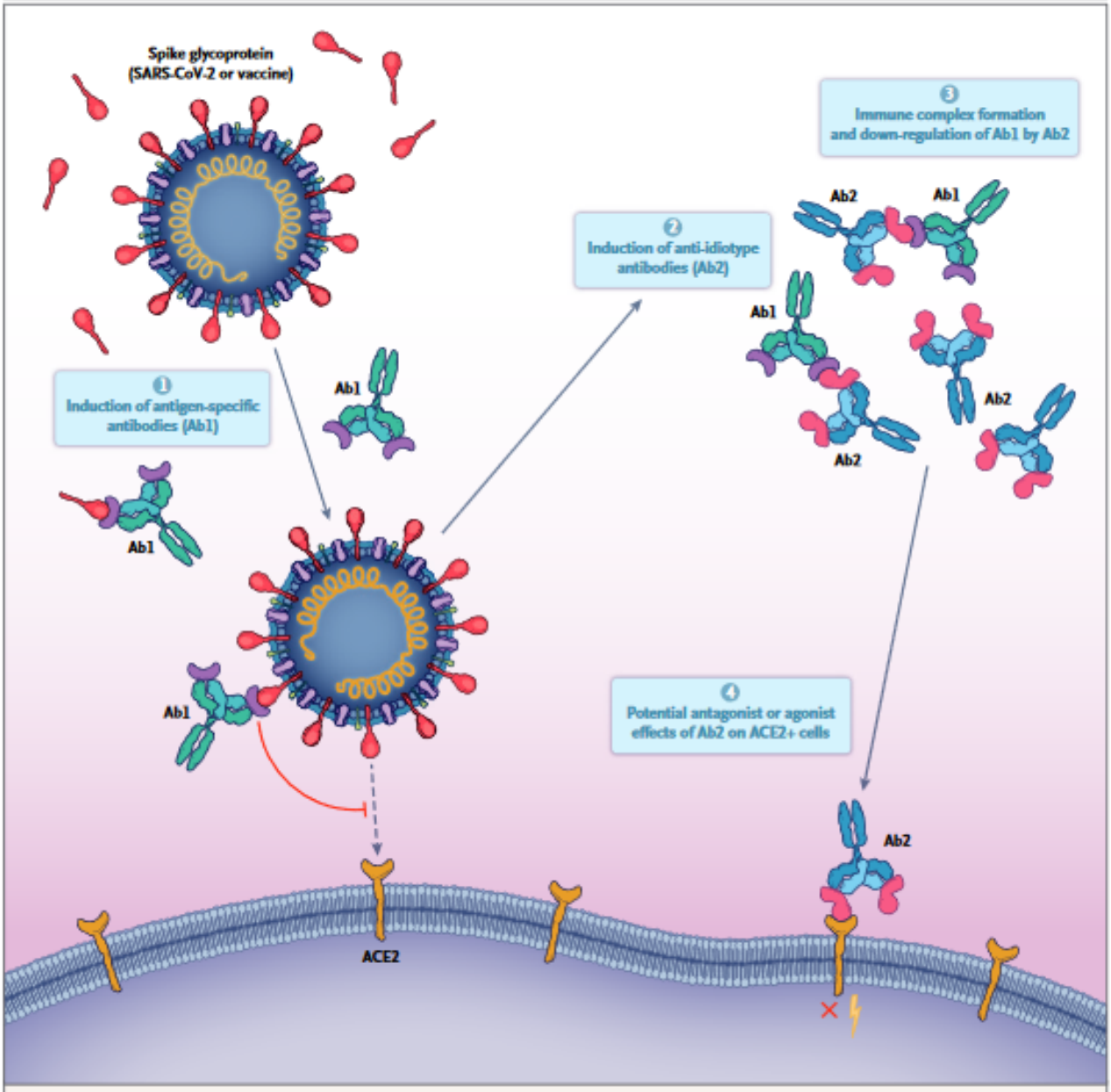


Figure 1. Anti-idiotype Antibodies and SARS-CoV-2.

Both severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection and the vaccines against it elicit antibodies to the spike protein that the virus uses to bind to the angiotensin-converting–enzyme 2 (ACE2) receptor on target cells. The receptor is widely expressed. These antibodies are called Ab1. The idiotype portions of Ab1 that bind and neutralize the spike protein have distinctive sequences in complementarity-determining region 3 (CDR3), and those antibody-binding regions can themselves elicit antibody responses called anti-idiotype (Ab2) antibodies as a means of down-regulation. Ab2 antibodies can act in several ways. They can bind to the protective neutralizing Ab1 antibody, resulting in immune-complex formation and clearance, thus impairing Ab1 efficacy. Some of the Ab2 binding regions, or paratopes, can also mirror the spike protein itself and bind to the same target as the spike protein, the ACE2 receptor. That binding could, in theory, exert several different — but not necessarily mutually exclusive — effects on the cell, depending on the nature of the Ab2 antibodies and the role of the receptors in the cell: for example, it could potentially block ACE2 function by competitively inhibiting normal ligand interactions. Alternatively, it could stimulate ACE2 function by triggering the receptor, affect expression of ACE2 after binding by down-regulating or internalizing ACE2, or, after binding the cells, induce a complement-mediated or immune-cell attack on ACE2-expressing cells.

NOTE- The lightning bolt and red X near the bottom right of the diagram indicates the two possible responses of the Ab2 binding with the ACE-2 receptor as described in the last two sentences of the Figure 1 description.

This aspect of regulation of immune-cell responses was postulated by Plotz in 1983 as a possible cause of autoimmunity arising after viral infection5 and has since been supported experimentally by direct transfer of anti-idiotype antibodies. Ab2 antibodies generated against the enterovirus coxsackievirus B3 in mice can bind myocyte antigens, resulting in autoimmune myo-carditis, and anti-idiotype responses can act as acetylcholine receptor agonists, leading to myasthenia gravis symptoms in rabbits. In addition, by displaying the mirror image of the viral anti-gen, Ab2 alone can even mimic the deleterious effects of the virus particle itself, as has been shown with bovine viral diarrhea virus antigen.

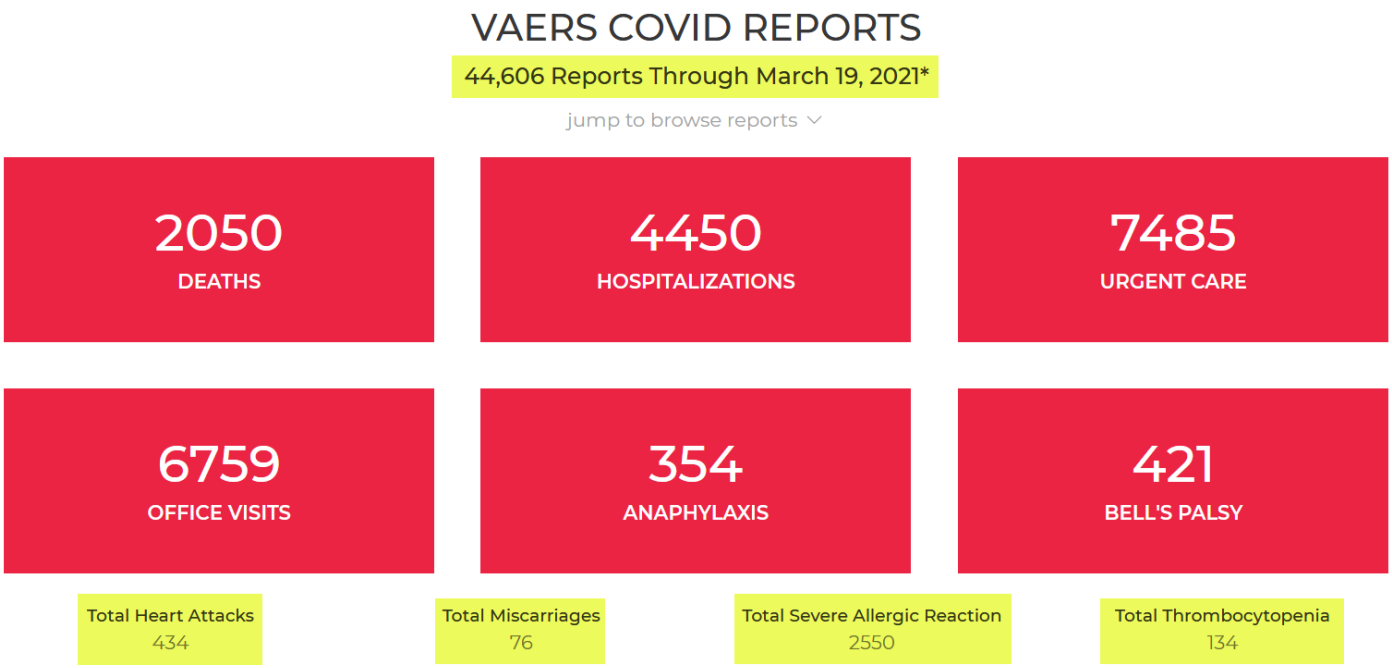
For SARS-CoV-2 infection, attention centers on the spike (S) protein and its critical use of the angiotensin-converting–enzyme 2 (ACE2) receptor to gain entry into the cell. Given its critical role in regulating angiotensin responses, many physiological effects can be influenced by ACE2 engagement. The S protein itself has a direct effect on suppressing ACE2 signaling by a variety of mechanisms and can also directly trigger toll-like receptors and induce inflammatory cytokines. Anti-idiotype responses may affect ACE2 function, resulting in similar effects. However, preclinical and clinical assessments of antibody responses to SARS-CoV-2 vaccines have focused solely on Ab1 responses and virus-neutralizing efficacy. The delineation of potential anti-idiotype responses has inherent difficulties because of the polyclonal nature of responses, dynamic kinetics, and the concurrent presence of both Ab1 and Ab2 antibodies. Furthermore, ACE2 expression within cells and tissues can be variable. The different vaccine constructs (RNA, DNA, adeno-viral, and protein) are also likely to have differential effects on Ab2 induction or in the mediation of vaccine effects that differ from responses to infection. Some off-target effects may not be directly linked to Ab2 responses. The association of thrombotic events with some SARS-CoV-2 vaccines in young women and the etiologic role of anti–platelet factor 4–polyanion antibodies may be the result of the adenoviral vector. However, the reported occurrence of myocarditis after vaccine administration bears striking similarities to the myocarditis associated with Ab2 antibodies induced after some viral infections. Ab2 anti-bodies could also mediate neurologic effects of SARS-CoV-2 infection or vaccines, given the ex-pression of ACE2 on neuronal tissues, the specific neuropathologic effects of SARS-CoV-2 infection, and the similarity of these effects to Ab2-mediated neurologic effects observed in other viral models.

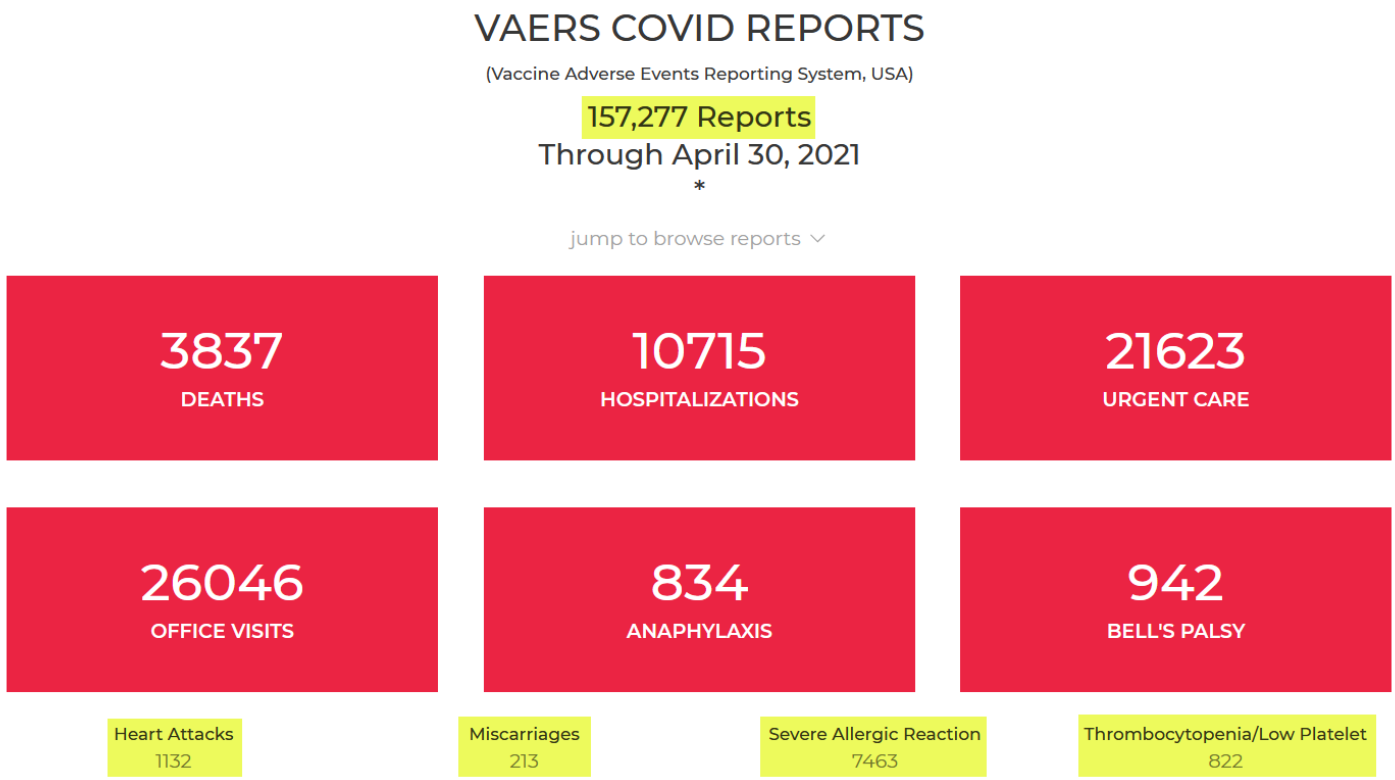
It would therefore be prudent to fully characterize all antibody and T-cell responses to the virus and the vaccines, including Ab2 responses over time. Using huACE2 transgenic mice and crossing them with strains that are predisposed to autoimmunity or other human pathologic conditions can also provide important insights. An understanding of potential Ab2 responses may also provide insights into Ab1 maintenance and efficacy and into the application of antibody-based therapeutic agents. However, much more basic science research is needed to determine the potential role idiotype-based immunoregulation of both humoral and cell-mediated responses may play both in antiviral efficacy and in unwanted side effects of both SARS-CoV-2 infection and the vaccines that protect us from it.

End of article

https://www.nejm.org/doi/full/10.1056/NEJMcibr2113694

VAERS Red Box COVID-19 monthly casualty comparisons over time





VAERS COVID REPORTS

(Vaccine Adverse Events Reporting System, USA)

262,521 Reports
Through May 21, 2021
*

jump to browse highlighted reports

4,406 DEATHS	14,986 HOSPITALIZATIONS	34,474 URGENT CARE
45,006 OFFICE VISITS	1,214 ANAPHYLAXIS	1,411 BELL'S PALSY

Heart Attacks 1,598	Miscarriages 511	Severe Allergic Reaction 12,219	Thrombocytopenia/Low Platelet 1222

VAERS COVID Vaccine Data

(Vaccine Adverse Events Reporting System, USA)

387,288 Reports
Through June 18, 2021
*

jump to browse highlighted reports

6,136 DEATHS	21,806 HOSPITALIZATIONS	51,575 Urgent Care
72,588 OFFICE VISITS	1,624 ANAPHYLAXIS	1,977 BELL'S PALSY

6,450 Life Threatening	2,483 Heart Attacks	1,644 Myocarditis/Pericarditis	1,776 Thrombocytopenia/Low Platelet
720 Miscarriages	17,408 Severe Allergic Reaction	5,194 Disabled	4,447 Tinnitus

VAERS COVID Vaccine Data

Reports from the Vaccine Adverse Events Reporting System.
Our data reflects all VAERS data including the "nondomestic" reports.

518,769 Reports
through July 23, 2021*

jump to browse highlighted reports

11,940 DEATHS	40,991 HOSPITALIZATIONS	65,067 URGENT CARE
88,920 OFFICE VISITS	4,110 ANAPHYLAXIS	3,714 BELL'S PALSY

1,272 Miscarriages	4,799 Heart Attacks	3,201 Myocarditis/Pericarditis	12,808 Permanently Disabled
1,932 Thrombocytopenia/ Low Platelet	11,199 Life Threatening	22,286 Severe Allergic Reaction	6,123 Tinnitus

VAERS COVID Vaccine Data

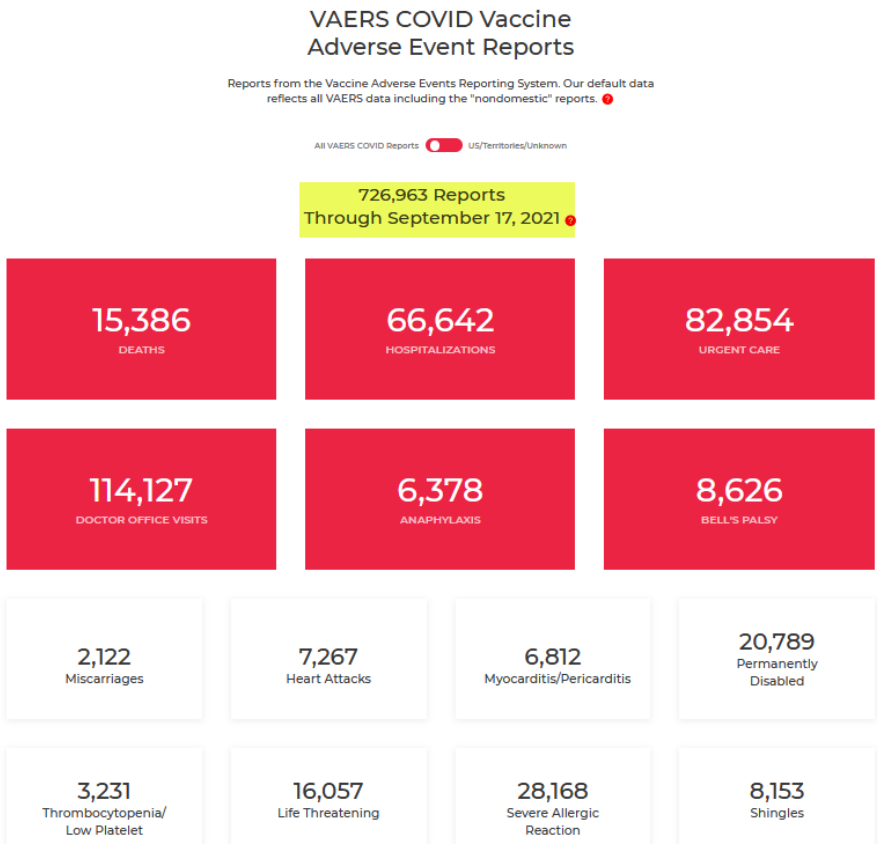
Reports from the Vaccine Adverse Events Reporting System.
Our data reflects all VAERS data including the "nondomestic" reports.
read the VAERS disclaimer

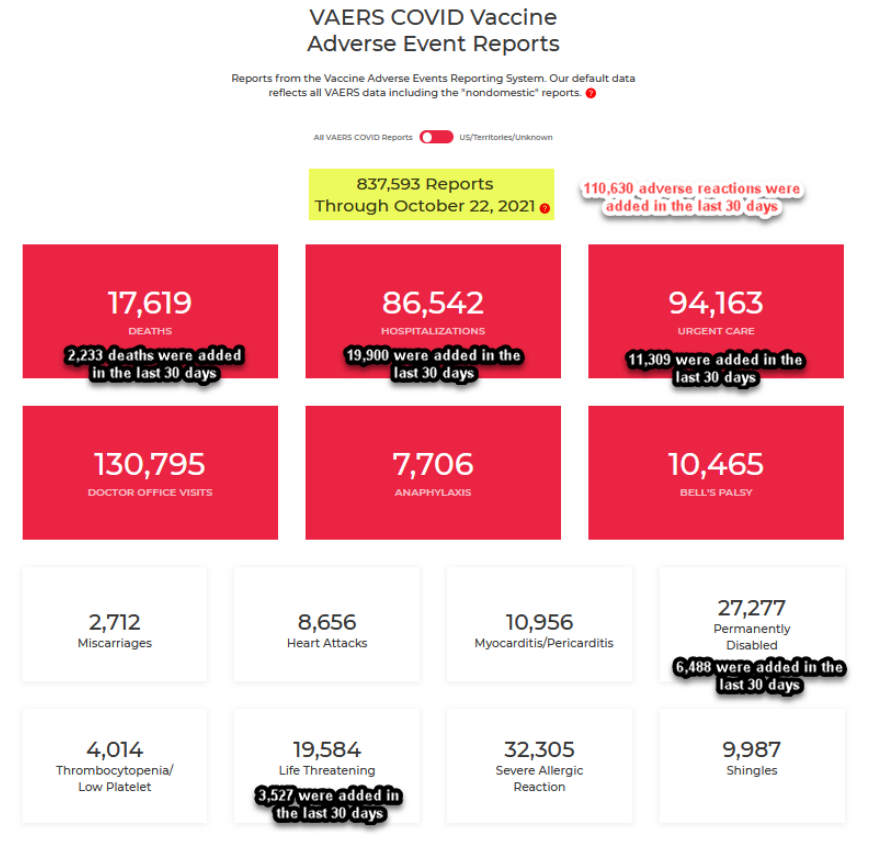
623,341 Reports
through August 20, 2021*

jump to browse highlighted reports

13,627 DEATHS	55,821 HOSPITALIZATIONS	74,368 URGENT CARE
100,966 OFFICE VISITS	5,721 ANAPHYLAXIS	4,785 BELL'S PALSY

1,671 Miscarriages	6,071 Heart Attacks	5,093 Myocarditis/ Pericarditis	17,794 Permanently Disabled
2,831 Thrombocytopenia/ Low Platelet	14,105 Life Threatening	25,921 Severe Allergic Reaction	7,324 Shingles


VAERS COVID Vaccine
Adverse Event Reports
Reports from the Vaccine Adverse Events Reporting System. Our default data reflects all VAERS data including the "nondomestic" reports.
All VAERS COVID Reports
US/Territories/Unknown
726,963 Reports
Through September 17, 2021
15,386
DEATHS
66,642
HOSPITALIZATIONS
82,854
URGENT CARE
114,127
DOCTOR OFFICE VISITS
6,378
ANAPHYLAXIS
8,626
BELL'S PALSY
2,122
Miscarriages
7,267
Heart Attacks
6,812
Myocarditis/Pericarditis
20,789
Permanently Disabled
3,231
Thrombocytopenia/ Low Platelet
16,057
Life Threatening
28,168
Severe Allergic Reaction
8,153
Shingles


VAERS COVID Vaccine
Adverse Event Reports
Reports from the Vaccine Adverse Events Reporting System. Our default data reflects all VAERS data including the "nondomestic" reports.
All VAERS COVID Reports
US/Territories/Unknown
837,593 Reports
Through October 22, 2021
110,630 adverse reactions were added in the last 30 days
17,619
DEATHS
2,233 deaths were added in the last 30 days
86,542
HOSPITALIZATIONS
19,900 were added in the last 30 days
94,163
URGENT CARE
11,309 were added in the last 30 days
130,795
DOCTOR OFFICE VISITS
7,706
ANAPHYLAXIS
10,465
BELL'S PALSY
2,712
Miscarriages
8,656
Heart Attacks
10,956
Myocarditis/Pericarditis
27,277
Permanently Disabled
6,488 were added in the last 30 days
4,014
Thrombocytopenia/ Low Platelet
19,584
Life Threatening
3,527 were added in the last 30 days
32,305
Severe Allergic Reaction
9,987
Shingles

VAERS COVID Vaccine Adverse Event Reports

Reports from the Vaccine Adverse Events Reporting System. Our default data reflects all VAERS data including the "nondomestic" reports.

All VAERS COVID Reports | US/Territories/Unknown

927,738 Reports
Through November 26, 2021

19,532 DEATHS	99,943 HOSPITALIZATIONS	102,602 URGENT CARE
145,286 DOCTOR OFFICE VISITS	8,301 ANAPHYLAXIS	11,636 BELL'S PALSY

3,148 Miscarriages	9,746 Heart Attacks	15,424 Myocarditis/Pericarditis	31,652 Permanently Disabled
4,602 Thrombocytopenia/ Low Platelet	21,932 Life Threatening	34,481 Severe Allergic Reaction	10,787 Shingles

VAERS COVID Vaccine Adverse Event Reports

Reports from the Vaccine Adverse Events Reporting System. Our default data reflects all VAERS data including the "nondomestic" reports.

All VAERS COVID Reports | US/Territories/Unknown

946,461 Reports
Through December 3, 2021

19,886 DEATHS	102,857 HOSPITALIZATIONS	104,217 URGENT CARE
148,181 DOCTOR OFFICE VISITS	8,432 ANAPHYLAXIS	11,896 BELL'S PALSY

3,230 Miscarriages	9,977 Heart Attacks	16,918 Myocarditis/Pericarditis	32,644 Permanently Disabled
4,717 Thrombocytopenia/ Low Platelet	22,422 Life Threatening	35,009 Severe Allergic Reaction	10,946 Shingles

Other valuable resources from Dr. Palmer:

Many other COVID-19 related resources as well as helpful health resources can be found on Dr. Alan Palmer's website at https://wellnessdoc.com

Dr. Palmer's highly acclaimed eBook

Check out Dr. Palmer's downloadable eBook called ***1200 Studies- Truth Will Prevail***. It is the most comprehensive exposé on vaccines ever produced. Dr. Palmer took on this project and mission because of his intense desire to educate people about the potential risks of vaccines and the troubling changes we have seen in the health of our children, coinciding with the significant increase in vaccine doses added to the schedule in the last 30 years (72 doses by age 18).

1200 Studies is updated periodically, and now contains 950 pages of excerpts and summaries from over 1,500 studies, published in journals representing 45 different medical and scientific disciplines and authored by thousands of scientists, contradicting what we are and have been told about vaccines. These are unbiased, objective studies by researchers who are not funded by vaccine manufacturers. The most recent update added 150 pages on the COVID-19 vaccines.

And it is designed it as a PDF with easy-to-use navigation tools, search capability and links directly to the studies on PubMed. The entire Table of Contents are links directly to the page in the book on that topic. And every page has the links directly to the study on PubMed or the source journal. It is available at https://1200studies.com or https://www.wellnessdoc.com/1200studies/

Want to learn information about all things COVID-19 that you'll never hear from the mainstream media?

Consider subscribing to Dr. Palmer's ***Monthly 1200 Studies COVID-19 newsletter***. It will provide you with the stories, the research, the data and what the top experts from all over the world are saying about the virus, the lockdowns, the vaccines and the real numbers. You will learn information that doesn't fit the mainstream media's narrative and the information that certain factions do not want you to know. Now with all things COVID-19, as the 24/7 media drives hysteria and fear mongering, a new push for public compliance or even mandated vaccines is on. If you don't have time to do all that homework yourself, let him do it for you. **Subscribe at** https://www.wellnessdoc.com/science-and-news-monthly-newsletter/

Other eBooks on all things COVID

Check out Dr. Palmer's **eBooks on the many different controversial topics surrounding the COVID-19 pandemic** and the public health responses countries have implemented and, in some cases, hang onto today.

Current and future release topics include:

- The ineffectiveness and harms of lockdowns
- The PCR testing debacle
- The ineffectiveness and harms of face masks
- Sweden- the world's control group
- Natural anti-viral prevention and treatment nutrients
- Safe and effective repurposed medications for COVID-19
- Natural infection and lasting immunity
- The origins of the SARS-CoV-2 virus
- Germ vs. Terrain Theory
- Cytokine and bradykinin storm

Check them out at https://www.wellnessdoc.com/ebooks-and-publications/

https://Wellnessdoc.com - My website has lots of free educational resources on health, diet, nutrition and healthy lifestyle habits.

CONCLUSION

Is the science really settled as we are all told?

As you can clearly see, the science IS NOT settled. In fact, the overwhelming amount of evidence must lead any objective person to conclude that things just don't add up. How can the narrative that is pitched to the public be so devoid of any of the facts I have just presented, unless there is a diabolical plot to hide it from them? In light of that, it's so tragic that uninformed, misinformed and deceptively informed people mock and denigrate what they don't understand, they don't believe or refuse to question. In the process, they harm people (and their children), that will be intimidated into accepting the status quo, without investigating the science for themselves in order to determine the truth. The worst part is, often they are simply too lazy to invest some time to seek the truth. Is it that, if they come to a conclusion that doesn't match their previous position, they would have to admit that they were wrong? I think that is a big part of why doctors also refuse to do their homework on this issue. It's a pride thing in part, but it's also having to look themselves in the mirror, as well as all of the patients that they misled over the years and admit that they were wrong. Pride, ego and arrogance.is at the core of so many things like this! By trusting the government, the pharmaceutical industry and ignorant doctors who tell them what to think, parents are subjugating their and their children's

health to people that have a vested interest in keeping the lies going. Follow the money trail! It is dangerous for people to stop thinking for themselves and blindly follow the masses no matter what the topic.
So why do government officials, medical doctors and the pharmaceutical industry turn a blind eye? That is the trillion-dollar question. And I'm not being facetious! There is an astronomical amount of money at stake and shareholders expecting returns on their investments. For some it's all about the money. For some it is pride and the rejection of anything that would make them reconsider their long-held beliefs. But, I also believe that many are convinced in their heart of hearts, that they are saying and doing what is best for children. Some even believe that they are saving humanity. Regardless, if each one of those categories of individuals would take the time to read what is contained in this document, their conscious would force them to re-evaluate and re-consider their position. For those who money is the main driving force for their beliefs and their position, some of those will still deny anything that disagrees with their career position or monetary rewards.
I want to encourage all of you to maintain a healthy level of skepticism about everything you read, see and hear, especially when the people telling you have an agenda. Question. Investigate. Look at both sides as they present their "facts" and decide for yourself. Every person accused of a crime would be convicted if the defense never had a chance to present their case. God gave us a brain and the intelligence to seek and find the truth. If only people would take the time and the effort to follow the evidence, they could get there too. **And the Truth Will Prevail!**

Who will step up?

The children of the world deserve a champion that will fight for their right to live a full and unencumbered life, full of health, intellectual well-being and the ability to contribute for themselves and society as a whole. The topic of questioning vaccination has been radioactive. No one wants to touch it. To do so, would mean corporate and private condemnation at the least and public condemnation, loss of career and income or revenue at the worst. Well now is the time! The evidence is incontrovertible. We are nearing the tipping point where the whole house of cards is about to come tumbling down. Be on the right side of this issue and history! The extent of the tragedy for millions of families dealing with everything from ADHD, learning disabilities, behavioral challenges, neurological deficits, autism spectrum disorders, multiple seizure disorders, allergies, eczema, asthma, autoimmune conditions, type 1 diabetes, rheumatoid arthritis, obesity, cancer, reproductive and thyroid issues and even death is unimaginable. As if that isn't bad enough, what about the economic and societal cost? As mentioned previously, if the current trajectory of the rates of autism continues, by the year 2032 one in two boys will have autism. And the rates for girls will not be far behind. The economic and societal impact of such a devastating future is unimaginable!

- **Who are the regular everyday citizens that will step up?**
- **Who will be the medical doctors, nurses and health care providers that will step up?**
- **Who will be the researchers and scientists that will step up?**
- **Who are the investigative journalists that will step up?**
- **Who are the network and cable media executives and CEOs that will step up?**
- **Who are the politicians that will step up?**

Thank you in advance for all of you that will step up and help to share this vitally important message. Now that you know the truth and are acting on your conscious, your actions will make the world a better place for millions today and future generation to come!

Now rate your level of confidence in the information the proponents of vaccination have been telling you

Now that you have read this, and have thoughtfully considered the evidence that I have provided, what is your level of confidence in what you are told regarding vaccines by the pharmaceutical industry, the government, the media and most medical doctors? Give me a percentage between zero and 100%. _____.

Is there any difference between now and before you read the article? Obviously, I'm hoping that the research and the facts have made an impact on you. And if nothing else, I hope it is been thought-provoking and will encourage you to continue to challenge the status quo, seek additional knowledge and look for the truth behind the claims.

My encouragement to you, is that unless you are still 100% bought in to all the claims that vaccines are completely safe, effective and deliver on their promises, you will take a stand for a full and transparent investigation into vaccine concerns.

- It is time for a change in the status quo.
- It is time to look at all the science.
- It is time to do the real science, free from biased researchers, industry funding and reverse engineered or flawed study design.
- It is time to develop a different strategy for keeping our children safe from disease and from overzealous special interests that profit from pumping toxins, chemicals and foreign DNA into the bodies of ourselves and our children.

The Bottom-Line Problems and Solutions- Including for those that still choose to vaccinate their children

Problem One-

- Certain individuals have a **genetic predisposition** that makes them vulnerable to toxins like MSG, formaldehyde, polysorbate 80 and other components of vaccines including metals like mercury and aluminum.

The solution-

- **Develop genetic testing** that would test babies in an effort to identify those individuals, so that they can avoid exposure to those components.
- Pharmaceutical companies need to clean up their act and develop vaccines without all the crap.

- See Problem Two and the Solutions

Problem Two-

- **Parents have a history of autoimmune or mitochondrial disease, maternal immune activation, exposure to environmental toxins or pollutants like pesticides, herbicides, synthetic chemicals or obesity** are all possible increased risk factors for having a child with neurodevelopmental problems.

The Solution-

- Avoid prenatal vaccines that could potentially influence one of these risk factor in a negative way, increasing the chance of harming the baby. After birth, consider a well-planned approach to either declining all vaccinations or working with a pediatrician that understands appropriate ways to only administer certain "absolutely necessary" vaccines and to modify the schedule in such a way to spread out the dosing. This approach can help to mitigate risk to a child that may either be genetically susceptible to injury or have a level of tissue burden already from the mother's prior to inception, or prenatal exposure to toxins or chemicals that have been passed through the placenta.

Problem Three-

- **Drug triggers**- Antibiotics and acetaminophen (i.e. Tylenol) seem to increase susceptibility to reactions and reduce glutathione production which allows the person to eliminate toxins and metals from their body.
- **If a child is sick, running a fever or on antibiotics, do NOT vaccinate**

The solution-

- Never mix vaccines with antibiotics or acetaminophen
- If you are going to vaccinate, do it when the immune system is functioning fully and not under duress.

Problem Four-

- There are **too many vaccine doses compressed into too short a time span and are given too early in life** before the blood brain barrier has a chance to close.

The solution-

- Eliminate vaccines such as the Hepatitis B given to newborns born to mothers that have tested negative for Hepatitis B. Other than maternal transmission, Hep B can only be transmitted by sexual contact or dirty needles, which at earliest will not occur until mid-teenage years. Even staunch proponents of Hep B vaccines would have to admit that even at the least, if mothers are tested and test negative their babies should not need to receive the shots.
- Spread the shots out. Prioritize which are more important early and which can wait until later.
- Children should get no more than one vaccine per visit and multiple vaccine injections such as MMR or DTP/TDaP should be separated into single component vaccines.

Problem Five-

- **Doctors often don't provide COMPLETE AND DETAILED informed consent** (if at all), before injecting children with vaccines

The solution-

- Mandate by law that doctors must provide full informed consent as to the risk of each vaccine they provide, not just the dumbed down Vaccine Information Statements they are supposed to, but rarely provide and discuss adequately.

Problem Six-

- Many young children are either **not breast fed, or breast fed long enough** and are on **diets that are nutritionally deficient** resulting in increased susceptibility to illness and infection.

The Solution-

- Breast feed up to one year, or more if possible. Mother's milk contains natural immunoglobulins that can give the baby powerful protection against illness.
- Provide babies and young children with organic, whole food. Avoid sugar, including fruit juices.
- Supplement them with probiotics, vitamins A, B's, C & D. They all provide immune strengthening benefits. In fact, the World Health Organization recommends vitamin A to prevent and treat measles. From the previously mentioned article, **Measles vaccines: WHO position paper** – April 2017 stated, **"…those who are malnourished especially with vitamin A deficiency…**". It also stated, "Vitamin A should be administered to all acute cases irrespective of the timing of previous doses of vitamin A. Vitamin A oral dosage should be given immediately on diagnosis and repeated the next day; 50 000 IU should be given to infants aged <6 months, 100 000 IU to infants aged 6–11 months and 200 000 IU to children aged ≥12 months."
  http://www.who.int/immunization/policy/position_papers/WHO_PP_measles_vaccine_presentation_2017.pdf
  Warning: A very important caveat here. The high dosage vitamin A recommendation by the W.H.O. is for malnourished infants and children. Most children and infants in first-world countries consume breast milk (fortified by mom), formula or foods that are fortified with vitamin A. Therefore, the amount to be supplemented would be much less. Since Vitamin A is a fat-soluble vitamin, excess levels taken for too long can build up and become toxic. See your health care provider for specific dosages and durations which are patient size, age and condition specific.

Problem Seven-

- **Doctors have been indoctrinated in the IDEOLOGY** that the vaccine industry has promoted and have forgotten their training to follow the evidence and scientific scrutiny wherever it leads. Doctors need to challenge themselves to dig deeper than just believing what their friendly neighborhood pharmaceutical rep and their superiors in big pharma tell them. God gave them a brain and they should

know how to use it. After all, it got them all the way through medical school. Instead of going through the motions and believing everything that is spoon fed to them, they need to do their own due diligence and search out the truth wherever that may lead. If that means changing their long-held beliefs in the light of new and compelling evidence, then that's what they should do. And then, they can sleep well at night knowing that they are doing the right thing.

The Solution-

- You have seen just a sampling of the credible scientific data conflicting with the blind ideology and talking points repeated vociferously by uneducated physicians, media outlets and politicians. It's time the doctors take the lead and invest some precious time and energy into investigating the evidence for themselves. Then on a grassroots basis, they need to educate their patients about appropriate ways to modify the vaccine schedule and eliminate unnecessary vaccines. Those same doctors also need to become educated on safe and natural alternatives, including teaching their patients how to adopt a lifestyle that practices great nutrition, proper hydration, exercise and stress management in order to optimize immune system function.

Problem Eight-

- **Limited recourse for vaccine victims**- Parents of vaccine damaged children have felt like there is very little recourse for them. Other than having to navigate the Vaccine Court in an attempt for some restitution, they are left to feel that nothing they can do can make a difference in changing the dynamics of the system. They want to be able to prevent other families from having to raise a child into an adult and then care for that same adult son or daughter for the next several decades, without ever seeing them reach their full potential.

The Solution-

- Implement reform and changes that would admit evidence into cases of vaccine injury. Recently, the highest court in the European Union took a step in the right direction allowing certain evidence to be taken into consideration in vaccine injury cases. They ruled that despite the lack of scientific consensus on the issue, a vaccine could be considered defective if there was *"specific and consistent evidence,"* which includes the time between when the vaccination was given and the onset of a disease. Also, to be allowed is the individual's previous state of health, the lack of any family history of the disease and a significant number of reported cases of the disease occurring following the vaccination. Source: http://bolenreport.com/eu-court-vaccines-can-blamed-illnesses-without-absolute-proof/#more-9791 We should also open up the ability for parents of vaccine injured children to sue the pharmaceutical company that made the vaccine. The burden of proof is on the person filing the lawsuit. If they cannot prove without a shadow of a doubt that the vaccine caused the injury, then the verdict will go in the vaccine maker's favor. The plaintiff will bear the burden of their own expenses. On the other hand, if the evidence proves beyond a shadow of doubt that the vaccine did cause the injury or death of the child, the vaccine maker should pay the fair and appropriate damages. You can bet that they would clean up their act quickly if court decisions started going in the favor of these victims. They would also

make a push for developing genetic testing to identify at risk individuals. They would also start to clean up the vaccine ingredients. But, as long as the pharmaceutical industry is given immunity against legal challenges from parents of vaccine injured children and adult victims of severe adverse reactions, they will feel as though they have no need to closely regulate the safety and efficacy of vaccines. Sadly, they accept a certain percentage of casualties as the "cost of doing business", when in reality it costs them nothing.

Problem Nine-

- **Vaccines contain ingredients that can be harmful. That is undisputable, especially to a genetically susceptible at-risk population doctors have no way of identifying yet**. I believe that I have effectively made that case and presented ample evidence to back that up. Does every person given a vaccine show an obvious adverse reaction to a toxin in the vaccine? No. Does every child given vaccines suffer an adverse reaction or some form of life long harm or illness later in life? No. But for the number that do, **it is unacceptable**. For the ones that will develop one of the neurological, behavioral, immune compromising and autoimmune illnesses that are skyrocketing in proportion to the escalation of the vaccine schedule, **it is unacceptable**. For the parents that suffer the anguish of raising a child that was fully functioning and developing perfectly normally, then regressed into a state of autism or developmental delay within hours or days of their vaccination, **it is unacceptable**. Look at the escalating rate of autism. If the projections that by 2032 one in two boys will develop autism are correct, how can our society possibly support that? **That is unacceptable!** One thing is certain. We need to change something, or nothing is going to change.

  Even for those that do not develop an obvious disease state, or chronic illness from the vaccines they have been given, how do we know what effect the added level of chemicals introduced by the vaccines will have over the course of their lifetime? And how might it influence, or add to the ever-increasing burden of toxins we are all exposed to from our air, our water, our food, our personal care products, our cleaning products, and on and on?

The Solution-

- **Protect yourself and your children**- Demand not only your God given right to the sanctity of what you allow into your body, but the rights afforded to you by law, proper and full informed consent of all the potential risks and by precedents like the Nuremberg Code of 1947, which prohibits human experimentation without coercion and "voluntary consent" as to what goes into a person's own body.

For those that choose to vaccinate, what can they do to prevent possible adverse reactions?

1. Refer to the solutions for problems 2, 3, 4 and 6 above.

2. As per CDC recommendations (see page 155-157), do not give the MMR with the Varicella (Chicken Pox) vaccine, or the MMRV (which includes the Varicella) to children under 4 years of age.

   In fact, the CDC website about the MMR and MMRV states the following:
   "Instead of MMRV, some children 12 months through 12 years of age might get 2 separate shots: **MMR** (measles, mumps and rubella) and **chickenpox** (varicella). MMRV is not licensed for people 13 years of age or older. There are separate Vaccine Information Statements for MMR and chickenpox vaccines. Your health care provider can give you more information."
   https://www.cdc.gov/vaccines/hcp/vis/vis-statements/mmrv.html

3. Provide support that will help the body detoxify from heavy metals, other toxins and provide antioxidant protection from free radicals including the dangerous superoxide radicals. **These include things like:**

   a. **Glutathione-** Glutathione is considered the "Master Antioxidant" and especially effective in countering oxygen free radicals produced in response to heavy metal exposure. Oral glutathione supplementation is considered only mildly effective as the glutathione can be degraded in the G.I. tract, thus results are poor. Supplementing with pure undenatured whey protein, N-Acetyl Cysteine (NAC), Vitamin C and magnesium has been shown to be effective in providing the "building blocks" for the body to produce glutathione. Liposomal delivery is another method that some believe to be better absorbed and assimilated than orally. Another method, although more inconvenient, invasive and requiring more expense, is intravenous administration
   b. **Vitamins A, B-complex including B12 and folic acid** (preferably the reduced form of folic acid called 5-methyltetrahydrofolate), C, D and E-
   c. Superoxide Dismutase (S.O.D.)
   d. Algae supplementation
   e. Lipoic Acid
   f. Flavonoids (catechins, epigallocatechin gallate [E.G.C.G.])
   g. Curcumin
   h. Mineral supplementation especially selenium, magnesium and zinc
   i. **Support a healthy microbiome-** Take quality pre and probiotics. Approximately seventy percent of the body's immune system resides in lining of the gut, called the Gut Associated Lymphoid Tissue (G.A.L.T.)
   j. **Take omega 3 fatty acids** (anti-inflammatory, nervous and immune supporting) and reduce omega 6 fatty acids (pro-inflammatory, nervous and immune disrupting). Dosage depends on age and bodyweight.

Many of these products are part of the formulas in the ***Toxic Exposure Protection & Elimination Protocols*** that can be purchased through Nutridyn. Details are given in the next 3 pages.

TESTING

It can be very helpful to test certain levels of these nutrients to be sure that you can reach the "optimal" tissue levels.

- **Vitamin D-** The test is called the ***25-Hydroxyvitamin D Test***- Optimal values are between 50-70 ng/mL. It is a blood test that is available through your doctor. Some states now allow patients to refer themselves to labs for this test and many others.
- **Magnesium**- The best test to determine tissue levels and not just the magnesium ions floating around in the blood is called The ***Red Blood Cell Magnesium Test (RBC magnesium***). It can be done with a venous blood draw or by blood spot analysis. The *ideal levels* are between 6 and 7 mg/dL
- **EPA/DHA ratios** as well as omega 6 to 3 ratio- The ideal omega 6 to 3 ratio is 3:1 or less. The lab I use is called ***Lipid Technologies*** (Lipid Labs). It is a self-administered blood spot test. You don't have to go to a doctor's office or lab. It is a simple finger prick test, where you place drops of blood on a card that they will send you when you order the test. The regular cost for the test $200, but you can order it now through this link at $160…….Just type in **1200 Studies** for the **Offer Code**.

  Click to order your test kit >>> **GET YOUR OMEGA LEVELS TESTED HERE**

  ***Not available outside the U.S. or in N.Y.. California residents will need a health care provider to sign the order form in the test kit when you receive it.**

DETOXIFICATION & IMMUNE SUPPORT

Use only quality nutritional supplements for detoxification and immune support against infectious disease. Here is a great resource for you!

If like many people, you are confused, unsure, or have questions about what supplements and manufacturers produce the highest quality products, I have a solution for you. **HOWEVER, I want to make sure that you understand that if you are under the care of a medical provider, and that provider has recommended specific products for you, you should follow their recommendations and not consider these products, UNLESS you have a discussion with them and they give you the green light and direction.** Since your personal

medical provider has evaluated you and knows your health history, current health conditions and risk factor considerations, you should follow their advice.

FINDING HIGH QUALITY AND EFFECTIVE PRODUCTS

One of the biggest challenges for the consumer is in finding high quality nutritional products in the marketplace. There are so many sketchy nutrition companies out there. Many of them use very unscrupulous formulating and manufacturing practices without regulation. That's why it is important to only use products from a company that has independent oversight for quality control and good manufacturing procedures. I have been doing business with a company named ***Nutridyn*** for over 30 years and have had excellent results with the brands and products I have recommended to thousands of patients. I have also personally known the owners and principals of Nutridyn for over 40 years. They are all individuals of the utmost integrity and honesty. Nutridyn is a distributor for only a few companies, ones that have impeccable reputations for quality and purity. The companies that they carry are GMP certified which means they have been certified for outstanding General Manufacturing Practices. GMP is the most trusted independent certification trademark for nutritional supplement manufacturing. In my three decades plus of recommending the products they sell, I have had an overwhelming degree of success and patient satisfaction.

In addition, Nutridyn's products are sold primarily through healthcare practitioners, so they are continually receiving feedback on the degree of success in clinical situations with the products they sell. By having their finger on the pulse of those results, they are able to refine the selection process for the products that they carry and sell.

*** If you are currently working with a health care practitioner that specializes in nutritional supplementation in their practice and with your care, please consult with them so that they can recommend and provide you with the products you need. If they are highly qualified in this area and know your complete health history, they can better recommend what you need.**

If you are NOT working with a health care practitioner that offers nutritional supplementation, click on the link below to explore the wide array of products and product categories at Nutridyn.

Setting up an account is easy:

- **Connect to Nutridyn** in just a couple clicks-
  - **Click here for the informed consent statement and connect to Nutridyn.**
  - Once you provide your consent, you will be directed to our Products Page.
  - At the bottom of the ***Quality Nutritional Products*** **column,** you will select the Shop Nutridyn and be take**n** directly to their site.
  - Once there, you may peruse the products they offer and set up an account if you wish.

To set up an account, click on "***create account***" at the top right

- Provide the requested information.
- Once you setup your account, it will take you to your account page.
- You can access the products by hovering your cursor over "Products" at the top.
- When the Health Categories drop down appears, move your cursor to the category you want to browse and click on it.

Detoxification programs and ancillary methods-

If looking specifically for the detox products, select the **Toxic Exposure and Elimination category** specific to the desired age range on the **Nutridyn Product Categories Page**.
There are three "kits" that are age specific for toxic exposure protection & elimination. They are indexed alphabetically under:

Toxic Exposure Protection & Elimination Products-

- Infant to age 2
- Child ages 3-6 (dosing for age ranges in this group are provided)
- Age 7 to Adult (dosing for age ranges in this group are provided)

You will find these at the bottom of the drop-down window when you follow the Nutridyn links above. If you don't see them in the drop-down window (which will depend on your browser window and screen magnification), scroll the entire window down a bit and that will allow you to see the last categories on the list. Click on the age-appropriate category and you will see the recommended products. To view details about each product, click on the image of the product and the complete details will appear including pricing. To navigate back to the list, hit your backspace button or click on the back arrow, which is usually located in the top left corner of your browser window.

The age specific detoxification dosing instructions have been provided by Nutridyn and can be downloaded here from the bottom of the page this link takes you to…….

View Detoxification information and instructions

Other methods for elimination of toxins

Far Infrared Saunas- Saunas have been used for decades in many cultures as a way to sweat out toxins. The far infrared saunas have heaters that emit an infrared energy which stimulates release of cellular toxins, which allows for a very effective result without the need for very high heat or longer sessions.

Oral detox programs- (see the **Nutridyn** link above for access to some excellent detox products)

Proper hydration and bowel elimination- In order for the bowel and kidneys to eliminate toxins and waste, a person must be well hydrated (at least ½ ounce of water per pound of bodyweight daily) and eating foods that enhance digestion and bowel motility (fruits and vegetables with limited processed and fried foods).

Exercise- Not only does exercise promote sweating for release of toxins, it stimulates bowel and kidney elimination (assuming your diet is healthy and you are well hydrated), and it increases the metabolism enhancing burning calories, immune function and improving digestion. In addition, moderate exercise increases the body's production of interferon, a natural immune boosting chemical.

DISCLAIMER: Always work with a qualified health professional that can help you determine what your unique considerations based on your personal health conditions and any medications you may be taking. That way they can tailor a program specific to your unique needs. In addition, your doctor can tell you if you are fit enough for exercise and saunas therapy. Based on your health and level of fitness, they can recommend programs specific for your needs.

PROTECTING AGAINST INFECTIOUS DISEASES, including my VIRAL PREVENTION AND TREATMENT PROTOCOLS

How can I maximize my immunocompetency to protect against bacterial and viral infections?

Nutritional Supplements to prevent and treat infectious diseases

The following products are just some of the many products for immune support from Nutridyn. The associated product information below is from their web site. I thought I would give you an idea of a few of the products they offer. Once again, if you are working with a health care provider trained in the nutritional/supplemental approach to these issues and any other health conditions you suffer from, please see them and follow their recommendations.

VIEW & PRINT

Nutritional Viral Prevention and Treatment Products

Order any of the following products here > Connect to Nutridyn

Here are a few of the basic nutritional compounds that are discussed in my protocols and a small sampling of the science that supports their use….
The complete protocol is much more comprehensive, but this should give you a sampling of some of what it contains.

Vitamin D- D3 5000 with K2- (product code R197) Supports Bone, Cardiovascular, and Immune Health
D3 5000 with K2 is a highly bioavailable form of Vitamin D3—as cholecalciferol—and vitamin K2—as patented MenaQ7®. Vitamin D3 and Vitamin K2 are essential micronutrients with ubiquitous roles throughout the body, such as supporting stress levels, bone health, skin health, heart health, and immune function.

It is crucial to obtain adequate amounts of vitamin D on daily basis, as deficiency can lead to a host of health issues. Vitamin K2 (menaquinone) comes in a variety of forms, with evidence suggesting that the form MK-7 is particularly important for people that have chronic health issues causing nutrient malabsorption.

Given the importance of adequate Vitamin D levels in the body and many people's lack of exposure to direct sunlight, D3 5000 with K2 supplementation can help users in a variety of ways. The most relevant research-backed benefits include:

- Support cardiovascular function
- Support healthy mood and stress levels

- Support bone and skin tissues
- Support immune function

It is highly recommended that serum 25 (OH) and 1 ,25 (OH) 2-vitamin D be monitored every 60-90 days while consuming this product to ensure that levels remain in an acceptable range.

STUDY
Randomized trial of vitamin D supplementation to prevent seasonal influenza A in schoolchildren
https://www.ncbi.nlm.nih.gov/pubmed/?term=20219962

"From December 2008 through March 2009, we conducted a randomized, double-blind, placebo-controlled trial comparing vitamin D(3) supplements (1200 IU/d) with placebo in schoolchildren. The primary outcome was the incidence of influenza A, diagnosed with influenza antigen testing with a nasopharyngeal swab specimen." ***I would recommend that the child's vitamin D status is measured. It is quite possible that they may need more than 1,200 IU/day to optimize their levels. I am confident that optimized levels of vitamin D would yield even better results than were achieved in this study!***

RESULTS:
"Influenza A occurred in 18 of 167 (10.8%) children in the vitamin D(3) group compared with 31 of 167 (18.6%) children in the placebo group. The reduction in influenza A was more prominent in children who had not been taking other vitamin D supplements and who started nursery school after age 3. In children with a previous diagnosis of asthma, asthma attacks as a secondary outcome occurred in 2 children receiving vitamin D(3) compared with 12 children receiving placebo."
CONCLUSION:
"This study suggests that vitamin D(3) supplementation during the winter may reduce the incidence of influenza A, especially in specific subgroups of schoolchildren."

For an exhaustive list of Vitamin D studies showing benefits in preventing and treating viral infections see my article on *Wellnessdoc.com* HERE.

Vitamin C- Ultra Potent C, Tablet or chewable-

- 500 mg tablet (M910)
- 1,000 mg tablet (M815)
- 250 mg chewable (M812)

STUDY
Vitamin C and Infections- *Journal Nutrients* 2017
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5409678/
"In the early literature, vitamin C deficiency was associated with pneumonia. After its identification, a number of studies investigated the effects of vitamin C on diverse infections. A total of 148 animal studies indicated that vitamin C may alleviate or prevent infections caused by bacteria, viruses, and protozoa."

Vitamin A-

- **A & D Natural capsules** - (P407) 10,000 I.U.s vitamin A and 400 I.U.s of vitamin D
- **Vitamin A Fish (cod) Liver Oil-** (P1616) 25,00 I.U.s vitamin A

Vitamin A plays an integral role in immune health and may be especially beneficial for warding off illness and infections. According to a review out of Baltimore, a deficiency in this key vitamin can weaken immunity and even alter the function of immune cells.

It's believed that vitamin A deficiency blocks the regeneration of the mucosal barriers, resulting in increased susceptibility of infections. Interestingly, a 2014 study out of Colombia actually estimated that giving 100,000 children vitamin A supplements could save over $340 million in medical costs by reducing the incidence of serious conditions like diarrhea and malaria.
Courtesy Dr. Axe- https://draxe.com/vitamin-a/

STUDY- ***Proceedings of the Nutritional Society***
Vitamin A and immunity to viral, bacterial and protozoan infections
https://www.ncbi.nlm.nih.gov/pubmed/10604208

"Studies in animal models and cell lines show that vitamin A and related retinoids play a major role in immunity, including expression of mucins and keratins, lymphopoiesis, apoptosis, cytokine expression, production of antibody, and the function of neutrophils, natural killer cells, monocytes or macrophages, T lymphocytes and B lymphocytes. Recent clinical trials suggest that vitamin A supplementation reduces morbidity and mortality in different infectious diseases, such as measles, diarrhoeal disease, measles-related pneumonia, human immunodeficiency virus infection and malaria. Immune responses vary considerably during different infections, and the available data suggest that the modulation of immune function by vitamin A may also vary widely, depending on the type of infection and immune responses involved."
There are many mentions and references of the value of vitamin A in preventing and treating infectious disease in this eBook.

Zinc- Zinc Pro- A highly Absorbable Zinc capsule (product code R913) or Zinc lozenges w/ Vit C (product code D75)

Zinc is an essential mineral, second only to iron as the most plentiful trace element in the body. It aids in the absorption of B vitamins, is a constituent of at least 25 enzyme systems, and is a component of insulin and of superoxide dismutase. Further, zinc is essential for growth and development of the sexual organs and prostate function. It is required for protein synthesis and collagen formation, promotes a healthy immune system, and healing of wounds. It is important for the formation of bones and plays a role in carbohydrate and phosphorus metabolism. Zinc also allows acuity of taste and smell.◆

Echinacea, Black Elderberry and ginger- Bacticidx- (product code T2191)

Bacticidx is an all-natural herbal immune support formula containing Echinacea root, elderflower/elderberry, and ginger root.◆
Proper immune function is critical for adults, especially if regularly in highly contagious environments such as schools or offices. Bacticidx by TonicSea is a great way to help you get the herbal ingredients you need for healthy immune function.◆

Bacticidx is formulated with three potent immune-supporting herbs: Echinacea, elderflower/elderberry, and ginger root. Research suggests that the Echinacea herb supports the body's immune function. For this reason, Echinacea is sometimes referred to as "nature's immune enhancer."◆ Ginger contains fragrant polyphenols called gingerols that have been shown to have antioxidant and immune supporting roles in the body.◆ Also contains elderflower and elderberry, which have polyphenols that help support healthy inflammatory response by inhibiting nitric oxide production in certain bodily tissues.◆

Mushroom Extracts & Micronutrient support- **Immune Support** (product code R156)
Immune Support combines vitamins C, D, and Niacin with trace elements Zinc and Selenium to create a product with potent immune support. To further support healthy immune function, a proprietary blend of various extracts of mushrooms traditionally found in Eastern medicine has been included.◆ Centuries of using mushrooms for their beneficial properties and modern clinical evidence reveal their potent ability to support a healthy immune system.◆

Olive leaf extract- **Olivirex High Potency Olive Leaf Combination** (product code B126)
Olivirex® is an innovative formulation combining standardized olive leaf with a synergistic blend of botanicals to enhance the broad-spectrum qualities of olive leaf. Both historical references and modern research attest to the value of the phytochemicals of this ancient tree. Summary of Benefits: Superior Olive Leaf combination offers broad-spectrum support; Highest potency Olive Leaf extract available (22-24% Oleuropein); Synergistic blend of additional botanicals supports detoxification. Contains added immune modulators and adaptogens.

Andrographis herb- **Andrographis Plus** (product code ANDRP)

Andrographis Plus® delivers a proprietary blend of Ayurvedic and Asian herbs including beneficial levels of concentrated andrographis extract and amla designed to support immune health. A proprietary herbal preparation traditionally used to support lung health rounds out this advanced immune support formula.

Resveratrol- **Resveratrol Plus** (product code R214)
Resveratrol Plus contains highly potent antioxidants from green tea leaves, grape seeds, and isolated quercetin. These plant-derived molecules have been shown to support healthy blood pressure, blood lipid

levels, blood flow, and immune function. A potent polyphenol compound, resveratrol has shown remarkable antiviral activity in numerus studies.

Beta glucan- **Immunity Pro (T2186)-** for teens and adults

-Suppys Immunity- All-Natural Immune Support for Children (product code Y1015)

Research shows that Beta glucan supports both innate and adaptive immune function. According to a clinical study, older adults (50-70 years old) taking Wellmune reported a 16% decrease in total upper respiratory tract infection (URTI) symptom days. A 4-week clinical study demonstrated that stressed women taking Wellmune® were 62% less likely to develop URTI than those taking a placebo.
Proper immune function is crucial in children, especially as they grow and mature. Children also tend to be at greater risk of foreign challenges due to activities like school, playing outside, and being in daycare. Suppys Immunity is a great way to help kids get the beta-glucan they need for healthy immune function in tasty chewable tablets.
Suppys Immunity is a delicious, all-natural immune support formula for children, containing patented Wellmune® a highly purified, proprietary strain of baker's yeast. A large body of clinical research suggests that Wellmune® can help support children's natural immune responses and provide protection from health challenges arising from physical and lifestyle stress.
According to clinical research, children supplementing with Wellmune® reported 66% fewer upper respiratory tract infections (URTI) symptoms and six fewer sick days over the course of 12 weeks than children taking a placebo.

Colostrum- **Immune PRP Pro** (product code T2178)

Immune PRP Pro contains pure bovine colostrum which is rich in immunoglobulins, especially IgG, as well as IgA and IgM. Bovine colostrum contains 40 times more immune-related components than human milk. In addition to these immune system enhancers, bovine colostrum contains viable cells, such as neutrophils and macrophages, which secrete special proteins that support your immune system◆; these proteins include cytokines, lactoferrin, and proline-rich polypeptides (PRP).

View and Print my Nutritional Viral Prevention and Treatment Protocols

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Is that a lot to digest? (pun intended 😊) This link will take you to my Nutritional Viral Prevention and Treatment Products page, where I have posted the complete program and have organized it all for you!

VIEW & PRINT

Nutritional Viral Prevention and Treatment Products

Diet and Lifestyle Recommendations

- **Get chiropractic adjustments**- As the methods for measuring nervous and immune system competency have improved, several studies have been able to connect the dots between getting adjusted and improving immune system function. In simple terms, the autonomic (automatic or self-governing) part of the nervous system has 2 parts, the sympathetic and the parasympathetic nervous systems. The sympathetic is the fight or flight part (adrenaline and action) and the parasympathetic one is the "chill" part (digestion, rest, sleep). Healing and enhanced immune function occur during parasympathetic dominant states. Chiropractic adjustments help regulate the autonomic nervous system toward the parasympathetic side. Another way of putting it, is that adjustments down-regulate the sympathetic nervous system. This results in better healing and enhanced immune competency. **ALTHOUGH…chiropractors don't treat disease or infection with adjustments, they adjust the dysfunctional segments of the spine, which allows the nervous system to regulate functions and systems of the body in the manner that they were designed to do. It is the innate or inborn wisdom of the body that heals. Removing interference and letting the body do the rest is how chiropractic works. YET, it is imperative to understand that chiropractors including myself do not treat infectious diseases. We simply enhance the function of the nervous system to reduce or remove interference that occurs from vertebral aberrant motion and position by treating the dysfunctional vertebral segments. There is a time and place for various medicines to treat infectious diseases and all illnesses. Chiropractic is an important part of complete health care, wellness strategies and preventative care.**

    - The role of the autonomic nervous system and its influence on the immune system. https://www.ncbi.nlm.nih.gov/pubmed/11121511
    - Chiropractic adjustments inhibit sympathetic tone improving immune function https://www.hindawi.com/journals/ecam/2017/4345703/
    - The famous Henry Winsor M.D. study, showing evidence of sympathetic segmental disturbances and visceral disease. https://danmurphydc.com/article-review - see link to free article review.

- **Reduce mucous forming foods**- like dairy, fried and deep-fried foods, cream sauces, sugar and excess grains. Foods that form mucous make your lymphatic system sluggish. The lymphatic drainage system is like the body's sewer system. They drain all of the cellular debris and waste from our tissues, so they can be eliminated. Mucous plugs up the system. It would be like having a clogged septic system and having all that putrid waste back up into your house!

- **Stay away from sugar and high glycemic foods** (foods that convert to sugar rapidly into the blood stream). Studies show that even small amounts of sugar inactivate the immune system for several hours.

- **Drink adequate pure water**- A minimum of ½ ounce per pound of bodyweight (more if exercising or sweating). Being well hydrated helps lymphatic drainage and all cellular processes work better.

- **Exercise**- at least 30 minutes 5 times per week.

- **Stop touching your nose**- Estimates are that we touch our noses between 20 and 40 times a day! Every time you touch your nose, you run the risk of transmission of a bacteria or virus into your body. This is the number one-way people become infected. They touch a door handle or other contaminated object and then touch their nose.

- **Get plenty of quality sleep**- Get a minimum of 7 hours per night and preferably 8. If you don't sleep well at night, take a power nap during the day.

- **Wash your hands regularly and be conscious of what you touch**- Do NOT use antibacterial soap. Regular hand soap will do the trick and prevents the development of bacterial resistant organisms.

VIEW ONLINE VERSION

10 Effective Ways to Prevent and Treat Viral Infections

IF VACCINES ARE GOING TO STAY, WHAT NEEDS TO BE DONE TO FIX THE PROBLEMS?

- A ***Vaccine Commission*** should be formed consisting of INDEPENDENT, NON-PHARMA or CDC AFFILAITED scientists and researchers, to look into systemic and systematic corruption, bias, financial conflicts of interest, and pay for play schemes. The involvement of media and biased reporting based on financial benefits from pharma should be regulated and fines should be instituted for those disseminating information provided by advertisers as "news" or "fact" rather than fully disclosing it to be a paid for commercial. The Commission should scrutinize studies on both sides of the argument and develop plausible theories to explore with additional studies that are carefully controlled for bias, conflicts of interest and methodological flaws. Then an all-out effort should be made to identify the root causes for the advancing neurological, immunological, reproductive and oncological epidemics we are seeing over the last 50 years. Once identified, sweeping changes need to be implemented to stem the rising tide of debilitating chronic disease that threatens to wipe us out physically, emotionally and financially.

- **Vaccine manufacturers need to work aggressively on vaccines that do not contain toxic substances and don't cross react with other vaccines**.

- **We need to eliminate prenatal vaccines for women until (or if) metals and other toxins are eliminated from vaccines.**

- **We need to develop genetic testing that identifies children that are susceptible to reacting to the ingredients in vaccines and do not vaccinate them**, or at least wait until they are much older and then only selectively vaccinate.

- We need to take a step back and **reduce the vaccine schedule** by eliminating the vaccines that many health professionals currently consider optional (but may be afraid to speak out).

- **Children should get no more than one vaccine and dose per visit**- The multiple vaccine injections such as MMR, DTP/TDaP and polyvalent (poly=many) vaccines like the trivalent (3), quadrivalent (4), pentavalent (5) or hexavalent (6) vaccines should be separated into single component vaccines, despite the desire for cost savings, compliance and convenience. Children's lives and health are worth the higher cost and inconvenience, aren't they?

- **We need to spread the schedule out significantly**, with less vaccines and doses before age 2.

- **We need to give parents written informed consent, which describes ALL the possible adverse reactions to the shots their children are about to receive, AND give the parents the right to refuse them if they so choose without being shamed, chastised, criticized or ejected from the doctor's practice**. Ignorant doctors need to learn this information and behave compassionately or run the risk of losing well-educated patients and their families.

- **There needs to be an independent investigation of and fundamental changes at the CDC**. The incestual relationships with the pharmaceutical companies need to be forbidden. The myopic agenda driven mantra and unquestioning support of the CDC for big pharma needs to stop. The CDC is supposed to be the protector of the public health and watchdog against medical practices that harm the public. There needs to leadership changes that take that role seriously and carry it out without bias, collusion or prejudice. Let the facts be the facts, don't allow appearances of fact to be "manufactured" in the lab.

- **Consider allowing healthy and well-prepared kids to contract certain childhood illnesses AND GIVE PARENT THIS OPTION without feeling pressure or coercion**- We should consider a concept that was used years ago to impart lifelong immunity to childhood disease. This may sound radical to some, but many years ago, when a child would develop chickenpox for example, other friends and family would bring their children over to become intentionally exposed. It was a way to provide lifelong immunity to that illness by allowing the child to contract the illness at an age when the symptoms are milder and much more tolerable. In fact, many of us who grew up in the 50s and 60s experienced the benefits of this philosophy. This process would work best of course, if were utilized with children who are not immune compromised. This should only be done with children that have healthy, vital, strong immune systems, whose parents live and promote to them a lifestyle that follows the following recommendations.

- **Support the immune system**- The previous recommendation would work best if parents knew how to provide food and nutrients that will build and enhance their child's immune system prior to exposure by feeding them natural whole foods, providing them with supplemental immune boosting nutrients like probiotics, vitamin C and vitamin A. They must also avoid sugar, fried foods and other immune compromising substances, drink purified water, get plenty of outdoor activity, exercise and quality sleep. If a child is not sick at the time and was properly prepared prior to exposure to what is supposed to be benign childhood illnesses, the risks and rates of serious complications would be dramatically reduced. These same recommendations would be solid advice for all parents wishing to reduce their children's susceptibility to any illness. Not only will this approach reduce the susceptibility to illness, but if the child does contract one of the many bacterial and viral infections, they will be well prepared for their own immune system to fight and defeat it. Remember, fighting and defeating childhood illnesses is one of the fundamental ways that the immune system develops and matures. If we try to

keep our children in a sterile bubble, we are doing them a major dis-service which we will talk about next.

- **Employ the *Hygiene Hypothesis***- Many scientists are now re-discovering and supporting what's called the Hygiene Hypothesis, which recognizes that exposure to germs is part of the development and maturation process of a strong and healthy immune system. A current example of this at work is that public health officials have reversed their stance on the use of antibacterial soaps and hygiene products. They have recognized that attempting to create a sterile environment is interfering with natural immunity and propagating antibiotic resistant germs. Promoting a system that would impart natural immunity as part of an intentional, safe, controlled and inexpensive (free) process, would make sense to anybody who doesn't stand to make a profit from the current system.

- **Control inflammation**- IL-6 is a pro-inflammatory cytokine (protein), which can activate inflammation systemically, including in the immune and brain cells of the fetus. This is definitely not a good thing during fetal development! Maternal intake of fish Oil, curcumin and resveratrol block IL-6. Decreasing inflammatory oils like high omega 6 vegetable oils during pregnancy can also reduce IL-6 and thus systemic inflammation. Reducing Il-6 is also a key to decreasing the chances of the mother and child from developing autoimmunity. Even soluble fiber and prebiotic fiber have been shown to reduce neuroinflammation in mice. https://www.ncbi.nlm.nih.gov/pubmed/?term=30154787

    - **Here is a case in point with fish oil.** A 2017 article from the Journal ***Lipids*** titled, **Do Omega-3/6 Fatty Acids Have a Therapeutic Role in Children and Young People with ADHD?**, looked at 16 studies, in which 13 of them revealed the benefits of fish oil in **the treatment of ADHD, as well as protecting against brain-inflammation and cellular damage and death**.

From the Article:

"Long-chain polyunsaturated fatty acids (LCPUFA) and particularly omega-3 fatty acids have been under the spotlight for decades. They are **key regulators of brain neurotransmission, neurogenesis, and neuroinflammation, all having an important role in the prevention and treatment of psychological and behavioural dysfunction disorders. Eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA) are two fatty acids that are highly concentrated in the brain, exhibiting antioxidative, anti-inflammatory, and antiapoptotic effects, with these contributing to neuron protection**."

Some of the studies also found that certain individuals don't metabolize and utilize these fatty acids efficiently. Like we have discussed previously with regard to other genetic defects (polymorphisms), some individuals may be genetically limited in their capacity to process these types of fat. Even those that have genetic polymorphisms, typically respond to higher doses, than someone whose genetic code allows for proper processing. Always check with a health care provider knowledgeable in these matters, to determine what dose is appropriate.

There are numerous natural compounds in addition to fish oil that down-regulate inflammation and oxidative stress. Those include curcumin (from turmeric), ginger root, quercetin, vitamin D, lipoic acid,

N-acetyl cysteine, alpha lipoic acid, resveratrol just to name a few. The Nutridyn product that I recommend containing a wide array of these nutrients is called Dynamic Inflam-Eze. It is one of the products that can be found by following the Nutritional Viral Prevention and Treatment Products button a few pages back.

Current vaccine exemptions in various states

Pay close attention to the attempts by state legislation to restrict your right to exercise an exemption for you or your child. According the NCSL link below, as of December 20, 2017, only 18 states are left to exercise a personal belief exemption. All states except California, Mississippi and West Virginia still offer a religious exemption. And all states currently offer a medical exemption. To stay current on exemptions I recommend these two resources:

The National Vaccine Information Center
https://www.nvic.org/vaccine-laws/state-vaccine-requirements.aspx
You can download a map of the U.S. showing the current states and the allowable exemptions here:
https://www.nvic.org/CMSTemplates/NVIC/pdf/state-vaccine-exemptions_blue.pdf

The National Conference of State Legislatures (NCSL)
http://www.ncsl.org/research/health/school-immunization-exemption-state-laws.aspx

Just another word on exemptions. If you are a parent and get "the letter" from your child's school warning you that your child will not be able to set foot on school property unless all of their vaccinations are up to date, and your child is not up to date, do not fear if you live in a personal exemption state. All you need to do is call the school and request an exemption form. Simply fill it out, checking the personal exemption box and return it. Usually there are no questions asked. If you live in one of the 47 states that allow for a religious exemption and your beliefs would preclude you from taking certain vaccines due to the aborted baby DNA contained in that shot, or another religious conviction, you would need to make your case and possibly provide a letter from your pastor, priest or rabbi. For a medical exemption, you will need a letter from your medical provider stating the reason for the request. Reasons include a history of allergic reaction to an ingredient found in the vaccine or a prior adverse reaction to the same vaccine.

Ask these questions if you intend to receive a vaccination, or vaccinate your child:

This is an excerpt from the National Vaccine Information Center (NVIC):

Under the National Childhood Vaccine Injury Act of 1986, over 3.6 *(now it's 4)* billion dollars have been awarded to children and adults for whom the risks of vaccine injury were 100%. Vaccines are

pharmaceutical products that carry risks, which can be greater for some than others. NVIC encourages you to become fully informed about the risks and complications of diseases and vaccines and speak with one or more trusted health care professionals before making a vaccination decision.

1. Am I or my child sick right now?
2. Have I or my child had a bad reaction to a vaccination before?
3. Do I or my child have a personal or family history of vaccine reactions, neurological disorders, severe allergies or immune system problems?
4. Do I know the disease and vaccine risks for myself or my child?
5. Do I have full information about the vaccine's side effects?
6. Do I know how to identify and report a vaccine reaction?
7. Do I know I need to keep a written record, including the vaccine manufacturer's name and lot number, for all vaccinations?
8. Do I know I have the right to make an informed choice?

If you answered yes to questions 1, 2, and 3, or no to questions 4, 5, 6, 7 and 8 and do not understand the significance of your answer, you may want to explore information on NVIC's website to better understand the importance of your answer. These questions are designed to educate consumers about the importance of making fully informed vaccine decisions

Source: http://www.nvic.org/Ask-Eight-Questions.aspx

Your opportunity to help support this effort

I have dedicated the last three and a half years of my life in the research and writing of this eBook. There are two main reasons I didn't want to write a conventional book and sell it through book outlets. The first is that my number one priority is to provide widespread distribution to this vital health and life saving information. Second, was to provide it in such a way that all of my statements, claims and sources could be easily verified with a mouse-click. The truth and substantiation to peer reviewed scientific literature to this information was essential. Financial compensation for my time was a distant consideration compared to those reasons. If you feel that you have been blessed in any way by your access to this document and the ability to easily share it and would like to donate to my efforts, that would be amazing and greatly appreciated.

Please consider donating to offset the costs for producing this eBook

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Donate securely here

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To email or share this document, look for an icon that looks something like one of these. They are usually located on the toolbar at the top of the page

F

orward the link to this e-Book to your state and federal representatives and senators- Their contact information can be found here…

To locate your Federal Representatives to Congress, go to either of these sites:

https://www.house.gov/representatives/find-your-representative

- Type in your zip code to locate your District Representative to the House

https://www.usa.gov/elected-officials - choose senate or house

- For the House, type your zip code in the box in the upper right to find your District Representatives and their contact information
- For the Senate, choose your state in the drop-down box

Each of the state official's contact forms are slightly different, but the information asked to be provided is very similar

Fill out your information

Under **Topic**: choose Healthcare

Under **Subject**: type "critical health care subject"

Under **Message:** You can copy and paste this if you like- -or- add your own content and style as you see fit. **Be sure to copy and paste the links to the download also**

SAMPLE:

I urge you to please read this document. Our country's future depends on it and that is not hyperbole. This E-book titled 1,200 Studies. This eBook is the most researched and scientific exposé on the safety and effectiveness of vaccines. It is searchable, with instant access to any page from the Table of Contents and

allows for direct link connection to the content's sources and information right from our own government's scientific database, called PubMed. You can access it at one of these sites.

- **www.1200studies.com**
- **www.wellnessdoc.com/1200studies**
- **www.chiropractic.org/1200studies**

To locate your State Representatives, go to this site:

https://openstates.org/find_your_legislator/
Once there you can use the auto locator to find your district Senators and Representatives -or-
Select your state at the top
Click the Legislators tab just under the state drop-down
Select both chambers
Enter your address on the right
Select your congress person and you will be able to email or call them
Copy and paste the statement above or add your own content and style as you see fit.

Support the National Vaccine Information Centers efforts to fight for the individual's right to choose what goes into their and their children's bodies

This is a page from NVIC's website that has a great summary of what is happening legislatively all over the country. https://www.nvic.org/NVIC-Vaccine-News/October-2017/state-vaccine-legislation-in-america-2015-2017.aspx
Get involved on your state and local level to fight these attempts to mandate vaccines and trample on your personal rights and freedoms. NVIC also has numerous resources including information on state exemption laws. Here is their home page: https://www.nvic.org/

If you like this work and the information that it provides, please consider subscribing to my monthly newsletter covering all science and evidence-based things related to the COVID-19 world-wide freak out

Not only is the data and the science on vaccines changing all the time, COVID-19 has added many layers to the rapidly changing information. What is fact? What is fiction? How is data and statistics manipulated to support an agenda (i.e. fuzzy math)? What do the real stats say?

Using multiple sources, I will share with you the stories behind the stories, the data to support them and the links to the studies or aticles so you can follow-up if you'd like. You won't hear these stories in the mainstream or pharma-controlled media. Get it all for only $6.00 a month.

Subscribe to the 1200 Studies monthly newsletter here....

Subscribe

Some closing thoughts

This document could have been well over 2,000 pages long. The point is, that there is such overwhelming evidence of major problems with the current system. More evidence of that emerges every week and the reports of adverse vaccine reactions continue to pile up, as does the payments to vaccine injured children and adults. And devastation is left in the wake of it all. Families and children's lives are destroyed and sometimes it seems that no one cares. But just know that there is a growing number of people that do care and are willing to take a stand. And it's up to each and every one of us to share this story and become active in our communities, working hard to get the truth out.

Closing Remarks

Going forward-

I'm going to make a couple relevant points using spirituality as an example, because there are some good correlations to the vaccine conversation.

- **Examining the evidence**
- **Holding firm to your convictions**
- **Treating all others with love and compassion**
- **Our freedom to chose**

In all life decisions, each person has to examine the evidence and come up with a verdict or decision. Here's an example that comes to mind. It's like all of the different religions in the world, even including atheism. There is the possibility that they could all be wrong, but one thing for sure is that they all can't be right. Each person

has to decide where they're going to stake their claim, their trust, their faith. We all put our faith and trust in something whether its ourselves, our spouses, our money, our career or a higher being.

Study the evidence, make your decision and then hold fast to your convictions

Since I have always been an evidence-based person, I like to analyze things before making up my mind about it. From a spiritual perspective, I have decided that Christianity makes the most sense to me and aligns with my spirit, therefore I have adopted a Christian worldview. I've put my faith and trust in Jesus Christ, in part because I have looked at all the evidence and come to that conclusion and in part because my spirit has felt drawn to Him. On the intellectual side, I've read several books by devout atheist attorneys and investigators, that set out to disprove Christianity but came full circle after examining the evidence.

And, I've examined the historical evidence and the archeological evidence myself. I've considered the hundreds of Old Testament prophecies that were all fulfilled, including the ones about the life, death and resurrection of Jesus. The odds of every one of those prophecies being fulfilled are infinitesimal, yet they all were. Every single one of them. His eleven disciples (after Judas's betrayal and demise), went from frightened doubters after seeing him die on the cross, to turning 180 degrees in their belief after seeing him alive again (along with over 500 other witnesses). And making known their convictions, they proclaimed his resurrection, standing firm in their testimony even to the point of being willing to be martyred for their faith decades later after boldly spreading the "Good News" about Jesus' life, death and resurrection. If they wouldn't have been absolutely and totally convinced that he rose from the dead, they would have just walked away and lived a comfortable, happy, easy and unassuming life…. Instead, they died for their faith.

So, like any life altering decision (and considering vaccination can be just that), a person needs to consider all the facts and evidence including the extenuating circumstances and decide what is true. Then they need to stand firm in their convictions and if they feel called, spread the news to others. If a preponderance of new evidence comes to life, we should all be willing to look at and consider it. We have all heard of the person convicted of murder that serves decades in prison until new facts come to life and they are exonerated and released. As new facts are presented, a person needs to have the integrity and honesty to say, "in light of the new evidence, I will change my opinion". I am hoping and praying that this will be the case with many staunch vaccine proponents. I believe that those with an open mind, intellectual honesty and a heart to serve others and do what's right, will do just that.

Another intersection between religion and the vaccine issue is the use of aborted baby tissue to grow the virus for vaccines. That coupled with the fact that fragments of that baby's DNA remain in each dose of the vaccine and are transmitted into the body of the vaccine recipient, potentially being combined or integrated into the DNA of that vaccine recipient. That poses significant moral, ethical, religious and health challenges. Several world religions would have issues with that, and I would imagine that many non-religious people would as well.

An appeal for civility and respectful discourse- Be loving and respectful

And one last point of encouragement which can also relate to the spiritual analogy, the bible commands Christ followers to love all people. In fact, the message at church last Sunday was on 1 John 4:13-21. It was all about how Christians are to love. And in 1 Corinthians 13:2 (ESV), it says, “And if I have prophetic powers, and understand all mysteries and all knowledge, and if I have faith, so as to move mountains, but have not love, I am nothing.” As Christians we are to love people regardless of what religion they believe in, even if it’s no religion at all. The Bible tells us that all people are made in God’s image. And that all people deserve our love and to be treated with respect.

In the same way (regardless of what your spiritual beliefs are), we should love people with opinions on vaccines that are different than ours. Let’s take the high road and debate with courtesy and respect, even if the other person resorts to hatred, name calling and bad behavior. Let’s set the example for civil discourse, sticking to the facts even when discussing an emotionally charged subject.

Our freedom to choose

One of the blessings of living in the United States of America is freedom. There are many freedoms we enjoy, freedom of religion (or no religion), freedom of expression or speech, freedom to pursue happiness, fulfillment and career choices. And the freedom to choose what we do with the health, well-being and sanctity of our body and the bodies of our children. We live in a country where our government allows us these freedoms. The opposite is true in totalitarian regimes and communist countries. The government tells you whether you can practice religion or not. In many cases it is outlawed, because the government wants complete and total allegiance to them. They tell you how to think and what to think. As human beings, this is antithetical to our nature. The desire for the freedom to think and choose our destiny is in in the heart of every human being. And our forefathers left England to escape an over-reaching government, that told them what religion they had to practice and what they had to believe to make a life in the new world. They created a nation built on different principles. So today, we can enjoy the very freedoms that our Founding Fathers so purposefully carved into our Constitution, including the Bill of Rights and with the Declaration of Independence. We as citizens, have to be steadfast in making sure that those rights do not erode over time. Critics would say that when it comes to your free choice regarding vaccines, the government must look out for the better welfare of the whole population. They know what is best for all of us and <u>they</u> will dictate our choices, which in the end becomes no choice at all. Well, after reading this document, I hope that you have a much better appreciation for why that argument doesn’t hold water. In fact, that bucket has so many huge gaping holes in it, that there is no water left.

Thank you for taking the time to read and explore this massive document. I ask that you follow your heart with this information. If inspired to do so, share it with as many people as you can. Nothing will change unless enough caring people take action to make it happen. You can be a part of that transformation.

Special Acknowledgements-

- Special thanks to my amazing wife, as she patiently waited for me, extending me grace while I spent hundreds of hours over two and a half years to complete the original eBook project. And many hundreds of hours since digging through data, studies and investigating all things COVID. Over the last 6 years so many things had to be put on hold, (including gainful employment 😊).

- I would like to extend a special thanks to my good friend Richard Trayler for teaching me how to construct a document like this. He taught me how to create the shortcuts, formatting, and cool features I used in 1200 Studies. Thank you Rich!

Bio for Dr. Palmer

Education and work experience

Dr. Palmer did his undergraduate studies at the University of Minnesota. He graduated with a Doctor of Chiropractic Degree from Northwestern College of Chiropractic in 1985. Dr. Palmer earned his certification (C.C.S.T.) in Conservative Care of Spinal Trauma, which gives him exceptional knowledge and experience in treating spine trauma including "whiplash" and traumatic sports and occupational injuries. Dr. Palmer is also certified in the care of Sports Injuries. Additionally, he holds state board certifications both in acupuncture and physiotherapy. Dr. Palmer is widely recognized in the sports care arena and in addition, works with individuals suffering from a wide array of health conditions utilizing functional medicine, lifestyle management and a clinical nutrition approach.
He has served as an Associate Clinical Faculty Member of several chiropractic colleges and has been a guest instructor teaching sports nutrition at the Southwest College of Naturopathic Medicine.

Dr. Palmer has worked with hundreds of professional and world class athletes over the years. He is the treating chiropractic physician for the Arizona Diamondbacks (20 years), the Arizona Coyotes (22 years) and was the San Francisco Giants team Chiropractic Consultant during spring training from 1996-2001 and the Phoenix Roadrunners Hockey Club for one season.

As a student of health and life, Dr. Palmer has spent three decades studying various healing arts and natural treatment options for health problems of all kinds. His practice has always been on the cutting edge of the latest developments from the world of clinical nutrition, functional therapeutics and natural healing. He has an intense and passionate desire to educate people about the benefits of a natural healthy lifestyle.

Professional accomplishments

Dr. Palmer was the co-founder of C.E.P.A., the Chiropractic Association for the Care of Elite and Professional Athletes. Dr. Palmer and C.E.P.A. were later co-founders of the U.S.S.C.F., the United States Sports Chiropractic Federation. The U.S.S.C.F. was the governing body for chiropractic care for all International Sporting events held in the United States. He is the founder and currently acts as the Assistant Director of the Professional Baseball Chiropractic Society (PBCS) and the founder and Director of the Professional Hockey

Chiropractic Society (PHCS). The PBCS and PBHS are professional societies consisting of the official chiropractors providing care for the players and staff of the teams in Major League Baseball and the National Hockey League respectively.

Presentations and workshops

He has presented 28 different workshops and keynote lectures on various aspects of health, wellness, disease and sports and back injury prevention to over 150 different groups. Dr. Palmer has been instrumental in teaching chiropractors how to integrate with professional and collegiate sports medical care systems for the interdisciplinary care of the players.

Has presented at national chiropractic symposiums teaching chiropractic physicians the proper protocols for working with teams and the care of elite and professional athletes.
More about Dr. Palmer and his approach: https://www.wellnessdoc.com/about/

Dr. Palmer's website is www.wellnessdoc.com

Additional Resources: (Appendix A, B & C to follow)

- If you have the opportunity to view the 7-part docu-series called ***The Truth about Vaccines***. It was outstanding and educational! It did a GREAT job of presenting the evidence that exposed so much corruption in the vaccine industry, from the drug companies themselves and the collusion between them and the CDC. They also presented tons of research and interviews that really shed the light on the dangers of particular vaccines and the recommended vaccine schedule. They really took a balanced approach with some of the experts being pediatricians that say they still believe in certain vaccines, but would give those limited ones in a schedule, that is more spaced out and once kids are a little older. That is part of the problem. The childhood vaccine schedule. that the government is pushing has grown from 15 shots to 72 over the past few years! They also offered options for safer alternatives. https://go.thetruthaboutvaccines.com/
    - Here is also a free link to their Episode 1: The History of Vaccines, Smallpox, Vaccine Safety & the Current CDC Schedule – https://go2.thetruthaboutvaccines.com/docuseries/episode-1/

  The have also released two more episodes as of April 2020. Episode 8, titled Censorship and Supression covers the latest assaults on our health freedoms. Episode 9 titled, WHO's NOT Telling the Truth, shows behind the closed-door meetings by the World Health Organization's committees in charge of vaccination programs discussing and admitting that their safety systems are solely lacking, despite the P.R. campaign which tells the public the opposite. It also covers the agendas behind the push for a coronavirus vaccine, including Bill Gates, Anthony Fauci and much more!

- Another remarkable and very well-done docuseries titled, ***Vaccines Revealed*** explores many of the same topics you have just read in this eBook. There are compelling interviews with doctors, scientists and victims of vaccine adverse reactions. https://www.vaccinesrevealed.com/

- Watch the documentary called ***Plandemic***. The web site is www.plandemicmovie.com It is an excellent expose of the corruption found at the highest levels of the incestuous relationship between our national health agencies and the pharmaceutical industry. It looks at events surrounding the COVID-19 pandemic and the stated globalist agenda behind the push for a mandated coronavirus vaccine, compliance tracking of individuals on all mandated vaccines and the stripping away of our freedom to chose and to maintain the autonomy of our and our children's bodies.

- Neil Z. Miller's book, **Miller's Review of Critical Vaccine Studies: 400 Important Scientific Papers Summarized for Parents and Researchers,** is it in outstanding resource. It was released in February of 2016 and 90% have given a 5 out of 5-star review ratings on Amazon.

- Web site for the Weston A. Price Foundation- https://www.westonaprice.org/vaccinations/ This page offers some excellent information and resources including many web site links at the bottom of the page, that provide additional information about the concerns regarding vaccines. The link titled WAPF Vaccination Index with references about 2/3 of the way down the page, provides some stunning statistics and the references where that information was derived from. Just below that is a video version of those statistics.

Appendix A

Websites of organizations that provide educational materials and information on vaccine risks and efficacy

www.aaemonline.org
www.acam.org
www.ageofautism.com
www.ahrp.org
www.anh-usa.org
www.Autisminvestigated.com
www.autismpolicyblog.com
www.autismsciencefoundation.org
www.avoiceforchoice.org
www.bolinreport.com
www.buildingthetruth.org
www.canaryparty.org
www.cccmovement.com
www.childhoodshots.com
www.childrenshealthdefense.org
www.chriskresser.com
www.circleofdocs.com
www.cmsri.org
www.cogforlife.org
www.cognitivetruths.com
www.conem.org
www.dailymail.co.uk
www.danmurphydc.org
www.kidnurse.org
www.davidhealy.org
www.davidrasnick.com
www.dissolvingillusions.com
www.doctorbob.com
www.drbrownstein.com
www.drjohnbergman.com
www.DrSuzanne.net
www.ecowatch.com
www.efvv.eu
www.Environmentalhealthnews.com
www.everydayexposures.com
www.experimentalvaccines.org

www.firstfreedoms.org
www.forwardthinkingchiropractic.com
www.fourteenstudies.org
www.freedomforceinternational.org
www.generationrescue.org
www.ghostshipmedia.com
www.globalfreedommovement
www.globalresearch.ca
www.greenmedinfo.com
www.groundzeromedia.org
www.healthcareinamerica.us
www.healthdata.org
www.healthfreedomidaho.org
www.healthnutnews.com
www.healthranger.com
www.healthwyze.org
www.holisticmoms.org
www.hpakids.org
www.icandecide.org
www.icapediatrics.com
www.icpa4kids.org
www.ifm.org
www.immunityeducationgroup.org
www.informedchoiceusa.org
www.icandecide.org
www.infowars.com
www.ipaknowledge.org
www.jeffhaysfilms.com
www.jonathanotto.tv
www.journeyboost.com
www.kellybroganmd.com
www.kellythekitchencop.com
www.kindredworld.org
www.know-vaccines.org
www.learntherisk.org
www.LC.org
www.lifecanada.org
www.livelongerfeelbetter.com
www.madinamerica.com
www.mercola.com
www.mercury-freedrugs.org
www.momsacrossamerica.org

www.naturalnews.com
www.newswithviews.com
www.nexusmagazine.com
www.nocodexgenocide.com
www.nworeport.me
www.over-vaccination.net
www.phibetaiota.net
www.plandemicmovie.com
www.pmai.us
www.Paulthomasmd.com
www.physiciansforinformedconsent.org
www.procon.org
www.rightinginjustice.com
www.rxisk.org
www.safeminds.org
www.sanevax.org
www.soundchoice.org
www.sparkforautism.org
www.texansforvaccinechoice.com
www.thedoctorwithin.com
www.theevidencebasedchiropractor
www.thehealthyhomeeconomist.com
www.thehighwire.com
www.thelibertybeacon.com
www.thetruthaboutvaccines.com
www.thevaccinereaction.org
www.thinktwice.com
www.traceamounts.com
www.truthkings.com
www.truthlibrary.info
www.vaccinationcouncil.org
www.vaccinationdecisions.net
www.vaccine.procon.org
www.vaccineawakening.blogspot.com
www.vaccineawareness.info
www.vaccinechoicecanada.com
www.vaccineimpact.com
www.vaccineinjury.info
www.vaccineinjurynews.com
www.vaccineliberationarmy.com
www.vaccinepapers.org
www.vaccineresearchlibrary.com

www.vaccinerights.com
www.vaccinesafetycommission.org
www.vaccines.net
www.vaccines.news
www.vaccinesrevealed.com
www.vaccinesafety.edu
www.vaclib.org
www.vactruth.com
www.vaxchoicevt.com
www.vaxhoax.com
www.vaxxter.com
www.v-ial.org
www.wakingtimes.com
www.thewestreichfoundation.org
www.worldmercuryproject.org
www.whale.to
www.yourfamilyyourchoice.org

Appendix B

Lists of references from letters to the Department of Health and Human Services from prominent scientists

Selection of significant publications from our group in the field

- Gherardi R. **Toxic Story: deux ou trois vérités embarrassantes sur les adjuvants des vaccins**. Actes Sud (publisher), Paris, 2016, 250 pages
- Crépeaux G, Eidi H, David MO, Baba-Amer Y, Tzavara E, Giros B, Authier FJ, Exley C, Shaw CA, Cadusseau J, Gherardi RK. **Non-linear dose-response of aluminium hydroxide adjuvant particles: Selective low dose neurotoxicity.** Toxicology. 2017 Jan 15;375:48-57.
- Masson JD, Crépeaux G, Authier FJ, Exley C, Gherardi RK. **[Critical analysis of reference studies on aluminium-based adjuvants toxicokinetics]**. Ann Pharm Fr. 2017 May 30. pii: S0003-4509(17)30033-0.
- Van Der Gucht A, Aoun Sebaiti M, Guedj E, Aouizerate J, Yara S, Gherardi RK, Evangelista E, Chalaye J, Cottereau AS, Verger A, Bachoud-Levi AC, Abulizi M, Itti E, Authier FJ. Brain (18) F-FDG **PET Metabolic Abnormalities in Patients with Long-Lasting Macrophagic Myofascitis**. J Nucl Med. 2017 Mar;58(3):492-498.
- Crépeaux G, Eidi H, David MO, Tzavara E, Giros B, Exley C, Curmi PA, Shaw CA, Gherardi RK, Cadusseau J. **Highly delayed systemic translocation of aluminum-based adjuvant in CD1 mice following intramuscular injections.** J Inorg Biochem. 2015 Nov;152:199-205.

- Eidi H, David MO, Crépeaux G, Henry L, Joshi V, Berger MH, Sennour M, Cadusseau J, Gherardi RK, Curmi PA. **Fluorescent nanodiamonds as a relevant tag for the assessment of alum adjuvant particle biodisposition.** BMC Med. 2015 Jun 17;13:144.
- Van Der Gucht A, Aoun Sebaiti M, Itti E, Aouizerate J, Evangelista E, Chalaye J, Gherardi RK, Ragunathan-Thangarajah N, Bachoud-Levi AC, Authier FJ. **Neuropsychological Correlates of Brain Perfusion SPECT in Patients with Macrophagic Myofasciitis.** PLoS One. 2015 Jun 1;10(6):e0128353.
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- Couette M, Boisse MF, Maison P, Brugieres P, Cesaro P, Chevalier X, Gherardi RK, Bachoud-Levi AC, Authier FJ. **Long-term persistence of vaccine-derived aluminum hydroxide is associated with chronic cognitive dysfunction. J Inorg Biochem**. 2009 Nov;103(11):1571-8.
- Authier FJ, Sauvat S, Christov C, Chariot P, Raisbeck G, Poron MF, Yiou F, Gherardi R. **AlOH3-adjuvanted vaccine-induced macrophagic myofasciitis in rats is influenced by the genetic background**. **Neuromuscul Disord**. 2006 May;16(5):347-52.
- Authier FJ, Sauvat S, Champey J, Drogou I, Coquet M, Gherardi RK. **Chronic fatigue syndrome in patients with macrophagic myofasciitis**. **Arthritis Rheum. 2003** Feb;48(2):569-70.
- Gherardi RK. **[Lessons from macrophagic myofasciitis: towards definition of a vaccine adjuvant-related syndrome]**. **Rev Neurol** (Paris). 2003 Feb;159(2):162-4. Review. French.
- Authier FJ, Cherin P, Creange A, Bonnotte B, Ferrer X, Abdelmoumni A, Ranoux D, Pelletier J, Figarella-Branger D, Granel B, Maisonobe T, Coquet M, Degos JD, Gherardi RK. **Central nervous system disease in patients with macrophagic myofasciitis. Brain. 2001** May;124(Pt 5):974-83.
- Gherardi RK, Coquet M, Cherin P, Belec L, Moretto P, Dreyfus PA, Pellissier JF, Chariot P, Authier FJ. **Macrophagic myofasciitis lesions assess long-term persistence of vaccine-derived aluminium hydroxide in muscle**. **Brain. 2001** Sep;124(Pt 9):1821-31.
- Gherardi RK, Coquet M, Chérin P, Authier FJ, Laforêt P, Bélec L, Figarella-Branger D, Mussini JM, Pellissier JF, Fardeau M. **Macrophagic myofasciitis: an emerging entit**. **Lancet. 1998** Aug 1;352(9125):347-52.

List of Recent, Relevant and Significant Publications From Christopher Exley PhD

- Exley C, Siesjö P & Eriksson H (2010) **The immunobiology of aluminium adjuvants: how do they really work?** Trends in Immunology 31, 103-109.
- Exley C and House E (2011) **Aluminium in the human brain**. Monatshefte für Chemie - Chemical Monthly 142, 357-363.
- House E, Esiri M, Forster G, Ince PG and Exley C (2012) **Aluminium, iron and copper in human brain tissues donated to the medical research council's cognitive function and ageing study**. Metallomics 4, 56-65.
- Exley C (2011) **Aluminium-based adjuvants should not be used as placebos in clinical trials.** Vaccine 29, 9289.
- Exley C (2012) **When an aluminium adjuvant is not an aluminium adjuvant used in human vaccination programmes**. Vaccine 30, 2042.
- Exley C (2012) **The coordination chemistry of aluminium in neurodegenerative disease.** Coordination Chemistry Reviews 256, 2142-2146.

- Exley C, House E, Polwart A and Esiri MM (2012) **Brain burdens of aluminium, iron and copper and their relationships with amyloid beta pathology in 60 human brains**. Journal of Alzheimer's Disease 31, 725-730.
- Davenward S, Bentham P, Wright J, Crome P, Job, D, Polwart A and Exley C (2013) **Silicon-rich mineral water as a non-invasive test of the 'aluminium hypothesis' in Alzheimer's disease**. Journal of Alzheimer's Disease 33, 423-430.

Appendix C

Resources as quick reference guides for vaccine information

Vaccines that contain DNA from aborted fetal cell lines and alternative vaccines if available- https://cogforlife.org/wp-content/uploads/vaccineListOrigFormat.pdf

Information on Human DNA from aborted fetuses, the damage it can cause and the effort to change the trend in the industry away from these practices.
http://soundchoice.org/aborted-fetal-products/

Clinical trials- http://clinicaltrials.gov/
An official site for U.S. clinical trials. Vaccine trials can be found by typing in appropriate keywords. Here you can find out vaccine trial details: the outcome measures investigated, the criteria that constituted the placebo control, number of participants, *etc.*

National Vaccine Information Center's Vaccine Adverse Event Reporting System (VAERS) searchable interface- http://www.medalerts.org/
The VAERS database is based on self-reporting of vaccine adverse effects. It is estimated that less than 10% of adverse events are reported. This database represents the range of possible adverse effects associated with vaccines. Some serious adverse effects are also disclosed on inserts that come with vaccine vials.
The Health and Human Services VAERS Database https://vaers.hhs.gov/ Click on the VAERS Data Tab.