

FLU VACCINES: ARE THEY EFFECTIVE AND SAFE?

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A central principle of democracy is freedom of choice. We can choose our political party, our religion, and the food we eat, but this does not seem to be the case when it comes to our medical choices and our freedoms to make them. The underlying foundation upon which the entire vaccine program rests is that they have been proven to be safe and effective. So much so, that if people choose not to be vaccinated they are criticized for making irresponsible and unscientific choices that will not only adversely affect themselves, but could also cause others to become infected with the pathogens their bodies harbor.

The US Public Health Service and its various agencies—the FDA, CDC, NIAID, NIH and CBER—oversee the distribution of information and the scheduling of vaccines, both voluntary and mandatory. These Federal agencies are the guiding light for the primary information and resources provided to Congressional oversight committees and professional medical organizations, such as the American Medical Association and the National Academy of Sciences. From there, information and resources trickle down to the various state health commissioners, who then present information to local health officials at the state level. In addition, they provide the local media with reports about pathogenic threats and new scientific breakthroughs on vaccines. At the Federal level, health agencies are responsible for doing either original research or contracting out research initiatives to universities, HMOs, and private companies. The government and the vaccine industry also work in close partnership. At the end of the day, conservatively, there are thousands of individuals making policy decisions for vaccination programs. As a result, mainstream media has taken the position that whatever the official word is about a vaccine, it goes virtually unchallenged. It becomes dogma. Those brave enough to criticize vaccines (whether they are physicians, scientists, journalists or citizens) are considered irresponsible, discredited and immediately viewed with suspicion, which brings us to our current dilemma.

Here in New York, the swine flu vaccine, followed by the seasonal flu vaccine, has been mandated for all health care workers. The vaccine is being proposed in many other states. It is already mandated for all members of the armed forces, as well as students in various

colleges and public health school systems. Simultaneously, there is a growing number of voices suggesting that they or their children's injuries are due to individual or combinations of vaccines. These include everything from Gulf War Syndrome to Autism Spectrum Disorders, debilitating neurological and autoimmune conditions and preventable infant deaths. Furthermore, there are a growing number of other disease epidemics, such as adult diabetes and cancers in children, enormous increases in allergies and gastro-intestinal disturbances, whose etiologies remain uncertain and may still be discovered to be attributable to the over-vaccination of the public. The government and the entire vaccine industrial complex have responded to all of these allegations by simply dismissing them as untrue and without proof. True science would interpret this as a radical decision. Being told that if we don't take a vaccine, then we will be fired immediately without exemptions or options is an equally extremist attitude.

Therefore, we decided to ask four basic questions. These questions would determine the truth.

The first question: Are vaccines truly effective in protecting people based upon a gold standard that can be applied to all other areas of science? If they are effective, what is the proof? Are there long-term individual and multi-vaccine combination studies and double-blind placebo control studies? Did these studies compare fully vaccinated groups of individuals against groups that were not vaccinated? Have there been trials that compared a vaccinated and another group put on a life style modification program?

Second question: Are vaccines safe? If so, what is the proof? If a vaccinated individual who doesn't come down with an infection, how do we know it is due to the vaccine or whether it is due to the natural immune system? How can we reconcile a very short timeframe used throughout vaccine trials to determine safety, when so much of the scientific literature shows delayed responses for the more serious adverse effects? How many people are excluded from being vaccine-injured because the statutes of limitation ran out on them, although their injury was in fact due to a vaccination? Also, how do we reconcile the very low number of adverse reactions that are actually being reported by the CDC? In addition, when we study the Vaccine Compensation Act over a billion dollars has been given to victims. Therefore, how do we know whether a person will be protected and the vaccine will be effective and safe? What is the proof?

Questions three and four: Are vaccines not effective? If so, what is the proof? And if vaccines are not safe, what is the proof?

After spending several years researching each of these four questions, our conclusions are startling. Research and statistical studies show that no single vaccine and no combination of vaccines have been proven to be effective or safe for any given individual. In addition, we found that vaccines do not confer the protected immunization for a given individual. To the contrary, vaccines may actually compromise and adversely alter the body's immune system.

How could modern medicine have gotten this so wrong and for so long? How could the vast majority of respected medical and health organizations—the American Medical Association, the pediatric community, prestigious medical schools, the Federal scientific community, etc.—have been so mistaken? And then why has the major media acted in such an irresponsible manner? This brings us to questions that cannot be based on true science but rather on greed. Greed is now something the average American is fully aware of. We have witnessed it on Wall Street, with multinational banks, with the healthcare and insurance industries, and increasingly with pharmaceutical companies who have an ever greater need for profits and now exploit their enormous influence and buying-power over our government's regulatory agencies. Legislators at both the state and federal levels have permitted unwarranted influence by these same pharmaceutical giants, lobbyists and consultants to influence how laws are written and how funds are appropriated. Sadly, public policy and corporate liability have been directly written for and by pharmaceutical interests.

This story is so vast, with so many details, that we have decided to release it in two parts. Due to the urgency of a state mandated swine flu vaccination, we are presenting first the part that focuses principally on the new H1N1 swine flu and influenza vaccines in general. The second part will later examine in greater detail all other vaccines. Our overall conclusion is that our vaccine program requires crucial reform.

DOES VACCINATION EQUAL IMMUNIZATION

Dr. Viera Scheibner is arguably one of the world's most respected researchers and scholars on vaccine science. She is the author of *Vaccination: 100 Years of Orthodox Research* and *Behavioral Problems in Children: The Link to Vaccination*, in addition to publishing almost 100 peer-reviewed papers. During a live radio broadcast on September 18, 2009, she shared an overview of vaccine history and presented a more realistic definition of vaccination theory in light of reviewing thousands of studies, articles and books written since Edward Jenner tested the first vaccine in 1796. Her investigations uncover how the vaccine industrial complex, and national and international agencies who oversee vaccination policies continue to entertain a pseudo-science that is fraught with inconsistencies, poorly designed studies, erroneous interpretations, and conclusions that are patently false. To take one simple example, practicing physicians today will tell us there is no natural immunity for tetanus; therefore, a vaccination is necessary. Yet, a large research study in India of over 70,000 people, none having received tetanus injections, found most had natural immunity to the pathogen.

Dr. Scheibner fundamentally redefines the rationale and terminology applied to vaccine immunization:

“Ever since the turn of the century medical journals published dozens and dozens of articles demonstrating that injecting vaccines [can] cause anaphylaxis, meaning harmful, inappropriate immunological responses, which is also called sensitization. [This means there is] increased susceptibility to the disease which the vaccine is suppose to prevent, and to a host of related and other unrelated infections. We see it in vaccinated children within days, within two or three weeks. Most vaccinated children, but not all, develop runny noses, ear infections, pneumonitis, bronchiolitis. It is only a matter of degrees, which indicates immuno-suppression. So it doesn't indicate immunity. It indicates the opposite. So I never use the word immunization because that is false advertising. It implies that vaccines immunize, which they don't. The correct term is either vaccination or sensitization.”

“Vaccines [can] damage internal organs, particularly the pancreas... So not only is it that children develop these infections with increased severity, but they develop... these autoimmune diseases like diabetes. That's a real pandemic...[Vaccination] is an illness industry. They cause pandemics of diabetes. They cause pandemics of

other degenerative diseases. They cause pandemics of behavioral problems.”

“The term immunization should be outlawed because it’s a lie. It’s false advertising. Vaccination is the right term because it simply means injecting a vaccine. The word immunization implies vaccines prevent disease... They actually [may lead to] them. If they don’t want to use the word vaccination, they should use the word sensitization.

Although that violates a person’s health freedom are numerous voices against vaccination, and even more against mandatory vaccination, it is equally important to bring attention to the words of dissent from within the government health agencies and the vaccine industrial complex. For example, in November 2007, the UK newspaper *The Scotsman*, made public warnings by the inventor of the “flu jab,” Dr. Graeme Laver. Dr. Laver was a major Australian scientist involved in the invention of the “flu jab” vaccine used throughout the UK in addition to playing a leading role in the discovery of anti-flu drugs. He went on record as saying the vaccine he helped to create was ineffective and natural infection with the flu was safer. “I have never been impressed with its efficacy,” said Dr. Laver.

Vaccines are suspensions of infectious agents used to artificially induce immunity against specific diseases. The aim of vaccination is to mimic the process of naturally occurring infection through artificial means. Theoretically, vaccines produce a mild to moderate episode of infection in the body with only symptomatic, temporary, and slight side effects. But, in reality, they may be causing diseases rather than preventing them. According to Jamie Murphy, an investigative journalist on vaccines and author of *What Every Parent Should Know About Childhood Vaccination*, “Vaccines produce disease or infection in an otherwise healthy person... And so, in order to allegedly produce something good, one has to do something bad to the human body, that is, induce an infection or a disease in an otherwise healthy person that may or may not have ever happened.”

When children contract a disease such as measles or mumps, they generally develop a permanent protection against that disease. Such is not necessarily the case with vaccines. As Murphy observes, “The medical profession does not know how long vaccine immunity lasts because it is artificial immunity. If you get measles naturally, in the vast majority of cases you have lifelong immunity..... However, if you get a measles vaccine or a DPT

vaccine, [it does not guarantee 100% immunity] that the vaccine will prevent you from getting the disease.”

Murphy continues: “You have a situation in which everyone is being given a disease with no control over that disease, because once you inject a vaccine into a person’s body, whether it contains bacteria or viruses or split viruses or whatever--you have no control over the outcome. It’s like dumping toxic wastes into a river and saying, ‘If we just put a little bit in, it won’t pollute the river. It will be just enough to do what we want it to do.’ Of course, what they want the vaccination to do is initiate the building up of our immune defenses, just like a regular infection would do. The problem is that the medical profession and science do not know, and have never known, what the infecting dose of an infection really is. It’s not something that can be measured. So they’re really guessing at the amount of antigen and other supplementary chemicals that they put in the vaccine.”

“Vaccines are portrayed as being indispensable and somehow better at disease protection than what our innate biological defenses and nutritional resources have accomplished for thousands of years. I think it’s the height of arrogance for the medical profession to think that they have duplicated a biological process that has taken care of people since the beginning of time. People can deal with infectious diseases without vaccines. Before the introduction of the measles and mumps vaccines, children got measles and they got mumps, and in the great majority of cases those diseases were benign.”

“The most important point I want to make is that there’s no logical reason for having a vaccine when these [naturally occurring] infectious agents...can stimulate the immune system to take care of that disease by itself. We don’t need anything artificial to do that for us.”

Walene James, founder of the organization Vaccine Liberation and author of *Immunizations: The Reality Beyond the Myth*, adds that the full inflammatory response is necessary to create real immunity, and reports that in *The Lancet* on June 5, 1985, there was an article about measles virus infection relating to a variety of diseases in adult life. Researchers in Denmark, the article explained, examined the histories of people claiming not to have had measles in childhood, yet who had blood antibody evidence of such infection. The researchers found that some of these people had been injected in childhood with the measles vaccine after exposure to the infection. This may have suppressed the

disease which was at the time developing in their bodies. A high percentage of these individuals were found in adult life to have developed immunoreactive diseases, such as sebaceous skin diseases, tumors, and degenerative diseases of bone and cartilage. The conditions included cancer, MS, lupus, and chondromalacia, which is softening of the cartilage.

James quotes Dr. Richard Moskowitz, past president of the National Institute of Homeopathy, and a cum laude graduate of Harvard and New York Medical School, as stating, “Vaccines trick the body so that it will no longer initiate a generalized inflammatory response. They thereby accomplish what the entire immune system seems to have evolved to prevent. They place the virus directly into the blood and give it access to the major immune organs and tissues without any obvious way of getting rid of it. These attenuated viruses and virus elements persist in the blood for a long time, perhaps permanently. This, in turn, implies a systematic weakening of the ability to mount an effective response, not only to childhood diseases but to other acute infections as well.’

Further, Jamie Murphy insists that introducing antigens directly into the bloodstream can prove dangerous. “When a child gets a naturally occurring infection, like measles, which is not a serious disease, the body reacts to that in a very set way. The germs go in a certain part of the body through the throat and into the different immune organs, and the body combats the disease in its own natural way. There are all sorts of immune reactions that occur. Inflammatory response reactions, macrophages, and different kinds of white blood cells are used to combat the virus. You also cough and sneeze and get rid of the virus that way.

“When you inject a vaccine into the body, you’re actually performing an unnatural act because you are injecting directly into the blood system. That is not the natural port of entry for that virus. In fact, the whole immune system in our body is geared to prevent that from happening. What we’re doing is giving the virus or the bacteria carte blanche entry into our bloodstream, which is the last place you want it to be. This increases the chance for disease because viral material from the vaccine stays in the cells, and is not completely defeated by the body’s own defenses. You overload the body.”

In his widely circulated critique of vaccines, “Vaccination: Dispelling the Myths,” Alan Phillips, a national health attorney and legal expert on vaccine policy, writes, “The clinical

evidence for vaccination is their ability to stimulate antibody production in the recipient, a fact which is not disputed. What is not clear, however, is whether or not such antibody production constitutes immunity. For example, a-gamma globulinemic children are incapable of producing antibodies, yet they recover from infectious diseases almost as quickly as other children....Natural immunization is a complex phenomenon involving many organs and systems; it cannot be fully replicated by the artificial stimulation of antibody production. Research also indicates that vaccination commits immune cells to the specific antigens involved in the vaccine, rendering them incapable of reacting to other infections. Our immunological reserve may thus actually be reduced, causing a generally lowered resistance.”

Echoing the thinking of Walene James, Phillips adds: “Another component of immunization theory is ‘herd immunity,’ which states that when enough people in a community are immunized, all are protected. There are many documented instances showing just the opposite--fully vaccinated populations do contract diseases; with measles, this actually seems to be the direct result of high vaccination rates. A Minnesota state epidemiologist concluded that the HiB vaccine increases the risk of illness when a study revealed that vaccinated children were five times more likely to contract meningitis than unvaccinated children.”

HOW SERIOUS IS THE SWINE FLU INFECTION?

Throughout the media, the World Health Organization, the FDA and CDC have been reports that the swine flu threat is pandemic. So, why is this particular strain of influenza being called a pandemic when every flu season is also a pandemic: it infects multiple people in multiple countries? Dr. Sherri Tenpenny, one of America’s most knowledgeable physicians opposing vaccine theory, states that there is technically no difference in calling this particular flu stain a pandemic threat compared to any other. Why is this occurring during this particular flu season? And why are we being warned of a pandemic with such urgency and warning, when prior flu seasons were not advertized as such and, nevertheless, by the vast majority known conclusive scientific indicators were much less severe than what we have witnessed with the H1N1 virus so far? Although reports from scientists around the world are starting to realize that infection rates, symptoms and

mortality for this particular H1N1 strain are milder than other flu viruses.

Dr. Tom Johnson, the epidemiologist for the Cochrane Database Group, said in an interview for the German magazine *Der Spiegel* on July 21, 2009: “Sometimes you get the feeling that there is a whole industry almost waiting for a pandemic to occur. The WHO and public health officials, virologists and the pharmaceutical companies. They’ve built this machine around the impending pandemic. And there’s a lot of money involved, and influence, and careers, and entire institutions! And all it took was one of these viruses to mutate to start the machine grinding.”

As of September 4, 2009, the World Health Organization (WHO) has reported 2,837 deaths from H1N1 infection. The WHO report further claims 250,000 have been infected worldwide; however, these numbers are unconfirmed. The United Nations argues the number is much higher. At the same time, the UN earlier relieved its member countries from reporting individual cases of H1N1 infection. This is an extraordinary decision in the context of a contagious pathogen being dramatized as a global pandemic threat to 6 billion humans. There is simply no accounting for the rationale of WHO’s deciding to no longer monitor H1N1’s spread accurately. The media continues to make the threat look much worse than it might actually be. For example, China, with a population of 1.3 billion people, reported 5,592 cases and no deaths. Given the enormous population size compared to the US, this is far less serious than a mild normal flu season, yet it is being reported to the world as “a grim situation.”

However, when we look at the government’s official statistics of a normal flu season, there is no indication that the new H1N1 strain poses now nor will it pose in any foreseeable future a pandemic warranting the current extreme Level 6 of alarm. For Canada, the *Canadian Medical Association Journal* reports that annual flu infection kills approximately 2,500 of its citizens, and about 36,000 Americans, which is the CDC’s annual estimate. Worldwide, annual flu deaths range between 250,000 and 500,000. In Mexico, which first brought attention to a new H1N1 strain, there were 176 flu deaths, yet only 7 of these deaths were corroborated by laboratory analysis and confirmed to be the new H1N1 swine flu strain.

As we enter the flu season this autumn and into winter, the Southern hemisphere is now

leaving its flu season and entering spring and summer. Our officials and media appear to be ignoring the reports from the developed global South, such as Australia, and pushing forward with a media blitz, predicting a dreadful scenario that will infect millions and kill thousands of people. However, scientists and researchers in the developed South have reported that, although many were infected, the symptoms have been mild and figures for hospitalization are exceptionally low. Even global South politicians concur with scientists that the risk of a H1N1 epidemic reoccurring there is over.

Peter Doshi, a doctoral student at Massachusetts Institute of Technology, has performed a thorough comparative analysis of several flu pandemics. His conclusions, published in the prestigious *British Medical Journal*, predict that the H1N1 swine flu is of “the same subtype as seasonal H1N1 that has been circulating since 1977.” He believes we may be witnessing substantial confusion between the high public attention the present H1N1 scare is receiving and the very low level of scientific certainty that H1N1 is more severe than other seasonal influenza.

Determining what influenza strains should be included in a vaccine is nothing more than a prediction. There is no true science involved, which is why there are so many instances when the flu season arrives, the viruses in the vaccine do not have a close match with the virus the scientific community had predicted. Dr. R. Neustaedter describes the methods that the CDC uses to make its predictions for which viral strains the vaccine industrial complex should develop for each forthcoming flu season. Their predictive methods are bizarre when reviewed rationally.

The history of the flu vaccine reads like one stumbling fiasco after another. Take an example. Ever wonder how the particular viruses are chosen for next year’s vaccine? The answer could be drawn from a 1930s film noir of Shanghai Villainy. Scientists kill migrating ducks in Asia, culture the viruses and put those in next year’s vaccine, because they have seen an association between bird and pig viruses and the following year’s human flu epidemics. Perhaps this desperate guesswork is responsible for so many years when the flu vaccines had nothing in common with circulating viruses.”

How accurate have been the CDC’s predictions? For the 1992-1993 flu season, the

prediction made for the virus used in the vaccine was off by 84 percent. For the 1994-1995 season, it was off by 43 percent for the primary strain targeted and off 87 percent and 76 percent for the other two strains. The Laboratory Center for Disease Control's study comparing vaccine strains with the strains appearing during the 1997-1998 season found the match was off by 84 percent. A person might consider that it may be more accurate to simply flip a coin.

Dr. Katherin Severyn, who monitors prediction results and compares them with CDC claims, makes the comment:

“Despite the poor track record in predicting which influenza viruses will infect communities, the CDC claims that influenza vaccine is ‘approximately 70%’ effective in preventing influenza in ‘healthy persons less than 65 years of age,’ if ‘there is a good match between vaccine and circulating viruses’” Depending on the study cited, vaccine efficacy actually ranges from a low of 0% to a high of 986%. And... the CDC often finds it difficult to match vaccines with circulating viruses.

An article published in the prestigious *British Medical Journal* in 2005, “Are US Flu Death Figures More PR Than Science?” is apropos for addressing the wildly inflated figures by the WHO and CDC to present their case for mass vaccination measures. The article begins, “US data on influenza deaths are a mess.” The study reviews the CDC's own statistical data and finds numerous inconsistencies and incompatibilities between “official estimates and national vital statistics data.” Although the government's predictions never came close to the “dire outcomes” being stated by health officials, the CDC's own communication strategy was marked by high levels of fear.

What few people recognize is that the majority of flu vaccine programs are purchased by the US government for distribution; therefore, in the current H1NI flu predictions, the government through the National Immunization Program (NIP) will be purchasing millions of vaccine units. This is one major incentive for the CDC's and HHS's large media blitz upon the public to encourage flu vaccination every year. The NIP does not want to be sitting with stockpiles of unused, purchased vaccines. There is a strong financial incentive, even for the government, for pushing their cause for mass inoculation.

The CDC Misinterprets Influenza Death Statistics

The official CDC website states that approximately 36,000 Americans die from the flu annually. We repeatedly hear this figure reported by officials and in the media across the nation, hence making flu infection the seventh cause of death in the US. But the reality is very different. The CDC's own website reports mortality rates under the heading "influenza/pneumonia." Dr. David Rosenthal, Director of Harvard University's Health Services, brings clarity to this confusion. Most of these so-called flu deaths are in fact pneumonias—not even viral pneumonias—and secondary infections. Furthermore, a study in the *Journal of the American Medical Academy* shows that many of these deaths are a result of pneumonias acquired by patients taking stomach acid suppressing drugs.

For example, if we are to take the combined figure of flu and pneumonia deaths for the flu period of 2001, and add a bit of spin to the figures, we are left believing that 62,034 people died from influenza. The actual figures are 61,777 died from pneumonia and only 257 from flu. Even more amazing, in those 257 cases, only 18 were scientifically identified as positive for the flu virus. A separate study conducted by the National Center for Health Statistics for the flu periods between 1979 and 2002 reveals that the range of annual flu deaths were between 257 and 3006, for an average of 1,348 per year.

How does the CDC respond to this discrepancy reported by the Harvard scientist? Read carefully the CDC's own statement.

“Typically, influenza causes death when the infection leads to severe medical complications... [and as most such cases] are never tested for virus infection... CDC considers these figures to be very substantial undercounting of the true number of deaths from influenza. Therefore, the CDC uses indirect modeling methods to estimate the number of deaths associated with influenza.” In an earlier 2003 article *JAMA*, William Thompson from the CDC's National Immunization Program attempted to explain “influenza-associated mortality.” He wrote, “Based on modeling, we think it's associated. I don't know that we would say that it's the underlying cause of death.”

In summary, the CDC is admitting 1) the deceased are not tested to determine the presence

of the flu virus, and 2) they do not directly perform any direct testing to determine the exact cause of death but rather “indirect modeling methods” as a professional way of saying subjective mathematical equations to arrive at their figures. The 36,000 mortality figure is nothing more than a mathematical model. The British journal concluded that the only possible rationale for the CDC’s complete disregard for scientific fact, even in face of independent research to discredit its statistics, is a public relations effort between the CDC and the vaccine manufacturer’s campaigns to increase flu vaccination.

There can be little doubt about this after statements presented by the CDC’s National Immunization Program’s spokesperson, Glen Nowak, at the 2004 National Influenza Vaccine Summit—co-sponsored by the CDC and the American Medical Association. Nowak outlined the CDC’s “Seven Step Recipe for Generating Interest In, and Demand for, Flu Vaccination.” One step requires “medical experts and public health authorities publicly.. [to] state concern and alarm (and predict dire outcomes)” to encourage influenza vaccination. Another step is “continued reports.. that influenza is causing severe illness and/or affecting lots of people, helping to foster the perception that many people are susceptible to a bad case of influenza.”

Why was the “Seven Step Recipe” implemented? Dr. Nowak publicly stated the CDC’s reasons on National Public Radio, “... the manufacturers were telling us that they weren’t receiving a lot of orders for vaccine for use in November or even December [of 2003]... It really did look like we [CDC] needed to do something to encourage people to get a flu shot.

Now that we have a better understanding of how the CDC calculated its statistics in the past and expert confirmation from renown publications and scientists that such data is erroneous, what do we find on the CDC website under the heading “Influenza Death Statistics” as of September 2009—five years after the published denunciation of the CDC’s erroneous calculations for influenza?

“For pneumonia and influenza (P&I) deaths, CDC estimates approximately 8,000 deaths are associated with seasonal flu. This represents 9.8% of (P&I) deaths. For respiratory and circulatory (R&C) deaths, CDC estimates approximately 36,000 deaths are associated with seasonal flu. This represents 3.1 percent of those deaths. For all-cause deaths, CDC estimates that approximately 51,000 deaths are

associated with seasonal flu. This represents 2.2% of all deaths.

How did the CDC arrive at these conclusions? The CDC site now continues to restate its scientifically flawed methodology: “Statistical modeling was used to estimate how many flu-related deaths occurred among people whose underlying cause of death on their death certificate was listed as a respiratory and circulatory disease.” This is clearly an indication of policy turned dogmatic that disregards sound scientific evidence proving their errors. It is all business as usual, disregard the critics, and full speed ahead.

Canadian health authorities are at least a bit more transparent over their investigations into vaccination results than the American government health cartel. However, like the US, they still report completely erroneous conclusions based on their own data. Every year Health Canada publicizes their laboratory results of swabs received from people with Influenza-Like Illnesses (ILI). Consistently the statistics show that approximately 95 percent of cases are attributable to pathogens, such as adenoviruses, rhinoviruses, para influenza and others, instead of the flu virus. Clinically, the symptoms appear very much the same, and unless laboratory tests with high specificity are performed, nobody can distinguish between what is a real flu infection from what might be any large number of different pathogenic infections giving flu-like symptoms.

During the 2004-2005 flu season, the Canada Communicable Disease Report showed that of the 68,849 laboratory tests performed for influenza, only 14.9% tested positive for a flu virus. All the remaining 85.1% specimens were a result of other pathogens impervious to flu vaccines. For the following 2005-2006 season, Health Canada received 68,439 confirmed tests for influenza like infections. Of these, only 6,580, or 10.4% confirmed positive for influenza. The rest, 89.6%, were other pathogens. Canadian health officials, nevertheless, disregarded their own statistics and continue their public relations campaign to boost the perception that the flu vaccine is 70-90% effective. In a debate published in the *Canadian Medical Association Journal*, Italian epidemiologist Dr. Vittorio Demicheli, now a colleague of Dr. Tom Jefferson at the Cochrane Database Group stated that Canada’s claims are “both wrong and misleading... and refers only to the ability of the vaccine to produce antibodies effective against the virus. But this is not the important measure of vaccine efficacy. Instead, we should measure the ability of the vaccine to prevent clinical disease, in this case influenza. By this measure, vaccine efficacy is no greater than 25%.”

To further complicate matters regarding influenza-like-illnesses attributed to non-influenza pathogens, there is also evidence showing that flu symptoms are synonymous with symptoms caused by toxic levels of pesticides, herbicides and fluoride. During his sworn testimony before a Congressional Hearing in the 1960s, Dr. Granville Knight, former president of the American Academy of Nutrition, stated, “waves of so-called ‘Virus X’ and similar diseases... are caused by exposure to such agricultural chemicals; [and] that it is impossible for doctors to diagnose the difference between London flu, virus conditions and pesticide poisoning.” This is an area of research that has been essentially boned and should be reviewed.

In August 2009, Swiss immunologist Dr. Beda Stadler at the Institute of Immunology at the University of Bern reported in European papers that based on his research and analysis, the swine flu has already ended through much of Europe and the United States. Dr. Stadler claims “the dangerous pandemic virus has mutated into a simple summer flu.” A different but equally reassuring independent conclusion on September 1, 2009 from the University of Maryland predicts the H1N1 will very unlikely mutate “in a natural way” into a more virulent virus. It would appear therefore that any dangers for a new and more virulent strain of H1N1 emerging would more readily be the result of vaccination. The important expression is “in a natural way.” What is not being taken into consideration in any manner by the vaccine industrial complex is the fact that human bodies are also superb incubators for viruses, and perhaps introducing viruses into our bloodstream, along with the numerous known and unknown genetic contamination found in vaccines, are giving rise to new strains of virus. However, chasing the origins of a new strain of flu virus would be as successful as standing on a beach and trying to find that one sand granule that is older than all the others.

The *Wall Street Journal* in April 2009 reported that the WHO grossly inflated the number of flu deaths reported as much as 15-fold. The actual confirmed swine flu deaths in Mexico were 7 instead 152. When the CDC reports flu mortality statistics, they are lumped in the same category with all pneumonia deaths. According to the independent vaccine journalist, Wynne Alexander, “this is patently ridiculous... this is just insanity on its face, and the CDC is comfortable with that.” If we think for a moment only about the number of deaths among the elderly from pneumonia infection, and then consider that the figures

being published by the government health agencies to support their dire warnings for a presumed epidemic in October include pneumonia deaths, then it should be clear that H1N1 infection dangers are far less than the government and vaccine makers want the nation to believe. This conclusion is actually supported by a relatively recent study published by the National Institutes of Health in 2005 that surveyed three decades of data on mortality rates among the elderly. The study, aired on Canada TV, discovered that flu shots for elderly American citizens did not save any lives.

Small children between 6 and 24 months are being recommended for the front of the vaccination line by the CDC. The agency's rationale remains unclear. However, biologists at Clemson University have determined that children under the age of 5 are the least likely to transmit swine flu. Therefore, the researchers recommend that smaller children not be given such a high ranking on the government's priority risk group list.

The chairman of the Health Committee in the German Parliament, Dr. Wolfgang Wodarg, stated to the *Neuen Presse* that the swine vaccine and the so-called pandemic "is great business for the pharmaceutical industry." In actual fact, the majority of independent science, unbiased by pharmaceutical corporate financing, has very well shown that the swine flu is not very different from normal season flu and does not warrant any special, dramatic alarm.

Dr. Marc Girard is a medical specialist in drug adverse effects. He was commissioned by the French courts as a medical witness on the swine flu vaccine's safety. During an interview on French television, Dr. Girard stated, "A vaccine is being developed in conditions of amateurism such as I have never seen before. Let's take the pessimistic hypothesis: one death among every 1000 patients. There are plans to vaccinate 60 million people, and so you already have 60,000 deaths, and this time, young people, children and pregnant women." Dr. Viera Scheibner comments on this scenario: "The swine flu vaccination is just a hoax. It's an attempt to create a pandemic so that they can sell a lot of vaccines."

According to Nancy Cox, Director of the Influenza Division at the Centers of Disease Control, "intensive analysis" studies seem to indicate that the novel H1N1 variant has lower respiratory transmission than the common seasonal H1N1 flu.

The WHO is estimating that 2 billion or approximately one third of the world's population might become infected during the course of the next two years. In the US, the CDC estimates that "swine flu could strike up to 40 percent of Americans." For this reason, world and national health agencies are mobilizing rapidly a massive vaccination campaign to vaccinate as much of the planets population as possible. The Director General of the WHO, Dr. Margaret Chan, estimates that vaccine makers could produce 4.9 billion pandemic flu shots.

International scholar of political and social affairs, Michel Chossudovsky, states, "There is ample evidence, documented in numerous reports, that the WHO's level 6 pandemic alert is based on fabricated evidence and a manipulation of the figures on mortality and morbidity resulting from the H1N1 swine flu." Chossudovsky has uncovered evidence that the CDCP and WHO are "recategorizing a large number of cases of common influenza as H1N1 swine flu."

PUBLIC FAITH IN VACCINE SCIENCE

Across the developed world there is a growing distrust in the pharmaceutical and vaccine industry, government health agencies, the insurance industry, and professional medical establishments. Although the National Vaccine Injury Compensation Program has paid out \$1.2 billion in damages due to vaccine adverse effects in children, the vaccine makers impose gag orders to prevent public disclosure of vital proprietary information during settlements. There remains confusion among the US health agencies on the actual percentages of vaccine adverse reactions. The FDA estimates only 1 percent are reported; the CDC claims it is 10 percent. According to the National Vaccine Information Center, only one in forty New York doctors report adverse reactions, and medical students have testified before Congress that they were instructed to not report vaccine incidents in their private practice. The recent authorization of the 2006 Public Readiness and Emergency Preparedness Act provides vaccine manufacturers with legal impunity in the event the new untested Swine Flu vaccines result in a wave of serious injury and death. Immediately this raises the question why the drug lobbyists would insist upon being granted immunity. Could it be because they know the potential dangers of their swine flu vaccines? It is therefore little wonder that more and more healthcare practitioners and the public are

growing increasingly suspicious of vaccine safety and the real intentions of the vaccine industrial complex.

Suspicious also reside in the government's own figures to support their predictions of a 2009-2010 swine flu threat. There is now evidence that the diagnostic kits being used are inaccurate for diagnosing the presence of H1N1. There are currently three rapid diagnostic tests for determining swine flu infection. A CDC report found that these tests can be wrong as much as nine out of ten times, and on average between 40-69 percent. The CDC determined that the rapid tests are "not highly worthwhile for diagnosing H1N1 infections." The report states that there is almost nothing to distinguish the swine flu from normal seasonal flu. In fact, the diagnostic tests were more accurate with the seasonal flu. Consequently, only professional diagnostic laboratories qualify for scientifically sound diagnosis of H1N1 incidents. Reports are coming into the CDC from many venues and the most common diagnostic usage being used around the world are these rapid diagnostic kits. This is one reason why many countries have to send their patient samples to the WHO and government health labs in developed countries for proper testing.

Throughout the world, healthcare practitioners, including physicians, are becoming nervous about the reports about the swine flu vaccine and are turning suspicious about governments' hype over their dire warnings of swine flu's dangers. Dr. Neal Rau, an Ontario medical director of infection prevention and control told the *Toronto Star*, "I won't get one until there have been a million doses given and there is evidence it is safe." Polls taken in European countries show an increase in the number of health workers and citizens ready to refuse the H1N1 vaccination. Twenty-nine percent of all Germans surveyed said they would refuse the vaccine "under any circumstance," and an additional 33 percent would likely refuse it. In the region of Bavaria and Baden Wurttemberg, only 10 percent of those polled said they would submit to the injection. In France, *Le Figaro* conducted a poll of 12,050 people showing 69 percent would refuse it. In a separate French survey, one third of 4,752 doctors, nurses and healthcare workers surveyed would not be inoculated.

In the UK, several polls reported in the *Daily Mail* in late August 2009, showed:

Half of family physicians do not want swine flu vaccination

Seventy-one percent of those polled do not believe the vaccine has been tested enough for safety and the swine flu is much milder than health authorities are saying

A third of UK nurses would refuse the vaccine

A survey published in the *British Medical Journal* of 8,500 healthcare workers in Hong Kong found that more than fifty percent would refuse the swine flu vaccine if they could.

Polls taken in the US so far are showing Americans are quickly losing faith in the federal health agencies' and the medical establishment's assurances about vaccine efficacy and safety. A poll of pregnant mothers taken by the parent support group Mumsnet.com indicates that women are becoming more suspicious of vaccines' ultimate value. The survey of 1500 respondents showed that only 6 percent of pregnant women would "definitely" take the shot, while 48 percent said they "definitely" wouldn't. The figures mirror an accompanying poll that showed 5 percent definitely would and 46 percent definitely wouldn't vaccinate their children.

Another reason to question the health agencies' credibility concerns the rapid push to have sufficient amounts of the drug Tamiflu to treat people with H1N1 infections. This may seem to be a vital and appropriate proactive measure if it wasn't for the fact that two separate peer-reviewed studies—one in the March 2009 *Journal of the American Medical Association* and the other in the *New England Journal of Medicine*—stated Tamiflu does not work for the H1N1 virus! The conclusion is clear. The CDC committed a grievous error in ordering massive amounts of Tamiflu for rapid distribution. Double-blind placebo controlled studies in respected orthodox publications unequivocally state that Tamiflu does not work for the virus. This is not an isolated incident. A similar scenario unfolded in the UK and with wide media coverage. During August 2009, across England, children taking Tamiflu fell deathly ill. Medical experts, outside the government's health ministry confirmed that Tamiflu is more harmful than good. But at the end of a brief spark of media publicity, the government turned around, rejected the experts' claims and continued to recommend Tamiflu in the advent of swine flu infection.

IS THE FLU VACCINE EFFECTIVE?

There is no better place to begin a discussion about the effectiveness of the flu vaccine than to introduce a statement on Canada's Vaccination Risk Awareness Network (VRAN)

website, a community of physicians, researchers and vaccine scholars who report vaccines' flawed promises and pseudo-science. Among all vaccines, the flu vaccine is listed as "The Most Useless Vaccine Of-All-Time Award." CDC officials are even forced to confess that "influenza vaccines are still among the least effective immunizing agents available, and this seems to be particularly true for elderly recipients." Dr. Anthony Morris is a distinguished virologist and a former Chief Vaccine Office at the FDA. His views regarding the flu shot go much further. "There is no evidence that any influenza vaccine thus far developed is effective in preventing or mitigating any attack of influenza," Dr. Morris states, "The producers of these vaccines know they are worthless, but they go on selling them anyway."

Before every flu season, the Federal health agencies and HMOs commence campaigns encouraging flu vaccination. More effort goes into advertizing, promoting, and deliberating government policies for influenza than any other vaccination. Therefore, we find individuals such as Dr. Marie Griffin, a consultant for the large vaccine manufacturer Burroughs Welcome, leading public relations campaigns to encourage flu vaccines on children. Who is Marie Griffin? Now an Associate Professor of Preventative Medicine at Vanderbilt University and an independent researcher with ties to the Burroughs Welcome Fund, Dr. Griffin was a principal researcher and author of flawed studies to supposedly exonerate the pertussis vaccine from earlier scientific evidence showing it caused neurological damage.

A discussion on a vaccine's effectiveness needs to first emphasize that vaccine theory has basically remained unchanged since Dr. Edward Jenner first inoculated a person with a smallpox virus at the end of the seventeenth century. The only essential knowledge a layperson requires to understand vaccination is that a virus is intentionally introduced in the body in order to stimulate the body's immune system to produce its own antibodies to fend off the virus in the wild. Today, there are other measuring factors being used to determine how much of an immune response is being triggered and then other predictive calculations to determine whether or not the response will be effective enough to ward off infection. Nevertheless, the entire basis for vaccination relies solely on the introduction of a virus to the body. Another difference today is that vaccines can have a live virus, an attenuated virus or an inactive virus. We are told that some of these viruses are "killed", but in fact, you can never fully kill a virus. Even a so called "killed virus" still presents its genetic code in the body and it is well known throughout the community of virologists that inactive or killed

virus can reactivate. Live virus vaccines are little different than that used by Jenner. Attenuated viruses are live viruses that have been weakened.

When a virus is administered, the immune response becomes over-stimulated to produce antibodies. One of the issues of vaccine medicine that has remained unexplored, an issue the pro-vaccine establishment very likely wishes to ignore, is that whenever the body's immune system is over-stimulated—the ultimate mission of a vaccination in order to stimulate protection against a virus—any other viruses and bacterium present in the body, which may or may not be dormant, can enter a hyperactive state and subsequently pose a new threat in the body. This is one reason why we so often hear people saying that after they have been vaccinated they feel sick and that they repeatedly have bouts of viral infection.

The CDC recommendations for the launch of the new swine flu vaccine include children starting at age six months. For years, seasonal flu vaccinations have been recommended to commence at six months. All of the recently FDA-approved intramuscular swine flu vaccines comprise an inactivated virus. So is there any evidence that inactivated viral H1N1 and influenza vaccines are effective and safe in very young children? After examining exhaustive studies, we have not come across such evidence. Some of the most damning evidence was reported in two studies performed by Dr. Tom Jefferson, head of the Vaccine Field group at the prestigious independent Cochrane Database Group, published in *The Lancet* and the prestigious *Cochrane Database Systems Review*. The first study was a systematic review of the effects of influenza vaccines in healthy children. The other was a review of all the available published and unpublished safety evidence available regarding the flu vaccine. The authors of the study had also contacted the lead scientists or research groups for all the efficacy and safety trial studies under their review in order to gain access to additional unpublished trial studies the corporations may possess. The conclusions are shocking. The only safety study performed with an inactivated flu vaccine on young children was conducted in 1976. Thirty-three years ago! And that single study enrolled only 35 children aged 12-28 months. Every other subsequent inactivated flu study involved children enrolled children 3 years or older.

Dr. Jefferson also told Reuters, “Immunization of very young children is not lent support by our findings. We recorded no convincing evidence that vaccines can reduce mortality,

[hospital] admissions, serious complications and community transmission of influenza. In young children below the age of 2, we could find no evidence that the vaccine was different from a placebo.”

Both studies also investigated evidence of live flu vaccine safety in studies with children. This is especially relevant today because Medimmune’s approved nasal vaccine for the H1N1 swine flu uses a live virus. As for live virus flu vaccines, no safety studies have been performed on children younger than 22 months. Medical reporter for the *Philadelphia Examiner*, Deborah Dupre, states, “Non-governmental organizations, intellectually honest health professionals agree that a person vaccinated with a novel A H1N1 live virus rather than inactive component viruses is contagious.” National Vaccine Information Prevention founder and president Barbara Lo Fisher concurs: “The live virus activated vaccine has the ability to spread flu.” Medimmune, the sole manufacturer of the live flu nasal vaccine, repeatedly refused to give unpublished data to Dr. Jefferson without executive clearance. The was also true for some vaccine makers working with inactive virus.

The reviewers’ final assessment quotes from another group of vaccine investigators who share similar views, “we are concerned by our findings of limited clinical trial evidence for inactivated vaccines. In addition, the withholding of safety data for live attenuated vaccines makes it impossible to present a complete evidence base of their safety. Although a frequent practice, lack of reporting of non-significant outcomes raises the real possibility that our review may present a biased picture.” In another article, Dr. Jefferson summarizes his main points concerning flu vaccines as follows:

Evidence from systematic reviews show that inactivated vaccines have little or no effect on the effects measured

Most studies are of poor methodological quality and the impact of confounders is high

Little comparative evidence exists on the safety of these vaccines.

Dr. Jefferson concludes, “We believe all unpublished trial safety data should be readily accessible to both the regulatory bodies and the scientific community on request. Our evidence gives rise to a concern that lack of access to unreported data prevents published data being put into context and hinders full and independent review. This cannot be good for public confidence in these vaccines.”

Independent vaccine investigators and scientists, with no vested interest in the vaccine industrial complex, and who wish to uphold the highest standards of scientific integrity, are faced with great resistance and are basically hamstrung to procure necessary scientific and clinical trial data from the vaccine industrial complex and their federal guardians in order to conduct thorough research. Federal agencies do not regulate what a corporation does or does not do with all of its clinical data on vaccine efficacy and safety. All that is required from vaccine makers is the necessary documentation required for FDA submission for approval and registration. All other data is a sealed proprietary vault, off-limits to the rest of the world's scientific community, unless such wishes for access be sanctioned by the corporations. This in itself is a violation of the highest ethics of true medical science, which by definition should be a quest for discovering and confirming medical facts and by sharing information publicly so scientists can further their knowledge to find the best solutions for tackling our health problems and to discover solutions for them.

Australian scientist and vaccine expert, Dr. Viera Scheibner, has investigated the criteria vaccine makers use to conduct human trials to determine a vaccine's safety and the means by which they determine their results. Vaccine makers use an "exclusion criteria." If the same data were calculated under a different set of guidelines, particularly guidelines requiring double blind studies and true placebos, the results could be dramatically different. As an example, Dr. Scheibner shows how vaccinated children in a MMR vaccine trial developed measles after injection were then able to be excluded from the final calculations based upon the company's "exclusion criteria". Unfortunately, her investigations show that this practice is "unashamedly" repeated time and time again by vaccine makers during clinical trials.

Measles would have very likely disappeared on its own due to better sanitation, nutrition and cleaner resources. By the time the measles vaccine was first launched for mass immunization, measles infection had already decreased 90 percent. Opponents of the measles vaccine, who have shown that vaccination actually perpetuates the virus, point to studies performed among the Amish people living in small communities in the United States. There were no reports of measles among the Amish between 1970 to 1987. Then on December 5, 1987, there was a large outbreak of measles, at the time the vaccine establishment was claiming victory over this infectious disease and contributing it to vaccination. Dr. Scheibner has studied this phenomenon extensively, and concludes that it

was the vaccine that kept measles alive.

“Are vaccines effective? Definitely not. They are only effective in creating harm, damage to organs in the body. They cause all those modern ills of humanity, all those autoimmune degenerative diseases.... And it is all published and refereed in medical journals. So the evidence is right from the horse’s mouth.”

A scientific study in review for peer-reviewed publication was reported on CTV, Canada’s largest private television network, on September 23, 2009. The study, conducted in three Canadian provinces—British Columbia, Ontario and Quebec—by Toronto’s Mount Sinai Hospital, raises serious concerns over the potential efficacy of the new H1N1 flu vaccine based upon new data showing that a person vaccinated with last year’s seasonal vaccine are more susceptible to contracting the H1N1 virus. Because of the critical questions being raised about the lack of safety trials that have been undertaken for the H1N1 vaccine, the researchers considered their findings too urgent before the vaccine is launched on the public. Moreover, there remains uncertainty over the concurrence of both H1N1 and the regular seasonal flu this Autumn. Canadian officials are even now discussing the possible need for small children to receive four flu vaccinations to cover each strain.

The Toronto study raises fundamental questions that are not being addressed. First, to date, no clinical trials have been conducted to determine how the swine flu vaccine will interact with other flu shots. Second, there are no studies to ascertain whether or not the swine flu vaccine will make recipients more susceptible to infection from other flu strains. What the study does assure us is that influenza vaccines are interfering with the body’s natural immunity. In fact this study is showing a causal relationship between the influenza vaccination given to a depressed immune system and the increase likelihood that an individual will contract another wild virus.

The vaccine industrial complex frequently attempts to inflate vaccines’ benefits by tacking on other medical indications it will protect against. Although there is strong evidence that vaccinations may contribute to the ever-increasing rise in ear infections that countless parents experience repeatedly with their small children, vaccine makers want to convince us that flu vaccines may prevent ear infections. Buried in unpublished papers is a study presented to the 2002 meeting of the Pediatric Academic Sciences involving 793 children

aged 6 to 14 months. The study found that there was no decrease in ear infections, doctor visits, ER visits, antibiotic prescriptions or missed daycare days between those children who received the vaccine and those who received placebo (meaning the vaccine without the viral component). However, every child in the study, had doctors' visits throughout the season. While this might dispel the vaccine industry's claims that the flu virus might cause ear infections, there is an obvious flaw. All children in the study received the same non-viral ingredients—adjuvants, thimerosal, and other chemicals—which contributed the children's infections and physician visits. SO might not the non-viral ingredients be contributing childhood incidences of ear infections?

Over the decades I have interviewed many of the world's most knowledgeable vaccine scientists, researchers and physicians working with children who have been victims of vaccination. Among the questions I routinely ask, is whether or not there is any evidence that vaccine makers conduct randomized double-blind placebo studies to determine efficacy and safety. Throughout true science, this protocol has served as the gold standard. And never have I heard anyone in the entire medical community, nor in any of my own research, say they found evidence for randomized double-blind placebo studies being conducted in vaccine trials.

The use of placebos most commonly used in vaccination trials is exceedingly important. In standard scientific methodology a placebo should be a very inert substance, such as water or a sugar, in order to accurately determine the tested substance's effects on human biology. According to world vaccine expert Dr. Viera Scheibner, vaccine trials do not employ an inert placebo. Instead, what is used as a placebo is "the vaccine with all the adjuvants and preservatives, certainly non-inert substances, minus those viruses and bacteria... That is why when they compare the trial children who were given the lot and those who were given placebo, they have the same rate of reaction." This means that almost all vaccine efficacy and safety trials using a non-inert placebo are based on scientifically flawed designs from the start. It is therefore evident that flawed methodology will inevitably result in flawed data. Yet that is the guiding principle the vaccine industrial complex relies upon, and our federal health establishment is all too ready to give a nod of approval and allow it to continue.

During the 1980s, Japan had mandatory flu vaccination for school children. Two large

scale studies that enrolled children from four cities with vaccination rates between 1 and 90 percent discovered there was no difference in the incidences of flu infection. As a result, in 1987, Japanese health authorities ruled that flu vaccination was ineffective and was no more than a serious liability if it was to continue. Therefore, the mandatory policy was quickly overturned. By 1989, the numbers of Japanese taking the flu vaccine dropped to 20 percent. A follow up study at that time found that there was statistically insignificant change in influenza infection rates compared to when the vaccine was mandatory.

The vaccine industrial complex makes the claim that flu vaccination will reduce asthmatic attacks brought on by flu infection among those children who are susceptible to them. A study by Dr. Herman Bueving at the Department of Family Practice at Erasmus University Medical Center in Rotterdam, Netherlands, conducted one of the few randomized, double-blind placebo studies found in vaccine literature. The two-year study enrolled 696 asthmatic children, half vaccinated and the rest administered a placebo. The study found there was no difference between the number and severity of asthmatic attacks between the two groups. This study gives further support in flu vaccination's ineffectiveness.

Vaccines are shown to be less effective among the elderly, people over 65 years of age. Nevertheless, this age group is one of the primary targets for the swine flu vaccine, as it has been with other flu vaccines each season. Even the CDC acknowledges this fact. There have been many studies conducted in nursing homes to determine how effective flu vaccines are in preventing infection. Average effectiveness, meaning only to stimulate an adequate immune response, are in the low to mid twenty percent range (21-27 percent). Another set of four studies indicate the flu vaccine was 0, 2, 8 and 9 percent effective. Yet despite some of these dismal results, the CDC still wishes us to believe that vaccinating elderly citizens is "50-60% effective in preventing hospitalization and pneumonia and 80% effective in preventing death.

Government health projections confirm, and the CDC has had to acknowledge this, that elderly people, with or without the flu shot, show less than a one percent rate of being hospitalized for pneumonia and influenza. That means that 99 percent of elderly people manage to weather the storm.

Dr. Sherri Tenpenny reviewed *The Cochrane Database of Systematic Reviews* to analyze

the efficacy of flu vaccines for children.

In a review of more than 51 studies involving over 294,000 children, there was “no evidence that injecting children 6-24 months of age with a flu shot was any more effective than placebo.

In children over 2 years of age, flu vaccine effectiveness was 33 percent of the time preventing flu.

In children with asthma, inactivated flu vaccine did not prevent influenza related hospitalizations in children. The database shows that children who received the flu vaccine were at a higher risk of hospitalization than children who did not receive the vaccine. In a separate study involving 400 children with asthma receiving a flu vaccine and 400 who were not immunized, there was no difference in the number of clinic and emergency room visits and hospitalizations between the two groups.

In recent years we are seeing supposed scientific studies emerging that are nothing more than commercials, public relation spectacles, to promote vaccination’s efficacy. Such studies either remain unpublished or are reinvented for publication well after the fact. Their sole purpose is to confuse a negative with a positive twist. They are no more than promotional spins designed by the vaccine industrial complex, and their cohorts in other private health sectors to support their financial interests. In turn, they are used as a means to influence the nation’s health policy makers, and to relieve doubts concerning their vaccine’s efficacy and safety. The nation’s health agencies then rely on these fabrications to convince the larger public healthcare community and citizens about the importance of being vaccinated.

Edward Yazbak, MD, an independent vaccine researcher and an expert in autoimmune regressive autism injury, did a thorough review of one such study entitled “Effectiveness of the 2003-2004 Influenza Vaccine Among Children 6 Months to 8 Years of Age, with 1 vs. 2 Doses”. After his analysis of the study’s data, he voted it “Most Creative Title of the Year.” The completely flawed study was meant to serve two fundamental purposes. First, to show flu vaccine’s efficacy, and second, to send a message that one dose was inadequate and two inoculations should be recommended in the vaccine schedule. Although the lead researcher Dr. Debra Ritzwoller and her colleagues claim in the document that they had no conflict of interest, they were employees of a large HMO, Kaiser Permanente. Dr.

Ritzwoller is an economist specializing in health services. Two other researchers worked for the National Immunization Program. The study was eventually published more than a year later in the November 2005 issue of *Pediatrics*. In the document's footnote, the study was first presented to the July 2004 meeting of the Advisory Committee on Immunization Practices (ACIP), an entity under the CDC. Therefore, it never went through peer-review before presentation to our nation's highest advisory group making the crucial decisions on vaccine policy recommendations.

The study enrolled 29,726 children in the Denver area, 5,142 who were 6 to 23 months old. While this figure may appear impressive, Dr. Yazbak makes the acute observation that "figures in the thousands or millions in medical writings always raise a red flag for me" and in almost all cases with studies of this magnitude, they represent a "smokescreen." Studies of this size simply cannot execute sound scientific inquiry nor perform proper due diligence to arrive at any accurate conclusion. He also noted a peculiar timing between when the study was conducted and an earlier Colorado study by the same group of researchers, which remains unpublished, and reported to the CDC's *Mortality and Morbidity Weekly Report* (MMWR). Both were sequentially and perfectly timed between the new recommendations to vaccinate children in the 6-23 month range and the beginning of the 2004 flu season.

As a result of Ritzwoller and her team's data, the ACIP declared vaccination of children 6 to 23 months of age decreased hospitalization rates. However, the study never tracked any hospital admissions of the enrolled children. Later, a separate medical investigator queried Dr. Ritzwoller on whether the flu vaccine caused any adverse reactions. By her own admission Ritzwoller stated there were none, but that "hospital admissions were not tracked, and the parents were not interviewed."

In a curious twist of fate, corporations, far removed from drug and vaccine development, but also obligated to test and market their own products, conduct studies that contradict the dogma of the pharmaceutical industrial complex. Procter and Gamble have conducted numerous studies on their common household products such as soap and liquid detergents. One such study was a randomized, placebo study of 611 hundred households, in 36 separate neighborhoods, in Karachi, Pakistan to determine whether frequent use of a common hand soap, an antibacterial promotional soap and a placebo would reduce the rate

of lung infections due to pneumonia among children. Trainers visited each family weekly to educate and teach proper hand washing use. When we review below the FDA's and CDC's flawed methodology for promulgating their myth that 36,000 Americans die annually from flu infections, we will see that over 90 percent of these mortalities are a result of pneumonia infections, not the influenza.

Proctor and Gamble's results are quite startling with a fifty percent lower incidence of pneumonia infections among children under five with the plain and antibacterial soaps compared to placebo. There was also a 53 percent reduction in diarrhea and a 34 percent decrease in incidences of impetigo. While this may appear to be an irrelevant example, it is not off the mark. Dr. Ton Jefferson at the Cochrane Database Group in Rome, who has performed some of the most extensive analysis in the efficacy of flu vaccination for the past 37 years, arrived at the conclusion, "People should ask whether it's worth investing these trillions of dollars and euros in these vaccines.. What you see is that marketing rules the response to influenza and scientific evidence comes fourth or fifth. The best strategy to prevent illness is to wash your hands." And if you are among those who would hold Dr. Jefferson suspect, then even the FDA's and CDC's 1999 directive to manufacturers to remove mercury from vaccines recommends that the safest and most effective way to prevent flu infections is frequent hand washing and a healthy lifestyle.

An equally disturbing scenario unfolds about efficacy and safety trials conducted with pregnant women. In 2001, the CDC started to recommend the flu vaccine to all pregnant women. Eight years later, pregnant women are now being targeted as a priority group for the H1N1 vaccine. Nevertheless the vaccine is a Category C drug, which means there are no adequate safety studies after two studies published in 1973 and 1979 to determine whether flu vaccination adversely affects pregnant mothers and their fetuses. What remains utterly amazing is that many serious questions about live flu vaccines remain unanswered. Most shocking is the uncertainty as to whether the vaccine itself, having been administered nasally, might not transmit contagious infection in others. Worse is the lack of studies to determine the possibility of a serious immunological threat when an attenuated virus, which replicates more rapidly, is administered to individuals with compromised immune systems.

An important Dutch study was conducted in a large home for the elderly. In spite of two thirds of them having been vaccinated, the flu infected 49% of them, including bacterial and

pneumonia infections, and 10% died. The critical observation found in the study was that 50% of those vaccinated got the disease whereas 48% of non-vaccinated people were infected. The results of this study clearly show that vaccination was useless.

Dr. Sherri Tenpenny reviewed *The Cochrane Database of Systematic Reviews* to analyze the efficacy of flu vaccines for the elderly.

In 64 studies involving 66,000 adults, “Vaccination of healthy adults only reduced risk of influenza by 6 percent and reduced the number of missed work days by less than one day. There was change in the number of hospitalizations compared to the non-vaccinated. In 64 studies during 98 separate flu seasons involving elderly adults residing in nursing homes, flu vaccinations were non-significant for preventing infection.

IS THE FLU VACCINE SAFE?

When we hear official reports released by the FDA and CDC, transmitted throughout major corporate media and publications, that a particular vaccine is safe, we should immediately perk to attention, raise a red flag, and muster reasonable suspicion. One of the most important questions is, what kind of studies were performed to determine that any vaccine is essentially safe, especially in infants, small children, pregnant mothers, the elderly, and those with compromised immune system due to pre-existing illnesses prior to vaccination?

Vaccine manufacturers, according to the statutes of the FDA’s Public Health Service Act are required to show that a vaccine complies with three criteria before approval and launch: safety, purity and potency. There is no requirement before FDA approval and licensing of a vaccine that the vaccine undergo any independent studies, by researchers with no vested financial interests, to validate a vaccine applications scientific claims. Rather, the entire approval process is nothing more than a good-faith relationship between the manufacturer and the FDA and its vaccine advisory departments and committees.

The FDA defines a vaccine’s effectiveness in terms of its potency to trigger a targeted immune response sufficient enough to produce antibodies against the particular virus strain.

The FDA guidelines require vaccine makers to conduct placebo-controlled clinical efficacy studies on healthy adults, who are free of at-risk complications. Clinical trials with at-risk individuals, including infants, small children, pregnant mothers and people over 65 of age are not mandatory for regulatory approval. How do the vaccine makers determine whether or not a vaccine is safe to these other at-risk groups before FDA approval? Well, they don't except by predicting past incidences of vaccine effectiveness and safety. The vaccine industrial complex is under no federal obligation to give sound scientific evidence that their vaccines are safe in anyone except health adults.

What is quite extraordinary in the FDA's Center for Biologics Evaluation and Research's document, "Guidance for Industry: Clinical Data Needed to Support the Licensure of Seasonal Inactivated Influenza Vaccines", is the great amount of leeway permitted vaccine manufacturers to prove a vaccine's safety. For example, "the protocol *should* include a clinic visit or telephone contact at least six months post-vaccination to ascertain serious adverse events." Or, "we *recommend* that you assess the safety of your investigational vaccine in several thousand subjects." Or, "we *assume* that approval for use in the adult population, including the geriatric population, would be sought with the initial application." More seriously is this allowance given to a vaccine manufacturer, "For vaccines using novel manufacturing processes and/or adjuvants, laboratory safety tests including hematologic and clinical chemistry evaluations, *may* be needed pre- and post-vaccination in the first clinical studies." (All *italics* are ours to clearly identify word choice in the official CDC document).

Curiously, we never hear an all-embracing confirmation from federal health agencies, which oversee the data of vaccine safety before a vaccine's release to physicians, hospitals and healthcare facilities, that ALL vaccines are collectively safe. Neither will you find such pronouncements made in any published literature. Instead, we hear only of individual vaccines. How are we suppose to interpret this?

One of the CDC's and vaccine industrial complex's secret weapons is the Vaccine Safety Datalink. No independent scientist or investigator has access to its contents without being annointed by of federal health officials who stand at its guard. How is this network of proprietary data used by its government overseers?

During the 2006-2007 flu season, a perfectly timed article appeared in the October 25, 2006, issue of the *Journal of the American Medical Association* entitled “Safety of Trivalent Inactivated Vaccine in Children 6 to 23 Months Old.” The study was conducted by investigators from an HMO and four co-authors from the CDC. According to the investigations by the independent vaccine expert, Dr. Edward Yazbak, the HMO “has had a close relationship with the CDC for years and its members have been enrolled in multiple pre-licensure vaccine trials.” Further, the publication of the article was perfectly timed for a national PR launch since the government health agencies had already purchased their stocks of flu vaccine from the vaccine industrial complex and needed to unload them. The study also relied on the data in the Vaccine Safety Link and we are told it analyzed “significant medically attended events in all the databank’s 6 to 23 month old children vaccinated between January 1991 and May 2003—supposed numbering 45,356 children and a total of 69,359 vaccinations.

The conclusions of the study state, “In the largest population study to date of the safety of trivalent inactivated influenza vaccine in young children, there were very few medically attended events, none of which were serious, significantly associated with the vaccine. This study provides additional evidence supporting the safety of universally immunizing all children 6 to 23 months old with influenza vaccine.”

What is most disturbing about this study, which *JAMA* should have rejected for publication, is that it relies on safety data unavailable to independent research and analyses. Therefore, it is a vagrant violation of medical science that can serve no other purpose than the financial goals of vaccine makers, the insurance industry and their federal health colleagues.

Three days after the *JAMA* article, the October 28, 2006 issue of the British Medical Journal had a piece by its editor Fiona Godlee, who commented on Dr. Tom Jefferson’s article attacking the UK’s vaccine policy—which consistently mirrors the US—in the same issue. Godlee wrote,

“As if to prove the point, we publish this week a broadside (based on a systematic review of the literature) about the lack of evidence for influenza vaccine. Why, asks Tom Jefferson (p. 912), is there such a gap between evidence and policy?

Governments go to great lengths to promote and provide the vaccine. But there is

almost no valid evidence that it does any good. Jefferson puts the gap down to our desire to do something, combined with “optimism bias”—an unwarranted belief in the value of interventions. Would randomized trials be unethical? No, says Jefferson, they are the only ethical response to the possible waste of resources on ineffective or only partially effective care. The problem is that the UK has no transparent process for evaluating the effectiveness or cost effectiveness of vaccines.”

More recent, a cohort study of 263 children, from 6 to 18 months who were confirmed positive with influenza, did an evaluation to determine the trivalent flu vaccine’s effectiveness. The Mayo Clinic in Rochester, Minnesota study was presented at the 105th International Conference of the American Thoracic Society and found that children who had received the vaccine had a three times risk of hospitalization compared to children who were not vaccinated. An earlier study of 800 children suffering with asthma found that those who received a flu vaccine had a significant increased risk of asthma-related doctor and emergency room visits. These results were later reinforced by another study showing that the attenuated live virus flu vaccine, FluMist, contributed to a triple risk of children with asthma being hospitalized.

As of 2007, the CDC’s recommended Immunization Schedule for physicians and pediatricians lists 9 separate vaccinations to be given to infants before completion of their second month, an additional 27 separate vaccinations to be injected in the child by 18 months of age. The total number of vaccinations a person should receive by 15 years of age is 64 (not including the HPV vaccine that has since been added to young girls entering their teens). Other vaccines are now in the R&D pipeline for diseases such as chlamydia, herpes simplex type 2, hepatitis C, West Nile virus, Epstein-Barr virus, and others. The World Health Organization notes that intensive efforts also are under way to develop effective vaccines for malaria, tuberculosis, dengue, and other diseases. A fundamental question being ignored is when is there enough. Furthermore, there is every indication that the number of mandated vaccinations will continue to rise as vaccine manufacturers continue to research and develop vaccines for other infections and illnesses.

The chart below provides a breakdown of recommended vaccine schedule.

Centers of Disease Control's Immunization Schedule for 2007

AGE	VACCINE	Number Shots
Birth	Hepatitis B	1 vaccine
1-2 Months	Hepatitis B	1 vaccine
2 Months	DPT, Polio, Hib, PCV, Rotavirus	7 vaccines
4 Months	2 nd shots of DPT, Polio, Hib, PCV, Rotavirus	7 vaccines
6 Months	3 rd shots of DPT, Hib, PCV, Rotavirus	6 vaccines
6 Months to 18 Months	Influenza (yearly), Hepatitis B, Polio	3 vaccines
12-15 Months	MMR, Hib, PCV, Varicella	6 vaccines
12-23 Months	Hepatitis A (twice)	2 vaccines
15-18 Months	DPT	3 vaccines
TOTAL (from birth to 18 months)		36 vaccines
4-6 Years	DPT, MMR, Polio, Varicella	8 vaccines
11-12 Years	Tetanus/Diphtheria, HPV (3 doses), MCV4	6 vaccines
15 Years	MCV4	1 vaccine
2-15 Years	Influenza (yearly)	14 vaccines
TOTAL (from birth to 15 years of age)		64 vaccines

It has now become a routine practice for physicians to administer multiple vaccine injections in infants and toddlers during a single visit. A review of the above chart numbers will show, especially among children, many vaccines can be given during a single month. Is there any evidence that the combination of all these vaccinations trigger disease and neurological malfunction? No, because no such studies have been performed. In fact, there is no regulatory requirement placed upon vaccine manufacturers to determine whether

their vaccines are safe in the presence of other vaccines or when multiple vaccines are administered together during a single doctor's visit.

In addition, there are numerous scientific reports and case studies to support the position that vaccine ingredients, particularly the adjuvants and preservatives used in the flu vaccines, are far more dangerous and pose a much higher health risk than the reported incidences of H1N1 infection. Patti White was a school nurse who testified before the House Government Reform Committee in 1999. In her statement she said, "Vaccines are supposed to be making us healthier; however, in twenty-five years of nursing I have never seen so many damaged, sick kids. Something very, very wrong is happening to our children."

A major concern among vaccine critics and medical and vaccine experts is that the new swine vaccine is being launched before scientifically sound human trials are conducted to determine efficacy and safety. Swine flu vaccines are being fast-tracked in order to have it ready for October. Results from human trials to test the new H1N1 flu vaccine are starting to be reported. In terms of the corporate articles being published, we might believe these results are promising. On closer inspection of a review of the methodology, number of trial participants, the particular age and health-risk groups selected, trial length and follow up, it is erroneous to conclude that these studies were performed with scientific rigor and integrity.

CSL Ltd is an Australian vaccine maker whose novel influenza A (H1N1) vaccine was recently approved by the FDA. The company's immunological and safety trials included only 240 subjects. This is far less than would be expected of vaccines because more serious and fatal adverse effects, unless in more infrequent circumstances such as with the polio vaccine, appear as one in thousands. All human subjects were healthy adults, meaning there were no known pre-conditions that would suppose an impaired immune system. CSL has not tested its vaccine on any children from 6 months and older, nor on pregnant women and the elderly. The trial lasted only 21 days and there is no indication of long term follow-up. Forty-five percent of the subjects reported systemic events such as headaches, malaise and myalgia, however, CSL decided to consider only 30.4 percent as vaccine related—for reasons that are unexplainable! More interesting, "three subjects had influenza-like illness, one of whom tested positive for 2009 H1N1 on day 8 after vaccination."

In 2008, the multinational vaccine maker Novartis was forced to withdraw its Aflunov vaccine, which contained the MS59 squalene adjuvant, for avian bird flu when the European Medicines Agency (EMA) found the clinical trials did not meet “good clinical practice” and the results were unreliable for approving the vaccine. In addition, the sample of participants was too few to assure the vaccine’s safety. What is particularly important in this one example is that Novartis’ Aflunov was a mock up vaccine being developed for what the WHO and other health organizations predicted to be a forthcoming global avian flu outbreak.

If the Novartis report is used as a recent precedent for the way Novartis conducts vaccine trials, how might we suppose it conducted its trials for the H1N1 swine flu? A report from *MedPage Today* has confirmed that Novartis’ trials for the H1N1 vaccine, called Celtura, are equally suspect, however, the EMA has given it a green light. According to the report, Novartis’ immune-efficacy and safety human trial enrolled only 100 healthy people at the University of Leicester in the UK. The study was sponsored by Novartis, and the lead scientist conducting the trials, Dr. Iain Stephenson, is on record for receiving funds from Novartis. Again, the vaccine includes the MF59 adjuvant and was determined “safe” during the two week trial.

The *British Herald* reports that GlaxoSmithKline, one of the swine flu manufacturers that will be using the squalene adjuvant, is conducting a two-inoculation trial with only 128 healthy adults enrolled.

Dr. Kathleen Neuzil, in her article in the September 10, 2009 issue of the *New England Journal of Medicine*, reviewed the swine flu vaccine trials of several of these companies and warned, “The immune responses in children are unknown. . . . Immunogenicity data in young children are critical to guide policy decisions.” The question can be aimed at the WHO whether or not Dr. Margaret Chan, the WHO’s Director General, realizes that giving adjuvanted vaccines where there is no discernable safety data amounts to a biological experiment that violates national and international law?

Pregnant women are now being listed as a high priority for swine flu inoculation. Yet the

product inserts so far from the pack inserts published by the vaccine manufacturers state the disclaimer: “Animal reproduction studies have not been conducted with influenza virus vaccine. It is also not known whether influenza virus vaccine can cause fetal harm when administered to a pregnant woman.” By their own admission, the vaccine industrial complex has not even performed clinical studies on pregnant animals, let alone pregnant human women!

The Canadian Health Ministry has confirmed that there is no data on the use of adjuvanted swine flu vaccine in pregnant women that would warrant administering it to this category of recipients. In fact flu vaccines, as with all other vaccines have not been fully tested to determine teratogenic effects, the dangers vaccines have on the fetus. Unlike the US, Canada is more wary about the medical evidence showing adjuvants have a high adverse threat to pregnant women and the fetus. This conclusion was drawn earlier by the WHO. Dr. Marie-Paule Kieny, head of the WHO’s vaccine research department, stated, “Does that mean that it (adjuvanted vaccine) will be unsafe? No. It means that there is no hard evidence that it will be safe.”

The pro-vaccination community abides by the prevailing myth that the placenta serves as a kind of barrier or wall that protects the fetus from toxic chemicals, metals and contaminants and pathogens in the pregnant mother. This belief has been destroyed by one of the most important discoveries in recent years. The Environmental Working Group, an independent non-profit organization that conducts laboratory research on environmental toxins. Upon testing umbilical cord blood for over 200 of some of the most dangerous chemicals found in our environment, the researchers came to the startling results that on average approximately three quarters of them were present in umbilical cord blood. The urgent importance of this discovery is that the placenta does not serve as a reliable filter for hazardous chemicals, which would include those used in vaccines, and these toxins will make their way to the developing fetus and can contribute to untold damage and genetic alterations leading to long-term diseases as the child grows up. This in and of itself should force us to pause and reconsider the serious side effects being inflicted on unborn children from vaccine ingredients such as ethylmercury (thimerosal), aluminum hydroxide, formaldehyde, polysorbate, MSG and others. A 1999 article in the *American Journal of Epidemiology* stated, “the greatest susceptibility to methylmercury neurotoxicity occurs during late gestation.” Although this particular study investigated the adverse effects of

methylmercury during pregnancy, given the strong evidence of neurotoxicity in children who received thimerosal-laced vaccines, the same can therefore be said concerning ethylmercury.

Although at the time of composing this document, we have been unable to identify specific FDA and/or EMEA approval of cancerous cell lines in the preparation of the flu vaccine, a secondary source confirms cancer cells are currently being used as vaccine cell substrates. Dr. Wolfgang Wodarg, the chairman of the Health Committee of the German Parliament and the European Council and a specialist in pulmonary medicine, warned that the nutrient solution used in Novartis's developing an H1N1 vaccine, which has now been approved by the FDA, includes known *animal cancer cells* (italics added) and, therefore, poses a serious health risk.

Johannes Lower, president of the Paul Erlich Institute predicts that the death rate in Germany in the event of mass vaccination, using the currently approved vaccines for Europe, would be 60,000 casualties. Calculating Dr. Lower's figure for the American public, we would be looking at over 307,000 deaths, nine-fold higher than the annual influenza mortality rate claimed by the CDC during a normal flu season. In such an instance, it is clear that the risks of vaccination far outweigh the benefits based on American health agencies' calculations.

Among the different more serious and life-threatening adverse effects that have been associated with the flu vaccine, and found in the scientific literature are:

Guillane-Barre Syndrome (discussed below)

Polyneuritis and related conditions such as polyradiculitis and polyganglioradiculitis

Parsonage Turner Syndrome

Meningeal infection, separate or as part of Guillain Barre Syndrome.

Encephalitis

Multiple sclerosis

Intense headaches suggestive or meningeal or brain irritation

Unconsciousness

Aphasia (loss of speech)

Bronchopneumonia

Sexual impotence

Impeded hearing

Eye disorders including proptosis, retina oedema, diplopia, nystagmus, eye muscle paralysis

Angor pectoris

Anaphylactic reactions

Death

GOVERNMENT FEARS OF GUILLAIN-BARRE SYNDROM

During the swine flu scare of 1976, President Gerald Ford approved a rapid mobilization of mass vaccination upon the American population that resulted in 40 million citizens unnecessarily vaccinated. The predicted epidemic never arrived, and the vaccine proved to be catastrophic. In fact, the entire incident was a debacle based on bad vaccine science and flawed predictive methodology. There were approximately 500 known cases of and 25 known deaths from Guillain-Barre Syndrome (GBS). Actual known deaths due to the H1N1 virus that same year were one. A retrospective study conducted by US health agencies discovered the vaccine had increased GBS risk eight-fold. The government was forced to pay out millions of dollars to injured vaccine recipients.

GBS is an autoimmune disorder affecting the peripheral nervous system, associated with an acute infectious mechanism. It exhibits paralytic symptoms spreading from the legs to the upper limbs followed by complete loss of deep tendon reflexes. Due to GBS's paralytic symptoms, severe pulmonary complications and autonomic nervous system dysfunction can result in death.

The evidence for an association between the flu vaccine and GBS did not first appear during the 1976 swine flu vaccine debacle. In 1958, there were two reports showing cases of severe paralytic nervous system disorders occurring after vaccination with the flu virus. There were also increased risks noted for GBS during the flu seasons between 1992 and 1994.

Although the H1N1 vaccine being fast tracked and launched on world nations is different in some ways from the vaccine distributed in 1976, there are also many similarities. For this reason, government health officials have been alerted of a strong possibility that cases of

GBS will result from the new vaccine this year. On August 15, 2009 the *British Daily Mail* released a leaked letter from the British Health Protection Agency addressed to 600 British neurologists with the warning that they should be on alert for incidences of GBS among citizens inoculated with the H1N1 vaccine. The letter originated from the highest level of the UK's health ministry, Dr. Elizabeth Miller, head of the HPA's Immunization Department. One senior British neurologist in response to the warning said, "I would not have the swine flu jab because of the GBS risk."

This begs the question of the lack of transparency between government health officials and the citizenry, and between the pharmaceutical vaccine makers and the professional medical associations who keep practicing physicians and clinicians educated with the latest findings and warnings about the drugs and vaccines they administer daily to their patient clientele. A statement by a Conservative member of the UK's Parliament's Health sector, Mike Penning, concerning the government's secrecy regarding the swine flu vaccine is apropos for leveling against our own White House health leaders. He stated, "The last thing we want is secret letters handed around experts within the NHS (National Health Service). Our job is to make sure that the public knows what's going on. Why is the government not being open about this? It's also very worrying if doctors, who will be administering the vaccine, aren't being warned."

Two weeks later the CDC publicly followed suit. As reported, "The US Centers for Disease Control and Prevention and the American Academy of Neurology have asked all neurologists to report new cases of Guillain-Barre in people who get vaccines this fall and winter to the Food and Drug Administration's Vaccine Adverse Event Reporting System."

These pronouncements are clear indicators of a serious concern burdening government health officials as they continue to push forth an experimental flu vaccine that has not been approved by the more stringent regulations of rigorous clinical trials to determine vaccine safety and effectiveness. They have a great deal to worry about if warnings by Dr. J. Seal of the National Institute of Allergy and Infectious Diseases is accurate: "Any and all flu vaccines are capable of causing Guillain-Barre."

VACCINE INGREDIENTS

It is uncertain whether or not the new swine flu vaccines approved in the US will contain the adjuvant squalene, a natural organic compound and precursor to the family of steroids. So far the ingredient information published by manufacturers does not list it. Health experts at the WHO have been calling for the inclusion of an adjuvant in order to increase the availability of vaccine lots throughout the world. Novartis has also publicly concluded the same (Novartis is the primary provider of MS59 squalene-laced adjuvant in vaccines). In the absence of an adjuvant, more viral antigen is required and, according to reports, vaccine manufacturers are unable to meet the demand from the global community of nations. Adjuvants, such as squalene and aluminum compounds, increase a vaccine's potency when there is not a close match between the virus contained in the vaccine and the projected strain of the virus being targeted in the event of a future outbreak.

This is always the case for influenza. Unlike other infectious pathogens, there is a great deal of guess work among flu vaccine makers to determine what flu vaccine they need to develop for any given flu season. The mathematical models used to make their decisions are based on the epidemiological and demographic records from the previous flu outbreaks. However, there is no way an accurate prediction can be made as to whether the viral antigen contained in flu vaccine will be an identical or a close match to the actual flu that appears. It is strictly a predictive, subjective calculation. Dr. Michael Decker from the flu vaccine maker Aventis admits, "By the time you know what's the right strain, you can't do anything about it. This is even acknowledged by the CDC,

"However in some years when vaccine and circulating strains were not-well matched, no vaccine effectiveness may be able to be demonstrated. It is not possible in advance of the influenza season to predict how well the vaccine and circulating strains will be matched, and how that may affect vaccine effectiveness."

If the selected vaccine antigen and actual virus is not a close match, the vaccine will be far less effective in creating sufficient antibodies to induce immunity. In order to compensate for this problem, an adjuvant is added to boost the antigen's effectiveness. So far, reports

from the H1N1 vaccine manufacturers are stating that the new flu vaccine antigens show a close matching and therefore US health officials, and vaccine makers, are saying vaccines can be released without an adjuvant. Of course, there is absolutely no way to confirm their claim until cases of the H1N1 strain begin to appear. Until then, it is all guesswork.

The flu virus is more susceptible to gene amplification than other viral and bacterial pathogens. Gene amplification is a cellular process by which a gene produces multiple copies of itself in order to amplify and preserve the phenotype the gene confers to the cell. Cancer cells, for example, undergo rapid gene amplification, which contributes to their greater drug resistance. When people are very sick from a flu infection, or when large numbers of individuals are infected, the flu virus' gene amplification increases dramatically. And with rising amplification, there are faster rates of viral mutation, thereby developing in new strains.

In the US, squalene has not been approved by the FDA for vaccines. Although the FDA has refused to take a strong stance on the serious, proven risks of squalene, the FDA's chief scientist Dr. Jesse Goodman states, the FDA's rationale for disallowing the adjuvant is because "there's just more uncertainty" while still claiming "there is not a known, specific safety danger or issue regarding them." Due to recent acts and provisions passed during the Bush Administration, squalene could be potentially used in compliance with an emergency authorization, that enables unapproved drug ingredients to be permitted and bypass the standard regulatory approval process.

The intramuscular vaccine is from influenza viruses propagated in embryonated chicken eggs and centrifugated with detergent. Other components used in the preparation of the vaccine include: octoxynol-, a-tocopheryl hydrogen succinate, polysorbate 80. The product literature states that thimerosal is used during the early manufacturing process and then removed to trace amount levels. Each dose may contain hydrocortisone, gentamicin sulfate, ovalbumin, formaldehyde, and sodium deoxycholate.

The intranasal vaccine administered to children 2 years and up is made from a live attenuated influenza virus for three strains. Other additives include: ethylene diamine tetracetic acid, monosodium glutamate, porcine gelatin, arginine, dibasic potassium phosphate, monosodium phosphate. Unlike the intramuscular vaccine, no thimerosal is

required in the preservative manufacturing of this vaccine.

We should be forewarned that Baxter International is also in the swine flu game, although there is no word yet on whether the vaccine maker intends to replace chicken embryos with its new cell culture systems research. According to Dr. Mae-Wan Ho, "Baxter International applied for a patent on a process using cell culture to produce quantities of infecting virus, which are harvested, inactivated with formaldehyde and ultraviolet light, and then detergent. Baxter has produced H5N1, whole virus vaccines in a Vero cell line derived from the kidney of an African green monkey... The main finding was that the toxic adjuvant did not increase neutralizing antibodies against the vaccine strain."

Noting the fact that vaccines include a host of undisputed toxins, such as thimerosal, aluminum phosphate, and formaldehyde, Alan Phillips reminds us that many of the ill effects caused by vaccines existed at nowhere near today's levels 30 years ago. He cites autism, ADD, hyperactivity, dyslexia, and a host of allergies as examples. In his book *What Every Parent Should Know About Childhood Immunization*, Jamie Murphy seconds the views of Phillips, and pulls even fewer punches.

"What sane person would consider using a hazardous waste, carcinogenic in rats, used in the manufacture of inks, dyes, explosives, wrinkle-proof fabrics, home insulation, and as a major constituent of embalming fluid, and inject it into the delicate body of an infant? What could formaldehyde, aluminum, phenol, mercury, or any number of other deadly chemical substances used in vaccines possibly have to do with preventing disease in children? The fact that they are needed at all in the vaccine formula argues that the product is toxic, unstable and unreliable with or without their presence."

THE HIDDEN INGREDIENTS IN VACCINES

The vast majority of scientists, physicians, nurses and public health educators' trust that the ingredients in a vaccine have been individually and synergistically proven safe and effective. The public believes these vaccines, aside from their specified virus(es), are sterile solutions, free from undesirable contaminants not listed on the manufacturer's package inserts. When the pediatrician injects a vaccine into the muscle of a child, the parents

unquestioning faith that this is the case. In other words, we want to believe that vaccines have been generated under perfect conditions for the safety of children and ourselves.

Our investigation shows that most people do not know what is actually in a vaccine: the active ingredients listed on product labels, inert ingredients, and, most important, the hidden ingredients. Even more remote is taking the time to actually study the subject matter, review the scientific literature and discover the truth for oneself. To our amazement, that truth was easy to find. But it is a truth that will scare the hell out of you.

Similar to eating veal parmesan, what would happen if a video were placed on your table and used as a living reality recipe instead of the actual meal. This video unfolds before your eyes every step in that little creature's life, from the veal's birth to the parmesan on your plate. You witness how this veal was starved of its natural nutrients, kept in a tiny stall, grossly malnourished and deformed, filled with drugs—antibiotics—diseased and suffering complete privations until finally slaughtered, sliced, cooked and served on your plate. Would your appetite be the same? Would you still desire the parmesan? Conveniently we rarely ask the questions, where does our food come from? How and where was it grown? What was sprayed on it prior to our consumption? Therefore, we are going to re-record something that even most top health educators and opinion leaders on vaccines are unaware of. That is, what goes into the making of vaccines and what is hidden from you that should give you a moment's of pause? Then ask yourself, do you want vaccines in your body?

To give us the most in depth, honest, scholarly and objective examination about the methods by which vaccines and their hidden ingredients are prepared we turn to the award-winning British investigative medical journalist, Janine Roberts, who paints an entirely different picture about the darker inferno in vaccines that do not appear on product labels. This is the same Janine Roberts who brought to the world's attention blood diamonds, genocide in the Congo and the destruction of aboriginal cultures by the Australian government.

Roberts' account of conversations between high level members from the World Health Organization (WHO), federal health agencies, and expert vaccine scientists, who determine whether or not a certain vaccine will be approved or not, is horrid. Her investigations are based on official meeting documents and her attendance at emergency vaccine meetings, and confirm that our world's vaccine and health experts agree there is no solution in sight to resolve the potential and uncertain threats posed by these hidden ingredients.

The story begins with the vaccine industrial complex's attempt to reduce vaccine manufacturing costs by seeking government approval to use cancerous cell lines in the development of vaccines. Vaccine industry's rationale is that cancerous cells are "immortal." Current vaccine methodology relies on animal cells, such as fertilized hen embryos and monkey kidneys, that die quickly in culture. Using cancerous cell lines are also much cheaper than relying on the purchase of animals, especially monkeys, that need to be sacrificed for vaccine substrates.

Roberts records two separate meetings—a meeting of the Vaccine and Related Biological Products Advisory Committee on November 9, 1998, and a subsequent gathering of the Evolving Scientific and Regulatory Perspective Workshop less than a year later. The conversations were conducted at a scientific level between top officials and expert scientists from the FDA, Centers for Biologics Evaluation and Research (CBER), the National Institute of Allergies and Infectious Diseases (NIAID), the WHO and others, each providing evidence and/or confirmation that all vaccines are dangerously contaminated.

Conversations focused primarily on the influenza, MMR and yellow fever vaccines, which rely on fertilized chicken eggs for their culturing viruses. Fertilized chicken eggs, while ideally suited for culturing certain viruses for vaccines, such as the influenza and MMR vaccines, are also living incubators for large numbers of known and unknown viruses in the animal kingdom. While these do not transmit from their animal host to humans naturally, they nevertheless are sequential genetic codes, which when injected into the human body, have the potential for any number of unpredictable adverse effects by interfering or merging with the codes of human cells. Vaccine research is at best a primitive science because it is injecting into the blood stream foreign substances, chemical and genetic, that would otherwise not enter the body naturally. When we include into the equation the enormous amount of known and unknown genetic material and foreign proteins that vaccines introduce into the body, and then consider the rapid increase in epidemics raging across the American population—adult diabetes in children, large numbers of various inflammatory and immune deficiency diseases, asthma and new allergies, severe gastro-intestinal disorders (eg., leaky gut syndrome and Crohn's Disease), chronic fatigue syndrome, and many different neurological disorders (eg., autism, ADD and ADHD, Parkinson's, Alzheimer's, etc.)—we must step back and reconsider their causes. We should avoid the kind of faith the vaccine industrial complex has in its determinist, reductionist perspective of genetic materialism to find these answers without

taking into account the bombardment of toxic chemicals such as vaccine adjuvants and preservatives, extraneous genetic material, and pathogenic organisms and foreign genetic fragments that we assault our bodies from shortly after birth into old age.

For some time, it was known that the enzyme reverse transcriptase (RT) was present in final vaccine solutions. RT has been used to this day as an indicator that there is a presence of a retrovirus. During the meeting's proceedings, the WHO decided to withhold public announcement of such genetic contamination, in this case concerning the MMR vaccine, and made the decision to not remove it from the market and, in the meantime, continue safety studies at various laboratories.

Roberts reports that Dr. Arifa Khan from the FDA confirmed:

The RT activity in the vaccine was associated with retrovirus particles from two separate viral strains: Avian Leukosis Virus (ALV) and Equine Arteritis Virus (EAV). The former was especially disturbing because ALV is a leukemia cancer, and Dr. Khan stated: "There was a theoretical possibility that the virus [ALV] could... infect the [human] cell." In summary, this means the ALV genetic code could integrate with human DNA, hence causing some kind of cancer.

The FDA's reassurance that the ALV RT activity was safe is based on laboratory observations that there was no viral-human DNA merger activity for "a full 48 hours". This kind of assurance is almost nonsensical and flies in the face of scientific reasoning since cancers can take years to develop!

As a side note, reverse transcriptase activity is one of the stalwarts of the HIV/AIDS hypothesis. An article, "Serious Questions Regarding the Safety and Efficacy of the Influenza Vaccine" published by Canada's Vaccine Risk Awareness Network reports that some studies, and even some vaccine package inserts, "indicate that vaccinations increase HIV viral replication." This means all vaccines stimulate a strong suppressive effect on the immune system. Under stress conditions, viruses turn hyperactive and increase their ability to replicate.

The other risk stated by the FDA official was the possibility of the ALV sequence merging with the measles virus, hence creating a completely new, mutant and dangerous virus. (This could also apply equally to the H1N1 swine flu and any other flu vaccines). As an aside,

the world renowned British geneticist Dr. Mae-Wan Ho from the Institute of Science in Society wrote that, “Vaccines themselves can be dangerous, especially live, attenuated viral vaccines or the new recombinant nucleic acid vaccines, they have the potential to generate virulent viruses by recombination and the recombinant nucleic acids could cause autoimmune disease.”

During the meeting, Dr. Andrew Lewis, then head of the DNA Virus Laboratory in the Division of Viral Products confirmed that “All the egg-based vaccines are contaminated. . . . These fertilized chicken eggs are susceptible to a wide variety of viruses.” The participants also realized that only a very small fraction of these small contaminants have been identified and there are likely hundreds more to be discovered.

Roberts found a 2001 CDC report showing that RT investigative studies for both the ALV and EAV retroviruses were conducted in 100 patients receiving the MMR vaccine. They found undesirable “RT activity in all measles vaccine lots from different manufacturers tested.” Their conclusion is that “this occurrence is not sporadic and that vaccine recipients may be universally exposed to these [chicken] retroviral particles.” In a separate National Institutes of Health transcript of a meeting, Dr. Conroy of the World Health Organization stated that EAV viruses are found in all fertilized chicken eggs. There appears to be little change in the scientific protocol for making the influenza, MMR and yellow fever vaccines. The current release of intramuscular H1N1 vaccines for the global market relies on the use of fertilized chicken embryos. These include each of the approved vaccines by CSL, Medimmune, Novartis and Sanofi-Pasteur, as well as GlaxoSmithKlines if and when it is approved in the US.

A later meeting of the FDA’s Scientific and Regulatory Perspective Workshop, without the press, was convened on September 7, 1999 in Washington DC, and attended by “representatives from all the largest public health institutions in the West.” The following are summaries of key points and statements raised during this meeting as recorded in Janine Roberts invaluable book *Fear of the Invisible*.

It was reconfirmed that vaccines are “widely contaminated by viral and DNA genetic code fragments, many viruses and proteins. There was expressed concern that these may also contain prions (tiny proteins responsible for incurable diseases and neurological disorders in both humans and animals) and oncogenes (a gene that turns normal cells into cancerous ones). One attendee, Dr. Goldberg, stated, “There

are countless thousands of undiscovered viruses, proteins and similar particles. We have only identified a very small part of the microbial world—and we can only test for those we have identified. Thus the vaccine cultures could contain many unknown particles.”

Dr. Andrew Lewis of the FDA said that a brand-new monkey-human mutant virus was created during the course of creating an adenovirus vaccine with adenovirus-SV40 hybrid viruses. Dr. Lewis also worried that “foreign cellular DNA” common in childhood vaccines could include “viral oncogenes” capable of causing cancer.

The scientists presented a question to themselves as to whether or not an attenuated vaccine strain could revert into a variant virus capable of replicating so fast that it would cause AIDS. They agreed that they were unable to answer this question.

On the question whether or not mutation events could occur in children after vaccination, the answer was that “Recombination among a variety of viruses [contaminant viruses] and cells co-infected in tissue culture is not uncommon.” What this basically means is that because it is “not uncommon” for genetic codes of both contaminant viruses and living cells to recombine and create mutations in laboratory cultures, it can certainly occur in a child’s body after vaccination.

Dr. Hana Golding, Chief of CBER’s Laboratory of Retrovirus Research, raised the fear that although DNA fragment contaminants in vaccines may be thought to be dead, they could remain active and dangerous. This meant that the codes of these contaminants could combine in vaccines and create new mutant strains of pathogens.

Dr. Leonard Hayflick, a virologist at both Stanford and the University of California at San Francisco raised a concern that the common primary culture used for making vaccines with animals and bird embryos has created a situation where it is “apparent that these cells contained many unwanted viruses, some of which were lethal to humans.” This was especially worrisome of those vaccines, such as polio, which still rely on monkey kidney cells that have contributed to widespread death and illness.

One of the UK’s leading vaccine expert, Dr. Phil Minor from the National Institute

of Biological Standards and Control, noted that some cases of polio vaccine are polluted with more monkey virus, SV40, than actual poliovirus. Although the uninitiated who are not informed about closed door vaccine science have been led to assume that SV40 was no longer in polio vaccines at the time of this meeting, the conversations confirmed that it was still in use. This is another example of deception at high levels within the vaccine industrial complex and high government health officials to withhold information that directly impacts the health and well being of citizens.

Dr. Rebecca Sheets from the CBER's laboratory responsible for monitoring vaccine safety stated the national health organizations had no control over how vaccines were made. In short, they could make recommendations but the vaccine industrial complex was free to act as it chooses.

It is impossible to remove DNA contaminants from vaccines. Although weight limits for contaminating DNA were set by the FDA as far back as 1986, vaccine makers have never been able to reach that goal. The CDC decided to limit their weight recommendation to cancerous cell lines and then increase the other DNA contamination allowance one hundred-fold. However, these limits are only "recommendations" and, therefore, the FDA is unable to enforce them. Vaccine manufacturers continue to have the freedom to take scientific measures to reduce contaminants only if they wish.

Remember, this level of contamination (10 nanograms) only applies to a single vaccine. Children today are inoculated with many vaccines before entering school, each with unique DNA and viral contaminants due to the specific cell substrates used for a given vaccine. This toxic genetic soup is what then flows through a vaccinated person's body.

One government health official stated, "I chaired the committee that licensed the chickenpox vaccine, and it [residual DNA] was actually an issue that we considered at that time. We looked among recipients of the vaccine for evidence of an autoimmune response associated with the DNA included in that vaccine..... Actually, we didn't look, we asked the company to look and they did not find one." Well, of course, only such assurances can be convincing if in fact the company conducted the study, for which there was no compulsory reason to. Clearly, what the official is saying is that health authorities may not possess any study documents

that such a study actually exists.

Can vaccine DNA contamination cause cancer or autoimmune disease? A meeting participant responded, “when you consider that almost every one of these vaccines is injected right into the tissue... I think you couldn’t do much more to get the DNA expressed [to get contaminating DNA taken up by human cells] than to inject it into a muscle in the way it’s being done.”

Again CBER’s Dr. Rebecca Sheets: “I think that the vast majority of licensed vaccines, US licensed vaccines, have not been tested for residual DNA.”

A more frightening question was raised as to whether it was known if there has been any presence of foamy virus. Foamy virus (HFV in human form and its more widespread parent SFV from monkeys), although not infectious, is a deadly carcinogen. To the participants’ knowledge, they did not know whether any laboratory has ever searched for it in vaccine preparations.

The meeting confirmed that a particular cell, “which under many conditions is neoplastic [tumor causing]” has been licensed for the production of both injectible and oral polio vaccines in the US, Thailand, Belgium and France. Therefore, these vaccines carry the high risk of containing cancer-causing oncogenes.

In order to appreciate the magnitude of the contamination problem in vaccine products, it is important to understand that vaccine filtration needs to allow the targeted virus’s passage to remain for vaccine use. Other particles and pathogens—DNA and RNA fragments from other organisms (and pathogens) in the manufacturing process, cellular substrates, and viral proteins--smaller than the vaccine’s virus will remain in the vaccine.

What the content of these meetings tells us is best expressed by one of the leading attendants at the meeting, Dr. Minor stated, “So even today then you have to bear in mind that a large amount of vaccine that’s made is made on really quite crude materials, from an adventitious agent point of view. It’s not a trivial usage. In fact, when considering what vaccines are actually made on these days, they are quite primitive in some respects.” Janine Roberts summarizes her investigations succinctly,

“In other words, the vaccines we give our children are liquids filled with a host of unknown particles, most of which came from the cells of non-humans: from chickens, monkeys and even from cancer cells. Truly we do not know what we are doing or what are the long-term consequences. All that is known for sure is that vaccines are a very cheap form of public medicine often provided by governments to assure the public that they really do care for the safety of our children.”

The conclusion that can be drawn from these meetings convened by our national and international health officials in vaccine science and safety is that vaccines are virtually genetic experiments, capable of causing mass cellular destruction, being injected into the world’s population, especially children. There remain so many unanswered questions about vaccine science. This includes the forthcoming swine flu vaccines that will include the contaminants mentioned above, if we take any of these meeting attendees’ words to heart.

If we are to express any awe and wonder it should be towards our body’s natural immune system and its ability to defend itself from the onslaught of vaccine brews. It is not vaccination that is a miracle of science, as the vaccine industrial complex, government health authorities and their congregations of believers are too eager to proclaim. In fact, the real miracle is the body’s ability to protect itself, in most cases, from the invasion of vaccines. Yet, even this statement is now turning suspect given the dramatic rise in multiple illnesses and inflammatory conditions across the age spectrum.

As with all living systems, whether it be a natural habitat in the wild, the planet’s climate system to support life, or the body’s immune system, a tipping point is eventually reached. Today, with the majority of the public still buying into the false promises of vaccination’s efficacy and safety, the vaccine industrial complex remains an extraordinarily lucrative business. More and more vaccines are now being developed for a wide variety of diseases and infections— Chlamydia, herpes simplex type 2, West Nile virus, Epstein-Barr virus, and others—that will only add to the overload of vaccines already recommended, especially

to children who are officially recommended to receive 36 separate vaccinations by the time they reach 18 months of age. As these new genetic poisons are added to the national health agencies' recommended vaccination schedule, a tipping point may be reached that will result in a more serious pandemic, a pandemic of Vaccine Disease, manifesting in myriad illnesses dependent upon each vaccinated person's genetic predisposition and the robustness of the immune system, than any epidemic threat posed by wild infectious pathogens, including the H1N1 swine flu, that could unfold in our so-called developed, hygienic society.

ADJUVANTS, PRESERVATIVES AND REAGENTS

Thimerosal (Ethylmercury)

Thimerosal, the ethylmercury preservative commonly found in vaccines, is perhaps the most controversial ingredient. Although thimerosal has been removed or greatly reduced from most vaccines, it remains a major ingredient in flu vaccines. The pharmaceutical company Eli Lilly tested thimerosal back in 1930, giving it a clean record of safety even though its own trials had shown this highly toxic form of mercury had caused serious neurological damage and even death in both animals and humans. During that decade, a competitor vaccine maker, Pittman-Moore, had also conducted toxicological studies, but with dogs, on thimerosal and concluded the preservative was "unsatisfactory as a serum intended for use on dogs." "Eli Lilly Knew of Thimerosal Dangers for Decades" June 18, 2009. During the Second World War, vaccines with thimerosal were required to be labeled as "poison," and later in 1972, Eli Lilly itself discovered that thimerosal in doses a hundred times weaker than in a typical vaccine at that time, was "toxic to tissue cells." Nevertheless,

the drug maker continued to promote the illusion that thimerosal was safe and highly suitable as a vaccine preservative. Government health officials and vaccine manufacturers to this day have known of the long history of research confirming thimerosal as a toxic poison unsuitable for human delivery. A former leading vaccine developer for Merck had once warned his firm of the dangers of administering mercury-laced vaccines to newborns and infants and declared that the industry knows very well there are “nontoxic alternatives” that were equally effective and could be used to replace thimerosal.

Dr. Hugh Fudenburg, a leading immunologist and founding director of Neuro Immuno Therapeutic Research Foundation, is one of the most quoted immunogeneticists of our times, with over 850 papers in peer-reviewed publications. After years of immunological study, he discovered that individuals who had had five consecutive flu shots between 1970 and 1980, the chances of acquiring Alzheimer’s Disease were ten times or 1000% higher than those who had only one or two vaccinations during that same time period. “Flu Shots and Alzheimer’s Disease.”

There is plenty of independent scientific evidence that shows trace amounts of mercury causes a particular nerve damage reminiscent of that frequently found in Alzheimer’s patients. The University of Calgary Medical School identified an abnormal nerve formation, known as neurofibrillar tangles, which is one of the two primary diagnostic markers for verifying Alzheimer’s, in samples exposed to mercury. Other research shows that mercury is also one causative agent for the formation of the other Alzheimer marker “amyloid plaque.” Dr. Lorscheider of the International Academy of Oral Medicine and Technology has produced a film showing how the introduction of mercury into a living organism will induce these two critical markers for Alzheimer’s. The nationally renowned toxicologist Dr. Boyd Haley at the University of Kentucky has stated, “Seven of the characteristic markers that we look for to distinguish Alzheimer’s disease can be produced in normal brain tissues, or cultures of neurons, by the addition of extremely low levels of mercury.”

Certainly, parents want to protect their children from debilitating and life threatening viral infections, and many parents therefore hold faith in the protection vaccination claims to offer. However, one aspect of vaccination that has fueled considerable controversy is the

use of thimerosal (which is approximately 50% percent ethylmercury by weight) as a preservative. This substance was contained in vaccines for many decades before the U. S. Public Health Service and the American Academy of Pediatrics issued a statement in 1999 urging its removal. Although the PHS agencies and AAP said this step was being taken as a precautionary measure—not because the mercury in vaccines had caused harm—the fact remains that as more vaccines were being mandated for children, the cumulative level of mercury to which some infants were exposed through vaccination exceeded that deemed safe by a federal guideline.’

Thimerosal, or ethylmercury, is a manmade neurotoxin and up until 1999 it was simply assumed to have the same toxicological profile as methyl mercury. Since then, the toxic differences between these two mercury compounds have been found to be critical. Even a more conservative group of researchers at The Macfarlane Burnet Institute for Medical Research and Public Health in Australia, were compelled to conclude that “there is an increased sensitivity of the fetal brain to mercury whether it is ethyl or methyl mercury. While there is no evidence to support the contention, it is at least theoretically possible that very low birth weight premature infants may be at increased risk from thiomersal-containing vaccines.”

On July 9, 1999, the American Academy of Pediatrics (AAP) issued a statement urging removal of the mercury-containing preservative thimerosal from vaccines. Thimerosal has since been eliminated from or reduced to trace amounts in all of the vaccines routinely given to children age 6 and younger, reports the FDA. The only exception for this age group is the influenza vaccine, for which a limited supply of a preservative-free version was available in 2006. (Trace amounts of thimerosal may remain in some vaccines given to children because it is used in the manufacturing process, not from its use as a preservative). With the new vaccines (excluding influenza), the maximum cumulative amount of ethylmercury an infant would be exposed to in the first six months of life through routine vaccinations is now <3 mcg. This exposure is down from a maximum of 187.5 mcg previously.

The reason behind this strong recommendation for the removal of thimerosal is a growing concern about the risk of exposing the developing brains of infants to mercury. While the precaution is certainly welcomed, we should ask why such a dangerous, known neurotoxin was allowed into vaccines in the first place. As far back as the early 1930s, along with thimerosal's hazardous dangers to human health, its effectiveness as an antimicrobial preservative was being questioned by the scientific community. During congressional hearings in June 2002, Congressman Dan Burton pressed government health officials on the safety of mercury in vaccines. He uncovered that thimerosal has been used in vaccines since 1929 and only one study was known to have been performed on thimerosal's safety in all that time. That one test was done by thimerosal's inventor, Eli Lilly, and much of the tests results were concealed because of the pending approval of a vaccine by Lilly using thimerosal.

Mercury exposure has been associated with nerve cell degeneration, adverse behavioral effects and impaired brain development. It has also been linked to degenerative chronic conditions such as Alzheimer's disease. The developing fetal nervous system is the most sensitive to its toxic effects, and prenatal exposure to high doses of mercury has been shown to cause mental retardation and cerebral palsy.

At the center of the debate over the use of mercury in vaccines is whether this substance has contributed to an increased incidence of autism in the U.S. An analysis of VAERS found that mercury exposure from thimerosal-containing vaccines (TCVs) was a significant risk factor for neurodevelopmental disorders (NDs). Other research, as discussed by David Kirby in *Evidence of Harm*, has suggested an association between mercury in the body and autism.' ' ' However, a number of population studies have found that there is no association between TCVs and the incidence of autism spectrum disorders.' ' The Institute of Medicine determined in a 2004 report that "the body of epidemiological evidence favors rejection of a causal relationship" between TCVs and autism and between the MMR vaccine, in particular, and autism.

Concerns about the safety of mercury in vaccines continue. In 2006, Washington State passed a law banning the use of thimerosal in vaccines given to young children and

pregnant women. This law made Washington the seventh state—after Iowa, California, Delaware, Illinois, Missouri, and New York—to limit the use of mercury in vaccines.

More than a dozen other states have introduced similar legislation.

A continuing concern is the use of thimerosal in vaccines that may be given to children age 7 and older (such as some flu and tetanus-diphtheria vaccines) and to adults who are elderly or immune compromised. The CDC recommended in 2004 that children 6-23 months of age receive the flu vaccine each year, and in 2003 it approved the “first live attenuated influenza vaccine licensed for 5-49 year old persons.” As late as the 2004-2005 flu season, however, two types of influenza vaccines were still on the market: some contained thimerosal as a preservative and some were preservative-free. The CDC said then that the amount of preservative-free flu vaccine would continue to increase as the capabilities of manufacturers grew. However, one wonders how many children are still suffering the effects of mercury-toxic injections from past flu seasons.

The FDA, for its part, says that with the maximum cumulative exposure to mercury for children under 6 months reduced to less than 3 mcg, “an infant could receive a thimerosal-containing influenza vaccine at 6 and 7 months of age.” The FDA reasons that the maximum exposure from routine vaccinations would be 28 mcg, which is “well below the EPA calculated exposure guideline for methylmercury of 65 micrograms for a child in the 5th percentile body weight during the first 6 months of life.”

The Vaccine-Autism Coverup

What you are about to read are some of the exact words by high level pro-vaccine officials in the government health agencies, their academic medical advisors and leading representatives in the vaccine industrial complex. These are the people who shape the propaganda about vaccine safety. Essentially they to assure us there is no relationship between mercury in vaccines and the epidemic rise in autism. The words are from a transcript of the now infamous secret meeting held by high level officials and scientists from the CDC, FDA, World Health Organization and representatives of every major

vaccine manufacturer, including GlaxoSmithKline, Merck, Wyeth and Aventis. This private meeting was held at a Christian retreat center in Simpsonwood, Georgia, during June of 2000. Thanks to the diligent efforts of Robert Kennedy Jr. and his filing a Freedom of Information Act, the 262 page official transcript of the gathering has been removed from obscurity and can be read on the Internet at HYPERLINK "http://www.autismhelpforyou.com" www.autismhelpforyou.com. Some of the more important statements made during this meeting have been highlighted by Robert Kennedy, Jr. with an excellent commentary in a 2005 Salon.com article, "Deadly Immunity," which we rely on here.

The closed Simpsonwood meeting was urgently called to address the results of an alarming CDC control study. CDC epidemiologist, Dr. Tom Verstraeten, after analyzing medical records of 100,000 children, noted the preservative thimerosal commonly used in vaccines, and which are listed as an ingredient in all the new intramuscular swine flu vaccines, was the very likely culprit for the large increase Autistic Spectrum Disorders—which include ADD, ADHD, speech problems, etc.—and neurological conditions being witnessed in vaccinated children. He stated, "I was actually stunned at what I saw." A top consultant for the American Academy of Pediatrics, Dr. Bill Weil, told the assembly, "you can play with this all you want... [the results] are statistically significant." Dr. Richard Johnston, a pro-vaccine immunologist and pediatrician from the University Colorado excused himself early from the gathering after stating, "Forgive my personal comment—I do not want my grandson to get a thimerosal-containing vaccine until we know better what is going on."

But, much of the meeting's discussion dealt with how the parties might cover up the CDC study's findings in order to avoid what Dr. Robert Brent, a leading pediatrician at Alfred DuPont Hospital for Children in Delaware, called a "bad position from the standpoint of defending lawsuits." Dr. John Clements, vaccine advisor for the World Health Organization stated the research "should not have been done at all.... [the study] will be taken by others and will be used in ways beyond the control of this group." Let us remember, these are the voices of the same expert scientists and the leading pro-vaccine spokespersons who for years denied publicly any relationship between immunization and childhood neurological disorders. These are also the guiding voices behind the very same CDC and professional medical association websites where we are directed to visit repeatedly to learn about vaccine safety and all the wonderful miracles it has to offer us.

The rest of this story is well documented and deals with how the CDC made attempts to hide the study by depositing the evidence of the meeting with a private firm and then whitewashing thimerosal's health dangers with subjectively re-designed studies published in subsequent years and released for dissemination through national health agencies and professional medical associations for pediatricians to follow obediently.

Something vaccine administering health practitioners and doctors are unaware of is that many people are hypersensitive to ethylmercury in vaccines, and result in allergic outbreaks and asthma. This was discovered during the course of research undertaken by the WHO's Initiative for Vaccine Research. Separate research reported by the same group found the same true for aluminum adjuvant and resulted in persistent adverse symptoms repeatedly after vaccinations. How many of people do you know who have been tested to determine whether or not they are allergic to either ethylmercury or aluminum?

In February 9, 2004, fifteen research scientists and medical doctors presented their findings on whether or not there is a direct relationship between vaccines and autistic spectrum disorder to the Immunizations Safety Review Committee of the Institute of Medicine of the National Academies. A review of the transcript and summaries of the meeting showed that:

60% (9) individuals felt there was a link to autism. None of these persons had conflict of interests with the private vaccine and/or health industries

26% (4) felt there was not a connection. All of these individuals had connections.

14% (2) were noncommitted and both an uncertain relationships to private industry.

Evidence for the Thimerosal-Autism Connection: The Research of the Geier's

During the past 5 years, Dr. David Geier and his son Mark Geier at the Institute of Chronic Illnesses in Silver Springs, Maryland, have been conducting the most thorough epidemiological and toxicological studies on the possible relationship between thimerosal or ethylmercury used in vaccines and the high incidence of neurological impairment in vaccinated children. In fact the Geiers were the first in the US to conduct and publish such epidemiological studies to map the trends vaccinations with and without thimerosal and the rates of autism spectrum disorders (ASD). The Geiers were originally skeptical that there was any relationship between thimerosal and ASD; however, the on-going studies convinced them otherwise. For the Geiers, the continual use of thimerosal is a "medical crisis" and, therefore, a separate section devoted to their research is warranted.

Although the Geiers do not rule out genetic factors associated with pathogenetic developments in ASD, their research convincingly shows that "mercury exposure can

induce immune, sensory, neurological, motor, and behavioral dysfunctions similar to traits defining or associated with ASDs.” Not only do their studies focus on the effects of thimerosal during the vaccination regimen of children but also mercury’s neurological effects during the neonatal period of an infant’s development. While the vast majority of attention to thimerosal is placed on its use as a preservative in vaccines, the compound is also used in other products such as nasal sprays, eye solutions, and other injectable biological products, including Rho(D)-immune globulin which is given to pregnant Rh negative women.

Beginning in 2003, the Geiers noted that the rapid increase in autism in the US, from 1 in approximately 2,500 in the mid-1980s to 1 in approximately 300 children in the mid-1990s (as of 2007, the ratio is now estimated at 1 in approximately 150) could correspond to the rise in the number of childhood vaccinations before the age of 2 years. The researchers stated that “the evidence presented here shows that the occurrence of neurodevelopmental disorders following thimerosal-containing childhood vaccines does not appear to be coincidental.” A subsequent study published the same year compared adverse neurodevelopment reports with the diphtheria, tetanus, acellular pertussis (DTaP) vaccine—those containing thimerosal and those that were thimerosal-free. Their research was based on the review of tens of millions vaccines administered in the U.S.

In 2004, they performed a similar study but looked at the measles, mumps and rubella (MMR) vaccine and ASD trends. Their results corroborated with their earlier DTaP investigation that “there is biological plausibility and epidemiological evidence showing a direct relationship between increasing doses of mercury from thimerosal-containing vaccines and neurodevelopmental disorders.” More startling for the Geiers was an additional potential relationship between the MMR vaccine itself and ASD. This convinced them in their study’s conclusions that “thimerosal be removed from all vaccines and additional research be undertaken to improve the MMR vaccine with an improved safety profile.”

In 2006, the Geiers performed the first major epidemiological study, an “ecological study” to assess the trends in certain reported neurological disorders—autism, mental retardation and speech disorders—in the Vaccine Event Reporting System (VAERS) between the years 1991 and 2004. This was a follow up of several earlier epidemiological studies. The

latter years of this timeline correspond to when thimerosal was removed from vaccines. It found “significant reductions in the proportion of NDs reported to VAERS as thimerosal was begun to be removed from childhood vaccines in the US from mid-1999 onwards.”

One of the Geiers more recent studies, sponsored by the Office for Human Research Protections, U.S. Department of Health and Human Services, screened a group of autistic children with only known exposure to mercury via vaccine thimerosal. Eight of the nine patients screened—each who was developing normally prior to the manifestation of encephalopathic traits—were exposed to significantly higher mercury levels from Thimerosal-containing biologic/vaccine preparations during their fetal/infant developmental periods, and subsequently, between 12 and 24 months of age. The follow adverse effects were common to each of the children under investigation.:

had regressive ASDs ;

had elevated levels of androgens;

excreted significant amounts of mercury post chelation challenge;

had biochemical evidence of decreased function in their glutathione pathways;

had no known significant mercury exposure except from Thimerosal-containing vaccines/ Rho(D)-immune globulin preparations;

had alternate causes for their regressive ASDs ruled out.

Their conclusions are that thimerosal intoxication should be considered as a component in the diagnosis of some regressive ASDs.

Many pregnant women are administered an injection of Rho(D) immuno globulins, better known as TCRs, containing thimerosal. Drs. David and Mark Geier conducted a race-matched controlled study of Rh negative women who received TCRs, the toxicity levels and effects of mercury on neonatal development, and the rate of autism in children. The results showed that autistic children were significantly more likely to have Rh-negative

mothers than those in the control group, and that each ASD child's mother was determined to have been administered a TCR with thimerosal during her pregnancy. The implications of the study seem to indicate that unborn children exposed to mercury by their mothers having received drugs and/or vaccines containing thimerosal might contribute to later neurological impairment.

Squalene

This paper stands by the opinion expressed by Dr. Joseph Mercola, a physician and health activist, who explains, "There can be no argument that unnecessary mass injection of millions of children with a vaccine containing an adjuvant known to cause a host of debilitating autoimmune diseases is a reckless, dangerous plan." Dr. Mercola is referencing the documented adverse side effects of the adjuvant known as squalene.

The dangers of squalene have been known since its inventor Dr. Jules Freund warned back in 1956 that it was responsible for incurable conditions: experimental allergic encephalomyelitis, allergic neuritis, allergic aspermatogenesis, and other autoimmune diseases.

Squalene is not listed in any of the package inserts for any of the swine flu vaccines approved for use in the United States. Health officials are stating the vaccines are non-adjuvanted. An unconfirmed report shared with us by a physician and international vaccine expert says there is now information that squalene will not be listed as an ingredient in the recently approved H1N1 flu vaccines to be administered in the US. Of course, in Canada and Europe, squalene is approved; therefore, it will be in their vaccines and listed accordingly on the package labels. However, this unconfirmed report claims there are plans to distribute squalene separately, to those health professionals, hospitals and agencies that will be administering the vaccine. There will be instructions for mixing the squalene in the vaccine vials that will now be larger in size. Government health officials have in fact ordered millions of dollars of shark oil, which is the primary source for manufacturing squalene. The question arises as to what possible purpose can such large amounts be ordered if our health officials are on record saying the vaccine will not contain an adjuvant?

The prestigious Cochrane Collaboration, an independent medical research group without any affiliations with private drug makers, reviews drug research and develops concise objective reports on drug and vaccine efficacy and safety. Cochrane's coordinator of vaccines, Dr. Thomas Jefferson, stated that "New vaccines never behave in the way you expect them to do... But it could end up being anything because one of the additives in one of the vaccines is a substance called squalene, and none of the studies [from the drug makers] we've extracted have any research on it at all." In summary, the new swine flu vaccines will have a potentially disease-threatening ingredient. What squalene research, independent of the pharmaceutical industry, has been performed to determine its adverse effects?

There is a growing consensus among doctors, researchers, health agencies and independent medical laboratories that flu vaccines are largely ineffective in protecting people from infection.

Squalene is a precursory biomolecule to cholesterol that directly stimulates the body's immune system. It is now known that the pandemic H1N1 vaccines now being manufactured by six pharmaceutical companies will contain one of two squalene adjuvant formulas: AS04 (GlaxoSmithKline) or MS59 (Novartis). In May 2009, the government HHS contracted the production of these two squalene formulas, at a cost of \$283 million, in an effort for rapid readiness for launching a national swine flu vaccination campaign.

The Karolinska Institute has been conducting clinical studies on the safety of injectable squalene adjuvant oil since 2000 and has documented repeatedly its association with adverse immunological responses contributing to T-cell mediated induced arthritic conditions. It has been proven to give rise to pathogenic cells developed within the lymphatic system.

The introduction of squalene oil, first, provokes a burst of pro-inflammatory arthritogenic cells in the lymphoid organs and, second, transmits arthritogenicity to other lymph nodes that in turn precipitate disease in peripheral joints.

Histopathological analyses have also shown that rats injected with the adjuvant oil quickly showed signs of bone and cartilage erosion, indicative of polyarthritic diseases.

Yet such a relationship between such oil-based adjuvants and polyarthritis and their adverse interaction with the lymph system was known back during the mid-1960s in veterinary research and with further confirmatory data produced in the 1980s.

According to investigative journalist Gary Matsumoto, there is a “close match between the squalene-induced diseases in animals and those observed in humans injected with this oil: rheumatoid arthritis, multiple sclerosis, and systemic lupus erythematosus. Matsumoto writes, “There are now data in more than two dozen peer-reviewed scientific papers, from ten different laboratories in the US, Europe, Asia and Australia, documenting that squalene-based adjuvants can induce autoimmune diseases in animals.” One example, was UCLA Medical Center’s study back in the 1970s to find oils that induced autoimmune disease. “Rats injected with... squalene all developed experimental allergic encephalomyelitis... The injected animals were left hobbled, dragging their paralyzed hindquarters through the wood chips of their cages.

Sweden’s Karolinska Institute has demonstrated that squalene alone can induce the animal version of rheumatoid arthritis. The Polish Academy Sciences has shown that in animals, squalene alone can produce catastrophic injury to the nervous system and the brain. The University of Florida Medical School has shown that in animals, squalene alone can induce production of antibodies specifically associated with systemic lupus erythematosus.”

A Tulane University Medical School study published in Experimental Molecular Pathology concluded its findings on the incidence of Gulf War Syndrome related to antibodies to squalene: “The substantial majority (95%) of overly 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.”

It can take many months and years for the adverse immunological effects of squalene to appear. Irresponsible clinical trials for vaccine safety lasting several weeks are unable to evaluate the long-term effects of squalene poisoning. An article appearing in the German

magazine *Der Spiegel* suggests that the mass vaccination on Europeans with squalene adjuvant vaccines is nothing more than a free experiment being provided to the FDA before the US approves squalene for the vaccine industrial complex.

International vaccine expert and historian Dr. Vera Scheibner lists the following diseases and conditions having been associated with squalene: arthritis, fibromyalgia, lymphadenopathy, chronic fatigue, abnormal body hair loss, non-healing skin lesions, aphthous ulcers, memory loss, seizures, neuropsychiatric problems, anti-thyroid effects, anaemia, elevated erythrocyte sedimentation rate, systemic lupus erythematosus, multiple sclerosis, ALS, Raynaud's phenomenon and Sjorgren's syndrome.

The biotechnology firm Chiron Corporation first developed squalene adjuvant, known as MS59. Before being purchased by the multinational pharmaceutical company Novartis, Chiron was a leading vaccine research and development firm. Novartis is currently in the forefront among the drug manufacturers preparing the release of a swine flu vaccine, which will include squalene as an adjuvant. The company announced as early as June 12 their preparedness to release its first batch of H1N1 vaccine in early fall. A review of the studies contradicting squalene's health risks, in addition to negating the body's immunological response against squalene, reveal that Novartis Vaccines has been a major source behind this research with the specific goal of trying to extend its safety profile for use in its vaccine development.

Aluminum

Aluminum salts are the most common adjuvants used in vaccines. These salts increased in use after federal legislation required the removal or reduction of thimerosal from vaccines. However, after 2007, aluminum has no longer been used in flu vaccines in developed countries for the simple reason it has very little effect in boosting immunity. Instead, vaccine manufacturers, notably Novartis and GlaxoSmithKline, have been relying on their proprietary squalene preparations, MS59 and AS03 respectively. Both companies remain adamant that their squalene adjuvants are safe.

Although aluminum will not be found in the forthcoming flu vaccines, in addressing the issue of negligent science in conducting clinical safety trials and corruption within the vaccine

industrial complex, we should look at the recent controversy over Merck's Gardasil vaccine for the HPV virus. Gardasil includes a reactive form of aluminum as an adjuvant.

The CDC's National Vaccine Information Center in June 2006 came out with a statement against the "universal use" of Merck's Gardasil for all pre-adolescent girls. According to NVIC's president, Barbara Loe Fisher, "Merck's pre and post-licensure marketing strategy has positioned mass use of this vaccine by pre-teens as a morality play in order to avoid talking about the flawed science they used to get it licensed." Review of the trial studies notes that the FDA "allowed Merck to use a potentially reactive aluminum containing placebo as a control for most trial participants, rather than a non-reactive saline solution placebo. A reactive placebo can artificially increase the appearance of safety of an experimental drug or vaccine in a clinical trial. Nearly 90 percent of Gardasil recipients and 85 percent of aluminum placebo recipients followed up for safety reported one or more adverse events within 15 days of vaccination. The NVIC believes the clinical trial investigators dismissed even the 17 deaths that may have been caused by the vaccine. Through a Freedom of Information request by Judicial Watch, a public interest group investigating government corruption, information was gained showing that there were 3 deaths early on, including one report of a woman who "died of a blood clot three hours after getting the Gardasil vaccine." Two others died of heart problems and/or blood clotting.

Aluminum compounds, most commonly aluminum hydroxide, have been used as adjuvants in vaccines for eighty years.

Very recent studies conducted by neuroscientist Dr. Chris Shaw at the University of British Columbia are showing a link between the vaccine adjuvant aluminum hydroxide and symptoms "associated with Parkinson's, amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease) and Alzheimer's. Shaw's study, conducted in mice, used the same anthrax vaccine used during the first Gulf War and which has been proven to cause Gulf War Syndrome in approximately 25 percent of 697,000 military personnel who were vaccinated. Why Shaw believes his study was different than others is that the symptoms appeared around five months after immunization. As we have seen above, the typical vaccine trial conducted by vaccine makers lasts only 2-3 weeks. His team also observed notable memory loss 41 times higher than in the control group. According to Shaw, there are thousands of studies showing aluminum hydroxide is a safe vaccine adjuvant, but none

of those studies look beyond the first several weeks after injection for serious side effects.

In addition to squalene, aluminum was also used as an adjuvant in the anthrax vaccine during the first Gulf War. Mouse studies the same vaccine as given to military personnel noted increased incidences of amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) and other neurological conditions. There was noticeable cognitive deficits and motor neuron loss due to apoptosis. The research however was unable to conclude that these detrimental effects were due to aluminum alone or in combination with squalene, which was also among the vaccine's ingredients. Petrik M, Wong M, Tabata R, Garry R, Shaw C. "Aluminum adjuvant linked to gulf war illness induces motor neuron death in mice." *J Neuro Molecular Med.* 2007, February. 9(1)

Some of the research to discover aluminum-adjuvanted vaccines toxic levels and their adverse effects have found the following:

Aluminum inflicts strong neurotoxicity on primary neurons.

Aluminum-laced vaccines increase the aluminum levels in murine brain tissue leading to neurotoxicity.

Aluminum hydroxide, the most common form of adjuvant used in vaccines deposits mostly in the kidney, liver and brain.

Long term exposure to vaccine-derived aluminum hydroxide (which is today an ingredient in almost all vaccines) results in macrophagic myofastitis lesions.

Although alum and aluminum hydroxide remain highly toxic adjuvants, geneticist Dr. Mae-Wan Ho that "numerous new adjuvants are no better, and could be worse." In a recent article published in a pharmaceutical magazine, BioPharm International, newer adjuvants, including all the squalene formulas, have "substantially higher local reactogenicity and systemic toxicity than alum."

Formaldehyde

Formaldehyde is used in some vaccines, including the flu, polio and DTaP shots, because it is believed to eliminate harmful effects of toxins used in the vaccine and to prevent the viral component from replicating and causing infection.

Formaldehyde is also a classified human carcinogen and is frequently listed as an ingredient in manufacturer's vaccine packaging, including several flu vaccines. During the preparation process to inactivate a virus, formaldehyde is commonly used. Formaldehyde has been suspected of being a human carcinogen since the early 1980s, but it was not until 2004 that the International Agency for Research on Cancer officially classified the chemical as a carcinogen, responsible for nasopharyngeal, hematopoietic and lymphatic (leukemia) cancers. Although the studies to establish formaldehyde's relationship to cancer were conducted among those who were frequently exposed to the chemical via inhalation, the molecule is known to be moderately unstable once in the physical body and can therefore contribute to more serious systemic cancers, such as myeloid leukemia. Therefore, the thought of injecting formaldehyde into the body's bloodstream, especially in small children, should be unthinkable to any rational person.

Among some of the more serious ingredients in common flu vaccines are:

Thimerosal: Afluria (CSL Biotherapies)

Fluraix and FluLaval (GlaxoSmithKline)

Fluviral (Shire)

Fluvirin (Novartis/Chiron)

Fluzone (Aventis Pasteur)

Vaxigrip (Sanofi Pasteur)

Formaldehyde: Begrivac (Wyeth)

Fluarix and FluLaval (GlaxoSmithKline)

Fluviral (Shire), Fluzone (Aventis Pasteur)

Influvac (Solvay), Vaxigrip (Sanofi Pasteur)

Chick protein: Afluria (CSL Biotherapies)

Begrivac (Wyeth), Enzira (CSL)

Flurarix and FluLaval (GlaxoSmithKline)

Fluviral (Shire), Fluvirin (Novartis/Chiron)

Fluzone (Aventis Pasteur)

Inflexal (Sanofi Pasteur)

Influvac and Mastaflu (Solvay)

Squalene: Flud (Novartis/Chiron)

Focetria (Novartis)

Latex: Fluraix (GlaxoSmithKline)

Fluzone and Mutagrip (Aventis Pasteur)

Gelatin: Fluzone (Aventis Pasteur)

Hydrocortisone: Fluraix (GlaxoSmithKline)

MSG: FluMist-nasal (Medimmune)

Dog Kidney Cells: Optaflu (Novartis)

CONCLUSIONS

So what have we learned? To our surprise we are outraged that we have been lied to repeatedly. We believe the sacred halls of science have been co-opted and corrupted by the pharmaceutical and vaccine industry and their search for ever-increasing proprietary money-making drugs. Let us be clear, vaccines are medicines. They are drugs. That is, many of the scientists promoting them have financial interests, and therefore, a bias. At worst, they are dishonest. We are also now aware that dozens of, hitherto, respected pharmaceutical companies do not deserve our respect, because they have been found guilty of falsifying drug trial results, price fixing, providing financial inducement to researchers and physicians, and lining the politicians pockets with consultants, lobbyists and foundations, all of who ultimately influence the CDC's scheduling of vaccines for children and adults.

We have also learned that what we call vaccine science does not exist. The biggest disappointment is that this truth was in front of us all along. All it would have required was an awareness that if a company had lied to us repeated in the past about the safety and efficacy of its drugs, why should we suspend all critical judgment and assume they would be honest all of a sudden about vaccines. Pharmaceutical companies have spent hundreds of billions of dollars settling lawsuits. Their drugs have killed hundreds of thousands of innocent Americans over the decades. Can you imagine that one drug, Vioxx, killed 53,000 people and caused over 100,000 strokes and heart attacks, and still the company gets a bonus? We have learned that real medical and scientific researchers and investigators, who did their homework and who were not influenced by special interests groups or any political and economic pressure, can find no long term double-blind placebo studies having been conducted to legitimize claims that vaccines are effective and safe. On the contrary, they found numerous studies that for fully vaccinated individuals coming down with the very disease for which they were vaccinated. They also showed that thousands of individuals have received compensation from the federal government due to vaccines. In addition, they have showed that the FDA, CDC and the HHS were fully aware that there were connections between vaccines and illnesses; but, they chose to either downplay it or cover it up, which supports the notion that there is a conspiracy between governmental health agencies and the vaccine industrial complex.

We believe we have also discovered that brave, courageous scientists, physicians, journalists and citizens, who have found the truth about vaccines, have been slandered, libeled and attacked for their truths. Recently an American Senator said the banks on Wall Street own Congress. Truthfully, he could have added the pharmaceutical industry as well. We must now begin an honest, open and scientific effort to prove what really protects the body from pathogens and what actually weakens it and makes it more susceptible to disease and illness. We should surrender the paradigm that vaccination represents immunization and protection when no sound objective science proves that to be the case. To the contrary we now have hundreds of thousands of children with Autistic Spectrum Disorders and a sound science to show that single and multiple vaccines, with their adjuvants and preservatives are clearly suspect. Yet, the vaccine industrial complex continues to deny it.

Across the country, lobbyists representing private vaccine manufacturers have been selling the story that the government must make certain vaccines mandatory with no exceptions. And it should be noted, if there should be a big mistake and thousands or millions of people should become seriously injured or die, everyone in the vaccine industrial complex, should be indemnified.

Several years ago, during production of my first three award-winning documentaries on Gulf War Syndrome, it was surprising to interview so many soldiers who said they suffered from Gulf War Syndrome—with real serious physical and neurological illnesses—who never fought overseas during the war. They did not have Post Traumatic Stress Disorder, which is a frequent result of combat; but, they all had something else in common. They had all been given multiple vaccines, including the anthrax and botulism, which contained the adjuvant squalene. Many were too sick after receiving the vaccine to deploy overseas. Yet for eighteen years, all of the several 100,000s of veterans who are sick with Gulf War Syndrome have been denied the truth of what actually caused their debilitating illnesses.

Further, we have also learned that very few cases of adverse effects have been recorded by the federal authorities that are at least available to independent scientists, researchers and journalists. Consequently, there is no actual number as to the true number of people who have been injured or died from vaccines.

In conclusion, we should ask for national public debates between those who advocate for vaccines and those who challenge them. We believe it is imperative to have this dialogue so we can enable the public to decide for themselves as to whether or not they approve of the new experimental H1N1 vaccine, and all vaccines collectively. Then let the public decide. In a real democracy, an informed patient should have freedom of choice in health decisions. Today, there is no honest debate, no informed consent, no real science, no transparency of vaccine research, and no accurate statistics. Instead, we have federal health agencies, such as the CDC, on its own website, making false claims by misinterpreting pneumonia as influenza. Obviously, this is surely not the case. Finally, it is worse that the power of federal and state governments are being used to mandate the enforcement of a scientifically unproven vaccine, namely the H1N1 swine flu vaccine, in a totalitarian manner upon its citizens. This is not democracy, this is medical tyranny.

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APPENDIX

NANOMEDICINE: Vaccines for the Twenty-first Century

Adjuvants such as aluminum hydroxide and squalene are antigen specific; that is, their strength is not uniform and are either weaker or stronger depending on the specific viral antigen being used. The new science of nanomedicine claims to show promise in developing a new kind of adjuvant that is far more effective, and believed to be more safe, than conventional adjuvants. According to independent scholar and investigator F. William Engdahl in Germany, “Vaccines which have been approved by the responsible government authorities for vaccination against the H1N1 Influenza A Swine Flu have been found to contain nano particles.” The governments in question are “Germany and other European countries.”

Nanomedical researchers are touting these new micromolecules as “smart adjuvants.” Nanoparticles are exceedingly tiny, one nano-size (nm) equals one millionth of a meter. They do not degrade until they are in the body and, therefore, do not require any preservatives for maintaining shelf life. The nanoindustry claims that nanoparticles are non-toxic and far less costly to develop than adjuvants and preservatives currently in vaccine use today.

Due to their minute size, they easily fuse with the membranes of a cell and can be designed to target some of the body’s most essential specialized immune cells known as dendritic cells. Nanoparticles are believed to induce “protective immunity at mucosal surfaces while avoiding destructive inflammation.” Current common adjuvants trigger a different immune response and do not stimulate cell-mediated immune responses within mucosal tissue. Briefly, a nanoparticle—an otherwise natural particle of a biochemical—is artificially engineered at the micro-structural level. In some instances, which is showing promise in nanomedicine, is to engineer a hollow cavity, called a vault, in the particle in order to house a specific viral antigenic protein(s). Given the extraordinary micro-size of these particles, they are easily absorbed by the cells being targeted.

Nanotechnology and nanomedicine are very new sciences and still in their infancy. Nanomedicine today is comparable to the very early stages of gene-technology in the early

90s. While gene-technology for creating a new generation of state-of-the-art drugs based on DNA science held great promise at the beginning, it was at that time so new that researchers were journeying through uncharted waters.

In a press release in August 2009, BioSante Pharmaceuticals announced they had developed an H1N1 flu vaccine that provided 100 percent protection after a single injection. Rather than relying on older adjuvants, it includes a nanoparticle of calcium phosphate to quicken and enhance the body's immune response. What a reader of the nano-adjuvant discovery press reports will find quite revealing is that, although the FDA, CDC, and major vaccine manufacturers remain adamant about aluminum adjuvant safety, developers of nanoparticles are quick to point out aluminum's serious long term dangers in order to increase the value nanomedicine's potential for new drug and vaccine delivery systems.

Nanoparticles have been explored as new adjuvants for several years. Scientists at Roswell Park Cancer Institute and the Pharmaceutical Research Institute at Albany College of Pharmacy developed a lactide-co-glycolide nanoparticle for delivering the Hepatitis B vaccine. In 2007, researchers at EPFL in Lausanne, Switzerland reported that they developed and patented a nanoparticle adjuvant for hepatitis and malaria. Although there has yet to be developed a suitable vaccine to combat *Chlamydia trachomatis*, a common sexually transmitted bacterial agent, scientists at California NanoSystems Institute at UCLA are showing promise in a new novel nano-adjuvant vaccine. Nanoparticles are also being researched and used in vaccines for anthrax and tetanus. Oregon State University has now developed a nano-adjuvant out of lecithin, the common food product and a major phytochemical found in eggs and many plants such as soy, that creates an immune response six-fold stronger than conventional adjuvants in vaccines against hepatitis B and tetanus.

It is very predictable that conventional adjuvants will phase out within the next several years and be replaced by nanoparticles. The National Institutes of Health Roadmap's Nanomedicine Initiative is heading full steam without a pilot to develop nanotechnology for "highly specific medical intervention at the molecular scale for curing disease or repairing damaged tissues, such as bone, muscle or nerve. The US National Cancer Institute is investing hundreds of millions of dollars into the private sector for nanomedical research. The US National Nanotechnology Initiative has already provided more than \$200 million for the NIH to advance the race against European countries and Japan, which are also

heavily invested in this high tech field. What is particularly disturbing after a review of the NIH's ten-year roadmap for nanomedicine is no mention at all on safety studies on human health and its potential contributing factors for disease. Instead, the entire initiative is being steered towards greater knowledge about nanoparticle discovery, their structures, how they can be manipulated and their commercial value for drug development.

Nanotechnology has been used in chemical material development and products longer than for medicine. Although very few health-risk studies have been conducted compared to the rapid increase of commercial products now containing nanoparticles and nanotubes, there is very clear reason to be alarmed. To just take one example, nanotubes, discovered in 1991 and found in many products, have been found to produce lesions in the lungs very similar to asbestos' resulting in mesothelioma, a deadly cancer.

One form of nanoparticle known as quantum dots are used in imaging technology for diagnosing diseases at even the sub-cellular level and have been used well before the development of nano-adjuvants. However, quantum dots have been shown to be highly toxic. We now hear of the development of peptide amphiphiles, magnetic nanoparticles, enzyme-sensitive nanoparticle coatings, and smart nanoparticle probes that are showing promise to replace some of our most dangerous drugs, even chemotherapy.

Even with these seemingly very positive advancements, there is very little experimental data to confirm nanoparticles' safety. Reporter Cathy Garber states, "The lack of knowledge about nanoparticles might affect or interfere with the biochemical pathways and processes of the human body is particularly troublesome." Europe, which is more aware of environmental health, has been more proactive than the United States in addressing the problem of nanotoxicity by including nanotechnology in its International Risk Governance Council. An article published in the *Medical Journal of Australia* raises a crucial question about how to classify such particles in the regulatory requirements of government health and environmental agencies. Given their recent novelty, and the lack of experience and research on nanotechnology's and nanomedicine's affects on human health and the environment, there remains no risk assessment protocol for agencies and manufacturers to follow. Yet, as of the middle of 2007, 130 nanotech-based drugs and delivery systems and 125 diagnostic devices and tests have entered pre-clinical, clinical or commercial development in just 2.5 years. Gunter Oberdorster, professor of Toxicology and

Environmental Medicine at the University of Rochester warns, “There is a lot of hype surrounding the promises of nanomedicine. Indeed many things look promising, but until now there are only animal studies to show a proof of principle.” Prof. Oberdorster also raises another fundamental concern being that there are no studies to show what might be nanomedicine’s toxicological risks to the environment due to the disposal of nanowaste.

In the September 2009 issue of the peer-reviewed *European Respiratory Journal*, scientific investigators at the prestigious Beijing Chaoyang Hospital seven women with exposure to polyacrylate nanoparticles concluded the particles induced nonspecific pulmonary inflammation, pulmonary fibrosis and foreign-body granulomas of pleuras. Upon inspection with electron microscopy, nanoparticles were observed lodged in the cytoplasm and caryoplasm of pulmonary epithelial and mesothelial cells.

In 2005, scientists at the University of Michigan discovered that certain nanoparticles, known as dendrimers, damaged cell membranes. In some instances the damage was severe enough to cause cell death. Dendrimers are minute spheres with a width ten thousand times smaller than the thickness of a human hair. These almost incomprehensibly small particles are now being explored as a potential delivery system to more accurately bring drugs to specific cell targets in the body. The Michigan researchers found that in high enough concentrations, these nanoparticles punctured holes in cell membranes, thereby destroying them, and hence the cells as well. In separate studies at the same institution, a different nanoparticle, polycationic polymers that are electrically charged—already used in drug and gene delivery—resulted in similar findings.

In a later 2007 study conducted at the University of Massachusetts, an undergraduate student, Sara Pacheco, first uncovered a link between nanoparticles and DNA damage and cancer. Her teams studies looked at two common nanoparticles found in electronic equipment, textiles and sporting goods—silica and C60 fullerene—and their role in the onset of breast cancer cells. Her comments very well summarize current nanotechnology and nanomedical product development, “Unfortunately only a very small portion of research on nanoparticles is focused on health and safety risks, or on threats to the environment. . . I am concerned because so many new nanoparticles are being developed and there is little regulation on their manufacture, use and disposal.” The nano-industry places great emphasis on the size of a nanoparticle; the smaller the particular, the better its

micromolecular benefits for a specific purpose. However, according to the University of Massachusetts study, the smaller the particle, the greater its toxicity.

In the report published by the Oregon State University on the use of lecithin as an adjuvant, the researchers state that their particle moves easily to the lymphatic system and that these particles physically “look like” a pathogen by the immune system. Therefore, the immune system winds to produce antibodies to fight them. Lecithin is a perfectly safe, non-toxic natural substance, found in many foods, and known to reduce negative cholesterol. However, that is the lecithin as it appears in the foods we eat such as soy or eggs. The question may be raised as to whether or not lecithin injected as a nano-adjuvants will present a condition similar to the dangers discovered when otherwise natural squalene is introduced to the body via injection, as opposed to its normal route via ingestion. Squalene, an important natural nutrient that contributes to the body’s joint health is found shark oil and foods such as wheat germ. As noted in the section on squalene above, when it is injected into the body as a vaccine adjuvant, it has a contrary effect. The body recognizes squalene as a foreign invader and develops antibodies to fight it. Thereafter, squalene occurring naturally in our diet and body will pose an immune response that ushers forth antibodies to attack it. This has contributed to various immune diseases such as arthritis and lupus. If a nano-adjuvant of lecithin physically looks like a pathogen to the immune system, and when injected, is there any assurance that the antibodies generated will not act against all lecithin that enters the body?

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