A CRITICAL ANALYSIS OF AN FDA DOCUMENT:

"Thimerosal in Vaccines, questions and answers: How does FDA evaluate vaccines to make sure they are safe?"

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SECTION 1. Analysis of the FDA document.

The following FDA report entitled, "Thimerosal in Vaccines, questions and answers: How does FDA evaluate vaccines to make sure they are safe?" presents only propaganda, misleading information, distortions, out-right lies, and worse (Last Updated: 07/10/2009 http://www.fda.gov/BiologicsBloodVaccines/Vaccines/QuestionsaboutVaccines/ucm070430.htm).

In the interests of brevity, I first will identify the misleading information, distortions, and fibs in a brief non-referenced statement prefaced by a number. In 6 numbered SEGMENTS in the NOTES of this document, that same number is referenced, and much more detailed information is provided for those who wish to analyze the evidence in support of my criticism.

FDA DOCUMENT:

"Thimerosal in Vaccines Questions and Answers: How does FDA evaluate vaccines to make sure they are safe?"

"FDA's Center for Biologics Evaluation and Research is responsible for regulating vaccines in the U.S. Before new vaccines are licensed, they are tested extensively for safety in the laboratory, in animals, and in successive stages of human clinical trials called phases."

CRITIQUE:

1. This is both wrong and misleading information. You can't test a vaccine for safety in a laboratory because In Vitro information almost universally is produced in laboratory dishes lacking any intact immune system, or in most cases even a functional tissue. So there is no way you can know anything about the safety of a vaccine or its components from laboratory experiments. Nor in many cases, can basic molecular mechanisms or proofs of principle be derived only from lab experiments, and in many cases, vaccines or disease models based on such laboratory evidence was wrong. I give many examples in SECTION 1 in NOTES.

It also is a distortion that these vaccines are first safety tested in animal models: in many cases there aren't even any animal models that recapitulate the disease vaccinated against, and in many cases, vaccine lots are tested on inappropriate animal models but then different formulations and lots are given to people, as is what happened during the 1971 swine flu debacle directed by David J. Sencer, M.D., M.P.H. then head of the CDC (please watch http://www.youtube.com/watch?v=Ro1WL5ketWg and http://www.youtube.com/watch?v=H0aIoa97X5k&NR=1 . Toxicity testing on animals is typically done, but the relevance and dosages of vaccines tested in animals remains in most cases unproven before given to humans.

Regarding the claim that "they are tested for safety in successive stages of human clinical trials," this is partly true and partly false-as many vaccines, such as the 1976 "HINI" vaccine and many others have been given to people without it even being safety tested even in animals. Thus this opening statement is riddled with false information (see NOTES: SECTIONS 1 and 2).

In 1979, a 16-minute segment of 60 minutes with Mike Wallace about the adverse effects and propaganda of the 1976 swine flu campaign is aired in which the then CDC Head, Dr. David Sencer, is interviewed (Dr. Sencer is now retired from working for a private industry job he obtained after being fired from the CDC: he can be heard defending his actions here (http://www.cnn.com/2009/HEALTH/04/30/swine.flu.1976/index.html), and he maintains as of

April 2009 that he believed he "was doing the right thing" when he urged widespread vaccinations with an untested vaccine after an unconfirmed flu-like illness broke out among 5 soldiers at Fort Dix, New Jersey, after one of the 14 eventually diagnosed with the illness at the military base, a Private Lewis, died several days after he collapsed during a marching exercise. Sencer's program was suspended after at least 25-32 people died from vaccine reactions, while about 500 others later suffered from Guillain-Barre syndrome. In this 60 Minutes Mike Wallace interview, it is clearly presented that although the initial "swine flu" vaccine was tested, the X53-a vaccine given to more than 40 million Americans never was tested. In the 16 minute documentary, a GBS patient also is interviewed whose life was ruined by the shot, footage is presented regarding the 1 soldier, Private Lewis, who collapsed while marching and who was revived by his commanding officer without that officer contracting any flu, and the statement is made that no confirmed cases of a flu variant was reported anywhere in the world before the CDC and the Federal Government decided to launch its vaccine campaign on some 40 million American lab rat recipients using an untested vaccine. That 16 minute part of 60 minutes with Mike Wallace and Dr. David Sencer can be seen here (and other information regarding this year's H1N1 hoax are provided in SECTION 3):

http://salsa.democracyinaction.org/dia/track.jsp?v=2&c=7m92vldwbQaXdxDDVDGpp7Fc57K5CWw6
(If this link asks for a Keychain password to view it, simply click cancel and the video will come up).

It also should be mentioned that there is little difference in the amount of safety testing of this Fall's H1N1 vaccine, and the amount of safety testing done (zero) with the 1976 swine flu vaccine given to more than 40 million Americans (from a transcript of virtual press conference with Gregory Hartl, WHO Spokesperson for Global Alert and Response and Dr Marie-Paule Kieny, Director of the Initiative for Vaccine Research, World Health Organization14 July 09: regarding the H1N1 vaccine roll-out planned for 4.9 billion people- "Vaccinate Health Care Workers, Pregnant Women, School Aged Children First):"

Dr Marie-Paule Kieny: "*You are **absolutely right that safety data**, at least in terms of **numbers are lacking in certain population groups**. You mentioned the children, certainly there **are no data in children** more than 6 months old and less than 3 years, **there are no data** in pregnant women, **there are no data in asthmatics**, so there are quite a number of populations for which **there are no data**. SAGE has also made the point that **as quickly as possible** data should be obtained on these populations groups **if they are to be vaccinated with these new vaccines.** In terms of use of this new novel adjuvant in children, there is no vaccine for very young children that is using the formulation.* The closest being the vaccine which is currently developed as the malaria vaccine, which has been tested in a few thousand children and is being tested now ***in Africa*** with this indication for malaria ***in a few thousand children***, but apart from that, ***these data*** ***are still lacking."***

FDA DOCUMENT:

"When a new vaccine is first tested in humans, a sponsor (a vaccine manufacturer, academic investigator or other individual or organization) must first submit an Investigational New Drug Application to FDA. If data at any stage of clinical development raise significant concerns regarding the safety of the product, FDA may request additional information or may halt ongoing or planned studies. "Phase 1 studies typically enroll less than 20 participants and are designed to look for very common adverse events. Phase 2 studies may include up to several hundred individuals and are designed to look at the overall safety profile of the vaccine for local reactions such as redness and swelling at the injection site as well as general side effects that may occur with some vaccines such as fever. For phase 3 studies, the sample size is often determined by the number required to establish efficacy of the new

vaccine, which may be in the thousands or tens of thousands of subjects. Phase 3 studies are usually of sufficient size to detect less common adverse events, such as those occurring at rates of 1 in 100 to 1 in 1000. For vaccines given concomitantly with other vaccines under the routine immunization schedules, the safety of new vaccines typically is studied with concurrent administration of these other vaccines. In addition, FDA carefully reviews information on the manufacturing process of new vaccines, and testing is performed on individual lots for safety and potency. If product development is successful, the completion of all three phases of clinical development can be followed by submission of a Biologics License Application (BLA)."

CRITIQUE:

This is a true statement about many, but certainly not all new modern vaccines, except for the wholesale and typically secret experimentation that goes on utilizing military recruits, who must comply with any medical vaccine experiment the military deems urgent or necessary, as was the case with the Gulf-War I anthrax vaccine. There are many other examples such as Gardasil, rotovirus (Dr. Paul Offit's first contribution to childhood death and intestinal perforations do to his rotovirus vaccine), encephalitis vaccines, hepatitis B vaccine, and others.

There is also much evidence that not only soldiers but other targeted groups such as children, prisoners, Africans, African Americans, the gay community, Third-World peoples, women, and people housed in mental institutions have been and are still being used by pharma and the Church of Modern Medicine as experimental guinea pigs before FDA approves vaccines.

The words in this FDA document paragraph also were carefully chosen so as to not to mention or emphasize severe systemic reactions, which often occur after vaccination-not just "redness at the injection site," or "fever," but also severely disabling and disfiguring or lethal reactions that are expected to occur and which the vaccine testers are of course most afraid of:

E.G. "*Phase 1 studies typically enroll less than 20 participants and are designed to look at the overall safety profile of the vaccine* ***for local reactions such as redness and swelling at the injection site*** *as well as general side effects that may occur with* ***some*** *vaccines* ***such as fever…*** *Phase 3 studies are usually of sufficient size to detect* ***less common adverse events****, such as those occurring at rates of 1 in 100 to 1 in 1000."*

The words that are chosen, and the testing procedure described here makes it sound as if only redness at the injection site, or perhaps a slight fever are all that typically occurs when new vaccines are tested. And in Phase III trials, we are told that *"less common adverse events, such as those occurring at rates of 1 in 100 to 1 in 1000,"* **without reference to the types of reactions that occur-which is a blatant and intentional distortion of the facts and historical record. Unless you consider 87% of polio in the U.S. due to the polio vaccine a "slight" inconvenience like swelling at the injection site or fever (-see NOTES 1 and 2), as if paralysis were simply like a fever or redness at the injection site, or a rare adverse reaction, or as in the case of the induction of Steven's-Johnson syndrome where the skin of a person nearly entirely peels off, or GBS which is a paralytic reaction to vaccines, then these and many other severe reactions constitute more than just "a mild swelling and discomfort at the injection site." Some of these syndromes include encephalitis, arthritis, cancers, intestinal perforations, demyelination syndromes, psoriasis, tissue rot, and a host of other syndromes not even mentioned, and which constitute part of the politely stated and misleading reference about** *"less common adverse events, such as those occurring at rates of 1 in 100 to 1 in 1000"* **with no mention of these severe reactions.**

FDA DOCUMENT:

"Following FDA's review of a license application for a new indication, the sponsor and FDA usually present their findings to an expert advisory committee in an open public meeting for comment and advice."

CRITIQUE:

3. This statement is a blatant lie, according to a board member and doctor who sat on the American Association of Pediatrics advisory committee for two decades but who quit because of the criminal behavior of his peers who ignored the carnage caused by vaccines (see NOTES Section 4-Dr. Stoller's complete resignation letter), especially with respect to the context of mercury in vaccines and illegal meetings that were held. I present a few highlights from Dr. Stoller's 2008 resignation letter here, that was published in Medical Veritas and which is presented in its entirety in NOTES (K.P. Stoller/Medical Veritas 5 (2008) 16991700 1699 Les Incompétents: My open letter to the American Academy of Pediatrics. K. Paul Stoller, MD):

"…In a first analysis of the VSD datasets, Verstraeten et al. had described a 7.6 to 11.4 fold increase of autism risk in children at one month, with the highest mercury exposure levels compared to children with no exposure. In four subsequent separate generations of the analysis, which involve the exclusion of children with no Thimerosal exposure and less than two polio vaccines, the statistical significance disappeared. This is what was published by the AAP even though they knew the truth. How did they know the truth?"

"Again, they were presented at the Simpsonwood meeting in June 2000, a meeting that was illegal to hold. No Federal agency is allowed to call a meeting together with representatives of private industry (all the vaccine manufacturers were represented at this meeting) without opening the meeting to the public."

FDA DOCUMENT*:*

"The safety of new vaccines continues to be monitored following licensure in several ways. The Vaccine Adverse Event Reporting System, co-administered by FDA and CDC, is a national passive surveillance system for the collection of all reports of adverse events following vaccination. As a spontaneous reporting system, VAERS has several limitations including under-reporting, incompleteness of reports, lack of consistent diagnostic criteria, and the inability in most cases to establish a cause and effect relationship. VAERS is useful, however, for raising "red-flags" and subsequently generating hypotheses that can be tested further in controlled clinical trials or epidemiological studies. As part of a post-licensure commitment, FDA often asks the manufacturer to conduct additional clinical studies (sometimes called phase 4 studies), to further evaluate safety, and to provide this information to FDA in a timely manner. In addition, controlled epidemiological studies may be conducted using pre-established large-linked databases, which have improved ability to evaluate whether rare adverse events are caused by vaccination. One such system is the Vaccine Safety Datalink, administered by the CDC."

CRITIQUE:

4. While it is true that VAERS has several limitations including under-reporting, and incompleteness of reports (only about 1-10% of vaccine reactions are reported), it is a distortion of reality to say that "VAERS has several limitations including…. lack of consistent diagnostic criteria, and an inability in most cases to establish a cause and effect relationship." Controlled

"epidemiological studies" that use VAERS or Vaccine Safety Datalink cannot establish causal relationships in the first place-because by their nature, epidemiological studies are associative (correlative) studies and not experiments. Yet this same objection is typically used to discount epidemiological evidence that points to any unfavorable associations between a vaccine and adverse events, and yet this lack of ability for epidemiological evidence to establish causal associations are overlooked when the pharma shills want to point out some benefit of vaccination. They can't have it both ways. In fact VAERS is the ONLY non-adulterated collection of reports, complete or not, regarding vaccine damage. The problem is that vaccine damage goes largely unreported because doctors are not educated, nor is anyone else, as to what adverse reactions look like in the vaccinated, because they are indoctrinated as to their safety DESPITE the existence of vaccine damage courts, VAERS, and the Vaccine Safety Datalink.

FDA DOCUMENT:

"What are preservatives and why are they added to vaccines?"

"Preservatives are compounds that kill or prevent the growth of microorganisms, such as bacteria or fungi. They are used in vaccines to prevent bacterial or fungal growth in the event that the vaccine is accidentally contaminated, as might occur with repeated puncture of multi-dose vials. Vaccines, both in the United States and throughout other parts of the world, are commonly packaged in multi-dose vials. In some cases, preservatives are added during manufacture to prevent microbial growth; with changes in manufacturing technology, however, the need to add preservatives during the manufacturing process has decreased markedly."

CRITIQUE:

5. This is false information. Many vaccines have been shown to be rife with bacteria DESPITE their containing mercury. Please see the FDA's own statements about the use of mercury as a preservative, such as http://www.fda.gov/BiologicsBloodVaccines/SafetyAvailability/VaccineSafety/UCM096228:

The FDA says that: *"Preservatives cannot completely eliminate the risk of contamination of vaccines. The literature contains several reports of bacterial contamination of vaccines despite the presence of a preservative, emphasizing the need for meticulous attention to technique in withdrawing vaccines from multi-dose vials." (Bernier et al 1981; Simon et al. 1993).*

The FDA also has (on their website linked above) many examples regarding how mercury is anything but safe. Also, certain vaccines (such as the polio vaccines) were shown to contain other pathogens such as mycoplasmas, cancer-associated viruses such as SV40, CMV, and a plethora of other viruses for which there is no preservative against that can eliminate these so-called putative cancer-inducing viruses (see section 1 in NOTES for a discussion regarding SV-40).

From an FDA Website:

"Preservatives have been used in vaccines for over 70 years. The requirement for a preservative in multi-dose, multi-entry vials was placed into the Code of Federal Regulations (21 CFR 610.15) in January 1968. There are exceptions to this requirement for preservative, primarily involving the live-attenuated viral vaccines."

"The general need for preservatives in multi-dose vials has been underscored by cases in which multi-dose vials that did not contain preservatives become contaminated during use and caused fatal infections in vaccine recipients; cf. the Narrative Section on Thimerosal."

CRITIQUE: Whenever the normal resistance structure of the immune system is bypassed (such as our mucosal immunity) and when pathogens such as enteric polio virus derived from a healthy child's feces (as were the first polio vaccines), flu viruses derived from sick persons, bacteria derived from sick persons, etc., are injected directly into the bloodstream, one runs the risk of causing sepsis or massive blood-borne infection in the vaccinated, depending on the strength of that person's innate immune response, and the slowness or rapidity of that immune response kicking into gear.

FDA DOCUMENT:

"What is thimerosal?"

"Thimerosal is a preservative that has been used in some vaccines since the 1930's, when it was first introduced by Eli Lilly Company. It is 49.6% mercury by weight and is metabolized or degraded into ethylmercury and thiosalicylate. At concentrations found in vaccines, it meets the requirements for a preservative as set forth by the United States Pharmacopeia; that is, it kills the specified challenge organisms and is able to prevent the growth of the challenge fungi. Prior to its introduction in the 1930's, data were available in several animal species and humans providing evidence for its safety and effectiveness as a preservative. Since then, thimerosal has a long record of safe and effective use preventing bacterial and fungal contamination of vaccines, with no ill effects established other than minor local reactions at the site of injection."

"As a vaccine preservative, thimerosal is used in concentrations of 0.003% to 0.01%. A vaccine containing 0.01% thimerosal as a preservative contains 50 micrograms of thimerosal per 0.5 ml dose or approximately 25 micrograms of mercury per 0.5 mL dose. The use of mercury-containing preservatives in vaccines has declined markedly since 1999."

"FDA is continuing its efforts toward reducing or removing thimerosal from all existing vaccines. Much progress has been made to date. FDA has been actively working with manufacturers, particularly those that manufacture childhood vaccines, to reach the goal of eliminating thimerosal from vaccines, and has been collaborating with other PHS agencies to further evaluate the potential health effects of thimerosal. In this regard, all vaccines routinely recommended for children 6 years of age or younger and marketed in the U.S. contain no thimerosal or only trace amounts (1 microgram or less mercury per dose), with the exception of inactivated influenza vaccine, which was first recommended by the Advisory Committee on Immunization Practices in 2004 for routine use in children 6 to 23 months of age."

"What has FDA done to address the issue of mercury containing preservatives in vaccines?"

"Under the FDA Modernization Act (FDAMA) of 1997, FDA carried out a comprehensive review of the use of thimerosal in childhood vaccines. Conducted in 1999, **this review found no evidence of harm from the use of thimerosal as a vaccine preservative, other than local hypersensitivity reactions.**"

"As part of the FDAMA review, FDA evaluated the amount of mercury an infant might receive in the form of ethylmercury from vaccines under the U.S. recommended childhood immunization schedule and compared these levels with existing guidelines for exposure to methylmercury, as there are no

existing guidelines for ethylmercury, the metabolite of thimerosal. At the time of this review in 1999, the maximum cumulative exposure to mercury from vaccines in the recommended childhood immunization schedule was within **acceptable limits** for the methylmercury exposure guidelines set by FDA, Agency for Toxic Substances and Disease Registry (ATSDR), and the World Health Organization (WHO). **However, depending on the vaccine formulations used and the weight of the infant, some infants could have been exposed to cumulative levels of mercury during the first six months of life that exceeded EPA recommended guidelines for safe intake of methylmercury.** As a precautionary measure, the Public Health Service (including FDA, National Institutes of Health [NIH], Centers for Disease Control and Prevention [CDC] and Health Resources and Services Administration [HRSA]) and the American Academy of Pediatrics issued a Joint Statement, urging vaccine manufacturers to reduce or eliminate thimerosal in vaccines as soon as possible. The U.S. Public Health Service agencies have collaborated with various investigators to initiate further studies to better understand any possible health effects from exposure to thimerosal in vaccines."

CRITIQUE: These paragraphs are riddled with lies and double-speak. For instance the paragraph above first says "the cumulative exposure to mercury from vaccines in the recommended childhood immunization schedule was within acceptable limits…" and then it says that, "However, depending on the vaccine formulations used and the weight of the the infant (most infants are rather small I think), some (SOME) infants COULD HAVE BEEN exposed to cumulative levels of mercury during the first six months of life that EXCEEDED EPA recommended guidelines for safe intake of methylmercury."

Also, in response to the paragraph touting the safety and dosage of mercury in vaccines, in 2000 at a San Diego research meeting on autism, Dr. Stephanie Cave presented the following information:

*"By the age of two, American children have received **237 micrograms** of mercury through vaccines alone, which far exceeds current EPA 'safe' levels of 0.1 mcg/kg. per day. That's one-tenth of a microgram, not one microgram."*

*"Three days in particular may be singled out as spectacularly toxic for infants: "Day of birth: hepatitis B—12 mcg mercury (**30 times** safe level).*

*"At 4 months: DTaP and HiB on same day—50 mcg mercury (**60 times** safe level).*

*"At 6 months: Hep B, Polio—62.5 mcg mercury (**78 times** safe level).*

*"At 15 months the child received another 50 mcg (**41 times** safe level).*

"These figures are calculated for an infant's average weight in kilograms for each age. These one-day blasts of mercury are called 'bolus doses.' Although they far exceed 'safe' levels, there has never been any research conducted on the toxicity of such bolus doses of mercury given to infants all these years." ["Autism and Mercury." Testimony presented by Stephanie Cave, MD before the Committee on Government Reform, US House of Representatives, July 18, 2000. Also presented at the Defeat Autism Now! Conference, 15 Sep 2000, San Diego, CA].

FDA DOCUMENT:

"Available data has been reviewed in several public forums including the Workshop on Thimerosal, held in Bethesda in August 1999 and sponsored by the National Vaccine Advisory Committee, two

meetings of the Advisory Committee on Immunization Practices of the CDC, held in October 1999 and June 2000, and by the Institute of Medicine's Immunization Safety Review Committee in July 2001 and February 2004. Data reviewed **did not** demonstrate **convincing** evidence of toxicity from doses of thimerosal used in vaccines. In case reports of accidental high-dose exposures in humans to thimerosal or ethyl mercury toxicity was demonstrated **only at exposures that were 100** or 1000 times that found in vaccines."

CRITIQUE: Dr. Stephanie Cave above states that children by the age of two received 237 times the "safe" exposure-and the FDA here says "only at exposures of 100 times (is mercury toxicity demonstrated).

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

CRITIQUE: Prudent, yes, so why do they continue to push vaccines containing mercury a decade after they decided it would be "prudent" to remove the neurotoxin from vaccines?

"In 2004, the IOM's Immunization Safety Review Committee again examined the hypothesis that vaccines, specifically the MMR vaccines and thimerosal containing vaccines, are causally associated with autism. In this report, the committee incorporated new epidemiological evidence from the U.S., Denmark, Sweden, and the United Kingdom, and studies of biologic mechanisms related to vaccines and autism that had become available since its report in 2001. The committee concluded that this body of evidence favors rejection of a causal relationship between thimerosal-containing vaccines and autism, and that hypotheses generated to date concerning a biological mechanism for such causality **are theoretical only**. Further, the committee stated that **the benefits of vaccination are proven and the hypothesis of susceptible populations is presently speculative,** and that widespread rejection of vaccines would lead to increases in incidences of serious infectious diseases like measles, whooping cough and Hib bacterial meningitis."

CRITIQUE:

The studies mentioned each were highly flawed studies, as has been pointed out by Dr. Andrew Wakefield, and the Geiers' analyses of the Vaccine Datalink, and others. Mercury is repeatedly referred to as "a preservative," although most microbiologists know that many types of bacteria can grow at the quantities of mercury that are placed into vaccine lots, and it never once is referred to by the FDA as "a neurotoxin." I suppose it sounds better to ask and answer the question: "What is thimerosal," by answering: "it's a preservative" rather than say "thimerosal is a neurotoxin?" The American Academy of Pediatrics pediatrician (AAP) who resigned recently, Dr. Stoller's story, differs slightly from that told above by the FDA's successive distortion of the data between 1999 and 2004 (his entire letter is presented in SECTION 4):

"The AAP shamefully played along, perhaps encouraged by the largesse of vaccine manufacturers who significantly contribute to the AAP's yearly budget. To publish studies that showed the removal of a known neurotoxin (mercury) from vaccine caused the incidence of autism to increase was shameful pseudo-science."

"There is another budget to consider for eighty percent of autistic Americans under the age of 18, and we will soon begin to see a dramatic impact on Social Security in coming years as these children become dependent adults. There are no studies that have found the previously undiagnosed or misdiagnosed autistic individuals among older Americans. They simply aren't there. So what is coming will significantly impact on society."

"As there are no genetic epidemics, which leaves an epidemic linked to some sort of exposure. Now, the increase of autism has been linked to the increase in mercury exposure through fish and industrial sources, amalgam and additionally, through increased parenteral exposure to Thimerosal - no controlled, randomized study regarding the safety of amalgam or Thimerosal exists."

"A recently released Scientific Consensus Statement on Environmental Agents Associated with Neurodevelopmental Disorders (by the Collaborative on Health and the Environment's Learning and Developmental Disabilities Initiative) concludes that environmental contaminants are an important cause of learning and developmental disabilities."

"Delayed detoxification of mercury severely impairs methylation reactions (required for the correct expression of DNA, RNA, and neurotransmitters), which further adversely affects growth factor derived development of the brain and attention abilities. Phospholipid methylation, which is crucial for attention, is impaired in autistic and attention deficit hyperactivity disorders."

"In a first analysis of the VSD datasets, Verstraeten et al. had described a 7.6 to 11.4 fold increase of autism risk in children at one month, with the highest mercury exposure levels compared to children with no exposure. In four subsequent separate generations of the analysis, which involve the exclusion of children with no Thimerosal exposure and less than two polio vaccines, the statistical significance disappeared. This is what was published by the AAP even though they knew the truth. How did they know the truth?"

"Again, they were presented at the Simpsonwood meeting in June 2000, ***a meeting that was illegal to hold****. No Federal agency is allowed to call a meeting together with representatives of private industry (all the vaccine manufacturers were represented at this meeting) without opening the meeting to the public."*

"Thimerosal was tested only once, by Eli Lilly on 22 adult patients suffering from meningitis. There was no chance for follow- up to observe long-term effects, as all of the patients in this "study" died. *Even if follow-up had been possible, damage to the developing brains of very young children would have remained an unknown. Eli Lilly said it was safe and the medical community accepted it. After the creation of the FDA, its use was simply continued. The federal government has never tested the type of mercury in vaccines for toxicity.* ***This is an unconscionable oversight failure at best, at worse it is an example that we have left consensus reality to be created by the liars, thieves, cheats, killers, and the junk scientists they employ.****"*

"How it came to pass the AAP joined these rogues and be-came an active participant in this skullduggery is beyond reason even beyond greed. They have remained silent as mercury-laden vaccine continues to be exported and used in all third world and second world countries."

"We are living in a time where an incredible overplay and lies, self-aggrandizing behavior and non-science are the norm. We have tolerated the junk science that has covered up the true cause of this epidemic at a considerable cost to science, the public, and our very way of life in this country. Is it a stretch to realize that by putting our collective heads in the sand about the autism epidemic we have made it possible for the destruction of our very civilization?"

"Not something easy to contemplate? Then ask why haven't pediatricians come forward to demand the end of the use of Thimerosal once and for all, and to advocate for the treatment of these children before it is too late? Why are they not at the front of the line protesting the amounts of mercury allowed to come out of coal-fired power plants? Why aren't they leading the charge to stop the use of mercury amalgam dental fillings that are placed in the mouths of young children and pregnant women?"

"The very Federal agencies that should have been sounding the alarm bell about environmental pollution creating future generations of mentally disabled citizens did less than remain silent because they have become arms of the very corporations that profit from selling and distributing poisons. Just look who sits on the FDA's Scientific Advisory Boards the conflicts of interest are so glaring as to suggest that the FDA has become a trade arm of Big Pharma."

FDA DOCUMENT:

"FDA is continuing its efforts toward reducing or removing thimerosal from all existing vaccines. Much progress has been made to date. FDA has been actively working with manufacturers, particularly those that manufacture childhood vaccines, to reach the goal of eliminating thimerosal from vaccines, and has been collaborating with other PHS agencies to further evaluate the potential health effects of thimerosal. Since 2001, all vaccines recommended for children 6 years of age and younger have contained either no thimerosal or only trace amounts, with the exception of inactivated influenza vaccines, which are marketed in both the preservative-free and thimerosal-preservative-containing formulations. **Thimerosal-preservative free influenza vaccine licensed for use in children six to 59 months of age is available in limited supply.** Nevertheless, **FDA is in discussions with manufacturers of influenza vaccine** regarding their capacity **to increase the supply of vaccine without thimerosal as a preservative.** Additionally, new pediatric vaccines that have received licensure do not contain thimerosal."

"Why did FDA wait until mandated by Congress under FDAMA 1997 to examine the use of preservatives containing mercury?"

"Several factors led to examination of mercury-containing preservatives in childhood vaccines. Over the past decade there has been increased attention focused on the health effects of human exposure to mercury, particularly methyl mercury. In 1994, the EPA revised its Reference Dose (RfD) for methylmercury exposure, lowering its guideline for safe exposure from 0.3 to 0.1 microgram per kilogram body weight per day. Prospective studies (in the Seychelles, Faroe Islands and others) of the effects of low dose exposure to methylmercury in the diet were published, and **some of these studies raised concern that neurodevelopmental outcomes in children may be subtly affected when their mothers were exposed to methylmercury from dietary sources at levels that were previously thought to be safe.** Also in the 1990's, the CDC's Advisory Committee on Immunization Practices (ACIP) and other recommending bodies added new vaccines (e.g., hepatitis B, Hib), some of which contained thimerosal as a preservative, to the routine childhood immunization schedule. Additionally, beginning in 1996, the replacement of whole cell DTP-Hib combination vaccines with separately administered DTaP and Hib vaccines increased the amount of thimerosal that **some infants** might have received (depending on vaccine formulation(s) received). In light of efforts by various federal agencies

to decrease human exposure to mercury from various sources, and **the potential increase** in infant exposure to thimerosal from vaccines, FDA undertook **review** of this issue."

CRITIQUE:

In other words, nothing has been done to remove mercury or decrease the exposure of this neurotoxin to the bodies and brains of our infants and children (and seniors) because the FDA is "reviewing" the issue, while they admit that "some infants might have received too much mercury" (depending of course on the qualified "formulation(s)" received), and that "some studies raised concern that neurodevelopmental outcomes in children may be subtly affected when their mothers were exposed to methylmercury from dietary sources (but not vaccines?) at levels that were previously thought to be safe." The IOM, FDA, ASIP, APP, the NIH, CDC continue to see nothing wrong with injecting 237 times the unsafe levels of a potent neurotoxin directly into the bloodstreams and brains of our infants, and other citizens, but see plenty wrong with eating mercury-laden fish.

FDA DOCUMENT:

"Thus, while enactment of FDAMA 1997 provided an official mechanism for review of this issue, the use of thimerosal as a preservative in vaccines **had already begun to be considered** by FDA. During the past ten years, FDA has provided **informal and formal** advice to manufacturers **recommending** (not demanding?) that new vaccines under development be formulated without thimerosal as a preservative."

"FDA had previously reviewed thimerosal use in biological products, including vaccines, in 1976. This review evaluated exposure to thimerosal from biological products using the 1974 American Academy of Pediatrics "Red Book" immunization schedule and concluded that, with the exception of long term immune globulin replacement therapy, **'no dangerous quantity of mercury is likely to be received from biologic products in a lifetime.'** Of note, immune globulin products licensed in the U.S. no longer use thimerosal as a preservative."

CRITIQUE: So what? How many people receive immune globulin products compared to routine immunizations? And although those receiving immune globulin injections are now spared mercury (we are told), they receive instead huge amounts of aluminum placed in the immune globulin and other injections or vaccines (given as an adjuvant to boost immunity non-specifically in often immune compromised individuals) to stimulate a massive and non-specific immune response. Extraordinary evidence was presented at a scientific meeting of US and French experts, held to discuss the safety of the aluminum 'adjuvants' added to certain vaccines. This was on the 11th-12th May 2000 in Puerto Rico, many years after aluminum was first added to vaccines and non-specific immune boosting formulations. According to the meeting's offical transcript, Dr Johnson, the Chairman, at first optimistically stated: 'Aluminium salts have a very wide margin of safety ...' and thus 'aluminum and mercury are often simultaneously administered to infants.'

But he immediately contradicted this by adding: 'There is absolutely no data, including animal data, about the potential for synergy, additively or antagonistic, all of which can occur in binary metal mixtures.' In other words the vaccine industry has been putting in both these metals without ever studying what they might do when present together (From investigative journalist and author, Janine Robert's compilation of Aluminium in vaccines can cause serious polio-like damage, may enhance the neurotoxic effects of mercury and cause brain Damage from the Transcripts of the Vaccines and Related Biological Advisory Committee Meeting (VRBAC) and Scientific Papers-more information about the French-discovered aluminum adjuvant disease,

macrophagic myofasciitis is presented in NOTES, SECTION 5):

"They reported finding these sharp aluminum needles can remain present in the vaccinated for at least 8 years following vaccination. And there was much more. They had so far tested over a hundred patients who had come to them with severe muscle and nervous system damage and had proved this was a consequence of aluminum-enhanced vaccination, mostly with the tetanus or hepatitis B vaccines. All these patients had these sharp aluminum crystals in them at the site of vaccination."

"The French scientists had confirmed with animal studies that this aluminum and the polio-like illness were causally linked. Animals exposed to the same suffered over time similar severe damage. In their patients, disabling muscle pains had commenced in both lower legs and spread upwards. Some 85% of these patients could no longer work. Many could now only do 'basic things.' In addition, 25% of their first 100 patients suffered from classic Chronic Fatigue Syndrome, with 34% also having Multiple Sclerosis."

"These nano-particles of aluminum also are capable of severely damaging nervous tissue throughout the body, disrupting controls over muscles. Potentially, this could also affect the lungs, limiting supplies of oxygen, as was also confirmed with animal studies. It was also found to disrupt the mitochondria in the cells it penetrated. It seemed capable of causing long-term massive poisoning events in the vulnerable – although these French cases were mostly among adult sports people. Was this because they put more stress on their muscles? The French said this was definitely a new serious illness. None of them had seen anything like it before. They had first suspected a virus, but then had found the aluminum. These cases had all occurred after a major French vaccination campaign that used aluminum-bearing Hepatitis vaccines and targeted adults as well as children."

"Up until then the French had used far less of these enhanced vaccines than had the Americans. They also found that this damage kept on happening over a long time. Sometimes the patients had not become incapacitated until years after vaccination. Most of these patients "had had four such injections. The muscle pains and Fatigue Syndrome were occurring from 3 months to eight years later. The median delay [after vaccination] was 11 months…"

"When they tested this 'aluminum adjuvant' on rats, they found it was not the aluminum alone that caused most damage but the aluminum combined with other particles, including antigens, that were in the vaccine. They concluded: 'So we have to consider the adjuvant plus the antigen' as the cause of the illness."

"They had only tested so far 100 patients – but their animal studies indicated this damage would be widespread and there must be many more cases out there. They said it was by chance that this new disorder was first found in France –it was because the French do biopsies on the arms vaccinated, something not done in America or the UK. They were thus the first to detect the aluminum crystals in the muscles injected."

"Americans are much more exposed to aluminum adjuvant than are the French. The latter have it in three types of vaccine – the hepatitis A and B vaccines, and in most of the tetanus vaccines. But in the USA it is also in acellular pertussis, anthrax, Lyme, DT absorbed and Hib, some of the Rabies, and in the anthrax vaccines given to the military who went to the first Gulf War. These vaccines are also among those most often blamed for the 'Gulf War' syndrome because of another adjuvant I will discuss in the context of the H1N1 vaccine latter."

"As the French scientists reported a clear and certain link between the 'aluminium-enhanced vaccines' and the illnesses, when the American scientists at this meeting cross-examined the French scientists, they could find no fault in their data. Instead, they applauded them for a brilliant piece of medical

sleuthing. Dr. Sam Keith noted at the meeting that aluminum is stored mostly in human bones, followed by kidneys, brains and muscles. When it binds to the larger proteins, he said it 'can inhibit the formation of neuronal microtubules,' thus affecting the structure of neurons. Environmental considerations also should be noted."

"Dr Harn Hogenesch noted that aluminum adjuvant can 'induce a type 2 immune response and set up an individual for allergic reactions to vaccine components.' Injected or inhaled metals have long been associated with severe muscle damage. Arsenic and lead have been shown in animal experiments to severely damage arm and leg muscles, causing symptoms identical to polio – thus very like what the French scientists observed" [See the several chapters on polio in "The Fear of the Invisible,' 2008 and 2009, by Janine Roberts].

"In 2001 the French team published their discovery and named their new vaccine-induced disease [R. K. Gherardi, M. Coquet, P. Cherin, L. Belec, P. Moretto, P. A. Dreyfus, J.-F. Pellissier, P. Chariot and F.-J. Authier: Macrophagic myofasciitis lesions assess long-term persistence of vaccine-derived aluminium hydroxide in muscle. Brain, Vol. 124, No. 9, 1821-1831, September 2001. Available online at ttp://www.informedchoice.info/hepB.html]."

FDA DOCUMENT:

"What progress has been made towards the goal of eliminating thimerosal from vaccines?"

"Great progress has been made in removing thimerosal from vaccines. Manufacturers have been able to accomplish this goal through changing their manufacturing processes, including a switch from multi-dose vials, which generally require a preservative, to single-dose vials or syringes. Since 2001, all vaccines manufactured for the U.S. market and routinely recommended for children ≤ 6 years of age have contained no thimerosal **or only trace amounts** (≤ 1 microgram of mercury per dose remaining from the manufacturing process), **with the exception of inactivated influenza vaccine.** In addition, all of the routinely recommended vaccines that had been previously manufactured with thimerosal as a preservative (some formulations of DTaP, Haemophilus influenzae b conjugate (Hib), and hepatitis B vaccines) had reached the end of their shelf life by January 2003."

"In the past, prior to the initiative to reduce or eliminate thimerosal from childhood vaccines, the maximum cumulative exposure to mercury via routine childhood vaccinations during the first six months of life was **187.5 micrograms.** With the introduction of thimerosal-preservative-free formulations of DTaP, hepatitis B, and Hib, the maximum cumulative exposure from these vaccines decreased to less than three micrograms of mercury in the first 6 months of life. With the addition of influenza vaccine to the recommended vaccines, an infant could receive a thimerosal-containing influenza vaccine at 6 and 7 months of age. This would result in a maximum exposure or 28 micrograms via routine childhood vaccinations. This level 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."

"Currently, all hepatitis vaccines **manufactured for the U.S. market** contain either no thimerosal or only trace amounts. Also, DT, Td, and Tetanus Toxoid vaccines are now available in formulations that contain no thimerosal or only trace amounts (see Table 3).

CRITIQUE:

But not the mercury-containing vaccines that are continuously being dumped on the 3rd World though, and, as of September 18, 2009, and according to John's Hopkin's Blumberg School of

Public Health, 25 micrograms of mercury still remains in the diphtheria, tetanus, various flu vaccines (FluLaval by GlaxoSmithKline; Fluvarin by Novartis; Fluzone-sanofi-Pasteur;H1N1-CSL limited; sanofi-Pasteur; meningiococcal-sanofi-Pasteur; http://www.vaccinesafety.edu/thi-table.htm).

FDA DOCUMENT:

"Furthermore, all new vaccines licensed since 1999 are free of thimerosal as a preservative. Inactivated influenza vaccine was added to the routinely recommended vaccines for children 6 to 23 months of age in 2004. FDA has approved thimerosal–preservative free formulations (containing either no or only trace amounts of thimerosal) for the inactivated influenza vaccines manufactured by Sanofi Pasteur and Chiron. These influenza vaccines continue to be marketed in both the preservative free and thimerosal-preservative containing formulations. In addition, in August 2005, FDA licensed GlaxoSmithKline's inactivated influenza vaccine, which contains 1.25 micrograms mercury per dose. Of the three licensed inactivated influenza vaccines, Sanofi Pasteur's Fluzone is the only one approved for use in children down to 6 months of age. Chiron's Fluvirin is approved for individuals 4 years of age and older, and GSK's Fluarix is approved for individuals 18 years of age and older. The live attenuated influenza vaccine (FluMist, manufactured by MedImmune), which contains no thimerosal, is approved for individuals 5 to 49 years of age. For the 2005-2006 season, Sanofi Pasteur was able to manufacture up to 8 million doses of thimerosal-preservative free influenza vaccine. Based on an estimated annual birth cohort in the United States of 4 million, there are 6 million infants and children between the ages of 6 and 23 months, most of whom would need two doses each. Thus, the amount of thimerosal-preservative-free vaccine that is available based on current manufacturing capacity is well below the number of doses needed to fully vaccinate this age group. FDA is in discussions with manufacturers of influenza vaccine regarding their capacity to further increase the supply of preservative-free formulations."

CRITIQUE:

In 2006 (March), an article in the March 10, 2006 issue of the Journal of American Physicians and Surgeons (JPandS.org) shows that since mercury was removed from some childhood vaccines, the alarming increase in reported rates of autism and other neurological disorders (NDs) in children not only stopped, but actually dropped sharply – by as much as 35%.

Using the government's own databases, David A. Geier, B.A. and Mark R. Geier, M.D., Ph.D. analyzed reports of childhood NDs, including autism, before and after removal of mercury-based preservatives. The authors analyzed data from the CDC's Vaccine Adverse Event Reporting System (VAERS) and the California Department of Developmental Services (CDDS) in "Early Downward Trends in Neurodevelopmental Disorders Following Removal of Thimerosal-Containing Vaccines."

"The numbers from California show that reported autism rates hit a high of 800 in May 2003. If that trend had continued, the reports would have skyrocketed to more than 1000 by the beginning of 2006. But in fact, the Geiers report that the number went down to only 620, a real decrease of 22%, and a decrease from the projections of 35%. This analysis directly contradicts 2004 recommendations of the Institute of Medicine which examined vaccine safety data from the National Immunization Program (NIP) of the CDC. While not willing to either rule out or to corroborate a relationship between mercury and autism, the IOM soft-pedaled its findings, and decided no more studies were needed. The authors write: "The IOM stated that the evidence favored rejection of a causal relationship between thimerosal and autism, that such a relationship was not biologically plausible, and that no further studies should be conducted to evaluate it."

FDA DOCUMENT:

"Why are some vaccines noted to be "thimerosal-free" while some are "thimerosal-reduced"? What is the difference between "thimerosal-free" and "preservative-free"?"

"Thimerosal may be added at the end of the manufacturing process to act as a preservative to prevent bacterial or fungal growth in the event that the vaccine is accidentally contaminated, as might occur with repeated puncture of multi-dose vials. When thimerosal is used as preservative in vaccines, it is present in concentrations up to 0.01% (50 micrograms thimerosal per 0.5 mL dose or 25 micrograms mercury per 0.5 mL dose). In some cases, thimerosal is used during the manufacturing process and is present in small amounts in the final vaccine (1 micrograms mercury or less per dose)."

"The term "preservative-free" indicates that no preservative (thimerosal or otherwise) is used in the vaccine; however, traces used during the manufacturing process may be present in the final formulation. For example, some vaccines may be preservative-free but may contain traces of thimerosal (1 micrograms mercury or less per dose); in such settings, this information is noted in the package insert. Similarly, the term "thimerosal-reduced" usually indicates that thimerosal is not added as a vaccine preservative, but trace amounts (1 micrograms mercury per dose or less) may remain from use in the manufacturing process. Such trace amounts are not felt to be clinically significant, nor would they result in exposure exceeding any federal guideline for mercury exposure. Vaccines may be termed "thimerosal-free" if no thimerosal can be measured; i.e., thimerosal content is below the limit of detection."

"Why is exposure to mercury a concern?"

"Mercury is an element that is dispersed widely around the earth. Most of the mercury in the water, soil, plants and animals is found as inorganic mercury salts. Mercury accumulates in the aquatic food chain, primarily in the form of the methylmercury, an organomercurial. Methylmercury is more easily absorbed and is less readily eliminated from the body than inorganic mercury. Exposure to one chemical with mercury, i.e., methylmercury, has been shown to pose a variety of health risks to humans. Extremely high levels, such as that observed in poisoning episodes in Japan and Iraq has caused neurological damage and death. The fetus is considered more sensitive to health effects of methylmercury than adults. In recent years some studies have found adverse health effects of methylmercury at levels previously thought to be safe. Other studies, however, have shown conflicting results."

CRITIQUE:

From Boyd Haley, Professor, and Chair Dept. of Chemistry, University of Kentucky:

"The toxicity of mercury from ingestion, i.e. that level set by the EPA in the USA is 0.1 microgram Hg per kilogram body weight per day based on ingestion of methylmercury from a fish diet. Notice that the level of mercury is presented in a fraction of grams. Therefore, to determine the toxicity of mercury in thimerosal or ethylmercury you have to determine the amount of mercury in fractions of grams. This is the way that all toxicologists do this. The amount of mercury by weight in the vaccines would make it safe by EPA standards if the subject getting the shot weighed 125 kilograms or 275 lbs."

"Compounds are defined as toxic by their action on living systems, not their elemental content. In this evaluation, thimerosal is known to rapidly release ethylmercury in aqueous systems. Ethylmercury is extremely neurotoxic, killing neurons at 10-25 <u>nanomolar</u> levels. For your information the vaccine is

125,000 nanomolar in thimerosal and injecting one vaccine (12.5 micrograms) into one 4-6lbs infant would represent a very toxic exposure. Further, unlike many elements (N,O,C, etc.), Hg has no known usefulness in biological systems, being toxic to them all. Also, all occurring forms of Hg (methylmercury, ethylmercury, thimerosal dental amalgams, Hg vapor, Hg2+, etc.) have been reported to be extremely toxic. That the anti-vaccine crowd uses the 50% mercury in thimerosal to scare people may be right, but they ought to be scared about injecting this much mercury into an infant. I am very pro-vaccine---I was raised on a farm and I own one today and I know the problems that can come from not vaccinating animals. However, that doesn't mean I have to accept anything less than a proven, safest vaccine and vaccine program for our children. I am under the opinion that thimerosal has been removed from most childhood vaccines, do you think our governments would do this if they did not think there was a problem?"

To Dr. Haley's comments, since he mentions animals and vaccines, I would add the following information:

Determining whether or not vaccines harm populations, protect populations, or do nothing for populations is also made difficult, if not impossible, because in most individuals, vaccine effects appear to be innocuous and cause little but "swelling and redness" at the injection site. However, comprehensive studies of what vaccines might do to neighboring or distant lymph nodes have not been conducted in humans.

Yet veterinary organizations such as The American Veterinary Medical Association, and Feline Sarcoma society report 160,000 cats/year who exhibit tumors at their vaccination injection sites also have elevated levels of anti-laminin and anti-fibronectin in their blood. Italian and English veterinary groups also have reported that dogs develop antibodies against collagens, laminins and fibronectins in association with post vaccination tumors at injection sites, in addition to vaccine-induced diabetes, arthritis, demyelination syndromes, tissue rot, non-healing and spreading bacterial infections, and a variety of other diseases regardless of the type of vaccine applied. The English and Australians in particular are launching moratoriums on all booster shots in dogs and cats, or re-vaccinations, due to these new and alarming findings. The World Small Animal Veterinary Association (WSAVA) Vaccination Guidelines Group and AAHA Canine Vaccine Task Force, note that *adverse reactions can range from mild, self-limiting illness to chronic disease or death*. Post-vaccination neurologic disorders, immune suppression, dermatologic abnormalities, and other problems have been demonstrated to occur after administration of both canine and feline vaccines:

The American Veterinary Medical Association (AVMA) Vaccine-Associated Feline Sarcoma Task Force initiated several studies to find out why 160,000 cats each year in the USA develop terminal cancer at their vaccine injection sites [See http://www.avma.org/vafstf/default.asp].

The fact that cats can get vaccine-induced cancer has been acknowledged by veterinary bodies around the world, and even the British Government acknowledged it through its Working Group charged with the task of looking into canine and feline vaccines [Veterinary Products Committee (VPC) Working Group on Feline and Canine Vaccination, DEFRA, May 2001] following pressure from Canine Health Concern.

A team at Purdue University School of Veterinary Medicine conducted several studies to determine if vaccines can cause changes in the immune system of dogs that might lead to life-threatening immune-mediated diseases [see "Effects of Vaccination on the Endocrine and Immune Systems of Dogs, Phase II", Purdue University, November 1,1999, at

http://www.homestead.com/vonhapsburg/haywardstudyonvaccines.html; See www.vet.purdue.edu/epi/gdhstudy.htm].

The vaccinated, but not the non-vaccinated, dogs in the Purdue studies developed autoantibodies to many of their own biochemicals, including fibronectin, laminin, DNA, albumin, cytochrome C, cardiolipin and collagen.This means that the vaccinated dogs -- "but not the non-vaccinated dogs"-- were attacking their own fibronectin, which is involved in tissue repair, cell multiplication and growth, and differentiation between tissues and organs in a living organism.

Italian and English veterinary groups also report that dogs develop antibodies against collagens, laminins and fibronectins in association with post vaccination tumors at injection sites, in addition to vaccine-induced diabetes, arthritis, demyelination syndromes, tissue rot, non-healing and spreading bacterial infections, and a variety of other diseases regardless of the type of vaccine applied.

Yet Many veterinarians are ignoring dog and cat vaccination guidelines issued by the World Small Animal Veterinary Association (WSAVA), and are continuing to send unsolicited reminder letters compelling pet owners to have their pets unnecessarily revaccinated for diseases such as parvovirus, distemper virus and adenovirus:

*"**This unethical practice of over-vaccination is of no benefit to the animal and puts it at needless risk of a range of adverse reactions, including death.** Professor Ronald Schultz, a member of the WSAVA Vaccination Guidelines Group and AAHA Canine Vaccine Task Force, notes that **adverse reactions can range from mild, self-limiting illness to chronic disease or death**. Post-vaccination neurologic disorders, immuno-suppression, dermatologic abnormalities, and other problems have been demonstrated to occur after administration of canine and feline vaccines. The most common signs of local reactions are facial edema, hives and itching. Signs of a systemic reaction include urination, vomiting, diarrhea (sometimes bloody), dyspnea and collapse. Pain, soreness, stiffness, lethargy, swelling, a persistent lump, irritation, hair loss and/or colour change of hair at the injection site have also been observed as common reactions. Change of behaviour has also been reported after vaccination."*

Bioethicist Professor Bernard Rollin warns there is increasing evidence that over-vaccination can actually be conducive to disease development. For example, frequent vaccination has been implicated in the development of autoimmune hemolytic anemia in dogs and injection-site sarcomas in cats, both of which can be fatal. Cancer is reported as being the single biggest cause of death in dogs over two years old. According to information from Texas A&M University, dogs and cats have a higher incidence of many tumors than do humans. Dogs have 35 times as much skin cancer, 4 times as many breast tumors, 8 times as much bone cancer, and twice as high an incidence of leukemia as do humans.

A paper published in the British Journal of Cancer in 2001 suggests long-term over-activation of the immune system could be a major cause of cancer. This research refers to cancer in humans, but is also relevant to other mammals. *Could over-vaccination, and the constant assault on the immune system, be causing a variety of cancers in dogs and cats over the long term?* It is certainly something to consider, especially as the scientific literature records the problem of injection site sarcomas in cats. This possibility is also another reason to cease unnecessary revaccination of animals.

But is there information regarding past vaccine programs that is reliable, that can help us determine if vaccines do only harm to a few individuals as we know already by the creation of

VEARS, and vaccine damage courts, or if they harm populations, or do no harm to populations, or do nothing to protect populations?

FDA DOCUMENT:

"It is important to note that the preservative thimerosal contains ethylmercury, a related though distinct chemical from methylmercury. Moreover, recent studies in animal models exposed to thimerosal containing vaccines or oral methylmercury suggest that methylmercury may not be a suitable reference to assess the risk from exposure to thimerosal (Burbacher et al, 2005). In addition, data from studies in human infants that were given routine immunizations with thimerosal-containing vaccines showed that mercury levels in blood and urine were uniformly below safety guidelines for methyl mercury and that unlike methylmercury excretory profiles, infants excreted significant amounts of mercury in stool after thimerosal (ethylmercury) exposure, thus removing mercury from their bodies (Pichichero ME, et al, 2002)."

"I understand that the Institute of Medicine (IOM) has reviewed the issue of thimerosal in vaccines. What were the IOM's findings?"

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

CRITIQUE:

Yes perhaps, but in 2001 (October 17), the law firm of Waters & Kraus revealed a confidential report by the Centers for Disease Control which studied autism as a neurological injury caused by mercury in vaccines. The CDC report stated: "We found increasing risks of neurological developmental disorder." Disorders noted were:

- **Developmental Speech Disorder**
- **Autism**
- **Stuttering**
- **Attention Deficit Disorder**
- **The study found a 2.48 times increased risk of autism.**
- **Children with mercury exposure were more than twice as likely to develop autism as children not exposed.**

U.S. law states that: "In a vaccine injury case, a relative risk greater than 2.0 establishes that there is a greater than 50% chance that the injury was caused by the vaccine." New Yorkers for Vaccination Information and Choice, press release by Waters & Kraus, Dallas, Texas.

Altered Report :A different version was made public and claimed results were inconclusive as to whether the mercury in vaccines has caused a nationwide epidemic of regressive autism and other neurological disorders in small children.

In 2002 (June), an articled appears: Mercury Horse Drug Recalled by The FDA-Drug contains mercury: poisonous to horses and people." Purchasers should not use it. Contact local waste-management authorities to learn how to destroy it without endangering animals, people, or waterways." The Salt Lake Tribune, June 1, 2002.

FDA DOCUMENT:

"The Committee believed that the effort to remove thimerosal from vaccines was 'a prudent measure in support of the public health goal to reduce mercury exposure of infants and children as much as possible.' Furthermore, in this regard, the Committee urged that "full consideration be given to removing thimerosal from any biological product to which infants, children, and pregnant women are exposed."

"In 2004, the IOM's Immunization Safety Review Committee again examined the hypothesis that vaccines, specifically the MMR vaccines and thimerosal containing vaccines, are causally associated with autism. In this report, the committee incorporated new epidemiological evidence from the U.S., Denmark, Sweden, and the United Kingdom, and studies of biologic mechanisms related to vaccines and autism that had become available since its report in 2001. The committee concluded that this body of evidence favors rejection of a causal relationship between thimerosal-containing vaccines and autism, and that hypotheses generated to date concerning a biological mechanism for such causality are theoretical only. Further, the committee stated that the benefits of vaccination are proven and the hypothesis of susceptible populations is presently speculative, and that widespread rejection of vaccines would lead to increases in incidences of serious infectious diseases like measles, whooping cough and Hib bacterial meningitis."

CRITIQUE: This FDA statement is clearly in error: "*that widespread rejection of vaccines would lead to increases in incidences of serious infectious diseases like measles, whooping cough and Hib bacterial meningitis."* **There have been numerous sero-surveys of populations that have been as much as 100% vaccinated which show that the vaccine given did nothing to prevent the disease vaccinated against from striking the population. A few examples may be in order, and I give 81 examples in SECTION 6 of this document and evaluate each of them to determine if: 1)** <u>vaccines do damage to individuals</u>, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above.

FDA DOCUMENT:

"The IOM urged that "full consideration be given to removing thimerosal from any biological product to which infants, children, and pregnant women are exposed" (IOM 2001). Routine administration of influenza vaccine is recommended in pregnant women, yet currently available U.S. licensed influenza vaccines contain thimerosal. Why are pregnant women receiving influenza vaccine containing thimerosal?"

"This issue was reviewed by the CDC's Advisory Committee on Immunization Practices (ACIP) in 1999 and again in 2001. At that time, the ACIP recommended no changes in the influenza vaccination guidelines, including those for children and pregnant women. The ACIP stated that "because pregnant women are at increased risk for influenza complications and because a substantial safety margin has been incorporated into health guidance values for organic mercury exposure, the benefit of influenza vaccine outweighs the potential risks for thimerosal". Furthermore, in its most recent recommendation regarding prevention and control of influenza the ACIP stated "The risks for severe illness from

influenza infection are elevated among both young children and pregnant women, and both groups benefit from vaccination by preventing illness and death from influenza. In contrast, no scientifically conclusive evidence exists of harm from exposure to thimerosal preservative-containing vaccine, whereas evidence is accumulating of lack of any harm resulting from exposure to such vaccines. Therefore, the benefits of influenza vaccination outweigh the theoretical risk, if any, for thimerosal exposure through vaccination" (MMWR 54 [RR08]: 1-40, 2005). Nonetheless, FDA is in discussions with manufacturers of influenza vaccine encouraging them to further increase the supply of preservative-free formulations."

CRITIQUE:

The book, "Evidence of Harm" by the journalist, David Kirby, explores many issues about these lies of the FDA and CDC regarding mercury. It documents how in the 1990s, autism spectrum disorder in American children began spiking, from 1 in 10,000 in 1987 to a shocking 1 in 150 or 1 in 60 today. In this period, two series of shots containing a mercury-based preservative called Thimerosal were added to the nation's already crowded vaccination schedule. Parents suddenly noticed their healthy children descending into silent, disturbed, and physically ill autism soon after receiving vaccinations. Ignored or dismissed by the FDA and the CDC, they discovered that children were being exposed to mercury at very young ages - even before birth - at levels far exceeding federal regulations. "Evidence of Harm" explores both sides of this controversy, which has pitted families against the federal government, public health agencies, doctors and researchers, and powerful pharmaceutical giants. It reveals: story of Thimerosal: a mercury-based additive approved by the FDA in the 1930s and never subsequently tested; increase in autism and the direct parallel to the increase in number and frequency of Thimerosal-containing vaccinations; secret meetings at which FDA, CDC, medical, and pharmaceutical company officials discussed mercury, vaccines, and autism; and mysterious rider to the Homeland Security bill, introduced by Senator Bill Frist, which would free drug companies of liability in lawsuits regarding autism. This disturbing, important book examines both the personal stories of families and the unfolding political drama in the courts and halls of Congress.

In conclusion, "Evidence of Harm" explains what is the real continuing cause of autism: Frist's rider clause inserted in "the homeland security act" Bill the night before it was to be voted on by Congress, and the financial interests of Eli Lilly.

http://books.google.com/books?id=w2PwVMgCK1UC&pg=PA226&lpg=PA226&dq=evidence+of+harm,+frist&source=bl&ots=-xndREvyxt&sig=W55yCipC38ZL4hu2o4qE-X2jghk&hl=en#v=onepage&q=evidence%20of%20harm%2C%20frist&f=false

FDA DOCUMENT:

"Is it safe for children to receive an influenza vaccine that contains thimerosal?"

"Yes. There is no convincing evidence of harm caused by the small doses of thimerosal preservative in influenza vaccines, except for minor effects like swelling and redness at the injection site."

CRITIQUE:

Yes perhaps, but by 2001 (April) a number of studies have shown a link between the excessive mercury exposure due to vaccines and rising rates of autism in children (a report issued by the California Health and Human Services Agency revealed a 273 percent increase in California children diagnosed with autism in the past decade). One study noted: "A review of medical

literature and US government data suggests that (i) many cases of idiopathic autism are induced by early mercury exposure from thimerosal; (ii) this type of autism represents an unrecognized mercurial syndrome; and (iii) genetic and non-genetic factors establish a predisposition whereby thimerosal's adverse effects occur only in some children." Bernard, S. et al., Autism: A novel form of mercury poisoning, *Med Hypotheses* 2001 Apr;56(4):462-71.

FDA DOCUMENT:

"Recent research suggests that healthy children under the age of 2 are more likely than older children and as likely as people over the age of 65 to be hospitalized with flu complications. Therefore, vaccination with thimerosal-preservative containing influenza vaccine and thimerosal-reduced influenza vaccine is encouraged when feasible in children, including those that are 6-23 months of age."

CRITIQUE:

Perhaps. However, modern flu vaccine programs don't prevent the diseases they are designed to protect against, and in many cases increase the incidence of diseases due to pathogens directly injected into the bloodstream:

2009 http://www.sciencedaily.com/releases/2009/05/090519172045.htm ScienceDaily. American Thoracic Society (2009, May 20). Children Who Get Flu Vaccine Have Three Times Risk Of Hospitalization For Flu, Study Suggests.

"*The inactivated flu vaccine does not appear to be effective in preventing influenza-related hospitalizations in children, especially the ones with asthma. In fact, children who get the flu vaccine are more at risk for hospitalization than their peers who do not get the vaccine, according to new research that will be presented on May 19, at the 105th International Conference of the American Thoracic Society in San Diego."*

"Flu vaccine (trivalent inactivated flu vaccine-TIV) has unknown effects on asthmatics."

"The concerns that vaccination maybe associated with asthma exacerbations have been disproved with multiple studies in the past, but the vaccine's effectiveness has not been well-established," said Avni Joshi, M.D., of the Mayo Clinic in Rochester, MN. "This study was aimed at evaluating the effectiveness of the TIV in children overall, as well as the children with asthma, to prevent influenza-related hospitalization."

"In order to determine whether the vaccine was effective in reducing the number of hospitalizations that all children, and especially the ones with asthma, faced over eight consecutive flu seasons, the researchers conducted a cohort study of 263 children who were evaluated at the Mayo Clinic in Minnesota from six months to 18 years of age, each of whom had had laboratory-confirmed influenza between 1996 to 2006. The investigators determined who had and had not received the flu vaccine, their asthma status and who did and did not require hospitalization. Records were reviewed for each subject with influenza-related illness for flu vaccination preceding the illness and hospitalization during that illness. ***They found that children who had received the flu vaccine had three times the risk of hospitalization, as compared to children who had not received the vaccine.*** *In asthmatic children, there was a significantly higher risk of hospitalization in subjects who received the TIV, as compared to those who did not (p= 0.006). But no other measured factors-such as insurance plans or severity of asthma-appeared to affect risk of hospitalization."*

FDA DOCUMENT:

"Is it safe for pregnant women to receive an influenza vaccine that contains thimerosal?"

"Yes. A study of influenza vaccination examining over 2,000 pregnant women demonstrated no adverse fetal effects associated with influenza vaccine. Case reports and **limited studies** indicate that pregnancy can increase the risk for serious medical complications of influenza. One study found that out of every 10,000 women in their third trimester of pregnancy during an average flu season, 25 will be hospitalized for flu related complications."

"Additionally, influenza-associated excess deaths among pregnant women have been documented during influenza pandemics. Because pregnant women are at increased risk for influenza-related complications and because a substantial safety margin has been incorporated into the health guidance values for organic mercury exposure, the benefits of thimerosal–reduced influenza vaccine or thimerosal-preservative containing influenza vaccine outweighs the theoretical risk, if any, of thimerosal."

CRITIQUE:

Where have we heard this argument before?

(Modified from DES action of Australia http://www.desaction.org.au/aboutdes.htm):

"Synthesised in 1938, laboratory studies showed animals administered DES developed mammary cancer, with high rates of fetal death, sterility and cancer in the offspring. Despite this, DES was approved for use in humans in 1940. Initially used to treat late pregnancy complications, by the mid 1940s the use was widened to include the prevention of miscarriage, i.e. for prophylactic use by women who had a history of miscarriage. However by 1949 DES was seen as making "a normal gestation more normal". By the early 1950s DES was being prescribed and marketed as a general pregnancy "tonic", mixed with vitamins and recommended for all pregnant women to ensure healthier pregnancies with "bigger and stronger" babies. A 1953 study showed, to the surprise of the researchers, that the DES-treated group experienced higher rates of miscarriage, premature labour and neonatal death than the control group, and the 1953 Dieckmann study was ignored. DES was already entrenched as standard obstetric clinical practice. Also by this stage DES was being aggressively promoted by the drug companies for use in all pregnancies. In 1971 it was discovered that DES caused clear cell cancer of the vagina/cervix in DES daughters. DES was thus proven to be carcinogenic in humans. Regardless of these findings, it was continued to be used as a treatment for acne, to dry up breast milk, as a contraceptive like a morning after pill, as hormone replacement therapy during menopause, as a treatment for "tall girls" to stunt their adult height, and to fatten up livestock to increase profits."

"In 1981 landmark publication, 'Developmental Effects of DES in Pregnancy' was edited by Arthur L Herbst and Howard A. Bern, which brought together leading experimental researchers and expert clinicians on DES. In an experiment ***on mice****, Herbst and Bern showed that in later life, the immune system of DES exposed mice was suddenly compromised. Preliminary studies of* ***DES daughters*** *in the early 1980s indicated that DES exposure is linked with* ***immune system problems****, including a higher incidence of* ***autoimmune disease****, such as asthma, arthritis, diabetes, systemic lupus and thyroid dysfunction."*

FDA DOCUMENT:

"You have said that thimerosal is no longer used as a preservative in vaccines routinely recommended for children 6 years or less of age, with the exception of influenza vaccine. What is being done about

the thimerosal content of other vaccines and other biological products given to infants, children, and pregnant women?"

Again, Dr. Stoller's observations are telling regarding this statement:

"As a pediatrician, who has been a fellow of the American Academy of Pediatrics (AAP) for two decades, I find the AAP's approach to the autism epidemic to be deeply disturbing. Not only have they allowed the myth of better diagnosing (as the reason for all the notice given to affected children) to be perpetuated, but when they were put on notice at the Center for Disease Control and Prevention's (CDC's) Simpsonwood meeting in 2000, that the mercury in the preservative Thimerosal was causing speech delays and learning disabilities, they obfuscated and hid that information. They never made good on their 1999 pledge to have Thimerosal eliminated from vaccines and almost a decade later joined in the protest against a fictitious TV show (Eli Stone) because it was critical of mercury being in vaccines."

"Today, in some states, the flu vaccine given to those under 3 year of age are supposed to contain no more than a trace level of Thimerosal, but with no government agency testing vaccines for mercury, the only ones who know whether a preservative-free vaccine (flu or otherwise) actually is mercury free are the manufacturers themselves."

Also, in 2000 at a San Diego research meeting on autism, Dr. Stephanie Cave presented the following information:

"By the age of two, American children have received 237 micrograms of mercury through vaccines alone, which far exceeds current EPA 'safe' levels of 0.1 mcg/kg. per day. That's one-tenth of a microgram, not one microgram."

"Three days in particular may be singled out as spectacularly toxic for infants: "Day of birth: hepatitis B—12 mcg mercury (30 times safe level).

"At 4 months: DTaP and HiB on same day—50 mcg mercury (60 times safe level).

"At 6 months: Hep B, Polio—62.5 mcg mercury (78 times safe level).

"At 15 months the child received another 50 mcg (41 times safe level).

"These figures are calculated for an infant's average weight in kilograms for each age. These one-day blasts of mercury are called 'bolus doses.' Although they far exceed 'safe' levels, there has never been any research conducted on the toxicity of such bolus doses of mercury given to infants all these years."Autism and Mercury." [Testimony presented by Stephanie Cave, MD before the Committee on Government Reform, US House of Representatives, July 18, 2000. Also presented at the Defeat Autism Now! Conference, 15 Sep 2000, San Diego, CA].

Consistent with Dr. Stoller's and Dr. Cave's warnings and admissions, we find as recently as March 2010 that:

2010 *(March) Danish Scientist who "proved" vax don't cause autism disappears with $2 million*
Key character who "proved" vaccines don't cause autism

A Danish scientist who was a key researcher in two studies that purport to show that mercury used in vaccines and the measles-mumps-rubella (MMR) vaccine do not cause autism is believed to have used forged documents to steal $2 million from Aarhus University in Denmark according to reports in the Copenenhagen Post Online and a statement from Aarhus University.

Poul Thorsen, MD PhD, headed up a research unit at Aarhus University that was hired by the Centers for Disease Control and Prevention to prepare a series of studies that would exonerate thimerosal, a mercury-based preservative and adjuvant used in vaccines, and the MMR vaccine from any role in causing autism. The veracity of the three studies he co-authored is now in doubt.

These studies formed the foundation for the conclusions of several Institute of Medicine reports that claimed that it was highly unlikely that thimerosal or MMR were implicated in autism.

In a statement Aarhus University officials said that believe Poulsen forged documents supposedly from the CDC to obtain the release of $2 million from the University. Poulsen resigned abruptly in March 2009 and left Denmark. Since then Thorsen has held several jobs in the US, first at Emory University in Atlanta and then at Drexel University in Philadelphia. Documents show that as late as January 22, 2009. Thorsenwas employed at Drexel. Any reference to Poulsen has now been deleted from the Drexel website.

Investigations also revealed that while employed full-time for the University of Aarhus in Denmark, Poulsen simultaneously held a fulltime position at Emory University in Atlanta, and drew salaries from both Universities despite a contract with Aarhus forbidding outside employment. According to the statement from Aarhus University.

Autism advocacy groups have published extensive analyses on Thorsen's studies and found many problems in methods, assumptions and conclusions that are supported by the data. And Thorsen is the lynchpin in the series of studies used to dismiss concerns about thimerosal and MMR causing autism.

See SAFEMINDS analysis of Thorsen's role in the discredited studies here:
http://www.safeminds.org/news/pressroom/press_releases/20040518_AutismAuthorsNetwork.pdf

See the Copenhagen Post Online article at:
http://www.cphpost.dk/news/international/89-international/48229-researcher-accused-of-cheating-uni-out-of-millions.html

See the statement from Aarhus University

http://www.rescuepost.com/files/thorsen-aarhus.pdf

Read more at Age ff Autism at: www.ageofautism.com

The two studies now in doubt include:

Thimerosal and the occurrence of autism: negative ecological evidence from Danish population-based data. Madsen KM, Lauritsen MB, Pedersen CB, Thorsen P, Plesner AM, Andersen PH, Mortensen PB, Pediatrics. 2003 Sep;112(3 Pt 1):604-6.

A population-based study of measles, mumps, and rubella vaccination and autism. Madsen KM, Hviid A, Vestergaard M, Schendel D, Wohlfahrt J, Thorsen P, Olsen J, Melbye M., N Engl J Med. 2002 Nov 7;347(19):1477-82.

FDA DOCUMENT:

"FDA is continuing its efforts to reduce the exposure of infants, children, and pregnant women to mercury from vaccines. FDA is in discussions with manufacturers of influenza vaccine regarding their capacity to further increase the supply of preservative-free formulations. Of note, all hepatitis B vaccines for the U.S., including for adults, are now available only as thimerosal-free or thimerosal-reduced containing formulations."

"Tetanus and Diphtheria toxoids (Td) which is indicated for children 7 years of age or older and adults, is now also available in thimerosal-free formulations. In addition, all vaccines licensed since 1999 with the exception of inactivated influenza vaccine have not contained thimerosal as a preservative. Also, all immune globulin preparations including hepatitis B immune globulin, and Rho(D) immune globulin preparations are manufactured without thimerosal."

CRITIQUE:

In 1998 (Sept), Johns Hopkins Newsletter Nov. 1998 stated Alzheimer's incidence would quadruple in coming years. According to Hugh Fudenberg, MD (the world's leading immunogeneticist, author of nearly 850 papers in peer-reviewed journals): "Individuals who have had five consecutive flu shots between 1970 and 1980 (years studied) have a ten times higher chance of getting Alzheimer's disease than if they had one, two or no shots… due to the mercury and aluminum in every flu shot. The gradual mercury and aluminum buildup in the brain causes cognitive dysfunction."

Also, in 2005 (August) deception appears to be the name of the game when the facts reveal that current medical practices are doing major harm to America's children. The media is often deceived by medical "experts"whose agenda the reporters don't recognize. NBC's moderator, Tim Russert, appears to have been "had" when he accepted as Gospel what Dr. Feinberg's false claim that since 2003 there has been no Thimerosal preservative used in any vaccines given to infants (other than flu vaccine).

FDA's current table of vaccine contents calls the lie. (See: www.FDA.gov/cber/vaccine/thimerosal.htm). *"The latest table still lists Multiple dose DT by Aventis Pastuer ltd as fully preserved; TT vaccine is preserved with Thimerasol; Japanese encephalitis vaccine JE-VAC is thimerasol preserved; Meningococcal vaccine (Menomune) in multidose vials is preserved with Thirmerasol. Tim Russert's effort to reassure parents that there is no longer any thimerasol in any vaccines was inappropriate--as it helps perpetrate deceptions.*

21CFR610.15(A) is part of the Code of Federal regulations. It is a law and it is legally binding. It states that a manufacturer must prove that the component is "safe" before putting it into a vaccine as a preservative. This SAFETY test has never been done. And FDA has never been taken to task for allowing preservatives that are known to cause neurological damage to be used in vaccines. According to our testing results from January of this year, there are vaccines that contained from .019 micrograms up to 66 micrograms per mL that either expired in 2005 or won't expire until 2006. The flu vaccine we tested that expired in June 2005 contained 48 micrograms per mL, or 24 micrograms per adult dose (and I assume 12 micrograms per adolescent dose) and that it is being used as a preservative." Dawn Winkler, Executive Director, Health Advocacy in the Public Interest (HAPI) www.hapihealth.com.

And in 2008, January 3, The NEJM Volume 358:93-94, Number 1, had an article entitled:

"Early Thimerosal Exposure and Neuropsychological Outcomes," By Thompson, W. W., which stated that:

To the Editor: Thompson et al. (Sept. 27 issue)1 report the results of a study investigating the neuropsychological outcomes of early exposure to thimerosal. ***As a dissenting member of the panel of external consultants for this study, I object to the authors' conclusion that there is no causal association between thimerosal and children's brain function.*** *The sample comprised children who were least likely to exhibit neuropsychological impairments. Specifically, children with congenital problems, those from multiple births, those of low birth weight, and those not living with their biological mother were excluded. The sample was skewed toward higher socioeconomic status and maternal education — factors that are associated with lower rates of neurobehavioral problems and higher intervention rates and that were not measured. The sampling frame included only children enrolled from birth in the health maintenance organization (HMO) and still enrolled after 7 to 10 years, excluding children in higher-mobility families, who tend to have lower academic and behavioral function.2 Children with neurobehavioral problems may have been less likely to remain with the HMO. Only 30% of families selected for recruitment participated, a low rate for scientific research. Among the families selected for recruitment, 26% refused to participate. Another 28% "could not be located," which included families that did not respond to multiple recruitment attempts (internal documentation from the study contractor, Abt Associates) — another form of refusal.*

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NOTES: SECTION 1.

Evidence why the statement "Before new vaccines are licensed, they are tested extensively for safety in the laboratory, in animals, and in successive stages of human clinical trials called phases" is a major distortion about the true facts.

I will give only 3 examples regarding how vaccines became approved by the FDA, two of the more well known ones most are familiar with, such as the polio vaccine, and the hepatitis B vaccine, and also for perspective, the most recent vaccine(s) including the 64 failed AIDS vaccines." It is hoped that this information may be helpful to more fully appreciate the truth of the FDA's opening statement that **"Before new vaccines are licensed, they are tested extensively for safety in the laboratory, in animals, and in successive stages of human clinical trials called phases"** as shown by the following chronology of events:

POLIO VACCINE:

In 1907, calcium arsenate comes into use primarily on cotton crops.

In 1908, a Massachusetts town with three cotton mills and apple orchards recorded that 69 children suddenly fell ill with infantile paralysis.

In 1909, the UK bans apple imports from the States because of heavy lead arsenate residues.

In 1910, Flexer and Lewis ground up human spinal cord of a paralysis victim and injected the suspension directly into a monkey's brain, the monkey became paralyzed, then they extracted some fluid from its brain, and injected it into another monkey's brain, and so on through a series of monkeys paralyzing all of them in the process. But making the monkeys drink the liquid or injecting into their arms, the suspension did not paralyze them.

In 1948 Dalldorf and Sickles took excrement from a polio victim and prepared a 20% suspension with ether and centrifugation, then injected it directly into the living brains of suckling mice 3-7 days old. They became paralyzed but no virus had been identified.

In 1949 Endocrinologist Dr Morton Biskind, a practitioner and medical researcher, found that DDT causes 'lesions in the spinal cord similar to human polio,' and in 1950 US Public Health Industrial Hygiene Medical Director, J.G. Townsend, notes the similarity between parathion poisoning and polio and believes that some polio might be caused by eating fruits or vegetables with parathion residues.

In 1950, Dr. Joseph Stokes of the University of Pennsylvania infects 200 women prisoners with viral hepatitis.

Also in 1950, US Public Health Industrial Hygiene Medical Director, J.G. Townsend, notes the similarity between parathion poisoning and polio and believes that some polio might be caused by eating fruits or vegetables with parathion residues.

In 1950 a small ball like particle, 24-30 nm in size, was isolated from human excrement, and made visible with an electron microscope. It was named the 'poliovirus.'

In 1950 Ralph R. Scobey, M.D., president of the Poliomyelitis Research Institute. Inc. Syracuse, New York (Archives of Pediatrics, Sept. 1950) lists 170 diseases of polio-like symptoms and effects but with

different names such as: epidemic cholera, cholera morbus, spinal meningitis, spinal apoplexy, inhibitory palsy, intermittent fever, famine fever, worm fever, bilious remittent fever, ergotism, and others. There are also such common nutritional deficiency diseases as beriberi, scurvy, Asiatic plague, pellagra, prison edema, acidosis, and others. "No drugs, medicines or medical treatments have ever been able to cure any of these diseases and no germs have been isolated as the cause. But they all respond to fasting, cleansing, proper diet and improved circulation. The similarity of these diseases to polio is too obvious to go unnoticed. They are, in reality, all one disease with varying stages of intensity and different names. It is ridiculous to assume that polio is caused by a virus and the rest of them are caused by nutritional deficiency. Inasmuch as nerve cells react in much the same way to various poisons, further research will probably show that in these cases polio micro-organisms are not always present, but intoxication (poisoning) may be produced through faulty metabolism or by the absorption of poisons from without" (Ralph Scobey, 1950).

Also in 1950, Dr. Biskind presented evidence to the US Congress that pesticides were the major cause of polio epidemics. He is joined by Dr. Ralph Scobey who reported he found clear evidence of poisoning when analyzing chemical traces in the blood of polio victims.

Also in 1951, scientists report they cannot find the designated polio virus in many polio victims.

Also in 1951, Dr. Biskind treats his polio patients as poisoning victims, removing toxins from food and environment, especially DDT contaminated milk and butter. Dr. Biskind writes: 'Although young animals are more susceptible to the effects of DDT than adults, so far as the available literature is concerned, it does not appear that the effects of such concentrations on infants and children have even been considered.'

Also in 1951, other doctors report they are having success treating polio with anti toxins used to treat poisoning, dimercaprol and ascorbic acid. Dr. F. R. Klenner reported: 'In the poliomyelitis epidemic in North Carolina in 1948 60 cases of this disease came under our care... The treatment was massive doses of vitamin C every two to four hours. Children up to four years received vitamin C injection intramuscularly... All patients were clinically well after 72 hours.'

In 1951 the man who became most responsible for the view that poliomyelitis was contagious was Dr. Simon Flexner, author of the famous (or infamous) Flexner Report, which led the way to the closing of the naturopathic and homeopathic colleges in the United States. Said Flexner: "It was not easy to establish in an individual case precisely how the disease was acquired; it was difficult to bring evidence that was not at all convincing that this disease was contagious." In discussing Flexner's report, L. Emmett Holt stated: "Even five years ago, if anyone had suggested that the disease under discussion was an infectious or contagious one, it would have been looked upon as a joke" (Scobey, Archives of Pediatrics, May 1951).

In 1952 Prof Konstantine Vinodouroff of the Institute of Neurology, Russian Academy of Medical Science, tells the Americans that Russia has never had an outbreak of polio. The Americans are amazed.

In 1953 Dr. Kumm was appointed Director of Research of the National Foundation for Infantile Paralysis (NFIP). The NFIP was funded by its "March of Dimes" program, and it sponsored the hasty development of the Salk vaccine in the early 1950s, at the height of the DDT/polio controversy. Dr. Kumm also "served as a civilian consultant to the Surgeon General . . . directing field studies of the use of DDT. . ." (American Journal of Digestive Diseases, 20:330, 1953).

In 1953, Dr. Biskind wrote: 'It was known by 1945 that DDT was stored in the body fat of mammals and appears in their milk... yet far from admitting a causal relationship between DDT and polio that is so obvious, which in any other field of biology would be instantly accepted, virtually the entire apparatus of communication, lay and scientific alike, has been devoted to denying, concealing, suppressing, distorting and attempts to convert into its opposite this overwhelming evidence. Libel, slander, and economic boycott have not been overlooked in this campaign.'

In 1954, legislation recognizing the dangers of persistent pesticides is enacted, and a phase out of DDT in the US accelerates along with a shift of sales of DDT to third world countries. DDT is phased out at the same time as widespread polio vaccinations are about to begin.

Also in 1954 Dr. Jonas Salk developed the first commercial polio vaccine from the pooled feces of three healthy children in Cleveland (not polio victims). The 'poliovaccine' is administered as a safety test to **400,000** US children. The official safety report stated that it protected '30-90 percent' of recipients.

Also In 1954 Dr. Bernice Eddy (bacteriologist) discovered live SV-40 monkey viruses in supposedly sterile inactivated polio vaccine developed by Dr. Jonas Salk [Harris RJ et al Contaminant viruses in two live vaccines produced in chick cells.J Hyg (London) 1966 Mar: 64(1) : 1-7]. This discovery was not well received at the NIH and Dr. Eddy was demoted. Later Dr. Eddy, working with Sarah Stewart, discovered SE polyoma virus. This virus was quite important because it caused cancer in every animal receiving it. Yellow fever vaccine had previously been found to contain avian (bird) leukemia virus. Later Dr. Hilleman isolated SV 40 virus from both the Salk and Sabin polio vaccines. There were 40 different viruses in these polio vaccines they were trying to eradicate. They were never able to get rid of these viruses contaminating the polio vaccines. The SV 40 virus has been associated with malignancies. It has now been identified in 43 % of cases of non-Hodgkin lymphoma [Vilchez RA et al Association between simian virus 40 and non-Hodgkin lymphoma Lancet 2002 Mar 9;359(9309):817-823], 36 % of brain tumors [Bu X. A study of simian virus 40 infection and its origin in human brain tumors [Zhonghu Liu Xing Bing Xue Zhi 2000 Feb;21 (1):19-21], 18 % of healthy blood samples, and 22 % of healthy semen samples, mesothiolomas and other malignancies. By the time of this discovery SV 40 had already been injected into 10,000,000 people in Salk vaccine. Gastric digestion inactivates some of SV 40 in Sabin vaccine. However, the isolation of strains of Sabin polio vaccine from all 38 cases of Guillan Barre Syndrome GBS in Brazil suggests that significant numbers of persons are able to be infected from this vaccine [Friedrich F. et al temporal association between the isolation of Sabin-related poliovirus vaccine strains and the Guillan-Barre syndrome Rev Inst Med Trop Sao Paulo 1996 Jan-Feb; 38(1):55-8]. All 38 of these patients had received Sabin polio vaccine months to years before the onset of GBS. The incidence of non-Hodgkin lymphoma has"mysteriously" doubled since the 1970s.

In 1955, IPV (inactivated polio vaccine) was first licensed (was later modified in 1987).

Also 1955, 8 days after the first roll out of Salk's vaccine, on April 24, 1955, an infant with paralytic poliomyelitis was admitted to Michael Reese Hospital in Chicago, Illinois. The patient had been inoculated in the buttock with Cutter vaccine on April 16, and developed flaccid paralysis of both legs on April 24.

Also in 1955 and one month after the Salk vaccine is rolled out, in May, "*and with the announcement that Cutter (a principal manufacturer of the first polio vaccine) was withdrawing its vaccine, there ensued a nationwide panic. The AMA put out the warning to all its members to stop using Cutter vaccine, although regrettably some doctors never received word. Many states and cities announced immediate cessation of mass immunizations, even though their vaccine had come from manufacturers other than Cutter. Local health departments began to track down every single dose of Cutter vaccine,*

which, it was soon discovered, had traversed the entire country. Throughout May and June, cases of polio caused by Cutter's vaccine spread beyond the Far West and began to appear in every region of the country. The epicenter of the devastation was in California and the rural state of Idaho. Ninety-nine cases of polio would eventually be attributed to Cutter vaccine in California, with the incidence of polio among Cutter vaccinees exceeding the textbook definition of a wild polio epidemic by nearly ***threefold.*** *In Idaho, with eighty-eight polio cases attributed to Cutter vaccine, the rate was* ***fifteen times*** *greater. Before it was over, the 'Cutter incident,' as it was euphemistically called in scientific circles, resulted in 260 people contracting polio and almost 200 cases of paralysis. Eleven people died. A devastating epidemic had been caused by two particularly bad batches of vaccine." Massachusetts reported* ***a 642% increase in polio since vaccinations*** *with vaccination of 130,000 children. In 1956, Idaho health director Peterson stated that polio only struck vaccinated children in areas where there had been no cases of polio since the preceding autumn.* ***In 90% of the cases, the paralysis occurred in the arm in which the vaccine had been injected.*** *Many of these physicians who had been notified that the polio vaccine was causing polio voluntarily stopped delivering the vaccine."* (The Virus and The Vaccine-The True Story Of A Cancer -Causing Monkey Virus-Contaminated Polio Vaccine, And the Millions Of Americans Exposed, by Debbie Bookchin and Jim Schumacher, St. Martin's Press, 2004).

Also in 1955, President Dwight Eisenhower awarded Salk the Congressional Medal declaring the polio vaccine a great victory for American science.

In 1956 Dr. Albert Sabin tests experimental polio vaccine on 133 prisoners in Ohio.

Also in 1956 health authorities change the rules for defining polio. Doctors are instructed to diagnose polio only if the patient has paralytic symptoms for 60 days or more. Milder cases of polio are no longer reported.

By 1957, Canada suspended its distribution of Salk's vaccine. By November all European countries had suspended distribution plans, apart from Denmark. By January 1957, 17 US states had stopped distributing the vaccine. The same year The New York Times reported that nearly 50 per cent of cases of infantile paralysis in children between the ages of five and 14 had occurred after vaccination" (Bookchin and Schumacker, 2004).

In 1958 the CDC changes the rules for defining polio again. Cases of inflammation of the membrane that protects the brain and spinal neuron cells, causing muscular weakness and pain, but not paralysis, are no longer to be classified as polio. These cases must now be called viral or aseptic meningitis. Non-paralytic cases were now to be re-named meningitis even if the poliovirus is present. The reported figures for polio were officially to exclude 'cases of aseptic meningitis due to poliovirus or other enteroviruses.' Reported cases of aseptic meningitis went from near zero to thousands, and polio cases dropped the same amount.

Also in 1958, officials reduce the definition of polio again. Now all cases with classic polio paralytic symptoms are to be diagnosed initially as Acute Flaccid Paralysis (AFP). Two stools are taken from the patient and sent to the CDC to see if they can find polio in them. If not, they are declared as not polio, even if the children have all the classic symptoms. Making fewer cases of polio by changing the definition was a fraudulent way to make it seem like the polio vaccinations were working.

Also in 1958 officials triumphantly declared large parts of the world polio free, even while the newly defined Acute Flaccid Paralysis (AFP) suddenly became common. Credit for this great victory over disease was given to Salk, Sabin and the vaccine manufactures.

In 1961 (Journal of the American Medical Association, Feb 25, 1961) it is stated that: "It is now **generally** recognized that **much** of the Salk vaccine used in the U.S. has been **worthless**, which is why **live strains** produced by Sabin and put in sugar cubes were adopted instead."

In 1961, OPV (the oral, live-virus Salk polio vaccine)was licensed.

Also in 1961, *"Merck stopped shipping Purivax (its 'purified' version of the Salk vaccine) as soon as its own tests in May 1961 confirmed that the vaccine was contaminated with SV 40…a putative cancer causing virus that induced cancers in hamsters and other test animals, such as mesotheliomas, bone cancer, and brain cancer. Its unilateral withdrawal of vaccine from the market had not been well received by the DBS (Division of Biological Standards). If Merck recalled vaccine, then everyone else would have to. That would have resulted in public panic and would have run counter to the Technical Committee's May 18 directive that polio vaccination 'continue to be pursued with vigor with the materials presently available.' In June, after the Girardi cancer results had come in, Hilleman (Merck's science director) had tried one more time to get all vaccine production halted. That suggestion was rebuffed. Merck had already suspended production and was trying to figure out how to screen SV40 out of the vaccine when DBS tests on vaccine samples indicated that Parke-Davis supplies were also badly contaminated. Parke-Davis now also stopped vaccine manufacture. The truth was that by the time the Associated Press reported the 'news' in late July, both companies had not produced vaccine for several weeks. Parke Davis eventually resumed production, but Merck would soon decide that producing a polio vaccine that at times might be contaminated was not worth the risk."*

Also in 1961, the Food and Drug Administration ordered all vaccine manufacturers to screen out the SV40. One study suggests that Lederle did not do so. Kops, S.P., *"Oral polio vaccine and human cancer: a reassessment of SV40 as a contaminant based upon legal documents,"* Anticancer Res 2000 Nov-Dec; 20(6C) :4745-9.

"In 1962 "The Wistar human tissue study" appeared in midsummer 1962, shortly before the human tissue study that Enders had completed at Hilleman's urging. Enders and his collaborator, another Harvard researcher, Harvey Shein, reached essentially the same conclusions as the Wistar group, with a different kind of tissue, human kidney cells. Koprowski had rushed the Wistar study into press hoping to scoop Enders and gain some publicity for Wistar. But in the end, despite being second, the Enders study attracted a good deal more attention because it was published in the prestigious Proceedings of the National Academy of Sciences. A lengthy New York Times story on August 10, 1962, reported the Enders study:

'A cancer-causing virus has for the first time produced cancer like changes in human cells… Changes that the virus produced in cultures of human kidney cells included greatly accelerated growth patterns and chromosomal aberrations...'

By the fall of 1962, as news of the most recent SV40 research spread, the anxiety that had been growing in scientific circles about the simian virus rearched its zenith. 'It was the worst thing in the world,' Hayflick recalls of the news. 'Please tell me: What else could we find worse in monkey kidney cells?' In Britain, Wellcome Laboratories decided to stop inactivated vaccine production and switch entirely to live polio vaccine production.

As in the United States, however, both the British and Canadian governments decided not to recall old stocks of Salk vaccine. Britain had a surplus of 6 million injections in 1961. In Sweden, the concern was about Sabin-type vaccine. There were plans to give monkey gamma globulin to four thousand children who had received oral vaccine in the belief that it would contain antibodies against any simian viruses, including SV40, which might have contaminated the oral doses. In the Soviet Union, site of the most

extensive use of Sabin's vaccine, tests were conducted to determine the spread of SV40. Many of the technicians and scientists involved in Chumakov's massive vaccination trial proved to have been infected by the virus, and the Soviets were now fearful of SV40's possible long-term effects. Among American research and health officials, a joke with gallows-type humor began to make the rounds: The Soviets would lose the 1964 Olympics because their athletes would all have tumors thanks to SV40" (Quoted material from Bookchin and Schumacker, 2004).

In 1972, Jonas Salk, inventor of the killed polio vaccine, testified before a Senate subcommittee that nearly all polio outbreaks since 1961 were caused by the oral polio vaccine (Dr. Salk didn't like Dr. Sabin very much, or so it is claimed, and the hatred flowed in both directions).

In 1988 A serological survey was performed on 573 subjects aged 3-80 years or older to evaluate presence of neutralizing antibodies for types 1,2,3 Sabin vaccines strains as well as a wild strain of poliovirus type 1 isolated in France (Virologie. 1988 Oct-Dec;39(4):241-5). The study reported that:

"The results obtained indicate a satisfactory polio immunity level in all the 4 groups: seropositives, 96.7%-98.9% for type 2, 91.8%-98.2% for type 1 (Sabin vaccine strain), 89.3%-96.6% for type 3 and 84.2%-96.4% for type 1 wild strain. The highest immunity levels were found in group D (children with recorded history of complete polio vaccination) and in group A (**unvaccinated people but contemporary with the past polio epidemics**). A special comment is made with respect to 14 subjects showing satisfactory antibody titres for all the three types of Sabin-vaccine strains but who have proved to be seronegative (less than 4) for the wild type 1 poliovirus strain."

Because "the best "neutralizing" antibody levels were found in groups A and D:" the completely vaccinated (having had all their shots), and group D (the non-vaccinated and who are thought to have acquired polio naturally, and overcome it naturally), it was concluded that if parents either get their children completely vaccinated, or don't bother, the children would end up in either group A or D with the highest neutralizing antibody levels.

In 1989, the country of Oman experienced a widespread polio outbreak six months after achieving a complete vaccination rate.

In 1992, America's Centers for Disease Control (CDC) in Atlanta admitted that the polio live-virus vaccine had become the main cause of polio in the United States. Specifically, the CDC asserted that, from 1973 to 1983, 87% of all (non-imported) cases of polio resulted directly from vaccine administration. Even more amazingly, it was asserted that every non-imported case of polio in the United States from 1980 to 1989 was vaccine-induced [Strebel, P. M., et al., Epidemiology of Poliomyelitis in the U.S. One Decade after the Last Reported Case of Indigenous Wild Virus Associated Disease, Clinical Infectious Diseases, CDC, February, pp. 568-579, 1992].

In 1995 Congress of the United States published a book which was The Office of Technology's assessment of the failure of the first 33 "HIV-vaccine" trials. Adverse Reactions to HIV Vaccines: Medical, Ethical, and Legal Issues. (Roger C. Herdman, Director), in which it is stated that:

From page 50:

"There is a narrow margin between surviving virus and the destruction of viral immunogenicity; this was highlighted early in the use of licensed polio vaccine when a number of vaccinated individuals developed paralytic poliomyelitis from vaccine lots containing residual live virus.

“In addition, the safety of the “lymphoblastoid” cell lines used to prepare the virus is unknown. “Adventitious agents,” that is, unwanted agents growing silently in the cell cultures used to prepare vaccine stock, have posed safety problems in the past. As an example, SV40, a monkey tumor virus, contaminated early lots of inactivated polio vaccine prepared in monkey cells.”

In 1997 Polio is not eradicated by vaccination, but likely lurks behind a disease redefinition and new diagnostic names like viral or aseptic meningitis.....According to one of the 1997 issues of the MMWR, there are some 30,000 to 50,000 cases of viral meningitis per year in the United States alone. That's where it is thought that 30,000 - 50,000 cases of polio disappeared after the introduction of mass vaccination.

"Today, various other forms of the word "polio" are still used to describe the effects of poisoning, though usually with regard to paralysis in animals. A search of Medline ("polio" and "poison") finds about 45 contemporary articles where poisoning causality is attributed to polio. The terminology found was: "polioencephalomalacia", "poliomyelomalacia", "polyradiculoneuritis", "neurological picture similar to that of poliomyelitis", "polioencephalomyelomalacia", "lumbal poliomyelomalacia", "cerebrocortical necrosis (polioencephalomalacia)", "Lead poisoning in grey-headed fruit bats (Pteropus poliocephalus)", "multifocal-poliomyelomalacia", "spinal poliomalacia", "Polio and high-sulfate diets", "atypical porcine enterovirus encephalomyelitis: possible interraction between enteroviruses and arsenicals", "polioencephalomalacia and photosensitization associated with kochia scoparia consumption in range cattle", "bovine polioencephalomalacia." Viral or aseptic meningitis, Guillaine Barre Syndrome (GBS), Chinese paralytic syndrome, chronic fatigue syndrome, epidemic cholera, cholera morbus, spinal meningitis, spinal apoplexy, inhibitory palsy, intermittent fever, famine fever, worm fever, bilious remittent fever, ergotism, ME, post-polio syndrome, acute flaccid paralysis (Jim West, Health and Research Publications).

In 2000 the CDC recommends use of IPV instead of OPV (polio vaccine).

In 2002 Figures from the US Centers for Disease Control and Prevention showed there were 1,920 confirmed cases of polio reported by laboratories in 2002, up from 483 the previous year.

Similarly, and despite the 2004-5 West African polio eradication campaign by the CDC and the WHO, intended as part of the World Health Organization’s 15 year drive to halt transmission of the poliomyelitis across the world by 2005 and to stamp out the polio in those regions, it turned out that the most heavily vaccinated countries like Nigeria now lead the world in new polio cases with 4,937 cases http://www.who.int/vaccines/immunization_monitoring/en/diseases/poliomyelitis/afpextract.cfm.

In another review of the early polio era, Hans J. Eggers (Milestones in Early Poliomyelitis Research (1840 to 1949) Journal of Virology, June 1999, p. 4533-4535, Vol. 73, No. 60) wrote:

“The history of the etiology of poliomyelitis is a history of errors. I mention only the "coccus era," when several investigators were prejudiced by a supposed parallelism between ***poliomyelitis*** *and* ***meningitis*** *epidemica.”*

“However, all in all, bacteriological findings were negative; likewise, attempts to transmit the disease to the usual laboratory animals, such as rabbits, guinea pigs, or mice, failed. Landsteiner and Popper (14) injected intraperitoneally into two Old World monkeys (Cynocephalus hamadryas and Macacus rhesus) a suspension of spinal cord from a 9-year-old boy who had succumbed to severe poliomyelitis ***after four days of illness.*** *The two monkeys, in good condition, had been available from previous experiments* ***with syphilis****. The inoculated material,* ***which was bacteriologically sterile,*** *yielded negative results when injected into rabbits, guinea pigs, and mice. The two monkeys, however, exhibited lesions in the spinal cord, medulla, pons, and brain stem that were indistinguishable from those observed in cases of human poliomyelitis.* ***One of the monkeys****, the rhesus monkey, developed complete flaccid paralysis of both legs. Landsteiner and Popper*

were unable to passage the agent, but this was achieved soon afterward and independently in 1909 by Römer (22), Flexner and Lewis (8), Leiner and von Wiesner (15), and Landsteiner and Levaditi (13)"
[showing perhaps that whatever was injected was not as important as the type of Old World primate it was injected into perhaps]?
"As early as 1910, Flexner and Lewis (9) had cautiously suggested that poliovirus gained access to the central nervous system ***via the nasal mucosa, a hypothesis supported by experiments with monkeys performed by Flexner's group and by Leiner and von Wiesner: swabs containing poliovirus were introduced into the nose and rubbed vigorously over the upper nasal mucous membrane, with ensuing clinical poliomyelitis. Flexner's views on the strict neurotropism of poliovirus and on its entry into the body by the nasal route (see above) dominated poliovirology so that other experimental evidence was more or less neglected for about 25 years until the 1930s.*** *In particular, the exciting results of a young Swedish team consisting of Carl Kling, Wilhelm Wernstedt, and Alfred Pettersson published in 1912 (11, 12) were disregarded: the authors had demonstrated poliovirus* ***in fatal and nonfatal cases*** *of poliomyelitis, not only as expected from the oropharynx and trachea but also from* ***the small intestine.*** *Certainly, one possible interpretation of the presence of virus in the intestines was that it had been swallowed. But the clue of poliovirus present in the intestines and its pathogenic significance was not seriously pursued. Revival of poliovirus infection* ***as an intestinal disease*** *came mainly from the work of Trask and Paul at Yale University (20) and the definite report by Albert Sabin and Robert Ward in 1941 (26) on the natural history of human poliomyelitis. By meticulous technique (the authors performed necropsies of fatal polio cases themselves), they proved that the virus is distributed predominantly in two systems: (i) certain regions of the nervous system and (ii) the alimentary tract."*
" The presence of virus in the walls of the alimentary tract appeared to be primary localization and portal of entry. ***Virus was absent in the nasal mucosa, olfactory bulbs, and anterior perforated substance, which suggested that neither the upper respiratory tract nor the olfactory pathway is of significance in cases of natural human poliomyelitis."***
" Another highpoint of poliovirus research was the finding in 1931 by the Australians Frank M. Burnet and Jean Macnamara (4) that ***there existed antigenic differences between strains of poliovirus****. So far, a complete similarity of the different strains had been* ***assumed****. The Australian authors compared the famous Rockefeller MV strain with a local strain isolated in Melbourne and found striking differences in* ***cross-immunity experiments and neutralization tests in monkeys.*** *The report was treated with scepticism, since it came from unknown investigators on a remote continent. But in light of the* ***ill-fated vaccine trials of 1935****, the significance of this finding was particularly realized by Hammon, Francis, and Rivers (2). Finally, the question was settled by the Committee on Typing of the National Foundation for Infantile Paralysis early in the 1950s (5)."*
" A further highlight of poliovirus research was ***the adaption of the Lansing strain of poliovirus to mice by the persistent efforts*** *of Charles Armstrong in 1939 (1). This meant that* ***at least one strain of poliovirus*** *was available for research purposes in an animal far less expensive than the monkey."*
" Some years earlier Maurice Brodie et al. (3) had already tried with ingenious techniques to reproduce poliovirus in mice for Brodie's vaccine trials, ***but with the vaccine failures this work was neglected.*** *All the more must Armstrong's persistence be admired. In this context it should be mentioned that Max Theiler (quoted by Paul [20]) in analogy to his work on yellow fever formed more than* ***150 mouse passages of the Lansing strain and observed a dramatic attenuation****-a term used first by John Kolmer of Philadelphia- in connection with poliomyelitis vaccines of the virus* ***after intracerebral inoculation of monkeys with results of from 100 to 0% paralysis****. In passing, I should like to mention that among all contemporary virologists, it was Max Theiler and likewise John Enders who were highly regarded by Albert Sabin."*
" There were attempts as early as 1913 by Constantin Levaditi (16) to replicate poliovirus in tissue culture. But as Sabin and Olitsky (25) stated in their famous paper of 1936, ***"there is no unequivocal evidence that the virus of poliomyelitis has as yet been successfully cultivated outside the body."***
" Sabin and Olitsky used various carefully dissected tissues of ***3- to 4-month-old human embryos****, e.g., brain and cord, lungs, kidney, liver, and spleen. The virus was the already mentioned MV (mixed virus) strain of the Rockefeller Institute, a virus mixture prepared by H. L. Amoss in 1914* ***and kept for decades through numerous intracerebral passages in monkeys*** *(23). The authors found that the virus multiplied readily* ***only in the presence of nervous tissue****, as evidenced by experiments* ***with monkeys, including neutralization tests.*** *The experiment appeared interesting at the time but of no practical value."*
" Despite this depressing failure and in view of the mounting evidence of the extraneural multiplication of poliovirus (see above), John Enders and his young collaborators Thomas Weller and Frederick Robbins

*made further attempts to cultivate poliovirus **in vitro**, in particular after Weller's successful cultivation of mumps virus in vitro. Enders and coworkers (7) demonstrated the dramatic replication of Lansing virus (testable in mice) in human embryonic cultures composed chiefly of skin, muscle, and connective tissue from the arms and legs, in cultures of human embryonic intestine, and in those of nervous tissue. It was Robbins who first recognized **differences in cell morphology** between inoculated and uninoculated cultures (24a). Enders coined the term **cytopathic effects** (CPE)."*

*" The implications of this famous paper, published in Science on 28 January 1949, were enormous and well recognized by the authors but surprisingly not by all colleagues in poliomyelitis research, at least initially. Enders et al. readily demonstrated the multiplication of all three poliovirus types in various primate tissues**, in particular in nonnervous tissues**, and showed that large amounts of virus could be propagated in vitro, that cultures most sensitive to the isolation of virus could be obtained in abundant amounts, and that precise quantitation of infectious virus could easily be achieved. Furthermore, besides Gilbert Dalldorf's and Grace Sickles' (6) isolation in newborn mice of coxsackieviruses, another major group of enteroviruses pathogenic for humans, the soon to be recognized potential of cell culture techniques led to the discovery of echoviruses, likewise important agents of human disease."*

HEPATITIS B VACCINE

Other FDA licensed vaccines have been FDA approved and extensively used, contrary to what is stated in this FDA report's first sentence, before they even had been tested in animals, because there never has been, nor is there currently an animal model for such diseases as "hepatitis B" in the first place as reported in characteristically dense scientific language or stated indirectly as in this Science article published in 1999, and in a Gastroenterology article published in 1990:

"Viral clearance without destruction of infected cells during acute HBV infection." Science Apr 30;284(5415):825-9, 1999):

"Viral clearance during hepatitis B virus (HBV) infection has been thought to reflect the destruction of infected hepatocytes by CD8(+) T lymphocytes. ***However, in this study, HBV DNA was shown to largely disappear from the liver and the blood of acutely infected chimpanzees long before the peak of T cell infiltration and most of the liver disease. These results demonstrate that noncytopathic antiviral mechanisms (i.e. viral mechanisms that do no harm to cells) contribute to viral clearance during acute viral hepatitis*** *by purging HBV replicative intermediates from the cytoplasm and covalently closed circular viral DNA from the nucleus of infected cells."*

In other words, there is no liver destruction observable even after exposure to hepatitis B in chimps.

From (Yamamura et al., HBV production in transgenic mice. From: Gastroenterol. 1990 Sep;25 Suppl 2:49-53):

"The founder mouse is now 19 months of age but shows no clinical or pathological change, suggesting that HBV itself is not cytopathic."

But these published facts, even though accepted in the world's and medical profession's most prominent journals, the carnage of the hepatitis B vaccine proceeded with renewed vigor during the 1990's, nor did these and many other disturbing facts stop the FDA from licensing vaccines and imposing universal forced hepatitis B vaccines on infants hardly several hours old, or for day care and school-entering populations, and indeed, in 48 states and numerous foreign countries.

A few examples:

The earliest record of an epidemic caused by hepatitis B virus was made by Lurman in 1885. An outbreak of smallpox occurred in Bremen in 1883 and 1,289 shipyard employees were vaccinated with lymph from other people. After several weeks, and up to eight months later, 191 of the vaccinated workers became ill with jaundice and were diagnosed as suffering from serum hepatitis. Other employees who had been inoculated with different batches of lymph remained healthy. Lurman's paper, now regarded as a classical example of an epidemiological study, proved that contaminated lymph was the source of the outbreak (from Wikipedia). (Lurman A. (1885) Eine icterus epidemic. (In German). Berl Klin Woschenschr 22:20–3).

From the 1950s –1972: Mentally disabled children at Willowbrook School (NY) were deliberately infected with hepatitis in an attempt to find a vaccine by one of Baruck Blumberg's collaborators, Klugman. Participation in the study was a condition for admission to the institution.

In 1965, Baruch Blumberg working at the National Institutes of Health (NIH), thought he discovered the Australia antigen (later known to be Hepatitis B surface antigen, or HBsAg) in the blood of healthy

black Australian aboriginal man's blood he kept in his refrigerator. (Alter HJ, Blumberg BS (1966). "Further studies on a "new" human isoprecipitin system (Australia antigen)". *Blood* **27** (3): 297–309).

In 1976, Baruch Blumberg is credited with the discovery of the Au antigen, HbsAg in the blood of a black Australian aboriginal, and was awarded the Nobel Prize that he shared with NIH's former Neurobiology Program director, D. Carlton Gajducek—the discoverer of the so-called "slow virus" prion diseases. The doctors were jointly given The Nobel Prize in Physiology or Medicine in 1976 *"for their discoveries concerning new mechanisms for the origin and dissemination of infectious diseases,"* because the infectious agents and mechanisms of disease causation were believed not to conform to the standards of accepted pathogen isolation, the idea of distinctive genetic (nucleic acid) identity in the case of prions, the timing of infection to demonstrable cell pathology or morbidity in the case of prions and hepatitis B in the context of cancer, or to the classic proofs of pathogenicity worked out by Koch. For instance, D. Carlton Gajducek championed the idea that "infectious proteins" devoid of nucleic acids were at the basis of slow, debilitating neurodegenerative disorders (e.g., kuru, CJD, Mad Cow, scrapie in sheep)—syndromes that are characterized by extremely long latency periods after initial "infection," and destruction of the brain tissue years or decades after "infection." Although the concept of slow viruses, and pathogens devoid of nucleic acids were vigorously challenged and rejected by many in the scientific establishment during the 1980's because the idea challenged the established biochemical chain of events worked out for all other infectious agents, and because these syndromes appeared to be both infectious and run in families, Stanley Pruisner believed Gajducek's hypotheses to be plausible, and found that the hypothesized disease-causing PRP protein was present in both diseased and healthy hamsters (for which another Nobel Prize was awarded to him). A similar sequence of events unfolded in the quest to isolate the hepatitis B "virus." A few examples may be helpful:

According to some reports, in 1970, Dane and others describe "virus-like particles" in serum of patients with Austrailia-Antigen-associated hepatitis. (Dane DS, Cameron CH, Briggs M (1970). "Virus-like particles in serum of patients with Australia-antigen-associated hepatitis". *Lancet* 1 (7649): 695–8. doi:10.1016/S0140-6736(70)90926-8discovered the virus particle in 1970 by electron microscopy.

Yet according to the Nobelist, and so-called discoverer of hepatitis B, Baruch Blumberg, there was considerable difficulty in linking any nucleic acid-containing viral particle to the syndrome of hepatitis B, which spontaneously resolves without any medication or vaccine in more than 95% of those who acquire the syndrome:

Baruch Blumberg's major focus at first was not directed toward studying liver hepatitis or liver cancer, but inherited genetic (blood) polymorphisms in the tradition of Boyd and others. He first found the so-called Au (Australian antigen-HPsAG surface antigen) polymorphism was rare in the West, but was present in the blood from a black man who was a healthy Australian aborigine he had in his freezer. The molecular signature also was present on rare occasions in the blood samples obtained from healthy Micronesians, healthy Vietnamese, and healthy Taiwanese, and in non-healthy patients with leukemia (not hepatocellular carcinoma), or Down syndrome, in the United states (Baruch Blumberg, PNAS, Vol. 94 pp 7121 -7125, page 7122-23, 1997, top of page).

"Hepatitis B virus" is now thought to be transmitted primarily through sex, dirty needles and perinatal transmission, or transfusions, and it is present in the blood of black men who are Australian aborigines, and occasionally, Micronesians, Vietnamese, Taiwanese, and with higher frequency, patients with leukemia or Down syndrome, who either all share these risks or risk behaviors, or as I would argue, are detected in these groups because it is a rare genetic polymorphism that can be induced in hepatitis patients because of tissue destruction, and perhaps, from many other causes. The HPsAG antigen represents a simple and relatively rare (in the West-not so rare in Asia or Australia or Africa) blood polymorphism because most people (>95%) who harbor the HBsAG molecular signature never become

sick, develop hepatitis, or cancer of any kind. Moreover, the hepatitis B era constituted the basis or foundation upon which “molecular recombinant vaccines,” as well as many of the mistaken theories of the AIDS era were based upon.

In the context of hepatitis B and cancer, Blumberg's hypotheses regarding HBsAG antigen suggested to him that (Blumberg B. PNAS, Vol. 94 pp 7121 -7125, 1997, page 7123 top):

"i) Individuals with Au have an increased susceptibility to leukemia (NOT HEPATOCELLULAR CARCINOMA as is continuously touted by The WHO and the PHS), and this susceptibility is inherited;"

*"ii) Leukemia causes Au (HbsAg)" (*again not hepatocellular carcinoma*);*

"iii) Au is related to "the virus" that has been postulated to be the cause of leukemia.

Where is the link between Au and "hepatocellular carcinoma?" Do Hepatitis B viruses cause leukemia?

And why did Blumberg initially think "family studies" of carriers (of HbsAG) "were consistent with a genetic hypothesis of inherited polymorphism," yet allowed the idea to be advanced that hepatitis B was transmitted as an infectious viral agent? How could an inherited trait be infectious? This question, stimulated a lot of controversy and dissent during the 1960's and 1980's.

Why did Blumberg believe that HbsAg was an infectious agent linked to leukemia when he was fully aware that "certain individuals were susceptible both to the development of Au-positivity and leukemia" (not hepatocellular carcinoma) and that "children with Down syndrome have a rate of HBsAG of approximately 30% compared to other patients housed in mental institutions whose rate of HbsAG was approximately 5%? Does trisomy have an infectious basis also? Are Down people more promiscuous? Do they share needles? Are they exposed more frequently to blood products? In mental institutions, do inmates eat feces and get infected, as was suggested by a gifted virologist friend of mine (who confuses Hep A with the pathogenesis of Hep B-more about this in a moment).

Blumberg in his autobiographical PNAS article also tells us about his collaborative work with Bayer and Werner in their Philadelphia laboratory who identified particles with the "appearance" of a virus in the serum of individuals with Au (HbsAg antigen) again on page 7123, (paragraph 3-4 at the bottom of the first column). Why does Blumberg then emphasize that these particles were subsequently shown to "not contain any nucleic acid" or even "core proteins," and tell us that they were "neither infectious or pathogenic?"

Also, why does Blumberg tell us about how I. Millman and V. Coyne in his lab were able to "localize Au" in the liver cells of patients with hepatitis, and yet elaborate as to why it was it so "difficult to confirm" they were able to sustain the growth of "the virus" in liver cells obtained from patients with liver disease associated with Au? A related question is, why don't chimps show any liver pathogenicity, cellular damage, or develop anything resembling hepatitis in modern studies when they are infected with hepatitis B?

Why does Blumberg in this Proceedings of The National Academy of Sciences paper make a big point emphasizing that:

“We subsequently realized that the virus had been transmitted to the leukemia patients (not hepatocellular carcinoma patients) by transfusion of blood contaminated with HBV, and that the high prevalence in the Down syndrome population was a consequence of crowding in large institutions.”

Why does he then tell us that:

*"But the answer was not that simple. Down syndrome patients were more likely than patients with different diagnosis within the same institution to become **carriers**."* [Here is that "healthy carrier state fear again)!

When Millman joined Blumberg's laboratory from Merck in 1967, why did he calculate that "the amount of Au (HbsAg) in the serum of carriers to be 1% of the serum proteins," and why did he feel that this amount of virus would be incompatible with the life of the carrier? [1% is a huge amount].

1% of anything in the bloodstream would be a gargantuan quantity. Millman thought that the hep B antigens constituted 1% of the serum. Is this consistent with current hepatitis viremia estimates? Hardly.

On page 7124, approximately paragraph 6, why does Blumberg again state that:

"Collaborating with M. Bayer and L. Loeb, we found that the small particles visualized in the electron microscope did not contain nucleic acid,"

and then tell us that:

*"We inferred that these were non-replicating, incomplete forms of the virus made up entirely of surface antigen, and that there **must be** additional particles which contained nucleic acid, that were replicating, infectious, and pathogenic."*

It's not that proteins injected into a recipient cannot induce a myriad of autoimmune syndromes, or severe toxicity? Almost 10% -22% of transfusion patients experience some form of toxicity or lung infections. How can particles or proteins that lack nucleic acids replicate? Is it chiefly through Gadjucek's and Pruisner's PRP hypotheses that can account for elaborate protein assembly without the direct participation of a nucleic acid template?

Furthermore, is there any proof of this hypothesis, before the PHS and WHO goes and vaccinates an entire planet with an isolate derived from an ill-defined soup that lacked viral nucleic acids, or before the FDA or similar agencies kills every cow that grazes in the US, Canada, or England?

If hepatitis B is an infectious virus, then why did Blumberg in his personal account of the Hepatitis B era make a point of stating that:

*"In animal experiments, Millman and London found that partially purified Au particles, which we had not **yet** visualized, could be transmitted by inoculation into experimental animals….The fully purified particles from which {THE WHOLE VIRUS} had been removed were not infectious."*

Were these "visualized" particles again isolated, and shown to cause cytopathic effects in yet newly injected animals to fulfill Koch's postulates? Were they even found in every (or any) inoculated animal who had been subjected to the "hepatitis B-infected sera?"

All subsequent studies using hepatitis B since Millman and London's studies also have borne out this same result in mice of all kinds, chimps, ducks, and other experimental animals.

Despite lack of any animal model for hepatitis B, in 1978 an experimental "hepatitis B" vaccine trials were conducted by the CDC, in New York, Los Angeles and San Francisco, and the ads for research

subjects specifically asked for promiscuous homosexual men, while there is also evidence that the first "hepatitis B" vaccines were also tested on Blacks in Central Africa, and mentally retarded children." (Leonard G. Horowitz, "Hepatitis B Vaccine and the Origin of HIV/AIDS: Perspectives on a Possible Vaccine Induced Pandemic" Les Premieres Recontres Medicales, May 29, 2001).

In 1986 the recombinant hepatitis B vaccine was licensed.

Between 1989- 2003 there was an explosion of autism in U.S. The incidence of autism (and other related disorders) went from about 1 in 2,500 children to 1 in every 166. Up until about 1989 pre-school children got only 3 vaccines (polio, DPT, MMR). By 1999 the CDC recommended a total of 22 vaccines to be given before children reach the 1st grade, including Hepatitis B, which is given to newborns within the first 24 hours of birth. Many of these vaccines contained mercury. In the 1990s approximately 40 million children were injected with mercury-containing vaccines. The cumulative amount of mercury being given to children in this number of vaccines would be an amount 187 times the EPA daily exposure limit.

In 1991 the recombinant Hepatitis B is recommended for all newborn infants and children.

Also in 1991, there were 210 REPORTED cases of hepatitis B vaccine injury from 1991 - 1998 in Illinois, and 5 deaths.

In 1996, there were 872 serious adverse events reported to VAERS in children under 14 years of age who had been injected with hepatitis B vaccine. 48 children were reported to have died after they were injected with hepatitis B vaccine that same year. By contrast, in 1996 only 279 **cases** of hepatitis B disease were reported in children under age 14.

In 1996 only 54 cases of hepatitis B were reported in the 0-1 age group. There were 3.9 million births that year, so the observed incidence of hepatitis B in the 0-1 age group was just 0.001 %. VAERS received 1,080 total reports of adverse reactions from hepatitis B vaccine in 1996 in that same age group including 47 deaths. The hepatitis B vaccine actually caused more illness than the disease by a 20 to 1 ratio.

In 1998 Hepatitis B Vaccine is linked to autoimmune rheumatoid diseases.

Also in 1998, 15,000 French citizens filed a lawsuit against the French government for understating the risks and overstating the benefits associated with the hepatitis B vaccine. Hundreds of people were reported to have suffered from auto immune and neurological disorders, including multiple sclerosis, following hepatitis B vaccination. As a result, in October 1998, the French Minister of Health ended the mandatory hepatitis B vaccination program for all school children. "The French decision to continue hepatitis B immunization at birth while discontinuing immunization starting at school age suggests the French Ministry of Health may believe that they can decrease vaccine induced autoimmunity by giving vaccines starting in the first month of life. They appear to be accepting our findings" (Classen www.healing-arts.org/children/vaccines/vaccines-information.htm).

Also in 1998, although the target population for the hepatitis B vaccine are prostitutes and drug addicts and not children, and France had just repealed the mandate because of high number of vaccine injuries, and the CDC admitted that the vaccine may not be effective after 7 yrs for 30-50% of the people vaccinated, the hepatitis B Vaccine is mandated anyway for school age children in first 46 and then 48 states in the US.

Also in 1998 data from France released at the 62nd Annual Meeting of the American College of Rheumatology, held November 8-12, 1998, in San Diego, California linked immunization against hepatitis B to the development of autoimmune rheumatoid diseases such as lupus and rheumatoid arthritis. The rise of autoimmunity following hepatitis B immunization in school children and adults became a major public health concern. In October, the Ministry of Health in France suspended routine hepatitis B immunization of school children while continuing hepatitis B immunization at birth. The reason for this decision was reportedly the increased risk of autoimmune diseases that has been associated with the vaccine when it is given starting at school age or later. The data from France links hepatitis B immunization to both the development of newly diagnosed cases of autoimmune rheumatoid diseases as well as the exacerbation of previously diagnosed cases that were in remission. This finding is supported by data from Canada published in September which linked immunization against hepatitis B to the development of autoimmune rheumatoid diseases in firefighters.

In 1999 (May 18) Dr. Jane Orient, MD, then President of the American Association of Physicians and Surgeons (AAPS) testifies on the "Hepatitis B Vaccine in a hearing held by the Criminal Justice, Drug Policy & Human Resources Subcommittee of the Committee on Government Reform in the U.S. House of Representatives:

"Mr. Chairman and Members of the Subcommittee: My name is Jane Orient, M.D. I am a practicing internist from Tucson, Arizona, and serve as the Executive Director of the Association of American Physicians & Surgeons ("AAPS").

"For most children, the risk of a serious vaccine reaction may be 100 times greater than the risk of hepatitis B. Overall, the incidence of hepatitis B in the U.S. is currently about 4 per 100,000. The risk for most young children is far less; hepatitis B is heavily concentrated in groups at high risk due to occupation, sexual promiscuity, or drug abuse. VAERS contains 25,000 reports related to hepatitis B vaccine (in 1999-it is about 40,000 as of 2003), about 1/3 of which were serious enough to lead to an emergency room visit, hospitalization, or death. It is often assumed that only 10% of reactions are reported."

"Striking increases in chronic illnesses have occurred in temporal association with an increase in vaccination rates. Asthma and insulin-dependent diabetes mellitus, causes of lifelong morbidity and frequent premature death, have nearly doubled in incidence since the introduction of many new, mandatory vaccines. There is no explanation for this increase. The temporal association (with universal hepatitis B vaccination), although not probative, is suggestive and demands intense investigation. Instead of following up on earlier, foreign studies suggesting a greater-than-chance association, the CDC, through vaccine mandates, is obliterating the control group (unvaccinated children)."

"Nonetheless, the implications are so grave that immediate investigation is needed. Measles, mumps, rubella, hepatitis B, and the whole panoply of childhood diseases are a far less serious threat than having a large fraction (say 10%) of a generation afflicted with learning disability and/or uncontrollable aggressive behavior because of an impassioned crusade for universal vaccination. There are plausible mechanisms such as molecular mimicry whereby vaccines could have such effects. Basic research, as well as epidemiologic studies (starting with a long-term follow-up of reactions reported to VAERS), is urgent."

Dr. Orient concludes her assessment and condemnation of the mandated hepatitis B vaccine thus to the Criminal Justice, Drug Policy & Human Resources Subcommittee:

"AAPS opposes federal mandates for vaccines, on principle, on the grounds that they are:

1.An unconstitutional expansion of the power of the federal government.
2.An unconstitutional delegation of power to a public - private partnership.
3.An unconstitutional and destructive intrusion into the patient-physician and parent-child relationships.
4. ***A violation of the Nuremberg Code in that they force individuals to have medical treatment against their will, or to participate in the functional equivalent of a vast experiment without fully informed consent.***
5. A violation of rights to free speech and to the practice of one's religion (which may require one to keep oaths)."

In 2000 at a San Diego research meeting on autism, Dr. Stephanie Cave presented the following information:

"By the age of two, American children have received 237 micrograms of mercury through vaccines alone, which far exceeds current EPA 'safe' levels of 0.1 mcg/kg. per day. That's one-tenth of a microgram, not one microgram."

"Three days in particular may be singled out as spectacularly toxic for infants: "Day of birth: hepatitis B—12 mcg mercury (30 times safe level).

"At 4 months: DTaP and HiB on same day—50 mcg mercury (60 times safe level).

"At 6 months: Hep B, Polio—62.5 mcg mercury (78 times safe level).

"At 15 months the child received another 50 mcg (41 times safe level).

"These figures are calculated for an infant's average weight in kilograms for each age. These one-day blasts of mercury are called 'bolus doses.' Although they far exceed 'safe' levels, there has never been any research conducted on the toxicity of such bolus doses of mercury given to infants all these years." [Testimony presented by Stephanie Cave, MD before the Committee on Government Reform, US House of Representatives, July 18, 2000].

In 2001 Dr. M.A. Fisher et al. publish that adverse events associated with hepatitis B vaccine in U.S. children less than six years of age, 1993 and 1994 and conclude:

"Evidence from this study suggests that hepatitis B vaccine is positively associated with adverse health outcomes in the general population of US children. The hepatitis B vaccine is also associated with prevalent arthritis, acute ear infections, pharyngitis/nasopharyngitis (throat and nasal infections) (Ann Epidemiol Jan;11(1):13-21), 2001.

Also in 2001 Vaccine Adverse Event Reporting System Tables published by the CDC in MMWR show adverse from the universally mandated hepatitis B vaccine by itself (9,022 cases) tops the list for adverse reactions between 1991-1995, followed by flu vaccines (4,696 cases). Between 1996-2001, Vericel tops the lists with 9,820 cases, followed by hepatitis B (9,022 cases), followed by flu vaccine (8,125 cases).

Also in 2001 VAERS data from January 1, 1990 to November 1, 2001 show that:

*Following the DTP shot **807** children died.*

*Following the DTaP shot **364** children died (acellular pertussis was adopted because of high reactions to live cell).*

*Following the hepatitis B shot **679** children died.*

*Following the haemophilus B shot **932** children died.*

*Following the poliovirus live oral vaccine **970** children died.*

Also, in 2002 British Medical Journal publishes article showing that:

*"Children vaccinated in infancy are **at increased risk** of hepatitis B virus infection in the late teens" (Hilton Whittle, Shabbar Jaffar, Michael Wansbrough, Maimuna Mendy, Uga Dumpis, Andrew Collison, Andrew Hall. Observational study of vaccine efficacy 14 years after trial of hepatitis B vaccination in Gambian children. (BMJ vol 325, 14 September, 2002).*

In 2003 Dr. James Howenstine, M.D. publishes that In New Zealand, the incidence of Type 1 diabetes in children rose by 61 % after an aggressive vaccine program against hepatitis B.. This same program has been started in the U.S.A. Similar rises in Type 1 diabetes have been seen in England, Italy, Sweden, and Denmark after immunization programs against Hepatitis B.

Thus there is no basis in fact and quite a lot of information, especially in the post-marketing experience that the FDA conveniently decides to omit mentioning, against the assertion that:

"Before new vaccines are licensed, they are tested extensively for safety in the laboratory, in animals, and in successive stages of human clinical trials called phases."

ADDENDUM: HEPATITIS C IS CAUSED BY EXCESSIVE DRINKING OF BOOZE.

Similar to "HIV," "HCV" has never been isolated-even according to orthodox Hepatitis C docs and the CDC's own fact sheets. Where is the evidence for this statement? It is assumed that a fictitious virus called Hepatitis C might explain it, but there is no evidence that this actually happened since neither Hepatitis B or C viruses have been isolated and shown to cause disease in animals or humans. It is more likely that transfusion itself is the prime immune suppressive factor in transfusion recipients, and that transfusions induce various autoimmune diseases that then generate the molecular signatures of HBV and HCV in some folks. Apparently, the best they can come up with today regarding hepatitis C is that they now claim that humans consume large quantities of alcohol while chimpanzees do not. In an article circulated among The Americans For Medical Advancement, Europeans For Medical Advancement, Japanese For Medical Advancement, a discussion regarding HCV and cancer is instructive regarding this so-called cancer causing virus: note how hepatitis C wasn't found to be pathogenic in chimps.

Hepatitis C and Chimpanzees

Are chimpanzees useful in HCV research? They can be infected with HCV as they can with other viruses that infect humans. Their ***liver enzymes*** *respond to HCV in a manner similar to humans. Researchers can harvest* ***the virus*** *from their blood as they can from humans'. Are those similarities sufficient for developing treatments or a vaccine?*

"The experts" claim that hepatitis C infection is estimated to have infected ***3% of the population of the planet*** *or 170-200 million people worldwide. It is the most common cause of* ***chronic liver disease in some*** *countries. In the United States 40% of chronic liver disease is related to HCV. HCV infection can lead to cirrhosis, liver failure, and* ***hepatocellular carcinoma****. Between 1990 and 1992 routine antibody testing by enzyme-linked immunoassay (EIA) became available. Recombinant immunoblot assay (RIBA) is also available as are viral RNA detection tests for HCV. Treatment* ***with interferon in combination with ribavirin, is ineffective in the majority of cases*** *hence* ***the need*** *for a* ***vaccine****.*

HCV is a single-stranded ***RNA*** *virus and was* ***cloned*** *in 1989 at which time it was found to be the cause of* ***80% to 90%*** *of cases of non-A, non-B hepatitis.*

Studying HCV has been difficult, in part, because of the lack of a reliable tissue culture for testing neutralizing antibodies or for passage and expanding of the virus. *Historically, the invention of such a tissue culture system allowed the development of other vaccines such as the polio vaccine.*

Using chimpanzees has presented ***numerous*** *problems in that they appear to respond to HCV* ***differently*** *than humans. Mother-infant transmission has been reported in humans but* ***not*** *chimpanzees.(1) Chronic infection occurs approximately 75% of the time in humans but only 30-50% of the time in chimpanzees.(2,3****) Humans progress to liver fibrosis and cirrhosis while chimpanzees do not. This may in part be due to environmental differences between the species; e.g., humans consume large quantities of alcohol while chimpanzees do not.*** *Other environmental differences also exist. Humans suffer from hepatocellular carcinoma as a result of HCV. Hepatocellular carcinoma after HCV infection* ***is very rare*** *in chimpanzees.(4) The course of HCV* ***is highly variable*** *in the chimpanzee, as it is in humans, but is the variability secondary to the same causes in both species?*

SIXTY-FOUR (AND PERHAPS AS MANY AS ONE-HUNDRED SIXTY-NINE) FAILED "HIV/AIDS" VACCINES:

As more and more vaccines are being introduced, there is little if any adequate laboratory work, relevant animal model work or safety testing, or proper human clinical trials conducted. Even more importantly, this FDA report doesn't even mention the importance of post-marketing experience, where the true colors of vaccines come to light.

Several of the most recent examples in support of this rather surprising statement stem from recent "HIV" laboratory research, AIDS animal models, and human "HIV" vaccine trials as documented by ISIS (Institute of Science In Society) reports. Furthermore, there has been a growing trend to test experimental vaccines on severely impoverished 3rd World peoples without any scientific basis or appropriate animal testing.

But before this information is presented, and although warnings against AIDS vaccines go back to Albert Sabin, one of the most prominent viral vaccine developers of the 20th century, who said, "The available data provide no basis for testing any HIV vaccine in human beings either before or after infection," these distortions of the above statements of the FDA, that " Before new vaccines are licensed, they are tested extensively for safety **in the laboratory, in animals, and in successive stages of human clinical trials** called phases" continue in the context of many other vaccines as well-even some of the most universally applied vaccines:

WHY THERE IS NO CULTURE MODEL OR BIOCHEMICAL ISOLATION OF AN "AIDS-VIRUS" OR "HIV" INFECTION.

Cell extracts thought to contain "HIV," when cultured in Petri dishes with lymphocytes or cancer cells:
A. Kill the cells.
B. Don't kill the cells.
C. Fuse cells together.
D. Don't fuse cells together.
E. Can't "infect" cells without toxic chemicals being added.
F. Is affected by mycoplasma removal agent.
G. Kills cells before virus production is maximal, although all viruses require cells for their propagation.
H. In 1997, The DAIDS official "HIV" culturing manual was published presenting a series of standard protocols for culturing "HIV." from the Reporting Results Section (section VII), a rationale was presented to unequivocally identify "non-HIV-infected" cells **as truly "HIV-negative" in "HIV" cell culturing labs** if the "HIV" capsid protein, p24, is measured at values less than 30 pg/ml (picograms/milliliter), and **truly positive** at readings of more than 30pg/ml. This is sort of like trusting people under 30, while suspecting the motives of persons over 30.

Although Dr. Robert Gallo and others have claimed that in a stadium full of "HIV-negative" people, not one molecule of "HIV" will be present, this DAIDS (Division of AIDS) culturing manual described above says that if "HIV-infected" cells from human blood express more than 30 units of "HIV-capsid specific" p24 protein on 2 or 3 separate tests (30 pg/ml), one is considered "HIV-positive," and if one sleeps with somebody without telling them they have these 30 or more units, one can be tried and convicted for attempted murder, one can't obtain health insurance, one might be fired from his or her job, one might be driven to commit suicide. If pregnant one may be frightened into aborting her baby. If your cells express less than 30 units of this protein 2 or 3 separate times (30 pg/ml), then one is considered **non**-"HIV-

infected" and is home free-one can donate blood, sleep with anyone he or she wants, without telling them his or her “less than 30 status,” etc. How could this be possible if there isn't one molecule of "HIV" in a stadium full of "HIV-negative" people? Its an arbitrary measurement of a molecular signature that may have nothing to do with a virus or immune suppression that is arbitrarily being measured at more than 30 units for an "infected" person, and less than 30 units for a non-infected person.

P24 itself, which supposedly is an essential "HIV" protein that forms the shell of “the AIDS virus,” is also found in the thymus gland cells of non-infected “HIV-negative” children (Dura WT; Wozniewicz BM; Expression of antigens homologous to human retrovirus molecules in normal and severely atrophic thymus. Thymus. 1994; 22(4):245-54):

Abstract: An immunopathologic study of normal and severely atrophic thymuses (STA) was undertaken in order to evaluate the expression of human retrovirus (envelope and core) molecules in thymic epithelial cells (TEC) ***in HIV negative children****. Both normal and STE thymuses disclosed p19, p24, p39, p45 and p55* ***viral core proteins*** *as well as gp46, gp63 glycoprotein* ***of envelope origin****. No evidence of gp160, gp120 and gp41 molecules were observed in TEC which suggested endogenous lack of receptor molecules for HIV. The results are discussed in the context of possible thymus oriented* ***autoimmune reaction*** *in HIV and* ***non-HIV bearing patients and in consequence, severe injury of TEC forming microenvironment.***

In 1997, two teams of investigators, one consisting of a French-German collaboration, and another whose investigators were involved in the AIDS Vaccine Program, SAIC, National Cancer Institute-Frederick Cancer Research and Development Center, Maryland, reported that PHA (phytohemagglutinin) and IL2 (interleukin-2) stimulated healthy cells to produce Human Immunodeficiency “viral like particles” and the molecular profile of “HIV” **only** when cells were stimulated with oxidizing agents that are toxic to cells like PHA and IL-2. They also claimed that microvesicles were a source of contaminating cellular proteins found in "**purified** HIV-1 preparations." As their titles of their papers suggest, even the "HIV" experts have published that "effective purification systems for {HIV} viruses free of host components **are lacking**:

Gluschankof P, Mondor I, Gelderblom HR, Sattentau QJ. “Cell membrane vesicles are **a major contaminant** of gradient-enriched human immunodeficiency virus type-1 preparations.” Virology 230(1):125-33, 1997.

Bess JW Jr, Gorelick RJ, Bosche WJ, Henderson LE, Arthur LO. *Microvesicles are a source of* ***contaminating cellular proteins*** *found in purified HIV-1 preparations.* Virology, 230(1):134-44, 1997.

Others have reported the same result:

"Cellular proteins bound to immunodeficiency viruses: implications for pathogenesis and vaccines." [Arthur et al., Science 258: 1935-38,1992].

If the cell's cytoskeletal proteins, actin, exrin, and other proteins are located INSIDE or on the virions as these and other authors have claimed, how can one tell if p24, for instance, or other molecules thought to represent the specific molecules of “HIV,” aren’t also proteins of cellular origin? Answer: One can’t.

NO ANIMAL MODELS FOR "HIV" OR AIDS.

In biomedical research, typically animals are used to demonstrate disease progression or the efficacies of new therapies. But in the context of "HIV/AIDS" and many other syndromes, and from the beginning of the AIDS era, more than one hundred and fifty chimps were inoculated with the sera and isolates of AIDS -patients 24 years ago and now these chimps live in 27 million dollar retirement homes, without one of them ever acquiring AIDS or any immune suppression as measured by lab tests.

This is why "simian immune difficiency virus or "SIV," a different "virus" (undefined molecular marker) than "HIV," has always been a better virus to study "HIV" than "HIV."

Wild African Green monkeys that are ***infected*** (that also may express what are called HERV's or retroids-strange genetic sequences that are rare, but present in normal contexts as well) throughout their lives with "HIV-like" simian immunodeficiency virus ("SIV"), and these non-human primates never get sick.

Studies by Sodora et al. (Journal of Immunology, pp. 3026-3034, 2008) provided evidence, using the sooty mangabey "SIV" natural host, that CD4 T-cell depletion, by itself, the so-called hallmark of AIDS, is **not sufficient** to induce AIDS in a natural host.

"When we first observed the dramatic CD4 depletion in all the tissues we examined in these monkeys, we were concerned that they might begin to exhibit clinical signs of AIDS," said Jeffrey Milush, Ph.D., lead author on the paper. "But after more than six years, we ***are sure*** *that CD4 depletion by itself* ***does not necessarily*** *result in progression to AIDS".*

Also regarding animal models in the context of AIDS research and "HIV-testing:" Strandstrom et al., found that 50% of dog sera contain antibodies which recognize human immunodeficiency virus structural proteins, but dogs don't develop AIDS (Cancer Res 1990 Sep 1;50 17 Suppl :5628S-5630S).

"Fifty percent of dogs exhibited "HIV" structural proteins but did not develop "AIDS."

In 1992, it was reported that "HIV gene sequences" exist in the DNA of **"uninfected"** humans, chimpanzees, and rhesus monkeys (Horwitz MS, Boyce-Jacino MT, Faras AJ. Novel human endogenous sequences related to human immunodeficiency virus type 1. J Virol. 66 (4):2170-9, 1992).

Reverse transcriptase (RT) was once thought to be a specific enzyme that indicated the presence of "HIV" or other retroviruses. However, if RT were unique and specific marker for "HIV," then why is reverse transcriptase also found in the uninfected cells of bacteria, spirochetes, yeasts, insects and mammals (Varmus H, 1987. Reverse transcription Sci. Am. 257:48-54)?

Therefore, RT is not specific for retroviruses. More recently, other investigators have claimed RT is important for telomere replication at the tips of normal chromosomes, and that telomere replication requires endogenous RT (Ghori A. et al., Colorectal Disease,, vol. 2, no. 2, pp. 106-112, 2000).

The Center For Biologics Evaluation and Research Advisory Committee on Vaccines and Related Biological Products stated in November, 1998, in a chapter regarding the Update On Reverse Transcriptase Activity In Chicken Cell Derived Vaccines, by Dr. Arifa Khan (pages 13-15), that:

"Initially Boni et al. (1996) published that low level reverse transcriptase activity was detected in ALL chicken cell derived vaccines using a highly sensitive PCR-based reverse transcriptase assay called PERT, which can detect one to ten virions which was reported to the WHO, and then additional studies were done by several laboratories in Europe, as well as the U.S., including the NIBSC, the CDC, as well as labs in the FDA to confirm this initial finding."

Sheep, goat, and cow milk induce the p24 antigen ("HIV's supposed capsid protein) and yet those that test positive do not develop any AIDS-defining syndromes (Willman et al., Heterophile Antibodies to Bovine and Caprine Proteins Causing False-Positive Human Immunodeficiency Virus Type 1 and Other Enzyme-Linked Immunosorbent Assay Results. Clinical and Diagnostic Laboratory Immunology, p. 615-616, Vol. 6, No. 4, July 1999).

But these are animals: what about human trials that proceeded anyway without a laboratory tissue culture model or an animal model of AIDS established in the first place?

"HIV" VACCINE TRIALS IN HUMANS DESPITE NO CONSISTENT LABORATORY CULTURE MODEL AND NO ANIMAL MODELS:

On August 3, 1999, written testimony of Dr. Howard B. Urnovitz to the Committee On Government Reform and Oversight was presented claiming that:

"House of Representatives I am grateful to this committee for allowing me to address the issue of vaccine safety. I am Dr. Howard B. Urnovitz. In 1979, I received my doctorate degree in Microbiology and Immunology from the University of Michigan, where I studied vaccines. I am testifying today as the Scientific Director of the Chronic Illness Research Foundation. For the record, I am also the chief science officer of a biotechnology corporation."

"My testimony will describe the insights of recent scientific studies into the health consequences of exposing individuals to both toxic and foreign biologic materials, particularly multiple bacterial and live virus vaccines. The conventional wisdom concerning the use of vaccines needs to be reconsidered, taking into account the adverse medical effects that vaccines can have on the human body. Vaccine science must evaluate not only acute adverse side effects, but also possible associated chronic illnesses such as learning and behavior disorders, Autism Spectrum Disorders, intussusception, arthritis, cancer, diabetes, chronic fatigue syndrome, multiple sclerosis, autoimmune thyroiditis, and other chronic health problems. These chronic illnesses are increasingly costly to society in both human and financial terms."

"By year's end, the Chronic Illness Research Foundation and its research colleagues will have published four peer-reviewed papers on the genetic basis of four different chronic diseases: vaccine associated human cancers, Gulf War Syndrome, multiple sclerosis, and AIDS. The implications of these findings for vaccine safety are:

1. the human body retains a genetic memory of the foreign substances to which it has been exposed, including viral and bacterial vaccines;

2. each individual responds to foreign substances differently, based on his or her own unique genetic background;

3. there appears to be a limit on how much foreign material to which the human body can be exposed before some level of genetic damage occurs and a chronic disease initiates."

"*…concerns the intensive effort to create a vaccine for the hepatitis C virus. If you read the literature very carefully, you will find that, while there is a strong marker for the disease,* ***there is no hard scientific evidence to support the existence of a hepatitis C virus****. Clearly, a non-A, non-B hepatitis disease exists,* ***but the science behind an associated virus is weak at best. As a scientist I am compelled to ask, how can we vaccinate people against a disease-causing agent that has not been fully characterized?"***

ISIS Report - July 29, 2001 AIDS-Vaccines Trials Dangerous. Dr. Mae-Wan Ho.

"The embattled OECD Conference in Genoa announced a $1.2 billion package to help combat AIDS in the Third World. Vaccine developers and United Nation agencies are pushing for large-scale clinical trials of AIDS vaccines in vulnerable Third World populations ravaged by the AIDS pandemic. AIDS virologists point to evidence that the vaccines are not only ineffective but dangerous."

Astonishingly, in one a vaccine trail in the U.S. several years ago that was paid for by the American taxpayer, it was stated that although dangerous adverse events were found in non-human primate trial testing, the vaccine proceeded to human clinical trials anyway, and was immediately halted once it was discovered that the vaccine was doing harm:

ISIS Report - 1 May 2002, Doubts Deepen over Safety of AIDS Vaccines, *Dr. Mae-Wan Ho:*

"Another key AIDS vaccine is abandoned before phase III trial. This latest setback comes at the end of a string of failures in developing vaccines that may be worse than useless."

Despite the fact that "a study was carried out by the Merck Research Laboratories in Pennsylvania, the Center for Aids Research in Duke University Medical Center and Division of Viral Pathogenesis in Harvard Medical School, two out of 15 immunised macaque monkeys became ill with AIDS-related symptoms six months after being challenged with the pathogenic HIV-SIV hybrid virus (SHIV)."

And despite the fact that "another study by researchers based in Harvard Medical School, Northwestern University of Chicago, Duke University Medical Center and the Southern Research Institute in Maryland which showed that two out of eight immunised rhesus monkeys died…as a result of the CTL [based "HIV" vaccine]…massive numbers of human trial participants were recruited anyway.

"Although the US government eventually abandoned the controversial AIDSVAX vaccine trial and announced it will combine the work of two federal institutions, the National Institutes of Health and the Department of Defence [to make both anthrax vaccines containing squalene to be tested on soldiers first with $870 million taxpayer dollars... and despite the fact that "the trial was designed to compare the types of immune responses the vaccine evoked with the protection it provided that required the vaccine to produce an immune response in at least 30 per cent of volunteers"… the analysis of the data suggests the response did not come up to scratch." "It didn't even come very close," said Anthony Fauci, director of the NIH's National Institute of Allergy and Infectious Diseases. "The cancelled NIH trial, which would have involved 11,000 volunteers, was anticipated to cost $60 to $80 million dollars. The Department of Defence trial, which was designed to test only the efficacy of the vaccine, will still go ahead. But that may be a grave mistake."

And in a similar "HIV" vaccine trial that was based on the same biology of the above mentioned AIDSVAX trial in which non-human primates were first harmed before the vaccine was given to

humans to induce 30% seroconversion but didn't, in 2007 the STEP trial was similarly halted once it was underway in human testing.

ISIS Report 11/10/07 New Strategy HIV Vaccine Fails More Infected with HIV

On 21 September 2007, the pharmaceutical giant Merck called a halt to a phase II trial of a new vaccine candidate against HIV. An interim assessment showed that the vaccine, long considered the most promising in development, failed both in preventing HIV infection and in reducing the viral load of those infected.

" The multi-centre, randomised, double-blind, placebo-controlled phase II trial enrolled 3 000 HIV-negative volunteers from diverse background between 18 and 45 years of age at high risk of HIV infection."

"The results were devastating. The vaccine did not prevent infection, if anything there were more infections among those given the vaccine. In 741 volunteers who received at least one dose of the three-dose vaccine series, 24 cases of HIV infection were found, compared to 21 cases of HIV infection in the 762 of the placebo group. In the subgroup of 672 who had received at least two vaccinations and who were HIV negative for at least the first 12 weeks of the trial, 19 cases of HIV infection were found, compared to 11 cases in the 691 volunteers who received placebo. The vaccine did not reduce the amount of virus in the bloodstream of those who became infected. The HIV RNA levels at approximately 8 to 12 weeks after diagnosis of infection expressed as geometric means were about 40 000 copies/mL in the vaccine group and 37 000 copies/mL in the placebo group.

Here is the latest failure of the "HIV" vaccine reported this month, with initial characteristic distortions regarding it's success, followed by this Wall Street Journal report about how the initial results were distorted:

2009, OCTOBER 10, Data Call Into Question HIV Study Results

Wall Street Journal, By GAUTAM NAIK and MARK SCHOOFS

Researchers from the U.S. Army and Thailand announced last month they had found the first vaccine that provided some protection against HIV. But a second analysis of the $105 million study, not disclosed publicly, suggests the results may have been a fluke, according to AIDS scientists who have seen it.

Quest for a Vaccine

The second analysis, which is considered a vital component of any vaccine study, shows the results weren't statistically significant, these scientists said. In other words, it indicates that the results could have been due to chance and that the vaccine may not be effective.

The additional data were available to the researchers on Sept. 24 when they announced the trial results, but they chose not to disclose them, said Jerome Kim, a scientist with the U.S. Army who was involved in the study. News of the second analysis was first reported on the Web site of Science magazine, but the story didn't provide specific data. Full details of the trial are to be aired at an AIDS meeting in Paris that starts Oct. 19.

The incomplete disclosure raises the question of whether the Army, the Thai government and the U.S. National Institutes of Health -- which helped fund the study -- rushed to give a positive spin to what may turn out to be another inconclusive AIDS-vaccine effort.

"We thought very hard about how to provide the clearest, most honest message," Dr. Kim said. "We stand by the fact that this is a vaccine with a modest protective effect." He called the trial results "complex."

Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, the part of the NIH that oversees AIDS research, declined to comment.

The study was criticized as pointless by some AIDS scientists when it was launched three years ago because ***it combined a failed vaccine with one widely thought to have little chance of success. It was the largest HIV vaccine trial ever conducted, with more than 16,000 participants in Thailand.***

Some AIDS researchers and activists who have learned of the additional data still think the vaccine shows promise and should be investigated further. But they worry that not disclosing the study transparently will cause people to conclude the vaccine trial was a failure and undermine support for more research.

"I would have preferred to have seen both results straight up. It might spring back on them, and that would be unfortunate," said Mitchell Warren, executive director of the AIDS Vaccine Advocacy Coalition in New York.

About 33 million people were living with HIV world-wide in 2007, according to the latest United Nations statistics. About two million people died from AIDS that year. There have been more than 100 HIV vaccine trials since 1987. None had succeeded until the latest Thai trial.

The results announced last month were based on a "modified intent to treat analysis," which includes virtually everyone who enrolled in the study, regardless of whether they ended up getting the full course of the vaccine. It is a good stand-in for the real world, where people don't always follow instructions properly. By this measure, the vaccine tested in Thailand reduced ***by 31%*** *the chance of infection with HIV, the AIDS-causing immunodeficiency virus.*

But the result was derived from a small number of actual HIV cases: New infections occurred ***in 51 of the 8,197*** *people who got the vaccine, compared with* ***74 of the 8,198*** *volunteers who got placebo shots. Statistical calculations showed there was a 3.9% probability that chance accounted for the difference.* ***In drug and vaccine trials, anything above a 5% probability of a chance result is deemed statistically insignificant.***

The second analysis is called "per protocol" and adheres strictly to how the trial was designed by only including the study participants who got the full regimen of vaccine shots at the right time. Because it excludes study participants who didn't get the full vaccine regimen, it usually provides corroboration to the looser "intent to treat" findings.

Two AIDS scientists, who have seen the "per protocol" analysis, said it indicates there is a ***16% chance*** *the study results were a fluke -- a far greater probability than is considered statistically acceptable. This analysis included* ***86 people*** *who received either the vaccine or a placebo and* ***were infected****. The "per protocol" analysis also showed that the supposed effectiveness was lower, at* ***26.2%.*** *Dr. Kim, of the U.S. Army, declined to comment on the data. It isn't clear why the vaccine was seemingly ineffective among participants who followed the guidelines to the letter.*

These anomalous results sparked discussion last week at a meeting of the Center for HIV-AIDS Vaccine Immunology in Durham, N.C. The group is made up of a team of universities and academic medical centers established by the NIH to help vaccine design and development.

"I think in general it's best to lay out as much data as possible," said Barton Haynes, director of the center and an HIV vaccine expert at Duke University, who was at the meeting. "This is a very difficult situation for everyone, and we'll have to wait until all the data are released so we can drill down into it."

When drug or vaccine trials results are disclosed, it is common for investigators to simultaneously provide "per protocol" and "intent to treat" data. For example, when Merck & Co. announced the details of its failed HIV vaccine trial in 2007, the Whitehouse Station, N.J., company provided both sets of statistics at the same time.

In September, the AIDS Vaccine Advocacy Coalition published a report in anticipation of the Thai results that noted: "The safest route is to report both PP [per protocol] and ITT [intent to treat] and to analyze the difference."

In January 2004, a group of 22 scientists in article in the journal Science noted that one component of the Thai vaccine, a primer dose made by Sanofi Pasteur, a division of Sanofi-Aventis SA of France, was poor at triggering an immune response. They also pointed out that trials of the second component of the Thai vaccine, a booster component now licensed to Global Solutions for Infectious Diseases, of South San Francisco, Calif., had been proven "to be completely incapable of preventing or ameliorating HIV-1 infection."

They added: "One price for repetitive failure could be crucial erosion by the public and politicians in our capability of developing an effective AIDS vaccine collectively."

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WHY THERE ARE NO HUMAN EXAMPLES OF EXOGENOUS "HIV" TRANSMISSION OR SEROCONVERSION.

When they did studies on human sexual couples, one of which was positive and the other one was negative for "HIV's" so-called molecular profile – in a famous study known as the Padian study -- they found **zero** conversions out of 175 pairs of so-called "discordant couples." These discordant couples all had varying degrees and frequencies of sex, one assumes, and among many couples, it was not "protected" sex either [Padian, et al. Heterosexual Transmission of HIV in Northern California: Results from a Ten-Year Study." American Journal of Epidemiology. August, 1997]. The researchers attributed this non-transmission to good counseling. So these promoters of AIDS believed simply by telling 175 couples to be careful protected all of them from sero-transmission over a 10 year period despite many of them not using condoms.

There have been numerous other similar non-transmission studies.

For instance, the wives of hemophiliacs don't acquire "HIV" or AIDS.

There have been no documented AIDS cases in hundreds of thousands of health care workers who have directly cared for AIDS patients.

Conversely, condom crusades, smearing microbicides on the genitals of Africans, have increased the incidence of "HIV infection" in highly publicized "HIV-transmission" studies instead of decreased the incidences.

Some of the most damning evidence, however, for non-transmission of "HIV," has been from more than 64 failed human "HIV-vaccine trials. According to what was believed two decades ago about the human immune system, it was assumed that a vaccinated individual would develop antibodies against molecules that are foreign to the human body. This would mean, in the case of an “HIV/AIDS” vaccine, that if vaccinated with the specific inactivated molecules of “HIV,” the vaccinated would need to carry around a letter to prove their “HIV-positive status” was caused by the components in a vaccine, rather than from "risky" behavior, or from being in an "at risk" group (from sex, dirty needles, exposure at the time of birth, breast-feeding, transfusions, being of African decent, being gay, being a drug addict, being pregnant, from having an autoimmune disease, or for dozens of other reasons).

But after more than as many 30 vaccine trials up until 1995 that were presented in Congressional documents, and perhaps as many as 65 "HIV" vaccine trials to date, letters as proof of "HIV" vaccination have not been needed.

Although the tiny fraction of those who have exhibited a “true” “HIV-positive” test result after vaccination that registered negative before vaccination, these individuals were told their “HIV-positive” status was due to their own recent "risky" activities (sex). The failure to produce an appropriate immune response in most of the vaccinated (conversion from a negative to a positive "HIV" test result) in at least 63 different human experiments, and not to mention the failure to acquire protection from an immune suppressive illnesses attributed to an “AIDS virus” after so many "HIV" vaccine trials, strongly suggests some measure of urgency or alarm is in order regarding the belief that "HIV" molecules are foreign molecules at all.

Failure to seroconvert to a truly positive and unambiguous “HIV-positive” test result after vaccination and even booster vaccination means that the principles underlying immunology, biochemistry, genetics, epidemiology, virology, cell biology, pharmacology, neonatology, and cancer biology don’t apply to “HIV/AIDS.” Or it means that the hypothesized "HIV” causation of “AIDS,” and the imagined molecular biological causal basis of AIDS AND several other "molecular diseases" have generated catastrophic disasters that require our immediate attention.

All that would be needed to prove that what I am saying is wrong, is to show us using an electron microscope, the “HIV virus” in the blood of someone with a "viral load" of 1,000,000 as measured by PCR. But the AIDS establishment won't do that after 25 years.

“Merck HIV vaccine fails, trials halted.”

“Trials of the most promising HIV vaccine to date have been halted following news that the vaccine did not protect against HIV ***infection****, according to a press release issued on Friday by developer Merck.The STEP study (HVTN 502, Merck V520 Protocol 023) was a multicenter, randomized, double-blind, placebo-controlled phase II test-of-concept clinical trial. The trial enrolled 3,000 HIV-negative volunteers from diverse backgrounds between 18 and 45 years of age* ***at high risk*** *of HIV infection.”*

*"The vaccine did not prevent **infection**: in volunteers who received at least one dose of the three-dose vaccine series, 24 cases of HIV **infection** were observed in the 741 volunteers who received vaccine and 21 cases of HIV **infection** were observed in the 762 participants in the placebo group."*

*"In the subgroup who had received at least two vaccinations and who were HIV negative for at least the first 12 weeks of the trial, 19 cases of HIV **infection** were observed in the 672 volunteers who received vaccine and 11 cases were observed in the 691 volunteers who received placebo."*

Also in the context of "HIV vaccine"-making, in 2004, AIDSVAX's CEO, former head of the CDC Donald Francis's 120 million dollar attempt to produce an "HIV" vaccine with his company VAXGEN, failed to generate antibodies against "HIV," or prevent a single case of "AIDS," casting doubt on claims that a virus, "HIV," has been isolated to Pasteur's standards developed for rabies, cholera, or anthrax more than 130 years ago. After this failure was announced, the U.S. Government rescued Francis's company by providing them with an 870 million dollar contract to make anthrax vaccine.

WHY THERE IS NOTHING SPECIFIC OF FOREIGN TO THE HUMAN BODY (EXOGENOUS) REGARDING "HIV'S" MOLECULAR PROFILE.

Simonsen L, Buffington J, Shapiro CN, et al. published that "Multiple false reactions in viral antibody screening assays [are detected] after **influenza vaccination**. [Am J Epidemiol 141:1089-1096,1995].

How could flu virus antigens stimulate an "HIV" reaction if there were anything specific or exogenous regarding the molecular profile(s) of "HIV" or the molecules from "the flu virus?" This would be like vaccinating someone for tetanus, and finding that they present antibodies against hepatitis B.

Yet it is also known that hepatitis B vaccines induce a positive "HIV" test, as do tetanus vaccines. Perhaps there are others?

How can flu virus molecules, hepatitis B molecules, or tetanus molecules share molecular similarity with the molecules of "HIV" or the body's specific immune response to these molecules? This absurdity would be like saying someone was vaccinated against yellow fever, and then generated antibodies against rabies.

In 2006, it was announced that "viral load is only able to predict progression to disease in 4% to 6% of HIV-positives studied, challenging much of the basis for current AIDS science and treatment policy" for any individual who tests "HIV" positive. Rodriquez B, Sethi AK, Cheruvu VK, et al. Predictive value of plasma HIV RNA level on rate of CD4 T-cell decline in untreated HIV infection. JAMA 296(12):1498-506, 2006.

So the question becomes, how could some 33 million people in the world be said to be "**infected**" and walking around with genuine specific molecules of "HIV" in their bodies, or with molecules generated by the body's response to "HIV," while only a tiny fraction of those vaccinated individuals in 64 vaccine trails (and 169 in "the pipeline") truly seroconvert to "HIV's molecular signature, even after injecting these same molecules twice directly into their bodies by route of a vaccine? For that matter, how could the same number of placebo-

vaccinated individuals also consistently seroconvert than "HIV-vaccinated individuals as they did in the placebo arm of these trials? This is non-sense.

This paradox suggests that perhaps the injected components of "HIV," or the antibody responses to these components have nothing to do with an “HIV” virus that is foreign to the human body or that has anything to do with immune suppression, and that these are mere testing artifacts. When you see the word “infect” or “infected” from here on out, simply think either non-specific molecules or “endogenous retroid or HERV sequence(s)” were detected in those said to be “infected,” and then many of the paradoxes and mysteries dissolve, as will the enormous waste of lives and resources that the failed notion of “an infectious exogenously derived virus” will continue to ruin and destroy.

WHY NO TEST TO DATE CAN DETECT “HIV.”

Even from the beginning of “HIV” testing, it has been known that none of the tests detect “HIV” virus particles directly, and that a positive antibody test may occur for 70 reasons that have nothing to do with “HIV” or “AIDS.” The first ELISA tests showed for instance, that out of 1.2 million applicants for military service (the Burke study), there were only 10,000 out of 12,000 false positives.

The “viral load tests” are based on the polymerase chain reaction (PCR) amplification of supposedly specific “HIV” gene sequences, but PCR tests are known to generate false-positive signals between 40-100% of the time, which is absurd if you consider what this really implies.

Someone with a high “viral load” should have their blood teaming with viral particles, and not be in need of any PCR amplification at all to detect this exponentially high quantity of viral gene sequences or viral particles. Perhaps this is one reason why the inventor of the PCR technique, the Nobelist, Kary Mullis, once said there is no evidence that “HIV” is the cause of AIDS years ago. A patient with high “HIV” viral load should be able to walk into a physician's office, have their blood drawn, the doctor should be able to send that blood to a lab, and it should be loaded with hundreds of thousands or millions of "HIV" virus particles. But this has not been the case with “HIV.” This is the reason why PCR amplification of “assumed” "HIV" viral gene sequences is measured biochemically rather than directly. Chemical amplification of “HIV gene sequences” has had to be employed using PCR, precisely because there are no detectable viral particles or real viral gene sequences in the blood or tissues, nor have there ever been, in someone who is said to harbor the molecular signature(s) of “HIV” genomic sequences.

The plausibility of false positive readings in the STEP trial participants in the vaccine trial described above accounting for the few who were accused of becoming “HIV-infected” because of their behavior after vaccination is supported by a study conducted in 1992, in which a seroservey of out of 20.2 million "HIV" tests done in Russia, only 112 were confirmed and about 20,000 were false positives (Voevodin A. *Lancet. 339:1548, 1992)*.

112 “confirmed” “HIV” molecular signatures out of 20 million negative ones doesn’t constitute the kind of numbers that signal a major AIDS pandemic in Russia. But what is important to emphasize here is that the reported numbers (“HIV-positives”) could represent statistical artifact, or, in the several who seroconverted and showed a positive test result may represent the presence of some kind of auto-immune condition, like psoriasis, arthritis, or warts, or physiological stress, or a genetic polymorphism (human genetic variability).

In 2004, the American Red Cross reported that even after repeated “HIV” testing using different test kit types, that “low-risk” populations, such as blood donors (or military recruits or nuns) will typically yield 12 (PCR) positive or 2 (ELISA) positive results out of 37,000,000 million units of blood, which means that 10 out of 12 were false positives. In a follow-up analysis of this Red Cross study, it was then claimed that 6 of the 12 PCR-positive subjects tests seroconverted within several months, thereby obtaining a "HIV" molecular signature in 8/12 cases, out of 37 million negatives. Again, these numbers could represent statistical artifact, or, the several who seroconverted may represent the detection of some kind of auto-immune condition in those who test positive, like psoriasis, arthritis, warts, or physiological stress, or a genetic polymorphism.

Abbott Laboratory's ELISA test kit package insert says*:*

"ELISA testing alone cannot be used to diagnose AIDS." (Abbott 1997).

Epitope's (the maker for one of the Western Blot kits) package insert says:

"Do not use this kit as the sole basis for HIV infection." (Epitope 1997).

Roche's "Amplicor test kit's insert states:

"The amplicor HIV-1 monitor test is not intended to be used as a screening test for HIV, nor as a diagnostic test to confirm the presence of HIV infection." (Roche 1996).

Then what in God's name are these tests used for? Perhaps as lie detectors?

Presumably, as grave as an "HIV" or "AIDS" diagnosis is, one might expect there should be awareness generated about the lack of a gold standard (virus isolation) disclosed to the public. Or one might minimally expect, if the test kits predict progression to an "AIDS-defining illness" in only 4% to 6% of the cases measured as Rodriquez et al. have stated, at least one test kit type or brand available of the 33 or more on the market, that by itself, can serve as a gold standard to identify individuals who carry specific antibodies against the "HIV" virus, or components of the "HIV" virus itself. But this is not and has not been the case. Assuming that these conditional statements on the "HIV" test kits aren't typos, and are stated as they are by the manufacturers for a reason (if they were typos Abbott's should say "Elisa testing **can** be used **alone** to diagnose AIDS," Epitope's should read, "Use this kit as **the sole basis** for HIV infection," and Roche's should read, Amplicor HIV-1 monitor test **can be used** as a screening test for HIV, **and** as a diagnostic test **to confirm** the presence of HIV infection"), we must assume there is yet no gold standard for any “HIV” virus identification.

Some other test kits have the following qualifiers:

NucliSens(R) HIV-1 QT -- HIV QT Nov. 13, 2001
http://www.fda.gov/cber/pmalabel/P0100010LB.pdf:

*"The NucliSens(R) HIV-1 QT assay is **not intended** to be used as a screening test for HIV-1 nor is it to be used as a diagnostic test to confirm the presence of HIV-1 infection."*

COBAS AmpliScreen HIV-1 Test, version 1.5
Approval Date: 12/19/2003 http://www.fda.gov/cber/label/hiv1roc121903LB.pdf:

"This test **is not intended** for use as an aid in diagnosis."

Procleix(R) HIV-1/HCV Assay -- IN0076-01, Rev. A
Approval Date: 6/4/2004 http://www.fda.gov/cber/label/hivhcvgen060404LB.pdf:

*"The Procleix HIV-1 Discriminatory Assay may be used **as an aid** in the diagnosis of HIV-1 infection."*

GENETIC SYSTEMS (TM) rLAV EIA
http://www.fda.gov/cber/sba/hiv1gen062998S.pdf:

*"The rLAV EIA is intended to be used as a screening test **for donated blood or plasma** and as **an aid** in the diagnosis of infection with HIV-1."*

VIRONOSTIKAT(R) HIV-1 PLUS O MICROELISA SYSTEM
http://www.fda.gov/cber/pmalabel/P020066LB.pdf:

*"System is intended for use as an aid in diagnosis of infection with HIV-1. It is **not intended** for use in screening blood."*

Defer et al. in a paper entitled, "Multicentre quality control of polymerase chain reaction [viral load] for detection of HIV DNA" (AIDS 6: 659-663, 1992), reported that:

*"False-positive and false-negative results were observed in **all** laboratories (concordance with serology ranged from 40 to 100%").*

Busch et al., in a paper entitled, "Poor sensitivity, specificity, and reproducibility of detection of HIV-1 DNA in serum by polymerase chain reaction. (The Transfusion Safety Study Group. J Acquir Immune Defic Syndr; 5 (9):872, *, pages 874-875* 1992), reported that:

*PCR-DNA tests on 151 ELISA-negative people found that 18.5% (28 people) had positive PCRs. Furthurmore, **only 25.5% of people diagnosed HIV-positive had positive PCR's.***

WHAT ARE THE SUCCESSES OF THE "HIV=AIDS" HYPOTHESIS?

Instead of mutation, in biology the nature of life suggests that genetic invariance (non- change of genetic identity) governs the characteristics of a species, a bacterial strain, or, a viral strain. The stability of the genetic code, largely because of the strong molecular material it is made out of, assures a continuance of distinctiveness of form and function in cells, organisms, and viruses.

Genetically, for "HIV's" protein coat to change rapidly and often means that "HIV" is capable of continuously reshuffling its tiny sinister genome like a card deck, to produce proteins that are perpetually novel and unrecognizable to the immune system, but which paradoxically have remained unchanged and diagnostic on the "HIV" tests of 33 million people for two decades- in 33 million "infected" folks.

It has been said that "HIV's" genome is more complex than most retroviruses because it has more than just the typical number of gag, pol, and env genes to facilitate its supernatural ability to mutate every time it is analyzed by genome analysts.

However, this juxtaposition of what is known as genetic invariance (non-change) in one context (two decades of "HIV" testing) and "HIV's" imagined ability to constantly mutate its genetic sequence in another context (in vaccine recipients, patients treated with HAART and who fail the "life-saving AIDS drugs" like nevirapine), violates what is known about the ability of the structure and chemistry of genetic material to maintain non-change over the geological time periods of hundreds of millions of years. During similar time frames, non-living things such as mountain ranges, or even continents, come and go. Therefore, it is without scientific basis to imagine that "HIV's" molecular signature has remained detectable with the same molecular probes on the more than 33 test kits in 33 million people for over a period of two decades, while at the same time, it mutates in almost each and every anti-retroviral drugged patient who dies. It is like a bad science fiction movie when we are told that “HIV” mutates in 41.7% of 875,000 African women and their infants who were told to imbibe a single dose of nevirapine during the first 6 months of life, or when we are told that “HIV’s” genetic structure can change in the time it takes the vaccine maker to make and ship off the vaccine in a truck until it arrives in your doctor's office, during which time, the clever "HIV" "mutates."

In support of "HIV's" molecular sequence or signature being a stable phenomenon, among the human population, there has been no measured change in sequence or structure of supposedly specific and diagnostic “HIV” molecules such as p24 that are detected today, and the p24 molecules the test kits supposedly detected at the beginning of the AIDS era.

Reverse transcriptase, another supposedly imported "HIV" gene, is known for its stability (and its stable and important long history within the genomes of organisms throughout Nature), not its mutability [1]. A person that would test positive for p24 protein in 1984, would test positive for the same p24 molecules today.

Therefore, it is unlikely that an unstable process such as mutation is the reason for “HIV’s” touted ability to evade the immune system after vaccination or anti-retroviral drugging to death.

Nor can mutation account for how “HIV” can evade drugs like AZT, HAART, or nevirapine by allowing “HIV” to form what has imaginatively been called “escape mutants.” Chicken pox, small pox, and rabies supposedly have the same or very similar genomes and proteins today as they did centuries ago, and they cause the same collection of symptoms as they have in the past.

A person bitten by a rabid dog in Pasteur’s day 150 years ago who acquired rabies would have the same symptoms as a person bitten last year in North Carolina who acquired rabies from a rabid dog. If a rabies virus were analyzable during Pasteur’s day, it would likely have had the same genes, and proteins as it does today.

The distinctiveness of the leper’s lesions described during in antiquity would likely exhibit the same appearance as they do today, and are associated with the same Mycobacteria. Like gives rise to like, and if doesn’t because of mutation, then it becomes something else that usually doesn’t work. This is the overwhelming lesson that genetics teaches regarding mutation, and genetic invariance.

That the vaccine failures, reports of testing artifacts, failure of animal or culture models, breast feeding dissuasion disasters, microbicide failures, the failures of “clean needle” programs and condom crusades, and anti-retroviral induction of escape mutants, don't represent simply carefully selected pieces of “cherry picked” evidence in favor any particular viewpoint, other failures of the hypothesis that have become evident only recently, also serve to undermine the

"HIV equals AIDS" hypothesis, and demonstrate how this molecular hypothesis of disease has been stretched beyond the limits of genetics or the germ theory, and now constitutes a quasi-religious series of heart-felt beliefs.

Some of these failures not only include the failure of "HIV" vaccines, but also the failure to isolate "HIV" and explain or predict the confusing molecular signatures that are detected in healthy drug-naïve persons, and the failure to consistently sequence the "HIV" genome or identify specific proteins that are not also found in normal, non-infected contexts.

In an analysis by an emergency room consultant, Val Turner of the Perth group of Australia, he once pointed out that:

"*The only thing the failure of the "HIV" vaccines shows is that there are problems in developing them. Among others, it suggests but does not prove that "HIV" does not exist. The "shatteringly important" experiments regarding "HIV" vaccines were published a long time ago. Although we have been trying to draw attention to them, everybody ignored us.*

In 1991, in their effort to develop a "HIV" vaccine, Stott et al. like everybody else used monkeys and "SIV" as a model. However, unlike everybody else, they used ***controls****, that is, in addition to injecting animals with "inactivated purified virus or fixed SIV-infected cells", they also injected other animals with* ***uninfected cells****. To their surprise, they found that* ***both*** *the "virus****" and the uninfected cells*** *protected against "infection". As Stott put it:*

" protection is mediated by antigens…protection was obtained by both the antigens in the "virus" and the uninfected cells…

The finding means that the antigens in the "virus" and the uninfected cells were the same, that is, there were no viral antigens or viral antibodies.

At about the same time, Kion and Hoffmann published evidence which showed that "mice that have been treated with T lymphocytes from another mouse strain, but not exposed to "HIV" in any form, have been found to generate antibodies against two of the proteins characteristic of "HIV" – those known as gp120 and gp24". The finding by Stott et al and Kion et al were interpreted by John Maddox as supportive of Peter Duesberg, and in a Nature editorial entitled: "AIDS research turned upside down." He stated: "Professor Peter Duesberg from the University of California at Berkeley is probably sleeping more easily at night now than for five years, since he first took up cudgels against the doctrine that AIDS is caused by the retrovirus HIV". In fact these findings say nothing about the role of "HIV" in AIDS. The successive immunization with ***non-"HIV" infected cells*** *and the generation of antibodies to the "proteins* ***characteristic of HIV"*** *by exposure to allogenic non-infected cells proves that both the "HIV" antigen and antibodies have nothing to do with "HIV". If there are no viral proteins and antibodies then there is no virus. If there is no virus, there can be no viral vaccine. That is, no effort in the development of "HIV" vaccines will succeed.*

At the 12th Worlds AIDS Conference, Geneva, 1998, Perth presented the following:

"…in the well known Bess and co-authors 1997 Virology paper, the authors had 3 HUT-78 cultures, two infected and one uninfected control. (The HUT human cancer cell line is that used by Gallo to "isolate" HIV in 1984 and since). The proteins from the banded material from all cultures including the control (lane A), which they called "mock virus", were compared using electrophoresis. They stated that the only difference between the 3 strips was that the infected strips contained major bands of p24, p17 and p6/7 and called them HIV proteins. But these same bands, although weaker, can also be seen

in the "mock" virus protein strip whereas, to be HIV proteins, requires them to be present exclusively in the "infected" strips. When asked for proof that p24 etc in the strips B and C were HIV proteins their answer was that the labels were added for the reader's convenience at the suggestion of the reviewers.

So Bess and his colleagues have shown that the same proteins are present in the pure HIV and "mock" virus. (Virol. 230:134-144).

In their effort to develop a vaccine, and because humans cannot be injected with either HIV or "mock" virus, Bess and his colleagues first injected macaques with the "mock" virus. (This is culture fluids from the uninfected H9 clone of the human HUT78 cell line "purified" as it would be to obtain "HIV" or "SIV"). After the initial immunisation, the animals were given boosters at 4, 8 and 12 weeks. At fourteen weeks, the monkeys were challenged with intravenous SIV prepared from the same human cells as "mock" virus and then monitored for seroconversion with the SIV Western blot.

According to the authors, the animal immunised with "mock virus" "did not seroconvert to viral proteins after intravenous challenge with SIV", and "These results are the first demonstration that immunisation with purified cellular protein can protect from virus infection...It has recently been suggested that immunisation with alloantigens might serve as a vaccine to protect against HIV infection. Our demonstration.supports this concept".

The underlying principle of immunisation is its specificity. That is, to protect against microbe 'X', the person or animal must be exposed to material from 'X' in order that the immune system generates specific antibodies. For example, immunisation with hepatitis vaccine does not protect agains poliomyelits. Since monkeys immunised with proteins derived from uninfected human cells are protected from infection with 'SIV' prepared from the same uninfected human cells, "mock" virus and "real" SIV must be identical. If such "mock" virus and "SIV" are one and the same we would expect that when "SIV" is prepared in antigenically different cells, for example, monkey cells, there will not be "protection". This is in fact what Bess and his colleagues proved in another experiment. The only logical explanation of these data is that they reflect immune responses to cellular proteins. Thus SIV proteins, and by inference, HIV proteins, are nothing else but cellular proteins."

THE MEANING OF "HIV'S" MOLECULAR MARKERS AND PROFILE.

Because the components of a so-called HUMAN retrovirus (NOT SIV) that is supposed to cause immune suppression haven't been isolated away from cellular proteins, because they can't induce seroconversion in significant numbers of the vaccinated to exhibit the 10 various so-caled specific "HIV" gene products claimed to be diagnostic of "HIV" infection on a WESTERN blot, or have not been shown to cause immune suppression in humans or animals, it can be stated at this point that a complete understanding of the molecular signature of "HIV" has not been obtained by anyone.

As mentioned, when they tried injecting chimpanzees with sera from AIDS patients or what they believed was purified "HIV," chimps didn't get sick, nor could viremia be demonstrated in the so-called organs that the virus was supposed to attack, or the blood, where there are supposed to be millions of copies, but no electron microscope photographs of isolated virus particles. This failure to induce the diseases attributed to this virus is not only the case with "HIV" but also with hepatitis B and hepatitis C as we shall later discuss.

Therefore, there are so many different types of examples why the "HIV=AIDS" hypothesis fails to explain anything about transmission, immune suppression, or disease, or why all these

vaccine trials have failed, that it cannot possibly be cherry picking of data to criticize the "HIV=AIDS" paradigm.

When they launched the anti- breast-feeding programs and they warned all these African women not to breast-feed because they might pass on the AIDS virus through their breast milk, they announced -- just a year or two ago -- that the women who were dissuaded from breast-feeding their infants, had a twenty times greater rate of death among their babies than infants of mothers that breast fed, because the infants were not achieving the proper protective immunity or nutrition that goes along with normal breast-feeding in these extremely poverty-stricken places where human experiments are typically tried out first, before they are implemented in the countries whose inhabitants matter in the corporate world.

If infants have higher infant mortality rates following the wisdom of The AIDS Establishment and AIDS promoters not to breast feed, even in regions of the world that are supposed to have high rates of "HIV," then how could it be even considered a possibility that vaccine makers could inject some component(s) of "HIV" directly into a human vein and induce protection from immune suppression, or, in the case of the failed Merck trial mentioned before, evoke "HIV's" "true" "molecular profile" in any significant number of vaccine recipients? Most or all of the vaccinated should have at least shown complete seroconversion if "HIV's" components had been isolated and are immunogenic in human beings.

These kinds of data that do not support an "HIV=AIDS" hypothesis, and should be compared in the context of at least 19 other hypotheses that have claimed they found a potential and compelling cause of AIDS. For example, in 1989-1990, a series of articles published by Shyh-Ching Lo of the Armed Forces Institute of Pathology, who presented evidence that a microbe called Mycoplasma incognitus was found in the thymus, liver, spleen, lymph node, or brain of 22 of 34 persons who had died of AIDS. The patients who were selected for this autopsy study had all had evidence of organ failures. In another study, mycoplasma was found in seven of ten persons with AIDS.

An incredible book has just been published, in French, by Luc Montagnier, the co-discoverer of "HIV", under the title of "Les Combats de la vie", JC Lattès, editor, 2008, Paris, readily available via Amazon.

The book says that "HIV" is not the only cause of AIDS, and that mycoplasma should be looked at. Montagnier was co-discoverer of "HIV" and the recent Nobel recipient (along with Barre-Sinoussi) who "isolated" the "AIDS virus" from a man with rubbery lymph nodes, who had been treated the year before for syphilis, who had been treated twice before for gonorrhea, who had evidence in his blood samples that he had been exposed to two types of herpes virus, cytomegalovirus and Herpes I, and Epstein-Barr virus. Is this the "Patient One" that could be considered an ideal subject for isolation of "an AIDS virus?" Did "Patient One" have lymph node fibrosis-the supposed new diagnositic hallmark for true AIDS illness?

"HIV's" MOLECLAR PROFILE MOST LIKELY ARE NON-SPECIFIC REACTIONS OR IT ORIGINATES FROM THE NORMAL GENE PRODUCTS OF THE HUMAN GENOME, NOT FROM TOYS, FOOD, BIZARRE AFRICAN SEXUAL PRACTICES, OR A "SPECIAL VIRUS PROGRAM" DEVELOPED FO DEPOPULATION THAT BEGAN AS A HEPATITIS VACCINE FOR GAY MEN IN NEW YORK.

There have been many theories regarding the origins of "HIV's" molecular profile. Most are based on racist ideas of a virus jumping from either monkeys or apes to black people who lived

in Africa. How transmission took place has been fraught with equally racist notions. We have been repeatedly told in journals such as Science, Nature, and The Lancet that supposedly poor Africans don't have enough food (so they are now given toxic chemotherapy drugs in massive drug roll-outs under George Bush's PEPFAR pogrom instead of food and clean water), but there is no basis for the belief that "HIV" can be transmitted through "eating the dead carcasses of monkeys hunted for their meat" by starving Africans, or because Africans can't afford toys for their children, so their parents give them dead carcasses of "SIV" or "HIV" infected monkeys. More egregious and racist notions were notions put forth involving African sexual practices (From Rosalind Harrison-Chirimuuta and Richard Chirimuuta (http://www.virusmyth.net/aids/data/rcafrica.htm):

"Researchers had originally proposed that AIDS was an "old disease of Africa" that had reached the West via recent intercontinental travel, a rather curious notion given the ***enforced intercontinental travel*** *of up to 100 million Africans in previous centuries (32) [*due to slavery*]. As this hypothesis become increasingly untenable attention was diverted to the possibility of a monkey origin of the virus. Such ideas cohabit easily with racist notions that Africans are evolutionary closer to sub-human primates. Dr. Robert Gallo and his co-workers were among the pioneers of this line of research, both for HTLV-I and HTLV-III (later renamed HIV).(5,33,34) Two of Gallo's colleagues, Kanki and Essex, reported the isolation of a virus similar to HTLV-III in macaque monkeys who were suffering from an AIDS-like illness, and labeled it simian T-lymphotropic virus type III (STLV-III) of macaques.(35) For those who were arguing an African origin of the AIDS virus, an Asian monkey like the macaque was not a suitable source, but less than six months later the same researchers reported finding the virus in "wild-caught" African green monkeys from Kenya and Ethiopia.(36) This research, like most other research on AIDS in Africa, was motivated only by a desire to prove an African origin of the disease, and was greeted with enthusiasm by the Western scientific community. Discussion quickly moved on to the question of how the virus crossed the species barrier, and two AIDS "experts" from St Mary's Hospital in London even offered this explanation:*

"Monkeys are often hunted for food in Africa. It may be that a hunting accident of some sort, or an accident in preparation for cooking, brought people in contact with infected blood. Once caught, monkeys are often kept in huts for some time before they are eaten. Dead monkeys are sometimes used as toys by African children."

Are we seriously to believe that African parents are so desperate for toys for their children that they give them putrefying carcasses of dead animals? More fantastic suggestions were published in The Lancet:

"Sir: The isolation from monkeys of retroviruses closely related to HIV strongly suggests a simian origin for this virus... Several unlikely hypotheses have been put forward... In his book on the sexual life of people of the Great Lakes area of Africa Kashamura writes: "to stimulate a man or a woman and induce them to intense sexual activity, monkey blood [for a man] or she-monkey blood [for a woman] was directly inoculated in the pubic area and also the thighs and back." These magic practices would therefore constitute an efficient experimental transmission model and could be responsible for the emergence of AIDS in man."

A more likely explanation of the origin of "HIV's" molecular signature comes instead not from racist notions, but from recent studies in genomic research that suggests that the so-called template for the protein molecular signatures of "HIV" may derive from endogenous DNA sequences (coming from cellular origin instead of viral origin). It is known that these cellular proteins are expressed under certain conditions by normal uninfected yeast, insects, dogs, rhesus monkeys,

chimps, and humans. “HIV” is said to have 9150 base pairs, but again, this template is constantly changing, and it has not been purified as a complete gene sequence or without contaminating cellular nucleic acids. “HIV’s” molecular signature could represent a HERV (Human Endogenous Retrovirus) nucleic acid sequence, or, what is called a ‘retroid’ of one kind or another. A retroid is a special kind of gene sequence associated with diseases such as multiple sclerosis, and with normal biological functions involving the placenta [2, 3], or many other sources/ syndromes. That these endogenous human genetic elements exist and are important has been shown again and again to be likely from studies on HERV's such as "the Phoenix viruses," that can be produced by infecting cells with certain sequences of DNA, which then is replicated and packaged by the cells into virus-like particles.

Also, any modern analysis of the human genome database will reveal more than 120, 000 full-length retroids containing reverse transcriptase transcripts [1]. Although "HIV=AIDS" proponents are always saying the "HIV virus's" reverse transcriptase sequence is mutating when patients die on “life saving” anti-retroviral drugs that supposedly target this enzyme, genomic analyses show that reverse transcriptase is among the most stable transcripts that make up these retroids, and it is the sequence stability rather than the instability or mutability of the reverse transcriptase sequence itself that make these 120,000 retroid sequences possible to classify.

We are all made up partly of “retroviral” components, they are part of us. What they call “HIV” and what they have successfully branded as the most dangerous and infectious virus known to man, is (and can be evoked) in many of us, and what we have been mistaking for the “virus” are the technologies for detecting it, without any of the sober analysis of what those tests are actually detecting or what “HIV’s” molecular signature means for a human being. The probable "cause of "HIV" could be these retroids and/or endogenous HERV sequences, or non-specific molecular reactions that can be evoked by the tests themselves, or under stress conditions, or which may become expressed in healthy persons as part of a relatively rare genetic polymorphism.

Yet there still persists after decades of data to the contrary, many researchers who still advocate the tacit assumption and arrogance that we know all there is to know about the human genome, or that the circumstances in which the genome may express novel but perhaps stereotypic gene sequences have all been discovered.

There may indeed be a relationship between “HIV’s” molecular signature and immune disorder in some individuals, but the hundreds of billion dollar question science has not been permitted to ask about these individuals is: which comes first? Which is cause and which is effect, and what is the meaning of the molecular signature of “HIV” in a healthy person who tests “HIV-positive?”

Other so-called “HIV-specific” sequences, such as those that give rise to the so-called GAG, POL, RT, ENV molecules are also found in the normal human genome database. In gene bank searches, one can find 16 samples of spuma virus transcripts, 6 examples of snakehead virus, 16 samples of FIV (feline immune deficiency virus), 60 examples of detecting one or more HBV (hepatitis B virus) genes, and at least 11 cases of “HIV” sequences that are said to be scattered throughout the normal human genome, according to the analyses of McClure and other modern human Genome Database analysts [1].

The confusing thing may be that some of these endogenous cellular DNA or RNA sequences are only expressed rarely, or in response to physiological stresses: they aren’t infectious, and they may represent as much a 8-17% of the normal human genome according to some scientists.

“HIV’s” molecular signature may have nothing to do with a specific virus: the molecular signature thought to be a virus may in fact be generated also in response to real viruses or other pathogens that at some point of physiological stress provoke a new and complex immune response, which is read sometimes as “HIV’s” molecular signature. The immune system of a person so infected by multiple or numerous real viral, bacterial, fungal, or parasitic infections could be perpetually generating new immunogens, which is read by AIDS scientists as an ever changing and mutating “HIV.” In theory, such an immune chain reaction caused by multiple real viral or bacterial or fungal infections would be progressively more debilitating for the stability and effectiveness of immune function, and, a vaccine against any specific virus or other pathogen would be ineffective against the development of AIDS, as the many failed vaccine trials already have demonstrated. If this hypothesis is correct, then an experimental animal model of AIDS should be induced in laboratory animals by infecting them at a low multiplicity with a very large number of diverse viruses, as was suggested one by Nobelist, and PCR-inventor, Kary Mullis, in a Genetica paper he wrote in 1995.

Most importantly, the nature and plasticity of potentially stereotypic signals of especially the immune cell’s or cancer cell’s genome under various stressful and even normal states are not yet known. Despite "AIDS establishment" claims that the whole human genome has been sequenced and is known, and that “HIV’s” molecular signature isn’t found in the normal human genome, or in stadiums full of "HIV-negative" people, the nature of some immune cells is their unique ability to re-arrange their genomes to produce antibodies to new agents. Therefore, all possible or even stereotypic re-arrangements of the genomes of immune cells is not yet sequenced, because, the antigens (foreign molecules from outside the organism) that would evoke new antibodies have not yet plagued Mankind yet, or, such novel sequences may only be assembled or evoked in immune cells when certain stresses are placed on the individual. The human genome project didn't sequence all human genomes, or even genomes from different "representative individuals." We have no idea regarding what most of these so-called genes do, or how they function.

Perhaps even more importantly, the significance of lymph node fibrosis has only come to light recently as a biomarker of true immune suppressive illness, and the significance of this fibrosis in the context of immune suppression has not been explored as it has been previously in the realm of malignant tumor progression. Tumors, and diseased organs in other contexts (cirrohsis) produce fibrosis as perhaps one of the strongest markers of true malignancy, or irreversible disease progression in other contexts. It is perhaps in the context of the production of these “fibrotic reactions” (the fibers of life as in the title) that the entire AIDS ediface needs now to be re-examined, perhaps in the context of drug resistant, polysaccharide-rich biofilms, known to be resistant to all drugs, at least in the realm of bacterial biofilms, and perhaps in tumor “biofilms” that also contribute to resistance of the tissue to all curative treatments?

Yet recently, the U.S. government acting through the directives of the Bush Administration is pressing for legislation requiring mandatory "HIV" testing for Americans between the ages of 3 and 80. This proposal is the biggest mistake that the U.S. could make -- the most costly mistake and the most damaging mistake for the largest number of people possible. When you test populations of people that are considered to be what the "AIDS establishment" says are “low risk,” you are going to get a huge number of false-positive test results, which is essentially going to ruin the lives of tens of thousands or perhaps as many as hundreds of thousands of people.

Many studies indicate, in addition, that you are going to get a number of people who really are not sick in any way, shape or form, to "test positive." And they won't be able to get health insurance. They may be fired from their jobs. The stigma of having AIDS causes accusastions of homicide, as it did with David Acer, the dentist whom the CDC later exonerated (after his death), because the CDC could find no evidence after he died that the dentist's 5 “HIV-positive” patients, including

Kimberly Bergalis, contracted their “HIV” profiles from him. There also is evidence that countless others who have been given the diagnosis of an “HIV infection,” have chosen to end their lives upon getting an “HIV-positive” test result.

Since expanding the AIDS definition in 1993 to include "HIV positives" with no clinical symptoms of disease, the majority of all new AIDS cases in America are diagnosed in healthy people with none of the opportunistic infections or Kaposi's sarcoma previously used to define AIDS. Epidemiology reports from around the US reveal that for the past 14 years, non-illness is the leading reason for an AIDS diagnosis in America, and depending on the region, 45% to 75% of all AIDS cases reported since 1981 were counted in clinically healthy HIV positives. Across the border in Canada where the AIDS definition still requires actual illness, AIDS cases per capita are 18 times lower than in the US.

It is concluded that global health strategies for AIDS, like any other public health activities, should be based on evidence instead of racist notions regarding sexual behavior. Many of the basic assumptions regarding the probability that "HIV" leads to "AIDS" are clearly wrong, contradictory, and defy common sense, to the extent that the "HIV/AIDS" hypothesis should be retracted, and a full examination of where we went wrong, conducted, so we can learn from "mistakes."

Consider the following example:

Although six health care workers in Libya were recently about to be executed due to the mistaken belief they transmitted "HIV" to 426 children, they were freed because Montagnier said the 426 children they supposedly infected were infected instead by "sub-Saharan health care workers" (read Black people) working in and around the Libyan hospital. Perhaps the individuals in leadership roles in our own government who press release these kinds of distortions and propaganda, or who direct these trials and distort data, are the ones who must be held legally, and criminally responsible?

In summary, there have been four indisputable successes in The War On AIDS claimed by the biomedical establishment, and there are recurring themes and principles to be learned from these claimed successes, and not just from the enormous failures like the recently halted “HIV” STEP vaccine trial, which was likened to a “Challenger-sized disaster,” or the Thailand-US military vaccine trial testing on some 16,000 victims. The four claimed successes include and are not limited to:

1) Dr. Nancy Padian’s ability to counsel 175 “HIV-positive” persons who had unprotected sex over a 10 year period and who did not transmit their positive test result to their non-“HIV-positive” serodiscordant partners, principally because of her ability to counsel them so well; 2) Dr. Robert Bailey’s success of The University of Illinois and his claimed successes regarding his African circumcision studies, in which African men’s foreskins were surgically removed, and the incidence of “HIV” transmission was claimed to have been half of that measured before they were circumcised in STD clinics, which again was due perhaps to Dr. Bailey’s amazing ability to give good advice to these STD-prone African men (personal communication); 3) Dr. Gero Hütter’s claim that he saved a man from his leukemia and AIDS after he whole-body irradiated him to wipe out his immune system, and after he gave him a bone graft to regenerate his immune system and his “HIV-positive” result disappeared, and 4), the many thousands of anti-retroviral studies, especially those which have claimed to block or prevent mother-to-child-transmission (pMTCT), and which hve been said to greatly extend the length and quality of life.

Similar to the hopeful news provided by these four success stories, there recently have been a new hopeful advances in the world of AIDS science and clinical care. More of a realization or admission than a scientific or medical advance per se, “HIV-discoverer” and Nobelist, Luc

Montagnier (awarded with Barre-Sinnousi the 2008 Nobel prize for their discovery of LAV ("HIV"), along with Harold Zur Hausen for his "discovery" of HPV (Human papilloma virius) has now reserected a Century old discussion regarding the typical person's acquisition of "HIV." In an interview Dr. Montagnier recently gave in a new documentary called "House of Numbers," Dr. Montagnier claimed that (http://www.youtube.com/watch?v=WQoNW7lOnT4):

Luc Montagnier:

"...I believe HIV, we can be exposed to HIV many times without being chronically infected. Our immune system will get rid of the virus in a few weeks, if you have a good immune system; and this is also the problem with African people; their nutrition is not very equilibrated, they are in oxidative stress, even if they are not infected with HIV, so their immune system doesn't work well already, so it is prone, you know, allow HIV to get in and persist. So there are many ways, not the vaccine, many ways to decrease the transmission, just by simple measures of nutrition, giving anti-oxidants, proper anti-oxidants-hygiene measures, fighting the other infections."
Interviewer:

"If you have a good immune system, then your body can naturally get rid of HIV?"

Luc Montagnier:

"Yes."

This documented and Youtube-posted statement (and interview in the movie "House of Numers) in which Dr. Montagnier harkens back to the arguments of his country's microbiological forerunners, Louis Pasteur and Beuchamps regarding the supremacy of soil versus seed in disease acquisition, it is widely acknowledges that the soil (the organism) and not the "seeds" or germs (or "HIV"), ultimately determined if illness would result from any seed.

And because Montagnier is now claiming that "we can be exposed to HIV many times without being chronically infected…because our immune system will get rid of the virus in a few weeks, if you have a good immune system," then clearly, Montagnier has sided with Beauchamp's argument in the context of "HIV" and AIDS.

Even more interesting, it is widely known and appreciated by many who have studied AIDS, cancer, or the AIDS era, that the so-called molecular markers detected originally by Luc Montagnier's and Barre-Sinoussi's group at the Pasteur Institute in France, were from the beginning problematic.

The molecular signals they detected were confounded by the fact that their "Patient One" was not the ideal patient to launch the AIDS era, or the anti-retroviral drugging or vaccination of entire continents. He had multiple infections according to their 1983 paper (syphilis, gonorrhea, herpes, cytomegalovirus, Epstein-Barr virus, and perhaps others)?

Incompletely treated syphilis, by itself in its secondary or tertiary form often presents as a syndrome characterized by an inverted T-cell ratio like AIDS, and, it is frequently accompanied by PARESIS-the symptoms of which are indistinguishable from AIDS dementia. In tertiary syphilis, the lymph system also is destroyed and the offending spirochete cannot be detected by any but the most rigorous tests, and often, only from serum obtained through cerebral spinal fluid (CSF). The "Pasteur group's" findings also were confounded because the molecular signal generated by their so-called "isolate" from this and other initial "pre-AIDS" patients itself was not consistently

detected or ever shown to produce disease in either animals or man: there is now much evidence to suggest that that molecules once attributed to being unique to "HIV" are in fact not unique, and are found in normal non-infected contexts. Reverse transcriptase (RT) was the enzyme once attributed incorrectly and specifically to retroviruses, while gargantuan 70s RNA's are found in a host of contexts such as non-infected cancer cells.

The initial "isolates" also were problematic because the healthy cells derived from normal placentas they used to serially propagate the LAV-BRU molecular profile in culture likely contributed human HERV's or retroids (HERV's are Human Endogenous Retro-Virus Sequences: retroids are phylogenetically conserved sequences of DNA or RNA within cells that are expressed or remain non-expressed for various reasons). These products of these so-called HERV and retroid conserved genetic sequences during phylogeny are now known to be expressed and present in many non-"HIV-infected" contexts. Also, it is now clear that in the 1983 paper published by these Nobel Prize-winning "LAVBRU" ("HIV")-discovering Pasteur scientists believed the sub-microscopic particles thought what they saw were foreign virus particles, even though they probably were not, because it is now known that similar particles are shed from non-infected normal placenta-derived T-cells they used to propagate the viral signature in Petri dishes. In brief, the AIDS era is based on a Petri dish artifact.

On the other side of the Atlantic, the U.S. NIH Bethesda group's initial "isolation" and publication of 4 papers in Science the next year in 1984, the effort headed by Robert Gallo and his associates, was also problematic. Gallo's group by all the information we have, merely "amplified" what turned out to be mostly human cancer cell cellular debris, or possibly their HERV or retroid products. They, like the Pasteur group, also misconceived this amplified molecular profile as being the same thing as virus isolation. In addition, we now have recently come upon new information, sent to me by Dr. Gallo himself, that claims their "HTLV-IIIB" "isolate" of his, was pooled from some 20 different individuals thought at that time to exhibit "pre-AIDS" and AIDS. The antibodies against this ill-defined molecular profile were not defined for a host of reasons, and in many cases, the markers that were defined as belonging to "HIV" had nothing to do necessarily with immunosuppressive illness, cancer, or other syndromes. Most of Gallo's "HTLV-III-positive" patients were healthy (HTLV-III was later renamed, like LAV-BRU, "HIV"), but upon the imagined specificity of these "HIV" markers, the first "HIV" test kits and their patents were made, and continue to be made.

These "isolations" and amplifications of cellular HERV or retroid sequences and products, along with suspected external or what are called "exogenous" retroviruses, have baffled AIDS science for 25 years. The focus on so called retroviral sequences and "70s RNA" during the early 1980's came at a time of growing distrust among the scientific community. The simple yet labor intensive methods of the classic "Pasteur Methods" of definitive virus isolation (and the needed proof of pathological association of suspected viruses), was rejected during the rise of the molecular cloning era. This new molecular focus emerged and rescued a failed Nixon "war on cancer," that became unfortunately focused on viruses and retroviruses. The discovery of "HIV" was ultimately based on Dr. Gallo's claims and techniques used to detect the first putative human cancer retrovirus, "HTLV-1," while the treatments devised to quell Acquired Immune Deficiency Syndrome under Sam Broder were grounded on failed cancer regimens and theorizing. During this period, molecular cloning, RNA isolation, c-DNA manufacture, and molecular biology came to dominate the biological and biomedical sciences.

Other pathogens and hypotheses that were accepted before and during the AIDS era, such as mycoplasma infections, or "hepatitis B" or "prion" pathogenesis, and syphilis, were never developed or adequately investigated. Especially important, immunological constructs like

immune chain reactions or imbalances of the Th1/Th2T-cell T-cell ratios, or the effect of multiple antigens on the immune system that are testable, and which were therapeutically shown to be reversible, also were ignored, unfunded, and were not pursued in favor of a one virus fits all theory.

It is in the modern context of molecular cloning and immunological set theories, rather than methods based on the so-called Pasteur rules, that new information and a series of new ideas should be discussed regarding cancer, "HIV/AIDS," hepatitis B, SV-40, oncogenes, mutation, HPV, and retroviruses more generally.

These ideas that are at the foundation of the AIDS era also have failed because of the ongoing racism, homophobia, and the selective biasing of individuals that the medical establishment, the World Health Organization, governments, and just about everybody else ,"knows" belong to those groups of "high risk individuals:" Africans, African Americans, IV drug abusers, Hispanic women, transfusion recipients, and of course, many other types of "risky" individuals."

If you look closely at the history of events during the AIDS era, alson with it's 20 or more hypotheses as to what causes the syndrome, you should clearly see that in the context of the ***origins*** of "HIV"

1) How certain individuals have claimed that indisputable art work evidence proved that black slaves caught a cancer virus ("HTLV-1") from monkeys on those lonely long ocean voyages in the 16th Century during the slave trade, which caused Japanese living near Nagasaki to catch cancer centuries later, after the Americans dropped the atomic bomb on their civilian populations (Robert Gallo, personal communication); 2) How journals such as the renowned and highly esteemed journal, The Lancet, published that African parents are too poor to buy their children toys, and how they let them play with the carcasses of dead animals like dead monkeys; 3) and how top scientists at Harvard, the NIH, and elsewhere believed and still maintain that there were African hunting parties when monkeys were caught and not cooked good enough (despite the human invention of fire in Africa some 2 million years earlier), and despite "HIV's" fragile sensitivity to just about everything. Top AIDS scientists also believe, without doubt, that something like this half-cooked "monkey-burger" may have first infected Africans; 4) and perhaps that Africans must have smeared monkey blood on their loins to enhance their sexual experience, or engage in dry sex, and the raping of their own child virgin daughters, and, as stated in The Lancet:

"Sir: The isolation from monkeys of retroviruses closely related to HIV strongly suggests a simian origin for this virus... Several unlikely hypotheses have been put forward... In his book on the sexual life of people of the Great Lakes area of Africa Kashamura wrote: "pour stimuler intense, on leur inocule dans les cuisses, la region du pubis et le dos du sang preleve sur un singe, pour un homme, sur une guenon, pour ne femme" (to stimulate a man or a woman and induce them to intense sexual activity, monkey blood [for a man] or she-monkey blood [for a woman] was directly inoculated in the pubic area and also the thighs and back). These magic practices would therefore constitute an efficient experimental transmission model and could be responsible for the emergence of AIDS in man (Noireau F. HIV transmission from monkey to man. " Lancet (i): 1498-1499, 1987).

In 2008, we even find that the journal Nature published that "HIV" and AIDS was definitely, unequivocally, and historically, the fault of dark skinned African peoples and their lack of self control regarding non-human primates, because of "their close associations with chimps." These exchanges, and abominable couplings, according to these high priced magazines, first took place in Cameroon, when the Africans built cities near non-human apes, and had "high risk" behaviors with

each other 125 years ago, according to their new ***genome*** analyses, and comparisons between "HIV" and "SIV" "genome" sequences.

These time tested, universally accepted, and now unequivocal historical and scientifically proven facts still may not demonstrate beyond all doubt that "HIV" "jumped" from monkeys and apes to blacks, and then of course to gays in California and New York, and then to many innocent victims, like Kimberly Bergalis, Ryan White, Arthur Ashe, Tommy Morrison, Rudolf Nuryev, the Glaser family, and indeed approximately 33 million others, but this idea does form one of the foundations of AIDS science.

Unfortunately, these unassailable racist "truths" about the origins of "HIV" still do not even phase a small group of junk-science enthusiasts, who advocate the incarceration of so-called accused "AIDS denialists," who they liken to Holocaust denialists.

Toward this end, there even are same talented scientists and doctors that have spent a great multitude of our tax dollars to deliver "HIV/AIDS" revelations again and again to us, like:

DRUNK MONKEYS GET AIDS FASTER:

2008 *http://www.aidsmap.com/en/news/AF9B8471-7615-4DEB-BA46-8D6228A901A5.asp*

*"**Heavy drinking can accelerate time to AIDS** among **rhesus macaques** infected with simian immunodeficiency virus (**SIV**), researchers from Louisiana State University report in the October edition of Alcoholism: Clinical & Experimental Research. The monkeys were exposed to alcohol for **four days a week** at levels designed to simulate `**binge`drinking**, and compared with **a control group**."*

*"The key issue with alcohol consumption and HIV/AIDS is when to start individuals on **life-saving antiretrovirals** versus **the need to avoid their toxic effects that damage the liver and gut** along with the alcohol," added Kendall Bryant, Coordinator of HIV/AIDS Research at the National Institute on Alcohol Abuse and Alcoholism."*

The value of such public tax-derived investments into AIDS research is beyond our ability to describe them with adequate congratulatory words (just kidding). It cannot be calculated how many people these and similar studies have saved from the ravages of "HIV/AIDS" (because there never have been non-drug-treated arms of any trials since the first fraudulent 1987 Fischl trail, despite some respectable physician's cries to the contrary (http://www.fairfoundation.org/).

"The FAIR Foundation (Fair Allocations In Research) foundation was formed because of the inequities in disease research spending by Congress, and by the National Institutes of Health (NIH). This emergency, of course, occurred duiring ecause of America's organ-donor crisis. Samples of bio-medical research inequities are as follows: The funding given HIV/AIDS over other diseases, including the sixteen diseases that kill a million more Americans than HIV/AIDS annually. For example, $29 and $39 is spent on each patient with cardiovascular disease (CVD) and diabetes respectively, compared to $2,774 on each patient with HIV/AIDS even though diabetes kills more Americans than HIV/AIDS and breast cancer combined and CVD kills 871,000 annually versus 14,000 for HIV/AIDS. The amounts spent on the "Health Effects of Climate Change," "Global Warming Climate Change" and "Climate Change" are greater than the funding for each of these: brain cancer, cystic fibrosis, autism, Down Syndrome, SIDS, child leukemia, cerebral palsy, COPD, Huntington's Disease, Hodgkin's Disease, multiple sclerosis, muscular dystrophy, uterine cancer and over six thousand other illnesses."

Although only a year or so ago, a director of the World Health Organization's HIV/AIDS department, Kevin de Cock, said the heterosexual AIDS epidemic is over except among African Blacks, and among blacks living in Washington D.C. and New York who die at a rate of one every 3 seconds, EVERYONE IS STILL AT RISK, accept of course for Luc Montagnier who now says "you can encounter "HIV" many times and if you have a good immune system you will fight it off no problem!!!!" But some AIDS promoters like Max Essex, and many others, would tell you that this "AIDS denialist view" of Montagnier is like denying the Holocaust: and, it even is at odds with today's (February 11, 2010) issue of the New England Journal of Medicine which claimed within its first prominent articles that:

AIDS IN AMERICA: FORGOTTEN BUT NOT GONE, BY WAFAA M. EL-SADR, M.D., M.P.H., KENNETH H. MAYER, M.D., AND SALLY L. HODDER, M.D.
"Over the past decade, limited attention has been paid to the human immunodeficiency virus (HIV) epidemic in the United States. The global epidemic-particularly the epidemic in sub-Saharan Africa, where approximately two thirds of the world's population living with AIDS resides-has rightfully received most of the focus. Meanwhile, however, the prevalence of HIV infection within some U.S. populations now rivals that in some sub-Saharan African countries (see graph). For example, more than 1 in 30 adults in Washington, D.C. are HIV-infected-a prevalence higher than that reported in Ethiopia, Nigeria, or Rwanda. Certain U.S. subpopulations are particularly hard hit. In New York City, 1 in 40 blacks (I'm not sure if this includes half-white blacks like President Obama), *1 in 10 men who have sex with men, and 1 in 8 injection are HIV-infected, as are 1 in 16 black men in Washington D.C."*

Why such a disparity between Washington D.C., New York City, and 'African AIDS?' According to the views of these esteemed authors and world renowned NEJM journal editors who monthly publish these kinds of articles yet won't respond to my letters or submissions:
"For the past decade, however, progress has been stalled. It had been anticipated that effective antiretroviral therapy, with its suppressive effect on viral replication, would reduce the overall rate of new infections, but this expectation has not been realized,"

Why not?

"Many of the populations most affected (in the U.S.) tend to have limited social mobility…"

So it stands to reason that instead of providing these "infected" "high risk negroes" in Washington D.C. or New York, or elsewhere with Donald Rumsfeld's drug, atripla, or Mark Wainberg's drug 3TC, or Roche's drug AZT, or the addictive drug saustiva that children are now smoking to get high in South Africa, that we provide them instead, with more frequent flyer miles so they may get out a little more often since their social mobility is so limited, according to these learned NEJM authors.

Or perhaps we should listen to Doctors Without Boarders, instead of the CDC and the WHO:

DOCTORS WITHOUT BORDERS NEEDS MONEY FOR PLUMPYNUT: SAY CHILDREN NEED FOOD, NOT DRUGS:

Oct. 21, 2007. Doctors Without Borders Briefing Paper: Food Is Not Enough: African children need food, not drugs (See the video free at:
http://www.cbsnews.com/stories/2007/10/19/60minutes/main3386661.shtml).

Plumpynut is cheap, nutritious and needs no refrigeration. It is saving starving children in the developing world and could save more … ***if there were more of it.***

You've probably never heard a good news story about malnutrition, but you're about to. Every year, malnutrition kills ***five million*** *children -- that's* ***one child every six seconds****. But now, the Nobel Prize-winning relief group "Doctors Without Borders" says it finally has something that can save millions of these children.*

It's cheap, easy to make and even easier to use. What is this miraculous cure? As CNN's Anderson Cooper reports, it's a ready-to-eat, vitamin-enriched concoction called "Plumpynut," an unusual name for a food that may just be the most important advance ever to cure and prevent malnutrition.

"It's a revolution in nutritional affairs," says Dr. Milton Tectonidis, the chief nutritionist for Doctors Without Borders.

"Now we have something. It is like an essential medicine. In three weeks, we can cure a kid that is looked like they're ***half dead****. We can cure them* ***just like an antibiotic****. It's just, boom! It's a spectacular response," Dr. Tectonidis says.*

"It's the equivalent of penicillin, you're saying?" Cooper asks.

"For these kids, for sure," the doctor says.

No kids need it more than a group of children 60 Minutes saw in Niger, a desperately poor country in West Africa, where child malnutrition is so widespread that most mothers have watched at least one of their children die.

Why are so many kids dying? Because they can't get the milk, vitamins and minerals their young bodies need. Mothers in these villages can't produce enough milk themselves and can't afford to buy it. Even if they could, they can't store it -- there's no electricity, so no refrigeration. Powdered milk is useless because most villagers don't have clean water. Plumpynut was designed to overcome all these obstacles.

Plumpynut is a remarkably simple concoction: it is basically made of peanut butter, powdered milk, powdered sugar, and enriched with vitamins and minerals. It tastes like a peanut butter paste. It is very sweet, and because of that kids cannot get enough of it.

Knowing these kinds of facts can greatly increase your chances to identify and expose AIDS denialists where you work, go to church, or where you organize your cross burnings. When AIDS denialist statements are aimed at denying the obvious-that "HIV" undoubtedly emerged from Black African's close associations with chimps and gorillas, perhaps when they built cities with them 125 years ago as described in prestigious peer-reviewed journals such as Nature, Nature Medicine, The Lancet, or the New England Journal of Medicine, there is good cause to incarcerate, or torture such persons until they get their minds right.

As further evidence for the harm this AIDS denialism can do, and to expose it when you see it happening, it should be emphasized here that it was only in 2008 when a African woman who tested "HIV" positive was shown to have probably "exposure(s)" with a gorilla or a chimp. And in doing so, the virus rapidly mutated in her body (although she didn't have any symptoms-she is a healthy carrier of a New AIDS virus) and now, because she herself is probably lying and claims

she had no such association with a gorilla and is not ill, she is creating the threat of yet a new pandemic AIDS virus, and a new virus that causes AIDS. Why would the journal Nature Medicine otherwise publish that although she is not sick, this woman in Camaroon definitely caught "HIV" from a gorilla, and like the Andromeda strain, it has mutated immediately in her body to form a new, rapidly growing, probably widespread, deadly pandemic virus? Because "AIDS-speak," "AIDS-science," and cancer biology and treatment involving numerous drugs or treatments can be complex and highly coded in the language with which it is often presented.

A NEW RAPIDLY GROWING, PROBABLY WIDESPRED, DEADLY PANDEMIC AIDS VIRUS.

New HIV strain discovered in woman from Cameroon, Randolph Schmidt Ap Science Writ

A new strain of the virus that causes AIDS has been discovered in a [black] *woman from the African nation of Cameroon.*

It differs from the three known strains of human immunodeficiency virus and appears to be closely related to a form of simian virus recently discovered in ***wild gorillas****, researchers report in Monday's edition of the journal* ***Nature Medicine****.*

The finding "highlights the continuing need to ***watch closely for*** *the emergence for new HIV variants, said the researchers, led by Jean-Christophe Plantier of the University of Rouen, France.*

The three previously known HIV strains are related to the simian virus that occurs in chimpanzees.

The ***most likely explanation*** *for the new find is* ***gorilla-to-human transmission,*** *Plantier's team said. But they added they cannot rule out the possibility that* ***the new strain started in chimpanzees*** *and* ***moved into gorillas*** *and* ***then humans****, or* ***moved directly from chimpanzees to both gorillas and humans****.*

The 62-year-old ***patient*** *tested positive for HIV in 2004, shortly after moving to Paris from Cameroon, according to the researchers. She had lived near Yaounde, the capital of Cameroon, but* ***said she had no contact with apes*** *or* ***bush meat****, a name often given to meat from wild animals in tropical countries.* ***The woman currently shows no signs of AIDS*** *and remains untreated, though she still* ***carries*** *the virus, the researchers said.How widespread this strain is* ***remains*** *to be determined. Researchers said it* ***could be*** *circulating* ***unnoticed*** *in Cameroon* ***or elsewhere****. The virus'* ***rapid replication*** *indicates that it is* ***adapted to human cells****, the researchers reported. Their research was supported by the French Health Watch Institute, the French National Agency for Research on AIDS and Viral Hepatitis and Rouen University Hospital.*

In 1987, there were even theories that over-vaccinations especially with the small pox vaccine triggered the emergence of AIDS in Africa, but now of course, the same agencies who supported this idea are now saying that too few small pox vaccinations triggered the emergence of AIDS in Africa:

London Times Edition 1 MON 11 ***MAY 1987***
Smallpox vaccine 'triggered Aids virus' *BY PEARCE WRIGHT, SCIENCE EDITOR*

The Aids epidemic ***may have been triggered by the mass vaccination campaign*** *which eradicated smallpox. The World Health Organization, which masterminded the* ***13-year campaign****, is studying new scientific evidence* ***suggesting that*** *immunization with the smallpox vaccine Vaccinia* ***awakened*** *the unsuspected, dormant human immuno defence* [i.e. immune difficiency] *virus infection (HIV).* ***Some experts fear that in obliterating one disease, another disease was transformed from a minor endemic illness of the Third World into the current pandemic.*** *While* ***doctors*** *now accept that Vaccinia can activate other viruses, they are divided about whether it was* ***the main catalyst*** *to the Aids epidemic. But*

an adviser *to WHO who disclosed* ***the problem****, told The Times: 'I thought it was just a coincidence until we studied the latest findings about the reactions which can be caused by Vaccinia.* ***Now I believe the smallpox vaccine theory is the explanation to the explosion of Aids.'*** *'In obliterating one disease, another was transformed.'*

Further evidence comes from ***the Walter Reed Army Medical Centre*** *in Washington. While smallpox vaccine is no longer kept for* ***public*** *health purposes,* ***new recruits to the American armed services are immunized*** *as a precaution against* ***possible*** *biological warfare. Routine vaccination of a 19-year-old recruit was the trigger for stimulation of* ***dormant*** *HIV virus into Aids. This discovery of how people with* ***subclinical*** *HIV infection are* ***at risk*** *of rapid development of* ***Aids as a vaccine-induced disease*** *was made by* ***a medical team*** *working with* ***Dr Robert Redfield*** *at Walter Reed. The recruit who developed Aids after vaccination had been healthy throughout high school. He was given* ***multiple immunizations****, followed by his first smallpox vaccination. Two and a half* ***weeks*** *later he developed fever, headaches, neck stiffness and night sweats. Three weeks later he was admitted to Walter Reed suffering from meningitis and rapidly developed further symptoms of Aids* ***and died after responding for a short time*** *to treatment. There was* ***no evidence*** *that the recruit had been involved in* ***any homosexual activity****.* ***The smallpox vaccine theory would account for the position of each of the seven Central African states which top the league table of most-affected countries; why Brazil became the most afflicted Latin American country; and how Haiti became the route for the spread of Aids to the US. It also provides an explanation of how the infection was spread more evenly between males and females in Africa than in the West and why there is less sign of infection among five to 11-year-olds in Central Africa. Although no detailed figures are available, WHO information indicated that the Aids league table of Central Africa matches the concentration of vaccinations****. Dr Robert Gallo, who first identified the Aids virus in the US, told The Times: 'The link between the WHO programme and the epidemic in Africa is an* ***interesting.*** ***The greatest spread of HIV infection coincides with the most intense immunization programmes, with the number of people immunised being as follows: Zaire 36,878,000; Zambia 19,060,000; Tanzania 14,972,000; Uganda 11,616,000; Malawai 8,118,000; Ruanda 3,382,000 and Burundi 3,274,000. Brazil, the only South American country covered in the eradication campaign, has the highest incidence of Aids in that region. About 14,000 Haitians, on United Nations secondment to Central Africa, were covered in the campaign. They began to return home at a time when Haiti had become a popular playground for San Francisco homosexuals.*** *'I cannot say that* ***it*** *actually happened, but I have been saying for some years that the use of* ***live*** *vaccines such as that used for smallpox can activate* ***a dormant infection*** *such as HIV.* ***'No blame*** *can be attached to WHO, but if the hypothesis is correct it is a tragic situation and a warning that we* ***cannot*** *ignore.' ....****The apartheid policy, they predict,*** *will intensify its outbreak by confining the groups into comparatively small, highly populated towns where it will be almost impossible to contain its spread."*

And now in May 2010 we read: [Story Source: Adapted from materials provided by BioMed Central, via EurekAlert!, a service of AAAS. Journal Reference: Raymond S Weinstein, Michael M Weinstein, Kenneth Alibek, Michael I Bukrinsky and Brichacek Beda. Significantly Reduced CCR5-tropic HIV-1 Replication in vitro in Cells from Subjects Previously Immunized with Vaccinia Virus. BMC Immunology, 2010; (in press).

Did the End of Smallpox Vaccination Cause the Explosive Spread of HIV?
*ScienceDaily (****May 18, 2010****) —*

"Vaccinia immunization, as given to prevent the spread of smallpox, produces a five-fold reduction in HIV replication ***in the laboratory****. Researchers writing in* ***the open access journal*** *BMC Immunology suggest that the end of smallpox vaccination in the mid-20th century* ***may have caused*** *a loss of protection that contributed to the* ***rapid*** *contemporary* ***spread*** *of HIV."*

" Raymond Weinstein, ***a family doctor*** *turned laboratory* ***scientist*** *at George Mason University, Manassas, Virginia, worked with a team of researchers from George Washington University and UCLA.*

*The researchers looked at **the ability of white blood cells** taken from people recently immunized with vaccinia to support HIV*
*replication compared to unvaccinated controls. They found **significantly lower viral replication** in blood cells from vaccinated individuals. Weinstein said, "There have been several proposed explanations for the rapid spread of HIV in Africa, including wars, the reuse of unsterilized needles and the contamination of early batches of **polio vaccine**. However, all of these have been either disproved **or do not sufficiently explain** the behavior of **the HIV pandemic**. Our finding that prior immunization with vaccinia virus may provide an individual with **some degree** of protection to subsequent HIV infection **suggests that the withdrawal of such vaccination may be a partial explanation**." Smallpox immunization was gradually withdrawn from the 1950s to the 1970s following the worldwide **eradication** of the disease, and HIV has been spreading **exponentially** since approximately the same time period. Weinstein and his colleagues propose that vaccination may confer **protection** against HIV by producing long term alterations in the immune system, possibly including the expression of a certain receptor, **CCR5**, on the surface of a person's white blood cells **which is exploited by both viruses**. Speaking about the results, Weinstein said, "While these results are very interesting and hopefully **may lead** to **a new weapon** against the HIV **pandemic**, they are **very** preliminary and **it is far too soon** to recommend the general use of vaccinia immunization for fighting HIV."*

So which is it? Smallpox vaccinions of Africans caused the AIDS epidemic, or did it prevent the spread of "HIV" through smallpox vaccine antagonization of the "HIV" CCR5 receptor," (as Dr. Weinstein suggests, about which we will hear more about later, and which makes no scientific sense to begin with.

In conclusion, AIDS as a collection of some 58+ syndromes all known and described before the AIDS era are not due to a virus: these syndromes, in following Montagnier's new proclamations, are due to failing or disrupted immunity. Immunity is mediated by the immune system. Therefore, we should explore new ways to correct immune difficiencies that don't involve viral theorizing.

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SECTION 2.

Evidence that soldiers (and other targeted groups such as children, prisoners, and mental institution-housed persons, Africans, African Americans, and others) are used as experimental guinea pigs before FDA approves vaccines:

In 1928, the question of encephalitis following vaccination was investigated by the health organization of the League of Nations in 1928, and on August 27 that year, at Geneva, the League published a report on the situation. Says the report: *"The post-vaccinal encephalitis with which we are dealing has become a problem of itself mainly in consequence of the events of the last few years in the Netherlands, England and Wales. In each of these countries, the cases which have occurred have been sufficiently numerous and similar to require them to be considered collectively. Their occurrence has led to the realization that a new, or at least previously unsuspected or unrecognized risk attaches to vaccination. . . the risk has, in the Netherlands, been considered of sufficient gravity to cause the temporary suspension of the administrative measures by which the vaccination of children has been secured, while in England the subject has already received the attention of two expert committees, appointed by the Ministry of Health."*

In 1931, Lubeck, Germany, 75 children died in from pediatrician's experiment with tuberculosis vaccine.

In 1941, in the April, 1941 issue of the Naval Medical Bulletin, reporting on the results of tests on 20,000 recruits at the Naval Training Station at San Diego, California, between July, 1939, and January, 1941, Captain G. E. Thomas of the Medical Corps of the Navy tells the story. He describes an experiment on these men. "*All had been checked by all known means and found free of syphilis, and were then confined. These men were vaccinated against smallpox. Those who did not show 'successful' vaccination were re-vaccinated. The experiment showed that more of these developed syphilis from the smallpox vaccination than the percentage who developed syphilis from all causes in the civilian population in the United States."*

In 1941, and on the eve of US entry into World War II, concern about a repeat of the 1918 influenza pandemic and its effect on armed forces led the US military to establish the Commission on Influenza (later combined with other commissions to become the present Armed Forces Epidemiological Board) and place high priority on developing a vaccine (Woodward TE, editor. The histories of the commissions. Washington: Office of The Surgeon General; 1992). "*Pandemic influenza did not materialize, but the vaccine did. The first successful large-scale influenza vaccine field trials were completed in 1943 (Francis T. Vaccination against influenza. In: World Health Organization. Influenza, a review of current research. Geneva: The Organization; 1954. p. 689–740). In 1947, failure of the vaccine to provide protection against the epidemic influenza type A antigenic variant confirmed concerns of vaccine obsolescence and led to the term "antigenic shift"* (von Magnus P. The influenza virus: its morphology, immunology, and kinetics of multiplication. Bull World Health Organ. 1953;8:647–60) and designation of the 1947 FM1 strain by the Commission on Influenza as subgroup A´ on the basis of the hemagglutination inhibition (HI) test.

In 1942, a report of the US Secretary of War, Henry L. Simpson regarding the deaths from yellow fever shots stated that: *"Recent Army experience with yellow fever vaccine resulted in 28,505 cases of hepatitis with 62 deaths."*

In the 1950's *"...Starting in the 1950s Africans experienced a massive increase in medical injections associated with mass injection campaigns targeted at yaws, with introduction and spread of parenteral therapies to treat other diseases, and with plummeting prices for antibiotics and injection equipment. For example, UNICEF administered 12 million injections for yaws in Central Africa alone during*

1952-57. From the 1950s into the 1980s, unsafe injections may have contributed to the silent spread of HIV in Africa in much the same way that unsafe injections for schistosomiasis and other treatments in Egypt established hepatitis C as a major blood-borne pathogen, infecting about 15% to 20% of the general population at the end of the 1990s" (Editorial with Gisselquist, statistics quoted from: International Journal of STD & AIDS Royal Society of Medicine, October 2002 Africa HIV/AIDS through unsafe medical care. Also available: Africa Policy E-Journal. www.africaaction.org/docs02/hiv0210t.htm.)

In 1963, the use of coercion to compel parents to vaccinate their children became particularly prevalent. A 1963 publication by the federal Communicable Disease Center, the original name for the CDC, contended that *"the use of the word epidemic itself in public statements is the most effective single means of simulating the public to action."* That same year, the measles vaccine was approved for use in children. Shortly thereafter, a nationwide campaign to eradicate a national measles "epidemic" was spearheaded by the president of the Joseph P. Kennedy Foundation, Massachusetts Senator Ted Kennedy. To implement the vaccination strategy, a mixture of cooperative appeals and coercive school mandates were set in motion. REF: Achieving Public Response to Immunization Programs. (Referenced by Colgrove, pg 12).

In 1959-1968, Quadrigen (DPT-IPV combo) used routinely pulled off the market in1968 for safety and efficacy reasons.

Question: Why was it pulled off the market if it was adequately safety tested in Phase I,II, or III trials?

In 1970, The HEW reported in 1970 that as much as **26 percent** of children receiving rubella vaccination, in national testing programs, developed arthalgia or arthritis. Many had to seek medical attention and some were hospitalised to test for rheumatic fever and rheumatoid arthritis. (Science, US, March 26, 1977.)

Isn't arthritis more than "simple redness at the injection site or slight fever," contrary to the FDA's statement that: look at the overall safety profile of the vaccine for local reactions such as redness and swelling at the injection site as well as general side effects that may occur with some vaccines such as fever?

In 1972, Jonas Salk, inventor of the IPV, testified before a Senate subcommittee that nearly all polio outbreaks since 1961 were caused by the oral polio vaccine.

In 1976, and uring the great swine flu hoax, President Ford is vaccinated before a TV audience of millions. More than 500 people receiving flu vaccinations become paralyzed with Guillain-Barre Syndrome.

Guillain-Barre Syndrome is more than simple redness at the injection site: it involves paralysis.

In 1978, experimental "hepatitis B" vaccine trials were conducted by the CDC, in New York, Los Angeles and San Francisco, and the ads for research subjects specifically asked for promiscuous homosexual men, while there is also evidence that the first "hepatitis B" vaccines were also tested on Blacks in Central Africa, and mentally retarded children. (Leonard G. Horowitz, "Hepatitis B Vaccine and the Origin of HIV/AIDS: Perspectives on a Possible Vaccine Induced Pandemic" Les Premieres Recontres Medicales, May 29, 2001).

Between 1983 and 1985 the first Hib (Hemophilus influenza B) vaccine is taken off the market in1985 for safety and efficacy reasons.

In 1988, JAMA publishes a report claiming that a case-control study has shown that 41 percent of meningitis occurred in children vaccinated against the disease. The vaccine's protective efficacy was minus 58 percent. This means that children are much more likely to get the disease if they are vaccinated. (JAMA, 1988, Osterholm et al., 260: 1423-1428.)

In 1989- 2003, an explosion of autism and autism spectrum disorders in U.S. begins to be seen. The incidence of autism (and other related disorders) went from about 1 in 2,500 children to 1 in every 166. Up until about 1989 pre-school children got only 3 vaccines (polio, DPT, MMR). By 1999 the CDC recommended a total of 22 vaccines to be given before children reach the 1st grade, including Hepatitis B, which is given to newborns within the first 24 hours of birth. Many of these vaccines contained mercury. In the 1990s approximately 40 million children were injected with mercury-containing vaccines. The cumulative amount of mercury being given to children in this number of vaccines would be an amount 187 times the EPA daily exposure limit. Mercury was only tested by Ely Lilly once, in the 1930's and 11/11 people died of it. Therefore they are continuing to experiment with our children without knowing what mercury does, especially that these high toxic doses, that violate the EPA's limits, and other government agencies that regulate toxics.

In 1990, the FDA granted the Department of Defense a waiver of The Nuremberg Code for use of unapproved drugs and vaccines in Desert Shield.

In 1992, Alfred Hassig, former 35-year Director of the Swiss Red Cross Transfusion Service, and President of the Board of Trustees of the International Society of Blood Transfusion states:

"The sentence of death accompanying the medical diagnosis of AIDS should be abolished. In the virological research, so much money is invested, and the research people want to stay in that area because if you deviate to research in other directions probably other people come in and must be funded. Virologists have nothing new to offer. They keep coming up with excuses, they find constant growth and change in the virus structure, it evades, attacks, strange things, but none of them has the courage to explain properly how these things could possibly be so. AZT (anti-viral AIDS medicine) has, in countless cases, brought about the inevitable and slow asphyxiation of the patient's body cells. The doctors wrongly diagnose the fatal consequences of AZT medication as AIDS following a prior HIV infection. Treatment with AZT and allied toxic substances may be equivalent to joining a suicide squad with a time fuse. It is the duty of every doctor to preserve life at any cost -- and not death-curse people based on any test so they are so frightened they kill themselves. I am sad to say that these voodoo methods were practiced despite there never being any proof that the detected antibodies are an indication of mortality in all diagnosed people. I consider it medical malpractice to push patients into dying by prophesying an early death. We are medical scientists, not prophets!" (Meditel 1992;Continuum Jan/Feb 1996).

In 1998, although the target population for the hepatitis B vaccine are prostitutes and drug addicts and not children, and France had just repealed the mandate because of high number of vaccine injuries, and the CDC admitted that the vaccine may not be effective after 7 yrs for 30-50% of the people vaccinated, 1998, the hepatitis B Vaccine is mandated for school age children in first 46 and then 48 states in the US.

In 1999 (October), Paul Offit's rotavirus vaccine pulled off the market due to significant madverse reactions such as perforation of the intestine.

2000 U.S. children aged 2 months began receiving hepatitis B vaccine in December 2000.No peer-reviewed studies of the safety of hepatitis B in this age bracket had been done. Over 36,000 adverse

reactions with 440 deaths were soon reported but the true incidence is much higher as reporting is voluntary so only approximately 10 % of adverse reactions get reported. This means that about 5000 infants are dying annually from the hepatitis B vaccine. The CDC's Chief of Epidemiology admits that the frequency of serious reactions to hepatitis B vaccine is 10 times higher than other vaccines. Hepatitis B is transmitted sexually and by contaminated blood, so the incidence of this disease must be near zero in this age bracket. A vaccine expert, Dr. Philip Incao, states that "the conclusion is obvious that the risks [16] of hepatitis B vaccination far outweigh the benefits. Once a vaccine is mandated the vaccine manufacturer is no longer liable for adverse reactions.

In 2002, GSK pulled Lymerix (lyme disease vaccine) off the market.

In 2004 (February), a West Africa polio campaign is boycotted by Nigerian states. A mass poliomyelitis vaccination campaign got under way to immunize 63 million children across west Africa but was boycotted by four predominantly Muslim states in Nigeria, where leaders claim the oral vaccine causes sterility and spreads AIDS BMJ (328:485 2004). The West African campaign was intended as a final push to stamp out the disease in the region and is part of the World Health Organization's 15-year drive to halt transmission of the poliomyelitis virus across the world by 2005. According to Dr Haruna Kaita, the head of the medical team that conducted the test in India, the vaccines contain "undeclared contaminants that can cause malfunctioning of the testes and cause infertility in women." The team also found "some toxic substances."

"Polio controversy started long ago," said Dr Kaita. *"If you find one batch defective, you should condemn all batches. What these people [proponents of the vaccine] are saying is unethical, illegal, and criminal, and they know that these things are contaminated and they have the potential to cause human hazards. They should be banned rather than cause diseases in innocent children."*

In 2005, evidence that vaccine adjuvants like squalene (MF-59), when they have been added to certain lots of anthrax (and perhaps "HIV") vaccines given to soldiers on threat of court martial if they don't roll up their shirt on command, have induced autoimmune syndromes in almost 100% of every sick Gulf-War I veteran tested, and have evoked antibodies to squalene in their blood (Gary Matsumoto. Vaccine A, Basic Books Publisher, 2005). Squalene and other adjuvants have been used by scientists for many years to induce rodents to develop arthritis, macrophagic myofasciitis, mutliple-sclerosis (demyelinating syndromes), and lupus (Holmdahl et al. Arthritis induced in rats with nonimmunogenic adjuvants as models for rheumatoid arthritis Immunol Rev. Dec;184:184-202, 2001; Gherardi NK. Lessons from macrophagic myofasciitis: towards definition of a vaccine adjuvant-related syndrome. Rev Neurol (Paris). Feb;159(2):162-4), 2003).

In 2005, an "encephalitis vaccine" mandated by the CDC for collage-age (young adults) was withdrawn for safety reasons (see FDA's 2005 recall list). Also see CDC's MMWR
www.cdc.gov/mmwr/preview/mmwrhtml/mm5541a2.htm

I suppose it was adequately safety tested in Phase I, II, and III trials before it was given to college-aged men and women?

In 2005, Merck claims that its Human papilloma vaccine: "was 100 percent effective in preventing precancerous cervical disease, but only when given to women and girls who had never engaged in sex at the time of the shots," yet, "documents prepared by the FDA suggest some women with persistent HPV infections could be at higher risk of cervical cancer after taking the vaccine."

Dr. Schiffman heads the HPV Troup in the Division of Cancer, Epidemiology, and Genetics at NCI and is a tenured senior investigator. In mid March, Dr. Mark Schiffman, MD, MPH, called CAP TODAY's

editor to voice a troubling concern: that laboratories are failing to clinically validate their HPV tests" (September 2005 issue of Pathology/Laboratory Medicine/ and Laboratory Management article released monthly by The Collage ofAmerican Pathologists-CAP).

"What surprises me is that this {the certainty with which these tests for HPV and cervcal cancer} could in any way be controversial, he says. "The issue is not so much controversial, of course, as it is loaded-with money and competitive claims, scientific complexity, and grave medical concerns" (Dr. Schiffman).

In 2006** (March), Chiron Recalls Nearly 5.5 Million Vaccine Doses. California-based biotechnology company **Chiron Corp. announced Thursday that it's recalling and withdrawing almost 5.5 million doses of a measles, mumps and rubella vaccine distributed to developing countries and in Italy.** The move was made because the vaccine caused a higher rate of such adverse effects such as fever, allergic reactions and glandular swelling than other similar vaccines, the Associated Press reported. The reactions occurred just after inoculation and do not indicate any long-term risk, according to Chiron, which described the recall and withdrawal as a precaution. **About five million doses of the vaccine were distributed to developing countries and about 450,000 doses were distributed in Italy.

In 2006 (April), Associated press releases article claiming that Bangladesh will vaccinate about 18 million children aged 5 and under to combat polio, which recently re-emerged after authorities believed it had been eradicated five years ago, the country's health minister said Saturday. Bangladesh carried out extensive vaccination programs in 1995-2004, with the last polio case reported in August 2000, according to the government and WHO.

Also in 2006 (Sept 1), polio reported on the rise in Nigeria Lagos, Nigeria despite near-universal vaccination. Nigerian authorities on Friday reported a sharp rise in the number of polio cases in Africa's most populous country over recent months, despite a government immunization drive.

"A total of 784 cases of the disease were registered in 17 states at the end of July, the National Programme on Immunisation said. In June the figures were 501 cases in 15 states, compared to 244 cases in 18 states for the same period in 2005, it said in a statement."

"From June 29 to July 3, Nigerian health officials in collaboration with United Nations health agencies launched an ambitious five-day Polio Plus immunization campaign of 10-million children in northern Nigeria aimed at eradicating the deadly disease from the country by the end of 2006."

Also in 2006 (December), and despite the 2004-5 west African polio eradication campaign intended as a final push to stamp out the disease in the region and is part of the World Health Organization's 15 year drive to halt transmission of the poliomyelitis virus across the world by 2005, the CDC, and WHO report that Nigeria now leads the world in new polio cases:

http://www.who.int/vaccines/immunization_monitoring/en/diseases/poliomyelitis/afpextract.cfm.

-Country: Nigeria
-Year: 2006
-AFP cases (acute flaccid paralysis) reported: **4937**
-Non-polio AFP rate: 6.7%
-AFP rate with adequate specimens: 88
-Total confirmed polio cases: 1044
-Wild-virus confirmed polio cases: 1043
-**Polio cases attributed to vaccine**: **9**

In 2007 (March), The Alliance For Human Research Protection (AHRP) Promoting Openness, Full Disclosure, and Accountability reported http://www.ahrp.org/ and http://ahrp.blogspot.com

"Two weeks ago, the controversial anthrax vaccine which has not been fully tested for safety, became mandatory for the military. Since then, Meryl Nass, MD, (AHRP board member) has received numerous requests for help and information from military personnel who refuse to be vaccinated with this controversial vaccine."

"The military has issued an unsigned, anonymous "informational brochure" filled with misinformation about the anthrax vaccine. The very fact that no one in the military wants "credit" for this document should raise red flags about its veracity!"

"Dr. Nass has appended the DOD "informational brochure" with relevant facts, additional information, comments and copious references about the Surveillance Program for Short-term Health Effects of AVA and Surveillance Program for Long-term Health Effects of AVA. She demonstrates how the DOD misrepresents the findings of several vaccine safety studies."

For example, Dr. Nass writes:

"Military medical providers have been loathe to file anthrax vaccine adverse event reports due to perceived adverse effects on their careers if they do so. This probably stems from the instruction to medical providers NOT to report adverse events unless the patient missed more than 24 hours of work, was hospitalized, or contamination of an entire lot of vaccine was suspected." [1]

"Therefore, after changing this guidance in response to Congressional testimony about the failures to file,[2] repeated instructions to file these reports by top military leaders have been issued to providers in 1999,[3] 2000[4] and 2004.[5] This would suggest that military medical providers continued to fail to file the reports."

"See complete annotated document at: http://www.anthraxvaccine.org/NassDOD.htm"

References:

[1] <http://www.anthraxvaccine.org/NassDOD.htm#_ftnref1> Instructions fromSecretary of the Navy: SECNAVINST 6230.4. April 29, 1998. ANNEX C TO ENCLOSURE (1). PAGE C-5. It stated, "Report all adverse vaccine reactions resulting in hospitalizations or time lost from duty (more than 24 hours),using the Health and Human Services Vaccine Adverse Events form. Otherreactions will not be reported unless contamination of lots is suspected."
[2] <http://www.anthraxvaccine.org/NassDOD.htm#_ftnref2> Hearing, Committee on Government Reform. Subcommittee on National Security, Veterans Affairs and International Relations. Anthrax Vaccine Adverse Reactions. July 21, 1999.
[3] <http://www.anthraxvaccine.org/NassDOD.htm#_ftnref3> Bailey S. (Assistant secretary of defense for Health Affairs). Memorandum for Service Surgeons General. Subject: Policy for reporting adverse events associated with anthrax vaccine. October 15, 1999.
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[5] <http://www.anthraxvaccine.org/NassDOD.htm#_ftnref5> Peake JB. (Lieutenant General Commanding). Memorandum for Commanders, regional Medical Commands. Subject: Learning from adverse events after vaccination-ACTION MEMORANDUM. FEBRUARY 10, 2004.

Read entire critique at: http://www.anthraxvaccine.org/NassDOD.htm

By 2007, 113 vaccine antigens from at least 10 different vaccines had been added as school requirements. Many parents are asking: How many more vaccines are going to be forced on children in order to obtain tax-funded, public education? Now, more than ever, parents are starting to say no. Many parents blame the health problems of their children on the sheer number of vaccines and additives they receive. Tens of thousands of parents have watched their children regress into poor health after vaccinations. REF: Cited in Brooklyn Medical Journal. 8(1894):576 and reference in Colgrove, p.14.

In 2008, January. Prince George's County, Upper Marlboro, Maryland (CNN).

"A crowd of frustrated parents gathered on a chilly Saturday morning outside Prince George's County Circuit Court to comply with an order from the school system to have their children vaccinated -- or else."

"Prince George's County State's Attorney Glenn Ivey, whose office began the effort, was at the courthouse to answer questions."

"Judge C. Philip Nichols, who signed the letters threatening parents with jail or fines, said he felt the tactic worked."

"We got a thousand kids back in school just by sending one letter," he said.

"Nichols ordered parents to come to court Saturday to either immunize the children on the spot, or to provide proof that they already had their shots, according to The Associated Press."

"Families who failed to comply could face 10 to 30 days in jail."

"The schools started out with phone calls, even home visits, and this became a last resort for parents who wouldn't comply one way or another," Ivey said.

"Some parents who received letters saying they were not in compliance with the vaccination mandate complained that it was the fault of the school system, which they described as disorganized."

"It was the school's mistake. [My daughter] didn't have documentation. This is the second or third time we had to redo her again because her shot records got misplaced," Ron Brooking told CNN."

"Authorities said they will decide in the next few days what to do with families who refused to obey the vaccination order."

"Ivey was still mulling whether to prosecute parents not in compliance."

"We have to sit down with school and health services," he told the AP. "We haven't ruled anything out. We need to figure out where we stand."

"The parents of about 1,700 children received letters from Ivey reminding them of the consequences for not complying, said John White, spokesman for Prince George's County Public Schools."

"That number was down to 1,111 by Thursday, and was reduced to 939 children by Saturday evening, he said."

"White said that number was the lowest since a law requiring additional vaccinations went into effect January 1…"

In 2008 (July 10), 12 Babies Die During Vaccine Trials in Argentina. (Trading Markets).
At least 12 infants who were part of a clinical study to test a pneumonia vaccine have died in Argentina over the course of the past year.

The study was sponsored by GlaxoSmithKline, and uses children from poor families. According to the Argentine Federation of Health Professionals, the families are "pressured and forced into signing consent forms. The vaccine trial is still ongoing despite the denunciations."

SECTION 3

MORE INFORMATION REGARDING THIS YEARS H1N1 HOAX:

In 2009 (July), The WHO releases a statement and holds a conference regarding the H1N1 vaccine roll-out planned for 4.9 billion people-From a transcript of virtual press conference with Gregory Hartl, WHO Spokesperson for Global Alert and Response and Dr Marie-Paule Kieny, Director of the Initiative for Vaccine Research, World Health Organization14 July 09: "Vaccinate Health Care Workers, Pregnant Women, School Aged Children First." Here are a few excerpts:

Richard Knox, National Public Radio: "*Dr Kieny, you said earlier that **you do not expect safety issues to arise with the pandemic vaccine** and tests but do you think that **there is less risk** of **Guillain-Barre syndrome** with this new **swine flu vaccine** than there was in **1976** and why? And secondly, I wonder with the accelerated safety tests **that will be necessary**, how many subjects will you expect to have tested and how can experts draw conclusions about safety from these tests **when the vaccine has put into a hundreds of millions of people.**"*

Dr Marie-Paule Kieny: ***It is not completely known** why **the vaccine which was distributed against the swine flu in 1976 induced higher risk of Guillain-Barre syndrome**. There are a number of hypotheses and one of the hypotheses is that the vaccine **was contaminated by a component coming from <u>a bacterial infection</u>** that was inducing antibodies that cross reacted with **self protein** and therefore, caused Guillain-Barre syndrome. The vaccines which are produced now **are much better purified** than the way they were in 1976, so we really **do not think** that it is **likely** that we will have **these side effects again**, **but to be absolutely honest, of course it is only when you have a large scale distribution of vaccines that you know with certainty the safety profile of the vaccine.** Modern vaccines such as those which are used to immunize children and adults currently in all countries of the world **are very safe products**. **Nevertheless**, in a **very small numbers** of people they do induce adverse reactions and this **can be** the case as well **for adjuvanted vaccines and non adjuvanted vaccines**. So what needs to be put in place and everyone is working towards this direction is **a very good surveillance system and monitoring adverse effects** so that as soon as a signal pops up it can immediately be followed-up, investigated and adequate public health measures be taken to respond to that.*

Now, in terms of these new vaccines, new adjuvants there is one manufacturer who has had an oil-in-water adjuvanted influenza vaccine in use for many years for seasonal vaccination and the safety database for this particular antigen is very large although mainly in elderly people and there does not seem to be any signal for any unexpected severe event like Guillain-Barre. But as I said, all must be put in place to detect any signal as early as possible.

Journalist, Sky Television: *Your referred previously that **the obese people** should probably be among those that the national government should consider to vaccinate. On what scientific basis are made these recommendations and if you could elaborate more on the body mass index? And the second question is, if we have the vaccine later than October in the Northern Hemisphere, don't you think it would be **too late** to protect the people from **the second pandemic wave**?*

Dr Marie-Paule Kieny: *In terms of obesity, obesity has been observed as being one of the risk factors for more severe diseases **other than** H1N1 influenza. This is **an observation**. We **still don't know** exactly if it is **obesity itself** which is a risk factor, or if it is other health conditions which arise because of obesity. For the time being it is an observation and a lot of investigations are conducted to try and understand this better.*

*It has been observed in several countries that people with a body mass index over 30, and even more, over 40, have a higher chance of having a severe disease than noon obese people. This is why one of the groups that was mentioned, that was listed by SAGE, and that was worth considering for pandemic influenza vaccination contains **all populations over 6 months of age with risk factors**, and one of the risk factor listed is obesity. Its not the only one of course, you have **asthma, chronic lung disease**. All these are considered as being risk factors based on observation so far. About availability of vaccines, all the manufacturers and the regulatory authorities are working to have vaccine available as soon as possible. Vaccines will be available starting from September or*

October. If the situation remains as it is, of course the ***regulatory authorities will certainly want to have a better handle at the safety in clinical trials and dosing in clinical trials and these clinical trials will take some time****, and therefore, to have a full license of this new vaccine may take until the end of the year.* ***This being said, many countries have provision in their law, so if there is an emergency they can invoke an emergency situation to use vaccine for which you would have already good characterization in terms of pharmaceutical data but not yet, all the data on clinical trials.*** *We certainly look towards seeing* ***how*** *the epidemic* ***evolves*** *and* ***when it unfolds****, to see what is the situation in countries and we will take our own decisions on whether or not to use vaccine under* ***an emergency provision*** *as compared to waiting for full registration of these vaccines.*

Maggie Fox, Reuters: *If WHO wants to reassess its best case scenario for how many vaccine doses might be available – I think the last number for the best case scenario was* ***4.9 billion****. And I am also wondering about this issue with the virus strain not producing good results. Was this also the same for the live vaccine or only for the killed vaccine?*

Dr Marie-Paule Kieny: "*In terms of updating the figures that we have published for likely vaccine supply over the next 12 months, we will update these figures but we want to wait to have some further information to update these with some meaningful changes. First as we have to have a definite idea of what yield manufacturers are getting with inactivated vaccines: is it the same as seasonal, which was the assumption that we took when we made the first calculation, or is it 50%, and these of course as you may imagine will change the total output. The other information which is still lacking as* ***what is a dose of inactivated H1N1 vaccine. Is it, without adjuvant, is it 50 micrograms, is it 30 micrograms, we don't know.*** *And we will know as soon as the result of the first clinical trial will come out, although the result will certainly be very adapted or relevant only to the vaccine which will be tested, it will still give* ***a flavour*** *of what kind of results we will have with the other inactivated vaccines. You asked a question about the* ***live-attenuated vaccine****, the response and the way this vaccine induces an immune response is* ***very different*** *because these are* ***replicative organisms****, so they induce antibodies and also* ***anti-cell response****.*

"So for the time being, the results that we have from the manufacturers who make live-attenuated vaccines, is that in terms of yields, and this is yields in terms of growth this time – how these vaccine strains grow – there does not seem to be any surprise and they grow with the same titres as the seasonal vaccine that they have obtained in normal production for a seasonal vaccine. ***Still there need to be clinical trials to know what titres*** *of these live-****attenuated vaccines will have to be used*** *in a dose to make an effective dose.* ***So the quick response is that we don't know****, but in terms of growth they seem to be behaving* ***normally****."*

Helen Branswell, Canadian Press: *I would like to get some information about adjuvants and children. Obviously young people are among the people* ***hardest hit by this strain*** *so far but I don't think that there is much evidence at all about safety of adjuvants in that group. I was looking at a document yesterday that shows that with* ***MS59*** *for instance, it has been given to* ***6 or 700 children*** *which is not a long safety record. Are there any other vaccines – not influenza vaccines –but marketed vaccines with these kind of adjuvants that children receive now and that might give us a sense of whether or not they are safe to use in children?*

Dr Marie-Paule Kieny: *You are* ***absolutely right that safety data****, at least in terms of* ***numbers are lacking in certain population groups****. You mentioned the children, certainly there* ***are no data in children*** ***more than 6 months old and less than 3 years****, t****here are no data*** ***in pregnant women, there are no data in asthmatics, so there are quite a number of populations for which there are no data.*** *SAGE has also made the point that* ***as quickly as possible data should be obtained on these populations groups if they are to be vaccinated with these new vaccines.*** ***In terms of use of this new novel adjuvant in children, there is no vaccine for very young children that is using the formulation.*** *The closest being the vaccine which is currently developed as the malaria vaccine, which has been tested in a few thousand children and is being tested now* ***in Africa*** *with this indication for malaria* ***in a few thousand children****, but apart from that,* ***these data are still lacking.***

In 2009 (July), the Swiss army stockpiles "swine flu" vaccines in preparation for mass forced vaccination. *"The army in Switzerland is starting to stockpile "swine flu" vaccines as it gears up for a mass forced vaccination of the Swiss population in autumn, according to a report in the Basler Zeitung"* (http://bazonline.ch/schweiz/standard/Erste-Impfspritzen-in-der-Schweiz-eingetroffen/story/22051646).

In 2009, (Thu, 02-July) http://www.norwaypost.no/content/view/22196/26/ The Norwegian health authorities will this fall begin a program of mass vaccination against the A H1N1 flu, also called the swine flu. A total of 9.4 million doses have been ordered from the suppliers. All will be given two innoculations, two weeks apart, Bergens Tidende reports. The total cost will be NOK 650 million. So far, only 23 cases of the flu has been diagnosed in Norway, but the authorities expect that the number will increase.

Also in 2009 (August), Greece to Vaccinate Population for Swine Flu, Rolleiv Solholm, Filed Under Pandemic, Vaccines

Greece will vaccinate its entire population of 12 million against the H1N1 swine flu pandemic which has swept around the world in weeks, killing hundreds of people, the country's health minister said on Friday.

The Mediterranean country, which receives about 15 million tourists every year, has confirmed more than 700 swine flu cases and no deaths, but world health experts say the true number of cases globally is far higher as only a few patients get tested.

"We decided that the entire population, all citizens and residents, without any exception, will be vaccinated against the flu," Health Minister Dimitris Avramopoulos said after a ministerial meeting.

Greece has already earmarked 40 million euros for vaccines and has placed orders with Novartis, Glaxo and Sanofi for 8 million vaccine doses, to be received gradually by January.

Vaccine experts say people will likely need two doses of vaccine to be protected from H1N1 swine flu, so Greece would need a total of 24 million doses to vaccinate its entire population. Other countries are taking similar steps.

"Greece will order 16 million more doses from the same companies in the future," a health ministry official who declined to be named told Reuters.

"We are only waiting for the European Union's approval to start vaccinating everyone."

The European Medicines Agency has begun reviewing pandemic flu vaccines under development, aiming to get them approved before the flu season starts, sometime in September.

The health ministry official said children, the elderly and ailing would be the first to be vaccinated.

About 800 people have died worldwide since the outbreak of the flu in April.

http://tvnz.co.nz/health-news/greece-vaccinate-population-swine-flu-2881876

SECTION 4.

RESIGNATION LETTER OF DR. STOLLER

K.P. Stoller/Medical Veritas 5 (2008) 16991700 1699 Les Incompétents:
My open letter to the American Academy of Pediatrics. K. Paul Stoller, MD, 2008.

Abstract
A protest resignation from the American Academy of Pediatrics (AAP), by a pediatrician with two decades of membership, is precipitated by the organization's sellout of the world's children by a policy that arrogantly and blindly ignored basic toxicology and safety limits when it involved vaccine and enabled a dangerous immunization mandate by the compromised Centers for Disease Control (CDC) via publication of CDC sponsored low quality epidemiology studies showing no connection between vaccines with Thimerosal written by individuals involved in producing Thimerosal-containing vaccines without disclosure (the conclusion of the studies showed Thimerosal removal caused autism). The AAP is fully aware of the untainted CDC analysis presented at the secret Simpsonwood conference and has known for almost a decade that Thimerosal causes neurodevelop-mental disorders. Perpetuating the myth that affected children have come to the fore only because of better diagnosing, or because of a genetic epidemic (there are no genetic epidemics), the AAP has helped to subject the world's children to environmental triggers that effect both mitochondrial function and brain activity. Driven by hubris and the largesse of vaccine manufacturers, the AAP has helped cause the loss of valuable time to rectify the crisis, the loss of a generation of children and perpetuated untold suffering worldwide.

Keywords: autism, immunization policy, mercury, mitochondrial dysfunction, Thimerosal, vaccine

"Diet, injections, and injunctions will combine, from a very early age, to produce the sort of character and the sort of beliefs that the authorities consider desirable, and any serious criticism of the powers that be will become psychologically impossible. Even if all are miserable, all will believe themselves happy, because the government will tell them that they are so." -Bertrand Russell, The Impact of Science on Society p50, 1953.

As a pediatrician, who has been a fellow of the American Academy of Pediatrics (AAP) for two decades, I find the AAP's approach to the autism epidemic to be deeply disturbing. Not only have they allowed the myth of better diagnosing (as the reason for all the notice given to affected children) to be perpetuated, but when they were put on notice at the Center for Disease Control and Prevention's (CDC's) Simpsonwood meeting in 2000, that the mercury in the preservative Thimerosal was causing speech delays and learning disabilities, they obfuscated and hid that information. They never made good on their 1999 pledge to have Thimerosal eliminated from vaccines and almost a decade later joined in the protest against a fictitious TV show (Eli Stone) because it was critical of mercury being in vaccines.

Out of about 120 million doses of the worthless [1] flu vaccine shipped for the 2007-08 flu season, no more than about 15 million doses, including the less than 4 million live-virus doses, were no-Thimerosal doses. That means that about 87% contained some level of Thimerosal and at least 42% contained the maximum level (0.01%) of Thimerosal.

If a pregnant woman got a flu shot in 2001 and her child followed the flu shot recommendations, the baby/fetus would have received six flu shots with the full amount of Thimerosal by the year 2005.

Today, in some states, the flu vaccine given to those under 3 year of age are supposed to contain no more than a trace level of Thimerosal, but with no government agency testing vaccines for mercury, the only ones who know whether a preservative-free vaccine (flu or otherwise) actually is mercury free are the manufacturers themselves.

Vaccines with "trace" amounts of Thimerosal are supposed to contain less than 1 microgram of mercury (Hg) per 0.5 ml dose (1 microgram of Hg per 0.5 mL is the same as 2 micrograms of Hg per mL, which is the same as 2000 liter; micrograms per liter is parts per billion [ppb][2])

0.5 parts per billion (ppb) mercury = Kills human neuroblastoma cells (Parran et al., Toxicol Sci 2005; 86: 132-140).

2 ppb mercury = U.S. EPA limit for drinking water
(http://www.epa.gov/safewater/contaminants/index.html#mcls).

20 ppb mercury = Neurite membrane structure destroyed (Leong et al., Neuroreport 2001; 12: 733-37).

200 ppb mercury = level in liquid the EPA classifies as hazardous waste
(http://www.epa.gov/epaoswer/hazwaste/mercury/ regs.htm#hazwaste)

25,000 ppb mercury = Concentration of mercury in multi-dose, Hepatitis B vaccine vials, administered at birth from 1991-2001 in the U.S.

50,000 ppb mercury = Concentration of mercury in multi-dose DTP and Haemophilus B vaccine vials, administered 8 times in the 1990's to children at 2, 4, 6, 12 and 18 months of age and currently "preservative" level mercury in multi-dose flu, meningococcal and tetanus (7 and older) vaccines.

For years the Infectious Disease division at the CDC (and others) has said the reason for the dramatic increase in autism is due to "better diagnosing" and "greater awareness." They have encouraged those like the AAP to manufacture uncertainty by publishing articles that were less than truthful. The AAP shamefully played along, perhaps encouraged by the largesse of vaccine manufacturers who significantly contribute to the AAP's yearly budget. To publish studies that showed the removal of a known neurotoxin (mercury) from vaccine caused the incidence of autism to increase was shameful pseudo-science.

There is another budget to consider for eighty percent of autistic Americans under the age of 18, and we will soon begin to see a dramatic impact on Social Security in coming years as these children become dependent adults. There are no studies that have found the previously undiagnosed or misdiagnosed autistic individuals among older Americans. They simply aren't there. So what is coming will significantly impact on society.

As there are no genetic epidemics, which leaves an epidemic linked to some sort of exposure. Now, the increase of autism has been linked to the increase in mercury exposure through fish and industrial sources, amalgam and additionally, through increased parenteral exposure to Thimerosal - no controlled, randomized study regarding the safety of amalgam or Thimerosal exists.

A recently released Scientific Consensus Statement on Environmental Agents Associated with Neurodevelopmental Disorders (by the Collaborative on Health and the Environment's Learning and Developmental Disabilities Initiative) concludes that environmental contaminants are an important cause of learning and developmental disabilities.

Delayed detoxification of mercury severely impairs methylation reactions (required for the correct expression of DNA, RNA, and neurotransmitters), which further adversely affects growth factor derived development of the brain and attention abilities. Phospholipid methylation, which is crucial for attention, is impaired in autistic and attention deficit hyperactivity disorders.

In a first analysis of the VSD datasets, Verstraeten et al. had described a 7.6 to 11.4 fold increase of autism risk in children at one month, with the highest mercury exposure levels compared to children with no exposure. In four subsequent separate generations of the analysis, which involve the exclusion of children with no Thimerosal exposure and less than two polio vaccines, the statistical significance disappeared. This is what was published by the AAP even though they knew the truth. How did they know the truth?

Again, they were presented at the Simpsonwood meeting in June 2000, ***a meeting that was illegal to hold****. No Federal agency is allowed to call a meeting together with representatives of private industry (all the vaccine manufacturers were represented at this meeting) without opening the meeting to the public.*

Thimerosal was tested only once, by Eli Lilly on 22 adult patients suffering from meningitis. There was no chance for follow- up to observe long-term effects, as all of the patients in this "study" died. *Even if follow-up had been possible, damage to the developing brains of very young children would have remained an unknown. Eli Lilly said it was safe and the medical community accepted it. After the creation of the FDA, its use was simply continued. The federal government has never tested the type of mercury in vaccines for toxicity.* ***This is an unconscionable oversight failure at best, at worse it is an example that we have left consensus reality to be created by the liars, thieves, cheats, killers, and the junk scientists they employ.***

How it came to pass the AAP joined these rogues and be-came an active participant in this skullduggery is beyond reason even beyond greed. They have remained silent as mercury-laden vaccine continues to be exported and used in all third world and second world countries.

We are living in a time where an incredible overplay and lies, self-aggrandizing behavior and non-science are the norm. We have tolerated the junk science that has covered up the true cause of this epidemic at a considerable cost to science, the public, and our very way of life in this country. Is it a stretch to realize that by putting our collective heads in the sand about the autism epidemic we have made it possible for the destruction of our very civilization?

Not something easy to contemplate? Then ask why haven't pediatricians come forward to demand the end of the use of Thimerosal once and for all, and to advocate for the treatment of these children before it is too late? Why are they not at the front of the line protesting the amounts of mercury allowed to come out of coal-fired power plants? Why aren't they leading the charge to stop the use of mercury amalgam dental fillings that are placed in the mouths of young children and pregnant women?

The very Federal agencies that should have been sounding the alarm bell about environmental pollution creating future generations of mentally disabled citizens did less than remain silent because they have become arms of the very corporations that profit from selling and distributing poisons. Just look who sits on the FDA's Scientific Advisory Boards the conflicts of interest are so glaring as to suggest that the FDA has become a trade arm of Big Pharma.

Nevertheless, the hand writing is on the wall as the US government has quietly conceded a vaccine-autism case in the Court of Federal Claims [3]. Pediatricians will no longer be able to hide behind the skirts of "Standard of Care" if they are giving autistic children heavy-metal laden vaccines, or children

with mitochondrial dysfunction vaccine, or when it is established most "autistic" children have mitochondrial dysfunction.

The AAP should proactively be bringing in risk management specialists to determine how this could affect pediatricians in civil litigation for following the CDC recommendations on vaccinations after a diagnosis of any type of neurodevelopmental delay in a child. Of course, this is what they are afraid of and this is what the law of attraction will bring in upon the AAP and their minions who just followed the recommendations and drank the Kool-Aid that Big Pharma wanted them to drink.

For all the above reasons, I will no longer enable the AAP to be party to the damage that is being done to the world's chil-dren by sending in my dues for a third decade. It is a token pro-test, but it has to begin with someone.

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b. Geier DA, King PG, Geier MR. Influenza Vaccine: Review of effec-tiveness of the U.S. immunization program, and policy considerations. JAPS (Journal of American Physicians and Surgeons) 2006 Fall; 11(3): 69-74
[2] http://www.ajph.org/cgi/eletters/AJPH.2007.113159v1
[3] http://www.huffingtonpost.com/david-kirby/government-concedes-vacci _b_ 88323.html

3. Regarding preservatives and the FDA's own statements, the following information is relevant:

"Thimerosal in concentrations of 0.001% (1 part in 100,000) to 0.01% (1 part in 10,000) has been shown to be effective in clearing a broad spectrum of pathogens. A vaccine containing 0.01% thimerosal as a preservative contains 50 micrograms of thimerosal per 0.5 mL dose or approximately 25 micrograms of mercury per 0.5 mL dose."

"Prior to its introduction in the 1930's, data were available in several animal species and humans providing evidence for its safety and effectiveness as a preservative (Powell and Jamieson 1931). Since then, thimerosal has been the subject of several studies (see Bibliography) and has a long record of safe and effective use preventing bacterial and fungal contamination of vaccines, with no ill effects established other than minor local reactions at the site of injection."

"....Humans are exposed to methylmercury primarily from the consumption of seafood" (Mahaffey et al. 1997).

"Methylmercury is a neurotoxin. The toxicity of methylmercury was first recognized during the late 1950s and early 1960s when industrial discharge of mercury into Minimata Bay, Japan led to the widespread consumption of mercury-contaminated fish (Harada 1995). Epidemics of methylmercury poisoning also occurred in Iraq during the 1970s when seed grain treated with a methylmercury fungicide was accidentally used to make bread (Bakir et al. 1973). During these epidemics, fetuses were found to be more sensitive to the effects of methylmercury than adults. Maternal exposure to high levels of methylmercury resulted in infants exhibiting severe neurologic injury including a condition resembling cerebral palsy, while their mothers showed little or no symptoms. Sensory and motor neurologic dysfunction and developmental delays were observed among some children who were exposed in utero to lower levels of methylmercury."

"More recently, several epidemiological studies have examined the effect of low dose dietary exposure to methylmercury, with inconsistent results. Studies from the Faroe Islands reported that subtle

cognitive deficits (e.g., performance on attention, language, and memory tests), detectable by sophisticated neuropsychometric testing, were associated with methylmercury levels previously thought to be safe (Grandjean et al 1997). Studies in the Seychelles, evaluating more global developmental outcomes, did not reveal any correlation between abnormalities and methylmercury levels" (Davidson et al. 1998).

"Various agencies have developed guidelines for safe exposure to methylmercury, including the U.S. Environmental Protection Agency (Mahaffey et al. 1997), U.S. Agency for Toxic Substances and Disease Registry (ATSDR 1999), the FDA (Federal Register 1979)1, and the World Health Organization (WHO 1996). These exposure levels range from 0.1 µg/kg body weight/day (EPA) to 0.47 µg/kg body weight/day (WHO)2. The range of recommendations is due to varying safety margins, differing emphasis placed on various sources of data, the different missions of the agencies and the population that the guideline is intended to protect. All guidelines, however, fall within the same order of magnitude. While these guidelines may be used as screening tools in risk assessment to evaluate the "safety" of mercury exposures, they are not meant to be bright lines above which toxicity will occur. However, as exposure levels increase in multiples of these guidelines, there is increasing concern on the part of the public health community that adverse health consequences may occur (Mahaffey 1999)."

Dr. Paul Stoller (whose resignation letter is presented in its entirety above) disagrees with the FDA's assessment:

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"25,000 ppb mercury = Concentration of mercury in multi-dose, Hepatitis B vaccine vials, administered at birth from 1991-2001 in the U.S."

"50,000 ppb mercury = Concentration of mercury in multi-dose DTP and Haemophilus B vaccine vials, administered 8 times in the 1990's to children at 2, 4, 6, 12 and 18 months of age and currently "preservative" level mercury in multi-dose flu, meningococcal and tetanus (7 and older) vaccines."

"Thimerosal was tested only once, by Eli Lilly on 22 adult patients suffering from meningitis. There was no chance for follow- up to observe long-term effects, as all of the patients in this "study" died. *Even if follow-up had been possible, damage to the developing brains of very young children would have remained an unknown. Eli Lilly said it was safe and the medical community accepted it. After the creation of the FDA, its use was simply continued. The federal government has never tested the type of mercury in vaccines for toxicity.* ***This is an unconscionable oversight failure at best, at worse it is an example that we have left consensus reality to be created by the liars, thieves, cheats, killers, and the junk scientists they employ."***

"How it came to pass the AAP joined these rogues and be-came an active participant in this skullduggery is beyond reason even beyond greed. They have remained silent as mercury-laden vaccine continues to be exported and used in all third world and second world countries."

"We are living in a time where an incredible overplay and lies, self-aggrandizing behavior and non-science are the norm. We have tolerated the junk science that has covered up the true cause of this epidemic at a considerable cost to science, the public, and our very way of life in this country. Is it a stretch to realize that by putting our collective heads in the sand about the autism epidemic we have made it possible for the destruction of our very civilization?"

"Not something easy to contemplate? Then ask why haven't pediatricians come forward to demand the end of the use of Thimerosal once and for all, and to advocate for the treatment of these children before it is too late? Why are they not at the front of the line protesting the amounts of mercury allowed to come out of coal-fired power plants? Why aren't they leading the charge to stop the use of mercury amalgam dental fillings that are placed in the mouths of young children and pregnant women?"

SECTION 5.

Extraordinary evidence was presented at a scientific meeting of US and French experts, held to discuss the safety of the aluminum 'adjuvants' added to certain vaccines. This was on the 11th-12th May 2000 in Puerto Rico, many years after aluminum was first added to vaccines and non-specific immune boosting formulations. According to the meeting's offical transcript, Dr Johnson, the Chairman, at first optimistically stated: 'Aluminium salts have a very wide margin of safety ...' and thus 'aluminum and mercury are often simultaneously administered to infants.'

But he immediately contradicted this by adding: 'There is absolutely no data, including animal data, about the potential for synergy, additively or antagonistic, all of which can occur in binary metal mixtures.' In other words the vaccine industry has been putting in both these metals without ever studying what they might do when present together (From investigative journalist and author, Janine Robert's compilation of Aluminium in vaccines can cause serious polio-like damage, may enhance the neurotoxic effects of mercury and cause brain Damage from the Transcripts of the Vaccines and Related Biological Advisory Committee Meeting (VRBAC) and Scientific Papers about the French-discovered aluminum adjuvant disease, macrophagic myofasciitis):

Dr. Myers, the Acting Director of the National Vaccine Program Office, also stated at the start of this meeting: 'Those of us who deal with vaccines have really very little applicable background with metals and with toxicological research – that is the reason why this meeting is occurring today." Dr Alison Maule reported at the end of the meeting: 'I certainly had a sense of déjà vu after the Thimerosal last year and the lack of information we have. The presentations [we heard yesterday] clearly demonstrate that there are huge gaps in what we know about the toxicology of aluminum. ... On the difference (in effects) between adults and infants, there appears to be practically not even animal data, let alone human data.'

It turns out, from the evidence in this transcript, and recent scientific papers, that the vaccine manufacturers decided to add this form of aluminum because some vaccines seemed unable without this adjuvant to produce protective antibodies. This form of aluminum had been known for some 80 years to create a strong immune response in a recipient [Fiona Sharp et al., Uptake of late vaccine adjuvants by dendritic cells activates the NALP3 inflammasome. Proceedings of the National Academy of Sciences. 2000]. It was also relatively cheap – currently it retails at $76 for 100 grams. It was presumed it was good to add it. But, now it came out why it produces a prolonged strong immune response. It was because our cells perceive the aluminum as far more dangerous than any viruses in the vaccine. What the manufactures amazingly did not investigate was just how much damage this aluminum 'salt' did to produce this response.

After an aluminum-containing vaccine is injected, our white blood cells will immediately move in great numbers to clean up the mess of foreign particles that has just arrived as they do with all injected vaccines. One of the first cell types to arrive will be the macrophages. These cells leave the blood vessels and move with unerring instinct to the site of the injection. They then start to remove dangerous particles by absorbing and dissolving them. But with the aluminum in vaccines, the macrophages run into grave trouble. French scientists at the above meeting reported the nano-sized aluminum needles enter the macrophages and cannot be digested by them. The macrophages have not evolved a way to deal with this new challenge. They engage in a long and difficult struggle – which the vaccine scientists observed and thought was a useful, prolonged immune reaction.

Aluminum nano-needles have been discovered in biopsies to remain undissolved in immobilized marcophages at the site of vaccine injections for at least up to 8 years. This also was reported at this

meeting. The vaccinated muscles contained "sheets of large cells of the monocyte/macrophage lineage" with aluminium inclusions inside. 'Muscle biopsy showed dense accumulations of large macrophages' containing much aluminum crystal – probably all casualties of these nano particles. But the tangle of aluminum needles injected has other dangerous properties. It has for its weight a huge surface area and an electrical charge: so many particles will adhere to it. The vaccine scientists observed that some of these were vaccine antigens – and again thought this good as it meant a stronger immune response would be stimulated. But they had no control over the adjuvant once it was injected. They did not know what else it might attract and carry – other metallic ions for example. They found that within three days the aluminum needles travel rapidly to many parts of the body in red blood cells, macrophages and other immune system cells that it can so easily penetrate. [Chenggang Li1 et al. Nanoparticles Promote Acute Lung Injury by Inducing Autophagic Cell Death through the Akt-TSC2-mTOR Signaling Pathway. Journal of Molecular Cell Biology, doi:10.1093/jmcb/mjp002]. `Macrophages have been found to carry the dangerous aluminum crystals into the local lymph glands and beyond these to the other organs and gut. They are also carried towards the brain – where they are known to hitchhike their way through the protective Blood Brain Barrier and into brain cells. This creates a cascading immune reaction throughout the body.

The consequences of this started to come home to the 'experts' attending the above meeting, when a party of scientists from France presented new research findings to them. They reported finding these sharp aluminum needles can remain present in the vaccinated for at least 8 years following vaccination. And there was much more. They had so far tested over a hundred patients who had come to them with severe muscle and nervous system damage and had proved this was a consequence of aluminum-enhanced vaccination, mostly with the tetanus or hepatitis B vaccines. All these patients had these sharp aluminum crystals in them at the site of vaccination.

The French scientists had confirmed with animal studies that this aluminum and the polio-like illness were causally linked. Animals exposed to the same suffered over time similar severe damage. In their patients, disabling muscle pains had commenced in both lower legs and spread upwards. Some 85% of these patients could no longer work. Many could now only do 'basic things.' In addition, 25% of their first 100 patients suffered from classic Chronic Fatigue Syndrome, with 34% also having Multiple Sclerosis.

These nano-particles of aluminum also are capable of severely damaging nervous tissue throughout the body, disrupting controls over muscles. Potentially, this could also affect the lungs, limiting supplies of oxygen, as was also confirmed with animal studies. It was also found to disrupt the mitochondria in the cells it penetrated. It seemed capable of causing long-term massive poisoning events in the vulnerable – although these French cases were mostly among adult sports people. Was this because they put more stress on their muscles? The French said this was definitely a new serious illness. None of them had seen anything like it before. They had first suspected a virus, but then had found the aluminum. These cases had all occurred after a major French vaccination campaign that used aluminum-bearing Hepatitis vaccines and targeted adults as well as children.

Up until then the French had used far less of these enhanced vaccines than had the Americans. They also found that this damage kept on happening over a long time. Sometimes the patients had not become incapacitated until years after vaccination. Most of these patients 'had had four such injections.' The muscle pains and Fatigue Syndrome were occurring from 3 months to eight years later. 'The median delay [after vaccination] was 11 months…'

When they tested this 'aluminum adjuvant' on rats, they found it was not the aluminum alone that caused most damage but the aluminum combined with other particles, including antigens, that were in the vaccine. They concluded: 'So we have to consider the adjuvant plus the antigen' as the cause of the illness.

They had only tested so far 100 patients – but their animal studies indicated this damage would be widespread and there must be many more cases out there. They said it was by chance that this new disorder was first found in France –it was because the French do biopsies on the arms vaccinated, something not done in America or the UK. They were thus the first to detect the aluminum crystals in the muscles injected.

As mentioned, Americans are much more exposed to aluminum adjuvant than are the French. The latter have it in three types of vaccine – the hepatitis A and B vaccines, and in most of the tetanus vaccines. But in the USA it is also in acellular pertussis, anthrax, Lyme, DT absorbed and Hib, some of the Rabies, and in the anthrax vaccines given to the military who went to the first Gulf War. These vaccines are also among those most often blamed for the 'Gulf War' syndrome because of another adjuvant I will discuss in the context of the H1N1 vaccine latter.

As the French scientists reported a clear and certain link between the 'aluminium-enhanced vaccines' and the illnesses, when the American scientists at this meeting cross-examined the French scientists, they could find no fault in their data. Instead, they applauded them for a brilliant piece of medical sleuthing. Dr. Sam Keith noted at the meeting that aluminum is stored mostly in human bones, followed by kidneys, brains and muscles. When it binds to the larger proteins, he said it 'can inhibit the formation of neuronal microtubules,' thus affecting the structure of neurons. Environmental considerations also should be noted.

Dr Harn Hogenesch noted that aluminum adjuvant can 'induce a type 2 immune response and set up an individual for allergic reactions to vaccine components.' Injected or inhaled metals have long been associated with severe muscle damage. Arsenic and lead have been shown in animal experiments to severely damage arm and leg muscles, causing symptoms identical to polio – thus very like what the French scientists observed [See the several chapters on polio in "The Fear of the Invisible,' 2008 and 2009, by Janine Roberts].

In 2001 the French team published their discovery and named their new vaccine-induced disease [R. K. Gherardi, M. Coquet, P. Cherin, L. Belec, P. Moretto, P. A. Dreyfus, J.-F. Pellissier, P. Chariot and F.-J. Authier: Macrophagic myofasciitis lesions assess long-term persistence of vaccine-derived aluminium hydroxide in muscle. Brain, Vol. 124, No. 9, 1821-1831, September 2001. Available online at ttp://www.informedchoice.info/hepB.html].

The French scientists had observed in their MMF patients: "Persistent systemic immune activation that fails to `switch off'. (They reported this 'previously has been regarded as the possible cause of chronic fatigue and arthromyalgias (Landay et al., 1991; Hassan et al., 1998), through sustained release of inflammatory cytokines and production of autotoxic T cells and autoantibodies (Konstantinov et al., 1996). Consistently, we have observed that MMF patients have B-cell hyperlymphocytosis, higher IL-6 circulatory levels than healthy vaccinated controls and detectable circulating antinuclear and anti- phospholipid autoantibodies (50%) (Gherardi et al.,2001). These data indicate that MMF is associated with a shift of immune responses towards a Th-2 profile, which is typically induced by aluminium hydroxide (Brewer et al., 1999), and probably contributes to emergence of chronic fatigue and associated manifestations (Rook and Zumla, 1997).' This had helped make them permanently ill, hypersensitive and severely disabled. This finding is confirmed by other research, the French scientists stated, adding: 'These data indicate that MMF is associated with a shift of immune responses towards a Th-2 profile, which is typically induced by aluminium hydroxide (Brewer et al., 1999), and probably contributes to emergence of chronic fatigue and associated manifestations (Rook and Zumla, 1997).' ['Aluminium hydroxide has been reported to induce IL-1 (interleukin-1) production by monocytes, complement activation, eosinophilia, increased specific and non-specific IgG1 and IgE antibody

responses and delayed-type hypersensitivity (Gupta et al., 1995)' 'Persistent systemic immune activation that fails to `switch off' previously has been regarded as the possible cause of chronic fatigue and arthromyalgias (Landay et al., 1991; Hassan et al., 1998), through sustained release of inflammatory cytokines and production of autotoxic T cells and autoantibodies (Konstantinov et al., 1996).'

Another paper recorded that, among 92 MMF patients, eight had a symptomatic demyelinating CNS disorder with some 6 others having other CNS disorders [It was also reported: 'Brain T2-weighted MRI showed single (two out of seven) or multiple (four out of seven) supratentorial white matter hyperintense signals and corpus callosum atrophy (one out of seven). Evoked potentials were abnormal in four out of six patients and CSF in four out of seven.' Its authors concluded that 'The association between MMF and multiple sclerosis-like disorders may give new insights into the controversial issues surrounding vaccinations and demyelinating CNS disorders.' Aluminum some time ago was suggested as a cause of dementia because dialysis patients, who sometimes develop dementia, were found to have high aluminum levels in their blood. However at that time no definitive link was established.

Other research findings may now explain what the French scientists reported at the meeting cited at the beginning of this section. They had found severely disabling polio-like symptoms with much muscular pain and weakness in those exposed for many months and years to the aluminium adjuvant.

It has been discovered that a third of the animals exposed to this adjuvant received damage to their spinal cords and primary motor cortex. Many also had significant neuron loss. Also, another study in the Journal of Inorganic Biochemistry has found that aluminum hydroxide injections 'showed profound effects on motor and other behaviours.' [Christopher A. Shaw, et al, Aluminum hydroxide injections lead to motor deficits and motor neuron degeneration, Journal of Inorganic Biochemistry, 2009 Aug 20.] Finally, research has also shown a link between the aluminum multiple aluminium hydroxoide [vaccine] injections' when given proportionately to mice, 'produced ... changes in locomotion behaviour an induced memory deficits.' In an interview, Professor Christopher Shaw who teaches neurology at the Institute of Psychiatry, Kings's College, London University, said after this experiment; "No one in my lab wants to get vaccinated. This totally creeped us out. We weren't out there to poke holes in vaccines. But all of a sudden, oh my God-we've got neuron death!" [Petrik M.S. et al. Aluminum Adjuvant linked to Gulf War Syndrome induces motor neurone death in Mice. http://www.whale.to/vaccines/shaw.pdf].

SECTION 6.

TIMELINE OF 81 STUDIES REGARDING THE EFFECTS OF VACCINES ON SMALL GROUPS AND WIDELY VACCINATED POPULATIONS OF HUMANS.

As one would take a test in history class in high school, let's go through the following examples and decide after each entry, whether the information given points to a conclusion that **1)** vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/ harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above. In each case, I will underline the answer(s) I believe is/are correct, and you do the same. I also will provide the reason following my answer, and/or **embolden words** in the information that support my conclusion(s). In many cases you will find more than one correct answer, which is a principal point of this exercise, and a finding of great interest being presented here for the first time I am aware of in a chronological, systematic way that hopefully will raise awareness for future epidemiological surveys of vaccinated populations.

(1) 1850 In 1850, in the U.S. frigate Independence, with a ship's company of 560 people aboard, there were 116 cases of smallpox, seven fatal. Fleet-surgeon Whelen wrote: *"The crew of this ship **almost universally** presented what are regarded as **genuine vaccine marks**. The protection, however, proved to be quite imperfect."*

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above.
One cannot be sure with only 7 deaths and 116 cases whether this was simply an unlucky crew that acquired a "mutated strain" of small pox, or whether the vaccination and revaccination among the "almost universally vaccinated crew caused the 116 out of 560 cases on board immediately after they left port, which is why 1) "vaccines do damage to individuals," 2) "do nothing like a shot filled with water," and 3) "cause small outbreaks/harm populations, and 5) can spread the disease vaccinated against to non-vaccinated people, are all underlined.

(2) 1850 The New Orleans Medical and Surgical Journal 1880, published a communication from Dr. T. H. Bemiss, Lahaina, Hawaii, on the introduction and spread of leprosy in these islands. *"Alarmed,"* says the writer, *"by an invasion of small-pox in 1853, a general vaccination of the whole population was ordered, and physicians being at that time very few on the islands, non-professionals aided in the work. It is charged by some that, as a natural result of the labours of the heterogeneous force so appointed, not only syphilis but also leprosy was greatly increased. In my last circuit trip in my district, I found very few adults who had never been vaccinated. This involves the question of inoculability (of leprosy), in my opinion the main, if not the only means of propagation, other than inheritance."*

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/ harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above.

An “invasion” of small pox is hardly an epidemic, despite the entire population being vaccinated (or very few adults who had never been vaccinated). The appearance of syphilis and leprosy after a general vaccination was ordered suggests that the shot(s) given did not behave as if they were filled with water, as inoculations of this era were known to spread syphilis and leprosy.

(3) 1860 The following is part of a letter which appeared in the Lancet on July 7th, 1860, signed a "Military Surgeon:”*"VACCINATION AT SHORNCLIFFE.— SIR,— Having seen in the Lancet of last week an article commenting on a return moved for by Mr. DUNCOMBE, respecting those who have died from Vaccination, the number of amputations required to save life at the camp at Shorncliffe, I can only say that it would be advisable to extend this return, and ask for the number of those who have died or had their arms amputated since the promulgation of an order from the late Director-General ALEXANDER, limiting the performance of the operation to a particular part of the arm, viz., two inches above the elbow-joint in front, immediately over the insertion of the deltoid muscle.* ***The results from this unfortunate erroneous rule, have, I fear, produced an amount of injury that will never be known,*** *as it will be exceedingly difficult, even in the present day, to procure an accurate return, as military medical men are too fully alive to the injury likely to occur to their future prospects of promotion in the service, were they found ready and willing to expose such mistakes. The irritation, inflammation, and consequent loss of limb, and in some cases of life, from adopting this rule, I myself am practically acquainted with, as I was on board, not very long since, in a case where a fine healthy young soldier had his arm amputated at the shoulder-joint to save his life, in consequence of mortification supervening upon erysipelatous inflammation of the forearm after Vaccination."*

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above.

The irritation, inflammation, and consequent loss of limb, and in some cases of life, from adopting this “erroneous” method of vaccination, qualifies as a small outbreak due to smallpox vaccines, which was large enough to institute a medical policy change because “a number died or had their arms amputated due to inoculating the soldiers two inches above the elbow-joint” (so that when reactions occurred it would be easier to amputate than if the vaccine was given on the shoulder as was typically practiced before amputation of limbs became common practice in those vaccinated that developed these severe reactions.

(4) 1864 *"Upon the U.S. steamship Jamestown, serving in Japanese waters, there occurred, in 1864, among a ship’s company of 212 persons, 31 cases of small-pox, with four deaths. The entire crew had been vaccinated after leaving the United States."*

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/ harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above. 31 cases out of 212 persons is a small outbreak, or maybe again these sailors were just unlucky, and got infected with another “mutated” strain…one assumes that the small pox vaccine they received either caused the 31 cases, or did nothing like a shot filled with water, for those 31/212 sailors.

(5) 1868 *"Small-pox was introduced from San Francisco in the year 1868. In that year a general vaccination took place, spring lancets being used, which the President of the Board of Health (Mr. David Dayton) informed me were difficult, if not impossible, to disinfect—the operation causing*

irreparable mischief. ***The synchronicity of the spread of leprosy with general vaccination is a matter beyond discussion,*** *and this terrible disease soon afterwards obtained such a foothold amongst the Hawaiians that the Government made a first attempt to control it* ***by means of segregation.*** *Another outbreak of smallpox occurred in 1873, and yet another in 1881, both followed by general arm-to-arm vaccination and a rapid and alarming development of leprosy, as may be seen in successive reports of the Board of Health. While the preponderance of medical and scientific opinion is against the theory that leprosy is, in the ordinary sense of the word, a contagious disease, the evidence in favour of its being communicable by inoculation is overwhelming."*

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/ harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above. "*…this terrible disease soon afterwards obtained such a foothold amongst the Hawaiians that the Government made a first attempt to control it by means of segregation* qualifies as an outbreak.

(6) 1868 The excessive mortality among the prisoners at Andersonville, in the American Civil War, has been mainly attributed to the general re-vaccination, practiced upon them under conditions of severe morbidity. JOSEPH JONES, M.D., Professor of Physiology and Pathology, University, Nashville, U.S.,1868, wrote: *"The Federal prisoners confined in Camp Sumpter, Andersonville, Georgia, were vaccinated, and, in a number of cases, large gangrenous ulcers appeared at the points where the vaccine lymph had been inserted, causing extensive destruction of tissues, exposing arteries, nerves and bones, and necessitating amputation in more than one instance. From the establishment of the prison, on February 24th, 1864, to October 1st, over 10,000 Federal prisoners died, i.e., near one-third of the entire number perished in less than seven months. These accidents led to the belief among some of the prisoners that the surgeons had intentionally introduced poisonous matter into their arms during Vaccination. No wonder they had such a persuasion, seeing that about 100 of them lost the use of their arms, and about 200 were so injured that they soon afterwards died. Though some medical officers were tried before a special military commission, convened in accordance with orders from the War Office at Washington, on the charge of having willfully poisoned the Federal prisoners with vaccine lymph, it was shewn that the unhappy consequences of Vaccination at Andersonville were paralleled in the Northern prisons. 'After careful inquiries,' says Dr. JONES, 'among returned Confederate prisoners, I am convinced that the accidents attending Vaccination were quite as numerous and severe in Northern prisons as in Southern."*

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/ harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above. "*over 10,000 Federal prisoners died, i.e., near one-third of the entire number perished in less than seven months…" the "accidents attending Vaccination were quite as numerous and severe in Northern prisons as in Southern." All qualify as statements suggesting* a lot of vaccine damage to individuals and perhaps small outbreaks of different diseases due to vaccination of prisoners.

(7) 1870 *"In 1870, sixty-one cases [of smallpox] occurred on the United States steam ship Franklin.* ***The disease first appeared on a sailor with 'an excellent vaccine scar.'*** *The officers and crew were immediately vaccinated with fresh vaccine matter obtained at Lisbon, this vaccination being the third one during the cruise. Nineteen days later, the second case occurred. The disease has been epidemic in many places in Europe during the past season, but I hoped our vaccinations would prevent trouble with it on board ship. In a cruise of the North Carolina up the Mediterranean, she shipped at Norfolk a crew of 900 men, most of whom had been vaccinated, or had the small-pox, but were nevertheless twice*

vaccinated prior to the ship sailing, a third time at Gibraltar, and a fourth time at Port Mahon. Dr. HENDERSON, who reports these facts, states that notwithstanding this ultra Vaccination under such various circumstances of virus, climate, 157 of the crew had varioloid."

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/ harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above. "*...The disease first appeared on a sailor with 'an excellent vaccine scar.' The officers and crew were immediately vaccinated with fresh vaccine matter obtained at Lisbon, this vaccination being the third one during the cruise,"* suggesting the vaccines do nothing like a shot filled with water in most of the vaccinated which is why they violated Jenner's paradigm that weakened strains (from cows-cow pox) protects against small pox for life. Because 157 men out of 900 had varioloid, however, and the fact that all were vaccinated multiple times also qualifies as information pointing to the idea that the smallpox vaccines they obtained may have caused a small outbreak among the crew.

(8) 1871 *"Europeans resolutely object to be vaccinated with lymph from native sources; and, notwithstanding the law, when imported lymph cannot be obtained they and their children remain unvaccinated. As a consequence, the population of Europeans* ***attacked with leprosy*** *is comparatively small and, indeed, of rare occurrence,* ***except in the case of soldiers*** *who are subject to the military regulation of revaccination. This repugnance to native lymph on the part of Europeans in the West Indies was pointed out by Dr. R. Hall Bakewell, Vaccinator - General, Trinidad, in his remarkable evidence before the Select Parliamentary Committee of 1871, and has been referred to by Dr. Castor, of British Guiana, and other authorities."*

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/ harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above. "*…the population of Europeans attacked with leprosy is comparatively small and, indeed, of rare occurrence, except in the case of soldiers who are subject to the military regulation of revaccination"* qualifies as a small outbreak (of leprosy) among soldiers compared to the general population. The lack of leprosy among the non-vaccinated Europeans cannot be interpreted to mean any of the above answers with any certainty regarding the Europeans.

(9) 1879 Mr. P. A. TAYLOR, reveals his intention to introduce a Bill during the next Session for the Repeal of the Compulsory Clauses of the Vaccination Acts, and told the House of Commons, in April, 1879, that he had ***"seen dozens and scores of persons*** *who had stated to him that they honestly believed that their children had died from Vaccination. They took perfectly healthy children to be vaccinated, an incision was made in the arm, in a few days a sore appeared on the arm, from thence it spread all over the body, and finally the children died in agony"* (Lancet, August 21st, 1881).

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/ harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above. "*dozens and scores of persons who had stated to him that they honestly believed that their children had died from Vaccination,"* qualifies as a small outbreak, although these are the beliefs of parents and hearsay information from a politician introducing a Bill, and everybody knows how unreliable parents are with respect to their beliefs that vaccines harmed their children.

(10) 1880 Mr. J. T. HIBBERT, M.P., then Parliamentary Secretary to the Local Government Department, written in June, 1880: *"The Return (433) shews an increase of deaths from syphilis of infants under one year from 255, in 1847,—to 1,554, in 1875,—which, in my opinion, is one of the most unsatisfactory features in connection with Vaccination, and one which leads me to support the proposed modification of the Vaccination Law now before the House of Commons."*—Lancet, July 17th, 1880.

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/ harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above. This may represent a small outbreak from 255 dead infants to 1,554 infants dying of syphilis under one year of age, but it may not only be due to vaccination but due to increased promiscuity among the mothers of these infants since syphilis is a sexually transmitted disease and we assume they aren't talking about the infants acquiring syphilis from a syphilis vaccine since none was known to yet exist in 1875.

(11) 1880 MEAN ANNUAL RATE OF MORTALITY IN ENGLAND from SMALL-POX (P. lxxix., Table 34, of the 43rd Annual Report of the Registrar-General, 1882) N.B.—Vaccination made compulsory, 1853; more stringently so, I867.

"Small-pox vaccination was made compulsory by an Act of Parliament in the year 1853; again in 1867; and still more stringent in 1871. Since 1853, we have had three epidemics of small-pox, each being more severe than the one preceding."

Date		*Deaths from Small-pox.*
1st	*1857—58—59*	*14,244*
2nd	*1863—64—65*	*20,059*
3rd	*1870—71—72*	*44,840*

AND…in **1894** In his inaugural Address to Medical Society of King's College, October 26th, Dr. Edward Crookshank claimed that: "That vaccination is capable of extirpating the disease or of controlling epidemic waves is absolutely negated by the epidemic in 1825, and the epidemics which followed in quick succession in 1838, in 1840, 1841, 1844-5, 1848, 1851-2. Vaccination was made compulsory in 1853, but epidemics followed in 1854, 1855, and 1856, culminating in the terrible epidemic in 1871-72 with more than 42,000 deaths. Epidemics followed in 1877 and 1881." en.wikipedia.org/w/index.php?title=Edgar_Crookshank&action=edit&section=2>

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/ harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above. 14,244 to 44,840 deaths in a context off more stringent compulsory vaccination policies qualifies as a small outbreak, or that vaccines do nothing like a shot filled with water.

(12) 1885 The earliest record of an epidemic caused by Hepatitis B virus was made by Lurman in 1885. An outbreak of smallpox occurred in Bremen in 1883 and 1,289 shipyard employees were vaccinated with lymph from other people. After several weeks, and up to eight months later, 191 of the vaccinated workers became ill with jaundice and were diagnosed as suffering from serum hepatitis. Other employees who had been inoculated with different batches of lymph remained healthy. Lurman's paper, now regarded as a classical example of an epidemiological study, proved that contaminated lymph was

the source of the outbreak (from Wikipedia). (Lurman A. (1885) Eine icterus epidemic. (In German). Berl Klin Woschenschr 22:20–3).

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191 workers out of 1,289 employees developing jaundice and serum hepatitis after a small pox vaccination is a small outbreak.

(13) 1886-1892 In Australia when a few children died as a result of smallpox vaccinations, the government abolished compulsory vaccination in that country and smallpox suddenly declined to the vanishing point. Australia had only three cases of smallpox in 15 years as compared with Japan's record of 165,774 cases and 28,979 deaths from this cause in only 7 years under compulsory vaccination and re-vaccination.

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(14) 1892 Honolulu Board of Health for 1892 documents that: *"Resistance to vaccination is spreading in many districts in these islands, and at the same time there is observed a sensible diminution in the number of lepers. In New Zealand, prosecutions for non-vaccination have for some time been abandoned. In the South African Colonies of Natal and Cape Colony the vaccination laws are enforced only during outbreaks of small-pox, and vaccination is everywhere regarded with mistrust. In the Transvaal and Orange Free State vaccination is entirely optional. In England there are about one hundred towns and poor law unions where the vaccination laws are a dead letter. In several of the Swiss cantons compulsory vaccination has been tried and abolished, and in no canton is there any penalty for non-vaccination. An attempt was made to pass a federal vaccination law in 1881, and was defeated in a Referendum by 253,968 votes against 67,820. In the Australasian Colony of Tasmania the compulsory law has been suspended by reason of* ***its deleterious effects on the health of the people****. In the Colonies of New South Wales. and Queensland, Australia, the people have successfully resisted every attempt to impose the hotly-disputed Jennerian dogma upon them."*

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(15) 1892 "In an article on Keanu's inoculation, the Occidental Medical Times, April, 1892, Dr Sidney Bourne Swift intimates that*: "It must not be forgotten that the* ***leprosy was first discernible at the points of inoculation****. Nor can it be considered remarkable, knowing how the disease had been propagated by*

the vaccination lancet. In one instance reported to Queen Liliuokokalani, an entire school in Hawaii was swept away, with the exception of a single survivor, by this means."

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(16) 1898 The Royal Commission of England was appointed to inquire into certain aspects of the vaccination question. The committee would be in session for 7 years and would issue 6 reports, with the final report in 1896. The result of the final report was The Vaccination Act of 1898, and the 1898 Vaccination Act removed penalties from vaccination law, and they recommended that mandatory vaccination should be stopped.

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(17) 1905 after the famous Jocobsen case in Boston, the U.S. Supreme Court upheld state laws mandating smallpox vaccinations and in 1906 to 1928 the vaccines against pertussis. Records show that in 1907, the neurotoxin calcium arsenate came into use primarily on cotton crops, and in 1908 in a Massachusetts town with three cotton mills and apple orchards, 69 children suddenly fell ill with infantile paralysis. And in 1909, the UK banned apple imports from the States because of the heavy lead arsenate residues.

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(18) 1909 Landsteiner and Popper ground up the spinal cord of a 9-year-old paralysis victim, and injected a cup of the suspension directly into the brains of two monkeys. One died immediately, and the other slowly became paralyzed. In 1910, Flexer and Lewis again ground up human spinal cord of a paralysis victim and injected the suspension directly into a monkey's brain, the monkey became paralyzed, then they extracted some fluid from its brain, and injected it into another monkey's brain, and so on, through a series of monkeys paralyzing all of them in the process. But making the monkeys drink the liquid or injecting it into their arms, the suspension did not paralyze them.

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(19) 1916 The first American public health intervention and control programs occurred during and following the Great 1916 epidemic of paralysis that is now attributed to poliovirus. During the

“epidemic" in New York, fear of contagion and a healthy carrier state were being asserted as fact for the first time in its recognizable modern form.

The epidemic began 4 years after the implementation of mandatory small pox vaccination in 1911 of military recruits. Both before and during this 1916 New York acute paralysis epidemic, and still today, nobody could figure out why both rich and poor became paralyzed, and every person and every thing became a suspected source or carrier of the paralytic syndrome. Despite the fact that nobody could explain why individuals that were well fed or hungry became paralyzed, or why paralysis prevalence was also occurring among gentiles and, at a seemingly less rate among the "unwashed immigrants" living in New York's burrows, swimming in public pools, and admission of children in movie theatres was banned or regulated. Small towns in New York State wouldn’t allow trains from Vermont to stop, and they did not allow persons from these trains into their shops. Residents in New York were fined if they failed to maintain their living quarter environs as clean as possible. Travelers leaving New York were shunned and children were prohibited from entering restaurants in places like Vermont.

Dirt was the primary suspect. Fear turned into public health campaigns to police the residents and enforce quarantines and levy fines at those who didn’t keep their windows tightly closed during the hot summer and early fall to ward off an imagined house fly vector that might carry the "illness" from the poorer districts of New York to where the middle class or upper classes lived. Despite their experiments, public health officials, and medical doctors such as Flexner (who believed polio to be spread through the air and sputum) couldn't explain why rich Philadelphia playboys and orphans of the state would both contract paralysis, or how only one individual out of a family of many children acquired symptomatic paralysis, while others in the same family may present with only a runny nose, or no symptoms at all.

An excellent account of this era leading up to the Great 1916 “polio epidemic” can be found in “Infantile Paralysis in Vermont,” published in 1924 by The Burlington Vermont State Department of Public Health. This “record” is a collection of yearly maps of Vermont, compiled by Dr. Charles Solomon Caverly. The book begins with a description of a paralytic outbreak that took place in the summer of 1894, and a series of maps of Vermont then is provided where each recorded case was marked on the map with a red dot to note the location of the victim. Not only did each year’s map record every reported case of paralysis that occurred, and where in the state each case occurred (by county), detailed information about each case was also provided by Dr. Caverly-the ethnic background of the family, the employment status and line of work of the head of the household, the time of year it was reported, the temperature and weather at the time of diagnosis, the amount of rainfall measured, how the paralysis became manifested (and in which limb(s)), how many days the incubation period likely lasted before paralysis was first observed (typically no longer than several days), and dozens of other interesting facts that Caverly recorded about each case. At the end of each chapter in The Record, Caverly speculated about each year’s case clusters, as to how paralysis and reported cases could possibly “travel” infectiously from county to county from the previous year, in an attempt to discover how “paralysis” cases spread (along train routes, roadway routes, water routes, etc). But there appeared to be no railroad lines, or roads, rivers, natural barriers such as mountains, or any other reason to account for how one year, 1910 for instance, higher clusters of paralysis occurred on one side of a mountain valley while the next year, the other side of the mountain and across the state was where the new cases occurred, while no new cases occurred again in the first place, and even though the mountains would have restricted spread, by limiting travel of “infected” people.

Despite not knowing the cause of paralysis, it has been noted by medical historians, that to “reduce” the symptoms of paralysis, certain doctors performed more spinal taps than could be counted. Records of

"exsanguinations" of cerebral spinal fluid, and/or the practice of injecting highly neurotoxic mercury into the spinal cord were also kept by some State Health Departments.

During the 1940's, advertisements appeared in American magazines showing cartoons of huge house-flies attacking babies as they slept in their cribs, as it was still thought in the 1940's that flies were still perhaps the most likely source of paralysis. DDT was then developed to spray everything, including the household kitchen and the food supply, when it wasn't yet appreciated that DDT and other pesticides such as arsenic used at the turn of the century in the orchards scattered about New England induced the same pathological damage to the same areas of nerve tissue that was and is characteristic of that now assumed to be infection-acquired paralysis from a virus.

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(20) 1937 The Philippines had the worst smallpox epidemic ever in the early 1900s even after a vaccination rate of 95 percent. Physician William Howard Hay's address of June 25, 1937; printed in *The Congressional Record.*

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DO VACCINES CAUSE EPIDEMICS IN POPULATIONS? WHAT DO WE KNOW ABOUT THE WORST EPIDEMIC OF ALL TIME: THE "GREAT SPANISH FLU EPIDEMIC" AND THE UPCOMING COMPAIGN NEXT MONTH TO VACCINATE 4.9 BILLION PEOPLE AGAINST "SWINE FLU?"

(21) 1917 U.S. soldiers are vaccinated prior to going overseas to fight in WW I. They soon begin to drop dead by the thousands from a strange syndrome that preferentially attacks young adults.

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above.

(22) 1918 DEPARTMENT OF THE NAVY -- NAVAL HISTORICAL CENTER 805 KIDDER BREESE SE -- WASHINGTON NAVY YARD WASHINGTON DC in a report entitled, "The Pandemic of Influenza in 1918-1919" prepared by the US Department of Health, Education and Welfare Public Health Service National Office of Vital Statistics indicates that the extraordinary feature of "the Great Spanish flu" was that it attacked young people in the prime of life unlike any other epidemics recorded:

"The pandemic of influenza in 1918-19 which swept over nearly every continent and island of the whole globe has been described as one of the great human catastrophies. There are excellent descriptions of epidemics and pandemics as far back as the year 1500, and various records of epidemics since the

1918-19 holocaust. ***Many of them were relatively mild infections, while others were severe, but none of them showed the extraordinary high mortality in young adults that characterized the 1918-19 pandemic and its aftermath in 1920.*** *The greatest amount of mortality in epidemics prior to and subsequent to 1918-19 was found in children under 1 year of age and in persons 65 years and over."*

"Frost, in one of his reports, pointed out that influenza and pneumonia mortality rose sharply in some cities in the United States in December 1915 and January 1916, which may or may not have been related to the 1918 epidemic. In January 1916, influenza was reported to be epidemic in 22 States, but it was described as a mild type of illness."

"As early as December 1917, influenza was prevalent in Camp Kearny, California, and in other Army camps in January 1918, but the disease was said to be mild. In the spring, localized outbreaks occurred in the civilian population of the United States, and mortality from pneumonia rose sharply in certain cities. In March and April, Camp Funston, Kansas, experienced three waves of influenza. The first two affected all types of personnel, and the third, which occurred late in April, was predominantly in recruits who arrived shortly after the second wave. Mild epidemics of influenza were reported in various localities in Western Europe in April and May of 1918, and in June and July more extensive outbreaks occurred in Great Britain and in Europe, China, India, the Philippine Islands, and Brazil. In these countries, mortality rose moderately. The 1918-19 epidemic was often referred to in the United States as "Spanish influenza," but there is no reason to believe that it originated in Spain. Indeed the occurrence of influenza in the United States in the spring of 1918 may have preceded that which occurred in Spain."

"During August 1918, epidemics of influenza were reported in Greece, Sweden, Switzerland, Spain, the West Indies, and late in the month it appeared almost simultaneously in Camp Shelby, Mississippi, and Boston, Massachusetts. In September, it appeared in rapid succession in other Army camps and in the civilian population along the Atlantic seaboard and the Gulf of Mexico and spread rapidly westward over the country. By October, the epidemic had involved the entire United States, except isolated places and some mountain areas. The interval between the peaks of the epidemic in Boston and San Francisco was about 4 weeks, and the peaks in the number of deaths usually were reached in about 1 month following the beginning of the epidemic in a community or area. As a rule, epidemics affected rural areas later than cities in the same sections. In some areas there was a recrudescence of the epidemic in January and February 1919, which was most marked in cities where the autumn epidemic was less severe. Thus the influenza epidemic of 1918-19 in the United States was characterized by a relatively mild phase in the spring of 1918, an explosive outbreak with high mortality in the fall, and a third phase or recrudescence early in 1919."

"The incidence and mortality of influenza in military personnel in 1918-19 has been described in great detail in Epidemiology and Public Health by Vaughan, and in Volume 9 of the history of the Medical Department of the United States Army in the World War. [See also the Surgeon General's account in Annual Report of the Secretary of the Navy, 1919 -- Miscellaneous Reports]. ***About 90 percent of the men in military service in World War I were young adults between 20 and 35 years of age. Consequently, the Armed Forces were seriously affected, as were the same age groups in the civilian population.*** *In the Army over a million men were hospitalized for influenza and pneumonia, and of these there were more than* ***44,000*** *deaths. There were approximately 5,000 deaths among Navy personnel.* ***Hospital admission rates and death rates for American troops stationed in Europe were lower than for troops in the United States.*** *The large number of recruits concentrated in close quarters probably accounted for higher rates in the latter. In the camps having the larger numbers of trainees, incidence and mortality was highest, and in all camps the rates were higher in recruits than in seasoned troops. The crowding in camps probably favored the spread of secondary invading organisms as well as the etiologic agent of influenza. The peak of the epidemic was reached in September in Navy*

personnel and about the middle of October in the Army. A secondary rise in incidence of these respiratory diseases occurred in the Army in January and February 1919, but it was limited to troops stationed in Europe.

When appropriate adjustments are made for differences in the age and sex distribution of military and civilian populations, ***it appears that the death rate was about one-fourth higher in the Army than in the civilian population of the United States.*** *It is reasonable to assume that* ***this difference was largely due to greater crowding*** *in the recruit population of the Army. Collins showed mortality rates from influenza and pneumonia by age in 1918 as compared with certain other years.* ***The relatively high mortality in young adults in 1918 and the 2 years immediately following seems to have been characteristic of that period and was not found in epidemics prior to or subsequent to this 3-year period."***

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above. Although this Naval record of the "Great Spanish Flu epidemic describes that *"it appears that the death rate was about one-fourth higher in the Army than in the civilian population of the United States… this difference was largely due to greater crowding… seems to have been characteristic of that period and was not found in epidemics prior to or subsequent to this 3-year period,"* and I have underlined 7) "none of the above," I also have underlined 3) because that is possible that over-vaccination of military recruits and young persons, and a lack of illness in the old and very young indicates vaccine spread of the disease, although not in any way proves this assertion given the Navy's information.

In the account of survivor of the "Great Spanish Flu," Elenor McBean, the following is claimed: Honor of, E. McBean (Vaccination The Silent Killer p28) (Source: Dr. Rebecca Carley):

Very few people realize that the worst epidemic ever to hit America, the Spanish Influenza of 1918 was the after effect of the massive nation-wide vaccine campaign. The doctors told the people that the disease was caused by germs. Viruses were not known at that time or they would have been blamed. Germs, bacteria and viruses, along with bacilli and a few other invisible organisms are the scapegoats, which the doctors like to blame for the things they do not understand. If the doctor makes a wrong diagnosis and treatment, and kills the patient, he can always blame it on the germs, and say the patient didn't get an early diagnosis and come to him in time.

If we check back in history to that 1918 flu period, we will see that it suddenly struck just after the end of World War I when our soldiers were returning home from overseas. That was the first war in which all the known vaccines were forced on all the servicemen. This mish-mash of poison drugs and putrid protein of which the vaccines were composed, caused such widespread disease and death among the soldiers that it was the common talk of the day, that more of our men were being killed by medical shots than by enemy shots from guns. ***Thousands were invalided home or to military hospitals, as hopeless wrecks, before they ever saw a day of battle. The death and disease rate among the vaccinated soldiers was four times higher than among the unvaccinated civilians.*** *But this did not stop the vaccine promoters. Vaccine has always been big business, and so it was continued doggedly.*

It was a shorter war than the vaccine-makers had planned on, only about a year for us, so the vaccine promoters had a lot of unused, spoiling vaccines left over which they wanted to sell at a good profit. So they did what they usually do, they called a meeting behind closed doors, and plotted the whole sordid

program, a nationwide (worldwide) vaccination drive using all their vaccines, and telling the people that the soldiers were coming home with many dread diseases contracted in foreign countries and that it was the patriotic duty of every man, woman and child to get "protected" by rushing down to the vaccination centers and having all the shots.

Most people believe their doctors and government officials, and do what they say. The result was, that almost the entire population submitted to the shots without question, ***and it was only a matter of hours until people began dropping dead in agony, while many others collapsed with a disease of such virulence that no one had ever seen anything like it before. They had all the characteristics of the diseases they had been vaccinated against, the high fever, chills, pain, cramps, diarrhea, etc. of typhoid, and the pneumonia like lung and throat congestion of diphtheria and the vomiting, headache, weakness and misery of hepatitis from the jungle fever shots, and the outbreak of sores on the skin from the smallpox shots, along with paralysis from all the shots,*** *etc.*

The doctors were baffled, and claimed they didn't know what caused the strange and deadly disease, and they certainly had no cure. They should have known the underlying cause was the vaccinations, ***because the same thing happened to the soldiers after they had their shots at camp****.* ***The typhoid fever shots caused a worse form of the disease, which they called para-typhoid. Then they tried to suppress the symptoms of that one with a stronger vaccine, which caused a still more serious disease, which killed and disabled a great many men.*** *The combination of all the poison vaccines fermenting together in the body, caused such violent reactions that they could not cope with the situation. Disaster ran rampant in the camps. Some of the military hospitals were filled with nothing but paralyzed soldiers, and they were called war casualties, even before they left American soil. I talked to some of the survivors of that vaccine onslaught when they returned home after the war, and they told of the horrors, not of the war itself, and battles, but of the sickness at camp.*

The doctors didn't want this massive vaccine disease to reflect on them, so they, agreed among themselves to call it Spanish Influenza. Spain was a far away place and some of the soldiers had been there, so the idea of calling it Spanish Influenza seemed to be a good way to lay the blame on someone else. The Spanish resented having us name the world scourge on them. They knew the flu didn't originate in their country.

20,000,000 died of that flu epidemic, worldwide, and it seemed to be almost universal or as far away as the vaccinations reached. Greece and a few other countries, which did not accept the vaccines, were the only ones that were not hit by the flu. Doesn't that prove something?

At home (in the U.S.) the situation was the same; the only ones who escaped the influenza were those who had refused the vaccinations. My family and 1 were among the few who persisted in refusing the high pressure sales propaganda, and none of us had the flu not even a sniffle, in spite of the fact that it was all around us, and in the bitter cold of winter. Everyone seemed to have it. The whole town was down sick and dying. The hospitals were closed because the doctors and nurses were down with the flu. Everything was closed, schools, businesses, post office everything. No one was on the streets. It was like a ghost town. There were no doctors to care for the sick, so my parents went from house to house doing what they could to help the stricken in any way they could. They spent all day and part of the night for weeks, in the sick rooms, and came home only to eat and sleep. If germs or viruses, bacteria, or any other little organisms were the cause of that disease, they had plenty of opportunity to latch onto my parents and "lay them low" with the disease that had prostrated the world. But germs were not the cause of that or any other disease, so they didn't "catch" it. I have talked to a few other people since that time, who said they escaped the 1918 flu, so I asked if they had the shots, and in every case, they said they had never believed in shots and had never had any of

them. Common sense tells us that all those toxic vaccines all mixed up together in people, could not help but cause extreme body-poisoning and poisoning of some kind or another is usually the cause of disease.

Whenever a person coughs or sneezes, most people cringe, thinking that the germs are being spread around in the air and will attack people. There is no need to fear those germs any more, because that is not the way colds are developed. Germs can't live apart from the cells (host) and can't do harm anyway, even if they wanted to. They have no teeth to bite anyone, no poison pouches like snakes, mosquitoes or bees, and do not multiply, except in decomposed substances, so they are helpless to harm. As stated before, their purpose is useful, not destructive.

The 1918 flu was the most devastating disease we ever had, and it brought forth all the medical bag of tricks to quell it, but those added drugs, all of which are poisons, only intensified the over-poisoned condition of the people, so the treatments actually killed more than the flu did. This is from Vaccination The Silent Killer: Honorof, Ida and McBean, E.: Vaccination the silent killer (U.S.A.) Honor Publications, P.O. Box 346, Cutten, CA 95534, U.S.A.http://www.whale.to/vaccines/books.html

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above. In this highly critical account of the "Great Spanish Influenza," Elenor McBean corroborates the information of the Navy records indicating that the epidemic was 1/4th higher among soldiers than the general population. The emboldened sentences in the account are the reason all of the possibilities are underlined accept 2) "do nothing like a shot filled with water," and 7) "none of the above."

Other accounts and records recorded the following information regarding the Great "Spanish Flu:"

It has been estimated that there were about 20,000,000 cases of influenza and pneumonia in the United States in 1918-19, with approximately 850,000 deaths. In 1918 alone, 464,959 deaths from influenza and pneumonia were registered in the registration States and the District of Columbia as compared with 115,526 in 1917. This includes deaths in the Army, Navy, and Marine Corps which occurred in registration States. Eighty percent of the deaths in 1918 occurred in the last 4 months of the year.

*The numbers of deaths from influenza and pneumonia by age in registration States in 1917, 1918, and 1919 are shown in the table. A number of States in which Army camps were located are not included in this table**, so a considerable number of deaths of civilians and of military personnel for 1918-19 are missing which accounts for the difference in an estimated total of 850,000 for the United States and the figure of 650,399 for the registration States.*** *In 1918 the death rate for males* was 669.0 per 100,000 population; for females, 507.5. At ages 25 to 34, the rate was 1,216.6 for males and 781.4 for females. These excessively high mortality rates profoundly influenced the estimated average length of life calculated for the year 1918. It was reduced 24 percent from 1917 to 1918 for males and 22 percent for females. However, these estimated average lengths of life in years returned to their previous trends in 1920.

Influenza and Pneumonia Mortality by Age: Death-Registration States, 1917-19
(For 1917, area includes 27 States and the District of Columbia; for 1918, 30 States and the district of Columbia; and for 1919, 33 States and the District of Columbia):

Year	**1917**	**1918**	**1919**
Age		**Number of deaths**	
All ages	115,526	464,959	185,440
Under 1 year	22,207	38,428	27,736
1-4 years	12,859	49,699	21,133
5-14 years	3,319	28,054	10.598
15-24 years	4,861	78,158	20,381
25-34 years	6,915	126,792	32,159
35-44 years	9,387	60,902	20,690
45-54 years	10,652	28,596	14,043
55-64 years	12,571	19,632	12,530
65-74 years	14,771	17,643	13,065
75-84 years	13,224	11,829	9,548
85 years and over	4,600	3,680	3,173
Not stated	160	1,546	384
Rate per 100,000 population			
All ages	164.5	588.5	223.0
Under 1 year	1,474.5	2,273.3	1,594.2
1-4 years	211.5	718.0	293.9
5-14 years	24.0	176.2	63.3
15-24 years	38.9	580.5	141.4
25-34 years	59.3	992.6	235.9
35-44 years	98.1	554.8	181.0
45-54 years	148.8	347.8	163.9
55-64 years	281.4	381.9	233.2
65-74 years	614.6	646.3	459.6
75-84 years	1,503.0	1,179.0	913.9
85 years and over	3,187.4	2,230.6	1,842.2

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"***Etiology"***
Pfeiffer isolated an organism in 1892 variously referred to as Pfeiffer bacillus or influenza bacillus which was accepted by many as the causative agent of influenza. ***However, in 1918, various observers failed to find this organism in many cases, antemortem or postmortem.*** *A report on sputum cultures taken from 47 individuals in Baltimore during the epidemic showed that streptococci were present in 24 sputums, staphylococcus in 1, pneumococcus in 15, and the influenza bacillus in 8. In cultures taken in various Army camps prior to and during the epidemic of influenza in the fall of 1918, varying proportions of persons were found to carry streptococci, pneumococci, and the Pfeiffer bacilli. Such variations were also found in cultures from the bronchi or lungs at autopsy,* ***and differences were found from camp to camp.*** *The proportion of persons carrying streptococci or some other secondary invader did not remain constant, being replaced from time to time by another bacterium."*

"It was ***the impression*** *of many in 1918 that an unrecognized virus was the primary cause of influenza and that the streptococci, pneumococci, and influenza bacilli were secondary invaders which might be termed "bacterial hitch-hikers."* ***Attempts by two groups of investigators to transmit the infection by nasal instillation of filtered and unfiltered secretions from influenza cases in human volunteers were not successful****. Nor could they produce influenza in the volunteers by nasal instillations with Pfeiffer bacilli."*

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"Prevention and Control"
It often happens that when a severe outbreak of a disease occurs many measures are applied, some of which appear to be extreme and dictated by panic. In 1918, which was no exception, isolation of cases and quarantine of contacts were applied vigorously in some areas, but there is little evidence to indicate that these measures were successful in preventing introduction or spread of the disease. Closure of schools and prohibition of public gatherings likewise were of doubtful value. The use of face masks to protect the wearer against infection had its advocates. The use of germicidal gases to destroy the organism was suggested. ***The use of a vaccine containing the influenza bacillus was advocated, but as one would expect, no value could be demonstrated.*** *If a vaccine containing the viruses now known to cause the disease had been made available early in the epidemic, it is doubtful whether it would have been effective, since the epidemic in the fall of 1918 spread with great rapidity."*
In 1922, Victor Gaughan stated in retrospect that the most reasonable administrative action that could have been taken was to direct efforts toward relief measures, namely, medical and nursing care and hospitalization."

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(Much of the descriptive material and charts on the 1918-19 epidemic used in this comprehensive Department of Navy report were obtained from published reports or books by W.H. Frost, Edgar

Sydenstricker, Victor Vaughan, and Eugene Opie. The publications of Selwyn Collins were a valuable source of information on characteristics of epidemics of influenza in the United States prior to and subsequent to 1918).

1918 ***"****Pathologists became intimately familiar with the condition of lungs of victims of bacterial pneumonia at autopsy. But the viral pneumonias caused by the influenza pandemic were so violent that many investigators said the only lungs they had seen that resembled them were from victims of poison gas."*

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(23) 1941 In the April, 1941, issue of the Naval Medical Bulletin, reporting on the results of tests on 20,000 recruits at the Naval Training Station at San Diego, California, between July, 1939, and January, 1941, Captain G. E. Thomas of the Medical Corps of the Navy tells the story. He describes an experiment on these men. "*All had been checked by all known means and found* ***free of syphilis****, and were then confined.* ***These men were vaccinated against smallpox****. Those who did not show 'successful' vaccination were re-vaccinated. The experiment showed that more of these developed* ***syphilis from the smallpox vaccination*** *than the percentage who developed syphilis from all causes in the civilian population in the United States."*

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(24) 1941 On the eve of US entry into World War II, concern about a repeat of the 1918 influenza pandemic and its effect on armed forces led the US military to establish the Commission on Influenza (later combined with other commissions to become the present Armed Forces Epidemiological Board) and place high priority on developing a vaccine (Woodward TE, editor. The histories of the commissions. Washington: Office of The Surgeon General; 1992). Pandemic influenza did not materialize, but the vaccine did. The first successful large-scale influenza vaccine field trials were completed in 1943 (Francis T. Vaccination against influenza. In: World Health Organization. Influenza, a review of current research. Geneva: The Organization; 1954. p. 689–740). **In 1947, failure of the vaccine to provide protection against the epidemic influenza type A antigenic variant confirmed concerns of vaccine obsolescence and led to the term "antigenic shift"** (von Magnus P. The influenza virus: its morphology, immunology, and kinetics of multiplication. Bull World Health Organ. 1953;8:647–60) and designation of the 1947 FM1 strain by the Commission on Influenza as subgroup A´ on the basis of the hemagglutination inhibition (HI) test.

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(25) 1948 The Vaccination Inquirer reports that the English and Scottish Health Ministers acknowledged more than 25,000 cases of diphtheria in immunized children from 1941 to 1945, with nearly 200 deaths in immunized children. The clinical picture of diphtheria immunization is brought up-to-date by the Journal of the American Medical Association for June 5, 1948, in an article entitled, "Danger of Vaccination and Inoculation."

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(26) 1950's *"Starting in the 1950s Africans experienced **a massive increase in medical injections** associated with mass injection campaigns **targeted at yaws**, with introduction and spread of parenteral therapies to treat other diseases, and with plummeting prices for antibiotics and injection equipment. For example, UNICEF administered **12 million injections for yaws** in Central Africa alone during 1952-57. From the 1950s into the 1980s, unsafe injections **may have** contributed to the silent spread of HIV in Africa in much the same way that unsafe injections for schistosomiasis and other treatments in Egypt established hepatitis C as a major blood-borne pathogen, infecting about **15% to 20% of the general population** at the end of the 1990s"* (Editorial with Gisselquist, statistics quoted from: International Journal of STD & AIDS Royal Society of Medicine, October 2002 Africa HIV/AIDS through unsafe medical care. Also available:
Africa Policy E-Journal. (www.africaaction.org/docs02/hiv0210t.htm).

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(27) 1955 On April 24, 1955, an infant with paralytic poliomyelitis was admitted to Michael Reese Hospital in Chicago, Illinois. The patient had been inoculated in the buttock with Cutter vaccine on April 16, and developed flaccid paralysis of both legs on April 24.

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(28) 1955 (May)*"With the announcement that Cutter was withdrawing its vaccine, there ensued a nationwide panic. The AMA put out the warning to all its members to stop using Cutter vaccine, although regrettably some doctors never received word. Many states and cities announced immediate cessation of mass immunizations, even though their vaccine had come from manufacturers other than Cutter. Local health departments began to track down every single dose of Cutter vaccine, which, it was soon discovered, had traversed the entire country. Throughout May and June,* ***cases of polio caused by Cutter's vaccine*** *spread beyond the Far West and began to appear in every region of the country. The epicenter of the devastation was in California and the rural state of Idaho.* ***Ninety-nine cases of polio*** *would eventually be attributed to Cutter vaccine in California, with the incidence of polio among Cutter vaccinees exceeding the textbook definition of a wild polio epidemic* ***by nearly threefold****. In Idaho,* ***with eighty-eight polio cases*** *attributed to Cutter vaccine,* ***the rate was fifteen times greater****. Before it was over, the 'Cutter incident,' as it was euphemistically called in scientific circles, resulted in* ***260 people*** *contracting polio and* ***almost 200 cases of paralysis. Eleven people died****. A devastating epidemic had been caused by two particularly bad batches of vaccine"* (The Virus and The Vaccine- The True Story Of A Cancer -Causing Monkey Virus-Contaminated Polio Vaccine, And the Millions Of Americans Exposed, by Debbie Bookchin and Jim Schumacher, St. Martin's Press, 2004).

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(28) 1956 Health Authorities change the rules for defining polio. Doctors are instructed to diagnose polio only if the patient has paralytic symptoms for 60 days or more. **Milder cases of polio are no longer reported**.

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(29) 1957 *"Canada suspended its distribution of Salk's vaccine. By November all European countries had suspended distribution plans, apart from Denmark. By January 1957, 17 US states had stopped distributing the vaccine. The same year* ***The New York Times reported that nearly 50 per cent of cases of infantile paralysis in children between the ages of five and 14 had occurred after vaccination"*** (Bookchin and Schumacker, 2004).

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(30) 1958 CDC changes the rules for defining polio again. Cases of inflammation of the membrane that protects the brain and spinal neuron cells, causing muscular weakness and pain, **but not paralysis**, are no longer to be classified as polio. These cases must now be called **viral or aseptic meningitis**. **Non-**

paralytic cases were now to be re-named meningitis even if the poliovirus is present. The reported figures for polio were officially to exclude 'cases of aseptic meningitis due to poliovirus or other enteroviruses.' **Reported cases of aseptic meningitis went from near zero to thousands, and polio cases dropped the same amount.**

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(31) 1958 Officials reduce the definition of polio again. Now all cases with classic polio paralytic symptoms are to be diagnosed initially as Acute Flaccid Paralysis (AFP). **Two stools are taken from the patient and sent to the CDC to see if they can find polio in them. If not, they are declared as not polio**, even if the children have all the classic symptoms. Making fewer cases of polio by changing the definition was a fraudulent way to make it seem like the polio vaccinations were working.

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(32) 1970 The HEW reported in 1970 that as much as 26 percent of children receiving rubella vaccination, in national testing programs, developed arthalgia or arthritis. Many had to seek medical attention and some were hospitalised to test for rheumatic fever and rheumatoid arthritis. (Science, US, March 26, 1977).

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(33) 1972 Jonas Salk, inventor of the IPV, testified before a Senate subcommittee that nearly all polio outbreaks since 1961 were caused by the oral polio vaccine.

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(34) 1976 In a published report of the April 7, 1976, WHO meeting of international experts, the final paragraph urged extreme caution in developing live vaccines from a New Jersey strain, (H1N1) because of the possible **danger of spread** to susceptible human or animal hosts (World Health Organization. Influenza. Wkly Epidemiol Rec. 1976;51:123). That paragraph was written specifically to respond to reports that several investigators outside Western Europe had plans to develop and test such vaccines. One year later, an H1N1 virus, identical to the laboratory strain from1950–1951, swept the world.

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(35) 1976 During the great swine flu hoax, President Ford is vaccinated before a TV audience of millions. More than 500 people receiving flu vaccinations become paralyzed with Guillain-Barre Syndrome.

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(36) 1976 Bassili WR, Stewart GT. Epidemiological evaluation of immunisation and other factors in the control of whooping-cough. Lancet 1976 Feb 28;1(7957):471-4:

"The general incidence of whooping-cough is lower in fully immunised children, ***but present immunisation schedules do not adequately protect the infant below 1 year of age*** *either from contracting infection or from its complications. In a recent outbreak in Glasgow,* ***nearly one-third of notified cases were fully immunised****."*

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(37) 1977 *"Vaccination against whooping-cough. Efficacy versus risks" (The Lancet, vol. 1, January 29, 1977, pp. 234-7): Calculations based on the* ***mortality*** *of whooping-cough before 1957 predict accurately the subsequent decline and the present low mortality…* ***Incidence [is] unaffected either by small-scale vaccination beginning about 1948 or by nationwide vaccination beginning in 1957… No protection is demonstrable in infants."***

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above. This one is self-evident as the emboldened sentences indicate.

(38) 1978 *Several scientific reports published in esteemed medical journals were linking the smallpox vaccine to a broad spectrum of increasingly common diseases and disorders. Autism, diabetes, neuromyelitis, other neurological diseases, tuberculosis, chromosome damage and sudden infant death were being associated with the smallpox vaccine. References to those reports, as published in the world's leading primarily foreign medical journals between 1960 and 1978, are available at www.vaclib.org/basic/smallpoxindex.htm*<http://www.vaclib.org/basic/smallpoxindex.htm*

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(39) 1979 *Bulletin No. 6, March 30, Wyeth DPT Vaccine Recall. "Between August 1978 and March 1979, 77 infants in Tennessee* ***died suddenly*** *from unexpected causes - compared with 74 during the same period in 1977-78. These deaths were diagnosed as sudden infant death syndrome, or crib death. Of these 77 infants, eight died within a week of being vaccinated against diphtheria, tetanus and pertussis (whooping cough) using the same lot of DTP vaccine."*

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Although alarming and prone to a cursory interpretation suggesting that this recalled vaccine caused widespread death in 77 infants in Tennessee, and 8 of them died within a week of being vaccinated against diphtheria (given a liberal count here and not the conservative 8 deaths within a week), all that can be concluded is 1) “vaccines do damage to individuals.”

(40) 1979 Dr. Robert S. Mendelsohn, who was the National Medical Director of “Head Start,” a syndicated columnist who wrote “The People’s Doctor, and the chairman of the Medical Licensure Committee for the State of Illinois, Associate Professor at The University of Illinois, Chicago, and Medical Director of Chicago’s Michael Reese Hospital was quoted as saying: "My suspicion, which is shared by others in my profession, is that the nearly 10,000 SIDS deaths that occur in the United States each year are related to one or more of the vaccines that are routinely given children. The pertussis vaccine is the most likely villain, but it could also be one or more of the others"(See: Confessions of a medical heretic, Contemporary Books, 1997).

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(41) 1979 A 16-minute segment of 60 minutes with Mike Wallace about the adverse effects and propaganda of the 1976 swine flu campaign: Head of CDC program interviewed, GBS patient interviewed, and footage regarding the 1 soldier who died from marching is presented upon which the Federal Government launched its vaccine campaign to some 40 million American recipients.

http://salsa.democracyinaction.org/dia/track.jsp?v=2&c=7m92vldwbQaXdxDDVDGpp7Fc57K5CWw6
>

http://loveforlife.com.au/node/6636<http://salsa.democracyinaction.org/dia/track.jsp?v=2&c=%2BqlgrEBv4ZWhHApYUW1lBbFc57K5CWw6

The **EVALULATION** of this 60 minutes exposee on the 1976 swine flu hoax is referenced above in the 1976 entry and shows that vaccines 1) harm individuals, and 6) cause different diseases in humans than vaccines are supposed to immunize against.

(42) 1979 Ditchburn, Robert K.; Whooping Cough after stopping pertussis immunisation; British Medical Journal; 1979, 1, 1601-1603; 16, June 1979;

"Summary and Conclusions: An epidemic of whooping cough occurred in a rural practice in Shetland, containing 144 children under 16. Before July 1974, all children were immunised against pertussis, but after that date immunisation was stopped. ***Of the 134 children studied, 93 had been immunised. Sixty five*** *of the children developed whooping cough. The incidence of infections* ***was similar*** *in those who had and had not been immunised. The incidence was also similar in those born before and after July 1974. There* ***was not*** *evidence to support the routine use of pertussis immunisation in rural Shetland."*

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I have underlined this strange set of reasons because it is possible that the high rate of whooping-cough (65/93) among vaccinated children who developed whooping-cough after immunization, was due to the vaccine-which harmed each of these 65/93 children 1) , and which also possibly could have caused this small outbreak 3). Notice I haven't underlined "harm populations," however, despite the fact that whooping-cough can be a serious illness, and it is unknown outside of the 63 of 93 vaccinated children presented in this study, whether that proportion would be repeated in a vaccine program covering the general population-a figure that would amount to 68% of the entire vaccinated population coming down with whooping-cough.

(43) 1984 The Centers for Disease Control (CDC) reported a measles outbreak in a documented 100 percent vaccinated population. Morbidity and Mortality Weekly Report (MMRW) 33 (24),6/22/84.

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(44) 1985 (Development of Biological Standards, vol. 61, 1985, pp. 395-405): "Whooping cough and pertussis vaccine: a comparison of risks and benefits in Britain during the period 1968-83" "Since 1975, **acceptance** of pertussis vaccine has fallen from over 70% to 50% or less in most parts of Britain. This permits evaluation of a continuing **natural experiment** in which the frequency and severity of whooping cough can be compared [with] those of adverse events following injections of pertussis vaccine… **There is a significant correlation between vaccine-acceptance and hospital admission by**

district of residence… It is concluded that, in children living in **non-deprived circumstances** in Britain, the risk of pertussis vaccine [adverse events following injections of pertussis vaccine] during the period 1970-83 exceeded those of whooping cough. In some deprived sectors, the risks from whooping cough might have been marginally higher but there was no evidence that this was associated with any increase in deaths or permanent disabilities."

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(45) 1986 In 1986, **90% of 1,300** pertussis cases in Kansas were "adequately vaccinated." In Chicago, **72%** of pertussis cases were up-to-date with their vaccinations. Neil Miller, Vaccines: Are They Safe and Effective? p. 33.

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(46) 1988 In Clinical Investigative Medicine, (Vol. 11, no. 4, August 1988, pp. 304-9), it says that:

"17 had been vaccinated for measles. All 17 experienced measles again, showing IgM antibodies indicating acute infection. "A history of prior vaccination is not always associated with immunity nor with the presence of specific antibodies."

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(47) 1988 JAMA publishes a report claiming that a case-control study has shown that 41 percent of meningitis occurred in children vaccinated against the disease. The vaccine's protective efficacy was minus 58 percent. This means that children are much more likely to get the disease if they are vaccinated. (JAMA, 1988, Osterholm et al., 260: 1423-1428).

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above. 41% of children who are vaccinated get this deadly disease? This clearly designates 3) "small outbreaks/harms populations, and 1) "vaccines do damage to individuals."

(48) 1988 A serological survey performed on 573 subjects aged 3-80 years or older to evaluate presence of neutralizing antibodies for types 1,2,3 Sabin vaccines strains as well as a wild strain of poliovirus type 1 isolated in France reported that (Virologie. 1988 Oct-Dec;39(4):241-5):

"The results obtained indicate a satisfactory polio immunity level in all the 4 groups: seropositives, ***96.7%-98.9%*** *for type 2,* ***91.8%-98.2%*** *for type 1 (Sabin vaccine strain),* ***89.3%-96.6%*** *for type 3 and* ***84.2%-96.4%*** *for type 1 wild strain. The highest immunity levels were found in group* ***D*** *(children with recorded history of complete polio vaccination) and in group A (****unvaccinated people but contemporary with the past polio epidemics****). A special comment is made with respect to 14 subjects showing satisfactory antibody titres for all the three types of Sabin-vaccine strains but who have proved to be seronegative (less than 4) for the wild type 1 poliovirus strain."*

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(49) 1989 The country of Oman experienced a widespread polio outbreak six months after achieving a complete vaccination rate.

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(50) 1989- 2003 Explosion of autism in U.S. The incidence of autism (and other related disorders) **went from about 1 in 2,500 children to 1 in every 166.** Up until about 1989 pre-school children got only 3 vaccines (polio, DPT, MMR). By 1999 the CDC recommended a total of 22 vaccines to be given before children reach the 1st grade, including Hepatitis B, which is given to newborns within the first 24 hours of birth. Many of these vaccines contained mercury. In the 1990s approximately 40 million children were injected with mercury-containing vaccines. **The cumulative amount of mercury being given to children in this number of vaccines would be an amount 187 times the EPA daily exposure limit.**

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(51) 1990 The FDA grants Department of Defense waiver of Nuremberg Code for use of unapproved drugs and vaccines in Desert Shield.

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(52) 1991 210 REPORTED cases of hepatitis B vaccine injury from 1991 - 1998 in Illinois, and 5 deaths. Average cost for caring for damaged children for life is about 1,000,000 dollars=210 million dollars for families and insurance from a single vaccine.

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(53) 1992 The hepatitis B vaccine causes false positive "HIV" test results (Lee, D, Eby W, Molinaro, G. *"HIV false positivity after Hepatitis B vaccination."* Lancet 339: 1060, 1992).

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so-called "HIV/AIDS" patients according to many medical organizations currently. The stigma of an "HIV" positive test can and often does ruins a person's life from the moment a "positive" "HIV-test" is obtained.

(54) 1992 JM Fine, LC Chen "Confounding in studies of adverse reactions to vaccines," American Journal of Epidemiology, 136 (1992), pp. 121-35. Studies show that children die at a rate **eight times greater than normal** within three days of getting a DPT shot.

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(55) 1994 The Lancet publishes claims that "The incidence of asthma has been found to be five times more common in vaccinated children." -The Lancet, April, 1994.

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(56) 1994 Failure to reach the goal of measles elimination. **Apparent paradox** of measles infections **in immunized persons**. Mayo Vaccine Research Group, Archives of Int. Medicine 154(16):1815-20, 1994 Aug. 22. *"The apparent paradox is that as measles immunization rates rise to high levels in a population, measles becomes a disease of immunized persons."*

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(57) 1995 In Rev. Soc. Bras. Med. Trop., vol. 28, no. 4, Oct-Dec pp. 339-43, 1995, we read:

"The history of previous vaccination [in very early childhood] did not diminish the number of complications of the cases studied."

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(58) 1996 De Serres, Gaston, MD, MPH, Boulianne N., MSC, Duval, B. MD, Déry, P. MD, Rodrigquez, A. M., MD, Massé, R., MD, and Halperin, S. MD, *"Effectiveness of whole cell pertussis vaccine in child-care centers and schools,"* The Pediatric Infectious Disease Journal, 1996;15:519-524.*"**Despite the high rate of pertussis vaccine coverage** in children between the 2 and 9 years of age, **pertussis was a common illness in these preschool and school age children.** Although the whole cell vaccine was demonstrated to be effective, estimates of vaccine effectiveness were lower than the estimated in the United States and elsewhere. ... In those studies a different whole cell vaccine manufactured by Connaught Laboratories Inc. (Swiftwater, PA) had an efficacy of 48% in Sweden and 36% in Italy."*

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(59) 1996 872 serious adverse events reported to VAERS in children under 14 years of age who had been injected with hepatitis B vaccine. 48 children were reported to have died after they were injected with hepatitis B vaccine that same year. By contrast, in 1996 only 279 cases of hepatitis B disease were reported in children under age 14.

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/harm populations, **4)** are the reason that disease definitions are changed since

vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above.

(60) In 1996, The U.S. National Immunization Program, Centers for Disease Control and Prevention, (JAMA. 1996 Jun 5;275(21)):1639-45 reported that:

"In Houston, Texas, and in Detroit, Michigan, between 1990 to 1991, a total of 526 children aged 12 to 47 months seeking medical care were enrolled in the seroprevalence study; 144 children aged 12 to 35 months ***without a history of previous oral poliovirus vaccination*** *were enrolled. Seropositive rates were similar in children in both cities, ranging from about* ***80%*** *for types 1 and 3 in 12- to 23-month-old children to more than* ***90%*** *in those aged 36 to 47 months."*

"In children ***likely to have been unvaccinated****, seropositive rates ranged from* ***9% to 18%*** *for poliovirus types 1 and 3 and from* ***29% to 42%*** *for type 2;* ***secondary spread of vaccine virus*** *appeared to have occurred among children who had previously received 1 dose or less but not those with 2 or more doses."*

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(61) 1996 In 1996 only 54 cases of hepatitis B were reported in the 0-1 age group. There were 3.9 million births that year, so the observed incidence of hepatitis B in the 0-1 age group was just 0.001 %. VAERS received 1,080 total reports of adverse reactions from hepatitis B vaccine in 1996 in that same age group including 47 deaths. The hepatitis B vaccine actually caused more illness than the disease by a 20 to 1 ratio.

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(62) 1997 Polio is not eradicated by vaccination, but likely lurks behind a disease redefinition and new diagnostic names like viral or aseptic meningitis.....According to one of the 1997 issues of the MMWR, there are some 30,000 to 50,000 cases of viral meningitis per year in the United States alone. That's where it is thought that 30,000 - 50,000 cases of polio disappeared after the introduction of mass vaccination.

"Today, various other forms of the word "polio" are still used to describe the effects of poisoning, though usually with regard to paralysis in animals. A search of Medline ("polio" and "poison") finds about 45 contemporary articles where poisoning causality is attributed to polio. The terminology found was: "polioencephalomalacia", "poliomyelomalacia", "polyradiculoneuritis", "neurological picture similar to that of poliomyelitis", "polioencephalomyelomalacia", "lumbal poliomyelomalacia", "cerebrocortical necrosis (polioencephalomalacia)", "Lead poisoning in grey-headed fruit bats (Pteropus poliocephalus)", "multifocal-poliomyelomalacia", "spinal poliomalacia", "Polio and high-sulfate diets", "atypical porcine enterovirus encephalomyelitis: possible interraction between

enteroviruses and arsenicals", "polioencephalomalacia and photosensitization associated with kochia scoparia consumption in range cattle", "bovine polioencephalomalacia." Viral or aseptic meningitis, Guillaine Barre Syndrome (GBS), Chinese paralytic syndrome, chronic fatigue syndrome, epidemic cholera, cholera morbus, spinal meningitis, spinal apoplexy, inhibitory palsy, intermittent fever, famine fever, worm fever, bilious remittent fever, ergotism, ME, post-polio syndrome, acute flaccid paralysis (Jim West, Health and Research Publications).

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(63) 1997 Poland, Gregory A., "Still more questions on pertussis vaccines", The Lancet, November 29, 1997, Vol. 350, pp. 1564-1565. "*Despite sharply reducing severe pertussis and pertussis deaths, whole-cell vaccines have not stopped circulation of Bordetella in the population, do not induce sustained protective immunity, and are precluded from routine use as boosters in adolescents and adults because of their side-effects. In addition, questions about safety and efficacy remain."*

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(64) 1998 Data from France released at the 62nd Annual Meeting of the American College of Rheumatology, held November 8-12, 1998, in San Diego, California links immunization against hepatitis B to the development of autoimmune rheumatoid diseases such as lupus and rheumatoid arthritis. The rise of autoimmunity following hepatitis B immunization in school children and adults **has become a major public health concern**. In October, the Ministry of Health in France suspended routine hepatitis B immunization of school children while continuing hepatitis B immunization at birth. The reason for this decision was reportedly the increased risk of autoimmune diseases that has been associated with the vaccine when it is given starting at school age or later. The data from France links hepatitis B immunization to both the development of newly diagnosed cases of autoimmune rheumatoid diseases as well as the exacerbation of previously diagnosed cases that were in remission. This finding is supported by data from Canada published in September which linked immunization against hepatitis B to the development of autoimmune rheumatoid diseases in firefighters.

"The data from humans and animals is very clear, when you stimulate the immune system with vaccines you increase the risk of autoimmunity and exacerbate smoldering inflammatory conditions. Vaccine induced autoimmunity is a major public health problem because of the number of vaccine doses given and the large percentage of people with undiagnosed inflammatory conditions. We need to develop ways of giving vaccines without increasing the risk of autoimmune diseases" (Classen).

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(65) 1998 (Sept). Johns Hopkins Newsletter Nov. 1998 stated Alzheimer's incidence would quadruple in coming years. According to Hugh Fudenberg, MD (the world's leading immunogeneticist, author of nearly 850 papers in peer-reviewed journals):

"Individuals who have had five consecutive flu shots between 1970 and 1980 (years studied) have a ten times higher chance of getting Alzheimer's disease than if they had one, two or no shots… due to the mercury and aluminum in every flu shot. The gradual mercury and aluminum buildup in the brain causes cognitive dysfunction."

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(66) 1999 The Lancet Volume 353, Number 9150 30 January 1999 Risk of diphtheria among schoolchildren in the Russian Federation in relation to time since last vaccination:

"In 1993, the Russian Federation reported 15,229 cases of diphtheria, ***a 25-fold increase over the 603 cases reported in 1989****.1 The incidence rate among children 7-10 years of age (15·7 per 100000) was twice that of adults aged 18 years or over (7·9 per 100000).4* ***81%*** *of the affected children aged 7-10 years had been vaccinated with at least a primary series of diphtheria toxoid, and most had received the first booster recommended to be given 12 months after completion of the primary series."*

"So, it's pretty hard to ascribe low immunization rates as a cause for the outbreak of Diptheria. ***A much more likely explanation*** *is the social disruption that was going on at the time of great political upheaval. Breakdown of hygiene, poverty, etc."*

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(67) 1999 The Lancet, vol. 353, January 9, 1999, pp. 98-102):

" Subclinical measles occurred in 45 percent of **vaccinated** children exposed to natural measles."

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(68) 2001 (April) A number of studies have shown a link between the excessive mercury exposure due to vaccines and rising rates of autism in children (a report issued by the California Health and Human Services Agency revealed a 273 percent increase in California children diagnosed with autism in the past decade). One study noted: "A review of medical literature and US government data suggests that (i) many cases of idiopathic autism are induced by early mercury exposure from thimerosal; (ii) this type of autism represents an unrecognized mercurial syndrome; and (iii) genetic and non-genetic factors

establish a predisposition whereby thimerosal's adverse effects occur only in some children."Bernard, S. et al., Autism: A novel form of mercury poisoning, *Med Hypotheses* 2001 Apr;56(4):462-71.

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(69) 2001 Vaccine Adverse Event Reporting System Tables published by the CDC in MMWR show adverse reactions from various vaccines, with the universally mandated hepatitis B vaccine by itself (9,022 cases) topping the list for adverse reactions between 1991-1995, followed by FLU vaccine (4,696 cases). Between 1996-2001, Vericel tops the lists with 9,820 cases, followed by hepatitis B (9,022 cases), followed by FLU vaccine (8,125 cases).

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(70) 2001 VAERS data from January 1, 1990 to November 1, 2001 show that:
*Following the DTP shot **807** children died.*
*Following the DTaP shot **364** children died (acellular pertussis was adopted because of high reactions to live cell).*
*Following the hepatitis B shot **679** children died.*
*Following the haemophilus B shot **932** children died.*
*Following the poliovirus live oral vaccine **970** children died.*

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(71) 2002 Midwest Nurse Week, Vol. 3, No. 2; March/April 2002, p.27. Nursing Home Residents Get Flu Despite Flu Shot-A flu outbreak in Nebraska's urban area killed one nursing home resident. Nearly all of the residents received flu shots A similar outbreak at the Grand Island Veterans Home occurred **although 98% of the residents were given flu shot.**

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(72) 2002 Figures from the US Centers for Disease Control and Prevention showed there were 1,920 confirmed cases of polio reported by laboratories in 2002, up from 483 the previous year [**despite** universal vaccination].

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(73) 2002 British Medical Journal publishes article showing that: *"Children vaccinated in infancy are at increased risk of hepatitis B virus infection in the late teens" (Hilton Whittle, Shabbar Jaffar, Michael Wansbrough, Maimuna Mendy, Uga Dumpis, Andrew Collison, Andrew Hall. Observational study of vaccine efficacy 14 years after trial of hepatitis B vaccination in Gambian children.* (BMJ vol 325, 14 September, 2002).

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(74) 2003 Weeks after the announcement that the "HIV" vaccine, AIDSVAX, had failed, VaxGen (the makers of AIDSVAX) was hit with a shareholder lawsuit that accused the company's officials of continuing to make positive statements about their vaccine to artificially pump up the company's stock price, despite mounting evidence **that it was not effective.** The suit was dismissed last year and VaxGen, under new management, remade itself into a biodefense company, and is now supported with 877 million or our tax dollars to play with anthrax.

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(75) 2005 An "encephalitis vaccine" mandated by the CDC for collage-age (young adults) withdrawn for safety reasons (see FDA's 2005 recall list). Also see CDC's MMWR www.cdc.gov/mmwr/preview/mmwrhtml/mm5541a2.htm

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(76) 2005 Biodefense and Pandemic and Vaccine and Drug Development Act is passed by George Bush's Administration, largely mediated by Dr. Bill Frist by changing sentences buried in thousand-page-long documents hours before the huge documents are presented to officials in Congress for a vote. The Biodefense and Pandemic and Vaccine and Drug Development bill is a bill to amend the Public Health Service Act to enhance biodefense and pandemic preparedness activities, to use untested vaccines, drugs, medical products, or "security countermeasures." without any liability for claims for loss of property, personal injury, or death arising out of, reasonably relating to, or resulting from the design, development, clinical testing and investigation, manufacture, labeling, distribution, sale, purchase, donation, dispensing, prescribing, administration, or use of a security countermeasure or qualified pandemic or epidemic product distributed, sold, purchased, donated, dispensed, prescribed, administered, or used in anticipation of and preparation for, in defense against, or in response to, or recovery from an actual or potential public health emergency that is a designated security countermeasure or a qualified pandemic or epidemic product..." (http://thomas.loc.gov/ Search Bill Title or Number – S.1873RS click 'enter bill number).'

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above. Such legislation relieves pharmaceutical companies of liability from any of these possibilities because they know these phenomena occur yet the framers of this bill don't want to assume blame

(77) 2005 1,775 sera collected from three population samples within the Melbourne, Australia between 1990 and 1995 were tested for neutralizing antibody titres (amount of antibody measured in blood) against each poliovirus type. The results of this serosurvey (Aust N Z J Public Health, 2002 Oct; 26(5):432-6)) showed that:

*"In infants over three months and adults under 40 years, **76-100%** of people in each age group were seropositive to all poliovirus types, with **90-100%** seropositive to type I, **94-100%** seropositive to type II and **80-97%** seropositive to type III. Of the very small number of adults over 40 years tested (**n = 13**), **85%** were seropositive to each of types I and II, and **62%** to type III. **92%** of vaccination histories taken and checked were confirmed, **and reported immunization rates were significantly below seropositive rates**."*

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above. The fact that reported "immunity" rates (among populations in which antibodies can be detected **from either vaccination, or natural immunity**, which is not the same thing as vaccination rates) were ***significantly*** below seropositive rates in these and most studies of this kind, is very important. Although they don't say how significantly lower they were in this study, in many others it is clear that natural immunization and natural antibody production to various "viruses" are legion in most populations, while the rate of disease symptoms associated with seropositive subjects is always vanishingly low.

(78) 2006 Article appears in the New England Journal of Medicine confirming that "HIV" tests show positive results after recent flu vaccination in 2% of recipients. (Christian, P. Erickson,Todd McNiff, Jeffrey D. Klausner. Influenza Vaccination and False Positive HIV Results New England Journal of Medicine, Number 13, Volume 354:1422-1423, March 30, 2006).

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(79) 2006 (March) Chiron Recalls Nearly 5.5 Million Vaccine Doses. California-based biotechnology company Chiron Corp. announced Thursday that it's recalling and withdrawing almost 5.5 million doses of a measles, mumps and rubella vaccine distributed to developing countries and in Italy. The move was made because the vaccine caused a higher rate of such adverse effects such as fever, allergic reactions and glandular swelling than other similar vaccines, the Associated Press reported. The reactions occurred just after inoculation and do not indicate any long-term risk, according to Chiron, which described the recall and withdrawal as a precaution.

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above.

(80) 2006 (Sept 1) Polio reported on the rise in Nigeria Lagos, Nigeria **despite near-universal vaccination**. Nigerian authorities on Friday reported a sharp rise in the number of polio cases in Africa's most populous country over recent months, **despite** a government immunization drive.

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above.

(81) 2007Aidsmap NEWS, Keith Alcorn: *"Merck HIV vaccine fails, trials halted."*

*"Trials of the most promising HIV vaccine to date have been halted following news that the vaccine did not protect against HIV infection, according to a press release issued on Friday by developer Merck. The STEP study (HVTN 502, Merck V520 Protocol 023) was a multicenter, randomized, double-blind, placebo-controlled phase II test-of-concept clinical trial. The trial enrolled 3,000 HIV-negative volunteers from diverse backgrounds between 18 and 45 years of age **at high risk** of HIV infection."*

*"The vaccine did not prevent **infection**: in volunteers who received **at least one** dose of **the three-dose** vaccine series, **24** cases of HIV infection were observed in the **741** volunteers who received vaccine and **21** cases of HIV infection were observed in the **762** participants **in the placebo group**."*

*"In the subgroup who had received **at least two** vaccinations and who were HIV negative for at least the first **12 weeks** of the trial, **19** cases of HIV **infection** were observed in the **672** volunteers who received vaccine and **11** cases were observed in the **691** volunteers who received **placebo**."*

EVALUATION: 1) vaccines do damage to individuals, **2)** do nothing like a shot filled with water, **3)** cause small outbreaks/harm populations, **4)** are the reason that disease definitions are changed since vaccines do nothing to prevent diseases, **5)** can spread the disease vaccinated against to non-vaccinated people, **6)** cause different diseases in humans than vaccines are supposed to immunize against, **7)** none of the above. 1) is also underlined, "vaccines do damage to individuals," because "HIV" is considered by the Church of Modern Medicine to be a death sentence unless you are forced to take anti-retrovirals for life, which are the leading cause of mortality in so-called "HIV/AIDS" patients according to many medical organizations currently. The stigma of an "HIV" positive test can and often does ruins a person's life from the moment a "positive" "HIV-test" is obtained. There is no evidence that the 24 cases of "HIV-infection" cited in one arm of the STEP trial have anything to do with the vaccine, nor do the 19 cases in another arm have anything to do with the vaccine. The false positive testing rates were not explored.

Recent H1N1 Madness

Out ot the trash cans of The CDC:

CDC will not clarify different flu strains in diagnostic testing

Friday, October 2, 2009 Kenet, Missouri, Daily Dunlkin Democrat

The Centers for Disease Control and Prevention (CDC) recently informed the public that diagnostic testing for influenza will **not** clarify between the different strains of flu, including H1N1, in most cases.

Individuals having one or more of symptoms including, fever, cough, sore throat, runny or stuffy nose, body aches, headache, chills, fatigue, and sometimes diarrhea and vomiting, may have the flu, according to the CDC. The organization added that most individuals with 2009 H1N1 have had mild illnesses and have not needed medical care or antiviral drugs, which is also true of seasonal flu.

The CDC noted that most people with flu symptoms do not need a test for 2009 H1N1 because the test results usually do not change the treatment style for the illness.

Flu tests are available to detect the influenza virus and the most common are called "rapid influenza diagnostic tests," which can be used in an outpatient setting, according to the CDC. These tests can be used to provide results within 30 minutes or less, **but the ability of the tests to detect the flu can vary greatly**. Individuals receiving negative results on rapid tests may still have the flu, the CDC added.

Several more accurate and sensitive flu tests are available, but must be performed in specialized laboratories.

The CDC noted that the rapid tests **vary in the ability to detect the flu** and the ability can range from being **10 percent to 70 percent effective.** The organization added that the rapid tests have appeared to be better at detecting the flu in children as opposed to adults.

The CDC noted that **healthcare providers may diagnose individuals with the flu based on symptoms and their clinical judgment** without a influenza diagnostic test.

The CDC has provided the Interim Recommendations for Clinical Use of Influenza Diagnostic Tests During the 2009-2010 Influenza Season, which recommends that certain individuals receive the diagnostic testing including, people who are hospitalized with suspected flu and people, such as pregnant women, with weakened immune systems.

Individuals **may not be able** to find out definitely what strain of the flu virus they have contacted, according to the CDC. The current available rapid influenza diagnostic tests cannot distinguish between 2009 H1N1 and seasonal influenza A viruses.

The organization added that as of September 2009, more than 99 percent of circulating influenza viruses in the United States were 2009 H1N1. If a healthcare provider determines a diagnosis of flu, then the individual most likely has the 2009 H1N1. The CDC noted that as the season progresses, different influenza viruses may circulate.

Patrick White
Winnipeg — From Monday's Globe and Mail
Published on Sunday, Sep. 27, 2009 8:52PM EDT
Last updated on Wednesday, Sep. 30, 2009 1:44PM EDT

A “perplexing” Canadian study linking H1N1 to seasonal flu shots is throwing national influenza plans into disarray and testing public faith in the government agencies responsible for protecting the nation's health.

Distributed for peer review last week, the study confounded infectious-disease experts in suggesting that people vaccinated against seasonal flu **are twice as likely** to catch swine flu.

The paper is under peer review, and lead researchers Danuta Skowronski of the British Columbia Centre for Disease Control and Gaston De Serres of Laval University must stay mum until it's published.

Met with intense early skepticism both in Canada and abroad, the paper has since convinced several provincial health agencies to announce **hasty suspensions of seasonal flu vaccinations**, long-held fixtures of public-health planning.

“It has confused things very badly,” said Dr. Ethan Rubinstein, head of adult infectious diseases at the University of Manitoba. “And it has certainly cost us credibility from the public because of conflicting recommendations. Until last week, there had always been much encouragement to get the seasonal flu vaccine.”

On Sunday Quebec joined Alberta, Saskatchewan, Ontario and Nova Scotia in suspending seasonal flu shots for anyone under 65 years of age. Quebec's Health Ministry announced it would postpone vaccinations until January, clearing the autumn months for health professionals to focus on vaccinating against H1N1, which is expected to the more severe influenza strain this season.

“By the time the H1N1 wave is over, there will be ample time to vaccinate for seasonal flu,” Dr. Rubinstein said.

B.C. is expected to announce a similar suspension during a press conference Monday morning.

Other provinces, including Manitoba, are still pondering a response to the research.

New Brunswick is a lone hold-out, announcing last week it would forge ahead with seasonal flu shots for all residents in October, as originally planned.

So far, the study's impact is confined to Canada. Researchers in the U.S., Britain and Australia have not reported the same phenomenon. Marie-Paule Kieny, the World Health Organization's director of vaccine research, said last week the Canadian findings were an international anomaly and could constitute a “study bias.”

An international panel is currently scrutinizing the research data. “The review process has been expedited, so we're hoping for a response within days,” said Roy Wadia, spokesman for the B.C. Centre for Disease Control.

Dr. Rubinstein, who has read the study, said it appears sound.

“There are a large number of authors, all of them excellent and credible researchers,” he said. “And the sample size is very large – 12 or 13 million people taken from the central reporting systems in three provinces. The research is solid.”

The vaccine suspensions do not apply for people over 65. Seniors are considered more susceptible to severe seasonal flu symptoms. At the same time, they carry antibodies from a 1957 pandemic that seem to neutralize the current version of H1N1.

Even if the statistical link is proven, the medical link between seasonal flu shots and H1N1 remains mysterious. One hypothesis suggests seasonal flu vaccine preoccupies the cells that would otherwise produce antibodies against H1N1.

But, according to Dr. Rubinstein, the research shows that people who received the seasonal shot during the 2007-08 flu season remained vulnerable to swine flu well into 2009 – an interval that should provide most immune systems ample restoration time.

“We don't understand the mechanism,” Dr. Rubinstein said. “At the present time it is quite perplexing.”

Ground-Breaking Monkey Study: Mercury-Containing Hepatitis B Vaccine Causes Brain Damage

SafeMinds calls for moratorium on use of mercury-containing H1N1and seasonal influenza vaccine

September 30, 2009 - A study published today in Neurotoxicology, the leading scientific journal in its field, discovered brain damage in newborn monkeys given the Hepatitis B vaccine containing the mercury preservative thimerosal. The Centers for Disease Control (CDC) added this vaccine to the recommended immunization schedule for newborn babies in 1991. The vaccine caused a significant delay in the acquisition of key primate survival reflexes essential for life in the wild. Mercury is especially toxic to the developing brain and immune system.

Chronic neurological disorders, especially autism, have increased rapidly during the past two decades in association with increases in vaccines (from 10 to 36) and total mercury exposure. In July 1999, CDC, the American Academy of Pediatrics and vaccine companies agreed to remove mercury from all childhood vaccines "as soon as possible," but it still remains in 16 licenses vaccines, five of which are still given to infants. Contrary to its own recommendation, now a decade old, CDC is now recommending the H1N1 and seasonal flu vaccines for "high priority" groups of pregnant women and babies older than six months who could get four doses. While some doses will be available in single syringes without mercury for those who ask, most doses contain mercury and CDC has refused to state a preference for the mercury-free versions.

An elite interdisciplinary team of top scientists from across the country collaborated on the study, "Delayed Acquisition of Neonatal Reflexes in Newborn Primates Receiving a Thimerosal-Containing Hepatitis B Vaccine: Influence of Gestational Age and Birth Weight." The lead author, Dr. Laura Hewitson, oversaw the study, which was funded in part by SafeMinds. The animals were housed at the University of Pittsburgh School of Medicine. This study compared infant macaque monkeys vaccinated with the Hepatitis B vaccine containing the mercury preservative thimerosal with those who received a saline placebo and those who received no shots at all. The vaccine group showed significant delay in the acquisition of key survival reflexes. Neonatal responses in unexposed animals were not delayed.

This paper focuses on one part of a larger comprehensive research program investigating the safety of the entire human infant vaccine schedule by employing standard animal research protocols. The program is examining differences in developmental behaviors, brain, blood, GI tissues, the immune system, health status, pathology, and gene expression profiles between vaccinated and unvaccinated primates. Preliminary results of the wider program were presented at the International Meeting for Autism Research in London in May 2008. The presentation suggested evidence of widespread harm caused by the CDC-recommended vaccine schedule.

Despite the 1986 Mandate for Safer Childhood Vaccines, the Combating Autism Act efforts, and a recent unanimous recommendation in June from the National Vaccine Advisory Committee, the Government has refused to fund research comparing vaccinated versus unvaccinated humans or animals. Such a comparison is the only way to assess baseline health and vaccine-caused damage, and is absolutely necessary to fulfill our moral obligation to protect children by preventing vaccine-caused damage. Safety can be enhanced, for example, by removing the heavy metals, changes to the schedule, screening for susceptibility, reliance on anti-virals, separating the combination vaccines.

In the Hewitson study, the three key survival reflexes (root, snout, and suck) found to be delayed in the vaccinated animals are functions controlled by the brainstem, a crucial area especially susceptible to damage from mercury. "Many studies have reported that autistic children show damage in this brain region," noted Theresa Wrangham, president of SafeMinds.

The neurodevelopment delays were statistically significant without regard to birth weight and gestational age. However, further analysis of the impact of these factors demonstrated that more time in the womb and greater birth weight reduced the delay in survival reflex acquisition. "Smaller babies, premature babies and fetuses would thus appear to be especially at risk for mercury injuries," noted Ms. Wrangham.

This is the strongest direct evidence yet that mercury-containing vaccines may cause brain injury in human infants. Animal studies using primates are routinely employed to assess the safety profile of medicines. "Had this study been done as a pre-clinical trial, the FDA could have never licensed a mercury-containing Hepatitis B vaccine, nor could CDC have ever recommended one, at least for young children and infants," explained Ms. Wrangham. "We are especially alarmed because the seasonal influenza and swine flu vaccines contain mercury. We think pregnant women and young children should not be given mercury-containing medicines with such significant side effects."

The present study examined the impact of the first vaccine, Hepatitis B, and did not try to isolate the particular component responsible for causing harm. Although mercury is the most likely culprit because of its known toxicity to the brain and the immune system, other components such as aluminum may play a critical role. While there is more than sufficient evidence to eliminate all mercury now, further research will be required to validate the safety of the entire schedule and establish baseline data for necessary changes.

Controversy has raged for years over whether mercury received through vaccines is sufficient to cause harm to children. Virtually all studies absolving mercury-containing vaccines of safety deficiencies have been conducted by vaccine insiders with a stake in the outcome. The new primate study is important because it begins to fill a crucial gap in basic vaccine safety science, comparing the overall health status of those vaccinated versus those not unvaccinated. CDC claims there is "no convincing evidence of harm" that vaccines cause significant neurological damage or autism, and cites a number of studies claiming to exonerate mercury. "The studies they reference are all deeply flawed, and, as was the case with decades of 'tobacco epidemiology,' were deliberately manufactured to hide the truth," stated Jim Moody, director of SafeMinds.

In fact the Institute of Medicine, Congress, Health & Human Service's National Vaccine Advisory Committee, the American Academy of Pediatrics former President Dr. Lou Cooper, and former Director of the National Institutes of Health Dr. Bernadine Healy all agree that current research is inadequate to demonstrate vaccine safety, as required by law, especially in terms of risk for neurological damage, including autism, in a genetically susceptible subset of the population. Most have made statements in support of a study evaluating health outcomes in vaccinated compared with unvaccinated subjects.

This study adds substantially to the scientific evidence that mercury-containing vaccines given early in development may lead to increased risk of neurodevelopmental delays and possibly autism," stated Sallie Bernard, SafeMinds Executive Director. Data from CDC's Vaccine Safety Datalink first revealed an association between mercury and brain damage, but these findings were suppressed and the data were manipulated to exonerate thimerosal. This scientific manipulation was first revealed by SafeMinds through documents obtained under the Freedom of Information Act, leading to a best-selling book, Evidence of Harm, and to a published retraction of any "no cause" interpretation by the study's lead author Thomas Verstraeten (who by then had left CDC for a vaccine manufacturer, GlaxoSmithKline). The most recent study of VSD data by Young et al. made additional findings that vaccine mercury caused not only autism but several other neurodevelopmental disorders. Despite criticism from the

Institute of Medicine and Congress, CDC still refuses to grant access to VSD to private researchers and the Justice Department refuses to permit petitioners in Vaccine Court access to these crucial data.

Supporting the new Hewitson study, two recent epidemiological studies by Gallagher and Goodman at Stony Brook University Medical Center have demonstrated an association between mercury-containing Hepatitis B and a seven-fold increase in early interventionservices and twice the risk for autism.

In light of this new research, the Government must immediately fulfill its promise, now ten years old, to eliminate mercury from all vaccines. Pregnant women and infants are especially at risk for mercury injuries and must be warned against getting mercury-containing flu shots. CDC has listed pregnant women and infants older than 6 months as priority groups to receive the first shots, and children under 10 could get up to four mercury-containing shots. Yet supplies of single-dose influenza vaccines that do not contain mercury are readily available. "Giving mercury-containing flu vaccines to such vulnerable groups is medical insanity, especially when there are sufficient supplies of mercury-free shots," said Mr. Moody.

Please see the SafeMinds Science Summary for a list of animal and cell studies which have demonstrated the harmful effects of mercury. Review papers by SafeMinds founders have demonstrated that the symptoms of autism are a unique form of mercury poisoning and that vaccine-induced autism is a plausible hypothesis because the prevalence of autism increased rapidly along with a simultaneous sharp rise in vaccine mercury. Environmental mercury and other pollutants are on the rise, contributing to autism susceptibility. Mercury in vaccines is unnecessary and should not add to background pollution body burden in children.

CONCLUSIONS

We know so little about vaccines and their relationship to epidemics. There are certain principles that seem to emerge though, by examining this history, other than they don't work:

1. Epidemics caused by humans are predictable to the extent that vaccine campaigns and epidemics have been frequently associated. Evidence from the 1800's in the Lancet and from elsewhere shows that the medical profession of that era was aware of this alarming relationship, which is why they tried to stop compulsory vaccination as shown by the British Parliament outlawing the practice. In the 1900's, much evidence demonstrates that through proper nutrition, sanitation, adequate care of the sick, or lack of war or vaccination, that epidemics can be avoided, and common diseases vanquished. The positive examples that Dr. Tom Spies and others who helped erect our public health system without vaccination during and after the FDR era are numerous (De Kruif, 1949).

2. Vaccination began with a history of the infusion of lymph puss (cells), cellular materials, associated microbes, toxins, and other substances into the human body that are foreign. From a tissue grafting point of view, inoculation was practiced in Persia and elsewhere as an operation where the surface of the body was injured with needles or lancets, and foreign puss from "pox" or perhaps other eruptions similar to pox was made to have contact directly to the bloodstream (or mucus membranes of the nose- as in the case of the Chinese method of smallpox inoculation). This practice suggested moreover, that the smallpox of that era was not particularly frightening with respect to its virulence, although there are reports that natural epidemics carried off 50% of the population during small outbreaks (Crookshank, History and Pathology of Vaccination Vol 1, p 7). In this context, there was intense discussion regarding whether to use year-old puss (dried out from a previous bout of illness, versus obtaining material directly from an ill person). The application of aged versus fresh lymph from a pock probably made quite a difference in the severity of the inoculated disease. Pasteur's later findings with rabiesvirus are relevant to this claim in that he found that drying of neural tissue infected with highly virulent rabies for at least 10-12 days could attenuate the most virulent (8-day-lethal) strains of that virus and provide immunity in dogs.

3. In a real sense, inoculations, as well as vaccinations were and are a complex and dangerous medical procedure, not unlike blood transfusions or liver transplants, and should be regarded as such by the scientific and medical communities, as well as the general public. To exclude even more people from medical insurance and save our astronomical health care debt, on medical questionnaires, next to the box that asks if you have ever had a blood transfusion, organ transplant, or cancer, there should also be a box asking about what vaccines you have had. The infusion of foreign cells such as lymph early during the vaccine era is not unlike the early experiments that revealed graft versus host disease at the beginning of the 1900's. In graft versus host disease, foreign lymphocytes were infused into mice, and these foreign lymphocytes rejected the host's lymph nodes first. The Peyer's patches of the intestines were affected soon after the infusion, as were the cervical, axillary, and inguinal lymph nodes of the neck, arm-pit, and groin, followed by massive rejection of the recipient's tissues, followed by extreme morbidity and death in >50% of the recipients, depending upon their genetic background. In the context of vaccination, history suggests that it should never be forgotten that one is attempting to alter the entire immune system and its future responses to the universe of antigens. Although intact and living eukaryotic cells are no longer infused, their components are, and some of these components can evoke massive responses of the immune system.

4. Pasteur was challenged to give an anthrax vaccine demonstration that was very well documented before the Agricultural Society of Melun, at the farm of Pouilly-le-Fort. On Europe's most famous horse doctors, human doctors, animal breeders, senators, reporters from the San Francisco Chronicle and London Times, farmers, and scientists anxiously waited, and watched, as 24 out of 24 anthrax-

inoculated sheep grazed happily next to a row of 22 out of 24 dead ones, because the 22/24 dead ones weren't pre-vaccinated with Pasteur's anthrax vaccine before they were challenged with live anthrax. The promise of this experiment alone deserves support for continued intensive experimental research (on animals), but by no means signals the wholesale and wanton experimentation on humans at this point. These accomplishments remain intriguing for the experimentalists, but should not constitute carte blanche permission to try out in humans a medical procedure that may alter the entire immune system. A medical intervention such as vaccination, although usually harmless to most individuals, is extremely harmful to some groups of people, and in so doing, lacks a predictable outcome, not to mention a sound theoretical and empirical foundation. When ten million vaccinations are given, however, the so-called sensitive group(s) can amount to tens or even hundreds of thousands. With respect to the modern “HIV” vaccines and Luc Montagnier’s revelatory statement that he now sides with Pasteur’s rival Beauchamp, in that he believes one can acquire “HIV” many times and not get sick,” and that it is “the soil” as Beauchamp argued that determines illness and not “the seed” or germ, we should stop to re-evaluate our beliefs in the protective effects of any vaccine on populations.

5. Soldiers (young adults) have always been the best victims for vaccine experimentation, and war efforts have always been associated with epidemic disease, and in recent times, with mandatory vaccination and revaccination. Thus, the negotiating tongue, rather than the poisoned needle, would go far in preventing epidemics such as the 1918 "Spanish Flu," or “Gulf-War Syndrome.” Next in the hierarchy of human guinea pigs have been unsuspecting new parents, who would do anything authorities told them to do to protect their cherubs. Blacks, gay persons, and those groups deemed to be impoverished, inferior, prisoners, or handicapped, have also been extensively used as victims of vaccinology.

6. Similar problems have been associated with vaccines both before and after the molecular era. For instance, contamination has always been an issue. Early vaccinologists in the middle 1800's were afraid that diseases such as leprosy were transmitted through cuts caused by the vaccinator's lancet in regions of the world such as Hawaii, where lymph was derived from potentially leprosy-bearing peoples, and there is some evidence from the middle to late 1800's to support the idea that in some instances, smallpox vaccination caused outbreaks of both leprosy and syphilis, as well as out breaks of other diseases. Similarly, vaccinologists in the middle of the 1900's, were afraid that the Salk and Sabin vaccines were contaminated with SV40, the so-called simian virus that was shown to be capable of causing mesotheliomas, lymphomas, brain tumors, and other cancers in animals. During the "polio era" this fear accounted for published statements suggesting that "*The Soviets would lose the 1964 Olympics because their athletes would all have tumors thanks to SV40"* (Bookchin and Schumacker, 2004). Even in the 35 year post-polio vaccine mortality studies, initiated because a so called potent cancer-causing virus, SV-40 was inoculated into millions of people, along with the polio virus, has not been long enough to determine if SV-40 is contributing to escalating cancer rates. Indeed, the thirty-five year mortality study on people now in middle age following receipt of SV40-simian-(cancer) virus-contaminated polio vaccine showed that out of 1073 newborns that were vaccinated and carefully followed for 35 years, (which the authors claim is not really long enough) between 1959 and 1963, there was no apparent increase in cancer above the expected background incidences in this carefully followed subgroup (Carroll-Pankhurst et al., British Journal of Cancer 85 (9) 1295-1297, 2001), although others would contest this claim and argue that the polio vaccine has contributed greatly to certain cancer rates, such as lymph cancers.

7. Among the acellular or molecular vaccines, the fear is finally beginning to emerge that the effects of contaminants such as adjuvants like squalene used by vaccinologists to bolster the non-specific immune response can cause autoimmune diseases with high frequency. Yet, these adjuvants are thought to be necessary in modern vaccinology, because it is clear that the molecularly designed vaccines or highly purified components of antigens seldom can be shown to evoke an adequate, or any, immune response

on their own, probably because the antigens are too pure, too fragmentary, or they are non-immunogenic because of faulty isolation (as demonstrated by the more than 60 or more so-called "HIV" trails that have completely failed), or too denatured because of harsh reagents used to isolate or purify the various pathogens or their parts, or because the immune system doesn't really work the way the textbooks say it does (or the way Jenner hypothesized that it does-that a single or even multiple exposures of a foreign substance, organism, or molecular epitope will protect for life). The frequent tetanus vaccines foisted on us at hospitals every few years, despite the fact we constantly are cutting ourselves, or the failure of the hepatitis B vaccine to prevent rather than promote the syndrome in Gambian teenagers, and the increase in polio and smallpox rather than their abatement following near universal vaccination campaigns are all good examples why Mr. Jenner's hypothesis is not applicable in practice.

8. So-called epidemic diseases have historically been, and continue to be, a hodge-podge of various syndromes and symptoms lumped together under a single name or disease entity.

9. Vaccinology has always been fraught with politics and financial interests. Despite the fact that inoculation was outlawed by the British Parliament in 1840, in 1853 The Compulsory Vaccination Act in England was passed by Parliament and every parent was required to have their baby vaccinated within 3 months of birth or face a fine of 20 shillings. In modern times, we face similar threats that our children won't be admitted to school unless they are jabbed with the hepatitis B vaccine (a rare syndrome) and whose safety data we have yet to see. The school nurse and Public Health Department, or school admittance policies should not threaten you to believe that you cannot enroll your kid, based on the madness surrounding the possibility that your 5-year-old will transmit a sexual, or needle-borne, or blood-product-transmitted "syndrome" that has a 99% or greater spontaneous resolution rate in otherwise healthy individuals, to someone else's 5 year old, (when they have sex or shoot heroin in the gym locker-room, or if they share razor blades-are the reasons typically given to support mandatory vaccination) as the pharmaceutical company and Public Health Service logic goes. Currently, parents are being threatened that their daughters have a 70% chance of acquiring cervical cancer if they test "HPV" positive, unless they fork over $300.00 dollars for a series of 3 HPV shots. More frightening and more egregious, and as the co-founder of the National Vaccine Information Center recently wrote:

"There is no question that, right now, the fear and hysteria that is being whipped up by politicians and public health officials about bioterrorism in the aftermath of September 11 is paving the way for a serious threat to informed consent to vaccination. The passage of oppressive Emergency Health Powers Acts in the states will allow public health officials to use the state militia to arrest, quarantine and forcibly medicate and vaccinate citizens without their consent. It gives unprecedented power to public health officials who, in some states, will not even have to have a state of emergency declared by the Governor in order to detain and forcibly vaccinate whole families without a court order if they so choose. It is the most serious threat to civil liberties since the Constitution was written..."(Barbara Loe Fisher, co-founder of the National Vaccine Information Center (NVIC).

10. Regarding conflicts of interests and fear-mongering, is it ethical or for the good, that VaxGen, and similar Challenger-sized disasters, be awarded an $877.5 million contract from our tax money to produce and manufacture a new Anthrax vaccine (potentially loaded with squalene or other adjuvants), against a rare disease that Pasteur with his 2 lab technicians and his somewhat limited resources successfully immunized ungulates against over 100 years ago? In this regard, since 9/11, there has been much discussion and even Hollywood movies made regarding the destructive potential of technological achievements such as box-cutters, but little discussion for some reason regarding the source and destructive potential of the weaponized anthrax derived from Utah's Dugway Proving Ground "found" in the mail of Tom Brokaw and Senator Daschl shortly before the Homeland security vote in the Senate. This could have been a new chapter in the History of Vaccine timeline, but wasn't.

11. You shouldn't permit your dogs or cats to get booster vaccinations or according to many veterinarians, any vaccines, because of the induction of some 160,000 cancers/ year in cats, and a huge disease burdon that vaccines cause in dogs, but it is probably alright to permit your healthy infant or child to obtain 22 of them (according to the current schedule) before they leave home. Although it should be stressed that the Pankhurst et al. 35 years study of post-vaccinated infants who received the SV-40-contaminated vaccine has apparently not increased cancer in these humans, according to her report, although other scientists, like Michele Carbone in Hawaii, and Australian researchers have found the SV-40 sequences in many cancers. such controversy, however, doesn't diminish the findings of the Veterinary societies' findings of various antibodies against normal molecules such as laminin and fibronectin in vaccinated animals harboring a plethora of diseases including cancers.

12. Perhaps the newest idea to hit the Internet, since the information is censored by the mainstream scientific community and not yet published in peer-reviewed journals, is the idea that foreign proteins, adjuvants, and other irritants cause what have been referred to as "ministrokes," or micro-ischemic episodes. Vaccine induced over-responses of immune cells do to vaccines and adjuvants cause ischemia in M.S., Alzheimers, arthritis, demyelination syndromes, autism spectrum disorders, and after vaccination(s). The principle advocate of this idea is a neurologist and child behavioral analyst, Andrew Moulden and his interesting ideas can be found in an interview of him at:

http://vactruth.com/2009/07/21/dr-andrew-moulden-interview-what-you-were-never-told-about-vaccines/

His ideas are very plausible. From his non-invasive and impressive collection of brain-imaging studies, Moulden essentially argues that irritants such as foreign proteins, adjuvants such as squalene or aluminum, and cellular debris stimulate an over-response of macrophages, which clog up tissue capillaries, rendering them anoxic or ischemic, which lead to a host of different diseases. His hypothesis doesn't however, account for why there is a range of reactions to vaccines, from redness and swelling at the injection site, to full-blown autism, or as he claims, such diseases as MS. With modern brain and body non-invasive scanning technologies, he claims to see ischemia in disparate syndromes widely assumed to be cause by different agents or processes. He sees ischemia in demyelination syndromes, MS, Parkinson's ,Alzheimers, autism, arthritis, and others, and he sums up all of these processes to macrophages clogging up capillaries. One thing should be made clear, however, that might escape those who haven't engineered tissues when he refers to vaccines causing "mini-strokes" versus ischemia.

Strokes are different that ischemia or ischemic tissue. Strokes, considered medically or clinically, are sudden losses of blood flow to an important tissue or region of the body-most easily visualized in neural tissue, leading to the familiar loss of function that is manifest as a sagging lip, face, or arm or leg, due to the fact that innervation to that region has been blocked because the neurons innervating it have died due to ischemia or anoxia.

Now ischemia, which is Moulden's real claim as the principal mechanism of vaccine damage, is being detected by his imaging machines in a number of different contexts. He claims to detect it in autism, Alzheimer's and in a variety of other contexts. He has detected it particularly intensively in MS. These are data I haven't seen (because I suspect he can't get them published), but I will suspend my disbelief in his favor until I do see them. Let's for a moment assume he sees these ischemic tissues under all these conditions?

It is assumed as the underlying principle of immunology that when foreign substances or artificial immune stimulants like squalene are injected into a recipient's blood stream, that those substances stimulate an "immune response." Indeed a bee sting, spider bite, or snake bite, mosquito bite, or vaccine will all cause "swelling and pain and burning" at the bite or injection site. So far so good. These responses are mediated by

immediate mechanisms of self-versus non-self INHERENT IN THAT TISSUE WHERE THE SUBSTANCE IS PERFUSED, and the responses can be broken down at the cellular level in different regions of the body by the presence of certain steryotypic cell populations that are recruited at the irritant's site of entry, which again, may very depending on the route of entry (where the poison is injected).

The immediate response of most tissues (not all) is invariably the same: the body walls off the poison or toxin because of the very breakdown of the homeostatic scaffolding mechanisms that are in place but not active during normal, non-ruptured conditions. When you cut yourself with a knife (for example), the blood vessels are broken open and the platelets, normally not coagulative when exposed to normal endothelium, become "activated" by touching almost anything other than laminin or endothelial cells, and the region becomes "blocked off" or walled off due to the formation of a clot. This in effect begins the ischemic response. In the hours and days following the insult, cells begin to make matrix, and a fibrotic response follows. This contributes even more in most cases to ischemia, but normally is self-limiting. Eventually, the macrophages will be accumulated near and around the ischemic zone, and will begin to secrete NO, various enzymes such as colllagenase, and matrix matalloproteases, and "remodeling" will begin. Various cells will dump a toxin VEGF (vascular endothelial growth factor) which is a hypoxic response (due to a lack of O2) which in turn recruits new capillary endothelial cells which then migrate, just like metastastizing tumor cells, through tissue and re-establish a circulation.

The process can be over the course of days, but in special (very special) tissues, it can occur in hours. Such special tissues (like a penis) are somewhat different: when engorged with blood they act as marvelous machines and become able to defy gravity itself, but, as the Viagra commercial correctly says, "if you have an erection lasting more than 4 hours, go see your [lady/man] doctor (to get relief from her/him somehow)? The “relief” for the problem will not be “given” the way you might think! It is widely held that the engorged vessels in the Viagra-recalcitrant erection that continue un-naturally to remain engorged also cause ischemia as there is little circulation as the blood engorges the millions of little sacks which fill with blood when blood pressure is lowered (from the viagra), and in about 4 hours, the wonderful reproductive organ would begin to turn black and fall off due to gangrene. Therefore heightened blood pressure must be restored as quickly as possible, in order to get flow going again, and O2 to the tissue within the penis. (I just love physiology, and pharmaceuticals don't you)?

Back to Moulden and his new hypothesis regarding ischemia. He is essentially correct, if his scans show what he says they show. If an adjuvant is given for instance, an artificial stimulation of the non-specific immune responses of T-cells will continue to occur long after the normal, front-line mechanisms would have normally "self-limited" the response of a ruptured tissue. Moulden is right about that...while showing or claiming no data of his own, this is the very reason adjuvants are used since Freund's first adjuvants were first employed in vaccinology decades ago (and before Freund's was discontinued because it caused such morbidity in vaccines and was replaced by things such as aluminum as Mouldan also discusses correctly). Adjuvants are irritants. Therefore, it is entirely possible, that before we even consider the effects of foreign proteins (such as "HIV's “capsid protein,” P24, and their effects on the immune response), we must consider how adjuvants, bee sting venom, snake venom, mosquito toxin, and the proteins in vaccines all can hijack the normal process of tissue healing after an assault.

In the recent STEP trial, GP120 was used, another so-called "HIV-specific protein, and it caused only 19 out of more than 700 men in one trial, and 22 men or so out of 700 in another trial, to test "HIV" positive, which the trial investigators chalked up to the experimentally vaccinated men's wild sexual behavior after being vaccinated, without even stopping to consider the absurdity of this claim. In all arms of the trial, the control (placebo) vaccinated had ever so slightly less sero-conversion than the experimentals, but the differences in seroconversion were not in any way statistically significant, similar to the preceding 62 failed “HIV” trails on humans. In other words, all positive signals in both control and experimental groups following experimental and placebo vaccinations, even given in booster series, was due to testing artifact. If you look at similar

seroconversion-survey data (which are presented numerous times in the Timeline you just read), you will see seroconversion rates with the feces-derived polio extracts in the region of 90%+ rates of seroconversion for "strain A" and 89% for "strain B" and 80 or so% for "strain C" in multiple trials done in many countries. This is because something, I won't say a killed virus, but 3 non-self molecular components (strains A,B,C, or chemicals A,B,C,) don't belong in the vaccine recipients bloodstreams naturally, and therefore over the course of weeks, most of the vaccinated will exhibit seroconversion to the foreign molecules in the ill-defined, feces-derived gamish injected into them. This is why "HIV" is not exogenous or an exogenous virus, and vaccinology is the greatest experiment with the greatest N-numbers to prove the validity of this assertion.

Look at it this way: somebody said to Peter Duesberg once that if his stupid idea that "HIV" is harmless is to believed, he should inject himself with it and prove it to the world. Well, he did't have to. The promoters of AIDS did it for him. In fact they did it no less than 64 times in different vaccine trials by my count, and haven't demonstrated seroconversion in any what would be significant numbers of experimentally-vaccinated recipients. This is why "the probable cause of "HIV" is a retroid."

Sorry for the digression. Back to Moulden. Now what happens to the body over the weeks after "strain A, B, and C" are introduced. First, the longer these molecules are in the body, and away from the proximal assault during which they are first introduced (the snake bite, vaccine, etc.) the less we understand. But in clear studies such as Andrew Wakefield's on MMR, and molecular mimicry studies done by Gary and Asa with squalene and the antibodies it generated in Gulf -War Vets WHO BECAME ILL, and in Barbara Loe Fisher's studies of molecular mimicry regarding demylination, and in the 160,000 cats/year that develop tumors at their injection sites, and also Yarkoni and Raff's work with mineral oil and squalene being able to "reject" tumors in 12/13 tumor-inoculated hamsters, and the ability of Coley's toxins to cause rejection of cancer in approximately half of more than 800 patients he chronicled who were inoperable, end-stage cancer patients, we find a wealth of information that can help resolve the long-term effects of foreign molecules artificially placed in the human body.

In all of these cases, be it demyelination, tumor formation, tumor rejection, and auto-immune disease induction, ischemia plays a decidedly important role, either in combination with extracellular matrix formation or dissolution, which is a process that occurs over weeks. In other words, the long-term effects of all of these irritants have an important association in the way they either stimulate the long-term "seroconversion"-associated mechanisms to resist matrix or promote an imbalance of matrix production, away from that which is normally present during the hours and days following the initial assault by FOREIGN molecules. All of these processes probably involve ischemia.

With vascuogenic mimicry as a case in point, and as we discovered that malignant tumors erect their own perfusion channels I called vasculogenic mimicry channels, the rules of normal tissue homeostasis are obviated from those principles of homeostasis seen in normal wound and tissue repair contexts, but, the matrix or biofilm-encased cell clusters of malignant tumor cells still acquire "perfusion," and clearance of their waste products, otherwise, like Viagra-treated penises, the tissue would become necrotic, and the cancer in this case would be cured. We rarely see necrosis in melanomas containing vasculogenic mimicry channels, and when we do (in about 8% of them), there typically are huge immune responses occurring (presence of macrophages in the channels-again consistent with Moulden's idea). We know that these tumor cells can grow without significant or at times, any measureable levels of O2, and all that they appear to need is oxygen poor blood plasma to carry in nutrients and carry out waste products, but that is because these channels are tiny (less than the diameter of red blood cells-most of them are a micron or two in diameter) and the malignant cells acquire the ability like anaerobic bacteria, to switch to glycolytic metabolism so they still acquire their electron transport chain-dependent ATP and GTP molecules in order to grow and function as living cells.

In the 160,000 vaccinated cats/year that will develop tumors at their injection sites, the long-term "seroconversion" process is perhaps revealed most clearly. The foreign substances injected (the irritants) become walled off at the injection site and interfere with fibronectin and laminin production, disrupting the balance of these "gas" and "break" molecules of all tissue growth, and they become walled off, and begin a poorly understood process of characteristic ischemic responses amidst or surrounded by the body's successful attempts at normal tissue repair, which includes angiogenesis. This is why you can inject the tumor implanted in a mouse with a drug or dye, and that dye will "flush" through the entire mouse within a second. At the same time the tumor tissue is ischemic and walled off, the channels provide a direct hook-up to the organism's normal perfusion system, and the injected substance rapidly is disseminated throughout the circulation. But there is ischemia in place despite the readily measured perfusion-a kind of microischemia due to the matrix, that functions to derail the normal tissue healing process, indefinitely.

Similarly in the dogs that develop tumors at their injection sites, or arthritis or demyelination syndromes, or other autoimmune diseases after vaccination (as recently reported by the Italians), each of these processes involves what probably will eventually be understood and referred to now as molecular mimicry-but this molecular mimicry, instead of simply tricking the immune system to attack foreign molecules and one's own foreign-molecule-similar tissues (myelin) alike, one needs to incorporate how long-term mechanisms such as matrix dynamics serves to impede or accelerate the normal process of tissue repair. In many of these syndromes, however, ischemia will be detected-in arthritic joints, in myelin sheaths that are normally highly vascularized, in Chrone's disease where the normal diverticula are no longer perfused normally, in MS, in autistic children, whose unifying characteristic is the gut/brain axis, due perhaps to the body being tricked into attacking foreign food molecules or anything consumed by the infant following or immediately before vaccination, when their intestines are highly permeable due to their age and the food they eat isn't prohibited from directly entering the blood, and sometimes the brain directly, as shown by Wakefield.

In theory, vaccines could cause one of three outcomes to occur: 1) protection from foreign disease agents, or when disease occurs from these agents, it is in a milder form, 2) no protection from disease agents, as evidenced by numerous trials of 100% vaccinated populations that acquire the disease they were vaccinated against anyway, as shown in Texas, Kansas, and elsewhere with MMR vaccine campaigns, as if water or saline were injected (and like water the vaccine does no harm, or 3) when they cause harm to a small or even not so small proportion of the vaccinated, they spread the disease agent and create epidemics, as is what happened perhaps most clearly with the Cutter incident, and many, many other vaccine crusades as is outlined in this How to predict epidemics timeline. Perhaps the most confusing issue here is the fact that vaccines do no harm, like most mosquito bites, or as if water were injected, into millions of people. This is a fact, and federal authorities, and even former heads of the NIH and Red Cross like Bernadine Healy and the IOM are coming out with statements regarding “susceptible individuals” which of course are always related to genetics, or the fact that the victims of vaccination are “freaks” of some kind. But the rare damage due to vaccination (160,000 cats of out millions which are jabbed for instance, or in the case of GBS in the 1976 “swine flu” vaccine, need not be due to the fact that the severely damaged individuals are genetic freaks of some kind.

The "punnet square" of wound-healing possibilities is limited, given all these variables, and broken down into only perhaps 100-1000 different tissue repair disease states that fill medical textbooks, while yet new ones and no combinations may continue to occur as long as the organism, and species, aren't extinct, especially where the immune system is so heavily involved in the process.

Immunology began, if you recall, with Mechnikoff's great discovery, whereby he jabbed star fish and other marine creatures with splinters of wood, where he then observed the macrophages coming to "eat" the spliters, via a process he called, "phagocytosis."

Then others, like Coley, explored toxins in cancer patients, creating the field of tumor immunology at the end of last Century, where he demonstrated that the noxious poisons of two bacterial species, when injected into tumors and around them, if they cause fever, then 1/2 the tumors are rejected "for life" because he and his daughter did a 90 year follow-up on those patients. Mayo Clinic also used his toxins as did many throughout the world successfully, until in 1962 the American Cancer Association came out with their grandfather clause statement, that non-proven remedies did not hold grandfather protection rights and must be banned, banishing Coley's toxins to the quack list of unproven remedies.

There have been many other examples in the history of biomedial research that support the idea that tissue repair or the induction of cancer or autoimmune diseases an extremely multifactorial process involving thousands of variables-none of which need to be genetic in nature, but may be biomechanical or immunological in nature. With the first descriptions of something resembling Graft Versus Host Disease induced rodents subjected to foreign lymphocyte infusions during the first decades of the last Century signaled that it is not only possible, but probable, that when foreign lymphocytes or proteins of one strain of animals is placed into another strain and they begin to "reject" first the lymph nodes of the recipient host, beginning with and including the Peyer's patches in the gut, the inguinals and axillaries, thymus and spleen, and then if death ensues in approximately 50% of the recipients, it may begin to become clear that foreign substances are more harmful to populations, than we have been taught to believe. The following reports all indicate that even in 100% vaccinated populations, the disease vaccinated against occurs anyway:

Journal of Infectious Diseases, vol. 179, April 1999; 915-923. *"Temporal trends in the population structure of bordetella pertussis during 1949-1996 in a highly vaccinated population:*

"Despite the introduction of large-scale pertussis vaccination in 1953 and high vaccination coverage, pertussis is still an endemic disease in The Netherlands, with epidemic outbreaks occurring every 3-5 years." One factor that might contribute to this is the ability of pertussis strains to adapt to vaccine-induced immunity, causing new strains of pertussis to re-emerge in this well-vaccinated population.

"The epidemiology of pertussis in the Republic of Ireland" (Communicable Disease Report[:] CDR Review, vol. 2, no. 3, February 28, 1992, pp. R31-3): Following adverse publicity in 1973, uptake of the vaccine fell to 30% in 1976. In recent years, it has leveled out at only 40-45%. Yet when large epidemics of pertussis occurred in 1985 and 1989, mortality from pertussis fell to almost negligible levels.

"Severity of whooping cough in England before and after the decline in pertussis immunisation" (Archives of Disease in Childhood, vol. 59, no. 2, February 1984, pp. 162-5): "Since the decline of pertussis immunisation, hospital admission and death rates from whooping cough have fallen unexpectedly… The severity of attacks and the complication rates in children [who were] admitted to hospital were virtually unchanged."

O. Tonz and S. Bajc, *"Convulsions or status epilepticus in 11 infants after pertussis vaccination"* (Schweiz. Med. Wochenschr., vol. 110, no. 51, December 20, 1980, pp. 1965-71):

"In three of 11 cases, grand mal epilepsy persisted and two children developed infantile epileptic encephalopathy (Lennox Syndrome). "The following conclusions are drawn from these observations: 1) In view of the usually benign course of whooping cough today, current vaccination is hardly satisfactory. Improvement of the available vaccines is an urgent necessity… 2) Parents should be better informed about the risks involved in pertussis vaccination. 3) Booster inoculations should be

abandoned. 4) Health authorities should decide whether the current pertussis vaccination program should be abandoned. 5) Complications following vaccination should be registered….."

"Whooping cough and pertussis vaccine: a comparison of risks and benefits in Britain during the period 1968-83" (Development of Biological Standards, vol. 61, 1985, pp. 395-405): "Since 1975, acceptance of pertussis vaccine has fallen from over 70% to 50% or less in most parts of Britain. This permits evaluation of a continuing natural experiment in which the frequency and severity of whooping cough can be compared [with] those of adverse events following injections of pertussis vaccine… There is a significant correlation between vaccine-acceptance and hospital admission by district of residence… It is concluded that, in children living in non-deprived circumstances in Britain, the risk of pertussis vaccine during the period 1970-83 exceeded those of whooping cough. In some deprived sectors, the risks from whooping cough might have been marginally higher but there was no evidence that this was associated with any increase in deaths or permanent disabilities."

"Vaccination against whooping-cough. Efficacy versus risks" (The Lancet, vol. 1, January 29, 1977, pp. 234-7): Calculations based on the mortality of whooping-cough before 1957 predict accurately the subsequent decline and the present low mortality… Incidence [is] unaffected either by small-scale vaccination beginning about 1948 or by nationwide vaccination beginning in 1957… No protection is demonstrable in infants."

Bassili WR, Stewart GT. Epidemiological evaluation of immunisation and other factors in the control of whooping-cough. Lancet 1976 Feb 28;1(7957):471-4

"The general incidence of whooping-cough is lower in fully immunised children, but present immunisation schedules do not adequately protect the infant below 1 year of age either from contracting infection or from its complications. In a recent outbreak in Glasgow, ***nearly one-third of notified cases were fully immunised****. In Glasgow and probably in the U.K. as a whole, the persistance of whooping-cough in some areas is more strongly correlated with adverse socio-economic conditions than with lack of immunisation. The decline in recent years could be attributable to improvement in these conditions at least as much as to immunisation. There is no epidemiological justification for continuing mass immunisation, but there is a strong case for an intensified eradication policy which might include selective immunisation in high-risk groups and areas."*

Stewart, GT; *"Immunisation against whooping cough;"* British Medical Journal, 31 January 1976; letters:

"Sir: In showing that 75% of infants below 3 months of age with whooping cough were admitted to hospital and that 42% of all hospital admissions of children notified as whooping cough were infants or 5 months or younger, Drs. Christina L. Miller and W.B, Fletcher (17 January, p 117) have indeed confirmed the widely-held belief that :in young infants whooping cough is still dangerous". They have not shown that "at all ages previous vaccination reduced the severity of the disease." What they have shown is that, among notified cases, a significantly higher proportion of the more severe cases and of those admitted to hospital were not immunised or were incompletely immunised. This does not mean that immunisation is necessarily protective. ***Of 8092 cases notified to them, 2940 (36%) were fully immunised while only 2424(30%) were definitely not immunised.***

In the same issue (p128) Dr. ND Noah claims that "current vaccines provide young children with substantial protection against whooping cough". What he actually shows, in a single tabulation of notifications uncorrected for age, is that the incidence of whooping cough is lower in immunised than in non-immunised children. But the rate of notified infection was still relatively high (50 per 100,000) in

1974 in children fully immunised with the new vaccine. There is no evidence in either article that immunisation of older children protects younger ones.

Several questions arise:

What kind of immunisation is this for which success is being claimed? It is an immunisation which leaves those at highest risk (that is, below 6 months of age) unprotected and which, even when complete, is associated only with partial protection of those in the lowest risk groups.

What kind of epidemiology is this which advocates immunisation by excluding consideration of factors other than immunisation? It is admitted in both articles and is indeed obvious from the data that factors other than immunisation must influence susceptibility to whooping cough. If immunisation is to be tested for efficacy, the data must be standardised for domestic, demographic and social factors.

Whooping cough is much lower in incidence, hospital admissions are less frequent, and immunisation schedules are often better maintained in districts where socioeconomic conditions are favourable. Thereported association between protection and immunisation could be an expression of better social conditions and child care as much as of biological protection by pertussis vaccine.

What kind of editorial policy is this which publishes incomplete data and promotes far-reaching claims about the efficacy of immunisation but refuses to publish collateral data questioning this efficacy?

Paradoxically, the articles by Drs. Miller and Fletcher and Dr. Noah reinforce the suggestion made in my letter in your issue of 10 January (p 93) that evidence about the efficacy of pertussis vaccine is lacking. But the question remains."

Ditchburn, Robert K.; *"Whooping Cough after stopping pertussis immunisation;"* British Medical Journal; 1979, 1, 1601-1603; 16, June 1979;

Summary and Conclusions: *"An epidemic of whooping cough occurred in a rural practice in Shetland, containing 144 children under 16. Before July 1974, all children were immunised against pertussis, but after that date immunisation was stopped.* ***Of the 134 children studied, 93 had been immunised. Sixty five*** *of the children developed whooping cough. The incidence of infections* ***was similar*** *in those who had and had not been immunised. The incidence was also similar in those born before and after July 1974. There* ***was not*** *evidence to support the routine use of pertussis immunisation in rural Shetland."*

Tomaszunas-Blaszczyk J Zaklad ["*Pertussis in 1997"*]. Epidemiologii Panstwowego, Zakladu Higieny, Warszawa. Przegl Epidemiol 1999;53(1-2):23-32 [Article in Polish]

"*In 1997 an epidemic increase of pertussis was observed in Poland. The incidence was* ***5.4/100,000*** *population and was* ***more than six times higher*** *than in the preceding year. No clear reason for a sudden increase in pertussis incidence was found, in particular the vaccination coverage rates* ***have remained high****. In December 1997 the DTP vaccine coverage rate for children below two with four doses of DTP was* ***97.5%.*** *The distribution of cases according to age during the last 20 years was analysed and it was shown that since the beginning of the '90 a growing proportion of cases* ***occurs among fully vaccinated children*** *and the average age of the cases has a steadily growing tendency. A hypothesis was put forward that the come-back of pertussis is presently due to waning of short-term immunity following immunisation, in cohorts of children who grew up in conditions of very low B. pertussis natural transmission. An open question remains whether to introduce to the immunisation calendar an additional booster dose of pertussis vaccine in school-aged children." PMID: 10402846, UI: 99331257*

D. C. Christie, et al., *"The 1993 Epidemic of Pertussis in Cincinnati: Resurgence of Disease in a Highly Immunized Population of Children,"* New England Journal of Medicine (July 7, 1994), pp. 16-20:

MMWR November 05, 1993 / 42(43);840-841,847 Diphtheria Outbreak -- Russian Federation, 1990-1993:

*"**Despite** high levels of vaccination coverage against diphtheria, an ongoing outbreak of diphtheria has affected parts of the Russian Federation since 1990 (1); as of August 31, 1993, 12,865 cases had been reported. This report summarizes epidemiologic information about this outbreak for January 1990-August 1993, and is based on reports from public health officials in the Russian Federation."*

Within the report is also says: *"an estimated **90%** of children were fully vaccinated with four or more doses of diphtheria toxoid by the time they entered school.*
*"*URL: http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00022128.htm

The Lancet Volume 353, Number 9150 30 January 1999. "Risk of diphtheria among schoolchildren in the Russian Federation in relation to time since last vaccination:"

Quote:
"*In 1993, the Russian Federation reported 15,229 cases of diphtheria, a 25-fold increase over the 603 cases reported in 1989.1 The incidence rate among children 7-10 years of age (15·7 per 100000) was twice that of adults aged 18 years or over (7·9 per 100000).4 **81%** of the affected children aged 7-10 years had been vaccinated with at least a primary series of diphtheria toxoid, and most had received the first booster recommended to be given 12 months after completion of the primary series."*

"*So, it's pretty hard to ascribe low immunization rates as a cause for the outbreak of Diptheria. A much more likely explanation is the social disruption that was going on at the time of great political upheaval. Breakdown of hygiene, poverty, etc."*

de Melker HE, et al. *" Pertussis in The Netherlands: an outbreak despite high levels of immunization with whole-cell vaccine."* Emerg Infect Dis. 1997 Apr-Jun;3(2):175-8. PMID: 9204299; UI: 97348248.

Shimoni, Zvi; Dobrousin, Anatoly; Cohen, Jonathan; et al. "Tetanus in an Immunised Patient" British Medical Journal Online (10/16/99) Vol. 319, No. 7216, P. 1049;

"Israeli researchers present the case of a 34-year-old construction worker who was hospitalized after having a reported epileptic fit and experiencing flu-like symptoms. The patient had a low-grade fever, but was alert and coherent. Any attempts to speak or get up on the second day resulted in attacks of risus sardonicus, opisthotonus, and trismus. The patient was diagnosed with tetanus and given 2000 U of human tetanus immunoglobulin. Further treatment was provided, and after 15 days, the patient had stopped taking diazepam and ventilatory support was withdrawn. The man had been fully immunized against tetanus, and had received booster shots five and two years before being hospitalized. Antitetanus immunization has shown to be very successful, and the researchers note that it is exceedingly rare--about four cases per 100 million immunocompetent vaccinated people--for tetanus to develop after being vaccinated."

Kirchner, Jeffrey T., *"Manifestations of Pertussis in Immunized Children and Adults",* American Family Physician, November 1, 1999, Vol. 60, p. 2150:

"Recent epidemiologic studies have shown that the incidence and prevalence of Bordetella pertussis infection in adults are much greater that previously reported. In studies of adults with chronic cough, 20 to 25 percent were found to have serologic evidence of recent B. pertussis infection.

However, pertussis is rarely considered in adults because the signs and symptoms are nonspecific."

Bykowski, M., *"Pertussis in Adults."* OB GYN News, November 1, 1999, Vol. 34, p. 29:

*"It was **formerly believed*** (The Jennerian Paradigm-**my addition**) *that infection or immunization conferred lifetime immunity, but **now appears** that any resultant immunity is in fact short lived. Thus, there is a growing interest in **the selective reimmunization** of adults, he said. And while pertussis was once considered uncommon in adults and older adolescents, it's now believed that the disease is endemic in these populations, who actually serve as the primary reservoir for pertussis, explained Dr. Ogle, professor of pediatrics at the University of Colorado, Denver. Studies from throughout the developed world suggest a 25%-30% of persistent coughing illness in these age groups is pertussis, he added."*

Poland, Gregory A., *"Still more questions on pertussis vaccines."* The Lancet, November 29, 1997, Vol. 350, pp. 1564-1565

"Despite sharply reducing severe pertussis and pertussis deaths, whole-cell vaccines have not stopped circulation of Bordetella in the population, do not induce sustained protective immunity, and are precluded from routine use as boosters in adolescents and adults because of their side-effects. In addition, questions about safety and efficacy remain."

De Serres, Gaston, MD, MPH, Boulianne N., MSC, Duval, B. MD, Déry, P. MD, Rodrigquez, A. M., MD, Massé, R., MD, and Halperin, S. MD, *"Effectiveness of whole cell pertussis vaccine in child-care centers and schools."* The Pediatric Infectious Disease Journal, 1996;15:519-524

"Despite the high rate of pertussis vaccine coverage in children between the 2 and 9 years of age, pertussis was a common illness in these preschool and school age children. Although the whole cell vaccine was demonstrated to be effective, estimates of vaccine effectiveness were lower than the estimated in the United States and elsewhere. ... In those studies a different whole cell vaccine manufactured by Connaught Laboratories Inc. (Swiftwater, PA) had an efficacy of 48% in Sweden and 36% in Italy."

Cherry, James D., MD, Brunell, Philip A. MD, Golden, Gerald A., MD, and Karzon, David T., MD. *"Report of the Task Force on Pertussis and Pertussis Immunization - 1988"*, Pediatrics, June 1988, Volume 81, Number 6, Part 2, Supplement, p. 955

"Reported cases and outbreaks in older children and young adults may reflect a less durable vaccine-induced protection than seen in natural disease. The duration of protection has varied in several studies, depending on the epidemiological setting, ie, prevalence of natural disease as well as the vaccine product used. A study in Michigan showed an efficacy of 80% 3 years after the last dose, 50% between 4 and 7 years, and virtually none after 12 years. Breakthrough disease noted in this study was usually mild."