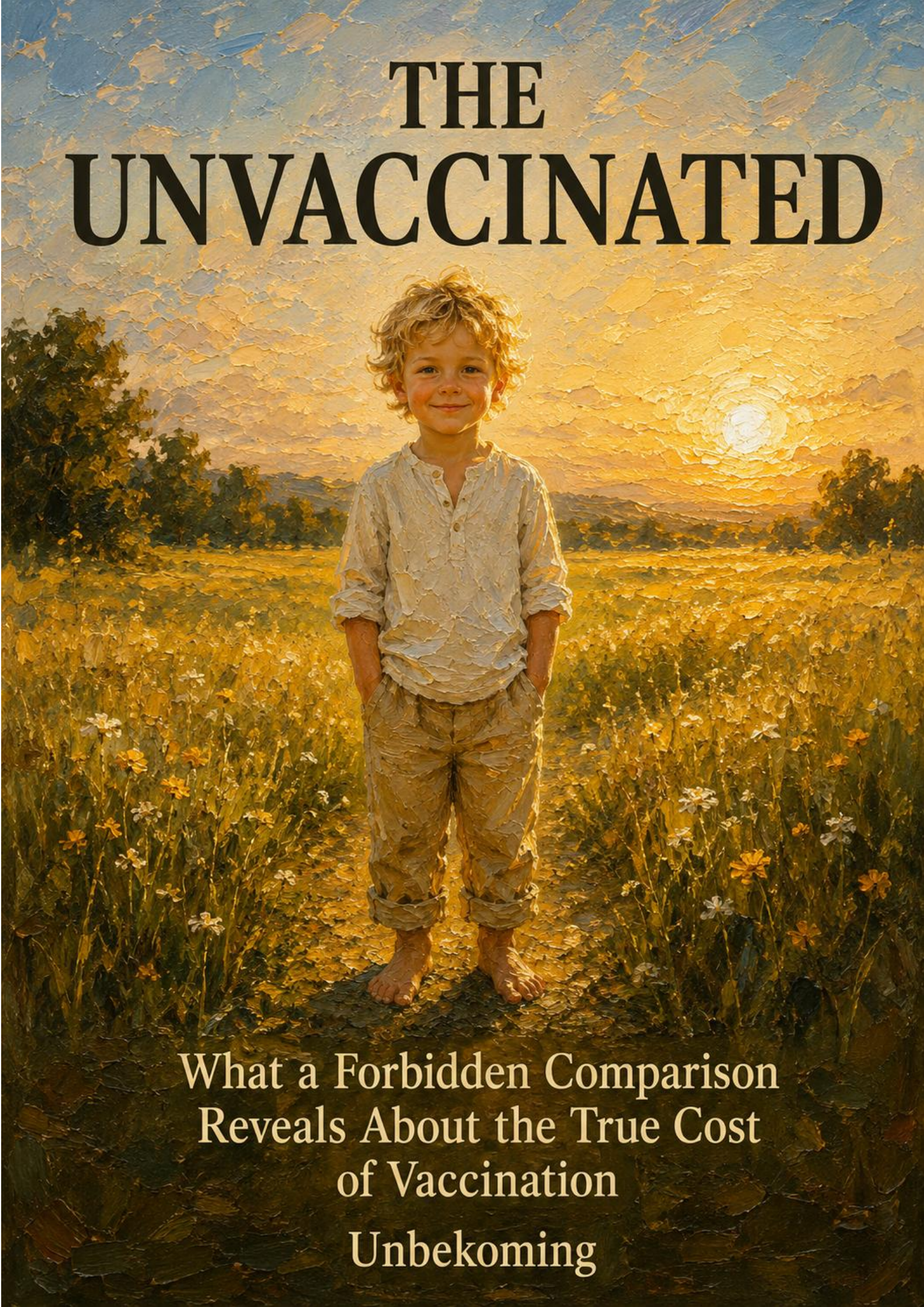
THE UNVACCINATED



What a Forbidden Comparison Reveals About the True Cost of Vaccination

Unbekoming

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Introduction

One comparison would settle most of what is argued about childhood vaccination, and it has never been carried out. Take a large group of children given the full schedule. Take a comparable group given none of it. Follow both for years, across every measure of health that matters — the chronic conditions, the developmental disorders, the allergies, the rates of ordinary thriving. The design is not difficult, the groups exist, and the question is the most important one in pediatric medicine. The study has not been done. The reason offered is that withholding the schedule from a control group would be unethical.

The comparison exists anyway. It was never assembled deliberately, which is the only reason it survives. Across the United States there are children who received nothing — no vitamin K injection, no maternal injections during pregnancy, none of the schedule that follows — and their health has been documented. Joy Garner's Control Group Survey gathered that data across forty-eight states and found a rate of chronic conditions among the completely unexposed of 2.64 percent. The general population, almost entirely exposed to the schedule, carries chronic conditions at roughly 60 percent. The comparison that medicine declares unethical to run has run itself, and the result is the subject of this book.

Two responses are available once those numbers are on the table. The first is to insist the unexposed group is unrepresentative, self-selected, too healthy to begin with — the standard objection, and one the survey's scale and consistency make difficult to sustain. The second is to take the figures seriously and ask what they mean. If the baseline rate of chronic illness in children left alone is a small fraction of the rate we have been taught to accept as normal, then the difference is not natural, not genetic, and not inevitable. It was produced. Something was done to the 60 percent that was not done to the 2.64 percent, and the most obvious candidate is the one the unexposed group is defined by not receiving.

What this book documents

Most of these pages make that case in detail, and on the establishment's own ground. They set out what is actually in the injections — the metal adjuvants that accumulate in tissue and do not clear, the surfactants chosen for their ability to open the barrier that protects the brain, the preservatives and process residues, the foreign biological material, and the manufacturers' own admission that none of it has been evaluated for cancer-causing or mutation-causing potential. The legal architecture is traced from 1986, when the ordinary discipline of liability was lifted from a single product category and the schedule began its climb from a handful of doses to dozens. The financial machinery is laid bare, down to the arrangements that pay a physician to reach a vaccination threshold and erase the bonus of any practice that falls short. And the dropped history is recovered: that the great killers of the past, the conditions medicine classifies as infectious, had already retreated by ninety-five to ninety-eight percent before the relevant injections arrived, falling alongside diseases for which no injection was ever made, as clean water and adequate food did the work later credited to the syringe.

That case is thorough, it is sourced, and it holds. A reader who goes no further than the safety argument will already have more than enough reason to question everything they were told was settled. But the safety argument, taken alone, leaves something standing — and it is the thing that matters most.

The concession made before the argument begins

Almost everyone who fights vaccination fights it on safety. They argue that the products are dangerous, that the trials were rigged, that the injuries are real and denied. These arguments are correct. But they are conducted inside an assumption that neither side examines: that the diseases being vaccinated against are caused by transmissible particles — viruses — that pass from the sick to the well, and that a properly made product could, in principle, defend against them. Grant that assumption and the entire argument becomes a dispute about the dose. You are left conceding that there is a real enemy and a real defence, and quarrelling only about whether the defence does more harm than good.

I should be plain about something here, because the book itself makes it unavoidable. Many of the articles collected in these pages were written by people who accepted that assumption when they wrote them, and in several places they were written by me, before I had done the deeper work. The safety points in them are sound. I stand by them, and I have left them as they were rather than rewrite history to make myself look as though I always saw the whole picture. There is a value in that honesty beyond candour. A case against vaccination strong enough to persuade people who still believed in viruses, who accepted contagion without question, who had every conventional assumption intact — that case did not need the deeper argument to land. It landed on the establishment's own terms. That is how strong the safety evidence is.

But persuading someone within the frame is not the same as freeing them from it. The frame is where the deeper corruption lives, and it is time, for everyone still working in this space, to do that part of the work.

Virology is the problem that vaccination solves

The particle that virology calls a virus has never been taken from a sick person, separated from everything else, purified, characterised, and shown to cause the illness in a healthy host under controlled conditions. The tests that find it amplify constructed sequences and return positives in people with no symptoms at all. And the belief at the bottom of all of it — that the sick make the well sick by passing something between them — has been put to the most rigorous experimental test available, repeatedly, by people trying to prove it, and has failed. The deficiency diseases that once looked exactly like epidemics — scurvy, beriberi, pellagra — turned out to be caused by what people lacked, not by anything that passed among them. Shared deprivation produces the appearance of contagion without any contagion taking place.

This is not a tangent from the vaccine question. It is the foundation the vaccine question rests on, and it is rotten. Vaccination is the product sold to solve the problem that virology invented. With no virus ever demonstrated and no route of spread ever shown, vaccination has nothing left to defend against. The injuries it produces no longer sit on one side of a trade against protection from something worse, because there is no something worse that was ever shown to exist. What the schedule delivers into an infant becomes pure toxic insult, administered against a phantom, with nothing on the other side of the ledger. Both halves of the structure — the disease that justifies the product, and the product that answers the disease — are corrupt, and they hold each other up.

I have made the full case for this in my book *No Virus*, and the executive summary of it, with the experiments and the sources, is set out in the final appendix here. I am

not asking any reader to accept it in this introduction. I am asking them to notice that the question exists, and that the people who have built careers and movements around vaccine safety have, for the most part, declined to ask it — because asking it means giving up the shared ground on which the safety debate is fought, and standing instead on terrain that the entire profession denies.

What the unvaccinated prove

The unvaccinated are not a fortunate minority who gambled and won. They are a population that was not subjected, from the first hours of life, to a sequence of toxic insults justified by a danger that was never established. Their health is not luck. It is what the body does when it is left in good terrain — nourished, unburdened, and not injected — and allowed to do the work it does on its own. The 2.64 percent is not a remarkable achievement. It is the ordinary condition of a body that was let alone, and the only reason it looks remarkable is that we have been trained to mistake the managed chronic illness of the other 60 percent for normal.

That is what makes this population so threatening to the structure built around them, and why the comparison that would confirm it is declared unethical rather than simply conducted. The unvaccinated are the evidence that the thing we were told was natural was done to us. The pages that follow document how it was done, on the establishment's own terms and then beneath them. A reader can stop at the safety case and have lost their illusions about the schedule. A reader willing to go further will find that the floor under the safety case gives way too, and that what is revealed beneath it is larger than vaccination, and older, and still standing.

The Unvaccinated: Proof of What We Lost

An Essay

1. The First Betrayal

The midwife's words hang in the delivery room air like a casual afterthought: "We'll just give baby the vitamin K shot now." Just a vitamin. Nothing more than what you'd find in your morning orange juice. The language itself is the first deception - calling a synthetic blood-clotting agent manufactured by Pfizer's subsidiary Hospira a "vitamin" transforms an industrial pharmaceutical intervention into something as wholesome as sunshine.

In those first raw hours after birth, when parents are overwhelmed by the miracle of new life, the medical system strikes with practiced precision. The entire infrastructure - from the delivery nurse to the pediatrician, from the hospital protocols to the documentation systems - has been calibrated for this moment. Every medical professional in that room has been trained, not in the science of whether a newborn needs synthetic phytonadione, but in the art of securing compliance.

They've learned to frame it as routine, to present it as universal, to make refusal seem like dangerous eccentricity.

Murphy's father, one of the few who came prepared, discovered what awaits those who dare say no. After his daughter was delivered using vacuum extraction five times - creating a visible blood-filled sac on her head - the red-shirted pediatrician entered within three minutes. Not to examine the baby. Not to celebrate the birth. But to begin the assault. When Murphy's father cited the Australian Paediatric Surveillance Unit study showing only six deaths from vitamin K deficiency bleeding in five million babies over 25 years, with none occurring in hospital births where vitamin K was refused, the doctor didn't engage with the data. Instead, he turned to the mother: "Do you feel differently?"

The pattern revealed itself through escalation. First the doctor. Then the nurse lecturing about irresponsibility. Then the NICU admission - not for medical necessity, but for "monitoring" a baby whose parents had refused the injection. Then the failed attempts to insert cannulas, the repeated heel pricks for blood tests. Strange behavior for medical professionals who claim the baby cannot clot blood properly. If she truly couldn't clot, why were they so eager to make her bleed?

The ingredients tell their own story. In one milliliter of this "vitamin," there are 70 milligrams of polyoxyl 35 castor oil - a known irritant that causes skin, eye, and respiratory irritation according to the NIH's own safety data. There are 37.5 milligrams of dextrose monohydrate and 9 milligrams of benzyl alcohol, which the manufacturer admits has "no evidence" it doesn't cause toxicity - not because they've proven it safe, but because they've never looked. The actual vitamin K? Just 2 milligrams. The "inactive" ingredients outweigh the "active" one by a factor of 39.5 to 1.

This elaborate performance isn't about preventing bleeding. Natural vitamin K levels are low at birth because they're meant to be low. Evolution didn't make a mistake that Pfizer needs to correct. The rise to normal levels happens naturally over eight days - which is why Jewish and Muslim traditions wait until day eight for circumcision. The entire vitamin K narrative exists to solve a problem created by another unnecessary intervention: immediate circumcision for the 80.5% of American baby boys whose foreskins will be harvested and sold to cosmetic companies.

Sixty percent of babies develop jaundice after receiving their vitamin K shot. The medical establishment calls this "idiopathic" - of unknown origin - while the product insert plainly states that synthetic vitamin K causes jaundice and hyperbilirubinemia. They inject the cause, observe the effect, and declare it a mystery.

The Control Group Survey found that exposure to just the vitamin K shot alone, without any vaccines, increased a child's risk of developing at least one chronic condition from 2.64% to 11.73% - a 344% increase. When combined with maternal vaccines during pregnancy, that risk jumps to 30%. Yet parents are told it's "just a vitamin," as harmless as a prenatal supplement.

The genius of starting with vitamin K is that it establishes the precedent. Once parents have agreed to that first injection, once they've surrendered their newborn's bodily sovereignty in those vulnerable first hours, the pattern is set. The baby has been enrolled in the system. The medical records will forever show "vitamin K administered," marking this child as one who receives injections. The psychological

barrier has been broken. If you said yes to the first one, why would you say no to the rest?

Those who refuse face the full weight of institutional pressure. Police have knocked on doors in Illinois because parents declined the vitamin K shot. Child Protective Services has been weaponized as a threat. Parents are told their babies will die, that they're irresponsible, that they're endangering their child. All for refusing an injection that even the manufacturer admits hasn't been studied for carcinogenic or mutagenic effects, or for its impact on fertility.

The first hours after birth are a carefully orchestrated vulnerability. Parents are exhausted, emotional, overwhelmed. They're in an unfamiliar environment, surrounded by medical authority. They've just been through one of life's most intense experiences. And in that moment of maximum vulnerability, when they should be bonding with their newborn, the system demands its first tribute.

This is where the battle for your child's health is won or lost. Not at the two-month vaccines. Not at the MMR. But in those first moments when someone in scrubs approaches with a syringe and says it's "just a vitamin." Because once you've said yes to injecting your hours-old baby with synthetic chemicals that have never been tested for cancer, mutation, or fertility effects, you've already agreed that strangers in white coats have more authority over your child's body than you do.

The parents who successfully refuse have done their homework months in advance. They've printed the safety data sheets. They've read the product inserts. They've studied the actual rates of vitamin K deficiency bleeding. They've prepared their responses to each wave of pressure. They know they're not preventing a epidemic of bleeding babies - they're refusing to participate in a ritual of submission that marks their child as property of the medical system from the moment of birth.

2. The Baseline They Don't Want You to See

Joy Lucette Garner's Control Group Survey achieved what the CDC, FDA, and NIH have steadfastly refused to do for decades: establish what human health looks like without pharmaceutical intervention. Working with data from unvaccinated Americans across 48 states, she documented a reality so stark it threatens the entire foundation of modern pediatrics. Only 5.97% of completely unvaccinated adults had any chronic condition. The general population, 99.74% vaccine-exposed, suffers at a rate of 60%.

The numbers become more disturbing with each level of analysis. Among those with zero exposures - no vaccines, no vitamin K shot, no maternal vaccines during pregnancy - only 2.64% reported any disorders or disease conditions. This is the true baseline of human health. Not the 60% chronic disease rate we've been told is normal. Not the 27% of children with chronic conditions that we've been trained to accept. But 2.64%.

The statistical certainty of these findings defies dismissal. With a 99% confidence level and an error margin of less than 0.04%, the survey calculated overwhelming odds that vaccines are responsible for over 90% of disabling chronic conditions in adults. The number is so large it requires scientific notation: 1 in 2.45 x 10^62. To put this in perspective, physicists accept the existence of theoretical particles at "five sigma" - a 1 in 3.5 million chance of error. The Control Group's findings exceed this gold standard by a margin that makes the word "certainty" seem inadequate.

In the Vaxxed 2 documentary, the unvaccinated children tell their own story. They don't interrupt. They don't fidget. They make eye contact. They speak clearly. Parent after parent describes the same pattern: children who rarely get sick, and when they do, recover quickly. No chronic ear infections requiring tubes. No endless rounds of antibiotics. No learning disabilities. No allergies requiring EpiPens. No ADHD medications. No autism therapies. They simply grow, learn, and thrive.

The Australian Paediatric Surveillance Unit study that Murphy's father cited reveals another layer of this truth. Across five million babies over 25 years, there were six deaths from vitamin K deficiency bleeding. Three of those six had received the vitamin K shot. All six suffered intracranial hemorrhaging - nearly always fatal regardless of vitamin K status. Not a single baby born in a hospital who didn't receive vitamin K died. The baseline risk approaches zero, yet every newborn is treated as if they're hemorrhaging internally from the moment of birth.

When Sweden discontinued pertussis vaccination from 1979 to 1996 due to safety and efficacy concerns, the predicted catastrophe never materialized. No surge in deaths. No epidemic of whooping cough mortality. The baseline held steady. Similarly, when Leicester, England's vaccination rates plummeted from 95% to 10% in 1885 after citizens revolted against mandatory vaccination, smallpox mortality continued its decline. The disease "never reared its head again" despite authorities warning that everyone would die without vaccination.

Dr. Paul Thomas MD pediatric practice provided a natural experiment in real-time. His vaxxed versus unvaxxed data showed his unvaccinated patients had dramatically lower rates of office visits, ear infections, breathing issues, behavioral problems, and ADHD. When he published this data with Dr. James Lyons-Weiler, the Oregon Medical Board didn't dispute his findings. They suspended his license anyway. The message was clear: documenting the baseline is professionally dangerous.

The financial implications explain the suppression. If only 2.64% of children developed chronic conditions instead of 27%, the pediatric business model collapses. No more well-baby visits every few months for vaccine administration. No more managing childhood chronic diseases that shouldn't exist. No more ADHD medications, autism therapies, allergy treatments, or autoimmune protocols. The entire structure of pediatric medicine as it currently exists depends on that elevated baseline of chronic illness.

The Vaccine Adverse Event Reporting System (VAERS) adds another dimension to this picture. A Harvard Pilgrim Healthcare study found that fewer than 1% of vaccine adverse events are reported to VAERS. Yet even with 99% underreporting, VAERS contains millions of injury reports. The Vaccine Injury Compensation Program has paid out over $4.9 billion in damages despite requiring families to fight for years through a special court system designed to deny claims. These payouts represent perhaps 1% of 1% of actual injuries - the visible tip of an immense iceberg of harm.

Anthony Fauci himself, in a January 2023 paper, admitted what critics have argued for decades: "After more than 60 years of experience with influenza vaccines, very little improvement in vaccine prevention of infection has been noted." He acknowledged that none of the predominantly mucosal respiratory viruses has ever been effectively controlled by vaccines. These admissions, buried in scientific journals, never reach the pediatrician's office where parents are told vaccines are "safe and effective."

The childhood vaccine schedule expanded dramatically after the 1986 National Childhood Vaccine Injury Act granted manufacturers complete liability protection. A child born in 1962 received 5 doses of vaccine antigens. By 1983, it was 24 doses. Today, it's 73 doses by age 18, with 26 doses in the first year alone. This escalation correlates precisely with the explosion in childhood chronic disease, developmental disorders, and autism rates that began in the late 1980s.

Roman Bystrianyk's analysis of historical data reveals the ultimate baseline truth: 95-98% of the mortality decline for all major infectious diseases occurred before vaccines were introduced. Measles, scarlet fever, whooping cough, and diphtheria were all declining at the same rate, regardless of whether vaccines were eventually developed for them. The baseline improvement came from sanitation, nutrition, clean water, and better living conditions - not from injecting children with aluminum adjuvants and formaldehyde.

The unvaccinated aren't dying from preventable diseases. They're thriving with prevented chronic conditions. Their existence proves that the 60% chronic disease rate in adults and 27% rate in children isn't natural, inevitable, or genetic. It's iatrogenic - caused by medical intervention. The baseline of human health is extraordinary vitality, not managed chronic illness.

Every unvaccinated child is living evidence of what was stolen from the rest of their generation. Every healthy, vibrant, unmedicated child who rarely sees a doctor represents what all children could be if we stopped poisoning them from their first hours of life. They are the control group in an experiment so vast and devastating that those running it cannot allow the results to be seen.

This is why studies comparing vaccinated to unvaccinated children are declared "unethical." Not because it would deprive children of protection, but because it would reveal the crime. The baseline exists. It's been documented. It shows that we've traded temporary, mild childhood infections that conferred lifetime immunity for permanent chronic diseases that generate lifetime customers.

3. The Architecture of Deception

The manipulation begins with the charts. When the CDC presents measles mortality data, they start their graphs at 1939 and use a logarithmic scale. This visual trick compresses the bottom of the scale, making the tiny decline after the 1963 vaccine introduction appear dramatic. Show the same data on a standard chart starting from 1900, and the truth emerges: measles mortality had already fallen by 98% before the vaccine existed. The vaccine arrived to claim credit for a victory already won by soap, sewers, and sufficient food.

This isn't incompetence. It's architecture. Every element of the vaccine narrative has been deliberately engineered to obscure reality while maintaining the appearance of scientific rigor. The corruption of placebos represents perhaps the most elegant deception. In vaccine trials, the "placebo" is another vaccine or an aluminum adjuvant - the very substance suspected of causing harm. When both groups suffer similar injuries, the vaccine is declared safe. It's like comparing cigarettes to cigars and concluding cigarettes don't cause cancer because both groups developed lung disease.

Katherine Watt's excavation of the legal framework reveals how deep the architecture goes. The system wasn't built through random accumulation of policies. It was constructed through decades of deliberate legislation, each piece fitting into a larger

design. The 1969 law establishing the chemical and biological warfare program introduced the terms "protective," "prophylactic," and "defensive" - linguistic camouflage for weapons development. The 1986 liability protection for vaccine manufacturers. The 1997-98 transfer of biological weapons from DOD to HHS classification. The 2001 Authorization for Use of Military Force creating permanent emergency conditions. Each law builds on the previous, creating an edifice of legal protection for what Watt identifies as a military operation disguised as public health.

The financial architecture operates through cascading coercion. The Bank for International Settlements controls access to the financial system. Compliance flows downward: federal funding contingent on vaccine uptake, state funding tied to federal compliance, hospital systems financially rewarded for meeting vaccination targets, individual doctors receiving bonuses for fully vaccinated patient populations. Blue Cross Blue Shield pays pediatricians $400 per fully vaccinated child - but only if 63% of their patients are fully vaccinated. Fall below the threshold, and the bonus disappears. The architecture ensures that financial survival depends on compliance at every level.

The information architecture employs calculated omission. Vaccine inserts state clearly that vaccines haven't been tested for carcinogenic or mutagenic potential. The CDC website doesn't mention this. Pediatricians don't know it. Parents never hear it. When childhood cancer rates increased 37% between the early 1980s and 1990s - immediately following the expansion of the vaccine schedule after 1986 liability protection - the medical establishment declared it a mystery. The architecture ensures that those administering vaccines know the least about their contents and effects.

The term "vaccine" itself represents architectural genius. It carries the cultural weight of smallpox and polio victories, even though modern vaccines bear no resemblance to those historical interventions. The original smallpox inoculation involved transferring pus from one person's vaccination wound to another's open cuts - a practice that spread tuberculosis and syphilis for a century. Today's vaccines contain DNA fragments, aluminum nanoparticles, polysorbate 80 that opens the blood-brain barrier, and what researchers euphemistically call "process-related impurities" - contamination from the manufacturing process including glyphosate from the GMO feed given to animals used in vaccine production.

The emergency architecture deserves special attention. As Watt documents, the 2005 International Health Regulations created automatic triggers. When WHO declares a Public Health Emergency of International Concern, power transfers from sovereign governments to international organizations. National constitutions become subordinate to global health security. The architecture was tested through SARS 2003, MERS 2006, H1N1 2009 - each iteration refining the system. COVID represented full deployment, revealing that decades of public health infrastructure had actually constructed what Watt calls a "kill box" - a military term for a geographic area designated for coordinated attack.

Pfizer's April 2022 legal filing exposed another architectural level. Their COVID vaccine wasn't legally a vaccine but a Department of Defense prototype. Under "other transaction authority," normal pharmaceutical regulations didn't apply. No valid clinical trials were required. No proof of safety or efficacy was necessary. The architecture had pre-positioned legal frameworks that transformed experimental

gene therapies into military countermeasures, bypassing every consumer protection law through the magic of reclassification.

The surveillance architecture tracks every injection from manufacture to administration. Vaccine lots are numbered, tracked, and monitored. VAERS exists not to protect children but to provide early warning of lots causing excessive visible damage that might threaten the program. When a hot lot is identified, it's quietly recalled while the overall program continues. The architecture maintains the appearance of safety monitoring while ensuring that signals of harm never trigger systematic investigation.

The corruption extends to the very definition of health. The architecture has redefined normal childhood as a state of managed chronic illness. Pediatricians now expect to see children with allergies, asthma, eczema, behavioral problems, and developmental delays. These conditions are considered normal variants rather than signs of systematic poisoning. The architecture has moved the baseline so successfully that healthy children - those who can play outside all day, who recover quickly from minor illnesses, who learn without pharmaceutical assistance - are now seen as unusually lucky rather than simply normal.

Professional architecture ensures compliance through targeted destruction. Doctors who question vaccines lose their licenses - not for malpractice or patient harm, but for documenting health outcomes. Scientists who find problems with vaccines lose funding, publications, and careers. The architecture doesn't require universal participation in the conspiracy. It only requires that those who see the truth understand the consequences of speaking it.

The testing architecture deliberately avoids asking dangerous questions. No study has ever compared the full CDC schedule to completely unvaccinated children. The Institute of Medicine admitted in 2013 that the vaccine schedule has never been tested for safety as administered. When independent researchers conduct such studies, they're attacked not on their methodology but on their audacity. The architecture protects itself by declaring certain questions unethical while ignoring the ethics of injecting neurotoxins into newborns.

Language architecture shapes thought itself. Adverse events become "temporally related coincidences." Vaccine injuries become "rare adverse events following immunization" - never caused by, only following. Parents who report their child's regression after vaccination are "anti-vaccine" even though they vaccinated. Doctors who advocate for informed consent are "vaccine hesitant." The architecture ensures that language itself prevents clear thinking about what's happening.

The legal architecture creates a closed loop. The 1986 Act shields manufacturers from liability. The Vaccine Court requires parents to fight for years to prove injuries that legally cannot be acknowledged as vaccine-caused. Even when parents win, they must sign gag orders preventing them from warning others. The Countermeasures Injury Compensation Program for COVID vaccines makes the Vaccine Court look generous - it has compensated almost no one while thousands die and millions suffer injuries. The architecture ensures that legal remedy is theoretical, not practical.

This isn't a system that made mistakes. It's an architecture designed to create chronic illness while maintaining plausible deniability. Every seemingly broken element - from corrupted science to captured regulators to silenced dissent - functions perfectly within the larger design. The architecture doesn't hide its purpose. It declares it openly in obscure journals and technical documents, knowing that

fragmentation of information ensures the picture remains invisible to those inside the system.

4. The Poisoners in White Coats

Dr. Robert Mendelsohn understood what pediatricians really are: "The pediatrician serves as the recruiter for the medical profession. He indoctrinates your child from birth into a lifelong dependence on medical intervention." This isn't hyperbole. It's a business model. The well-baby visit has nothing to do with wellness and everything to do with ensuring compliance with a poisoning schedule that generates customers for life.

Marcella Piper-Terry exposed the mechanism with surgical precision. Vaccines cause encephalitis. Encephalitis causes the constellation of symptoms that get labeled as autism, ADHD, learning disabilities, and behavioral disorders. The pediatrician injects the cause, observes the effect, and prescribes a lifetime of interventions for the damage they created. When parents report their child's regression after vaccination, the same pediatrician who wielded the syringe gaslights them about correlation and causation.

The training of pediatricians deliberately excludes relevant knowledge. They learn vaccination schedules but not vaccine ingredients. They memorize disease names but not disease history. They can recite antibody theory but can't explain why antibody presence doesn't equal immunity. Most critically, they never learn that 95-98% of disease mortality declined before vaccines existed. Their education is designed to create true believers who poison children with the confidence that comes from carefully cultivated ignorance.

Larry Cook's recent survey revealed what happens when parents wake up: 54.7% who ranked pediatricians as "very trustworthy" before their child was injured now rank them at zero trust. These aren't anti-medicine extremists. They're parents who learned through devastating experience that the person they trusted most with their child's health was their child's primary poisoner.

The financial architecture ensures pediatric compliance. A pediatrician with 1,000 patients who meets Blue Cross Blue Shield's 63% fully vaccinated threshold receives $400,000 in bonuses. Fall to 62%, and that money vanishes. The economics are brutal and intentional. A pediatrician who questions vaccines doesn't just lose bonuses - they lose their practice. Insurance companies drop them. Hospitals revoke privileges. Medical boards launch investigations. The system ensures that financial survival requires participating in the poisoning.

Consider the "well-baby" visit schedule: 2 weeks, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months. An infant who never leaves the medical system long enough to establish what normal health looks like. Each visit involves multiple injections, ensuring that when problems develop, they can't be traced to a specific cause. The pediatrician loads the gun with multiple bullets, fires them simultaneously, and when the child develops chronic illness, declares it a mystery.

The corruption of informed consent represents pediatric medicine's greatest betrayal. True informed consent requires disclosure of ingredients, risks, and alternatives. Instead, parents receive a CDC-generated "information" sheet that minimizes risks and maximizes benefits. Pediatricians refuse to provide vaccine inserts, claiming they're "too technical" for parents to understand. They won't

discuss the aluminum content that exceeds FDA safety limits by factors of 10 to 50. They don't mention that vaccines have never been tested for carcinogenic or mutagenic potential. The "informed" part of informed consent is systematically withheld.

When parents resist, pediatricians deploy emotional manipulation. "Do you want your child to die from whooping cough?" they ask, knowing that whooping cough mortality had declined 99% before the vaccine existed. "You're putting other children at risk," they claim, unable to explain how unvaccinated children threaten vaccinated ones if vaccines work. "I'll have to report you to Child Protective Services," they threaten, weaponizing the state against parental authority. The white coat becomes a costume that grants authority to override fundamental parental rights.

The most damaging pediatric lie is that vaccine reactions are "normal." Inconsolable crying for hours - the medical term is encephalitic cry, literally brain inflammation - gets dismissed as "fussiness." High fever, lethargy, and loss of eye contact are called "expected reactions." Parents are told their baby is "just tired" when what they're witnessing is neurological damage in real-time. The pediatrician normalizes injury, ensuring parents don't connect the injection to the aftermath.

Dr. Paul Thomas's experience illuminates the institutional protection of pediatric poisoning. His practice data showed definitively that unvaccinated children were healthier across every metric. Rather than investigate why his unvaccinated patients thrived, the Oregon Medical Board suspended his license. The message to other pediatricians was clear: document vaccine failure and lose your career. The system protects itself by destroying those who reveal its crimes.

The pediatric gaslighting extends to treatment. When vaccine-injured children develop chronic conditions, pediatricians prescribe medications that compound the damage. Antibiotics for recurrent infections caused by immune dysfunction. Steroids for eczema and asthma triggered by adjuvants. Psychiatric drugs for behavioral problems stemming from brain inflammation. Each prescription generates profit while deepening the child's dependence on medical intervention. The pediatrician who created the problem positions themselves as the only solution.

Pediatricians exhibit a peculiar blindness to their own data. They see the explosion in autism, allergies, and autoimmune conditions. They witness the transformation of childhood from a time of robust health to an era of chronic illness. Yet they refuse to connect this epidemic to the parallel expansion of the vaccine schedule. This isn't ignorance - it's willful blindness maintained by financial incentive and professional pressure.

The recruitment begins in medical school, where students accumulate hundreds of thousands in debt. By graduation, they're financially enslaved to a system that demands compliance. Questioning vaccines means losing the ability to pay off loans, support families, and maintain the social status that comes with being a doctor. The architecture ensures that those with the most power to protect children have the most to lose by doing so.

Pediatric organizations function as pharmaceutical marketing departments. The American Academy of Pediatrics receives millions from vaccine manufacturers. Their recommendations align perfectly with industry profits, never with children's health. They publish position papers defending aluminum adjuvants while aluminum devastates infant brains. They promote vaccines for diseases that no longer exist while ignoring the chronic diseases their interventions create.

The well-baby visit is a misnomer that would be comedic if it weren't tragic. There's nothing "well" about injecting neurotoxins into healthy children. The visit exists solely to maintain the vaccination schedule, to ensure compliance with a protocol that transforms healthy babies into chronically ill customers. Parents bring in a perfect child and leave with a ticking time bomb of immune dysfunction, neurological damage, and gastrointestinal destruction.

The pediatrician's betrayal is intimate. Parents trust them with their most precious creation. They believe the white coat represents knowledge, compassion, and healing. Instead, it disguises a pharmaceutical representative who profits from creating illness. The pediatrician who should be the guardian of children's health has become their primary threat.

Every pediatrician who continues vaccinating after witnessing regression, after seeing healthy children become chronically ill, after watching the explosion of autism and autoimmune disease, has made a choice. They've chosen their mortgage over your child's mind. They've chosen their medical license over your baby's health. They've chosen their place in the system over their oath to first do no harm.

5. The Historical Erasure

Roman Bystrianyk spent years in archives, pulling mortality data from dusty volumes that haven't been digitized, constructing graphs that tell a story so devastating to the vaccine narrative that it's been systematically erased from medical education. Between 1850 and 1940, measles mortality fell by 98%. The vaccine wasn't introduced until 1963. This pattern repeats for every major infectious disease: whooping cough, diphtheria, scarlet fever. The diseases were conquered by sewers and soap, not syringes.

The erasure is comprehensive. Medical students learn that vaccines saved humanity from infectious disease. They're shown charts beginning in 1940 or 1950, after the mortality decline was nearly complete. They never see the full timeline showing diseases like typhoid and cholera - for which no vaccines were deployed - declining at identical rates to diseases that were later vaccinated against. The historical record has been edited to create an illusion that vaccines arrived just in time to save humanity, when in reality they arrived after the battle was won.

Scarlet fever tells the story that cannot be hidden. It killed more children than measles, diphtheria, and whooping cough combined in the 1800s. By 1950, it had virtually disappeared. No vaccine was ever deployed. The same improvements that eliminated scarlet fever - clean water, sewage systems, improved nutrition, better housing, labor laws ending child exploitation - eliminated the others. But only the diseases that later received vaccines get credited to medical intervention. The ones that disappeared without vaccines are forgotten, their decline attributed to mysterious "natural cycles."

The conditions of the 1800s that made disease deadly have been scrubbed from the narrative. Roman found descriptions of cities as "giant communal toilets" where all waste - human, animal, industrial - flowed through the streets into water supplies that people then drank. Children as young as three worked 16-hour days in factories without ventilation, arriving home to single rooms where families of eight lived with their dead until burial money could be scraped together. Malnutrition was endemic. Vitamin C deficiency - scurvy - was so common it was thought to be an infectious disease.

Dr. Thomas Mack, who worked on smallpox eradication, admitted in 2002 what the medical establishment won't acknowledge: "If people are worried about endemic smallpox, it disappeared from this country not because of mass herd immunity. It disappeared because of economic development." He explicitly stated that smallpox vanished from developing nations "long before the World Health Organization's smallpox eradication program." Economic development, not vaccination, eliminated the disease.

The Leicester rebellion of 1885 provides the natural experiment that proves the narrative false. After a major smallpox outbreak despite 95% vaccination coverage, the citizens revolted, threw out their government, and replaced it with one that made vaccination voluntary. Vaccination rates plummeted to 10%. The medical establishment predicted catastrophe - mass death, smallpox devastating the unprotected population. Instead, smallpox never returned to Leicester. The mortality rate continued declining. The predicted disaster never materialized because sanitation, not vaccination, controlled the disease.

Medical journals from the pre-vaccine era tell a different story than modern textbooks. The British Medical Journal in 1959 described measles as "a relatively mild and inevitable childhood ailment" with "few serious complications." By 1960, they questioned whether "universal vaccination against pertussis is always justified" given "the increasing mild nature of the disease and the very small mortality." These aren't anti-vaccine extremists - these are the medical authorities of the time acknowledging that these diseases had already become mild before vaccines existed.

Alexander Langmuir, the "father of infectious disease epidemiology" who created what became the CDC, admitted his motivation for developing the measles vaccine: "To those who ask me, 'Why do you wish to eradicate measles?' I reply with the same answer that Hillary used when asked why he wished to climb Mt. Everest: 'Because it is there.'" Not because it was dangerous. Not because children were dying. But because it was technically possible. He described measles as "a self-limiting infection of short duration, moderate severity, and low fatality."

The nutrition connection has been systematically obscured. Vitamin A deficiency was the primary factor determining measles mortality. Studies showed vitamin A supplementation reduced measles mortality by 60% overall and 90% in infants. Dr. Klenner demonstrated in the 1950s that vitamin C at appropriate doses could clear "all evidence of infection" from measles within 48 hours. This knowledge has been buried because vitamins can't be patented and don't generate recurring revenue.

The smallpox vaccine's true history has been rewritten into mythology. The original procedure involved cutting multiple wounds in a person's arm and rubbing in pus from infected animals or other humans' vaccination sites. For 100 years, "arm-to-arm" vaccination spread tuberculosis, syphilis, and other blood-borne diseases. Historical physicians documented that "consumption follows on the footsteps of vaccination." The hero narrative of smallpox vaccination omits that it killed and maimed thousands while the disease was already disappearing due to improved living conditions.

Charles Creighton's fate illustrates the active suppression of historical truth. Initially pro-vaccine, he was commissioned to write the Encyclopedia Britannica entry on vaccination in 1888. His research into the actual history led him to write a scathing critique documenting vaccination's failures and dangers. His meticulously researched article remained in the Encyclopedia until 1922, when it was replaced

without explanation by a brief entry praising vaccines. Creighton, once respected, was professionally destroyed for documenting what he found.

The graphs tell the story words cannot hide. When you plot disease mortality from 1850 forward, you see a smooth, continuous decline that begins decades before vaccines. The trajectory doesn't change when vaccines are introduced. There's no inflection point, no sudden drop, no acceleration of the existing trend. The decline that began with the first sewer continues unchanged through the introduction of vaccines. Only by starting graphs after the decline was nearly complete can the illusion of vaccine efficacy be maintained.

Tuberculosis provides the control experiment. It killed more people than all other infectious diseases combined in the 1800s - far more than measles or smallpox. By 1945, before antibiotics and without widespread vaccination in the US, tuberculosis mortality had declined by 96%. The same factors that conquered tuberculosis conquered all infectious diseases. But only the diseases that eventually received vaccines get credited to medical intervention.

The 1918 flu pandemic revealed the truth about disease susceptibility. It didn't kill randomly. It killed the malnourished, the exhausted, those in overcrowded conditions, those with compromised terrain. Military camps with good sanitation and nutrition had minimal mortality. Ships where men were packed in unhygienic conditions saw death rates exceeding 50%. The determining factor wasn't exposure to the virus but the condition of the host.

The World Health Organization's own data undermines the vaccine narrative. Infectious disease mortality in developing nations follows the same pattern seen in the West: declining with economic development, improved nutrition, and sanitation - before vaccine programs begin. But WHO credits vaccines for mortality reductions that were already occurring, using the same truncated timelines and manipulated charts that obscure the historical record.

Modern medicine has created an origin myth where vaccines play the role of savior. This myth requires erasing the history of public health improvements, denying the role of nutrition, and ignoring data from countries and time periods that contradict the narrative. It requires pretending that correlation equals causation when vaccines are involved but dismissing correlation when it threatens the narrative.

The erasure extends to current data. When whooping cough outbreaks occur in fully vaccinated populations, it's not reported as vaccine failure. When mumps sweeps through vaccinated college campuses, it doesn't make headlines. When the vaccinated contract and spread diseases they're supposedly protected against, the failures are explained away or ignored entirely. The historical pattern of medical authorities denying evidence that challenges their paradigm continues unchanged.

The true history of disease decline is a story of human progress through improved living conditions, not medical intervention. It's a story where plumbers and sanitation workers saved more lives than all the doctors combined. Where building codes and labor laws prevented more disease than any vaccine. Where access to fresh food and clean water accomplished what no pharmaceutical product could achieve. This history has been erased because it reveals an uncomfortable truth: health comes from how we live, not from what we inject.

6. The Choice Point

Every parent faces the moment. It arrives in different ways - through a friend's vaccine-injured child, through their own research, through an instinct that something isn't right - but eventually the moment comes when they must choose. Will they hand their child over to the system that first morning, or will they stand against the entire medical infrastructure and say no to that first injection?

The parents who successfully refuse have invariably done months of preparation. They've printed safety data sheets highlighting where it says "fatal if swallowed" for ingredients being injected into newborns. They've memorized the Australian surveillance study showing zero hospital deaths from vitamin K deficiency bleeding in unvaccinated babies. They've practiced their responses to each wave of coercion. They know they're not entering a medical consultation but a carefully orchestrated campaign to break their will.

The system counts on parental unpreparedness. It strikes in those first exhausted hours after birth when mothers are recovering from labor and fathers are overwhelmed by new responsibility. The nurse appears with a syringe already prepared, consent form in hand, speaking as if refusal isn't an option. "We'll just give baby the vitamin K now." Not a question. A statement. The architecture assumes compliance.

Those who've exited the dome - like Truman Burbank finally breaking through the artificial sky of his manufactured world - describe a consistent pattern of escalation. First comes the casual assumption of consent. When parents refuse, enter the doctor with "concerns." Then the warnings about death and bleeding. Then the emotional manipulation - turning to the mother, asking if she "feels differently" than the father. Then the threats, either explicit or implied, about Child Protective Services. Each wave designed to break resistance at a different psychological point.

Murphy's father endured it all. The pediatrician. The nurse. The NICU admission for "monitoring." The repeated attempts to pierce his daughter's skin with needles while claiming she couldn't clot blood. He held firm because he'd done the work. He knew the truth. His daughter remains unvaccinated, one of the 0.26% who've never been enrolled in the pharmaceutical system.

The preparation must be comprehensive. Print everything in duplicate - one set to leave with the doctor, one to keep. The vaccine inserts showing "carcinogenicity studies have not been performed." The safety data sheets revealing that "inactive" ingredients are actually industrial chemicals that cause organ damage. The state laws proving vaccination isn't required for anything except school attendance. The studies showing unvaccinated children have 90% fewer chronic conditions than their vaccinated peers.

But knowledge alone isn't enough. Parents must be prepared for the emotional assault. The system has refined its techniques through millions of interactions. Medical staff know exactly which buttons to push: maternal guilt, paternal responsibility, social conformity, fear of judgment. They've learned to identify which parent is more vulnerable and focus their pressure there. They understand that exhausted, emotional parents in unfamiliar environments make poor defenders of their children's bodily sovereignty.

The financial pressure extends beyond the hospital. Pediatricians increasingly refuse to accept unvaccinated patients, not for medical reasons but for financial ones.

Insurance companies punish practices with unvaccinated patients. Some daycares require vaccination. Families find themselves excluded from playgroups, schools, and social circles. The architecture ensures that refusing vaccination carries a social and economic cost designed to break parental resolve over time.

Yet something remarkable is happening. Larry Cook's survey shows 54% of respondents have observed vaccine injury in their own children or others. Parents are talking to each other, sharing stories the media won't report. They're discovering that their "rare" adverse reaction is common, that their child's regression wasn't unique, that the chronic illnesses plaguing this generation aren't normal. The awakening accelerates with each injured child, each parent who speaks out, each doctor who finally sees what they've been doing.

The unvaccinated children themselves become walking testimonies to what's been stolen from their generation. When parents see unvaccinated children who rarely get sick, who don't need psychiatric medications, who learn without special education services, who thrive without medical intervention, the contrast with their own medicated, chronically ill children becomes undeniable. Every healthy unvaccinated child is evidence of a crime.

The legal framework parents must understand is deliberately obscured. Vaccines are mandated only for school attendance, and even then, 47 states offer religious or philosophical exemptions. No law requires vaccination for private life. Doctors who threaten CPS for vaccine refusal are committing extortion. Hospitals that claim vaccination is required for discharge are lying. Parents have absolute authority over their children's medical care, but the system counts on them not knowing this.

The informed consent parents should receive but never do would include disclosure that aluminum adjuvants exceed FDA safety limits, that vaccines contain DNA fragments from aborted fetal cells, that formaldehyde and polysorbate 80 cross the blood-brain barrier, that no vaccine has been tested for carcinogenic potential, that the entire schedule has never been tested for cumulative safety. True informed consent would end vaccination overnight, which is why it's never provided.

The conversations with pediatricians reveal the system's weakness. When parents ask specific questions - "What is the aluminum content of this vaccine?" "Has this been tested for cancer-causing potential?" "Can you show me the safety study comparing vaccinated to unvaccinated children?" - most pediatricians can't answer. They've never read a vaccine insert. They don't know the ingredients. They can't explain the mechanism by which vaccines supposedly provide immunity. Their authority evaporates under informed questioning.

The strength required to refuse isn't just intellectual but spiritual. Parents describe feeling a profound wrongness about vaccination, an instinct that transcends logic. Many identify this as divine guidance, the same protective instinct that keeps children from danger. The system works to override this instinct, to make parents doubt their intuition, to replace parental wisdom with medical authority. Those who successfully refuse report that honoring this instinct, despite enormous pressure, was the most important decision they made for their children.

The exit from the dome requires recognizing that everything about the medical system's approach to children is inverted. They inject poisons and call them vitamins. They create chronic illness and call it prevention. They damage immune systems and call it immunization. They assault newborns and call it care. Once parents see this

inversion, they can't unsee it. The white coat loses its power. The hospital becomes recognizable as a place of danger, not healing.

The parents who've made this choice describe a peculiar isolation followed by unexpected community. They lose friends who can't understand their decision but find others who've traveled the same path. They discover networks of parents raising healthy, unvaccinated children. They find doctors who practice actual health care rather than pharmaceutical distribution. They create parallel systems of support outside the medical industrial complex.

The choice to refuse that first injection is really a choice about worldview. It's accepting that institutions claiming to protect health actually destroy it. That authorities presenting themselves as experts are either ignorant or complicit. That the responsibility for protecting children can't be delegated to systems that profit from their illness. It's the recognition that parental instinct, informed by knowledge and guided by wisdom, supersedes medical authority.

For those still inside the dome, the unvaccinated represent an impossibility. How can these children thrive without medical intervention? Why aren't they dying from vaccine-preventable diseases? How do they learn without ADHD medication, play without autism therapy, live without chronic illness? Their existence challenges everything the system teaches about health requiring pharmaceutical products.

The moment of choice arrives for every parent. Armed with knowledge or vulnerable in ignorance. Prepared for the assault or ambushed by authority. Ready to defend their child's sovereign body or conditioned to submit to medical decree. The choice made in those first hours - whether to allow that first injection of synthetic vitamin K laced with industrial chemicals - determines whether their child enters the pharmaceutical system or remains free.

Those who choose freedom discover what human health actually looks like. Their children become living proof that the chronic disease epidemic isn't genetic, isn't mysterious, isn't inevitable. It's iatrogenic - caused by the very interventions claimed to prevent it. Every unvaccinated child is evidence that health comes from avoiding the medical system, not from compliance with it.

The exit from the dome is possible. It requires courage, preparation, and the willingness to stand against enormous pressure. But on the other side is what every parent actually wants: a healthy child, unburdened by chronic illness, free from pharmaceutical dependency, capable of achieving their full human potential. The door is there. The choice is yours. The only question is whether you'll take it.

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The Unvaccinated

The Baseline: What Unvaccinated Children look like.

"The Unvaccinated", it sounds like the title of a horror movie co-produced by the FDA and the CDC.

I wrote this in June 2022, when I first watched Vaxxed 2.

Infertility, Vaccines, Teflon and Ukraine. (substack.com)

If you were going to only watch one doco, watch **Vaxxed 2.**

If you were only going to spend 30 minutes then just watch the last 30 minutes of Vaxxed 2 and listen to all the parents of unvaccinated children tell you how healthy these kids are, how they never go to the doctor, how they have hardly ever been ill and if ill, it's mild and short. This is the only place I am aware of where we get to SEE the vision of what our children (and all of us for that matter) might have been like had we not pumped them with a toxic stew.

Oh, and another theme among the unvaxxed kids is just how smart they are…

I lied, it's actually not the last 30 mins, but the last 21 mins, which I have cut out and headlined this stack piece with.

This is the baseline.

This is what a human being not injected with 72 doses (US), 42 doses (Australia), that include a total of 38 chemicals, looks like.

Who should watch this 21-minute extract?

- If you raised vaccinated children and are open to seeing how we were led astray.
- If you are planning on having a baby.
- If you have a baby and have started the vaccine schedule…it's never too late to just stop.
- If you are a grand-parent and you think you have a chance of talking some sense to your kids.

Who else have I missed?

If these unvaccinated kids were dying of disease, then the CDC and the FDA and the TGA (Australia) would be right.

But seeing that they are not, then all the lettered agencies and the propaganda they fund and spew, are wrong.

This from Handley in his magnificent book How to end the autism epidemic, discussing the one ingredient out of thirty-eight that has been "studied" by the authorities:

And here are all **thirty-eight vaccine ingredients**. Once again I've underlined (bold) the one that has been studied for its relationship to autism: 2-Phenoxyethanol, albumin, aluminum hydroxide, aluminum potassium sulfate, amino acids, ammonium sulfate, antibiotics, bovine components, bovine serum, chick embryo cell culture, culture, detergent, dextrose, enzymes, formaldehyde, gelatin, glutaraldehyde, human components, human embryonic cells, lactalbumin

hydrolysate, medium 199, mineral salts, monosodium l-glutamate, phenol, phosphate, polymixin B sulfate, polysorbate-80, potassium aluminum sulfate, potassium chloride, potassium phosphate monobasic, sodium borate, sodium chloride, sodium phosphate dibasic, sorbitol, soy peptone, sucrose, **thimerosal**, vero (monkey kidney) cells, and yeast protein.

Do you think it's reasonable to say, "Case closed; we've studied vaccines and autism"?

The other 37 have not been studied for their relationship to autism.

Here is Handley (from the crowd) talk to "the doctors" or should I say Cult Members.

This YouTube comment summed it up:

Those two doctors are on the take, no question. The gentlemen in the audience supplied facts and studies proving his statements and the doctor basically said 'You're a big meanie and I won't listen to you' in so many words.

I am absolutely fascinated by unvaccinated children.

And in awe of their parents.

I look at our two wonderful kids and reflect on their pain and suffering from vaccine injury, and what a different reality, via a different sliding door, would have looked like. Parents in deep sleep are easily manipulated into sacrificing their children to the orthodoxy.

Considering my interest in the "baseline state" I recently came across this website which opens with a good 15-minute video about an unvaccinated family and their three children. It is now part of the "baseline" collateral.

Unvaccinated Children: A Beacon of Hope for Humanity

Vaccinated (60%) vs Unvaccinated (2.64%)

33 Questions & Answers

A story on the unvaccinated seems a bit incomplete without bothering to include the data on the entirely unvaccinated population (of all ages) across 48 states, i.e., the Control Group study, for which a peer-reviewed and published paper can be seen here.

Total risk of at least one chronic condition after the age of 18 in the vaccinated is now over 60%. TRUE total baseline risk for those who have never once been exposed to any vaccines and those who've also avoided the "vitamin" K shot, is 2.64%. Take your pick. - **Joy Garner**

"The biggest problem that all of this comes down to is the refusal of most people to believe that people in power wish them harm, actively want to do harm to them. This is the hardest thing for most people to accept". - **Bob Moran**

Autism: The rate of autism in entirely unvaccinated individuals with no exposure to the Vitamin K shot or maternal vaccines was 0%, compared to the national rate of 2.79% in 2019 and 3.49% in 2020. – **The Control Group Survey**

Let's start with Bob Moran's clip.

We are going to take a look at the recently published paper titled:

Health versus Disorder, Disease, and Death: Unvaccinated Persons Are Incommensurably Healthier than Vaccinated

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Analogy

Imagine two large orchards side by side. One orchard (representing the vaccinated population) has been treated with a new pesticide spray that's supposed to protect the trees from harmful insects. The other orchard (representing the unvaccinated population) has been left untreated.

The makers of the pesticide claim it's safe and effective, and that without it, the untreated orchard would be overrun with pests and produce little fruit. They've done studies comparing trees sprayed with their new pesticide to trees sprayed with older pesticides, showing little difference, and conclude their product is safe.

However, an independent researcher decides to compare the treated orchard to the untreated one. To everyone's surprise, they find that the untreated orchard is thriving. The trees there have far fewer diseases, produce more fruit, and are generally healthier than the treated orchard.

Moreover, they notice that even light exposure to the pesticide – like overspray on the edge of the untreated orchard – seems to cause problems. Trees receiving both the new spray and remnants of old sprays fare the worst.

The researcher also discovers that the official pest reporting system only catches a tiny fraction of the actual pest damage in the treated orchard.

This study is like that researcher's report. It's saying that contrary to popular belief and official claims, the untreated (unvaccinated) population is actually much healthier than the treated (vaccinated) one. It says that the treatment itself, meant to protect, is causing widespread harm, and that the system for monitoring this harm is deeply flawed.

Here's a 10-point summary of the most important aspects and data points from the study:

1. The Control Group Survey (CGS) found that only 5.97% of unvaccinated adults had any chronic condition, compared to 60% in the vaccinated population.
2. Among children under 18, 5.71% of unvaccinated children had at least one chronic condition, versus 27% of vaccinated children.
3. The study found zero cases of autism in fully unvaccinated individuals who also avoided the Vitamin K shot and maternal vaccines, compared to national autism rates of 2.79% in 2019 and 3.49% in 2020.

4. Exposure to the Vitamin K shot alone was associated with an 11.73% risk of at least one disorder/disease condition, a 344% increase over the baseline rate of 2.64% for those with no exposures.
5. Maternal vaccination during pregnancy was linked to a 21.05% risk of at least one condition in children, a 697% increase over the baseline rate.
6. The study calculated the odds that vaccines are not the cause of over 90% of disabling chronic conditions in adults at 1 in 245,083,100,778,672,000,000,000,000,000,000,000,000,000,000,000,000,000,000,000 ($p < 4.08E-63$).
7. The Vaccine Adverse Event Reporting System (VAERS) was found to account for less than 1% of actual vaccine injuries and deaths, according to a cited study.
8. The study critiques conventional vaccine safety studies for using the 99.74% vaccine-exposed population as a baseline, potentially underestimating vaccine risks.
9. Glyphosate contamination was found in all live virus vaccines tested, with the MMR vaccine showing significantly higher levels.
10. The study concludes that avoiding vaccines and related pharmaceutical products is the most effective way to reduce the risk of chronic diseases, challenging the conventional narrative about vaccine safety and efficacy.

33 Questions & Answers

Question 1: What is the Control Group Survey of Unvaccinated Americans (CGS) and what was its purpose?

The Control Group Survey of Unvaccinated Americans (CGS) was a nationwide survey conducted in 2019/2020 to quantify the long-term health risks of total vaccine avoidance against the health outcomes observed in the 99.74% vaccine-exposed American population. Its purpose was to establish a baseline for disease risk in those without exposure to vaccination and to compare this with the health outcomes in the vaccinated population.

The CGS aimed to provide empirical evidence for assessing the risk-to-benefit ratio of vaccination, both at a population level and for individual risk assessment. It sought to challenge the claim that vaccine injuries are "rare" by providing concrete data on health outcomes in unvaccinated individuals.

Question 2: Who is Joy Garner, and what is her role in the CGS?

Joy Garner is the author of the paper and the founder of the Control Group. She is credited with conducting the Control Group Survey of Unvaccinated Americans (CGS). As the founder and primary researcher, Garner was responsible for designing the study, collecting and analyzing the data, and presenting the findings in this paper.

Garner's role involved overseeing the entire research process, from conceptualization to implementation and analysis. She was also responsible for interpreting the results and drawing conclusions about the health impacts of vaccination based on the survey data.

Question 3: What methodology was used in conducting the Control Group Survey?

The Control Group Survey (CGS) employed a multi-faceted approach to data collection. Survey notices were posted on social media outlets, podcasts, and radio broadcasts across the nation and in foreign countries. In-person surveys were also conducted in key population centers. The data were collected through three main methods:

1. Completed mailed-in surveys
2. In-person interviews
3. Telephone follow-up conversations to complete some surveys

The survey focused on entirely unvaccinated individuals, collecting information on their current and historical health issues, mental conditions, and other health-related data. The vast majority of the CGS forms were handwritten in ink, with postmarked envelopes verifying the physical address of the source and the date of mailing.

Question 4: How were data analysis and statistical confidence established in the CGS?

Data analysis and statistical confidence in the CGS were established through several methods:

1. Sample size: The CGS achieved a 0.178% random sample of the unvaccinated control population from across 48 American states in all ages. This included a 0.2% sample of unvaccinated adults and a 0.175% sample of unvaccinated children.
2. Confidence level: The dataset produced a 99% confidence level with an interval (error) spanning less than 0.04% from the sample means (interval at 5.953 to 5.987).
3. Comparison: The accuracy of the CGS was compared to other national surveys, such as the National Survey of Children's Health (NSCH), which had a smaller sample fraction for its population of interest.
4. Statistical calculations: The study used various statistical methods, including odds ratios, p-values, and finite population correction, to establish the significance of its findings.

Question 5: What statistical methods were used in the CGS, and what significance do the p-values hold?

The CGS employed several statistical methods to analyze the data:

1. P-values: The study calculated p-values to determine the statistical significance of the differences between vaccinated and unvaccinated populations. For example, the odds that vaccines are not the cause of well over 90% of the disabling chronic conditions suffered by Americans over the age of 18 were calculated to be 1 in 245,083,100,778,672,000,000,000,000,000,000,000,000,000,000,000,000,000,000,000,000,000 (or $p < 4.08E-63$).
2. Odds ratios: These were used to quantify the association between vaccination status and various health outcomes.

3. Confidence intervals: A 99% confidence level was established with a very narrow interval.
4. Finite population correction: This was applied to further refine the statistical analysis.

The extremely low p-values indicate that the observed differences in health outcomes between vaccinated and unvaccinated populations are highly unlikely to have occurred by chance, suggesting a strong causal relationship between vaccination and chronic health conditions.

Question 6: How does the study compare its statistical significance to standards used in physics for proving theories?

The study compares its statistical significance to the gold standard threshold used in particle physics for proving the existence of theoretical particles. In particle physics, the standard is "five sigma," which represents a 1 in 3,500,000 chance that an observed event or outcome is due to mere chance.

The CGS findings far exceed this threshold. For example, the odds that vaccines are not the cause of over 90% of disabling chronic conditions in adults are calculated at 1 in 245,083,100,778,672,000,000,000,000,000,000,000,000,000,000,000,000,000,000,000,000,000,000,000 ($p < 4.08E-63$). This level of certainty is described as "exponentially more certain than the highest threshold standard of proof relied upon in any branch of science in existence today."

The study argues that while the five sigma standard is used for unobservable theoretical particles, the health outcomes observed in the CGS are not theoretical, making the astronomical odds against vaccine innocence even more compelling.

Question 7: How does the health of unvaccinated individuals compare to that of vaccinated individuals according to the CGS?

According to the CGS, unvaccinated individuals are significantly healthier than their vaccinated counterparts across various health metrics:

1. Chronic conditions: Only 5.97% of unvaccinated adults had at least one chronic condition, compared to 60% of the general (vaccinated) adult population.
2. Multiple chronic conditions: 0.94% of unvaccinated children had multiple chronic conditions, compared to 6.66% of vaccinated children.
3. Autism: The rate of autism in entirely unvaccinated individuals with no exposure to the Vitamin K shot or maternal vaccines was 0%, compared to the national rate of 2.79% in 2019 and 3.49% in 2020.
4. Overall health: The study concludes that unvaccinated persons are "incommensurably healthier" than vaccinated persons.

The study argues that these stark differences in health outcomes provide strong evidence that vaccines are causing chronic diseases and disorders, rather than preventing them.

Question 8: What are the main findings regarding chronic diseases and disorders in vaccinated versus unvaccinated populations?

The CGS reports several significant findings regarding chronic diseases and disorders in vaccinated versus unvaccinated populations:

1. Prevalence: 60% of vaccinated adults have at least one chronic condition, compared to only 5.71% of unvaccinated adults.
2. Multiple conditions: 42% of vaccinated adults have two or more chronic conditions, versus 0.95% of unvaccinated adults.
3. Severe cases: 12% of vaccinated adults have five or more chronic conditions, while 0% of unvaccinated adults fall into this category.
4. Children's health: 27% of vaccinated children have at least one chronic condition, compared to 5.97% of unvaccinated children.
5. Autism: The study found no cases of autism in fully unvaccinated individuals who also avoided the Vitamin K shot and maternal vaccines.

These findings led the study to conclude that vaccines are not moving the population toward better health, but rather toward epidemic levels of lifelong debilitating chronic disorders.

Question 9: How are odds ratios used to demonstrate the significance of health outcomes in the study?

The study uses odds ratios to quantify the strength of association between vaccination status and various health outcomes. While specific odds ratios are not directly quoted in the provided text, the concept is used to illustrate the magnitude of difference in health outcomes between vaccinated and unvaccinated populations.

For example, the study calculates the odds that vaccines are not the cause of over 90% of disabling chronic conditions in adults. These odds are presented as 1 in an extremely large number (245,083,100,778,672,000,000,000,000,000,000,000,000,000,000,000,000,000,000,000,000,000,000,000,000), effectively demonstrating the strength of the association between vaccination and chronic health conditions.

The use of odds ratios, combined with the extremely low p-values, is intended to show that the observed health differences between vaccinated and unvaccinated populations are not only statistically significant but also of substantial magnitude.

Question 10: What are the reported chronic disease rates in the US population, and how do they compare to the unvaccinated group?

The study reports significant differences in chronic disease rates between the general US population (which is 99.74% vaccinated) and the unvaccinated group:

General US population (vaccinated):

- 60% of adults have at least one chronic condition
- 42% of adults have two or more chronic conditions
- 12% of adults have five or more chronic conditions
- 27% of children have at least one chronic condition

Unvaccinated group:

- 5.71% of adults have at least one chronic condition
- 0.95% of adults have two or more chronic conditions
- 0% of adults have five or more chronic conditions
- 5.97% of children have at least one chronic condition

These comparisons show substantially lower rates of chronic diseases in the unvaccinated group across all categories. The study argues that these differences are too large to be attributed to chance and are likely caused by vaccination.

Question 11: What health outcome differences are noted between partially and fully unvaccinated groups?

The study notes differences in health outcomes between fully unvaccinated individuals and those who received some vaccine-related exposures:

1. Fully unvaccinated (no vaccines, no Vitamin K shot, no maternal vaccines): 2.64% reported any disorders or disease conditions.
2. Unvaccinated but exposed to Vitamin K shot and/or maternal vaccines: 13.32% reported at least one condition.
3. Unvaccinated but exposed to Vitamin K shot alone: 11.73% reported at least one condition.
4. Unvaccinated but exposed to maternal vaccines alone: 21.05% reported at least one condition.
5. Unvaccinated but exposed to both Vitamin K shot and maternal vaccines: 30% reported at least one condition.

These findings suggest that even partial exposure to vaccine-related substances is associated with increased health risks compared to complete avoidance.

Question 12: What does the study conclude about long-term health risks of vaccine avoidance?

The study concludes that vaccine avoidance is associated with significantly better long-term health outcomes. Key findings include:

1. Only 5.97% of unvaccinated adults had any chronic condition, compared to 60% in the vaccinated population.
2. Unvaccinated individuals showed lower rates of specific conditions such as heart disease, diabetes, digestive disorders, eczema, asthma, allergies, developmental disabilities, birth defects, epilepsy, autism, ADHD, cancers, and arthritis.
3. The study argues that avoiding vaccines and related products (like the Vitamin K shot) is the most important preventative health measure one can take.
4. It concludes that vaccine avoidance reduces the risk of any chronic condition in adulthood to less than 5%, compared to 60% in the vaccinated population.

The study posits that these findings demonstrate the long-term health benefits of avoiding vaccines, challenging the conventional narrative about vaccine safety and efficacy.

Question 13: What effects do vaccines have on the immune system, according to the CGS?

According to the CGS, vaccines have detrimental effects on the immune system:

1. The study suggests that vaccines "seriously injure the immune systems of most people who are exposed to them."
2. This injury to the immune system is linked to the development of disabling and deadly chronic conditions.
3. The study argues that instead of strengthening immunity, vaccines are causing epidemic levels of lifelong debilitating chronic disorders.
4. It posits that the immune system damage caused by vaccines leads to a wide range of health problems, from allergies and autoimmune disorders to developmental disabilities and cancer.
5. The study concludes that the immune system effects of vaccines are long-term and progressive, leading to health destruction over time.

Question 14: How does the study address synergistic effects of multiple toxicant exposures?

The study addresses the synergistic effects of multiple toxicant exposures in several ways:

1. It acknowledges that the effects of toxicants are known to interact, sometimes in multiplicative ways, making their synergistic impact possibly many times more intense than if the toxicants were not concomitantly impacting the recipient.
2. The study points out that it's extremely unlikely for combinations of toxicants to cancel out their combined harmful effects.
3. It notes that as the number of combined toxicants increases beyond 5 or more, the likelihood of these effects being examined in systematic clinical safety studies rapidly drops to zero.
4. The study highlights that vaccines contain numerous toxicants, including excipients, adjuvants, and animal proteins, as well as unnamed or unknown components.
5. It argues that the interactions between these multiple toxicants in vaccines have not been adequately studied, particularly considering the different medical histories and genetic constitutions of vaccine recipients.

The study uses these points to critique the safety assessment of vaccines, suggesting that the synergistic effects of multiple toxicants in vaccines may be contributing to the observed health differences between vaccinated and unvaccinated populations.

Question 15: What risks are associated with the Vitamin K shot given to newborns, according to the survey?

According to the survey, the Vitamin K shot given to newborns is associated with increased health risks. The study found that unvaccinated individuals who received only the Vitamin K shot had an 11.73% risk of at least one disorder/disease condition, which is a 344% increase over the baseline rate of 2.64% for those with zero exposure to any vaccines, no Vitamin K shot, and no maternal vaccines.

The study points out that the Vitamin K shot contains some of the same toxicants of interest as some vaccines, particularly the aluminum adjuvant. It also contains other ingredients such as benzyl alcohol, hydrochloric acid, synthetic vitamin K, polysorbate 80, propylene glycol, sodium acetate anhydrous, and vinegar. The presence of these substances, especially the aluminum adjuvant, is suggested to be responsible for the increased health risks associated with the Vitamin K shot.

- The very first injection - Vitamin K: "It's just a vitamin" (substack.com)
- Murphy's stellar "Vitamin K" story - Lies are Unbekoming (substack.com)

Question 16: How does maternal vaccination during pregnancy affect health outcomes in children?

The study reports significant negative health impacts from maternal vaccination during pregnancy. In the group of unvaccinated (post-birth) individuals with exposure to maternal vaccines but no Vitamin K shot, 21.05% were reported to be suffering from at least one condition, an increase of 697% over the baseline rate of 2.64% for those with no exposures.

Even more concerning, the study found a 30% risk of at least one condition in the group with exposure to both the Vitamin K shot and maternal vaccines, which increased the risk by 1,036% above the baseline. These findings suggest that maternal vaccination during pregnancy may have substantial long-term health consequences for children, even if they receive no further vaccinations after birth.

Question 17: What connection does the study make between maternal vaccination and autism risk?

The study reports a strong connection between maternal vaccination and increased autism risk. In children between the ages of 3 to 17 years, the group with maternal vaccine exposure (with or without K shot) showed a 3.13% risk of autism. This risk increased to 4.76% in children who had exposure to both maternal vaccines and the Vitamin K shot, but no post-birth vaccines.

Importantly, the study found zero cases of autism in individuals who had no exposure to vaccines (including maternal vaccines) or the Vitamin K shot. The authors argue that while an entirely unvaccinated (post-birth) child can become autistic, the fact that there were no autism cases in those without any vaccine-related exposures strongly suggests a causal link between maternal vaccination and autism risk.

Question 18: What does the CGS reveal about autism rates in vaccinated versus unvaccinated populations?

The CGS reveals stark differences in autism rates between vaccinated and unvaccinated populations. In the entirely unvaccinated group with no exposure to the Vitamin K shot or maternal vaccines, the autism rate was 0% (0 of 1,024 individuals). This contrasts sharply with the reported national autism rates of 2.79% in 2019 and 3.49% in 2020.

However, the study found that even among the unvaccinated, those with some vaccine-related exposures showed increased autism rates. For example, in children aged 3-17 years with maternal vaccine exposure, the autism rate was 3.13%, rising to 4.76% in those exposed to both maternal vaccines and the Vitamin K shot. These findings suggest a strong link between vaccine-related exposures, particularly maternal vaccination, and autism risk.

Question 19: How does the study correlate glyphosate usage with autism rates?

The study references previous research showing a strong correlation between the rise in glyphosate usage on core crops and the increase in autism prevalence in the United States. Specifically, it cites a 2014 paper by Swanson et al. that demonstrated an extremely strong correlation ($r = 0.99$, $p < 0.00000036$) between glyphosate usage and autism prevalence in children aged 6 to 21 years.

While the CGS itself did not directly measure glyphosate exposure, it uses this correlation to support its argument about the potential link between environmental toxins, including those found in vaccines, and autism rates. The study suggests that the strong correlation between glyphosate usage and autism rates may be indicative of broader concerns about the impact of various toxins on neurological development.

- Glyphosate - Lies are Unbekoming (substack.com)
- Interview with Stephanie Seneff Ph.D - Lies are Unbekoming (substack.com)

Question 20: How is glyphosate contamination in vaccines linked to health outcomes?

The study discusses glyphosate contamination in vaccines as a potential factor contributing to negative health outcomes. It cites independent testing that found detectable levels of glyphosate in all live virus vaccines, with the MMR (Measles, Mumps, and Rubella) vaccine showing significantly higher levels than other vaccines. The presence of glyphosate is attributed to its use in the production of vaccine ingredients derived from animals fed glyphosate-contaminated feed.

The study suggests that the presence of glyphosate in vaccines may be particularly problematic because vaccines are injected, bypassing the gut mucosal barrier that typically helps to keep ingested glyphosate out of the circulation. While the CGS itself did not directly measure the health impacts of glyphosate in vaccines, it presents this information as part of its broader argument about the potential harmful effects of vaccine ingredients and contaminants.

Question 21: What role do aluminum adjuvants in vaccines play, according to the study?

The study identifies aluminum adjuvants as a key toxicant of interest in vaccines and the Vitamin K shot. While it doesn't provide detailed mechanisms, the study suggests that aluminum adjuvants contribute to the negative health outcomes observed in vaccinated individuals and those exposed to the Vitamin K shot.

The presence of aluminum adjuvants is highlighted as one of the reasons why even partial exposure to vaccine-related substances (such as the Vitamin K shot alone) is associated with increased health risks. The study implies that the aluminum adjuvant, along with other vaccine ingredients, may have synergistic effects that contribute to long-term health problems and immune system dysfunction.

- Interview with Dr Christopher Exley - Lies are Unbekoming (substack.com)
- Aluminium “Safety” - Lies are Unbekoming (substack.com)
- Imagine you are an Aluminum Atom - Lies are Unbekoming (substack.com)

Question 22: What specific concerns are raised about the MMR vaccine?

The study raises specific concerns about the MMR (Measles, Mumps, and Rubella) vaccine, particularly in relation to glyphosate contamination. It reports that independent testing found the MMR vaccine to have significantly higher levels of glyphosate than any other vaccine tested. This finding is presented as potentially significant given the reported links between the MMR vaccine and autism by some parents.

While the study doesn't provide direct evidence of harm from the MMR vaccine, it uses these findings to support its broader argument about the potential risks of vaccines. The higher levels of glyphosate in the MMR vaccine are presented as a possible factor in the reported adverse effects, particularly in relation to autism risk.

Question 23: How does the CGS challenge conventional claims about vaccine safety and efficacy?

The CGS challenges conventional claims about vaccine safety and efficacy by presenting data that shows significantly better health outcomes in unvaccinated individuals compared to the vaccinated population. It argues that the dramatically lower rates of chronic diseases and disorders in the unvaccinated group provide strong evidence that vaccines are causing, rather than preventing, a wide range of health problems.

Furthermore, the study critiques the methods used to establish vaccine safety, arguing that the synergistic effects of multiple vaccine ingredients are not adequately studied. It also challenges the claim that vaccine injuries are "rare," suggesting instead that they are common and have long-term impacts on health. By presenting these findings, the CGS fundamentally questions the current narrative about the overall benefits of vaccination programs.

Question 24: How does the study critique conventional vaccine science and safety studies?

The study critiques conventional vaccine science and safety studies on several fronts. It argues that mainstream vaccine science uses faulty baseline rates for diseases and disabilities, basing them on the rates observed in the 99.74% vaccine-exposed population. This approach, the study contends, leads to an underestimation of vaccine risks because new vaccines are compared to similarly injurious vaccines already on the market rather than to a truly unvaccinated population.

Additionally, the study criticizes the lack of comprehensive safety testing for vaccine ingredients and their interactions. It points out that as the number of toxicants in vaccines increases beyond five, the likelihood of their interactions being examined in systematic clinical safety studies rapidly drops to zero. The study also highlights the exclusion of certain populations (like institutionalized children) from some vaccine safety surveys, arguing that this may lead to an underestimation of vaccine injuries.

Question 25: How does the study critique the use of placebos in vaccine trials?

The study critiques the use of placebos in vaccine trials by arguing that what are often referred to as "placebos" in these trials are actually other vaccines or substances containing similar toxic ingredients. It contends that when comparing new vaccine injuries to old vaccine injuries, there is likely to be far less difference

than if the vaccine-injured persons were compared against persons who never received any vaccine.

This approach, according to the study, leads to a false declaration of safety for new vaccines. If the injuries from the new product are not significantly worse than the injuries from similarly injurious vaccine products already on the market, the new product is deemed "safe." The study argues that this method of comparison obscures the true risks of vaccines and fails to establish genuine safety profiles for new vaccine products.

On Corrupting Placebos: A feature, not a bug. (substack.com)

Question 26: How does the Vaccine Adverse Event Reporting System (VAERS) factor into vaccine safety assessments?

The study critically examines the role of the Vaccine Adverse Event Reporting System (VAERS) in vaccine safety assessments. It cites an authoritative study by Lazarus et al. (2010) which found that VAERS accounts for less than 1% of the actual injuries and deaths observed shortly after vaccination. This severe underreporting, the study argues, undermines the reliability of VAERS as a tool for assessing vaccine safety.

Furthermore, the study points out that VAERS provides no data relevant to the frequency of long-term health damage produced by vaccine exposure. It notes that despite the findings of the Lazarus study, no improvements were made to the VAERS methodology for collecting or reporting data about vaccine injuries. This critique challenges the common assertion that vaccine injuries are "rare," suggesting instead that the current reporting system grossly underestimates the true extent of vaccine-related adverse events.

Question 27: How does the CDC explain the causes of chronic diseases, and how does this contrast with the CGS findings?

According to the study, the CDC attributes the high rates of chronic diseases in the U.S. population primarily to "lifestyle risks" such as tobacco use, poor nutrition, lack of physical activity, and excessive alcohol use. This explanation stands in stark contrast to the findings of the CGS, which suggest that vaccination status is a primary factor in the development of chronic diseases.

The CGS findings indicate that unvaccinated individuals have significantly lower rates of chronic diseases compared to the vaccinated population, regardless of lifestyle factors. While the CDC focuses on individual behaviors as the main drivers of chronic disease, the CGS argues that the introduction of vaccines and related pharmaceutical products is the most significant factor in the rising rates of chronic conditions. This fundamental disagreement challenges the prevailing narrative about the causes of the chronic disease epidemic in the United States.

Question 28: What connection does the study make between healthcare costs, the pharmaceutical industry, and vaccination?

The study draws a direct connection between rising healthcare costs, the pharmaceutical industry, and widespread vaccination. It notes that the CDC itself reports that chronic life-threatening diseases and disorders are exceedingly common in the US population and are becoming even more so, driving annual healthcare costs to $4.1 trillion.

However, the study argues that while the CDC promotes pharmaceuticals, including vaccines, as the solution to the nation's chronic disease issues, these very products

are in fact the primary causal factors of the health crisis. The CGS findings suggest that by avoiding vaccines and related pharmaceutical products, individuals could dramatically reduce their risk of chronic conditions, potentially leading to significant reductions in healthcare costs. This perspective implies that the current approach to public health, heavily reliant on vaccination and pharmaceutical interventions, may be perpetuating a cycle of poor health and high healthcare costs.

Question 29: How do state vaccine policies impact unvaccinated populations, according to the study?

The study indicates that state vaccine policies have a significant impact on unvaccinated populations. It notes that after 2015, there was a sharp decline in the rate of total vaccine avoidance in children under 18 years due to the passage of harsh new vaccine mandate laws in the most populated states. This trend suggests that stricter vaccine policies are reducing the number of entirely unvaccinated individuals.

The study also mentions that in two states, Iowa and Mississippi, the entirely unvaccinated numbers dropped so close to zero that it made no sense to persist in trying to locate unvaccinated persons in those states for the survey. This observation highlights how state-level policies can effectively eliminate the option of remaining unvaccinated, potentially impacting the ability to conduct comparative health studies between vaccinated and unvaccinated populations in the future.

Question 30: What legal and ethical considerations are mentioned regarding the health survey?

The study mentions several legal and ethical considerations regarding the health survey. It notes that the study was initiated as a product safety survey, conducted in accordance with the requirements of the federal rules of evidence for admissibility in product safety actions. This approach suggests an intention to use the survey results in legal proceedings related to vaccine safety.

Additionally, the study emphasizes privacy protection for participants. It states that all personally identifying information would be redacted before any documents were copied or shared, and that originals would be kept in a secured location until destroyed. The study also notes that while surveyors might need to testify under oath to authenticate that respondents were real people who swore their answers were truthful, the law does not require sharing the identities of respondents with anyone, even when submitting the surveys as evidence in court. These measures indicate a commitment to protecting participants' privacy while maintaining the legal validity of the survey data.

Question 31: How does the paper apply toxicology principles to the interpretation of vaccine ingredients and their effects?

The paper applies basic toxicology principles to interpret the effects of vaccine ingredients. It states that the general rule in toxicology is that, all else being equal, incrementing toxicant exposures must trend toward a greater number and severity of disorders, diseases, and deaths with algebraic certainty. This principle is applied to vaccines, maternal shots during pregnancies, and the vitamin K shot given to neonates.

The study also discusses the concept of synergistic effects of multiple toxicants, noting that these effects can be multiplicative and potentially many times more intense than if the toxicants were acting in isolation. It points out that as the number

of combined toxicants increases beyond five, the likelihood of their interactions being examined in systematic clinical safety studies rapidly drops to zero. This application of toxicology principles leads the study to question the safety of vaccines, which contain multiple ingredients and potential contaminants.

Question 32: What alternative health perspectives does the study present?

The primary alternative health perspective presented in the study is the idea that avoiding vaccines and related pharmaceutical products is the most effective way to prevent chronic diseases and maintain good health. The study suggests that by remaining unvaccinated, individuals can significantly reduce their risk of developing a wide range of chronic conditions.

This perspective challenges the conventional medical approach that promotes vaccination as a key preventive health measure. Instead, the study proposes that the avoidance of vaccines and related products should be considered the "number one most imperative preventative 'health measure' anyone can take to reduce their risk of disabling and deadly diseases and disorders." This alternative view is based on the study's findings of significantly better health outcomes in unvaccinated individuals compared to the vaccinated population.

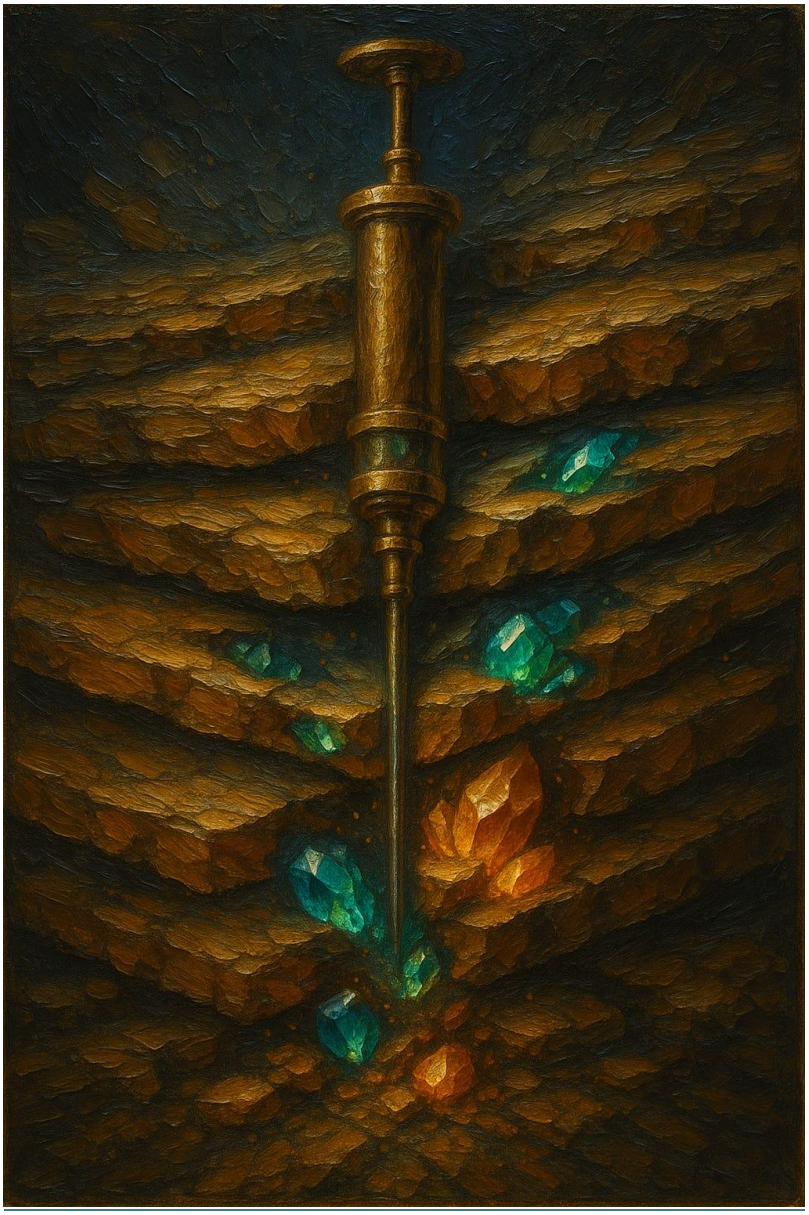
Question 33: How does the paper critique the CDC's use of baseline disease rates in vaccine studies?

The paper criticizes the CDC's use of baseline disease rates in vaccine studies, arguing that these rates are fundamentally flawed. It states that mainstream vaccine science bases the natural background rates for diseases and disabilities upon the rates observed in the 99.74% vaccine-exposed population. This approach, according to the study, leads to a significant underestimation of vaccine risks.

The study argues that when comparing new vaccine injuries to old vaccine injuries, there is likely to be far less difference than if the vaccine-injured persons were compared against persons who never received any vaccine. As a result, new vaccines can be declared "safe" if they do not significantly increase the risk of illness or death compared to the already elevated baseline rates in the vaccinated population. The study contends that this method obscures the true impact of vaccines on health and fails to establish a genuine safety profile for vaccine products.

An Inconvenient Study

A Documentary Review



“An Inconvenient Study” delivers a gripping piece of investigative journalism that will leave viewers questioning everything they thought they knew about vaccine safety research. When medical journalist Del Bigtree challenged Dr. Marcus Zervos of the prestigious Henry Ford Health System to conduct the most comprehensive vaccinated versus unvaccinated study ever undertaken, neither anticipated the explosive journey that would follow. The documentary’s hidden camera revelation—capturing Dr. Zervos admitting that publishing his completed study would end his career—provides one of the most stunning moments in recent documentary filmmaking. With over 18,000 subjects studied and shocking disparities found between vaccinated and unvaccinated children’s health outcomes, this film exposes what appears to be a deliberate suppression of critical public health data that every parent deserves to see.

Del Bigtree brings unique credibility to this investigation, having evolved from CBS medical journalist to becoming one of the most persistent voices demanding

transparency in vaccine safety science. Through his nonprofit ICAN (Informed Consent Action Network), he's successfully sued government agencies and uncovered the startling absence of proper placebo-controlled trials for childhood vaccines—victories that provide crucial context for understanding why the Henry Ford study matters so profoundly. The documentary skillfully weaves Bigtree's personal journey with the larger narrative, showing how his production of the original "Vaxxed" documentary opened his eyes to thousands of parents reporting similar patterns of vaccine injury. His encounter with Colton, a 13-year-old paralyzed by the HPV vaccine who tragically took his own life in 2018, provides emotional weight that grounds the statistical arguments in human reality.

The relationship between Bigtree and Dr. Zervos forms the documentary's compelling core, with Zervos emerging as a complex figure caught between scientific integrity and institutional pressure. His credentials—having solved the Flint water crisis and conducted controversial hydroxychloroquine research—establish him as someone willing to challenge orthodoxy when lives are at stake. The film's presentation of the study's findings is staggering: vaccinated children showed 4.29 times higher rates of asthma, nearly six times higher rates of autoimmune disease, and 5.5 times higher rates of neurodevelopmental disorders. Most remarkably, among nearly 2,000 unvaccinated children, there were zero cases of ADHD compared to 262 cases in the vaccinated group. When Zervos admits on hidden camera that he would publish the study "just how it is" if not for the current climate, calling the findings "important" while simultaneously refusing to publish out of career preservation fears, the documentary captures a scientist's moral crisis in real-time.

The film's methodological approach demonstrates sophisticated understanding of epidemiological research while remaining accessible to general audiences. Rather than simply dismissing potential criticisms, the documentary shows how the Henry Ford team conducted multiple sensitivity analyses, adjusting for follow-up time, healthcare-seeking behavior, and various confounders—yet the alarming disparities persisted. The visual presentation of data, particularly the graph showing that by age 10 only 43% of vaccinated children remained free from chronic health conditions compared to 83% of unvaccinated children, makes complex statistics immediately comprehensible. The film strengthens its case by contextualizing the Henry Ford study within other independent research, including Dr. Peter Aaby's shocking findings from Guinea-Bissau where DTP-vaccinated children had five times higher mortality rates despite being protected from the target diseases.

The documentary's investigative techniques create undeniable dramatic tension while raising important questions about scientific transparency. The decision to use hidden cameras, while controversial, proves justified when Zervos's candid admissions reveal the gulf between private acknowledgment and public silence. The film effectively contrasts heart-wrenching parent testimonials—particularly the devastating account of triplets who simultaneously regressed after vaccination—with the cold institutional responses that dismiss their experiences. Attorney Aaron Siri's deposition of vaccine luminary Dr. Stanley Plotkin provides another documentary highlight, with Plotkin admitting under oath that five-day safety trials cannot detect autoimmune or neurological conditions that develop after that window, essentially acknowledging that vaccine safety science rests on assumptions rather than data.

From a cinematographic perspective, "An Inconvenient Study" excels at building narrative tension through careful pacing and strategic reveals. The filmmakers wisely

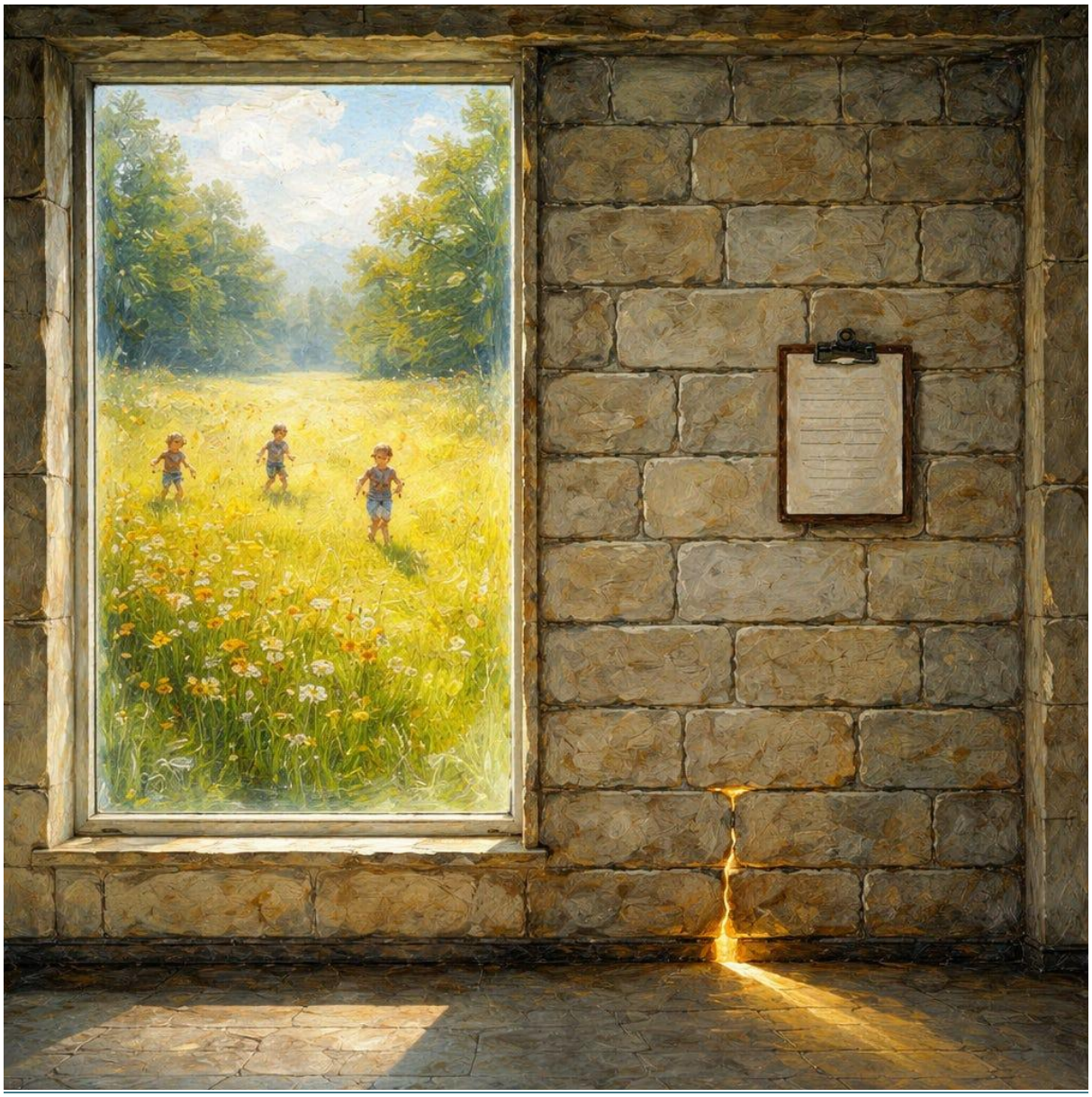
hold back the actual study results until after establishing the credibility of both Bigtree and Zervos, making the eventual revelations land with maximum impact. The hidden camera footage, while grainy, carries the authentic tension of genuine investigative journalism—this isn't polished propaganda but raw documentation of a scientist's confession. The film's emotional range, from parents' anguished testimonials to Bigtree's visible frustration when Zervos refuses to publish, creates a human dimension that prevents the documentary from becoming merely a data presentation. The inclusion of the cease-and-desist letter from Henry Ford Health's attorneys in the film's conclusion adds a layer of institutional intimidation that reinforces the documentary's central thesis about suppression.

"An Inconvenient Study" stands as essential viewing for anyone concerned about children's health, scientific integrity, or institutional transparency. The documentary's power lies not in telling viewers what to think but in exposing information that has been deliberately withheld, allowing audiences to draw their own conclusions. When Dr. Zervos states that "nothing is going to come out of it other than me losing my job," he inadvertently explains why this study remained hidden and why Bigtree felt compelled to expose it through unconventional means. The film's call for other institutions to replicate this research feels less like activism and more like basic scientific principle—if the Henry Ford study is flawed, prove it through replication, not suppression. For parents making health decisions for their children, medical professionals questioning orthodox positions, and citizens concerned about institutional capture of science, this documentary provides crucial information that has been systematically kept from public view. Its ultimate message—that parents deserve access to all safety data before making medical decisions for their children—should resonate regardless of one's position on vaccines, making "An Inconvenient Study" one of the most important documentaries of our time.

WATCH NOW | An Inconvenient Study

The Last Twenty-One Minutes

An Essay on Vaxxed 2, Unvaccinated Children, and the Comment Section That Became the Study



In October 2022, I wrote a short piece called “The Unvaccinated.” The idea was simple: embed the last 21 minutes of the documentary *Vaxxed 2*, where parents of unvaccinated children describe what their kids are actually like, and let readers watch for themselves. Twenty-one minutes. That’s all. Parents talking about their children’s health, one family at a time.

The Unvaccinated

The documentary itself covers a lot of ground, but those final 21 minutes function as a kind of control group made visible. These are children who never received the 72 doses on the US schedule, or the 42 doses on the Australian one. They never had the 38 chemical ingredients injected into their bodies. And their parents — with nothing to gain and quite a lot to lose socially — sat in front of a camera and described what these children are like.

I thought I was sharing a video. What I got back, over three years and counting, was something I didn't expect. The comment section became the study.

They're Calm

The first comment worth noting came from a reader named Sez77, posted in September 2023:

"You know what I notice in the Vaxxed 2 documentary, with all those un-vaxxed kids? They're CALM. They're not interrupting. They're not whining. They're not touching things. They're not fidgeting, or jumping up and down."

She then posed the question that matters: "They've all been either exceptionally well-parented, and well-raised. Or the neurological dysfunction that characterises an overly-vaccinated child is completely absent."

That comment drew 97 likes. It also drew something more important — confirmation from other parents. Kate Freeman noted the children "spoke clearly and in full sentences." Others who had spent time around both vaccinated and unvaccinated children recognised the pattern immediately.

This observation — the calm — is not something you'll find in a peer-reviewed journal. No one has funded a study measuring fidgeting rates in unvaccinated versus vaccinated five-year-olds. But hundreds of independent observers, across years, report the same thing. That convergence is its own kind of data.

The Parental Reports

Over three years, the comment section accumulated testimony from parents across multiple countries, family sizes, and circumstances. The pattern was so consistent it bordered on monotonous. The same observations, from people who had never met, often using the same words.

AstroMommy, mother of five unvaccinated children: "All are very healthy. When they do get sick, they recover beautifully." She described using vitamin C protocols when her children contracted whooping cough — a strain not covered by vaccination — and noted they now carry natural immunity estimated at around 30 years. Only two of her five children ever had an ear infection. Her medicine cabinet: "Food, herbs, essential oils, sleep, vitamin C, sunlight and water."[1]

Michelle Rivera, mother of two unvaccinated children: "Zero vaccines. No rx or otc medications. No allergies, get sick for 2 days max. Like night and day compared to my childhood — fully vaxxed and ear infections and antibiotics constantly."

Kelly: "My kids are also completely unvaccinated. They are now 18 and 12 and never been sick. Best decision I've ever made."

Joe Jacovino: "My two unvaxxed kids were always healthier than their classmates."

Misterkel, father of two unvaccinated teenagers: "Healthy as fuk. Sicknesses very brief and mild. Much better than v'd friends."

GENDUN LAMA: "My son and his wife were about to have their first and I told them not to vax. Now they have three brilliant, healthy totally unvaxxed and organically fed kids, and we're all beyond glad for that decision."

The recurring themes across these reports are worth cataloguing. Parents consistently describe:

Illness brevity. When unvaccinated children get sick — and they do get sick — the illness resolves quickly. Two days is a common reported duration. Parents of vaccinated children, by contrast, describe protracted illnesses, recurring infections, and antibiotic cycles.

Absence of chronic conditions. Allergies, asthma, eczema, and ear infections are conspicuously absent from the unvaccinated reports. These conditions are so common among vaccinated children that many parents consider them normal features of childhood. They are not.

Cognitive and behavioural sharpness. Multiple parents describe their unvaccinated children as unusually focused, articulate, and emotionally regulated. This observation crops up independently across the thread, from parents who have no contact with each other.

Marissa, mother of five unvaccinated children, noticed something specific about ear infections: “Literally never have any had an ear infection. We all go swimming in pools and Galveston (dirty Gulf water lol). It’s not for lack of trying! Ear infections seem like a major bugbear for some kids, especially my fully vaccinated niblings.”

The ear infection observation is worth pausing on. Dr. Paul Thomas’s practice data from Portland, Oregon — 2,763 vaccinated children compared with 561 unvaccinated children over ten years — found that office visits for ear infections were significantly more common in the vaccinated group.[2] Hooker and Miller’s 2021 study found an odds ratio of 27.8 for chronic ear infections in fully vaccinated versus unvaccinated children, with a p-value below 0.001.[3] Marissa didn’t know about these studies. She just knew her five kids never got ear infections despite swimming in the Gulf of Mexico.

ADHD showed the same convergence. In Dr. Thomas’s practice, zero unvaccinated patients exhibited ADHD, compared to 5.3% of the vaccinated group.[4] The Control Group survey of unvaccinated Americans, covering 1,482 participants across 48 states, found the vaccinated population had roughly 20 times the incidence of ADHD.[5] Again, the parents in the comment section didn’t cite these numbers. They just described what they saw: calm kids who could focus, sit still, and regulate their emotions.

This is what triangulation looks like in practice. The formal studies, the practice data, and the parental reports all point in the same direction. No single thread is conclusive. Together, they become difficult to dismiss.

The Ingredient Question

In the original post, I quoted J.B. Handley’s observation from *How to End the Autism Epidemic*. Of the 38 ingredients present in two or more vaccines on the American schedule, exactly one — thimerosal — has been studied for its relationship to autism. The other 37 have not been studied at all.[6]

Handley lists them: 2-Phenoxyethanol, albumin, aluminum hydroxide, aluminum potassium sulfate, amino acids, ammonium sulfate, antibiotics, bovine components, bovine serum, chick embryo cell culture, culture, detergent, dextrose, enzymes, formaldehyde, gelatin, glutaraldehyde, human components, human embryonic cells, lactalbumin hydrolysate, medium 199, mineral salts, monosodium L-glutamate, phenol, phosphate, polymixin B sulfate, polysorbate-80, potassium aluminum sulfate, potassium chloride, potassium phosphate monobasic, sodium borate, sodium

chloride, sodium phosphate dibasic, sorbitol, soy peptone, sucrose, thimerosal, vero (monkey kidney) cells, and yeast protein.

One out of 38 studied, and the case is declared closed.

Three years later, nothing has changed. No additional ingredients have been studied for their relationship to autism or any other neurodevelopmental condition. The same authorities who insist vaccines have been thoroughly studied continue to rely on the examination of a single ingredient as evidence that the entire cocktail is safe.

David Kirby, former *New York Times* investigative journalist, put it precisely: "It is illogical to exonerate all vaccines, all vaccine ingredients, and the total US vaccine program as a whole, based solely on a handful of epidemiological studies of just one vaccine and one vaccine ingredient."[7]

The Veterinary Parallel

One of the more unexpected threads in the comments came from outside human medicine entirely.

Cara K described reading *What Your Vet Won't Tell You About Vaccines* and its discussion of calmer, less hyperactive puppies when they skipped their shots. She had two husky-cross pups — breeds known for high energy — who were "surprisingly calm." She made an observation that deserves wider attention: "A practicing vet sees more generations of dogs than human docs, so sometimes the differences in health and longevity can be seen more clearly."

Theo Farmer, who runs a herd of 75 cattle, went further: "We haven't vaccinated any of our cows since we started farming in 2010. No pharmaceuticals ever. The herd health is stunning, particularly our calving experiences, which are hands off."

The cross-species pattern matters because it eliminates several common objections. You can't attribute a cow's health to parenting style, diet ideology, or confirmation bias. Animals don't read Substack. They don't have beliefs about vaccines. They either get sick or they don't. When unvaccinated herds consistently outperform vaccinated ones in calving outcomes and general health, the variable being tested is the injection itself.

The Ones Who Regret

Not everyone in the comments was celebrating. A significant thread came from parents who vaccinated their children and wish they hadn't.

Carol Rivers: "I unfortunately raised three children before I found out, woke up in regards to vaccinations. I have to live with this the rest of my life and I am very regretful."

J. Harris: "I too am a mother of three who unfortunately, listened to the 'experts' and vaxxed my kids at 'well-visits.' My eldest even had a reaction (a seizure 2-3 days after vax) to his first MMR or the combination of all the vaxxes he received. And, I still continued to vaxx my kids because what did I know compared to the paediatricians?"

Robin Landry: "My vaccinated son (1989) had pneumonia 3 times starting at 5 months old. He was on antibiotics for one whole winter as a toddler."

Green Fields: "I can't turn back time and dearly wish I had known this information before he was born."

These voices carry a particular weight because they come with nothing to gain. No parent enjoys publicly admitting they harmed their child through trust in medical authority. The regret is not performative. It's the kind of statement people make when the evidence has become impossible to deny in their own household.

J. Harris's detail is especially significant — her son seized within days of vaccination, and she continued the schedule anyway. Not because she was reckless, but because the asymmetry of authority was total. She was a mother. They were paediatricians. The idea that they could be systematically wrong was, at that point, unthinkable.

The Sharpest Grief

The most painful thread came from parents who did everything right for decades — and then watched their adult children surrender to coercion.

Christine Grace raised two children completely unvaccinated to the ages of 28 and 30. Then came 2020. Both took the COVID injections "out of pure fear and domination." Both cut her out of their lives for years during the period of mandates. She wrote: "I am welcome back now and no discussion bout past… i have surrendered completely."

The phrase "out of pure fear and domination" deserves attention. These were not children making an informed medical decision. They were adults who had been healthy their entire lives, raised by a mother who had done the research and made the harder choice for 28 years — and they broke under social and economic pressure that was deliberately designed to be unbearable. Employment mandates. Travel restrictions. Social exclusion. The architecture of coercion worked exactly as intended.

A reader using the name "Unapologetically Me" told a parallel story from Canada. She raised her son unvaccinated from birth in 1997. He was healthy his entire childhood. In 2021, aged 24, he took two Pfizer doses under Trudeau's mandates. By February 2024, he was diagnosed with a severe autoimmune disease. He is now 28, on three immunosuppressive drugs and an antidepressant, likely for life.

"For new parents, old parents and grandparents," she wrote. "Teach your children well. Flee any country which would force you to poison your babies."

When I reached out to publish her story, she responded months later with a weariness that has become familiar among vaccine-injury families: "Is there really any importance in relating my Canadian jab injured son's story here? There are MILLIONS of Covid vaccine injured victims. No acknowledgement from medical 'specialists.' No inquiries."

These stories represent a category of harm that no clinical trial will capture. A mother protects her child from a pharmaceutical programme for a quarter century, and a government mandate undoes it in an afternoon. The formal study that would document this — health outcomes in previously unvaccinated adults who took COVID injections under coercion — will never be funded. But the testimony exists, timestamped and public. The pattern is there: protect for decades, lose to mandate pressure, suffer the consequences, receive no acknowledgement.

Cindy: A Case Study in Institutional Thinking

Among hundreds of comments, one voice stood out for its persistence and its precision as an exhibit of how institutional capture operates at the individual level. A commenter named Cindy returned to the thread repeatedly over more than a year,

offering increasingly elaborate defences of the vaccination orthodoxy. She is articulate. She is educated. She has family members in medicine and science. And her arguments, taken together, constitute a near-perfect catalogue of the cognitive architecture that prevents otherwise intelligent people from engaging with inconvenient evidence.

Her arguments followed a recognisable sequence. Each one deserves examination — not to ridicule Cindy, but because every curious sceptic has either made these arguments or heard them from someone they trust.

The demand for peer review. Cindy insisted repeatedly that she "only pays attention to hard, peer-reviewed science." This is a reasonable-sounding position until you examine what it actually excludes and why. The peer-reviewed journals she trusts are predominantly funded through pharmaceutical advertising revenue and industry fees. The FDA receives 65% of its drug review budget from user fees paid by the companies whose products it evaluates. The studies Cindy demands — large-scale vaccinated-versus-unvaccinated comparisons — have been actively blocked by the very agencies that would need to conduct them. Robert F. Kennedy Jr. and Aaron Siri documented this in detail: when they pressed the NIH for such a study, officials first claimed the Vaccine Safety Datalink couldn't support it, then claimed there weren't enough unvaccinated children in the database.[8] Both claims were false. The CDC's own 2013 data showed approximately 3,200 completely unvaccinated children in the VSD within a four-year window alone, with 25 years of data available.[9]

The demand for peer review becomes circular when the institutions controlling the journals are the same institutions avoiding the research. It's like demanding a confession from the suspect while allowing the suspect to decide which questions get asked.

The dismissal of observation while relying on it. Cindy dismissed others' personal experiences as mere "anecdotes" — then offered her own at length. Her son received all scheduled vaccinations and has been sick "exactly FIVE TIMES in HIS ENTIRE LIFE." Her family of 26 members never had problems from any vaccination. She presented this as evidence that vaccines are safe — having just finished explaining that personal experience is inadmissible evidence.

She did not see the contradiction. This is not because she is stupid. It is because the framework she operates within has a one-way valve: observations that confirm the orthodoxy are "experience." Observations that challenge it are "anecdotes."

The appeal to credentials. Her closing argument was a declaration of caste: "What I see underlying all the fear and concern about vaccinations is that none of you folks are scientists or paediatricians." Her brother teaches paediatric infectious diseases. Her husband is a scientist. Their friends have PhDs. "These are not stupid people. Anyone who thinks they're smarter than them is a fool."

This forecloses inquiry by social hierarchy rather than evidence. And it ignores what happens to credentialed people who dissent. Dr. Paul Thomas was a paediatrician — a highly successful one with over 15,000 patients — and when he published data showing his unvaccinated patients were healthier, the Oregon Medical Board suspended his licence within a week.[10] Not for harming patients. For publishing data. The order accused him of "unprofessional or dishonorable conduct" and stated his "continued practice constitutes an immediate danger to the public" — a remarkable claim about a doctor whose unvaccinated patients had zero cases of ADHD.

The system does not reward credentialed dissenters. It destroys them. Cindy's brother publishes safely because he publishes within the lines. The credentials argument only works if you ignore what happens to the credentialed who break ranks.

The seatbelt analogy. "My kids never wear seatbelts in the car and they're still doing fine," she wrote sarcastically. "Do you really want to take that risk?" The analogy fails at every joint. Seatbelts have been tested in crash scenarios with inert control groups. The mechanism of protection is transparent and mechanical. The failure mode is visible and immediate. Vaccines have not been tested against true saline placebos.[11] The mechanism by which 38 injected ingredients interact with a developing infant immune system has never been studied as a system. And the failure mode — neurological damage that unfolds over months or years — is designed to be invisible within the timeframe of any clinical observation window. A seatbelt either holds you in a crash or it doesn't. The question with vaccines is whether the crash was caused by the seatbelt.

Cindy is not the enemy. She is the product. She represents what a well-educated, well-meaning person looks like after a lifetime of trusting institutions that have earned that trust in some domains and systematically abused it in others. Every defence she offers is one the curious sceptic has used themselves, or heard from someone they respect. Her arguments deserve serious engagement — not because they're correct, but because they're the exact barriers that prevent otherwise intelligent people from examining the evidence with their own eyes.

The Study That Exists

While the comment section was accumulating testimony, the formal research was quietly advancing.

Joy Lucette Garner, founder of The Control Group study, appeared in the comments with specific numbers. Her survey of entirely unvaccinated Americans across 48 states found that the total risk of at least one chronic condition after age 18 was 2.64% for lifetime unvaccinated individuals, compared to over 60% for the vaccinated population.[12]

The Control Group data showed vaccinated children had roughly 20 times the incidence of ADHD (9.4% versus 0.47%) and over 10 times the incidence of autism (2.5% versus 0.21%) compared to unvaccinated children.[13] These findings aligned with Hooker and Miller's 2021 study, which found odds ratios for ADD/ADHD and autism of 20.8 and 5.0 respectively between vaccinated and unvaccinated children.[14]

The Mawson pilot study of homeschooled children found an odds ratio of 4.2 for both autism and ADHD between vaccinated and unvaccinated groups.[15] The Dutch NVKP survey showed substantially higher levels of single and multiple chronic disorders among vaccinated versus unvaccinated children across asthma, allergies, and eczema.[16]

These studies exist. They are published. They consistently show the same thing. And they are consistently ignored, attacked, or retracted under pressure.

Dr. Thomas's story is instructive. He opened his Portland practice in 2008, offering parents the option to delay, modify, or decline vaccines based on informed consent. The practice grew to over 15,000 patients. In 2019, the Oregon Medical Board demanded he prove his approach was as safe as the CDC schedule. So he did. He hired an independent researcher, gathered over ten years of data on every child born

into his practice, and published the results with James Lyons-Weiler. The findings were unambiguous: vaccinated children had four to eight times more office visits for chronic conditions including asthma, allergic rhinitis, behavioural issues, and eczema. ADHD was nonexistent among the unvaccinated.[4]

Thomas himself later reflected on what this meant: "Having your brain on fire is not comfortable. No matter how hard it is to parent a kid with ADHD, it's that much harder to be a kid with ADHD."

The Oregon Medical Board's response to receiving the evidence it had demanded was to suspend Thomas's licence within a week of publication. The order stated that his "continued practice constitutes an immediate danger to the public."[10] They accused him of "fraudulently asserting" that his schedule would prevent autism — an accusation that amounts to punishing a doctor for publishing data that showed his patients were healthier.

The journal retracted the paper under circumstances the authors described as procedurally improper — with a vague statement about "concerns regarding the validity of the conclusions" and no specific methodological critique.[17] The paper was subsequently republished in the *International Journal of Vaccine Theory, Practice, and Research*.[18] Thomas, unable to practise under the Board's restrictive conditions, relinquished his licence in December 2022.

The pattern is not subtle: publish data showing unvaccinated children are healthier, and face professional destruction. Dr. Thomas lost his licence. Dr. Andrew Wakefield lost his career decades earlier. The studies get retracted. The journals close ranks. And the absence of further research is then cited as proof that the question has been settled.

This is the environment in which Cindy demands peer-reviewed evidence. The machine that produces peer-reviewed evidence destroys anyone who uses it to ask the wrong question.

The Segregation

There is one more mechanism worth naming, because it operates beneath all the others.

Across most Western countries, unvaccinated children are barred from childcare and preschool. The stated reason is disease prevention — protecting other children from unvaccinated carriers. The actual function is simpler: it prevents vaccinated families from seeing unvaccinated children.

If unvaccinated three-year-olds sat in the same rooms as vaccinated three-year-olds, the differences described throughout this essay — the calm, the absence of ear infections, the lack of chronic illness, the cognitive sharpness — would be observable by every parent at pickup time. Mothers would notice. They would talk. They would ask questions. The comparison that no institution will fund as a formal study would happen informally, thousands of times a day, in waiting rooms and playgrounds and birthday parties.

The exclusion of unvaccinated children from communal spaces is not just punitive. It is epistemic. It is constructed ignorance — a system designed to ensure that the control group remains invisible to the people who would benefit most from seeing it.

This is why the comment section matters as much as it does. It is one of the few places where the segregation breaks down. Parents of unvaccinated children and

parents of vaccinated children occupy the same space, read each other's accounts, and see the pattern. The 21-minute clip from *Vaxxed 2* did the same thing — it put the control group on camera and made it available to anyone willing to press play.

The system cannot afford that comparison. Everything — the exclusion policies, the refusal to fund vax-versus-unvax studies, the retraction of papers, the destruction of dissenting doctors — serves a single function: keeping the two populations apart so the difference between them remains theoretical rather than visible.

What the Comment Section Proves

A comments section on a Substack post is not a controlled trial. It is not peer-reviewed. It does not meet the standards that Cindy and her brother would accept as evidence.

But it is something. And the something it is matters.

It is several hundred independent observations, made over three years, by people with no financial incentive to lie, describing the same phenomenon from different angles: unvaccinated children who are calm, healthy, rarely sick, quick to recover, free of chronic conditions, and cognitively sharp. Alongside them, parents of vaccinated children reporting the opposite — ear infections, behavioural issues, autoimmune problems, developmental delays — and wishing they had known.

These observations converge with formal study data from Thomas's practice, Hooker and Miller's research, The Control Group survey, the Mawson studies, and the Dutch NVKP survey. The parental reports and the published data describe the same reality from different vantage points. The convergence is the evidence.

When insurance actuarial data, paediatric practice records, parent surveys, cross-species veterinary observation, and an open comment thread all point in the same direction — at some point, the demand for "more research" stops being scientific caution and starts being a refusal to look.

The comment section also revealed something the formal studies cannot: the human texture of what this knowledge costs. The mother who vaccinated three children before she learned. The father who watched his grandson change overnight. The woman who protected her son for 27 years, only to see a government mandate undo her work in an afternoon. These are not data points. They are lives. And they carry a kind of evidence that no p-value can capture — the evidence of consequence, lived and irreversible.

The question that no institution will ask — *What does a human being look like who has never been injected with the current vaccine schedule?* — has been answered anyway. Not by the CDC. Not by the FDA. Not by the TGA. By parents, in a comment section, one family at a time.

The 21-minute clip from *Vaxxed 2* that I embedded in 2022 showed us these children on camera. The comment section showed us that they're everywhere — quiet, healthy, and invisible to a medical system that has no interest in studying them.

Three years of testimony. Hundreds of families. Multiple countries. One consistent finding.

Zero institutional curiosity.

The document is public. The comments are timestamped. The pattern is there for anyone willing to look.

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The very first injection - Vitamin K: "It's just a vitamin"

Monkeys and bananas

I remember the midwife asking me if it was OK to give our first child Vit K. I didn't really know what to do with the question and was surprised I was being asked. The conversation went something like this:

Me: I don't know how to answer that question, I have no idea what the pros and cons are.

Her: All parents do it, it's good for the babies.

Me: So, are you advising us to do it?

Her: No, it's your choice, you need to tell us to do it. But everybody does it.

Anyway, something like that, and I was entirely ill equipped to think my way through it, so I gave the go ahead. Why wouldn't I…everybody did it after all.

There was no mention of it being a clotting agent, of bleeding nor of circumcision (but more on that later).

When I reflect on that discussion, I am confident SHE didn't even know why she was pushing it. She was simply a monkey in the cage, beating up the new monkey (me) so that I wouldn't climb the ladder (not inject). But none of us knew why we shouldn't climb the ladder, all we knew is that "everybody" stays away from the ladder (watch the video above).

What I especially like about his Vit K injection is that it's NOT on the vaccine schedule, yet you are still coerced into getting it, so it might as well be. This time the "vaccine" halo isn't relied upon, instead the "vitamin" halo is used. I truly admire their genius at language use and linguistic engineering.

Here is the first of two episodes (Episodes 2 + 3) that Candace Owens does on the subject (although the beginning of Episode 4 also addresses it) that forms the backbone of this article.

A Shot In The Dark - "It's Just A Vitamin" (Vitamin K)

A Shot In The Dark | The Circumcision Decision

She starts the episode following on from Episode 1 (HPV vaccine) and makes the point that all Vaccine Pharma needs to do to shut everybody up is fund a study to track vaccinated vs unvaccinated kids to see what the different health outcomes are. This is a point that I've heard Kennedy Jr. make several times. But according to Candace the reason they won't do it is because it's "too unethical" to deprive the unvaccinated kids of the wonders of vaccination. I would have found that hard to believe in the past, but not today as I've seen them use the "ethics" argument to destroy the Covid jab control groups.

None of these products (including Vit K) have been tested for their impact on cancer. It says so in the product inserts. You could make the case that Pharma is most honest in the fine print (for obvious legal reasons) but nobody reads the fine print, as we don't read the Terms & Conditions of our iPhone software update, but at least with the software updates we know that we are agreeing to allow the companies to basically spy on us, but with vaccines nobody has an intuition about the horrors found inside.

So, if you ask a doctor whether any of these injections cause cancer, there are only two possible answers. An honest doctor will say "I don't know" in which case I'm not sure how that doctor can tell you to inject the potion into your kid, or she will say "No" in which case, as Candace says you have a liar with a degree on your hands.

This point about NOT KNOWING is an important one for me and one I thought about with the Covid jabs back in June last year.

These "vaccines" have not been studied over enough TIME…they have been rushed to market…their primary defect is the spike protein that is now running riot inside the body.

Pricing the UNKOWN is impossible (you can price Probability, but not the Unknown), that's why the Unknown is so risky. Think of Russian Roulette and imagine a gun with a 20 bullet capacity. If you know there was one bullet in the barrel, well you have a 1 in 20 risk (5% probability) of blowing your brains out…the risk has been quantified and you can decide whether to play from there…. obviously if you knew there were 20 bullets in the barrel, you wouldn't pick up the gun.

But what if you DIDN'T KNOW how many bullets there were…could be 20 and could be Zero…would you pick up the gun…I wouldn't, and I don't think anybody else

would? Not knowing how many bullets are in the barrel is the same as knowing there are 20.

Without TIME, you don't know how many bullets are in the vaccine barrel…it is that simple.

So, knowing that it will cause cancer is the same as not knowing whether it will cause cancer!

We need a long terms study that says IT DIDN"T CAUSE CANCER and that study doesn't exist because they don't do them.

But we can come at the question sideways by looking at data straight from the NIH.

There has been a 37% increase in childhood cancer from the early 80s to the early 90s (obviously 1986 they received immunity from being sued and the childhood vaccine schedule increased dramatically), with that rise most pronounced in the first 12 months of life being a 54% rise.

But "there is no apparent explanation" according to The Science.

The Merck Vit K insert that Candace reads from says: Studies of carcinogenicity (its potential to cause cancer), mutagenesis (the production of genetic mutations) or impairment of fertility have not been conducted.

"We don't know if this will make your beautiful baby girl infertile, or develop cancer for that matter, but we strongly recommend you take it…because Monkeys and Bananas."

I am no cancer expert and it's something I have realised I don't properly understand, but one thing I have come to learn during the last two years and specifically from reading Duesberg is that when you mess with the immune system, cancers pop up. It seems that one of the functions of the immune system is to keep a harmony and balance in the system, when that balance is lost, cells can start to split in ways they shouldn't, and cancers emerge. It makes absolute sense that flooding a child's body with agents that mess around with their immune systems would lead to a rise in cancers.

Candace tells the story of an Illinois couple who had the police turn up at their door because they chose to not stab their kid with Vit K (it's hard to believe but there you have it). The State being co-opted as a willing participant into the coercion of citizens to get a chemical intervention seems to be very much an American innovation and an American export. The police knocked on this couple's door in Illinois and those same police have knocked on doors all over the world during Covid. Industry and government joining forces against the gradually less and less sovereign citizen.

So, what is Vitamin K and why do they want you to take it?

Well, it's a coagulant to prevent you baby from bleeding as they don't have much natural Vitamin K when they are born.

Ok, let's stop here for a moment and think this through; Why would my baby be bleeding after birth?

Bleeding isn't some mystery condition, they are either bleeding or they are not, you can SEE it, there is no guess work…so why not just give it to the baby IF it's bleeding instead of to all of them. That would make too much sense. Monkeys and bananas.

You can retort with “well you cannot see internal bleeding”, and I would say, why would a baby be bleeding internally and how often does that happen anyway and why would you inject all babies on the off chance they MIGHT have internal bleeding. That sounds stupid to me. Monkeys and bananas.

Then there’s the point about having naturally low Vitamin K. Are we saying that mother nature got this one wrong all these years, that somehow evolution messed up on this point and industry has thankfully jumped in to save us and correct this oversight?

If you have “low” (there is another great use of language) levels of something at birth, that means IT IS MEANT TO BE THAT WAY! There is nothing “low” about it.

Vit K “deficiency”, there’s another great word!

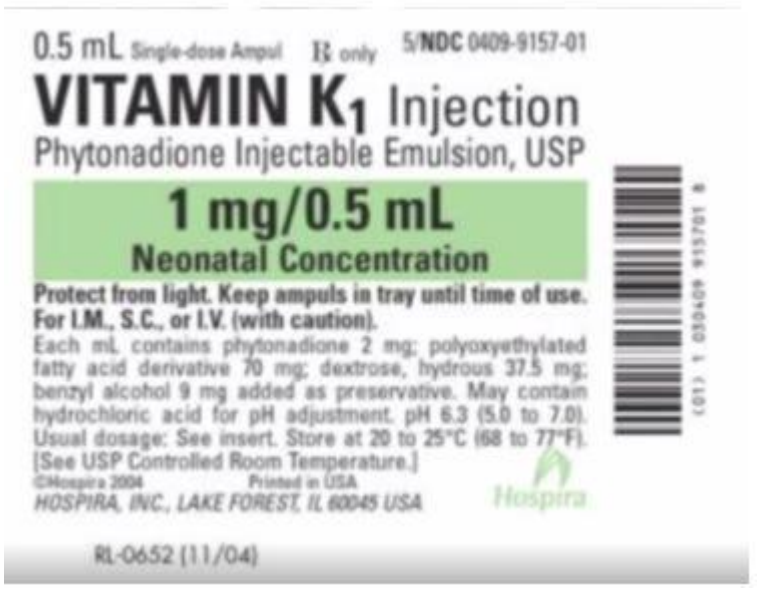
VKDB: Vitamin K Deficiency Bleeding. What a great acronym full of great words.

So, Pharma has managed to turn something natural into a deficiency problem that now requires their solution.

The Vit K Candace is looking at is made by Hospira (there are others) that is owned by Pfizer. The trusted tentacles of Pfizer and very long.

She makes an interesting point about the severity of the warnings in the insert. They are even more extreme than usual.

Phytonadione is synthetic Vit K.



The product insert says that Vit K has been seen to cause jaundice and hyperbilirubinemia (severe jaundice), if that isn’t bad enough, it turns out that 60% of babies have jaundice. I had to listen to her say this multiple times because I thought Candace made a mistake, surely 60% of babies don’t have the same problem, do they? So, I did a couple of searches and found this:

Hyperbilirubinemia in Neonates: Types, Causes, Clinical Examinations, Preventive Measures and Treatments: A Narrative Review Article - PMC (nih.gov)

Between 60%–80% of healthy infants are expected to present with idiopathic neonatal jaundice.

Idiopathic is the key word:

Relating to or denoting any disease or condition which arises spontaneously or for which the cause is unknown.

So, in summary, most babies are injected with Vit K, that is known to cause jaundice, most babies have jaundice, yet apparently it is a total mystery to the medical establishment…the cause is unknown.

What a shameless racket.

"There is no evidence that…"

Candance makes this point well. The insert is full of references to there being "no evidence that so and so causes so and so". For example, the insert says that in relation to benzyl alcohol as a preservative in Vit K "there is no evidence that it is associated with toxicity".

It's such a wonderful bit of linguistic engineering. It reads as if they have done all the studies and concluded that "they found no evidence", but they haven't done that, they haven't done the studies. They don't go looking in the first place, that's why "there is no evidence".

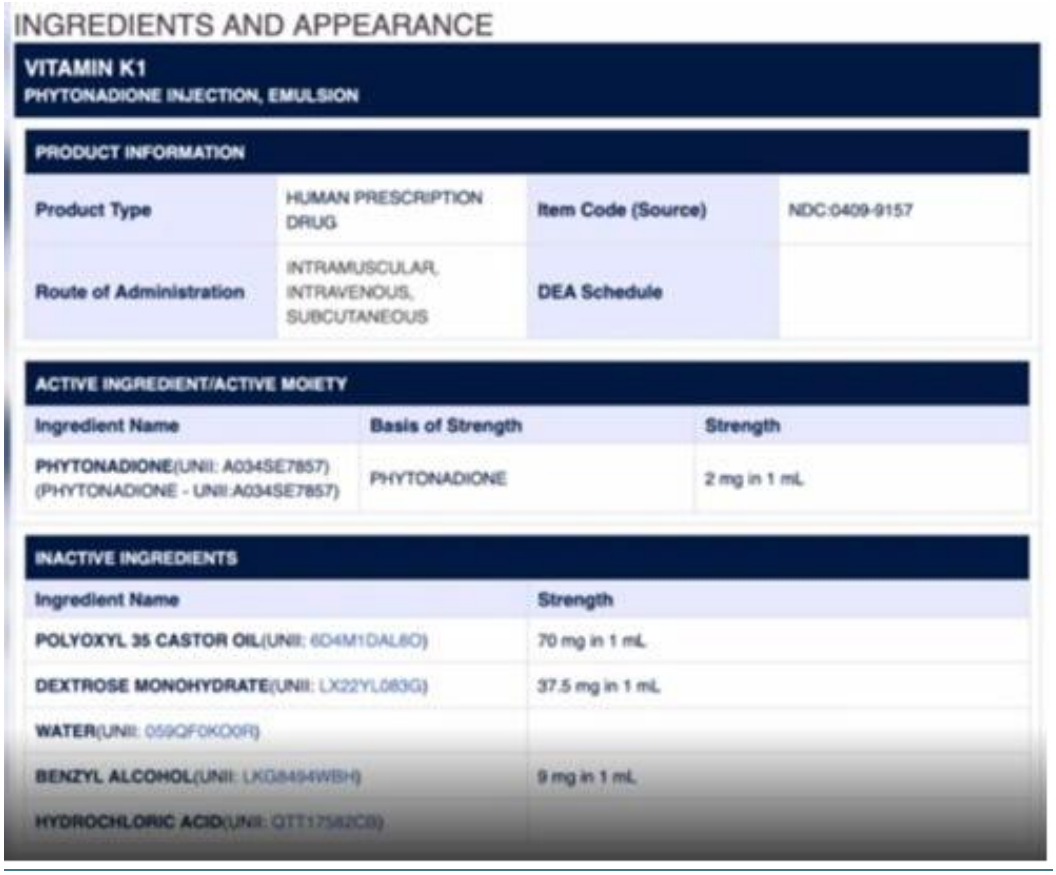
It's a bit like the rule of court room lawyers, you don't ask a question of a witness that you don't already know the answer. You don't do a study that might tell you something that you don't want to know, a truth that is inconvenient to your narrative.

This is arguably the primary dynamic that has led to the corruption of medicine. The directing of research. Pharma and it's captured agencies get to decide what they study and what they don't and in doing so have focused on what is useful and profitable to the business model and purposefully ignored what is hurtful to all the narratives. Aaron Kheriaty said it well in a recent tweet.

Remember "there is no evidence" that the Vit K shot causes cancer.

As to the ingredients, you can see the synthetic Vit K (phytonadione) is the smallest component of this injection. For example, there is 2mg of Vit K in 1 mL but there is:

- 70 mg of polyoxyl 35 castor oil
- 37.5 dextrose monohydrate
- 9 mg benzyl alcohol



INGREDIENTS AND APPEARANCE

VITAMIN K1
PHYTONADIONE INJECTION, EMULSION

PRODUCT INFORMATION			
Product Type	HUMAN PRESCRIPTION DRUG	Item Code (Source)	NDC:0409-9157
Route of Administration	INTRAMUSCULAR, INTRAVENOUS, SUBCUTANEOUS	DEA Schedule	

ACTIVE INGREDIENT/ACTIVE MOIETY		
Ingredient Name	Basis of Strength	Strength
PHYTONADIONE(UNII: A034SE7857) (PHYTONADIONE - UNII:A034SE7857)	PHYTONADIONE	2 mg in 1 mL

INACTIVE INGREDIENTS	
Ingredient Name	Strength
POLYOXYL 35 CASTOR OIL(UNII: 6D4M1DAL8O)	70 mg in 1 mL
DEXTROSE MONOHYDRATE(UNII: LX22YL083G)	37.5 mg in 1 mL
WATER(UNII: 059QF0KO0R)	
BENZYL ALCOHOL(UNII: LKG8494WBH)	9 mg in 1 mL
HYDROCHLORIC ACID(UNII: QTT17582CB)	

What I like the most is that all these sit under the heading of “inactive ingredients”, another great word play…”inactive” suggests “that it does nothing”. Well according to the NIH itself, on one of its other sites it doesn’t seems to be an entirely “idle ingredient”.

Polyoxyl 35 castor oil | C63H116O15 - PubChem (nih.gov)

Turns out our castor oil is an irritant:

H315 (13.97%): Causes skin irritation [Warning Skin corrosion/irritation]

H319 (99.13%): Causes serious eye irritation [Warning Serious eye damage/eye irritation]

H335 (13.54%): May cause respiratory irritation [Warning Specific target organ toxicity, single exposure; Respiratory tract irritation]

That doesn’t sound very “inactive” to me, but I’m sure that “there is no evidence” that it is a problem…please continue with injecting this into your baby.

Benzyl Alcohol | C6H5CH2OH - PubChem (nih.gov)

H302: Harmful if swallowed [Warning Acute toxicity, oral]

H332: Harmful if inhaled [Warning Acute toxicity, inhalation]

But I’m sure that it’s safe and “inactive” if injected rather than swallowed or inhaled.

So, just between these two “irritants” you have 79 mgs which is 39.5 times more than the 2 mgs of the “just a vitamin” Vit K.

So, let’s recap for a moment:

What is synthetic Vit K? It’s a coagulant, it helps with blood clotting.

Why does my baby need a coagulant? In case he bleeds.

Why would my baby bleed? Because we are going to cut him.

Why would you cut my baby? It's called circumcision.

Hold on, it's a baby girl, what are you talking about?

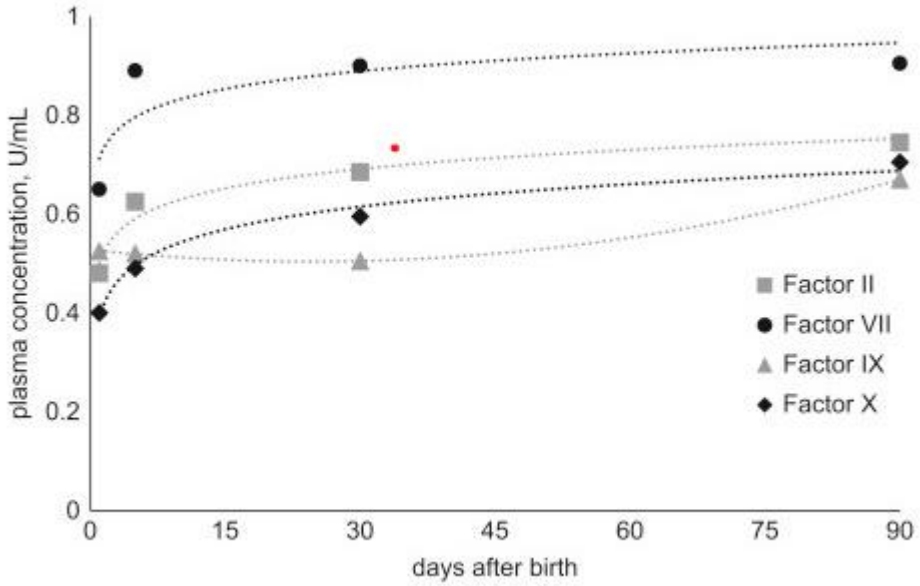
Just take the damn vitamin, it's good for her.

So, it turns out that this whole Vit K charade is the by product of US Pharma circumcision mania. Outside of all the Muslim countries America has the highest circumcision rate, an astonishing 80.5%, followed by South Korea (whose medical system was built by the US after the Korean War) with 77% and then followed by Australia (America Lite) with 58%.

Circumcision by Country 2022 (worldpopulationreview.com)

Mali	86.00%	21,473,764
Guinea	84.20%	13,865,691
Bahrain	81.20%	1,783,983
United States	80.50%	334,805,269
French Polynesia	78.00%	284,164
Qatar	77.50%	2,979,915
South Korea	77.00%	51,329,899
United Arab Emirates	76.00%	10,081,785
Chad	73.50%	17,413,580
Tanzania	72.00%	63,298,550
Republic of the Congo	70.00%	5,797,805
Central African Republic	63.00%	5,016,678
Burundi	61.70%	12,624,840
Malaysia	61.40%	33,181,072
Lebanon	59.70%	6,684,849
Australia	58.00%	26,068,792
Angola	57.50%	35,027,343
Kazakhstan	56.40%	19,205,043

Here is a graph that shows the quick rise in natural Vit K after birth in the first 8 days as which point religious circumcision occurs. Turns out Jewish and Muslim faiths figured out that you don't do it on day 1 but that there is less life threatening bleeding at day 8.



If you want to circumcise for "health" reasons, why not simply wait until day 8 like everybody else and then your baby doesn't need "clotting assistance".

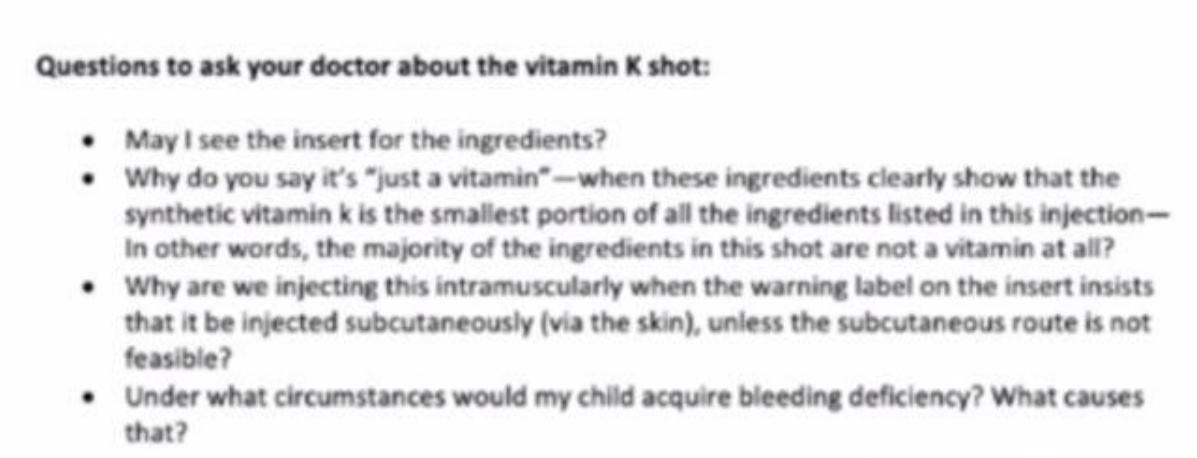
A "story" has been sold that secular circumcision is a health based decision. It somehow reduces your risk of an STD, that it reduces the risk of HIV and transmitting HPV and reduces the risk of penile cancer. That is all Pharma generated BS.

As to penile cancer, if it was true that it is reduced by circumcision you simply look at countries that don't circumcise for health reasons such as Denmark (5.3% circumcision rate) and a penile cancer rate of 0.82 per 100,000 men compared to the US (80.5% circumcision rate) and a 1 in 100,000 rate of penile cancer in men. Yes, higher in the US that in Denmark!

You might be wondering why US Pharma would concoct a "health circumcision" narrative, well it turns out at least one of the reasons is that there is a "foreskin" industry. Yes, you heard that right, hospitals sell the baby foreskin, it's a money spinner apparently. Candace cover this is the beginning of Episode 4 in the first 8 minutes, definitely worth a listen.

Here is a link to an example of a foreskin product. It is finding its way into very expensive beauty products.

If you get pressured by the nurses and Drs to get Vit K into your babies (and you will) here is some questions from Candace that might help.



Questions to ask your doctor about the vitamin K shot:

- May I see the insert for the ingredients?
- Why do you say it's "just a vitamin"—when these ingredients clearly show that the synthetic vitamin k is the smallest portion of all the ingredients listed in this injection—In other words, the majority of the ingredients in this shot are not a vitamin at all?
- Why are we injecting this intramuscularly when the warning label on the insert insists that it be injected subcutaneously (via the skin), unless the subcutaneous route is not feasible?
- Under what circumstances would my child acquire bleeding deficiency? What causes that?

And here are some resources relating to Episode 3.

Circumcision by Country 2022

https://worldpopulationreview.com/country-rankings/circumcision-by-country

2. Decline in male circumcision in Korea

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3526493/

3. The Philippines Department of Health meanwhile sponsors an annual *Operation Tuli* project to circumcise boys; others assist and provide the service for free.

https://en.wikipedia.org/wiki/Department_of_Health_(Philippines)

https://mrh.doh.gov.ph/25-events/312-operation-tuli-2019

4. Vitamin K deficiency is a problem for newborns due to inadequate vitamin K placental transfer.

https://www.sciencedirect.com/topics/agricultural-and-biological-sciences/vitamin-k-deficiency

5. Haematological Basis of 8th Day Male Child Circumcision in The Holy Bible

https://www.researchgate.net/publication/321462229_Haematological_Basis_of_8th_Day_Male_Child_Circumcision_in_The_Holy_Bible

6. Can Penile Cancer Be Prevented?

https://www.cancer.org/cancer/penile-cancer/causes-risks-prevention/prevention.html

The "Well Baby" Visit

On Pediatricians and Encephalitis

It is very significant to go to a place where you have no control, to give yourself up to authority, to let them do a ritual in which you are a participant. – **Liam Scheff**

Vaccination: The best of all possible worlds.

I have recently come across the work of Marcella Piper-Terry, and I'm very much enjoying and appreciating it. This stack is to amplify her work.

Pediatricians are poisoners. They are brainwashed, well-intentioned, and lethal.

We don't talk enough about the poisoners. The doctors.

Often people talk about every other piece in the puzzle, except for the white coat that hypnotises you to then poison your baby.

I like talking about the doctors. I like pointing the finger at them. So did Mendelsohn.

“The pediatrician serves as the recruiter for the medical profession. He indoctrinates your child from birth into a lifelong dependence on medical intervention. It begins with a succession of needless "well-baby check ups" and immunizations and then moves on to routine annual physical examinations and endless treatment of minor ailments that would cure themselves if they were left alone.”

"Avoid your doctor whenever you can."

“For some, the temptation to display their knowledge and thus win the gratitude of parents, even when the treatment is superfluous and even potentially damaging, can be overwhelming. This indefensible medical behavior is a real threat to your child.”

- Dr. Robert Mendelsohn

More and more are catching on. This recent survey by Larry Cook.

It’s hard to imagine a more vile doublespeak in the English language.

The Well-Baby visit.

How about…

The Come-In-To-Get-Your-Baby-Poisoned visit.

Or

The Sacrifice-Your-Baby visit.

Is this our modern-day child sacrifice ritual?

With thanks to Marcella Piper-Terry.

Marcella’s Substack | Marcella Piper-Terry | Substack

Leave a comment

Share

Preparing for the "Well-Baby" or "Well-Child" Visit if You Don't Plan to Vaccinate

Marcella Piper-Terry

Let’s pretend.

I am a young mother. I have a new baby. I also have a 4-year-old. My 4-year-old was fully vaccinated as an infant and young child. I didn’t know anything about vaccines, and I didn’t know to question. I did things differently with my little one, and she has not had any vaccines - no hepatitis B at birth, and no vitamin K injection.

I have received a notice from my family doctor (or pediatrician) that it is time to bring my children in for their “well-baby” and “well-child” check-ups. Getting that notice makes me feel sick to my stomach. I know that I do not want to further vaccinate my older child, and I know that I do not want to vaccinate my baby at all.

My decision has not been made lightly. I have spent many hours researching and learning about vaccines, their ingredients, the lack of placebo-controlled studies, and the fact that they have never been studied for safety or efficacy as they are administered according to The CDC’s Childhood Schedule.

I have also prayed about this. A lot.

When I allowed my older child to be vaccinated, I felt a horrible sense of dread every time. I “knew” it was wrong. My mother’s intuition was screaming at me to grab my baby from that table and run out the door… but I didn’t know why… and I didn’t listen to that voice. I realize now that that voice… that “intuition”… is the voice of God. I didn’t listen before, but I am listening now. And now, I know why vaccinating my babies is not right for my family. I know better now; so now, I will do better.

Vaccines Do Not Cause Autism (Pt 1)

(They cause other stuff)

by **Marcella Piper-Terry**

[What follows is the text of an essay I wrote in 2008, which was originally published as a Facebook Note.]

Okay. I give up.
Vaccines do not cause autism.

Autism is a behavioral diagnosis. In order to receive the diagnosis of "Autism" a child must exhibit a certain number of behaviors over a certain time frame. If he or she does not do so, the diagnosis of "autism" is not warranted.

There is no blood test for "autism."

"Autism" can't be confirmed or "ruled-out" by laboratory analysis. It's strictly a behavioral diagnosis.

Therefore, anything that causes physiological damage cannot directly "cause" autism.

Ergo... vaccines cannot "cause" "autism."

Vaccines cause other stuff.

Vaccines cause encephalitis.
Vaccines cause seizures.
Vaccines cause immune system deficiencies.
Vaccines cause gastrointestinal problems.

Encephalitis causes mood swings.
Encephalitis causes extreme pain.
Encephalitis causes inattention and impulsivity.
Encephalitis causes aggression.
Encephalitis causes balance problems and difficulty relating to one's environment.

Seizures cause mood swings.
Seizures cause inattention and impulsivity.
Seizures cause alterations in consciousness.

Immune system deficiencies cause children to have more frequent bacterial infections, such as ear infections, upper respiratory infections (URIs), sinusitis, and strep infections.

Immune system deficiencies cause children to have more frequent viral infections, such as stomatitis, "fevers of unknown origin," "viral rashes," hives, conjunctivitis, and gastrointestinal viruses that cause vomiting and diarrhea.

Immune system deficiencies cause children to be more vulnerable to "everything that's going around" and to have a tougher time getting over things than their peers.

Gastrointestinal damage from vaccines causes diarrhea.
Gastrointestinal damage from vaccines causes nausea, reflux, vomiting, and the recently discovered "disease" now known as GERD (Gastro-Esophageal Reflux Disease).

Gastrointestinal damage from vaccines causes increased vulnerability to viruses and bacteria, which leads to increased administration of antibiotics, which leads to overgrowth of pathogenic yeast.

Pathogenic yeast overgrowth leads to intestinal hyperpermeability ("leaky gut syndrome").

Pathogenic yeast overgrowth leads to constipation.
Pathogenic yeast overgrowth leads to food allergies.
Pathogenic yeast overgrowth leads to skin eruptions, "drunken, silly behavior," inattention and impulsivity, and cravings for bread, sugar, ice cream, milk, and carbohydrates.

This is the basis of my faith. I have erred in the past. I have asked for forgiveness and said many prayers of thanks that my oldest appears to have escaped significant harm as a result of my uninformed actions. I will not make the same mistake again. My resolve is strong. But I still feel so anxious about this appointment. I think I'm going to vomit.

How can I prepare myself? What can I do to ensure I am not coerced or bullied? What can I take with me to let the doctor know that I have not made a snap decision, and I am not just listening to others' opinions?

Here is my plan:

1. Find out exactly what vaccines my children are "due to receive."
2. Call the doctor's office and ask which brands of vaccines they use.
3. Find out what the ingredients are in those vaccines.
4. Print the Safety Data Sheets (SDS) for those ingredients.
5. Print the vaccine manufacturer's inserts for each vaccine.
6. Print out the state law regarding school attendance.

I will put everything in a binder (actually, I'll get two copies of everything so I can leave one with my doctor and have one to keep).

Here is where I will find the information I need...

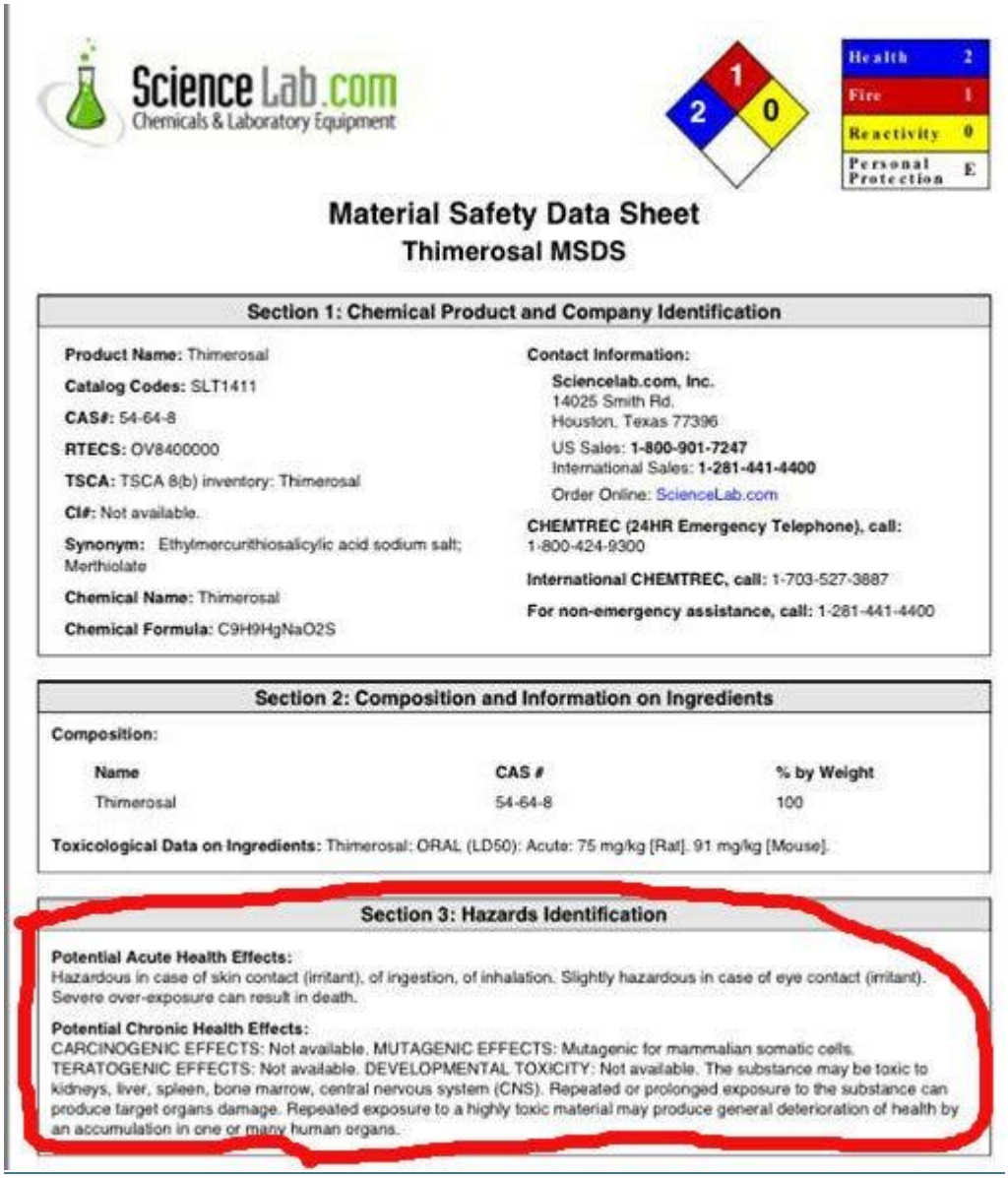
To find out what vaccines my child is "due" for, and the ingredients (and doses), I will use the Vaccine Ingredient Calculator. (This used to be free on the National Vaccine Information Center [NVIC] website. It is no longer free to use and is no longer on the NVIC site. IMO, it is absolutely worth the minimal cost to pay for one day use and get what you need so you will be better prepared for this journey.) I will print out my child's customized plan (2 copies).

Toby Rogers

Imagine a free online database that lists vaccine ingredients so that when your doctor tells you 'it's just killed virus and saline' you can look it up for yourself and prove that s/he is lying. BAM! Here it is (hot off the digital press):

https://openvaers.com/resources/vaccine-excipients

Next, I will get the SDS sheets and highlight the toxicity sections.



ScienceLab.com
Chemicals & Laboratory Equipment

Health	2
Fire	1
Reactivity	0
Personal Protection	E

Material Safety Data Sheet
Thimerosal MSDS

Section 1: Chemical Product and Company Identification

Product Name: Thimerosal
Catalog Codes: SLT1411
CAS#: 54-64-8
RTECS: OV8400000
TSCA: TSCA 8(b) inventory: Thimerosal
CI#: Not available.
Synonym: Ethylmercurithiosalicylic acid sodium salt; Merthiolate
Chemical Name: Thimerosal
Chemical Formula: C9H9HgNaO2S

Contact Information:
Sciencelab.com, Inc.
14025 Smith Rd.
Houston, Texas 77396
US Sales: **1-800-901-7247**
International Sales: **1-281-441-4400**
Order Online: ScienceLab.com
CHEMTREC (24HR Emergency Telephone), call: 1-800-424-9300
International CHEMTREC, call: 1-703-527-3887
For non-emergency assistance, call: 1-281-441-4400

Section 2: Composition and Information on Ingredients

Composition:

Name	CAS #	% by Weight
Thimerosal	54-64-8	100

Toxicological Data on Ingredients: Thimerosal: ORAL (LD50): Acute: 75 mg/kg [Rat]. 91 mg/kg [Mouse].

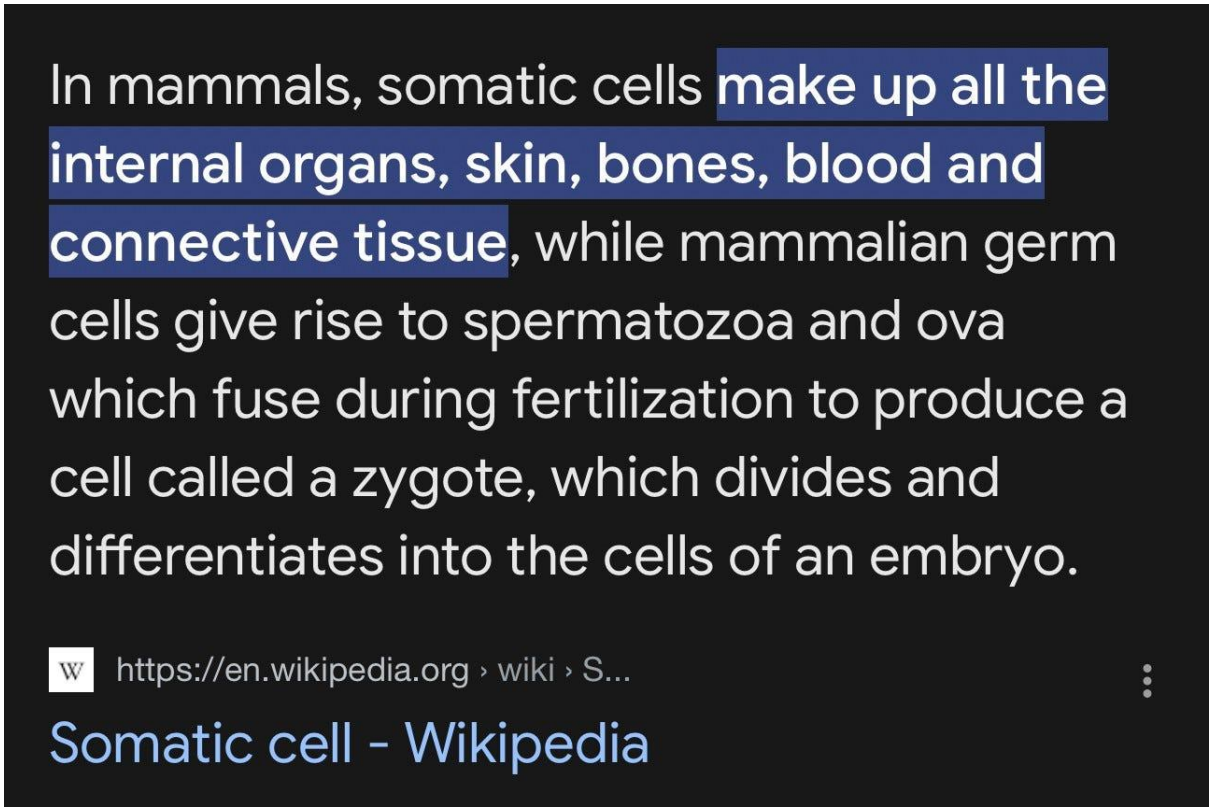
Section 3: Hazards Identification

Potential Acute Health Effects:
Hazardous in case of skin contact (irritant), of ingestion, of inhalation. Slightly hazardous in case of eye contact (irritant). Severe over-exposure can result in death.

Potential Chronic Health Effects:
CARCINOGENIC EFFECTS: Not available. MUTAGENIC EFFECTS: Mutagenic for mammalian somatic cells. TERATOGENIC EFFECTS: Not available. DEVELOPMENTAL TOXICITY: Not available. The substance may be toxic to kidneys, liver, spleen, bone marrow, central nervous system (CNS). Repeated or prolonged exposure to the substance can produce target organs damage. Repeated exposure to a highly toxic material may produce general deterioration of health by an accumulation in one or many human organs.

Page 1 of the Material Safety Data Sheet (MSDS) for Thimerosal. Mutagenic for mammalian somatic cells. Mutagenic means capable of causing changes, or mutations, in the genetic material of an organism. Mutations in DNA are associated with increased risk of cancer.

Mammalian somatic cells are a big deal…



Note: The newer SDS (Safety Data Sheet) for Thimerosal says, “Not mutagenic in AMES test.” The AMES test is used to determine if the chemical compound (Thimerosal, in this case) can cause mutagenic changes in bacteria. Your child is not a bacterium. The fact that the SDS says “Not mutagenic in AMES test” has nothing to do with the FACT that Thimerosal IS mutagenic to mammalian somatic cells. Your child IS a mammal.

The following is a partial list of ingredients in vaccines given to infants and children in the U.S. (click each ingredient to view the Safety Data Sheet (SDS):

- Aluminum Hydroxide
- Thimerosal
- Formaldehyde
- 2-Phenoxyethanol
- Triton X-100

If you click on each of the above links, you will be taken to the SDS for that vaccine ingredient. Scroll down and look at the information under **Section 11: Toxicological Information**. This is where you can learn about:

- Carcinogenic Effects – the KNOWN ability to cause cancer
- Mutagenic Effects – the KNOWN ability to cause alterations in DNA (FYI… alterations in DNA cause childhood cancers)
- Teratogenic Effects – the KNOWN ability to cause harm to a developing fetus in utero

- Developmental Toxicity – the KNOWN ability to cause harm to children in one or more ways

As you are looking through section 11 of the Safety Data Sheets, when you come across the statement, "**No known information**," use your critical thinking skills. "Not known" is not the same as "proven safe." You will see this "Not known" statement on the same SDS sheets that list such harms as "fatal if swallowed" and "Highly toxic to aquatic life." Are you willing to take the chance, just because they haven't done the safety studies? FYI… refusing to do the studies is the game plan for many things that are deemed "safe and effective." If you don't want to know the answer, and especially if you don't want to have to REPORT the answer, you don't ask the question.

Vaccines Do Not Cause Autism (Pt 2)

Technically, vaccines do not cause autism because technically there is no such thing as autism.

Vaccines cause the underlying physical conditions that result in the pain, neurological damage, immune system disorders, gastrointestinal damage, and yeast overgrowth – all of which combine to produce the behavioral symptoms that result in the "autism" diagnosis.

Gastrointestinal damage is the most obvious result of vaccine damage.

When a previously healthy child suddenly starts having multiple episodes of watery and extremely stinky diarrhea every day, and this happens shortly after receiving vaccinations, it is notable as a "vaccine injury." What is not so obvious is that when the child's gut is permanently damaged, he or she is no longer able to absorb nutrients necessary to produce neurotransmitters necessary for proper brain function. So, when the child develops mood swings, sleep difficulties, and learning disabilities several months later, these issues are not recognized as being related to the vaccine injury because the initial damage occurred many months earlier.

Please re-read the previous paragraph.

This is why Dr. Andrew Wakefield is such a threat to the pharmaceutical industry.

Dr. Wakefield NEVER said vaccines cause autism.
Dr. Wakefield is a gastroenterologist. He saw a number of children with gastrointestinal problems who also happened to be diagnosed with autism. Dr. Wakefield reported his observations. He never claimed that the MMR "caused" autism. He merely reported that a number of children he had seen had BOTH gastrointestinal problems AND autism, and according to parental report, these issues developed within a short time of when the children received the MMR vaccine.

Again… Why is Dr. Wakefield such a threat to the pharmaceutical industry?

Hint: Not because vaccines cause autism – they don't.

Vaccines cause gastrointestinal damage.

Gastrointestinal damage causes malabsorption of nutrients necessary for proper brain function.

Malabsorption of essential nutrients causes immune system disorders, seizures, encephalopathy, etc… and THAT's what leads to the ultimate diagnosis of "autism."

[Unbekoming: The primary cause of encephalitis is the aluminum smuggled into the child's brain. Clearly this is another contributor.]

If Dr. Wakefield's observations are correct, SOMEONE, SOMEWHERE will eventually draw the connection between vaccines and the domino-effect that leads to the "autism" diagnosis. From the perspective of the pharmaceutical industry, better to "nip it in the bud" now, which means discrediting Dr. Wakefield to the extent that no one will look further into the science.

Has this ploy worked?

Not for me. And not for many of the very intelligent parents I know.

Only time will tell if there are enough of us to make a difference.

Note: For more on vaccines and encephalitis: http://www.whale.to/v/buttram.html

Links to peer-reviewed medical literature.[1]

Another good thing to put in my binder is the Excipient List from the CDC, which lists all of the vaccines, their ingredients, and substances used in their manufacture.

Next, I need the Vaccine Manufacturer's Inserts for each vaccine. On each vaccine manufacturer's insert, I will highlight the part where it says the vaccine should not be given to anyone who has an allergy to any of the ingredients in the vaccine. Given that my child has not been tested to determine if he or she is allergic to any or all of the ingredients, there won't be any injecting going on just so we can see what happens.

merck.com

----------CONTRAINDICATIONS----------

- History of anaphylactic reaction to neomycin or hypersensitivity to gelatin or any other component of the vaccine. (4.1)
- Primary or acquired immunodeficiency states. (4.2)
- Family history of congenital or hereditary immunodeficiency. (4.2)
- Immunosuppressive therapy. (4.2, 7.3)
- Active untreated tuberculosis or febrile illness (>101.3°F or >38.5°C). (4.3)
- Pregnancy. (4.4, 8.1, 17)

---------- WARNINGS AND PRECAUTIONS----------

- Administration of ProQuad (dose 1) to children 12 to 23 months old who have not been previously vaccinated against measles, mumps, rubella, or varicella, nor had a history of the wild-type infections, is associated with higher rates of fever and febrile seizures at 5 to 12 days after vaccination when compared to children vaccinated with M-M-R® II and VARIVAX® administered separately. (5.1, 6.1, 6.3)
- Use caution when administering ProQuad to children with a history of cerebral injury or seizures or any other condition in which stress due to fever should be avoided. (5.2)
- Use caution when administering ProQuad to children with anaphylaxis or immediate hypersensitivity to eggs (5.3) or contact hypersensitivity to neomycin. (5.4)

The above image is from ProQuad (MMR & Varicella) Vaccine Contraindications, Warnings & Precautions. Page 1 of Merck's Vaccine Manufacturer's Insert.

On each vaccine manufacturer's insert, I will highlight section 13.1 (and I will highlight the absence of section 13.1 on the Varivax vaccine, since it has been removed), which states clearly, "This vaccine has not been studied for carcinogenic or mutagenic effects, or for effects on fertility."

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

ProQuad has not been evaluated for its carcinogenic, mutagenic, or teratogenic potential, or its potential to impair fertility.

16

If we get this far in our discussion, I will show the doctor this information, and then we will discuss each of the Safety Data Sheets for the vaccine ingredients – at length. If you want more information on vaccine ingredients, this post seems to be pretty helpful for a lot of people. At least they keep using it a lot…

If, after this discussion, my doctor still wants to grasp at straws and tell me that my child cannot go to school without vaccines, I will calmly point out that in Arkansas, and 45 other states, we have the right to religious exemption from vaccination for school attendance, and that as my children's parent, I will be exercising that legal right on their behalf.

Here is where I go to find the law regarding vaccines for school attendance.

Here is where I go to find information on the laws in a particular state.

If I happen to live in California, Maine, New York or West Virginia… my next step (as far as school is concerned) is to figure out how to homeschool or how to move to another state. There are a lot of options for homeschooling, and many of my friends are doing it with fabulous success. If I am able, this is what I will do because now that I know better, I know there is no way I would sacrifice my child's health and well-being just so he can go to a (failing) public school where he will have to sit still and have his creativity and joy stamped out of him for the next 12 years. No thanks.

If my doctor attempts to bully me after all of this, I will calmly inform him (or her) that I am aware of my rights and I am aware that the only laws regarding vaccination are for school attendance. I will also let him (or her) know that I am aware that **physicians are receiving bonuses for meeting benchmarks and having a certain percentage of patients fully vaccinated by age two years.** I will let the physician know in no uncertain terms that coercion (threatening to call CPS, for example) is unethical and possibly against the law (look up the definition of extortion), and I will be reporting him (or her) to the state medical board for ethics violations. For good measure, I will probably throw in, "And you'll be hearing from my attorney," as I pick up my babies and walk calmly and confidently out of his or her office. For the very last time.
The last thing I will say, if it gets to this point?

"You're fired."

NOTE: This originated as a post on Facebook, in response to a young father's question about how to handle the upcoming 2-month appointment for his new baby. That post was shared 400 times in the first 48 hours. Judging by the comments, this is something that is really resonating with parents. To be clear: There is no law that you have to use a pediatrician or an allopathic physician (Family Practice M.D. or D.O.) for your children. Chiropractors, Naturopathic Physicians, and Homeopaths are all fully capable of providing excellent routine care for your family. If you need emergency medical treatment, you can seek it through an Urgent Care facility or hospital Emergency Room. The fact is, if you are not vaccinating, you generally do not need a pediatrician or other medical doctor. Obviously, this may not be the case for all children. Use your judgment and do what is right for your family.
My hope in putting this information together is that those who are unsure or feel insecure about standing up for themselves, but who still feel they must go to the "well-baby" or "well-child" check-up (aka "vaccine appointment"), will take the steps outlined in this post, and as a result, they will feel empowered and

strengthened in their knowledge base. We all must do the work and be prepared to defend our choices. – mpt

If you are just beginning your research on vaccines, here is where you can find many excellent resources for your journey.

Levi Quackenboss is another childhood vaccination write worth following. The Substack has been silent for quite some time. This post explains why. It is well worth the whole read, emotional, read.

RFK JR the Sellout - by Levi Quackenboss (substack.com)

And all of that brings me to the point of writing this note tonight. This is what I want you to know.

In that moment, independent candidate Robert F. Kennedy, Jr. did not throw in the towel. He didn't ruin third party politics forever. He didn't quit so that he could get a job. He did not sell out.

In that moment, this most important member of the most famous Democratic family in America chose our children above all else. He chose our children above his Hollywood friends. Above his long standing Trump-hating environmental supporters. Above the entire Democratic party. Above his once-adoring Kennedy family. Above peace in his own home.

Can you imagine the pressure he was under to do anything but this?

He chose my kids. He chose yours. He chose all the babies being born from here on out. Robert F. Kennedy, Jr. is going to prove what is causing this 40-year tsunami of childhood chronic illness. He is going to root it out, shine the light on it, make the public understand, and he is going to burn down the alter it's been living on.

In that moment, on Friday afternoon in Phoenix, Arizona, I witnessed the most selfless human act of my entire lifetime.

We all did.

1

CNS Recruitment of CD8+ T Lymphocytes Specific for a Peripheral Virus Infection Triggers Neuropathogenesis during Polymicrobial Challenge

Epidemiologic Characteristics of 500 Patients with Inflammatory Bowel Disease in Iran Studied from 2004 through 2007

Phenotypic expression of autoimmune autistic disorder (AAD): a major subset of autism.

Interaction of free radicals, matrix metalloproteinases and caveolin-1 impacts blood-brain barrier permeability.

Consumption of mercury-contaminated rice induces oxidative stress and free radical aggravation in rats.

Toxicity of nano gamma alumina to neural stem cells.

Abnormal measles-mumps-rubella antibodies and CNS autoimmunity in children with autism.

If you believe the above links are biased, then please, get it straight from the horse's mouth and check out the vaccine inserts (direct from the manufacturers) for yourself. Link: http://www.vaccinesafety.edu/package_inserts.htm

300 Injections: What the Childhood Vaccine Schedule Looks Like Scaled to Body Weight

An Essay on the Arithmetic Nobody Does

A newborn weighing 3.5 kg (7.7 lb) receives a 1 mL intramuscular injection of Vitamin K within the first hour of life.[1] One millilitre doesn't sound like much. It fits inside a standard syringe that a nurse can depress with one thumb.

An average adult male weighs 80 kg (176 lb). That's a ratio of roughly 23:1.

Scale that single 1 mL Vitamin K injection to the adult male by body mass, and the equivalent is 23 mL — 23 of those same syringes, one after another, into the same arm.

No adult would sit still for 23 injections in one session. Yet this is the proportional load placed on a newborn in the first hour of life, for a product that isn't even a vaccine.

The Arithmetic

The calculation throughout this essay uses a simple formula:

Adult equivalent volume = (Infant dose in mL) × (Adult weight ÷ Infant weight)

The reference weights used come from WHO and CDC growth chart medians:[3] [4]

- **Birth:** 3.5 kg (7.7 lb)
- **6 months:** 7.5 kg (16.5 lb)
- **12 months:** 9.5 kg (20.9 lb)
- **Reference adult male:** 80 kg (176 lb)

These are median figures. Many babies are smaller. The ratios for a premature infant — who receives the same doses on the same schedule — would be considerably more dramatic.[5]

The arithmetic is not complicated. What's complicated is why no one in the regulatory apparatus appears to have done it.

The US Schedule: Birth to 18 Months

The CDC's recommended childhood immunisation schedule is publicly available.[6] Here is what it requires, broken into the injection sessions a compliant parent would attend, with the volume injected at each visit.

Most injectable vaccines come in 0.5 mL doses.[2] The exceptions are the Vitamin K injection (1 mL) and the oral rotavirus vaccine, which is swallowed rather than injected. The volumes below include only injected products — what enters the body bypassing all digestive and filtration systems.

Birth

Product Volume Vitamin K 1.0 mL Hepatitis B (dose 1) 0.5 mL **Total injected 1.5 mL**

Infant weight: 3.5 kg (7.7 lb). Body mass ratio to adult male: 22.9:1.

Adult equivalent: 34.3 mL — the proportional equivalent of an adult receiving 23 Vitamin K syringes and 23 Hepatitis B syringes in a single session.

2 Months

Product Volume DTaP (dose 1) 0.5 mL IPV / Polio (dose 1) 0.5 mL Hib (dose 1) 0.5 mL PCV13 / Pneumococcal (dose 1) 0.5 mL Hepatitis B (dose 2) 0.5 mL **Total injected 2.5 mL**

Note: Rotavirus is administered orally and excluded from injection volume totals.[7] Some of these may be combined into fewer syringes using hexavalent products like Vaxelis, but the total volume of injected material remains the same.[8]

Infant weight at 2 months: approximately 5.5 kg (12.1 lb). Body mass ratio: 14.5:1.

Adult equivalent: 36.4 mL — the proportional equivalent of an adult receiving 73 of those same 0.5 mL injections in a single visit.

4 Months

Product Volume DTaP (dose 2) 0.5 mL IPV / Polio (dose 2) 0.5 mL Hib (dose 2) 0.5 mL PCV13 / Pneumococcal (dose 2) 0.5 mL **Total injected 2.0 mL**

Infant weight at 4 months: approximately 6.5 kg (14.3 lb). Body mass ratio: 12.3:1.

Adult equivalent: 24.6 mL — the proportional equivalent of 49 of those same injections.

6 Months

Product Volume DTaP (dose 3) 0.5 mL IPV / Polio (dose 3) 0.5 mL Hib (dose 3) 0.5 mL PCV13 / Pneumococcal (dose 3) 0.5 mL Hepatitis B (dose 3) 0.5 mL Influenza (dose 1) 0.5 mL **Total injected 3.0 mL**

The CDC also now recommends COVID-19 vaccination beginning at 6 months, potentially adding another 0.5 mL.[9] The figures above exclude this.

Infant weight at 6 months: 7.5 kg (16.5 lb). Body mass ratio: 10.7:1.

Adult equivalent: 32.0 mL — the proportional equivalent of 64 injections.

Paul Thomas, a paediatrician of 35 years, identified the 6-month visit as "the most dangerous doctor visit babies ever encounter," noting that infants are scheduled to receive up to 10 different vaccine antigens at once.[10]

12 Months

Product Volume MMR (dose 1) 0.5 mL Varicella (dose 1) 0.5 mL Hepatitis A (dose 1) 0.5 mL PCV13 / Pneumococcal (dose 4) 0.5 mL **Total injected 2.0 mL**

Infant weight at 12 months: 9.5 kg (20.9 lb). Body mass ratio: 8.4:1.

Adult equivalent: 16.8 mL — the proportional equivalent of 34 injections.

15–18 Months

Product Volume DTaP (dose 4) 0.5 mL Hib (dose 4) 0.5 mL Hepatitis A (dose 2) 0.5 mL **Total injected 1.5 mL**

Infant weight at 15–18 months: approximately 10.5 kg (23.1 lb). Body mass ratio: 7.6:1.

Adult equivalent: 11.4 mL — the proportional equivalent of 23 injections.

Cumulative Totals: Birth to 18 Months (US)

Visit Injected Volume Adult Equivalent Birth 1.5 mL 34.3 mL 2 months 2.5 mL 36.4 mL 4 months 2.0 mL 24.6 mL 6 months 3.0 mL 32.0 mL 12 months 2.0 mL 16.8 mL 15–18 months 1.5 mL 11.4 mL **Total 12.5 mL 155.5 mL**

Over the first 18 months of life, the US schedule requires approximately 12.5 mL of injected pharmaceutical product across six sessions.

Scaled to an 80 kg (176 lb) adult male, the body-mass equivalent is 155.5 mL.

Over 300 injections.

The Australian Schedule: Birth to 18 Months

Australia's National Immunisation Program (NIP) follows a similar but not identical schedule.[11] The key differences: Australia does not include Hepatitis A in the infant schedule, uses a combination hexavalent vaccine (Infanrix Hexa) from 2 months, and administers meningococcal B (Bexsero) at 2, 4, and 12 months.

Birth

Product Volume Vitamin K 1.0 mL Hepatitis B (dose 1) 0.5 mL **Total injected 1.5 mL**

Adult equivalent: 34.3 mL

2 Months

Product Volume Infanrix Hexa (DTaP-HepB-IPV-Hib) 0.5 mL Prevenar 13 (Pneumococcal) 0.5 mL Bexsero (Meningococcal B, dose 1) 0.5 mL **Total injected 1.5 mL**

Adult equivalent: 21.8 mL — the proportional equivalent of 44 injections.

4 Months

Product Volume Infanrix Hexa (dose 2) 0.5 mL Prevenar 13 (dose 2) 0.5 mL Bexsero (Meningococcal B, dose 2) 0.5 mL **Total injected 1.5 mL**

Adult equivalent: 18.5 mL — the proportional equivalent of 37 injections.

6 Months

Product Volume Infanrix Hexa (dose 3) 0.5 mL **Total injected 0.5 mL**

Adult equivalent: 5.3 mL — the proportional equivalent of 11 injections.

12 Months

Product Volume MMR (dose 1) 0.5 mL Prevenar 13 (dose 3) 0.5 mL Bexsero (Meningococcal B, dose 3) 0.5 mL Meningococcal ACWY 0.5 mL **Total injected 2.0 mL**

Adult equivalent: 16.8 mL — the proportional equivalent of 34 injections.

18 Months

Product Volume Varicella + MMR (Priorix-Tetra or separate) 0.5 mL DTPa-IPV booster (Infanrix IPV) 0.5 mL **Total injected 1.0 mL**

Adult equivalent: 7.3 mL — the proportional equivalent of 15 injections.

Cumulative Totals: Birth to 18 Months (Australia)

Visit Injected Volume Adult Equivalent Birth 1.5 mL 34.3 mL 2 months 1.5 mL 21.8 mL 4 months 1.5 mL 18.5 mL 6 months 0.5 mL 5.3 mL 12 months 2.0 mL 16.8 mL 18 months 1.0 mL 7.3 mL **Total 8.0 mL 104.0 mL**

The Australian schedule delivers approximately 8.0 mL across six sessions.

Scaled to an 80 kg (176 lb) adult male, the body-mass equivalent is 104.0 mL.

Over 200 injections.

What's in the Volume

The scaling arithmetic matters because these millilitres are not saline. Each injection contains bioactive ingredients — aluminium adjuvants, residual formaldehyde, polysorbate 80, antibiotics like neomycin, yeast proteins, bovine serum albumin, and other substances designed to provoke immune response.[12] [13]

The DTaP-IPV-Hib combination vaccine, for example, contains aluminium adjuvant, formaldehyde, polysorbate 80, neomycin sulphate, and polymyxin B sulphate — in addition to the antigens for five diseases.[14] Each of these ingredients has its own toxicological profile. Aluminium adjuvant, the most studied of them, has been shown to translocate from the injection site to the brain via macrophages.[15] [16]

The point is not to catalogue every ingredient here. The point is that when you scale by body mass, you are not just scaling volume. You are scaling the dose of every bioactive compound in that volume. An infant receiving 5 injections at 2 months is absorbing a per-kilogram chemical load that would require 73 injections to replicate in an adult. No adult would consent to that.

The Comparison Nobody Makes

The combined schedule has never been tested for safety as a whole. This is not a controversial claim. The CDC's own documentation acknowledges it. The Institute of Medicine noted in 2013 that the safety of the overall schedule had not been systematically examined.[17] The individual vaccines are tested before licensure — often against other vaccines or aluminium-containing "placebos" rather than inert saline controls — but the cumulative effect of the full schedule on a developing infant has never been the subject of a randomised controlled trial.[18]

Researchers who administered age-adjusted paediatric vaccines to infant rhesus macaques according to the US schedule found significant disturbances in amygdala development and total brain volume — abnormalities consistent with findings in children with autism.[19]

A study of 38,801 VAERS reports found that infants who received the most vaccines concurrently were significantly more likely to be hospitalised or die compared to those who received fewer.[20]

A comparison of fully vaccinated children to under-vaccinated children found that the most under-vaccinated group had significantly fewer healthcare visits, lower rates of upper respiratory illness, and fewer emergency department admissions.[21]

These are not fringe findings. They are published in peer-reviewed journals. They are simply not discussed.

A Proposal

The defenders of the US childhood schedule — Paul Offit, Peter Hotez, Stanley Plotkin, Anthony Fauci, Bill Gates, and others — have spent decades assuring parents that the schedule is safe, that infants can handle it, and that concerns about the volume, timing, or ingredients are unfounded. Offit has publicly claimed that an infant's immune system could theoretically handle 10,000 vaccines at once.[22]

Here is a proposal to test that confidence.

Recruit 100 of the most prominent public advocates of the current US childhood vaccine schedule. Offit, Hotez, Plotkin, Fauci, Gates, and their peers. Adults who have staked their professional reputations on the safety of these products.

Calculate the adult-adjusted equivalent of the full US schedule from birth to 18 months using the body-mass scaling methodology described above. This yields approximately 155.5 mL of injected pharmaceutical product, distributed across the same six sessions, spaced at the same intervals: birth, 2 months, 4 months, 6 months, 12 months, and 15–18 months.

Administer the adult-adjusted doses to the 100 volunteer advocates on the same schedule. Same intervals. Same products. Same proportional volume. The only adjustment is body mass.

Recruit a matched control group of 100 adults. Administer the same volume of sterile saline on the same schedule.

Follow both groups for five years. Monitor neurological function, autoimmune markers, inflammatory biomarkers, allergy development, cardiac events, and overall health outcomes. Publish all data.

This is the clinical trial design that has never been applied to the childhood schedule itself — a vaccinated group measured against an inert control. The only addition is that the subjects would be adults who can provide informed consent and articulate their symptoms, rather than infants who cannot.

If the schedule is as safe as its advocates insist, the trial would vindicate them conclusively. The 100 vaccinated advocates would show no meaningful difference in health outcomes compared to the saline group. Their decades of public assurance would be confirmed by the one form of evidence they have never produced: a controlled comparison against an inert placebo.

If the results went the other way, that would also be informative.

The advocates have spent careers insisting this schedule is safe for 3.5 kg (7.7 lb) newborns. The proposal merely asks whether they would accept the same proportional dose in their own bodies.

Their answer to that question may be more revealing than any clinical trial.

References

[1] American Academy of Pediatrics, Policy Statement: “Controversies Concerning Vitamin K and the Newborn,” *Pediatrics*, 2003.

[2] Standard adult vaccine dose is 0.5 mL per injection as specified in FDA-approved package inserts for most injectable vaccines.

[3] WHO Child Growth Standards: Length/height-for-age, weight-for-age, weight-for-length, weight-for-height and body mass index-for-age. Geneva: World Health Organization, 2006.

[4] CDC Growth Charts, National Center for Health Statistics, 2000 (revised 2010).

[5] AAP recommends premature and low-birth-weight infants receive vaccines according to chronological age, not adjusted age, at the same doses as full-term infants. See: Saari TN, AAP Committee on Infectious Diseases, “Immunization of Preterm and Low Birth Weight Infants,” *Pediatrics*, 2003.

[6] CDC Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2024–2025.

[7] Rotavirus vaccine (RotaTeq or Rotarix) is administered orally at 2, 4, and 6 months. Volume is approximately 2.0 mL per oral dose.

[8] Vaxelis (DTaP-IPV-Hib-HepB) combines six vaccine antigens into a single 0.5 mL injection. See FDA package insert, Vaxelis, 2018.

[9] CDC, "COVID-19 Vaccination for Children and Teens," updated 2024.

[10] Thomas P, *Vax Facts*, 2024.

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[12] CDC Vaccine Excipient Summary, "Pink Book," Appendix B.

[13] Fraser H, *The Peanut Allergy Epidemic*, 2011.

[14] *Turtles All the Way Down: Vaccine Science and Myth*, 2022 (English edition). Ingredient list from DTaP-IPV-Hib package insert.

[15] Crépeaux G, Eidi H, et al., "Non-linear dose-response of aluminium hydroxide adjuvant particles: Selective low dose neurotoxicity," *Toxicology*, 375:48–57, 2017.

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[19] Hewitson L, Lopresti BJ, et al., "Influence of pediatric vaccines on amygdala growth and opioid ligand binding in rhesus macaque infants: a pilot study," *Acta Neurobiologiae Experimentalis*, 70:147–64, 2010.

[20] Goldman GS, Miller NZ, "Relative trends in hospitalizations and mortality among infants by the number of vaccine doses and age, based on the Vaccine Adverse Event Reporting System (VAERS), 1990–2010," *Human & Experimental Toxicology*, 31(10):1012–21, 2012.

[21] Glanz JM, Newcomer SR, et al., "Association between underimmunization and health care utilization among children 24–47 months of age," *JAMA Pediatrics*, 167(3):274–81, 2013.

[22] Offit PA, Quarles J, et al., "Addressing Parents' Concerns: Do Multiple Vaccines Overwhelm or Weaken the Infant's Immune System?" *Pediatrics*, 109(1):124–129, 2002.

The Trojan Horse: How Vaccines Deliver Aluminum to Infant Brains

An Essay

Preface

This essay relies heavily on the groundbreaking research of Dr Christopher Exley, who spent forty years at Keele University studying aluminum toxicity and became the world's foremost authority on the subject. His recent publications documenting aluminum deposits in autistic brain tissue, combined with his decades of peer-reviewed research, form the scientific foundation of this work.

I have also drawn extensively from the analytical frameworks of J.B. Handley and Toby Rogers, who have masterfully connected disparate scientific discoveries to reveal the mechanism by which aluminum adjuvants in vaccines trigger autism. The work of Dr. Guillemette Crépeaux and her French colleagues on aluminum transport mechanisms, and the epidemiological studies of independent researchers like Mawson, Hooker, and Miller, provide crucial supporting evidence.

These scientists have risked their careers, faced institutional suppression, and endured professional exile to bring this truth to light. Dr. Exley was forced from his university position after his autism findings. Dr. Crépeaux struggles for funding while studying one of the most important medical questions of our time. Yet they persist, because the science demands it and children's lives depend on it.

I am merely a compiler and translator of their work, attempting to make their discoveries accessible to those who need to understand what has been done to a generation of children. All errors in interpretation or presentation are my own.

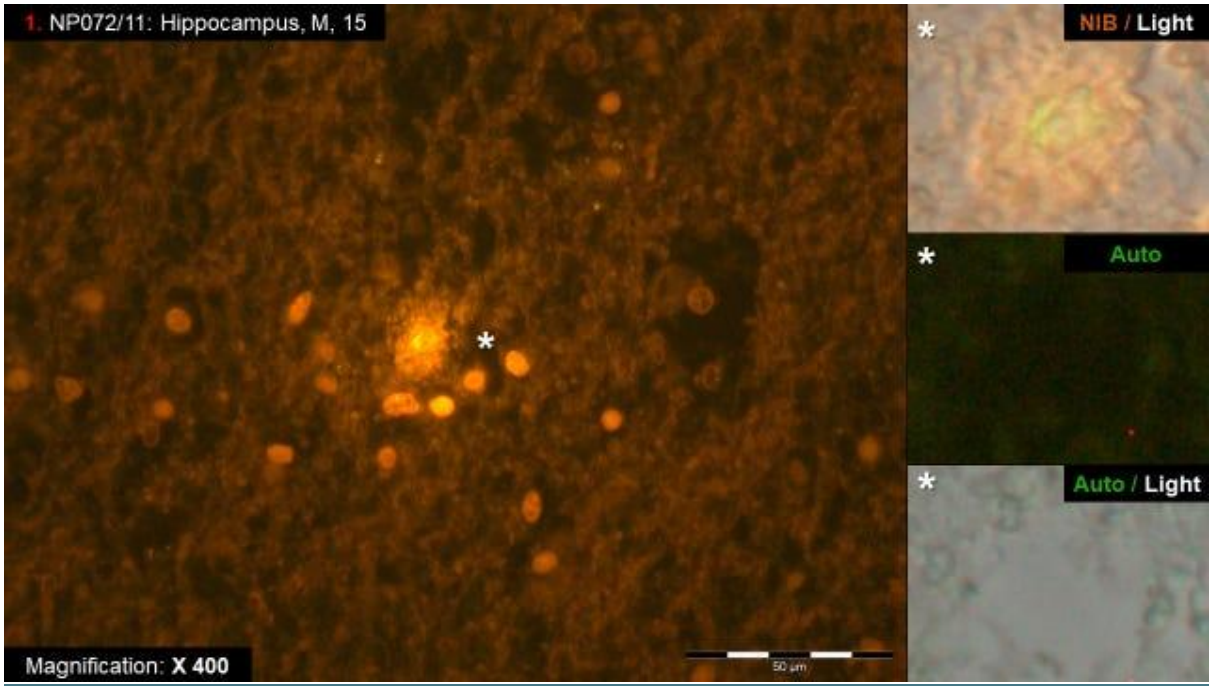
—Unbekoming

1. The Aluminum Paradox

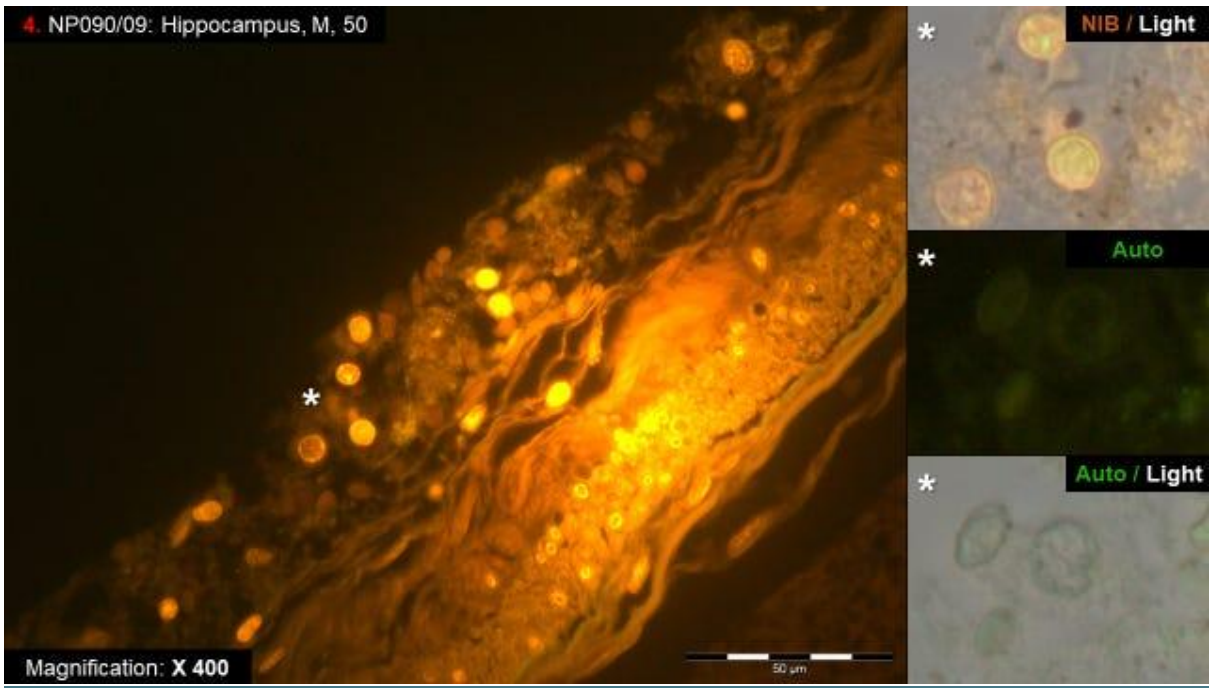
Aluminum is the third most abundant element in the Earth's crust, yet it does not exist naturally in living biological systems. Nature, across billions of years of evolution, developed elaborate mechanisms to keep this element out of living tissue. Silicon-rich compounds in soil bind aluminum and prevent its uptake by plants. Cell membranes evolved specific barriers against it. The human gut, when functioning properly, blocks the vast majority of ingested aluminum from entering the bloodstream.

This fundamental biological exclusion should have been warning enough. Instead, we inject it directly into our infants.

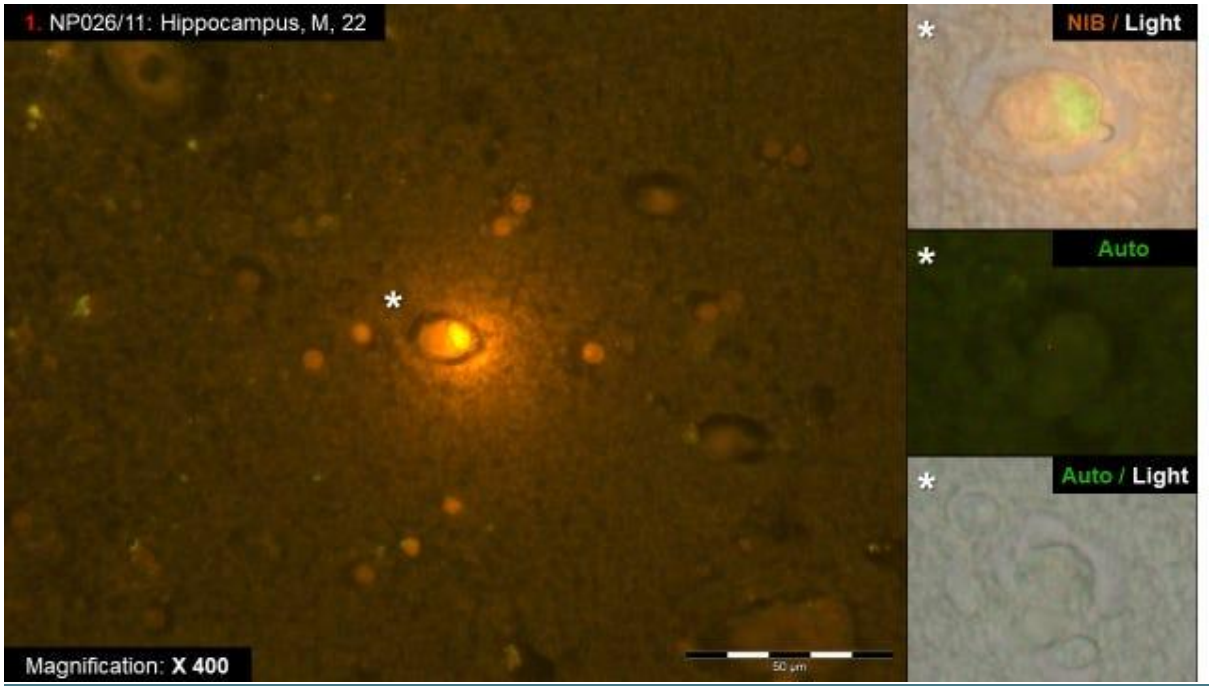
Dr. Christopher Exley spent nearly forty years studying this paradox at Keele University, becoming the world's leading authority on aluminum toxicity. His recent Substack posts reveal something extraordinary: direct visual evidence of aluminum deposits in the brains of young people who died with autism diagnoses. In a 15-year-old boy, Exley's team measured aluminum levels of 8.74 (11.59) µg/g dry weight in the occipital lobe—among the highest values for aluminum in human brain tissue yet recorded, as Exley asks: "one has to question why?"



The images are damning. Orange and yellow fluorescence marks aluminum's presence, concentrated not randomly throughout the tissue but specifically within immune cells. Microglia and macrophages, the brain's housekeeping cells, appear loaded with aluminum they cannot digest or eliminate. In one striking image from the hippocampus—the brain region targeted in epilepsy—glial cells loaded with aluminum, likely microglia, surround an area of aluminum-induced damage, possibly neuronal damage.



The hippocampus finding connects two observations that parents have long reported but medicine has dismissed: that autism and seizures often appear together, and that both frequently emerge after vaccination. Exley's images suggest why. The hippocampus, critical for memory and emotional regulation, sits at the intersection of autism and epilepsy pathology. When aluminum-loaded immune cells breach the blood-brain barrier and deposit their cargo there, they trigger what Dr. Paul Patterson would later call "an ongoing, permanent immune-system activation in the brains of autistic people."



This isn't theoretical. In brain tissue from a 50-year-old man with autism, Exley found proliferation of positive aluminum fluorescence across entire tissue sections. The meninges—the protective membranes surrounding the brain—showed multiple inflammatory cells, probably lymphocytes and macrophages, loaded with aluminum. These weren't healing; they were in a state of chronic activation, permanently switched on by the presence of a metal the body has no mechanism to eliminate.

Exley draws a straight line from his findings to the Camelford water poisoning incident of 1988, where 20,000 people were exposed to aluminum-contaminated drinking water. Mrs. Carole Cross, who died from congophilic amyloid angiopathy (CAA), a form of Alzheimer's disease rarely if ever observed in someone in their fifties, showed the same pattern: aluminum predominantly inside inflammatory and glial cells including microglia, astrocytes, lymphocytes, and cells lining the choroid plexus. In 2013, at the inquest into her death, coroner Michael Rose confirmed in his narrative verdict a role for aluminum in the brain damage leading to her death—the first time in a court of law where human exposure to aluminum was causatively linked to Alzheimer's disease.

The parallel is unsettling. In both CAA (the case of Mrs Cross) and autism, as Exley states, "an acute exposure to aluminum (in drinking water and vaccines respectively) lead to excessive accumulation of aluminum in brain tissue resulting in severe inflammation and almost identical aluminum-driven brain tissue pathology."

The mechanism matters as much as the outcome, and Exley identified that too. When his team investigated whether amyloid beta protein was present in autism brain tissue, they confirmed not only its presence but that, as in CAA, the amyloid beta was predominantly associated with the vasculature—essentially unequivocal evidence of CAA in autism brain tissue.

This is what autism is—not a genetic mystery or an unexplained epidemic, but as it's more correctly called, vaccine-induced encephalitis, brain inflammation caused by aluminum that shouldn't be there, carried by immune cells doing what they evolved

to do, triggered by injections that bypass every protective mechanism nature developed.

Exley's conclusion is unequivocal: "Ever since we first measured and imaged aluminum in brain tissue in autism I have racked my brain to find any reason why such a load of aluminum and in particular intracellular non-neuronal aluminum would not have a causal role in the brain damage occurring in autism. I failed." After decades of research, publishing over 200 peer-reviewed papers on aluminum toxicity, he states simply: "Aluminum has a causal role in the instigation and subsequent development of autism."

2. The Trojan Horse Mechanism

The story of how aluminum reaches the brain reads like a Greek tragedy—our own immune system, designed to protect us, becomes the unwitting accomplice in our destruction. J.B. Handley, whose son regressed into autism after routine vaccinations, spent years piecing together the biological mechanism that mainstream medicine refused to acknowledge. What he found was eleven separate discoveries, published since 2004 across different disciplines, that together reveal exactly how vaccines trigger autism.

The first piece fell into place in 2004 when Dr. Carlos Pardo-Villamizar at Johns Hopkins discovered that autistic brains are permanently inflamed. Not temporarily, not occasionally, but permanently. The brain's immune system remains activated in a subclinical state, fighting an enemy it cannot defeat. Dr. Paul Patterson at Caltech, reading Pardo-Villamizar's work, recognized the implications immediately: "There's an ongoing, permanent immune-system activation in the brains of autistic people. It's a subclinical state, because there's no overt infection. But it's there."

Patterson's own research revealed the second piece: immune activation events during critical periods of brain development cause autism. As he explained in 2006: "As we learn more about the connections between the brain and the immune system, we find that these seemingly independent networks of cells are, in fact, continually talking to each other." His team could reproduce autism-like behaviors in mice through maternal immune activation during pregnancy. The offspring displayed "deficient social and communicative behavior, as well as high levels of repetitive behaviors, all of which are hallmarks of autism."

When researchers at UC Davis replicated his work in monkeys, the results were identical: "MIA yields offspring with abnormal repetitive behaviors, communication, and social interactions. These results extended the findings in rodent MIA models to more human-like behaviors resembling those in both autism and schizophrenia."

But what triggers this immune activation after birth? This question haunted researchers until Christopher Shaw at the University of British Columbia conducted what seems, in retrospect, an obvious experiment. As he recounts: "We did the really simple experiment of taking the same stuff out of the vaccines, the aluminum hydroxide, and injecting it into mice, into the muscles, to see what would happen if we tried to mimic the vaccine schedule."

Shaw was "quite surprised to see how rapidly the behavioral symptoms emerged. They showed not only behavioral deficits of motor function but they ultimately showed cognitive deficits as well. Once we sacrificed the animals and started looking inside their brains and spinal cords, we found massive damage to motor neurons."

Then came the crucial discovery from French scientists Drs. Romain Gherardi and Josette Cadusseau in 2013. Their study, "Slow CCL2-Dependent Translocation of Biopersistent Particles from Muscle to Brain," demonstrated that aluminum adjuvant, when injected into the body of a mouse, ended up in the brain one year later. The study authors expressed serious concerns: "continuously escalating doses of this poorly biodegradable adjuvant in the population may become insidiously unsafe, especially in the case of overimmunization or immature/altered blood brain barrier."

"Insidiously unsafe" should cause any parent worry. The very thing they express concern about—escalating doses—is exactly what has been happening to children since the early 1990s, when the immunization schedule more than tripled.

The French team discovered the mechanism they called the "Trojan horse." As they explained: "Thus alum and other poorly biodegradable materials taken up at the periphery by phagocytes circulate in the lymphatic and blood circulation and can enter the brain using a Trojan horse mechanism similar to that used by infectious particles."

Like Greek soldiers hidden inside a wooden horse, aluminum particles hide inside macrophages that the brain welcomes as its own defenders. Once inside, the aluminum triggers exactly what it was designed to trigger in the muscle: immune activation. But in the brain, this activation doesn't resolve. The brain's immune cells, finding aluminum they cannot eliminate, remain permanently activated, creating the chronic neuroinflammation that defines autism.

In 2015, the same French team showed that aluminum adjuvant slowly makes its way to the brain, where it then stays, possibly forever, due to its "biopersistence"—our body has no ability to rid itself of aluminum adjuvant, because it's a man-made substance we have no natural designs to eliminate.

The mechanism explains a paradox that puzzled researchers: why do smaller, repeated doses of aluminum cause more damage than a single large dose? A 2016 French study, "Non-linear Dose-Response of Aluminium Hydroxide Adjuvant Particles: Selective Low Dose Neurotoxicity," found that the lowest dosage (200 mcg/Kg) was the most toxic. The high dosages caused intense inflammation at the injection site, forming "granulomas" that trapped the aluminum. But the 200 mcg/Kg dosage did not produce granulomas, allowing the aluminum to disperse throughout the body.

This is why the vaccine schedule matters so profoundly. A newborn receives the hepatitis B vaccine containing 250 micrograms of aluminum on their first day of life. By eighteen months, a fully vaccinated child has received 4,925 micrograms of injected aluminum—a near quadrupling from the 1,250 micrograms children received in the mid-1980s.

Chinese scientists in 2016 demonstrated the final piece of the puzzle. They injected newborn rats with the hepatitis B vaccine and measured what happened in their brains. The vaccine triggered elevated levels of IL-6 in the hippocampus, the exact cytokine that Patterson had identified as critical for mediating behavioral and transcriptional changes in offspring. As the Chinese team noted: "This work reveals for the first time that early HBV vaccination induces impairments in behavior and hippocampal neurogenesis."

But there's one more twist to this mechanism, one that explains why so many parents report their child's regression immediately after the MMR vaccine, even though MMR contains no aluminum. As Vaccine Papers explains: the MMR vaccine stimulates MCP-1 production, which causes macrophages containing aluminum from prior vaccines to mobilize and transport aluminum into the brain. "This may explain how MMR could cause Al toxicity, even though it does not contain aluminum adjuvant."

Handley describes the result: "His head always seemed to hurt. Sometimes he slaps himself in the head, he often seeks head pressure, seemingly to alleviate discomfort." The child's brain is literally swollen, inflamed, fighting an invisible war it cannot win.

3. The Epilepsy Connection

The connection between autism and epilepsy has long puzzled clinicians. Parents report the cruel progression: first the vaccines, then the autism diagnosis, then the seizures. Dr. Exley's images of aluminum-loaded hippocampal tissue provide the missing explanation—the same aluminum deposits that trigger autism's behavioral symptoms also prime the brain for electrical storms.

The hippocampus acts as the brain's electrical relay station, and as Exley notes, it is "the main region of the brain targeted in epilepsy." When aluminum deposits accumulate there, they create what Exley describes in a 15-year-old boy's brain as areas where "glial cells loaded with aluminum, likely to be microglia surround an area of aluminum-induced damage, possibly neuronal damage."

In image after image from autistic brains, Exley finds the same pattern in the hippocampus: aluminum concentrated in non-neuronal cells, particularly astrocytes and microglia. These cells, normally responsible for maintaining the brain's electrical balance, instead become sources of chronic inflammation. A 14-year-old boy with autism showed "aluminum is clearly located in some form of glial cells." A 22-year-old man displayed glial cells, "probably astrocytes loaded with aluminum."

The consistency across cases suggests not coincidence but mechanism. As Exley observes: "I am sure that you can see the similarities between aluminum in the hippocampus in epilepsy and in autism."

The aluminum acts as a permanent irritant, like a splinter the brain cannot remove. Each attempt by immune cells to clear it triggers more inflammation, more cytokine release, more disruption to normal electrical patterns. The seizures that eventually emerge represent the brain's electrical system finally overwhelming its damaged regulatory circuits.

This explains why anti-epileptic medications often fail in autistic patients—they're treating the electrical symptoms while the underlying cause, aluminum-triggered inflammation, continues unchecked. It's like replacing fuses while leaving bare wires exposed. The brain keeps short-circuiting because the fundamental insult remains.

Dr. Guillemette Crépeaux's research adds another dimension. Her team discovered that aluminum adjuvants specifically impair autophagy—the cellular recycling process. As she explains: "Our working hypothesis is then that in certain people the autophagic capacities would be less good, and when the cells of these people find themselves faced with an environmental challenge that is particularly complicated to manage (aluminum particles), they find themselves overwhelmed and are unable to eliminate them, which results in (among other things) the persistence of these particles and the inflammation they cause."

In the hippocampus, failed autophagy means accumulating cellular debris, further inflammation, and progressive dysfunction. The aluminum doesn't just trigger initial damage; it prevents the brain from healing itself.

Autism typically manifests between twelve and thirty-six months, coinciding with the most intensive period of vaccination. The temporal relationship matters, as Sally Ozonoff's 2018 study showed that up to 88% of autism cases are characterized by regression—the child was developing normally and then suddenly lost skills.

What makes the hippocampal involvement especially tragic is its role in memory formation and emotional regulation. The hippocampus doesn't just regulate seizures; it encodes new memories, processes emotions, and enables learning. When aluminum-triggered inflammation damages this region, it doesn't just risk seizures—it fundamentally alters how a child experiences and remembers their world.

The aluminum-autism-epilepsy triad represents one of medicine's most devastating iatrogenic disasters. We inject aluminum to provoke immunity, it travels to the brain, triggers autism through immune activation, damages the hippocampus, and eventually may manifest as seizures. Each step follows logically from the last, each supported by published research, each visible in the fluorescent glow of aluminum in brain tissue that should never contain it.

4. The Architecture of Suppression

The story of aluminum adjuvant research is as much about what hasn't been studied as what has. Dr. Christopher Exley's forced departure from Keele University after 29 years illuminates how scientific institutions eliminate inconvenient research. Despite publishing over 200 peer-reviewed papers and becoming the world's foremost authority on aluminum toxicity, Exley was systematically defunded, censored, and ultimately removed when his research began definitively linking aluminum adjuvants to autism.

The suppression began subtly. As Exley describes, his university failed to support and publicize his groundbreaking findings on aluminum in brain tissue in Alzheimer's disease and autism. When Exley's team discovered the highest aluminum levels ever recorded in autistic brain tissue, institutional support evaporated.

Funding disappeared next. As Exley notes in his interview: "Sadly I am no more. Without an active research group and laboratory I am not much better than an internet commentator." The scientist who discovered aluminum's causal role in autism was reduced to writing on Substack because institutions wouldn't support the research.

Toby Rogers's analysis of over 850 autism causation studies exposes the broader pattern. The CHARGE study at UC Davis produced 144 peer-reviewed publications analyzing air pollution, pesticides, heavy metals, and other environmental factors—but never controlled for vaccines. As Rogers notes: "The failure to control for vaccine exposures renders all of the CHARGE studies unreliable."

Rogers identifies the mechanism: "Everyone involved with these studies knows that if they include vaccines as a variable they would instantly lose all of their research funding and be blacklisted from future research funding. That one, principled, and scientifically necessary decision would immediately and permanently end their careers."

The same pattern appears across all major autism studies. MARBLES produced 151 peer-reviewed publications but doesn't control for vaccines. SEED generated 54 publications without examining vaccination status. EARLI created 88 publications while ignoring the variable that matters most. Each study cost millions, involved hundreds of researchers, and carefully avoided the most obvious environmental exposure.

Dr. Guillemette Crépeaux confirms this reality: "There are only two small teams in the world studying these questions, even though serious warning signs are also present regarding the vaccination of adolescents against papillomaviruses." Two teams, studying what may be the primary cause of the autism epidemic.

The suppression extends beyond research. In 2017, three of the leading scientists in the world—Christopher Shaw, Romain Gherardi, and Christopher Exley—wrote private letters to the directors of the CDC, FDA, and NIH warning about aluminum adjuvants.

Shaw wrote: "I am convinced that aluminum adjuvants in vaccines may contribute to neurological disorders across the lifespan. In children, there is growing evidence that aluminum adjuvants may disrupt developmental processes in the central nervous system and therefore contribute to ASD in susceptible children.... In regard to the above, it is my belief that the CDC's claim on its website that 'Vaccines Do Not Cause Autism' is wholly unsupported."

Gherardi stated: "I strongly support the contention that aluminum adjuvants in vaccines may have a role in the etiology of autism spectrum disorder (ASD). My view is founded on a significant and burgeoning body of peer-reviewed scientific evidence which makes the link between ASD and exposure to aluminum through vaccinations and other sources."

Exley declared: "As an expert in the field of aluminum adjuvants and aluminum toxicity I solemnly declare that more research on the role of aluminum adjuvant in vaccines and neurological disorders, including ASD, is essential and urgently required."

These weren't fringe researchers but leading scientists at major universities, yet their warnings were ignored.

The Simons Foundation exemplifies institutional capture. Despite spending over $300 million searching for autism genes, they found nothing explaining more than 1% of cases. When the Hallmayer twin study they supported showed autism is primarily environmental (at least 62% of cases), not genetic, they continued funding genetic research while ignoring environmental factors.

As Rogers documents, the genetic studies have produced hundreds of papers identifying "risk genes" that collectively explain almost nothing. The ASC identified 174 genes, MSSNG found 134 genes, SPARK discovered ten genes—all accounting for trivial percentages of autism cases while consuming billions in research funding that could have investigated aluminum adjuvants.

French researchers faced similar suppression. After Gherardi and colleagues published their Trojan horse findings, showing aluminum travels from injection sites to the brain, they found their funding cut. As they noted in a 2018 paper: "To date, aluminum adjuvants per se have, perhaps surprisingly, not been the subject of any official experimental investigation, and this being in spite of the well-established neurotoxicity of aluminum."

The safety standards themselves reveal the suppression. As Vaccine Papers explains about the FDA's Mitkus study, which declares aluminum adjuvants safe: "Mitkus 2011 is the best scientific evidence vaccine promoters have for defending Al adjuvant safety. It is fatally flawed and incredibly bad. It is not based on any toxicity experiments with actual Al adjuvant."

The entire safety assessment for injecting aluminum into infants rests on a study that used the wrong aluminum (citrate not hydroxide), the wrong method (infusion not injection), and the wrong population (adults not infants). No other drug would ever be approved with such inappropriate safety testing.

5. The Epidemiological Proof

Toby Rogers spent years mapping the entire field of autism causation research—over 850 studies—and reached a startling conclusion: when you remove the studies compromised by financial conflicts of interest or fatal design flaws, a clear pattern emerges. The vaccine schedule, particularly its aluminum-containing shots, is driving the autism epidemic.

The numbers tell the story. A fully vaccinated child in the mid-1980s received 1,250 micrograms of aluminum by eighteen months. Today, a fully vaccinated child receives 4,925 micrograms of aluminum—a near quadrupling. The correlation with autism rates is undeniable.

But correlation, the eternal deflection goes, doesn't prove causation. Which brings us to the six vaccinated versus unvaccinated studies that mainstream medicine pretends don't exist. These studies, conducted by independent researchers without pharmaceutical funding, consistently find the same result: unvaccinated children have dramatically lower rates of autism.

Gallagher and Goodman, using National Health Interview Survey data, found that boys "who received the first dose of hepatitis B vaccine during the first month of life had 3-fold greater odds for autism diagnosis" compared with "boys either vaccinated later or not at all." Using different data from the National Health and Nutrition Examination Survey, they found boys who received all three hepatitis B doses were 8.63 times more likely to have a developmental disability including autism.

Mawson's 2017 study of 666 homeschooled children found vaccinated children were significantly more likely than unvaccinated to have been diagnosed with autism (4.7% vs. 1.0%; OR = 4.2). But the subgroup analysis revealed something more disturbing. Preterm birth coupled with vaccination increased the odds of neurodevelopmental disorders by more than fourteen-fold "compared to children who were neither preterm nor vaccinated."

If Mawson's findings are correct, then the high rates of neurodevelopmental disorders among premature infants may be due almost entirely to vaccination, rather than early arrival.

Hooker and Miller's 2021 study found even more dramatic differences. Vaccinated children were 5.03 times more likely to have autism. But the combination effects were staggering: "Children who were 'vaccinated and not breastfed' had a more than 12-fold higher risk of autism" and "Children who were 'vaccinated and delivered via cesarean section' had a more than 18-fold higher risk of autism."

These are the highest odds ratios seen in any autism causation study. In a functioning public health system, these findings would trigger immediate investigation and policy changes.

Mawson and Jacob's 2025 analysis of Florida Medicaid data for 47,155 children showed a clear dose-response relationship: "Children with just one vaccination visit were 1.7 times more likely to have been diagnosed with ASD than the unvaccinated whereas those with 11 or more visits that included vaccinations were 4.4 times more likely to have been diagnosed with ASD than those with no visit for vaccination."

Among children born preterm, "39.9% were diagnosed with at least one NDD compared to 15.7% among those born preterm and unvaccinated."

These studies expose the fatal flaw in every CDC-funded study claiming no vaccine-autism link. As Rogers explains: "Mainstream studies that attempt to prove that vaccines do not cause autism are all invalid because they do not have a proper unvaccinated control group."

The twenty-two studies the CDC cites compare fully vaccinated children to slightly less vaccinated children, then declare no difference found. It's like comparing different brands of cigarettes and concluding smoking doesn't cause cancer.

Sally Ozonoff's 2018 study adds crucial insight into timing. She found that "up to 88% of autism cases are characterized by autistic regression"—normal development followed by loss of skills. This isn't a genetic condition manifesting gradually; it's an acute injury with a specific trigger.

The genetic studies themselves disprove the genetic hypothesis. The Hallmayer twin study (2011), using California birth records and sixteen leading geneticists, found that "genetic heritability explains at most 38% of ASD cases" and noted this is likely an overestimate. "So at least 62% of autism cases (and likely significantly more) are caused by something other than genes."

Despite this definitive finding, billions continue flowing into genetic research. As Rogers documents, the various genetic studies—AGRE (169 papers), SSC (132 papers), ASC (22 papers), MSSNG (138 papers), SPARK (40 papers)—have collectively identified hundreds of "risk genes" that explain less than 1% of autism cases.

Meanwhile, every animal study examining aluminum adjuvants finds harm. As Crépeaux notes: "We have recently shown that in almost each of the 31 studies which have been carried out in animals on the questions of bio-persistence, translocation or neurotoxicity of aluminum adjuvants, a significant difference is observed between the exposed groups and the control groups. In other words, every time we expose an animal (rodents, rabbits, sheep) to these compounds, something negative happens."

The epidemiological picture is complete. We have a clear environmental exposure (aluminum adjuvants), a documented mechanism (immune activation via macrophage transport), a susceptible population (infants with immature blood-brain barriers), a temporal relationship (regression following vaccination), a dose-response curve (more vaccines equal more autism), and a control group (the unvaccinated with minimal autism).

6. The Reckoning

The evidence is now comprehensive and undeniable. As Dr. Exley states after forty years of research: "Aluminum has a causal role in the instigation and subsequent

development of autism. This is the conclusion I am expecting in the imminent announcement from Health and Human Services."

The mechanism is understood at every level. Handley summarizes the eleven discoveries: "We now know that autism is created by immune activation events in the brain during critical phases of brain development, typically by the time a child is thirty-six months old, and that these immune activation events in the brain can be triggered by the aluminum adjuvant in vaccines."

The aluminum travels to the brain via what the French scientists call the "Trojan horse mechanism"—macrophages carrying aluminum they cannot digest. Once there, it triggers the permanent immune activation that Dr. Patterson identified in autistic brains. The IL-6 elevation disrupts synapse formation during critical developmental windows. The result is what we call autism but what is more accurately termed vaccine-induced encephalitis.

Three of the world's leading aluminum researchers felt compelled to warn health authorities directly. Their letters to the CDC, FDA, and NIH represent extraordinary acts of scientific courage, knowing the career consequences of challenging vaccine orthodoxy.

Dr. Patterson himself, before his death in 2014, warned about the implications of his own research: "Should we really be promoting universal maternal vaccination? ... Remember that double-stranded RNA experiment—we activated the immune system, and it caused all these downstream effects on the fetus. And what does a vaccination do? It activates the immune system. That's the point of vaccination."

His widow Carolyn revealed that Patterson's own nephew regressed after vaccines, and that his colleagues "were favorable about your conclusions" regarding the vaccine-autism connection but "none of them would go against the vaccination theory, per se" because they fear being "Wakefielded."

The solutions are straightforward. As Exley prescribes: "We need to think carefully, is this vaccine a life-saving vaccine or not? If it isn't, don't have it with an aluminum adjuvant."

For those already injured, some hope exists. Exley discovered that silicon-rich mineral water facilitates aluminum excretion. In a clinical trial with Alzheimer's patients, "over just 12 weeks 20% of the participants registered clinically significant improvements in their cognitive performance. This level of success has never been achieved in any mainstream clinical trial on Alzheimer's disease."

Dennis Crouse, a PhD chemist who has spent years studying aluminum's role in neurological disease after his mother's Alzheimer's diagnosis, offers additional hope through what he calls the "Crouse Protocol." Beyond silicon-rich water (which he terms "Silicade"), Crouse has identified specific nutrients that facilitate aluminum detoxification: vitamin D, which lowers serum and tissue aluminum levels; selenium for mercury detoxification and immune support; B vitamins for lead and PCB detoxification; and zinc for additional lead removal. His protocol also addresses the mitochondrial damage aluminum causes through PQQ and CoQ10 supplementation.

Crouse's work confirms what Exley discovered—that orthosilicic acid (OSA) in silicon-rich water crosses the blood-brain barrier and facilitates aluminum elimination from all analyzed brain regions. He documented his mother's improvement on the Mini Mental State Exam after a year of drinking OSA-rich

water, with her sundowners eliminated and memory consolidation restored, allowing her to live to 97 without reaching end-stage Alzheimer's.

Most critically, Crouse emphasizes prevention through aluminum avoidance. As his wife Laurie Adamson, a psychologist who witnessed autism rates soar in schools, explains: mothers should drink OSA-rich water during pregnancy, and children should drink it from birth to counteract aluminum from soy formula and vaccines. Parents in online groups report dramatic improvements, including complete elimination of seizures in some autistic children after OSA treatment—unsurprising given that aluminum directly causes seizures in primate studies.

The broader implications are staggering. As Rogers calculates: "We can stop the autism epidemic by only allowing beneficial vaccines on the market (a couple of live virus vaccines) and giving them, if at all, under conditions of informed consent at later ages when the body's immune system can respond appropriately."

The French scientists who discovered the Trojan horse mechanism concluded their paper with words that should haunt every health official: "In the context of massive development of vaccine-based strategies worldwide, the present study may suggest that aluminum adjuvant toxicokinetics and safety require reevaluation."

"Require reevaluation" is scientific understatement. What's required is the immediate removal of aluminum adjuvants from all vaccines, especially those given to infants. Every day of delay, more children develop what Exley calls "autism spectrum disorders, considered to be the consequence of early inflammation and autophagy disorders."

The CDC continues to claim on its website that "Vaccines Do Not Cause Autism," a statement that Dr. Shaw, based on the scientific evidence, calls "wholly unsupported." The agency tasked with protecting public health instead protects the vaccine program, regardless of the human cost.

We stand at a crossroads. The science is complete. The mechanism is proven. The solution is obvious. All that remains is the courage to act on what we know. As Exley writes with palpable frustration about the expected announcement that aluminum causes autism: "This means a moratorium on the use of aluminum adjuvanted vaccines should follow and the instigation of a major NIH funding programme on human exposure to aluminum. My breath is baited!"

The science shows that autism is not a genetic mystery or an unexplained epidemic. It is vaccine-induced encephalitis, caused by aluminum adjuvants that transport to the brain and trigger permanent immune activation. Every piece of evidence—from the fluorescent images of aluminum in autistic brains to the epidemiological studies showing dose-response relationships to the animal studies showing universal harm—points to the same conclusion.

The age of injecting neurotoxic aluminum into infants will end. The only question is how many more children will be sacrificed before it does. As one researcher noted about the implications: "In time, it may well be shown that aluminum is a cause of this environmental disease."

That time has arrived. The evidence is in. Aluminum adjuvants cause autism. The epidemic is iatrogenic, caused by the medical system itself. And it will continue until we find the courage to stop injecting aluminum into babies, to stop pretending we don't know what we clearly know, to stop sacrificing children to preserve institutional reputations.

Rogers provides the stark conclusion: "We know what's causing the autism epidemic. The bloated, unscientific, profit-driven CDC vaccine schedules are causing the autism epidemic."

The reckoning is not coming. It is here.

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Where Did 0.85 Come From?

An Essay on Aluminum Adjuvants and the Science That Was Never Done

In May 2000, at a Workshop on Aluminum in Vaccines held in Puerto Rico, Dr. Michael Gerber from the National Institutes of Health posed a question to Dr. Norman Baylor of the Food and Drug Administration. The exchange, preserved in the workshop transcript, deserves to be read in full:

Dr. Gerber: "The standard of 0.85 milligrams of aluminum per dose set forth in the Code of Federal Regulations—can you tell us where that came from and how that was determined?"

Dr. Baylor: "Unfortunately, I could not. I mean, we have been trying to figure that out. We have been trying to figure that out as far going back in the historical records and determining how they came up with that and going back to the preamble to the regulation. We just have been unsuccessful with that but we are still trying to figure that out."

A senior FDA official publicly admitted the agency could not explain the basis for its own regulation on aluminum content in vaccines. This was not a fringe question posed by an outsider. It came from an NIH official at an official government workshop. And the FDA's answer was that they had searched their historical records and come up empty.

That was twenty-five years ago. In the intervening decades, the 0.85 mg limit has remained unchanged. It continues to govern vaccines administered to infants, children, and adults worldwide. And the question of where it came from—the foundational safety studies that would justify exposing newborns to this amount of injected aluminum—has never been answered.

Until now, no one had followed the documentary trail that regulators themselves claimed existed.

The Documents That Exist

In 2025, a team of French researchers—Loïc Angrand, Romain K. Gherardi, and Guillemette Crépeaux—published the results of a detailed investigation into the regulatory history of aluminum limits in vaccines. Their paper, appearing in *Environmental Toxicology and Pharmacology*, traces the documentary trail that regulatory agencies had apparently never followed.

The researchers began with the 2011 Federal Register, where they found this statement: "The aluminum content per dose in the formulation of a licensed biological product, as specified in § 610.15(a), reflects the NIH Minimum Requirements for Diphtheria Toxoid (1947) and Tetanus Toxoid (1952)."

These two documents—the 1947 and 1952 NIH Minimum Requirements—are the foundational texts cited as the basis for current aluminum limits. The researchers set out to obtain them.

A Freedom of Information Act request (Case Number 63550) was submitted to NIH and the National Library of Medicine in February 2025, requesting copies of these documents. On March 7, 2025, the NLM responded: "The NLM and Office of NIH History and Stetten Museum searched its files and no records responsive to your request were located."

The recommendation was to check with the FDA History Office, "as the Department of Biological Standards became the FDA." When contacted, the FDA's Foreign Regulatory Communications Coordinator replied: "I was unable to find the information that you are seeking. You may be able to obtain the requested documents by submitting a Freedom of Information Act (FOIA) request to the National Institutes of Health (NIH)."

A circular response: NIH directing them to FDA, FDA directing them back to NIH.

Eventually, after persistent efforts, the researchers obtained both documents from the FDA—8 pages and 19 pages respectively.

What the Documents Actually Say

The analysis of these foundational texts reveals something straightforward: they are not about aluminum safety. They are not about aluminum toxicity. They are about manufacturing diphtheria and tetanus toxoids.

The 1947 document on diphtheria toxoid and the 1952 document on tetanus toxoid describe composition, production methods, and quality criteria for the toxoids themselves. They address cultivation techniques, detoxification using formaldehyde, identity tests, and sterility requirements.

The only reference to general safety testing describes a brief animal observation: "A safety test shall be made on the contents of a final container... The parenteral injection... shall cause neither significant symptoms nor death. At least 2 animals of each species are used and the observation period is not less than 7 days."

Seven days. Two animals per species. This is the extent of safety testing described in the documents that supposedly establish safe aluminum limits for human infants.

On the subject of aluminum itself, the documents contain a single relevant statement: "In all instances the amount of aluminum used shall be the minimum needed to accomplish the purpose intended."

This is a statement about efficacy—using enough aluminum to achieve the desired immune response—not about the maximum amount that can be safely injected. The documents do not evaluate aluminum toxicity. They do not establish a toxicological threshold. They do not consider cumulative exposure, developmental windows, or long-term effects.

The researchers' conclusion is direct: "Neither document discusses Al toxicity."

From Efficacy Limit to "Safety Standard"

The historical record allows us to trace how an efficacy-based recommendation became encoded as regulatory law and eventually treated as a validated safety threshold.

In 1966, a Canadian study referenced allowances by British, Canadian, and American regulators for 15 mg of potassium alum per dose of toxoid—corresponding to 0.85 mg of elemental aluminum. This amount was derived from data on immunological effectiveness, not toxicological safety.

In 1968, the NIH codified this figure in the Federal Register, stating that an adjuvant "shall not contain more than 0.85 milligrams of aluminum."

In 1972, regulatory authority over biological products transferred from NIH to FDA. The maximum aluminum levels remained unchanged.

In 1981, the FDA aligned regulations with World Health Organization standards for hepatitis B vaccines, maintaining the 0.85 mg limit while permitting up to 1.25 mg in certain circumstances with approval.

The 2011 Federal Register explicitly cited the 1947 and 1952 NIH documents as the basis for current standards—the same documents that, as we now know, contain no toxicological evaluation of aluminum.

At no point in this seven-decade regulatory history did anyone conduct or cite studies establishing safe thresholds for injected aluminum in humans. The limit was set based on what worked immunologically. It was transferred between agencies. It was aligned with international standards. And it came to be treated as a safety benchmark—a threshold below which harm is assumed not to occur.

Two years after Baylor's admission that the FDA could not explain the origin of the 0.85 mg standard, he co-authored a paper with two other FDA officials stating: "The amount of 15 mg of alum or 0.85 mg aluminum per dose was selected empirically from data that demonstrated that this amount of aluminum enhanced the antigenicity and effectiveness of the vaccine."

Selected empirically for efficacy. Not derived from toxicological studies. Not validated for safety. The FDA itself acknowledges the standard was set based on what boosted immune response, not on what was proven safe to inject.

The Studies That Were Never Conducted

The absence of foundational safety studies is not merely a historical artifact. It reflects an ongoing gap that regulatory agencies have acknowledged but never filled.

In 2015, researchers from the Centers for Disease Control and Prevention published a paper examining cumulative and episodic vaccine aluminum exposure in young children. The paper, led by Jason Glanz, contained a remarkable admission: there was "complete absence, in children as well as in adults, of population-based studies on the long-term tolerance" of aluminum-based adjuvants.

The CDC was not claiming such studies had been conducted and showed safety. They were acknowledging such studies had never been done—while demonstrating that the data to conduct them existed.

In 2019, FOIA requests were submitted to both NIH and CDC asking for "copies of any human or animal studies involving the subcutaneous or intramuscular injection of aluminum adjuvant relied upon by the NIH to establish the safety of injecting infants and children with aluminum hydroxide, aluminum phosphate or amorphous aluminum hydroxyphosphate sulfate."

The NIH response: "The NIH Office of Intramural Research (OIR), National Institute of Allergies and Infectious Diseases (NIAID), the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) searched their files and no records responsive to your request were located."

The CDC and Agency for Toxic Substances and Disease Registry response: "A search of [the agency's] records failed to reveal any documents pertaining to your request."

No records. From either agency. For studies establishing the safety of a practice that has continued for a century.

What Happens When Someone Runs the Study

The rarity of proper safety studies makes the exceptions worth examining closely.

In 2010, Chinese researchers published a large multicenter, double-blind, randomized trial comparing anti-H1N1 vaccines with and without aluminum hydroxide, alongside an aluminum-free placebo. This study—involving 12,961 participants—represents the only major trial to have included a true neutral placebo when evaluating aluminum-adjuvanted vaccines.

The results were unambiguous. Across all tested antigen doses, the vaccine containing aluminum produced significantly more adverse events than both the placebo and the same vaccine formulated without aluminum. The methodologist

Peter Gøtzsche calculated from this data that aluminum-based adjuvant increased the frequency of severe adverse events by 2.5 to 3 times.

The study had limitations—it observed participants for only three days after each dose and therefore could not assess long-term or cumulative effects. But within its observational window, it demonstrated measurable harm attributable specifically to the aluminum adjuvant.

This finding stands largely alone. The standard practice in vaccine trials is to use aluminum-containing solutions as "placebos"—a methodology that renders the specific effects of aluminum invisible by comparison. When both test and control groups receive aluminum, any adverse effects common to both will not appear as a signal.

Dr Christopher Exley, a leading aluminum researcher, has argued that aluminum adjuvants should not be used as placebos in clinical trials for precisely this reason: it eliminates the baseline needed to detect adjuvant-specific harms.

The predictable response to concerns about injected aluminum is comparison to dietary intake—the argument that 0.85 mg is trivial relative to what we consume in food and water. This comparison is pharmacokinetically meaningless. Ingested aluminum passes through the gastrointestinal tract, where the vast majority is excreted without absorption. Injected aluminum bypasses this barrier entirely, entering tissue directly as particulate matter that immune cells engulf and transport throughout the body, including to the brain. These are not equivalent exposures.

In 2022, a systematic review pooled 102 randomized controlled trials comparing aluminum adjuvants to placebo or no intervention. The conclusion: serious adverse events *may* be increased, with a risk ratio of 1.18—but the evidence was graded "very low certainty" and the trials were underpowered to detect rare harms. After nearly a century of use in billions of doses, the best available meta-analysis cannot determine whether aluminum adjuvants cause serious harm. The authors of that review did not frame this as reassuring. They framed it as uncertainty. The field has simply never produced the high-quality, adequately powered trials that would be standard for any other long-term injected product.

The Danish Study: A Contemporary Example

In July 2025, Andersson et al. published a cohort study in *Annals of Internal Medicine* examining early-life exposure to aluminum-adjuvanted vaccines and 50 chronic diseases in 1.2 million Danish children. The study concluded that no association was found between aluminum exposure and increased disease risk.

Media coverage presented this as reassuring evidence of aluminum adjuvant safety. The study was cited as demonstrating what parents and physicians had long assumed: that these compounds are safe.

Within days, however, researchers with expertise in aluminum toxicology, epidemiology, and vaccine safety began identifying fundamental methodological problems. Their critique, published in the *Journal of Trace Elements in Medicine and Biology*, argues that the study's design prevented it from detecting the harms it claimed to rule out.

I interviewed the lead author, Guillemette Crépeaux, in March 2024—well before either of these papers appeared. Her research team at INSERM has spent over a

decade investigating aluminum adjuvant toxicity, and she is among the foremost experts in the field. Among her co-authors is Christopher Exley, whom I interviewed in April 2024. Exley spent three decades researching aluminum's role in biological systems before being removed from his position at Keele University—a consequence of following the science where it led. The critique they and their colleagues published represents a systematic examination of why the Danish study's conclusions cannot be supported by its methodology.

The Exposure Problem

Any study claiming to assess dose-response relationships depends on accurate measurement of exposure. The Danish study inferred aluminum exposure solely from vaccine records and manufacturer-reported aluminum content.

Published research has demonstrated significant variability between vaccine batches—actual aluminum content can differ substantially from labeled amounts. One analysis found that the aluminum content in certain pediatric vaccines was consistently four times lower than expected, with comparable variability observed across different products.

This variability renders exposure estimates unreliable. Children recorded as receiving identical aluminum doses may have received vastly different actual amounts. In a study examining narrow exposure increments (0-4.5 mg, assessed per 1 mg), even small misclassifications distort risk assessment.

The problem compounds further. The Danish study made no distinction between different types of aluminum adjuvants—aluminum oxyhydroxide, aluminum hydroxyphosphate, and amorphous aluminum hydroxyphosphate sulfate—despite significant differences in their physicochemical properties affecting how they behave in the body.

No adjustment was made for recipient body weight. An infant receiving 0.5 mg of aluminum at two months experiences a profoundly different body-weight-adjusted exposure than the same infant receiving the same amount at eighteen months.

The timing of exposures was collapsed into a cumulative measure, obscuring potentially critical windows of developmental susceptibility. The role of the immature blood-brain barrier in early infancy—a period when multiple aluminum-containing vaccines are administered—was not addressed.

Maternal vaccination during pregnancy, which could affect fetal aluminum burden, was not considered. Formula-fed infants receive substantial dietary aluminum that could confound estimates. Children who experienced adverse reactions early in the vaccination schedule may have had subsequent vaccines delayed or declined, potentially misclassifying them as "low exposure" when they were in fact vaccine-injured.

The Missing Control Group

The study included no children with zero aluminum exposure. Every child in the cohort received at least some aluminum-adjuvanted vaccines. This design makes it impossible to detect baseline toxicity—effects that occur at any exposure level—or to establish what health outcomes look like in an unexposed population.

The only comparison possible is between children with varying degrees of exposure. If aluminum causes harm at all exposure levels studied, this design will not detect it. The harm becomes invisible by being universal.

The analogy is straightforward: if you only compare people who smoke twenty cigarettes a day to those who smoke thirty, you will never detect that smoking itself causes cancer. You need non-smokers in your study. The Danish study has no non-smokers.

This is not a minor limitation. It is a structural feature that prevents the study from answering the question it claims to address.

What the Data Actually Shows

The published results contain findings that contradict the reassuring conclusions.

The statistical analysis found that increased aluminum exposure appeared to *reduce* risk for twelve categorical diseases. According to the authors' own analysis, each additional milligram of aluminum was associated with reduced risk of ulcerative colitis (38.9%), erythema nodosum (35.1%), asthma (4.2%), various allergic conditions (11-19%), and multiple neurodevelopmental outcomes including autism spectrum disorder (7.5%) and ADHD (11.1%).

These protective effects are biologically implausible. There is no known mechanism by which injected aluminum would protect against autoimmune, allergic, or neurodevelopmental conditions. The appearance of such effects indicates systematic bias in the analysis—confounding factors that distort the true relationship between exposure and outcome. The likely culprits are identifiable: healthy user bias (families who complete full vaccination schedules tend to be healthier and more resourced overall), exposure misclassification (the batch variability problem means recorded doses don't reflect actual doses), and survivor bias (children who experience early adverse reactions may drop out of the schedule and be misclassified as "low exposure" when they are in fact vaccine-injured).

When the researchers who authored the critique reconstructed comparisons using supplementary data, they found different results. Children who received no aluminum-containing vaccines in their first two years showed 25.7% lower odds of atopic dermatitis and 49.6% lower odds of allergic rhinoconjunctivitis compared to exposed children.

The supplementary data on Asperger syndrome showed positive associations with aluminum exposure across eleven different analyses, reaching statistical significance in subgroup analyses of children born after 2006 and those receiving higher cumulative doses. The risk difference analysis found significantly higher rates of multiple neurodevelopmental outcomes in children receiving >3-4.5 mg aluminum compared to those receiving >1.5-3 mg, including an additional 9.73 neurodevelopmental cases per 10,000 children.

These findings—buried in supplementary materials—were not emphasized in the paper's conclusions. When commenters noted the contradiction, the authors performed a reanalysis excluding 38% of one comparison group, citing a technical statistical concern. The significance disappeared.

The Pattern

The Danish study did not emerge in isolation. It represents the contemporary manifestation of a pattern that has persisted for nearly a century.

In 1947 and 1952, documents established aluminum levels based on efficacy, not safety. Those documents were cited as the foundation for regulations that endure today.

In 2000, when asked to explain the basis for aluminum limits, the FDA could not do so.

In 2015, the CDC acknowledged the complete absence of population-based studies on long-term tolerance of aluminum adjuvants.

In 2019, FOIA requests to NIH and CDC for studies establishing safety of injected aluminum in children returned no records.

In 2025, a large cohort study was designed and conducted in a manner that could not detect the harms under investigation: no true control group, unreliable exposure measurement, exclusion of vulnerable subpopulations, follow-up periods too short to capture relevant outcomes.

At each juncture, the question of aluminum adjuvant safety has been evaded rather than answered. The regulatory framework rests on documents that do not address toxicity. The agencies responsible for safety acknowledge they have no supporting studies. And when research is finally conducted, it is designed in ways that preclude meaningful conclusions.

Whether this pattern reflects institutional inertia, liability concerns, or something more deliberate, the result is the same: the foundational safety claim—that aluminum adjuvants in vaccines have been proven safe—rests on no toxicological or long-term, placebo-controlled human studies capable of establishing a safe dose for infants.

The Evidentiary Void

The confidence surrounding aluminum adjuvant safety is not supported by the underlying evidence. It is an inherited assumption that has been transmitted through decades of regulatory practice without ever being validated.

This is not a claim about what aluminum adjuvants do or do not cause. It is a simpler observation: the studies that would establish safety have not been conducted. There are no long-term, placebo-controlled trials in infants. There are no population-based studies with true unexposed controls. The regulatory limit was not derived from toxicological data. The agencies responsible for ensuring safety have been unable to produce supporting documentation when asked.

The evidentiary void is not controversial. It is documented in the agencies' own responses to FOIA requests, acknowledged in published papers by CDC researchers, and confirmed by the analysis of the foundational regulatory documents.

What remains controversial is what to do about it.

Guillemette Crépeaux and her colleagues conclude their critique of the Danish study with a quotation from Primo Levi: "If not now, when?"

The question applies to the broader situation. Aluminum-based adjuvants have been used in vaccines since 1932. Nearly a century later, the fundamental studies establishing their safety in infants and children have not been conducted. The regulatory framework rests on documents that address manufacturing efficacy, not biological harm. The single large trial that used a true neutral placebo found significantly elevated adverse events in the aluminum group.

How much longer does the question remain unanswered before the absence of an answer becomes the answer?

How to Explain This to a 6-Year-Old

Imagine you're playing a game where you have to follow the rules. One of the rules says you can only have a small cup of juice—not too much. You ask the grown-up, "Why that much? Who decided?"

The grown-up says, "That's the rule."

You ask, "But did someone check if that much juice is okay for kids like me?"

The grown-up looks in their folder. Then they look in another folder. Then they ask another grown-up. Nobody can find where the rule came from. Nobody can find anyone who checked if it was okay.

But they keep giving kids that much juice anyway.

That's what happened with something called aluminum that's put in some medicines. A long time ago, someone decided how much to use—but they decided based on whether it *worked*, not whether it was *safe*. Then everyone forgot to check if it was safe. They just kept using the same amount.

When scientists finally asked "Where did this rule come from?", the people in charge couldn't answer. They looked in their files and said, "We don't have that."

But they're still following the rule.

A Note on the Researchers

The work documented here represents years of effort by researchers operating without the institutional support typically available for vaccine-related research. Guillemette Crépeaux's team at INSERM has pursued these questions despite limited funding, publishing challenges, and the professional risks that accompany research in contested areas. Christopher Exley, after twenty-nine years at Keele University building one of the world's leading aluminum research programs, lost his position and laboratory—a pattern familiar to scientists whose findings threaten powerful industries.

The Angrand paper required persistent FOIA requests across multiple agencies, including circular referrals and initial non-responses, to obtain documents that should have been foundational to regulatory policy.

The Crépeaux critique assembled expertise from researchers across multiple countries and institutions—toxicologists, epidemiologists, specialists in neurodevelopmental disorders and autoimmunity—to provide the systematic methodological analysis that the original study warranted.

This is what independent science looks like: painstaking, underfunded, and willing to ask questions that institutional science has declined to pursue.

As the World Health Organization stated in 2004: “Adjuvant safety is an important and neglected field.”

Twenty years later, the neglect continues.

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The Impossible Mathematics of Vaccine Salvation

An Essay

Preface

This essay relies entirely on the rigorous analytical work of Denis Rancourt, Joseph Hickey, and Christian Linard, whose meticulous examination of mortality data and counterfactual claims has exposed fundamental impossibilities in the official COVID-19 narrative. Their courage in pursuing uncomfortable truths despite professional risks represents science at its finest - following evidence wherever it leads. Any errors in interpretation or presentation in this essay are mine alone and should not reflect on their exemplary research.

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1. The Three Million Lives

On October 10, 2024, Dr. Peter Hotez sat before Congress and delivered testimony under legal obligation to tell the truth. He declared that COVID-19 vaccines saved 3.1

or 3.2 million American lives and averted 18 million hospitalizations. Without them, he claimed, the United States would have seen 4 million deaths instead of "1-plus million deaths." These numbers, he assured the committee, came from studies by his "colleague and friend Alison Galvani at Yale."

The claim originated from a December 2022 blogpost on The Commonwealth Fund website, authored by Fitzpatrick, Moghadas, Pandey, and Galvani. Not a peer-reviewed paper with detailed methodology, but a blogpost. Yet this figure - 3.2 million lives saved - has achieved the status of revealed truth. Major media outlets from the New York Times to CNN have repeated it without question. Yale School of Public Health celebrated it on social media. The number has been carved into the congressional record, transforming speculation into official history.

The transformation of this claim from blogpost to gospel reveals the mechanics of epistemic capture in action. No journalist asked how these researchers could possibly know how many people would have died in an alternate reality. No editor demanded to see the calculations. No fact-checker wondered why such an extraordinary claim appeared first in a blog rather than a scientific journal. The number was simply too useful to question - it justified every policy, every mandate, every violation of bodily autonomy. Three million lives saved meant the vaccines were humanity's greatest medical achievement. To question this number was to align oneself with death itself.

But Rancourt and Hickey did what no one else would: they took the claim seriously enough to test it. If vaccines really saved 3.2 million lives in two years, then the mortality patterns without vaccination should follow predictable, logical patterns. The counterfactual reality should make mathematical sense. What they found instead was a portrait of impossibility so stark that it demolishes not just the specific claim, but the entire edifice of counterfactual modeling that supports the vaccine narrative.

2. The Counterfactual Shell Game

Counterfactual analysis sounds sophisticated, but it's essentially elaborate guesswork dressed in mathematical formalism. The premise is seductive: use models to predict what would have happened if an intervention hadn't occurred. In the case of COVID vaccines, researchers claim to calculate how many would have died without vaccination by modeling disease spread, infection fatality rates, and vaccine efficacy.

The first sleight of hand occurs in the modeling of viral[1] spread. Fitzpatrick and colleagues use contagion dynamics modeling, assuming the virus spreads predictably through populations based on contact patterns and transmission rates. But as Hickey and his co-authors have demonstrated elsewhere, the actual mortality patterns during COVID were incompatible with viral spread. Death spikes occurred simultaneously across vast geographic distances, immediately after policy announcements rather than following disease transmission timelines.

The second deception involves vaccine efficacy estimates. The counterfactual modelers treat clinical trial efficacy numbers as real-world effectiveness, despite these trials being, as Rancourt notes, "contrived, questionable and non-transparent." They assume vaccines prevent transmission and infection at rates that have been thoroughly debunked by real-world data. They ignore negative efficacy periods, waning "effectiveness," and the mounting evidence of immune system damage from repeated doses.

The third trick is the most insidious: the models assume that without vaccines, nothing else would have changed. No recognition that the ventilator protocols were

killing people would have emerged. No adaptation of medical practices would have occurred. No one would have stopped the deadly treatments. The counterfactual world is frozen in March 2020 panic, with ventilators running at full capacity and experimental protocols killing patients, somehow extending this carnage for two full years as if medical professionals would never notice the pattern of iatrogenic death.

Watson et al., using similar methodology, claimed vaccines saved 14.4 million lives globally in just the first year. Yet when Ioannidis and colleagues used actual seroprevalence data rather than contagion models, they found vaccines might have saved only 2.5 million lives globally through 2024 - an order of magnitude less. And when McNamara's team looked at actual age-stratified mortality data, comparing vaccinated and unvaccinated populations in real time, they found "the magnitude of the impact of vaccination roll-out on deaths was unclear." The more rigorous the methodology, the smaller the effect becomes, approaching zero.

3. The Impossible Virulence Surge

Rancourt and Hickey's analysis reveals the mathematical impossibility at the heart of the 3.2 million lives saved claim. For the counterfactual to be true, whatever was causing deaths would have had to become dramatically more lethal at precisely the moments when vaccination campaigns launched. Not gradually, not randomly, but in perfect synchronization with vaccine rollouts.

The actual excess all-cause mortality in the United States never exceeded approximately 25,000 deaths per week throughout the entire pandemic period, including 2020 when no vaccines were available and populations were supposedly most vulnerable. Yet accepting Fitzpatrick's model requires believing that without vaccines, excess mortality would have reached 150,000 deaths per week in late 2021 and early 2022 - a six-fold increase.

This hypothetical mortality explosion must have occurred twice. First, immediately after the initial vaccine rollout in early 2021 when doses 1 and 2 were administered. Second, immediately after the booster campaign in late 2021. Each time, whatever was supposedly causing deaths became catastrophically more deadly just as the vaccines arrived to save us. The timing is so precise, so convenient, so impossible that it reveals the game: the models were engineered backward from a desired conclusion.

The yearly aggregates expose the absurdity further. Actual excess mortality in 2021 (558,014 deaths) was only 16% higher than in 2020 (482,351 deaths), despite mass vaccination. But the counterfactual claims that without vaccines, 2021 would have seen 2.9 million excess deaths - five times the actual number and six times the 2020 baseline. Whatever caused half a million excess deaths in 2020 would have somehow caused nearly 3 million in 2021, but was prevented from doing so by vaccines that didn't actually reduce mortality compared to 2020.

4. Geographic Impossibilities

The counterfactual models produce geographic patterns that shatter any pretense of plausibility. When Rancourt and Hickey calculated what mortality would have looked like across different states under Fitzpatrick's assumptions, they found impossible synchronicities and disparities.

In New York, accepting the counterfactual means believing excess mortality would have been 6.1 times higher in 2021 without vaccines. In Illinois, 6.8 times higher. In California, 5.1 times higher. These multipliers aren't uniform - they vary wildly

between states with similar demographics and vaccination rates. The Bronx, already devastated in 2020, would have somehow experienced even more catastrophic mortality.

The models require believing that mortality patterns would have respected state boundaries with supernatural precision. Texas would have seen a 4.7-fold increase while neighboring states saw different multiples. Florida's excess mortality would have increased 4.4-fold while Georgia's increased 4.3-fold - slightly different, but why? The models can't explain why deaths would have been exactly 5.18 times higher across the entire United States but with state-level variations that make no epidemiological sense.

Most damning is the synchronization problem. All states would have experienced their hypothetical mortality explosions simultaneously, coordinated with vaccination campaigns. Deaths would have increased in rural Montana at exactly the same moment as in urban New York, in elderly Florida at the same time as younger Colorado. This synchronization defies any natural explanation. This is how computer models work when they're retrofitted to support predetermined conclusions.

5. The Ventilator Massacre

While counterfactual modelers imagine millions saved by vaccines, the actual evidence points to iatrogenic death on a massive scale combined with nocebo-induced illness. Hickey, Rancourt and Linard's analysis reveals what really drove the mortality spikes: hospital protocols, particularly mechanical ventilation. In New York City hospitals, 88% of patients placed on ventilators died. For elderly patients, the death rate reached 97%.

These weren't deaths from a spreading pathogen - they were deaths from treatment amplified by fear. The propaganda campaign of 2020 created unprecedented nocebo effects. When people were told a deadly disease was spreading, many developed the exact symptoms they were told to expect. Breathlessness, a primary "COVID symptom," is well-documented as inducible through nocebo effects. The fear campaign literally made people sick, driving them to hospitals where deadly protocols awaited.

Hospitals used anesthesia machines as ventilators with 70% mortality rates. They split single ventilators between multiple patients despite professional warnings. They sedated patients with midazolam at rates that delayed recovery and increased delirium. They administered hydroxychloroquine at doses ten times normal levels, combined with azithromycin in ways that caused fatal heart complications.

The geographic correlation is undeniable: regions that dramatically expanded ICU capacity and aggressively ventilated patients had the highest death rates. Lombardy created hundreds of new ICU beds and systematically ventilated COVID patients, experiencing catastrophic mortality. Neighboring Veneto focused on home care and avoided the death spike. The pattern repeated everywhere - aggressive treatment combined with fear-induced illness correlated with death, while conservative management avoided mass casualties.

This creates a grotesque irony in the counterfactual claims. The models assume that without vaccines, the combination of deadly protocols and nocebo-induced illness would have continued indefinitely. But the vaccines didn't stop the ventilator massacre or the fear campaign. Protocols changed when their lethality became undeniable, though this was never officially acknowledged. The propaganda was

eventually dialed down as more people saw through it and the most vulnerable had already died. The deaths that stopped weren't prevented by vaccination but by the waning of both deadly treatments and terror campaigns - along with the grim reality that many of the most susceptible had already been killed. Yet the counterfactual models count all these reductions as vaccine victories.

6. The Synchronized Death Spike

Perhaps the most damning evidence against any natural disease spread - and by extension, against any counterfactual model based on contagion dynamics - is the synchronization of death spikes. Excess mortality began not gradually, not following transportation routes, but simultaneously across multiple continents within three weeks of the WHO's pandemic declaration on March 11, 2020.

Before March 11, there were virtually no excess deaths anywhere. Not in Italy, despite reports of hospitals being overwhelmed. Not in China, despite being the supposed origin. Not in New York, despite massive international travel. Whatever was causing deaths had produced no detectable excess mortality until a political announcement triggered synchronized death spikes across the Western world.

This synchronization extended to the granular level. All regions within Spain peaked simultaneously despite vastly different population densities. Every New York City borough experienced maximum mortality in the same week regardless of demographics or hospital capacity. Rural counties peaked with urban centers, nursing homes with communities, rich neighborhoods with poor ones - all in perfect synchronization that defies any natural explanation.

The counterfactual models ignore this impossibility. They assume gradual spread along predictable transmission routes, creating the staggered, geographic progression their contagion dynamics require. But the real data shows no such progression. The deaths appeared simultaneously, like a policy being implemented rather than a disease spreading. The models retrofitted to explain these synchronized spikes are engaging in mathematical fiction.

7. The Infection Fatality Shell Game

The counterfactual calculations depend critically on infection fatality rates (IFR) - what percentage of those exposed die. But these rates are themselves products of corrupted data systems. Modelers use IFRs derived from periods when hospitals were killing patients with ventilators and deadly drug combinations, then project these inflated death rates onto hypothetical unvaccinated populations.

Consider the circular logic: During spring 2020, aggressive treatment protocols killed thousands. These iatrogenic deaths inflated the apparent IFR. Modelers then use this inflated IFR to calculate how many would have died without vaccines, essentially assuming the killing protocols would have continued indefinitely. They're counting lives saved from stopping interventions that should never have been implemented.

The IFR also varies impossibly in the models. Death rates are assumed to be multiple times higher in New York than in Florida, in black communities than white ones, in poor neighborhoods than wealthy ones. These variations don't reflect any biological reality but rather differential access to deadly treatments. Poor communities near large hospitals had higher death rates not because of greater danger, but because aggressive protocols were more available there.

The age stratification of IFR further reveals the game. The models use extremely high IFRs for elderly populations based on nursing home deaths, but most of these deaths resulted from policies that concentrated infected patients in facilities with vulnerable populations while denying early treatment. The counterfactual assumes these policies would have continued without vaccines, making vaccines appear to save lives that were actually saved by ending deadly policies.

8. The Plausibility Collapse

When Rancourt and Hickey plot what the counterfactual mortality would actually look like over time, the impossibility becomes visually undeniable. The graphs show mortality that doesn't rise gradually or follow disease dynamics, but explodes in perfect coordination with vaccination campaigns. The visual representation makes clear what the aggregated numbers obscure: this isn't what disease looks like. This is what retrofitted modeling looks like.

For the United States, accepting Fitzpatrick's counterfactual requires believing that excess mortality would have reached 100% of total 2019 mortality in 2021. Total deaths would have doubled. Every family in America would have been attending funerals. Hospitals would have been stacking bodies in refrigerated trucks not for weeks but for two entire years. Society would have collapsed under the weight of death, yet somehow the models assume normal economic and social functioning would have continued.

The state-level impossibilities are even starker. In Illinois, the counterfactual requires believing excess deaths would have reached 7 times their 2020 level. In Pennsylvania, 5.4 times. These aren't marginal increases that might be explained by viral evolution or seasonal patterns. These are apocalyptic death rates that would have been visible from space, yet the models treat them as hidden catastrophes prevented by vaccines.

The counterfactual also requires believing that vaccines prevented exactly the right amount of death to return mortality to levels similar to 2020. Not too much prevention, which would have driven mortality below 2020. Not too little, which would have left mortality higher. The vaccines supposedly titrated their effect with impossible precision to create the appearance of continuity with pre-vaccination mortality. This isn't science - it's numerology.

9. Peer Review's Epistemic Collapse

How did claims this obviously impossible pass through scientific scrutiny and become accepted wisdom? The Fitzpatrick paper itself bypassed formal peer review entirely, appearing as a blogpost on The Commonwealth Fund website. Yet it achieved greater influence than most peer-reviewed studies because it aligned with institutional needs. Public health officials needed justification for their policies. Pharmaceutical companies needed evidence of product value. Media needed dramatic numbers for headlines.

The few attempts at genuine peer review have been revealing. When Ioannidis applied more rigorous methodology, the lives saved shrank by 90%. When McNamara examined actual comparative mortality data, the effect disappeared entirely. Each increment of rigor reduces the claimed benefit, suggesting that perfect rigor would reveal no benefit at all. But these contradictory findings don't penetrate the epistemic bubble. They're dismissed as "antivax propaganda" or simply ignored.

The corruption extends to basic definitions. When vaccine studies claim to use "placebos," they're using aluminum adjuvants or previous vaccines - anything but actual saline. When they report "effectiveness," they're measuring antibody levels, not prevention of disease or death. When they model "lives saved," they're comparing to impossible counterfactuals rather than actual unvaccinated populations. The language itself has been weaponized to make critical analysis impossible.

10. Breaking the Mathematical Prison

The exposure of these impossible mathematics represents more than debunking a single false claim. It reveals the complete epistemic capture of public health, where impossible assertions become unquestionable truth through institutional repetition. The 3.2 million lives saved isn't just wrong - it's impossibly wrong, wrong in ways that reveal the systematic corruption of scientific reasoning itself.

Rancourt and Hickey haven't just disproven the counterfactual - they've demonstrated that anyone with basic mathematical literacy and access to public mortality data could have disproven it. The impossibility isn't hidden in complex calculations or proprietary data. It's visible in simple graphs, basic arithmetic, and logical analysis. The fact that this obvious impossibility became accepted truth indicts every institution that promoted it.

The implications extend beyond COVID vaccines. If public health institutions can promote mathematically impossible claims about the most important medical intervention in decades, what else have they lied about? How many other medical orthodoxies rest on equally impossible foundations? How many other treatments are justified by counterfactuals that wouldn't survive elementary scrutiny?

The path forward requires more than correcting this single false claim. It demands reconstructing the entire epistemic infrastructure of medical science. New journals, new funding mechanisms, new standards of evidence - all designed with safeguards against capture. Most critically, it requires cultivating the intellectual courage to state obvious truths: that the emperor has no clothes, that two plus two equals four, that 3.2 million lives saved by vaccines is a mathematical impossibility.

The COVID era has revealed that epistemic capture can make institutions promote claims that violate basic mathematics and logic. But it has also shown that truth, armed with nothing but data and reasoning, can expose these impossible constructs. Rancourt and Hickey, working outside captured institutions with no funding from pharmaceutical companies, have demolished claims that billions of dollars in propaganda couldn't make true. Their work proves that epistemic warfare can be fought and won with the simple weapon of demonstrable reality. The mathematical prison is breaking. The impossible is being revealed as impossible. And once seen, it cannot be unseen.

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Not the Same, Never Again

By Trish Dennis

I'm not the same person I was in March 2020.

I've reflected a lot on why I didn't go along with the crowd. The only thing I "knew" then was that theft is a sin.

They stole optimism.
They stole health, and life, and peace of mind.
They stole the ability to read faces, to see smiles.
They stole savings, livelihoods, and small businesses built over decades.
They stole the comfort of human touch, of handshakes and hugs.
They stole jobs, careers, and the dignity of work.
They stole the freedom to travel, to explore, to wander.
They stole time with loved ones, final goodbyes, weddings, births, and funerals.
They stole worship, fellowship, and spiritual communion.
They stole trust in institutions, in neighbors, in each other.

They stole the presumption of innocence - we all became potential threats.
They stole childhoods, educations, milestones that won't return.
They stole joy, spontaneity, community, and connection.
They stole truth and replaced it with fear.

Theft is evil.

This piece struck a chord.

With thanks to Trish Dennis.

Leave a comment

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When the world changed, I did too.

Trish Dennis

It started with a feeling that something wasn't right. Not just in the world outside my front door, but in the people around me, and eventually, within myself.

At first, I went along with it like everyone else. The lockdown was announced, and I felt, like so many did, a strange mix of apprehension and novelty. It was surreal. But even in those early days, I remember thinking: *This all feels a bit… over the top, doesn't it?* I told myself the authorities were probably just being cautious, preparing for the worst-case scenario. That's what they do, right?

But it wasn't just caution. What unfolded in the weeks and months that followed felt like something else entirely. I was disconcerted by the unrelenting tone of fear from the government and the media, night after night, the same doom-laden messages, the same rolling death tolls, the same press conferences steeped in anxiety and alarm. And then those slogans everywhere: *"Stay Home. Protect the NHS. Save Lives." "No one is safe until everyone is safe."* People banging saucepans on their doorsteps. Neon signs everywhere reminding you to stay apart and, perhaps, to stay afraid. It didn't feel like solidarity to me. It felt performative. Conformist. Almost cultish.

I couldn't join in. Not because I didn't care, because of course I care about the NHS, and about people's health, but because **deep down, I felt something was off**. The whole thing felt constructed and artificial. Like we were all trapped inside a global theatre production no one had auditioned for.

I remember one moment distinctly, a kind of turning point for me when I realised how profoundly everything had changed. A couple of months into the first lockdown, I came across a podcast interview with a retired UK Supreme Court judge. Because he was no longer on the bench, he was free to speak openly, and what he said took my breath away. He warned that lockdowns were a disaster for democracy. That they undermined fundamental freedoms. That they were devastating for society both in the immediate and longer term, especially for young people and the elderly. *Finally*, I thought, Someone with authority, someone with standing, saying what I'd been feeling. I was elated, relieved. *This,* I thought, *is what people need to hear.*

I sent the interview to some close friends and family on WhatsApp, expecting enthusiastic agreement. But as the hours and then days passed with no response, I remember **staring at that silence**, letting it settle in, feeling a mixture of confusion and sinking realisation: *Do they not agree with this? Do they think lockdowns are a good thing? Am I the only one who thinks this is all wrong?*

As I remember it now, that was the first real fracture in the bond between me and my family and friends. I found it deeply isolating to live in the same world as they did, yet see that world through a completely different lens.

Over time, as that first lockdown year unfolded in all its insanity and cruelty, I came to understand something painful but true: I wasn't going to find alignment, or even conversation, with those I loved most on this topic. I had to look elsewhere. So I went online. I started searching, listening, reading. And I found voices. A small but steady chorus of writers, podcasters, independent journalists, thinkers, and a handful of doctors who dared to speak out most of whom, heartbreakingly, have now lost their licences or been professionally discredited.

I keep a list of them. Not because I need convincing anymore, but because I don't ever want to forget those who stood up when it counted. The people on that list helped keep me sane throughout the most surreal, cruel, and disorienting time of my

life. Those people were my lifeline. My virtual allies. They reminded me that I wasn't crazy. That I wasn't alone. That the truth still existed somewhere.

Because the truth is, **I'm not the same person I was five years ago**. The world changed, and so did I. I'm more grounded, more aware, more spiritually open. But I'm also sadder. Sadder than I've ever been. It's a strange duality. **I've never felt more awake or more alive, and yet I've never felt more isolated**.

Before all of this, I moved through life with my certainties intact. I thought I understood how the world worked. I trusted the government, the institutions, the medical and legal professions and the expert class, too. **I trusted authority**. I believed I knew who the good guys were. I underestimated the power of psychological manipulation. I overestimated the goodness of the system.

But that's not all I've learned. Alongside the disillusionment, I've found something else: something deeper and older than any institution. A connection to God. I was raised Catholic, culturally at least, but this isn't about religion in the traditional sense. This is about what I now know to be true, which is that good and evil are real forces in this world. And if evil exists, as I believe I have seen it, then so does good. That good, that light is what I now call God.

I saw evil during those lockdown years, not in an abstract or philosophical sense, but in real time, right here in front of me. I saw it in the quiet compliance and seamless functioning of a system that normalised cruelty. I saw it in what Hannah Arendt called *the banality of evil*, not monsters, but ordinary people, institutions, and policies carrying out monstrous acts without question. I saw governments impose vaccine mandates. I saw people cheer on the creation of a two-tiered society, where the unvaccinated were to be excluded from participating as full members of society. I saw children referred to as "vectors of disease," stripped of their innocence and their humanity. I saw the elderly discarded, left to die alone in care homes, frightened and forgotten. I got a glimpse into hell.

So now I hold on tightly to what is good, and kind, and human. I hold on to love, to truth, to God. Because without that, none of this makes sense. And with it, well, everything still hurts, but at least it *means* something.

This is just the start of my story. I don't know where this Substack will go. I don't know who will read it, or whether I'll be speaking into a void. But I do know this: I have something to say, and I'm finally ready to say it.

If any of this resonates with you, welcome. You are not alone. And maybe neither am I.

10 Reasons I Will Never Get Another Vaccine

By D. Alec Zeck

I really appreciate Zeck and the work he's doing. He's a valuable addition to the collective of voices helping to accelerate the awakening of more people.

There's a much-needed authenticity and simplicity in his message, which makes his insights especially impactful.

I recently came across his latest Instagram carousel post and decided to amplify it. It serves as a great primer for anyone new to the subject—distilling powerful truths into an accessible, easy-to-digest format.

I've written extensively on each one of these points and am including some of those posts throughout.

With thanks to D. Alec Zeck

1. ALUMINUM ADJUVANTS ARE NOT PROVEN SAFE

Aluminum adjuvants in vaccines are allegedly used to provoke an immune response, but their safety is based on incredibly flawed comparisons. The WHO and other health agencies cite studies on ingested aluminum, which is largely excreted, rather than injected aluminum, which is absorbed differently and can persist in the body. Research by Dr. Christopher Exley and others suggests aluminum can accumulate in the brain, contributing to neurotoxicity, autoimmune disorders, and developmental issues. Some studies have found elevated aluminum levels in the brains of autistic individuals. Despite all of this, regulatory agencies continually dismiss concerns without proper long-term safety studies.

- Interview with Dr Christopher Exley - Lies are Unbekoming
- Interview with Guillemette Crépeaux - Lies are Unbekoming
- Imagine you are an Aluminum Atom - Lies are Unbekoming
- Aluminium “Safety” - Lies are Unbekoming

2. VACCINE INGREDIENTS: A TOXIC COCKTAIL WITH NO PROOF OF SAFETY

Vaccines contain a mix of chemicals, heavy metals, and genetically modified components, including formaldehyde, polysorbate 80, aluminum compounds, and fetal cell lines. While each ingredient is claimed to be "safe in small amounts," there is no long-term safety data proving that these substances are safe when injected together. Some studies indicate that polysorbate 80 is known to increase blood-brain barrier permeability, which raises major concerns about neurotoxic ingredients in vaccines crossing into the brain. Vaccines do not undergo long-term pharmokinetic studies to determine how these substances interact in the body over time Clearly, there are a number of wild unproven assumptions related to vaccine ingredient safety.

- Real Autism Science - Lies are Unbekoming
- Grey Wolves - Lies are Unbekoming
- The "Well Baby" Visit - Lies are Unbekoming
- Thimerosal (2015) - Lies are Unbekoming

3. ZERO DOUBLE-BLIND PLACEBO-CONTROLLED-RANDOMIZED-TRIALS PROVING VACCINE SAFETY

Vaccines are not subjected to proper DBPCRT testing with inert (saline) placebos — which is the gold standard for determining safety and efficacy. Instead, vaccine trials typically use another vaccine or aluminum adjuvants as the "placebo," which hides adverse effects by essentially ensuring both groups show reactions. Without proper DBPCRT studies comparing fully vaccinated vs. completely unvaccinated populations, claims of safety remain entirely unproven. If vaccines were truly safe, why not test them against a real inert placebo? Given infants receive multiple doses in one sitting every few months, isn't this a moral, ethical, health and scientific imperative?

- On Corrupting Placebos: A feature, not a bug.

4. UNVACCINATED CHILDREN HAVE BETTER HEALTH OUTCOMES

Several studies indicate that completely unvaccinated children have better overall health outcomes than their fully vaccinated peers. Studies by Dr. Brian Hooker, Dr. Paul Thomas, Dr. James Lyons-Weiler, Neil Z. Miller, and others indicate that unvaccinated children had far lower rates of chronic conditions, asthma, allergies, ADHD, learning disabilities and more. For example, data from Dr. Paul Thomas' pediatric clinic shows that unvaccinated children experience fewer ear infections, eczema, and autoimmune disorders compared to vaccinated children. Important note: by age one, children in the U.S. receive 26+ vaccine doses. If vaccines improve health, why do unvaccinated children appear healthier?

- Measles - Lies are Unbekoming
- Less is More - Lies are Unbekoming
- Infanrix Hexa - Lies are Unbekoming

5. THOUSANDS OF PARENTS REPORT INJURIES IN THEIR CHILDREN

Parents worldwide have shared devastating stories of their children regressing into autism, suffering seizures, or developing autoimmune conditions after vaccination. These parents have been gaslit, mocked, ostracized, attacked, and more for simply sharing their authentic stories. VAERS (Vaccine Adverse Event Reporting System) contains millions of vaccine injury reports, and the CDC admits VAERS is severely underreported, meaning actual cases could be much higher. In fact, a Harvard Pilgrim Health Care study funded by HHS found that fewer than 1% of vaccine adverse events are ever reported to VAERS. This suggests that the true number of vaccine injuries might be 100 times higher than official reports indicate.

- SIDS - Lies are Unbekoming
- Interview with Dr. Andrew Moulden - Lies are Unbekoming
- Killing Babies - Lies are Unbekoming
- Poisoning Babies - Lies are Unbekoming

6. VACCINE MAKERS AND THE FDA HAVE A LONG HISTORY OF CORRUPTION

Vaccine manufacturers — including Merck, Pfizer, Sanofi and GlaxoSmithKline (GSK) — have a track record of fraud, falsifying data, hiding risks bribing doctors, knowingly causing harm, and more. For example, in 2009, Pfizer paid $2.3 billion in a settlement that was the largest health care fraud settlement and criminal fine in US history at the time, and GSK paid $3 billion in fines for illegal drug marketing.

At the same time, the FDA receives 75% of its drug regulatory budget from the very same pharmaceutical companies it regulates due to the 1992 Prescription Drug User Fee Act (PDUFA). This financial arrangement has compromised regulatory oversight, prioritizing rapid drug approvals over public safety.

- HPV “Vaccine”: Help Pay for Vioxx - Lies are Unbekoming
- HPV Vaccine - Lies are Unbekoming
- Uninformed Consent - Lies are Unbekoming
- Infanrix Hexa - Lies are Unbekoming

7. VACCINE MAKERS ARE NOT LIABLE FOR INJURY OR DEATH

The 1986 National Childhood Vaccine Injury Act (NCVIA) shielded vaccine makers from liability. Instead of suing the pharmaceutical company responsible for the product that led to injury or death, victims must file claims through the Vaccine Injury Compensation Program (VICP) — a specialized court that operates under the US Court of Federal Claims. Parents describe that the process is lengthy, complex, and adversarial — cases often take years, require extensive medical documentation and expert testimony, and face aggressive government defense, leading to frequent denials. Despite these hurdles, the VICP has paid out over $4.9 billion, proving vaccine injuries exist. If vaccines are truly "safe and effective," why do manufacturers need legal immunity?

- 1986 Act, Desmet, Fibreglass Logs and Mubongi

8. DISEASE MORTALITY DECLINED BEFORE THE INTRODUCTION OF VACCINES

Historical data shows that infectious disease mortality declined by well over 90% before vaccine introduction, likely due to improvements in sanitation, nutrition, and other factors. Roman Bystrianyk and Dr. Suzanne Humphries document this in their book Dissolving Illusions, showing that diseases like measles, whooping cough, and diphtheria were becoming less deadly due not to vaccination, but a variety of other factors. This decline wasn't limited to diseases with vaccines — diseases like scarlet fever, which had no mass vaccination program, also saw major reductions in mortality in the same timeframe. If vaccines were the primary reason for disease control, why did mortality rates decrease well before vaccine introduction, and why did non-vaccine diseases also plummet?

- Dissolving Illusions - Lies are Unbekoming

9. OPTIMAL HEALTH COMES FROM RETURNING TO NATURE

Health doesn't come from vaccines, pharmaceuticals or endless supplements; vibrant health come from aligning with natural principles. Sunlight, grounding, nutrient-dense foods, clean water, circadian rhythm alignment, community, emotional regulation and more all contribute to vibrant health. The idea that health depends on vaccines totally contradicts the reality that adopting natural principles is sufficient to prevent, overcome, and totally reverse disease states. Health isn't found in a needle — perpetual pharmacuetical profiteering is.

- The Unvaccinated - Lies are Unbekoming
- The Unvaccinated Child - Lies are Unbekoming

10. (and most important) THERE'S NO PROOF THAT "VIRUSES" EXIST OR CAUSE DISEASE

There is no evidence that viruses exist or cause illness. Virology does not follow the scientific method (please see my previous post for more details). Virology operates on a series of unproven assumptions, not empirical scientific evidence. The foundational claim — that viruses cause disease — is based on highly manipulated lab experiments, not direct evidence from nature. What virologists call "virus isolation" is fraudulent. A virus is never actually extracted from the bodily fluids of a sick person, but is assumed to exist within the fluids. Virologists mix unpurified bodily fluids with toxic antibiotics, antimycotics, and starved foreign cell cultures, which

destroys the cells — then they wrongly blame a "virus" assumed to be in the sample for the damage.

Control studies by Dr. Stefan Lanka and others falsify the assumption that viruses cause cell death by showing that cell death occurs even without a human sample that is assumed to contain viruses. Additionally, 224 Freedom of Information (FOI) requests submitted to health institutions worldwide have failed to produce a single record of a virus being isolated directly from human bodily fluids. The images presented as "viruses" are actually cellular debris or artifacts from electron microscopy preparation, misidentified due to flawed methodology. This is just a short list of the problems with virology. With that, since vaccines require the existence of viruses and viruses have never been shown to exist, there is literally zero reason to ever receive a vaccine.

- The Virus™ Paradigm: Assumptions, Lies, and the Foundation of Modern Medicine
- Settling the Virus Debate - Lies are Unbekoming
- An End to Upside Down Medicine - Lies are Unbekoming
- Measles “Virus” - Lies are Unbekoming

Dissolving My Vaxxed Illusions

Breaking free from the prison of my mind.

Vaxxed II: In 2016, a media firestorm erupted when Tribeca Film Festival abruptly censored its documentary selection, VAXXED: From Coverup to Catastrophe, amid pressure from pro-pharmaceutical interests.

Waking up to vaccination malfeasance has really gotten to me, and I've been wondering why it would bug me so much.

I arrived in Australia, in late 1992, having left war torn Iraq. I chose to leave an authoritarian state and start a new life in what I considered to be the best address on earth. It never crossed my mind that the free state I ran towards was built on an invisible yet highly sophisticated authoritarian government-corporate fascist enterprise that bullied its population to inject its children with multiple dangerous disease causing chemicals…for the greater good.

Multigenerational indoctrination is real. Prisons of the mind are real.

And so it is that the two beautiful children we brought into this "free land", we injected with those chemicals, giving them a range of conditions that included:

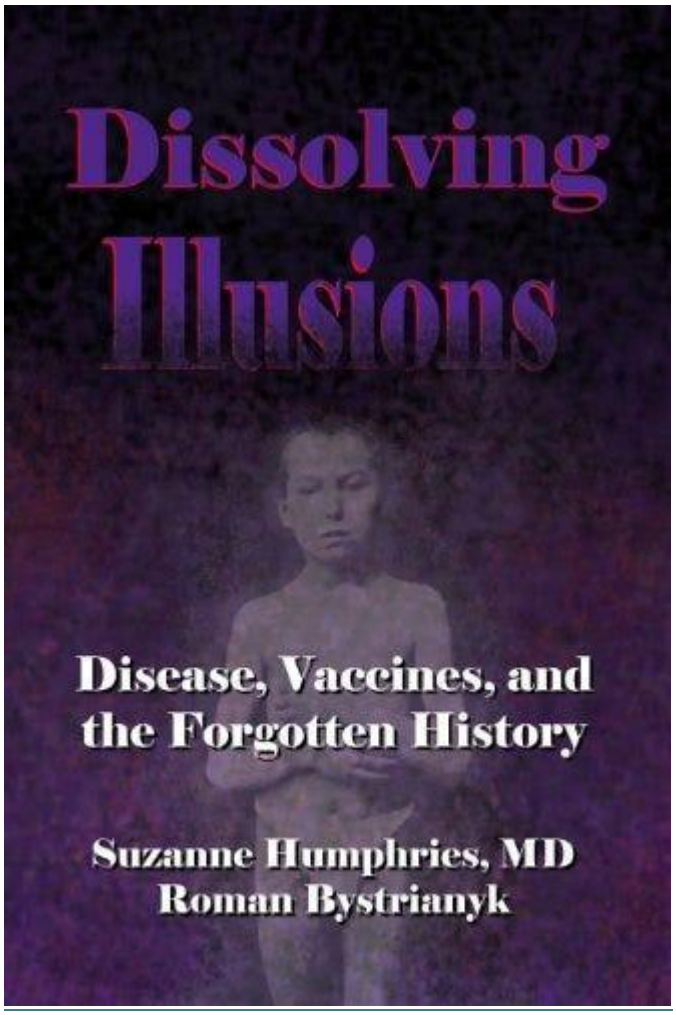
- Stutter and delayed speech development
- Hyperactivity
- Asthma
- Vitiligo
- Hay fever

It is a fascist totalitarian enterprise that managed to sleep walk me into doing this.

I wonder; if you are hypnotised, are you free?

I am going to meander around in this vaccination rabbit-hole for quite some time as I come to terms with all of this.

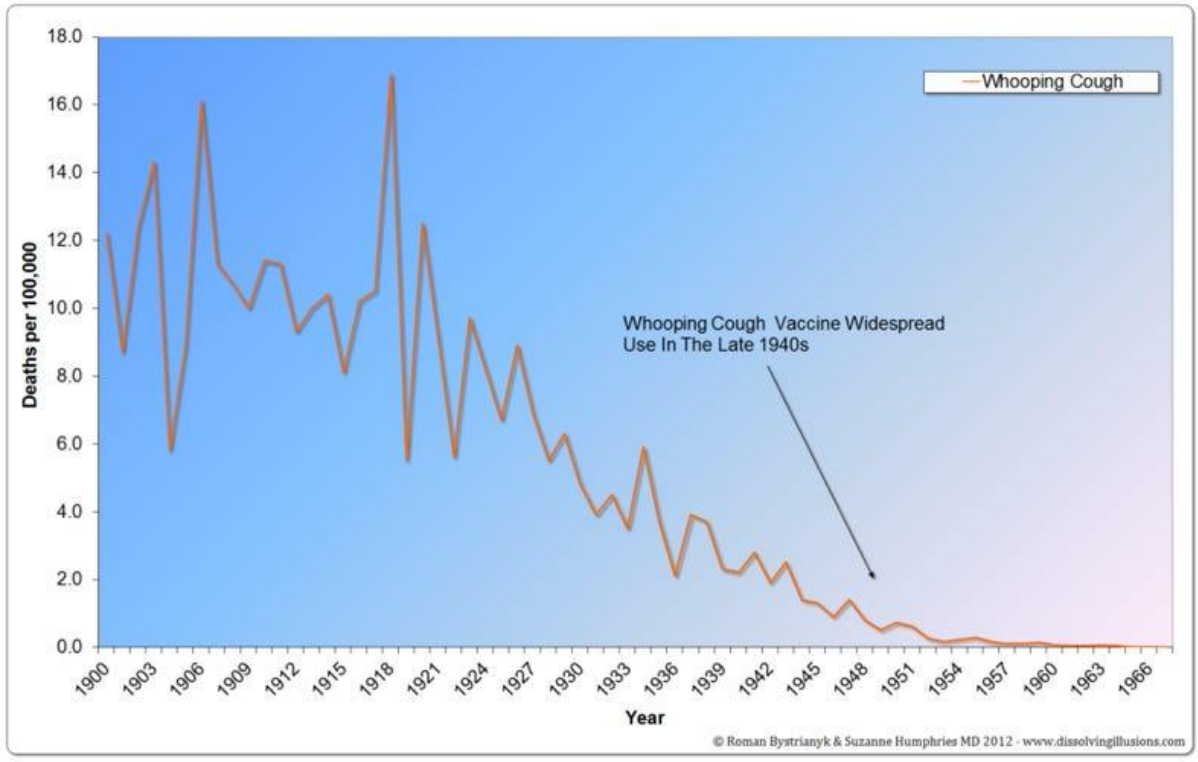
I'm about two thirds through Dissolving Illusions and without a doubt its one of the most important books I have ever read. Books that reorient you to reality are pretty rare and this is one of them.



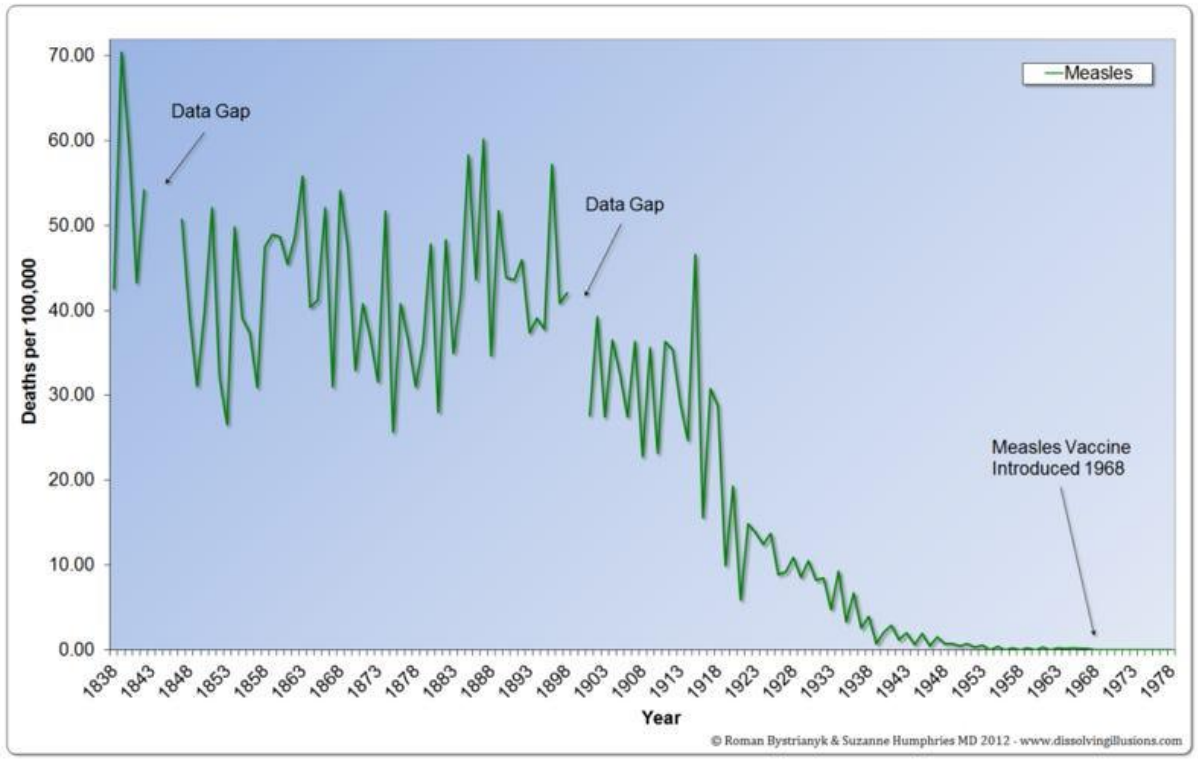
The book has a website that includes a gallery of photos and graphs help you "see" the decline and virtual vanishing of disease BEFORE vaccination came along.

Graphs & Images - Dissolving Illusions | Disease, Vaccines, and the Forgotten History

Here is whooping cough (pertussis) in the US.



Here is measles in England/Wales:



The thesis, proven in the book, is that disease vanished as water, nutrition, sanitation, sewerage and working conditions improved. Vaccines did NOT rid us of disease, our own immune systems did. Pharma simply came along and took the credit and in so doing made us all sick again.

I watched Vaxxed 2 recently.

Vaxxed 2 - CHD TV: Livestreaming Video & Audio (childrenshealthdefense.org)

Suzanne Humphries, one of the two authors of Dissolving Illusions features prominently in the documentary.

Here it is on Rumble.

Here it is on Odysee.

It's a profoundly important documentary from 2016 that has had the full weight of the censorship machine against it.

If you have little kids that you are injecting according to "the schedule" and especially if you have a baby on the way…this is for you. You will see first hand what vaccine injury looks like but even more importantly you will see, in the last 30 minutes, what unvaccinated children look like. As emotional as I was listening to the injured, seeing what real health looks like in children who have never had a single injection is something else. Family after family come on screen and tell you that they have NEVER needed to take their child to a doctor, that they NEVER had an ear infection and that they NEVER had to take an antibiotic. Human natural immunity, when left undamaged, turns out to be an incredible shield against disease.

Watching these super healthy children come on camera one after another made me think back to Kennedy Jr. in his Tyson interview where he said:

All are directly linked to vaccines in the scientific literature. On our website we have 1,400 peer reviewed studies published on NIH's website PubMed, linking various vaccines to all of those injuries.

Well, they're making $60 billion a year selling us vaccines, but they're making $500 billion a year selling the remedies for the injuries caused by vaccines.

The two least profitable versions of humanity are dead people and healthy people.

The most profitable version is an unhealthy person. They have the greatest “lifetime value” as they would say if you were studying an MBA.

Some people know what they are doing but in the main, the system leans towards “unhealth” unconsciously. The system leans towards sustaining itself. Unhealth sustains. Health doesn’t.

Witnessing the health of the unvaccinated I couldn’t help but reflect on the conditions we gave our kids. I know we got off lightly though as you will see from the stories of the injured.

The documentary spends some time on Gardasil (HPV vaccine), and Gardasil injured kids. Again, something that we sleepwalked our daughter into.

The theory is that it will help prevent cervical cancer in girls and penile cancer in boys (both claims are lies). At 42 minutes Robert Kennedy Jr. explains that children that take the vaccine are 37x more likely to die from the vaccine than from cervical cancer.

What can I say, I strongly recommend you watch the doco and get others to watch it if you can. It might be the only place that you will see what healthy unvaccinated kids and people look like.

Dissolving Illusions begins with a wonderful foreword by Dr. Jayne L. M. Donegan.

In it she describes her own awakening. Here is her story with some thoughts and comments along the way:

Vaccination is regarded as the most important health advance in the 20th century by most health professionals and laypeople. Although the dramatic decreases in morbidity and mortality from diseases that occurred in the course of the 20th century have been credited to the introduction of specific vaccines, scant acknowledgment has been given to improving social conditions.

Despite questioning the safety and efficacy of vaccination by reputable medical men since its introduction, debate has been, and is, increasingly discouraged.

Information published in scientific journals is used to support this position, other views being regarded as "unscientific."

It was a received "article of faith" for me and my contemporaries, that vaccination was the single most useful health intervention that had ever been introduced. Along with all my medical and nursing colleagues, I was taught that vaccines were the reason children and adults stopped dying from diseases for which there are vaccines.

We were told that other diseases, such as scarlet fever, rheumatic fever, typhus, typhoid, cholera, and so on, for which there are no vaccines at the time, diminished both in incidence and mortality (ability to kill) due to better social conditions.

This is such an obvious point!

If vaccines got rid of disease, did they get rid of every single disease? If not, what happened to the diseases that vaccines didn't "save us from"? They just seemed to go away…why? Yep, you guessed it: water, nutrition, sanitation, sewerage and working conditions improved.

You would think—as medical students who are supposed to be moderately intelligent—that some of us would have asked, "But if deaths from these diseases decreased due to improved social conditions, mightn't the ones for which there are vaccines also have decreased at the same time, for the same reason?" But we didn't.

The medical curriculum is so overloaded with information that you just have to learn what you hear, as you hear it: nonvaccinatable diseases into the social conditions box and vaccinatable diseases into the vaccines box and then on to the next subject.

Everything I was taught and read in textbooks, both before I qualified as a doctor and through all my post-graduate training, reinforced this view.

Along with most doctors, I regarded parents who would not vaccinate their children as ignorant or, if not ignorant, sociopathic, for withholding what I believed was a lifesaving intervention and putting everybody else at risk by reducing herd immunity.

In Vaxxed 2 many brave doctors show up for interviews. They are all asked what they were taught at university about vaccines, and they all say the same thing. Pretty much nothing, just that there is a childhood vaccine schedule and that the kids need to stick to it. They even manage to get an immunologist (with a PhD) onto the show…same thing.

Nothing on risks, all on benefit…make sure the kids get it.

They are the foot soldiers of a drug cartel and I do not give them a pass. They might not get taught it at university, but they willfully shut down their curiosity when let loose on the public and aim for purposeful conscience comforting ignorance on anything to do with vaccines.

Paediatricians are the absolute worst.

In Forrest Maready's short book Unvaccinated, and towards the end he talks about what medical students study at university about vaccination.

Finally, the really strange thing about doctors (and nurses) and vaccines - they are not taught much about them in school. Hardly anything, actually. Compared to the hundreds of hours an anti-vaxxer is likely to have spent studying vaccines, most health care providers know next to nothing. They learn a lot about disease and the immune system and assume that vaccines interact similarly. Unfortunately, they don't. As I mentioned about the ACT problem with the whooping cough vaccine, they are very different. Physicians may spend a few hours learning the schedules recommended by the government and spend a few hours learning which vaccines should be administered subcutaneously (under the skin) as opposed to intra-muscularly. Beyond that, they learn almost nothing about vaccines.

I was so confused by hearing this; I bought every book listed on the medical curriculum of a prestigious medical school. I even bought some auxiliary books that were not required but on the optional, "recommended" reading list. After going through each and every book on the list - over thousands and thousands of pages - there were only 4 pages that talked about how vaccines work! There were 11 pages that listed the vaccine schedule recommended by the government, but besides that, 4 pages that talked about vaccines.

I made a video about it, showing the books and how little a prestigious medical school's curriculum spent teaching about vaccines. Many doctors and nurses got in touch with me to confirm this had been their experience in medical school. Of course, students learn more than what is taught from their schoolbooks, but I imagine the disparity continues into their classroom and residencies.

Once I understood that doctors and nurses learn very little about vaccines in school, I began to realize why they are so hostile to people like myself who ask honest questions about them. I have written books on the subject, but there are many, many amateur anti-vaxxer mothers and fathers out there who are much, much smarter than me. Any of us could easily stump an average pediatric doctor or nurse on vaccines with some of our common knowledge.

Now back to Dissolving Illusions and Dr. Jayne L. M. Donegan:

Indeed, at special clinics in the 1980s, I used to counsel parents who wouldn't vaccinate their children against whooping cough—which was regarded as the problematic vaccine in those days. I acknowledged that there were dangers associated with the vaccine. I was a truthful doctor, but I told them the official line: that the disease was 10 times more likely to cause death or disability than the vaccine, so any sane person would choose to vaccinate.

What changed?

In 1994 there was a massive measles/rubella vaccination campaign in the UK. Seven million schoolchildren were vaccinated against measles and rubella to protect them from an epidemic of measles, which was said to be imminent.

In those days, there was only one measles shot in the schedule—it is a live viral vaccine and was supposed to be like the wild measles virus. We were told, "One dose and you are immune for life." I did realize that one shot, however, might not protect every child—no vaccine is one hundred per cent effective—but the chief medical officer said that even two shots of this "one-shot vaccine" would not necessarily protect children when the epidemic came and that they would need a third. He also said that the best way to vaccinate children was en masse to "break the chain of transmission."

This left me in a quandary. Obviously, the risk-to-benefit ratio of the vaccine was in favor of the vaccine if it was safer than the disease and if it stopped your child from getting the disease. This is what most parents expect to happen and certainly what they are encouraged to believe.

But if children can have the one-shot vaccine twice and still get the disease so they need to have a third shot, this means they can be exposed to all the risks of the vaccine two or three times… and at the same time, all the risks of the disease as well. Did I need to reevaluate what I had been saying to parents?

Also, if the best way of "breaking the chain of transmission" of an infectious disease was to vaccinate en masse, why did we vaccinate babies with all those different vaccines at two, three, and four months of age (UK schedule)? Why didn't we just wait for two or three years and then vaccinate all those who had been born in the interim en masse to break the chain of transmission?

Good questions!

This was the start of my long, slow journey researching vaccination and disease ecology and learning about other models and philosophies of health and natural hygiene such as those used by the great pioneers who cleaned up our cities and built clean water supplies and sewage systems.

I spent hours in libraries looking at archived journals and textbooks and the Office for National Statistics (ONS) getting out dusty volumes from the middle of the 19th century to make graphs of death rates from diseases for which we have vaccines but which, for some reason, have not been drawn - or made available to doctors or parents by the ONS or the Department of Health.

I read what prominent men of science, medical officers for health, and doctors wrote about vaccination and its sequelae that never made it into today's textbooks and found out what anyone with even a passing acquaintance with disease figures of the 19th and 20th century knew. **For example, by the 1950s when the whooping cough vaccine was introduced, data showed that whooping cough was killing only 1 percent of the numbers of people who used to die in England and Wales 50 years before.**

Official data showed that the same happened with measles. Indeed, when the measles vaccine was introduced to the UK in 1968, the death rate continued to drop steadily, even though the initial uptake of the vaccine was only 30 percent and didn't get above 50 percent until the 1980s.

Even the much-heralded success story of smallpox vaccination was not what it seemed. The enforcement of the compulsory smallpox vaccination law in 1867, when the death rate was already falling, was accompanied by an increase in the deaths from 100 to 400 deaths per million.

Yes, the "holy" smallpox vaccine managed to increase smallpox death and prolong widespread smallpox disease for about a century! Smallpox vaccination is one of the greatest man-made medical disasters, exactly the opposite of what all medical textbooks and Google will tell you.

After overcoming an awful lot of fear, I came to the gradual realization that it was true what people on the outside had been telling me, that "health is the only immunity." We don't need protecting from out there.

We get infectious diseases when our bodies need to have a periodic cleanout. Children, especially, benefit from childhood spotty rashes, or “exanthems” as they are called, at appropriate times in order to make developmental leaps, so long as they are treated appropriately. In my experience, the worst complications of childhood infections are caused by standard medical treatment, which involves suppression of all the symptoms.

Has this knowledge helped my career? It has certainly enabled me to give better advice to parents about treating childhood illness and to be able to provide parents with enough information to give truly informed consent for medical interventions such as vaccination.

My research also led me to being asked, in 2002, to act as an expert witness for the mothers of two unvaccinated children whose absent fathers were applying to the court for a vaccination enforcement order. I wrote a report based on my research, fully referenced, carefully using the methods and results of the studies I quoted to give my opinion, rather than the conclusions of the authors, which are often not supported by their results.

The experts for the fathers and the children were members of the Joint Committee on Vaccination and Immunisation (JCVI). They recommended vaccination for both children. If they had advised that vaccination was not necessary for these individual children, they would have been seen to be contradicting government health policy based on JCVI recommendations, which is a conflict of interest that was not explored in the case.

The judge decided that my opinion was less valid than theirs, and the mothers lost their case. When it went to appeal, one of the appeal judges called my evidence “junk science,” and on this basis I was charged with Serious Professional Misconduct by the General Medical Council (GMC) of the UK, which could have resulted in being struck off the Medical Register, banned from practicing as a doctor, and losing my livelihood.

In 2007, after a long, drawn-out case lasting three and a half years, the GMC panel completely exonerated me. They did not merely acquit me, but said they were “sure that in the reports you provided you did not fail to be objective, independent and unbiased.”

The successful outcome notwithstanding, the case took an inevitable and heavy toll on my children, our family, and my professional life.

In their meticulously researched book, Dr. Suzanne Humphries and Mr. Roman Bystrianyk take you right back to the roots of disease and the connection between living conditions, nutrition, and health.

They systematically piece together the information you need to pierce the myth that vaccination is what saved us from the infective scourges of the past. More worryingly, they also show how vaccines may be instrumental in creating a many-headed hydra of overt and covert disease, which is hardly recognised, barely understood, and may well be of immense consequence to our children and future generations.

With all this information there, waiting to be found, why don’t more doctors go and look for it?

Why do doctors not even entertain the possibility that the Universal Childhood Vaccination Program may not be the unmitigated success that it is portrayed to be?

Why do doctors not even consider that there may be other ways of achieving health that are better and longer lasting?

In my opinion, the biggest obstacle to independent research and thinking is the professional consequence of stepping out of line and being seen to be different—as I know to my cost. As George Bernard Shaw says in his preface to "The Doctor's Dilemma" 1906:

Doctors are just like other Englishmen: most of them have no honour and no conscience: what they commonly mistake for these is sentimentality and an intense dread of doing anything that everybody else does not do, or omitting to do anything that everybody else does.

So next time you are in your doctor's office and you say, "I'm worried about the safety of vaccination," and you are told, "You don't understand, you're not a doctor…" remember that, if you are a doctor and say, "I'm worried about the safety of vaccination," you will be told, "We're charging you with serious professional misconduct…"

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No Liability, No Studies, No Accountability: The Vaccine System Aaron Siri Exposed in Federal Court

An Essay on the 1986 Act, the CDC Court Order, and What Comes Next

Aaron Siri, attorney and managing partner of Siri & Glimstad LLP, appeared on the Joe Rogan Experience in early March 2026. What he described over the course of that conversation is worth examining carefully.

In 2019, the United States Department of Justice signed a court order on behalf of the Centers for Disease Control and Prevention. The order, entered in the Southern District of New York, stipulated the complete list of studies the CDC relied upon to support its public claim that vaccines administered in the first six months of life do not cause autism.

There were twenty studies on the list.

Nineteen had nothing to do with the vaccines given in the first six months of life. They were either MMR studies — and MMR is not given until at least twelve months — or studies of vaccine ingredients not present in the products in question.

The twentieth was a 2012 Institute of Medicine review that had specifically examined whether the DTaP vaccine causes autism. The IOM found exactly one study on the subject. That study showed an association between DTaP and autism. The IOM discarded it because it lacked an unvaccinated control group — and concluded there was insufficient evidence to accept or reject a causal relationship.

The DOJ signed the order. A federal judge entered it. The CDC's evidentiary basis for one of its most repeated public health claims was now a matter of court record.

Aaron Siri, the managing partner of Siri & Glimstad LLP and author of *Vaccines, Amen: The Religion of Vaccines*, described this outcome in a recent appearance on the Joe Rogan Experience.[1] He had spent years demanding the studies through Freedom of Information Act requests on behalf of his client, the Informed Consent Action Network (ICAN). The CDC stonewalled. He sued in federal court. Days before the hearing, the DOJ produced its list of twenty studies. Siri read them. Then he called the DOJ attorney.

"Are you sure," he told Rogan he asked, "that your client, the CDC, wants to settle this case on the basis that these are the studies they rely upon?"

They did. The stipulation was signed. It is publicly available.

The Mechanism Behind the Gap

The absence of those studies is not a mystery once you understand the economic structure that governs vaccine development.

In 1986, Congress passed the National Childhood Vaccine Injury Act.[2] The law gave vaccine manufacturers something that exists for no other product category in America: immunity from civil liability for design defect claims. If a pharmaceutical company's drug harms or kills someone, the injured party can sue and argue the product could have been made safer. That threat — the prospect of catastrophic jury verdicts — is what drives companies to invest in long-term safety data before and after products reach the market. Pfizer's four top-selling drugs, as Siri noted on the podcast, each had between two and seven years of follow-up in placebo-controlled clinical trials before licensure.[3] That is not philanthropy. It is economic self-interest.

Vaccines are exempt. A parent whose child is injured cannot bring a design defect claim against the manufacturer. The only avenue is a federal compensation program with a $250,000 statutory cap on pain and suffering and death, no article III judge, and no discovery as of right.[4] The program has paid out approximately $5 billion in total since its inception — a figure that looks large until you consider it spans four decades of a mandatory national program administered to virtually every American child.

Remove the liability, and you remove the incentive to generate safety data. The result is not sinister concealment. It is ordinary corporate behaviour in the absence of accountability. Why fund a five-year placebo-controlled trial when the law does not require it and no plaintiff can ever use the results against you?

The vaccine schedule in 1986 included three injections before a child's first birthday.[5] By the time the current schedule was published in early 2025, that number had reached twenty-nine — recently reduced to nineteen following new policy review. The schedule expanded nine-fold over four decades without the safety accountability mechanism that governs every other pharmaceutical product. The CDC's inability to produce a single study showing the vaccines given in the first six months of life do not cause autism is the predictable downstream result of that structure, not an anomaly within it.

What the CDC's Own Data Shows About Measles

The 1986 Act was sold on a specific premise: that vaccines are so essential to human survival that the normal rules of product accountability cannot apply. Siri addressed this directly.

In the year before the measles vaccine was introduced, approximately 400 Americans died of measles annually — in a population of roughly 180 million.[6] That is a death rate of about 1 in 450,000. The CDC's own historical mortality records, publicly available on its website, confirm this figure. It is not a fringe claim.

More important than the number itself is the trend behind it. Between 1900 and the early 1960s — before the measles vaccine existed — measles mortality in the United States declined by over 98 percent.[7] Improved sanitation, better nutrition, less crowded living conditions, and advances in acute medical care drove that decline. The vaccine arrived at the end of a decades-long mortality collapse, not at its beginning.

There is a 1969 episode of *The Brady Bunch* in which the children get measles and treat it as a holiday from school. Rogan played the clip. The children joke that if you have to get sick, measles is the one to get. That is not Hollywood carelessness. That is a culturally accurate portrayal of how measles was understood by the American public in the era before the vaccine narrative was constructed. A disease that killed roughly 1 in 450,000 people, that typically struck children — in whom it was far less dangerous than in adults — and that conferred lifelong immunity after a single episode, was not the existential threat the current public health apparatus describes.[8]

Then there is the cardiovascular data. A twenty-two-year prospective cohort study in Japan, funded by the Japanese government and conducted across major universities, tracked approximately 100,000 people and found that those who had experienced natural measles and mumps in childhood had a statistically significant 20 percent reduction in deaths from cardiovascular disease compared to those who had not.[9] Separate studies have found that women who had natural measles had approximately 50 percent less ovarian cancer, and that the absence of natural measles infection is associated with substantially elevated rates of Hodgkin's and non-Hodgkin's lymphoma.[10] These studies are on PubMed. They are not retracted. They are simply not discussed.

The implication — which Siri was careful to mark as inference rather than established fact — is that childhood febrile infections may confer long-term immune system benefits that outlast the acute illness. If eliminating measles infection has increased cardiovascular deaths in the United States by even 1 percent, the life-years lost from that increase likely exceed the life-years saved by preventing four hundred

measles deaths per year. That calculation has never been seriously attempted by any public health authority.

The Business Model

Siri summarised the vaccine program's economic structure in a passage from the podcast that deserves to be quoted at length, because it makes visible what is otherwise obscured by institutional language.

Imagine a product you want to sell, he said. You are a little worried it might hurt people. But the government has given you complete immunity from liability — no matter how many people are harmed or killed. And because of that immunity, you don't need to worry about the safety data. Better still, the government will mandate that people take your product. For those who can't afford it, a federal program guarantees payment. And the government will spend billions promoting it, so you don't need to build a marketing budget. No liability. Guaranteed market. Mandated uptake. Guaranteed payment. Free promotion.

"If it wasn't vaccines," Siri told Rogan, "you'd say it's insane."[11]

He is describing a disclosed, legal arrangement. The National Childhood Vaccine Injury Act is a public law. The Vaccines for Children program, which purchases vaccines for underinsured children using federal funds, is a public program. The CDC's Advisory Committee on Immunization Practices, which votes vaccines onto the mandatory schedule, meets on a public calendar. The financial relationships between ACIP members and vaccine manufacturers are disclosed — selectively and incompletely — in conflict-of-interest forms that are technically available under FOIA.[12]

The system is not hidden. It is simply not described plainly.

What Siri's legal work adds to this picture is the evidentiary layer. When he deposed Dr. Stanley Plotkin — widely regarded as one of the world's leading vaccinologists — and asked whether there were studies showing DTaP does not cause autism, Plotkin said he assumed such studies would show no association. When shown the IOM review establishing there were none, he said: "Oh, okay." Siri then asked whether, in the absence of those studies, Plotkin should wait before telling parents that vaccines don't cause autism. Plotkin's answer: No. Because he had to take into account the health of the child.[13]

That exchange is on video. It is publicly available. The world's leading vaccinologist acknowledges there are no studies, and confirms he tells parents the matter is settled regardless. That is not science. It is the operation of a belief system using scientific language.

What Chronic Disease Trends Show

In the early 1980s, under 10 percent of American children had a chronic health condition.[14] By the time of the most recent comprehensive surveys, that figure exceeded 40 percent — with some surveys finding over 50 percent of children carrying at least one chronic diagnosis. The conditions driving that increase are not infectious diseases. They are immune-system disorders: asthma, atopic dermatitis, food allergies, ADHD, autism spectrum disorder, autoimmune conditions.

Approximately ten peer-reviewed studies have compared health outcomes in fully unvaccinated children against children who received one or more vaccines. The results are consistent across studies conducted in different countries and by different research teams: unvaccinated children have substantially lower rates of the chronic conditions that have exploded in the vaccinated population.[15] The studies vary in their methodologies and each carries limitations. None is funded by the CDC or NIH. The studies that would settle the question — large, prospective, placebo-controlled vaccinated versus unvaccinated trials — have never been conducted.

The absence of those trials is not an oversight. Siri's FOIA work established that HHS, when legally demanded to produce long-term placebo-controlled trial data for childhood vaccines, acknowledged in writing that no such records existed.[16] The agency has been legally required since 1987 to submit biennial reports to Congress on vaccine safety improvements. A separate ICAN lawsuit established that those reports had never been produced.

A manufacturer with full liability exposure and an incoming class-action bar would have funded those studies decades ago. The economic incentive to know — to find the signal before a plaintiff's attorney did — would have been overwhelming. That incentive was removed in 1986. The studies were not done. Children got sicker. The CDC website said the science was settled.

The Religion Thesis

Siri's book is titled *Vaccines, Amen: The Religion of Vaccines* for a reason he articulated clearly to Rogan. The vaccine program operates with the social and epistemological structure of a religion: a foundational doctrine that cannot be questioned, a class of priests authorised to interpret the doctrine, rituals of compliance enforced through institutional pressure, and the treatment of doubt as moral transgression rather than scientific inquiry.

The tell is the response to evidence. When Siri presents the court stipulation — the CDC's own document, entered by a federal judge — the standard response is not to examine it. It is to dismiss Siri as an anti-vaxxer and move on. When he presents the Gallagher and Goodman study from the University of Stony Brook — the only peer-reviewed study examining HepB vaccine and autism, which found a threefold increase in autism rates in vaccinated versus unvaccinated infants — the response is not to replicate it or fund larger studies. It is to find procedural objections to this one study while citing the absence of others as proof of safety.[17]

"Vaccines don't cause autism has been thoroughly debunked," Siri told Rogan, "is a belief. It is not science. It is not fact. It is not based on data."

The CDC's own updated website, as of early 2025, now acknowledges there are no studies showing that the vaccines administered in the first six months of life do not cause autism. That is a quiet admission with enormous implications, made without press release or apology, to no major coverage in mainstream outlets.[18]

The document exists. The signature is on it. The date is what it is.

Whatever you call the gap between what the CDC said publicly for decades and what the DOJ signed in a federal court — delay, negligence, institutional failure, or something harder to name — the court record does not change. It is publicly available. It says what it says.

References

[1] Joe Rogan Experience #2462, Aaron Siri, March 4, 2026. Available at youtube.com/PowerfulJRE.

[2] National Childhood Vaccine Injury Act of 1986, 42 U.S.C. §§ 300aa-1 to 34 (2016). See also Mary Holland, Kim Mack Rosenberg, and Eileen Iorio, *The HPV Vaccine on Trial* (Skyhorse Publishing, 2018), pp. 247–249.

[3] JRE #2462 (Siri). See also J.B. Handley, *How to End the Autism Epidemic* (Chelsea Green Publishing, 2018), pp. 43–46, for discussion of comparative clinical trial lengths between drugs and vaccines.

[4] National Vaccine Injury Compensation Program (VICP), Health Resources & Services Administration, hrsa.gov. Statutory cap: 42 U.S.C. § 300aa-15(a)(2). See Handley, *How to End the Autism Epidemic*, pp. 54–57.

[5] Robert F. Kennedy Jr. and Brian Hooker, *Vax-Unvax: Let the Science Speak* (Skyhorse Publishing, 2023), p. 2. See also comparison of 1986 and 2023 CDC schedules, figure 1.1.

[6] CDC historical mortality data on measles; cited in Paul Thomas, *Vax Facts* (2024). See also JRE #2462 (Siri).

[7] Suzanne Humphries and Roman Bystrianyk, *Dissolving Illusions: Disease, Vaccines, and the Forgotten History* (self-published, 2013), chapter 14, graphs 14.1 and 14.2. U.S. and England measles mortality data, 1901–1965.

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[10] Miller, *Miller's Review*, studies 169–171. See also JRE #2462 (Siri).

[11] JRE #2462 (Siri).

[12] See ACIP conflict-of-interest disclosure process; discussed in Holland et al., *The HPV Vaccine on Trial*, pp. 198–205.

[13] Deposition of Dr. Stanley Plotkin, conducted by Aaron Siri on behalf of ICAN, 2018. Video available publicly online.

[14] *Turtles All the Way Down: Vaccine Science and Myth* (anonymous, Israel, 2022 English edition), chapter on chronic disease rise, citing U.S. periodic health surveys 1960–2010.

[15] Kennedy and Hooker, *Vax-Unvax*, chapters 2–3. Mawson et al. 2017; Hooker and Miller 2020, 2021; Enriquez et al. 2005; Netherlands NVKP survey. See also Thomas, *Vax Facts*, Mawson study table.

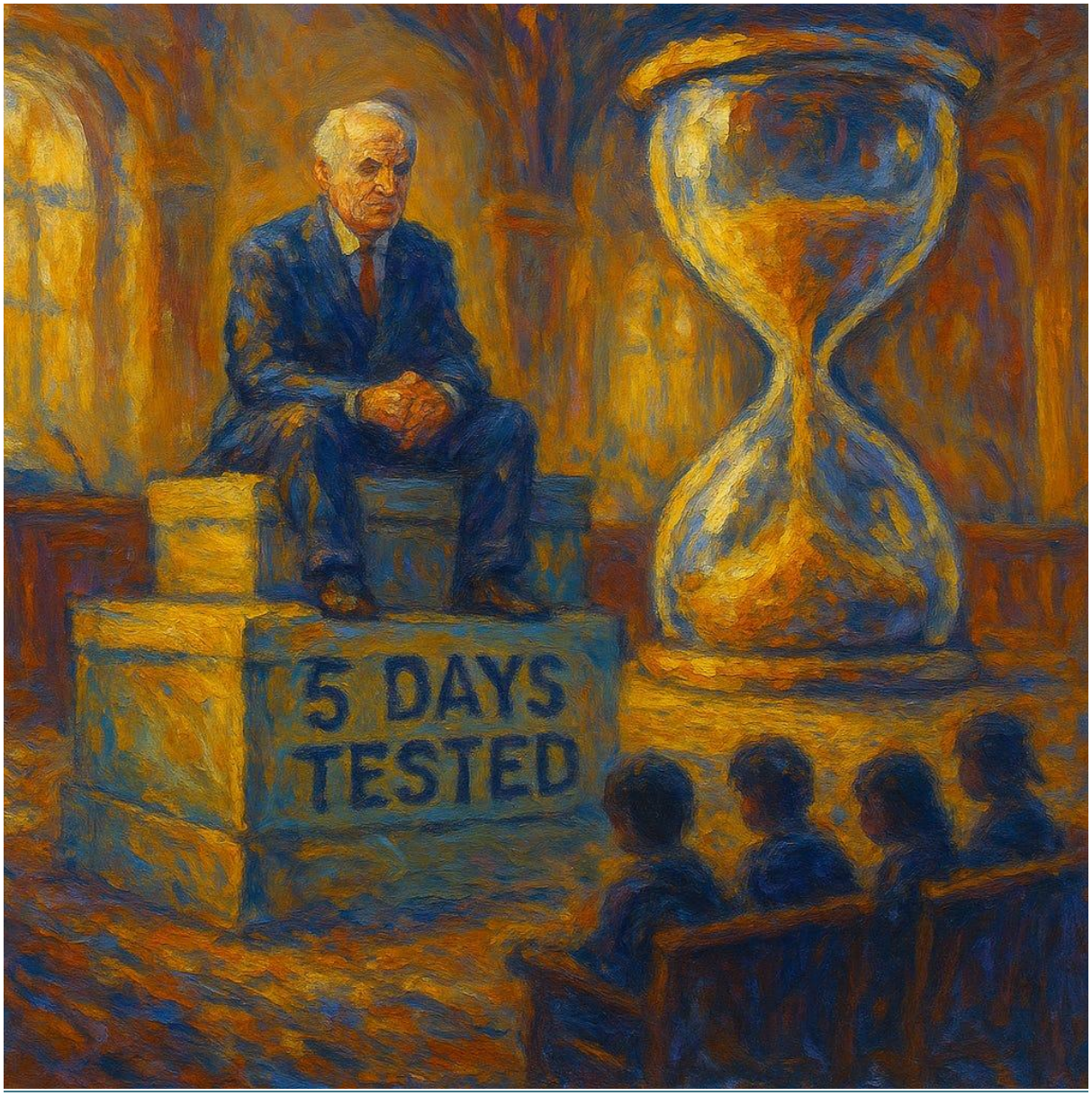
[16] Kennedy and Hooker, *Vax-Unvax*, pp. x–xi. HHS written acknowledgment, June 27, 2018; Federal Court order, July 6, 2018.

[17] Gallagher CM, Goodman MS. "Hepatitis B vaccination of male neonates and autism diagnosis, NHIS 1997–2002." *Journal of Toxicology and Environmental Health, Part A* 2010; 73(24):1665–77. Cited in JRE #2462 (Siri).

[18] JRE #2462 (Siri); CDC autism and vaccines page update, 2025.

Plotkin Under Oath: Nine Hours That Exposed the Vaccine Industry

Aaron Siri's Deposition – 30 Q&As - Plus a Psychological Profile of Plotkin



In January 2018, attorney Aaron Siri conducted a nine-hour deposition of Dr. Stanley Plotkin that stands as one of the most revealing insider testimonies about vaccine development ever recorded under oath. Plotkin, widely regarded as the "godfather of vaccines" and developer of the rubella vaccine, was forced to confront the systematic failures, ethical violations, and scientific inadequacies that define modern vaccine science. What emerged was not merely testimony about regulatory shortcuts or financial conflicts of interest, but a window into something far more disturbing. When we judge a man by his actions and their fruits, Plotkin's entire career reveals someone who has been attracted to, nurtured by, and richly rewarded within an evil system. A *pathocracy*. **Listening to his testimony, it becomes hard not to think of witchcraft and satanic ritual. What else describes the injection of a newborn baby with parts of a dead baby?** His casual description of harvesting organs from 76 aborted fetuses, his experiments on

vulnerable populations deemed "human in form but not in social potential," and his gleeful willingness to "go to hell" for his vaccine work suggest something that doesn't make sense through a scientific worldview but makes perfect sense through a demonic perspective. The systematic suppression of adverse event reporting, the complete absence of basic safety studies, and the contempt for religious conscience all point to forces that transcend mere corporate malfeasance.

Siri's methodical dismantling of Plotkin's credibility over nine grueling hours represents historically important testimony that exposes the fundamental corruption at the heart of vaccine science. Under oath, the world's most prominent vaccine expert admitted that comprehensive safety studies comparing vaccinated to unvaccinated children have never been conducted, that adverse event reporting captures less than one percent of actual injuries, that safety monitoring typically lasts only days after injection, and that financial conflicts of interest permeate every level of vaccine development and regulation. Plotkin's own admissions revealed a man who couldn't remember receiving millions of dollars from vaccine manufacturers, claimed he'd never read basic safety studies about his own products, and showed profound contempt for parents' religious concerns while profiting from vaccines containing aborted fetal tissue. His psychological profile emerges as someone with narcissistic grandiosity, utilitarian dehumanization of vulnerable populations, and an atheistic supremacy that dismisses moral constraints as obstacles to his self-perceived mission to save humanity. The more people who understand what Siri accomplished in those nine hours—forcing the vaccine industry's most respected figure to admit under oath that the entire foundation of vaccine safety is built on willful ignorance, suppressed data, and ethical violations—the better equipped society will be to confront a medical establishment that has prioritized ideology and profits over the health of children.

With thanks to Aaron Siri.

Analogy

Imagine if the automotive industry operated like the vaccine industry. Car manufacturers would only crash-test their vehicles for the first five minutes of driving, never comparing accidents in cars with safety features versus cars without any safety equipment. When crashes occurred, less than 1% would be reported to safety agencies. The manufacturers would be immune from lawsuits - if your car's brakes failed and caused an accident, you couldn't sue the company but would have to petition the government for compensation while the same government agencies that promoted the cars defended against your claim.

The engineers designing the cars would receive millions of dollars from the car companies while also serving on the government committees that decide which safety features should be mandatory. Independent researchers couldn't access crash data to verify safety claims. When asked why comprehensive safety testing wasn't done, officials would say it would be unethical to let people drive cars without the latest safety features, even though they'd never actually studied whether those features were safe or effective long-term. This system would be considered utterly corrupt in any other industry, yet it describes exactly how vaccines are developed, tested, regulated, and monitored.

The One-Minute Elevator Explanation

Vaccines are developed by a handful of pharmaceutical companies that make billions annually while being protected from lawsuits by a 1986 law. The same people who

develop vaccines also advise government agencies on which vaccines to recommend, creating massive conflicts of interest. Safety testing is shockingly brief - often just days after injection - and true placebo studies are rarely done. Instead of comparing vaccines to harmless saline, they're compared to aluminum adjuvants or other vaccines, hiding the real rate of side effects.

We've never done the most basic safety study - comparing the overall health of vaccinated kids to completely unvaccinated kids - despite decades of requests. When independent researchers tried to improve injury reporting, government agencies stopped cooperating. The ingredients are concerning: aluminum that can travel to the brain, DNA fragments from aborted fetuses, animal proteins, and contaminating viruses discovered after widespread use. Many serious conditions listed on vaccine inserts have never been properly studied to prove vaccines don't cause them.

The current system prioritizes industry profits over public safety, with inadequate testing, minimal monitoring, and suppressed research. People deserve transparent, independent safety science before injecting products into healthy children.

[Elevator dings]

Research threads to follow:

- Institute of Medicine reports on vaccine safety and their "inadequate evidence" conclusions
- The Harvard VAERS study showing less than 1% of adverse events are reported
- Financial relationships between vaccine advisory committee members and pharmaceutical companies

12-Point Summary

1. Financial Conflicts of Interest Are Extensive: Dr. Stanley Plotkin, one of the world's leading vaccine experts, has received millions of dollars from vaccine manufacturers over his career through consulting fees, royalty payments, and board positions with all major vaccine companies. He continues to receive approximately $200,000 annually from vaccine-related entities while serving as an expert witness promoting vaccination. This level of financial entanglement between vaccine developers, regulatory advisors, and public health officials creates significant potential conflicts of interest in vaccine policy decisions.

2. Vaccine Safety Studies Are Remarkably Short: Prelicensure safety monitoring for vaccines typically lasts only days after each dose - five days for hepatitis B vaccines, 48 hours for polio and Hib vaccines, and four days for some formulations. This brief monitoring period cannot detect autoimmune disorders, neurological conditions, or other serious adverse events that may develop weeks or months after vaccination. The stark contrast with drug studies, which often follow patients for years, reveals a double standard in safety evaluation.

3. True Placebo Controls Are Rarely Used: Most vaccine clinical trials use aluminum adjuvant or other vaccines as control groups rather than inert saline placebos, making it impossible to determine the true rate of adverse events caused by vaccines. When saline placebos are used, the groups are often very small compared to the vaccine recipients. This study design obscures the actual safety profile of vaccines by making adverse events appear similar between vaccine and "control" groups.

4. Comprehensive Vaccinated vs. Unvaccinated Studies Have Never Been Done: Despite decades of requests, no large-scale study has ever compared the total health outcomes of vaccinated versus completely unvaccinated children. A small pilot study found vaccinated children had significantly higher rates of allergies, ADHD, autism, eczema, learning disabilities, and neurodevelopmental disorders, but larger studies are needed to confirm these findings. The absence of this fundamental safety research represents a massive gap in vaccine science.

5. Adverse Event Reporting Captures Less Than 1% of Reactions: A Harvard study funded by HHS found that fewer than 1% of vaccine adverse events are reported to the official VAERS system. When researchers tried to automate reporting to capture more adverse events, the CDC stopped cooperating. This means the vast majority of vaccine injuries go unrecorded, severely undermining post-market surveillance and making vaccines appear safer than they actually are.

6. Aluminum Adjuvants Can Travel to the Brain: Multiple animal studies demonstrate that aluminum injected into the body can travel to and accumulate in the brain, where it may cause neurological damage. Studies have found aluminum deposits in the brains of autistic children at some of the highest levels ever recorded in human tissue, concentrated specifically in immune cells within the brain. Children following the CDC schedule receive several milligrams of aluminum by six months of age, with unknown long-term consequences.

7. Vaccines Contain Concerning Contaminants: Vaccines contain numerous animal-derived components (monkey kidney cells, calf serum, egg proteins, pig gelatin) and human fetal cell lines from aborted fetuses. Human vaccines contain millions of fragments of DNA from other humans, raising concerns about genetic integration and cancer risks. Contaminating viruses like SV40 and porcine circovirus have been discovered in vaccines after widespread use, highlighting ongoing contamination risks.

8. The 1986 Vaccine Injury Act Eliminated Manufacturer Liability: This law gave vaccine manufacturers immunity from lawsuits for vaccine injuries, removing financial incentives to improve safety while ensuring profits regardless of harm caused. Injured families must petition the federal government rather than sue manufacturers, creating a system where the same agencies promoting vaccines also defend against injury claims. This liability protection, combined with government purchasing programs, creates guaranteed markets worth billions.

9. Vaccine Immunity Wanes Significantly Over Time: Many vaccines provide protection for only a few years, with effectiveness dropping substantially over time. Pertussis vaccine effectiveness falls to 30-50% within five years, meaning most adults are not protected by vaccination. Mumps outbreaks occur in vaccinated college populations due to waning immunity. Long-term effectiveness studies are limited, raising questions about the need for lifelong boosters and whether natural immunity might be more durable.

10. Historical Vaccine Research Involved Serious Ethical Violations: Vaccine development included experiments on vulnerable populations including orphans, mentally handicapped children, prisoners' babies, and people under colonial rule. Dr. Plotkin defended using "children and adults who are human in form but not in social potential" for initial vaccine studies. Research involved 76 aborted fetuses whose organs were harvested for cell culture development, with some abortions performed for social and psychiatric reasons.

11. Regulatory Agencies Have Extensive Industry Ties: ACIP committee members, while supposedly conflict-free, rely on working groups that often include industry-funded researchers. A congressional investigation found "overwhelming" industry ties among committee members. Vaccine manufacturers receive special access to speak at meetings while public comment is restricted. The revolving door between agencies and industry, combined with industry funding of research, creates systemic conflicts in the regulatory process.

12. Fundamental Questions About Vaccine Safety Remain Unanswered: The Institute of Medicine repeatedly concluded that evidence was "inadequate" to determine causality for the vast majority of serious conditions allegedly caused by vaccines due to insufficient research. Predisposing factors that make some children more susceptible to vaccine injury are poorly understood. The absence of proper long-term safety studies, combined with short monitoring periods and inadequate adverse event reporting, leaves fundamental questions about vaccine risks unanswered after decades of mass vaccination programs.

The Most Unbelievable Parts of Plotkin's Testimony

1. His Cavalier Attitude Toward Going to Hell

When discussing religious objections to vaccines containing aborted fetal tissue, Plotkin stated: "I think it implies that I am the individual who will go to hell because of the use of aborted tissues, **which I am glad to do**." This shocking statement reveals an almost gleeful willingness to embrace damnation for his vaccine work, showing complete disregard for the moral concerns of religious families.

2. Defending Experiments on "Subhuman" Children

Plotkin wrote to a medical journal defending experiments on "children and adults who are human in form but not in social potential" rather than "fully functioning adults" and "children who are potentially contributors to society." He acknowledged this "may be objected that this question implies a Nazi philosophy" but defended distinguishing "nonfunctioning persons" from others. This eugenic mindset is chilling from someone whose vaccines are given to millions of children.

3. Complete Financial Amnesia

Despite receiving millions of dollars from vaccine manufacturers over decades, Plotkin claimed he couldn't remember basic financial details. When told his co-inventor Paul Offit received $6 million from RotaTeq sales, Plotkin said he wouldn't remember receiving $6 million himself, stating "I actually do not read my own tax returns." This willful ignorance of massive financial conflicts is either deceptive or demonstrates shocking irresponsibility.

4. Admitting He Never Read Safety Studies

When challenged about the safety of injecting millions of DNA fragments into babies, Plotkin admitted he had "not seen such studies" and "not read such studies" about aluminum traveling to the brain, despite being shown multiple peer-reviewed papers during his deposition. The world's leading vaccine expert apparently doesn't read basic safety research about his own products.

5. Claiming Vaccines Are Safe Without Evidence

Plotkin repeatedly stated vaccines don't cause various conditions, then admitted under questioning that he had no evidence to support these claims. When pressed

about whether DTaP causes autism, he acknowledged the Institute of Medicine found evidence "inadequate" to make any determination, yet he continues telling parents vaccines don't cause autism despite the absence of supporting science.

6. The Harvard VAERS Revelation

Plotkin was forced to acknowledge that a Harvard study found less than 1% of vaccine adverse events are reported to the official safety monitoring system. When researchers tried to improve reporting, the CDC stopped cooperating. This means 99% of vaccine injuries go unreported, yet Plotkin continues claiming vaccines are safe based on this fraudulent surveillance system.

7. No Vaccinated vs. Unvaccinated Studies in 70+ Years

Despite being the world's leading vaccine expert, Plotkin admitted that no comprehensive study has ever compared the health outcomes of vaccinated versus unvaccinated children - the most basic safety study imaginable. When shown a pilot study finding vaccinated children had dramatically higher rates of chronic diseases, he agreed "larger studies should be conducted" but couldn't explain why this hasn't been done in decades.

8. Vaccine Trials That Last Only Days

Plotkin confirmed that vaccine safety trials typically monitor adverse events for only 4-5 days after injection, despite vaccines causing immune system changes intended to last a lifetime. When challenged about this absurdly short monitoring period, he claimed longer studies must have been done but admitted he had no evidence to support this speculation.

9. Using Aluminum as "Placebo" Controls

Plotkin defended using aluminum adjuvants as control groups in vaccine trials instead of harmless saline, making it impossible to determine true adverse event rates. When shown that GARDASIL trials found 2.3% autoimmune disorder rates in both vaccine and aluminum "control" groups, but 0% in the tiny saline group, he couldn't explain why the aluminum control wasn't broken out separately.

10. Systematic Use of 76 Aborted Babies

Plotkin casually described experiments using 76 aborted fetuses, all three months or older, whose organs (lungs, hearts, kidneys, spleens, tongues) were "cut up into little pieces" for research. Some came from women in psychiatric institutions who had abortions for "social and psychiatric reasons." His matter-of-fact description of this industrial-scale use of aborted babies for vaccine development is deeply disturbing.

11. Claiming Religious Exemptions Are Invalid

As an admitted atheist, Plotkin stated he "takes issue with religious beliefs" and called people seeking religious exemptions "religious zealots who believe that the will of God includes death and disease." This blanket dismissal of religious conscience rights while profiting from products containing aborted fetal tissue demonstrates extraordinary arrogance and intolerance.

12. Experiments on Colonial Subjects

Plotkin admitted conducting vaccine experiments involving "almost a million people" in the Belgian Congo while it was under colonial rule, visiting locations like Leopoldville and Stanleyville for months. He also experimented on orphans, mentally

handicapped children, and babies of imprisoned mothers, yet showed no remorse for these exploitative practices targeting the most vulnerable populations.

The most unbelievable aspect is that this testimony comes from the world's most respected vaccine expert, whose vaccines are mandated for millions of children, yet his own words reveal a system built on inadequate testing, financial conflicts, suppressed safety data, and profound ethical violations. His casual acknowledgment of these systematic failures while continuing to promote mass vaccination represents perhaps the most damning insider testimony about vaccine safety ever recorded under oath.

Plotkin's Psychological Profile Based on His Testimony

Core Psychological Traits

Narcissistic Grandiosity with Messianic Complex Plotkin exhibits classic narcissistic traits combined with a messianic worldview where he sees himself as humanity's savior through vaccines. His willingness to "go to hell" for vaccine development reveals someone who views himself as a martyr for the greater good. He shows no capacity for self-doubt or genuine introspection about potential harm from his work, suggesting pathological certainty in his own righteousness.

Utilitarian Dehumanization His writing about experimenting on people who are "human in form but not in social potential" reveals a deeply utilitarian mindset that categorizes human worth based on perceived social value. This dehumanizing perspective allowed him to rationalize experiments on orphans, mentally handicapped children, and colonial subjects as acceptable sacrifices for his research goals. He demonstrates the same cold calculation that enabled historical medical atrocities.

Relationship with Truth and Reality

Compartmentalized Cognition Plotkin exhibits remarkable cognitive compartmentalization, simultaneously claiming vaccines are safe while admitting he hasn't read safety studies, doesn't know basic financial details despite millions in payments, and acknowledges that fundamental safety research has never been conducted. This suggests either deliberate deception or profound psychological compartmentalization that allows him to hold contradictory beliefs without experiencing cognitive dissonance.

Willful Ignorance as Defense Mechanism His repeated claims of not remembering massive financial payments, not reading safety studies, and not knowing basic details about his own work suggest willful ignorance as a psychological defense. By maintaining plausible deniability about inconvenient facts, he can continue promoting vaccines while avoiding conscious acknowledgment of potential harm or conflicts of interest.

Moral and Ethical Framework

Consequentialist Amorality Plotkin operates from a purely consequentialist ethical framework where any means are justified by what he perceives as beneficial ends. This explains his comfort with using aborted fetal tissue, experimenting on vulnerable populations, and dismissing safety concerns - all justified by his belief that vaccines save lives. He shows no evidence of deontological moral constraints about inherent human dignity or rights.

Religious Contempt and Atheistic Supremacy His self-described atheism combined with contempt for "religious zealots" reveals someone who views religious belief as fundamentally irrational and inferior to his scientific materialism. His dismissive attitude toward religious exemptions and moral concerns about fetal tissue suggests he sees religious conscience as an obstacle to his mission rather than a legitimate human consideration.

Emotional and Interpersonal Patterns

Emotional Detachment from Human Suffering Throughout the deposition, Plotkin shows remarkable emotional flatness when discussing potential vaccine injuries, experiments on vulnerable populations, or ethical violations. His matter-of-fact description of harvesting organs from 76 aborted babies or experimenting on mentally handicapped children suggests either psychopathic emotional deficits or profound psychological numbing to human suffering.

Defensive Hostility Under Scrutiny When challenged about safety data or financial conflicts, Plotkin becomes defensive and hostile, calling questioning "baloney" and suggesting the attorney is trying to "legitimize" anti-vaccine views. This defensive reaction suggests underlying anxiety about his position combined with narcissistic injury when his authority is questioned.

Worldview and Belief System

Scientific Authoritarianism Plotkin embodies scientific authoritarianism - the belief that scientific experts should have ultimate authority over individual choice and democratic governance. His dismissal of parental concerns, religious objections, and informed consent reflects someone who believes expert knowledge justifies overriding individual autonomy and democratic processes.

Technocratic Elitism His attitude throughout the testimony reflects deep technocratic elitism - the belief that technical experts like himself should make decisions for the masses who are too ignorant to understand complex scientific issues. This explains his comfort with paternalistic policies and his irritation at being questioned by non-experts.

Psychological Adaptation Mechanisms

Rationalization and Intellectualization Plotkin extensively uses rationalization and intellectualization to avoid emotional engagement with the human costs of his work. By framing everything in technical, scientific terms, he avoids confronting the moral and emotional implications of experimenting on vulnerable populations or potentially harming children with inadequately tested products.

Identification with the Aggressor His career trajectory from academic researcher to industry insider suggests psychological identification with powerful pharmaceutical interests. Rather than maintaining independent scientific integrity, he appears to have psychologically merged his identity with industry goals, explaining his fierce defense of vaccine policy regardless of evidence.

Overall Assessment

Plotkin's testimony reveals someone with significant narcissistic and potentially psychopathic traits, operating from a utilitarian worldview that dehumanizes vulnerable populations in service of what he perceives as greater goods. His combination of grandiosity, emotional detachment, willful ignorance, and contempt for those who question his authority suggests a personality structure that prioritizes

his own sense of importance and mission over genuine concern for individual human welfare.

Most concerning is his apparent lack of genuine empathy or moral constraint when it comes to potential harm from his work. His psychological profile suggests someone who has rationalized away normal human moral intuitions in service of an ideological commitment to vaccination as humanity's salvation - making him psychologically incapable of objectively evaluating vaccine safety or acknowledging legitimate concerns about his life's work.

30 Questions and Answers

1. Who is Dr. Stanley Plotkin and what are his credentials in vaccine development?

Dr. Stanley Plotkin is one of the world's most prominent vaccine developers, often referred to as the "godfather of vaccines." He has authored over 794 scientific articles and serves as editor of the leading vaccine textbook "Plotkin's Vaccines." His career spans decades at prestigious institutions including the University of Pennsylvania, Children's Hospital of Philadelphia, and the Wistar Institute.

Plotkin developed several vaccines currently in use, including the rubella vaccine component of the MMR vaccine and the RotaTeq rotavirus vaccine. He served as medical and scientific director of Sanofi Pasteur from 1991-1997 and executive advisor from 1997-2009. He holds professor emeritus positions at the University of Pennsylvania and Wistar Institute, continues teaching vaccine courses, and serves on scientific advisory boards for numerous vaccine companies worldwide.

2. What financial relationships does Dr. Plotkin have with vaccine manufacturers?

Dr. Plotkin has extensive financial relationships with all major vaccine manufacturers spanning decades. He receives ongoing consulting fees from Sanofi, Merck, GlaxoSmithKline, and Pfizer - the "big four" vaccine companies. In 2017 alone, he received approximately $200,000 from entities involved in vaccine development or sales.

Beyond consulting fees, Plotkin owns a company called Vaxconsult through which he receives payments from pharmaceutical companies. He also serves on the boards of directors for numerous vaccine biotechnology companies including Dynavax Technologies, VBI Vaccines, Inovio Biomedical, CureVac, and others. When pressed for total lifetime compensation from vaccine manufacturers, he acknowledged it could be "a few million dollars" but stated his wife handles the finances and he doesn't track exact amounts.

3. What vaccines did Dr. Plotkin personally develop and what compensation did he receive?

Dr. Plotkin developed the rubella vaccine (RA 27/3 strain) currently used in the MMR vaccine, the RotaTeq rotavirus vaccine, and contributed to rabies and varicella vaccine development. These vaccines generated substantial royalty payments through patent licensing agreements between manufacturers and the institutions where he worked.

For RotaTeq alone, Children's Hospital of Philadelphia sold its royalty rights to Royalty Pharma for $182 million in 2008, and Plotkin received a portion of those proceeds. His co-inventor Paul Offit reportedly received approximately $6 million from this sale. The Wistar Institute also sold partial royalty rights to RotaTeq for $45 million. While Plotkin couldn't provide exact figures, he acknowledged receiving

"considerable amounts" and "sizable" payments from these vaccine sales over the years.

4. What are the "big four" vaccine manufacturers and what is their market share?

The "big four" vaccine manufacturers are Merck, Sanofi, GlaxoSmithKline (GSK), and Pfizer. These companies produce virtually all vaccines recommended on the CDC childhood vaccine schedule. Johnson & Johnson is attempting to enter the market but is not yet considered a major manufacturer.

According to Plotkin's estimates, the global vaccine market is approximately $30 billion annually, with the big four accounting for roughly $20 billion of that total. This represents about two-thirds of the global vaccine market. The concentration of vaccine manufacturing among so few companies is attributed to the difficulty and cost of vaccine production, creating significant barriers to entry for potential competitors.

5. What human fetal cell lines are used in vaccine production and how are they obtained?

Two primary human fetal cell lines are used in vaccine production: MRC-5 and WI-38. Both were created from lung tissue obtained from aborted fetuses - MRC-5 from one fetus and WI-38 from another. These cell strains were developed to grow viruses for vaccine production because human cells can support the growth of human viruses more effectively than animal cells.

The fetal tissue was obtained from elective abortions, with Plotkin noting that some came from women in psychiatric institutions and some for "social and psychiatric reasons." One study he co-authored involved 76 fetuses, all three months or older when aborted. The cell strains replicate for about 50 generations before dying, requiring researchers to maintain seed stocks of early passage cells to continue vaccine production.

Dr. Plotkin's Testimony About Aborted Fetuses

Personal Work with Fetuses

When initially asked how many fetuses were involved in his vaccine-related work, Dr. Plotkin first answered "two," claiming these were the only fetuses used to actually make vaccines. However, when pressed further and shown his own published research, he revealed much more extensive fetal experimentation.

In one study alone that he co-authored, Plotkin's team used **76 aborted fetuses**, all three months or older when aborted. These were described as "normally developed fetuses" that were aborted for various reasons including "social and psychiatric reasons." Some of the abortions were performed on women in psychiatric institutions.

Organ Harvesting and Experimentation

The research involved systematic harvesting of organs from these 76 fetuses. Plotkin acknowledged that "a whole range of tissues were harvested," including:

- Lungs
- Kidneys
- Hearts

- Spleens
- Pituitary glands
- Skin
- Tongues

These organs were then "cut up into little pieces" and cultured to develop cell lines for potential vaccine production. While Plotkin claimed he didn't personally harvest the organs, he was directly involved in the research and experimentation using the harvested fetal tissue.

Cell Lines Currently in Use

Two human fetal cell lines developed from aborted fetuses are currently used in vaccine production:

MRC-5 cells: Created from lung tissue taken from a 14-week-old aborted fetus. The abortion was described as being performed by "maternal choice."

WI-38 cells: Created from lung tissue of another aborted fetus.

These cell lines are used to grow viruses for vaccines including:

- Rubella vaccine (part of MMR)
- Varicella (chickenpox) vaccine
- Hepatitis A vaccine

Manufacturing Process

The fetal cell lines replicate for about 50 generations before dying. To maintain continuous vaccine production, manufacturers keep "seed stocks" of early passage cells that can be used to create new batches. This means vaccines are continuously produced using cells originally derived from aborted fetal tissue.

Plotkin confirmed that these human cells, along with human DNA fragments, remain in the final vaccine products that are injected into children.

Plotkin's Attitude Toward Ethical Concerns

When asked about religious objections to vaccines containing aborted fetal tissue, Plotkin showed remarkable callousness. He stated that the Catholic Church has issued guidance saying people should still receive these vaccines, adding: "I think it implies that I am the individual who will go to hell because of the use of aborted tissues, **which I am glad to do**."

He suggested that if the mother (in the custody case) has religious objections, "she should consult her priest," showing dismissive contempt for conscience-based concerns about fetal tissue use.

Scale of Fetal Experimentation

When pressed about the total number of fetuses used throughout his career, Plotkin was evasive but acknowledged it was "quite a few" beyond the 76 documented in the single published study. He estimated it was "probably not many more than in this paper," suggesting the total was likely around 100 fetuses used in his vaccine-related research.

Ethical Framework

Plotkin emphasized that "we had nothing to do with the cause of the abortion," attempting to distance himself from the actual killing while acknowledging extensive use of the resulting tissue. However, his research created demand for fresh fetal tissue, potentially incentivizing the abortion industry.

The systematic harvesting of organs from dozens of aborted babies for vaccine research represents one of the most disturbing aspects of modern vaccine development, yet Plotkin showed no remorse and even expressed willingness to "go to hell" for his use of aborted fetal tissue.

Current Impact

Parents today who follow the CDC vaccine schedule are unknowingly having their children injected with products containing cells and DNA fragments from aborted human beings. The vaccines affected include some of the most commonly given childhood vaccines, making it nearly impossible for families with moral objections to avoid these products while following standard medical recommendations.

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6. What animal-derived components are found in vaccines and why are they used?

Vaccines contain numerous animal-derived components used in the manufacturing process. These include monkey kidney cells (from which polio vaccine is produced), calf serum (used to nourish cells during production), egg proteins (from chicken eggs used to grow influenza viruses), and gelatin derived from pigs and cows. Some vaccines also contain recombinant GMO yeast.

While manufacturers claim these components are removed during purification, the FDA's official vaccine excipient list shows many remain in final products. For example, calf serum is listed as an ingredient in some vaccines despite claims it's removed because it could cause children to develop allergies to cow products. The presence of these materials raises concerns about potential allergic reactions and the development of antibodies against animal proteins.

7. What is aluminum adjuvant and why is it added to vaccines?

Aluminum adjuvant (often called "alum") is added to vaccines to enhance the immune response to antigens. Without adjuvants, the antigens in killed vaccines produce very weak immune responses. The aluminum binds to antigens and creates a persistent immune stimulation, increasing antibody production and improving vaccine effectiveness.

Aluminum adjuvants can increase production of various inflammatory cytokines including IL-1, IL-2, IL-6, and IL-17. The aluminum and bound antigens are taken up by immune cells called macrophages and dendritic cells. Children following the CDC vaccine schedule receive several milligrams of aluminum by age six months. The aluminum can be recovered from injection sites months or years after vaccination, indicating it persists in the body long-term.

8. What evidence exists that aluminum from vaccines can travel to the brain?

Multiple animal studies demonstrate that injected aluminum can travel to the brain. Studies in rabbits showed aluminum deposits in brain tissue after injection. A 2009 study in mice found that aluminum injections caused motor deficits and motor neuron degeneration. Additional studies in 2013 and 2015 showed pictures of aluminum deposits in the brains of mice that had been injected with aluminum.

Researchers at the University of British Columbia have extensively studied aluminum neurotoxicity and concluded that aluminum adjuvants may disrupt developmental processes in the central nervous system. A 2017 study found some of the highest levels of aluminum ever recorded in human brain tissue - specifically in the brains of autistic individuals who died prematurely, with the aluminum concentrated in immune cells within the brain.

9. How long are vaccines typically studied for safety before licensure?

Vaccine safety monitoring in prelicensure clinical trials is typically very short - often only a few days after each dose. For example, hepatitis B vaccines (Recombivax HB and Engerix-B) monitored safety for only 5 days and 4 days respectively after each dose. The polio vaccine (IPOL) monitored adverse reactions for just 48 hours. The Hib vaccine (ActHIB) monitored for 48 hours in most trials.

This limited monitoring period cannot detect autoimmune disorders, neurological conditions, or other adverse events that may develop weeks or months after vaccination. In contrast, when the same companies study drugs for sick adults (like Enbrel), they follow patients for years. The short monitoring periods mean that longer-term adverse events would not be captured in prelicensure safety data.

10. What types of control groups are used in vaccine clinical trials?

Vaccine clinical trials rarely use true placebo controls (inert saline injections). Instead, they typically use other vaccines or aluminum adjuvant as the "control" group. For example, in GARDASIL trials, the control group received aluminum adjuvant rather than saline, making it impossible to determine the true rate of adverse events caused by the vaccine versus the adjuvant.

When saline placebos are used, the groups are often very small. In GARDASIL trials, only about 600 participants received saline placebo compared to thousands who received aluminum adjuvant controls. This design obscures the true safety profile of vaccines because adverse events caused by aluminum adjuvant appear in both the vaccine and "control" groups, making the vaccine appear safer than it actually is.

11. What is VAERS and how effective is it at capturing adverse events?

VAERS (Vaccine Adverse Event Reporting System) is a passive surveillance system maintained by CDC and FDA where anyone can report suspected vaccine adverse events. However, a Harvard study funded by HHS found that fewer than 1% of vaccine adverse events are actually reported to VAERS. The study identified over 35,000 possible reactions among 376,000 vaccine recipients over three years.

The Harvard researchers wanted to automate VAERS reporting to capture more adverse events, but CDC stopped cooperating and wouldn't partner with them to implement the system. This means the vast majority of vaccine adverse events go unreported. Even so, VAERS contains hundreds of thousands of reports of serious adverse events including deaths, permanent disabilities, and life-threatening reactions following vaccination.

12. What specific adverse events are listed in vaccine package inserts?

Vaccine package inserts list extensive adverse events reported after vaccination, though manufacturers state these don't prove causation. Common serious adverse events include encephalitis (brain inflammation), encephalopathy (brain dysfunction), Guillain-Barré syndrome, seizures, autoimmune disorders, and various neurological conditions.

For example, hepatitis B vaccine inserts list reports of multiple sclerosis, lupus, arthritis, Bell's palsy, and transverse myelitis. GARDASIL's insert shows that 2.3% of trial participants developed systemic autoimmune disorders within six months. MMR vaccine lists extensive adverse events including thrombocytopenia and febrile seizures. The inserts note that because these are voluntary reports, causality cannot be established, but the sheer number and severity of reported events is concerning.

13. What did the Institute of Medicine conclude about vaccine safety and causality?

The Institute of Medicine conducted multiple comprehensive reviews of vaccine safety, examining hundreds of alleged vaccine injuries. In their 2011 report reviewing 158 vaccine-adverse event pairs, they found evidence was "inadequate to accept or reject a causal relationship" for 135 of them - meaning they couldn't determine whether vaccines caused these conditions due to insufficient research.

The IOM found that for the vast majority of serious conditions allegedly caused by vaccines, the science simply hasn't been done to make causality determinations. They noted "many gaps and limitations in knowledge bearing directly and indirectly on the safety of vaccines" and stated that "if research capacity and accomplishment in these areas are not improved, future reviews of vaccine safety will be similarly handicapped."

14. Has there ever been a comprehensive study comparing vaccinated to unvaccinated children?

No comprehensive study comparing the total health outcomes of vaccinated versus completely unvaccinated children has ever been conducted, despite decades of requests from advocacy groups. Plotkin acknowledged this study has never been done, stating it's probably considered "malpractice not to vaccinate a child," making prospective studies unethical.

However, a small pilot study by researchers at Jackson State University compared homeschooled vaccinated and unvaccinated children. The study found vaccinated children had significantly higher rates of allergies (3.9 times), ADHD (4.2 times), autism spectrum disorder (4.2 times), eczema (2.9 times), learning disabilities (5.2 times), and neurodevelopmental disorders (3.7 times). While Plotkin criticized the study's methodology, he agreed larger, better-designed studies should be conducted to confirm or refute these findings.

15. What is ACIP and how does it make vaccine recommendations?

ACIP (Advisory Committee on Immunization Practices) is a committee that makes vaccine recommendations for the CDC. When ACIP recommends a vaccine for universal use, it essentially creates a liability-free market of millions of children for pharmaceutical companies. About 50-60% of pediatric vaccines in the US are purchased with federal money through the Vaccines for Children Program.

ACIP meets in public sessions, but much of the preparatory work occurs in private working groups whose discussions aren't transcribed. These working groups often include members with financial conflicts of interest with vaccine manufacturers, though the final voting members are supposed to be conflict-free. Plotkin noted that the conflict-free requirement sometimes results in committee members who aren't the most knowledgeable about vaccines.

16. What conflicts of interest exist within vaccine advisory committees?

A 1999 House of Representatives Committee on Government Reform report found that "the overwhelming majority of members, both voting members and consultants, have substantial ties to the pharmaceutical industry." The report concluded that ACIP "reflects a system where government officials make crucial decisions affecting American children without the advice and consent of the governed."

Even when voting members are required to be conflict-free, the working groups that prepare recommendations often include members with extensive financial ties to vaccine manufacturers. Additionally, vaccine manufacturers are given special access to speak at ACIP meetings outside of public comment periods, while public members must wait for designated comment times. The revolving door between government agencies and industry creates ongoing potential for conflicts.

17. What is the 1986 National Childhood Vaccine Injury Act and how does it protect manufacturers?

The 1986 Act created the Vaccine Injury Compensation Program and gave vaccine manufacturers immunity from liability for injuries caused by vaccines. Parents cannot sue vaccine manufacturers for design defects - meaning they cannot claim a vaccine could have been made safer. The only exception is for manufacturing defects.

Instead of suing manufacturers, vaccine-injured families must file claims with the federal government through a special court system where HHS defends against injury claims. This system removed financial incentives for manufacturers to make vaccines safer while ensuring they get paid regardless of injuries caused. The Act essentially created a liability-free market for vaccine manufacturers while shifting compensation costs to taxpayers.

18. What ethical issues arose in historical vaccine research?

Dr. Plotkin conducted vaccine experiments on vulnerable populations including orphans, mentally handicapped children, babies of imprisoned mothers, and people under colonial rule in the Belgian Congo. He wrote to a medical journal defending experiments on "children and adults who are human in form but not in social potential" rather than "fully functioning adults" who could "contribute to society."

In one study alone, Plotkin's team used 76 aborted fetuses three months or older, harvesting organs including lungs, kidneys, hearts, spleens, and tongues for cell culture research. He gave experimental vaccines to 13 mentally retarded children and participated in studies involving nearly a million people in colonial Africa. While acknowledging these practices were common in the 1960s, he stated he has "since changed my mind" about the ethics of such research.

19. What contaminating viruses have been found in vaccines?

Several contaminating viruses have been discovered in vaccines after they were already in use. SV40 (Simian Virus 40) was the 40th simian virus found contaminating polio vaccines in the 1950s and 1960s, potentially infecting millions of people. Porcine circovirus type 2 was discovered in rotavirus vaccines after they were already on the market.

These discoveries were unintentional - manufacturers didn't know these viruses were present when the vaccines were released. This raises concerns about unknown contaminants that may still be present in current vaccines. The use of animal and

human cell lines in vaccine production creates ongoing risks of viral contamination that may not be detected until years after widespread use.

20. How effective are vaccines over time and does immunity wane?

Vaccine immunity wanes significantly over time for many vaccines. The acellular pertussis vaccine provides protection for only about 2-3 years after the preadolescent dose, dropping to 30-50% effectiveness by five years. This means most adults are not protected against pertussis from vaccination and rely on natural boosting from exposure to the bacteria.

Mumps vaccine effectiveness also diminishes over time, causing outbreaks in college settings where students are in close contact. Studies on long-term immunity are limited - many vaccines haven't been studied for effectiveness beyond 10 years. This waning immunity raises questions about the need for ongoing booster shots throughout life and whether natural immunity might provide more durable protection.

21. What is the difference between whole-cell and acellular pertussis vaccines?

Whole-cell pertussis vaccines (DTP) contain the entire pertussis bacteria and were withdrawn from the US market due to safety concerns, particularly causing significant fever and febrile seizures. They were replaced with acellular pertussis vaccines (DTaP) that contain only selected components of the bacteria and cause fewer immediate reactions.

However, acellular vaccines provide shorter-lasting immunity and may not prevent colonization and transmission of pertussis bacteria as effectively as whole-cell vaccines. Studies in baboons suggest that individuals vaccinated with acellular pertussis vaccines can still become infected and transmit the bacteria to others, even if they don't become ill themselves. Whole-cell vaccines are still used in most developing countries because they're considerably cheaper.

22. What did Peter Aaby's studies in Africa reveal about vaccine effects?

Dr. Peter Aaby, a respected researcher, conducted studies in Africa that found concerning effects from some vaccines. In a randomized study, children who received DTP vaccine in the first six months of life had a death rate ten times higher than children who received no vaccines. This was a properly randomized study where vaccination status was determined by birth date.

Aaby also found that live vaccines like measles vaccine had positive effects, reducing overall mortality beyond just preventing measles. However, his findings about DTP increasing mortality have been controversial. While WHO has reviewed his studies multiple times, they haven't changed their recommendations for whole-cell pertussis vaccines, which are still widely used in developing countries where children's lives may be at stake.

23. What role do aluminum adjuvants play in autoimmune disorders?

Aluminum adjuvants can bind not only to vaccine antigens but also to impurities and byproducts from the manufacturing process, potentially causing the immune system to develop antibodies against these unintended targets. There is a proposed syndrome called autoimmune/autoinflammatory syndrome induced by adjuvants (ASIA), though it remains controversial in mainstream medicine.

In GARDASIL trials, 2.3% of participants developed systemic autoimmune disorders within six months, but this rate was similar in both the vaccine group and the aluminum adjuvant control group. Notably, the small saline placebo group (about 600 people) had zero cases of autoimmune disorders. This suggests the aluminum adjuvant, present in both groups, may have been responsible for the autoimmune reactions rather than the HPV antigens themselves.

24. What concerns exist about human DNA fragments in vaccines?

Vaccines produced using human fetal cell lines contain millions of fragments of human DNA. For example, VARIVAX contains approximately 2 micrograms of human DNA fragmented into about 1 trillion pieces, while MMR II contains about 150 nanograms of human DNA. This DNA is purposefully fragmented to below 500 base pairs in length, but concerns exist about its safety.

The potential risks include insertional mutagenesis - where foreign DNA inserts into the recipient's genome - and the theoretical possibility of causing cancer or other genetic changes. While Plotkin believes the risk is "zero," he acknowledged having no studies to support this claim. The presence of millions of DNA fragments from another human being injected into babies and children represents an unprecedented biological exposure with unknown long-term consequences.

25. How transparent is vaccine safety data to independent researchers?

Vaccine safety data is largely controlled by manufacturers and government agencies with limited access for independent researchers. The Vaccine Safety Datalink (VSD), which contains health records for millions of Americans, is not publicly available. Independent researchers must apply for access and face significant restrictions on what they can study and publish.

Most vaccine safety studies cited in the medical literature are conducted by manufacturers themselves or by researchers with financial ties to the vaccine industry. The Harvard VAERS study showed that when independent researchers tried to improve adverse event reporting, CDC stopped cooperating. This lack of transparency makes it difficult for independent scientists to verify safety claims or conduct unbiased research on vaccine risks.

26. What predisposing factors might make some children more susceptible to vaccine injury?

The Institute of Medicine noted that "most individuals who experience an adverse reaction to vaccines have a pre-existing susceptibility" due to genetic variations, environmental exposures, developmental stage, or other factors. However, very little research has been conducted to identify these predisposing factors before vaccination.

Only a few researchers, primarily at Mayo Clinic, Vanderbilt, and University of British Columbia, are studying genetic and other factors that might predict vaccine injury susceptibility. The 1994 IOM report stated "the committee was able to identify little information pertaining to why some individuals react adversely to vaccines when most do not." This knowledge gap means children are vaccinated without knowing if they're at increased risk for adverse reactions.

27. What is the controversy surrounding vaccines and autism?

The Institute of Medicine reviewed whether DTaP and Tdap vaccines can cause autism and concluded the evidence was "inadequate to accept or reject a causal

relationship." This means they found no studies proving vaccines don't cause autism, nor studies proving they do. For MMR vaccine, the IOM found studies that "favored rejection" of a causal relationship with autism.

The key issue is that proper studies comparing autism rates in vaccinated versus unvaccinated children have never been conducted for most vaccines. Without such studies, definitive statements about vaccines not causing autism cannot be scientifically supported. The absence of evidence is not evidence of absence, yet public health officials routinely state that vaccines don't cause autism despite the lack of comprehensive safety studies.

28. How do religious and philosophical exemptions factor into vaccine policy?

Dr. Plotkin strongly opposes religious exemptions, stating "I take issue with religious beliefs" and calling those who refuse vaccines "religious zealots who believe that the will of God includes death and disease." As an atheist, he believes no one should have valid religious objections to vaccination. Medical exemptions are only acceptable for immunocompromised individuals or those with specific contraindications.

The tension between individual conscience rights and public health policy creates ongoing legal and ethical debates. Some families object to vaccines containing aborted fetal tissue on religious grounds, while others have philosophical concerns about vaccine safety or government mandates. The elimination of exemptions in many states has forced families to choose between their beliefs and their children's education or healthcare access.

29. What are the economic incentives driving vaccine recommendations?

When ACIP recommends a vaccine for universal use, it creates guaranteed markets worth billions of dollars for manufacturers. With liability protection from the 1986 Act and government purchasing through the Vaccines for Children Program (50-60% of pediatric vaccines), companies have strong financial incentives to develop new vaccines and lobby for their inclusion in the schedule.

The revolving door between government agencies and industry, combined with the extensive financial relationships between advisory committee members and manufacturers, creates potential conflicts of interest in the recommendation process. The global vaccine market of approximately $30 billion, dominated by just four major manufacturers, represents enormous financial stakes in vaccine policy decisions.

30. What gaps exist in current vaccine safety science and monitoring?

Major gaps in vaccine safety science include the lack of proper placebo-controlled trials, short-term safety monitoring (often just days), absence of vaccinated versus unvaccinated studies, limited research on predisposing factors for vaccine injury, and inadequate long-term follow-up. Most adverse events listed in vaccine package inserts have never been properly studied to determine causality.

The passive VAERS system captures less than 1% of adverse events, while active surveillance systems like VSD are not accessible to independent researchers. Long-term studies on vaccine effectiveness show waning immunity for many vaccines, but corresponding long-term safety studies are largely absent. The IOM has repeatedly noted these knowledge gaps, yet comprehensive safety research remains limited, leaving fundamental questions about vaccine risks unanswered.

The Three-Legged Stool That Cannot Stand: How Prevnar 20 Exemplifies the Childhood Vaccine Fraud

On Childhood Vaccination - The NSE Framework - Plus Questions for Your Doctor

When examining whether any medical intervention is justified, particularly for children, there's a simple yet powerful framework that cuts through the noise: the three-legged stool of Necessity, Safety, and Effectiveness. Like any three-legged stool, if even one leg collapses, the entire structure falls. This framework, developed by me in 2022 as a way to think clearly about childhood vaccination, reveals an uncomfortable truth - not a single routine childhood vaccine can withstand this basic scrutiny. The latest addition to this rogues' gallery, that I've recently become aware of, is Prevnar [Prevnar 20 to be precise,] a pneumococcal vaccine that exemplifies the fraudulent template used to push unnecessary, unsafe, and ineffective products onto our most vulnerable population.

Prevnar 20, manufactured by Pfizer and targeting 20 strains of Streptococcus pneumoniae, recently caught attention through Candace Owens' groundbreaking "A Shot in the Dark" series. What makes this vaccine particularly insidious is how perfectly it demonstrates the systematic deception at the heart of the childhood vaccination program. The FDA's own documentation reveals that most pneumococcal infections are mild, yet parents are terrorized with rare worst-case scenarios to manufacture consent for injecting their babies at 2, 4, 6, and 12-15 months with a cocktail containing aluminum phosphate, polysorbate 80, and modified diphtheria toxin. The package insert admits there's no established antibody level that predicts protection, and for seven of the twenty strains, approval was based solely on antibody production - not disease prevention. This is the same playbook used for every childhood vaccine: exaggerate the threat, hide the true risks, and redefine effectiveness to mean "produces antibodies" rather than "prevents disease."

The clinical trial fraud runs even deeper, as exposed in Aaron Siri's devastating exchange with Dr. Paul Offit, considered the world's leading vaccine safety expert. When Siri pointed out that not a single routine childhood vaccine was licensed based on a true placebo-controlled trial, Dr. Paul Offit's response revealed the corruption at the core of vaccine science. Instead of saline placebos, these trials use other vaccines or toxic aluminum adjuvants as "controls," then declare the new vaccine safe because it causes no more harm than the equally untested comparator. This "vaccine safety pyramid scheme," as Siri calls it, just claimed another victim: in June 2025, the FDA approved MenQuadfi for infants as young as 6 weeks old, despite 5.3% experiencing serious adverse events in trials. How was this deemed acceptable? Because it was compared to Menveo (3.6% serious events), which was compared to Menactra, which was compared to Menomune - none ever tested against a true placebo. In Prevnar's case, the same shell game showed serious adverse events in 8.2% of recipients - including death, life-threatening conditions, and permanent disability - yet this was deemed acceptable because the control vaccine showed similar devastation. As Siri notes, this is "morally and ethically bankrupt," especially when pharmaceutical companies' paid researchers decide which deaths and injuries to count as vaccine-related. The entire safety assessment is theater, designed to create the illusion of scientific rigor while protecting the program rather than children.

There's a sinister logic to the timing of these injections that becomes clear once you understand the stakes. The entire childhood vaccine schedule is front-loaded into the first 12-18 months of life, with most doses administered before children can speak. This isn't coincidence - it's strategy. When a verbal three-year-old suddenly loses language, stops making eye contact, or develops seizures after vaccination, the connection is undeniable. But when the same regression happens to a pre-verbal infant, doctors can gaslight parents with "born that way" or "would have happened anyway." The case of baby Sawyer in Maine reveals how deadly this system can be: at just 8 weeks old, still fighting an illness, he received four vaccines including Prevnar 13. Within 34 hours, he was dead. The medical examiner blamed the parents for "inappropriate sleep position" - until independent testing revealed aluminum levels at adult toxicity in his blood. His mother, a registered nurse who had asked to delay the vaccines because her baby was sick, was told by the pediatrician it would be "perfectly safe." The medical establishment has weaponized the natural parental instinct to protect by creating a system where the evidence of harm is systematically obscured. They've turned the most vulnerable period of child development into a window of plausible deniability, ensuring that by the time parents might connect the

dots, their children have already received dozens of shots and any damage can be attributed to genetics, bad luck, or anything but the injections.

The segregation of unvaccinated children from daycare settings reveals another layer of this protection racket - but it's not about protecting children from disease. Unvaccinated children stand out like sore thumbs in any group setting: they develop faster, rarely get sick, and when they are ill, they recover quickly without complications. These children are walking control groups that threaten the entire narrative. If vaccinated and unvaccinated children mixed freely in early childhood settings, mothers would immediately notice the stark differences in health, development, and vitality. The ban on unvaccinated children in daycare isn't about public health - it's about preventing parents from discovering what baseline human health actually looks like. As the data from doctors like Paul Thomas demonstrates, unvaccinated children have dramatically lower rates of ear infections, allergies, ADHD, autism, and virtually every chronic condition plaguing modern childhood.

Prevnar 20 represents the perfection of a fraud template that has been refined over decades: manufacture fear about mild diseases, use rigged trials with no true placebos, redefine effectiveness to mean antibody production rather than disease prevention, hide safety signals behind statistical manipulation, and mandate the product before children can speak to obscure the damage. The three-legged stool analysis reveals that not a single leg can support this vaccine - necessity fails because pneumococcal disease is predominantly mild and self-limiting, safety collapses under the weight of untested carcinogenicity and 8.2% serious adverse events, and effectiveness crumbles when antibody levels don't correlate with protection. This isn't failed science; it's successful racketeering. They will continue using this template, poisoning generation after generation, extracting billions while leaving a wake of damaged children, until they are stopped. The question isn't whether the stool has fallen - it's whether we'll finally clear away the wreckage and protect our children from those who profit from their harm.

Systematic Analysis of Prevnar 20 Using the NSE Framework

Executive Summary

Prevnar 20 is a pneumococcal 20-valent conjugate vaccine manufactured by Pfizer, targeting 20 strains of *Streptococcus pneumoniae*. This analysis examines whether the vaccine meets the three critical criteria of Necessity, Safety, and Effectiveness using the framework provided.

Key Finding: All three legs of the stool show significant weaknesses, with particular concerns in the safety and effectiveness domains.

I. NECESSITY ANALYSIS

Disease Burden Investigation

1. Pre-vaccine Disease Statistics

The package insert notably **lacks comprehensive pre-vaccine disease incidence data**. This omission is significant because:

- No baseline mortality rates are provided for the 20 targeted serotypes
- No age-stratified disease burden data before vaccine introduction
- No comparison to historical declining trends

2. Risk Exaggeration Analysis

Red Flags Identified:

- The insert uses broad language about "pneumonia and invasive disease" without quantifying actual risk
- No stratification of risk by health status (healthy vs. immunocompromised)
- Conflates all pneumococcal disease without distinguishing mild from severe presentations
- No mention of the fact that most people exposed to *S. pneumoniae* remain asymptomatic carriers

3. Natural Immunity Assessment

Critical Omission: The package insert completely ignores natural immunity:

- No discussion of naturally acquired immunity through exposure
- No comparison of vaccine-induced vs. natural immunity duration
- No mention that historically, most people developed natural immunity without serious consequences

Necessity Verdict: BROKEN

The necessity leg fails due to lack of transparent disease burden data and complete omission of natural immunity considerations.

II. EFFECTIVENESS ANALYSIS

Core Effectiveness Questions

1. Primary Endpoint Manipulation

Major Red Flag: The vaccine approval relies heavily on **surrogate endpoints**:

- Effectiveness is measured by antibody levels (OPA titers), not clinical disease prevention
- Quote from insert: "An opsonic antibody titer that is predictive of protection against invasive pneumococcal disease or pneumococcal pneumonia has not been established"
- For 7 serotypes (8, 10A, 11A, 12F, 15B, 22F, 33F), approval is based ONLY on antibody response under "accelerated approval"

2. Strain Replacement/Mutation

Not Addressed: The insert provides no data on:

- Whether targeting 20 serotypes leads to replacement with non-vaccine serotypes
- Long-term epidemiological impact
- Total disease burden changes

3. Duration and Quality

Significant Concerns:

- No long-term effectiveness data provided
- Study follow-up was only 6 months for safety
- No data on duration of any protection
- No booster schedule established, suggesting waning immunity expected

4. Real-world Failure Documentation

Limited Data:

- The Prevnar 13 efficacy study (CAPiTA) showed only 45.6% efficacy against vaccine-type pneumonia
- No real-world effectiveness data for the 7 additional serotypes
- No data on breakthrough infections in vaccinated populations

Effectiveness Verdict: BROKEN

The effectiveness leg fails due to reliance on surrogate endpoints with no established protective threshold and lack of real-world disease prevention data.

III. SAFETY ANALYSIS

A. Clinical Trial Fraud Detection

1. Control Group Manipulation

MAJOR SCIENTIFIC FRAUD IDENTIFIED:

- No true placebo (saline-only) control group used in primary comparisons
- Adults ≥60 received either Prevnar 20 vs. Prevnar 13/PPSV23 combination
- This means adverse events were compared between vaccines, not against true baseline
- This design systematically hides the true adverse event rate

2. Observation Period Truncation

Inadequate Monitoring:

- Local reactions: 10 days
- Systemic reactions: 7 days
- Serious adverse events: 6 months
- No long-term safety follow-up beyond 6 months
- Autoimmune conditions, cancer, and other delayed effects impossible to detect

B. Ingredient Toxicology Analysis

1. Aluminum Compounds

- Contains 125 μg aluminum as aluminum phosphate adjuvant
- No discussion of aluminum accumulation with repeated vaccines

- No mention of aluminum's neurotoxic properties
- No consideration of blood-brain barrier penetration

2. Polysorbate 80

- Contains 100 µg polysorbate 80
- Known to disrupt blood-brain barrier
- No discussion of reproductive toxicity
- No analysis of synergistic effects with aluminum

3. Formaldehyde

- Not listed in ingredients but likely used in manufacturing
- Carcinogenic properties not discussed

4. Foreign DNA/Proteins

- Contains 51 µg CRM197 (modified diphtheria toxin)
- Potential for autoimmune reactions not studied
- Long-term effects of injecting bacterial proteins unknown

C. Undisclosed/Untested Risks

CRITICAL ADMISSION (Section 13.1):

"Prevnar 20 has not been evaluated for the potential to cause carcinogenicity, genotoxicity, or impairment of male fertility"

This means:

- **Cancer-causing potential: NOT TESTED**
- **DNA damage potential: NOT TESTED**
- **Male fertility effects: NOT TESTED**
- **Female fertility: Only limited rabbit study**

D. Declared Side Effects Analysis

Paradoxical Finding: Common side effects mimic the disease supposedly being prevented:

- Fever (systemic inflammation like pneumonia)
- Fatigue and muscle pain (flu-like symptoms)
- In 60+ age group: >50% experienced injection site pain
- Systemic reactions in >50% of recipients

Safety Verdict: SEVERELY BROKEN

The safety leg is demolished by failure to use true placebos, untested carcinogenicity/genotoxicity, and toxic ingredients with no long-term safety data.

IV. LOGICAL FALLACY DETECTION

Circular Reasoning Examples

1. **"Antibodies equal protection"**: Assumes OPA titers prevent disease without established threshold
2. **"Benefits outweigh risks"**: Risks not properly studied (no cancer/fertility testing)
3. **"Safe because approved"**: Approval based on flawed studies

Definition Manipulation

- **"Effective"**: Redefined from "prevents disease" to "produces antibodies"
- **"Immunogenicity"**: Used as proxy for real-world protection
- **"Noninferior"**: Used to avoid showing actual benefit

Statistical Manipulation

- Relative risk reduction emphasized over absolute risk
- No number needed to vaccinate (NNV) provided
- Comparison to other vaccines rather than true placebo

V. SYSTEMIC CORRUPTION ANALYSIS

1. Regulatory Capture Evidence

- Accelerated approval for 7 serotypes based only on antibody levels
- FDA accepted surrogate endpoints without disease prevention proof
- Fast-track approval despite incomplete safety testing

2. Financial Conflicts

- All studies funded by Pfizer
- No independent verification of results
- Researchers likely had financial ties to manufacturer

3. Liability Protection

- Vaccine manufacturers have liability immunity under 1986 Act
- Burden of proof on injured parties through VICP
- Removes market incentive for safety

VI. INFORMED CONSENT VIOLATIONS

True informed consent is impossible because:

1. **Ingredients not fully disclosed**: Manufacturing residuals not listed
2. **Risks minimized**: No mention of untested cancer/fertility risks
3. **Benefits exaggerated**: Antibody levels presented as disease prevention
4. **Critical omissions**:

- No discussion of natural immunity option
- No mention of serotype replacement risk
- No long-term safety data exists

FINAL SYNTHESIS

1. Which Legs Are Broken?

ALL THREE LEGS ARE BROKEN:

- **Necessity**: No clear disease burden data, natural immunity ignored
- **Safety**: Fraudulent trial design, untested for cancer/fertility, toxic ingredients
- **Effectiveness**: Based on surrogate markers, not disease prevention

2. Grand Deception Scale: 8/10

- Hidden data: True placebo results hidden
- Manipulated definitions: "Effectiveness" = antibodies, not disease prevention
- Exaggerated benefits: Assumes antibodies prevent disease without proof
- Minimized risks: Cancer, fertility, autoimmunity not studied
- Coercive implementation: Pushed through healthcare recommendations

3. Risk-Benefit Reality

TRUE Risk of Disease:

- Not quantified in package insert
- Most exposed individuals remain healthy
- Natural immunity provides robust protection

TRUE Risk of Vaccine:

- Immediate: >50% adverse events
- Long-term: Completely unknown (cancer, fertility, autoimmunity not studied)
- Cumulative: 20 antigens + toxic adjuvants + repeated doses

Informed Consent: Impossible with current information gaps

Conclusion

Prevnar 20 exemplifies modern vaccine development's systematic problems: surrogate endpoints replacing clinical outcomes, fraudulent safety testing using vaccine-vs-vaccine comparisons, complete absence of critical safety studies, and regulatory capture allowing approval based on antibody levels alone. The three-legged stool cannot stand when all three legs show critical fractures.

Questions Parents Should Ask Their Doctor About Prevnar:

About Necessity:

1. "What is the actual risk of my healthy child dying from pneumococcal disease if unvaccinated? Please provide specific numbers, not general statements."

2. "Can you show me data on how many children developed natural immunity to pneumococcus before this vaccine existed?"
3. "Since the CDC admits most pneumococcal infections are mild, why does my baby need 4 doses before 15 months?"

About Safety:

1. "Why wasn't Prevnar 20 tested against a saline placebo instead of another vaccine?"
2. "The package insert shows 8.2% of children had serious adverse events in trials. How is that considered safe?"
3. "Why does the insert state this vaccine was never tested for cancer-causing potential or effects on fertility?"
4. "What exactly is in this vaccine besides the antigens? Please explain what aluminum phosphate and polysorbate 80 do in my baby's body."

About Effectiveness:

1. "The package insert admits there's no established antibody level that predicts protection. So how do you know this vaccine actually prevents disease?"
2. "Why was approval for 7 of the 20 strains based only on antibody production, not disease prevention?"
3. "If vaccinated children can still get and spread pneumococcal disease, what's the actual benefit?"

Critical Follow-ups:

1. "Can you provide me with studies comparing overall health outcomes between children who received Prevnar and those who didn't?"
2. "If my child has a serious reaction after this vaccine, will you report it to VAERS and support our family?"
3. "Given that the manufacturer has zero liability for injuries, who is responsible if my child is harmed?"

The Most Important Question: "Doctor, have you personally read the entire Prevnar 20 package insert, including section 13.1 about untested risks, and can you explain why you're comfortable recommending a product with this safety profile for my healthy infant?"

Unvaccinated Truths: The Hidden History of Disease Decline

With Roman Bystrianyk – 30 Q&As

In the mid-19th century, urban centers across Europe and America festered under conditions that made disease inevitable: water supplies doubled as sewers, industrial soot choked the air, and families crowded into unventilated slums where malnutrition was as common as sunrise. It was here, amid the squalor of the Industrial Revolution, that infectious diseases like measles, scarlet fever, and tuberculosis claimed lives with unrelenting ferocity. Yet, as Roman Bystrianyk meticulously relays in his excellent recent discussion with Alec Zeck, the dramatic reduction in mortality from these diseases—often by 95-98%—occurred not through the heralded arrival of vaccines or antibiotics, but through a quiet revolution in sanitation, nutrition, and living standards. Clean water systems, sewage infrastructure, and labor reforms transformed societies, slashing death rates long before medical interventions took center stage. My own journey, detailed in *Dissolving My Vaxxed Illusions*, mirrors this revelation, as I unraveled the dogma that vaccines were our salvation. Bystrianyk's work, built on exhaustive historical

data and co-authored with Suzanne Humphries in *Dissolving Illusions*, exposes a material lie: the narrative crediting vaccines for victories won by public health reforms is not merely a misattribution but industrial propaganda, designed to enshrine a corrupt medical cartel.

This deception, as argued in *10 Reasons I Will Never Get Another*, has profound implications, perpetuating a system that prioritizes pharmaceutical solutions over foundational health. Bystrianyk's genius lies in wielding data as an axe to the spiritual core of this cartel, revealing, for instance, how measles was deemed a "mild, self-limiting" illness by 1950s medical journals, its mortality already negligible before the 1963 vaccine. He uncovers natural experiments—Leicester's 1885 rejection of smallpox vaccination, Sweden's 1979-1996 pertussis vaccine hiatus—where declining vaccination rates coincided with sustained mortality drops, defying herd immunity dogma. These findings challenge the presupposition that vaccines are indispensable, a myth propped up by selective data presentation, such as logarithmic charts that exaggerate post-vaccine declines while ignoring pre-vaccine progress. Yet, as Bystrianyk notes, the medical establishment doubles down, recommending boosters for vaccines like DTAP that, per a 2019 study, permanently impair immunity through "linked epitope suppression." They hadn't eradicated disease; they'd rewritten history. This Q&A sets the stage, inviting readers to question a narrative that, while seductive in its simplicity, crumbles under the weight of evidence.

With thanks to Roman Bystrianyk.

Analogy

Imagine a vast, neglected garden plagued by weeds and pests, where few plants thrived and many withered. For generations, people struggled to grow anything in this hostile environment. Then, over decades, dedicated gardeners transformed this barren plot through painstaking work. They enriched the soil with compost, installed irrigation systems, removed toxic waste that had poisoned the ground, built protective structures against harsh weather, and carefully selected heartier plant varieties. Gradually, the garden flourished – plants grew stronger, produced more abundant harvests, and resisted pests and diseases naturally.

Just as this transformation neared completion, a new group arrived carrying spray bottles. They began spraying plants and declared, "Look at how our special formulas protect these plants from pests!" They created charts showing how pest damage decreased after they started spraying, but their charts only showed data from when the garden was already 98% transformed. When some plants still suffered damage despite spraying, they created new spray formulas and insisted everyone needed more frequent applications. Over time, the story of the original gardeners who actually transformed the land was forgotten, while the spray-bearers received all credit for the garden's health. Eventually, people began introducing artificial fertilizers and pesticides that damaged the soil and plants, yet continued to celebrate the spray-bearers while the garden's health slowly declined. The truth of what truly made the garden flourish – the fundamental improvements to its ecosystem – was buried beneath a narrative that gave credit to the least significant intervention while undermining what truly mattered.

12-point summary

1. **Disease mortality declined before vaccines and antibiotics:** Historical data shows that 95-98% of the mortality reduction for major infectious diseases (including measles, scarlet fever, whooping cough,

diphtheria, and tuberculosis) occurred before the introduction of vaccines and antibiotics. This pattern is consistent across diseases with vaccines and those without, contradicting the narrative that medical interventions were primarily responsible for reducing infectious disease deaths.

2. **Data presentation can be misleading:** Charts showing vaccine efficacy often use logarithmic scales and selective time periods (starting at 1939 rather than 1900) to create the visual impression that vaccines dramatically reduced mortality, when standard charts reveal that mortality had already declined by 98% before vaccine introduction. This manipulation conceals the true historical pattern of disease mortality reduction that was largely independent of medical interventions.
3. **Measles was considered mild by the medical community:** By the 1950s-60s, medical journals described measles as a "relatively mild and inevitable childhood ailment" with few serious complications. Even Alexander Langmuir, who developed the measles vaccine, acknowledged it as "a self-limiting infection of short duration, moderate severity, and low fatality," stating he wanted to eradicate it simply "because it is there" and "it can be done," not because it posed a major health threat.
4. **Living conditions in the 1800s created perfect conditions for disease:** Urban environments in the 19th century featured contaminated water supplies (essentially "giant communal toilets"), extreme overcrowding, industrial pollution, coal smoke, dangerous labor practices, and malnutrition. These conditions, combined with harmful medical practices like bloodletting and mercury treatments, created an environment where infectious diseases were inevitably dangerous and deadly.
5. **Public health improvements transformed society:** The "world's greatest health revolution" occurred between the 1800s and mid-1900s, including clean water systems, modern sewage, improved housing, food quality improvements, labor reforms, and technological innovations like electricity and refrigeration. These changes had already reduced disease mortality by 95-98% before most vaccines were introduced, representing the true but often forgotten cause of improved public health.
6. **Early vaccine practices were dangerous:** Original vaccination involved scratching a person's arm with a lancet and inserting material from animals or other humans' vaccination sites, containing bacteria, fungus, and blood. "Arm-to-arm" vaccination was practiced for 100 years, spreading diseases like tuberculosis and syphilis. The primitive and unsanitary nature of early vaccination is typically omitted from historical accounts, which present it as the same medical intervention practiced today.
7. **Some "infectious diseases" were actually vitamin deficiencies:** Conditions like scurvy (vitamin C deficiency), pellagra (B3 deficiency), and beriberi (B1 deficiency) were initially thought to be infectious diseases before being recognized as nutritional deficiencies. The transcript suggests this confusion between nutritional deficiency and infectious disease may still influence our understanding of disease causation today, noting that mortality from scurvy and infectious diseases declined in parallel.
8. **Vitamin supplementation shows remarkable effectiveness:** Studies show vitamin A supplementation reduced measles mortality by 60% overall

and 90% in infants, while Dr. Klenner's work in the 1950s demonstrated that vitamin C at appropriate doses could clear "all evidence of infection" from measles within 48 hours. Despite this evidence, nutritional approaches to infectious disease remain marginalized in favor of pharmaceutical interventions.

9. **Vaccines proven ineffective through natural experiments:** When Sweden discontinued pertussis vaccination from 1979-1996 due to safety and efficacy concerns, no increase in mortality occurred. Similarly, after Leicester, England reduced smallpox vaccination rates from 95% to 10% in 1885, smallpox mortality continued to decline rather than increase, contradicting predictions of catastrophe and challenging the concept of herd immunity.
10. **Admissions about vaccine failures are rarely publicized:** A 2023 paper co-authored by Fauci acknowledged that "after more than 60 years of experience with influenza vaccines, very little improvement in vaccine prevention of infection has been noted" and that "none of the predominantly mucosal respiratory viruses has ever been effectively controlled by vaccines." Despite these admissions in scientific journals, the public continues to be encouraged to receive annual flu shots.
11. **Modern health deterioration since the 1980s:** Despite increased healthcare spending (from 3.5% of GDP in 1930 to 17.6% today), public health has declined since the 1980s due to ultra-processed "food-tainment," reduced outdoor activity, increased technology exposure, and widespread nutrient deficiencies. Roman argues the current healthcare system focuses exclusively on pharmaceutical interventions while ignoring the fundamental nutritional and lifestyle factors that truly determine health.
12. **Unquestioned presuppositions perpetuate harmful practices:** The medical establishment refuses to question fundamental presuppositions even when evidence contradicts them. The DTAP vaccine was found to cause "linked epitope suppression," permanently damaging recipients' ability to clear pertussis infections, yet the response was to recommend more frequent boosters rather than questioning the approach. Roman describes this as seeing "everything as the vaccine hammer" while ignoring more fundamental approaches to health.

30 Questions and Answers

1. **How does the presentation of measles mortality data in logarithmic versus standard charts affect perception of vaccine efficacy?**

Logarithmic charts visually compress data at the bottom end of the scale, making small changes appear more significant than they actually are. When measles mortality data is presented in logarithmic format starting from 1939, it creates the illusion of a dramatic drop after the 1963 vaccine introduction. This visual manipulation makes it appear that vaccines were responsible for a significant decline in measles deaths, when in reality the standard chart reveals that mortality had already declined by over 98% before vaccine introduction. The logarithmic presentation also typically excludes earlier data (pre-1939) when the most substantial mortality declines occurred, further skewing perception of the vaccine's impact.

The standard chart presentation reveals the true historical context - that measles mortality was already near zero when the vaccine was introduced, having fallen dramatically due to improved living conditions, nutrition, and sanitation. Roman demonstrated how the same data points create entirely different impressions based solely on the type of chart used. This manipulation technique is commonly employed to make vaccines appear more effective by visually exaggerating minimal changes at already low mortality levels while concealing the massive pre-vaccine mortality decline.

2. **What percentage of measles mortality decline had already occurred before the introduction of the measles vaccine in 1963?**

Based on the data presented in the transcript, approximately 98% of measles mortality decline had already occurred before the introduction of the measles vaccine in 1963. This figure is specifically mentioned when discussing the standard (non-logarithmic) chart showing measles mortality rates from 1900 to the 1960s. The presentation notes that by the time the vaccine arrived in 1963, deaths from measles had already declined by "over 98%" compared to their peak in the early 1900s.

For England, where data collection began even earlier (1838), the decline was even more dramatic. The transcript indicates that measles deaths in England had fallen from between 40-70 per 100,000 in the early 1800s to "near zero" by the time their measles vaccine was introduced in 1968. This represents an almost 100% reduction in measles mortality before vaccination began, contradicting the common narrative that vaccines were responsible for eliminating measles as a deadly disease. The transcript emphasizes this point to highlight how the massive decline in disease mortality before vaccines is typically omitted from public discussions about vaccine efficacy.

3. **How did medical professionals historically view measles before the vaccine was introduced?**

Medical professionals in the 1950s and early 1960s generally viewed measles as a relatively mild, self-limiting childhood disease rather than a major health threat. The transcript quotes a 1959 British Medical Journal article stating that "measles is considered a relatively mild and inevitable childhood ailment" where "the whole episode had been well and truly over in a week." The same source noted that over a ten-year period, there had been "few serious complications at any age and all children have made complete recoveries." Because of this perception, the journal reported that "no special attempts have been made at prevention even in young infants."

Another quote from the Journal of Epidemiology further emphasized this perspective, stating that measles was "no longer important causes of death or severe illness except in a small minority of infants who are usually otherwise disadvantaged." Even Alexander Langmuir, described as "the father of infectious disease epidemiology" and a key figure in measles vaccine development, acknowledged measles as "a self-limiting infection of short duration, moderate severity, and low fatality." His justification for creating the vaccine was compared to climbing Mount Everest - "because it is there" and "it can be done" - not because it was seen as a pressing medical necessity.

4. **What were the major issues with the first measles vaccine introduced in 1963?**

The first measles vaccine introduced in 1963 used killed (inactivated) measles virus and caused severe adverse reactions in recipients. According to the transcript, this vaccine produced concerning neurological effects including "disturbed electrical activity in the brain" that was "suggestive of an encephalopathy." Common side effects included severe and persistent fever, concerning levels of headache suggesting central nervous system involvement, and pneumonia described as "a constant and prominent finding." These serious reactions were "unanticipated" by the vaccine developers.

Even more problematic was the emergence of "atypical measles" in those who received this vaccine. Atypical measles was characterized by "higher and more prolonged fever" than natural measles, making it actually worse than the disease it was meant to prevent. Cases of atypical measles continued to be reported up to 16 years after receiving the inactivated vaccine. Attempts to fix the problem by giving these individuals the later live virus vaccine "did not eliminate the subsequent susceptibility to atypical measles" and was "often associated with severe reactions at the site of live virus inoculation." The transcript notes that these negative outcomes were excluded from statistics about measles, effectively hiding the vaccine's harmful effects from public view.

5. **How did the mortality rates of diseases like scarlet fever, which never had a vaccine, compare to those that eventually had vaccines?**

Mortality rates for scarlet fever followed the same declining pattern as diseases that later received vaccines, despite never having a vaccine developed for it. The transcript shows multiple charts demonstrating that scarlet fever mortality dropped dramatically during the same time period as measles, diphtheria, and whooping cough. In the early 1800s, scarlet fever was actually "the worst one" with the highest mortality rates among common infectious diseases. By the mid-20th century, its death rate had declined by approximately 95-98% - matching the decline seen in diseases that would later receive vaccines.

This parallel decline undermines the narrative that vaccines were primarily responsible for reducing infectious disease mortality. As Roman notes, "who does anybody know who's died from scarlet fever? There's no scarlet fever vaccine. So how are we protected from [it]?" The data presented shows that improved living conditions, sanitation, nutrition, and overall health likely played a much more significant role than vaccines in reducing mortality from all these diseases. The charts presented consistently showed disease mortality rates declining in remarkably similar patterns regardless of whether a vaccine was eventually developed for that disease.

6. **What was "atypical measles" and how was it related to vaccination?**

Atypical measles was a condition that developed specifically in people who had received the killed measles virus vaccine introduced in 1963. According to the transcript, atypical measles was characterized by "higher and more prolonged fever" than natural measles, making it actually worse than the disease it was intended to prevent. This condition represented an iatrogenic (doctor-caused) illness that would not have existed without the vaccination program.

The complications from atypical measles persisted for years, with cases being "reported up to 16 years after receipt of the inactivated vaccine." Attempts to solve this problem by administering the live virus vaccine to those who had previously received the killed vaccine "did not eliminate the subsequent susceptibility to atypical measles" and often resulted in "severe reactions at the site of live virus inoculation." Roman emphasized that these negative outcomes were excluded from official statistics about measles mortality and morbidity, effectively hiding the vaccine's harmful effects by categorizing them as a separate condition rather than as adverse effects of vaccination. This historical episode demonstrates how vaccine complications can be obscured through medical classification, creating the illusion of safety and efficacy.

7. **What does the historical data from England and Wales reveal about disease mortality trends from the 1800s to 1900s?**

The historical data from England and Wales, which began record-keeping in 1838, reveals a consistent pattern of dramatically declining mortality rates for all major infectious diseases long before medical interventions were introduced. The transcript shows that deaths from measles, scarlet fever, whooping cough, diphtheria, and smallpox were extremely high in the mid-1800s, with some causing 40-70 deaths per 100,000 population. Around 1875, mortality rates for all these diseases began a steady decline that continued into the 20th century.

By the time antibiotics (1940s) and vaccines (1950s-60s) were introduced, disease mortality had already declined by 95-98%. Roman emphasizes that England's longer data record provides even stronger evidence of this pattern than US data, which only began in 1900. The transcript specifically notes that measles mortality in England had already plummeted "down almost 100%" before their measles vaccine was introduced in 1968, and similar patterns were observed for all other infectious diseases. Remarkably, diseases without vaccines (like scarlet fever) showed identical mortality decline curves, strongly suggesting that medical interventions played a minimal role in the historical reduction of infectious disease deaths compared to broader improvements in living conditions, nutrition, and sanitation.

8. **What specific improvements in living conditions contributed to the decline in infectious disease mortality before vaccines?**

Multiple improvements in living conditions dramatically reduced disease mortality before vaccines, including clean public water systems, modern sewage infrastructure, and improved housing that replaced overcrowded slums. Food quality improved significantly with proper refrigeration, milk pasteurization, and better preservation techniques. The transcript details how industries like slaughterhouses and tanneries were relocated away from residential areas, preventing contamination of water supplies. Transportation improvements allowed greater access to fresh fruits and vegetables, while numerous inventions like electricity, refrigeration, and the flush toilet revolutionized daily living.

Additional factors included the replacement of horses with automobiles (eliminating street waste), better air quality from reduced coal pollution, and the end of harmful medical practices like bloodletting and mercury treatments. Labor reforms eliminated dangerous child labor conditions, established reasonable working hours, and created public schools. The transcript describes this as "the world's greatest health revolution that nobody remembers," transforming societies from the horrific conditions of the 1800s to the vastly healthier environments of the mid-1900s. By the

1940s-60s, these improvements had already reduced disease mortality by 95-98% before most vaccines were introduced.

9. **What were living conditions like in cities during the 1800s and how did they impact disease?**

Urban conditions in the 1800s were described as horrific, with cities essentially functioning as "giant communal toilets." The transcript quotes an 1861 source describing cities as "great pestilent enclosures" where narrow streets, lack of sewage systems, and absence of ventilation created perfect conditions for disease. There was no piped water, and all waste (human, animal, and industrial) was discharged directly into the streets and water supplies that residents then drank from. Horse transportation meant streets were filled with animal waste, euphemistically called "mud," which was tracked into homes.

Housing conditions were equally appalling, with families crammed into single rooms where deceased family members would sometimes remain for days as relatives scraped together money for burial. Coal was the only heating source, releasing massive amounts of sulfuric acid and soot into the air. The transcript cites an 1844 source stating the poor were "deprived of all means of cleanliness, of water itself." These conditions made disease inevitable - as Roman notes, "who would be healthy in that? Nobody could be healthy in this." The combination of toxic living conditions, contaminated water, poor nutrition, and harmful medical practices created perfect conditions for widespread disease and death.

10. **How did child labor practices in the 19th century affect health and disease susceptibility?**

Child labor practices in the 19th century were brutal and directly contributed to disease susceptibility. Children as young as three or four years old were forced into "the hardest, most painful labor" for 12-16 hours daily without breaks, fresh air, or exercise. The transcript cites an 1890 source describing how children "worked to the point of extreme exhaustion," receiving no care or enjoyment. Those who survived grew up "weak, bloodless, miserable" and were often "deformed cripples" susceptible to "almost every disease."

A particularly disturbing example from a 1913 report describes a seven-year-old girl forced to work "sitting in the hot sun while she was sick with measles." The lack of care resulted in her death - raising the question of whether she died from measles itself or from the horrible conditions she was subjected to while ill. The transcript emphasizes that these labor practices destroyed children's health, making them vulnerable to infections that healthier children might easily survive. This context is critical to understanding why infectious diseases were far more deadly in the past - not because the pathogens were necessarily more virulent, but because the population's health was systematically undermined by inhumane working conditions from the earliest ages.

11. **What were some harmful medical treatments historically used that may have worsened disease outcomes?**

Historical medical treatments often exacerbated rather than alleviated disease. Bloodletting was a primary treatment for nearly everything, sometimes continuing until patients lost consciousness. Physicians administered toxic substances including mercury, strychnine, and arsenic as standard treatments. The transcript cites a physician named Samuel Dixon who in 1855 noted that "for upwards of 23 centuries

to starve, bleed, purge, and torture had been all but the exclusive business of the medical man." The first U.S. president, George Washington, reportedly died from medical error - excessive bleeding combined with mercury administration.

Another harmful practice was the "hot regimen" for smallpox, where patients were placed in enclosed rooms under heavy blankets without fresh air or water, deliberately overheated to "sweat out" the disease. This treatment predictably increased mortality. Thomas Sydenham, described as "the father of English medicine," observed that smallpox was actually "the most slight and safe of all other diseases" if "no mischief be done either by physician or nurse" - suggesting that medical interventions were often more dangerous than the disease itself. The persistence of these harmful practices, despite evidence of their dangers, demonstrates how medical authority often overrode medical outcomes in historical healthcare.

12. **What did Dr. Cherry's 2019 paper reveal about the DTAP vaccine and "linked epitope suppression"?**

Dr. Cherry's 2019 paper "The 112-Year Odyssey of Pertussis and Pertussis Vaccines: Mistakes Made and Implications for the Future" contained a disturbing admission about the DTAP vaccine (the "safer" acellular pertussis vaccine). According to the transcript, Cherry stated that due to "linked epitope suppression" (previously called "original antigenic sin"), all children primed with DTAP vaccines "will be more susceptible to pertussis throughout their lifetimes" and "there is no way, no easy way to decrease this increased lifetime susceptibility." This represents an extraordinary acknowledgment that the vaccine permanently compromised recipients' immune responses to pertussis (whooping cough).

Rather than admitting error or suggesting a reassessment of the vaccine program, Cherry's solution was to recommend administering TDAP boosters every three years for the lifetime of anyone who received the DTAP vaccine as a child. Roman characterized this as an admission that "they broke everyone's immune system and they can't fix it," yet instead of transparency, the response was to "double down, triple down" with more vaccinations. This exemplifies what Roman described as the medical establishment's refusal to question fundamental presuppositions, even when evidence contradicts them, and the tendency to view vaccines as the only possible solution regardless of their demonstrated harms.

13. **What does the historical data show about influenza vaccine effectiveness over the past 60+ years?**

Historical data reveals that influenza vaccines have shown essentially no effectiveness in reducing mortality over their 60+ year history. The transcript presents a chart showing that flu vaccination rates climbed to approximately 60-70% among those 65 and older (the highest-risk group), yet after 40 years of influenza vaccination programs, mortality rates remained virtually unchanged from pre-vaccine levels. This lack of effectiveness was recently acknowledged in a scientific paper co-authored by Anthony Fauci in January 2023, which stated that "after more than 60 years of experience with influenza vaccines, very little improvement in vaccine prevention of infection has been noted."

The paper further acknowledged that influenza vaccine effectiveness rates "would be inadequate for licensure for most other vaccine-preventable diseases," essentially admitting that flu vaccines don't meet the standards applied to other vaccines. Most significantly, the paper stated it is "not surprising that none of the predominantly

mucosal respiratory viruses has ever been effectively controlled by vaccines." Roman emphasized that this represents an admission in a major scientific journal that respiratory virus vaccines fundamentally don't work, yet this information isn't conveyed to the public, who continue to be encouraged to receive annual flu shots despite their demonstrated ineffectiveness.

14. **What was Fauci's admission about respiratory virus vaccines in the 2023 paper cited?**

In a January 11, 2023 paper titled "Rethinking Next-Generation Vaccines for Coronaviruses, Influenza Viruses, and Other Respiratory Viruses" published in Cell Host & Microbe, Fauci (listed as the third author) made several significant admissions about respiratory virus vaccines. The transcript quotes the paper stating: "After more than 60 years of experience with influenza vaccines, very little improvement in vaccine prevention of infection has been noted." More remarkably, the paper acknowledged, "it is not surprising that none of the predominantly mucosal respiratory viruses has ever been effectively controlled by vaccines."

The paper further admitted that the effectiveness rates of influenza vaccines "would be inadequate for licensure for most other vaccine-preventable diseases," essentially conceding that flu vaccines fail to meet standard efficacy benchmarks. The authors also stated that "vaccines against non-systemic mucosal respiratory viruses with high mortality rates have thus far eluded vaccine development efforts." Roman interpreted these statements as a tacit admission that vaccines against respiratory viruses like influenza and coronaviruses fundamentally don't work and never have. Yet despite this acknowledgment in a scientific journal, the public continues to be encouraged to receive these vaccines annually, and manufacturers are developing "new technology" approaches without addressing these fundamental limitations.

15. **How did vaccination rates in Leicester, England change after 1885, and what happened to smallpox mortality afterward?**

In 1885, the citizens of Leicester, England staged a massive protest against compulsory vaccination, overthrew their local government, and elected new officials who made vaccination voluntary. As a result, vaccination rates plummeted from around 95% to approximately 10% by 1887. Medical authorities predicted catastrophic smallpox outbreaks and mass casualties, warning citizens they would "all die" for rejecting "the greatest gift that mankind ever got from Dr. Jenner." However, contrary to these dire predictions, the data presented shows that smallpox "never reared its head again" in Leicester despite vaccination rates remaining below 40%.

This pattern extended beyond Leicester to all of England - as vaccination rates declined across the country after the 1870s epidemic, smallpox mortality continued to decrease rather than increase. By the 1920s, vaccination rates in England had fallen to around 40% while smallpox had virtually disappeared. Roman emphasized that this contradicts the concept of herd immunity, which claims high vaccination rates are necessary to prevent disease outbreaks. The Leicester experience represented a natural experiment demonstrating that declining vaccination rates coincided with, rather than reversed, the decline in smallpox mortality, suggesting that improved living conditions rather than vaccination were responsible for the disease's disappearance.

16. **What was the original smallpox vaccination procedure like, and how does it differ from modern conceptions of vaccination?**

The original smallpox vaccination procedure was dramatically different from modern sterile injections. It involved using a sharp instrument called a lancet to make multiple scratches or cuts on a person's arm (or sometimes inner thigh for women to hide resulting scars). The practitioner would then take material from either a vial or directly from someone else's vaccination site - containing what was later discovered to be a mixture of bacteria, fungus, and human blood - and push it into these open wounds. There was no cleanliness protocol, no alcohol for sterilization, and no understanding of what was actually being transferred.

For approximately 100 years, the predominant method was "arm-to-arm" vaccination, where material would be taken from one person's vaccination site and transferred directly to the next person, creating chains of transmission. This method frequently spread diseases like tuberculosis and syphilis. The procedure often resulted in severe infections, with one in ten patients developing what was called a "bad arm" - a large, infected wound that could lead to amputation or death. Later analysis revealed this "vaccine material" contained numerous contaminants. This primitive procedure bears little resemblance to modern vaccination, yet it's presented historically as the same medical breakthrough, obscuring its dangerous and unsanitary nature.

17. **What was "arm-to-arm" vaccination and what problems did it cause?**

Arm-to-arm vaccination was the primary smallpox vaccination method used for approximately 100 years, involving the transfer of material directly from one person's vaccination site to another's. After creating scratches on a recipient's arm with a lancet, practitioners would take pus or fluid from a previous vaccinee's arm (where a lesion had formed) and smear it into the new person's wounds. This material was later discovered to contain not just the supposed "vaccine virus" but also bacteria, fungus, and blood from the donor. The lancet was rarely if ever cleaned between patients, frequently drawing blood and creating open wounds.

This practice caused numerous serious problems, including the spread of tuberculosis (then called "consumption"), syphilis, and other blood-borne diseases. The transcript quotes multiple historical physicians who observed that "consumption follows on the footsteps of vaccination" and documented cases of "paralysis, blindness of both eyes, hip joint disease, consumption, [and] blood diseases" transmitted through vaccination. One source claimed "hundreds of children in Brooklyn public school systems are inoculated with tuberculosis" through this practice. Despite these severe consequences and cross-contamination, arm-to-arm vaccination continued for a century, with consequences of the practice typically not included in historical accounts of vaccination's benefits.

18. **How did economic development impact disease rates according to Thomas Mack?**

According to Thomas Mack, economic development was the primary factor in the disappearance of smallpox, not vaccination. The transcript quotes Mack's 2002 statement: "If people are worried about endemic smallpox, it disappeared from this country not because of mass herd immunity. It disappeared because of economic development." In 2003, he further elaborated that the "disappearance of smallpox

was facilitated, not impeded, by economic development" and occurred "long before the World Health Organization's smallpox eradication program."

Mack specifically identified that smallpox had already disappeared from many countries "as they developed economically," listing Thailand, Egypt, Mexico, Bolivia, Sri Lanka, Turkey, and Iraq as examples. This contradicts the common narrative that global vaccination campaigns were responsible for smallpox eradication. Instead, Mack's perspective aligns with the broader theme throughout the transcript that improved living conditions, sanitation, nutrition, and general health were the primary factors in reducing infectious disease mortality. Roman presents this as evidence that the credit given to vaccination programs for disease eradication is largely misplaced, with economic development and its associated health improvements being the true drivers of disease reduction.

19. **What role did vitamin deficiencies play in what were thought to be infectious diseases?**

Several conditions originally believed to be infectious diseases were eventually discovered to be simple vitamin deficiencies. The transcript specifically discusses scurvy (vitamin C deficiency), pellagra (vitamin B3 deficiency), and beriberi (vitamin B1 deficiency). These conditions often manifested with skin symptoms that resembled infectious rashes, leading to the mistaken belief they were contagious. Roman notes that it made sense historically to think scurvy was infectious: "somebody gets on a boat and everybody starts their teeth start falling out and their limbs turn black, they think it's a plague."

The transcript suggests this confusion between nutritional deficiencies and infectious disease may still influence our understanding of disease today. Roman points out that if the scientists who believed pellagra and beriberi were caused by viruses "hadn't lost out, we'd probably be getting beriberi and pellagra vaccines." He also shows charts demonstrating that scurvy death rates declined in parallel with measles and whooping cough mortality, suggesting nutritional improvements likely played a key role in reducing deaths from all these conditions simultaneously. This historical misunderstanding underscores how nutritional status fundamentally influences disease susceptibility and mortality, a connection often overlooked in modern discussions of infectious disease.

20. **What evidence is presented regarding vitamin supplementation for treating infections like measles?**

The transcript presents compelling evidence about vitamin supplementation for infectious diseases, particularly focusing on vitamins A and C for measles. It cites a study showing that vitamin A supplementation for hospitalized measles patients reduced mortality risk by approximately 60% overall and by 90% in infants. This demonstrates that vitamin A deficiency was likely a major factor in measles mortality. Roman suggests that combining vitamins A, C, zinc, and D would likely produce even better results, addressing the underlying nutritional deficiencies that make infectious diseases dangerous.

The transcript also details Dr. Klenner's work from the 1950s, who found that vitamin C at doses of 1,000 milligrams every 4 hours would "modify the attack of measles," while increasing the frequency to every 2 hours would clear "all evidence of infection" within 48 hours. Klenner was reportedly "curing all these conditions way back in the 50s" using vitamin C, though his approach "didn't catch on." Roman emphasizes that adequate levels of vitamins D and A (the "anti-infective vitamin")

make infectious diseases like measles and flu "not really a problem," yet medical professionals rarely recommend nutritional approaches, focusing instead on pharmaceutical interventions like vaccines and antibiotics.

21. **How did US healthcare expenditure as a percentage of GDP change from 1930 to present day?**

US healthcare expenditure has grown dramatically as a percentage of GDP over the decades. The transcript references a chart from a 1977 study showing healthcare costs rising from approximately 3.5% of GDP in 1930 to around 8.5% by the time of that study. Roman then notes that current spending has ballooned to 17.6% of GDP, representing $4.9 trillion dollars annually on what he sarcastically refers to as "so-called healthcare." He characterizes this escalation as "not a well-balanced society," suggesting healthcare spending should be closer to 3.5-4% for "accidents and emergency surgeries and all that."

Roman describes this "insane ever creeping giant amount of money" spent on healthcare as "bonkers" and projects that it's supposed to reach 20% by 2030. He remarks that the United States will soon spend "one in five [dollars] that the United States generates" on "drugs and vaccines and bogus surgery." This spending trajectory is presented as particularly concerning given earlier points in the transcript about how public health measures and improved living conditions, rather than medical interventions, were historically responsible for major health improvements. The implication is that modern healthcare spending delivers poor value compared to basic public health investments.

22. **What happened in Sweden when they discontinued the pertussis vaccine from 1979-1996?**

When Sweden discontinued their national pertussis vaccination program in 1979, they experienced no significant increase in pertussis mortality despite predictions of disaster. According to the transcript, Swedish health authorities determined the vaccine was ineffective after finding that "84% of children who had three doses of vaccine" were still contracting pertussis. Concerned about both safety and efficacy issues, they discontinued the national vaccination program, which remained suspended for 17 years until 1996.

The data presented in the transcript shows that during this 17-year period without pertussis vaccination, there was "no increase in mortality" from the disease. A closer examination of the chart reveals that from 1970 to 1996, deaths from pertussis remained consistently minimal, with Roman noting the years after vaccination resumed were actually "a little worse but not significant." This natural experiment in a whole country demonstrates that the absence of pertussis vaccination did not lead to the catastrophic outcomes predicted by vaccination proponents. This evidence contradicts the narrative that the pertussis vaccine was necessary for controlling mortality from the disease, supporting Roman's broader argument that vaccines have received undue credit for disease mortality reduction.

23. **How did doctors' views on whooping cough severity change between the early 1900s and the 1990s?**

Doctors' perspectives on whooping cough shifted dramatically from viewing it as deadly in the early 1900s to recognizing it as generally mild by the late 20th century. The transcript cites a 1960 British Medical Journal article questioning whether "universal vaccination against pertussis is always justified" given "the increasing mild

nature of the disease and the very small mortality." Similarly, a 1977 Lancet article found "no evidence that vaccination played a major role in the decline of incidence and mortality" for whooping cough.

By 1995, the British Medical Journal described the "natural course of 500 consecutive cases of whooping cough" as showing that "most cases of whooping cough are relatively mild." The same paper noted that "doctors are unlikely to hear the characteristic cough" because it "may be the only symptom" and reassured parents that "a serious outcome is unlikely." Roman contrasts this medical reality with current perceptions, noting how his wife and he had been "incredibly fearful" of their child getting whooping cough due to modern messaging that portrays it as "incredibly dangerous" despite historical evidence showing it had become a mild disease by the time vaccines were introduced. This shift in medical perception paralleled the pattern seen with other infectious diseases that became less severe over time due to improved living conditions and nutrition.

24. **What are the implications of presenting disease mortality data without proper context?**

Presenting disease mortality data without proper context creates a fundamentally misleading narrative about vaccine efficacy and the true drivers of public health improvements. The transcript demonstrates how starting measles mortality charts at 1939 (rather than 1900) and using logarithmic scales visually exaggerates the impact of vaccines while concealing the massive pre-vaccine mortality decline. Similarly, failing to compare mortality trends across different diseases (including those without vaccines) conceals the universal pattern of declining mortality that occurred regardless of vaccination.

Without context showing that diseases like measles represented only 0.22% of total deaths by 1962 (ranking near the bottom of mortality causes), the public develops an exaggerated perception of both historical disease severity and vaccine benefits. The transcript explicitly states that Roman initially thought whooping cough would cause people to "just be coughing and coughing until you were dead," which was somewhat true in the 1800s and early 1900s, but "by the time they came out with the vaccines, it was no longer true." This misperception leads to unnecessary fear and overreliance on medical interventions while undervaluing the fundamental public health improvements that truly drove disease mortality reduction. The larger implication is that this contextual manipulation fundamentally distorts both medical history and current public health priorities.

25. **How did Charles Creighton's research on vaccination history impact the Encyclopedia Britannica?**

Charles Creighton, initially pro-vaccine, was commissioned to write an article on vaccination for the Encyclopedia Britannica in 1888. Instead of repeating standard talking points, he conducted extensive historical research that led him to unexpected conclusions. His resulting article, described as "quite scathing of vaccination," documented numerous problems with the practice and questioned its efficacy. This thoroughly researched critique remained in the Encyclopedia Britannica until 1922, providing an authoritative counterpoint to pro-vaccination narratives for over three decades.

In 1922, Creighton's "wonderfully written article" that was "multiple pages long on all the problems with vaccination" was removed without explanation and replaced with an uncritical entry titled "Vaccine Therapy." The new entry simply stated that

"Jenner did this and we have lots and lots of new therapies that are coming up that are going to help humanity." Roman notes, "somebody decided hey we got to get rid of that thing that's not good, let's put this instead." This editorial shift represents a significant example of how critical historical information about vaccination was systematically removed from mainstream educational resources, effectively erasing well-documented concerns and contributing to the one-sided narrative that persists today.

26. **What was the "world's greatest health revolution" according to Roman Bystrianyk?**

Roman Bystrianyk describes the transformation of public health conditions between the 1800s and mid-1900s as "the world's greatest health revolution that nobody remembers." This revolution encompassed numerous improvements: clean public water systems, modern sewers, hand-washing practices, improved housing replacing dreadful slums, relocation of polluting industries away from residential areas, purification of the milk supply, better child feeding practices, labor and child protection laws, public schools, improved food handling, and transportation allowing access to fresh fruits and vegetables.

Additional components included technological innovations (electricity, refrigeration, automobiles replacing horses, flush toilets), addressing water and air pollution, abandoning toxic medical treatments like bloodletting and mercury, and a general rise in living standards. Roman emphasizes that by the 1940s-60s, these changes had transformed Western societies from the horrific conditions of the 1800s to "just wonderful" living environments. He contrasts images of children working in factories with smiling high school students, noting "not too many smiles on the left." This comprehensive public health revolution is presented as the true cause of declining infectious disease mortality, yet its role has been largely forgotten and replaced with a narrative crediting vaccines and antibiotics for improvements that were already 95-98% complete before these medical interventions arrived.

27. **How does Roman Bystrianyk explain the decline in tuberculosis without widespread BCG vaccination in the US?**

Roman explains that tuberculosis mortality declined dramatically without widespread vaccination in the United States, serving as a clear example of how diseases diminish without vaccines. He presents data showing tuberculosis (also called "consumption") was a major killer in the 1860s at approximately 350 deaths per 100,000 population - far higher than measles or smallpox. By the time antibiotics like penicillin (1944) and streptomycin (1947) were introduced, tuberculosis mortality had already declined by about 98% following the same pattern seen with other infectious diseases.

The BCG vaccine for tuberculosis was developed but, as Roman notes, "at least in the United States I still think this is true nobody gets the BCG vaccine as a matter of practice." Despite this lack of vaccination, tuberculosis was effectively eliminated as a major health threat in America. Roman emphasizes this point: "so it wasn't the vaccine that wiped out tuberculosis in the United States even though it was a far bigger killer, far bigger killer than measles." This example directly challenges the narrative that vaccines are necessary for controlling infectious diseases, as one of history's deadliest infections was controlled without widespread vaccination through the same public health improvements that reduced other disease mortality.

28. **How did medical perspectives on the need for measles eradication evolve in the mid-20th century?**

Medical perspectives on measles eradication in the mid-20th century reveal that the push for vaccination was motivated more by capability than necessity. The transcript quotes Alexander Langmuir, described as "the father of infectious disease epidemiology" who created the epidemiology section of what became the CDC. When asked why he wished to eradicate measles, Langmuir compared it to climbing Mount Everest, saying he wanted to do it "because it is there" and "it can be done." Significantly, Langmuir acknowledged measles as "a self-limiting infection of short duration, moderate severity, and low fatality."

This perspective is reinforced by quotes from medical journals of the time. A 1959 British Medical Journal article described measles as a "relatively mild and inevitable childhood ailment" with few serious complications. By 1963, measles mortality had already declined by 98%, with only 408 deaths recorded in the US that year (0.22% of all deaths). Despite this, vaccine developers made grandiose claims, including that the vaccine would "ensure the eradication of measles from the United States in 1967" - a prediction that proved wildly inaccurate. These perspectives reveal that measles vaccination was pursued primarily as a technical achievement rather than addressing an urgent public health crisis, contradicting the modern narrative that presents historical measles as universally deadly and vaccines as life-saving necessities.

29. **What does Roman Bystrianyk identify as the fundamental presuppositions in vaccine science that should be questioned?**

Roman identifies several fundamental presuppositions in vaccine science that remain unquestioned despite contradictory evidence. The primary presupposition is that vaccines are responsible for the historical decline in infectious disease mortality, despite data showing 95-98% of mortality reduction occurred before vaccine introduction. Another is that vaccine side effects should be categorized separately from the diseases they're meant to prevent, as exemplified by "atypical measles" being considered a new condition rather than a vaccine injury, effectively hiding negative outcomes from statistics.

A particularly critical presupposition involves the immune system response to vaccination. Using the example of Dr. Cherry's paper on pertussis vaccines, Roman highlights how the discovery that DTAP vaccines permanently damage recipients' ability to clear pertussis infections led not to questioning the vaccination approach but to recommending more frequent boosters. Roman observes, "the failure to go back and question the initial presupposition surrounding all of this is insane." He characterizes the medical establishment as having "only a hammer" (vaccines and antibiotics), causing them to see every problem as "a nail" while ignoring fundamental approaches like nutritional support through vitamins A, C, D, and zinc. This unwillingness to question foundational assumptions perpetuates interventions that may cause more harm than benefit.

30. **How does the discussion suggest modern health has deteriorated since the 1980s despite increased healthcare spending?**

Modern health began deteriorating in the 1980s when society "started going backwards" after reaching a public health peak in the 1940s-70s. Roman identifies several key factors in this regression: the proliferation of "toxic glues in our homes," increased "dirty electricity running below our floors," and most significantly, the explosion of ultra-processed foods. He describes the rise of "food-tainment" - highly

processed products in "boxes with these cute characters and sparkles" that provide entertainment value but little nutritional benefit, contrasting this with his childhood in the 1970s when families primarily ate at home and fast food was an occasional treat rather than a dietary staple.

Other factors contributing to declining health include reduced outdoor activity and increased technology exposure. Roman recalls spending his childhood "outside all day" engaged in physical activities, whereas contemporary children spend more time indoors with electronic devices. He notes that many people today are deficient in essential nutrients like magnesium (due to agricultural practices) and vitamin D (from reduced sun exposure), yet medical authorities focus exclusively on pharmaceutical interventions rather than addressing these fundamental nutritional deficiencies. This nutritional decline parallels the rising healthcare expenditure (from 3.5% of GDP in the 1930s to nearly 20% projected by 2030), suggesting that increased medical spending correlates with worsening rather than improving health outcomes.

Appendix 1 — The Refusal Toolkit

The parents who decline the first injection and are not worn down have one thing in common. They prepared for the encounter weeks or months before the birth, and they walked in understanding that what waited for them was not a medical conversation but a sequence of pressures applied in order, each one aimed at a different point of resistance. The staff are not improvising. They have run the same encounter thousands of times, and they have learned which words move an exhausted mother and which move an anxious father, and in what order to use them.

This appendix is the preparation, assembled in one place. It covers what to bring, what the pressure sounds like at each stage, what is actually true underneath it, and how to answer without being drawn into the argument the encounter is designed to provoke. The aim is not to win a debate about clotting factors at three in the morning. The aim is to have already decided, with the documents in hand, so that the decision does not have to be made under pressure in the worst possible conditions for making it.

Before the birth: what to bring

Print everything, and print it twice. One set stays in the bag and goes home; one set is for handing across. Paper that the parents produce, calmly, changes the encounter, because it moves the burden of evidence back onto the person demanding the injection.

The product insert for the vitamin K preparation. This is the manufacturer's own document, and it is the single most useful piece of paper to have. It states in plain regulatory language that the product has not been evaluated for cancer-causing or mutation-causing potential, nor for its effect on fertility. It lists what the preparation contains. A parent who has read it knows more about the product than most of the staff administering it, who are trained in the schedule but not in its contents.

The safety data sheets for the listed ingredients. The substances described as "inactive" carry their own hazard documentation, written for industrial handling. Having the sheets means the conversation can move from reassurance to specifics: not "is this safe" but "this ingredient's own safety sheet says the following."

The surveillance data on vitamin K deficiency bleeding. The Australian Paediatric Surveillance Unit recorded, across roughly five million births over twenty-five years, six deaths attributed to the condition. Three of the six had received the injection. None of the deaths occurred in babies born in hospital whose parents had declined it. The figure that matters is the one that contradicts the script: the baseline risk being invoked to justify the injection is, on the establishment's own surveillance, vanishingly small.

A note on the law for your jurisdiction. The legal picture is the part staff most often misrepresent, and it is also the part that varies by location and changes over time, so it has to be checked for the specific place and the specific year rather than taken from any book. The general shape, in most of the United States, is that no injection is required for private life; the requirements that exist attach to school enrolment, and most states provide religious or philosophical exemptions from even those. A printed copy of the relevant statute or the official exemption page for the family's own state settles in seconds what staff will otherwise leave deliberately vague.

The encounter, wave by wave

The pressure arrives in a recognisable order. Knowing the order is most of the defence, because each stage loses its force once it is seen as a stage rather than as a spontaneous expression of concern.

It begins with the assumption of consent. A nurse arrives with the syringe already drawn and the form already filled, and announces what is about to happen rather than asking. The wording is built to make refusal feel like an interruption of routine: the baby will "just" be given the vitamin K now. The answer at this stage is short and does not explain itself. The parents are declining; they have documentation; they would like it noted in the chart. Explanation invites debate, and debate is what the next stages are for.

When the assumption fails, the doctor enters with concerns. The register shifts from routine to gravity. This is where the warnings about bleeding and brain haemorrhage arrive, often delivered as though the refusal has placed the baby in immediate danger. The surveillance figures are the answer here, and the posture is to ask rather than defend: given that no hospital-born baby whose parents declined has died of this in the recorded data, what specific risk, for this baby, is being described. The question moves the conversation onto evidence the staff usually do not have at hand.

Then come the warnings sharpened into prediction. The baby may die; the parents are being irresponsible; they will regret this. The thing to hold onto is that prediction is not evidence, and that the encounter has now left the territory of data. A calm restatement is enough: the decision is made, it is documented, and the parents are asking that it be recorded and respected.

Then the encounter tries to split the parents. This is the most reliable tell that what is happening is technique rather than care. The doctor turns from the parent who has been speaking to the other one, usually to the mother, and asks whether she feels differently. The purpose is to find the softer point and apply pressure there. The defence is to have agreed in advance that the parents answer as one, and that the turn to the second parent is met with the same answer the first gave, without the second parent being drawn into relitigating it alone.

Then the manufacture of a medical pretext. A baby whose parents have declined may be admitted for "monitoring" that has no clinical basis, or subjected to repeated heel pricks and attempts to place a cannula. The contradiction is worth naming, quietly and for the record: staff who insist the baby cannot clot blood are unlikely to be the ones eager to make the baby bleed for tests. Parents can decline procedures that are not medically necessary, can ask for the clinical justification for each one in writing, and can ask that refusals be documented.

Then the threats, explicit or implied, about the state. The most common is the suggestion that Child Protective Services will be contacted, or that the baby cannot be discharged without the injection. Both are pressure rather than law in the ordinary case. A hospital does not generally have the authority to hold a healthy baby because the parents declined an optional injection, and a referral to child protection made solely for declining one is not the same thing as a lawful child-protection action. These are exactly the points to have checked in advance for the family's jurisdiction, and to have the relevant page printed, because staff rely on the parents not knowing where the line actually sits.

What it sounds like, and what is underneath it

The pressure	What it sounds like	What is underneath it
Assumption of consent	"We'll just give baby the vitamin K now."	A routine framed to make refusal feel abnormal. No consent has been given.
The doctor's concern	"I'm worried about bleeding on the brain."	The recorded death rate in declining hospital births is effectively zero.
Sharpened warning	"Your baby could die. This is irresponsible."	Prediction presented as evidence; the data conversation has been abandoned.
Splitting the parents	"Do you feel differently?" (turning to the mother)	Technique for finding the softer point. Answer as one.
Manufactured pretext	"We need to admit baby for monitoring."	Monitoring without clinical basis; repeated blood draws contradict the stated concern.
State threats	"I'll have to call CPS." / "You can't be discharged."	Pressure, not law, in the ordinary case. Verify your jurisdiction in advance.

The posture that holds

The single most useful thing a parent can carry into the room is the understanding that they do not owe the encounter a debate. The staff are equipped to win debates conducted at the worst possible hour by people who have just been through labour. What they are not equipped for is a parent who has already decided, has the documents, declines without explaining, and asks only that each refusal be noted in the record.

Two habits make the difference. The first is documentation in both directions: handing over the manufacturer's own paper, and asking that every refusal and every demand be written into the chart. A request to have a refusal documented changes the behaviour of the person making the demand, because it moves the exchange onto a record. The second is unity: deciding in advance that the parents answer together, so that the turn to the softer parent meets the same wall as the first approach did.

The encounter is built on the assumption that parents arrive unprepared, exhausted, and unaware of where authority actually ends. The preparation in this appendix removes all three assumptions. What remains, once the technique is recognised for what it is, is a decision the parents have already made, stated plainly, and held.

Appendix 2 — What's Actually in the Vial

In one millilitre of the vitamin K preparation given to newborns, the substance named on the label accounts for two milligrams. Everything else in the millilitre — seventy milligrams of polyoxyl 35 castor oil, thirty-seven and a half milligrams of dextrose monohydrate, nine milligrams of benzyl alcohol, and the remaining additives — comes to more than fifty times the weight of the ingredient the injection is named for. The thing the baby is given is mostly not vitamin K. It is a carrier solution of industrial excipients, with a small amount of the named compound suspended in it.

This appendix sets out what is actually being injected, across the first injection and across the schedule that follows. The reference matters because the contents are the part of the conversation that the system works hardest to keep vague. Parents are handed a summary sheet that describes benefits and minimises risks; the inserts that list the contents are withheld as "too technical," and the staff administering the products are, as a rule, trained in the schedule rather than in what the schedule delivers.

The first injection

The label word "vitamin" does a great deal of work. It places the injection alongside orange juice and sunshine and makes refusal sound like a refusal of nutrition. The contents tell a different story.

Component (per 1 mL)	Amount	What it is
Polyoxyl 35 castor oil	70 mg	A surfactant; its own hazard documentation lists skin, eye, and respiratory irritation.
Dextrose monohydrate	37.5 mg	A sugar carrier.
Benzyl alcohol	9 mg	A preservative. The manufacturer's position is that there is no evidence of associated toxicity — a statement about absence of study, not about safety established.
Vitamin K (phytonadione)	2 mg	The named active ingredient.

The ratio is the point. The three listed excipients together come to 116.5 milligrams against 2 milligrams of the named compound — they outweigh it by more than fifty to one. Even the two flagged irritants alone, the castor oil and the benzyl alcohol, come to 79 milligrams, almost forty times the vitamin the injection is named for. The word "inactive" describes a regulatory category, not a biological one. A surfactant that irritates skin, eye, and lung does not become inert because it has been classified as a carrier, and the manufacturer's "no evidence of toxicity" for the preservative rests on the fact that the question was never properly studied rather than on any finding that it is harmless.

The formulation above is one of several in use, and the variation is worth knowing. Other preparations of the same "vitamin" injection carry a different mix — among them polysorbate 80, propylene glycol, and, in some, the aluminium adjuvant that

recurs throughout the later schedule. A parent told the injection is a simple vitamin is, depending on the product drawn up, being handed the same blood–brain-barrier surfactant and the same accumulating metal that define the vaccines to come. The first injection is not a separate category of thing. It is the schedule's chemistry, administered in the first hours of life.

The same insert that lists these contents also records that the preparation has not been evaluated for cancer-causing or mutation-causing potential, or for its effect on fertility. The product given in the first hours of life, on the grounds of preventing a rare bleeding event, has not been tested for the three things parents would most want tested.

The insert is candid about one effect in particular. It states that the synthetic preparation can cause jaundice and, in its severe form, hyperbilirubinemia. Set that admission beside a second fact: most newborns develop jaundice, with the commonly cited range running between sixty and eighty percent of healthy infants. The establishment files this near-universal jaundice under the word "idiopathic" — of unknown origin. So the manufacturer's own document names jaundice as an effect of the injection, most injected babies develop jaundice, and the cause that was administered hours earlier is set aside as a mystery. The point is not that every case traces to the injection; neonatal jaundice has more than one contributor and the figures alone cannot apportion it. The point is the relabelling. A listed effect of a product the baby was just given is reclassified as having no known cause, which is what it takes to keep the product and the outcome from ever being connected in the record.

The schedule that follows

The vitamin K injection is the entry point; the schedule is the volume. The published ingredient lists for the childhood schedule run to dozens of distinct substances. Grouped by what they are, rather than listed alphabetically as the inserts present them, the categories are these.

Category	Examples on the published lists	Why it matters
Metal adjuvants	Aluminium hydroxide, aluminium potassium sulfate, potassium aluminium sulfate	Aluminium is the load that accumulates; see below.
Preservatives and disinfectants	Thimerosal, phenol, 2-phenoxyethanol, formaldehyde, glutaraldehyde	Industrial biocides, injected rather than ingested.
Surfactants and solvents	Polysorbate 80, sorbitol, detergents	Polysorbate 80 is associated with increased permeability of the blood–brain barrier.
Animal-derived material	Bovine serum, chick embryo culture, monkey (vero) kidney cells, gelatin, egg components	Foreign biological material introduced directly into tissue.
Human-derived material	Human embryonic cell lines, albumin, "human components"	Includes fragments of foreign human cellular material.

Category	Examples on the published lists	Why it matters
Process residues	Antibiotics, ammonium sulfate, yeast protein, amino acids, buffers and salts	Carried over from manufacture; the "process-related impurities."

Three features of this list deserve separate attention.

Aluminium is a cumulative load, not a single dose. A child following the schedule receives several milligrams of aluminium by six months of age, delivered by injection directly into tissue rather than taken in through the gut, which filters and largely excretes it. The aluminium does not clear quickly. It can be recovered from injection sites months or years afterward, which means each dose adds to a burden that the previous doses have not finished processing. By the standards the regulator itself applies to aluminium in intravenous solutions, the amount delivered by the schedule sits well above the limit set for that route — and there is no point in the schedule at which the cumulative figure is presented to parents.

Several components are described as crossing into the brain. Polysorbate 80 is used in pharmacology precisely because it increases the permeability of the barrier that normally protects the brain, and formaldehyde is among the substances reported to cross it. A surfactant chosen for its ability to open that barrier, injected alongside a metal that accumulates in neural tissue, is a combination whose interaction has not been studied in the way its presence would seem to demand.

The contamination is documented, not hypothetical. Foreign genetic fragments, the simian virus SV40, and porcine circovirus have all been identified in vaccine products after those products were already in widespread use, which means the contamination was found by looking later rather than prevented by checking first. Animal-derived components carry their own residues, including material from the feed given to the animals used in production.

What the contents are not

The list above is striking for what it does not contain: any evidence that the combination is safe to inject into an infant. The inserts state that the products have not been evaluated for cancer-causing or mutation-causing potential. No study has assessed the schedule as it is actually administered — many substances, injected together, repeatedly, into a body in its period of fastest development. The Institute of Medicine acknowledged as much in 2013, noting that the safety of the overall schedule had not been systematically examined. The individual products are tested before licensure, often against other products or against aluminium-containing solutions rather than against an inert saline control, but the cumulative effect of the full schedule on a developing infant has never been the subject of a controlled trial. The body is left to process the entire load, and the load is real whatever one believes about what else the injection is supposed to accomplish.

The word "inactive" is worth a last look, because it carries more weight in the framing than it can bear in fact. It is a regulatory category that means "not the named active ingredient." It does not mean inert, and it does not mean studied and cleared. A surfactant whose own hazard sheet lists irritation, a preservative the manufacturer can only describe as having "no evidence" of toxicity because the study was never done, a metal that persists in tissue for years — these are "inactive" only in the

narrow sense that they are not the molecule on the label. In every sense that matters to the body receiving them, they are active.

This is the reference to keep on hand. When the contents are named one substance at a time, with their amounts and their own hazard documentation, the framing of the injection as a vitamin, or as a routine and obviously beneficial measure, becomes difficult to sustain. The contents are industrial and biological materials placed directly into tissue, in quantities and combinations that the manufacturers' own documents decline to vouch for.

Appendix 3 — The Legal Architecture: A Timeline

In April 2022, defending itself against a False Claims Act case, Pfizer told a federal court that its COVID-19 product was not, in the legal sense, a vaccine at all. It was a Department of Defense prototype, developed under a contracting mechanism called "other transaction authority," and on that footing the ordinary pharmaceutical rules — the requirement for valid trials, for proof of safety, for proof of efficacy — did not apply. The same product was a vaccine in the public messaging and a military prototype in the legal filing, and the gap between those two descriptions is where this appendix lives.

That gap did not open suddenly in 2022. The legal scaffolding that made the reclassification possible was assembled over more than half a century, one instrument at a time, each one unremarkable on its own and load-bearing only in combination. Katherine Watt's work is the excavation of that sequence, and what follows is her timeline laid out as a spine. A distinction runs through it that is worth stating at the outset: the statutes, the filings, and the dates are matters of record and can be checked against the documents; the reading of the sequence as a single deliberate design — a "military operation disguised as public health" — is Watt's interpretation of what the record means. The documents are firm. The intent behind them is the inference she draws, and readers can weigh the documents and the inference separately.

The sequence

Year	Instrument	What it established
1969	Chemical and biological warfare program legislation	Introduced the vocabulary of "protective," "prophylactic," and "defensive" into the law governing biological agents — the language that would later let offensive capability be described in defensive terms.
1986	National Childhood Vaccine Injury Act	Shielded manufacturers from ordinary product-liability suits and routed injury claims into a federal compensation program instead. The keystone.
1997–98	Reclassification of biological-weapons authority	Moved biological-agent authority from Department of Defense framing toward Health and Human Services, blurring the line between military and public-health control.
2001	Authorization for Use of Military Force	Created a standing condition of emergency that did not expire, supplying the permanent backdrop against which emergency powers could later be invoked.
2005	International Health Regulations	Built automatic triggers: a declared Public Health Emergency of International Concern shifts authority from national governments toward international bodies.

Year	Instrument	What it established
2003 / 2006 / 2009	SARS, MERS, H1N1	Successive activations through which the emergency machinery was exercised and refined before its full use.
2022	Pfizer's motion in the Brook Jackson case	The product reclassified in open court as a DoD prototype under "other transaction authority," with normal pharmaceutical regulation declared inapplicable.

How the pieces interlock

The 1986 Act is the keystone because it removed the mechanism by which a defective product is ordinarily corrected. In every other consumer market, the threat of liability is what disciplines a manufacturer: a product that injures its users becomes a financial liability, and the manufacturer has a direct incentive to make it safer or withdraw it. The 1986 Act severed that link for one product category. A manufacturer whose product injures a child cannot, as a rule, be sued for it; the injured family's only route is a federal program. With liability removed, the ordinary feedback that would shrink a harmful product was switched off, and the schedule was free to expand. It did: from a handful of doses for a child born in the early 1960s to dozens by adulthood, the steepest growth following directly on the liability shield.

The compensation program that replaced the courts is structured to limit, not to redress. Claims run for years, demand extensive documentation and expert testimony, and are met with government defence rather than the manufacturer's. There is no ordinary judge and no discovery as of right. The award for a death is capped by statute. Over roughly four decades the program has paid out on the order of five billion dollars — a figure that sounds large until it is set against a mandatory program administered to nearly every child in the country across that span, and against the estimate, drawn from the system's own under-reporting, that recorded injuries represent a small fraction of the actual total. Families who do prevail are often required to sign agreements that prevent them from warning others, so that each success is sealed rather than added to a public record.

The emergency instruments are what turned a domestic liability shield into something larger. The 2001 authorization supplied a state of emergency that never ended. The 2005 health regulations supplied automatic triggers that move authority upward, away from national governments, the moment an emergency is declared. The earlier activations through SARS, MERS, and H1N1 were the rehearsals. By the time of COVID, the machinery had been built, tested, and left standing, and the only remaining step was the reclassification that the Pfizer filing made explicit.

The load the shield permitted

The clearest measure of what the liability shield changed is the schedule itself. A child born in 1962 received five doses of vaccine material. By 1983 the figure had risen to twenty-four. The current schedule reaches seventy-three doses by the age of eighteen, with twenty-six of them in the first year of life. The steepest part of that climb follows the 1986 Act, which is what the removal of liability would predict: once a product category can grow without its maker bearing the cost of the injuries it produces, the ordinary brake on expansion is gone.

The expansion was never matched by a test of the expanded whole. No study has compared the full schedule to no schedule at all. The Institute of Medicine acknowledged in 2013 that the safety of the schedule as administered had not been systematically examined. The individual products are licensed one at a time; the cumulative load, delivered on a fixed timetable to a developing infant, has never been the subject of a controlled trial. The legal architecture protects this gap by routing the question into the language of ethics — a study that withheld the schedule from a control group is declared unethical — while the ethics of administering an untested cumulative load to every child goes unexamined.

The financial layer

Liability law sets the outer frame; money does the work inside it. The compliance that the architecture requires is purchased, level by level, through a chain of financial incentives that makes refusal expensive at every point. Federal funding is tied to vaccine uptake; state funding is tied to federal compliance; hospital systems are rewarded for meeting vaccination targets; and the individual physician is paid directly. Under one major insurer's arrangement, a pediatrician receives a bonus of four hundred dollars for each fully vaccinated child — but only on the condition that at least sixty-three percent of the practice's patients are fully vaccinated. For a practice of a thousand children, clearing that threshold is worth four hundred thousand dollars; falling a single percentage point below it erases the entire sum. A physician who entertains a parent's hesitation is not weighing an abstract principle. They are weighing their income against it, and the threshold is set so that a handful of declining families can tip the whole bonus into loss.

The pressure does not end at lost bonuses. A physician who declines to participate risks being dropped by insurers, having hospital privileges revoked, and drawing the attention of the licensing board. The financial architecture is built so that the path of least resistance, at every level from the federal government down to the individual practice, runs through compliance — and so that the cost of stepping off that path is borne by the person who steps off it.

The reclassification

The 2022 filing is the point where the whole structure becomes legible, because it states in legal language what the rest of the sequence had only made possible. A product can be presented to the public as a vaccine — carrying all the cultural authority of that word, recommended, mandated, administered to millions — while being defended in court as a military prototype to which the safety and efficacy requirements of a vaccine do not attach. The compensation program for COVID-era countermeasures, separate from the older Vaccine Court and even less accessible, has compensated almost no one, which is the practical expression of the same reclassification: a product positioned outside the framework that would otherwise govern it.

What the timeline shows is not a system that broke down under pressure in 2020, improvising badly in a crisis. It shows a legal architecture in which each instrument was in place before it was needed, so that when the moment came, the reclassification required no new law — only the invocation of frameworks that had been waiting, in some cases, for decades. The documents are public. The dates are fixed. Whether they amount to design or to accumulation is the question the timeline puts to the reader, and the documents are the place to start answering it.

Appendix 4 — The Terrain Reading of the Schedule

In 1913 the Nobel Prize in Physiology or Medicine went to Charles Richet for his work on anaphylaxis. What he had demonstrated was that injecting a foreign protein into an animal did not make it more resistant on later exposure. It made the animal react more violently — sometimes fatally — the second time. The body, having been sensitised by the first injection, treated the second as an emergency. This was not a fringe finding. It was honoured at the highest level the profession offers, and it sits in the record to this day.

It also points in exactly the opposite direction from the story the schedule is sold on. The schedule is presented as a way of training the body's defences: a small, controlled exposure that teaches the body to recognise a threat and stand ready for it. Richet's finding describes something else entirely — that putting foreign proteins past the body's normal barriers and directly into tissue is the way you sensitise a body, not the way you protect it. The framework that produced the 1913 Nobel and the framework that produces the modern schedule cannot both be right about what injection does. This appendix lays out the terrain reading: what the schedule is, when it is described in terms of what the body actually is and does, rather than in the military language of defence and attack.

The defence that cannot be located

The schedule's entire rationale rests on a structure called the immune system — a defence network that identifies invaders, attacks them, and remembers them for next time. The difficulty with this structure is that it cannot be pointed to. A body can be opened and the lymphatic vessels traced, the fascial network followed, the organs identified. There is no organ called the immune system, no anatomical defence force standing ready. The term names a model, assembled to explain why the same exposure leaves one person ill and another untouched, and the model is built from the military metaphor outward: defence, attack, invasion, surveillance, memory. Even the discipline's own leading figures have conceded that medicine lacks an agreed measure of what a healthy "immune system" would even look like.

What can be observed is a cleansing, communication, and repair network. The lymphatic and fascial systems move waste, carry signals, and bring repair resources to damaged tissue. The white cells that the military model casts as soldiers are, on inspection, engaged in waste management — engulfing and breaking down debris and spent material. This is housekeeping, not warfare, and it is the actual biology the metaphor was laid over.

The proteins called antibodies belong to the same model. They have never been separated from human serum and characterised directly; they are inferred from reactions in the laboratory and then spoken of as though they had been held in the hand. Their presence does not track protection in the way the model requires. Children born unable to produce them recover from illness in the ordinary way, and a mid-century British Medical Research Council report found no correlation between the count of these proteins and susceptibility to the disease they were supposed to guard against. The schedule's promise — that it raises these proteins and that raising them confers protection — rests on a mechanism whose two halves have each failed to hold.

None of this is required as a leap of faith. It is the establishment's own evidence, read without the metaphor. Once the metaphor is set aside, the question the schedule

answers — how to train a defence network — dissolves, because the network it claims to train is a model rather than a thing.

What the injection actually does

Strip the model away and what remains is concrete and physical. An injection bypasses every route by which substances normally enter the body. Food passes through the gut, which sorts and largely excretes what it cannot use. Air passes through the airways, which trap and expel irritants in mucus. Injection skips all of it, depositing the contents — the metal adjuvant, the surfactants, the preservatives, the foreign proteins detailed in Appendix 2 — directly into tissue, where the body has no comparable means of refusing entry.

Two things follow. The first is persistence. The aluminium does not clear the way an ingested dose would; it can be recovered from injection sites months and years later, which means each dose adds to a load the previous doses have not finished processing. The toxic burden accumulates across the schedule rather than resetting between visits. The second is sensitisation, which is Richet's finding applied to a human infant. Foreign proteins introduced directly into tissue prime the body to respond more strongly to later encounters with the same or similar material. The schedule introduces such proteins repeatedly, during the period of fastest development, into bodies whose capacity to process and clear is least established.

When the body then responds to this — with inflammation at the site, with the systemic disturbance that follows, with the longer-term disorders that settle in afterward — medicine reads the response through the same inverted lens it applies everywhere else. Inflammation, which is the body bringing repair resources to injured tissue, is treated as the problem rather than the repair. And when the damage shows up as the body responding against its own tissue, the response is given a name that places the blame on the body: it is called the body attacking itself. The terrain reading reverses the arrow. The sequence is exposure, then injury, then the body's response to the injury. Medicine records the response, loses the exposure that caused it, and is left with a body that appears to have turned on itself for no reason — a mystery of its own making.

The acute-to-chronic mechanism

Herbert Shelton described the engine that turns this into lasting disease. The body's acute responses — fever, discharge, eruption, the whole repertoire of expulsion — are its way of clearing a toxic load. Suppress those responses with pharmaceuticals and two things happen at once: the clearing is interrupted, and the suppressing agent adds its own toxic burden. New symptoms emerge from the unresolved load plus the new insult; those in turn are suppressed; the burden compounds. The progression that medicine describes as a disease becoming chronic is, on this reading, not an inherent trajectory of the illness but the predictable result of continuous loading and continuous suppression.

The schedule fits this mechanism exactly. It delivers a toxic load on a fixed timetable through the years of fastest growth, and the conditions it is associated with — the allergies, the eczema, the breathing troubles, the disorders of attention and development — are then managed with further pharmaceuticals, each carrying its own burden. A child enters the system in good health and is moved, step by step, from acute responses that would have resolved toward chronic conditions that require lifelong management. The well-baby schedule keeps the child in the system

long enough that no one ever establishes what that child's health looked like before the loading began.

The disease that was already gone

The remaining defence of the schedule is historical: that whatever the mechanism, the diseases retreated when vaccination arrived. The record does not support it. Across the major conditions classified as infectious, something on the order of ninety-five to ninety-eight percent of the decline in deaths had already occurred before the relevant vaccine was introduced. Measles, whooping cough, diphtheria, and scarlet fever all fell together, at similar rates, and scarlet fever — which killed more children than the others and for which no vaccine was ever deployed — fell just as far. The decline tracks clean water, sewers, better food, and the end of the worst overcrowding and child labour. It does not track the arrival of injections, which came after the work was substantially done and were credited with a victory already won.

This is the terrain reading of the history. The conditions retreated as the terrain improved — as nourishment, sanitation, and living conditions removed the deprivations that had made people susceptible in the first place. The injection arrived late to a battlefield that had already gone quiet and claimed the ground.

What this leaves on the ledger

There is a further question underneath all of this, which is whether the threats the schedule claims to address — transmissible particles passing from the sick to the well — were ever demonstrated to exist or to spread at all. That question is taken up in Appendix 5, and the answer there reframes everything in this one. If the particle was never isolated and the transmission was never shown, then the schedule is not even a misguided defence against a real danger. It is toxic loading administered against a danger that was never established.

Hold the two readings together. The mechanism the schedule claims — training a defence network — rests on a model that cannot be located in the body. The injuries it produces are real, physical, and cumulative: persistent metal, sensitisation, the slide from acute response to chronic condition. The historical victory it claims was won before it arrived. And the threat it claims to defend against has not been shown to be what it is said to be. Each of those is a separate problem, and they do not cancel one another; they accumulate, the way the load in the tissue does.

This is why the baseline that runs through this book is not a surprise but an expectation. A child whose terrain was never repeatedly assaulted — not loaded with metal and foreign protein on a schedule, not moved from acute clearing into chronic management — is simply a child whose terrain was left intact. The 2.64 percent at the heart of this book measures nothing more exotic than that: a body that was never handed the load to carry.

Appendix 5 — The Question Underneath: Virology, Contagion, and the Frame Both Sides Share

In the closing weeks of 1918, while more people were dying than in any sickness on record, the United States Public Health Service and the United States Navy set out to demonstrate how the illness passed from one person to another. The work was supervised by Milton J. Rosenau, a physician who had built his career warning the public about germs and overseeing quarantines. It ran across three sites — Deer Island and Gallops Island in Boston Harbor, and Angel Island in San Francisco. The men conducting it were not doubters. They expected to confirm what every authority of the day already took as settled.

They took healthy volunteers, sailors who had not been caught up in the outbreak, and tried everything a believer in transmission could devise. Cultured bacteria were sprayed into the men's noses and throats. Mucus drawn directly from the sick was instilled into nasal passages, and volunteers drank nasopharyngeal washings mixed with milk. The well and the sick were brought face to face so the sick could breathe and cough directly into the mouths of the healthy. Across twenty-five separate experiments involving 161 volunteers, the rate of illness came to 1.2 percent — lower than you would expect in any ordinary winter, and produced during what the record calls the deadliest outbreak in modern history. At Deer Island not one of the fifty men fell ill, and the doctors wrote down their disbelief that their most determined efforts had failed. A parallel set of experiments at Goat Island, run by McCoy and Richey on men with no prior exposure, reached the same result. The disease could not be passed on.

Rosenau published in the *Journal of the American Medical Association* in 1919. He had walked in certain he knew the cause and the route, and he walked out conceding that they were "not quite sure what we know about the disease." That admission, from the man who ran the most thorough transmission experiments ever attempted, during the worst outbreak on record, is missing from the standard histories. The 500-page *Textbook of Influenza* published in 2013 refers to transmission of the condition several hundred times without offering a single controlled study in support, and never mentions Rosenau. His own obituary left the work out.

The burial is the point. The experiments were not refuted; refutation would have required someone to run the transmission study properly and get a different answer, which has never happened. They were simply removed from view. That distinction — between evidence that has been answered and evidence that has been disappeared — runs through everything that follows.

Why this appendix exists

Every other book that questions childhood vaccination, including the careful and well-sourced ones, makes its case on safety. It documents the adjuvants, the missing trials, the injuries, the conflicts of interest, the captured regulators. The preceding appendices in this book do the same, and that work matters. But all of it concedes a premise before the argument begins: that the diseases being vaccinated against are caused by transmissible particles that move from person to person and that a correctly designed product could, in principle, defend against. Arguing that the defence is dangerous while granting that there is something real to defend against leaves the entire enterprise standing, and concedes in advance the ground on which the question is actually decided.

The forbidden comparison this book is built around — the health of the unvaccinated set beside the health of everyone else — only delivers its full meaning once a reader sees that there may have been nothing on the other side of the ledger to begin with. If the particle was never shown to exist and the disease was never shown to pass between people, then the injection is not a flawed shield against a genuine threat. It is a toxic insult administered against a phantom, and every harm it produces sits on the books with nothing credited against it.

This is an executive summary of a much larger case. The full treatment, with the primary sources laid out in detail, is in my book *No Virus*. What follows is enough to show why the question deserves to be asked, and why the answer reframes the rest of this book.

What "isolation" actually means

When virologists say a virus has been isolated, an ordinary person hears what the word means everywhere else. A chemist isolates a compound by separating it from the solution around it. An electrician isolates a circuit by cutting it off from everything connected to it. In every other field the word means the same thing: take the thing you are interested in and remove everything that is not that thing.

Virology does not do this. The procedure described in the published methods runs the other way entirely. A sample of fluid is taken from a sick person and added to a dish of cultured cells — usually monkey kidney cells — along with antibiotics, fetal bovine serum, and other additives. The nutrients feeding the cells are then reduced. The culture is watched until the cells begin to break down and die, a process given the name cytopathic effect. When the cells degrade, the breakdown is attributed to a virus in the original sample, and the virus is declared isolated.

Nothing has been separated. Everything has been combined. Thomas Cowan's analogy is exact: isolating a hammer from a toolbox means lifting the hammer out and setting it apart from the screwdriver and the nails. Virology's version is to tip the whole toolbox into a blender, add chemicals, run it, and then point at the slurry and announce that the hammer has been isolated. The starved and chemically stressed cells have ample reason to die without any particle being present. The experiment that would settle it — running the identical procedure with no patient sample added, to see whether the cells break down anyway — is the control that the foundational studies omit. When independent researchers have since run those controls, the cells have died in the same way without any sick person's sample involved at all.

The significance of separation was not invented by the critics. Luc Montagnier, who shared a Nobel Prize for work on what is said to cause AIDS, stated plainly that the purpose of purification is "to make sure you have a real virus." By that standard, the foundational work was never done. A particle has never been taken directly from the fluids of a sick person, separated from everything else, photographed in that purified state, characterised, and then shown to produce the same illness when introduced into a healthy host under controlled conditions. The whole structure rests on the cytopathic effect in a dish, read as a signature of something that was never held in the hand.

For the full account of the culture method and what it can and cannot show, see Chapters 2 and 3 of *No Virus*.

What the tests actually detect

If no particle has been separated and characterised, a question follows immediately: what are the tests detecting? The answer reaches back to the tool that defined the events of 2020.

The polymerase chain reaction is a method for amplification. It takes a tiny quantity of genetic material and copies it, doubling it again and again until there is enough to register. Kary Mullis, who won the Nobel Prize in Chemistry for inventing it, described what it does in flat terms: it makes "a whole lot of something out of something." He was equally direct about what it does not do — it does not tell you that you are sick, or that what you ended up with was ever going to hurt you. Run through enough cycles of doubling, PCR will find minute traces of genetic material in almost any sample. The number of cycles is a dial set by the operator, and turning it determines how many "positives" appear.

The diagnosis the test is built on points back at the same problem. The genetic sequences attributed to a given virus are not lifted intact from a purified particle. They are assembled by computer from short fragments found in the soup of a patient sample, stitched together against a template the software is told to expect. This is construction, not discovery. A sequence built to a specification and then used to design a test that searches for that sequence is a closed loop. It can return positives indefinitely without a whole organism ever having been shown to exist.

The clinical consequence was written into policy in plain sight. On 7 August 2020 the World Health Organization defined a confirmed case as a person with a positive laboratory result, "irrespective of clinical signs and symptoms." A healthy person with no cough and no fever could be counted as a case on the strength of an amplified fragment. The case counts that justified the global response were generated by a manufacturing tool reading constructed sequences, with sickness itself made optional.

The detail is laid out fully in Chapter 4 of *No Virus*.

Contagion, examined rather than assumed

The belief that sick people pass illness to well people is held more deeply than almost anything else in medicine, because everyone has watched it happen. One child brings something home and the household follows. An office moves through a wave of coughs. The pattern is real and the explanation feels self-evident. But the pattern is consistent with more than one cause, and when the contagion explanation has been put to a controlled test, it has not held.

Rosenau's failure in 1918 was not an isolated curiosity. It sits within a long record of human transmission experiments — for the common cold and for influenza — that set out to pass illness deliberately from the sick to the well and could not reliably do it. Daniel Roytas has assembled that record at length in *Can You Catch a Cold?*, and the consistency of the failures is what makes them difficult to wave away. A single negative experiment can be called a fluke. Decades of them, conducted by people trying to prove the opposite, are a finding.

The pattern that looks like contagion has a different explanation, and the history of medicine is full of cases where that explanation was eventually forced into the open. Scurvy killed more than two million sailors over three centuries. Men in the same place at the same time developed the same specific symptoms and died together, which looked exactly like an epidemic. The cause was a deficiency of vitamin C, and

citrus made it vanish. Beriberi struck whole populations at once in patterns that seemed infectious; Robert Koch, the architect of germ theory, personally convinced Japanese researchers it was caused by a contagious organism and sent them on years of fruitless searching. The cause was a deficiency of thiamine from diets of polished rice. Pellagra was classified as an infectious disease in the early-twentieth-century United States, complete with a researcher who declared it was spread by biting flies and another who claimed to have isolated the responsible bacterium. Joseph Goldberger demonstrated it was a deficiency of niacin, correctable by diet.

In each case, many people becoming ill together pointed not to something passing between them but to something they shared — the same depleted rations, the same stripped food, the same conditions. Shared exposure produces the appearance of transmission without any transmission taking place. When the studies that could distinguish the two were finally done, the contagion reading collapsed. The studies that would settle the question for the conditions still called infectious were, for the most part, never funded — and the experiments that were done, like Rosenau's, were buried rather than answered.

The contagion question is the subject of Chapter 5 of *No Virus*, and the deficiency cases are taken up in Chapter 6.

What this does to the vaccine argument

Set the pieces beside each other. The particle has never been separated from a sick person, purified, and shown to cause the illness in a healthy host. The tests amplify constructed sequences and return positives in people with no symptoms at all. The most rigorous attempts to pass these illnesses from the sick to the well have failed across more than a century. None of this is fringe speculation; each piece rests on the published methods, the inventors' own statements, and the experimental record.

A vaccine is sold as a way to prepare the body against a specific transmissible threat. Strip out the threat and the rationale has nothing to stand on. You cannot prepare a defence against a particle that was never demonstrated to exist, arriving by a route that was never shown to function. This is the move no safety-focused critique can make, because the safety critique needs the threat to be real in order to argue that the product is the wrong response to it.

Once the threat is removed from the equation, the injuries change character. In the safety frame, a vaccine injury is the cost side of a trade — harm accepted in exchange for protection against something worse. Remove the something worse and there is no trade. What the schedule delivers into an infant is a sequence of toxic insults — the aluminium, the polysorbate 80, the contaminants documented in the earlier appendices — administered against nothing. Every reaction the manufacturers call rare, every regression the pediatrician calls coincidence, every chronic condition that settles in afterward, sits on the ledger as pure cost. There is no benefit column once the benefit was never there to begin with.

This is why the baseline in this book is so stark, and why it is so threatening. The unvaccinated are not people who declined a genuine shield and got lucky. They are people who were not subjected to a series of poisonings justified by a danger that was never established. Their health is not the result of a gamble that paid off; it is what the body does when it is left alone, kept in good terrain, well nourished, and not injected. The 2.64 percent figure does not mark out a fortunate cohort. It is roughly what health looks like when the intervention is simply absent.

Where to go from here

This appendix has compressed into a few thousand words a case that took an entire book to make properly. If it has done its work, it has not convinced you of everything — it has made the question impossible to set back down. That question is whether the framework underneath the entire vaccine debate, accepted equally by those who defend the schedule and most of those who attack it, was ever built on demonstrated science or on a method that proves its conclusions by assuming them.

The full case is in *No Virus*. The germ-theory foundations and the history of how the framework was assembled are in Chapters 1 and 2. The isolation problem is in Chapter 3. The testing and diagnosis machinery is in Chapter 4. The contagion experiments are in Chapter 5, and the question of what actually makes people sick is in Chapter 6. The second half of that book takes the disease-by-disease cases — influenza, the childhood illnesses, measles, polio, HIV/AIDS, and COVID — and examines each on its own terms.

The evidence was never hidden. The methods are published. The inventors said what their tools could and could not do. The transmission experiments are in the journals. What was missing was the framework to read all of it as a single picture rather than a scatter of disconnected anomalies. That picture, once assembled, does not make the vaccine question smaller. It makes it the surface of something much larger.