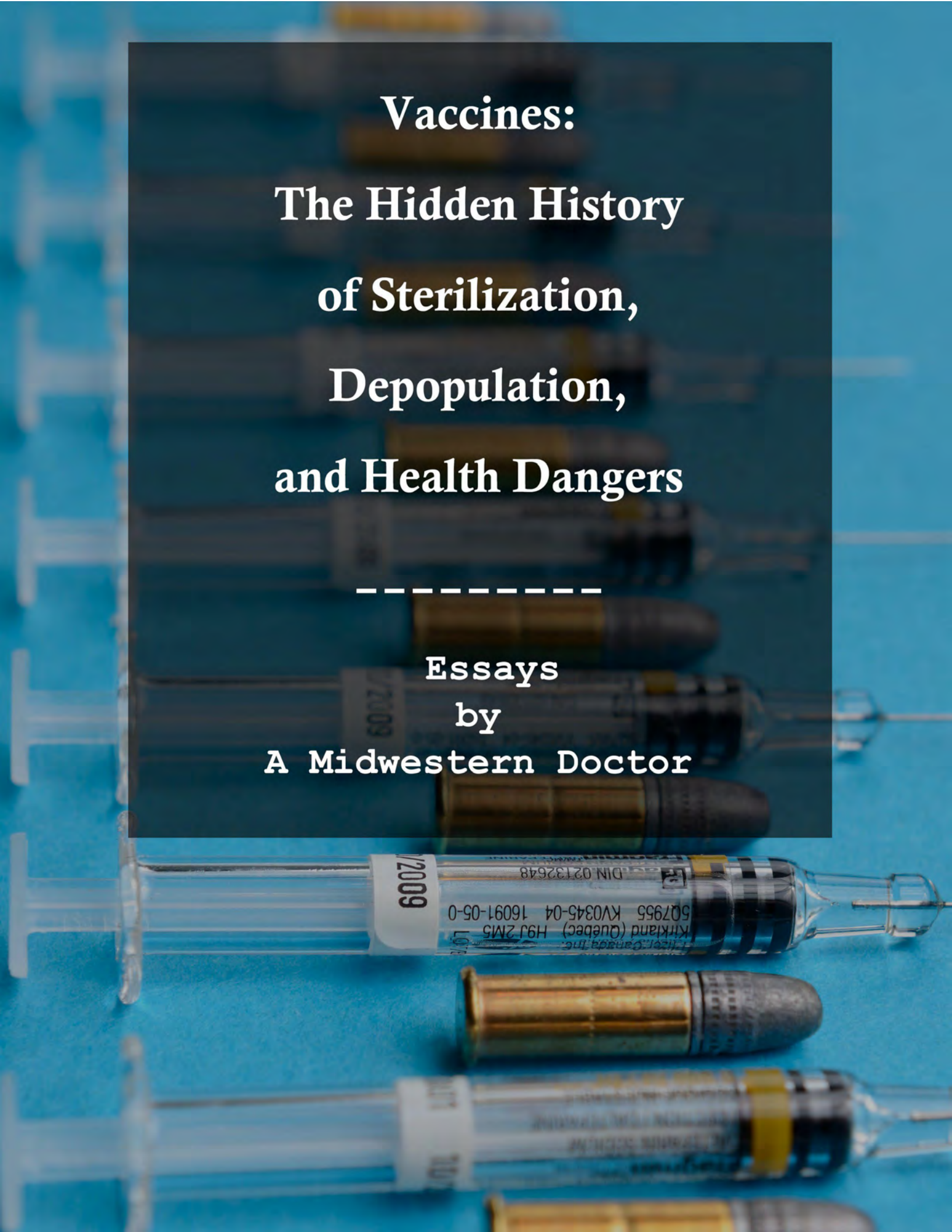

Vaccines:
The Hidden History of Sterilization, Depopulation, and Health Dangers

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Essays
by
A Midwestern Doctor

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A Midwestern Doctor

As a physician in practice with multiple jobs, I have a very full plate. The main reason I do a lot of this work to support charitable projects for the world because my value system prioritizes good karma over profit. There seems to be a critical need for the type of content I can produce on here, so as time allows, I have taken up that responsibility as well.

Because of my unique situation, I will only produce content I feel is important and worthwhile to read; if it's not I would rather spend my time somewhere else. I do not like getting spammed, and you have my word I will be quite selective in what I send to your inbox.

Having more subscribers allows the messages I am writing to reach more people. It is my hope that what I produce here has earned your trust and made you comfortable being part of that by signing up for this newsletter.

Additional reasons to sign up

I am making a sincere effort to lay out the concepts a lot of people want to know now but don't have access to. It's a bit of a challenging project,

but at the rate I'm going I'm think I can complete it in the next year or two. My hope is this means the majority of emails you receive will be insightful and non-repetitive.

Join the crew

These essays were compiled by Curious Outlier, Producer of The Universal Antidote Documentary. Curious Outlier is a Jesus follower, dad, and registered nurse with 25 years of critical care experience. He chooses to remain anonymous, but you can reach him at theuniversalantidote@protonmail.com. The Curious Outlier loves educating and inspiring other humans to find their full potential for life, health, and spiritual well-being.

Note: This life is short and there is a greater purpose to life. The purpose of life is to know and experience God. This is what all humans were made for. God loves us and has a plan that we all should know Him and experience Him fully. To learn how you can know and experience God please visit:

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The History of Population Control is Important for Understanding COVID-19

There is a past precedent of using experimental vaccinations for sterilization

Reducing global population has been a consistent goal of the ruling class for centuries. While **many** support the abstract idea of population control, **no one** wants to volunteer to be the ones who are culled. The business of population control has hence been a very messy subject.

When the COVID vaccine program began, I—and likely many others—suspected the COVID vaccines would have an "unexpected" side effect of reducing fertility. Early in their development, Mike Yeadon (and others) at great personal risk publicly warned regulators of a clear

fertility danger inherent to the vaccine (found in section IX of their petition).

Subsequent regulatory document leaks from the European FDA revealed Pfizer exempted themselves from testing the key areas of concern (infertility, autoimmunity and cancer) in animals. This highly unusual moved further suggested serious problems existed in these three areas (as you can't find something if you don't test for it).

Despite repeated denials, signs of each of these key complications from the vaccine have now emerged. While I do not have every piece of the puzzle—there are likely many "population control initiatives" I've never heard of—I know enough to paint a clear picture of this dirty business.

The first half of this two-part article will lay out the historical precedent of using any means necessary to reduce the population, while the second part will examine how this has been attempted with vaccinations.

Beliefs of Population Control

As best as I can tell, there are three overlapping schools of thought that have created the zealous belief in a need for population control.

1. Many governments, especially those in the East, have adopted the viewpoint that periodic wars are necessary for the stability of the society. This viewpoint primarily arises from social instability caused by too many young adult males in the state coupled with the issues that occur when there is insufficient food available to the population. In turn, many wars have been fought specifically for this reason. (I am most familiar with this being a common theme in China, as they have observed over the centuries the one thing that will create rebellions are famines.)

Following World War 2, the Western ruling elite came to a consensus that the war approach was no longer tenable due to the extreme collateral infrastructure and environmental damage modern weaponry (ie. nukes) created. There are only two exceptions to this rule: wars in third-world countries lacking

modern weaponry, where collateral damage was inconsequential to first-world countries

Talks that occurred within the Chinese military leadership, but have so far not materialized, over starting a war with India so both countries could mutually alleviate their challenging population burden. For context, China has attempted population control with their “one-child” policy, but it has been met with mixed success and widespread social resistance.

The alternative to war is a multipronged attack that seeks every possible avenue to reduce fertility and accelerate aging, which many argue is the more humane option of the two. One of the curious facts I have observed over the decades is how frequently an odd policy or environmental agent always seems to converge on the common pathway of reducing population. Once or twice, you can write it up as a coincidence, but at a certain point, you have to wonder if it is all intentional.

When I studied the early history of infectious diseases (discussed in my previous articles ~~on~~ smallpox), one of the most striking things to me was the absolute squalor the serfs were

forced into as the feudal lords kicked them off the land to live in the early cities. It was much worse than most people of this modern era can even conceive of.

When I first learned of this, I guessed this must have been viewed as a necessary trade off by the European rulership to support the Industrial Revolution, which was vital for national development. After I learned about the Malthusian philosophy, I realized the abhorrent living situations was likely the goal in of itself.

In 1798, Rev. Thomas R Malthus published the influential work *An Essay on the Principle of Population,* which argued that human populations tend to increase at a geometrical (exponential) rate, but the means of subsistence (food) grows at only an arithmetic (linear) rate. "*The power of population is indefinitely greater than the power of the earth to produce subsistence for man,*" according to Malthus, who therefore believed the standard of living of the masses could not be improved without the checks of war, famine, or disease. In their

absence, population would increase by a geometric rate and lead to a catastrophic "*Malthusian*" food supply collapse.

While there are numerous errors in his theory, Malthus was appointed to multiple important positions, and his ideas appear to have gradually become a prevailing conviction among members of the ruling classes in the 19th century. These ideas also influenced other key figures, such as Charles Darwin as he created his theory of evolution and natural selection.

Numerous groups were founded over the decades, which emphasized birth control and increasing mortality of the poor. These groups included Dr. George Drysdale's Elements of Social Science in 1854, **the Malthusian League** in 1877, and Margret Sanger's National Birth Control League in 1915, which became the Planned Parenthood Federation of America in 1942. Initially these groups were domestic, but gradually they became global where they tied international aid and development to population control measures.

The Malthusian and Darwinian ideals gradually gave birth to Social Darwinism and Eugenics, which were widely adopted by

the ruling elite. Social Darwinism argued that class divisions were the will of nature and that this form of natural selection, rather than being evil, was necessary. The most extreme version of this ideology, eugenics, appears to have arisen from two key factors:

The tribal nature of human beings and the tendency to view all other tribes as inferior (the ruling class felt this way towards the poor).

The advances of society were making it possible for many of the weaker members of society, who previously would have died off, to survive long enough to reproduce and, over time, significantly weaken the gene pool. Eugenics in turn advocated preventing those who were less “fit” from breeding. This has been responsible for horror upon horror since its inception, and it provided the theoretical foundation for why, among other things, the Nazis forcibly sterilized the mentally ill. In many cases, programs with more immediate results were also implemented. While most are aware of the millions executed by Hitler, other dictators such as Pol-Pot, Joseph Stalin, and Mao Zedong

arguably did even worse. A lead researcher in this field coined the term “democide” and estimates these governments executed approximately 150 million people in the previous century. When the Nazis eventually were tried at Nuremberg for their crimes against humanity, few know that that many cited the fact similar actions were first conducted by the “Great United States” in their defense.

For example, consider one of the more problematic Supreme Court rulings, Jacobson vs. Massachusetts. It held that Jacobson, who having previously suffered a severe adverse reaction from a smallpox vaccine which led him to contest Massachusetts’ smallpox booster mandate, did not have the right to refuse forced vaccination.

Following this ruling, Virginia passed a law authorizing the involuntary sterilization of people the deemed to be "feeble-minded," or mentally ill. Citing Jacobson vs. Massachusetts, a Supreme Court Justice wrote: "The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes." By 1930, dozens of states were forcing

women to undergo involuntary sterilization, and more than 60,000 American women were sterilized by the government against their will.

While books could be written on the horrors of eugenics, the key point to remember is that the discipline never disappeared and has enjoyed sustained support from the upper class. Did you know that the creators of the dangerous AstraZeneca COVID vaccine—which has been promoted as the vaccine of choice for the third world—have extensive ties to major eugenics organizations? **I wish I was making this up.**

One of the major shifts that has appeared within these movements has been who they target. Until recently, they seemed to be racist against specific sets of people, primarily those of color. Planned Parenthood's founder, for example, wanted to reduce the black birth rate, but many were far worse. Eugenics was also conducted by whites against other whites, however it typically was due to class differences or perceived genetic quality rather than race (the only exception I can think of was the British Empire towards the Irish). This all seems to have

shifted recently to where the healthy and affluent white members of society are now being targeted too. As this is a new change, much of the western population has been caught off guard, and there has been a much higher COVID vaccination uptake in whites than other races who remember being targeted by their government.

Governmental Planning for Population Control

Numerous documents and conferences (a few of which will be discussed) suggest population control has also been a priority for both national governments and international governments. The infamous 1966 Iron Mountain Report is the most well-known example, and while it echoes many of the themes laid out in this article, there are serious questions regarding its authenticity.

As such, I do not feel it is appropriate to discuss in detail, but I will note that it contained the argument that the need for war could be replaced by having the population gradually only become able to reproduce through artificial fertilization. This is a theme echoed in many other places, such as Aldous Huxley's novel *Brave New World*.

While it is difficult to estimate precisely, the use of in- vitro fertilization (IVF) has steadily increased and is expected to continue to do so: the CDC estimates its use has "more than doubled" in the last decade. I have also heard numerous reports that since the vaccines have launched, COVID has

significantly increased the need for and difficulty of IVF (that being said, at this time I could not locate data directly supporting this contention). For those interested in medicine's monopolization of the pregnancy process and the tragic harm it creates, *The Business of Being Born* (which can be viewed online) and Robert S. Mendelsohn's writings on the subject are two of the best resources I've found on the subject.

National Security Study Memorandum 200 is the most well-known authentic government document advancing a systematic population control agenda. Written in 1974 by Kissinger during Nixon's presidency (and unclassified decades later), it identified third world population growth as a critical national security issue for the United States and outlined a variety of steps to combat it.

Population control has also been discussed within the public media. The 9/4/94 Associated Press article *"Compromise near on Population Control Plan"* stated:

"On the eve of the opening of the United Nations Population Conference in Cairo, a U. S. official said that a compromise on the sensitive issues of abortion and birth control was "very

close."…During three preparatory conferences, delegates from 170 countries agreed on more than 90% of the plan for controlling population."

The confidential *Cobden Club Memo Mandate for Reduction of Existing World Population* is a now accessible document allegedly presented to a group of international representatives shortly before the 1992 United Nations Conference on Environment and Development, which focused on managing the consequences of overpopulation. This memo referenced many other projects for population reduction, stressed the urgency of globally implementing population reduction, and advocated having each member of the UN security council (the primary military powers) force the rest of the world into submission to this agenda. While the actual summit occurred (this is where Agenda 21 was formulated), like the Report from Iron Mountain and many other documents in this genre, I am ultimately unsure if this document is authentic, which is part of what makes researching these subjects so challenging.

Mechanisms of Population Control

As best as I can tell, population control measures typically follow one of three approaches:

Create social changes that discourage having children.

Introduce an environmental factor that decreases male testosterone and sperm viability.

Directly sterilize (or give birth control to) women of childbearing age.

Social Approaches:

The first approach is a politically touchy subject. I will cite a few quick examples:

•Second Wave Feminism transitioned a significant

portion of the population from raising families at home to a sterile existence working outside the home. Second Wave Feminism was essential for our country and corrected many serious injustices towards women, but there is also some evidence to suggest the movement was hijacked to help the

upper class by removing women from a motherly role and doubling the workforce. For example a pioneer of this movement, Gloria Steinem who strongly discouraged being a housewife, was also a CIA operative.

•The societal messages around dating have been shifted from romantic bonding (which produces children) to a hookup culture without intimacy.

•Women are strongly encouraged to pursue a career before having children or a family, which frequently results in them missing the opportunity to do so.

•Previously rare sexual pairings that either cannot or are unlikely to produce children are actively encouraged by the media and corporatocracy.

•Alternatives to relationships, such as computer or video addictions, are strongly encouraged in society.

•Economically, it has become more and more difficult for individuals to afford to have children.

•Having children is labeled as environmentally destructive and hence strongly discouraged.

•Having children is now characterized as a major obstacle to spiritual growth and self-development.

•The widespread support and social validation for having children has gradually diminished.

I have personally observed as the years have gone by, fewer and fewer people are interested in having children, and some combination of the above reasons are typically cited. I also find people who have children have a much deeper sense of happiness than those who do not, despite media messages suggesting the opposite.

The idea of population control or mass extinction for the greater good has also been increasingly observed within the media. *Avengers Endgame* was the top grossing film of 2019, and it was so heavily promoted throughout the media that it accomplished the unique feat of almost doubling the revenue of the runner-up. I have often wondered whether this was deliberate on account of the message the movie spread in the

months immediately preceding COVID-19 of the need to be evil and eliminate half the population for the “greater good”.

There are also many factors that directly affect fertility. Each of these appears to have followed a gradual progression like the myth of a “boiling frog” where the onset has been too slow for most of the victims to recognize.

Male Approaches:

At this time, male health is significantly less studied than female health (for example, many recent graduates I have spoken to felt “transexual medicine” may have had a greater focus in their curriculum than “male health” in their medical school

curriculum). As a result, much of this section, such as the importance of testosterone, is still relatively unknown.

Despite this knowledge gap, it is almost universally agreed within the scientific literature that there has been a massive, sustained decline in male testosterone levels over the decades (a male's testosterone levels goes hand in hand with his health and fertility). This decline directly affects male (and to a lesser extent female) health, and numerous integrative physicians have found rectifying it creates profound benefits in a large percentage of their patients. The decline of sperm quality and viability has also been observed, but as it is more difficult to objectively quantify, not as much as data exists to clearly support this trend.

A common means of controlling animal populations is to universally introduce an agent which decreases male fertility (as these tend to be easier to distribute on a large-scale basis than agents which target female reproduction). In addition, a common method of controlling animal behavior is to neuter males, as this reduces their aggression and "disobedience to

authority." (For example, a recent lawsuit was filed by a 16-year-old boy who developed breasts after he was forced to take estrogen in jail to "control his behavior.") It is hence understandable why those in the ruling class would be open to using similar approaches on the "useless eaters" of the population (many terms for this concept exist, including those originating from the Nazis' eugenics program).

Many of the factors causing this decline appear to have been deliberately placed in the environment. The most influential are xenoestrogens, artificial chemicals that mimic the characteristics of estrogen and feminize organisms. Alex Jones's infamous commentary on chemicals that "turn the friggin' frogs gay," for example, was a reference to atrazine, a still widely used herbicide, that for over 20 years has been known to create hermaphroditic frogs. For those interested, the eight-hour audiobook, *Estrogeneration: How Estrogenics Are Making You Fat, Sick, and Infertile* provides an excellent summary of the topic.

Some of the most common xenoestrogens in addition to atrazine (and some other herbicides) include:

•Birth control pills, which are designed to not break down and thus cycle back into the water supply (this is a common problem in areas that reuse waste water, particularly China, where oral contraceptives are widely used).

•Soy (excluding the rare exception where it is fermented

like in Miso or Natto), is a food that comprises a significant portion of the food supply. While much less common (but sometimes still) an issue, a similar effect results from lavender products.

•Bisphenol A and S found in many plastics, which constantly contact our bodies and food.

•Phalates (also found in many plastics, I particularly care about this when sourcing IV supplies)

•Parabens (these are uses for fragrances in many cosmetic products).

•DDT and PCBs are highly dangerous mutagenic chemicals. Despite their known toxicity (Monsanto, the initial PCB producer, saw within three years 23 of their 24 researchers develop disfigured faces) it took decades, and in some cases almost a century of activism, to remove them from the market. Massive amounts of these chemicals were produced, and they persist in the environment, accumulate up the food chain (especially via fish), and still affect people today. In addition to being destructive to both humans and wildlife, a good case can be made these chemicals created many of the changes we are still seeing today (such as the decline of male sperm counts).

While it is appreciated that increasing estrogen levels will directly feminize males, it is less appreciated that there are estrogen receptors in the brain that reduce testosterone levels when stimulated. Clomifene, a drug designed for inducing ovulation (either for patients who cannot ovulate, or to collect eggs for IVF) blocks this anti-testosterone receptor. Direct testosterone administration can be used for male health, however, many physicians also find significant benefit from

using clomifene, as it alone can raise testosterone, and in many cases treat male infertility. This (and many pieces of

evidence) suggest xenoestrogens play a key role in the male decline of testosterone.

One of the largest influences on testicular function is microwave radiation (emitted by cell phones and Wi-Fi enabled devices). Brain matter, the heart, and the testicles are the most susceptible tissues in the body to this microwave radiation (for those curious, there is actually a lot of research proving this). Microwave field strength (per the inverse square law) exponentially decreases from its source, and a frequently successful approach for treating male infertility is to avoid carrying a phone in the pocket or using a laptop near the lap. While I am not familiar with the effects of this radiation on the ovaries, it has been shown that microwave field strength increases within the uterus rather than decreases as would be expected (the uterus is a fascinating organ) and that some degree of correlation between birth defects and prenatal EMF exposure exists.

Many other factors also influence testosterone levels and fertility. Two of the more interesting examples are metformin, a very commonly used medication for diabetes that has the curious side effect of reducing testosterone (which can be debilitating for older men who are already deficient in testosterone), and the widely used sugar replacement stevia, which has been repeatedly studied for its testosterone reducing and contraceptive properties. This all goes in a full circle as these many of these substances also interfere with metabolism thereby creating obesity, and fat cells via aromatase further perpetuate the cycle by turning testosterone to estrogen.

To tie this all together, Niels E. Skakkebæk, MD PhD, an expert in testicular cancer, has shown through Denmark's national cancer registry (maintained since 1943) that the rate of testicular cancer more than tripled from 1943 to 1993 and continues to grow since that time. At the same time, he also found sperm density fell from 113 million per milliliter in 1940 to 66 million per milliliter in 1990 and that the volume of sperm has dropped an average of 19%. I suspect part of this correlation results from the increasing rates of undescended testicles in

males, a condition that causes both male infertility and testicular cancer. In the 1950s per English research, an undescended testicle occurred in 1.6% of births, but now occurs in 3-5% of full terms births and 30% of premature births. This chronology (continual mismanagement of an eventually cancerous undescended testicle) amongst other things was responsible for the death of an anonymous blog writer I followed for years and learned a great deal from.

Female Approaches:

While male sterilization methods tend to be uniformly administered throughout the environment, due to mammalian biology, female sterilization typically requires more targeted approaches. The only exception I know of to this rule occurred in India in the 1970s, where their prime minister in return for international loans declared martial law and with military force mandated vasectomies, gruesomely sterilizing six million men before being forced to abandon this initiative due to violent male counter-protest (hence why only women are directly targeted for sterilization).

Sterilization through vaccination has long been viewed as the holy grail of population control, as global faith in vaccination allows the covert mass administration of sterilizing substances, and unlike many other methods, in theory it only needs to be done once. As such, a lot of research has been done in this area, but at least until recently, the technology for it was lacking. To fully understand the context of that approach, we will first review what has been done with the forced administration of traditional contraceptive and sterilizing technologies.

While the Nazis, who forcefully sterilized or executed millions they deemed unfit to breed, are history's most notorious offenders, many sterilization campaigns have been forcibly conducted by governments around the world against poor women of color. One of the best- known examples occurred in the United States from the 1960s to the 1970s. There, the Indian Health Services, through force and deceit, sterilized between 25% to 40% of the female native American population via tubal ligations and hysterectomies, resulting in a halving of their birth rate.

Other examples include:

•40,000 women that were sterilized in Colombia between 1963-65 by Rockefeller-funded programs.

•A million women were sterilized in Brazil between 1965-1971.

•A U.S.-imposed population control program

administered by the Peace Corps in Bolivia sterilized Quechua Indian women without their knowledge or consent.

Population control is less straightforward once direct sterilization is no longer utilized, so it is important to understand the parameters of the existing technologies. On that note, one of the aspects of modern life I have always found to be particularly unfair is the lack of good birth control options. Every single option has serious associated health issues or creates barriers to intimacy.

The only ones that don't (I know many people who use behavioral or spiritual practices such as the rhythm method and semen retention) inevitably fail.

As far as I can tell, the best birth control option is a well-designed diaphragm. Unfortunately, research on this approach was shelved once it was realized birth control pills represented a much more profitable market. While not ideal, my present belief is IUDs that can be tolerated are the best available option. Unfortunately, many women do not tolerate these either (for example, one of my classmates nearly failed out of her first year of medical school due to a bad reaction to a copper IUD).

Sadly, while there are serious health issues associated with the present forms of birth control, the current approaches (with the exception of the recently discontinued Essure) are much safer than many of the earlier experimental forms of birth control (the horror of the Dalkon Shields being an excellent example). Much of this is unknown, because as discussed in the previous article about the military's horrific forced experimentation with the Anthrax vaccine (which laid the groundwork for Operation Warp Speed), medical research is often conducted on vulnerable populations that typically remain out of sight and out of mind.

From a population management perspective, a long- lasting injectable birth control option is the only feasible option. After all, there's no guarantee people will take expensive pills indefinitely, it's unlikely you can regularly re-inject a population, and anything besides an injection is too time consuming to apply to large numbers of people.

One of the best candidates for that approach is the injectable Depo-Provera, one of the more harmful birth control options that has seriously affected the health of many women I know. Depo-Provera, as you would guess, is regularly used by international organizations in third- world countries. Going as far back as almost 50 years ago, in 1979, USAID through the International Planned Parenthood Federation supplied Depo-Provera to 378, 000 women in Mexico, Sri Lanka. and Bangladesh in experimental research projects. Widespread administration of Depo-Provera by these organizations continues to this day (with the additional involvement of more modern organizations such as the Gates Foundation who continue the tradition relentlessly distributing it to vulnerable women).

A push was made to distribute Depo-Provera far and wide, as you might expect, this was often done in an unethical manner where the recipients often had little knowledge of what was being done to them. We will briefly review a few of those examples.

In societies where whites controlled a non-white population, Depo-Provera was often questionably administered to the undesirable demographic. In South Africa, during apartheid, as the whites became increasingly concerned about the accelerating black birth rate, Depo-Provera was forcibly administered to black women at government-funded family planning agencies.

To quote Dr. Nthato Motlana, who was at the time one of the country's leading Black physicians: "*there is no such thing as 'informed consent' here. The agencies are*

administering Depo-Provera shots to young black girls without even asking their consent." This practice also existed in Zimbabwe, where under white rule Depo-Provera was the most widely used contraceptive among black women until Robert

Mugabe, a black man, became prime minister and cancelled the program. Canada, another country that sterilized their indigenous population, also made frequent use of Depo-Provera on this demographic. Lastly, in Western Australia, Depo-Provera was also widely administered by government health services to Aboriginal women. This is a critical context to the cries for help this community has made against the Australian government's forced COVID vaccination programs.

When desperate situations arise, these too are frequently taken advantage of by international organizations to implement population control campaigns. Receiving Depo-Provera or a sterilization procedure is often made a requirement for receiving international aid. In Bangladesh, an area where individuals frequently starved to death, this was the condition for receiving food. In Thai refugee camps for Cambodians fleeing the collapse of the Khmer Rouge, refugees were often required to receive Depo-Provera to access necessities for survival, and in some cases simply forced to receive it, while male refugees were paid to recruit as many refugees as possible for injection.

When you look back at the above events, there are a variety of different “narratives” that could be used to describe them. Because of how many Depo-Provera shots had been stockpiled for and the money behind the project, for many of those involved in the process, the focus was simply on how to distribute as many as possible. So, whenever an opportunity to increase Depo- Provera uptake arose, it was taken advantage of it, and the ethical questions of using individuals’ desperate circumstances or taking away their right to consent was not even considered.

In other cases, such as that in Bangladesh, it could have easily been reasoned that “if there are too many people here and everyone is starving to death, it is not appropriate to feed someone unless they are also kept from having kids.” Finally, there are the cases, where selected races were deliberately sterilized to protect the interests of the ruling class and it is hard to argue their intentions were anything besides selfish and evil.

Each of these narratives is important to consider as we look at the immoral way the COVID-19 vaccines have been distributed and mandated. These ideas are recurring themes throughout history, and they have all repeatedly shown themselves during the current vaccination campaign.

Conclusion

Contrary to popular believe, most of the existing food shortages are a product of people wanting to profit from the unequal allocation of resources rather than a lack of available food. Many, I included, believe if we can live in harmony with our environment, the Earth has the ability to support at least 40 billion people. Similarly, if we have a more cooperative existence where we evolve the community around us, the motivation to have large numbers of children (the principal driver of population growth) will likely disappear. This is all very doable and does not require extreme sacrifices in the quality of life for each human being. However, the nature of that model would create a cooperative self-sufficient social model where the oligarchy no longer has control over everything. This way of

living is unacceptable to those in power, so the focus has always been on maintaining their power and keeping the population at a level that supports the existing hierarchy, something progressively more difficult to accomplish as our standards of living increase.

In our current era, the labor value of individual human beings has been significantly decreased by modern technology (particularly in the recent times with AI and Robotics). From many publications I've read, it appears that the Oligarchy now holds the perspective that the productive value our current population level offers has become outweighed by the costs of having that many people. The second part of this article will be released soon and discusses the various ways vaccinations have been used to affect fertility. In the meantime, I request you consider how the oligarchy might approach their current population dilemma.

Additionally, if you wish to know more on the subject for forced sterilization campaigns by the WHO, I would highly recommend

reading Chapter 10 of *The Real Anthony Fauci*. It also researched this topic, but goes into much greater detail in many areas and provides supporting references.

The Complete History of Depopulation Vaccines

They are much more common than you would think

In part 1 of this article, I attempted to make the case that there has been a longstanding interest within the ruling class of our society to reduce the population by targeting individuals deemed undesirable. In the past, these programs typically targeted the poor, people of color, colonial subjects and those with genetic defects that were considered dangerous to the country's gene pool. For those of you interested in learning more about this topic and how common it is even in the present day, I would highly recommend reading the first part of this article and Chapter 10 of the book *The Real Anthony Fauci* by Robert F. Kennedy Jr.

In recent times, the targeted demographic appears to have been expanded to include most of the Western population. Because of this, groups (that you, dear reader, likely belong to) that were not typically targeted for population reduction in the past now are. We are all the prey now.

As there is no good way to go about population control, a lot of very messy approaches have been tried. In the last article I attempted to highlight some of the horrific examples from the past, in order to show there is a clear case precedent for this being implemented on a large scale.

Given that vaccines are unconditionally trusted by most people and are very easy to administer, if a vaccination could produce sterilization or at least reduce fertility from a single injection, it would provide a technological solution to a dilemma the ruling class has faced for over a century. The only possible superior alternative I can think of would be a highly contagious respiratory virus (or "self-spreading vaccine") that impaired future fertility without otherwise causing too much damage (and to some extent has been observed in men after COVID-19).

As a result, methods of making fertility-impairing vaccines have been repeatedly researched. Each of the candidate vaccines I was able to identify worked in a similar manner: they carried an antigen that was similar to a protein necessary for fertilization or pregnancy, and thus created an autoimmune response that impaired fertility. There are basically two ways this can be done.

The first is to produce the needed antigen and mix it with an immunostimulatory adjuvant. The second is to genetically engineer an infectious organism that has the antigen within it, and as with rheumatic fever, the damage to fertility will occur because the immune system is programmed to fight this pathogen.

In the previous article on the military's anthrax vaccination program, I discussed a class of bioweapons originally developed by Russia that spliced necessary human tissue onto infectious organisms to create a time-delayed autoimmune bioweapon. One of the curious aspects of the SARS-CoV-2 spike protein is that it has a high number of similarities with normal human tissue, which I suspect may have been deliberately engineered in the virus to cause severe autoimmunity.

A friend who worked in this field was at the site of the original SARS outbreak in Canada and told me they were relatively certain the original SARS outbreak was an accidental lab leak. As that virus is very easy to modify and is an excellent delivery platform, they said it has been a favorite subject for everyone in the field to mess around with engineering. From the start of this pandemic, they were also positive SARS-CoV-2 was artificial (which was

painfully obvious from the gene sequence), but like many others they did not publish their views for fear of retaliation. Due to the long history of population control measures and the ruling class's increasing need to develop an effective tool for it, I suspected the COVID vaccines would eventually be found to reduce fertility. After all, this was a once in a lifetime opportunity I could not see the eugenicists would let themselves miss.

Early on Dr. Mike Yeadon recognized an overlap in the spike protein with a protein necessary for maintaining a pregnancy (Syncytin-1) created a clear risk for fertility. At great personal risk, he filed a formal petition to the regulators to protect women of childbearing age in the initial vaccine trials. His concerns were not addressed and subsequent regulatory document leaks from the European FDA revealed Pfizer exempted themselves from testing the fertility risk, something that is typically always required.

Once the vaccine emerged on the market, it was discovered that one of the most common effects was severe disturbances and alterations to women's menstrual cycles. This side effect was

initially denied by every medical authority (it does not occur with other vaccines), but eventually acknowledged and rationalized as being an insignificant manifestation of inflammation (so once again “that means the vaccine is working”).

I initially wondered if these changes were due to varying degrees of clotting in the body (in Chinese medicine, blood stasis is the main cause of menstrual abnormalities, and many vaccinated patients reported massive clots during their menstrual cycle none of us had seen prior to these vaccines). Later, when a Japanese FOIA request was approved, biodistribution studies of the lipid nanoparticle (containing the vaccine mRNA) became available for review and showed they concentrated in the ovaries. This is very unusual and raises the possibility that the lipid nanoparticle may have been designed for this purpose.

Since the ovaries regulate the menstrual cycle, this suggested that menstrual changes were a result of the vaccine creating some type of disturbance in the ovaries, which was a much more plausible explanation than simply saying “oh, it must be coming from general inflammation.” This also made me worry that some type of permanent change was being created in the eggs with an

ensuing effect that would take decades to show up (many potential health issues come to mind). The only related precedent I can even think of for this was DES, a now banned estrogen analog that was widely prescribed to pregnant mothers (ironically to prevent complications in pregnancy). DES had many side effects including alteration of genitalia and an increased risk for cancer decades later in the fetus's life.

While I have some experience working in drug development and with regulators, Dr. Yeadon has significantly more experience than me, and with his permission I will quote him:

> *"I was just reflecting on my first encounters with the fundamental design points of the leading c19 "vaccines". I focused on mRNA because I believed that to be the most dangerous option. The industry had spent years trying to make this a viable mode of treatment and had not overcome several serious barriers. One was that mRNA wasn't stable & would get broken down quickly. Another was that it was nearly impossible to get cells to take up the mRNA without violent processes involving electrical fields or toxic chemicals. Why would that be? Consider that the integrity of your genetic complement is the most important thing to pass to your progeny. No wonder your cells*

have multiple defense mechanisms to prevent alien genetic codes invading them.

So the mRNA "vaccine" companies chemically altered the ribose nucleic acid bases so these aren't even natural bases. They also wrapped up the mRNA in special lipids to help fool your immune system & allow an alien install.

All that looks risky & nowhere near long enough was given to look for unwanted effects. Even though they planned to inject BILLIONS who didn't even need it, and even that only if they worked (which they don'tso they've lied about efficacy, as real-world numbers are nothing like the trial claims).

But recently, I've realized they've all made appalling errors and they all made the same errors. That's not possible to happen if they were completing honestly.

They picked the most dangerous part of the virus to express, the spike protein. We now know that most of the serious complications arise from the toxicity of spike. Why did all four choose this piece? This is 13% of the gene sequences, so there were plenty of other options.

They've picked the genetically most unstable part of the virus. That's just stupid, and had they not done so, they couldn't have played the "new variant claim". Was that why they picked it?

They've picked the least dissimilar part from numerous other human proteins. That maximizes the risk of auto immune reactions.

The more you look at it, the more it looks like collusion to injure people.

By the way, there have now been really comprehensive studies of how human immune systems deal with infections like this. Only 10% of immune responses in your extensive "immune repertoire" is directed to spike protein. All the rest go to other parts of the pathogen. Coincidence? I don't think so.

My initial hypothesis during the COVID rollout was that the mRNA vaccines would be pushed through and everything else would be thrown under the bus (which is largely what happened) due to the trillions of dollars to be made from opening up the mRNA market. Since the mRNA products were too unsafe to give to humans outside of the unprecedented "emergency" situation created through unnecessary lockdowns, commercial interests dictated that this window would be used to the maximum extent

possible.

I also had two alternative hypothesizes. The first was that mRNA vaccines were going to be used as some type of Malthusian tool

to reduce the population. The second was that the Chinese military had designed the Sars-CoV-2 so that the most likely vaccine candidate, a vector that mass produced spike proteins, would be the actual weapon and would end up being deployed in enemy territory and allow the country to self-destruct from within. It should be noted that while China also developed these vaccines, they were never deployed and traditional vaccination platforms were used for its citizenry instead.

At this time, I feel each hypothesis is still quite likely to be true, and the purpose of this article series is to introduce the evidence for the Malthusian interpretation Dr. Yeadon hints at in his commentary. Lastly, while I believe it is likely the virus was deliberately engineered to create significant autoimmunity (a key characteristic of both COVID-19 infections and vaccine injuries), it is much harder to know if it was specifically engineered to reduce the fertility of those infected or was an early prototype for a virus that will be able to do this.

We will now review each of the vaccinations I have identified that appear to have contributed to reduced fertility. Each has most of the following characteristics:

•A tendency to produce autoimmunity to a protein necessary for pregnancy

•An unusual dosing schedule

•Distributed to all women of childbearing age

•Coercive and forceful measures are implemented that ensure a high rate of vaccination uptake.

Sound familiar?

We will now review the following vaccinations:

•Whole Cell Pertussis Vaccines

•hCG Vaccines

•The HPV Vaccine

•The Anthrax Vaccine

•The Porcine zona pellucida contraceptive vaccine

Whole Cell Pertussis Vaccines

The Tetanus-Diptheria-Pertussis vaccine has a very questionable past. Due a petty squabble between England and Ireland that originally arose over an English King wanting a divorce, the English treated the Irish terribly. Irish orphanages not surprisingly ended providing the preferred vulnerable subjects to test dangerous vaccinations on.

In 2014, unmarked mass graves belonging to Irish orphans were discovered. Further research revealed these graves belonged to a group of 2,051 children on which an early and dangerous diphtheria vaccine was covertly tested on in the 1930s. This unethical human experimentation on Irish children (including infants and handicapped children) continued at least through the 1960s and 1970s at Irish care homes, where a separate investigation found early Tetanus, Diptheria and Pertussis vaccinations were covertly tested on these children.

The whole cell pertussis vaccine (given in combination with tetanus and diptheria) developed through these programs was problematic. Physicians at the time observed that sudden infant

death syndrome (SIDS) did not exist prior to introduction of the vaccine, and infant death always happened in correlation with vaccination. I have seen a variety of different resources on exact timing of SIDS, but most references state that 90% of SIDS occurs between 2-4 months of age, and the 3 doses of the DTP vaccine are typically given at 2, 4 and 6 months of age.

The evidence that most strongly supports this hypothesis came from the initial COVID lockdowns. Many people in the conventional medical community predicted that infants not coming in for their well child (vaccine) visits would be severely harmed. In contrast, individuals in the vaccine safety movement predicted before the data was even available that this was a once in a lifetime opportunity to see a reduction in SIDS. A reduction in SIDS did occur, alongside an unprecedented decline in premature births (which are also linked to vaccination).

In addition to SIDS, the DTP vaccine was known for causing brain damage, and to some extent is correlated with increasing crime and ADHD rates (both of which are often reflective of brain damage). The brain damage issue was quite common (two children within my extended family for example experienced these

complications) and a torrent of lawsuits were filed against the manufacturer in the 1980s. Since the legal cost of these lawsuits exceeded the revenue from vaccination, that litigation situation served as the basis for the creation of National Vaccine Injury Program.

The program was intended to be a compromise between consumer advocates in Congress creating support for parents who were facing unreasonable difficulties in the courts and the manufacturers who needed a way to be able to continue producing vaccines. Fauci played a key role in brokering this deal, and the program rapidly drifted from its original vision to one that protected vaccine manufacturers from all legal liability. This led to a gold rush to add more unsafe vaccines to the vaccine schedule. An explosion of chronic autoimmune and neurologic illnesses (such as autism) followed not long afterwards within the population (the *Real Anthony Fauci* provides an excellent summary of these changes).

There were two ways the DTP combination vaccine could be manufactured: a “whole cell” pertussis preparation (DTwP), or an “acellular” pertussis preparation (DTaP). The trade-off is that

although the whole cell preparation is more effective in preventing disease, it is also more likely to cause severe adverse events. The secondary trade off relates to cost. To quote the Journal of the Medical Association: “Although DTaP vaccines are associated with significantly fewer adverse events, they are more expensive than DTwP.”

Given that context, see if you can guess what happened next…

Due to the mass public outcry in America against this vaccine, the “safer” DTaP was used in the U.S., while the DTwP was sent to Africa where it continues to be widely used to this day.

There are 3 vaccines that are considered the cornerstone of all global public health programs, Polio, MMR and DTP (especially DTP). The distribution and uptake of these vaccines is hence an unquestioned priority in almost all of these programs. Dr. Peter Aaby, a renowned vaccine scientist and promoter of vaccination, was commissioned by the WHO to study the overall effect of these vaccines on infant mortality. For context, these types of studies are almost never conducted which is why we still do not have data

to show if many of the vaccines given to children do in fact provide a net benefit.

The results were not what Aaby expected. While a significant reduction in death was observed from the MMR vaccine as he had likely expected to find, the opposite effect was found for the DTP and his data suggested the program needed to be scrapped.

To quote his paper:

> *"DTP was associated with 5-fold higher mortality than being unvaccinated. No prospective study has shown beneficial survival effects of DTP. Unfortunately, DTP is the most widely used vaccine, and the proportion who receives DTP is used globally as an indicator of the performance of national vaccination programs."*

In another section of his paper, it is specified that the overall death rate increased by 3.93 time in boys and 9.98 time in girls (for an average of 5.00). This has been hypothesized to explain the higher incidence of autism in boys (boys get autism while girls just die, once again the ideal effects for reducing population).

> *"It should be of concern that the effect of routine vaccinations on all-cause mortality was not tested in randomized trials. All currently available evidence suggests that DTP vaccine may kill more children*

from other causes than it saves from diphtheria, tetanus or pertussis. Though a vaccine protects children against the target disease, it may simultaneously increase susceptibility to unrelated infections."

This is analogous to the COVID vaccines being mandated for the population to save lives from COVID despite the total number of deaths being much greater in vaccinated individuals due to circulatory disorders caused by the vaccine (which may be even higher once the long-term effects become known). Aaby's results were of course buried. Since his publication, instead of being re-evaluated, the distribution of DTP has only increased, largely due to Bill Gates shifting the focus of the WHO towards vaccination (rather than public health projects that save lives).

Peter Gøtzsche MD, is one of the heroes and a critical reformer in evidence-based medicine who has repeatedly stuck his neck out to speak truth to power and end unsafe medical practices (although in general he supports vaccination). When Gøtzsche was subsequently requested to provide a meticulous systematic review of the evidence for DTP, he concluded from the data "evidence tells us that it is likely that the DTP vaccine increases total mortality in low-income countries."

hCG Vaccines:

One of the most studied methods of sterilization through vaccination (now euphemistically termed “immunocontraception”) is producing an immune response to hCG, which is a hormone necessary to maintain pregnancy. This results in the immune system lowering hCG levels enough to prevent viable pregnancy.

The chronology of the hCG vaccine is very similar to that of the anthrax vaccines, as described in a previous article. A significant need was present that had no viable technological solution (an effective adjuvant to enable a new generation of vaccines products versus an effective means of sterilization through vaccination).

A workable but problematic solution was identified (hCG added to a vaccine as opposed to squalene used as an adjuvant).

A large secret forced experimental campaign was conducted to

develop this approach.

Public outcry and suspicion arose towards all the sketchy aspects of this approach.

The responsible authorities initially vehemently denied on all grounds that this could possibly be happening (WHO/hCG vaccine vs. the military/anthrax vaccine).

Independent tests were conducted and suggested the substance in question was present in the vaccines.

The responsible authorities back-peddled to a softer denial (the positive results were due to lab error, we have do have vaccines with this additive but we'd never use it on people, etc.). Further testing proved without ambiguity that the agents were present. The debate ended while unethical experimentation continued over the decades and the technology was gradually improved. Use of the technology is normalized.

The more I thought about this ten-step process, the more I wondered if we are in fact at step 6 of introducing injectable nanotechnology such as graphene oxide (there is suggestive but not irrefutable evidence of its presence in the vaccines), which will eventually arrive at step 10.

Prior to the development of more advanced approaches, hCG was typically deployed by being added to the tetanus toxoid and then administered in the tetanus vaccine. In 1972 the WHO

initiated their "Special Programme" in Human Reproduction (approximately $400 million was invested in the first 20 years of the program). Later that year WHO and Rockefeller scientists were able to present a successful prototype to the National Academy of Sciences. A few years later, to quote *The Real Anthony Fauci*:

> *"By 1976, WHO scientists had successfully conjugated a functional "birth-control" vaccine. The WHO researchers reported triumphantly that their formula could induce "abortions in females already pregnant and/or infertility in recipients not yet impregnated." They observed that "repeated inoculations prolong infertility."*

Experimental campaigns soon followed. Their classic giveaways were as follows:

•A new "special" version of an existing vaccine is introduced.

•The vaccinations are only administered to women of childbearing age.

•Requiring additional doses was not needed for the regular vaccine (each campaign followed the published protocol for the

WHO birth-control conjugate of tetanus toxoid linked to βhCG: five spaced doses of “TT” vaccine at six-month intervals).

In 1993, WHO announced a “birth-control vaccine” for “family planning.” By November 1993 publications had appeared saying an abortifacient vaccine was being used as a tetanus prophylactic.

Human Life International (HLI), a Catholic pro-life organization, raised questions about it and the apparent activity of the WHO, where millions of unsuspecting women in Mexico, the Philippines, Tanzania and Nicaragua were allegedly being used as human guinea pigs in which they were injected with an anti-fertility vaccine but told it was nothing more than a tetanus vaccine.

As detailed in the June 1995 HLI Reports newsletter, when the first reports surfaced in the Phillipines, health officials at The WHO and Phillipine health agencies categorically denied that the vaccine contained hCG. When confronted with lab test evidence showing the vaccine vials contained hCG as well as laboratory evidence that there were high levels of hCG antibodies in 27 out

of 30 women who had been vaccinated, WHO officials started to make excuses.

> *To quote the author,* "first they said there was no hCG in the vaccine, then they said there was, but it was in tiny amounts. Then they said that hCG is part of the vaccine manufacturing process. Now they are saying the tests to detect hCG are flawed and produce 'a lot of false positives'.
>
> *But, there is one fact that cannot be disputed. There is no known way for the vaccinated women to have hCG antibodies in their blood unless hCG had been artificially introduced into their bodies." For reference, 30*

women who received this vaccine were tested and 26 had antibodies to hCG.

As described in my previous article, this the exact same thing that happened with the anthrax vaccines and is visible within the WHO's response to the controversy. These types of denials are always extremely insightful once twenty years of additional information is available.

One of the very first articles I invested a lot of time into for this substack focused on the PR industry. I did this because it is critical to understand that whenever an unpopular public policy is proposed, instead of listening to public opinion, everyone involved lies and PR makes it possible for this approach to work and the unpopular policy to materialize.

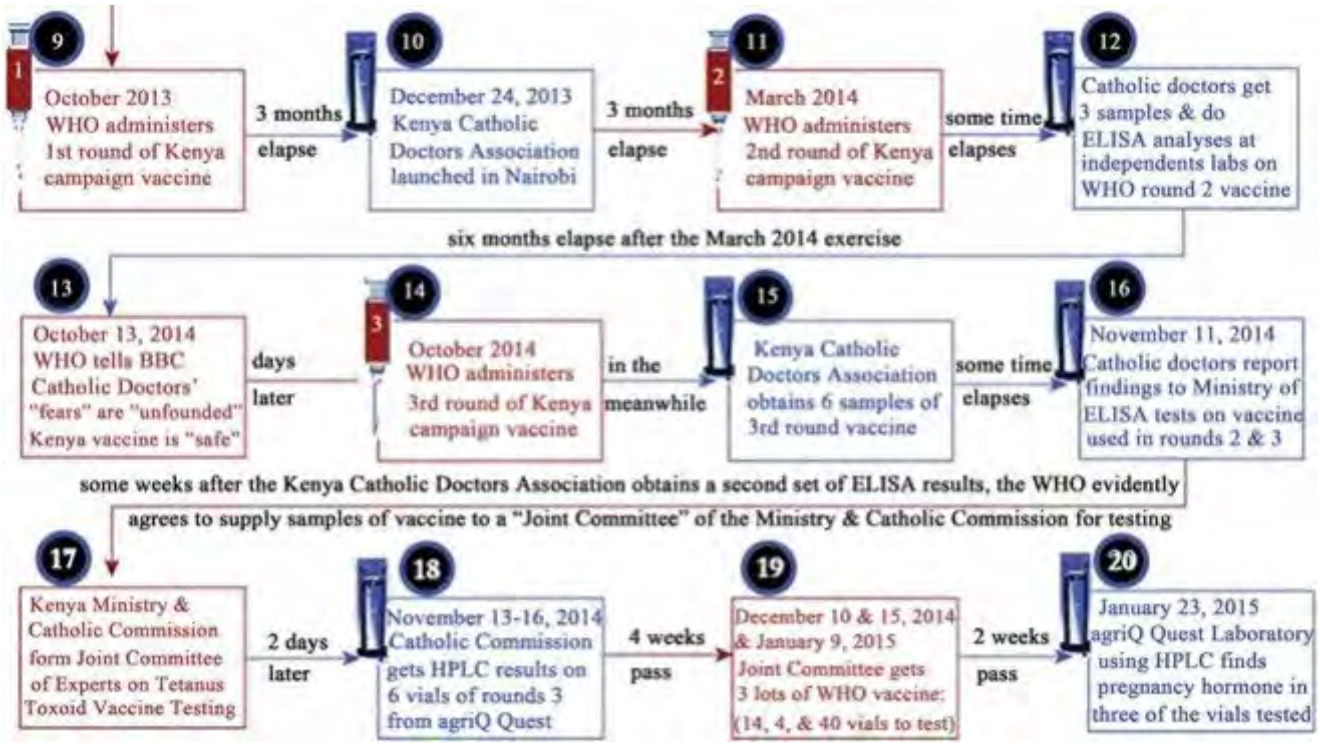
After the widespread outcry against the hCG vaccinations, the WHO backed off and planned “tetanus” vaccination campaigns were cancelled. In the following years, Bill Gates initiated his campaign to buy out the WHO, and with a 10-billion-dollar investment in 2010 shifted the WHO’s focus much further towards vaccination and fertility control.

In 2013, the previously postponed tetanus vaccination campaign was finally initiated in Kenya. This shady campaign only targeted women of childbearing age and the vaccines were not administered in a normal fashion (five doses were required with 6 months between each booster).

The distribution was also suspicious as the sites that would typically be required to distribute the vaccines across the country

did not receive them. Instead, a centralized location received the vaccines, and they were continually guarded by police (including their empty vials). The only other instance I can identify of a heavily guarded vaccine where samples could not be obtained for independent testing was during the early days of the COVID-19 vaccine rollout (because of an alleged critically limited supply).

Nonetheless, a small team of Kenyan Catholic Doctors were eventually able to obtain samples of the vaccines which when tested clearly showed the presence of hCG. After repeated denials by all involved, the program was eventually terminated by Kenya's government. Briefly the chronology of events is as follows:



After I published this article, one reader left the following commentary that highlights the long term effects on fertility this sterilizing vaccine was able to produce:

> *"My wife is Kenyan and sometime around 15 years ago, when she was still a teenager, she was forced to take one of those "tetanus" vaccines. She and another student who had refused were cornered in a room and forcibly administered the shot. Nearly every one of her school mates whom she is still in touch with have developed some sort of fertility- related problem, and difficulty bringing a baby to full term. My wife*

herself has had multiple miscarriages. horribly painful and several weeks- long menstrual cycles, sudden death of the baby in the womb, and more. We have one baby who lived. The doctor who delivered her via emergency Csection said he had never seen anything like it everything was going wrong, the baby stopped developing early on our daughter is now 5 and is normal in every way, but it is a miracle. The girls from her village who were too poor for school fees were spared the vaccine, and they haven't had any problem conceiving or giving birth. This horror is still going on in Kenya, now with the Covid shots."

At the same time this was happening, step 9 was also being implemented. Consider this 2011 paper:

Human chorionic gonadotropin (hCG) is synthesized soon after fertilization and is essential for embryonic implantation. A vaccine targeting hCG would be an ideal choice for immuno-contraception; an anti-hCG vaccine developed by Talwar et al., has previously undergone Phase II efficacy trials, providing proof of principle. These trials established the threshold levels of bio-neutralizing anti-hCG antibody titers required to prevent pregnancy; however, these titers (>50 ng/ml) were achieved in only 80% of immunized women. In this communication, we report a novel recombinant anti-hCG vaccine which demonstrates improved immunogenecity. hCGβ was genetically fused at C-terminal to the B-subunit of E. coli heat-labile

enterotoxin. The recombinant fusion protein (hCGβ-LTB) was expressed in Pichia pastoris and, upon adsorption on Alhydrogel along with Mycobacterium indicus pranii (MIP) as an immuno-modulator, evoked a very high anti-hCG immune response in 100% of immunized BALB/c mice. This recombinant vaccine is expected to reduce cost as well as facilitate production of a molecularly consistent conjugate on a large scale.

In plain language, this means that after the initial research on hCG was done, the knowledge was used to genetically engineer infectious microbes that produced sterility. This cumulation of decades of research has been studied by many researchers beyond those mentioned in the above paper.

RFK Jr. always focuses on the 1988 law that led to the establishment of the National Vaccine Injury Program because it was the turning point in America's vaccination program that began our current era of chronic illness. The three most dangerous vaccinations developed in this new era had two characteristics in common: a frequent association with the development of severe autoimmune conditions and negative effects on fertility.

The first one, anthrax, was covered in a previous article. Prior to COVID-19, the second vaccine, Gardasil, was the one I considered to be the most dangerous on the market and had injured or disabled multiple people I directly knew. The third is of course the COVID-19 vaccines. After discussing these vaccines, I will also briefly review the Porcine Zona Pellucida vaccine.

The Anthrax Vaccine:

(the following content was not *covered in the previous article)*

In addition to horrific autoimmune conditions, the anthrax vaccine was also frequently associated with infertility. To quote one reader (with their permission) who never received the vaccine or went to Iraq:

> *"We purposely were careful NOT to get pregnant immediately (which is common after deployments), because my husband was concerned about the shot and pills he was given during the Gulf War and his ensuing stomach issues. We soon found out that was a good call as soooo many women we knew miscarried or had still births. The few who did deliver had severely ill babies with bizarre issues, like...extreme allergies to everything, extreme skin issues, digestive abnormalities, etc... and several of those babies eventually died. This*

was all word of mouth as there was no internet, cell phones, or social media then. During that first year there were also several soldiers my husband knew who just dropped dead during runs from massive heart attacks.

I also heard of several people dying with bizarre cancers. For example, a civilian Dr. friend I knew told me of one woman who became almost completely covered with cancerous moles. She died a horrible death with no one knowing what she had, why, or how to treat it."

This reader, despite being from the opposite end of the world experienced similar effects to those shared from Kenya, which once again illustrates how no one is safe from these global predators. Western medicine has a massive body count and a central argument of this substack is that those human beings represents an important, but forgotten side of medicine.

One of the most concerning aspects of the anthrax vaccine was its tendency to affect the family and future children of the vaccinated soldier, and in many cases, the shedding which was "theoretically impossible" was quite severe (inexplicable shedding appears to also occur with the COVID-19 vaccine, but is less severe than what occurred following Anthrax vaccination). For

example, the family of the reader quoted above (particularly the children) experienced continual severe or life-threatening health issues that are still occurring today.

There are multiple points of evidence suggesting the disease was partially due to an infectious stealth bacterium that had also been developed through bioweapons programs. However as this is a complex subject, for the sake of simplicity, I focused on squalene adjuvants as being the primary cause and will discuss the stealth pathogens in a future article.

The HPV Vaccine:

Like the COVID-19 vaccines, there were many issues with Merck's HPV vaccine Gardasil that should have led to it never being approved or at least pulled from the market years ago. The vaccine provides no benefit and is linked to numerous severe harms.

Peter Gøtzsche for example, typically supportive of vaccination, realized how problematic the HPV vaccine was and broke with his colleagues to speak out against it. Shortly before this happened, the Gates Foundation bought out the Cochrane Collaboration

(widely regarded as the most unbiased evaluators of medical evidence in the world). Gøtzsche was then expelled from the Collaboration he cofounded for speaking out against this vaccine.

This shook the evidence-based medicine community and many of the most ethical people in the field spoke out against it. Since that time, the Cochrane Collaboration has stopped producing honest papers (for example, as covered in *The Real Anthony Fauci*, Cochrane's new leadership knowingly published a very bad review that was used to tank Ivermectin and hence killed many people).

The HPV vaccine was specifically targeted to girls of child-bearing age (since the goal was to get the vaccine before their first HPV exposure from sexual activity, the first dose is scheduled for 11-year olds, although it is sometimes given earlier). These girls were the most likely members of society to become pregnant and in a normal world, the vaccine's effects on fertility should have been a key focus for any drug regulator

In this section (primarily sourced from Chapter 10 of the book *HPV Vaccine on Trial*), we will look at the potential effects on fertility that were actually addressed by those responsible for evaluating them. In 2020 it was estimated 77.1% of girls between 13 and 17 years of age had received this vaccine, while in England roughly 90% of girls had received the vaccine. The numbers here matter, so try to keep them in mind before we move to the graphs.

In the clinical trials, the miscarriage rate for recipients of the Gardasil was 25%, and 27.4% for the later Gardasil 9. This compares with a typical miscarriage rate of 8% to 15% with miscarriage rates increasing by age (so 10% is a safe estimate). Despite the catastrophic implications of these findings, in the same way the COVID-19 vaccination was given a free pass, the FDA chose not to find this miscarriage data concerning. The FDA's "reasoning" was that the 25% miscarriage rate was also observed in the placebo group, which arose because the "placebo" was Gardasil's adjuvant, the primary toxic component of the vaccine. In the clinical trials for the competing HPV vaccine Cervarix, which used a less dangerous adjuvant, an 8.3%

miscarriage rate was observed in controls, while a 13.5% was observed in the vaccine arm, which should have informed the FDA that Gardasil quadrupled the miscarriage rate. This rate was even higher when the vaccine was received within 30 days of conception. In the case of Gardasil 9, an overall miscarriage rate of 28.4% occurred compared to the 12.7% rate observed in the placebo group. Of those receiving this vaccine, the rate was 40% in the 23-26 age range, and 18.9% in those aged 16 to 22. Once again, the FDA completely ignored this safety signal, while the Europe's FDA equivalent (the EMA) simply asked for an explanation and then signed off on it.

During the first Gardasil vaccine approval process, the FDA also noticed a large increase in birth defects (5 compared to 0 in the "placebo") when Gardasil was given within 30 days of conception. Like before, the FDA ultimately decided to drop the issue (it was not even mentioned on the package insert which simply stated there was no data on Gardasil's effects on pregnant women).

Pfizer's COVID vaccine (and likely the other COVID vaccines whose documents were not leaked), skipped much of the necessary animal testing (with the testing that was conducted

often very incomplete) before proceeding to human trials. Gardasil similarly had only very partial animal studies, and its effects on fertility were only tested during those animal studies. Key toxicology studies were not conducted on the reproductive systems of female rats, there was no long-term observation of rat fertility, and the male rats were quickly disposed of after receiving the vaccines.

Prior to Gardasil, unexplained premature ovarian failure (POF) was very rare (2 cases were identified by researchers from 1998 to 2008, while 13 were found from 2008 to 2013 following Gardasil's initial entry to the market). In 2013 the American Journal of Reproductive Immunology presented 3 cases of autoimmunity and POF following HPV vaccine administration. In 2014, Dr. Deidre Little published three case of healthy teenagers developing POF following vaccination.

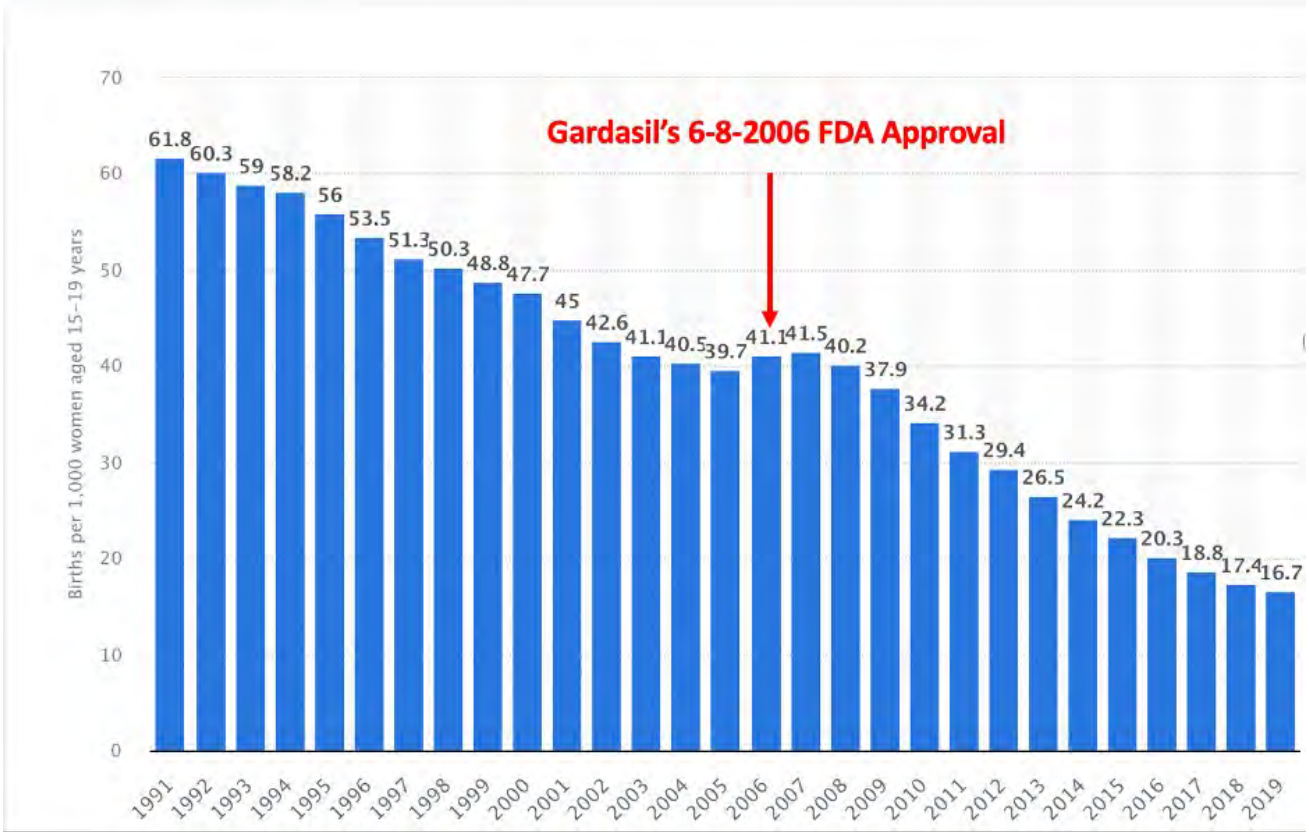
VAERS (which typically captures less than 1% of the adverse events that occur) tells a similar story. Currently on VAERS (which has been in operation since 1990), 25 cases of POF have been reported, 21 from the HPV vaccine and 4 from the COVID vaccine, while 75 cases of premature menopause (a related

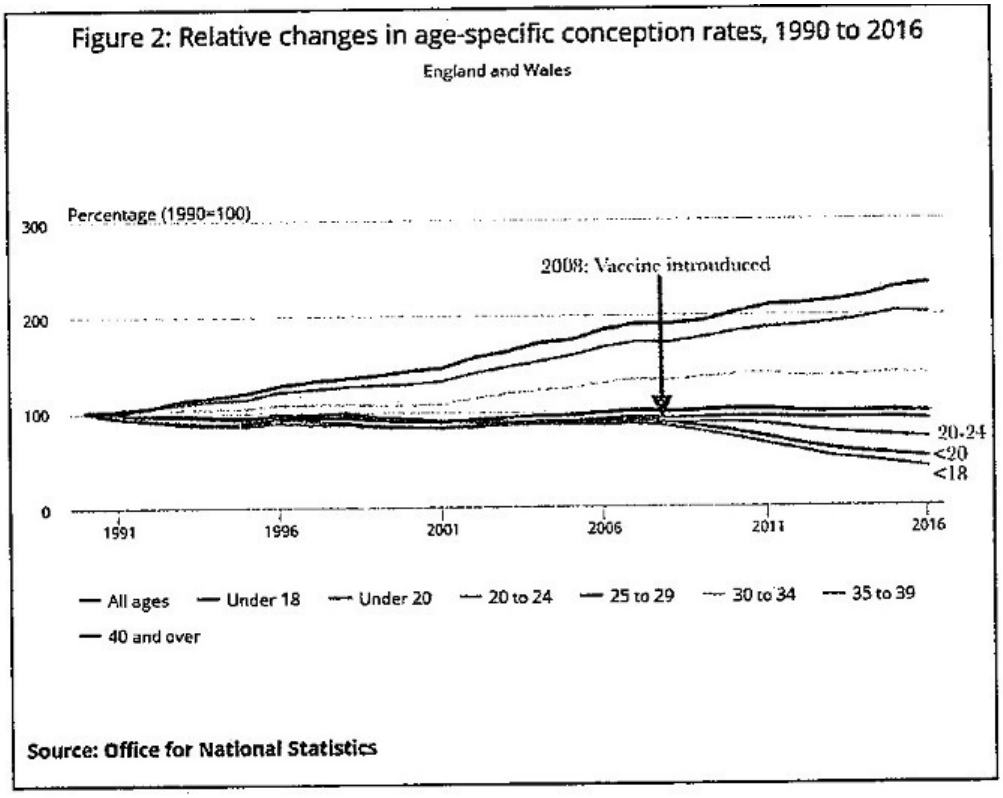
condition) have been reported, of which 54 came from an HPV vaccine and 16 from a COVID vaccine. Polysorbate 80 is associated with autoimmune damage to the ovaries and has direct ovarian toxicity. Since it is found in Gardasil (as well as the COVID-19 vaccines), it was suggested as a possible cause of POF; however, because it is also in other vaccinations, I do not think this link is specific enough.

Given all of this, what would you expect to occur once Gardasil was given to our next generation?

Birth rate among U.S. teenagers aged 15-19 years

(per 1,000 women)





Source: Office for National Statistics UK Conception Statistics 2016

To clarify this chart: an overall decline of 44% was observed for girls under 18, most of whom lived in England. The rate in decline was the greatest in those under 16. For example, in neighboring Scotland, also a part of the United Kingdom the teen pregnancy rate declined 60% from 2007 to 2015.

Typically, it is very difficult to draw causation between two events because so many other variables are also present. While fertility in all age ranges was affected by Gardasil, this dataset is remarkable for how clearly it is able to show this correlation. This

profound drop in teenage fertility was originally acknowledged and met with alarm. Because no cause could be identified, it was then forgotten and the trend has continued ever since (the first graph I just pulled off google was produced a few years after the HPV vaccine on trial was published).

I personally believe the younger a mother is at conception, the healthier her children are (there is a dramatic difference in the constitution of a baby born to a 16-year-old mother versus a 40-year-old mother) and I have often wondered what the effects of this age shift in pregnancy has had on the health of society.

The Porcine Zona Pellucida Vaccine:

To conclude this article, we will review the Porcine zona pellucida (PZP) vaccine with the disclaimer that this the most speculative section of this article. A key point I've tried to illustrate in this series is that the population control methods we see adopted for civilians significantly overlap with those used in wildlife management. This could either be a product of those methods being first developed on animals, or because the predatory ruling class sees us as their animals.

A key reason why I support animal rights and oppose inhumane animal experimentation is because if allowed there, those abuses eventually happen to humans. As an example, the Biotech company Oxitec has spent years developing male mosquitos that sterilize female mosquitos when they mate, hence providing an extremely effective means of mosquito population reduction. A wide coalition of scientists and activists have opposed this plan due to numerous irreversible problems it has the potential to create. Nonetheless these mosquitos have been deployed and recently the EPA approved their release in Florida and California. As far as I know from studying the subject, for humans, the closest we've come to an agent that can sterilize the recipient's sexual partner were the anthrax vaccines. You have to honestly ask yourself if this is the type of research you want done.

Like the hCG vaccines, the COVID-19 mRNA vaccines have a very unusual dosing schedule. This schedule does match one vaccine, the PZP vaccine (which also utilizes one of the more toxic oil adjuvants discussed in Vaccine A), and like the mRNA vaccines must be frozen (although it does not require as low of temperatures). The PZP vaccine is designed to create antibodies

to the sperm receptor found in the eggs of all mammals, thereby making fertilization impossible. It is used for controlling wild populations of mammals such as horses.

While the PZP vaccine is claimed to just safely block sperm fusing with an egg, there is some controversy around the vaccine, since evidence suggests that PZP antibodies actually work by inducing ovarian dystrophy, oophoritis (inflammation of the ovaries), destruction of oocytes in all growing follicles, and depletion of resting follicles. While difficult to calculate precisely, like hCG vaccines, the PZP vaccine appears to cause progressively longer periods of sterility with each booster administered (8 years of sterility after 3 doses was one estimate).

Like the COVID vaccines, PZP can also cause significant menstrual irregularities. PZP antibodies are also transferred through breast milk (it's a bit of stretch to connect this, but there have been VAERS reports of infants who were severely injured or died following drinking their vaccinated mothers' breast milk).

Finally there is an association between PZP vaccines and stillbirths, which has also been reported with the COVID-19 vaccines.

A major challenge for the PZP vaccine was ensuring a lengthy period of sterility, as it was not practical to repeatedly vaccinate wild animals. Multiple groups have examined this question and the relatively new biotech company, SpayVac was able to solve this issue with Lipid Nanoparticles.

These particles are designed to hold onto the antigen so they create a prolonged sustained immune response in the tissue, which may be part of the reason why vaccine spike proteins are more destructive than those from a COVID-19 infection. I also read speculation that the lipid nanoparticle used by SpayVac (IMV's DPX) was designed to travel to ovaries where it finally releases its contents (IMV is also developing a DPX-based COVID vaccine). Despite my best efforts, I was unable to located the patents or drug studies on these lipid nanoparticles, so as far as I know there, is no evidence to support that speculation. That said, I don't know if it matters because Pfizer's lipid nanoparticle clearly travels to the ovaries. This is quite problematic if they

behave in a similar manner to DPX's lipid nanoparticle, something specifically designed is designed to create a prolonged immune response in that region.

It was also noted that Pfizer's CEO Albert Bourla is a veterinarian and likely worked with the PZP vaccine. When I dug into this, I found out something possibly even more disturbing. When male pigs are farmed, if you do not castrate them, 20% of males will develop meat that some people dislike the taste of (known as "boar taint").

Pfizer developed the vaccine Improvac, which creates autoimmunity to GnRH, thereby significantly dropping the production of hormones in the body. This chemically castrates the pigs and gives a cheap and easy way to prevent boar taint. Some of the most toxic drugs on the market such as Lupron, that are typically used for more severe women's health issues or to block puberty in transgender children, function interfering with the GnRH receptor, albeit in a more temporary fashion than Improvac.

In the following obscure 3 minute video (it had 2,000 views when I found it you might want to save a copy in case it disappears!), Bourla, already in an executive position eagerly presents Improvac to the European market.

From seeing this, I am relatively certain he knew about the PZP

vaccine and likely was aware of the value of using a similar approach to manage fertility in human males. On December 28, 2020, he also signed a $4.2 billion deal for the rights to Relugolix, a new human GnRH receptor blocker.

In conclusion

I hope the following points have been made:

•A central belief of the ruling class has been the (false) belief that it is imperative to reduce the population.

•If a policy that harms or kills many people is viewed as necessary, our leaders will typically not hesitate to enact the policy.

•When implementing a questionable policy, those implementing it will always lie and a massive (PR) industry enables those lies.

•Many policies have not been enacted solely because the technology needed to implement them did not yet exist.

•Unethical covert medical experiments occur on a regular basis to develop these technologies.

•Vaccines are inescapably interwoven with the above points.

•The need to create a culture where standing up for vulnerable members of society is in everyone’s best interest, because if abuse is not stopped there, it will eventually show up on our own doorstep.

This post and the preceding posts to put it in context took a great deal of effort to write. I sincerely appreciate you sharing it.

This post is public so feel free to share it.

The Forgotten History of Sterilizing Vaccines

What Can Their Dark Past Teach Us About The Present Moment?

During the COVID-19 vaccine roll-out, the unprecedented nature of the vaccination campaign caused many to suspect it might adversely affect global fertility. These concerns grew as more and more evidence emerged suggesting the vaccines were adversely affecting fertility, but nonetheless were disregarded and instead the vaccines were mandated on pregnant women.

Now that the dust has cleared, it is clear that something had a profound impact on global fertility which is so large it cannot be explained by anything except something being introduced to the population at the exact same times the spike protein vaccines were. Simultaneously, numerous datasets have been uncovered (e.g., through FOIA requests) that all suggest vaccinated women have an increased risk of miscarrying during their pregnancy.

In parallel, numerous mechanisms have emerged to explain why this is happening (e.g., blood clots are well known for adversely affecting pregnancy, abnormal menstruation is observed in approximately half of vaccine recipients, Pfizer's mRNA vaccine was shown to concentrate in the ovaries and the vaccine was shown to have a homology to a vital protein needed for sustaining pregnancy). Many of these (along with other red flags and major gaps existing in fertility safety data) were known prior to the vaccine roll-out, which has left many wondering why the sacred rule of medical ethics, never giving an experimental pharmaceutical to pregnant women, was so flagrantly violated.

Note: Early on Dr. Michael Yeadon, a former Pfizer scientist and executive, recognized that an overlap between the vaccine spike protein and a protein necessary for maintaining a pregnancy (Syncytin-1) created a clear fertility risk.

At great personal risk, ~~he filed a formal~~ he petition to the drug regulators to exclude women of childbearing age in the initial

vaccine trials. His warning was ignored and Yeadon is now essentially blacklisted from working in pharmaceutical industry.

In my eyes, there are two possible explanations for how all of this could have happened (which may not be mutually exclusive):

The first, and more likely one, was that there was such a panic to get the vaccines to market and end COVID-19 that a mass-formation (collective hypnosis) formed which caused vaccination proponents to become easily manipulated by Big Pharma and be blind to anything which threatened worldwide adoption of the mRNA vaccines.

The second possibility was that the vaccination program was seeking to advance a longstanding objective of the ruling class—global population reduction.

Malthus's Legacy

Prior to the mass production of fertilizer, a recurring challenge for the ruling class was preventing catastrophic famines (which in many cases toppled the existing government). In 1798, Rev. Thomas R Malthus, drawing upon this fear, published the influential work *An Essay on the Principle of Population,* which argued that human populations tend to increase at a geometrical (exponential) rate, but the means of subsistence (food) grows at only an arithmetic (linear) rate—which meant unchecked population growth would be catastrophic.

Malthus's ideas were rapidly adopted by the European aristocracy who came to believe they held a sacred duty to keep their populations in check so a resource collapse could not happen. Before long, this philosophy merged with the concept of Social Darwinism, an ideology which argued that certain individuals (e.g., due to race or social

class) were more fit to survive, while other human beings were not.

All of this gave way to the philosophy that many human beings should not be having children, and numerous campaigns to advance this agenda (e.g., mass forced sterilizations, aggressive deployment of birth control methods, and endless social initiatives to discourage individuals from having having children).

Although the history of these campaigns (and their victims) is well documented, most are unaware of them. For that reason, one of the first series I wrote on Substack sought to provide evidence showing that these campaigns really happened, some of which were even conducted by the same players (e.g., Bill Gates) that are currently directing global public health.

Recently, I published a revised version of the first half of this series which provides the clear documentation to show population control has been a focus of the ruling class for decades and possibly centuries.

Note: In full disclosure, I opted to revise this series because my writing was not the best when I first started here, and since I was not as strict with references, I cited a few bad sources that could not substantiate their claims (which I no longer believe to be true).

In the first article, I sought to establish three key points.

•The first is that while the extent of it can be debated, the depopulation agenda is very much a real thing and at least was the national policy of the US government.

•The second is that when unscrupulous things are done, they are typically first tested out on marginalized group whom the rest of the society will turn a blind eye toward the suffering of. I argue those initial injustices must be opposed because otherwise, the injustice becomes normalized and before long is done to the un-marginalized groups (e.g., much of what Fauci did to America throughout COVID-19 was identical to what he did to the gay community during the AIDS crisis).

Throughout COVID-19, I repeatedly saw things happen that many had difficultly believing could ever happen in America, yet I understood exactly what was happening because I had already seen smaller versions of it happen throughout the country (or the world). Similarly, I believe the reason why the population control agenda has been able to advance so far is because its victims have been largely forgotten—and it is my hope they will at last be remembered since everyone has now become a target of the global predators.

•The third is that with all these programs (as discussed in the previous article) the primary obstacle to them was not a question of ethics (outside of the Catholic Church, no outside groups opposed most of those campaigns). Rather, it was the technological feasibility of those programs.

Note: one well known example of this was no one in the German medical profession speaking out against the gross violations of medical ethics and human rights committed by the Nazi Eugenicists.

Technological Feasibility

Note: many of the points in this section are referenced and expanded upon in the previous article.

The consistent problem encountered by those seeking to reduce the population is that the more effective the approach is, the more likely people are to resist its implementation.

For example, mass sterilizations (with forced male vasectomies or female tubal ligations) were attempted in India, had to be terminated because males fought back against the initiative. Conversely, while a target population is often willing to initially take birth control pills, it is extremely unlikely they will use them for a prolonged period.

Initially, the most effective option was surgical sterilization of women (e.g., by tying their tubes), which was both conducted covertly (while the woman was receiving a

surgery for something else) or overtly with the government forcing it to happen. Many battles broke out against this, and disturbingly enough, an infamous U.S. Supreme Court ruling decided that the same principle that allowed mandatory vaccination (for smallpox) also allowed compulsory sterilization.

Much later, a better balance was found between efficacy and practicality, Depo-Provera, a long acting injectable birth control method—which represented the ideal way to mass administer a sterilizing agent. Once Depo-Provera became available, decades of campaigns were conducted in the third world where it was forcefully deployed on the women there.

Note: I have long disliked Depo-Provera because it has a variety of overt side effects and can cause much longer losses of fertility than initially expected.

Nonetheless, Depo-Provera had two major shortcomings for the ruling class. The first was that it did not guarantee

permanent sterility. The second was that people gradually became more and more skeptical of this approach and did not fully comply with the Depo-Provera campaigns.

Given those constraints, I could only see two potential ways to address meet these population control goals.

One option is to administer an agent which could spread throughout the population.

As far as I know, this has only been done for animals. For example, Oxitec has become notorious for releasing mosquitos (e.g., in Florida, Texas and California) which carry a gene that only allows male mosquitos they father to survive…which rapidly creates a decline in the existing mosquito populations because far fewer females are born. This approach has been met with public protest and currently citizen activists are trying to prevent another mosquito sterilizing biotechnology from being deployed in Hawaii.

More recently, Robert Malone brought attention to an adenovirus being genetically engineered so that it could sterilize cats and more importantly transmit between them, thereby significantly reducing the feral cat population.

Note: Both the J&J and Astrazeneca (along with Russia's COVID vaccine) were adenoviruses modified to carry the spike protein and then reproduce within the body. Oddly enough, the developers of the Astrazenca's vaccine—which was promoted as the vaccine of choice for the third world—have extensive ties to major eugenics organizations.

Although these technologies offer the potential to eliminate an invasive organism (e.g., I love cats but in many places the number of feral cats threatens the native wildlife), many have nonetheless been extremely concerned about these technologies. There are two primary reasons for these concerns:

First, attempts to disrupt ecosystems by introducing a biological agent (e.g., another predator to deal with an

invasive species) frequently backfire due to the unintended consequences they create. There are numerous examples of this around the world, with Hawaii, due to the isolated nature of its ecosystems being one of the best examples in America.

To some extent, we have also seen this with the depopulation efforts, as the same Western Governments which pushed for reducing their birthrates are now facing a demographic crisis where they no longer have enough young workers to support the economy.

Note: As Ed Dowd's team has shown, this issue has recently become much worse due to radically increasing disability rates within the workforce from the vaccine mandates that disabled a significant portion of the American workforce.

Second, the possibility always exists that self-spreading approaches will come to affect humans too. For example with the cat virus, a lengthy ethical review (which in this climate is unlikely to ever happen) must be conducted before anyone ever considers releasing it. Likewise, can

you imagine a world where you had to fear a mosquito bite might make you infertile?

Note: to some extent this was the fear that was used to promote the mass spraying of toxic pesticides to contain mosquitos carrying the Zika virus.

My best guess is that the global elites are fully aware of this issue, and are unlikely to release any sterilizing agent which can self-spread throughout the population because they would not be safe from it either. However, at the same time, I also believe there are too few checks on science at this point (e.g., the gain of function research at the Wuhan lab should not have been conducted, but nonetheless was by a few individuals who prioritized their own benefit over the potential risks they were bringing to the world), so its still possible we may face an issue like this in the future.

Note: this is somewhat analogous to the AI situation, which many such as Elon Musk have labeled as an existential threat to the human race, since if AI becomes sentient and has

access to the tools it needs to exterminate the human race, there's no reason why that might not happen. Nonetheless, since there is a lot of money to be made with AI, people keep on pushing the envelope with it, irrespective of the massive risks they are creating through doing so.

Sterilizing Vaccines

Since anything which can self-spread throughout the population carries the inherent risk that it will spread too far, the alternative option is to be able to conduct targeted sterilizations. The best candidate for this role has been vaccinations. This is because:

•Vaccines are very easy for untrained personnel to rapidly administer to large numbers of people.

•The vaccine brand has such a halo around it (due to the mythology they rescued us from the dark age of disease) that people will trust an injection solely on the basis of it

being a vaccine, even if a large number of adverse effects are reported from recipients of the injection.

Note: I believe this is why the experimental mRNA gene therapies the population was injected with were labeled as vaccines, as had they been accurately labeled as a gene therapy, it is unlikely most of the population would have ever taken them. Conversely, the reason why I refer to the mRNA injections as vaccines is because I believe the vaccine brand should be subject to the same skepticism the disastrous mRNA injections now are beginning to face.

•All vaccines work by disturbing the immune system. Since a disturbed immune system is something which can permanently impair fertility, accomplishing this through vaccination thus represents an irresistible target for the population control fanatics.

As a result, methods of making fertility-impairing vaccines have been researched over and over again. Each of the candidate vaccines I was able to identify worked in a similar manner: they carried an antigen that was similar to

a protein necessary for fertilization or to maintain a pregnancy, and thus created an autoimmune response that impaired fertility.

There are basically two ways this can be done. The first is to produce the needed antigen and mix it with an immunostimulatory adjuvant.

The second is to genetically engineer an infectious organism that has the antigen within it, and as with rheumatic fever, the damage to fertility will occur because of the immune system being programmed to fight the pathogen and anything similar to it (e.g., the cat virus discussed above is one such example). Since mRNA technology did not exist until recently, it does not exist within this schema, but were it to be designed to impair fertility, it would essentially fall into the second category.

Note: In a previous article on the military's anthrax vaccination program, I discussed Gary Matsumoto's discovery that a class of bioweapons were originally developed by Russia which worked by splicing necessary human tissue onto infectious

organisms to create a delayed and thus harder to detect autoimmunity to vital human tissues, something which over time can be devastating where it is deployed. One of the curious aspects of the SARS-CoV- 2 spike protein (which was noticed by concerned scientists early on is that has an almost impossibly high number of similarities with normal human tissue and I've long wondered if it that was deliberate.

Ultimately, while it is possible this was done with COVID-19 (e.g., to some extent male fertility issues have been observed after COVID-19), due to the inherent risks with any self-spreading vector, I suspect it is unlikely the virus was designed for this purpose. However at the same time, due to their ease of modification coronaviruses have always been one of the most popular viruses for virologists to experiment with and countless research papers exist showing how this was done with the SARS virus in the years preceding the COVID-19.

Given the recurring interest in sterilizing vaccines, I believe it is worth looking at exactly what has already happened so we can better understand what might be happening now.

hCG Vaccines:

One of the most studied methods of sterilization through vaccination (now euphemistically termed "immunocontraception") is to produce an immune response to hCG, a hormone necessary to maintain pregnancy. This acquired autoimmunity results in the immune system lowering hCG levels enough to prevent a pregnancy's viability.

After the realization that hCG was the best available candidate for "immunocontraception," various administration methods were explored and it was discovered hCG elicited the strongest immune response when it was combined with the tetanus toxoid (as the body is typically reluctant to develop autoimmunity to its own vital proteins). As such, "hCG vaccine" refers to a tetanus vaccine that is laced with hCG.

Note: the diphtheria toxoid (the commonly administered DPT vaccine contains both the tetanus and diphtheria toxoids) was also found to work, but as far as I know only tetanus toxoid was utilized in the hCG vaccines that were deployed.

The chronology of the hCG vaccine follows a general pattern I have seen with objectionable technologies being introduced to the marketplace.

- A significant need was present that had no viable technological solution (e.g., an effective means of sterilization through vaccination).
- A workable but problematic solution was identified (e.g., hCG being added to a vaccine).
- A large, secret, and most importantly, forced campaign was conducted to experimentally refine the approach.

Public outcry and suspicion arose towards what they could see was happening. The responsible authorities (in this case the WHO) initially vehemently denied on all grounds that this could possibly be happening.

Despite great difficult in doing so, independent tests were conducted and suggested the substance in question was indeed present (e.g., hCG in the vaccines). The responsible authorities back-peddled to a softer denial (the positive results were due to lab error, we have do have

vaccines with this additive but we'd never use it on people, etc.). Further testing proved without ambiguity that the agents were indeed present. The debate ended while unethical experimentation continued over the decades and the technology was gradually improved.

Use of the technology went from being categorically denied to becoming normalized.

Note: much of the chronology that follows was sourced from this article.:

In 1972 the WHO initiated their "Special Programme" in Human Reproduction (approximately $400 million was invested in the first 20 years of the program). Later that year WHO and Rockefeller scientists were able to present a successful prototype to the National Academy of Sciences. A few years later, to quote *The Real Anthony Fauci*:

"By 1976, WHO scientists had successfully conjugated a functional "birth-control" vaccine. The WHO researchers reported triumphantly that their formula could induce "abortions in females already pregnant and/or infertility in recipients not yet impregnated." They observed that "repeated inoculations prolong infertility."

Experimental campaigns soon followed. They tended to have a few commonalities that suggested something bad was being done. Those tells were as follows:

A new "special" version of an existing vaccine is introduced (the tetanus vaccine is one of the most commonly administered vaccines across the world).

•The vaccinations are only administered to women of childbearing age.

•Requiring additional doses that were not needed for the regular vaccine (each campaign followed the published protocol for the WHO birth- control conjugate of tetanus

toxoid linked to βhCG: five spaced doses of “TT” vaccine at six-month intervals).

Note: I was unable to find a copy of the published five dose protocol the above article referenced, as the link to it no longer exists.

In 1993, a peculiar paper was published that many would have difficulty believing actually made it to print. I’ll quote some of it:

> *“Vaccines for control of fertility are likely to have an important impact on family planning methods. They are designed to act by mobilization of an internal physiological process and do not require external medication on a continuous basis. A number of birth control vaccines are at different stages of development, the most advanced being a vaccine inducing antibodies against human chorionic gonadotrophin (hCG).*
>
> *This vaccine consists of a heterospecles dimer (HSD, PhCG associated with asubunit of ovine lutelnizing*

hormone, PhCG:aoLH) linked to tetanus toxoid m) or diphtheria toxoid (DT) as carriers. The vaccine has recently passed an important milestone; ***it has completed the first leg of phase II efficacy trials****.*

Women of proven fertility leading active sexual life were protected from becoming pregnant at antibody titres 250 ng of hCG bioneutralization capacity per ml. This vaccine has previously been demonstrated to be reversible in its effect. ***It is free from any notable side-effects on endocrlne, cardiovascular and other body functions*** *[keep this is mind as you read today's article].*

Ovulation was not disturbed and menstrual regularity was maintained. ***A logistic disadvantage of the present vaccine is the requirement for multiple injections****. This is expected to be overcome by encapsulation of the requisite doses of the vaccine in biodegradable microspheres, which could be given at a single contact point for sustained antibody titres lasting over a year. A live recombinant vaccine [this is how J&J and Astrazeneca work] has also been made that elicits high anti-hCG*

titres in monkeys for nearly 2 years following primary immunization and a booster at 8-9 months.

We have been inspired to develop new methods for family planning because of the conviction that the presently available methods do not suit everyone and are not accepted in all countries, especially in those where the population problem is pressing.

"In India, the current net population growth is 2.1% and about 17 million people are added annually to an already massive figure of 876 million. The Government of India was one of the first to introduce Family Planning as an official policy. An array of currently available contraceptive methods are provided at highly subsidized rates or even free of charge. Incentives are offered to undergo tubal and vas ligations [these are surgical sterilizations]."

"These methods are, however, perceived largely as terminal, and people accept them fairly late in reproductive life after engendering a number of children. Condoms and pills require constant

motivation, and their use is limited, especially in rural areas, where 80% of the people reside. IUDs entail extra blood loss, which women who are already anaemic (average haemoglobin is about 9 g/dl) can hardly support NORPLANT has not as yet entered the scene, though it is under large-scale evaluation. There is thus a need for new methods which do not disturb menstrual regularity or increase bleeding, which are reversible and which do not demand daily intake. We have been working on vaccines that can regulate fertility."

Research is underway to make more than one birth control vaccine. These are directed against:

gonadotrophin-releasing hormone (GnRH) as a postpartum vaccine for extending lactational amenorrhoea, for control of male fertility with supplementation of androgens, and for control of hormone- dependent carcinoma of the prostate follicle stimulating hormone (FSH) for control of male fertility

sperm antigens - a number of target antigens have been identified zona pellucida hCG. The vaccines which have reached the clinical trials stage are against GnRH and hCG; others are currently at the experimental stage.

While our group is working on both these and other vaccines, we will confine this presentation to the hCG vaccine for two reasons. This is the vaccine which is at present at the most advanced stage; it is undergoing phase II efficacy trials [at three hospitals in India]."

The rest of the paper discusses the specifics of each generation of the hCG vaccines. It also noted that a virus modified to carry hCG was highly effective in preventing fertility, but it was never deployed, which I suspected was due to a fear it would spread to undesired targets.

Many things within the paper suggests there was a great deal of interest in this technology. Consider for example the funding sources:

> *"Research and clinical trials discussed here were supported by S&T Project of the Department of Biotechnology, India, the International Development Research Centre of Canada and the* ***Rockefeller Foundation****. The work benefited from cooperative interaction with the International Committee for Contraception Research of the Population Council, New York."*

Later that year, Catholic publications began to appear saying a tetanus vaccine was being used as means to reduce fertility. Before long, Human Life International (HLI), a Catholic pro-life organization, raised questions about the vaccines and the apparent activity of the WHO, where millions of unsuspecting women in Mexico, the Philippines, Tanzania and Nicaragua were allegedly being

used as human guinea pigs in which they were injected with an anti-fertility vaccine but told it was nothing more than a tetanus vaccine.

As detailed in the June 1995 HLI Reports newsletter, when the first reports surfaced in the Phillipines that an anti-fertility vaccine had been deployed, health officials at The WHO and Phillipine health agencies categorically denied that their vaccine contained hCG. When confronted with lab test evidence showing the vaccine vials contained hCG as well as laboratory evidence that there were high levels of hCG antibodies in 27 out of 30 women who had been vaccinated, WHO officials started to make excuses:

> *"First they said there was no hCG in the vaccine, then they said there was, but it was in tiny amounts. Then they said that hCG is part of the vaccine manufacturing process. Now they are saying the tests to detect hCG are flawed and produce 'a lot of false positives'. But, there is one fact that cannot be*

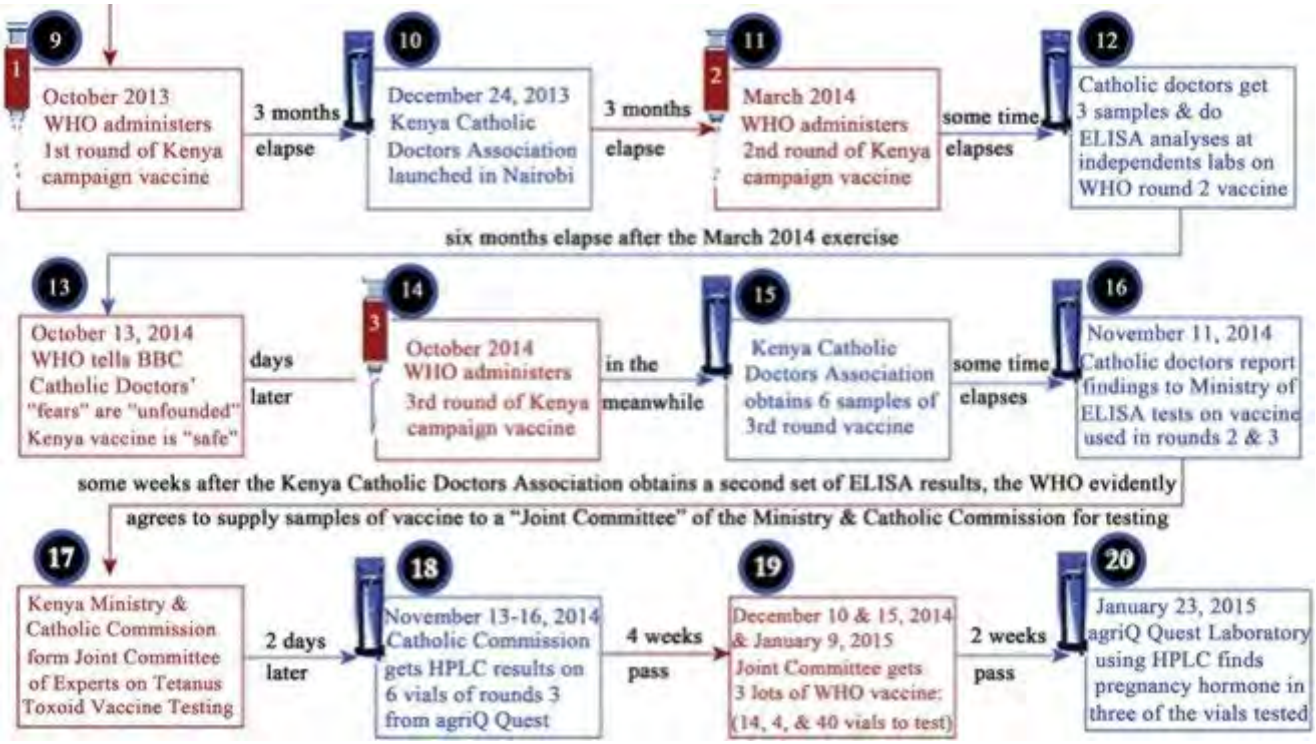
disputed. There is no known way for the vaccinated women to have hCG antibodies in their blood unless hCG had been artificially introduced into their bodies."

After the widespread outcry against the hCG vaccinations, the WHO backed off and planned "tetanus" vaccination campaigns were cancelled. In the following years, Bill Gates initiated his campaign to buy out the WHO, and with a 10-billion-dollar investment in 2010 shifted the WHO's focus much further towards vaccination and fertility control (doing so at the expense of the traditional approaches that had previously greatly improved global public health).

In 2013, the previously postponed tetanus vaccination campaign was finally initiated in Kenya. This campaign only targeted women of childbearing age and the vaccines were not administered in a normal dosing schedule (five doses were required with six months between each booster).

The distribution was also suspicious as the sites that would typically be utilized to distribute a vaccine across the country did not receive them. Instead, a centralized location received the vaccines, and they were continually guarded by police (including their empty vials). The only other instance I can identify of a heavily guarded vaccine where samples could not be obtained for independent testing was during the early days of the COVID-19 vaccine rollout (because of an alleged critically limited supply).

Nonetheless, a small team of Kenyan Catholic Doctors were eventually able to obtain samples of the vaccines which when tested clearly showed the presence of hCG. After repeated denials by all involved, the program was eventually terminated by Kenya's government. Briefly the chronology of events is as follows:



After I published this article, one reader left the following commentary that highlights the long term effects on fertility this sterilizing vaccine was able to produce:

> *"My wife is Kenyan and sometime around 15 years ago, when she was still a teenager, she was forced to take one of those "tetanus" vaccines. She and another student who had refused were cornered in a room and forcibly administered the shot. Nearly every one of her*

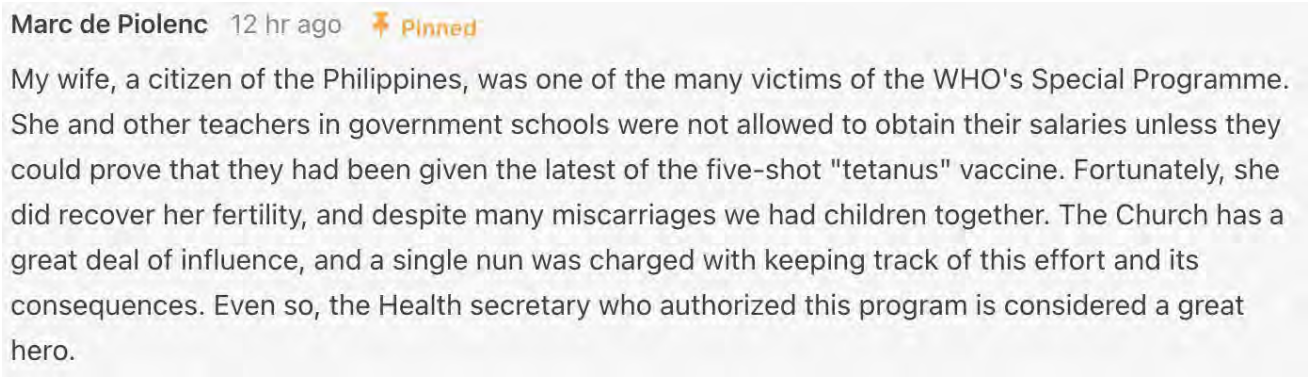
school mates whom she is still in touch with have developed some sort of fertility-related problem, and difficulty bringing a baby to full term. My wife herself has had multiple miscarriages. horribly painful and several weeks-long menstrual cycles, sudden death of the baby in the womb, and more. We have one baby who lived. The doctor who delivered her via emergency C-section said he had never seen anything like it everything was going wrong, the baby stopped developing early on our daughter is now 5 and is normal in every way, but it is a miracle.

The girls from her village who were too poor for school fees were spared the vaccine, and they haven't had any problem conceiving or giving birth.

This horror is still going on in Kenya, now with the Covid shots."

Note: compare these stories to the 1993 researcher's claim their hCG vaccine was safe and did not affect menstruation.

Following publications of this article, I likewise received a comment from the spouse of a woman who received this vaccine in the Philippines:


Marc de Piolenc 12 hr ago Pinned

My wife, a citizen of the Philippines, was one of the many victims of the WHO's Special Programme. She and other teachers in government schools were not allowed to obtain their salaries unless they could prove that they had been given the latest of the five-shot "tetanus" vaccine. Fortunately, she did recover her fertility, and despite many miscarriages we had children together. The Church has a great deal of influence, and a single nun was charged with keeping track of this effort and its consequences. Even so, the Health secretary who authorized this program is considered a great hero.

Let's now look forward a few years and see what happened with this technology. To quote a 2011 paper:

> *"Human chorionic gonadotropin (hCG) is synthesized soon after fertilization and is essential for embryonic implantation. A vaccine targeting hCG would be an ideal choice for immuno-contraception;*
>
> *an anti-hCG vaccine developed by Talwar et al., has previously undergone Phase II efficacy trials, providing proof of principle. These trials established the threshold levels of bio-neutralizing anti-hCG antibody*

titers required to prevent pregnancy; however, these titers (>50 ng/ml) were achieved in only 80% of immunized women.

In this communication, we report a novel recombinant anti-hCG vaccine which demonstrates improved immunogenecity. hCGβ was genetically fused at C-terminal to the B-subunit of E. coli heat-labile enterotoxin. The recombinant fusion protein (hCGβ-LTB) was expressed in Pichia pastoris and, upon adsorption on Alhydrogel along with Mycobacterium indicus pranii (MIP) as an immuno- modulator, evoked a very high anti-hCG immune response in 100% of immunized BALB/c mice. This recombinant vaccine is expected to reduce cost as well as facilitate production of a molecularly consistent conjugate on a large scale."

This paper again shows that despite widespread protest against this approach, there is serious interest in it from the ruling class.

Two months after this series was originally published, Children's Health Defense (in partnership with Andrew Wakefield) released this

28-minute documentary:

It tells the hCG vaccination story described in the previous section, but also shows something even more important—the human cost of the Kenyan campaign through interviewing women, who like the previous

reader's wife were directly affected by this program. The documentary can be watched here. Additionally, if you scroll down this page, there is also an hour long roundtable discussion on the topic you can watch.

As I pondered the hCG story, I could not help but note that each of the vaccines with known fertility issues tended to share a few common characteristics:

•A tendency to produce autoimmunity to a protein necessary for

pregnancy.

•An unusual dosing schedule.

•Being distributed to all women of childbearing age.

•Coercive and forceful measures being implemented to ensure a high rate of vaccination.

Some of these might sound *a bit familiar* (e.g., most vaccines do not require two vaccinations and then annual boosters).

The Anthrax Vaccine:

Prior to the COVID vaccines, with the possible exception of the smallpox vaccines, I believe the anthrax vaccines were the most harmful vaccines ever given to a large number of Americans and that what the U.S. military did in the 1990s with that vaccine paved the way for Operation Warp Speed (which was also run by the military) and its COVID vaccines—to the point I've previously argued the anthrax campaign was a beta test for COVID.

Anthrax was viewed as one of the most dangerous agents soldiers could be exposed to, so the military had long been searching for an effective vaccination towards it, but every vaccine candidate had serious short comings. When the Gulf War started, a major concern was Saddam Hussein using anthrax on American troops, and this

emergency was used to justify the mass immunization of them with an experimental vaccine.

At the time this campaign occurred, it was shrouded in secrecy, many veterans thought they were part of a covert clinical trial, and severe injuries frequently occurred which the military relentlessly denied could possibly be linked to the vaccine (the gaslighting was extraordinary).

Before long a mysterious condition emerged known as Gulf War Syndrome which left approximately 37% of the Gulf War veterans permanently debilitated (estimated at 175,000 to 250,000 soldiers). To this day, the cause of that syndrome remains unknown, despite there being an almost irrefutable correlation between it and anthrax vaccination.

Rather than abandon this dangerous and unnecessary vaccine, the military chose to push it on servicemen, who often due to the military's command structure had no choice to refuse the vaccine. Numerous severe vaccine injuries followed (some of which are documented here),

many of which resembled those seen from the COVID-19 vaccines.

Eventually, Congressional hearings were held to get to the bottom of what happened (which resulted in a law being passed that made experimental vaccines illegal for military servicemen…although that all went out the window during COVID-19).

From these investigations, two competing narratives emerged over what happened:

The first was that the goal of the program was to develop a new generation of adjuvants (oil based ones like squalene), and the reason why troops were forced to participate was so the necessary data could be gathered to develop these adjuvants.

The second was that the anthrax vaccine was an inherently dirty vaccine and made much worse by the manufacturing process utilized during the Gulf War. Specifically, its contaminants would clog the filters used to purify it, making the vaccine production cost more and

take much longer. The defense contractor (Bioport) tasked with creating the anthrax vaccine decided to *economically* solve this problem by using larger filters that would not clog but also did not take out many critical contaminants from the vaccines.

I initially believed the former as it had numerous compelling pieces of evidence for it (the adjuvant in question [squalene] was found in the vaccines, vaccinated soldiers developed antibodies to squalene, and squalene later emerged on the market as an adjuvant). Later, I spoke to Meryl Nass, one of the physicians who worked with Congress to get the bottom of this mess and she convinced me that the second theory was the more likely explanation. Regardless of which explanation is correct, it's also clear there was a faction in the military that was very dedicated to advancing this work, likely both for ideological reasons and because many of them stood to financially profit from it.

Because of the toxicity of the anthrax vaccine, it has a variety of unusual symptoms associated with it. For

instance, I have talked to spouses of individuals of injured Gulf War veterans, and many have stated the negative effects of the vaccine were transmitted to family members and sometimes improved with the administration of doxycycline (which argues for Garth Nicholson's competing theory that the illness was coming from a weaponized mycoplasma).

Likewise, microstrokes were frequently observed in vaccine recipients that were much greater than those typically observed following vaccination (discussed further here). This argues for Nass's theory that the vaccine was simply an exceptionally dirty vaccine (as each additional contaminant increases the likelihood the vaccine will cause a zeta potential collapse and obstruct critical blood supplies in the body).

In addition to permanent neurological disability and a wide range of debilitating autoimmune conditions, the anthrax vaccine was known for causing a variety of other issues including effects on fertility. I'd like to quote one reader

since many aspects of her story resemble what we are seeing now:

"We purposely were careful NOT to get pregnant immediately (which is common after deployments), because my husband was concerned about the shot and pills he was given during the Gulf War and his ensuing stomach issues. We soon found out that was a good call as soooo many women we knew miscarried or had still births. The few who did deliver had severely ill babies with bizarre issues, like...extreme allergies to everything, extreme skin issues, digestive abnormalities, etc... and several of those babies eventually died. This was all word of mouth as there was no internet, cell phones, or social media then. During that first year there were also several soldiers my husband knew who just dropped dead during runs from massive heart attacks.

I also heard of several people dying with bizarre cancers. For example, a civilian Dr. friend I knew told me of one woman who became almost completely covered

with cancerous moles. She died a horrible death with no one knowing what she had, why, or how to treat it."

Although the vaccine was forcefully administered to female servicemen, including those who were pregnant, it seems highly unlikely that was done to prevent them from having children. Rather the observed effects on fertility appeared to be a side effect of the vaccines ability to cause significant autoimmunity and impairment of the physiologic zeta potential (both of which the COVID vaccines also have an unusual affinity for doing) and a callous leadership in the military which cared much more about advancing their own agenda than having any consideration for basic biomedical ethics.

The HPV Vaccine:

Like the COVID-19 vaccines, there were many issues with Merck's HPV vaccine, Gardasil that should have led to it never being approved or at least pulled from the market years ago. The vaccine provides no benefit and is linked to numerous severe harms.

To illustrate that political climate: Peter Gøtzsche, a widely respected expert in evidence based medicine and typically highly supportive of vaccination, realized how problematic the HPV vaccine was and broke with his colleagues to speak out against it. Shortly before this happened, the Gates Foundation bought out the Cochrane Collaboration (who were widely regarded as the most unbiased evaluators of medical evidence in the world). Gøtzsche was then expelled from the Collaboration (which he helped found) for speaking out against this vaccine.

This shook the evidence-based medicine community and many of the most ethical people in the field spoke out against it. Since that time, the Cochrane Collaboration has stopped producing honest papers (for example, as covered in *The Real Anthony Fauci*, Cochrane's new leadership knowingly published a very bad review they knew was bad that was used to tank Ivermectin and hence killed many people).

Note: Since much of what happened with the HPV vaccines mirrored what we saw with the COVID vaccines (e.g., both had doctored clinical trials which concealed the high rates of adverse reactions from the injections), I discussed it in detail here.

The HPV vaccine was specifically targeted to girls of child-bearing age (since the goal was to get the vaccine before their first HPV exposure from sexual activity, the first dose is scheduled for 11-year olds, although it is sometimes given earlier). These girls were the most likely members of society to become pregnant and in a normal world, the vaccine's effects on fertility should have been a key focus for any drug regulator

Chapter 10 of the book *The HPV Vaccine on Trial* examined the data collected on that vaccine's potential effects on fertility and how regulators failed to respond to that data. In 2020 it was estimated 77.1% of girls between 13 and 17 years of age had received the HPV vaccine, while in England roughly 90% of girls had received the vaccine. Keep those figures in mind as we consider the trial data.

In the clinical trials, the miscarriage rate for recipients of Gardasil was 25%, and 27.4% for the later Gardasil 9. This compares with a typical miscarriage rate of 8% to 15% with miscarriage rates increasing by age (so 10% is a safe estimate). Despite the catastrophic implications of these findings, in the same way the COVID-19 vaccination was given a free pass, the FDA chose not to find this miscarriage data concerning.

The FDA's "reasoning" was that the 25% miscarriage rate was also observed in the placebo group, which arose because the "placebo" was Gardasil's adjuvant, the primary toxic component of the vaccine and thus provided a way for Gardasil's manufacturer (Merck) to conceal the disastrous side effects of their highly lucrative product. In contrast, a competing HPV vaccine, Cervarix used a much less dangerous adjuvant, and in its clinical trials, a 8.3% miscarriage rate was observed in controls, while a 13.5% was observed in the vaccine arm, which should have informed the FDA that Gardasil quadrupled the miscarriage rate… something *completely unacceptable* for a

vaccine that would be given to all women of childbearing age.

This rate was even higher when the vaccine was received within 30 days of conception. In the case of Gardasil 9, an overall miscarriage rate of 28.4% occurred compared to the 12.7% rate observed in the placebo group. Of those receiving this vaccine, the rate was 40% in the 23-26 age range, and 18.9% in those aged 16 to 22. Once again, the FDA completely ignored this safety signal, while the European FDA equivalent (the EMA) simply asked for an explanation and then signed off on it.

During the first Gardasil vaccine approval process, the FDA also noticed a large increase in birth defects (5 compared to 0 in the “placebo” group) when Gardasil was given within 30 days of conception. Like before, the FDA ultimately decided to drop the issue (it was not even mentioned on the package insert which simply stated there was no data on Gardasil’s effects on pregnant women).

Furthermore, prior to being given to humans, Gardasil only had incomplete animal studies that were conducted on it, and many of the rats were quickly disposed of after receiving the vaccines (thereby making it impossible to evaluate chronic health issues they might develop like cancers). In regards to fertility, key toxicology studies were not conducted on the reproductive systems of female rats and there was no long-term observation of rat fertility.

Note: Knowing this history made me believe the reason why the COVID vaccines were never animal tested for effects on autoimmunity, cancer, fertility or birth defects (revealed within Pfizer's EMA leaks) before being given to humans was because pharmaceutical companies early on found concerning data and felt it was better to have plausible deniability when those events eventually came to pass. Likewise, it was very strange the drug regulators allowed the requirements for those tests to be waived due to the "emergency" situation of COVID-19.

Prior to Gardasil, unexplained premature ovarian failure (POF) was very rare (2 cases were identified by researchers from 1998 to 2008, while 13 were found from 2008 to 2013 following Gardasil's initial entry to the market). In 2013 the American Journal of Reproductive Immunology presented 3 cases of autoimmunity and POF following HPV vaccine administration. In 2014, Dr. Deidre Little published three case of healthy teenagers developing POF following vaccination. VAERS (which typically captures less than 1% of the adverse events that occur) tells a similar story. Currently on VAERS (which has been in operation since 1990), POF can be documented as either "ovarian failure" or "premature menopause," and when these symptoms are searched for, 132 cases come up, many of which explicitly describe the characteristic POF observed following HPV vaccination.

The vaccines responsible for those cases were as follows:

- Anthrax-1 case (in a mid 40s woman and which mirrored those seen after COVID vaccination)

- •COVID-31 cases (all adults from 30-49, one was older)
- •HPV-85 cases (all in women either 6-17 or 18-29)
- •TDAP-1 case (a mid 30s adult)
- •Unspecified-3 cases

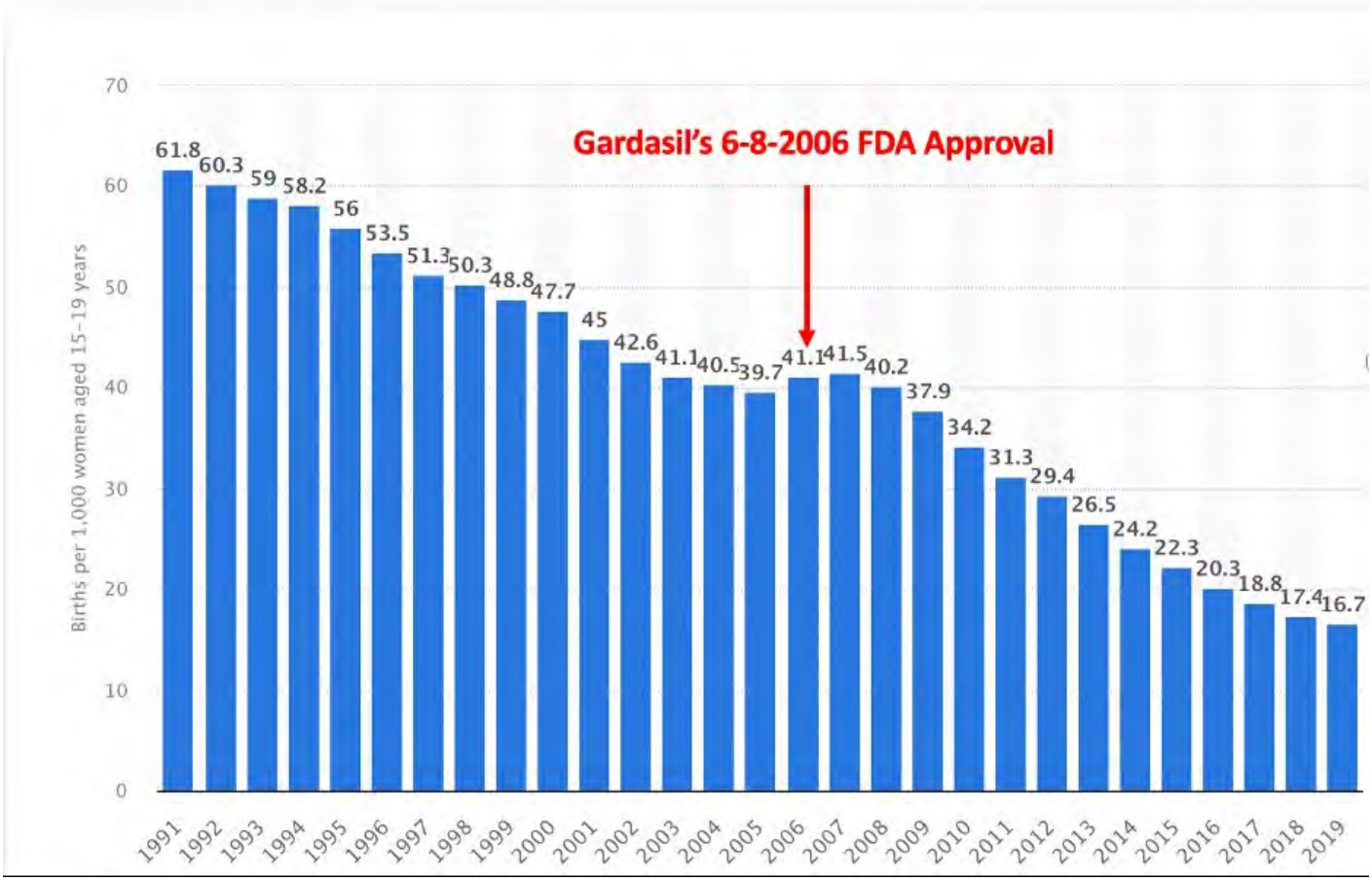
Additionally, of that 132 there were 11 other cases that were entered twice (8 HPV ones were entered twice, and 3 HPV cases were also either entered as menigiococcal or Hep-A since those vaccines were taken in a similar time period).

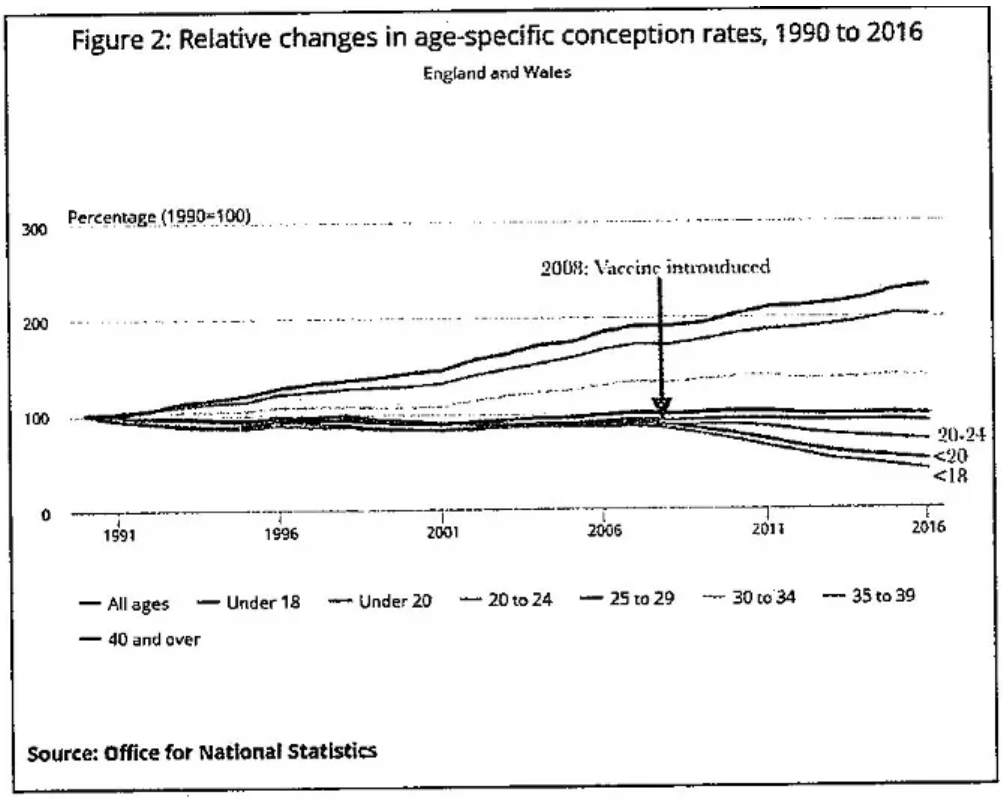
In my eyes, this data demonstrates that a red flag exists in VAERS regulators have deliberately ignored for over a decade.

So, given all of this, what would you expect to occur once Gardasil was given to our next generation?

Birth rate among U.S. teenagers aged 15-19 years

(per 1,000 women)





Source: Office for National Statistics UK Conception Statistics 2016

To clarify this chart: an overall decline of 44% was observed for girls under 18, most of whom lived in England. The rate in decline was the greatest in those under 16. For example, in neighboring Scotland (also a part of the United Kingdom) the teen pregnancy rate declined 60% from 2007 to 2015.

Typically, it is very difficult to draw causation between two events because so many other variables are also present. While fertility in all age ranges was affected by Gardasil, this dataset is remarkable for how clearly it is able to show

this correlation. Initially this profound drop in teenage fertility was acknowledged and met with alarm. However, because no cause could be identified, it was then then forgotten and the trend has continued ever since (the first graph I just pulled off Google was produced a few years after the *HPV Vaccine on Trial* was published).

The Porcine Zona Pellucida Vaccine:

To conclude this article, I'd like to ~~share~~ (~~per~~ Wikipedia) the current consensus on immunocontraception:

> *"Typically immunocontraception involves the administration of a vaccine that induces an adaptive immune response which causes an animal to become temporarily infertile. Contraceptive vaccines have been used in numerous settings for the control of wildlife populations. However, experts in the field believe that major innovations are required before immunocontraception can become a practical form of contraception for human beings."*

The specific areas which has been targeted by immune contraception match those detailed within the 1993 article. Per the Wikipedia article, the following has been attempted:

- •Gonadotropin-releasing hormone or GnRH (regularly used in multiple animals).
- •Zona Pellucida (regularly used in animals, tested in humans, self- spreading ones have been tested in animals)
- •Sperm (tested in humans)
- •hCG (used in humans but has not publically made it past phase II trials)

I find the mammal immunocontraceptives useful for understanding these approaches a few reasons. First, since mammals have the same biology as humans, many of the approaches used in them are likely to be considered for human use as well.

Second, a case can be made that the perspective the ruling class has towards the common people is not all that different from how farmers see their livestock or those responsible for wildlife management view their animal populations. Because of this, there is always an eerie resemblance between the approaches implemented on animals and the ones you see being utilized for human beings.

During the vaccine roll-out, individuals online noticed something unusual about the COVID-19 vaccine. It had many parallels to the widely used Porcine (pig derived) Zona Pellucida (PZP) vaccine. These include the highly unusual dosing schedule of the mRNA vaccines matching that used for the PZP vaccine, that PZP vaccines must be frozen prior to use (although it does not require temperatures as low as the mRNA vaccines) and the PZP vaccine’s side effect profile.

The PZP vaccine is designed to create antibodies to the sperm receptor found in the eggs of all mammals, thereby making fertilization impossible and is used for controlling wild populations of mammals such as horses. While the PZP vaccine is claimed to just safely block sperm fusing with an egg, there is some controversy around the vaccine, since evidence suggests that PZP antibodies actually work by inducing ovarian dystrophy, oophoritis (inflammation of the ovaries), destruction of oocytes in all growing follicles, and depletion of resting follicles.

While difficult to calculate precisely, like hCG vaccines, the PZP vaccine appears to cause progressively longer periods of sterility with each booster administered (8 years of sterility after 3 doses was one estimate).

Like the COVID vaccines, PZP can also cause significant menstrual irregularities and PZP antibodies are also transferred through breast milk. Finally there is an association between PZP vaccines and stillbirths.

A major challenge for the PZP vaccine was ensuring a lengthy period of sterility, as it was not practical to repeatedly vaccinate wild animals. Multiple groups have examined this question and the relatively new biotech company, SpayVac was able to solve this issue with Lipid Nanoparticles.

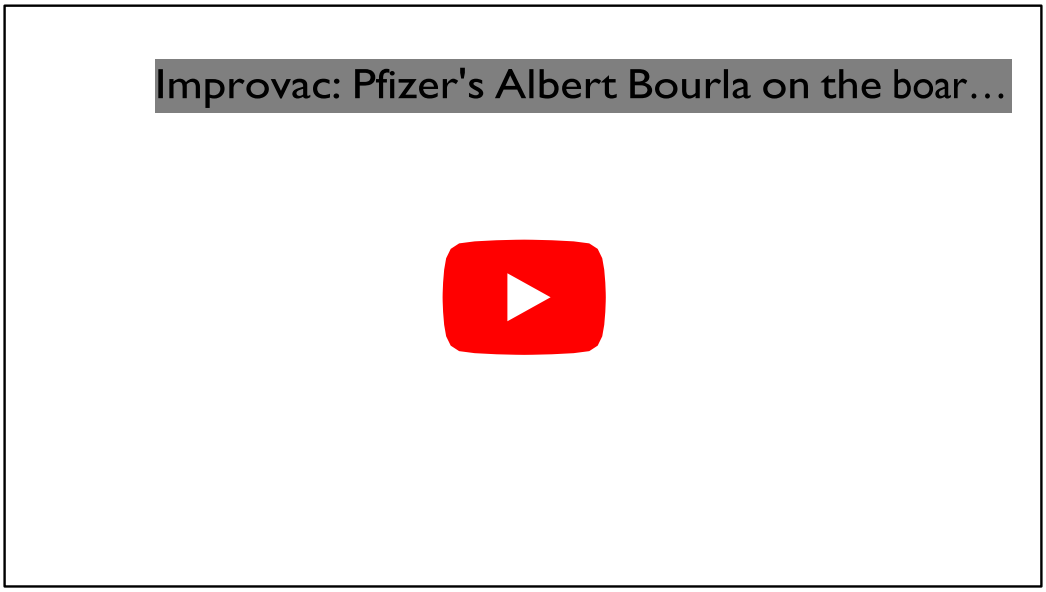
These particles are designed to hold onto the antigen so they create a prolonged sustained immune response in the tissue, which may be part of the reason why vaccine spike proteins are more destructive than those from a COVID-19 infection. I also read speculation that the lipid nanoparticle used by SpayVac (IMV's DPX) was designed to travel to ovaries where it finally releases its contents (IMV is also developing a DPX-based COVID vaccine). Despite my best efforts, I was unable to located the patents or drug studies on these lipid nanoparticles, so as far as I know there, is no evidence to support that speculation. That said, I don't know if it matters because Pfizer's lipid nanoparticle clearly travels to the ovaries. This is quite problematic if they behave in a similar

manner to DPX's lipid nanoparticle, something specifically designed is designed to create a prolonged immune response in the region where it settles.

It was also noted that Pfizer's CEO Albert Bourla is a veterinarian and likely worked with the PZP vaccine. When I dug into this, I found out something curious about Bourla's background.

When male pigs are farmed, if you do not castrate them, 20% of males will develop meat that some people dislike the taste of (known as "boar taint"). Pfizer developed the vaccine Improvac, which creates autoimmunity to GnRH, thereby significantly dropping the production of hormones in the pig's body. This chemically castrates the pigs and gives a cheap and easy way to prevent boar taint.

In the following obscure 3 minute video Bourla, already in an executive position eagerly presents Improvac to the European market.



Note if this video is deleted, I also uploaded it here.

From watching this, I am relatively certain he knew about the PZP vaccine and likely was aware of the value of using a similar approach to manage fertility in human males. On December 28, 2020, he also signed a $4.2 billion deal for the rights to Relugolix, a new human GnRH receptor blocker.

Conclusion

In my eyes, the mRNA technology may present a potential solution for many of the long standing challenges with

developing a viable form of immunocontraception many population control advocates have spent decades searching for. Specifically:

- •mRNA technology reliably creates an immune response to any desired antigen, especially when paired with a highly immunogenic protein (e.g., the spike protein). This creates the potential for new fertility impairing antigens (e.g., Syncytin-1*)* that had not previously been possible to produce immunocontraceptives against.
- •mRNA lipid nanoparticles accumulate in the ovaries, thereby making it possible to selectively target the reproductive system with a vaccination.
  Note: pathologists have also found the spike protein is present in the sperm of vaccinated males, but it is still unclear what the implications of those findings are.

mRNA technology makes it possible to create a sustained immune response to the target antigen without multiple dosings being needed (because synthetic mRNA keeps on producing its target protein).

Furthermore, it accomplishes this without a significant risk of affecting unvaccinated individuals (a risk always inherent when using a viral vector).

•Because of the widespread faith in vaccination, mRNA gene therapies being branded as vaccines will make many be unlikely to consider their issues, much in the same way vulnerable young women in Africa took at face value the claims they were simply receiving an experimental tetanus vaccine that was essential for their health.

While I have some experience working in drug development and with drug regulators, Dr. Yeadon, a former chief scientist and vice-president of the allergy and respiratory research division at Pfizer, has significantly more experience than me. So, with his permission, to conclude this article, I will quote what he told me:

> *"I was just reflecting on my first encounters with the fundamental design points of the leading c19 "vaccines". I focused on mRNA because I believed that to be the most dangerous option. The industry had*

spent years trying to make this a viable mode of treatment and had not overcome several serious barriers. One was that mRNA wasn't stable & would get broken down quickly. Another was that it was nearly impossible to get cells to take up the mRNA without violent processes involving electrical fields or toxic chemicals. Why would that be? Consider that the integrity of your genetic complement is the most important thing to pass to your progeny. No wonder your cells have multiple defense mechanisms to prevent alien genetic codes invading them.

So the mRNA "vaccine" companies chemically altered the ribose nucleic acid bases so these aren't even natural bases. They also wrapped up the mRNA in special lipids to help fool your immune system & allow an alien install."

All that looks risky & nowhere near long enough was given to look for unwanted effects. Even though they planned to inject BILLIONS who didn't even need it, and even that only if they worked (which they don't so

they've lied about efficacy, as real-world numbers are nothing like the trial claims).

*But recently, **I've realized they've all made appalling errors and they all made the same errors**. That's not possible to happen if they were competing honestly.*

They picked the most dangerous part of the virus to express, the spike protein. We now know that most of the serious complications arise from the toxicity of spike. Why did all four choose this piece? This is 13% of the gene sequences, so there were plenty of other options.

*They've picked the genetically most unstable part of the virus. That's just stupid, and had they not done so, they couldn't have played the "new variant claim". Was that why they picked it? **They've picked the least dissimilar part from numerous other human proteins**. That maximizes the risk of auto immune reactions.*

The more you look at it, the more it looks like collusion to injure people. By the way, there have now been really comprehensive studies of how human immune systems deal with infections like this. Only 10% of immune responses in your extensive "immune repertoire" is directed to spike protein. All the rest go to other parts of the pathogen.

Coincidence? I don't think so."

The only related precedent I can even think of for this was DES, an estrogen analog that was widely prescribed to pregnant mothers (ironically to prevent complications in pregnancy) that many doctors now know of because it is a frequent test topic on medical board examinations. DES had many side effects including alteration of genitalia and an increased risk for cancer decades later into the fetus's life, many lawsuits were filed against it (which the mRNA injections have immunity from) and in the early 2000s it was by and large withdrawn from the market.

I thank each of you for reading this lengthy and discomforting article. I greatly appreciate the kind support each of you have provided to this publication as it has made it possible to get important messages like this one out to the public.

The Century of Evidence That Vaccines Cause Sudden Infant Deaths

The Disturbing Parallels between Sudden Infant Death Syndrome and Sudden Adult Death Syndrome

Note: due to the significant interest in this topic, this article is a revised version of a previously published article about it.

The Sudden Adult Death Syndrome (SADS) that was seen worldwide after the COVID-19 vaccines rolled out was so unmistakable that it made the general public see how much their governments had lied to them. What is less known, however, is the link between vaccines and the sudden death of children (euphemistically called Sudden Infant Death Syndrome or SIDS).

Like SADS, SIDS has a clear-cut relationship to vaccination, and in the case of SIDS, there is over a century of evidence to substantiate it. Like SADS, our healthcare authorities have worked tirelessly to conceal this link, even when faced with significant protests from the public who know what is

happening. For the most part, these authorities have succeeded, and as a society, we have come to see SIDS as a normal event that does not require an investigation each time another child dies from vaccination.

I was compelled to write about this topic for a few key reasons:

•The children who died from SIDS and their parents deserve recognition and justice. Because of the attention highlighting SADS and vaccine dangers in general, I believe this may, at last, be possible.

•Infants cannot speak up for themselves (other than by crying, which is typically ignored). When you observe these vaccine injuries and the trauma they experience, it's very apparent what happened, but in almost all cases, those around them can't see it— so I feel I have a duty to speak out for those without a voice.

•Understanding how the government has handled SIDS provides essential context for understanding how it has dealt with SADS.

•New evidence supporting the link between SIDS and vaccination emerged during COVID-19.

In this article, I have done the best I could to provide all the evidence clearly demonstrating this link with a focus on that which can explain why vaccination causes SIDS. Additionally, I have also discussed much of this with a US government researcher who specializes in the vaccine most associated with SIDS and has requested their privacy be respected for understandable reasons.

The Forgotten Victims of Medicine

A key theme I have tried to illustrate is the need to stand up for the forgotten victims of medicine (over the years, I have formed a close connection with many of these victims). I believe we all must stand up for them because, in almost all cases, malicious agendas by those in power are first tested on vulnerable groups no one advocates for. Then, once the methods are sufficiently refined and implicitly condoned by the public, those same atrocities will always be committed on the general population.

For example, much of what has happened throughout COVID-19 parallels the early days of the AIDS epidemic. Fauci fought to keep a variety of effective treatments for AIDS off the market so that he could push through a deadly and ineffective (but highly lucrative) drug to treat HIV, AZT (which oddly enough has much in common with Fauci's recent pet project Remdesvir and the other COVID-19 medications). Once AZT entered the market, rather than end the epidemic, it significantly worsened the trajectory of AIDS (this book and this book provide the untold history of what happened). That tragic history hence allowed me, in late 2019, to predict the identical course that COVID-19 followed):

A mock graveyard during an ACT UP demonstration at the National Institutes of Health in Bethesda, Md. (Courtesy of Donna Binder)

Because the gay community was still heavily marginalized in the late 1980s, and despite being extraordinarily outspoken and often accusing Fauci of being a mass murderer, their plight was ignored. Fauci was never held accountable for his actions, and instead became the most powerful scientist in America. Since then, his influence has grown, and he has transformed the NIH (and related

agencies) into pharmaceutical pipelines that prioritize profits over human lives.

Imagine how different our world would be now if we had taken the concerns of these protesters seriously. Unfortunately, the prevailing attitude within America is to never focus on issues that do not directly affect our lives (e.g., the human cost of our wars in the Middle East). Thus, there often ends up being no one left to speak out for everyday Americans when the same abuses they passively condone elsewhere finally arrive on their doorsteps (this is also the subject of a well-known poem about Nazi Germany).

Vulnerable Groups

Being successful in business is often a question of finding a way to break a rule that should not be broken, capitalize upon the economic benefit from doing so, and finally, leverage this newfound wealth to ensure that the rule can continue to be broken.

For example, you are not supposed to bribe public officials.

Still, if you find a way to (such as through "lobbying"), it creates a massive advantage over smaller competitors who still follow the rules, and as recent years have shown, the paid-off officials will eventually legalize each novel form of bribery.

Historically, the best example of this predatory capitalism is told within The Robber Barons. It tells the story of a group of conniving scoundrels, such as John D. Rockefeller, who broke every rule imaginable post-Civil War era and monopolized America's fledging industrial system to become some of the wealthiest individuals in history. This story is still relevant today because those economic

predators defined our national character and, in the centuries since their rise to power, have applied similar tactics to dominate almost every facet of American life (my focus relates to how they transformed medicine).

Contemporarily, one of the best examples of this principle lies within the COVID-19 response, where pandemic profiteers flagrantly violated countless critical rules that had been well established before the pandemic. Deadly hospital protocols with no evidence supporting them were mandated throughout America, untested experimental vaccines with highly concerning safety data were rushed to the market, the manufacturers of these deadly products obtained complete immunity from any harm they caused, and the general populace lost their fundamental human rights through forced lockdowns and mandatory vaccinations. Much of this was illegal, but because an "emergency" situation was created, the wiggle room existed to bypass every legal protection afforded to the public. Pfizer bent every rule it could and gained significant power in the process all while making vast sums of money.

In the pharmaceutical industry, two recurring issues always emerge:

- How to regularly test countless experimental drugs with high potential toxicities to identify the one that could become a commercial success.
- How to create guaranteed markets for unsafe pharmaceuticals with questionable benefits.

In most cases, bribery plays a crucial role in addressing these challenges. For example, I documented the Bush family's involvement in forcing SSRI antidepressants onto the market and the FDA's subsequent decades of complicity in this disaster by suppressing all evidence of the extreme harm from these drugs— the FDA ignored a tsunami of credible adverse reports, put gag orders on employees who tried to report them, authored fake studies defending SSRIs and even fought against congressional investigations. The SSRI saga, I would argue, provides an excellent case study for understanding many aspects of the FDA's egregious conduct throughout COVID-19.

Then, once the regulatory hurdles have been cleared, these commercial needs are often fulfilled by exploiting vulnerable groups who are either experimented upon or forced to become a captive market for various lucrative pharmaceuticals.

Unethical Human Experimentation

In the earlier days of American medicine, dangerous medical treatments were often forcibly tested on prisoners, colonized indigenous populations, the mentally disabled, and orphans (some of the more well-known examples are summarized in

this Wikipedia article). Following the Nuremberg trials (where many Nazi doctors argued they should not be convicted as their ethical principles in human experimentation matched that conducted throughout the United States) and the Anti-Vivisection movement campaigning against unethical human experimentation, a changing political climate made it far more difficult to continue those experiments. The business-focused

members of the medical field thus (reluctantly) switched to conducting future grotesque experiments less visibly.

This new approach included experiments on children in foster care that were no longer published in medical journals, outsourcing this research to the third world (where no one would raise questions), and regularly making use of the military's command structure to force lower-ranking servicemen to participate in highly controversial "research" studies.

Captive Markets

Almost every successful business is built upon creating a source of recurring revenue, and the entire pharmaceutical industry is structured to do this in as many ways as possible. For example, the industry continually funds corrupt guidelines that advocate for large segments of the population to consume countless non- beneficial and often harmful pharmaceuticals, then sells more drugs to treat the side effects of the original pharmaceutical they spread to every corner of America.

This process can best be observed in the elderly, upon whom countless drugs are prescribed until, eventually, the combined toxicity of these medications causes enough degeneration to land the patient in an isolated nursing home or hospital. After this, even more (sometimes necessary) medical therapies are provided until a critical point is inevitably reached and the elder dies (e.g., care in the final year of life accounts for approximately 25% of all spending by Medicare). In contrast, societies worldwide have more traditional forms of medicine that do not prioritize profit and emphasize cultivating vitality. Within them, you will often observe elders who maintain their health and functionality until the very end of their lives.

Note: one study found taking away a few non-necessary drugs from elderly patients reduced their overall risk of death by 56%.

I feel our approach to "managing" aging is particularly tragic because, in the quest to extract as many billable medical services as possible from the elderly (who often cannot refuse receiving said services), they are subjected to a variety of torturous medical interventions that directly

disrupt the dying process (in contrast, doctors typically will refuse these interventions). One of my foundational beliefs (which is shared by many religious faiths) is that the death process represents one of, if not the most important, moments in our life, and medicine's interference with it has profound consequences for the human soul.

Amongst the most common recurring pharmaceutical products are the endless annual vaccinations, and those with knowledge of this business model suspected that once the COVID vaccines were shown to be highly ineffective, health officials would pivot to adopting an annual COVID immunization program instead of being discarded (which they tried to do but due to public resistance against the vaccines were unable to enshrine it upon the populace). Furthermore, a key driver behind the mRNA vaccine technology was its rapid production cycle, which enabled it to be deployed on short notice. In contrast, existing vaccines (e.g., influenza) must be manufactured far in advance, which explains why the annual flu shot almost always ends up not matching the circulating strain.

Something that is less appreciated about each of these universal vaccine programs is that when individuals are given a choice not to receive a vaccine, many will opt out. For example, between 80-90% of children are vaccinated (this figure includes influenza vaccinations). In contrast, last year, only 50.2% of the adult population received a flu shot, and in many cases, the adults who vaccinate only do so because of work requirements.

Note: the CDC recently admitted the COVID-19 mandates have

significantly reduced the number of adults willing to get the other annual vaccinations.#

The key demographics I know of who are forced to receive vaccinations in the United States are pets, children, those in foster care, the elderly, prisoners, service members, students, and healthcare workers. In most cases, the business model around vaccines places intense pressures on the vaccinators to vaccinate:

- Veterinarians and pediatricians can only financially support their practices if they regularly vaccinate their patients.

- Corruption is rife throughout the military's experimental vaccine programs.
- Medicare, through "quality" measures (a component of Obamacare), such as this one, financially penalizes doctors who fail to vaccinate most of their elderly patients.

There are many sad stories of the forced medication of these groups (e.g., I have many astounding stories from friends who were subject to it). For the elderly, over the years, I have heard many stories of nursing homes where numerous residents suffered significant illnesses immediately following the annual vaccination of their facility, and I have admitted a few patients to the hospital for a severe injury that onset immediately following influenza or pneumococcal vaccination. During the recent vaccine push, I had numerous friends whose parents suffered a rapid and subsequently fatal cognitive decline immediately following COVID-19 vaccination, and I know someone who worked at a nursing home which experienced multiple deaths

immediately after the vaccine was administered (similar stories have also been reported elsewhere).

This (abridged) comment I received after the previous article is an example of this tragedy. Sadly, I have run across many other similar cases, and in almost all instances, the vaccine is never considered as a potential cause:

> *"My dad developed dementia when he was 80. He was the picture of health and had not been in a hospital since the day he was born in 1928. The youngest of 4 brothers, his 3 older brothers all lived into their 90s with full mental faculties. Dad's dementia downfall was swift and sobering to watch. His decline frustrated him more as he was always a very healthy man. We had no idea what could cause this decline, but over the next 4 years, it was a contentious battle to get him the care he needed. He always knew who I was, not so much for other members of the family. When he died, he was 84, and I was beside myself to understand what the **** happened to my dad. Well, going through his papers and medical records, I found evidence that he had received the annual influenza vaccinations (pushed on him by his then-girlfriend who worked for the medical industrial complex) for several years*

immediately preceding his dementia downfall. Was THIS the cause of his dementia? Or was I just fishing for a cause? I don't know. But I will say that I can find very little research on flu vaccination and dementia."

How we treat our elderly is particularly tragic because they often hold the collective wisdom that can divert us from many of the catastrophic directions the predatory economic system has reshaped society to follow. Instead of listening to our elders, we warehouse them in facilities where they can be held out of sight and out of mind as their bodies decay from the inevitable consequences of a profit-driven medical model that does not cultivate health and vitality.

For the remainder of this article, I will review how unsafe pharmaceuticals have harmed another vulnerable demographic that cannot fully advocate for themselves. If you can review the previous installment in the series before reading the remainder of the article, it will provide valuable context toward understanding the critical lessons to be learned from sudden infant death syndrome (SIDS):

What Is The Story Behind Sudden Death Syndromes?

When you study the history of medicine, you will frequently observe that the nature of disease completely changes depending on the era, and these forgotten sides of medicine can be found within many different sources and medical systems. As far as I know, Chinese medicine provides the most detailed picture of how human health has changed over the centu…

Read more

Medical Blindness and SIDS

Although to this day, I harbor a great deal of animosity towards some of the physicians I trained under (that I believe is justified based on how they have conducted themselves throughout their careers), I also had the opportunity to train under many remarkable human beings I am forever grateful to. One pediatrician, for example, genuinely cared about his patients, was immensely intelligent, and, although we had radically different

perspectives on many issues, was very kind and open-minded toward the parts of myself I shared with him.

At the very start of my medical education, he made a point during a lecture to state he believed with absolute certainty that vaccination was the most beneficial medical innovation in human history. A few years later, when I worked with him in clinic, over and over, I saw him perform a remarkable job caring for his patients, but I also periodically saw cases that led me to seriously question his judgment. For example, we once saw a patient who had an unambiguous adverse reaction to a vaccine, and upon being presented with clear evidence this had transpired, I observed the pediatrician suddenly enter a hypnotic trance where he became completely unable to recognize the existence of that evidence.

I share this story because I sincerely believe medical gaslighting is evil, but, at the same time, I think many of the gaslighters are anything but evil (e.g., often they are simply incapable of recognizing medical injuries). This pediatrician coincidentally was responsible for teaching us the lecture

on SIDS. At the start of that lecture, I can still remember him stating the following:

> *"To this day, we are not sure what causes SIDS, but from a lot of research, we have determined that it clusters at two months of age, four months of age, and six months of age, after which point it sharply declines. Currently, we believe SIDS arises from infants suffocating after sleeping in a facedown position, and the Back To Sleep campaign, by preventing those deaths, has been one of the most successful public health accomplishments in history."*

My immediate thought as the words exited his mouth was to look up the childhood vaccination schedule:

Note: the vaccine schedule has been repeatedly expanded since I first saw it in medical school (e.g., Hep A, HPV, and annual COVID-19 ones were added), but the relevant parts of it to this story have remained unchanged.

To this day, it still amazes me how few medical students had thought to ask the same question I did when this fact was shared in the lecture (there is so much to learn in medical school, which is by design, that students typically focus on memorizing information rather than critically examining it). I am immensely grateful to the pediatrician for explicitly stating his biases and blind spots at the very start. Had he not done so, I likely could have made a verbal misstep around him or his colleagues that would have prevented my graduation from medical school.

One of the most challenging experiences throughout my medical education was having to repeatedly bear witness to children being unambiguously injured from vaccinations (that, for some reason, the healthcare workers I trained with could never recognize) and again and again seeing the

terror that would often appear in a child's eyes whenever they saw someone in a white coat because they knew what was coming next.

To this day, I vividly remember one girl screaming for her mommy and pleading for her not to break her promise the girl would not get shots that visit as the child was forcefully restrained by two nurses who joked about the fact it would be over before the girl even noticed the needle had gone in. I made a point to keep an eye on her after this ritualistic initiation. I observed her for approximately 30 minutes, throughout which her demeanor did not improve, and her vitality continually worsened.

In sharing all of this, I hope it helps to illuminate both the commercial advantages and ethical questions of pushing pharmaceutical products on individuals who cannot advocate for themselves and refuse those products. A large part of why I am putting so much into writing here is how much it gnawed at me that I could do nothing in these circumstances other than bear witness to what was occurring.

Historical Evidence Connecting Vaccination to SIDS

In many cases, the only ones who can recognize the impact of an environmental change contributing to a disease are those in practice before and after the toxin was introduced. One of my fundamental objections to evidence-based medicine is that our current religion of science believes that humans are irrational and incapable of accurately interpreting events in their environment. Because of this, whenever someone observes a correlation that questions a medical dogma, it is reflexively argued no causation (and often no correlation) exists, and that the perception one did was simply the product of a variety of erroneous cognitive biases.

The problem with this argument is that the "science" to establish causation on most controversial topics will never be done (due to the controversial nature of the subject), so an impossible standard is created for any unconventional viewpoint to meet. Additionally, while the unconscious

biases explanation can be credibly argued to dismiss a causation that only has a weak correlation behind it, if a strong correlation is present and no other explanation exists for the correlation, the burden of proof (and the need for further scientific studies) rests on disproving rather than proving the causation.

These conflicting epistemological perspectives have far-reaching consequences. In the earlier days of medicine, countless valuable insights could be obtained by reading the early medical literature and the treatment successes of physicians trying to understand the diseases they were encountering. For example, many of my original (successful) protocols for treating COVID-19 were developed from studying the long-forgotten approaches to managing viral pneumonia devised by individual doctors on the front lines and subsequently proven throughout the 1918 influenza pandemic.

Nowadays, it is incredibly rare to read case reports highlighting the same vital investigative process by clinicians, as anyone who authors such a report exposes

themselves to significant liability for violating the standard of care and "experimenting" upon their patients. I am only able to hear of these reports through word of mouth from many valuable contacts I have cultivated over the years, and as a result, the knowledge base that can successfully treat a wide range of complex illnesses is virtually inaccessible to most of the population who lack that same access.

Since its inception, the Diphtheria-Pertussis-Tetanus vaccination (DPT and DTP are used interchangeably) has been plagued with controversy. Before we continue, I should disclose that I am biased toward this vaccine because two members of my extended family experienced permanent brain damage from the original whole-cell formulation.

The early history of DPT is discussed in a previous article on the many attempts to create population-reducing vaccines:

> *"The DPT vaccine has a very questionable past. Due to a longstanding animosity between England and Ireland that*

originally arose over an English King wanting a divorce to be granted by the church, the English treated the Irish terribly. Unsuprisingly, Irish orphanages, were used to source (likely forced) research subjects for trials of the early vaccine prototypes.

In 2014, unmarked mass graves belonging to Irish orphans were discovered. Further research revealed these graves belonged to a group of 2,051 children upon whom an early diphtheria vaccine was covertly tested in the 1930s. Additionally, an earlier investigation had shown that early vaccine experiments (including DPT) were conducted in the 1960s to 1970s at Irish care homes and the test subjects included babies and handicapped children."

Note: as detailed by Sir Graham Wilson, in the early 1900s, there were over a dozen cases documented within the medical literature (and likely far more that weren't documented) where groups of children received an incorrectly prepared diphtheria vaccine, and collectively, thousands became severely ill with hundreds suffered an agonizing death.

Diphtheria for reference is the D component of the DPT vaccine.

When the DPT vaccine entered the market, statements can be found from many physicians who observed it caused the emergence of SIDS (previously termed crib death due to

babies being found dead in their cribs). Although these statements are likely authentic, in most instances, I have not found the source of the physician asserting that link and hence cannot reference them.

One exception would be Robert Mendelsohn, a remarkable pediatrician, patient advocate, and early pioneer for vaccine safety, whom I recently learned mentored a reader here. In our correspondences, that doctor informed me of a conversation that followed him asking Mendelsohn why he was willing to sacrifice the eminent position he had earned to speak out against the medical system:

> *"Mendelsohn told me that during his appointment as Medical Director of Project Head Start's Medical Consultation Service in 1968, he was horrified by the discussions held privately in the White House with his medical colleagues.* ***They were openly discussing how they could control the population of the poor*** *by promoting infant formula vaccinations, sadistic hospital birthing practices, deficient government schools, and neighborhood abortion clinics. This was just too much of an assault on his strong Jewish faith and his Hippocratic oath."*

Note: one of the many benefits of breastfeeding is a significant reduction of SIDS.

In *How to Raise a Healthy Child in Spite of Your Doctor*, Mendelsohn wrote:

> *"My suspicion, which is shared by others in my profession, is that the nearly 10,000 SIDS deaths that occur in the United States each year are related to one or more of the vaccines that are routinely given to children. The pertussis vaccine is the most likely villain, but it could also be one or more of the others."*

Note: Although I believe pertussis (DPT) is the vaccine most strongly linked to SIDS, other vaccines also appear to share an association. For example, a 2007 VAERS analysis of neonatal (less than one month old) deaths evaluated the 29 unexplained deaths reported following the hepatitis B vaccine. Twenty-four were classified as SIDS; of the twenty-nine total deaths, 13.8 % died within 24 hours, 32 % within three days, and 44.8 % within seven days. Earlier in 1999, legislative testimony by Philip Incao, MD, made a case for the hepatitis B vaccine being associated with SIDS. A key piece of evidence Incao cited for this claim was that SIDS did not occur in those under two months of age until the hepatitis B vaccine entered the market. Hepatitis B is the only vaccine given before two months of age, a time when the immune system's

ability to develop the desired antibodies that result from vaccination is impaired, and as the vaccine wears off over time, too early to later protect a child during the later years they might engage in the blood to blood contact (e.g., unprotected sex or sharing drug needles) necessary to transmit the disease.

A Shot in the Dark

In 1985, *DPT, A Shot in the Dark*, was published. This damning indictment of the DPT vaccine was pivotal in the cheaper but more dangerous whole-cell formulation being withdrawn from the domestic market (an acellular formulation replaced it). Its publication also helped create the political will for the National Vaccine Injury Compensation Program, established twenty months later because many of the parents who successfully lobbied members of Congress to take on the issue of vaccine injury had DPT-injured children. At the time, this law appeared to be a step in the right direction; unfortunately, the US government failed to uphold the spirit of what the law intended, and instead, it only served to grant vaccine manufacturers immunity for producing unsafe vaccines.

Note: the history behind that law is discussed in much more detail here (e.g., the activists who got it passed made creating the acellular DPT vaccine a condition of the act.

From that *DPT, A Shot in the Dark*, I learned that pertussis bacteria are highly immunogenic pathogens with many toxic components. As a result, the existing manufacturing techniques (based on culturing and then killing large numbers of the bacteria to create the raw vaccine material) could never produce a clean vaccine free of side effects. I also suspect the later development of a less toxic acellular DPT vaccine (which took quite a bit of work) was initiated in response to a wave of lawsuits for injuries by the more toxic whole-cell formulation.

Note: as mentioned before, there were also significant issues with inactivating the Diphtheria toxin.

As somewhat of a parallel, Meryl Nass, MD, is one of the foremost experts on anthrax vaccine injuries (which were what most likely caused the severe illness that afflicted over 100,000 service members). Nass (who was able to directly review documents unearthed by a congressional

investigation of the vaccine) believes the most probable cause of the Anthrax vaccine's toxicity was it being an inherently dirty vaccine due to the raw material necessary to produce it. The vaccine manufacturer, Bioport, further worsened the vaccine by making the misguided choice to use larger filters (which let more problematic contaminants into the final vaccine) because the smaller filters were clogged by the vaccine ingredients (large quantities of killed, but still toxic, anthrax bacteria).

Due to the perceived danger of infection with the highly immunogenic pertussis bacteria, the medical field and the governing bodies overseeing immunization programs assumed that a certain number of injuries were an acceptable trade-off to mitigate the significant dangers posed by pertussis. However by the time pertussis became a relatively mild illness, most likely due to improvements in public sanitation or public nutrition (hence no longer justifying a dangerous vaccine), there was enough inertia

behind DPT that attempts to curtail its use met fierce resistance.

Note: Pertussis can be treated with antibiotics while many outside the conventional medical system find vitamin C is remarkably effective for treating it.

As reports of injuries from the DPT vaccine exploded following the continually increasing administration of the vaccine, widespread allegiance to the vaccine resulted in the victims of DPT and the physicians who reported the injuries being attacked instead of listened to. Some of these reports, including those resulting in death, were summarized within *DPT, A Shot In The Dark*, and the indented passages that follow are direct quotations from it.

Note: For those of you who are not able to locate an electronic copy of the book, many of the cited studies here are also synopsized within this committee's report (I do not agree with the committee's attempt to refute the link between DPT and SIDS, which like almost every other official evaluation of this issue appears heavily biased towards

arriving at its predetermined conclusion, but at the same time, I also believe it is imperative to consider both sides of each argument).

> *"Death was the first reaction to be associated with the pertussis vaccine. Thorwald Madsen, the Danish vaccine pioneer, published an article in 1933 describing the deaths of two babies a few hours after they had been vaccinated. One had hiccups and convulsions, while the other had nothing more visible than a bluish tint of the skin. Following his report, other physicians added their own case histories of infant deaths immediately following pertussis vaccination."*

> *"In 1946, Werne and Garrow described the deaths of identical twins within twenty-four hours of their second shot."*

Cases of identical twins developing a condition immediately following an intervention are often considered a gold standard in proving causality. If SIDS occurs spontaneously, it is virtually impossible it would happen in the same amount of time after vaccination in twin infants. That article reviewing thirteen cases of simultaneous twin deaths, 10 of which were officially certified as SIDS, discusses the near impossibility of these events being due

to chance. Likewise, while we know of many cases of SIDS occurring immediately after vaccination, we do not know of any that happened prior to vaccination.

Note: this also holds true for sudden regressions into autism.

Due to the political ramifications of these types of reports, American physicians are highly reluctant to publish these incidents in the current era. Nonetheless, many case reports (such as the ten cited in the above article do exist). Some cases are as follows:

To quote a 2006 case report from Turkey: "*Twin girls (3.5-month-old) were found dead by their mother in their crib, both in the supine position lying on their backs]. The infants were identical twins and delivered at a hospital by cesarean section. Both infants were healthy and did not have any serious medical history. Two days before the incident, the twins had received the second dose of oral polio, DPT, and the first dose of hepatitis B vaccines. They had a fever on the first day of the vaccination and were given a teaspoonful of acetaminophen [catastrophic vaccine injuries often follow the administration of tylenol for fevers and infant distress that follow vaccination—I have seen this first hand]. Death scene investigation, judicial investigation, parental*

assessment, macroscopic and microscopic autopsy findings, and the toxicological analysis yielded no specific cause of death."

Other case reports of twins dying immediately following vaccination include:

- A 1987 case report of twins who simultaneously succumbed to sudden unexpected deaths 3 hours after DPT vaccination
- A 2007 case report of healthy 15-week-old identical twins who both died suddenly two days after receiving oral polio, hepatitis B, and DPT vaccines and were found by their mother **both in the supine position**.
- A 2010 case report of 12-week-old identical twins who died "**lying on their backs**" 5 days after receiving six vaccines concurrently.
- A 2013 case report of 10-week-old twins who were found dead **both in the supine position** and ten days earlier they had received their first doses of DPT and oral polio vaccines.

Note: I emphasized them being in the supine position (on their backs) as SIDS is often blamed on infants sleeping face down and suffocating themselves.

"In 1947, Matthew Brody, at the Brooklyn Hospital, gave detailed descriptions of two cases involving brain damage leading to death after the [DPT] shot."

"In 1978, Griffith studied severe reactions occurring after fifteen million doses of pertussis vaccine were administered to children in England. He stated that one child "was admitted to the hospital with pyrexia, signs and symptoms of meningeal irritation; transferred after three days with provisional diagnosis of encephalomyelitis but died thirty days after vaccination; necropsy showed no specific changes; recorded cause of death: encephalopathy due to injection of triple vaccine."

"At the Thirty-fourth Annual Meeting of the American Academy of Neurology in 1982, Torch presented a study suggesting a link between the DPT shot and certain cases of SIDS. After observing four sudden deaths within nineteen hours of DPT vaccinations in Nevada, Torch studied the relationship between this shot and SIDS in over two hundred randomly reported SIDS cases.

In a preliminary report on the first seventy cases. Torch stated that two-thirds had been vaccinated prior to death. Of these 6.5 percent died within twelve hours of vaccination; 13 percent within twenty-four hours; 26 percent within three days; and 37,

61, and 70 percent within one, two, and three weeks, respectively. He found that SIDS frequencies peaked at age two months in the non-DPT group and had a biphasic peak occurrence at two and four months in the DPT group.

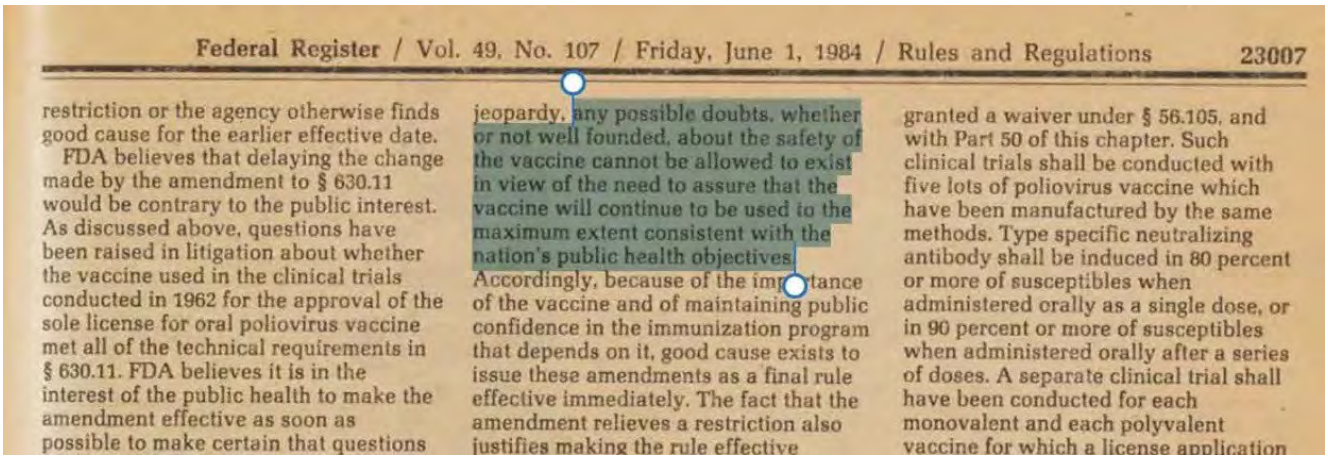
Torch added that cot death occurred maximally in the fall/winter season in the non-DPT group, but was nonseasonal in the DPT group. Death occurred most often in sleep in healthy, allergy-free infants following brief periods of irritability, crying, lethargy, upper respiratory tract symptoms, and sleep disturbance. Autopsy findings in both groups were typical of SIDS (e.g. petechiae of lung, pleura, pericardium, and thymus; vascular congestion; pulmonary edema; pneumonitis; and brain edema).”

But it was Torch's conclusion that infuriated neurologists and government health officials attending the meeting: “These data show that DPT vaccination may be a generally unrecognized major cause of sudden infant and early childhood death, and that the risks of immunization may outweigh its potential benefits. A need for reevaluation and possible modification of current vaccination procedures is indicated by this study.”

[In 1986, Torch also summarized case reports of more than 200 deaths that occurred following DPT vaccination, as reported by 37 authors in 12 countries. About half of these deaths occurred within 24

hours, 75 % within 3 days, and 90 % within 1-week post-vaccination. For most of these deaths a specific cause could not be found, although many were labeled as SIDS.]"

It should also be mentioned that the federal government has adopted a long-standing position that information that challenges public faith in the immunization program, for the sake of "the public good," must be censored and suppressed.



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restriction or the agency otherwise finds good cause for the earlier effective date.

FDA believes that delaying the change made by the amendment to § 630.11 would be contrary to the public interest. As discussed above, questions have been raised in litigation about whether the vaccine used in the clinical trials conducted in 1962 for the approval of the sole license for oral poliovirus vaccine met all of the technical requirements in § 630.11. FDA believes it is in the interest of the public health to make the amendment effective as soon as possible to make certain that questions

jeopardy, any possible doubts, whether or not well founded, about the safety of the vaccine cannot be allowed to exist in view of the need to assure that the vaccine will continue to be used to the maximum extent consistent with the nation's public health objectives. Accordingly, because of the importance of the vaccine and of maintaining public confidence in the immunization program that depends on it, good cause exists to issue these amendments as a final rule effective immediately. The fact that the amendment relieves a restriction also justifies making the rule effective

granted a waiver under § 56.105, and with Part 50 of this chapter. Such clinical trials shall be conducted with five lots of poliovirus vaccine which have been manufactured by the same methods. Type specific neutralizing antibody shall be induced in 80 percent or more of susceptibles when administered orally as a single dose, or in 90 percent or more of susceptibles when administered orally after a series of doses. A separate clinical trial shall have been conducted for each monovalent and each polyvalent vaccine for which a license application

Although this policy was formally stated in 1984 (in reference to widespread and valid concerns about the purity of the polio vaccines), it appeared to have been in effect long before this date. It is hence insightful to observe how the frequent harm from the DTP vaccine was suppressed by the authorities, to the point the FDA even

overrode a manufacturer who wanted to disclose the potential harms!

> *"The FDA's pertussis vaccine specialist, Charles Manclark, commented in 1976: "Pertussis vaccine is one of the more troublesome products to produce and assay. As an example of this, pertussis vaccine has one of the highest failure rates of all products submitted to the Bureau of Biologies for testing and release. Approximately 15-20 percent of all lots which pass the manufacturer's tests fail to pass the Bureau's tests."*

Note: as demonstrated by Wilson, abundant medical literature existed showing that hot lots were a frequent issue that often resulted in clusters of injuries and deaths.

> *"In 1978—79, eleven babies were found to have died within eight days of a DPT vaccination (in Tennessee). Nine of the eleven had been vaccinated with the same lot of pertussis vaccine, Wyeth #64201, and five (four from the same lot) had died within twenty-four hours of vaccination.*
>
> *A statistical analysis of the clustering of deaths revealed that the likelihood of observing four or more deaths occurring randomly on any of the first eight days after the use of lot*

#64201 was 3 in 100. This meant that such a clustering could occur purely by chance only 3 in 100 times. E. B. Mortimer later reported that the probability of this being a chance association was even lower—between 2 and 5 in 1,000."

"In June, CDC director Foege wrote a memo to the Surgeon General stating that the experts "did not feel that a causal relationship had been established between vaccination with DPT from Wyeth's lot #64201 and sudden infant death in infancy. ***However they did not feel that a causal relationship could be totally excluded.****"*

Three weeks later, Foege's interpretation of the events stated in this memo to the Surgeon General was used by Harry Meyer, Director of the FDA Bureau of Biologies, as evidence to oppose a request by Wyeth Laboratories to list among its pertussis vaccine contraindications circumstances thought to predispose to SIDS. Meyer told Wyeth in a July 11 letter, "Based on the available data ***we do not see a medical basis for listing circumstances thought to predispose to SIDS as contraindications to the use of DPT vaccine. We do not agree, therefore, with your proposal on page two of the circular under 'Contraindications.'*** *There is no evidence that such a change would prevent SIDS."*

Wyeth apparently also decided to act to prevent a clustering of deaths following DPT vaccination from a single lot from ever occurring again in a single geographical area. This 1979 internal memo (revealed through litigation) shows that Wyeth's senior management decided to solve this problem by making sure individual lots were distributed throughout the country so it would be much less obvious if one lot was hot as the deaths it created would not be concentrated in one area

INTERNAL CORRESPONDENCE

Wyeth

Mr. Larry Hewlett		from	Alan Bernstein
ny WLD	located Radnor	company	WLI located Marietta
t DTP Vaccine		date	August 27, 1979

After the reporting of the SID cases in Tennessee, we discussed the merits of limiting distribution of a large number of vials from a single lot to a single state, county or city health department and obtained agreement from the senior management staff to proceed with such a plan.

This subject has been discussed with Charlie Young and the following guidelines were developed by FSRD. I would appreciate your comments concerning this procedure and the advisability of formalizing these guidelines.

Interim Measures in Affect

1. Allocation of stock to Distribution Centers is designated by lot number in a manner designed to leave the maximum variety of lot numbers in Great Valley and Marietta to service substantial orders.

2. Managers in D.C.'s carrying average inventories of over 3000 packages (approximate) have been requested to advise FSRD of any orders exceeding 2000 vials. FSRD will then designate shipment by lot number, furnishing additional stock as needed.

Permanent Policy Proposal

1. A D.C. will not fill any order with stock exceeding 2000 packages of one lot number before clearing with FSRD.

2. When additional stock is needed for compliance, FSRD will make necessary arrangements.

3. In the event that the national inventory does not permit compliance, FSRD will clear exception with Marietta management, or make arrangements for split delivery.

WYE PP

Alan

Alan Bernstein

AB/tjs

cc: Mr. Gray
Dr. Shaw
Dr. Bierly, Dr. McCarthy

Note: if this practice became the industry standard, it helps to explain why similar incidents (many people dying in one area after a vaccination drive) have stopped repeating, and why it has become so much more difficult to trace hot lots. Nonetheless, since there were so many COVID-19 vaccine hot lots (due to the rushed production of these vaccines) researchers have nonetheless been able to identify them now.

> *"Vaccine manufacturers **[also] mention the connection to SIDS in their product information inserts.** In 1984, Wyeth Laboratories insert stated: "The occurrence of sudden infant death syndrome (SIDS) has been reported following administration of DTP. The significance of these reports is unclear. It should be kept in mind that the three primary immunizing doses of DTP are usually administered to infants between the age of two and six months and that approximately 85 percent of SIDS cases occur in the period 1 through 6 months of age, with the peak incidence at age 2 to 4 months." In 1986, Connaught's insert stated, "SIDS has occurred in infants following administration of DTP," but went on to state that one study showed that there was no causal connection."*

"On March 19, 1979, a special meeting was called by the FDA on the Relation Between DPT Vaccines and Sudden Infant Death Syndrome. Daniel Shannon, MD, who is director of the Pediatric Pulmonary Unit at Massachusetts General Hospital and a principal investigator of SIDS, spoke about his research:

"We do have a number of parents whose infants . . . have been doing entirely well after their initial near death spell who then go to the doctor, get a DPT and a polio and that is usually the two combined on the same day, and within twenty- four hours have either prolonged apnea [intermittent cessation of breathing] with the alarm going off or the need for resuscitation, having not needed one since the first time, perhaps a month preceding. Whether we would advise the parents to not have any further immunizations or not at that point does not really matter. They will not. Until we tell them that we feel the infant is out of danger, perhaps six or seven months later, you could not get them near the pediatrician's office."

He added, "We do have this data. It is all recorded on tabular sheets and we have it on nearly 200 infants that we have evaluated this way. It is in a capacity that it can be pulled."

In 1982, when Shannon published an extensive two-part study on SIDS in the New England Journal of Medicine, ***a study which was financed in part by the Public Health Service****, he did not*

once mention his data on the near-miss SIDS infants who had prolonged apnea after their DPT shots. When questioned about this omission, he replied in a letter, "I did not mention DPT shots in my review article on SIDS in the New England Journal of Medicine because there are no data collected in a scientific way that support an association

(Shannon at the time of this statement was also aware of Dr. Torch's report, which is detailed above)."

Shortly after the 1979 meeting, the CDC also completed its own analysis 1980 of 23 deaths within 28 days of DPT vaccination. 12 (52.2 %) occurred within 24 hours, and 18 (78.3 %) occurred within one week. In 16 of the 23 deaths, autopsy findings were consistent with SIDS. Of the 16 SIDS deaths, 6 (37.5 %) occurred within 24 hours, and 12 (75 %) occurred within one week.

Archie Kalokerinos

Archie Kalokerinos, MD, was a young Australian doctor who elected to pursue advanced medical training in England after graduation and returned to Australia in 1957. Uncomfortable with the profit-driven mindset he found had

taken over the direction of medicine in his brief time away, he requested to be transferred from the wealthy urban parts of the country and assigned to care for the neglected rural Aboriginal communities. For context, the Aboriginal people have been subjected to the worst of colonialism for over a century, which included terrible social and physical living conditions (the extent of which are discussed further here).

In these communities, diseases such as pneumonia, severe ear infections, severe infant irritability, and a frequent inability to feed afflicted the children, and the infant mortality rate was over 10%, an unprecedented figure that greatly exceeded the 2% death rate found in the surrounding white communities. The local medical authorities, in turn, wrote off the community's poor health as simply resulting from poor child-rearing habits by their uncivilized parents and the widespread filthy living conditions.

Kalokerinos became driven to address this problem, broke from his peers, and eventually discovered each of these issues primarily arose from severe vitamin C deficiencies (colonial powers often destroy the diets of native

populations), and in many cases, saw infants on the verge of death recovering minutes after vitamin C injections (he also found their inability to feed was due to zinc deficiency rather than poor parenting alongside other issues arising from missing B vitamins). Initially, Kalokerinos faced significant opposition to this perspective. Still, after igniting a media firestorm to defend a woman accused of murdering her child (as the bruising that occurs from vitamin C deficiency was assumed in that case to have resulted from child abuse), the vitamin C approach was proven, accepted, and when implemented profoundly improved the childhood diseases that had plagued the Aboriginal communities.

Note: quite a bit of evidence (e.g., this paper, this paper, this paper, this medical report, and this rapid response) has been compiled that "shaken baby syndrome" actually is a result of vitamin C deficiency compounded by vaccination. Likewise, a recent review found that the evidence diagnosing "shaken baby syndrome" rests upon is quite weak.

Having already observed that vitamin C levels would often be depleted during viral infections (which sometimes caused the symptoms of severe vitamin C deficiency to emerge), Kalokerinos then witnessed the infant death rate in one Aboriginal community reach 50% (yes 50%) after an immunization campaign and realized that the same process occurred following vaccination. Kalokerinos proved that widespread vitamin deficiencies existed in the aboriginal community and postulated that vitamin C deficiency was likely why so many cases of infant diseases and deaths following vaccination campaigns. Kalokerinos later obtained proof in an animal model that vitamin C supplementation prevented the animal deaths commonly seen after vaccination and eventually convinced the local medical authorities to hear his case that the vaccines could be causing unintended deaths.

It should also be noted that at the same time, Kalokerinos developed his vitamin C protocols in Australia, Frederick R. Klenner MD independently discovered vitamin C (administered either orally or by injection at comparable

doses to those used by Kalokerinos) yielded profound benefits similar to those observed by Kalokerinos for protecting pregnant women and their children. Klenner also discovered vitamin C could be used to treat various infectious diseases, including polio, effectively. It is quite sad that, to this day, no knowledge of their discoveries exists within either gynecology or pediatrics.

Lastly, in the same way that vaccines, particularly the DPT vaccine, have been connected to SIDS, the DPT vaccine has also been linked to childhood ear infections by many physicians, including Kalokerinos, who were able to observe the suspected causation directly. For myself, the strongest proof I've come across for this hypothesis came from a friend's brother, who was an American MD that spent time in an ashram (monastery) in India and decided as a medical missionary to provide all the children there with the DPT vaccine. Not long after, most of the children developed middle ear infections, a condition he had not seen once in the ashram in the years before his vaccination campaign. Since sharing this story, many parents who

initially vaccinated their children but stopped in their later ones also noticed how the ear infections that so troubled their oldest children were absent in their younger unvaccinated children. From reviewing Kalokerinos's research (detailed within his 1976 book), I suspect the vitamin C deficiency induced by the DPT vaccine may be one of the factors that contribute to ear infections that follow that vaccination.

Raymond Obomsawin

Raymond Obomsawin PhD was a dedicated researcher (a recent obituary from the CHD can be read here) who unearthed many of the harms from the widespread vaccination programs (such as Canada's vaccine program in Thailand increasing death andb disability for those vaccinated, which was of course never published).

While locating the sources (i,ii,iii) for this statement from Obomsawin:

> *"In the period of 1970-1974, when DPT vaccination was begun at 3 to 5 months of age, the Japanese national compensation*

system paid out claims for 57 permanent severe damage vaccine cases, and 37 deaths. During the ensuing six year period 1975- 1980, when DPT injections were delayed to 24 months of age, severe reactions from the vaccine were reduced to a total of eight with three deaths. This represents an 85 to 90 percent reduction in severe cases of damage and death [per vaccine given].”

“Note: when the infant mortality rate (per 1000 births) in Japan during the mid-1970s was later compared to the mid-1980s (ten years after the age of vaccination was moved from 3 months to 2 years of age), it declined from 12.4 to 5. That’s a big deal, and in the context of Obomsawain’s quote, again speaks to the massive underreporting factor in all vaccine injury reporting systems.”

I found this interview by him:

For those who cannot, the key points are:

- •Obomsawin knew Kalokerinos personally and shared his stories of the forced vaccinations the Aborigines experienced and the hostility Kalokerinos received from the Australian medical system for challenging their entrenched dogmas.
- •Global data shows infant mortality increases as more vaccines are given to children (a more recent study also confirmed this correlation).
- •An Australian group developed a way to monitor infants at home continuously and, like many others, **was able to demonstrate non- fatal disruptions of breathing spiked following DPT and Polio vaccination** (this is the most likely cause of SIDS) and that this disruption continued for over six weeks post-vaccination (hence overlapping with the typical period of death that has been observed to follow vaccination).
- •Simultaneous administration of multiple vaccines can create brain damage.
- •When SIDS cases at morgues are examined, **they cluster at precisely 2, 4, or 6 months of age** (rather than

throughout the 2 to 6 month period), which can only be explained as a consequence of vaccination—however (like I saw in medical school) this association is rarely if ever considered by coroners.

- •There are widespread and often severe contamination issues with many vaccines on the market (something we have also seen with the COVID-19 vaccines).
- •Certain cases of SIDS are erroneously assumed to be due to abusive parents shaking or beating their children. **Because of this, parents have been unjustly jailed for a murder they never committed.** The only parallel I can draw to this evil are the many cases of mentally healthy individuals being placed on antidepressants, turning psychotic, brutally murdering a treasured loved one, and then being locked away for that murder.

Note: in addition to the articles above showing that vaccination causes what is termed "shaken baby syndrome" a compilation of many other references and testimonies on the topic can be found here.

Historical Trends in SIDS

SIDS is defined as an infant's sudden and unexpected death, which remains unexplained after a thorough investigation, including the performance of an autopsy and review of the clinical history (both of which share many characteristic findings). My hope is that the following sections will illustrate why this definition is obscene.

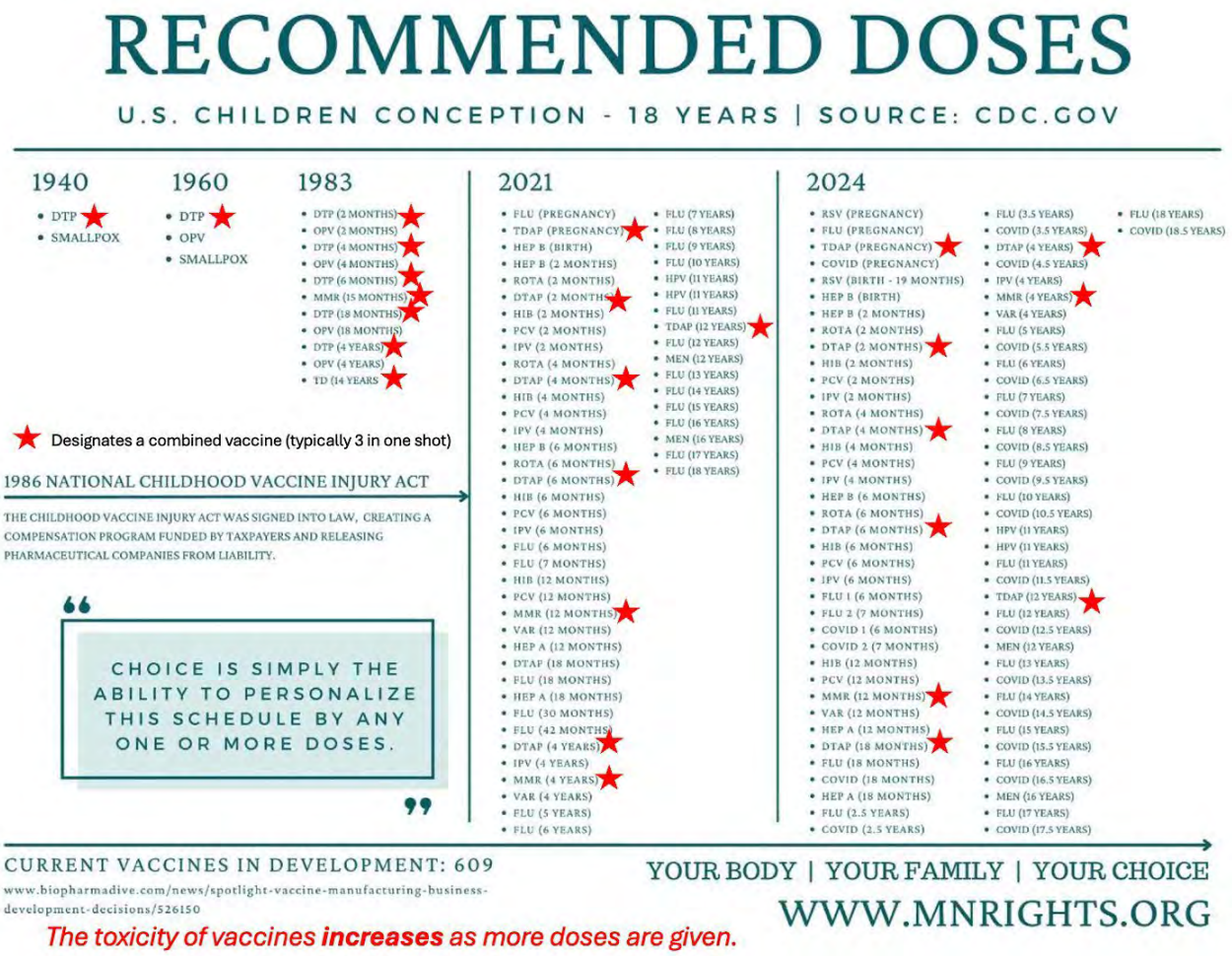
It is often argued that SIDS is entirely due to vaccination (few were aware crib death even occurred before the national immunization programs that began in the 1960s where multiple vaccines were suddenly given throughout the country) and argued that SIDS subsequently increased as more and more vaccines were brought to the market.

This statement from James Howenstine, MD is one such example:

> *"The incidence of Sudden Infant Death Syndrome SIDS has grown from .55 per 1000 live births in 1953 to 12.8 per 1000 in 1992 in Olmstead County, Minnesota. The peak incidence for SIDS is age 2 to 4 months the exact time most vaccines are*

being given to children. 85 % of cases of SIDS occur in the first 6 months of infancy. The increase in SIDS as a percentage of total infant deaths has risen from 2.5 per 1000 in 1953 to 17.9 per 1000 in 1992. This rise in SIDS deaths has occurred during a period when nearly every childhood disease was declining due to improved sanitation and medical progress except SIDS. These deaths from SIDS did increase during a period when the number of vaccines given a child was steadily rising to 36 per child."

note—this graphic helps one to fully appreciate how many more vaccines we give now:



The opposing (and far more common) narrative is that SIDS is an inexplicable phenomenon that suddenly emerged out of thin air and is due to infants suffocating from sleeping face down (which, for some reason, never was an issue prior to the 1960s). Thus, by having infants sleep face up, it

resulted in a profound decline in infant deaths, and as existing data shows, the Back To Sleep campaign was one of the most successful public health measures in history.

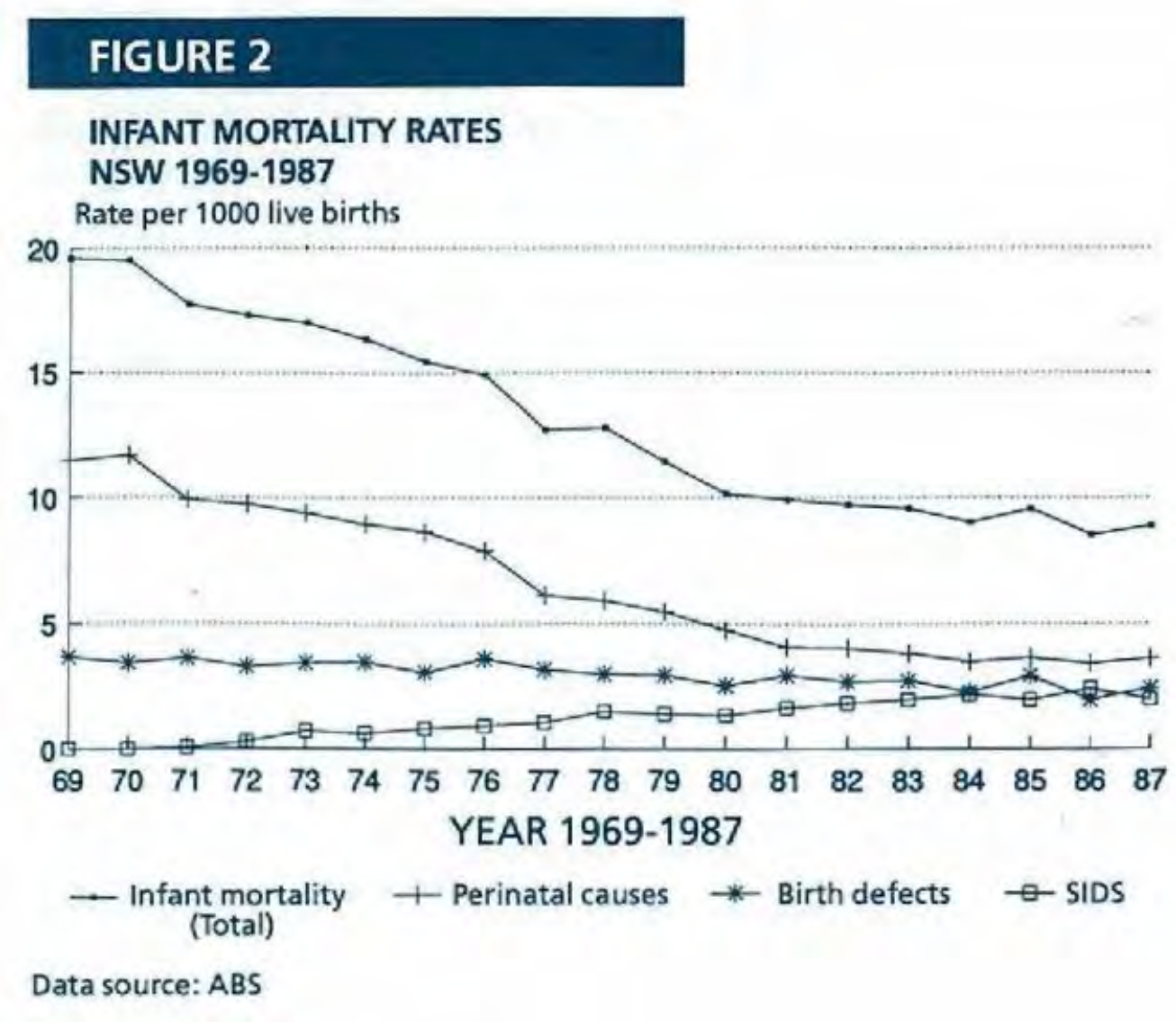
Despite some data that supports this narrative, I nonetheless question it. This is primarily because of how commonly I encounter cases of SIDS where the dead children were not lying face down (e.g., the many twin deaths referenced earlier were found on their backs alongside heartbreaking stories told to me by mothers who saw their babies die in other positions). Additionally, this campaign has always bothered me because a variety of subtle neurological issues result from the deformation (e.g., plagiocephaly) that often is found in infants who are forced to always lie on their backs.

I will also note a case can be made SIDS arises from the crib itself. This can either be due to their mattresses off-gassing toxic chemicals (which may be more toxic if the baby is face down) or from infants being at a greater risk of death when not sleeping with their parents (infants thrive from close contact with their mothers)—this was a potential cause of SIDS Mendelsohn frequently considered (as changing "crib death" to "SIDS" psychologically influenced where parents chose to have their

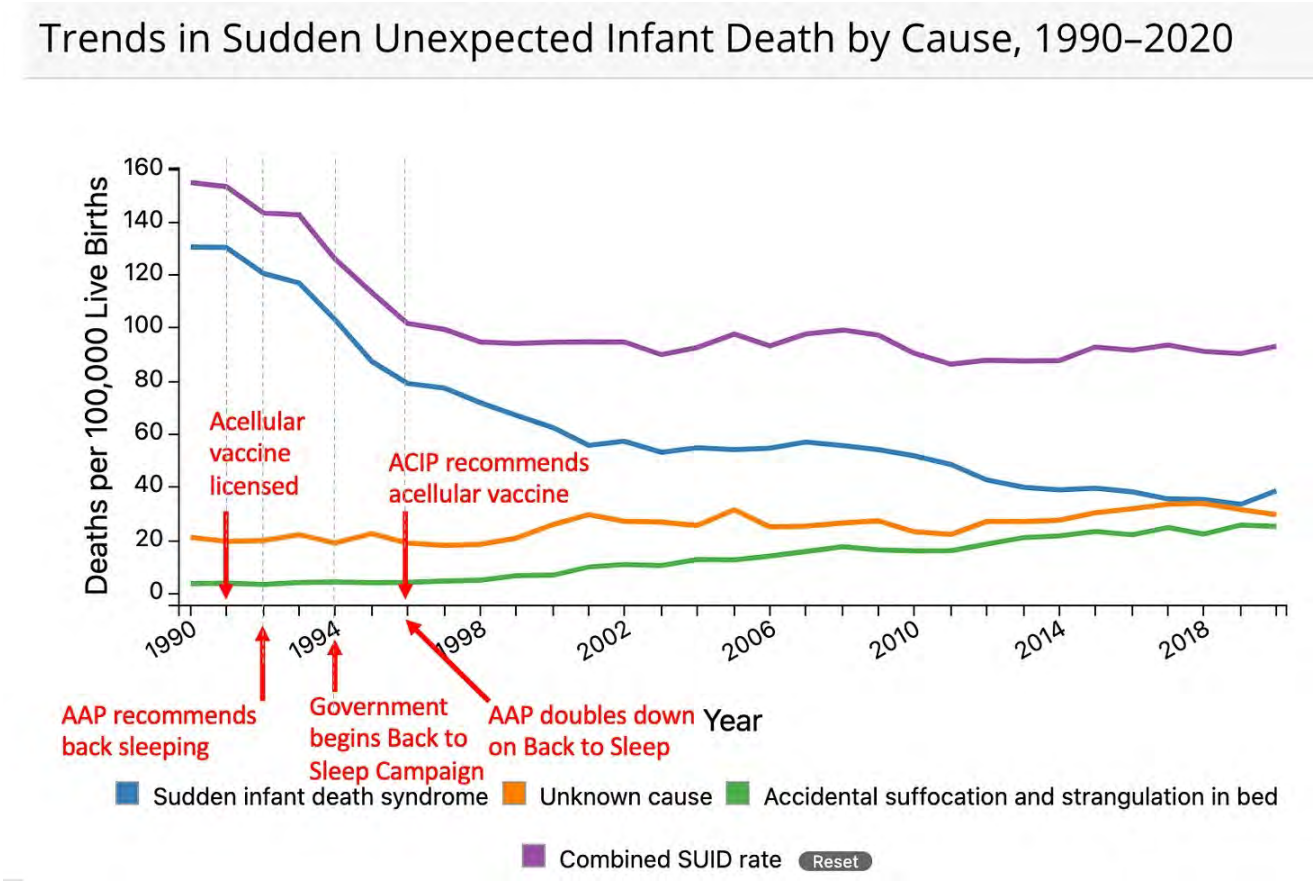
babies sleep). While I believe it is possible these two factors could each influence the overall chance of SIDS occurring (in the same way breastfeeding reduces it), from a preliminary look at the evidence, I believe their possible influence on the disease process is much smaller than the effect of vaccination.

Many of the discrepancies between these two explanations for SIDS are challenging to clarify because, before 1969 (the time at which the condition had become too frequent to sweep under the rug), SIDS was not classified as a disease entity (and hence “crib death” was not documented in the vital statistics). By 1972, SIDS had become the leading cause of death in the first 1-12 months of life within the United States, and in 1973, the National Center for Health Statistics (part of the CDC), had made SIDS a category for documentation of infant deaths that occurred. Unfortunately, likely to conceal the chronology of these events, most references to the incidence of SIDS will only show you data starting when the Back To Sleep started (hence making it impossible to determine if SIDS was increasing before the decline the compilers of those statistics wished to show).

The only dataset I have found so far that tracked the incidence of SIDS since 1969 came from Australia rather than the United States (where the trend, in theory, would be much more apparent), but does nonetheless confirm a gradually increasing incidence of SIDS.



Let's now review the CDC's (annotated) data:



Note: The sources for the annotations in the above chart can be found here and here. Additionally, it should be mentioned that no decrease in TDP vaccination occurred between 1990 to 1996.

From reading this annotated chart, two different interpretations emerge:

The first is that the decline in SIDS resulted from the acellular TDaP vaccine entering the market, and because it took time to be adopted (it only became the standard

recommendation in 1996), the removal of the more harmful whole cellular TDwP was gradual.

The missing data I could not locate to evaluate this argument further is the rate at which that shift occurred, but I feel it is reasonable to assume a gradual change occurred as more and more parties were trying to avoid being sued for TDwP injuries.

The second is that the Back To Sleep was a resounding success (which, conversely, some argue was simply a PR campaign to address the concerns of American parents surrounding the increasingly common cases of SIDS reaching a fever pitch—for example, in 1984 congressional hearings were conducted on vaccination and SIDS).

Although the above timeline appears superficially to support the success of Back to Sleep (and I will admit I have not researched the data on it in depth), I am nonetheless quite skeptical of the campaign's impact. The decline of SIDS began before Back To Sleep was launched, and the campaign had no appreciable effect on the existing trend of SIDS. The critical piece of data I am

missing here is the effect of the American Academy of Pediatrics' 1992 recommendation to physicians to advocate for infants sleeping on their backs. Still, I am doubtful these recommendations could have had an impact that was in any way comparable to the later massive 1994 campaign by the federal government.

I thus suspect Back To Sleep (viewed as one of the most successful health initiatives in history) ultimately served to distract the public from the damage caused by the TDwP vaccine. This is somewhat analogous to the polio vaccine being introduced at the same time

DDT was pulled from the market (DDT caused an illness indistinguishable from polio and produced nearly identical lesions to the spinal cord), and the polio vaccine then becoming a mythology the success of modern medicine was based upon.

Similarly, it can be credibly argued that the widespread adoption of lead (particularly in gasoline) was a key cause

of the still unexplained explosion of heart disease we experienced in the last century. Hence the withdrawal of lead from the market was the actual factor responsible for the later reduction in heart disease the medical community has repeatedly claimed credit for through its severely misguided war on cholesterol.

These events are also analogous to the societal mythology that the earliest vaccines were responsible for ending the era of infectious disease, even though eradicating those diseases was most likely a result of improved living conditions, and most of the eradication preceded vaccination. The correlation is not causation argument is always thrown around to debunk any claim which challenges the authority of modern medicine, but as this example shows, some of the most sacred mythologies of medicine rest on shaky foundations and highly questionable correlations.

For those wishing to learn more about the actual early history of vaccination, the first article on this substack

covers the early data on immunizations (many of the most deadly diseases that declined in that era never had a vaccine) and shows how smallpox vaccination (which killed many young children) was a century-long tragedy that was not in any manner responsible for eradicating smallpox.

Diagnostic Reclassification

There are two competing hypotheses (both of which I agree with) to explain the decline of polio after the polio vaccination campaigns. In addition to the DDT hypothesis discussed above, it has also been argued that the diagnostic criteria for polio were changed so that almost every condition that previously qualified as polio was relabeled as something else (e.g., now we have conditions such as **Non-Polio** Acute Flaccid Paralysis**)**.

Bureaucrats love to tinker with classifications to advance political agendas, which recently came to the attention of the general public after it became recognized that most (but not all) of the deaths attributed to COVID-19 did not alter the total number of deaths occurring, demonstrating many

COVID-19 “deaths” were simply other fatal conditions being reclassified as COVID-19 deaths.

A similar situation also may exist here as a change in diagnostic classifications could explain the decline I attribute to removing the TDwP vaccine from the market. Prior to 1979, the WHO’s ICD system (which is required to be utilized in the paperwork for every death that occurs) listed vaccinations as a cause of death. In 1979, ICD permanently removed this classification, thereby making it impossible, even if the doctor wished to, for there to be any official record of vaccines causing an infant’s death (instead, these deaths were shunted to the nebulous category of SIDS where debunkers could then argue the deaths had nothing to do with vaccination). It is difficult for me to believe this was not done intentionally to conceal the issue.

There is also data suggesting this diagnostic shunting expanded during Back to Sleep, and the campaign’s benefit was primarily an artifact of different ICD codes for death being utilized after the campaign started (potentially

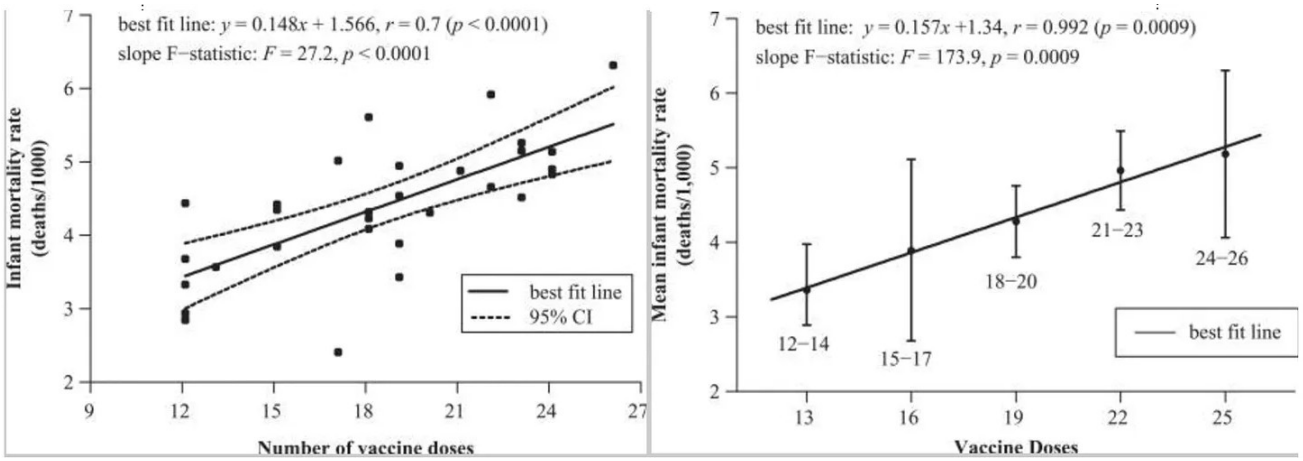
because doctors believing in the value of their advice, did not then want to classify the death of an infant whose mother had followed the doctor's instructions to sleep on their back as SIDS).

> *"The all-cause post-neonatal mortality rate declined 27% and the post-neonatal SIDS rate declined 55% between 1992 and 2001.*
>
> *However, for the period from 1999 to 2001 there was no significant change in the overall postneonatal mortality rate, whereas the postneonatal SIDS rate declined by 17.4%.*
>
> *Concurrent increases in postneonatal mortality rates for unknown and unspecified causes and suffocation account for 90% of the decrease in the SIDS rate between 1999 and 2001."*

However, while this explanation is also compelling, it does not match the above trends with the CDC's data (combined SUID encompasses all of these classifications) or trends I found on overall infant mortality. This suggests an error exists in the data underlying these opposing viewpoints, and I must acknowledge it is beyond my ability to determine where that error lies (a more detailed discussion on the misclassifications of SIDS that potentially extends beyond

the three categories contained within SUID can be found here).

Lastly, although some inherent challenges exist in comparing the historical trends of SIDS to vaccination, a recent 2011 study found another means to assess this association by comparing the current infant mortality rates of the 34 nations with the lowest infant mortality (34 were chosen since the USA is #34) to the number of required childhood vaccines in the country. The relationship is unmistakable..



Whole Cell Pertussis in Africa

Because the whole cell pertussis vaccination is cheaper to produce than the safer acellular formulation, its primary use shifted to the third world once it was removed from the Western marketplace.

Peter Aaby, a renowned vaccine scientist and promoter of vaccination, was commissioned by the WHO to study the effects of vaccines commonly utilized in charitable programs by the international community on infant mortality. For context, these types of studies are rarely conducted, which is why we still do not have the data to determine if the vaccines we give our children provide a net benefit or harm.

The results were not what Aaby expected. While a significant reduction in death was observed from MMR (to my knowledge, this is one of the only studies that has ever found a clear benefit from a vaccination program, likely on account of the immune stimulation from the MMR vaccine to protecting against a variety of often fatal infectious diseases

endemic to the area), the opposite was found for DTP and Aaby's data suggested the program needed to be scrapped:

*"**DTP was associated with 5-fold higher mortality than being unvaccinated.** [DPT increased deaths 3.93 times in boys and 9.98 times in girls] . No prospective study has shown beneficial survival effects of DTP. Unfortunately, DTP is the most widely used vaccine, and the proportion who receives DTP is used globally as an indicator of the performance of national vaccination programs."*

"It should be of concern that the effect of routine vaccinations on all-cause mortality was not tested in randomized trials. All currently available evidence suggests that DTP vaccine may kill more children from other causes than it saves from diphtheria, tetanus or pertussis. Though a vaccine protects children against the target disease, it may simultaneously increase susceptibility to unrelated infections."

Aaby's results were, not surprisingly, buried. Since his publication, instead of being re-evaluated, the distribution of DPT has only increased, largely due to Bill Gates, through his foundation shifting the focus of the WHO towards vaccination (rather than public health projects that save

lives, a concern that has been repeatedly shared with me by employees of the WHO).

Peter Gøtzsche, MD, is a renowned expert on research fraud and has been a critical reformer in evidence-based medicine who has repeatedly stuck his neck out to speak truth to power (Gøtzsche nonetheless fully supports most but not all vaccines). After Aaby's report, Gøtzsche was requested to provide a systematic review of the DPT program. Gøtzsche, in turn, concluded, "Evidence tells us that it is likely that the DTP vaccine increases total mortality in low-income countries." This is about as strong an indictment of a vaccine as can be stated within a scientific publication.

Exacerbating Factors

Standard criteria for proving causality are if a dose-response relationship exists between a disease-causing agent and a disease and if logical predisposing factors increase the likelihood of an agent causing it's associated disease. In *Miller's Review of [400]*

Critical Vaccine Studies, *Neil Miller* located a series of studies

published within the peer-reviewed literature demonstrating those relationships, and that hard work made this section possible.

The particularly sad thing about these exacerbating factors is that if the medical field acknowledged them, immunization could be easily modified to continue vaccinating but avoid many of the high-risk immunization strategies. However, this is never done because it requires acknowledging vaccines are not 100% safe, which is fundamentally unacceptable to the medical field

(pediatricians who still vaccinate but space them out are frequently retaliated against). I have discussed the evidence

outlined in this section with colleagues who are trained pediatricians, and without exception, they all told me they were never aware this evidence existed.

Hexavalent Vaccines

Existing data suggests that multiple vaccines being given simultaneously (e.g., through vaccines that combine multiple immunizations into a single shot), particularly the hexavalent vaccines (DTP + Polio + Haemophilus Influenza B + Hepatitis B) correlate with an increased incidence of SIDS. The following three studies support that link:

After GSK's hexavalent vaccine was made available in Europe in 2000, several reports of infant deaths immediately following the administration of that vaccine emerged. This prompted a 2005 study of Germany's adverse event database that analyzed the risk of sudden unexpected death in young children within 1 to 28 days after receiving a hexavalent vaccine. The study found standardized mortality ratios (SMR) were non-significantly higher than expected on the first day after receiving a hexavalent vaccine during infancy and that in the second year of life, children were significantly more likely to die within one day (SMR = 31.3) or two days (SMR = 23.5) after hexavalent vaccination.

A follow-up to the German study using Italy's national database of death certificates found that administering a hexavalent vaccine to infants of 1-24 months of age increased their risk of death in the 14 days after vaccination by 2.2 times (when six antigens were administered differently, a more minor increase was also observed). Although these results were statistically significant, the authors nonetheless concluded they did not present a substantial concern for vaccine safety (a conclusion I suspect was either due to an existing bias or because the authors did not understand the underreporting factor for most vaccine injuries).

Because of data suggesting a link between hexavalent vaccines and SIDS, in 2011, an Italian judge ordered the release of GlaxoSmithKline's confidential safety monitoring data within Italy. Although GSK's report argued that fewer deaths than would naturally be expected occurred following vaccination (which suggests fraud as none of the vaccinated diseases cause sudden death—suspect government COVID-19 data sets have made similar claims it was reducing deaths unrelated to COVID-19), but even though GSK claimed this, their database revealed that approximately 90% of the

reported infant deaths occurred immediately following vaccination.

Later, a confidential report by GSK was submitted to European regulators in 2015. Of the vaccine-linked deaths that were reported, 52.5 % clustered within three days post-vaccination and 82.2 % occurred within seven days post-vaccination, and 97.9 % of all sudden deaths following the first dose of hexavalent vaccination (four doses are recommended) happened in the first ten days post-vaccination while just 2.1 % occurred in the next ten days.

GSK's reports again substantiate the link countless others have found that SIDS disproportionately occurs immediately after vaccination. If, by some quirk of fate, those suspect vaccines had coincidentally been administered at the same time SIDS would have occurred naturally (which is what debunkers have the audacity to argue), the timing that is consistently found for SIDS would not occur, and the cases of death would be evenly spaced out over the entire 2-6 month period rather than being clustered immediately following vaccination.

Premature Infants

Providing vaccines earlier in life, particularly to premature infants, has been observed to correlate with an increased likelihood of a potentially fatal disease episode (e.g., severe inflammatory responses, heart issues, and most importantly, impairment or cessation of breathing, which, when sufficiently severe, results in SIDS). This association is common enough that many studies have been conducted on the subject, and mainstream journals have published articles suggesting the need to monitor these complications in premature infants.

Beyond the critical systems of the body being less able to tolerate the stress of immunization in an incompletely developed (premature) body since vaccine doses are not calibrated to an infant's weight (instead, a one size fits all model is followed), premature infants effectively receive a much higher vaccine dose. Since this "higher" amount correlates to a higher likelihood of a life-threatening vaccine injury, a dose-response relationship to vaccination is again demonstrated. In each of these studies where premature

infants were evaluated, "cardiorespiratory events" typically referred to interruptions of breathing (apnea), a slowed heart rate (bradycardia), and or reduction of tissue oxygenation.

Note: a dose-response relationship is considered a key criteria for determining causality in toxicology.

If cardiorespiratory events are not addressed, they are often fatal. Since premature infants are often kept in the hospital for monitoring, they represent the one cohort whose vital signs will be monitored following vaccination (as the primary job of the NICU is to do this and intervene to save babies who develop unsafe vital signs). Based on the evidence presented here, I believe it is fair to advance the argument that many cases of SIDS involved incidents of vaccine-induced cardiorespiratory events that progressed to death while the infant could not be unattended to as they lay in their crib. Furthermore, this was also demonstrated by the previously mentioned Australian study where a specialized device was made to monitor an infant's breathing at home following vaccination.

Some of the studies assessing the effect of vaccination on at-risk infants are as follows:

- A 1997 study monitored premature infants for 24 hours before and after being vaccinated at two months. Before vaccination, 1 of 98 preterm infants had a cardiorespiratory event, while 17 of 98 had one after vaccination. Of those 17 who did, 29% required respiratory support.
- A 1998 study found that 30% of premature infants had a cardiorespiratory event within 24 hours after vaccination (and in all but one infant, key inflammatory markers rose to abnormal levels after vaccination).
- A 2001 study found adverse vaccine reactions occurred in 38% of premature infants, and 20% of the premature infants (who were significantly younger and smaller at the time of vaccination than the uninjured) developed cardiorespiratory events following vaccination. One-third (33%) of premature infants vaccinated at 70 days of age or less had major adverse reactions compared with none when vaccinated over 70 days of age.
- A 2005 study found recurrent or increased severity of cardiorespiratory events occurred in 13% of preterm infants following vaccination.

- A 2006 study found that vaccinated preterm infants were 2.41 times more likely to have a resurgence of or increased cardiorespiratory events than unvaccinated controls. Low weight at the time of vaccination increased the risk of these events.
- A 2007 study found 11% percent of vaccinated premature newborns experienced cardiorespiratory events. Of the infants with existing chronic diseases, 21.7% experienced these reactions.
- A 2007 study found cardiorespiratory events were observed in 0- 22% of infants who received a single vaccine (this rate varied by the vaccine, TDaP was the highest at 22%) and in 32% of those who received multiple vaccines simultaneously (who were on average 3.62 times more likely than those receiving a single vaccine to develop a cardiorespiratory event). 13% of those receiving multiple vaccines subsequently required ventilation, and abnormal elevation of inflammatory markers occurred in up to 70% of those given a single vaccine, and 85% of infants administered multiple vaccines.
- A 2008 study found that 51.5% of all vaccinated premature infants had a cardiorespiratory event after their first

vaccination, and 18% had a recurrence after their second vaccination.

- A 2010 study found cardiorespiratory events occurred in 10.8% of very low birth weight infants after vaccination and that when apnea occurred, they were 6.4 times more likely to develop bradycardia.
- A 2011 study found that of preterm infants who experienced apnea after their initial vaccinations, 18% had recurrent apnea with subsequent vaccinations.
- A 2012 study found that cardiorespiratory events occurred in 35% of very low birth weight preterm infants after vaccination, and this risk increased with low gestational age or the infant already requiring respiratory support prior to vaccination.
- A 2012 study found nearly 32% of vaccinated premature infants had cardiorespiratory events following vaccination. Adverse reactions were more common in younger and lower-weight infants.

An analysis of VAERS also supported this association:

A 2012 analysis found 38,801 reports in VAERS that occurred in infants between 1990–2010 (keep in mind these injuries are massively underreported—often in the range of only capturing 1- 3% of the actual instances) were filtered for cases of hospitalizations (6279) and deaths (1881) and then compared to the number of vaccines received and the child's age. The hospitalization rate increased linearly from 11.0% (107 of 969) for two doses to 23.5% (661 of 2817) for eight doses and decreased linearly from 20.1% (154 of 765) for children aged <0.1 years to 10.7% (86 of 801) for children aged 0.9 years. Children who received 5-8 vaccine doses were 1.5 times as likely to die as children who received 1-4 doses (3.6% to 5.5%), and boys were 1.4 times as likely to die as girls.

Were the COVID-19 Lockdowns a Blessing in Disguise?

A key reason why it has been impossible to improve the safety of existing vaccines is that clinical trials that evaluate

the safety of vaccinations are, for all practical purposes, forbidden (and when they are conducted, the researchers experience extreme persecution many believe is designed to discourage other researchers from pursuing the same research).

The rationale for this prohibition is that vaccines are so incredibly safe and effective that it is unethical to conduct a trial that withholds these life-saving therapies from children who serve as the controls. Conversely, any evidence that argues vaccines are unsafe is always dismissed by stating no placebo control data exists to substantiate that harm.

This circular logic designed to shield the available vaccinations from any scrutiny (which, due to their toxicity profiles, they could not stand up to) has been an endless source of frustration for vaccine safety advocates. Because the harms from vaccination are so far-reaching, they only become apparent in control groups (which still exist and consistently show an absence or significant reduction of most chronic illnesses). This is likely why such a relentless

push has been made to ensure unvaccinated comparison groups cannot exist (this was also floated as a reason for governments around the world having a fanatical drive to vaccinate the population as otherwise, they will face profound liability for the obvious wave of injuries that only occurred in those who received the spike protein vaccines).

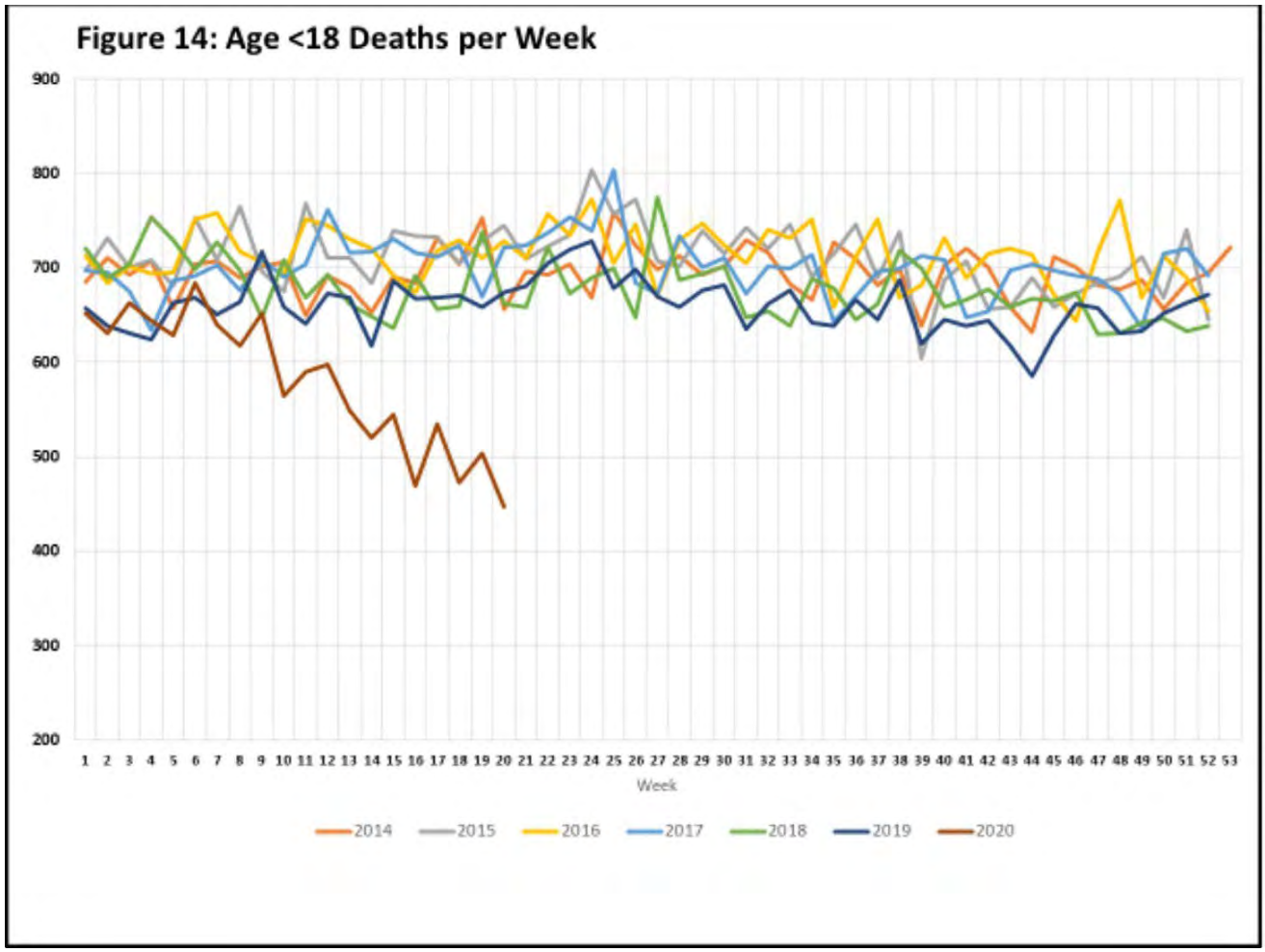
At this point, we have witnessed a century-long cat-and-mouse game of authorities concocting reason after reason to reject each new way that is found to prove profound adverse vaccination reactions occur. I hope this article provides sufficient evidence to demonstrate a clear and indisputable between vaccination and SIDS has existed for decades. In this type of situation, it is imperative for clinical trials to be conducted to settle the question (which I would argue has always been prohibited because they would show vaccines kill babies). However, while much work has been done to maintain that prohibition, the embargo was inadvertently broken in 2020.

When the COVID-19 lockdowns were enacted, and nonessential medical services were terminated (including

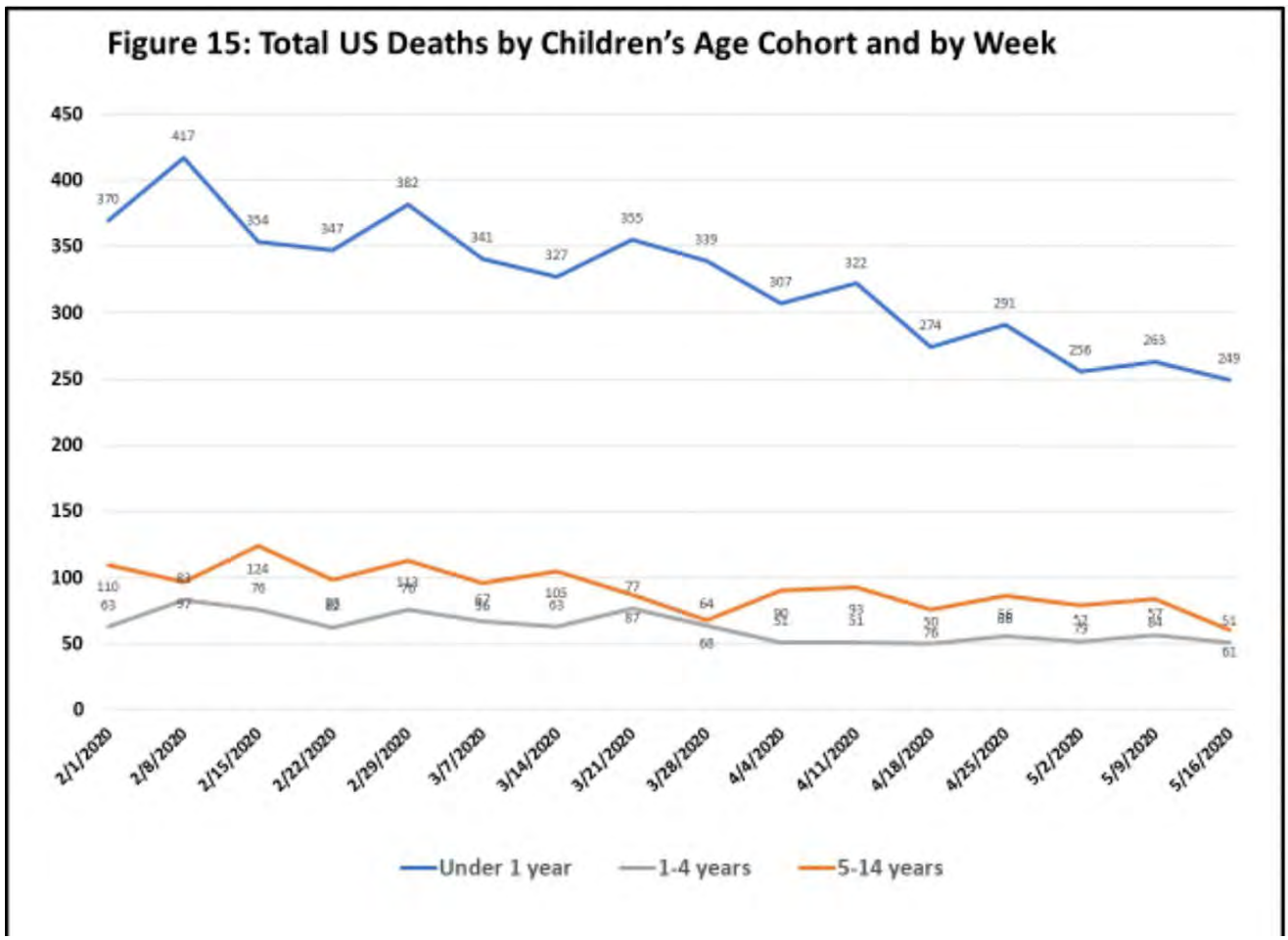
the routine visits with the pediatrician for the scheduled immunizations), the vaccine safety advocates realized this represented a once-in-a-lifetime chance to prove the immunization schedule caused SIDS because there would be a brief period where the childhood vaccine uptake substantially dropped.

Before we go any further, I want to note that this was, for all practical purposes, this was a prospective study (which is considered to be far more valid than a retrospective study) because so many physicians in the communities I belonged to announced their intent to study this issue the moment the lockdowns were announced. I will now cite a few figures from a report compiled on this data.

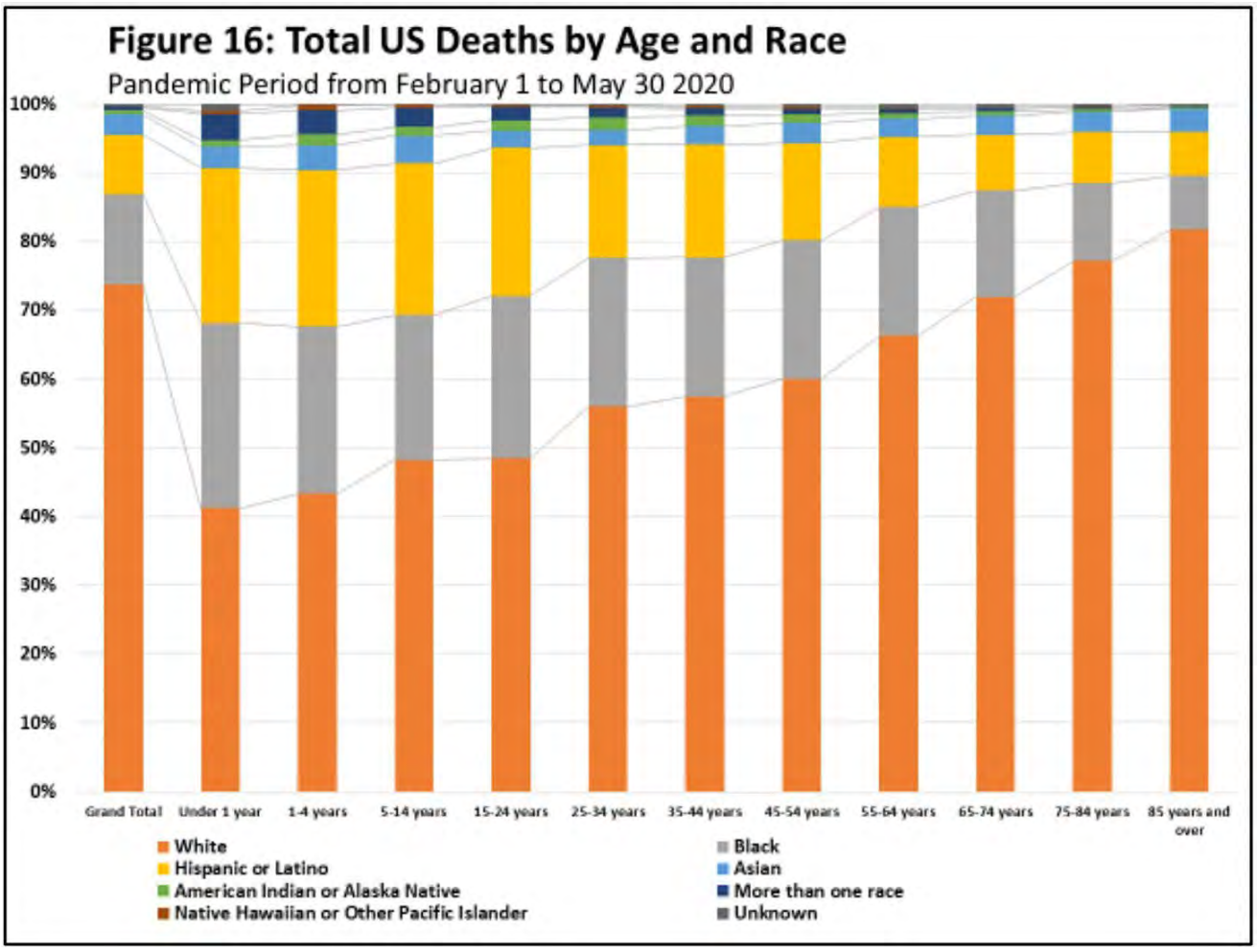
Although deaths for many segments of the population increased during the early days of COVID-19, one group instead experienced an unexpected decline:



More curiously, this decline was primarily found in children at the same age as those who experienced SIDS:



Oddly enough, the greatest reduction in mortality occurred in ethnic minorities (who often experience the most severe vaccine injuries):



Odder still, an unprecedented decline in vaccination also occurred at this time within the United States:

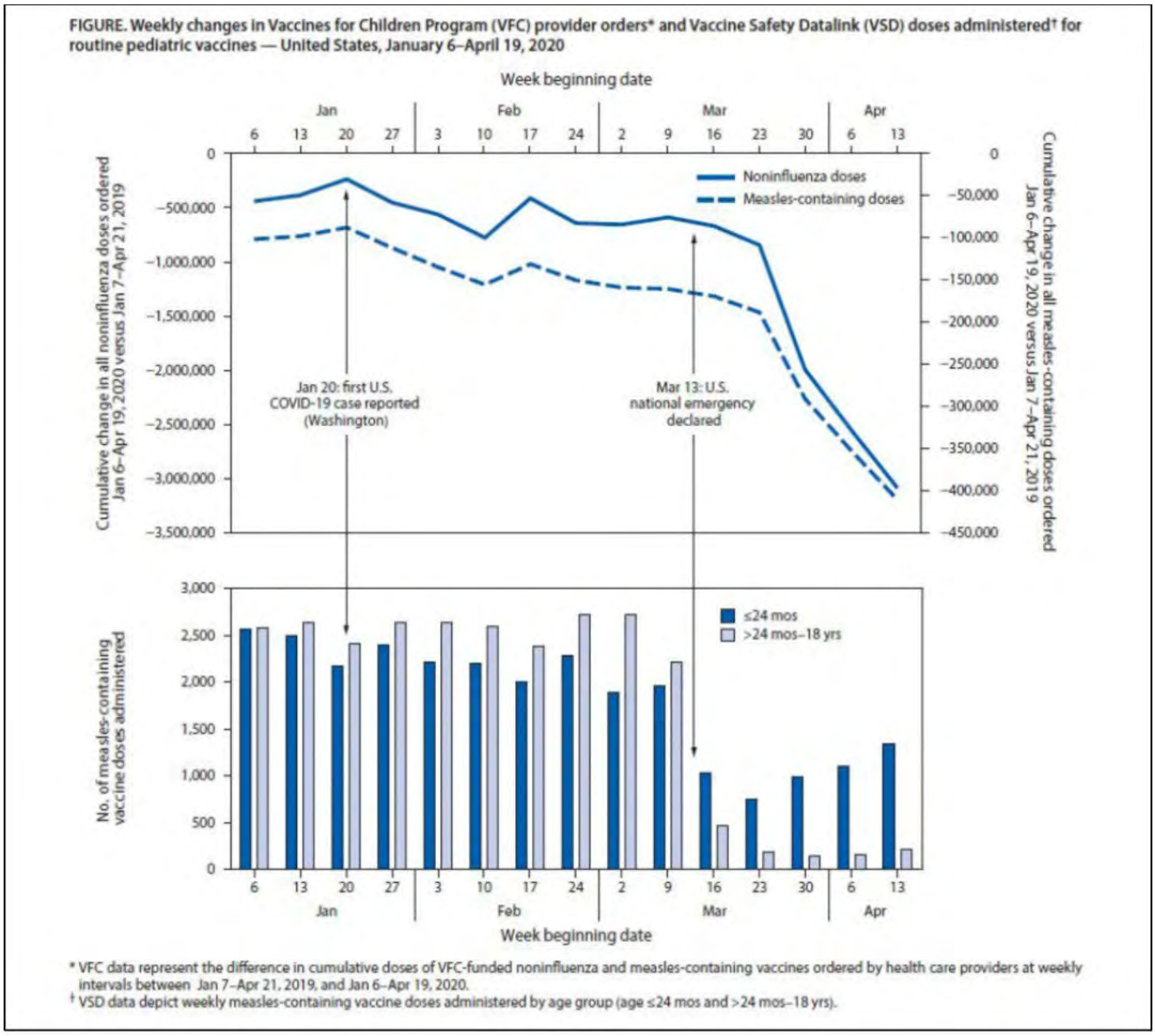


FIGURE. Weekly changes in Vaccines for Children Program (VFC) provider orders* and Vaccine Safety Datalink (VSD) doses administered† for routine pediatric vaccines — United States, January 6–April 19, 2020

* VFC data represent the difference in cumulative doses of VFC-funded noninfluenza and measles-containing vaccines ordered by health care providers at weekly intervals between Jan 7–Apr 21, 2019, and Jan 6–Apr 19, 2020.
† VSD data depict weekly measles-containing vaccine doses administered by age group (age ≤24 mos and >24 mos–18 yrs).

Furthermore, this effect was not confined to the United States. For example, WHO also issued a press release on May 22, noting that "*Since March 2020, routine childhood immunization services have been disrupted on a global scale that may be unprecedented since*

the inception of expanded programs on immunization (EPI) in the 1970s."

It should also be noted the most common refutation of this data set suggesting declining vaccination rates reduced infant deaths was the CDC recording a slight increase in the cases of SIDS in 2020; however, given that such a significant drop in overall childhood mortality occurred in 2020, I am not sure if this slight increase is substantial (and whether or not it is the result of erroneous classifications in death that occurred during 2020 such as those resulting from less diagnostic resources being available).

Furthermore, due to the political climate of Florida, the state was uniquely suited to lead this trend (as far as I know, no other state has had a similar decline in vaccine uptake). In 2021, Florida's childhood vaccination rate decreased from 93.4% in 2020 to only 79.3% in 2021. At the same time this happened, all-cause infant mortality under one year of age in Florida also decreased by 8.93% (a reversal of 2020's trend where infant mortality had increased by 0.67%). As a 14 percent decrease in vaccination coverage was

associated with a 9 percent decrease in infant mortality, this led Chudov to conclude that roughly half of the infant deaths in Florida could potentially be attributed to vaccinations.

VAERS

Lastly, to assess the evidence concerning this hypothesis, I consulted VAERS, where I discovered many compelling (and tragic) cases (some are listed here) whose descriptions identically match the patterns described in this article and often include the key objective diagnostic findings that have been associated with vaccine caused SIDS (the consistent autopsy findings, such as those reported here and here, are another critical piece of evidence for vaccines causing this disease will be discussed in the final part of this series).

It is also clear (you can quickly replicate my work in VAERS) that the DPT vaccine was:

- •The vaccine most commonly linked to infant deaths (however, it is also one of the only ones given in that age range).

- Deaths in infants that occurred following vaccination in the first year of life were much more common in the 2-6 month DPT age range (which technically does not refute the conventional hypothesis that SIDS spontaneously occurs at this age for no apparent reason).
- That the timing of deaths was dramatically more common in the days immediately following vaccination (which skeptics could attribute to a tendency for parents to be more likely to erroneously associate a spontaneous death with vaccination if it occurred immediately following vaccination).

Historically, I could not determine if the trends reviewed earlier during the 1990s were supported or refuted by the VAERS data of the time, while during the year of the COVID-19 lockdowns, a decrease in reported infant deaths did occur that reversed the following year in 2021.

From further investigating this issue, I discovered Miller (the author referenced before) performed a much more comprehensive 2019 review of the existing VAERS data as

a statistically significant association between the timing of death and vaccination would provide evidence for causality. In his analysis of all infant deaths in VAERS restricted to those within 60 days of vaccination (87.2% of the total deaths), he found:

- Of the 2605 reported infant deaths, 58% clustered within 3 days post-vaccination and 78.3 % within 7 days post- vaccination. The remaining deaths occurred between 8 days and 60 days post-vaccination at a rate approximately 69 times less than that found during the first week. This difference is statistically significant ($p < 0.00001$).
- Of the 1048 SIDS cases within that sample, 51 % clustered within 3 days post-vaccination and 75.5 % within 7 days post- vaccination. The remaining SIDS cases occurred between 8 days and 60 days post-vaccination, at a rate approximately 57 times less than that found during the first week. This difference was also statistically significant ($p < 0.00001$). A male-to-female ratio was 61.6%–38.4% was present in these

cases and 89.9 % of the cases occurred in infants under 6 months of age.

This once again confirms the association between vaccination and infant deaths.

Motivations

One of my major questions with the COVID-19 vaccine program was what motivation could have justified forcing such a dangerous and ineffective vaccination on the public, given that while this initially made money, it would cost everyone a lot long term (e.g., due to the economic damage that wave of disabilities created and the public becoming much less willing to purchase future pharmaceutical products).

Since initially publishing this article, a former executive from a major vaccine manufacturer reached out to me to share a few things that helped to answer this question. They told me that because of how quickly executives cycle in and out of top positions at these companies, their focus is

often on what will get short-term stock increases that translate to bonuses for the executive.

Furthermore, they told me that the unit profitability with selling adult vaccinations is much greater than with infant ones (additionally, the adult ones are often sold on an annual recurring basis—yielding much more long-term profitability). Additionally, while much of their company's portfolio was in childhood vaccines, Pfizer's was not, and they believed that Pfizer threw their competitors under the bus to make money off the COVID-19 vaccine franchise.

Conclusion

When the mandatory vaccination laws for school children were pushed through at a state level in the years before COVID-19, a highly polarized political climate emerged, making it virtually impossible for members of the medical community who were opposed to those mandates to question them around their colleagues. One of the most common arguments cited by that pro- mandate crowd was

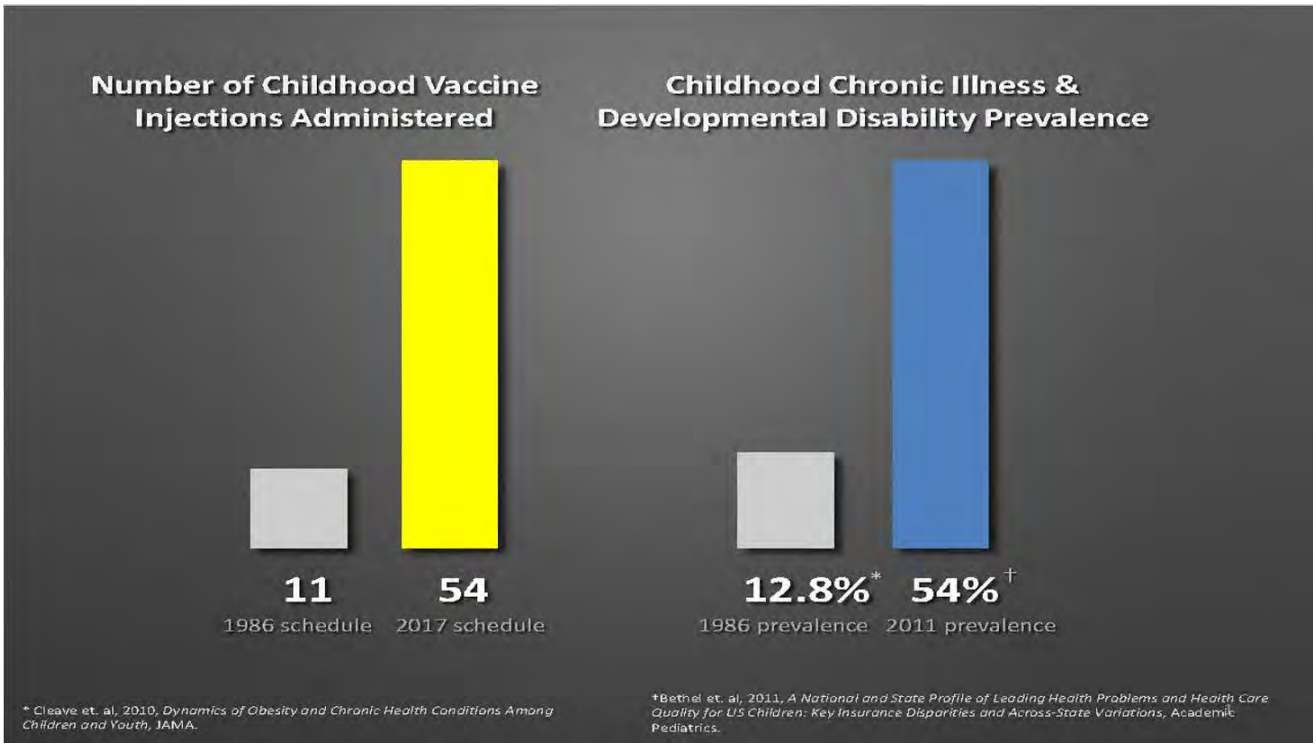
that anyone who opposed vaccinating the children of America was, for all practical purposes, a "baby killer."

In truth, that argument is absurd because almost none of the childhood vaccinations are for a life-threatening illness (and in the cases where they are, the vaccine often fails to prevent the disease, and an unvaccinated child could rarely develop a fatal infection of the illness).

Data aside, this rhetorical framing left many of us in a situation where we felt we were being accused of being baby killers for being opposed to a practice that did, in fact, kill babies (and, more importantly, cannot be justified based on the minuscule benefits that arise from vaccination). Fortunately, in just a few years, a titanic shift has occurred, and it appears that things have evolved enough in the culture that perspectives like the ones I shared here can finally be heard. From the bottom of my heart, I sincerely thank you for being a receptive audience to something that has been weighing on me for a very long time (and for taking the time to read all of this).

As we conclude this piece, we must remember that two critical themes mentioned throughout this Substack are also pivotal to the story of SIDS and everything we have seen with the COVID-19 vaccine injuries.

The first is that physiologic responses to a toxin always distribute on a bell curve. This means that the most severe reactions (e.g., deaths) lie at the edge of the bell curve and, in fact, only represent the tip of an iceberg, while under the water lie far more chronic injuries that have rapidly become so prevalent in the culture we no longer even think to question their presence. It is by no means an exaggeration to claim books could be written (many already have been) on the widespread chronic neurological and immunological disorders that are a direct result of childhood (and, to some extent, adult) vaccination programs.



Note: as it just so happens, infants born during the lockdowns (and hence less vaccines) were observed to have lower rates of a variety of chronic diseases.

The second is that a central mechanism of corruption within the medical establishment stems from the committee model we utilize, where "unbiased" panels of experts review evidence to produce guidelines everyone else is expected to follow. In almost all cases, these experts are arbitrarily appointed and hold significant financial interests that make them beholden to advancing the commercial needs of the

pharmaceutical industry. As a result, they will consistently produce guidelines crafted to support their pharmaceutical sponsors' needs regardless of the evidence against those decisions.

The CDC's Advisory Committee on Immunization Practices (ACIP) is one such repeat offender, as without exception, whenever the FDA approves a vaccination, ACIP will assume solely by virtue of it being a vaccine it is 100% safe and effective, which is a major reason why our ever-expanding vaccine schedule has never been directly tested for safety (even though evidence like that cited in this article shows vaccine toxicity cumulative increases with the number of vaccines given).

Following FDA approval, ACIP will always economically support its manufacturer and vote to add it to the vaccination schedule.

ACIP's recommendation, in turn, almost always results in the vaccine becoming mandated throughout America (hence creating a guaranteed market that incentivizes the overproduction of unnecessary vaccines), and many

harmful vaccines that should not have entered the market have sailed in on the ACIP's good graces.

For example, immediately following the FDA's widely protested EUA's of Pfizer and Moderna's vaccine for young children in June (this brief review of one trial unambiguously shows the decision could not in any way be justified), "ACIP determined that the benefits of COVID-19 vaccination outweigh the known and potential risks" and without hesitation recommended vaccinating our children—despite children having no risk of dying from COVID-19 and a very real risk of a severe injury from the vaccine.

As I detailed in an earlier article, the reason why we have not been able to end COVID-19 is because Fauci appointed a committee of corrupt colleagues who remdesivir's manufacturer was paying off, and as a result, the official treatment guidelines for COVID-19 created by that committee have not permitted any of the proven but no longer patented treatments to enter the official COVID-19 treatment guidelines. Although guidelines have been ruled in federal court to not constitute law, the medical, industrial

complex frequently uses them to bypass the legislative process and have their policies become the de facto law because so many other institutions that wield significant power in our lives inappropriately treat these guidelines as law.

This model has to change.

This is an extremely important story that has not yet received significant exposure, so I have spent a lot of time compiling this article and trying to vet it for accuracy. Fortunately, when my colleague recently shared it on Twitter, it received more than half a million views, which indicates many are at last open to hearing this story.

Now that the evidence has been presented to show that vaccines (especially multiple ones given in succession to premature infants) can cause fatal respiratory arrests, the next question is, “Why?”

The best model put forward is that the vaccination causes blood in the body to clump together, triggering microstrokes in the brain and symptoms of those strokes, which can easily be recognized by a trained observer (all of

which are discussed in detail here). In the case of SIDS, these microstrokes appear to occur in the area of the brain which regulates breathing (discussed here), hence leading to the abnormal findings repeatedly observed in hospitals and with home monitoring.

I have been trying to expose this issue and its treatments for the last year because the COVID-19 vaccines can severely impair the vital circulation of blood and other fluids. I believe this accounts for many of the side effects attributed to them (discussed in detail here). To illustrate the difference between the COVID-19 vaccines and those that preceded them, I am now observing many clinical signs of a previous microstroke appearing in adults following COVID-19 vaccination I had previously only seen in vaccine-injured children.

I sincerely thank each of you for your support of this publication and taking the time to read this and to share it with the appropriate audiences so that this vital story can at last be heard.

In the next few weeks, I will publish a companion article which synopsizes many other long forgotten vaccine disasters that happened almost a century ago .

What Makes All Vaccines So Dangerous?

Exploring the forgotten but critically important science of zeta potential

Note: this is a significantly revised version of an article I wrote two years ago on this topic.

Many problems in medicine are ultimately a product of the diagnostic paradigm a physician brings to the situation. This holds particularly true for complex illness, which due to their complexity cannot be solved by the majority of doctors and result in the patient continually struggling with their condition.

A hallmark of complex conditions is that the same disease can cause a wide variety of symptoms depending upon the person and likewise that numerous “complex illnesses” can present with very similar symptoms (e.g., fibromyalgia vs. chronic fatigue syndrome). Because the symptoms are so varied, severe, and inexplicable, doctors who have not been specifically trained to recognize them typically won’t and often will default to assuming they must be psychiatric in nature.

This very much characterizes vaccine injuries, as you can read hundreds reports from over a century ago (which I am currently compiling for an upcoming article) which describe many of the same inexplicable symptoms seen now in those with COVID-19 vaccine injuries, but simultaneously, there is immense variability between each individual report.

In turn, my interest has been in determining what the underlying mechanisms of harm could be. Presently, I believe there are four primary things which underlie vaccine injury:

First (as will be discussed in the upcoming article) there is a longstanding issue with vaccinations being improperly produced and contaminated with things that can injure the recipient. This in turn is why vaccine hot lots repeatedly emerge.

Note: some evidence exists (e.g., a DPT vaccine memo revealed through litigation) that this issue was largely "solved" by distributing each lot throughout the country so that it would be much harder to identify the hot ones as injuries would not cluster in a single area.

Because vaccines are designed to unnaturally activate the immune system, they can create longterm immunological dysfunction and off target immunity. This most commonly manifests through the immune system attacking the body (there is a lot of evidence tying vaccination to a myriad of autoimmune disorders), but other immunological issues (e.g., varying degrees of immune suppression) are also sometimes observed after vaccination.

When cells are threatened, they will sometimes enter a primitive metabolic state to protect themselves where their mitochondria stop performing their normal functions. This state is supposed to be temporary, but some (myself included) believe cells can get stuck in this response, and that an unresolved and persistent cell danger response underlies many chronic and complex conditions. In turn, when the cell danger response is treated, many severe conditions (e.g., those linked to vaccination like autism) have been observed to resolve as well.

Vaccines cause moderate to severe impairments of the fluid circulation of the body through impairing the physiologic zeta potential (which causes fluids like blood to clump together) and to a lesser degree by having the white blood cells enter capillaries, where, due to their larger size, they obstruct the flow of blood through the capillary.

In this newsletter, I've tried to bring attention to the subject of zeta potential as I believe it underlies a wide variety of chronic conditions, but outside of a few niche areas (e.g., designing lipid nanoparticles for drug delivery or how the ESR test works) there is no knowledge of the concept within medicine. My focus was specifically drawn to the zeta potential concept after I realized many of the mysteries of COVID-19 (and later the vaccine) were a result of the spike protein being extremely disruptive to the body's zeta potential. In short, I believe that if the zeta potential was instead recognized and understood by the medical system, patient outcomes would significantly improve.

Note: much of this article was made possible by the pioneering work of Andrew Moulden, Melvin Knisely and Thomas Riddick.

Andrew Moulden

Andrew Moulden was a Canadian Ph.D. neuroscientist who focused on childhood development and acquired brain injuries, and then subsequently became a doctor specializing in neuropsychiatry.

During Moulden's clinical training, he came across numerous cases of young children who developed textbook neurological signs of strokes none of his colleagues recognized, and over time, he noticed some of those children would subsequently develop severe neurological disorders (such as autism or losing the ability to speak). As Moulden began to try and understand what could be causing all of this, it became very clear the initial strokes followed vaccination, sometimes within hours of a vaccine.

Previously, to explain the extremely cruel phenomena of medical gaslighting, I illustrated how well-intentioned doctors typically cannot see signs of a condition unless they were specifically trained to look for them. I believe this is primarily because relatively few doctors have the perceptual capacity to continually monitor the entire

patient in front of them (which is necessary for many diagnostic insights) and instead must filter the patient through the diagnostic algorithms they were taught in their medical education.

So, quite remarkably, Moulden was one of the first doctors to realize the same subtle signs doctors and particularly neurologists are taught to look for in adults to assess for signs that a stroke occurred should also be identified in children (as typically doctors only recognize overt signs of a pediatric stroke such as a large facial droop). Because no one diagnoses these less obvious strokes in infants, we are left with a variety of conditions that are written off as the infant being “cute,” or having a disorder of unknown cause (for example, esotropia, a fancy term for the eye turning inwards, affects 2% of the population).

One of the major challenges in science is making the “invisible” visible so it can be researched in a reproducible fashion, and typically the smaller something is, the more challenging this is to do. Fortunately, in neurology that invisibility can be bypassed because when there is a

problem somewhere in the brain (commonly as a result of impaired blood flow to that region) the corresponding function that region is responsible for will become disrupted as well. In turn, with appropriate training, a physical examination can often detect that disruption and hence determine exactly where a stroke has occurred.

In many cases, the status of the cranial nerves provides the most accessible window for evaluating the brain, which is why all medical students are taught to cursorily evaluate them (unfortunately they rarely perform the in-depth examinations that can tell you much more about the patient such as the more subtle manifestations of their microstrokes).

Most nerves that travel throughout your body (not counting those that remain within the central nervous system) originate from your spinal cord. The twelve cranial nerves are the exception and instead originate from the brain (with most originating in the brainstem).

The cranial nerves within the brainstem are vulnerable to strokes because of the anatomy of the circulatory system.

In most cases, the tissues of the body (especially those that cannot tolerate an interruption of their blood supply like the heart and brain) have multiple sources of blood so that a disruption within one of their blood vessels is unlikely to cause a critical failure. Watershed areas denote locations where that redundancy does not exist, and as a result, strokes are much more common within the watershed areas.

Many of the cranial nerves in the brainstem originate in watershed areas, which allows their dysfunction to serve as an early warning sign blood flow is being disrupted throughout the brain.

Additionally, the blood vessels that feed the back of the brain where these cranial nerves are located are narrower than those that feed the front of the brain (20% of cerebral blood flow originates from the back, 80% from the front). This is important because an increased thickness of blood will always reduce blood flow, and that thickening has the greatest impact on smaller blood vessels (e.g., the narrower arteries that feed the brainstem).

The cranial nerves that typically indicate the presence of vaccine- caused micro-strokes (due to their less robust blood supply) are those responsible for controlling the movement of the eyes and facial muscle tone. The three nerves originating from the watershed areas most commonly affected by vaccine microstrokes are as follows:

- Cranial Nerve VI: This nerve is responsible for controlling the muscle that makes the eye look outward. When a deficit is present, the eye will often look inwards at rest (less common), and when both eyes look from side to side, the affected side will often jump rather than moving in a slow continuous motion like the unaffected side (more common).

Note: I believe CN VI is the nerve most frequently affected by COVID-19 injuries.

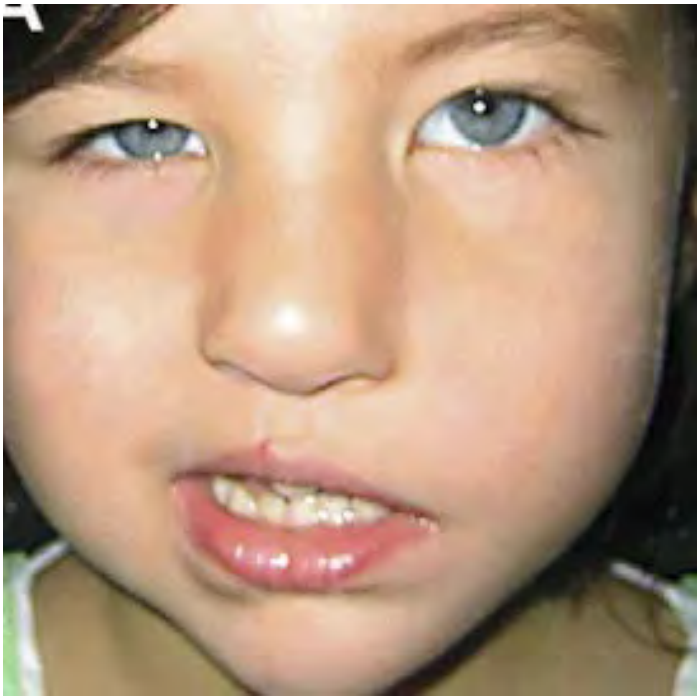
- Cranial Nerve VII: This nerve is responsible for controlling most of the muscles in your face and one of the most commonly associated issues with this nerve is Bell's Palsy, where one side of the face droops downwards. Less easily recognized facial changes can also occur, such as a flattening of the nasolabial fold, or the development of a crooked smile. In a previous article that discussed Justin Bieber's recent vaccine

injury, I showed how historical photography demonstrates that the age of vaccination has caused widespread cranial nerve damage that has resulted in asymmetrical faces going from being the exception to the norm.

Note: CN VII damage is considered to be the most common vaccine injury to the cranial nerves. I believe this is because CVII

damage is immediately noticeable, whereas you typically have to specifically look for CN VI damage.

- Cranial Nerve IV: This nerve serves as a leveler that maintains the eyes at an equal height. When there is an issue, individuals will typically tilt their heads to one side to restore the levelness between the eyes (asymmetries in the heights and vertical motion of the eyes can also be observed). Once you know how to look for this, it is very easy to spot.



Moulden also observed problems would arise in other cranial nerves (e.g., CN III), and his preferred test for these issues was to monitor blinking (either spontaneously or when provoked through a reflex). Once those nerves had become damaged, the eyes would no longer blink evenly. This difference is best observed on a slowed-down video recording and is also valuable diagnostically because it is very difficult to fake this dysfunction.

Note: you can observe both overt and subtle cranial nerve dysfunctions. The examples I am sharing throughout this article are the overt ones (e.g., a drooping face or a deviated eye), but a variety of other more subtle signs of cranial nerve dysfunction can also be recognized by an experienced clinician. Unfortunately, cranial nerve diagnosis is typically taught as a quick evaluation where you either designate the nerve being grossly intact or "damaged" which causes many of these more subtle findings to be missed by the majority of physicians.

As Moulden continued to study these microstrokes, he realized the cranial nerve dysfunctions he observed also suggested strokes were happening in many other

watershed areas of the body (such as the peripheries of the internal organs or the center of the brain that controls speech). Some of the key pieces of evidence to support his theory were:

- Moulden was able to review at least one autopsy study of a child who had died from congenital rubella (the R in MMR and a disease that can sometimes cause many birth defects including autism independent of vaccination if the mother is infected while pregnant). In these studies, Moulden found that in addition to strokes occurring within the brain, signs of strokes were also found throughout the internal organs (which have watershed areas at their periphery).
- With the two vaccines that were best known for causing severe reactions (HPV and anthrax), Moulden observed a very similar disease process to what he had seen in children instead happen in teenagers and young adults.

- One of the most striking examples showing the effect of vaccination on circulation were children of soldiers who received the anthrax vaccine and were born without limbs (thalidomide was notorious for this and instead did so by blocking the formation of new blood vessels).

Note: the anthrax children are discussed further in this article and this article.

- Moulden observed many cases of these same neurodegenerative processes occurring in the elderly after vaccination (like many of the readers here, I have come across numerous cases of permanent dementia rapidly appearing after the spike protein vaccines).
- Moulden thus believed Alzheimer's disease was another manifestation of this same disease process and we have observed it often improves once cerebral fluid circulation is improved.
- Moulden observed numerous individuals with psychiatric disorders (such as schizophrenia) who also shared this characteristic cranial nerve damage. A major shortfall within conventional medicine is not recognizing that neurological damage creates psychiatric issues, and as a result, when patients present with medical injuries that also affect their nervous system, the emotional changes they undergo are labeled as the cause of their illness rather than a symptom of it.

With time, Moulden recognized that many different diseases (e.g. vaccine injuries, complications of infections, autoimmune disorders, and neurological conditions) appeared to share the same cause — pervasive microstrokes throughout the body.

He also noted that certain microbes tended to disrupt the blood flow in specific regions of the body (this is a foundational belief within Chinese Medicine) and that the responses to the same blood flow impairing process could produce entirely different responses in different individuals. To this point, Moulden liked to cite the case of two identical twin boys who shared the same disrupted placental blood supply during prenatal development: one then developed features of autism, and the other developed learning disabilities and language problems.

All of this raises two major questions. What could be causing these microstrokes, and how do you treat them?

Moulden eventually concluded a non-specific response to toxins and infections was responsible for a wide range of diseases, and that the fundamental error of our medical model was it being focused on the countless causative agents of disease rather than addressing the universal response itself. Moulden announced he had developed a means to address this response, but unfortunately died in suspicious circumstances shortly after the announcement, leading to his work being lost (this is a key reason why my mentors have not published on this topic and part of why I write anonymously).

For those interested, Moulden's three videos can be found here:

Note: many have lamented that Moulden's cures for this were lost. However, since I had independently researched this topic for years before I came across Moulden's work, I was familiar with many of the same primary sources he used (along with others I suspect he did not) and hence had some insight into the options he found for tackling the problem (e.g., fixing the physiologic zeta potential). Additionally, following his passing, I learned friends of mine were friends with Moulden and I have since been able to glean additional insights into what he was working on from what he left with them.

Scientific Distortions

When you study the history of science, one of the fascinating things you will discover is how many important scientific discoveries fell to the wayside, either due to politics, chance circumstances, or financial interests in promoting one scientific model over another.

One of the biggest distortions within medicine is that while numerous branches of science exist which can explain what happens within the body, we only focus on the one which consistently makes money. Specifically, I believe the following scientific fields are crucial for understanding the human physiology:

•General (and organic) chemistry

•Physical chemistry

•Biophysics

•Biochemistry

Treatments created from the first three tend to apply to a wide range of illness. Conversely, treatments created through biochemistry tend to be very disease specific (as biochemistry revolves around precise molecular structures matching specific receptors or enzymes) and hence much easier to produce a myriad of proprietary and lucrative therapies.

Unfortunately, since many medical issues are ultimately an issue in other area (e.g., I discussed some of the instances where biophysics is needed to produce a cure here), our biochemically based medical system often fails at addressing many of the issues it comes across.

This in turn is why I believe the well developed physical science of colloidal chemistry (from which zeta potential originates) is almost never studied or considered in medicine.

Note: less affiuent countries which cannot afford an endless slew of proprietary drugs often have the a much greater focus on connecting the other branches of science to medicine and utilizing the affordable treatments that science provides. This

for example is why a lot of the modern medical biophysics research I utilize originated from the former Soviet nations (whereas much of the older research originated with America as it was old enough to have been conducted prior to the monopolization of American medicine that happened during Rockefeller's time).

The Fourth Stroke

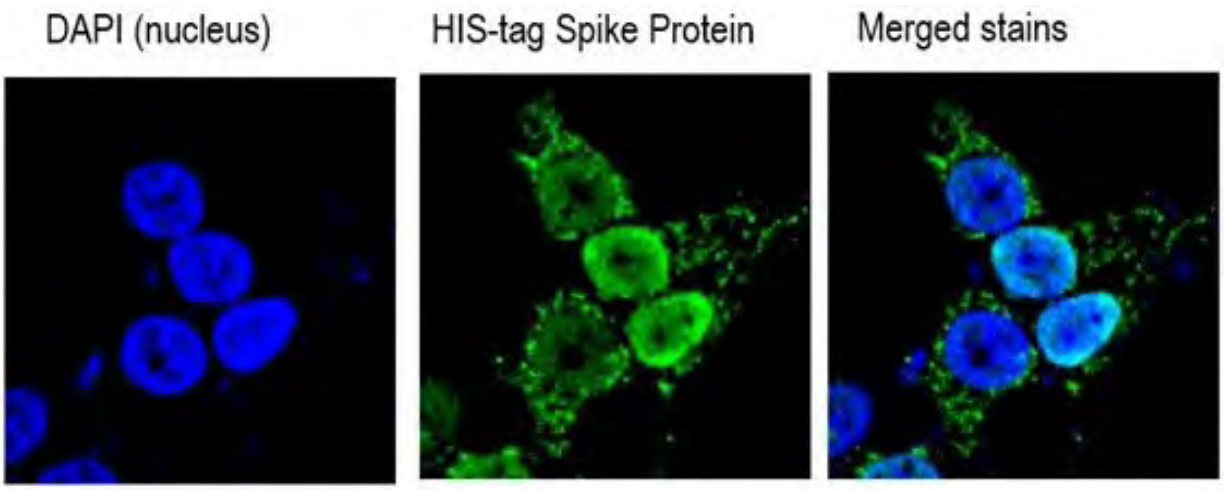
Classically, three types of strokes can occur:

- A clot forms somewhere in the circulation and eventually arrives at a blood vessel it is too big to fit through and blocks it (an embolic stroke).
- A blood vessel ruptures and leaks blood into the surrounding tissue (a hemorrhagic stroke).
- Damage occurs to the endothelium (the lining of the blood vessel walls) and the protective response of the endothelium causes a blood clot to form at the site of injury (which can give rise to a thrombogenic stroke).

The SARS-CoV-2 spike protein is remarkably effective at causing all three of these to occur. I believe this is a consequence of the spike protein being highly disruptive to zeta potential (due to its specific positive charge), the endothelium having a high concentration of the ACE-2 receptors that the spike protein binds, and the positively charged spike protein being electrically attracted to the glycocalycx. The glycocalyx is a massive network of negatively charged glycoproteins that protectively coat the endothelium and when this critical function fails, many circulatory diseases emerge (diabetes for example destroys the glycocalyx, which may explain why diabetics are so much more vulnerable to circulatory disorders and COVID-19).

Note: there was an excellent article on the genotoxicity of the spike protein that included a study showing the (positively charged) spike protein enters the (negatively charged) nucleus. In addition to illustrating the cancer- causing potential of the spike protein, that study also illustrates how the spike protein's charge

causes it to attack many negatively charged parts of the body like the glycocalyx.



In addition to the three recognized types of strokes, there is also a condition known as a transient ischemic attack (TIA), where one develops clinical signs of a stroke that later improve, while signs of the stroke are rarely seen on brain imaging. Although TIAs are viewed as self-limiting episodes, they are also recognized to be prognostic of a severe stroke in the future.

Some, including Moulden, believed TIAs represented a fourth class of stroke and indicate dangerous impairments to the microcirculation are occurring. However, unlike the

previously described types of strokes, these strokes are too small to see with the resolution of existing radiologic imaging technologies and thus not believed to exist.

Frequently in the history of science, an important hypothesis with strong evidence supporting it will be denied until visual proof can be found for the hypothesis for example:

Semmelweis was a physician who proved doctors were killing approximately 10% (yes 10%) of the women they delivered babies from by refusing to wash their hands after dissecting corpses prior to the delivery. Semmelweis received severe reprisals for suggesting his colleagues could be infecting their patients, and his ideas only came to be accepted once Pasteur showed germs existed under the microscope.

Continental drift, the now generally-accepted model to explain the Earth's geography, was initially widely ridiculed by the scientific field even though ample evidence existed to support the theory. Rather, it only became accepted after the U.S. Navy was able to provide direct visual

evidence of underwater fault zones required for the continental drift model.

Because these microstrokes cannot easily be seen, they hence fall into the same scientific black hole as the previous examples and when recognized, have been lumped under the nebulous umbrella of “TIAs.” Moulden then concluded they were caused by two phenomena, pathologic changes in zeta potential and the Moulden

Anoxia Spectrum Syndromes (MASS for short) created by large white blood cells entering and obstructing the capillaries.

Blood Sludging

A common question that arises in many conditions (such as infections, severe crushing injuries, burns, or cancer) is how the individual insult can subsequently cause severe sickness or death throughout the body. Since at least the 1700s, Western medicine has observed that in certain disease states, the blood will partially solidify or increase its viscosity (i.e., thicken), which in the 1800s was observed

to result from blood cells agglomerating or clumping together (many terms including blood sludging described this process). Starting in the 1930s, advances in optical microscopy made these changes possible to study within living tissues, and researchers such as Melvin Knisely Ph.D. extensively studied blood sludging until the 1960s, after which it became another forgotten side of medicine.

In totality this research demonstrated that blood sludging appears to be a common phenomena the body has developed numerous adaptations to (e.g. the terminal pulmonary arterioles have evolved traps to catch small sludges). However, once a critical threshold of blood sludging is reached, those adaptations are overwhelmed and critical failures emerge (e.g. larger clots causing pulmonary embolisms are often fatal and a common cause of death following spike protein vaccination).

One of Knisely's most important experiments involved studying the progression of malaria in monkeys. There, he discovered that the parasite killed monkeys by creating severe blood sludging that initially occurred in the smaller

vessels, and that as it increased (and the monkeys moved closer to death), could also be found obstructing the blood flow of the largest blood vessels in the body.

For example, in the inferior vena cavas (the largest veins) of these monkeys, he observed the bottom third was a solid sludge of blood cells infested with malaria, the middle third had slowly moving clumps of blood cells and the top third was free flowing plasma without blood cells. The existence of infected sludges potentially explains the present day mystery of why infections can “reactivate” (Lyme with its biofilms is well known for doing this) as Knisely periodically observed longstanding blood sludges (which the immune system cannot enter) rupture and release infectious organisms into the circulation.

Note: Pierre Kory (a world expert in point of care ultrasound—a revolutionary technique which lets you see inside critically ill patients and know what they need) shared that he had a few cases of patients where the blood in their IVC became echogenic (meaning something solid had formed in them the US bounced off of) who then died shortly after this happened.

He interpreted this to mean silent blood clots had formed that were too small to see with normal imaging techniques and found it be one of the

most prognostic signs of immediate death (even in seemingly healthy patients). I would argue that what he observed was identical to what Knisley saw in the critically ill monkeys at the terminal stage of a malaria infection.

Additionally, larger blood vessels have their own blood supply, and when those smaller vessels becomes blocked by blood sludging, the resulting infarction can often destroy the lining of the larger vessel, leading to many diseases including vasculitides.

Most importantly, Knisely also found that if he provided heparin (a commonly used anticoagulant) to the monkeys, it dispersed their blood sludging and allowed them to survive dramatically longer with an untreated infection. This survival (both in monkeys and humans) also provided a key piece of evidence to support Moulden's hypothesis of the damage blood sludging caused to the brain:

"Those patients who survive in attack of real cerebral malaria always carry residual diffuse brain disease in the form of healed microscopic infarct's (from microclots). This condition may be clinically so slight as to be unmeasurable or there may be evidence of diffuse cerebral involvement with general dulling of the intellect."

Most importantly, Knisely discovered that the blood sludging he could externally observe in the monkey's eyes **matched** that found within their internal blood vessels (which were made visible through surgical incisions).

Recognizing the utility of this discovery, Knisely then developed a stereo microscope for observing blood sludging in the eye (henceforth termed the sclerascope) and observed the eyes of countless individuals. With the sclerascope, Knisely (and others) found many different diseases (and certain toxins), appeared to cause their pathology through initiating widespread blood sludging and Knisely produced a grading scale for the varying degrees of blood sludging and pre-blood sludging that

could occur that consistently correlated to disease prognosis.

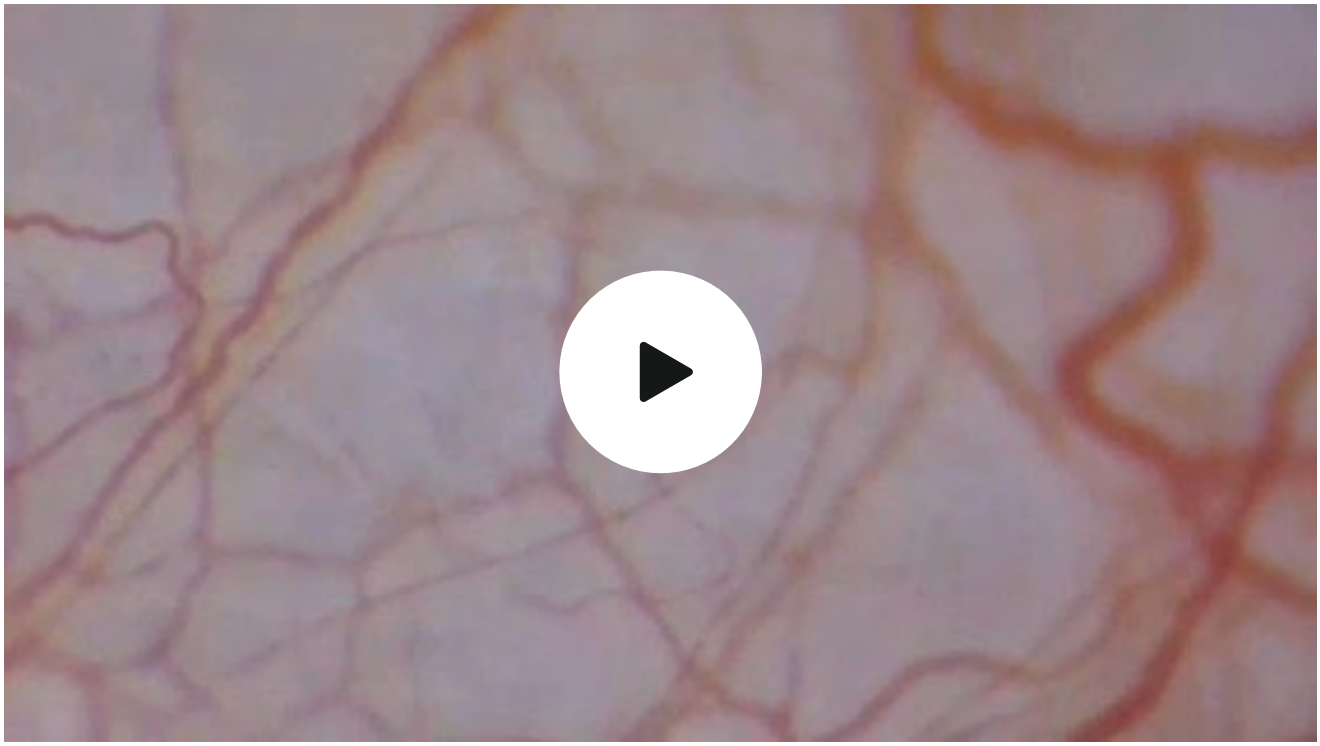
TABLE NO. 28

GRADES AND DEGREES OF INTRAVASCULAR COAGULATION

Grade	*Degree of IVC*	*Comets*	*Chain-like Agglomeration*	*Partial Stasis*	*Clumping*	*Sedimentation in lumen*
0	Absent	Absent	Absent	Absent	Absent	Absent
1	Slight	Some	Absent	Absent	Absent	Absent
2	Moderate	Many	Noticeable	Absent	Absent	Absent
3	Significant	—	Pronounced	Some	Some	Absent
4	Heavy	—	—	Noticeable in some vessels	Noticeable in some vessels	Absent
5	Very Heavy	—	—	Pronounced in some vessels	Pronounced in many vessels	Absent
6	Terminal	—	—	Pronounced in many vessels	Heavy in many vessels	Noticeable in a few vessels

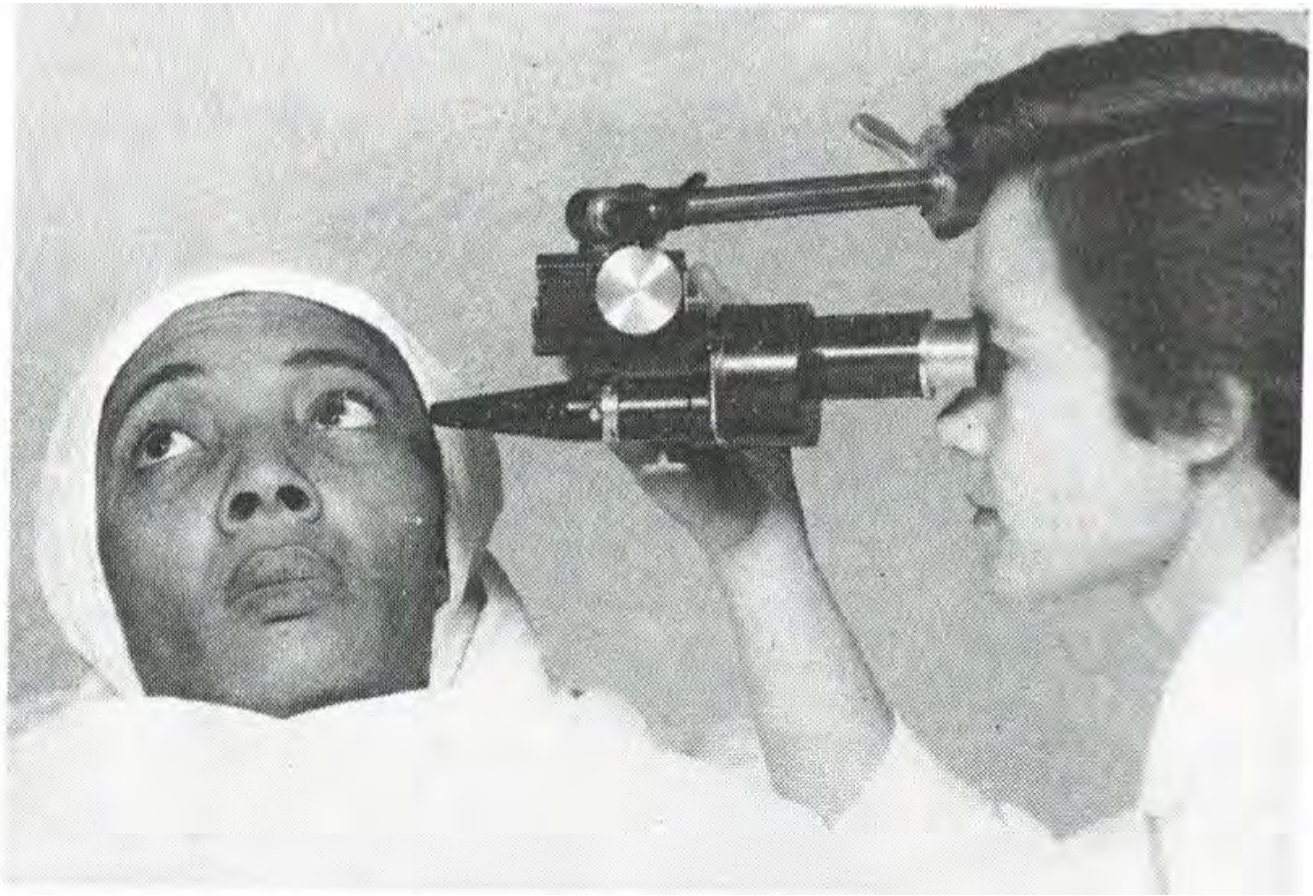
Note: this is the scale Riddick made off of Knisely's, which Riddick observed did correlate disease severity and one's risk of dying.

After learning of this, we attempted to replicate Knisely's microscope and have been able to see the same sludging he observed 80 years ago in his patients. This video for example was taken from the eyes of a COVID-19 vaccine injured patient:



Knisely (using a portable sclerascope) also found blood sludging was the most severe in hospitalized patients. I in turn believe blood sludging plays a large role in causing people to require hospital care and why IV saline (which

partially improves zeta potential) is frequently so helpful for hospitalized patients.



Note: Knisely also observed that certain agents such as hydroxychloroquine, atabrine, and quinine reversed blood sludging. This led him to suspected a significant degree of the benefit from hydroxychloroquine arose from it reducing blood sludging rather than it directly inhibiting the malaria parasite; I also suspect this property may account for its value in treating

autoimmune conditions and COVID-19. Similarly, a 2022 paper which showed the spike protein directly impaired blood cell zeta potential also showed that ivermectin dispersed blood cells the spike protein had clumped together.

The blood sludging process is a consequence of blood cells agglutinating (clumping) together, because once this happens, they stop being suspended in the plasma and with gravity settle to the

bottom, creating sludged blood that is often deoxygenated and unable to flow. This issue was the most impactful within the smaller vessels where Knisely was able to observe it often completely blocked blood flow within the affected vessels (especially at branching points as the sludged blood would sink with gravity to the lower branch and block it, which was proposed to explain the changes patients with severe blood sludging experience as they change positions).

I will now share some additional points about blood sludging I believe provide important context on it:

Moulden emphasized that these microstrokes would predominantly afflict the watershed areas of the body, including those in the periphery of the circulation such as tips of the fingers, toes, and nose (likewise the limited vascular supply in these regions is widely accepted as the reason for many conditions like frostbite).

The best-known example of a disorders of impaired peripheral microcirculation is Raynaud's syndrome, which in the conventional model is attributed to involuntary constrictions of the smallest arteries in the fingers and toes. I do not fully endorse this explanation because Raynaud's syndrome often responds to treatments that address blood sludging, and has been repeatedly observed to onset following many of the older vaccines, COVID-19, and spike protein vaccines.

Knisely argued that sludging was responsible for the anemia frequently found in hospitalized patients as the red blood cells could no longer be measured due to them being trapped in sludges.

One “mystery” of COVID-19, is that COVID-19 patients can survive with blood oxygenation levels that are normally fatal. A key reason why many patients died in the early days of COVID-19 was that doctors did yet not realize COVID-19 patients could tolerate the dangerously low oxygen saturations they had and hence had a greater risk than benefit of being ventilated (which was then further worsened by a severe shortage of personnel who were sufficiently trained to safely manage ventilators).

I am almost certain this medical mystery resulted from COVID-19’s blood sludging being sufficient to partially freeze the blood flow in the smaller peripheral vessels, including those in the fingertips where blood oxygenation, through a wonderful application of biophysics, is almost always measured. Because this sludging prevented many of the red blood cells in the fingers from returning to the

lungs, those cells were stuck in a deoxygenated state and thus created a low blood oxygenation reading.

In most cases, peripheral blood oxygenation matches the central blood oxygenation (which when low is fatal) but since the central blood vessels are so much wider, COVID-19's blood sludging did not create the same obstruction within them. As a result, COVID-19 patients could be relatively well with a blood oxygenation reading

that would normally suggest a high risk of death. To support all of these points, this 2020 study confirmed the presence of obstructive microclots within the capillaries of COVID-19 patients.

Note: I found many of the effective treatments for COVID-19 also fixed the zeta potential or addressed microclots.

Presently two common diagnostic tests can show these changes in microcirculation. The first is the D-dimer test, which shows if microclotting has been occurring throughout the body (this test is frequently used to evaluate for vaccine

injuries), but typically lacks diagnostic utility due to the large number of conditions that can elevate D-dimer levels.

The second is the erythrocyte sedimentation rate (ESR) test, a test developed by the early blood sludging researchers that evaluates how quickly blood cells will settle to the bottom of plasma. This test turns positive in some inflammatory (typically those of an autoimmune nature) conditions and is thought to result from positively charged proteins that are released in inflammatory states (erythrocyte zeta potential is also considered but not conventionally viewed as the primary factor influencing the test although it has been shown to be it in some studies like this one).

Note: In addition to being elevated in severe cases of COVID-19, the ESR is also elevated in migraine headaches, an extremely common disorder for which the cause remains unknown, and which I would argue results from blood sludging in the head (migranes often respond to treatments that address blood sludging and one researcher has attracted a large following with a model that I would argue does just that). It should also be noted

that many other disorders thought to result from blood sludging or blood stasis, such as menstrual irregularities (e.g. pain or clotting) and tinnitus, like migraines, are frequently a consequence of spike protein vaccination.

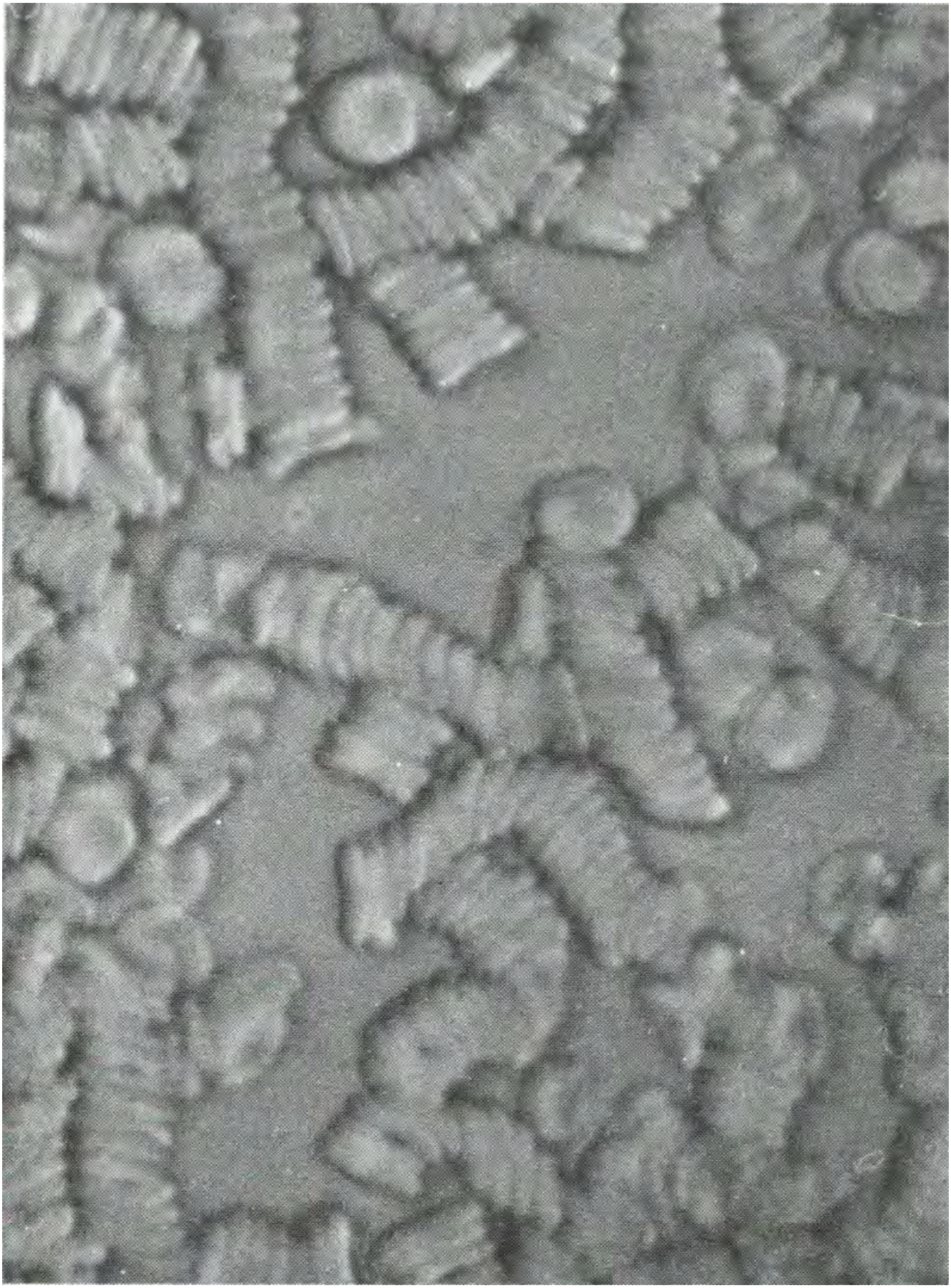
Knisely discovered that when blood is taken out of the body, a significant number of factors change how it sludges which leads to the ESR test (and microscopic examination of extracted blood) inaccurately assessing how much sludging is present within the patient. Some of the issues included:

- Blood draws being more likely to draw unsludged blood and protein structures forming in test tubes that prevented blood cells from settling.
- Anytime blood is removed from the body (excluding the rare individual with a disorder like factor XII deficiency), **it will spontaneously clot** and many of the agents that are used to prevent this intrinsic blood clotting pathway from disrupting a blood draw also disperse blood sludging (e.g. sodium **citrate** or heparin).

Note: these artifacts were why Knisely chose to go through the hassle of magnifying the eyes rather than simply looking at a blood sample under a microscope.

In my medical practice, mostly to perform ultraviolet blood irradiation, I frequently draw blood that is mixed with a small amount of heparin and then dilute the blood in saline bags and have thus observed the behavior of many blood samples. I (and a few colleagues) have found that typically in patients who are quite ill (e.g., someone with a severe case of COVID-19) and in whom we suspect blood sludging is occurring, the blood is much darker, and in the worst cases will also have the erythrocytes separate from the plasma and settle to the bottom of the bag (which requires you to periodically shake the bag during the treatment).

Similarly, many alternative health care practitioners will observe blood samples on slides and believe that if the red blood cells clump together in a rouleaux formation, this suggests systemic problems within the body. Consider for example this vintage picture from Knisely:



As you might expect, similar changes have also been observed in the blood from spike protein vaccinated individuals (many similar images can be found online):

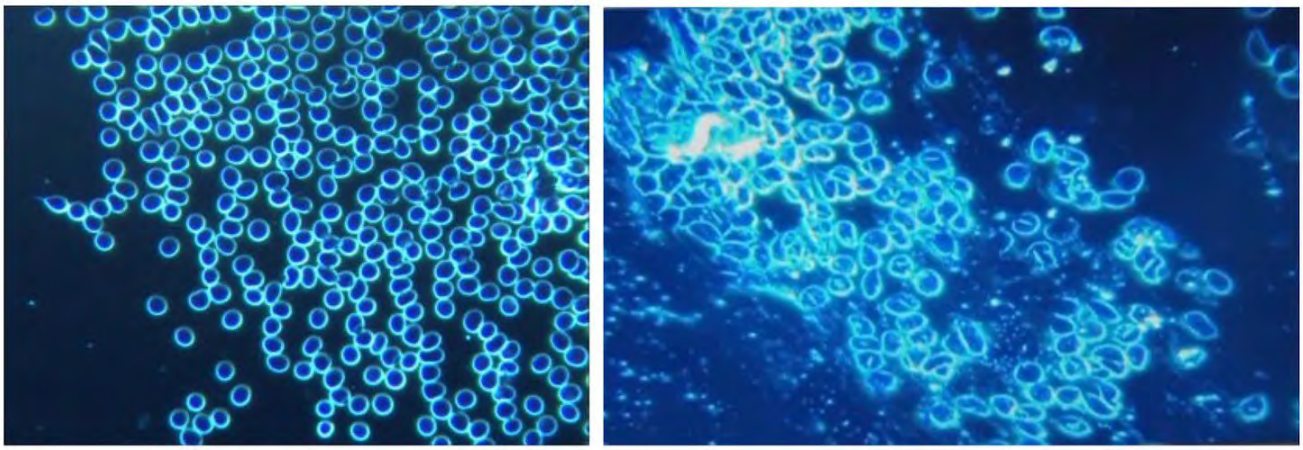


Figure 1. These photos are at 40x magnification. At the left side, (a) shows the blood condition of the patient before the inoculation. The right side image, (b) shows the same person's blood one month after the first dose of Pfizer mRNA

There are also approaches that can bypass the numerous diagnostic artifacts that are created when blood leaves the body. Overall, I believe a sclerascope is the best approach for detecting blood sludging. As shown in the video above, my team is using this approach for studying COVID-19 vaccine injuries as we believe therapies that can be observed to improve the blood sludging within the eyes will also improve many other aspects of these vaccine injuries.

Outside of sclerascopy, I believe the best approach is to know the clinical signs of blood sludging and some of the findings we use in Western medicine can indicate the presence of blood stasis (you can easily deduce which diagnostic signs likely result from blood sludging). However, I believe Chinese medicine, a system that does not require technology to make a diagnosis, offers some of the most useful diagnostic tools. This is because "blood stasis" is a key disease condition within Chinese medicine and almost perfectly overlaps with each characteristic Western researchers attributed to blood sludging; the Chinese government has also funded research that proves the presence of blood stasis with modern instrumentation.

Note: the ~~first article~~ I wrote here discussed how the early smallpox vaccines frequently severely injured their recipients and caused rather than prevented smallpox outbreaks. Many of the perplexing and debilitating symptoms of the smallpox vaccine matched what Western researches attributed to blood sludging and what Chinese medicine attributed to blood stasis (furthermore, the progression of the untreated malaria infection mentioned above by Kniseley followed the progression of an

increasing severe blood stasis affiiction described within Chinese medicine).

As discussed in the smallpox article, approximately 200 years ago (shortly after the smallpox vaccines began being used in China), blood stasis became viewed as a key cause of illness by Chinese medicine, and since that time, blood stasis has gradually become to be seen as the primary cause of most illness by the Chinese medicine profession. All of this has led me to conclude that "blood stasis" has played a pivotal role in the massive decline in the vitality of the human species observed over the last 150-200, especially since many of the other key culprits I identified (discussed in this recent article) would also be expected to cause blood stasis. However, while Knisely was able to consistently observe the presence and consequence of blood sludging in many conditions, to my knowledge, he was never able to definitively establish what caused it. Instead, his best guess was that it resulted from the protein-like aggregates and strands he frequently observed in concurrence with sludgey blood and conditions like rheumatoid arthritis.

Zeta Potential

Most phenomena in the realm we inhabit are the product of an equilibrium where competing forces meet a state of balance. When a substance is mixed in a liquid, exactly what happens to it, especially if the liquid is water, is also a complex equilibrium process. In some cases, the substances do not mix and separate by density (e.g. oil floating to the top or water or sand sinking to the bottom) and in other cases, the substance completely dissolves (salt mixing in water is a classic example).

Commonly however, the mixing process results in the formation of a colloidal suspension (most liquid systems in nature are colloids).

Here the mixed substance disperses into particles that evenly distribute themselves throughout the liquid and an equilibrium is established between the attractive forces (gravity, electostatic attraction and the inherent attraction between molecules known as the van der Waals force)

and the dispersive forces (the electrostatic repulsion between the particles and the presence of microscopic barriers, both of which prevent the particles from coming in contact with each other).

Colloidal stability (and the colloid being able to separate into the tiniest particles possible) in turn results from the dispersive forces outweighing the attractive forces.

A few factors besides the charge of the colloidal particle can affect colloidal stability. These include the other electrically charged substances present in the water, the presence of a protective colloid like gelatin or albumin that prevents agglomeration (the body utilizes these to prevent abrupt colloidal agglomeration from occurring), and large molecules that block colloidal particles from contacting each other.

If a charged substance goes into water, it will attract ions (a certain portion of water is always positively or negatively charged) that have the opposite charge and form a tightly packed layer around the substance. That layer will then attract a second loosely packed layer of ions with the

opposite charge (which thus matches the charge of the initial substance). Zeta potential represents the electrical charge difference between this second layer and that of the bulk water surrounding it.

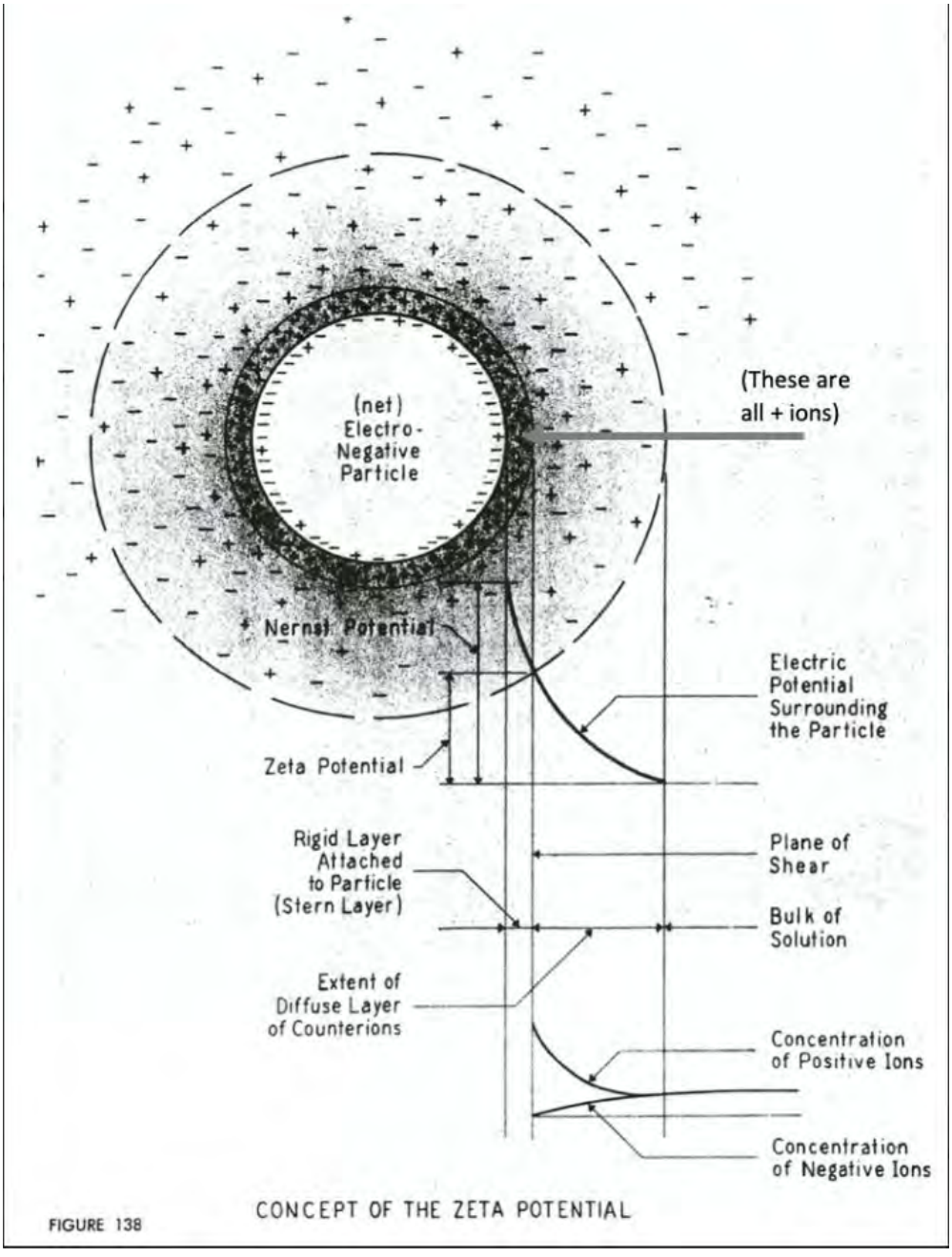


FIGURE 138 CONCEPT OF THE ZETA POTENTIAL

Almost all colloidal systems in nature depend on the mutual repulsion of negative charges, and as a result, each requires a zeta potential that is negative enough to outweigh the attractive forces that are always present. Thus, as zeta potential moves toward zero, agglomeration onsets, while as zeta potential becomes more negative, colloidal stability increases (e.g., I would argue Knisely's grading scale for the blood sludging he saw in the eyes was a reflection of how blood cells behaved at each zeta potential).

Note: since zeta potential "increases" as it moves further away from 0, this can create semantic confusion (e.g., a negative one becoming more negative is technically a "decrease"). For this reason, I always use words like "improve" rather than "increase" when discussing zeta potential changes.

Colloidal stability is critical for the body, so almost every surface inside the body is negatively charged to maintain a negatively charged colloidal system (for example see this paper on red blood cells and note that the source of their

zeta potential is also what the spike protein preferentially binds within the glycocalyx).

Note: I believe this negatively charged coating is largely a product of water's frequent tendency to form a negatively charged liquid crystal while in the presence of charged surfaces and ambient energy. Colloidal systems which instead depend upon positive charges for dispersion do exist, but I believe water's tendency to form this negatively charged structure explains why positively charged colloidal system are so much rarer to encounter.

An example to illustrate a colloidal system can be seen in dust

particles floating in the air that are made visible by sunlight illuminating them.

In this state, the positively charged dust particles repel each other and thus stay suspended in the air, but if they ever touch the floor, they take on a negative charge which causes them to stick together and never float up again. Negative ion generators likewise purify the air by having the negative ions agglomerate the floating dust particles, making them lose their suspension and sink to the ground. *Note: approximately 50 years ago, there was a large volume of research which traced weather conditions predominated with positive ions to poor health and negative ion rich environments to improved health and physical performance. Many of the specific health changes described throughout that research perfectly matched the physiologic effects of an improved or worsened zeta potential.*

Thomas Riddick

One of the early pioneers in the applications of zeta potential was Thomas Riddick, an industrial engineer whose firm was frequently required to adjust colloidal stability for clients. For example, clays are colloidal suspensions that need to remain suspended; if they agglomerate, they will clog the pipes they travel through.

Similarly, sewage is also a colloidal suspension that frequently creates issues for those who work with it. Because sewage is a colloidal suspension, treating it requires breaking its colloidal stability (termed flocculating) and causing the particles of organic matter to separate from the water and “sludge” together at the bottom where they can subsequently be removed.

Of the factors affecting colloidal stability, zeta potential is the easiest to modify (remember zeta potential is also dependent on the ions surrounding a suspended particle), and thus the primary focus of Riddick’s research. Changing zeta potential however is surprisingly complex for three key reasons:

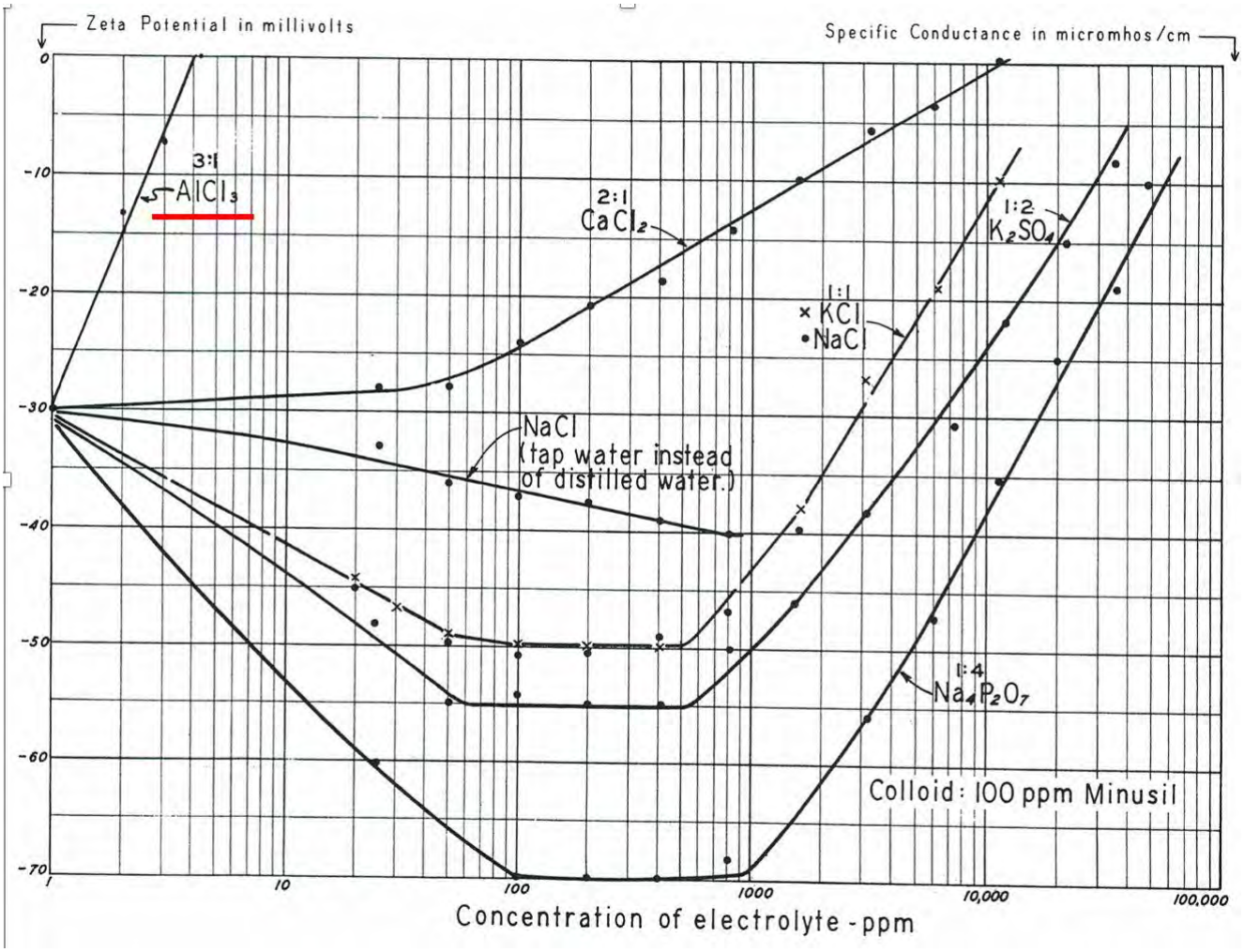
- As the tables in this section show, different ions have very different effects on zeta potential. This is largely due to their effect exponentially increasing with valence number (other characteristics also matter). As a result, +3 positively charged ions (cations) and -3 negatively charged ions (anions) have the greatest

impact on zeta potential, while other ions like calcium (a +2 cation) will also have a significant influence.

Note: most physiologic worsenings of zeta potential are mediated through calcium ion transport, and a strong case can be made that the body utilizes the effect of calcium ions ($Ca^{2}+$) on zeta potential to contract muscles and fire neurons.

- Each ion that dissolves in water must originally be paired with an oppositely charged ion (e.g. table salt is sodium and chloride that separate in water), and the other ion can also have a significant effect on zeta potential. Potassium, unlike sodium, does not significantly weaken zeta potential, so potassium salts (e.g. potassium phosphate) tend to perform much better than sodium salts when each is used for improving zeta potential.
- Any negatively charged ion (anion) which improves zeta potential will follow a U-shaped curve as its concentration increases, which requires a concentration of the anionic dispersant to be used

that does not reach the other end of that curve and worsen rather than improve the zeta potential.



While reading the graph, *pay attention to the logarithmic scale of the graph* that is necessary to show the enormous differences in how different cations affect zeta potential. To put these values further into context:

Stability Characteristics	*Avg. ZP in millivolts*
Maximum agglomeration and precipitation....	0 to +3
Range of strong agglomeration and precipitation	+5 to −5
Threshold of agglomeration	−10 to −15
Threshold of delicate dispersion.....	−16 to −30
Moderate stability	−31 to −40
Fairly good stability	−41 to −60
Very good stability	−61 to −80
Extremely good stability	−81 to −100

In the cases where Riddick needed to agglomerate (flocculate) colloids, such as when treating sewage, he used aluminum, a +3 cation that was known to be the most effective substance for agglomerating colloids (this is standard practice in municipal water facilities). In cases where Riddick needed to increase colloidal dispersion, he instead used the strongest anions (phosphate, citrate, and sulfate), which coincidentally are also used throughout the body. Sulfate for example is the active ingredient in heparin (heparin has the highest negative charge density of any known biological macromolecule) and coats the surfaces of many tissues (including the glycocalyx) and likewise, ATP (which contains 3 phosphates), when released, rapidly

changes the molecular structure of a cell. Riddick astutely noted many anticoagulants (heparin sulfate and sodium citrate) “coincidentally” were also effective anionic dispersants.

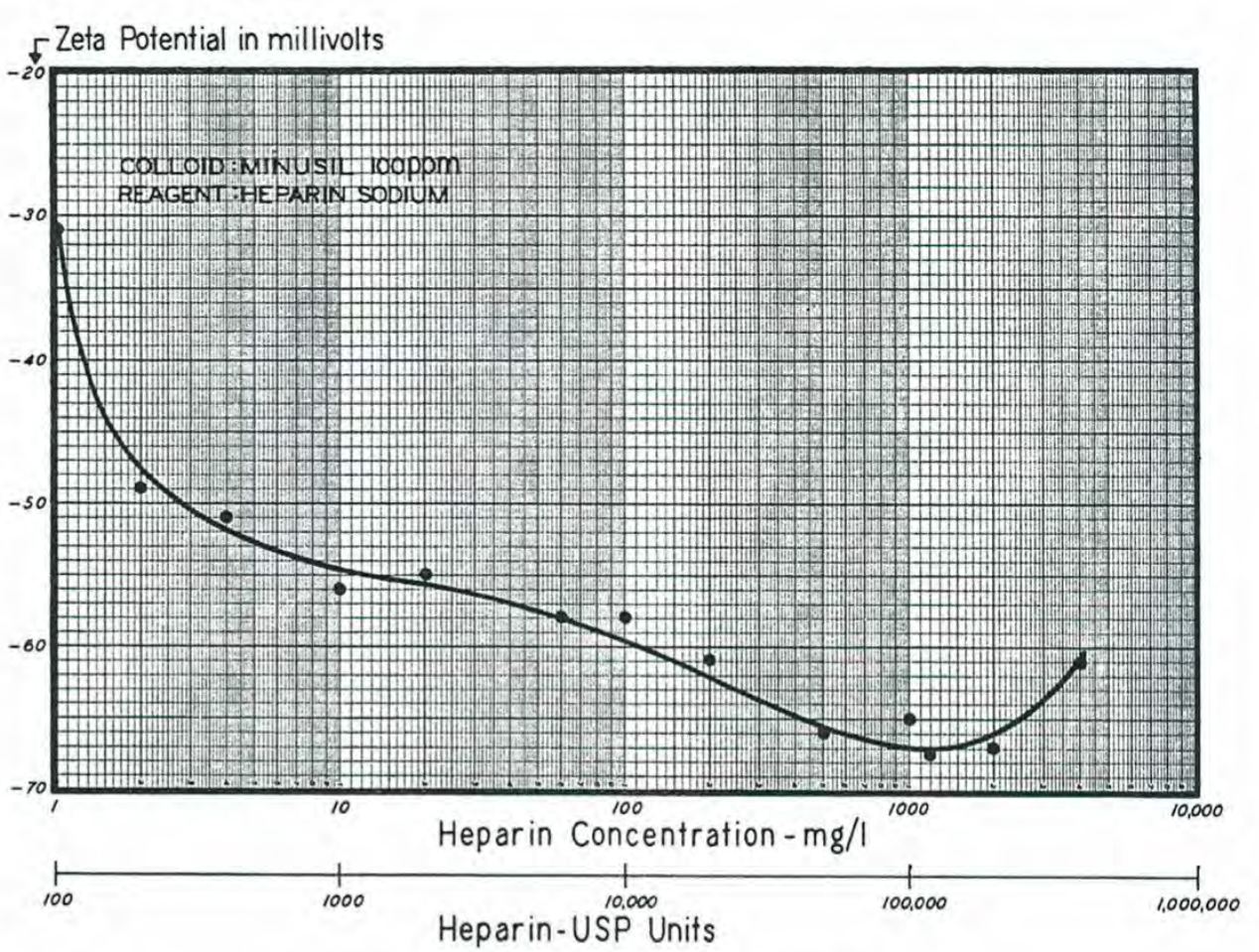


FIGURE 187—DISPERSION CURVE—HEPARIN

Note: many authors (myself included) who study liquid crystalline water believe a key biological function of sulfates is to create a

surface that water will aggregate at (this is why the glycocalyx is "slimy"). Presently, I believe the formation of that water depends upon the surrounding balance of anions and cations matching the physiologic zeta potential. We also believe a key role of sunlight is to synthesize sulfates (and nitric oxide), which is why vitamin D, while helpful, is not an adequate replacement for sunlight.

Finally, when proteins are synthesized, they start as a long chain of amino acids. Due to a variety of interactions, proteins have with

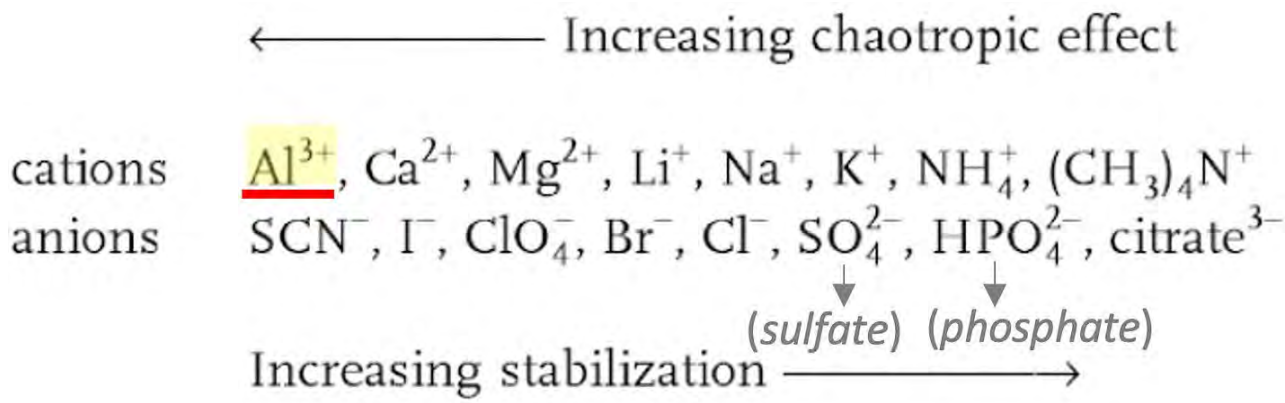
their surroundings (particularly water), these chains then "fold" into complex three-dimensional structures that allow the proteins to perform their intended functions. What is less appreciated about this process is that it means most three-dimensional proteins are colloidal suspensions (some scientific schools of thought now agree with this perspective) and the stability of their three-dimensional configurations is thus dependent on the same factors that elsewhere influence colloidal stability.

Note: I believe the precise colloidal suspension process each protein undergoes is what allows them to "violate" the second law of thermodynamics and spontaneously decrease their entropy.

As a result, ions that disrupt zeta potential can also cause protein misfolding or denaturing, and I believe this is a key reason why aluminum is associated with Alzheimer's disease (Alzheimer's plaques are misfolded proteins that are often found with aluminum). This also may explain why the SARS-CoV-2 spike protein is associated with two other protein misfolding diseases: amyloidosis and prion diseases. Additionally, this may explain why the spike protein will rapidly cause misfolding in blood clotting proteins which then leads to pathologic clotting frequently found in the blood of spike protein poisoned individuals (which I in turn argued is the root cause of the mysterious fibrous clots frequently found in by embalmers in vaccinated individuals).

Finally, in 1888, a series was assembled by Franz Hoffmeister that showed how various substances would either stabilize folded proteins or denature and salt them

out of solutions (e.g. consider what happens when you cook egg whites and denature the albumin within). Interestingly, his series was almost identical to the relative effects of specific ions on zeta potential.



Note: one popular home COVID-19 remedy, Alka-Seltzer, coincidentally contained some of the key electrolytes Riddick found were ideal for dispersing blood sludging. Similarly, as far back as the 1918 infiuenza, records exist of physicians sometimes achieving exceptional results by administering potassium citrate to their patients.

Zeta Potential and the Blood

Although I have many criticisms of modern medicine, I also recognize that it has had a profoundly positive

impact on our modern lives and has solved many problems that plagued humanity for eons. In many cases, it is difficult to even conceive of what life would be like if we still faced those problems, and oftentimes developing the solutions we now take for granted required an immense amount of blood sweat and tears that involved going down many dead ends and conducting many disastrous experiments.

At the time Riddick was alive, most of the approaches we now use for heart disease did not exist, and various common heart conditions like Riddick's were a death sentence. This motivated Riddick to independently develop a solution to his disease, and he had the insight “what if blood is a colloidal suspension of blood cells in plasma and thus follows the rules I have developed from my industrial work with colloids?”

Before long, Riddick was able to establish that the process which caused blood sludging to occur was electrical, and through applying the anionic (negatively charged) dispersants he had previously utilized for industrial applications, he was able to reverse blood sludging (I will

also note that aspirin, a well known anticoagulant, acetylates proteins and by doing so imparts a negative charge to them).

Note: in addition to the anionic dispersants, Riddick also experimented with a few other effective approaches for treating zeta potential such as consuming stabilizing colloids.

All of this led Riddick to postulate the initial step in blood clotting was blood cell agglomeration. This is extremely important because treating the agglomeration provides a way to "anticoagulate" the blood without incurring the risks inherent to any anticoagulant therapy (and also explains why things like dehydration or not moving for long periods are known to cause blood clots as these are also factors which are known promote colloidal agglomeration).

Riddick later discovered the body keeps the blood zeta potential near the agglomeration threshold (e.g. this study found red blood cells have a -15mv zeta potential and this study found -15.7mv). This causes blood to initiate the life saving clotting process whenever it begins to leave the circulation (as numerous elements only present within the

blood vessels stabilize colloidal suspensions and colloidal stability is created by the normal flow of blood within the vessels), but simultaneously makes it quite likely the countless modern disruptions to zeta potential (which our species has not yet adapted to) will also cross that critical threshold for blood that has not left the circulation.

Note: this is also why I believe blood stasis has become such a huge issue in modern society.

In dermatology, a commonly encountered issue is a wound on the skin that will not stop bleeding after skin surgery. One of the most common approaches in these instances is to apply aluminum chloride onto the skin as this agglomerates the blood and therefore begins the clotting process to stop the bleeding (in this context aluminum is viewed as a protein coagulant). This application provides a vital illustration of what occurs anytime there is a physiologic loss of zeta potential (extreme heat or cold can also cause agglomeration and modern surgery relies on this injurious principle when

cutting tissue with electrically heated instruments so that bleeding is rapidly prevented through coagulation).

With further study, Riddick found the degree of blood sludging or loss of physiologic zeta potential significantly varied from person to person, and Knisely's grading scale for blood flow in the eyes could be used to accurately predict who was at risk of an arrhythmia, a stroke, or a fatal heart attack. Most importantly, Riddick discovered that once the colloidal dispersion of the blood was fixed, **heart arrhythmias normalized** and circulatory problems greatly improved.

Riddick also discovered a primary function of the kidneys was to excrete the cations that destroyed physiologic zeta potential, and that when these cations were in excess, they could trigger cardiac episodes the kidneys would work in overdrive to correct (this likely explains the belief in Chinese medicine that the kidneys control the heart).

This clearance seems to peak at night (likely from cations leaving the tissues and entering the bloodstream) and I have had a few experiences where I ate a lot of salty food before bed, woke up suddenly in the middle of the night with a fast heart rate and a feeling of being completely dried out inside which persisted until I drank a few glasses of distilled or reverse osmosis water (these are the two available forms of deionized water; any other form of water I tried did not work).

In these instances, I also observed I had unusual and highly conductive urine (this the easiest way to test for how many cations the kidneys are excreting). Riddick had more severe incidents of what I experienced, and by saving his urine for analysis during one episode, was able to show the kidneys had frantically worked to correct his zeta potential by boosting their excretion of dangerous cations like aluminum.

As individuals age, the kidney's ability to maintain zeta potential declines (Moulden hypothesized this was due to microstrokes in the peripheral watershed areas of the kidneys and Knisely produced videos showing blood

sludges halving the kidney's blood supply and plugging many of its filtration units). This decline makes the elderly much more susceptible to sudden influxes of positive charges and I am now of the belief a primary cause of aging is the gradual loss of the kidney's function to maintain zeta potential (and to a lesser extent from albumin declining with age).

Note: One of the pioneers of zeta potential in medicine demonstrated that many of the complications of aging (e.g., dementia) could be reversed by restoring the physiologic zeta potential. Likewise, I discussed the link between the kidneys, aging and zeta potential further in this recent article about osteoporosis.

As Riddick attempted to deduce why unhealthy blood zeta potentials were so common (he found them in the majority eyes he looked at), he realized our society had contaminated the food supply with cations that were destructive to zeta potential (the first head of the FDA fought to stop aluminum from entering general use but was muscled out by industry) .

Examples included:

- Potassium being replaced by sodium in most processed foods
- Aluminum being used in most municipal water systems
- The widespread use of aluminum kitchenware
- Aluminum being added to many foods (e.g. most salt has aluminum added to keep it from caking, which amongst other things I believe explains why salty meals are often observed by hospitalists to cause heart failure exacerbations)
- Many medications like antacids being full of aluminum and other problematic cations
- Many foods being stored in metal cans (acidic foods leach these metals), especially cans that are aluminum.

Riddick also performed experiments that showed consuming water stored in aluminum significantly impaired microcirculation and for this reason, I will never drink anything from an aluminum can. .

Similarly, I have seen a few cases of patients with longstanding zeta potential impairments having a stroke a few hours after eating a meal that was cooked in aluminum.

Note: this subject was discussed further in a recent article about which waters are the healthiest to drink and which are the worst.

Lastly a more disappointing note for some, Riddick also found excessive alcohol consumption induced intravascular coagulation (it his research, two 2oz drinks of 90-100 proof seem to be cut off for triggering this).

Microbes and Zeta Potential

One of Riddick's most interesting discoveries was that the bacterial metabolism of proteins would consistently lower their zeta potential, which he theorized was due to the decarboxylation reaction that occurs during the bacterial metabolism of protein (decarboxylation removes negative charges that would otherwise suspend these colloids). Many sewage treatment systems (e.g. septic tanks) work under this principle, as over time the bacteria within destroy the colloidal stability of the organic matter suspended in

wastewater and cause it to separate from the water and sink to the bottom.

Because of this observation, Riddick also began assessing how zeta potential changed in human beings during periods of acute infections. In these cases, much like Knisely had previously seen in the eyes of his acutely ill test subjects, Riddick consistently observed a decrease in physiologic zeta potential occur during an infectious condition. In addition to their metabolism of human proteins, I believe another factor accounting for this phenomena is most pathogenic organisms having a positive charge since this charge allows them to adhere to the negatively charged cells of the body (which likely helps to explain the universal applicability of oxidative therapies as they preferentially target positively charged organic molecules).

These observations were important because they provided a means to explain why the elderly are so much more vulnerable to infections like influenza. Sadly, it also

likely explains the greater susceptibility of the elderly to vaccinations (e.g., I still remember admitting one patient to the hospital who during her intake perfectly described a zeta potential collapse happening after a pneumococcal vaccination, including it being preceded by the kidney's failed attempt to discharge the cations from the vaccine).

Regardless of who gets sick, infections consistently reduce zeta potential, but in the elderly who have a more impaired zeta potential to begin with, the reduction is often sufficient to cross a threshold into serious illness. This process also explains why, as Moulden observed, vaccine damage is cumulative and more severe diseases onset as blood sludging progressively increases.

Although, as Riddick proved, the kidney can address many causes of impaired zeta potential, it typically struggles with disruptions caused by infectious microorganisms, particularly the smaller mycoplasma (which are instead eliminated by the spleen, liver and bone marrow). Lida Mattman provided strong evidence for this, as she showed many of the stealth bacteria her research group

discovered (once detected with the appropriate instrumentation), could be found to underlie numerous chronic kidney conditions (in most cases, the cause of those conditions remains unknown in the conventional paradigm).

Note: the tendency for bacteria to transform into harmful stealth pathogens and how these organisms underlie many chronic disease is discussed further here.

Certain integrative doctors also have had remarkable success in treating a variety of complex illnesses through lengthy antibiotic protocols, and I believe those successes are often a result of eliminating stealth bacteria that are impairing physiologic zeta potential. As antibiotics always have some degree of toxicity, I prefer other approaches to eliminate these organisms (e.g. oxidative therapies like ultraviolet blood irradiation).

In addition to the alternative broad-spectrum treatments for stealth bacteria, in some patients with impaired zeta

potential, I have also had a great deal of success with specific German pleomorphic remedies that were developed to remove the pathogenicity of the stealth bacteria rather than directly eliminate them (one of the most well known researchers in this area, Gaston Naessens made a key observation that the foundational non-pathogenic form of these bacteria **had a strong negative charge** but that this charge was lost as they became pathogenic). Interestingly, one of these affordable German remedies has also proven remarkably effective for reducing the blood sludging that commonly follows spike protein injuries.

MASS and Zeta

Vaccinations consistently contain many agents which are excellent at reducing the zeta potential of the body, particularly since aluminum, the most effective agent for reducing zeta potential is also the most widely used immune-stimulating vaccine adjuvant (I believe this is the reason why aluminum is such an effective adjuvant as attacking the zeta potential is a common characteristic of

most pathogenic organisms and hence a likely trigger for the innate immune system). Moulden thus realized alterations in zeta potential could explain many of the injuries resulting from microstrokes he was seeing.

From studying the autopsies of children who had died from infections in the womb, Moulden also realized a second process occurred concurrently. Whenever an immunostimulatory event occurs, the white blood cells will migrate to certain capillaries so that they can exit them to enter the surrounding tissue. Because the white blood cells are much larger than red blood cells, if sufficient numbers of them are present within a capillary (particularly if partial blood sludging is already occurring there), their presence will block the flow of blood within the microcirculation. Moulden termed this process the Moulden Anoxia Spectrum Syndromes (MASS).

Thus, by reducing zeta potential and simultaneously provoking white blood cell recruitment through immune stimulation, the stage was set for vaccines to always cause

varying degrees of harm. Additionally, certain vaccines like the HPV vaccine do so even more frequently because they utilize a specialized aluminum adjuvant designed to create a stronger immune response the vaccine needs to “work”. It should also be noted aluminum is the ingredient most directly responsible for the wide range of severe autoimmune disorders vaccines cause (although the spike proteins likely will ultimately prove to be worse in this regard). This is important because autoimmunity is classically considered to be the most significant complication of vaccination#, and it is likely either a direct result of the immune-stimulatory nature of the adjuvants or arises from the fluid stagnation they create.

Moulden’s (and Riddick's) model is immensely valuable because it provides a way to understand how:

- Vaccines, regardless of the design, consistently cause harm.
- Why vaccine damage is cumulative, as the microcirculation (and other fluid circulations) will progressively worsen with each successive vaccine

until a critical threshold is met where severe injury occurs.

- Why there can be so much variability in the injuries that are observed.
- How many infectious diseases can sometimes cause similar injuries to vaccines (but in almost all cases, the obstructions to blood flow are much worse following vaccination).

Further Reading:

Since a mission of this publication has been to bring awareness to the importance of the zeta potential concept, I have written a few other articles on this subject. They are as follows (with their links included in the description):

All the methods I know of for improving the physiologic zeta potential.

Note: I have spent years on this subject because I find an impaired zeta potential is one of the most common causes of illness in my patients and that it is frequently possible to create

“miraculous” health improvements through simple treatments targeted at fixing their zeta potential.

How the water you drink profoundly affects your zeta potential and what we consider to be the healthiest and most dangerous water options (e.g., for water filters or bottled water).

What the relationship is between liquid crystalline water and zeta potential.

Note: I also wrote a piece describing what is liquid crystalline water is, how this water is the driving force behind much of the (otherwise inexplicable) vital fiuid circulation throughout the body, how this water creates the structure and stability of the body and how to increase it within the body.

Patients who are the most sensitive to environmental and pharmaceutical injuries also tend to have significant ligamentous laxity and hypermobility. I believe this is in part due to this laxity affecting their blood vessels and that laxity making the blood vessels be more prone to becoming compressed unless the zeta potential within the vessel is

strong enough to create a force which expands it from the inside. Likewise, I believe that the common observation these patients have specific autoimmune conditions (e.g., mast cell disorder) is a response to stagnant blood pooling in their body.

A review of the evidence showing that vaccine induced microstrokes in the respiratory centers of the brain is the likely mechanism of sudden infant death syndrome (something which has been conclusively linked to vaccination).

•How zeta potential collapse and the cell danger response are often the mechanisms that underlie vaccinations causing autism.

- An article about how the positively charged lipid nanoparticles of the mRNA vaccines affect zeta potential. This was initially a confusing subject, as I saw many signs the lipid nanoparticles rapidly caused microclotting (e.g., it could immediately be seen when the vaccine was mixed with blood and was the most plausible explanation for the sudden heart attacks

which immediately after vaccination) but per Pfizer's regulatory submissions, the lipid nanoparticles had a negative zeta potential. I eventually learned there were significant quality control issues with their production (which led to many of them being positive charged) which in turn also explained why different lots of the vaccine concentrated in different parts of the body (as their zeta potential heavily influences the biodistribution of the vaccine).

Note: I also wanted to share ~~this~~ paper (published in a peer-reviewed journal), which provided the strongest proof I have come across in the published literature that the SARS-CoV-2 spike protein adversely affects zeta potential which I will expand upon in the future to discuss exactly how the physical chemistry of the spike protein affects zeta potential.

In addition to these article in the next year I hope to write:

- A discussion of how zeta potential also effects inorganic colloidal agglomerations in the body, and how treating zeta potential can resolves conditions such as kidney stones, osteophytes (bone spurs) and coronary artery disease.
- A detailed discussion of the evidence underlying the ion effect (the myriad of health benefits gained from being exposed to negative ions in the air and the myriad of harms created by exposure to positive ions in the air). Sadly, despite decades of research proving negative ion therapy works, it is typically viewed as pseudoscience, largely because there is no mechanism to explain *why it could work* (as zeta potential was never taken into consideration). Given that around 25% of the population is sensitive to positive ions and that countless number of otherwise inexplicable diseases (particularly psychiatric and respiratory ones) which result from positive ions in the environment, I view it as a great shame this knowledge was lost.

- A detailed discussion of the Chinese medicine concept of blood stasis which will highlight its parallels to forgotten western research on blood sludging and the common observation blood stasis is linked to autoimmune disorders.
- A discussion of how interstitial stagnation created by poor zeta potential appears to underlie many skin conditions.

Conclusion

Poor zeta potential is one of the most common root causes of disease I encounter in my patients and “zeta potential” is the clearest correlate I have found to the ever-elusive concept of “health.” Books could be written on the profound consequences of a non-physiologic zeta potential, yet outside of a few applications like designing lipid nanoparticles, it is virtually unheard of in medicine (which is likely why the potential consequences of using **positively charged** lipid nanoparticles for the mRNA vaccines were never considered). A few leading members of the vaccine safety movement, along with some of the most talented

integrative physicians I have met agree with these sentiments, but due to what happened to Moulden, none of them have spoken publicly on this issue.

Although many of the early pioneers of this concept established that poor zeta potential impaired blood circulation, which when addressed, can yield profound benefits for patients in countless areas, blood is not the only colloidal suspension in the body. Many other fluids in the body, also require a physiologic zeta potential, and when that becomes disturbed, many other diseases arise (e.g. I would argue dementia is largely a result of lymphatic and cerebrospinal fluid stagnation, while pneumonia is conventionally recognized to be a result of insufficient lymphatic drainage from the lungs).

Similarly, I have observed that patients with many of the common chronic disease that require years of integrative therapies (e.g. Lyme disease or chronic mold toxicity), almost always have signs of significant fluid stagnation throughout their bodies. I can often connect this stagnation directly to their disease (e.g. mycotoxins and the

Lyme bacteria carry a strong positive charge, which amongst other things is why I believe Lyme disease, something Justin Bieber had prior to his vaccine injury, causes Bell's Palsy). In many cases, these patients can only get better if something is done to either fix their zeta potential or lymphatic circulation (otherwise antimicrobials will be often ineffective and overwhelm the patient) and since most integrative doctors are unaware of this concept, they often are quite limited in what they can do to help these patients.

A disease commonly seen in hospitalized patients, diabetic ketoacidosis (where the body becomes overwhelmed with excess levels of sugars and acidic ketones) further illustrates this concept. When these patients are treated in the hospital, they are always given insulin to lower their blood sugar along with potassium (as insulin moves potassium into cells). In addition to those two therapies, these patients are also always gives a saline solution under the rationale that without saline being administered, insulin cannot get where it is needed to reduce blood sugar levels.

Although this need for saline is commonly attributed to the patients being “dehydrated,” I believe it is due to the fact that sugar, when present at high levels, is a highly effective agent for disrupting colloidal stability (this is also why diabetics have so many problems with their peripheral microcirculation). Additionally, acidic environments disrupt physiologic zeta potential while alkaline ones support it (this is likely what accounts for many of the benefits attributed to health approaches that seek to alkalinize the body), so this impaired circulation is further compounded by the acidity of the ketones within the body.

Saline solution in turn is a somewhat effective means for restoring zeta potential (I have personally witnessed some profound examples that proved this concept to me) and it (or another fluid solution) is reflexively provided to almost all hospitalized patients despite almost no knowledge of its effect on zeta potential existing within the medical field. Because of this, I have long suspected the routine use of saline (and some other IV fluids) explains many of the benefits patients experience from hospital care.

Note: with saline, it is important to remember the U-shaped zeta potential curve Riddick described, as in higher concentrations (such as what follows consuming large amounts of salt), sodium chloride causes colloidal aggregation rather than dispersion.

Beyond hospitalized patients often having an immeasurable need for therapeutics that treat their zeta potential (which besides saline they rarely get), I am now of the opinion that many different holistic therapies (e.g., ozone therapy or chelation therapy) all share the common mechanism of improving zeta potential.

One popular therapy, Earthing, for example, functions by electrically attaching oneself to the ground (a reservoir of negative charge) while sleeping so that the physiologic negative charge within the body can be regained (sleep, through melatonin sulfate and the redistribution of calcium ions, plays a key role in restoring zeta potential of the nervous system, but often cannot initiate if significant fluid stagnation is present).

Earthing's proponents in turn argue that many modern health problems have arisen from us no longer being electrically connected to the ground. Almost every benefit I have seen attributed to Earthing (Earthing *sometimes* produces miraculous results such as the resolution of insomnia), reflects an improvement of zeta potential (which has been directly demonstrated in this study).

Similarly, one reader recently shared Earthing significantly improved his son's Reynaud's syndrome, while another shared it improved his COVID-19 vaccine injury.

I thank you for taking the time to read this article, and for your incredible support over the last two years which has made this newsletter possible. It is my sincere hope that with your help, we can begin to make treating zeta potential become a serious consideration within medicine as so many essential processes depend upon an adequate circulation of fluids within the body.

Finally for those interested, the approaches we currently use for treating zeta potential can be found in the article which can be read here.

Note: A complete index of the articles published here on the Forgotten Side of Medicine can be found here.

Why subscribe to my Substack?

A Midwestern Doctor

As a physician in practice with multiple jobs, I have a very full plate. The main reason I do a lot of this work to support charitable projects for the world because my value system prioritizes good karma over profit. There seems to be a critical need for the type of content I can produce on here, so as time allows, I have taken up that responsibility as well.

Because of my unique situation, I will only produce content I feel is important and worthwhile to read; if it's not I would rather spend my time somewhere else. I do not like getting spammed, and you have my word I will be quite selective in what I send to your inbox.

Having more subscribers allows the messages I am writing to reach more people. It is my hope that what I produce here has earned your trust and made you comfortable being part of that by signing up for this newsletter.

Additional reasons to sign up

I am making a sincere effort to lay out the concepts a lot of people want to know now but don't have access to. It's a bit of a challenging project, but at the rate I'm going I'm think I can complete it in the next year or two. My hope is this means the majority of emails you receive will be insightful and non-repetitive.

Join the crew

These essays were compiled by Curious Outlier, Producer of The Universal Antidote Documentary. Curious Outlier is a Jesus follower, dad, and registered nurse with 25 years of critical care experience. He chooses to remain anonymous, but you can reach him at theuniversalantidote@protonmail.com. The Curious Outlier loves educating and inspiring other humans to find their full potential for life, health, and spiritual well-being.

Note: This life is short and there is a greater purpose to life. The purpose of life is to know and experience God. This is what all humans were made for. God loves us and has a plan that we all should know Him and experience Him fully. To learn how you can know and experience God please visit: https://www.everyperson.com/