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The Flu Vaccine: Science at Its Worst

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Joshua Hadfield was a normal, healthy developing child as a toddler. In the midst of the H1N1 swine flu frenzy and the media fear mongering about the horrible consequences children face if left unvaccinated, the Hadfield family had Joshua vaccinated with Glaxo's Pandermrix influenza vaccine. Within weeks, Joshua could barely wake up, sleeping up to nineteen hours a day. Laughter would trigger seizures.

Joshua was diagnosed with narcolepsy, "an incurable, debilitating condition" associated with acute brain damage.[1] Looking back, Pandermrix was a horrible vaccine. Research indicates that it was associated with a 1400% increase in narcolepsy risk. A medical team at Finland's National Institute for Health and Welfare recorded 800 cases of narcolepsy associated with this vaccine. Aside from the engineered viral antigens, the other vaccine ingredients are most often found to be the primary culprits to adverse vaccine reactions. The Finnish research, on the other hand, indicated that the vaccine's altered viral nucleotide likely contributed to the sudden rise in sleeping sickness.[2]

Although Pandermrix was pulled from the market for its association with narcolepsy and cataplexy (sudden muscle weakness), particularly in children, it should never have been approved and released in the first place. The regulatory fast tracking of the HINI flu vaccines is a classic, and now common, example of regulatory negligence by nations' health officials. The failure of proper regulatory evaluation and oversight resulted in Joshua and over 1,000 other people becoming disabled for life. Settlements to cover lawsuits exceeded 63 million pounds in the UK alone.

No one should feel complacent and assume flu vaccine risks only affect young children. Sarah Behie was 20 years old after receiving a flu shot. Three weeks later her health deteriorated dramatically. Diagnosed with Guillain-Barre syndrome, a not uncommon adverse effect of influenza vaccination, four years later Sarah remains paralyzed from the waist down, incapable of dressing and feeding herself, and rotting away in hospitals and nursing homes.[3]

Flu vaccines are perhaps the most ineffective vaccine on the market. Repeatedly we are told by health officials that the moral argument for its continued use is for "the greater good," although this imaginary good has never been defined scientifically. Year to year, how effective any given seasonal flu vaccine will be is a throw of the dice. Annual flu vaccine efficacy rates in the US have demonstrated significant variability. Data from the CDC reveal efficacy estimates of approximately 39% for the 2020–2021 season, 37% for 2021–2022, 52% for 2022–2023, and a preliminary estimate of 50% for the 2023–2024 season. Preliminary CDC estimates for this flu season estimates 34% likely efficacy. Although these are CDC's figures, independent figures are consistently much lower. At their best, flu vaccines in recent years are around 50% effective according to official health analysis. During some seasons, vaccine efficacy is a bust. For example, the 2014-2015 flu

season strain match was such a failure that the CDC warned the American public that the vaccine was only 23% effective.[4] Nevertheless, these rates underscore the vaccine's inconsistent protection.

Studies such as those by Skowronski and Belongia further highlight flu vaccines' variability and force to question whether the vaccine is capable of providing any reliable protection.[5,6] Moreover, Cochrane Collaboration reviews, known for their rigorous analyses, consistently find that flu vaccines reduce influenza-like illness by only about 1% in healthy adults and have negligible impact on hospitalizations and mortality rates. This limited efficacy raises critical concerns about the vaccine's utility, particularly when weighed against its risks.

Perhaps the most useless flu vaccine that should have never been approved was Medimmune's live attenuated flu vaccine (LAIV) FluMist, which the CDC later had removed from the market because it was found to so ineffective—only 3 percent according to an NBC report.[6] However the real reason may be more dire, and this a fundamental problem of all live and attenuated vaccines: these vaccines have been shown to "shed" and infect people in contact with the vaccinated persons, especially those with compromised immune systems. Consequently, both the unvaccinated and the vaccinated are at risk. The CDC acknowledges this risk and warns "Persons who care for severely immunosuppressed persons who require a protective environment should not receive LAIV, or should avoid contact with such persons for 7 days after receipt, given the theoretical risk for transmission of the live attenuated vaccine virus."[7]

According to the FDA's literature on FluMist, the vaccine was not studied for immunocompromised individuals (yet was still administered to them), and has been associated with acute allergic reactions, asthma, Guillain-Barre, and a high rate of hospitalizations among children under 24 months – largely due to upper respiratory tract infections. Other adverse effects include pericarditis, congenital and genetic disorders, mitochondrial encephalomyopathy or Leigh Syndrome, meningitis, and others.[8]

The development and promotion of the influenza vaccine was never completely about protecting the public. It has been the least popular vaccine in the US, including among healthcare workers. Rather, similar to the mumps vaccine in the MMR, it has been the cash cow for vaccine makers. Determining the actual severity of any given flu season is burdened by federal intentional confusion to mislead the public. The CDC's first line of propaganda defense to enforce flu vaccinations is to exaggerate flu infections as the cause of preventable deaths. However, validating this claim is near impossible because the CDC does not differentiate deaths caused by influenza infection and deaths due to pneumonia. On its website, the CDC lumps flu and pneumonia deaths together, currently estimated at 51,000 per year. The large majority of these were pneumonia deaths of elderly patients. Yet in any given year, only 3-18% of suspected influenza infections actually test positive for a Type A or B influenza strain.[9]

As an aside, it is worth noting that during the first two years of the COVID-19 pandemic, an extraordinary and unprecedented phenomenon occurred: influenza infections, which have long been a seasonal health challenge, seemingly disappeared. Federal health agencies such as the CDC attributed this sharp decline in flu cases to the implementation of non-pharmaceutical interventions (NPIs) like mask-wearing, social distancing, and widespread lockdowns. However, this explanation raises critical questions about its plausibility. If these measures were effective enough to virtually eliminate influenza, why did they not similarly

prevent the widespread transmission of SARS-CoV-2? This contradiction highlights the need to critically examine the possible explanations behind the anomaly, questioning whether the disappearance of the flu was truly a result of public health measures or due to other factors such as diagnostic practices, viral interference, and disruptions to seasonal flu patterns. If these interventions were indeed effective, their impact should not have been so starkly selective between two similarly transmitted viruses. This contradiction undermines the plausibility of attributing the disappearance of flu cases solely to NPIs.

A more plausible explanation for the disappearance of flu cases lies in the diagnostic focus on SARS-CoV-2 during the pandemic. Individuals presenting with flu-like symptoms were overwhelmingly diagnosed for COVID-19 with faulty PCR testing methods rather than influenza, as public health resources were directed toward managing the pandemic. This prioritization inevitably led to a significant underreporting of flu cases. Furthermore, the symptoms of influenza and COVID-19 overlap significantly, including fever, cough, and fatigue. In the absence of influenza testing, many flu cases were wrongly diagnosed as COVID-19, further inflating SARS-CoV-2 case numbers while contributing to the perceived disappearance of the flu.

One of the more controversial findings in recent flu vaccine research involves the phenomenon of viral interference, wherein vaccinated individuals may become more susceptible to other respiratory pathogens. To date there is only one gold standard clinical trial with the flu vaccine that compares vaccinated vs. unvaccinated, and it is not good news for the CDC, the vaccine makers, and the push to booster everyone with the Covid-19 mRNA vaccines. This Hong Kong funded double-blind placebo controlled study followed the health conditions of vaccinated and unvaccinated children between the ages of 6-15 years for 272 days. The trial concluded the flu vaccine holds no health benefits. In fact, those vaccinated with the flu virus were observed to have a 550% higher risk of contracting non-flu virus respiratory infections. Among the vaccinated children, there were 116 flu cases compared to 88 among the unvaccinated; there were 487 other non-influenza virus infections, including coronavirus, rhinovirus, coxsackie, and others, among the vaccinated versus 88 with the unvaccinated.[10] This single study alone poses a scientifically sound warning and rationale to avoid flu vaccines at all costs. It raises a further question: how many Covid-19 cases could be directly attributed to weakened immune systems because of prior flu vaccination?

A 2019 study conducted by the US Armed Forces investigated the relationship between influenza vaccination and susceptibility to other respiratory infections, including coronaviruses. Analyzing data from over 9,000 individuals, the researchers found that people who received the flu vaccine were more likely to test positive for certain non-influenza respiratory viruses. Notably, influenza vaccination was associated with an increased likelihood of contracting coronaviruses and human metapneumovirus.[11] These findings suggest a complex interaction between influenza vaccination and susceptibility to different respiratory pathogens, and challenges the belief that flu vaccines provide greater benefits over risks. The same researchers' follow up study in in 2020 furthermore concluded that "vaccine derived virus interference was significantly associated with coronavirus and human metapneumovirus.[12]

Additional recent studies, such as those by Bodewes, which identified immune interference due to repeated annual flu vaccinations,[13] and Shinjoh, which highlighted increased viral interference in vaccinated children, provide further evidence of this relationship.[14] These findings challenge the prevailing assumption that flu vaccination has only positive effects on

immune health and raise important questions about the broader implications of repeated annual vaccination.

In a follow up study after the H1N1 swine flu scare, Canadian researcher Dr. Danuta Skowronski noted that individuals with a history of receiving consecutive seasonal flu shots over several years had an increased risk of becoming infected with H1N1 swine flu. Skowronski commented on the findings, "policy makers have not yet had a chance to fully digest them [the study's conclusions] or understand the implications." He continued, "Who knows, frankly? The wise man knows he knows nothing when it comes to influenza, so you always have to be cautious in speculating."[15]

There is strong evidence suggesting that all vaccine clinical trials carried out by manufacturers fall short of demonstrating vaccine efficacy accurately. And when they are shown to be efficacious, it is frequently in the short term and offer only partial or temporary protection. According to an article in the peer-reviewed Journal of Infectious Diseases, the only way to evaluate vaccines is to scrutinize the epidemiological data obtained from real-life conditions. In other words, researchers simply cannot — or will not — adequately test a vaccine's effectiveness and immunogenicity prior to its release onto an unsuspecting public.[16]

According to Dr. Tom Jefferson, who formerly led the Cochrane Collaboration's vaccine analyses, it makes little sense to keep vaccinating against seasonal influenza based on the evidence.[17] Jefferson has also endorsed more cost-effective and scientifically-proven means of minimizing the transmission of flu, including regular hand washing and wearing masks. There is also substantial peer-reviewed literature supporting the supplementation of Vitamin D.

Dr. Jefferson's conclusions are backed by former Johns Hopkins University School of Medicine scientist Peter Doshi, PhD, in the British Journal of Medicine. In his article Doshi questions the flu vaccine paradigm stating:

"Closer examination of influenza vaccine policies shows that although proponents employ the rhetoric of science, the studies underlying the policy are often of low quality, and do not substantiate officials' claims. The vaccine might be less beneficial and less safe than has been claimed, and the threat of influenza appears overstated."[18]

A significant body of research proves that receiving the flu shot does not reduce mortality among seniors.[19] One particularly compelling study was carried out by scientists at the federal National Institutes of Health (NIH) and published in the Journal of the American Medical Association (JAMA). Not only did the study indicate that the flu vaccine did nothing to prevent deaths from influenza among seniors, but that flu mortality rates increased as a greater percentage of seniors received the shot.[20]

Dr. Sherri Tenpenny reviewed the Cochrane Database reviews on the flu vaccine's efficacy. In a review of 51 studies involving over 294,000 children, there was "no evidence that injecting children 6-24 months of age with a flu shot was any more effective than placebo. In children over 2 years of age, flu vaccine effectiveness was 33 percent of the time preventing flu. In children with asthma, inactivated flu vaccines did not prevent influenza related hospitalizations in children. The database shows that children who received the flu vaccine were at a higher risk of hospitalization than children who did not receive the vaccine.[21]

In a separate study involving 400 asthmatic children receiving a flu vaccine and 400 who were not immunized, there was no difference in the number of clinic and emergency room visits and hospitalizations between the two groups.[22]

In 64 studies involving 66,000 adults, "Vaccination of healthy adults only reduced risk of influenza by 6 percent and reduced the number of missed work days by less than one day. There was a change in the number of hospitalizations compared to the non-vaccinated. In further studies of elderly adults residing in nursing homes over the course of several flu seasons, flu vaccinations were insignificant for preventing infection.[23]

Today, the most extreme wing of the pro-vaccine community continue to diligently pursue mandatory vaccination across all 50 states. During the flu season, the debate over mandatory vaccination becomes most heated as medical facilities and government departments attempt to threaten employees and schools who refuse vaccination. Although this is deeply worrisome to those who advocate their Constitutional rights to freedom of choice in their healthcare, there are respectable groups opposing mandatory flu shots. The Association of American Physicians and Surgeons "objects strenuously to any coercion of healthcare personnel to receive influenza immunization. It is a fundamental human right not to be subjected to medical interventions without fully informed consent."

The good news is that the majority of Americans have lost confidence in the CDC after the agency's dismal handling of the Covid-19 pandemic. Positive endorsement of the CDC would plummet further if the public knew the full extent of CDC officials lying to Congress and their conspiracy to commit medical fraud for two decades to cover=up evidence of an autism-vaccine association.

When considering the totality of evidence, the benefit-risk ratio of flu vaccination becomes increasingly problematic. The poor and inconsistent efficacy rates, combined with the potential for serious adverse reactions and the phenomenon of viral interference, clearly indicates that the vaccine does not deliver the public health benefits it promises. Public health strategies must balance the benefits of vaccination against its risks, particularly for vulnerable populations such as children and pregnant women.

Imagine the tens of thousands of children and families who would have been saved from life-long neurological damage and immeasurable suffering if the CDC was not indebted to protecting the pharmaceutical industry's toxic products and was in fact serving Americans' health and well-being? One step that can be taken to begin dismantling the marriage between the federal health agencies and drug companies is to simply refuse the flu vaccine and protect ourselves by adopting a healthier lifestyle during the flu season.

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Notes

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Featured image: GSK's pandemic flu vaccine Pandemrix (Source: Alcibiades/Wikimedia Commons)

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