

SECTION 1

Summary for the Public (2014 Supplement)

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I. SUMMARY FOR THE PUBLIC

A. Introduction

The BioInitiative Working Group concluded in 2007 that existing public safety limits were inadequate to protect public health, and agreed that new, biologically-based public safety limits were needed five years ago. The BioInitiative Report was prepared by more than a dozen world-recognized experts in science and public health policy; and outside reviewers also contributed valuable content and perspective.

From a public health standpoint, experts reasoned that it was not in the public interest to wait. In 2007, the evidence at hand coupled with the enormous populations placed at possible risk was argued as sufficient to warrant strong precautionary measures for RFR, and lowered safety limits for ELF-EMF. The ELF recommendations were biologically-based and reflected the ELF levels consistently associated with increased risk of childhood cancer, and further incorporated a safety factor that is proportionate to others used in similar circumstances. The public health cost of doing nothing was judged to be unacceptable in 2007.

What has changed in 2012? In twenty-four technical chapters, the contributing authors discuss the content and implications of about 1800 new studies. Overall, these new studies report abnormal gene transcription (Section 5); genotoxicity and single- and double-strand DNA damage (Section 6); stress proteins because of the fractal RF-antenna like nature of DNA (Section 7); chromatin condensation and loss of DNA repair capacity in human stem cells (Sections 6 and 15); reduction in free-radical scavengers, particularly melatonin (Sections 5, 9, 13, 14, 15, 16 and 17); neurotoxicity in humans and animals (Section 9); carcinogenicity in humans (Sections 11, 12, 13, 14, 15, 16 and 17); serious impacts on human and animal sperm morphology and function (Section 18); effects on the fetus, neonate and offspring (Section 18 and 19); effects on brain and cranial bone development in the offspring of animals that are exposed to cell phone radiation during pregnancy (Sections 5 and 18); and findings in autism spectrum disorders consistent with EMF/RFR exposure. This is only a snapshot of the evidence presented in the BioInitiative 2012 updated report.

There is reinforced scientific evidence of risk from chronic exposure to low-intensity electromagnetic fields and to wireless technologies (radiofrequency radiation including microwave radiation). The levels at which effects are reported to occur is lower by hundreds of times in comparison to 2007. The range of possible health effects that are adverse with chronic exposures has broadened. There has been a big increase in the number of studies looking at the effects of cell phones (on the belt, or in the pocket of men radiating only on standby mode) and from wireless laptops on impacts to sperm quality and motility; and sperm death (fertility and reproduction). In other new studies of the fetus, infant and young child, and child-in-school – there are a dozen or more new studies of importance. There is more evidence that such exposures damage DNA, interfere with DNA repair, evidence of toxicity to the human genome (genes), more worrisome effects on the nervous system (neurology) and more and better studies on the effects of mobile phone base stations (wireless antenna facilities or cell towers) that report lower RFR levels over time can result in adverse health impacts.

Importantly, some very large studies were completed on brain tumor risk from cell phone use. The 13-country World Health Organization Interphone Final study (2010) produced evidence (although highly debated

among fractious members of the research committee) that cell phone use at 10 years or longer, with approximately 1,640 hours of cumulative use of a cell and/or cordless phone approximately doubles glioma risk in adults. Gliomas are aggressive, malignant tumors where the average life-span following diagnosis is about 400 days. That brain tumors should be revealed in epidemiological studies at ONLY 10 or more years is significant; x-ray and other ionizing radiation exposures that can also cause brain tumors take nearly 15-20 years to appear making radiofrequency/microwave radiation from cell phones a very effective cancer-causing agent. Studies by Lennart Hardell and his research team at Orebro University in Sweden later showed that children who start using a mobile phone in early years have more than a 5-fold (more than a 500%) risk for developing a glioma by the time they are in the 20-29 year age group. This has significant ramifications for public health intervention.

In short order, in 2011 the World Health Organization International Agency on Cancer Research (IARC) classified radiofrequency radiation as a Group 2B Possible Human Carcinogen, joining the IARC classification of ELF-EMF that occurred in 2001. The evidence for carcinogenicity for RFR was primarily from cell phone/brain tumor studies but by IARC rules, applies to all RFR exposures (it applies to the exposure, not just to devices like cell phones or cordless phones that emit RFR).

B. Why We Care?

The stakes are very high. Exposure to electromagnetic fields (both extremely low-frequency ELF-EMF from power frequency sources like power lines and appliances; and radiofrequency radiation or RFR) has been linked to a variety of adverse health outcomes that may have significant public health consequences. The most serious health endpoints that have been reported to be associated with extremely low frequency (ELF) and/or radiofrequency radiation (RFR) include childhood and adult leukemia, childhood and adult brain tumors, and increased risk of the neurodegenerative diseases, Alzheimer's and amyotrophic lateral sclerosis (ALS). In addition, there are reports of increased risk of breast cancer in both men and women, genotoxic effects (DNA damage, chromatin condensation, micronucleation, impaired repair of DNA damage in human stem cells), pathological leakage of the blood–brain barrier, altered immune function including increased allergic and inflammatory responses, miscarriage and some cardiovascular effects. Insomnia (sleep disruption) is reported in studies of people living in very low-intensity RF environments with WI-FI and cell tower-level exposures. Short-term effects on cognition, memory and learning, behavior, reaction time, attention and concentration, and altered brainwave activity (altered EEG) are also reported in the scientific literature. Biophysical mechanisms that may account for such effects can be found in various articles and reviews (Sage, 2012).

Traditional scientific consensus and scientific method is but one contributor to deciding when to take public health action; rather, it is one of several voices that are important in determining when new actions are warranted to protect public health. Certainly it is important, but not the exclusive purview of scientists alone to determine for all of society when changes are in the public health interest and welfare of children.

C. Do We Know Enough to Take Action

Human beings are bioelectrical systems. Our hearts and brains are regulated by internal bioelectrical signals. Environmental exposures to artificial EMFs can interact with fundamental biological processes in the human body. In some cases, this may cause discomfort, or sleep disruption, or loss of well-being (impaired mental functioning and impaired metabolism) or sometimes, maybe it is a dread disease like cancer or Alzheimer's disease. It may be interfering with one's ability to become pregnant, or to carry a child to full term, or result in brain development changes that are bad for the child. It may be these exposures play a role in causing long-term impairments to normal growth and development of children, tipping the scales away from becoming productive adults. The use of common wireless devices like wireless laptops and mobile phones requires urgent action simply because the exposures are everywhere in daily life; we need to define whether and when these exposures can damage health, or the children of the future who will be born to parents now immersed in wireless exposures.

Since World War II, the background level of EMF from electrical sources has risen exponentially, most recently by the soaring popularity of wireless technologies such as cell phones (six billion in 2011-12, up from two billion in 2006), cordless phones, WI-FI ,WiMAX and LTE networks. Some countries are moving from telephone landlines (wired) to wireless phones exclusively, forcing wireless exposures on uninformed populations around the world. These wireless exposures at the same time are now classified by the world's highest authority on cancer assessment, the World Health Organization International Agency for Research on Cancer to be a possible risk to health. Several decades of international scientific research confirm that EMFs are biologically active in animals and in humans. Now, the balance has clearly shifted to one of 'presumption of possible adverse effects' from chronic exposure. It is difficult to conclude otherwise, when the bioeffects that are clearly now occurring lead to such conditions as pathological leakage of the blood-brain barrier (allowing toxins into the brain tissues); oxidative damage to DNA and the human genome, preventing normal DNA repair in human stem cells; interfering with healthy sperm production; producing poor quality sperm or low numbers of healthy sperm, altering fetal brain development that may be fundamentally tied to epidemic rates of autism and problems in school children with memory, attention, concentration, and behavior; and leading to sleep disruptions that undercut health and healing in numerous ways.

In today's world, everyone is exposed to two types of EMFs: (1) extremely low frequency electromagnetic fields (ELF) from electrical and electronic appliances and power lines and (2) radiofrequency radiation (RFR) from wireless devices such as cell phones and cordless phones, cellular antennas and towers, and broadcast transmission towers. In this report we will use the term EMFs when referring to all electromagnetic fields in general; and the terms ELF or RFR when referring to the specific type of exposure. They are both types of non-ionizing radiation, which means that they do not have sufficient energy to break off electrons from their orbits around atoms and ionize (charge) the atoms, as do x-rays, CT scans, and other forms of ionizing radiation. A glossary and definitions are provided in this report to assist you. Some handy definitions you will probably need when reading about ELF and RF in this summary section (the language for measuring it) are shown in Section 26 – Glossary.

II. SUMMARY OF THE SCIENCE

A. Evidence for Damage to Sperm and Reproduction

Several international laboratories have replicated studies showing adverse effects on sperm quality, motility and pathology in men who use and particularly those who wear a cell phone, PDA or pager on their belt or in a pocket (See Section 18 for references including Agarwal et al, 2008; Agarwal et al, 2009; Wdowiak et al, 2007; De Iuliis et al, 2009; Fejes et al, 2005; Aitken et al, 2005; Kumar, 2012). Other studies conclude that usage of cell phones, exposure to cell phone radiation, or storage of a mobile phone close to the testes of human males affect sperm counts, motility, viability and structure (Aitken et al, 2004; Agarwal et al, 2007; Erogul et al, 2006). Animal studies have demonstrated oxidative and DNA damage, pathological changes in the testes of animals, decreased sperm mobility and viability, and other measures of deleterious damage to the male germ line (Dasdag et al, 1999; Yan et al, 2007; Otitoloju et al, 2010; Salama et al, 2008; Behari et al, 2006; Kumar et al, 2012). There are fewer animal studies that have studied effects of cell phone radiation on female fertility parameters. Panagopoulous et al (2012) report decreased ovarian development and size of ovaries, and premature cell death of ovarian follicles and nurse cells in *Drosophila melanogaster.* Gul et al (2009) reported rats exposed to stand-by level RFR (phones on but not transmitting calls) had a decrease in the number of ovarian follicles in pups born to these exposed dams. Magras and Xenos (1997) reported irreversible infertility in mice after five (5) generations of exposure to RFR at cell phone tower exposure levels of less than one microwatt per centimeter squared (μW/cm2). See Section 18 for references.

HUMAN SPERM AND THEIR DNA ARE DAMAGED
Human sperm are damaged by cell phone radiation at very low intensities (0.00034 – 0.07 μW/cm2). There is a veritable flood of new studies reporting sperm damage in humans and animals, leading to substantial concerns for fertility, reproduction and health of the offspring (unrepaired de novo mutations in sperm). Exposure levels are similar to those resulting from wearing a cell phone on the belt, or in the pants pocket, or using a wireless laptop computer on the lap. Sperm lack the ability to repair DNA damage. (Behari and Rajamani, Section 18) young child are more vulnerable than older persons are to chemicals and ionizing radiation. The US Environmental Protection Agency (EPA) proposes a 10-fold risk adjustment for the first 2 years of life exposure to carcinogens, and a 3-fold adjustment for years 3 to 5. These adjustments do not deal with fetal risk, and the possibility of extending this protection to the fetus should be examined, because of fetus' rapid organ development.

The Presidential Cancer Panel (2010) found that children "are at special risk due to their smaller body mass and rapid physical development, both of which magnify their vulnerability to known carcinogens, including radiation." The American Academy of Pediatrics, in a letter to Congressman Dennis Kucinich dated 12 December 2012 states: "Children are disproportionately affected by environmental exposures, including cell phone radiation. The differences in bone density and the amount of fluid in a child's brain compared to an adult's brain could allow children to absorb greater quantities of RF energy deeper into their brains than adults. It is essential that any new standards for cell phones or other wireless devices be based on protecting the youngest and most vulnerable populations to ensure they are safeguarded through their lifetimes."

The issue around exposure of children to RFR is of critical importance. There is overwhelming evidence that children are more vulnerable than adults to many different exposures (Sly and Carpenter, 2012), including RFR, and that the diseases of greatest concern are cancer and effects on neurodevelopment. Yet parents place RFR-emitting baby monitors in cribs, provide very young children with wireless toys, and give cell phones to young children, usually without any knowledge of the potential dangers. A growing concern is the movement to make all student computer laboratories in schools wireless. A wired computer laboratory will not increase RFR exposure, and will provide safe access to the Internet (Section, Sage and Carpenter, BioInitiative 2012 Report).

C. Evidence for Fetal and Neonatal Effects

Effects on the developing fetus from in-utero exposure to cell phone radiation have been observed in both human and animal studies since 2006. Sources of fetal and neonatal exposures of concern include cell phone radiation (both paternal use of wireless devices worn on the body and maternal use of wireless phones during pregnancy). Sources include exposure to whole-body RFR from base stations and Wi-Fi, use of wireless laptops, use of incubators for newborns with excessively high ELF-EMF levels resulting in altered heart rate variability and reduced melatonin levels in newborns, fetal exposures to MRI of the pregnant mother, and greater susceptibility to leukemia and asthma in the child where there have been maternal exposures to ELF-EMF. Divan et al (2008) found that children born to mothers who used cell phones during pregnancy develop more behavioral problems by the time they have reached school age than children whose mothers did not use cell phones during pregnancy. Children whose mothers used cell phones during pregnancy had 25% more emotional problems, 35% more hyperactivity, 49% more conduct problems and 34% more peer problems (Divan et al, 2008). Aldad et al (2012) showed that cell phone radiation significantly altered fetal brain development and produced ADHD-like behavior in the offspring of pregnant mice. Exposed mice had a dose-dependent impaired glutamatergic synaptic transmission onto Layer V pyramidal neurons of the prefrontal cortex. The authors conclude the behavioral changes were the result of altered neuronal developmental programming in utero. Offspring mice were hyperactive and had impaired memory function and behavior problems, much like the human children in Divan et al (2008). See Sections 19 and 20 for references. Fragopoulou et al (2012) reports that brain astrocyte development followed by proteomic studies is adversely affected by DECT (cordless phone radiation) and mobile phone radiation.

> Fetal (in-utero) and early childhood exposures to cell phone radiation and wireless technologies in general may be a risk factor for hyperactivity, learning disorders and behavioral problems in school. Common sense measures to limit both ELF-EMF and RF EMF in these populations is needed, especially with respect to avoidable exposures like incubators that can be modified; and where education of the pregnant mother with respect to laptop computers, mobile phones and other sources of ELF-EMF and RF EMF are easily instituted.
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> A precautionary approach may provide the frame for decision-making where remediation actions have to be realized to prevent high exposures of children and pregnant woman.
>
> (Bellieni and Pinto, 2012 – Section 19)

D. Evidence for Effects on Autism (Autism Spectrum Conditions)

Physicians and health care practitioners should raise the visibility of EMF/RFR as a plausible environmental factor in ASC clinical evaluations and treatment protocols. Reducing or removing EMF and wireless RFR stressors from the environment is a reasonable precautionary action given the overall weight of evidence for a link to ASCs.

Several thousand scientific studies over four decades point to serious biological effects and health harm from EMF and RFR. These studies report genotoxicity, single-and double-strand DNA damage, chromatin condensation, loss of DNA repair capacity in human stem cells, reduction in free-radical scavengers (particularly melatonin), abnormal gene transcription, neurotoxicity, carcinogenicity, damage to sperm morphology and function, effects on behavior, and effects on brain development in the fetus of human mothers that use cell phones during pregnancy. Cell phone exposure has been linked to altered fetal brain development and ADHD-like behavior in the offspring of pregnant mice.

Many disrupted physiological processes and impaired behaviors in people with ASCs closely resemble those related to biological and health effects of EMF/RFR exposure. Biomarkers and indicators of disease and their clinical symptoms have striking similarities. At the cellular and molecular level many studies of people with ASCs have identified oxidative stress and evidence of free-radical damage, as well as deficiencies of antioxidants such as glutathione. Elevated intracellular calcium in ASCs can be associated with genetic mutations but more often may be downstream of inflammation or chemical exposures. Lipid peroxidation of cell membranes, disruption of calcium metabolism, altered brain wave activity and consequent sleep, behavior and immune dysfunction, pathological leakage of critical barriers between gut and blood or blood and brain may also occur. Mitochondria may function poorly, and immune system disturbances of various kinds are common. Changes in brain and autonomic nervous system electrophysiology can be measured and seizures are far more common than in the population at large. Sleep disruption and high levels of stress are close to universal. All of these phenomena have also been documented to result from or be modulated by EMF/RFR exposure.

- • Children with existing neurological problems that include cognitive, learning, attention, memory, or behavioral problems should as much as possible be provided with wired (not wireless) learning, living and sleeping environments.
- • Special education classrooms should observe 'no wireless' conditions to reduce avoidable stressors that may impede social, academic and behavioral progress.
- • All children should reasonably be protected from the physiological stressor of significantly elevated EMF/RFR (wireless in classrooms, or home environments).
- • School districts that are now considering all-wireless learning environments should be strongly cautioned that wired environments are likely to provide better learning and teaching environments, and prevent possible adverse health consequences for both students and faculty in the long-term.
- • Monitoring of the impacts of wireless technology in learning and care environments should be performed with sophisticated measurement and data analysis techniques that are cognizant of the non-linear impacts of EMF/RFR and of data techniques most appropriate for discerning these impacts.
- • There is sufficient scientific evidence to warrant the selection of wired Internet, wired classrooms and wired learning devices, rather than making an expensive and potentially health-harming commitment to wireless devices that may have to be substituted out later.
- • Wired classrooms should reasonably be provided to all students who opt-out of wireless environments.

(Herbert and Sage, 2012 – Section 20)

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The public needs to know that these risks exist, that transition to wireless should not be presumed safe, and that it is very much worth the effort to minimize exposures that still provide the benefits of technology in learning, but without the threat of health risk and development impairments to learning and behavior in the classroom.

Broader recommendations also apply, related to reducing the physiological vulnerability to exposures, reduce allostatic load and build physiological resiliency through high quality nutrition, reducing exposure to toxicants and infectious agents, and reducing stress, all of which can be implemented safely based upon presently available knowledge.

E. Evidence for Electrohypersensitivity

The contentious question of whether electrohypersensitivity exists as a medical condition and what kinds of testing might reveal biomarkers for diagnosis and treatment has been furthered by several new studies presented in Section 24 – Key Scientific Evidence and Public Health Policy Recommendations. What is evident is that a growing number of people world-wide have serious and debilitating symptoms that key to various types of EMF and RFR exposure. Of this there is little doubt. The continued massive rollout of wireless technologies, in particular the wireless 'smart' utility meter, has triggered thousands of complaints of ill-health and disabling symptoms when the installation of these meters is in close proximity to family home living spaces.

McCarty et al (2011) studied electrohypersensitivity in a patient (a female physician). The patient was unable to detect the presence or absence of EMF exposure, largely ruling out the possibility of bias. In multiple trials with the fields either on or not on, the subject experienced and reported temporal pain, feeling of unease, skipped heartbeats, muscle twitches and/or strong headache when the pulsed field (100 ms, duration at 10 Hz) was on, but no or mild symptoms when it was off. Symptoms from continuous fields were less severe than with pulsed fields. The differences between field on and sham exposure were significant at the $p < 0.05$ level. The authors conclude that electromagnetic hypersensitivity is a neurological syndrome, and statistically reliable somatic reactions can be provoked in this patient by exposure to 60-Hz electric fields at 300 volts per meter (V/m). Marino et al (2012) responded to comments on his study with McCarty saying:

> *"EMF hypersensitivity can occur as a bona fide environmentally inducible neurological syndrome. We followed an empirical approach and demonstrated a cause-and-effect relationship ($p < 0.05$) under conditions that permitted us to infer the existence of electromagnetic hypersensitivity (EHS), a novel neurological syndrome."*

The team of Sandstrom, Hansson Mild and Lyskov produced numerous papers between 1994 and 2003 involving people who are electrosensitive (See Section 24 - Lyskov et al, 1995; Lyskov et al, 1998; Sandstrom et al, 1994; Sandstrom et al, 1995;

Sandstrom et al, 1997; Sandstrom et al, 2003). Sandstrom et al (2003) presented evidence that heart rate variability is impaired in people with electrical hypersensitivity and showed disruption of the autonomic nervous system.

"EHS patients had a disturbed pattern of circadian rhythms of HRF and showed a relatively 'flat' representation of hourly-recorded spectral power of the HF component of HRV". This research team also found that "EHS patients have a dysbalance of the autonomic nervous system (ANS) regulation with a trend to hyper-sympathotonia, as measured by heart rate (HR) and electrodermal activity, and a hyperreactivity to different external physical factors, as measured by brain evoked potentials and sympathetic skin responses to visual and audio stimulation." (Lyskov et al, 2001 a,b; Sandstrom et al, 1997).

The reports referenced above provide evidence that persons who report being electrosensitive differ from others in having some abnormalities in the autonomic nervous system, reflected in measures such as heart rate variability.

F. Evidence for Effects from Cell Tower-Level RFR Exposures

Very low exposure RFR levels are associated with bioeffects and adverse health effects. At least five new cell tower studies are reporting bioeffects in the range of 0.001 to 0.05 μW/cm2 at lower levels than reported in 2007 (0.05 to 0.1 uW/cm2 was the range below which, in 2007, effects were not observed). Researchers report headaches, concentration difficulties and behavioral problems in children and adolescents; and sleep disturbances, headaches and concentration problems in adults. Public safety standards are 1,000 – 10,000 or more times higher than levels now commonly reported in mobile phone base station studies to cause bioeffects.

Since 2007, five new studies of base station level RFR at intensitites ranging from lessthan 0.001 uW/cm2 to 0.05 uW/cm2 report headaches, concentrationdifficulties and behavioral problems in children and adolescents; and sleep disturbances, headaches and concentration problems in adults.

G. Evidence for Effects on the Blood-brain Barrier (BBB)

The Lund University (Sweden) team of Leif Salford, Bertil Persson and Henrietta Nittby has done pioneering work on effects of very low level RFR on the human brain's protective lining – the barrier that protects the brain from large molecules and toxins that are in the blood.

THE BLOOD-BRAIN BARRIER IS AT RISK

The BBB is a protective barrier that prevents the flow of toxins into sensitive brain tissue. Increased permeability of the BBB caused by cell phone RFR may result in neuronal damage. Many research studies show that very low intensity exposures to RFR can affect the blood-brain barrier (BBB) (mostly animal studies). Summing up the research, it is more probable than unlikely that non-thermal EMF from cell phones and base stations do have effects upon biology. A single 2-hr exposure to cell phone radiation can result in increased leakage of the BBB, and 50 days after exposure, neuronal damage can be seen, and at the later time point also albumin leakage is demonstrated. The levels of RFR needed to affect the BBB have been shown to be as low as 0.001 W/kg, or less than holding a mobile phone at arm's length. The US FCC standard is 1.6 W/kg; the ICNIRP standard is 2 W/kg of energy (SAR) into brain tissue from cell/cordless phone use. Thus, BBB effects occur at about 1000 times lower RFR exposure levels than the US and ICNIRP limits allow.

(Salford et al, 2012 - Section 10)

H. Evidence for Effects on Brain Tumors

The Orebro University (Sweden) team led by Lennart Hardell, MD, an oncologist and medical researcher, has produced an extraordinary body of work on environmental toxins of several kinds, including the effects of radiofrequency/microwave radiation and cancer. Their 2012 work concludes:

> "Based on epidemiological studies there is a consistent pattern of increased risk for glioma and acoustic neuroma associated with use of mobile phones and cordless phones. The evidence comes mainly from two study centres, the Hardell group in Sweden and the Interphone Study Group. No consistent pattern of an increased risk is seen for meningioma. A systematic bias in the studies that explains the results would also have been the case for meningioma. The different risk pattern for tumor type strengthens the findings regarding glioma and acoustic neuroma. Meta-analyses of the Hardell group and Interphone studies show an increased risk for glioma and acoustic neuroma. Supportive evidence comes also from anatomical localisation of the tumor to the most exposed area of the brain, cumulative exposure in hours and latency time that all add to the biological relevance of an increased risk. In addition risk calculations based on estimated absorbed dose give strength to the findings. (Hardell et al, 2012 – Section 11)

> "There is reasonable basis to conclude that RF-EMFs are bioactive and have a potential to cause health impacts. There is a consistent pattern of increased risk for glioma and acoustic neuroma associated with use of wireless phones (mobile phones and cordless phones) mainly based on results from case-control studies from the Hardell group and Interphone Final Study results. Epidemiological evidence gives that RF-EMF should be classified as a human carcinogen. Based on our own research and review of other evidence the existing FCC/IEE and ICNIRP public safety limits and reference levels are not adequate to protect public health. New public health standards and limits are needed. (Hardell et al, 2012 – Section 11)

I. Evidence for Genotoxic Effects (Genotoxicity)

Genetic Damage (Genotoxicity Studies): There are at least several hundred published papers that report EMF (ELF/RFR) can affect cellular oxidative processes (oxidative damage). Increased free radical activity and changes in enzymes involved in cellular oxidative processes are the most consistent effects observed in cells and animals after EMF exposure. Aging may make an individual more susceptible to the detrimental effects of ELF EMF from oxidative damage, since anti-oxidants may decline with age. Clearly, the preponderance of genetic studies report DNA damage and failure to repair DNA damage.

> One hundred fourteen (114) new papers on genotoxic effects of RFR published between 2007 and early 2014 are profiled. Of these, 74 (65%) showed effects and 40 (35%) showed no effects. (Lai, 2014 – Section 6)
>
> Fifty nine (59) new ELF-EMF papers and two static magnetic field papers that report on genotoxic effects of ELF-EMF published between 2007 and early 2014 are profiled. Of these, 49 (83%) show effects and 10 (17%) show no effect. (Lai, 2014 – Section 6)

Factors that act directly or indirectly on the nervous system can cause morphological, chemical, or electrical changes in the nervous system that can lead to neurological effects. Both RF and ELF EMF affect neurological functions and behavior in animals and humans.

Two hundred eleven (211) new papers that report on neurological effects of RFR published between 2007 and early 2014 are profiled. Of these, 144 (68%) showed effects and 67 (32%) showed no effects.

One hundred five (105) new ELF-EMF papers (including two static field papers) that report on neurological effects of ELF-EMF published between 2007 and early 2014 are profiled. Of these, 95 (90%) show effects and 10 (10%) show no effect. (Lai, 2014 – Section 9)

K. Evidence for Cancer (Childhood Leukemia)

With overall 42 epidemiological studies published to datel power frequency ELF-EMF is among the most comprehensively studied environmental factors. Except ionizing radiation no other environmental factor has been as firmly established to increase the risk of childhood leukemia.

Sufficient evidence exists from epidemiological studies of an increased risk from exposure to EMF (power frequency ELF-EMF magnetic fields) and cannot be attributed to chance, bias or confounding. Therefore, according to the rules of IARC such exposures can be classified as a **Group 1 carcinogen (Known Carcinogen).**

There is no other risk factor identified so far for which such unlikely conditions have been put forward to postpone or deny the necessity to take steps towards exposure reduction. As one step in the direction of precaution, measures should be implemented to guarantee that exposure due to transmission and distribution lines is below an average of about 1 mG. This value is arbitrary at present and only supported by the fact that in many studies this level has been chosen as a reference. (Kundi, 2012 – Section 12)

L. Melatonin, Breast Cancer and Alzheimer's Disease

MELATONIN AND BREAST CANCER: Eleven (11) of the 13 published epidemiologic residential and occupational studies are considered to provide (positive) evidence that high ELF magnetic fields (MF) exposure can result in decreased melatonin production. The two negative studies had important deficiencies that may certainly have biased the results. There is sufficient evidence to conclude that long-term relatively high ELF MF exposure can result in a decrease in melatonin production. It has not been determined to what extent personal characteristics, e.g., medications, interact with ELF MF exposure in decreasing melatonin production.

There is sufficient evidence to conclude that long-term relatively high ELF MF exposure can result in a decrease in melatonin production, which may increase risk for breast cancer. It has not been determined to what extent personal characteristics, e.g., medications, interact with ELF MF exposure in decreasing melatonin production. New research indicates that ELF MF exposure, in vitro, can significantly decrease melatonin activity through effects on MT1, an important melatonin receptor. Five longitudinal studies have now been conducted of low melatonin production as a risk factor for breast cancer. There is increasingly strong longitudinal evidence that low melatonin production is a risk factor for at least post-menopausal breast cancer.

(Davanipour and Sobel, 2012 – Section 13)

ALZHEIMER'S DISEASE: There is now evidence that a) high levels of peripheral amyloid beta are a risk factor for AD, and b) medium to high ELF MF exposure can increase peripheral amyloid beta. High brain levels of amyloid beta are also a risk factor for AD and medium to high ELF MF exposure to brain cells likely also increases these cells' production of amyloid beta. There is considerable in vitro and animal evidence that melatonin protects against AD. Therefore it is certainly possible that low levels of melatonin production are associated with an increase in the risk of AD.

There is strong epidemiologic evidence that exposure to ELF MF is a risk factor for AD. There are now twelve (12) studies of ELF MF exposure and AD or dementia. Nine (9) of these studies are considered positive and three (3) are considered negative. The three negative studies have serious deficiencies in ELF MF exposure classification that results in subjects with rather low exposure being considered as having significant exposure. There are insufficient studies to formulate an opinion as to whether radiofrequency MF exposure is a risk or protective factor for AD.

There is now evidence that (i) high levels of peripheral amyloid beta are a risk factor for AD and (ii) medium to high ELF MF exposure can increase peripheral amyloid beta. High brain levels of amyloid beta are also a risk factor for AD and medium to high ELF MF exposure to brain cells likely also increases these cells' production of amyloid beta.

There is considerable in vitro and animal evidence that melatonin protects against AD. Therefore it is certainly possible that low levels of melatonin production are associated with an increase in the risk of AD.

(Davanipour and Sobel, 2012 – Section 13)

M. Stress, Stress Proteins and DNA as a Fractal Antenna

Any agent (EMF, ionizing radiation, chemicals, heavy metals, heat and other factors) that continuously generates stress proteins is not adaptive, and is harmful, if it is a constant provocation. The work of Martin Blank and Reba Goodman of Columbia University has established that stress proteins are produced by ELF-EMF and RFR at levels far below what current safety standards allow. Further, they think DNA is actually a very good fractal RF-antenna which is very sensitive to low doses of EMF, and may induce the cellular processes that result in chronic 'unrelenting' stress. That daily environmental levels of ELF-EMF and RFR can and do throw the human body into stress protein response mode (out of homeostasis) is a fundamental and continuous insult. Chronic exposures can then result in chronic ill-health.

> *"It appears that the DNA molecule is particularly vulnerable to damage by EMF because of the coiled-coil configuration of the compacted molecule in the nucleus. The unusual structure endows it with the self similarity of a fractal antenna and the resulting sensitivity to a wide range of frequencies. The greater reactivity of DNA with EMF, along with a vulnerability to damage,*

underscores the urgent need to revise EMF exposure standards in order to protect the public. Recent studies have also exploited the properties of stress proteins to devise therapies for limiting oxidative damage and reducing loss of muscle strength associated with aging." (Blank, 2012- Section 7)

- DNA acts as a 'fractal antenna' for EMF and RFR. The coiled-coil structure of DNA in the nucleus makes the molecule react like a fractal antenna to a wide range of frequencies.
- The structure makes DNA particularly vulnerable to EMF damage.
- The mechanism involves direct interaction of EMF with the DNA molecule (claims that there are no known mechanisms of interaction are patently false).
- Many EMF frequencies in the environment can and do cause DNA changes.
- The EMF-activated cellular stress response is an effective protective mechanism for cells exposed to a wide range of EMF frequencies.
- EMF stimulates stress proteins (indicating an assault on the cell).
- EMF efficiently harms cells at billions of times lower levels than conventional heating.
- Safety standards based on heating are irrelevant to protect against EMF-levels of exposure. There is an urgent need to revise EMF exposure standards. Research has shown thresholds are very low (safety standards must be reduced to limit biological responses). Biologically-based safety standards could be developed from the research on the stress response. (Blank, 2012 – Section 7).

N. Effects of Weak-Field Interactions on Non-Linear Biological Oscillators and Synchronized Neural Activity:

A unifying hypothesis for a plausible biological mechanism to account for very weak field EMF bioeffects other than cancer may lie with weak field interactions of pulsed RFR and ELF-modulated RFR as disrupters of synchronized neural activity. Electrical rhythms in our brains can be influenced by external signals. This is consistent with established weak field effects on coupled biological oscillators in living tissues. Biological systems of the heart, brain and gut are dependent on the cooperative actions of cells that function according to principles of non-linear, coupled biological oscillations for their synchrony, and are dependent on exquisitely timed cues from the environment at vanishingly small levels (Buzsaki, 2006; Strogatz, 2003). The key to synchronization is the joint actions of cells that co-operate electrically and link populations of biological oscillators that couple together in large arrays and synchronize spontaneously. Synchronous biological oscillations in cells (pacemaker cells) can be disrupted by artificial, exogenous environmental signals, resulting in desynchronization of neural activity that regulates critical functions (including metabolism) in the brain, gut and heart and circadian rhythms governing sleep and hormone cycles (Strogatz, 1987). The brain contains a population of oscillators with distributed natural frequencies, which pull one another into synchrony (the circadian pacemaker cells). Strogatz has addressed the unifying mathematics of biological cycles and external factors disrupt these cycles (Strogatz, 2001, 2003)

"Rhythms can be altered by a wide variety of agents and that these perturbations must seriously alter brain performance." (Busaki, 2006)

III. EMF EXPOSURE AND PRUDENT PUBLIC HEALTH PLANNING

Chronic exposure to low-intensity RFR and to ELF-modulated RFR at today's environmental levels in many cities will exceed thresholds for increased risk of many diseases and causes of death (Sage and Huttunen, 2012). RFR exposures in daily life alter homeostasis in human beings. These exposures can alter and damage genes, trigger epigenetic changes to gene expression and cause de novo mutations that prevent genetic recovery and healing mechanisms. These exposures may interfere with normal cardiac and brain function; alter circadian rhythms that regulate sleep, healing, and hormone balance; impair short-term memory, concentration, learning and behavior; provoke aberrant immune, allergic and inflammatory responses in tissues; alter brain metabolism; increase risks for reproductive failure (damage sperm and increase miscarriage risk); and cause cells to produce stress proteins. Exposures now common in home and school environments are likely to be physiologically addictive and the effects are particularly serious in the young (Sage and Huttunen, 2012).

RECOMMENDED ACTIONS

A. Defining Preventative Actions for Reduction in RFR Exposures

ELF-EMF and RFR are Classified as Possible Cancer-causing Agents – Why Are Governments Not Acting?

The World Health Organization International Agency for Research on Cancer has classified wireless radiofrequency as a Possible Human Carcinogen (May, 2011)*. The designation applies to low-intensity RFR in general, covering all RFR-emitting devices and exposure sources (cell and cordless phones, Wi-Fi, wireless laptops, wireless hotspots, electronic baby monitors, wireless classroom access points, wireless antenna facilities). The IARC Panel could have chosen to classify RFR as a Group 4 – Not A Carcinogen if the evidence was clear that RFR is not a cancer-causing agent. It could also have found a Group 3 designation was a good interim choice (Insufficient Evidence). IARC did neither.

New Safety Limits Must Be Established – Health Agencies Should Act Now

Existing public safety limits (FCC and ICNIRP public safety limits) do not sufficiently protect public health against chronic exposure from very low-intensity exposures. If no mid-course corrections are made to existing and outdated safety limits, such delay will magnify the public health impacts with even more applications of wireless-enabled technologies exposing even greater populations around the world in daily life.

Scientific Benchmarks for Harm Plus Safety Margins = New Safety Limits that are Valid

Health agencies and regulatory agencies that set public safety standards for ELF-EMF and RFR should act now to adopt new, biologically-relevant safety limits that key to the lowest scientific benchmarks for harm coming from the recent studies, plus a lower safety margin. Existing public safety limits are too high by several orders of magnitude, if prevention of bioeffects and resulting adverse health effects are to be minimized or

eliminated. Most safety standards are a thousand times or more too high to protect healthy populations, and even less effective in protecting sensitive subpopulations.

Sensitive Populations Must Be Protected

Safety standards for sensitive populations will more likely need to be set at lower levels than for healthy adult populations. Sensitive populations include the developing fetus, the infant, children, the elderly, those with pre-existing chronic diseases, and those with developed electrical sensitivity (EHS).

Protecting New Life – Infants and Children

Strong precautionary action and clear public health warnings are warranted immediately to help prevent a global epidemic of brain tumors resulting from the use of wireless devices (mobile phones and cordless phones). Commonsense measures to limit both ELF-EMF and RFR in the fetus and newborn infant (sensitive populations) are needed, especially with respect to avoidable exposures like baby monitors in the crib and baby isolettes (incubators) in hospitals that can be modified; and where education of the pregnant mother with respect to laptop computers, mobile phones and other sources of ELF-EMF and RFR are easily instituted.

Wireless laptops and other wireless devices should be strongly discouraged in schools for children of all ages.

Standard of Evidence for Judging the Science

The standard of evidence for judging the scientific evidence should be based on good public health principles rather than demanding scientific certainty before actions are taken.

Wireless Warnings for All

The continued rollout of wireless technologies and devices puts global public health at risk from unrestricted wireless commerce unless new, and far lower exposure limits and strong precautionary warnings for their use are implemented.

EMF and RFR are Preventable Toxic Exposures

We have the knowledge and means to save global populations from multi-generational adverse health consequences by reducing both ELF and RFR exposures. Proactive and immediate measures to reduce unnecessary EMF exposures will lower disease burden and rates of premature death.

B. Defining New 'Effect Level' for RFR

Section 24 concludes that RFR 'effect levels' for bioeffects and adverse health effects justify new and lower precautionary target levels for RFR exposure. New epidemiological and laboratory studies are finding effects on humans at lower exposure levels where studies are of longer duration (chronic exposure studies). Real-world experience is revealing worrisome evidence that sperm may be damaged by cell phones even on

stand-by mode; and people can be adversely affected by placing new wireless pulsed RFR transmitters (utility meters on the sides or interiors of homes), even when the time-weighted average for RFR is miniscule in both cases.

There is increasing reason to believe that the critical factor for biologic significance is the intermittent pulse of RF, not the time-averaged SAR. For example, Hansson Mild et al, (2012) concluded there could be no effect on sleep and testicular function from a GSM mobile phone because the "*exposure in stand-by mode can be considered negligible*". It may be that we, as a species, are more susceptible than we thought to intermittent, very low-intensity pulsed RFR signals that can interact with critical activities in living tissues. It is a mistake to conclude that the effect does not exist because we cannot explain HOW it is happening or it upsets our mental construct of how things should work.

This highlights the serious limitation of not taking the nature of the pulsed RFR signal (high intensity but intermittent, microsecond pulses of RFR) into account in the safety standards. This kind of signal is biologically active. Even if it is essentially mathematically invisible when the individual RFR pulses are time-averaged, it is apparently NOT invisible to the human body and its proper biological functioning.

For these reasons, and in light of parallel scientific work on non-linear biological oscillators including the accepted mathematics in this branch of science regarding coupled oscillators (Bezsaki, 2006; Strogatz, 2001, 2003), it is essential to think forward about the ramifications of shifting national energy strategies toward ubiquitous wireless systems. And, it is essential to re-think safety standards to take into account the exquisite sensitivity of biological systems and tissue interactions where the exposures are pulsed and cumulatively insignificant over time-scale averaging, but highly relevant to body processes and functioning. If it is true that weak-field effects have control elements over synchronous activity of neurons in the brain, and other pacemaker cells and tissues in the heart and gut that drive essential metabolic pathways as a result, then this will go far in explaining why living tissues are apparently so reactive to very small inputs of pulsed RFR, and lead to better understanding of what is required for new, biologically-based public exposure standards.

A reduction from the BioInitiative 2007 recommendation of 0.1 uW/cm2 (or one-tenth of a microwatt per square centimeter) for cumulative outdoor RFR down to something three orders of magnitude lower (in the low nanowatt per square centimeter range) is justified on a public health basis. We use the new scientific evidence documented in this Report to identify 'effect levels' and then apply one or more reduction factors to provide a safety margin. A cautionary target level for cumulative, outdoor pulsed RFR exposures for ambient wireless that could be applied to RFR sources from cell tower antennas, Wi-Fi, WiMAX and other similar sources is proposed. Research is needed to determine what is biologically damaging about intermittent pulses of RFR, and how to provide for protection in safety limits against it. With this knowledge it might be feasible to recommend a higher time-averaged number.

A scientific benchmark of 0.003 uW/cm2 or three nanowatts per centimeter squared for 'lowest observed effect level' for RFR is based on mobile phone base station-level studies. Applying a ten-fold reduction to compensate for the lack of long-term exposure (to provide a safety buffer for chronic exposure, if needed) or for children as a sensitive subpopulation (if studies are on adults, not children) yields a 300 to 600 picowatts per

square centimeter precautionary action level. This equates to a 0.3 nanowatts to 0.6 nanowatts per square centimeter as a reasonable, precautionary action level for chronic exposure to pulsed RFR. Even so, these levels may need to change in the future, as new and better studies are completed. This is what the authors said in 2007 (Carpenter and Sage, 2007, BioInitiative Report) and it remains true today in 2012.

We leave room for future studies that may lower or raise today's observed 'effects levels' and should be prepared to accept new information as a guide for new precautionary action.

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BIOINITIATIVE 2012 - CONCLUSIONS Table 1-1

(Genetics and Neurological Effects Updated March 2014)

Overall, more than 1800 or so new studies report abnormal gene transcription (Section 5); genotoxicity and single-and double-strand DNA damage (Section 6); stress proteins because of the fractal RF-antenna like nature of DNA (Section 7); chromatin condensation and loss of DNA repair capacity in human stem cells (Sections 6 and 15); reduction in free-radical scavengers - particularly melatonin (Sections 5, 9, 13, 14, 15, 16 and 17); neurotoxicity in humans and animals (Section 9), carcinogenicity in humans (Sections 11, 12, 13, 14, 15, 16 and 17); serious impacts on human and animal sperm morphology and function (Section 18); effects on offspring behavior (Section 18, 19 and 20); and effects on brain and cranial bone development in the offspring of animals that are exposed to cell phone radiation during pregnancy (Sections 5 and 18). This is only a snapshot of the evidence presented in the BioInitiative 2012 updated report.

BIOEFFECTS ARE CLEARLY ESTABLISHED

Bioeffects are clearly established and occur at very low levels of exposure to electromagnetic fields and radiofrequency radiation. Bioeffects can occur in the first few minutes at levels associated with cell and cordless phone use. Bioeffects can also occur from just minutes of exposure to mobile phone masts (cell towers), WI-FI, and wireless utility 'smart' meters that produce whole-body exposure. Chronic base station level exposures can result in illness.

BIOEFFECTS WITH CHRONIC EXPOSURES CAN REASONABLY BE PRESUMED TO RESULT IN ADVERSE HEALTH EFFECTS

Many of these bioeffects can reasonably be presumed to result in adverse health effects if the exposures are prolonged or chronic. This is because they interfere with normal body processes (disrupt homeostasis), prevent the body from healing damaged DNA, produce immune system imbalances, metabolic disruption and lower resilience to disease across multiple pathways. Essential body processes can eventually be disabled by incessant external stresses (from system-wide electrophysiological interference) and lead to pervasive impairment of metabolic and reproductive functions.

LOW EXPOSURE LEVELS ARE ASSOCIATED WITH BIOEFFECTS AND ADVERSE HEALTH EFFECTS AT CELL TOWER RFR EXPOSURE LEVELS

At least five new cell tower studies are reporting bioeffects in the range of 0.003 to 0.05 μW/cm2 at lower levels than reported in 2007 (0.05 to 0.1 uW/cm2 was the range below which, in 2007, effects were not observed). Researchers report headaches, concentration difficulties and behavioral problems in children and adolescents; and sleep disturbances, headaches and concentration problems in adults. Public safety standards are 1,000 – 10,000 or more times higher than levels now commonly reported in mobile phone base station studies to cause bioeffects.

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EVIDENCE FOR FERTILITY AND REPRODUCTION EFFECTS: HUMAN SPERM AND THEIR DNA ARE DAMAGED

Human sperm are damaged by cell phone radiation at very low intensities in the low microwatt and nanowatt/cm2 range (0.00034 – 0.07 uW/cm2). There is a veritable flood of new studies reporting sperm damage in humans and animals, leading to substantial concerns for fertility, reproduction and health of the offspring (unrepaired de novo mutations in sperm). Exposure levels are similar to those resulting from wearing a cell phone on the belt, or in the pants pocket, or using a wireless laptop computer on the lap. Sperm lack the ability to repair DNA damage.

Studies of human sperm show genetic (DNA) damage from cell phones on standby mode and wireless laptop use. Impaired sperm quality, motility and viability occur at exposures of 0.00034 uW/cm2 to 0.07 uW/cm2 with a resultant reduction in human male fertility. Sperm cannot repair DNA damage.

Several international laboratories have replicated studies showing adverse effects on sperm quality, motility and pathology in men who use and particularly those who wear a cell phone, PDA or pager on their belt or in a pocket (Agarwal et al, 2008; Agarwal et al, 2009; Wdowiak et al, 2007; De Iuliis et al, 2009; Fejes et al, 2005; Aitken et al, 2005; Kumar, 2012). Other studies conclude that usage of cell phones, exposure to cell phone radiation, or storage of a mobile phone close to the testes of human males affect sperm counts, motility, viability and structure (Aitken et al, 2004; Agarwal et al, 2007; Erogul et al., 2006). Animal studies have demonstrated oxidative and DNA damage, pathological changes in the testes of animals, decreased sperm mobility and viability, and other measures of deleterious damage to the male germ line (Dasdag et al, 1999; Yan et al, 2007; Otitoloju et al, 2010; Salama et al, 2008; Behari et al, 2006; Kumar et al, 2012). There are fewer animal studies that have studied effects of cell phone radiation on female fertility parameters. Panagopoulous et al. 2012 report decreased ovarian development and size of ovaries, and premature cell death of ovarian follicles and nurse cells in *Drosophila melanogaster*. Gul et al (2009) report rats exposed to stand-by level RFR (phones on but not transmitting calls) caused decrease in the number of ovarian follicles in pups born to these exposed dams. Magras and Xenos (1997) reported irreversible infertility in mice after five (5) generations of exposure to RFR at cell phone tower exposure levels of less than one microwatt per centimeter squared (μW/cm2).

EVIDENCE THAT CHILDREN ARE MORE VULNERABLE

There is good evidence to suggest that many toxic exposures to the fetus and very young child have especially detrimental consequences depending on when they occur during critical phases of growth and development (time windows of critical development), where such exposures may lay the seeds of health harm that develops even decades later. Existing FCC and ICNIRP public safety limits seem to be not sufficiently protective of public health, in particular for the young (embryo, fetus, neonate, very young child).

The Presidential Cancer Panel (2010) found that children '*are at special risk due to their smaller body mass and rapid physical development, both of which magnify their vulnerability to known carcinogens, including radiation.*'

The American Academy of Pediatrics, in a letter to Congressman Dennis Kucinich dated 12 December 2012 states "*Children are disproportionately affected by environmental exposures, including cell phone radiation. The differences in bone density and the amount of fluid in a child's brain compared to an adult's brain could allow children to absorb greater quantities of RF energy deeper into their brains than adults. It is essential that any new standards for cell phones or other wireless devices be based on protecting the youngest and most vulnerable populations to ensure thay are safeguarded through their lifetimes.*"

FETAL AND NEONATAL EFFECTS OF EMF

Fetal (*in-utero*) and early childhood exposures to cell phone radiation and wireless technologies in general may be a risk factor for hyperactivity, learning disorders and behavioral problems in school.

Fetal Development Studies: Effects on the developing fetus from *in-utero* exposure to cell phone radiation have been observed in both human and animal studies since 2006. Divan et al (2008) found that children born of mothers who used cell phones during pregnancy develop more behavioral problems by the time they have reached school age than children whose mothers did not use cell phones during pregnancy. Children whose mothers used cell phones during pregnancy had 25% more emotional problems, 35% more hyperactivity, 49% more conduct problems and 34% more peer problems
(Divan et al., 2008).

Common sense measures to limit both ELF-EMF and RF EMF in these populations is needed, especially with respect to avoidable exposures like incubators that can be modified; and where education of the pregnant mother with respect to laptop computers, mobile phones and other sources of ELF-EMF and RF EMF are easily instituted.

Sources of fetal and neonatal exposures of concern include cell phone radiation (both paternal use of wireless devices worn on the body and maternal use of wireless phones during pregnancy). Exposure to whole-body RFR from base stations and WI-FI, use of wireless laptops, use of incubators for newborns with excessively high ELF-EMF levels resulting in altered heart rate variability and reduced melatonin levels in newborns, fetal exposures to MRI of the pregnant mother, and greater susceptibility to leukemia and asthma in the child where there have been maternal exposures to ELF-EMF.

A precautionary approach may provide the frame for decision-making where remediation actions have to be realized to prevent high exposures of children and pregnant woman.

(Bellieni and Pinto, 2012 – Section 19)

EMF/RFR AS A PLAUSIBLE BIOLGICAL MECHANISM FOR AUTISM (ASD)

- Children with existing neurological problems that include cognitive, learning, attention, memory, or behavioral problems should as much as possible be provided with wired (not wireless) learning, living and sleeping environments,
- Special education classrooms should observe 'no wireless' conditions to reduce avoidable stressors that may impede social, academic and behavioral progress.
- All children should reasonably be protected from the physiological stressor of significantly elevated EMF/RFR (wireless in classrooms, or home environments).
- School districts that are now considering all-wireless learning environments should be strongly cautioned that wired environments are likely to provide better learning and teaching environments, and prevent possible adverse health consequences for both students and faculty in the long-term.
- Monitoring of the impacts of wireless technology in learning and care environments should be performed with sophisticated measurement and data analysis techniques that are cognizant of the non-linear impacts of EMF/RFR and of data techniques most appropriate for discerning these impacts.
- There is sufficient scientific evidence to warrant the selection of wired internet, wired classrooms and wired learning devices, rather than making an expensive and potentially health-harming commitment to wireless devices that may have to be substituted out later, and
- Wired classrooms should reasonably be provided to all students who opt-out of wireless environments. (Herbert and Sage, 2012 – Section 20)

Many disrupted physiological processes and impaired behaviors in people with ASDs closely resemble those related to biological and health effects of EMF/RFR exposure. Biomarkers and indicators of disease and their clinical symptoms have striking similarities. Broadly speaking, these types of phenomena can fall into one or more of several classes: a) alteration of genes or gene expression, b) induction of change in brain or organismic development, c) alteration of phenomena modulating systemic and brain function on an ongoing basis throughout the life course (which can include systemic pathophysiology as well as brain-based changes), and d) evidence of functional alteration in domains such as behavior, social interaction and attention known to be challenged in ASD.

Several thousand scientific studies over four decades point to serious biological effects and health harm from EMF and RFR. These studies report genotoxicity, single-and double-strand DNA damage, chromatin condensation, loss of DNA repair capacity in human stem cells, reduction in free-radical scavengers (particularly melatonin), abnormal gene transcription, neurotoxicity, carcinogenicity, damage to sperm morphology and function, effects on behavior, and effects on brain development in the fetus of human mothers that use cell phones during pregnancy. Cell phone exposure has been linked to altered fetal brain development and ADHD-like behavior in the offspring of pregnant mice.

Reducing life-long health risks begins in the earliest stages of embryonic and fetal development, is accelerated for the infant and very young child compared to adults, and is not complete in young people (as far as brain and nervous system maturation) until the early 20's. Windows of critical development mean that risk factors once laid down in the cells, or in epigenetic changes in the genome may have grave and life-long consequences for health or illness for every individual.

All relevant environmental conditions, including EMF and RFR, which can degrade the human genome, and impair normal health and development of species including homo sapiens, should be given weight in defining and implementing prudent, precautionary actions to protect public health.

Allostatic load in autism and autistic decompensation - we may be at a tipping point that can be pushed back by removing unnecessary stressors like EMF/RFR and building resilience.

The consequence of ignoring clear evidence of large-scale health risks to global populations, when the risk factors are largely avoidable or preventable is too high a risk to take. With the epidemic of autism (ASD) putting the welfare of children, and their families in peril at a rate of one family in 88, the rate still increasing annually, we cannot afford to ignore this body of evidence. The public needs to know that these risks exist, that transition to wireless should not be presumed safe, and that it is very much worth the effort to minimize exposures that still provide the benefits of technology in learning, but without the threat of health risk and development impairments to learning and behavior in the classroom.

(Herbert and Sage, 2012 – Section 20)

THE BLOOD-BRAIN BARRIER IS AT RISK

The BBB is a protective barrier that prevents the flow of toxins into sensitive brain tissue. Increased permeability of the BBB caused by cell phone RFR may result in neuronal damage. Many research studies show that very low intensity exposures to RFR can affect the blood-brain barrier (BBB) (mostly animal studies). Summing up the research, it is more probable than unlikely that non-thermal EMF from cell phones and base stations do have effects upon biology. A single 2-hr exposure to cell phone radiation can result in increased leakage of the BBB, and 50 days after exposure, neuronal damage can be seen, and at the later time point also albumin leakage is demonstrated. *The levels of RFR needed to affect the BBB have been shown to be as low as 0.001 W/kg, or less than holding a mobile phone at arm's length. The US FCC standard is 1.6 W/kg; the ICNIRP standard is 2 W/kg of energy (SAR) into brain tissue from cell/cordless phone use. Thus, BBB effects occur at about 1000 times lower RFR exposure levels than the US and ICNIRP limits allow.* (Salford et al, 2012 - Section 10)

If the blood-brain barrier is vulnerable to serious and on-going damage from wireless exposures, then we should perhaps also be looking at the blood-ocular barrier (that protects the eyes), the blood-placenta barrier (that protects the developing fetus) and the blood-gut barrier (that protects proper digestion and nutrition), and the blood-testes barrier (that protects developing sperm) to see if they too can be damaged by RFR.

EPIDEMIOLOGICAL STUDIES CONSISTENTLY SHOW ELEVATIONS IN RISK OF BRAIN CANCERS

Brain Tumors: There is a consistent pattern of increased risk of glioma and acoustic neuroma associated with use of mobile phones and cordless phones.

"Based on epidemiological studies there is a consistent pattern of increased risk for glioma and acoustic neuroma associated with use of mobile phones and cordless phones. The evidence comes mainly from two study centres, the Hardell group in Sweden and the Interphone Study Group. No consistent pattern of an increased risk is seen for meningioma. A systematic bias in the studies that explains the results would also have been the case for meningioma. The different risk pattern for tumor type strengthens the findings regarding glioma and acoustic neuroma. Meta-analyses of the Hardell group and Interphone studies show an increased risk for glioma and acoustic neuroma. Supportive evidence comes also from anatomical localisation of the tumor to the most exposed area of the brain, cumulative exposure in hours and latency time that all add to the biological relevance of an increased risk. In addition risk calculations based on estimated absorbed dose give strength to the findings.

"There is reasonable basis to conclude that RF-EMFs are bioactive and have a potential to cause health impacts. There is a consistent pattern of increased risk for glioma and acoustic neuroma associated with use of wireless phones (mobile phones and cordless phones) mainly based on results from case-control studies from the Hardell group and Interphone Final Study results. Epidemiological evidence gives that RF-EMF should be classified as a human carcinogen.

Based on our own research and review of other evidence the existing FCC/IEE and ICNIRP public safety limits and reference levels are not adequate to protect public health. New public health standards and limits are needed.

(Hardell et al, 2012 –Section 11)

EVIDENCE FOR GENETIC EFFECTS (Updated March 2014)

One hundred fourteen (114) new papers on genotoxic effects of RFR published between 2007 and early 2014 are profiled. Of these, 74 (65%) showed effects and 40 (35%) showed no effects.

Fifty nine (59) new ELF-EMF papers and two static magnetic field papers that report on genotoxic effects of ELF-EMF between 2007 and early 2014 are profiled. Of these, 49 (83%) show effects and 10 (17%) show no effect. (Lai, 2014 – Section 6)

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EVIDENCE FOR NEUROLOGICAL EFFECTS (Updated March 2014)

Two hundred eleven (211) new papers that report on neurological effects of RFR published between 2007 and early 2014 are profiled. Of these, 144 (68%) showed effects and 67 (32%) showed no effects.

One hundred five (105) new ELF-EMF papers (including two static field papers) that report on neurological-effects of ELF-EMF published between 2007 and early 2014 are profiled. Of these, 95 (90%) show effects and 10 (10%) show no effect. (Lai, 2014 – Section 9)

EVIDENCE FOR CHILDHOOD CANCERS (LEUKEMIA)

With overall 42 epidemiological studies published to date power frequency EMFs are among the most comprehensively studied environmental factors. Except ionizing radiation no other environmental factor has been as firmly established to increase the risk of childhood leukemia. Sufficient evidence from epidemiological studies of an increased risk from exposure to EMF (power frequency magnetic fields) that cannot be attributed to chance, bias or confounding. Therefore, according to the rules of IARC such exposures can be classified as a **Group 1 carcinogen (Known Carcinogen).**

There is no other risk factor identified so far for which such unlikely conditions have been put forward to postpone or deny the necessity to take steps towards exposure reduction. As one step in the direction of precaution, measures should be implemented to guarantee that exposure due to transmission and distribution lines is below an average of about 1 mG. This value is arbitrary at present and only supported by the fact that in many studies this level has been chosen as a reference.

Base-station level RFR at levels ranging from less than 0.001 uW/cm2 to 0.05 uW/cm2. In 5 new studies since 2007, researchers report headaches, concentration difficulties and behavioral problems in children and adolescents; and sleep disturbances, headaches and concentration problems in adults.

MELATONIN, BREAST CANCER AND ALZHEIMER'S DISEASE

MELATONIN AND BREAST CANCER

Conclusion: Eleven (11) of the 13 published epidemiologic residential and occupational studies are considered to provide (positive) evidence that high ELF MF exposure can result in decreased melatonin production. The two negative studies had important deficiencies that may certainly have biased the results. There is sufficient evidence to conclude that long-term relatively high ELF MF exposure can result in a decrease in melatonin production. It has not been determined to what extent personal characteristics, e.g., medications, interact with ELF MF exposure in decreasing melatonin production

Conclusion: New research indicates that ELF MF exposure, in vitro, can significantly decrease melatonin activity through effects on MT1, an important melatonin receptor.

(Davanipour and Sobel, 2012 – Section 13)

ALZHEIMER'S DISEASE

There is strong epidemiologic evidence that exposure to ELF MF is a risk factor for AD. There are now twelve (12) studies of ELF MF exposure and AD or dementia which . Nine (9) of these studies are considered positive and three (3) are considered negative. The three negative studies have serious deficiencies in ELF MF exposure classification that results in subjects with rather low exposure being considered as having significant exposure. There are insufficient studies to formulate an opinion as to whether radiofrequency MF exposure is a risk or protective factor for AD.

There is now evidence that (i) high levels of peripheral amyloid beta are a risk factor for AD and (ii) medium to high ELF MF exposure can increase peripheral amyloid beta. High brain levels of amyloid beta are also a risk factor for AD and medium to high ELF MF exposure to brain cells likely also increases these cells' production of amyloid beta.

There is considerable in vitro and animal evidence that melatonin protects against AD. Therefore it is certainly possible that low levels of melatonin production are associated with an increase in the risk of AD.

(Davanipour and Sobel, 2012 – Section 13)

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STRESS PROTEINS AND DNA AS A FRACTAL ANTENNA FOR RFR

DNA acts as a 'fractal antenna' for EMF and RFR.

The coiled-coil structure of DNA in the nucleus makes the molecule react like a fractal antenna to a wide range of frequencies.

The structure makes DNA particularly vulnerable to EMF damage.

The mechanism involves direct interaction of EMF with the DNA molecule (claims that there are no known mechanisms of interaction are patently false)

Many EMF frequencies in the environment can and do cause DNA changes.

The EMF-activated cellular stress response is an effective protective mechanism for cells exposed to a wide range of EMF frequencies.

EMF stimulates stress proteins (indicating an assault on the cell).

EMF efficiently harms cells at a billion times lower levels than conventional heating. Blank, 2012 – Section 7)

Safety standards based on heating are irrelevant to protect against EMF-levels of exposure. There is an urgent need to revise EMF exposure standards. Research has shown thresholds are very low (safety standards must be reduced to limit biological responses). Biologically-based EMF safety standards could be developed from the research on the stress response. (Blank, 2012 – Section 7)

EVIDENCE FOR DISRUPTION OF THE MODULATING SIGNAL HUMAN STEM CELL DNA DOES NOT ADAPT OR REPAIR

Human stem cells do not adapt to chronic exposures to non-thermal microwave (cannot repair damaged DNA), and damage to DNA in genes in other cells generally do not repair as efficiently. (Belyaev, 2012 – Section 15)

Non-thermal effects of microwaves depend on variety of biological and physical parameters that should be taken into account in setting the safety standards. Emerging evidence suggests that the SAR concept, which has been widely adopted for safety standards, is not useful alone for the evaluation of health risks from non-thermal microwave of mobile communication. Other parameters of exposure, such as frequency, modulation, duration, and dose should be taken into account.

Lower intensities are not always less harmful; they may be more harmful.

Intensity windows exist, where bioeffects are much more powerful.

A linear, dose-response relationship test is probably invalid for testing of RFR and EMF (as is done in chemicals testing for toxicity).

Resonant frequencies may result in biological effects at very low intensities comparable to base station (cell tower) and other microwave sources used in mobile communications. These exposures can cause health risk. The current safety standards are insufficient to protect from non-thermal microwave effects.

The data about the effects of microwave at super-low intensities and significant role of duration of exposure in these effects along with the data showing that adverse effects of non-thermal microwave from GSM/UMTS mobile phones depend on carrier frequency and type of the microwave signal suggest that microwave from base-stations/masts, wireless routers, WI-FI and other wireless devices and exposures in common use today can also produce adverse effects at prolonged durations of exposure.

Most of the real signals that are in use in mobile communication have not been tested so far. Very little research has been done with real signals and for durations and intermittences of exposure that are relevant to chronic exposures from mobile communication. In some studies, so-called "mobile communication-like" signals were investigated that in fact were different from the real exposures in such important aspects as intensity, carrier frequency, modulation, polarization, duration and intermittence.

New standards should be developed based on knowledge of mechanisms of non-thermal effects. Importantly, because the signals of mobile communication are completely replaced by other signals faster then once per 10 years, duration comparable with latent period, epidemiologic studies cannot provide basement for cancer risk assessment from upcoming new signals.

In many cases, because of ELF modulation and additional ELF fields created by the microwave sources, for example by mobile phones, it is difficult to distinguish the effects of exposures to ELF and microwave. Therefore, these combined exposures and their possible cancer risks should be considered in combination.

As far as different types of microwave signals (carrier frequency, modulation, polarization, far and near field, intermittence, coherence, *etc.*) may produce different effects, cancer risks should ideally be estimated for each microwave signal separately.

The Precautionary Principle should be implemented while new standards are in progress.

It should be anticipated that some part of the human population, such as children, pregnant women and groups of hypersensitive persons could be especially sensitive to the non-thermal microwave exposures.
(Belyaev, 2012 – Section 15)

N. EFFECTS OF WEAK-FIELD INTERACTIONS ON NON-LINEAR BIOLOGICAL OSCILLATORS AND SYNCHRONIZED NEURAL ACTIVITY

A unifying hypothesis for a plausible biological mechanism to account for very weak field EMF bioeffects other than cancer may lie with weak field interactions of pulsed RFR and ELF-modulated RFR as disrupters of synchronized neural activity. Electrical rhythms in our brains can be influenced by external signals. This is consistent with established weak field effects on coupled biological oscillators in living tissues. Biological systems of the heart, brain and gut are dependent on the cooperative actions of cells that function according to principles of non-linear, coupled biological oscillations for their synchrony, and are dependent on exquisitely timed cues from the environment at vanishingly small levels (Buzsaki, 2006; Strogatz, 2003). The key to synchronization is the joint actions of cells that co-operate electrically - linking populations of biological oscillators that couple together in large arrays and synchronize spontaneously. Synchronous biological oscillations in cells (pacemaker cells) can be disrupted by artificial, exogenous environmental signals, resulting in desynchronization of neural activity that regulates critical functions (including metabolism) in the brain, gut and heart and circadian rhythms governing sleep and hormone cycles (Strogatz, 1987). The brain contains a population of oscillators with distributed natural frequencies, which pull one another into synchrony (the circadian pacemaker cells). Strogatz has addressed the unifying mathematics of biological cycles and external factors disrupt these cycles (Strogatz, 2001, 2003). *"Rhythms can be altered by a wide variety of agents and that these perturbations must seriously alter brain performance"* (Buzsaki, 2006).

"Organisms are biochemically dynamic. They are continuously subjected to time-varying conditions in the form of both extrinsic driving from the environment and intrinsic rhythms generated by specialized cellular clocks within the organism itself. Relevant examples of the latter are the cardiac pacemaker located at the sinoatrial node in mammalian hearts (1) and the circadian clock residing at the suprachiasmatic nuclei in mammalian brains (2). These rhythm generators are composed of thousands of clock cells that are intrinsically diverse but nevertheless manage to function in a coherent oscillatory state. This is the case, for instance, of the circadian oscillations exhibited by the suprachiasmatic nuclei, the period of which is known to be determined by the mean period of the individual neurons making up the circadian clock (3–7). The mechanisms by which this collective behavior arises remain to be understood." (Strogatz, 2001; Strogatz, 2003)

Synchronous biological oscillations in cells (pacemaker cells) can be disrupted by artificial, exogenous environmental signals, resulting in desynchronization of neural activity that regulates critical functions (including metabolism) in the brain, gut and heart and circadian rhythms governing sleep and hormone cycles. The brain contains a population of oscillators with distributed natural frequencies, which pull one another into synchrony (the circadian pacemaker cells). Strogatz has addressed the unifying mathematics of biological cycles and external factors disrupt these cycles.

EMF AND RFR MAKE CHEMICAL TOXINS MORE HARMFUL

EMF acts on the body like other environmental toxicants do (heavy metals, organic chemicals and pesticides). Both toxic chemicals and EMF may generate free radicals, produce stress proteins and cause indirect damage to DNA. Where there is combined exposure the damages may add or even synergistically interact, and result in worse damage to genes.
(Sage and Carpenter, 2012 – Section 24)

EMF IS SUCCESSFULLY USED IN HEALING AND DISEASE TREATMENTS

"The potential application of the up-regulation of the HSP70 gene by both ELF-EMF and nanosecond PEMF in clinical practice would include trauma, surgery, peripheral nerve damage, orthopedic fracture, and vascular graft support, among others. Regardless of pulse design, EMF technology has been shown to be effective in bone healing [5], wound repair [11] and neural regeneration [31,36,48,49,51,63,64,65,66]. In terms of clinical applica- tion, EMF-induction of elevated levels of hsp70 protein also confers protection against hypoxia [61] and aid myocardial function and survival [20,22]. Given these results, we are particularly interested in the translational significance of effect vs. efficacy which is not usually reported by designers or investigators of EMF devices. More precise description of EM pulse and sine wave parameters, including the specific EM output sector, will provide consistency and "scientific basis" in reporting findings."

"The degree of electromagnetic field-effects on biological systems is known to be dependent on a number of criteria in the waveform pattern of the exposure system used; these include frequency, duration, wave shape, and relative orientation of the fields [6,29,32,33,39,40]. In some cases pulsed fields have demonstrated increased efficacy over static designs [19,21] in both medical and experimental settings." (Madkan et al, 2009)

(Sage and Carpenter, 2012 – Section 24)

ELF-EMF AND RFR ARE CLASSIFIED AS POSSIBLE CANCER-CAUSING AGENTS – WHY ARE GOVERNMENTS NOT ACTING?

The World Health Organization International Agency for Research on Cancer has classified wireless radiofrequency as a Possible Human Carcinogen (May, 2011)*. The designation applies to low-intensity RFR in general, covering all RFR-emitting devices and exposure sources (cell and cordless phones, WI-FI, wireless laptops, wireless hotspots, electronic baby monitors, wireless classroom access points, wireless antenna facilities, etc). The IARC Panel could have chosen to classify RFR as a Group 4 – Not A Carcinogen if the evidence was clear that RFR is not a cancer-causing agent. It could also have found a Group 3 designation was a good interim choice (Insufficient Evidence). IARC did neither.

(Sage and Carpenter, 2012 – Section 24)

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NEW SAFETY LIMITS MUST BE ESTABLISHED - HEALTH AGENCIES SHOULD ACT NOW

Existing public safety limits (FCC and ICNIRP public safety limits) do not sufficiently protect public health against chronic exposure from very low-intensity exposures. If no mid-course corrections are made to existing and outdated safety limits, such delay will magnify the public health impacts with even more applications of wireless-enabled technologies exposing even greater populations around the world in daily life. (Sage and Carpenter, 2012 – Section 24)

SCIENTIFIC BENCHMARKS FOR HARM PLUS SAFETY MARGIN = NEW SAFETY LIMITS THAT ARE VALID

Health agencies and regulatory agencies that set public safety standards for ELF-EMF and RFR should act now to adopt new, biologically-relevant safety limits that key to the lowest scientific benchmarks for harm coming from the recent studies, plus a lower safety margin. Existing public safety limits are too high by several orders of magnitude, if prevention of bioeffects and minimization or elimination of resulting adverse human health effects. Most safety standards are a thousand times or more too high to protect healthy populations, and even less effective in protecting sensitive subpopulations.
(Sage and Carpenter, 2012 – Section 24)

SENSITIVE POPULATIONS MUST BE PROTECTED

Safety standards for sensitive populations will more likely need to be set at lower levels than for healthy adult populations. Sensitive populations include the developing fetus, the infant, children, the elderly, those with pre-existing chronic diseases, and those with developed electrical sensitivity (EHS). (Sage and Carpenter, 2012 – Section 24)

PROTECTING NEW LIFE - INFANTS AND CHILDREN

Strong precautionary action and clear public health warnings are warranted immediately to help prevent a global epidemic of brain tumors resulting from the use of wireless devices (mobile phones and cordless phones). Common sense measures to limit both ELF-EMF and RFR in the fetus and newborn infant (sensitive populations) are needed, especially with respect to avoidable exposures like baby monitors in the crib and baby isolettes (incubators) in hospitals that can be modified; and where education of the pregnant mother with respect to laptop computers, mobile phones and other sources of ELF-EMF and RFR are easily instituted.
(Sage and Carpenter, 2012 – Section 24)

Wireless laptops and other wireless devices should be strongly discouraged in schools for children of all ages. (Sage and Carpenter, 2012 – Section 24)

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STANDARD OF EVIDENCE FOR JUDGING THE SCIENCE

The standard of evidence for judging the scientific evidence should be based on good public health principles rather than demanding scientific certainty before actions are taken. (Sage and Carpenter, 2012 – Section 24)

WIRELESS WARNINGS FOR ALL

The continued rollout of wireless technologies and devices puts global public health at risk from unrestricted wireless commerce unless new, and far lower exposure limits and strong precautionary warnings for their use are implemented.
(Sage and Carpenter, 2012 – Section 24)

EMF AND RFR ARE PREVENTABLE TOXIC EXPOSURES

We have the knowledge and means to save global populations from multi-generational adverse health consequences by reducing both ELF and RFR exposures. Proactive and immediate measures to reduce unnecessary EMF exposures will lower disease burden and rates of premature death.
(Sage and Carpenter, 2012 – Section 24)

DEFINING A NEW 'EFFECT LEVEL' FOR RFR

On a precautionary public health basis, a reduction from the BioInitiative 2007 recommendation of 0.1 uW/cm2 (or one-tenth of a microwatt per square centimeter) for cumulative outdoor RFR down to something three orders of magnitude lower (in the low nanowatt per square centimeter range) is justified.

A scientific benchmark of 0.003 uW/cm2 or three nanowatts per centimeter squared for 'lowest observed effect level' for RFR is based on mobile phone base station-level studies. Applying a ten-fold reduction to compensate for the lack of long-term exposure (to provide a safety buffer for chronic exposure, if needed) or for children as a sensitive subpopulation yields a 300 to 600 picowatts per square centimeter precautionary action level. This equates to a 0.3 nanowatts to 0.6 nanowatts per square centimeter as a reasonable, precautionary action level for chronic exposure to pulsed RFR.

These levels may need to change in the future, as new and better studies are completed. We leave room for future studies that may lower or raise today's observed 'effects levels' and should be prepared to accept new information as a guide for new precautionary actions.

(Sage and Carpenter, 2012 – Section 24)

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Reported Biological Effects from Radiofrequency Radiation at Low-Intensity Exposure
(Cell Tower, Wi-Fi, Wireless Laptop and 'Smart' Meter RF Intensities)

Power Density (Microwatts/centimeter2 - uW/cm2)		Reference
As low as (10^{-13}) or 100 femtowatts/cm2	Super-low intensity RFR effects at MW reasonant frequencies resulted in changes in genes; problems with chromatin conformation (DNA)	Belyaev, 1997
5 picowatts/cm2 (10^{-12})	Changed growth rates in yeast cells	Grundler, 1992
0.1 nanowatt/cm2 (10^{-10}) or 100 picowatts/cm2	Super-low intensity RFR effects at MW reasonant frequencies resulted in changes in genes; problems with chromatin condensation (DNA) intensities comparable to base stations	Belyaev, 1997
0.00034 uW/cm2	Chronic exposure to mobile phone pulsed RF significantly reduced sperm count,	Behari, 2006
0.0005 uW/cm2	RFR decreased cell proliferation at 960 MHz GSM 217 Hz for 30-min exposure	Velizarov, 1999
0.0006 - 0.0128 uW/cm2	Fatigue, depressive tendency, sleeping disorders, concentration difficulties, cardio- vascular problems reported with exposure to GSM 900/1800 MHz cell phone signal at base station level exposures.	Oberfeld, 2004
0.003 - 0.02 uW/cm2	In children and adolescents (8-17 yrs) short-term exposure caused headache, irritation, concentration difficulties in school.	Heinrich, 2010
0.003 to 0.05 uW/cm2	In children and adolescents (8-17 yrs) short-term exposure caused conduct problems in school (behavioral problems)	Thomas, 2010
0.005 uW/cm2	In adults (30-60 yrs) chronic exposure caused sleep disturbances, (but not significantly increased across the entire population)	Mohler, 2010
0.005 - 0.04 uW/cm2	Adults exposed to short-term cell phone radiation reported headaches, concentration difficulties (differences not significant, but elevated)	Thomas, 2008
0.006 - 0.01 uW/cm2	Chronic exposure to base station RF (whole-body) in humans showed increased stress hormones; dopamine levels substantially decreased; higher levels of adrenaline and nor-adrenaline; dose-response seen; produced chronic physiological stress in cells even after 1.5 years.	Buchner, 2012
0.01 - 0.11 uW/cm2	RFR from cell towers caused fatigue, headaches, sleeping problems	Navarro, 2003

Stress proteins, HSP, disrupted immune function	Brain tumors and blood-brain barrier
Reproduction/fertility effects	Sleep, neuron firing rate, EEG, memory, learning, behavior
Oxidative damage/ROS/DNA damage/DNA repair failure	Cancer (other than brain), cell proliferation
Disrupted calcium metabolism	Cardiac, heart muscle, blood-pressure, vascular effects

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Reported Biological Effects from Radiofrequency Radiation at Low-Intensity Exposure
(Cell Tower, Wi-Fi, Wireless Laptop and 'Smart' Meter RF Intensities)

Power Density (Microwatts/centimeter2 - uW/cm2)		Reference
0.01 - 0.05 uW/cm2	Adults (18-91 yrs) with short-term exposure to GSM cell phone radiation reported headache, neurological problems, sleep and concentration problems.	Hutter, 2006
0.005 - 0.04 uW/cm2	Adults exposed to short-term cell phone radiation reported headaches, concentration difficulties (differences not significant, but elevated)	Thomas, 2008
0.015 - 0.21 uW/cm2	Adults exposed to short-term GSM 900 radiation reported changes in mental state (e.g., calmness) but limitations of study on language descriptors prevented refined word choices (stupified, zoned-out)	Augner, 2009
0.05 - 0.1 uW/cm2	RFR linked to adverse neurological, cardio symptoms and cancer risk	Khurana, 2010
0.05 - 0.1 uW/cm2	RFR related to headache, concentration and sleeping problems, fatigue	Kundi, 2009
0.07 - 0.1 uW/cm2	Sperm head abnormalities in mice exposed for 6-months to base station level RF/MW. Sperm head abnormalities occurred in 39% to 46% exposed mice (only 2% in controls) abnormalities was also found to be dose dependent. The implications of the pin-head and banana-shaped sperm head. The occurrence of sperm head observed increase occurrence of sperm head abnormalities on the reproductive health of humans living in close proximity to GSM base stations were discussed."	Otitoloju, 2010
0.38 uW/cm2	RFR affected calcium metabolism in heart cells	Schwartz, 1990
0.8 - 10 uW/cm2	RFR caused emotional behavior changes, free-radical damage by super-weak MWs	Akoev, 2002
0.13 uW/cm2	RFR from 3G cell towers decreased cognition, well-being	Zwamborn, 2003
0.16 uW/cm2	Motor function, memory and attention of school children affected (Latvia)	Kolodynski, 1996
0.168 - 1.053 uW/cm2	Irreversible infertility in mice after 5 generations of exposure to RFR from an 'antenna park'	Magras & Zenos, 1997
0.2 - 8 uW/cm2	RFR caused a two-fold increase in leukemia in children	Hocking, 1996
0.2 - 8 uW/cm2	RFR decreased survival in children with leukemia	Hocking, 2000
0.21 - 1.28 uW/cm2	Adolescents and adults exposed only 45 min to UMTS cell phone radiation reported increases In headaches.	Riddervold, 2008

Stress proteins, HSP, disrupted immune function	Brain tumors and blood-brain barrier
Reproduction/fertility effects	Sleep, neuron firing rate, EEG, memory, learning, behavior
Oxidative damage/ROS/DNA damage/DNA repair failure	Cancer (other than brain), cell proliferation
Disrupted calcium metabolism	Cardiac, heart muscle, blood pressure, vascular effects

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Reported Biological Effects from Radiofrequency Radiation at Low-Intensity Exposure
(Cell Tower, Wi-Fi, Wireless Laptop and 'Smart' Meter RF Intensities)

Power Density (Microwatts/centimeter2 - uW/cm2)		Reference
0.5 uW/cm2	Significant degeneration of seminiferous epithelium in mice at 2.45 GHz, 30-40 min.	Saunders, 1981
0.5 - 1.0 uW/cm2	Wi-FI level laptop exposure for 4-hr resulted in decrease in sperm viability, DNA fragmentation with sperm samples placed in petri dishes under a laptop connected via WI-FI to the internet.	Avendano, 2012
1.0 uW/cm2	RFR induced pathological leakage of the blood-brain barrier	Persson, 1997
1.0 uW/cm2	RFR caused significant effect on immune function in mice	Fesenko, 1999
1.0 uW/cm2	RFR affected function of the immune system	Novoselova, 1999
1.0 uW/cm2	Short-term (50 min) exposure in electrosensitive patients, caused loss of well-being after GSM and especially UMTS cell phone radiation exposure	Eltiti, 2007
1.3 - 5.7 uW/cm2	RFR associated with a doubling of leukemia in adults	Dolk, 1997
1.25 uW/cm2	RFR exposure affected kidney development in rats (in-utero exposure)	Pyrpasopoulou, 2004
1.5 uW/cm2	RFR reduced memory function in rats	Nittby, 2007
2 uW/cm2	RFR induced double-strand DNA damage in rat brain cells	Kesari, 2008
2.5 uW/cm2	RFR affected calcium concentrations in heart muscle cells	Wolke, 1996
2 - 4 uW/cm2	Altered cell membranes; acetycholine-induced ion channel disruption	D'Inzeo, 1988
4 uW/cm2	RFR caused changes in hippocampus (brain memory and learning)	Tattersall, 2001
4 - 15 uW/cm2	Memory impairment, slowed motor skills and retarded learning in children	Chiang, 1989
5 uW/cm2	RFR caused drop in NK lymphocytes (immune function decreased)	Boscolo, 2001
5.25 uW/cm2	20 minutes of RFR at cell tower frequencies induced cell stress response	Kwee, 2001
5 - 10 uW/cm2	RFR caused impaired nervous system activity	Dumansky, 1974
6 uW/cm2	RFR induced DNA damage in cells	Phillips, 1998

Stress proteins, HSP, disrupted immune function	Brain tumors and blood-brain barrier
Reproduction/fertility effects	Sleep, neuron firing rate, EEG, memory, learning, behavior
Oxidative damage/ROS/DNA damage/DNA repair failure	Cancer (other than brain), cell proliferation
Disrupted calcium metabolism	Cardiac, heart muscle, blood-pressure, vascular effects

Reported Biological Effects from Radiofrequency Radiation at Low-Intensity Exposure
(Cell Tower, Wi-Fi, Wireless Laptop and 'Smart' Meter RF Intensities)

Power Density (Microwatts/centimeter2 - uW/cm2)		Reference
8.75 uW/cm2	RFR at 900 MHz for 2-12 hours caused DNA breaks in leukemia cells	Marinelli, 2004
10 uW/cm2	Changes in behavior (avoidance) after 0.5 hour exposure to pulsed RFR	Navakatikian, 1994
10 - 100 uW/cm2	Increased risk in radar operators of cancer; very short latency period; dose response to exposure level of RFR reported.	Richter, 2000
12.5 uW/cm2	RFR caused calcium efflux in cells - can affect many critical cell functions	Dutta, 1989
13.5 uW/cm2	RFR affected human lymphocytes - induced stress response in cells	Sarimov, 2004
20 uW/cm2	Increase in serum cortisol (a stress hormone)	Mann, 1998
28.2 uW/cm2	RFR increased free radical production in rat cells	Yurekli, 2006
37.5 uW/cm2	Immune system effects - elevation of PFC count (antibody producing cells	Veyret, 1991
45 uW/cm2	Pulsed RFR affected serum testosterone levels in mice	Forgacs, 2006
50 uW/cm2	Cell phone RFR caused a pathological leakage of the blood-brain barrier in 1 hour	Salford, 2003
50 uW/cm2	An 18% reduction in REM sleep (important to memory and learning functions)	Mann, 1996
60 uW/cm2	RFR caused structural changes in cells of mouse embryos	Somozy, 1991
60 uW/cm2	Pulsed RFR affected immune function in white blood cells	Stankiewicz, 2006
60 uW/cm2	Cortex of the brain was activated by 15 minutes of 902 MHz cell phone	Lebedeva, 2000
65 uW/cm2	RFR affected genes related to cancer	Ivaschuk, 1999
92.5 uW/cm2	RFR caused genetic changes in human white blood cells	Belyaev, 2005
100 uW/cm2	Changes in immune function	Elekes, 1996
100 uW/cm2	A 24.3% drop in testosterone after 6 hours of CW RFR exposure	Navakatikian, 1994
120 uW/cm2	A pathological leakage in the blood-brain barrier with 915 MHz cell RF	Salford, 1994

Stress proteins, HSP, disrupted immune function	Brain tumors and blood-brain barrier
Reproduction/fertility effects	Sleep, neuron firing rate, EEG, memory, learning, behavior
Oxidative damage/ROS/DNA damage/DNA repair failure	Cancer (other than brain), cell proliferation
Disrupted calcium metabolism	Cardiac, heart muscle, blood-pressure, vascular effects

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Reported Biological Effects from Radiofrequency Radiation at Low-Intensity Exposure
(Cell Tower, Wi-Fi, Wireless Laptop and 'Smart' Meter RF Intensities)

Power Density (Microwatts/centimeter2 - uW/cm2)		Reference
500 uW/cm2	Intestinal epithelial cells exposed to 2.45 GHz pulsed at 16 Hz showed changes in intercellular calcium.	Somozy, 1993
500 uW/cm2	A 24.6% drop in testosterone and 23.2% drop in insulin after 12 hrs of pulsed RFR exposure.	Navakatikian, 1994

STANDARDS		
530 - 600 uW/cm2	Limit for uncontrolled public exposure to 800-900 MHz	ANSI/IEEE and FCC
1000 uW/cm2	PCS STANDARD for public exposure (as of September 1,1997)	FCC, 1996
5000 uW/cm2	PCS STANDARD for occupational exposure (as of September 1, 1997)	FCC, 1996
BACKGROUND LEVELS		
0.003 uW/cm2	Background RF levels in US cities and suburbs in the 1990s	Mantiply, 1997
0.05 uW/cm2	Median ambient power density in cities in Sweden (30-2000 MHz)	Hamnierius, 2000
0.1 - 10 uW/cm2	Ambient power density within 100-200' of cell site in US (data from 2000)	Sage, 2000

Stress proteins, HSP, disrupted immune function	Brain tumors and blood-brain barrier
Reproduction/fertility effects	Sleep, neuron firing rate, EEG, memory, learning, behavior
Oxidative damage/ROS/DNA damage/DNA repair failure	Cancer (other than brain), cell proliferation
Disrupted calcium metabolism	Cardiac, heart muscle, blood-pressure, vascular effects

Reported Biological Effects from Radiofrequency Radiation at Low-Intensity Exposure
(Cell Tower, Wi-Fi, Wireless Laptop and 'Smart' Meter RF Intensities)

SAR (Watts/Kilogram)		Reference
0.000064 - 0.000078 W/Kg	Well-being and cognitive function affected in humans exposed to GSM-UMTS cell phone frequencies; RF levels similar near cell sites	TNO Physics and
0.00015 - 0.003 W/Kg	Calcium ion movement in isolated frog heart tissue is increased 18% (P<.01) and by 21% (P<.05) by weak RF field modulated at 16 Hz	Schwartz, 1990
0.000021 - 0.0021 W/Kg	Changes in cell cycle; cell proliferation (960 MHz GSM mobile phone)	Kwee, 1997
0.0003 - 0.06 W/Kg	Neurobehavioral disorders in offspring of pregnant mice exposed in utero to cell phones - dose-response impaired glutamatergic synaptic transmission onto layer V pyramidal neurons of the prefrontal cortex. Hyperactivity and impaired memory function in offspring. Altered brain development.	Aldad, 2012
0.0016 - 0.0044 W/Kg	Very low power 700 MHz CW affects excitability of hippocampus tissue, consistent with reported behavioral changes.	Tattersall, 2001
0.0021 W/Kg	Heat shock protein HSP 70 is activated by very low intensity microwave exposure in human epithelial amnion cells	Kwee, 2001
0.0024 - 0.024 W/Kg	Digital cell phone RFR at very low intensities causes DNA damage in human cells; both DNA damage and impairment of DNA is reported	Phillips, 1998
0.0027 W/Kg	Changes in active avoidance conditioned behavioral effect is seen after one-half hour of pulsed radiofrequency radiation	Navakatikian, 1994
0.0035 W/Kg	900 MHz cell phone signal induces DNA breaks and early activation of p53 gene; short exposure of 2-12 hours leads cells to acquire greater survival chance - linked to tumor agressiveness.	Marinelli, 2004
0.0095 W/Kg	MW modulated at 7 Hz produces more errors in short-term memory functioin on complex tasks (can affect cognitive processes such as attention and memory)	Lass, 2002
0.001 W/Kg	750 MHz continuous wave (CW) RFR exposure caused increase in heat shock protein (stress proteins). Equivalent to what would be induced by 3 degree C. heating of tissue (but no heating occurred)	De Pomerai, 2000
0.001 W/Kg	Statistically significant change in intracellular calcium concentration in heart muscle cells exposed to RFR (900 MHz/50 Hz modulation)	Wolke, 1996

Stress proteins, HSP, disrupted immune function	Brain tumors and blood-brain barrier
Reproduction/fertility effects	Sleep, neuron firing rate, EEG, memory, learning, behavior
Oxidative damage/ROS/DNA damage/DNA repair failure	Cancer (other than brain), cell proliferation
Disrupted calcium metabolism	Cardiac, heart muscle, blood-pressure, vascular effects

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Reported Biological Effects from Radiofrequency Radiation at Low-Intensity Exposure
(Cell Tower, Wi-Fi, Wireless Laptop and 'Smart' Meter RF Intensities)

SAR (Watts/Kilogram)		Reference
0.0021 W/Kg	A significant change in cell proliferation not attributable to thermal heating. RFR induces non-thermal stress proteins (960 MHz GSM)	Velizarov, 1999
0.004 - 0.008 W/Kg	915 MHz cell phone RFR caused pathological leakage of blood-brain barrier. Worst at lower SAR levels and worse with CW compared to Frequency of pathological changes was 35% in rats exposed to pulsed radiation at 50% to continuous wave RFR. Effects observed at a specific absorption (SA) of > 1.5 joules/Kg in human tissues	Persson, 1997
0.0059 W/Kg	Cell phone RFR induces glioma (brain cancer) cells to significantly increase thymidine uptake, which may be indication of more cell division	Stagg, 1997
0.014 W/Kg	Sperm damage from oxidative stress and lowered melatonin levels resulted from 2-hr per day/45 days exposure to 10 GHz.	Kumar, 2012
0.015 W/Kg	Immune system effects - elevation of PFC count (antibody-producing cells)	Veyret, 1991
0.02 W/Kg	A single, 2-hr exposure to GSM cell phone radiation results in serious neuron damage (brain cell damage) and death in cortex, hippocampus, and basal ganglia of brain- even 50+ days later blood-brain barrier is still leaking albumin (P<.002) following only one cell phone exposure	Salford, 2003
0.026 W/Kg	Activity of c-jun (oncogene or cancer gene) was altered in cells after 20 minutes exposure to cell phone digital TDMA signal	Ivaschuk, 1997
0.0317 W/Kg	Decrease in eating and drinking behavior	Ray, 1990
0.037 W/Kg	Hyperactivity caused by nitric oxide synthase inhibitor is countered by exposure to ultra-wide band pulses (600/sec) for 30 min	Seaman, 1999
0.037 - 0.040 W/Kg	A 1-hr cell phone exposure causes chromatin condensation; impaired DNA repair mechanisms; last 3 days (longer than stress response) the effect reaches saturation in only one hour of exposure; electro- sensitive (ES) people have different response in formation of DNA repair foci, compared to healthy individuals; effects depend on carrier frequency (915 MHz = 0.037 W/Kg but 1947 MHz = 0.040 W/Kg)	Belyaev, 2008
0.05 W/Kg	Significant increase in firing rate of neurons (350%) with pulsed 900 MHz cell phone radiation exposure (but not with CW) in avian brain cells	Beason, 2002

Stress proteins, HSP, disrupted immune function	Brain tumors and blood-brain barrier
Reproduction/fertility effects	Sleep, neuron firing rate, EEG, memory, learning, behavior
Oxidative damage/ROS/DNA damage/DNA repair failure	Cancer (other than brain), cell proliferation
Disrupted calcium metabolism	Cardiac, heart muscle, blood-pressure, vascular effects

Reported Biological Effects from Radiofrequency Radiation at Low-Intensity Exposure
(Cell Tower, Wi-Fi, Wireless Laptop and 'Smart' Meter RF Intensities)

SAR (Watts/Kilogram)		Reference
0.09 W/Kg	900 MHz study of mice for 7 days, 12-hr per day (whole-body) resulted in significant effect on mitochondria and genome stability	Aitken, 2005
0.091 W/Kg	Wireless internet 2400 MHz, 24-hrs per day/20 weeks increased DNA damage and reduced DNA repair; levels below 802.11 g Authors say "findings raise questions about safety of radiofrequency exposure from Wi-Fi internet access devices for growing organisms of reproductive age, with a potential effect on fertility and integrity of germ cells" (male germ cells are the reproductive cells=sperm)	Atasoy, 2012
0.11 W/Kg	Increased cell death (apoptosis) and DNA fragmentation at 2.45 GHz for 35 days exposure (chronic exposure study)	Kesari, 2010
0.121 W/Kg	Cardiovascular system shows significant decrease in arterial blood pressure (hypotension) after exposure to ultra-wide band pulses	Lu, 1999
0.13 - 1.4 W/Kg	Lymphoma cancer rate doubled with two 1/2-hr exposures per day of cell phone radiation for 18 months (pulsed 900 MHz cell signal)	Repacholi, 1997
0.14 W/Kg	Elevation of immune response to RFR exposure	Elekes, 1996
0.141 W/Kg	Structural changes in testes - smaller diameter of seminiferous	Dasdag, 1999
0.15 - 0.4 W/Kg	Statistically significant increase in malignant tumors in rats chronically exposed to RFR	Chou, 1992
0.26 W/Kg	Harmful effects to the eye/certain drugs sensitize the eye to RFR	Kues, 1992
0.28 - 1.33 W/Kg	Significant increase in reported headaches with increasing use of hand-held cell phone use (maximum tested was 60 min per day)	Chia, 2000
0.3 - 0.44 W/Kg	Cell phone use results in changes in cognitive thinking/mental tasks related to memory retrieval	Krause, 2000
0.3 - 0.44 W/Kg	Attention function of brain and brain responses are speeded up	Preece, 1999
0.3 - 0.46 W/Kg	Cell phone RFR doubles pathological leakage of blood-brain barrier permeability at two days (P=.002) and triples permeability at four days (P=.001) at 1800 MHz GSM cell phone radiation	Schirmacher, 2000
0.43 W/Kg	Significant decrease in sperm mobility; drop in sperm concentration; and decrease in seminiferous tubules at 800 MHz, 8-hr/day, 12 weeks, with mobile phone radiation level on STANDBY ONLY (in rabbits)	Salama, 2008

Stress proteins, HSP, disrupted immune function	Brain tumors and blood-brain barrier
Reproduction/fertility effects	Sleep, neuron firing rate, EEG, memory, learning, behavior
Oxidative damage/ROS/DNA damage/DNA repair failure	Cancer (other than brain), cell proliferation
Disrupted calcium metabolism	Cardiac, heart muscle, blood-pressure, vascular effects

Reported Biological Effects from Radiofrequency Radiation at Low-Intensity Exposure
(Cell Tower, Wi-Fi, Wireless Laptop and 'Smart' Meter RF Intensities)

SAR (Watts/Kilogram)		Reference
0.5 W/Kg	900 MHz pulsed RF affects firing rate of neurons (Lymnea stagnalis) but continuous wave had no effect	Bolshakov, 1992
0.58 - 0.75 W/Kg	Decrease in brain tumors after chronic exposure to RFR at 836 MHz	Adey, 1999
0.6 - 0.9 W/Kg	Mouse embryos develop fragile cranial bones from in utero 900 MHz The authors say "(O)ur results clearly show that even modest exposure (e.g., 6 min daily for 21 days" is sufficient to interfere with the normal mouse developmental process"	Fragopoulou, 2009
0.6 and 1.2 W/Kg	Increase in DNA single and double-strand DNA breaks in rat brain cells with exposure to 2450 MHz RFR	Lai & Singh, 1996
0.795 W/Kg	GSM 900 MHz, 217 Hz significantly decreases ovarian development and size of ovaries, due to DNA damage and premature cell death of nurse cells and follicles in ovaries (that nourish egg cells)	Panagopoulous, 2012
0.87 W/Kg	Altered human mental performance after exposure to GSM cell phone radiation (900 MHz TDMA digital cell phone signal)	Hamblin, 2004
0.87 W/Kg	Change in human brainwaves; decrease in EEG potential and statistically significant change in alpha (8-13 Hz) and beta (13-22 Hz) brainwave activity in humans at 900 MHz; exposures 6/min per day for 21 days (chronic exposure)	D'Costa, 2003
0.9 W/Kg	Decreased sperm count and more sperm cell death (apoptosis) after 35 days exposure, 2-hr per day	Kesari, 2012
< 1.0 W/Kg	Rats exposed to mobile phone radiation on STANDBY ONLY for 11-hr 45-min plus 15-min TRANSMIT mode; 2 times per day for 21 days showed decreased number of ovarian follicles in pups born to these pregnant rats. The authors conclude "the decreased number of follicles in pups exposed to mobile phone microwaves suggest that intrauterine exposure has toxic effects on ovaries."	Gul, 2009
0.4 - 1.0 W/Kg	One 6-hr exposure to 1800 MHz cell phone radiation in human sperm cells caused a significant dose response and reduced sperm motility and viability; reactive oxygen species levels were significantly increased after exposure to 1.0 W/Kg; study confirms detrimental effects of RF/MW to human sperm. The authors conclude "(T)hese findings have clear implicatiions for the safety of extensive mobile phone use by males of reproductive age, potentially affecting both their fertility and the health and wellbeing of their offspring."	De Iuliis, 2009
1.0 W/Kg	Human semen degraded by exposure to cell phone frequency RF increased free-radical damage.	De Iuliis, 2009

Stress proteins, HSP, disrupted immune function	Brain tumors and blood-brain barrier
Reproduction/fertility effects	Sleep, neuron firing rate, EEG, memory, learning, behavior
Oxidative damage/ROS/DNA damage/DNA repair failure	Cancer (other than brain), cell proliferation
Disrupted calcium metabolism	Cardiac, heart muscle, blood-pressure, vascular effects

Reported Biological Effects from Radiofrequency Radiation at Low-Intensity Exposure
(Cell Tower, Wi-Fi, Wireless Laptop and 'Smart' Meter RF Intensities)

SAR (Watts/Kilogram)		Reference
1.0 W/Kg	Motility, sperm count, sperm morphology, and viability reduced in active cell phone users (human males) in dose-dependent manner.	Agarwal, 2008
1.0 W/Kg	GSM cell phone use modulates brain wave oscillations and sleep EEG	Huber, 2002
1.0 W/Kg	Cell phone RFR during waking hours affects brain wave activity. (EEG patterns) during subsequent sleep	Achermann, 2000
1.0 W/Kg	Cell phone use causes nitric oxide (NO) nasal vasodilation (swelling inside nasal passage) on side of head phone use	Paredi, 2001
1.0 W/Kg	Increase in headache, fatigue and heating behind ear in cell phone users	Sandstrom, 2001
1.0 W/Kg	Significant increase in concentration difficulties using 1800 MHz cell phone compared to 900 MHz cell phone	Santini, 2001
1.0 W/Kg	Sleep patterns and brain wave activity are changed with 900 MHz cell phone radiation exposure during sleep	Borbely, 1999
1.4 W/Kg	GSM cell phone exposure induced heat shock protein HSP 70 by 360% (stress response) and phosphorylation of ELK-1 by 390%	Weisbrot, 2003
1.46 W/Kg	850 MHz cell phone radiation decreases sperm motility, viability is significantly decreased; increased oxidative damage (free-radicals) significantly decreased; increased oxidative damage (free-radicals)	Agarwal, 2009
1.48 W/Kg	A significant decrease in protein kinase C activity at 112 MHz with 2-hr per day for 35 days; hippocampus is site, consistent with reports that RFR negatively affects learning and memory functions	Paulraj, 2004
1.0 - 2.0 W/Kg	Significant elevation in micronuclei in peripheral blood cells at 2450 MHz (8 treatments of 2-hr each)	Trosic, 2002
1.5 W/Kg	GSM cell phone exposure affected gene expression levels in tumor suppressor p53-deficient embryonic stem cells; and significantly increased HSP 70 heat shock protein production	Czyz, 2004
1.8 W/Kg	Whole-body exposure to RF cell phone radiation of 900-1800 MHz 1 cm from head of rats caused high incidence of sperm cell death; deformation of sperm cells; prominent clumping together of sperm cells into "grass bundle shapes" that are unable to separate/swim. Sperm cells unable to swim and fertilize in normal manner.	Yan, 2007

Stress proteins, HSP, disrupted immune function	Brain tumors and blood-brain barrier
Reproduction/fertility effects	Sleep, neuron firing rate, EEG, memory, learning, behavior
Oxidative damage/ROS/DNA damage/DNA repair failure	Cancer (other than brain), cell proliferation
Disrupted calcium metabolism	Cardiac, heart muscle, blood-pressure, vascular effects

Reported Biological Effects from Radiofrequency Radiation at Low-Intensity Exposure
(Cell Tower, Wi-Fi, Wireless Laptop and 'Smart' Meter RF Intensities)

SAR (Watts/Kilogram)		Reference
2.0 W/Kg	GSM cell phone exposure of 1-hr activated heat shock protein HSP 27 (stress response) and P38 MAPK (mutagen-activated protein kinase) that authors say facilitates brain cancer and increased blood-brain barrier permeability, allowing toxins to cross BBB into brain	Leszczynski, 2002
2 W/Kg	900 MHz cell phone exposure caused brain cell oxidative damage by increasing levels of NO, MDA, XO and ADA in brain cells; caused statistically significant increase in 'dark neurons' or damaged brain cells in cortex, hippocampus and basal ganglia with a 1-hr exposure for 7 consecutive days	Ilhan, 2004
2.6 W/Kg	900 MHz cell phone exposure for 1-hr significantly altered protein expression levels in 38 proteins following irradiation; activates P38 MAP kinase stress signalling pathway and leads to changes in cell sie and shape (shrinking and rounding up) and to activation of HSP 27, a stress protein (heat shock protein)	Leszczynski, 2004
2.0 - 3.0 W/Kg	RFR accelerated development of both skin and breast tumors	Szmigielski, 1982
2 W/Kg	Pulse-modulated RFR and MF affect brain physiology (sleep study)	Schmidt, 2012

STANDARDS		
0.08 W/Kg	IEEE Standard uncontrolled public environment (whole body)	IEEE
0.4 W/Kg	IEEE Standard controlled occupational environment (whole body)	IEEE
1.6 W/Kg	FCC (IEEE) SAR limit for 1 gram of tissue in a partial body exposure	FCC, 1996
2 W/Kg	ICNIRP SAR limit for 10 grams of tissue	ICNIRP, 1996

Stress proteins, HSP, disrupted immune function	Brain tumors and blood-brain barrier
Reproduction/fertility effects	Sleep, neuron firing rate, EEG, memory, learning, behavior
Oxidative damage/ROS/DNA damage/DNA repair failure	Cancer (other than brain), cell proliferation
Disrupted calcium metabolism	Cardiac, heart muscle, blood-pressure, vascular effects



SECTION 2

Statement of the Problem

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Prepared for the BioInitiative Working Group

August 2007

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STATEMENT OF THE PROBLEM

Background and Objectives

This Report is the product of an international research and public policy initiative to document what is known of biological effects that occur at low-intensity EMF exposures (for both radiofrequency radiation RF and power-frequency ELF, and various forms of combined exposures that are now known to be bioactive). The Report has been written to document the reasons why current public exposure standards for non-ionizing electromagnetic radiation are no longer good enough to protect public health.

A working group composed of scientists, researchers and public health policy professionals (The BioInitiative Working Group) has joined together to document the information that must be considered in the international debate about the adequacy (or inadequacy) of existing public exposure standards.

Recognizing that other bodies in the United States, United Kingdom, Australia, many European Union and eastern European countries as well as the World Health Organization are actively debating this topic, the BioInitiative Working Group has conducted a independent science and public health policy review process.

Objectives

1) To establish a working group

2) To evaluate literature reviews for IEEE (2006) and WHO (2007) initiatives on standards that have resulted in (or continue to recommend) no change in thermally-based public exposure limits.

3) To identify systematic screening-out techniques that consequently under-report, omit or overlook results of scientific studies reporting low-intensity bioeffects and/or potential health effects.

4) To document key scientific studies and reviews that identify low-intensity effects for which any new human exposure standards should provide safety limits.

5) To document key "chains of evidence" that must be taken into account in new human exposure standards (melatonin and free-radical production effects on DNA damage and/or repair; stress protein induction at low-intensity levels; etc.)

6) To write a rationale for a biologically-based human exposure standard,

7) To identify "next steps" in advancing biologically-based exposure standards that are protective of public health; that are derived in traditional public health approaches.

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Eleven (11) chapters documenting key scientific studies and reviews that identify low-intensity effects of electromagnetic fields have been produced by the members of the BioInitiative Working Group; four additional chapters are provided that discuss public health considerations, how the scientific information should be evaluated in the context of prudent public health policy, and discussing the basis for taking precautionary and preventative actions that are proportionate to the knowledge at hand. Other scientific review bodies and agencies have reached different conclusions by adopting standards of evidence so unreasonably high as to exclude any finding of scientific concern, and thus justify retaining outdated thermal standards. The clear consensus of the BioInitiative Working Group members is that the existing public safety limits are inadequate. New approaches to development of public safety standards are needed based on biologically-based effects, rather than based solely on RF heating (or induced currents in the case of ELF). The Report concludes with recommended actions that are proportionate to the evidence and in accord with prudent public health policy.

The Report also presents information about what level of scientific evidence is sufficient to make changes now. It addresses the questions:

- What is "proof"? Do we need proof before we take any action? Is an unreasonably high and overly-restrictive definition of "proof" what is keeping some governments from facing the evidence that the need for new public exposure limits is demonstrated?
- What is sufficient evidence? How much evidence is needed? Do we have it yet?
- Do scientists and public health experts differ on when action is warranted? If so, how?
- What is the prudent course of action when the consequence of doing nothing is likely to have serious global consequences on public health, confidence in governments and social/economic resources?
- What are the costs of guessing wrong and under-reacting? Or, of over-reacting?
- Whose opinions should count in the process of deciding about health risks and harm?
- Is the global, governmental process addressing these questions transparent and responsive to public concerns? Or, is it a cosmetic process giving the illusion of transparency and democratic participation? Are some countries ostracized for views and actions that are more protective of public health? How can we equitably decide on the appropriate level of public protection within each country, when it is obvious that some countries would be best off spending their time and money on basic medical needs and infrastructure improvements to save lives, when others need to look at prevailing disease endpoints relevant to their populations, and wish to act accordingly?

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- How has the effort for global harmonization of ELF and RF exposure standards thwarted the efforts of individual countries to read, reason and choose?
- How much control have special interests exerted over harmonization goals and safety standards? How much over scientific funding, research design, dissemination of research results and media control? Are the interests of the public being conserved?
- What actions are proportionate to the knowledge we now have? What is preventative action and how does it differ from precautionary action?

It describes what the existing exposure standards are, and how some international governmental bodies are standing by the old exposure standards despite evidence that change is needed.

A good way to compare what kind of actions should be taken now is to look at what has been done with other environmental toxicants. It is well-established that public health decision-makers should act before it is too late to prevent damage that can reasonably be expected now; especially where the harm may be serious and widespread. Some actions that can prevent future harm are identified. The basis for taking action now rather than later is explained. This report can serve as a basis for arguing the scientific and public health policy reasons that changes are needed. It documents information for decision-makers and the public who want to understand what is already known biological effects occuring at low-intensity exposures; and why it is reasonable to expect our governmental agencies to develop new, biologically-based exposure standards that protect the public.

Problems with Existing Public Health Standards (Safety Limits)

Today's public exposure limits are based on the presumption that heating is the only concern when living organisms are exposed to RF and ELF. These exposures can create tissue heating that is well known to be harmful in even very short-term doses. As such, thermal limits do serve a purpose. For example, for people whose occupations require them to work around electrical power lines or heat-sealers, or for people who install and service wireless antenna towers; thermally-based limits are necessary to prevent damage from heating (or, in the case of ELF - from induced currents in tissues). In the past, scientists and engineers developed exposure standards for electromagnetic radiation based what we now believe are faulty assumptions that the right way to measure how much non-ionizing energy humans can tolerate (how much exposure) without harm is to measure only the heating of tissue (for – induced currents in the body). In the last few decades, it has been established beyond any reasonable doubt that bioeffects and some adverse health effects occur at far lower levels of RF and exposure where no heating occurs at all; some effects are shown to occur at several hundred thousand times below the existing public safety limits

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where heating is an impossibility. Effects occur at non-thermal or low-intensity exposure levels far below the levels that federal agencies say should keep the public safe. For many new devices operating with wireless technologies, the devices are exempt from any regulatory standards. The existing standards have been proven to be inadequate to control against harm from low-intensity, chronic exposures, based on any reasonable, independent assessment of the scientific literature. It means that an entirely new basis (a biological basis) for new exposure standards is needed. New standards need to take into account what we have learned about the effects of non-ionizing electromagnetic fields and to design new limits based on biologically-demonstrated effects that are important to proper biological function in living organisms. It is vital to do so because the explosion of new sources has created unprecedented levels of artificial electromagnetic fields that now cover all but remote areas of the habitable space on earth. Mid-course corrections are needed in the way we accept, test and deploy new technologies that expose us to ELF and RF in order to avert public health problems of a global nature.

At least three decades of scientific study and observation of effects on humans and animals shows that non-thermal exposure levels can result in biologically-relevant effects. There should be no effects occurring at all. Yet, clearly they do occur. This means the standards for protecting public health are based on the wrong premise - that only what heats tissue can result in harm. It does appear that it is the INFORMATION conveyed by electromagnetic radiation, rather than the heat, which causes biological changes, some of which may lead to unwellness, illness and even death, According to Adey (2004):

> *"There are major unanswered questions about possible health risks that may arise from human exposures to various man-made electromagnetic fields where these exposures are intermittent, recurrent, and may extend over a significant portion of the lifetime of an individual. Current equilibrium thermodynamic models fail to explain an impressive spectrum of observed bioeffects at non-thermal exposure levels."*

Recent opinions by experts have documented deficiencies in current exposure standards. There is widespread discussion that thermal limits are outdated, and that biologically-based exposure standards are needed. Section 4 describes concerns expressed by WHO, 2007 in its Health Criteria Monograph; the SCENIHR Report, 2006 prepared for the European Commission; the UK SAGE Report, 2007; the Health Protection Agency, United Kingdom in 2005; the NATO Advanced Research Workshop in 2005; the US Radiofrequency Interagency Working Group in 1999; the US Food and Drug Administration in 2000 and 2007; the World Health Organization in 2002; the World Health Organization International Agency for Cancer Research (IARC, 2001), the United Kingdom Parliament Independent Expert Group Report (Stewart Report, 2000) and others.

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A pioneer researcher, the late Dr. Ross Adey, in his last publication in Bioelectromagnetic Medicine (P. Roche and M. Markov, eds. 2004) concluded:

> *"There are major unanswered questions about possible health risks that may arise from exposures to various man-made electromagnetic fields where these human exposures are intermittent, recurrent, and may extend over a significant portion of the lifetime of the individual."*[1]
>
> *"Epidemiological studies have evaluated and radiofrequency fields as possible risk factors for human health, with historical evidence relating rising risks of such factors as progressive rural electrification, and more recently, to methods of electrical power distribution and utilization in commercial buildings. Appropriate models describing these bioeffects are based in nonequilibrium thermodynamics, with nonlinear electrodynamics as an integral feature. Heating models, based in equilibrium thermodynamics, fail to explain an impressive new frontier of much greater significance. ..... Though incompletely understood, tissue free radical interactions with magnetic fields may extend to zero field levels. (Adey, 2004)*

References

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SECTION 3

The Existing Public Exposure Standards

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The US Federal Communications Commission (FCC) Exposure Standard Recommendations

In the United States, the Federal Communications Commission (FCC) enforces limits for both occupational exposures (in the workplace) and public exposures. The exposure limits are variable according to the frequency (in megahertz) and the duration of exposure time (6 minutes for occupational and 30 minutes for public exposures). Table 3.1 show exposure limits for occupational and uncontrolled public access to radiofrequency radiation such as is emitted from AM, FM, television and wireless sources through the air. As an example, 583 microwatts/cm2 (μW/cm2) is the public limit for the 875 MHz cell phone wireless frequency and 1000 μW/cm2 is the limit for PCS frequencies in the 1800 – 1950 MHz range averaged over 30 minutes. The limits in Table 3.1 would pertain to exposures in the vicinity of transmitting antennas (not devices like cell phones, for which exposure limits are shown in Table 3.2).

The FCC is required by the National Environmental Policy Act of 1969 to evaluate the effect of emissions from FCC-regulated transmitters on the quality of the human environment. At the present time there is no federally-mandated radio frequency (RF) exposure standard. However, several non-government organizations, such as the American National Standards Institute (ANSI), the Institute of Electrical and Electronics Engineers, Inc. (IEEE), and the National Council on Radiation Protection and Measurements (NCRP) have issued recommendations for human exposure to RF electromagnetic fields. The FCC has endorsed these recommendations, and enforces compliance. http://www.fcc.gov/oet/rfsafety/

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Table 3.1 FCC LIMITS FOR MAXIMUM PERMISSIBLE EXPOSURE (MPE)

(A) Limits for Occupational/Controlled Exposure

Frequency Range (MHz)	Electric Field Strength (E) (V/m)	Magnetic Field Strength (H) (A/m)	Power Density (S) (mW/cm2)	Averaging Time $[E]^2$ $[H]^2$ or S (minutes)
0.3-3.0	614	1.63	(100)*	6
3.0-30	1842/f	4.89/f	$(900/f_2)$*	6
30-300	61.4	0.163	1.0	6
300-1500			f/300	6
1500-100,000		5		6

(B) FCC Limits for General Population/Uncontrolled Exposure

Frequency Range (MHz)	Electric Field Strength (E) (V/m)	Magnetic Field Strength (H) (A/m)	Power Density (S) (mW/cm2)	Averaging Time $[E]^2$ $[H]^2$ or S (minutes)
0.3-3.0	614	1.63	(100)*	30
3.0-30	824/f	2.19/f	$(180/f_2)$*	30
30-300	27.5	0.073	0.2	30
300-1500	--	--	f/1500	30
1500-100,000	--	--	1.0	30

f = frequency in MHz

*Plane-wave equivalent power density

NOTE 1: ***Occupational/controlled*** limits apply in situations in which persons are exposed as a consequence of their employment provided those persons are fully aware of the potential for exposure and can exercise control over their exposure. Limits for occupational/controlled exposure also apply in situations when an individual is transient through a location where occupational/controlled limits apply provided he or she is made aware of the potential for exposure.

NOTE 2: ***General population/uncontrolled*** exposures apply in situations in which the general public may be exposed, or in which persons that are exposed as a consequence of their employment may not be fully aware of the potential for exposure or can not exercise control over their exposure.

Source: OET, 1997.

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FCC Guidelines for Cell and PCS Phones (and other radiofrequency emitting devices)

Cell phones and portable transmitting devices that operate in the Cellular Radiotelephone Service, the Personal Communications Services (PCS), the Satellite Communications Services, the Maritime Services (ship earth stations only) and the Specialized Mobile Radio (SMR) Service are subject to routine environmental (not health) evaluation for RF exposure prior to equipment authorization or use by the FCC. Section 2.1093 of the FCC's Rules (47 CFR §2.1093) that apply to "portable" devices. For purposes of these requirements a portable device is defined as a transmitting device designed to be used so that the radiating structure(s) of the device is/are within 20 centimeters of the body of the user (OET, 1997).

Cell phones and some other wireless communication devices are regulated by the FCC according to their emissions, which depend on the amount of power absorbed into the body. The metric for measurement is specific absorption rate (SAR) and is expressed in watts per kilogram of tissue. The limit for absorption of radiofrequency radiation is limited to 1.6 W/kG within 1 gram of human tissue. This limit has been recommended for change (relaxation) by the IEEE in April of 2006. If adopted by the FCC, this amount of heat or 1.6 W/Kg would be measured over 10 times as much tissue (10 grams) so that far higher heating is possible from these devices over small amounts of tissue (would be far less strict that the current limit, if adopted). More cell phone and related PDA devices would then comply be able with the looser standard, and the public could potentially receive much higher radiofrequency radiation exposures, and it would be in compliance (legal).

"The SAR criteria to be used are specified below and apply for portable devices transmitting in the frequency range from 100 kHz to 6 GHz. The limits used for evaluation are based generally on criteria published by the Institute of Electrical and Electronics Engineers, Inc., (IEEE) for localized specific absorption rate ("SAR") in Section 4.2 of "IEEE Standard for Safety Levels with Respect to Human Exposure to Radio Frequency Electromagnetic Fields, 3 kHz to 300 GHz," ANSI/IEEE C95.1-1992.

These criteria for SAR evaluation are similar to those recommended by the National Council on Radiation Protection and Measurements (NCRP) in "Biological Effects and Exposure Criteria for Radiofrequency Electromagnetic Fields," NCRP Report No. 86, Section 17.4.5. Copyright NCRP, 1986, Bethesda, Maryland 20814."

(1) FCC Limits for Occupational/Controlled exposure: 0.4 W/kg as averaged over the whole-body and spatial peak SAR not exceeding 8 W/kg as averaged over any 1 gram of tissue (defined as a tissue volume in the shape of a cube). Exceptions are the hands, wrists, feet and ankles where the spatial peak SAR shall not exceed 20 W/kg, as averaged over any 10 grams of tissue (defined as a tissue volume in the shape of a cube). Occupational/Controlled limits apply when persons are exposed as a consequence of their

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employment provided these persons are fully aware of and exercise control over their exposure. Awareness of exposure can be accomplished by use of warning labels or by specific training or education through appropriate means, such as an RF safety program in a work environment (OET, 1997).

(2) FCC Limits for General Population/Uncontrolled exposure: 0.08 W/kg as averaged over the whole-body and spatial peak SAR not exceeding 1.6 W/kg as averaged over any 1 gram of tissue (defined as a tissue volume in the shape of a cube). Exceptions are the hands, wrists, feet and ankles where the spatial peak SAR shall not exceed 4 W/kg, as averaged over any 10 grams of tissue (defined as a tissue volume in the shape of a cube). General Population/Uncontrolled limits apply when the general public may be exposed, or when persons that are exposed as a consequence of their employment may not be fully aware of the potential for exposure or do not exercise control over their exposure. Warning labels placed on consumer devices such as cellular telephones will not be sufficient reason to allow these devices to be evaluated subject to limits for occupational/controlled exposure (OET, 1997).

In the United States, two professional societies - the Institute of Electrical and Electronics Engineers, Inc. (IEEE) and the National Council for Radiation Protection and Measurements (NCRP) develop recommendations for safety standards. . The IEEE charter calls itself the world's leading professional association for the advancement of technology, as well as the instigator of public safety standards. The IEEE recommendations have historically been endorsed by the American National Standards Institute (ANSI) and finally considered by the FCC for implementation. The US Federal Communications Commission (FCC) may then take the recommendations and adopt them as mandatory exposure limits. Several standard-setting processes have occurred like this in the last few decades.

The most recent IEEE recommendations for 3 kHz to 300 GHz were developed in 2006 (IEEE, 2006). Rather than lower the existing limits for radiofrequency and microwave radiation exposure, they greatly increase the exposure limits. This is perplexing since it ignores or discounts a large body of scientific evidence clearly documenting biologically-relevant changes at levels LOWER (much lower) than the existing standards.

ICNIRP Guidelines (International Radiofrequency Guidelines)

In April 1998, the International Commission on Non-Ionizing Radiation Protection (ICNIRP) published guidelines for limiting exposure to time-varying electric, magnetic and electromagnetic fields in the frequency range up to 300 GHz.. These guidelines replaced previous advice issued in 1988 and 1990. The main objective of the ICNIRP Guidelines is to establish guidelines for limiting EMF exposure that will provide protection against known adverse health effects (ICNIRP, 1998). An adverse health effect is defined by ICNIRP as one which causes detectable impairment of the health of the exposed individual or of his or her offspring; a biological effect, on the other hand, may or may not result in an adverse health effect.

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The guidelines presented in Table 3.2 apply to occupational and public exposure.

Table 3.2 ICNIRP Basic restrictions for time varying electric and magnetic fields for frequencies up to 10 GHz.

Exposure characteristics	Frequency range	Current density for head and trunk (mA m_{-2})(rms)	Whole-body average SAR (W kg_{-1})	Localized SAR (head and trunk) (W kg_{-1})	Localized SAR (limbs) (W kg_{-1})
Occupational exposure	up to 1 Hz	40	—	—	—
	1–4 Hz	40/*f*	—	—	—
	4 Hz–1 kHz	10	—	—	—
	1–100 kHz	*f*/100	—	—	—
	100 kHz–10 MHz	*f*/100	0.4	10	20
	10 MHz–10 GHz		0.4	10	20
General public exposure	up to 1 Hz	8	—	—	—
	1–4 Hz	8/*f*	—	—	—
	4 Hz–1 kHz	2	—	—	—
	1–100 kHz	*f*/500	—	—	—
	100 kHz–10 MHz	*f*/500	0.08	2	4
	10 MHz–10 GHz		0.08	2	4

Notes:

1. *f* is the frequency in hertz.
2. Because of electrical inhomogeneity of the body, current densities should be averaged over a cross-section of 1 cm^2 perpendicular to the current direction.
3. For frequencies up to 100 kHz, peak current density values can be obtained by multiplying the rms value by %2 (~1.414). For pulses of duration t_p the equivalent frequency to apply in the basic restrictions should be calculated as $f = 1/(2t_p)$. For frequencies up to 100 kHz and for pulsed magnetic fields, the maximum current density associated with the pulses can be calculated from the rise/fall times and the maximum rate of change of magnetic flux density. The induced current density can then be compared with the appropriate basic restriction.
4. All SAR values are to be averaged over any 6-minute period.
5. Localized SAR averaging mass is any 10 g of contiguous tissue; the maximum SAR so obtained should be the value used for the estimation of exposure.
6. For pulses of duration t_p the equivalent frequency to apply in the basic restrictions should be calculated as $f = 1/(2t_p)$. Additionally, for pulsed exposures, in the frequency range 0.3 to 10 GHz and for localized exposure of the head, in order to limit or avoid auditory effects caused by thermoelastic expansion, an additional basic restriction is recommended. This is that the SA should not exceed 10 mJ kg^{-1} for workers and 2 mJ kg^{-1} for the general public averaged over 10 g tissue.

In the frequency range from a few Hz to 1 kHz, for levels of induced current density above 100 mA m^{-2}, the thresholds for acute changes in central nervous system excitability and other acute effects such as reversal of the visually evoked potential are exceeded. In view of the safety considerations above, it was decided that, for frequencies in the range 4 Hz to 1 kHz, occupational exposure should be limited to fields that induce current densities less than 10 mA m^{-2}, i.e., to use a safety factor of 10. For the general public an additional factor of 5 is applied, giving a basic exposure restriction of 2 mA m^{-2}. Below 4 Hz and above 1 kHz, the basic restriction on induced current density increases progressively.

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ICNRP maintains that guidelines for limiting exposure have been developed following a thorough review of all published scientific literature (ICNIRP, 1998).

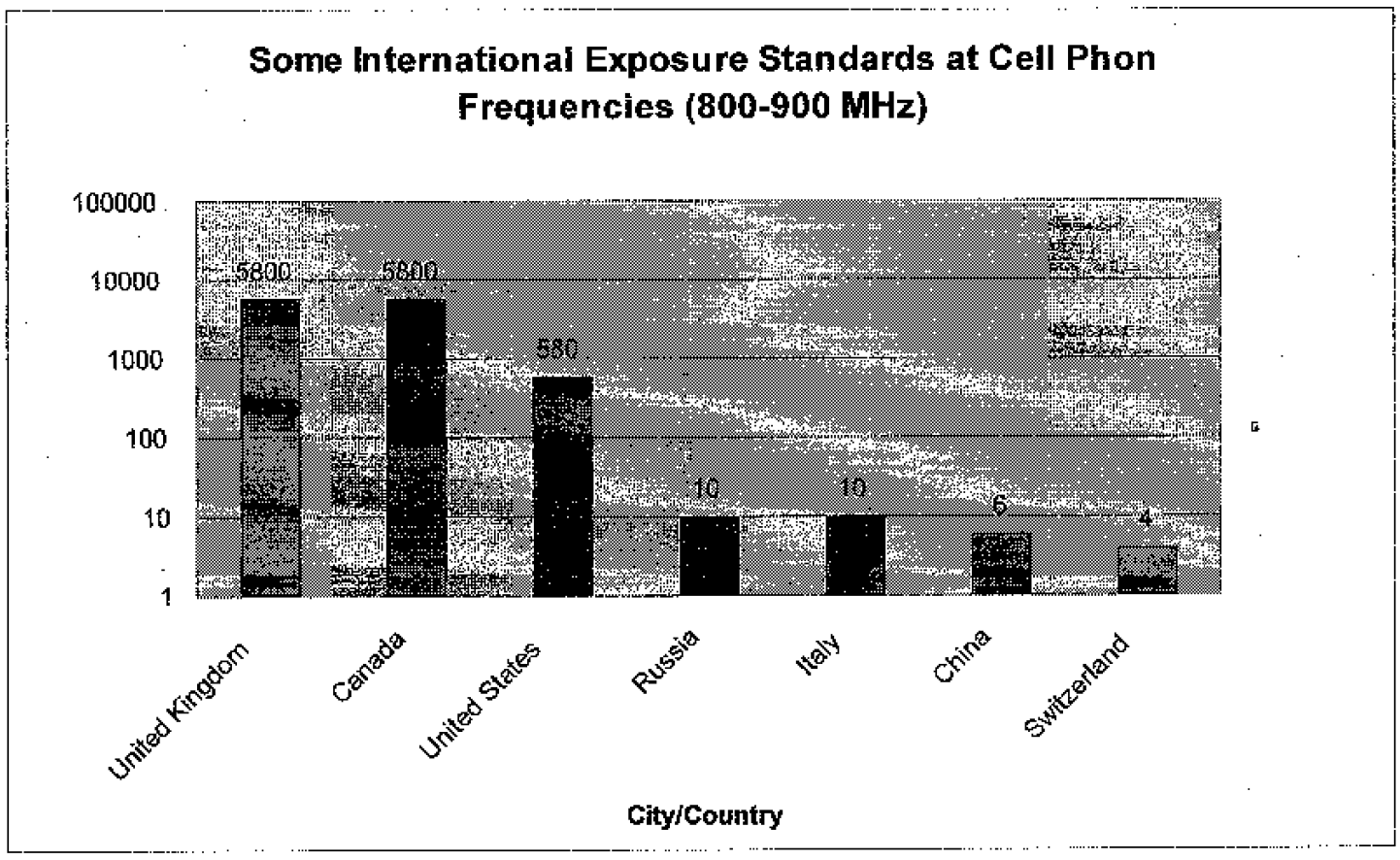
"The criteria applied in the course of the review were designed to evaluate the credibility of the various reported findings (Repacholi and Stolwijk 1991; Repacholi and Cardis 1997); only established effects were used as the basis for the proposed exposure restrictions. Induction of cancer from long-term EMF exposure was not considered to be established, and so these guidelines are based on short-term, immediate health effects such as stimulation of peripheral nerves and muscles, shocks and burns caused by touching conducting objects, and elevated tissue temperatures resulting from absorption of energy during exposure to EMF. In the case of potential long-term effects of exposure, such as an increased risk of cancer, ICNIRP concluded that available data are insufficient to provide a basis for setting exposure restrictions, although epidemiological research has provided suggestive, but unconvincing, evidence of an association between possible carcinogenic effects and exposure at levels of 50/60 Hz magnetic flux densities substantially lower than those recommended in these guidelines. In-vitro effects of short-term exposure to ELF or ELF amplitude-modulated EMF are summarized. Transient cellular and tissue responses to EMF exposure have been observed, but with no clear exposure–response relationship. These studies are of limited value in the assessment of health effects because many of the responses have not been demonstrated in vivo. Thus, in-vitro studies alone were not deemed to provide data that could serve as a primary basis for assessing possible health effects of EMF. " (ICNIRP, 1998) http://www.icnirp.de

Guidelines and Limits (Other Countries)

On the other hand, some countries in the world have established new, low-intensity based exposure standards that respond to studies reporting effects that do not rely on heating. Consequently, new exposure guidelines are hundreds or thousands of times lower than those of IEEE and ICNIRP. Table 3.3 shows some of the countries that have lowered their limits, for example, in the cell phone frequency range of 800 MHz to 900 MHz. The levels range from 10 microwatts per centimeter squared in Italy and Russia to 4.2 microwatts per centimeter squared in Switzerland. In comparison, the United States and Canada limit such exposures to only 580 microwatts per centimeter squared (at 870 MHz) and then averaged over a time period (meaning that higher exposures are allowed for shorter times, but over a 30 minute period, the average must be 580 microwatts per centimeter squared or less at this frequency). The United Kingdom allows one hundred times this level, or 5800 microwatts per centimeter squared. Higher frequencies have higher safety limits, so that at 1000 MHz, for example, the limit is 1000 microwatts per centimeter squared (in the United States). Each individual frequency in the radiofrequency radiation range needs to be calculated. These are presented as reference points only. Emerging scientific evidence has encouraged some countries to respond by adopting planning targets, or interim action levels that are responsive to low-intensity or non-thermal radiofrequency radiation bioeffects and health impacts.

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Table 3.3 Some International Exposure Standards at Cell Phone Frequencies



Professional bodies from technical societies like IEEE and ICNIRP continue to support "thermal-only" guidelines routinely defend doing so a) by omitting or ignoring study results reporting bioeffects and adverse impacts to health and wellbeing from a very large body of peer-reviewed, published science because it is not yet "proof" according to their definitions; b) by defining the proof of "adverse effects" at an impossibly high a bar (scientific proof or causal evidence) so as to freeze action; c) by requiring a conclusive demonstration of both "adverse effect" and risk before admitting low-intensity effects should be taken into account; e) by ignoring low-intensity studies that report bioeffects and health impacts due to modulation; f) by conducting scientific reviews with panels heavily burdened with industry experts and under-represented by public health experts and independent scientists with relevant low-intensity research experience; g) by limiting public participation in standard-setting deliberations; and other techniques that maintain the status quo.

Much of the criticism of the existing standard-setting bodies comes because their contributions are perceived as industry-friendly (more aligned with technology investment and dissemination of new technologies) rather than public health oriented. The view of the Chair of the latest IEEE standard-setting ICES Eleanor Adair is made clear by Osepchuk and Petersen (2003) who write in the abstract of their paper "*her goal and the goal of ICES is to establish rational standards that will make future beneficial applications of RF energy credible to humanity.*" Authors Osepchuk and Petersen note that *"(I)t is important that safety standards be rational and avoid excessive safety margins."* The authors specifically dismiss the body of evidence for low-intensity effects with *"(A)lthough the literature reporting "athermal" bioeffects of exposure to*

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microwave/RF energy (other than electrostimulation) is included in the review process, it has been found to be inconsistent and not useful for purposes of standard-setting."

This report addresses the substantial body of evidence reporting low-intensity effects from electromagnetic fields (both power-frequency fields in the ELF range, and radiofrequency/microwave fields at exposure levels that do not involve any heating. It also addresses the inconsistency in the literature quoted as the basis for retaining thermal-only exposure standards (see particularly the Genotoxics Section 6 where half of more of the published papers report negative effects and half positive effects).

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SECTION 25

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SECTION 26

Glossary of Terms and Abbreviations

Prepared for the BioInitiative Working Group

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Absorption. In radio wave propagation, attenuation of a radio wave due to dissipation of its energy, i.e., conversion of its energy into another form, such as heat.

Athermal effect. Any effect of electromagnetic energy on a body that is not a heat-related effect.

Blood–brain barrier. A functional concept developed to explain why many substances that are transported by blood readily enter other tissues but do not enter the brain; the "barrier" functions as if it were a continuous membrane lining the vasculature of the brain. These brain capillary endothelial cells form a nearly continuous barrier to entry of substances into the brain from the vasculature.

Conductance. The reciprocal of resistance. Expressed in siemens (S).

Conductivity: A property of materials that determines the magnitude of the electric current density when an electric field is impressed on the material.

Continuous wave. A wave whose successive oscillations are identical under steady-state conditions.

Current density. A vector of which the integral over a given surface is equal to the current flowing through the surface; the mean density in a linear conductor is equal to the current divided by the cross-sectional area of the conductor. Expressed in ampere per square metre (A m^{-2}).

Depth of penetration. For a plane wave electromagnetic field (EMF), incident on the boundary of a good conductor, depth of penetration of the wave is the depth at which the field strength of the wave has been reduced to 1/e, or to approximately 37% of its original value.

Dielectric properties: In the context of this document the properties of materials conductivity and permeability.

Dosimetry. Measurement, or determination by calculation, of internal electric field strength or induced current density, of the specific energy absorption, or specific energy absorption rate distribution, in humans or animals exposed to electromagnetic fields.

Electric field strength. The force (**E**) on a stationary unit positive charge at a point in an electric field; measured in volt per metre (V m^{-1}).

Electrosensitivity (Electrohypersensitivity): A working definition of EHS from Bergqvist et al. (1997) is "a phenomenon where individuals experience adverse health effects while using or being in the vicinity of devices emanating electric, magnetic or electromagnetic fields (EMFs)".

Electromagnetic energy. The energy stored in an electromagnetic field. Expressed in joule (J).

Electric field strength (E): The magnitude of a field vector at a point that represents the force (F) on a charge (q). E is defined as E = F/q and is expressed in units of Volt per meter (V/m).

EBL

Electromagnetic field: Electromagnetic phenomena expressed in vector functions of space and time.

Electromagnetic radiation: The propagation of energy in the form of electromagnetic waves through space.

EMF. Electric, magnetic, and electromagnetic fields.

Exposure: Exposure occurs wherever a person is subjected to electric, magnetic or electromagnetic fields or contact currents other than those originating from physiological processes in the body.

Extra low frequency (ELF): Extra low frequency fields include, in this document, electromagnetic fields from 1 to 300 Hz. Alternately, **ELF-** Extremely low frequency where the European convention is extremely low frequncy, US is extra-low frequency.

Frequency modulation (FM): Frequency Modulation is a type of modulation representing information as variations in the frequency of a carrier wave. FM is often used at VHF frequencies (30 to 300 MHz) for broadcasting music and speech.

Far field. The region where the distance from a radiating antenna exceeds the wavelength of the radiated EMF; in the far-field, field components (**E** and **H**) and the direction of propagation are mutually perpendicular, and the shape of the field pattern is independent of the distance from the source at which it is taken.

Frequency. The number of sinusoidal cycles completed by electromagnetic waves in 1 second; usually expressed in hertz (Hz).

Impedance, wave. The ratio of the complex number (vector) representing the transverse electric field at a point to that representing the transverse magnetic field at that point. Expressed in ohm (S).

Magnetic flux density (B): The magnitude of a field vector at a point that results in a force (F) on a charge (q) moving with the velocity (v). The force F is defined by $F = q*(v \times B)$ and is expressed in units of Tesla (T).

Magnetic field strength (H): The magnitude of a field vector that is equal to the magnetic flux density (B) divided by the permeability (μ) of the medium. H is defined as $H = B/\mu$ and is expressed in units of Ampere per metre (A/m).

Magnetic permeability. The scalar or vector quantity which, when multiplied by the magnetic field strength, yields magnetic flux density; expressed in henry per metre ($H\ m^{-1}$). *Note:* For isotropic media, magnetic permeability is a scalar; for anisotropic media, it is a tensor quantity.

Microwaves: Microwaves are defined in the frame of this expertise as electromagnetic waves with wavelengths of approximately 30 cm (1 GHz) to 1 mm (300 GHz).

EBZ

Milligauss (mG): A milligauss is a measure of ELF intensity and is abbreviated mG. This is used to describe electromagnetic fields from appliances, power lines, interior electrical wiring.

Milliwatt (mW): A unit of power equal to 10^{-3}.

Microwatt (uW): A unit of power equal to 10^{-6}

Microwatts per centimeter squared (µW/cm2)

Radiofrequency radiation in terms of power density is measured in microwatts per centimeter squared and abbreviated (µW/cm2). It is used when talking about emissions from wireless facilities, and when describing ambient RF in the environment. The amount of allowable RF near a cell tower is 1000 µW/cm2 for some cell phone frequencies, for example.

Nanowatt (nW): A unit of power equal to 10^{-9} Watt.

Non – thermal effects (or athermal effects): An effect which can only be explained in terms of mechanisms other than increased molecular motion (i.e. heating), or occurs at absorbed power levels so low, that a thermal mechanism seems unlikely, or displays so unexpected a dependence upon some experimental variable that it is difficult to see how heating could be the cause.

Near field. The region where the distance from a radiating antenna is less than the wavelength of the radiated EMF. *Note:* The magnetic field strength (multiplied by the impedance of space) and the electric field strength are unequal and, at distances less than one-tenth of a wavelength from an antenna, vary inversely as the square or cube of the distance if the antenna is small compared with this distance. Near field exposures are unreliable for estimation of exposures by calculation. The can zero out or be additive and nearly infinite, thus creating problems for exposure assessment.

Non-ionizing electromagnetic radiation (NIER). Includes all radiations and fields of the electromagnetic spectrum that do not normally have sufficient energy to produce ionization in matter; characterized by energy per photon less than about 12 eV, wavelengths greater than 100 nm, and frequencies lower than 3×10^{15} Hz.

Occupational exposure. All exposure to EMF experienced by individuals in the course of performing their work. Safety limits are five times higher for allowable occupational exposures than for general public exposures in the US.

Permeability (µ): A property of materials that indicates how much polarisation occurs when an electric field is applied.

Permittivity. A constant defining the influence of an isotropic medium on the forces of attraction or repulsion between electrified bodies, and expressed in farad per metre ($F\ m^{-1}$); *relative permittivity* is the permittivity of a material or medium divided by the permittivity of vacuum.

EBJ

Public Exposure. All exposure to EMF experienced by the general public excluding exposure during medical procedures and occupational work environments. Public exposure limits in the US are five times lower than for occupational exposures, where informed consent by employees is required.

Power Density. The power as measured in free space (ambient) as opposed to measured by SAR or specific absorption rate (within tissues or the body). The unit of measurement can be watts per square meter, milliwatts per square meter or microwatts per centimeter squared. Radiofrequency (RF). Any frequency at which electromagnetic radiation is useful for telecommunications, or broadcasting for radio and television. Frequency range is usually defined as 300 Hz (300 hertz) to 300 GHz (300 gigahertz).

Radiofrequency (RF): The frequencies between 100 kHz and 300 GHz of the electromagnetic spectrum.

Reasonance. The change in amplitude occurring as the frequency of the wave approaches or coincides with a natural frequency of the medium; whole body absorption of electromagnetic waves presents its highest value, i.e., the reasonance. for frequencies (in MHz or megahertz) corresponding to approximately 114/L where L is the height of the individual in meters. Reasonance can also be applicable to organs, tissues, or other body parts.

Specific Absorption Rate (SAR is measured in watts per kilogram or W/Kg)
SAR stands for specific absorption rate. It is a calculation of how much RF energy is absorbed into the body, for example when a cell phone or cordless phone is pressed to the head. SAR is expressed in watts per kilogram of tissue (W/Kg). The amount of allowable energy into 1 gram of brain tissue from a cell phone is 1.6 W/Kg in the US. For whole body exposure, the exposure is 0.8 W/Kg averaged over 30 minutes for the general public. International standards in most countries are similar, but not exactly the same.

Static electric field: Static fields produced by fixed potential differences.

Static magnetic fields: Static fields established by permanent magnets and by steady currents.

VDU: Video display units for computers, videos, TV and some measurement devices using cathode ray tubes

WI-FI: Stands for wireless fidelity. WI-FI systems create zones of wireless RF that allow access to wireless internet for computers, internet phone access and other wireless services. Access points that provide WI-FI to access Land Area Networks (LANs) can be installed on streets (for city-wide coverage) or indoors in buildings, Restaurants, hotels, coffee shops, airports, malls and other commercial enterprises are widely installing WI-FI. The range of typical WI-FI systems is about 300 feet.

WI-MAX: Stands for "Wireless interoperability for Microwave Access" and is a telecommunications technology aimed at providing wireless data over long distances. Like WI-FI, WI-MAX systems are designed to provide wireless access but over much broader geographic areas, with some systems transmitting signal up to 10 miles. Higher levels of RF are produced at the wireless transmission facilities than for WI-FI.s

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Section 20 LIST OF ABBREVIATIONS

µT	microtesla
µW	microwatt
AC	Alternating current
ALS	Amyotrophic Lateral Sclerosis
AM	Amplitude modulation
B	Magnetic flux density
BBB	Blood-Brain-Barrier
CENELEC	European Committee for Electrotechnical Standardization
CI	Confidence Interval
CNS	Central Nervous System
CW	Continuous wave
DC	Direct current
DECT	Digital Enhanced Cordless Telephone
DMBA	7,12-dimethylbenz[a]anthracene
DNA	Deoxyribonucleic acid
EEG	Electroencephalogram
EHS	Electromagnetic hypersensitivity
ELF	Extra low frequency (also ELF-EMF)
EMF	Electromagnetic field
FM	Frequency Modulation
GSM	Global System for Mobile Communication
H	Magnetic field strength
HSP	Heat-shock proteins (stress proteins)
Hz	Frequency in Hertz
IARC	International Agency for Research on Cancer
IL	Interleukin
kg	Kilogram
kHz	Kilohertz
kV	Kilovolt
MF	Magnetic Field (sometimes MF-ELF)
MHz	Megahertz
ms	Milliseconds
mT	Millitesla
mG	Milligauss
mW	Milliwatt
nT	Nanotesla

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nW Nanowatt

NRPB National Radiation Protection Board (HPA)

OR Odds Ratio (measure of increased risk of disease)

REFLEX European Research Program for Radiofrequency Hazards

RF Radiofrequency Radiation (also written as RFR or RF-EMF)

SCENIHR Scientific Committee on Emerging and Newly Identified Health Risks

TNO Nederlandse Onderzoek (Netherlands Organisation Applied Scientific Research

UMTS Universal Mobile Telephony System **UNEP** United Nations Environmental

VDT Video display terminal (VDU – for computers, videos, TV, that use cathode ray tubes).

Wi-Fi Short for wireless fidelity – wireless internet access - works for short- distances for cell phone and laptop computer access without wires.

WLAN Wireless Local Area Network (wireless internet coverage usually up to 300' provided by access points that create elevated radiofrequency radiation for that service zone.

WiMAX Worldwide Interoperability for Microwave Access (wireless service up to 10 miles in comparison to Wi-Fi that may serve 300' area)

WHO World Health Organisation

FCC The Federal Communications Commission (FCC) is an independent United States government agency, created, directed, and empowered by Congressional statute to oversee the regulation of radio and TV broadcasting and wireless technologies. It is not a health agency.

HPA Health Protection Agency (UK) that was formerly the National Radiation Protection Division Board). The Health Protection Agency (HPA) is an independent body that protects the health and well-being of the population. The Agency plays a critical role in protecting people from infectious diseases and in preventing harm when hazards involving chemicals, poisons or radiation occur.

DNA Deoxyribonucleic acid, or DNA is a nucleic acid molecule that contains the genetic instructions used in the development and functioning of all living things.

Melatonin Melatonin is a hormone produced in the brain by the pineal gland, It is a potent anti-oxidant that protects against oxidative damage from free radicals that can cause DNA damage.

Alzheimer's Alzheimer's disease is a progressive brain disorder that gradually destroys a person's memory and ability to learn, reason, make judgments, communicate and carry out daily activities. As Alzheimer's progresses, individuals may also experience changes in personality and behavior, such as anxiety, suspiciousness or agitation, as well as delusions or hallucinations.

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RFIAWG Radiofrequency Interagency Working Group (US) composed of members from federal agencies with some interest in radiofrequency radiation issues. This Working Group was made up of representatives from the US government's National Institute for Occupational Safety and Health (NIOSH), the Federal Communications Commission (FCC), Occupational Health and Safety Administration (OSHA), the Environmental Protection Agency (US EPA), the National Telecommunication and Information Administration, and the US Food and Drug Administration (FDA).

ICNIRP International Commission on Non-Ionizing Radiation. It is a body of independent scientific experts consisting of a main Commission of 14 members, 4 Scientific Standing Committees covering Epidemiology, Biology, Dosimetry and Optical Radiation and a number of consulting experts. This expertise is brought to bear on addressing the important issues of possible adverse effects on human health of exposure to non-ionising radiation.

EBT