THE informed PARENT
ISSUE TWO 2013 A NEWSLETTER ON VACCINATION ISSUES AND HEALTH

INOCULATING AGAINST VACCINE FEARS?

BY MICHAEL SMITH,
NORTH AMERICAN CORRESPONDENT,
MEDPAGE TODAY
http://www.medpagetoday.com/Infectious-Disease/Vaccines/39060
May 12, 2013

EDITOR: Here follows an article about monitoring and protecting the public from becoming informed! I have included this in the newsletter so you are aware of these surveillance schemes and what the so-called health authorities hope to achieve.

ACTION POINTS

- A new surveillance tool might help immunize communities against vaccine scares.
- Note that an international pilot project has demonstrated that it's possible, using the Internet, to quickly identify places where public fear about vaccines is on the rise.

A new surveillance tool might help immunize communities against vaccine scares, researchers reported.

An international pilot project has demonstrated that it's possible to trawl through the Internet and quickly identify places where public fear about vaccines is on the rise, according to Heidi Larson, PhD, of the London School of Hygiene and Tropical Medicine in England, and colleagues.

Larson and colleagues adapted the HealthMap automated data collection system - usually used to track disease outbreaks - so that it could monitor online reports about vaccines.

The system "allows systematic monitoring and assessment of media reports for vaccine sentiment, with the aim of detecting concerns as they emerge and evolve in real time," Larson and colleagues wrote online in The Lancet Infectious Diseases.

The issue is important, they noted, because vaccine scares can have serious consequences.

"The Internet has speeded up the global spread of unchecked rumors and misinformation about vaccines and can seriously undermine public confidence, leading to low rates of vaccine uptake and even disease outbreaks," Larson said in a statement.

A case in point, the authors wrote, is the 2003-2004 boycott of polio vaccination in Nigeria, which stalled the polio eradication program, cost millions, and led to the re-introduction of the disease in 20 countries that had been free of it.

In many such cases, they argued, "early signs of concern have often been available well before their most serious effects occurred, but were not acted on, largely because the potential results were not expected."

"A new surveillance tool might help immunize communities against vaccine scares, researchers reported."

To help fill that gap, the researchers adapted the HealthMap system to search for any online mentions of human vaccines or vaccination campaigns or programs.

Over a year, from May 1, 2011, to April 30, 2012, the system found 10,380 such reports from 144 countries.

Of those, 31% were negative - fears of adverse events, for instance, or distrust of the vaccine industry's motives - and the rest were either positive or neutral.

Of the 3,209 negative reports, 24% were associated with impacts on vaccine programs and disease outbreaks, 21% concerned beliefs, awareness, and perceptions, 16% discussed vaccine safety, and 16% were associated with vaccine delivery programs.

As might be expected, the positive and negative reports tended to accentuate different things, the researchers noted.

Some 33% of positive reports were about vaccine development and introduction, compared with just 3% of negative reports. In contrast, 21% of negative reports were about beliefs, awareness, and perceptions, compared with 3% of positive reports.

The researchers cautioned that the system has not been running long enough to demonstrate "long-term predictive value," but added it will let observers characterize, in real time, vaccine opinions by "topic, negative or positive content, location, time, and risk level."

Health authorities can't afford to wait and see if they hope to develop successful vaccination programs, according to Natasha Sarah Crowcroft, MD, of Public Health Ontario and Kwame Julius McKenzie, MD, of the Centre for Addictions and Mental Health, both in Toronto.

"Public health systems need to move beyond passive responses to vaccine safety events towards active preparedness," they argued in an accompanying commentary.

They added that researchers need to understand how to make communities "resilient to bad science and interest-driven scare stories."

Crowcroft and McKenzie noted that speed is often important in plans to eradicate diseases. But, they concluded, "moving quickly enough will only be possible by first building strong public belief and confidence in immunization."

Primary source: Lancet Infectious Diseases
Source reference: Larson HJ, et al "Measuring vaccine confidence: analysis of data obtained by a media surveillance system used to analyse public concerns about vaccines" Lancet Infect Dis 2013: DOI: 10.1016/S1473-3099(13)70108-7.

Additional source: Lancet Infectious Diseases
Source reference:
Crowcroft NS, McKenzie KJ "Inoculating communities against vaccine scare stories" Lancet Infect Dis 2013; DOI: 10.1016/S1473-3099(13)70131-2.

Editor's note

Magda Taylor

WELCOME TO ISSUE 2 2013, I CAN CONFIDENTLY CLASS THIS AS THE SUMMER ISSUE – GIVEN ALL THE LOVELY WEATHER WE HAVE BEEN EXPERIENCING IN THE UK.

Thank you very much for all your renewals and also 'hello' to recent new subscribers – I do hope you will find these newsletters useful towards your research.

Those of you who have kindly taken a standing order out for the annual subscription please can you update the annual amount to £20. I have tried to contact you to let you know but I often find that email addresses and phone numbers have changed. The annual fee increased at the end of January so I would appreciate it if you could contact your bank and let them know about the change - if your renewal is due.

Since the so-called measles epidemic in Wales the mainstream media machine has been relatively quiet on the subject. However there is always a steady flow of interesting articles and studies circulating the internet. I do have a Facebook Informed Parent group page which you may wish to be added on to – there are a lot of people out there sharing all kinds of interesting data on the subject and you will certainly not feel isolated with your views if you link up with some of these networks.

I am looking into organising a talk or possibly a half day workshop in the Worthing area with Dr Patrick Quanten, one of our regular writers, in the latter part of October. If you are interested please let me know as soon as you can so I can get an idea of the interest. Email me via the website or phone 01903 212969.

I am still needing an increase in subscriptions to ensure that I am able to keep The Informed Parent going, so please do continue to let others know about the publication and the website. I look forward to the time when newsletters such as this will not be needed – let's hope the truth will rear its head soon – anything is possible!

Good health and hope the sun shines on us over the next month or two.

MAGDA TAYLOR, EDITOR. AUGUST 2013

THE POTENTIAL SIGNIFICANCE OF ALUMINUM/DNA COMPOUNDS IN GARDASIL ON HEALTH

BY NORMA ERICKSON

www.sanevax.org

9th May 2013

EACH DOSE OF GARDASIL contains 225mcg of aluminum-based adjuvant. Adjuvants are in vaccines to bring the antigen (the substance that stimulates the specific protective immune response) into contact with the immune system and influence the type of immunity produced, as well as the magnitude or duration of the immune response.

In the case of Gardasil, the aluminum adjuvant is present to keep the HPV 6/11/16/18 virus-like particles in contact with the immune system long enough for the body to produce antibodies to those HPV genotypes. The theory is the more antibodies produced, the stronger the potential immunity is.

Excerpts from a recent paper entitled "Host DNA released in response to aluminum adjuvant enhances MHC class II-mediated antigen presentation and prolongs CD4 T-cell interactions with dendritic cells," by McKee et al. state:

Alum has been used to improve the efficacy of vaccines since the 1930s. Here we show that alum acts in part via host DNA to increase the interaction between T cells and APCs.

Many vaccines include aluminum salts (alum) as adjuvants despite little knowledge of alum's functions. Host DNA rapidly coats injected alum. Here, we further investigated the mechanism of alum and DNA's adjuvant function.

Thus, alum, once believed to extend the half-life of antigen in the body, is now recognized to engage many innate receptor pathways. Although some of these pathways may not be involved in the adjuvant effects of alum on DC and T-cell priming, DNA-mediated signaling appears to have important effects on DC antigen presentation and to contribute to the effects of alum as an adjuvant.

WHAT DOES THIS MEAN FOR THE AVERAGE MEDICAL CONSUMER?

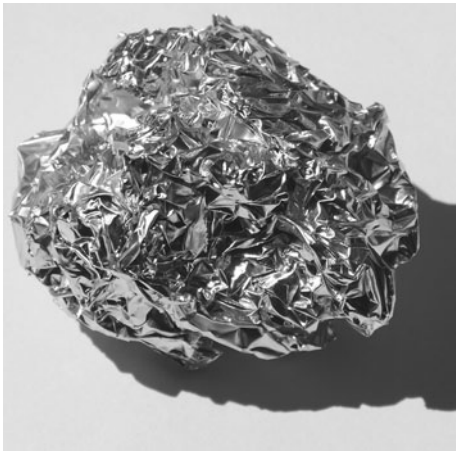
First, one has to have a basic understanding of the scientific terminology used in the paper quoted above.

- T CELLS are a type of white blood cell of key importance to the immune system. It is at the core of adaptive immunity, the system that tailors the body's immune response to specific pathogens. The T cells are like soldiers who search out and destroy the targeted invaders. There are several different types of mature T cells. Not all of their functions are known. T cells can produce substances called cytokines.
- CYTOKINES are small proteins produced by immune cells that act as

biological response modifiers. They have specific effects on cell to cell interaction, communication and behavior of other cells. They include biological response modifiers, colony stimulating factor, fibroblast growth factor, interferons, interleukins, platelet-derived growth factor, transforming growth factor , and tumor necrosis factor.

- ANTIGEN – a toxin or foreign substance that when introduced into the body stimulates the production of antibodies.
- APC – antigen presenting cell
- DC – A dendritic cell is a highly specialized white blood cell found in the skin, mucosa, and lymphoid tissues that initiates a primary immune response by activating lymphocytes and secreting cytokines.
- MACROPHAGE – A type of white blood cell that ingests (via phagocytosis) foreign material. Macrophages are key players in the immune response to foreign invaders of the body, such as infectious microorganisms or other toxic substances. They are normally found in the liver, spleen, and connective tissues of the body. Activated macrophages secrete a variety of cytokines, some of which are harmful, particularly in certain genetically predisposed people.

According to a presentation on Prophylactic HPV vaccines, by Margaret Stanley, Department of Pathology at Cambridge, low antibody levels protect against natural genital HPV infections in women. Peak antibody concentrations after HPV vaccination are 50 to 1,000 times the antibody levels after natural infections. The antibody level necessary for protection against HPV has not been determined.



"Have the 'experts' disregarded the potential harm resulting from overstimulation of a person's immune system and the cytokines produced by extended immune system stimulation? "

Have vaccine experts over-emphasized the benefits of increasing the interaction time between T cells and antigen presenting cells to boost immune reaction?

Have vaccine experts simply assumed higher antibody levels mean more protection with no potential negative consequences?

Have the 'experts' disregarded the potential harm resulting from overstimulation of a person's immune system and the cytokines produced by extended immune system stimulation?

What could happen in vaccine recipients when the DNA interacting with the aluminum adjuvant is not from the host, but from viral gene fragments with topological non-B conformational changes already bound to the aluminum adjuvant before it is injected – as it is with Gardasil?

In light of the recent publication by McKee et al. and the presentation by Margaret Stanley, our readers are urged to read the report by Lee, entitled "Detection of human papillomavirus L1 gene DNA fragments in postmortem blood and spleen after Gardasil® vaccination - A case report. Advances in Bioscience and Biotechnology.

Pay close attention to the following excerpt:

A potential consequence of these viral and microbial DNA fragments with their unmethylated CpG motifs in macro-phages [41-46] is to cause release of various cytokines, including tumor necrosis factor (TNF), a recognized myocardial depressant [47-51]. TNF-induced hypotensive shock is a documented observation among animals [52,53] and humans [54,55]. To answer the question whether the quantity of these persistent viral or microbial DNA fragments can stimulate the macrophages to release enough TNF to generate a significant pathophysiological impact following Gardasil® vaccination needs expanded research.

The SaneVax team could not agree more. In the interest of public health and safety, expanded research.

BRAINWASHED POLICE PROSECUTE PARENTS TO PROTECT VACCINES

BY CHRISTINA ENGLAND

www.vactruth.com

Nov 8th, 2012

I HAVE BEEN VERY HONORED to work with retired Sergeant Christopher Savage of the Queensland Police Service during the past few months. Mr. Savage contacted me after watching the short film I recently published on VacTruth highlighting cases of false accusations of child abuse after vaccine injuries. [1] The evidence of sheer corruption he revealed sent shivers down my spine.

His papers confirm that the police are writing off cases of possible vaccine injury as Sudden Infant Death Syndrome. They also highlight the fact that due to biased and inadequate training, the police are falsely accusing parents of manslaughter and Shaken Baby Syndrome and parents killing their own children because they have been brainwashed to search for signs of abuse, assault and foul play whenever a child dies.

GAINING A NEW PERSPECTIVE

Christopher William Savage joined the Queensland Police Service in 1989 at the age of 27. His training took place at the Oxley Police Academy and was completed six months later.

He had no particular views on vaccines before joining the police force and said that he cannot recall any real discussions on the topic of vaccinations while growing up. This perspective changed, however, when he received his Hepatitis B vaccine in October 1989 with his colleagues.

Sergeant Savage explained that after receiving the Hep B vaccine as part of the squad, he became totally exhausted. He spent the next two weeks in bed hardly able to stand up. When he asked a mainstream medical practitioner if the vaccine could have caused his symptoms, he was given a categorical no, and told that this suspicion would be impossible. Despite being reassured by the medical practitioner, Savage remains convinced to this day that the vaccine was responsible for his becoming so ill. His experience opened his eyes to a deeper evil still occurring, which I believe will rock the beliefs of many parents.

Ex-Police Sergeant Chris Savage

A BOLD REVELATION

Sergeant Savage has given me a copy of a signed statement, which has been countersigned by JP N. Newbury (Qualified Number 10175) of the Gympie Magistrates Court office, stating his belief that vaccines are the cause of many cases of Sudden Infant Death Syndrome (SIDS). He believes innocent parents are also being blamed and are being falsely charged with manslaughter when babies die.

The statement identifies clearly and succinctly a variety of cases in which babies appear fit and healthy on the day of their vaccination but deteriorate after they received the vaccine. He has revealed a clear catalog of cover-ups used by the police force and the medical professionals. He has exposed the fact that every case is treated as if it were a case of manslaughter and newly bereaved parents and parents of critically ill children are being interrogated as prime suspects and potential child abusers. Their homes are being ransacked for clues and precious possessions such as sheets, mattresses and medications are being bagged up as forensic evidence. Their homes are being treated as possible crime scenes.

Sergeant Savage's statement closes with these words:

"I understand that a person who intentionally makes a false statement in a statutory declaration is guilty of an offense under section 11 of the Statutory Declarations Act of 1959, and I believe that the statements in this declaration are true in every particular."

(I have been given permission to include this valuable document as part of my research on VacTruth.) [2] To view please go to http://vactruth.com/2012/11/08/brainwashed-police-ignore-vaccine-injuries/)

The police are supposed to be unbiased and nonjudgmental, examining all the evidence, no matter how small, in order to determine why an individual has died. However, it appears that whenever vaccination is suggested as a possible cause of death, the police are choosing to ignore this evidence in favor of SIDS, child abuse and manslaughter.

Intrigued by the document, I asked Mr. Savage if he would provide me with an interview for VacTruth, which he agreed to do.

FOLLOWING IMPROPER PROCEDURE

To clarify the normal series of events that occurs in cases of SIDS (Sudden Infant Death Syndrome), I asked Sergeant Savage what happens when a baby dies an unexpected death.

Sgt. Savage: When a baby dies suddenly from so-called SIDS, the parents become subjects of an investigation by medical staff and First Response police. If either of those find anything suspicious then detectives become involved. If both parents have a similar version that is credible they will most likely not face any prosecution. However, if there are inconsistencies in their stories, then the police look further into the matter.

Sole parents and de facto parents are the most likely to face prosecution because they don't have the same stability and some even suspect the other parent of having done something wrong, especially when the police start asking questions about their partner.

Christina England: Do you believe that the police, along with the medical profession, are blaming parents as a cover for vaccine damage?

Sgt. Savage: I believe the police are not realizing what has happened and don't even look at the evidence pointing

towards vaccines causing [infant death], as their minds are stuck in the SIDS scam diagnosis that is prevailing in everyone's mind due to annual RED NOSE day nonsense.

Christina England: Could you outline exactly what you believe?

What he answered will shock many parents across the world.

Sgt. Savage: The police officer is a member of the pro-vaccine brainwashed society and joins the Police Service where the SIDS mindset is already held. When he or she is tasked to attend a baby death, not only does the officer believe SIDS is real but they are also trained to look for signs of abuse and assault and manslaughter. So there is brainwashing on SIDS pushing the officer away from looking at vaccines and their training is to find evidence of foul play, which includes side effects of vaccines. The parents are too traumatized to think rationally and when the police start asking them questions about the other parent they become frightened, paranoid and defensive. The body is taken to a doctor for an autopsy to find out why the baby died. So there is another problem.

Doctors receive more pro-vaccine training than the public and so they won't think of the vaccines as being the cause. The police also don't want to rock the boat. They want to finalize the file. So in the absence of corroborating forensic evidence the police and doctors will most likely describe the case as SIDS.

BLAMING PARENTS INSTEAD OF VACCINES

Christina England: In your view at what point in the proceedings are parents being falsely accused of manslaughter or Shaken Baby Syndrome?

Sgt. Savage: Parents become subjects of the investigation regardless … in other words, police are looking for evidence of wrongdoing by anyone living in the house where a person dies, and of course, this includes babies. In the case of babies, police are told to seize clothing, medication and bedding for forensic analysis.

The shaken baby accusation may come if a parent recalls to police that they picked up [the dead baby] and shook the baby … or the autopsy finds physical signs such as bruising, broken ribs and the swollen or inflamed cerebral cortex.

The problem I have with the above scenario is that, in my experience, many parents who find their baby unresponsive, limp and lifeless, pick the infant up and give them a gentle shake to try to revive them. Parents may also be wrongly accused of shaking their baby to death if they inadvertently use the word 'shake' when they actually mean to say 'bounce' or 'pat.' [3]

Christina England: Are you telling me that in the majority of cases when parents admit that they have picked up their unresponsive child and given them a gentle shake in order to revive them, at the time of questioning, this will automatically be logged as abuse?

"Vaccine damage is rarely ever looked at … pointing the finger of blame at parents is frequently done and the most common action is to simply write off as SIDS"

Sgt. Savage: Exactly right, Christina. The way you described the gentle shaking is exactly what I meant, but the police are pre-programmed to identify Shaken Baby Syndrome, so as soon as they hear one of the parents say these words, the investigating officers misconstrue and begin questioning along the lines of Shaken Baby Syndrome and ask, "How much did you shake the baby?" and "Have you previously shaken the baby?" and "What happened after shaking?" They then ask, "Has your partner ever lost control and smacked the baby?" and "Has he ever shaken the baby in a rage?" The parent goes from primary witness to suspect for a serious crime and [parents] sense this and panic and police may interpret this as guilt. The police then write this on the report to the coroner and to the doctor doing the autopsy.

Often in de facto relationships, the other party may be abusive towards the baby and the mother. In these cases, police go after the father with vengeance because they honestly believe the father has done something to cause the death or injury, which the vaccines caused.

ABUSING THE EVIDENCE

Sergeant Savage explained that there are several signs that can be misinterpreted as evidence against the parents. These are:

- Bruising
- Inconsistent versions of events from parents
- Bruising and broken ribs
- Swollen cerebral cortex

He explained that, in most cases dealt with by the police, the baby will have some bruising. However, when a baby dies, bruising is then considered to be evidence of the parent being abusive.

He added that this interpretation of the evidence could be incorrect, as ambulance staff sometimes gives CPR, which can cause bruising and broken ribs, which he says is then blamed on the parents. Inconsistent versions of events from parents, who are understandably upset at this very difficult time, can also lead to police attacking their credibility. Savage stated that the most common outcome is to take the option of writing the file in conjunction with medical opinion as SIDS without prosecution.

Christina England: Do you feel that too many cases where vaccines could be the cause of death are being written off as either SIDS or abuse, instead of being fully investigated?

Sgt. Savage: Yes. Vaccine damage is rarely ever looked at … pointing the finger of blame at parents is frequently done and the most common action is to simply write it off as SIDS. The investigators could and should ask parents about their baby's health prior to vaccines. It would eventually expose the vaccines for being the root cause of injury and death that it is.

Sergeant Savage also believes with certainty that any evidence of vaccines being a possible cause of sudden infant death is likely to be buried.

Sgt. Savage: The parents rarely make the connection with vaccines because they are so tired due to the impact of vaccines on their baby's sleep, hence theirs. If they raise concern, the police should put it in the report, but the doctor who does the autopsy will see that and most likely dismiss it. There is pressure on the police not to rock the boat, too. That sort of information may save a parent from prosecution at least. [emphasis added]

CONCLUSION

Are the police simply unaware that vaccinations can cause injury and death? Or, are they very aware and this is why they will do all they can to cover up this fact? After all, the evidence has been there for years. (See "For Further Research" at the end of this article.)

It seems to me extremely odd that the very paper Sergeant Savage said his colleague had planted into the possession of a prisoner charged with Shaken Baby Syndrome was Shaken Baby Syndrome - The Vaccination Link by Dr. Viera Scheibner [4] especially when you consider that this prisoner believed that his child had died after he received his vaccinations.

Sergeant Savage gives a very damning account of what really is going on behind the scenes. It is shocking how cases of possible vaccine injury are being covered up, written off as SIDS and blamed on innocent parents in what appears to be a worldwide cover-up to protect the vaccine industry at any cost.

Sergeant Savage makes abundantly clear through his statement and interview that in many of the cases he has been involved in and knows of, the children only became ill after vaccination. As the police are brainwashed to believe that all vaccines are safe, it has become an appalling policy for all parents to be viewed as potential perpetrators of manslaughter.

Sadly, any child can suffer a severe reaction after a vaccination. In some cases, children do die after receiving vaccines. Is it fair for that grieving parent to then be interrogated by the police as a murder suspect?

Imagine how you would feel if this tragedy happened to your baby. As a grieving parent, would you want to be questioned by the police as a matter of routine? Could you imagine how painful the death of a child is and how easy it would be, as a distraught parent, to say the wrong thing? After all, you would be in shock, very scared and deeply saddened.

In reality, many parents have endured the nightmare of being falsely accused of their child's death. Some of them are behind bars today after being falsely accused and convicted of manslaughter after their child suffered fatal vaccine injuries. To help save parents from additional agony, when they are already facing the most heartbreaking loss imaginable, people like Sergeant Christopher Savage have decided to speak out and risk everything to break the silence.

"It is shocking how cases of possible vaccine injury are being covered up, written off as SIDS & blamed on innocent parents in what appears to be a worldwide cover-up to protect the vaccine industry at any cost."

ACKNOWLEDGEMENTS

I would like to thank Sergeant Christopher Savage who has provided all the information contained in this article. I believe his bravery will help many families faced with false accusations of child abuse and manslaughter after vaccine injuries.

~ In loving memory of Amanda Sadowsky and Cameron Bruce ~

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FOR FURTHER RESEARCH ON VACCINATION AND SIDS

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The Lonely World of Autism

By Christina England

Lost in the world of autism,
My child sits huddled alone,
Rocking backwards and forwards,
Humming a monotonous tone.

I reach out my hand to touch him,
Longing to be part of his life,
But he shrinks back into the shadows, As if I am holding a knife.

I whisper his name very quietly,
To prevent him from feeling afraid,
He looks at me with sheer terror,
As if I am still holding that blade.

I wonder how I can reach him,
I know that there must be a way,
I want him to be like the others,
I want him to laugh and to play.

I decide to ask the professionals,
Believing that they hold the key,
They laugh at my fears and my worries, they tell me the problem is me.

They tell me that my son is normal,
That the problem is all in my head,
Instead of the help that he needed,
They gave me a label instead.

I switch on the computer to guide me, I search for an answer online,
I find a psychologist with answers,
And realise that this is a sign.

She explained that my son is autistic, And helped me to learn and to see, She gave me the answers I needed, And explained that his problems, were not me.

She taught me that it was the vaccines, That made my son this way, She explained that it has happened to others, She helped him to laugh and to play.

My son has grown up now,
With friends and a life of his own,
I now spend my time helping others, So that they do not feel so alone.

HPV Vaccine – What will it take?

BY SANDY GOTTSTEIN

http://www.vaccinationnews.com/2013-6-20-HPV-vaccine-what-GottsteinS

20th June 2013

"THE HEALTH MINISTRY (JAPAN) has issued a nationwide notice that cervical cancer vaccinations should no longer be recommended for girls aged 12 to 16 because several adverse reactions to the medicines have been reported."

"SEVERAL". SEVERAL? SEVERAL!

I wrote some years ago about our apparent smug self-satisfaction when it comes to public health concerns as compared to "lesser" other nations, and just how misplaced this self-satisfaction can be.

WELL, HERE WE GO AGAIN!

In Japan it apparently only takes "several" adverse reaction incidents to withdraw or modify support for a vaccine.

In the United States what does it take? As of 15th June 2013, there have been over ten thousand emergency rooms visits and 85 deaths attributed to the various HPV vaccines reported to VAERS.* (Given the fact that a passive reporting system like VAERS is expected to result in only "a small fraction of actual adverse events", one can only speculate just what the reported numbers actually represent: 10%? 1% ?%) And wonder why the FDA and CDC don't require active surveillance of products that are nigh universally mandated.)

Moreover, in order to understand how little the CDC and FDA actually care about this information, one only need look as far as the "recovery" category. One would think that someone who never recovered would also be classified as having had a "serious" reaction. But a large number of those classified as "not recovered" were also classified as "not serious". Rather than raise a red flag, pointing to at least the need for further clarification, this obvious incongruity is simply ignored, further evidence of their utter disinterest in receiving and cataloging accurate and meaningful information.

Yet, in spite of expected considerable under-reporting and the little effort made to understand the significance of those reports that has been made, "Judicial Watch announced it has received documents from the Department of Health and Human Services (HHS) revealing that its National Vaccine Injury Compensation Program (VICP) has awarded $5,877,710 dollars to 49 victims in claims made against the highly controversial HPV (human papillomavirus) vaccines. To date 200 claims have been filed with VICP, with barely half adjudicated." (1)

Only the CDC knows its true motives. We, however, can be clear about one thing: judging by their actions (or inactions), we can say with near certainty that they have no genuine interest in understanding the extent of vaccine injury and death. Furthermore, we can only wonder if there is any number of HPV vaccine-associated reactions in the United States that will result in modification of HPV (or any other) vaccine policy, meaningful follow-up, and consequent protection of the public from what appears to be a dangerous vaccine.

And if, as it would seem, it is not the public that is being protected, then who is?

WANING OF MATERNAL ANTIBODIES AGAINST MEASLES, MUMPS, RUBELLA, AND VARICELLA IN COMMUNITIES WITH CONTRASTING VACCINATION COVERAGE

THE JOURNAL OF INFECTIOUS DISEASES

http://jid.oxfordjournals.org/content/early/2013/04/29/infdis.jit143.full

May 8th 2013

WAAIJENBORG S ET AL
Sandra Waaijenborg, PhD, National Institute of Public Health and the Environment, Centre for Infectious Disease Control, Epidemiology and Surveillance Unit, PO Box 1, 3720 BA Bilthoven, the Netherlands (sandra.waaijenborg@rivm.nl).

ABSTRACT

BACKGROUND. The combined measles, mumps, and rubella (MMR) vaccine has been successfully administered for >20 years. Because of this, protection by maternal antibodies in infants born to vaccinated mothers might be negatively affected.

METHODS. A large cross-sectional serologic survey was conducted in the Netherlands during 2006–2007. We compared the kinetics of antibody concentrations in children and women of childbearing age in the highly vaccinated general population with those in orthodox Protestant communities that were exposed to outbreaks.

RESULTS. The estimated duration of protection by maternal antibodies among infants in the general population, most of whom were born to vaccinated mothers, was short: 3.3 months for measles, 2.7 months for mumps, 3.9 months for rubella, and 3.4 months for varicella. The duration of protection against measles was 2 months longer for infants born in the orthodox communities, most of whom had unvaccinated mothers. For rubella, mothers in the orthodox communities had higher concentrations of antibodies as compared to the general population.

CONCLUSIONS

Children of mothers vaccinated against measles and, possibly, rubella have lower concentrations of maternal antibodies and lose protection by maternal antibodies at an earlier age than children of mothers in communities that oppose vaccination. This increases the risk of disease transmission in highly vaccinated populations.

ROTAVIRUS THE DISEASE, THE VACCINE AND THE SCIENCE OF THE IMPROBABLE

BY DR JAYNE DONEGAN
MBBS DRCOG DCH DFFP MRCGP MFHOM
GP & Homeopath

Dr Jayne L.M. Donegan

IN JULY 2013, a rotavirus vaccine called Rotarix is being added to the UK National Child Immunisation Programme. It will be given at eight weeks of age with the 5in1 and the pneumoccocal vaccine and at twelve weeks with the 5in1 and meningococcal C vaccine. It is a live viral vaccine and exerts its effect by giving the baby a mini infection.

As with the rubella vaccine, the mumps vaccine, the 'flu vaccine and the HPV vaccine, we are introducing a vaccine against an organism when we don't even know how much disease is associated with the organism that we are trying to prevent.

Every paper discussing the merits of introducing the vaccine states that rotavirus is the primary cause of gastroenteritis (a diarrhoea and vomiting illness to you and me) worldwide. It is stated that every year, rotavirus infection results in 138 million cases of rotavirus gastroenteritis, 25 million clinic visits, two million hospital admissions and 453,000 deaths in children under the age of five years.

These are amazingly precise figures when dealing with an organism which is present everywhere, whose symptoms, if you actually get clinical infection (ie with symptoms so that you know that you've got it) are identical to most other forms of viral gastroenteritis, which is not tested for either in general practice, or in hospital, and which is present in most people with no symptoms.

In terms of danger to infants, newborns are protected by their mothers' immunity up to the age of about three months, but if they are breast fed they will continue to be protected by this immunity, not just in the form of antibodies (immunoglobulins) but also by the "oft forgotten non-immunoglobulin fraction in breast milk which is an additional tool of protection against rotavirus disease". A study in Brasil confirmed that the main determinant of children under the age of one year presenting to health facilities with diarrhoea and rotavirus in their stools, was not being breast fed.

By the age of five years almost all children have been infected by rotavirus. The first episode of natural infection, with or without symptoms, doesn't usually give permanent immunity, this gradually builds up with each subsequent infection, each one being less severe than the last.

"A study in Brasil confirmed that the main determinant of children under the age of one year presenting to health facilities with diarrhoea and rotavirus in their stools, was not being breast fed.

But even after one single infection, 77% of children are protected against any rotavirus diarrhoea and 87% against severe diarrhoea in the future. What causes this protection, how the body becomes immune to rotavirus disease, is poorly understood, but this has not deterred ambitious pharmaceutical companies from developing vaccines against it.

A UK study of intestinal infections in 70 general practices in the 1990's found that rotavirus was detected in half of the cases of gastroenteritis in children under five years but it was also present in almost a quarter of children under five years without any symptoms; it was also present without symptoms in the stools of a quarter of young people aged up to 19 years and 4 -13 per cent of adults aged twenty years and over. Even using sophisticated laboratory tests like DNA polymerase chain reaction, twenty five percent of cases of diarrhoea have no infectious organism found.

The Joint Committee on Vaccination and Immmunisation (JCVI) has stated that these asymptomatic carriers are dangerous - a source of potential infection for non-immune individuals or those in whom immunity has waned. Yet it is this very 'silent' carriage which allows people to keep their immunity boosted to all the different types of rotavirus and which keeps them immune to a virus that has the ability to continually reassort its genes at a very high frequency, including interspecies transmission among human and other animal rotaviruses.

The live virus from the rotavirus vaccine is shed in babies' stools for more than thirty days. It is interesting that circulating wild rotavirus is regarded as a danger while the rotavirus vaccine virus, doing exactly the same thing is said to give, "indirect protection of the immunocompromised household member, thereby preventing wild-type rotavirus disease (and this) outweighs the small risk for transmitting vaccine virus to the immunocompromised household member." This is similar to what was said about the oral polio virus which was excreted in the stools for up to six weeks from the date of administration. It was said to provide: "an additional community benefit as contacts of recently immunised children may be protected through acquisition of the vaccine virus." It also used to paralyse people and was the reason for its withdrawal from the USA in 2000 and the UK and all other developed countries by 2004 and its replacement with the dead, injectable form.

The USA, Centers for Diseases Control Vaccine Guide states, "Although rotavirus is shed in the feces of vaccinated infants transmission of vaccine virus is said not to have been documented", However, the potential for transmission of vaccine virus to others was not assessed in the pre-licensing or post marketing trials even though it was predictable that it would

happen. Already a 2 ½ year old boy in the USA has had gastroenteritis severe enough to need hospital admission and treatment with intravenous fluids after getting infected with the vaccine virus from his two month old sibling, who had no symptoms, and who had been vaccinated ten days earlier with a rotavirus vaccine.

In terms of hospital cases of rotavirus disease, as many as a third of cases of rotavirus infections among patients in hospitals in the USA were actually acquired when people were already in hospital - so, a vaccination to make up for poor hospital hygiene. Treatment of natural rotavirus infection, even in cases severe enough to be admitted to hospital, usually involves oral rehydration only - there is no need to give fluids intravenously by drip. This means that most children admitted to hospital with diarrhoea, if their parents were better educated in how to manage their child's illness, could have been treated at home.

It is very rare for children to die of rotavirus infection in the UK. The JCVI has made a estimate at maybe three to four children per year but this is just a guess - they don't have the data. This estimate also takes no account of any underlying conditions that such children may have - as they are hypothetical cases.

In real life, GPs seeing children and adults with infective diarrhoea for whatever cause don't test the stools unless the person has been abroad, the history suggests food poisoning (a notifiable disease), or it continues for a long time with perhaps blood in the stools (may be bacterial) - the children are managed at home, by their parents, with appropriate instructions. Indeed as a paediatric doctor, the only children I admitted with diarrhoea and vomiting were those sent in by their GP who felt that the parents couldn't cope, usually because of poor social circumstances, lack of support, depression or other mental health problems.

WHY DO CHILDREN GET DIARRHOEAL ILLNESSES OR ANY INFECTIOUS DISEASES?

When children are born, they are, so to speak, an empty vessel. Then, due to the influence of perhaps birth trauma, pollution, junk food, sugar, parents arguing or simply the stresses and strains of being a child in the twenty first century, they build up a level of what can loosely be called 'toxins'. When these toxins reach a certain threshold a healthy child will initiate a clean-out reaction - they will get themselves a viral infection which causes:

"In terms of hospital cases of rotavirus disease, as many as a third of cases of rotavirus infections among patients in hospitals in the USA were actually acquired when people were already in hospital."

- FEVER - the chemical reactions required for the clean-out process work more efficiently at a higher temperature, as do the white cells in the immune system that help to scavenge and clean out rubbish.
- LOSS OF APPETITE - if you are trying to clean yourself out, the last thing you need is to fill yourself up with more food that needs processing.
- DIARRHOEA AND VOMITING - this happens especially when children are fed more formula milk to make up for their not eating, and may also happen as part of the clean-out process.
- RASH - this is a form of toxins coming out through the skin.

If this process is allowed to continue unhindered, at the end of it the child will do something new, depending on their age: a baby may produce a new tooth, a toddler who keeps wobbling around and banging their head on the corners of the furniture will start to walk straight, a six year old who isn't reading may suddenly start to read, a child who is a bit small will suddenly have a growth spurt, another will develop new vocabulary or mature emotionally.

It can be seen from this that, in order to take a developmental step forward, the child has to clean out their system first, and this takes the form of a crisis, rather like snakes, which have to crack off their old, too small skins before they can slither out with their shiny new ones. An appropriate infectious disease, well managed, is our friend, not our enemy, and is there to help us to correct the mistakes we make by being imperfect parents with imperfect children in an imperfect society.

It is important to realise that exposure to a micro-organism is no guarantee of getting the disease. One can be exposed and have a response that ranges from no infection through subclinical (no symptoms) infection, mild disease, moderate disease, severe disease, disability or death

For example, exposure to poliovirus can cause undetectable infection, mild symptoms of gastric 'flu or summer diarrhoea through to temporary or permanent paralysis;exposure to the meningococcus can lead to no obvious symptoms other than persistent carriage of the bacterium in the nose to severe illness causing disability or death.

WHAT DETERMINES WHICH ONE OF THESE OPTIONS IS LIKELY TO OCCUR IN YOUR CHILD?

- Firstly, the state of you child's immune system when they meet the organism and their developmental needs.
- Secondly, how the disease is treated - suppressively or supportively.

Supporting the body through illness, as opposed to suppressing the body's own self defence mechanisms (eg fever with paracetamol/ ibuprofen), is crucial so as to avoid complications and in order to come out of the illness stronger rather than weaker.

General measures include: fresh air (open the window), no dairy (increases production of mucus and worsens inflammation), plenty of fluids and no food unless starving (for full details, see my website).

HOW DO YOU MANAGE AN INFANT OR CHILD WITH DIARRHOEA? – SAME AS ANY OTHER INFECTION

If your child has diarrhoea or vomiting, it is important that you 'rest the patient and rest the bowel'. Resting the bowel means no food and clear fluids only. Breast feeding counts as clear fluids, in fact exclusive breast feeding provides infants with unique protection from travellers' diarrhoea. Breast feeding is ideal rehydration therapy.

ACTION:

- General Measures (as stated earlier)
- Do not stop breast feeding. If you are breast feeding, that is all you need to do.
- If bottle feeding, change over to clear fluids. Babies older than six months in developed countries do not need specific oral re-hydration fluids (NB Dioralyte contains saccharin).
- If your baby is less than six months old and you are not breast feeding, do not withhold milk for more than 12 hours.
- When you re-introduce the artificial formula milk, start with ¼ strength and increase by ¼ each feed so long as diarrhoea does not get worse.

SIGNS OF SEVERE DEHYDRATION:

- A sunken fontanelle in babies
- Skin that stays pinched after you have let it go
- Go immediately to hospital

Never try to block diarrhoea with proprietary medicines.

THE PROTECTIVE EFFECT OF BREAST FEEDING

Exclusive breast feeding provides infants with unique protection from diarrhoea and vomiting illnesses and even from travellers' diarrhoea when you are abroad. This is because breast milk is loaded with antibodies and also gut protective bacteria.

Apart from this, artificially fed babies have another reason for being prone to diarrhoeal disease. Every infection your child gets has a 'focus', which is determined by what they are trying to clear out and which part of their system they are trying to heal. Human breast milk is designed by nature specifically for the feeding of human babies - in the same way that human mothers are designed specifically to nurture human babies in their womb for nine months, rather than bovine mothers who are designed specifically to do that for calves.

Babies that are artificially fed with modified, pasteurised, homogenised, sterilised cow's milk lose the 'live' quality of maternal milk, the antibodies, the good bacteria, the enzymes and human hormones. Instead they have to cope with foreign cow proteins, blended vegetable oils, added sugars and supplements. As UNICEF put it,

"Formula is not an acceptable substitute for breast milk because formula, at its best, only replaces most of the nutritional components of breast milk: it is just a food, whereas breast milk is a complex living nutritional fluid... in the first few months, it is hard for the baby's gut to absorb anything other than breast milk.."

"Formula is not an acceptable substitute for breast milk because formula, at its best, only replaces most of the nutritional components of breast milk: it is just a food, whereas breast milk is a complex living nutritional fluid... in the first few months, it is hard for the baby's gut to absorb anything other than breast milk. Even one feeding of formula or other foods can cause injuries to the gut, taking weeks for the baby to recover".

So babies fed formula even when made up with clean water - a luxury in many developing countries - will be more prone to gastric upset just to clear the effects of this type of feeding from their body - it is their attempt to compensate. The last thing you would want to do is prevent it.

Older children and adults who are neither breast nor formula fed will also have gastric upsets at times in their lives when their body's innate intelligence decides that this area needs some attention or to get rid of dietary excesses and indiscretions or the effects of drinking sewage as occurs in countries with no clean water supply.

The big difference between a well fed child in a developed country and a malnourished child in a less economically developed country is that the well fed child has the resources and reserves to carry the process through to a successful conclusion whereas the child teetering on the edge of starvation will try to do the same thing but die in the process. That is why diarrhoea is so common and such a killer in developing countries and why breastfeeding is so crucial. UNICEF state that breastfed children have at least six times greater chance of survival in the early months than non-breastfed children due to reduced deaths from acute respiratory infection, diarrhoea and other infections especially in those countries with a high burden of disease and low access to clean water and sanitation.

"OK", you may say, "but I don't live in a developing country. I have clean water and a flush loo." but even in developed countries UNICEF states:

"Non-breastfed children in industrialized countries are also at greater risk of dying - a recent study of post-neonatal mortality in the United States found a 25% increase in mortality among non-breastfed infants. In the UK Millennium Cohort Survey, six months of exclusive breast feeding was associated with a 53% decrease in hospital admissions for diarrhoea and a 27% decrease in respiratory tract infections."

If you are unable to breast feed for any reason other than choice, this is not meant to make you feel incredibly guilty. It is so that you know that your baby will have more gut issues than a breast fed baby and so that you can appreciate their efforts to correct such deficiencies by acquiring gut based illnesses (diarrhoea and vomiting) which simply need to be appropriately managed.

Well maybe it would just be nice to have fewer cases of diarrhoea...You need to be aware that the vaccine itself causes diarrhoea in up to a quarter of babies, vomiting in 15-18%, and fever in almost half - these are all signs of the body trying to clear the effects of what they have just been administered - and irritability in 13%-62% because it is not very pleasant. The vaccine is not even marketed as preventing all rotavirus disease, just severe cases of gastroenteritis, and not all of them - only about 85%

In addition to the above there is a very

serious adverse reaction associated with the vaccine: Intussusception - a rare, potentially life-threatening form of intestinal obstruction. This occurs when one portion of the baby's gut telescopes into another. It may present as severe stomach pain, persistent vomiting, blood in the stools, a swollen belly and/ or high fever. A previously available rotavirus vaccine which was introduced in the USA in 1998 was withdrawn after less than a year, because it was associated with a more than twenty-fold increase in the incidence of intussusception. The newer vaccines in use now have had large prelicensure trials that found no increase in cases - but once the vaccines were introduced, post marketing studies in Mexico, Brasil and Australia found that intussusception was again increased though not to so large a degree. Professor Harry Greenberg, a world renowned expert in rotavirus and gut-based pathogens states, "A likely reason that the very large prelicensure safety trials of RV1 (Rotarix) and RV5 (RotaTeq) did not detect an intussusception signal is that they were simply underpowered to pick up rare events occurring at rates below 1 in 50,000". Subsequent studies in the USA that have found no increase in risk in cases of intussusception have been similarly small. It is acknowledged by the Chief Medical Officer, Professor Dame Sally Davies, that the use of the Rotarix vaccine may be associated with an increased risk of one to three extra cases of intussusception per 100,000 (5 to 15 affected children) per year in the UK, but she says that this is likely to be far outweighed by the benefit of the vaccine in reducing cases of rotavirus diarrhoea and vomiting and so reducing hospital admissions, GP consultations, NHS Direct calls and time off work for carers.

In order to give informed consent, parents must be fully informed of all the benefits and the risks of an intervention. The NHS Choice website makes no mention of the word 'intussusception' in its general description of rotavirus, the vaccine, the vaccine side effects, nor in the printed guide – which is worrying, as it is listed in the GlaxoSmithKline Patient Information Leaflet (PIL) and the Summary of Product Characteristics both in the UK and USA.

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THE VACCINE - ROTARIX

Rotarix is the rotavirus vaccine that will be available in the UK. It is a live viral vaccine of Human rotavirus RIX4414 strain (G1P1A[8]). It is produced on Vero cells, a cell line used in cell cultures. They were isolated from African green (vervet) monkey kidney by Japanese scientists in 1962. The cells are 'aneuploid' which means that they have an abnormal number of chromosomes (normal cells are diploid) and continuous which means that they will grow indefinitely in culture. Data presented by the US Public Health Service at a review of the cells in 2000 led to the conclusion:

"Vero cells have been extensively tested and shown to be free from adventitious (contaminating) agents for which there are currently available tests and to the limit of sensitivity of those tests. However, this cell line is an aneuploid cell line which does not form tumours at the passage levels used to produce vaccines, but develops tumorigenic (tumour producing) potential at higher passage levels."

CONTRAINDICATIONS TO THE VACCINE ARE:

- Hypersensitivity to the active substance or to any of the excipients - Sucrose, Di-sodium Adipate, Dulbecco's Modified Eagle Medium (DMEM), Sterile water.
- Hypersensitivity after previous administration of rotavirus vaccines.
- History of intussusception.
- Subjects with uncorrected congenital malformation of the gastrointestinal tract that would predispose for intussusception.
- Subjects with Severe Combined Immunodeficiency (SCID) disorder.
- Administration of Rotarix should be postponed in subjects suffering from acute severe febrile illness. The presence of a minor infection is not a contraindication for immunisation.

Rotavirus occurs in several strains. RotaTeq, available in the USA has five of them. Rotarix, available in the USA and the UK has one. It is predictable that once these strains are vaccinated against, there will be "evolutionary pressures on circulating rotavirus strains, favoring those that are most resistant to the neutralizing activity of vaccination-induced immunity. Reports from Brazil and Australia have described changes in rotavirus genotype prevalence following vaccine introduction but it has not been established that these observations are a result of vaccine-induced immune pressure or simply reflect natural temporal variations in rotavirus genotype circulation".

Wild rotavirus evolves and diversifies by reassortment, interspecies transmission, point mutation and intragenetic combination. A study in India published in 2013 has already identified children with rotavirus strains made by gene reassortment between bovine (cow) and porcine (pig) and human rotaviruses. With a whole reservoir of animal rotavirus strains with which to make new genetic combinations, it is inevitable that any vaccine will fail to keep up with the changes, as has happened with the whooping cough and mumps vaccines – or even encourage them.

IN SUMMARY

The rotavirus vaccine is being introduced against a virus that is present worldwide, for a disease that is part of normal growing up, for infection that can generally be prevented by breast feeding - and if it is acquired by babies it is usually at appropriate times when necessary for their own particular development - and can be easily managed using simple home nursing, because it has been found to be 'cost effective' by:

1. Making estimates of the number of hospital admissions, GP visits, Accident and Emergency cases and calls to NHS Direct that are caused by the rotavirus and assuming that the vaccine will stop them,
2. Assuming that the vaccine will protect

children for five years - which is unlikely, given that immunity from the first natural infection only lasts for about one year which has also been found in the USA to occur after vaccination.
3. Assuming that it will protect other people through 'herd immunity' - by reducing transmission of the virus so unvaccinated people are protected, and
4. Assuming it will stop 'community' infections which include cases of rotavirus gastroenteritis that are so mild that their parents don't even take them to their GP, practice nurse, health visitor, A&E department or call NHS Direct about them – so hardly life-threatening...

And all this for a vaccine which not only carries the risk of a diarrhoea and vomiting illness similar to the one you are trying to prevent, but also carries an increased risk of a very serious bowel condition – intussusception - which frequently requires surgery to correct it and is potentially life-threatening.
The decision is yours.

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MBBS DRCOG DFFP DCH MRCGP MFHom 19 June 2013

To book consultation by telephone or in person to discuss health or vaccination issues, or if you would be interested in hosting a lecture or workshop in your area, please call: T/F 0044 (0)20 8632 1634 (and leave a clear message) or email: jaynelmdonegan@yahoo.com

Dr Jayne LM Donegan
MBBS DRCOG DCH DFFP MRCGP MFHom
London, UK
www.jayne-donegan.co.uk/

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27 October 2013, Sunday afternoon, London NW4
11 November 2013, Monday evening, Central London W1

For further details see http://www.jayne-donegan.co.uk/lecturesworkshops

THE HEALING CRISIS
Organised by the Institute of Osteopathic Medicine

Sunday November 24th 2013, day conference

This is a day conference exploring the importance of the healing crisis as part of the practitioner/patient relationship in modern osteopathic practice. No current RQ college teaches the healing crisis as part of the core curriculum, instead it favours the more medical idea of 'tissues causing symptoms'. If we really want to get to grips with the full scope of osteopathic practice we need to both understand the relevance and management of reactions to treatment. The current obsession by medical researchers of 'adverse events data collection' is promising to muddy the waters further regarding what is/is not evidence.
So this conference seeks to dispel the myths and legends surrounding the healing crisis by presenting three keynote speakers who have years of practical experience understanding and managing the healing crisis as a vital part of the patient practitioner relationship. We will round off the day with a "panel of experts", giving you a great opportunity to join the floor with a lively discussion around the theme of the day.

Jayne Donegan GP – The darkest hour is right before the dawn - Children get infectious diseases at appropriate times to provoke a 'healing crisis' whereby they detoxify themselves. Adults do the same but less efficiently. Our patients, however, have been taught to believe that symptoms are wrong, and that they shouldn't have them. They come to us to get rid of them. However, in order to effectively practice holistic medicine, and allow the 'healing crisis' to occur – often getting worse before getting better – we must be able to educate our patients and to manage their expectations – but in order to be able to do this effectively, first of all we need to be able to manage our own! This event gives you the tools to do so.

Stephen Gamble – Super nutrition - Stephen will be talking about The Gerson Therapy and how it encourages and supports the organism to restore energy to the 'healing mechanism' by using super nutrition.

Howard Beardmore DO – Your first duty to the patient is to treat the toxic state.
The purpose of traditional osteopathic practice is to stir up the constitution, remove obstructions to elimination and make 'expensive' compensations unnecessary. The body does not really 'go wrong', it is always trying to do the best with the resources that it has. A slow bowel for example may lead to a compensatory elimination via the lung and produce a chronic cough in the patient. Understanding the healing crisis is half of practice, having no knowledge of its importance is like having a plane with no wings!

Leon Lewis – Master Chef and provider
It's winter and Leon will be here in person again to provide a hot winter buffet of amazing vegetarian and wholefood celebration for midday lunch. We have a reputation for providing good food and sustenance for our events, little point talking about health and then not seeing lunch as an opportunity to take the day further. Leon will also be bringing a selection of his great cookery books for you to buy and his wild food/mushroom walks get booked up so take this opportunity to link up with him.

For tickets go to:
https://bookwhen.com/72k3q
The 'healing crisis conference' will be held in Reading Berkshire and the venue will be announced just prior to the event.
http://www.british-institute-of-osteopathy.org/

PUERPERAL FEVER

SUZANNE HUMPHRIES

ONE OF THE UGLIEST, most tragic, and most avoidable chapters in the history of medicine is that of puerperal fever. Puerperal fever is the name given to a deadly infection that affected many mothers in the immediate post-partum period. Severe pain, pelvic abscesses, sepsis, high fever, and agonizing death were brought about by an ascending infection introduced by the contaminated hands of doctors and unsterile medical instruments.

In the United States, Europe, New Zealand, Sweden, and wherever conventional midwifery was abandoned and taken over by the new male midwives known as obstetricians and medical students, puerperal fever followed.

Man-midwifery was an uncertain but increasingly fashionable and sometimes quite lucrative area of practice for physicians; it may, for this reason, have been a field in which ideas about theory and practice were particularly strongly contested. Midwifery, formerly the preserve of women, was receiving increasing attention from medical men - both physicians and surgeons - during the eighteenth century. Prominent within this area of practice were the surgeons, for whom midwifery was seen as a natural extension of their activities. Surgeons had traditionally been called in to difficult births by midwives, usually when there was a need to extract an already dead foetus from the womb in order to save a mother's life. During the eighteenth century, surgeons were increasingly finding ways to extend their practice into the area of normal childbirth. Men-midwives, although recognized by society as holding respectable positions and possessing expertise, found their status limited by the "hands-on" nature of their work. Nevertheless, within broader social terms, man-midwifery could be seen as a field of financial and career opportunity. These ambiguities and uncertainties within the status of men-midwives may have contributed to the intensity and competitiveness of the debates which can be found in their writings.

Puerperal fever, also known as childbed fever, was a disease mediated by doctor arrogance. Dr. Oliver Wendell Holmes of the United States and Dr. Ignais Semmelweis of Austria were prominent, long-suffering advocates for women, who tried to get the medical profession to wash their hands and practice more like the traditional midwives did. Both were ignored and even professionally attacked for their views. After years of mental anguish, watching women die needlessly, they left the field of medicine in disgust. Dr. Holmes became a writer, and Dr. Semmelweis died in an insane asylum shortly after admission (beaten by the guards) at the age of 47.

"Doctors often went from touching infected corpses in the cadaver dissection lab, to the maternity ward, where they examined women and delivered babies without handwashing."

The reason puerperal fever is important in the context of the "not so good ol' days" is because the massive loss of maternal life impacted husbands, surviving infants, older surviving children, the family unit, society . . . and the statistics on life expectancy. Yet we rarely hear the words "puerperal fever" mentioned or discussed.

The epidemic of women and babies dying is documented from records as early as 1746, where more than 50 percent of mothers who gave birth in a Paris Hosptial died. However, the best and most comprehensive writing on the problem came from Dr. Ignais Semmelweis in his book, Etiology, Concept, and Prophylaxis of Childbed Fever. After noting that the mothers who were tended by medical doctors had more than three times the rate of death than those tended by midwives and that those who were not internally examined lived, he suspected a contagious agent. Doctors often went from touching infected corpses in the cadaver dissection lab, to the maternity ward, where they examined women and delivered babies without handwashing.

Dr. Semmelweis directed the doctors of his hospital to use a chlorinated lyme solution on their hands prior to touching women. When doctors and medical students complied, the maternal mortality rate went from a high of 32 percent down to zero. Using a similar antiseptic technique, Dr. Breisky of Prague reported in 1882 that he delivered 1,100 women in succession without a single death.

Dr. Semmelweis held several sequential staff positions, and wherever his hygiene method was followed, maternal mortality rates dropped. But most of his contemporaries ignored such outrageous and offensive "nonsense."

Doctors were insulted at the suggestion that their hands were dirty, and many had the arrogance to continue to ignore factual evidence showing that they were the cause of maternal suffering and death up until the 1940s

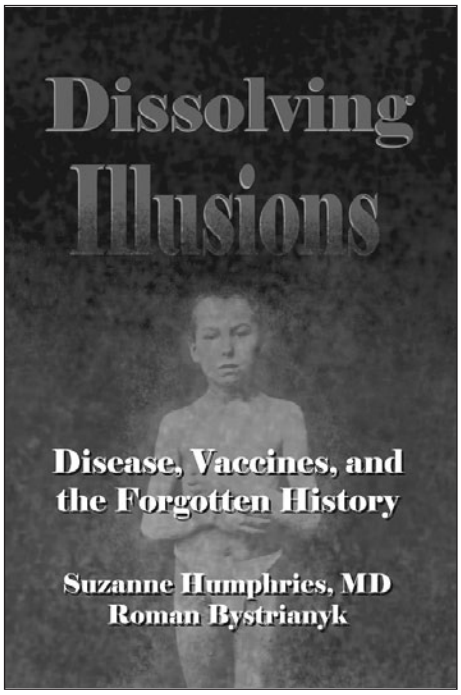
when antibiotics were invented.

After the invention of antibiotics, puerperal fever dropped significantly, but Semmelweis' and Breisky's records proved that doctors could have stopped all the puerperal fever deaths from occurring in the 1700s if they only washed their hands and their instruments and stopped using unnecessarily invasive birthing techniques.

Another example, from Britain, was the widespread use of chloroform and forceps by general practitioners in uncomplicated deliveries between 1870 and the 1940s. This was described by one observer as a tendency a "little short of murder" and accounted for many unnecessary deaths.

Considering that one-fifth of the population consisted of women of childbearing age and that a higher than 30 percent maternal mortality rate was not uncommon, the impact on society, life expectancy statistics, and the infectious disease rate (infants whose mothers died around childbirth had a four times higher risk of dying, most commonly from infections) was enormous. Yet vaccine enthusiasts never mention this tragedy in their assessment of history and infectious disease. Instead, vaccines are lauded as the great gift to humanity when, in fact, had doctors simply washed their hands, they would have prevented countless millions of deaths and raised the life expectancy curve markedly.

The end result of puerperal fever was millions of motherless children relegated to die, or to live a life of malnutrition and disease, often forced to work in mines, factories, and sweat shops. Puerperal fever fueled a social bonfire that left enormous damage in its path. If those infants had mothers to



breastfeed them and love them and the older siblings had a mother at home to tend to their needs, the disease and misery of the 1700s to 1900s would have been far less prominent. Doctors today believe that vaccines would have reduced those diseases, while they ignore the fact that their own predecessors created one of the situations, which resulted in high disease rates and low life expectancy.

It wasn't long ago when lethal infections were a regular part of living in the Western world. Starting in the mid-1800s, there was a steady drop in the deaths from all infectious diseases, decreasing by the early 1900s to relatively minor levels.

Many people believe that vaccines and antibiotics are responsible for the increase in lifespan and decline in mortality from diseases. However, the data clearly show that this is an illusion, propagated by misinterpretation of data, and dissemination of mythology by corporate interests.

The journey from disease cesspool into our modern world is a tale of plagues and famine, crushing poverty and filth, lost cures, eugenicist doctrine, individual freedoms versus state might, protests and arrests over vaccine refusal, and much more.

Dissolving Illusions paints a historic, medical, and statistical portrait with quotes from the pages of long overlooked medical journals, books, newspapers, and other sources that reveal a startling history that was almost forgotten. With this historic information and originally researched data in the form of myth-shattering graphs, Dissolving Illusions shines new light onto issues that are assumed to be clear-cut and settled long ago.
Perhaps the best reason to know our history is so that the worst things are never repeated.

Fracking protesters like MMR scaremongers, says Church of England

JOHN-BINGHAM,
TELEGRAPH 16 AUG

THE CHURCH OF ENGLAND has likened vocal opponents of fracking to scaremongers who spread misinformation about the MMR vaccine, leaving children at risk of a measles epidemic.

It also publicly accused opponents of shale gas exploration of ignoring the interests of the poor, who might benefit from cheaper energy bills and jobs.

And while strongly denying seeking to gain financially from fracking by reasserting centuries-old mineral rights, it refused to rule out the possibility of drilling on Church-owned land. In signs of a growing split within the Church over its approach to the controversial technique, senior officials also appeared to criticise one diocese that said fracking was a threat to "God's glorious creation" as being not "sound scientifically".

The row broke out as the Church issued its first official statement on the issue, setting out the arguments in favour of fracking. While insisting it had "no official policy" on whether or not it supported fracking, it criticised those who advocate "blanket opposition".

It also warned against giving "cowboys and cavaliers" free rein to exploit the Earth's natural resources but insisted that environmental risks could be minimised.

Fracking, which involves fracturing underground rocks to extract gas and oil, might be "less than ideal" in terms of cutting carbon dioxide emissions, it argued, but is still less harmful to the planet than burning coal.

MEASLES, FEAR AND DISINFORMATION

ALAN PARK
japp8888@yahoo.co.uk
16 June 2013

UNTIL I ATTENDED a lecture by Trevor Gunn in 2008, in which he set out the evidence for the dramatic reduction in mortality rates for various diseases prior to the introduction of vaccinations for these diseases, I had assumed, like the majority of the population, that vaccination was one of the great successes of Western medicine. Further research cast serious doubts on the effectiveness, safety and need for vaccination but, without children, the matter was academic.

In 2009 my wife became pregnant with our first daughter. And children, as we know, change everything. Although we had plenty of things to concern ourselves, we also knew we would have to make a decision about vaccination. Some or none? Later or never? How would GPs and health visitors react? For several months we read, researched and discussed. When the time came for our daughter's 2 month check, we wrote a letter to our GP setting out all our reasons why she would not be vaccinated. We invited our GP to challenge our stance and persuade us to reverse our decision. I prepared for a debate and marshalled my paperwork.

The appointment with our GP was without drama. No debate. No challenge. A simple, "Well, if that's your decision...." We were relieved and satisfied. There really was freedom of choice without pressure from the medical establishment.

But there isn't. In Scotland, where we live, vaccination rates generally exceed 95%. How many question the necessity or wisdom of 21 doses of several vaccines by the age of 5? How many challenge accepted medical paradigms and make an informed choice? Freedom of choice cannot exist in an information vacuum.

However, information is only part of the puzzle. Another is fear. There has been no better recent demonstration of that in the UK than the measles 'outbreak' in Wales this year.

News reports on the outbreak, such as the BBC news website articles of 25 April and 7 June, are typical. Like much of our news these days, the reports are made up principally of other organisations' press releases. Fear of getting measles and fear of the spread of measles is the central message, in the expectation this will ensure greater uptake of the MMR vaccination. There is no critical analysis by the media of any of the information presented or statements made by medical experts. A couple more small bricks placed in the wall of dogma and presented through the media to the population at large.

Yet the establishment is vulnerable. It has become lazy. On 2 May Public Health Wales (PHW) issued a press release stating that across the whole of Wales the total 'cases' of measles was 1170. Further down the press release is the crucial statement that:

"The number of laboratory confirmed cases in the outbreak stands at 370 out of a total of 850 samples tested."

After I read it the first time I had to read it again. This didn't make sense. How can the number of cases be 1170 if the number of confirmed cases is 370? How did the 850 samples relate to the number of cases?

A secondary issue was the statement in the press release that the 10-18 age group was the hardest hit when the bar chart illustrating notifications of measles clearly showed that most notifications were in the 1-9 age group.

I wanted to find out. On 7 May I sent a freedom of information request by email to PHW seeking clarification on both issues. Concerning the number of cases I asked:

"The press release states that the number of measles cases across Wales is 1170 (presumably as of 2 May) but goes on to explain that the number of laboratory confirmed cases is 370 out of a total of 850 samples tested.

If the 1170 figure is the total number of notifications, and 850 of 1170 notifications have now been tested, with only 370 confirmations, I do not understand why the press release refers to 1170 measles cases? Do I misunderstand the position? I would be very grateful for clarification."

On 8 May I received an emailed response from PHW's information governance department. The answer to my confusion over the number of cases was:

"....the 1170 number of cases are notified by GP's, Hospitals etc and as yet not laboratory confirmed as the 370 are. To be laboratory confirmed each notified case has been sent via the post or (done at the GP) a swab to be self taken and posted back. If this swab is received back by the laboratory (the 850 figure) it is tested and then a notified case becomes a confirmed case. Unfortunately if the swab is not returned, then we have no means of confirming the alleged case via laboratory testing.

At this time there is a possibility that any one presenting to a GP with a rash will be diagnosed with measles, hence the high figures. Public Health Wales data only shows laboratory confirmed cases, hence the difference. I hope this helps explain the situation for you."

IT DIDN'T EXPLAIN THE SITUATION AT ALL.

I was astonished. This was highly misleading. If one has information that, out of 1170 notifications, 850 swabs had been sent for lab testing and only 370 were confirmed as measles cases, how can PHW be justified in promoting the larger number of notifications as if they were confirmed cases of measles?

I responded on 9 May with:

"As I understand you, the 1170 are the notifications. Of that number 850 sent in swabs and of those 370 were confirmed as having measles. Even if the other notifications are measles cases then the total number of actual measles cases can be no higher than a maximum 690 (370 + 320). However, as 370 out of 850 notifications were confirmed as measles that leads to a conclusion that the notification/confirmation

percentage is 43.5%. Applying that percentage rate to the 320 notifications untested results in a figure of 139. Added to the 370 confirmed cases one is then able to argue there have been probably 509 cases of measles.

That brings me back to the Public Health Wales position of using the notification figure as the number of measles cases when you have data showing the majority of notifications actually tested for measles do not result in confirmation of measles. This is highly misleading."

PHW finally responded on 29 May:

"Dear Mr Park
I have asked our Epidemiologists to look at your questions.....
One of the reasons that notifications of cases are used to monitor the outbreak is that the information provided is more timely. Due to the logistics involved, there is usually a lag between a case being notified and its subsequent laboratory test result. Public Health Wales provide periodic updates of the numbers of notified cases that have tested positive throughout the outbreak. When the outbreak is over, Public Health Wales will be able to provide final totals for the numbers of notified cases that were laboratory tested and confirmed to be measles positive.
Totals for laboratory confirmed cases may be lower than notifications data for a number of reasons, samples may have been taken incorrectly (some patients will provide their own samples directly) or too long after the onset of illness and not all patients necessarily provide samples for testing. In addition to this, there are other conditions for which the early symptoms are similar to those of measles and sometimes these are reported to Public Health Wales by doctors erring on the side of caution, this is especially true for young children.
Notifications of measles represent people with measles symptoms who have consulted a doctor and are subsequently reported to the Public Health Wales Health Protection Team by the doctor, this will not be all cases in the population. Historically, prior to the introduction of MMR around 50% of cases of measles in the UK were notified."

It is not unreasonable to suggest that not all measles cases are reported. Whether 50% are unreported in the Wales outbreak seems unlikely given the media coverage and the massive vaccination drive over several weeks. However, what is unacceptable is the deliberate application of the number of notifications of measles cases as equivalent to the number of actual measles cases, especially as the majority of notifications prove not to be measles! Even if we doubled the number of notifications the figures suggest we would still be faced with the majority of these notifications proving not to be measles. In any event, where actual figures are available, these should be used and any speculation as to the extent of the problem should be clearly stated as such. Not only is clinical diagnosis proving to be hit or miss (more common than I would have believed) but the epidemiologists and statisticians appear entirely willing to present a fraudulent picture to encourage fear in support of the wider MMR campaign.

"If the measles virus attributed to the vaccine, as contrasted with the wild type measles virus, is identified in a case sent for laboratory confirmation, is that case recorded as a confirmed case of measles?"

What about the issue of the hardest hit group? The answer was also in the 29 May PHW response:
"It is true that from the notifications graph children aged younger than five years appear to account for the highest number of cases, however from the numbers of laboratory confirmed cases, children and young adults aged 10 to 18 years are the hardest hit group. For the reason given below, notifications of measles have been used to report progress of the measles outbreak."

I see. So when it suits PHW to concentrate on the most relevant figure, that of confirmed cases, it is prepared to do so. When the figures become available it will be very interesting to review them.

I should note that the press release of 2 May is the only one I can find which sets out the number of cases sent for lab testing and the number of confirmed cases (as of that date). There has been no updated release of similar aggregated information. Whilst the number of confirmed cases to 29 May is published on the PHW website as 303, it should be noted that PHW only publishes the results of cases sent to Welsh labs. Many of the samples are sent to labs in England and are not included in that figure. This explains the discrepancy between the 370 confirmations of 2 May (which must be the total from both Welsh and English labs as of that date) and the figure of 303 as at 29 May.

We will have to wait for complete data after the outbreak is regarded as over but two other issues of interest have arisen in the course of correspondence with PHW. The first is the number of unvaccinated v vaccinated patients contracting measles. The PHW website section on 'data about the outbreak' (as at 16 June) states "less than 10" cases of measles have occurred in the vaccinated, although this statement has been unchanged since early May and cannot be accurate now, even if it was earlier. If such a small number is accurate, this runs counter to other outbreaks of measles and of other childhood diseases. Indeed, some reports indicate the majority of the cases are in the vaccinated. I will, however, avoid further speculation in the current information vacuum!

On 3 June I asked PHW a final question at the suggestion of Informed Parent's editor, Magda Taylor, and Dr Jayne Donegan:
"If the measles virus attributed to the vaccine, as contrasted with the wild type measles virus, is identified in a case sent for laboratory confirmation, is that case recorded as a confirmed case of measles?"

This is clearly a crucial issue because ›

of questions over the real number of cases, the host of concerns over the effectiveness of vaccines and the possibility that the attenuated virus from the vaccine could be keeping more measles cases in circulation than would otherwise be the case.

As at the date of writing (16 June) no response has been received. However, I decided to ask the same question in an exchange of emails with a senior epidemiologist from Health Protection Scotland on 5 June. He responded the same day:

"We do on occasion get a vaccine-associated rash, which is due to the attenuated strain of measles. We do not however record this as a case of measles. There is a difference between de novo clinical infection and vaccine-precipitated rash. There are parallels with other vaccines e.g. the shingles vaccine can occasionally cause a rash – we wouldn't record that as a case of shingles however."

That does not answer the question but is a line of investigation for another day.

I was 39 in 2008. I believe most people form their understanding of how the world works by then and it is hard to change that understanding. Although my wife and I managed and we now know so much more, there remains a nagging worry as to whether our decision was and is the right one, a concern which is particularly relevant because of the birth of our second daughter last year. That will ensure we constantly assess our view and the view of the medical establishment because our children are too important not to do that. But we will not give in to fear and disinformation.

PARALYSIS HAUNTS "POLIO FREE" INDIA

BY JAGANNATH CHATTERJEE
M.O.K.S.H. (INDIAN ORGANISATION).
20/5/13

POLIO, synonymous with paralysis and disability, has been given a new name in India. It is now known as AFP or acute flaccid paralysis. This and the fact that cases of polio caused by the Oral Polio Vaccine (OPV) are not being reflected as polio have ensured that India is into its second year of "polio free" status. After this charade is maintained for one more year, India will be certified by the WHO as "polio free" and will be showcased as a success story of the Global Polio Eradication Initiative that was launched in 1988 by the World Health Assembly.

Small pox was declared eradicated in 1980. According to medical researcher Prof William Muraskin, the experts involved in this exercise were looking for another opportunity to flaunt their skills. When they chose polio many eyebrows were raised. Polio was not on the priority radar of the countries where this exercise was to be launched. These developing nations were struggling to provide basic health needs. India, for example, was incapable of providing clean water, sanitation, hygiene, and nutrition for a majority of its population even 65 years after Independence.

Furthermore OPV was chosen to be the only weapon to eradicate polio. Dr T Jacob John pointed out that this vaccine, consisting of live viruses, is notorious for causing vaccine induced polio. Not only does it cause polio in the recipient but as those vaccinated tend to shed the virus in their stools, it could mutate and regain its former virulence causing polio in others who come in contact with it, and also cause polio epidemics.

Dr Anant Phadke and C Sathyamala argued that it is not possible to eradicate polio, a disease primarily of poor sanitation and nutrition, with a vaccine. Polio like paralysis can also be caused due to other factors. DDT and other pesticides, exposure to lead and arsenic, the DPT vaccine, and any injection or surgery like tonsillectomies can trigger polio. Thus a holistic approach was needed to tackle the disease.

Medical textbooks reveal that exposure to polio viruses does not necessarily result in paralysis. More than 95% of those exposed will show no symptoms at all. Of the rest, many will exhibit symptoms resembling a common cold, a few will suffer temporary lameness, and less than 1% will exhibit permanent paralysis some of whom may die. Exposure to the polio virus is actually the best immunity against viral polio. It offers permanent immunity to more than 99% exposed to it. According to Dr Yash Paul, those who become permanently paralysed may have some inherent susceptibility that should be investigated.

Again, Dr Phadke pointed out that small pox and polio eradication are two entirely different things. Polio viruses can infect children without causing any

Another Polio victim

external symptoms and thus remain in circulation. He alleged that it was for the benefit of the developed nations, who could stop their vaccination programs once the wild polio virus was eradicated worldwide, and for the OPV manufacturers who were keen for the programme as their product was discontinued in the developed countries due to the risks involved, that the polio eradication strategy was launched. This eradication effort, costing over $ 1.2 billion from the Indian governments coffer alone has broken the backbone of the Indian health system.

The National Polio Surveillance Project data shows that it has instead increased paralysis among children from 3047 cases yearly in 1997 to 61,038 cases in 2012, being classified as AFP. The Government does not reveal how many of these cases are due to the vaccine. It was observed in 2005 that against 66 cases of polio caused by the polio virus in that year, 1645 were caused by the vaccine. Data reveals that those vaccinated are 6.26

times more likely to be paralyzed. The total number of children suffering AFP since 1996 in India has crossed 455,000 as per WHO polio surveillance figures.

It is known that there are many strains of the mutated virus strains running loose in India. In Japan, after three months of use, 31 strains of the vaccine viruses were found in sewerage and in its rivers, of which 16 were extremely virulent. India has been using the vaccine since 1978, intensively since 1997, and one cannot even imagine how many virulent strains could be circulating in the country that is devoid of basic sewerage disposal and sanitation facilities.

Why are more than 60,000 children in India coming down with paralysis every year? Dr Neetu Vashisht has analysed that the cases of AFP in India are directly proportionate to the number of doses of OPV given, implying a relationship. Taking into consideration the normal AFP rate, it has been deduced that in 2011, India has suffered 47,500 extra cases of paralysis. Studies have shown that death rates in children with AFP are twice as high as the death rate among children with polio paralysis.In Brazil, a study has implicated this vaccine in cases of Guillain Barre Syndrome, transverse myelitis, and facial palsy. Thus the claim of the Government that these cases of paralysis have no relation to the vaccine merits extensive investigation.

In April 2004 a memorandum has been submitted to the WHO, UNICEF and the Government of India by Prof Debabar Bannerjee and other eminent doctors pointing out that the WHO inflated 32,419 cases of polio to 350,000 to justify the programme. The definition of polio has been changed repeatedly after the programme was launched thus automatically leading to a drastic fall in the number of cases. A significant number of children being declared polio affected by the polio virus was sufficiently vaccinated and that, children were being rendered paralytic directly due to the vaccine.

"Why are more than 60,000 children in India coming down with paralysis every year? Dr Neetu Vashisht has analysed that the cases of AFP in India are directly proportionate to the number of doses of OPV given, implying a relationship."

The memorandum also pointed out that polio eradication was not possible in India as the vaccine viruses had mutated into virulent strains and were circulating. In August 2006, the Indian Medical Association reiterated the above and called for identifying the unfortunate victims and compensating them.

Today, throwing all caution to the winds, children are being given an unprecedented 50 doses of the vaccine and even those who should be medically exempt are being vaccinated. Dr Puliyel reveals that a synthetic version of the polio virus with a formula called 'CHNOPS' has been devised making a mockery of the eradication effort.

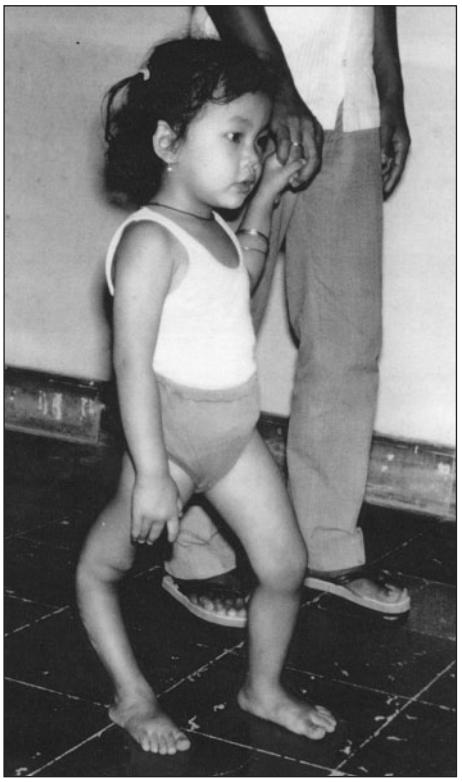
Dr Pushpa Bhargava points out that polio was already on the decline even before the eradication effort began. Polio in India was concentrated in few pockets of UP and Bihar which accounted for 96% of the cases reported. Improving sanitation and nutrition in these areas along with routine rounds of the relatively safer IPV would have drastically reduced polio without taking resort to chicanery which has resulted in an unprecedented toll of disability in children in all parts of the country.

Hidden in the packet inserts of the OPV is an ominous statement; the vaccine has not been tested for causing cancer or infertility. The presence of untested monkey viruses, phenol and polysorbate 80 in the vaccine raises concerns. It is also known that the vaccine virus strains can lie latent in the body and cause polio decades after administration. Health officials of Nigeria who have got batches of the vaccine tested in sophisticated laboratories in India have been shocked at the level of contaminants found in the vaccine.

India is now preparing to launch the much costlier IPV all over the country which will require money and trained manpower at a scale that it currently does not have, to counter the vaccine viruses in circulation. The wild polio viruses which actually conferred immunity from wild virus caused polio to children are now no longer widely prevalent leaving future children exposed to unexpected epidemics. The so called benefits of polio eradication have eluded the indebted country and its children stare at an uncertain future. It is important that lessons from this misadventure be learnt to oppose future assaults on the children of our country.

MOKSH: (Monitoring Knowledge & Social Health). An International Network of Eminent Scientists Questioning the Science Behind "Science".

NEW POLIO VICTIM APPEARS IN PUNJAB



UMAIR AZIZ
www.pakistantoday.com.pk
Sunday, 16 Jun 2013

LAHORE - A fresh polio case came to the forefront in a Punjab village, once again striking down tall claims of the Punjab Health Department in coping with the menace, despite billions of rupees spent by international donors, Pakistan Today has learnt.
Eight-year-old Noorun Nisa of Bhalwal, Sargodha is the new victim of the virus which is now found in only three third world countries including Pakistan, India and Afghanistan.

The Bill and Melinda Gates Foundation earmarked billions of rupees for bringing polio to an end in Pakistan, which remains far behind in performance. India, with its large population, only had one reported polio case last year.

However, according to the World Health Organisation (WHO), this is the second polio case appearing in Punjab, the other one reported in Mianwali.

A representative of the Bill and Melinda Gates Foundation met Prime Minister Nawaz Sharif only a few days ago, reiterating the resolve to eradicate polio.

According to initial medical reports of the patient, **Nisa was administered around eight to 10 doses of polio, yet she was found to be carrying the disease.** (Our emphasis.)

This also raises a lot of questions on the efficacy of the vaccination being procured, besides reflecting on the routine expanded programme for immunisation (EPI).

In a province already hit by measles, another consequence of flawed immunisation campaign, a fresh polio case is definitely not good news for the health department.

Health Director General (DG) Dr Tanwir confirmed that a case had been reported and that teams had been set to investigate the matter. "Polio drops are administered only till five years of age and she is an eight-year-old. It only indicates that the immune system in the child was not strong enough and bares no reflection on the efficacy of the medicine. The disease is very rare after 5 years of age. The case is still being investigated. A report will also be furnished," he said.

Responding to a question, he said per WHO guidelines, the government will take all measures and more than one million children will be administered vaccination surrounding this district in the coming days.

Health Secretary Hassan Iqbal said the government is investigating the matter since the case was reported only a couple of days ago. "Now that a case has appeared, we can only investigate the matter and evaluate possible causes," he added.

Polish study confirms vaccines can cause large number of adverse effects

ARJUN WALIA
www.collective-evolution.com
August 2, 2013

BRIEF EXTRACT

Despite the conviction of the necessity and safety of vaccinations, there are a number of studies coming forward that illustrate the potential dangers they may pose. A scientific review published by the Department of Paediatric Rehabilitation from the Medical School at the University of Bialystok has determined that there are a number of neurological adverse events that follow vaccination. This research is specific to Polish vaccinations, but is still useful given the fact that many ingredients used and examined in the study are still used in vaccinations all over the world.

The University of Bialystok is a well known medical university that has published a tremendous amount of research on various topics. The evidence that's out there supporting the hazards of vaccines is irrefutable. There is a lot of research that medical professionals are not privy to, this is credible research coming out of Universities done by doctors and professors. Medical professionals are usually guided to research done by pharmaceutical companies and the vaccine manufactures themselves. It's important to look at both sides of the coin, and examine all information available before coming to a conclusion.

It is not reasonable to assume that manipulation of the immune system through an increasing number of vaccinations during critical periods of brain development will not result in adverse neurodevelopment outcomes(1)

The study addresses the use of vaccines in terms of adverse effects, immune system effects, neurological symptoms following vaccinations and a history of vaccines demonstrating little benefit. We often hear of studies only from the western world, expanding our sphere of research to a global one provides us with a broad range of information coming from a variety of different sources. A report like this coming from a medical school should not be taken lightly. It coincides with a lot of other research that's emerging to suggest that vaccines can be hazardous to human health.

Declaring a truce with our microbiological frenemies

http://www.sciencedaily.com/releases/2013/03/130328125228.htm
Mar. 28, 2013

MANAGING bacteria and other microorganisms in the body, rather than just fighting them, may lead to better health and a stronger immune system, according to a Penn State biologist.

Researchers have historically focused on microbes in the body as primarily pathogens that must be fought, said Eric Harvill, professor of microbiology and infectious disease. However, he said that recent evidence of the complex interaction of the body with microbes suggests a new interpretation of the relationship.

"Now we are beginning to understand that the immune system interacts with far more beneficial bacteria than pathogens," said Harvill. "We need to re-envision what the true immune system really is."

Harvill said that this reinterpretation leads to a more flexible approach to understanding how the immune system interacts with microbes. This approach should balance between defending against pathogens and enlisting the help of beneficial microbes.

While the role that some bacteria play in aiding digestion is better known, microbes assist in improving body functions, including strengthening the immune system and responding to injuries.

In some cases, attacking pathogens can harm the beneficial effects microbes have on immune system, according to Harvill. For example, patients on antibiotics have an increased risk of contracting yeast infections and MRSA.

"Viewing everything currently considered immunity, including both resistance and tolerance, as aspects of a complex microbiome management system that mediates interactions with the sea of microbes that surround us, many of which are beneficial, can provide a much more positive outlook and different valuable perspectives," Harvill said.

"Now we are beginning to understand that the immune system interacts with far more beneficial bacteria than pathogens," said Harvill. "We need to re-envision what the true immune system really is."

The system that includes bacteria and other microbes in the human body, or the microbiome, is much larger and more integrated into human health than most people suspect, according to Harvill.

"The human body has 10 times more bacterial cells than human cells," said Harvill.

Adding to the complexity is the adaptive capacity of the human immune system. The immune system can develop antibodies against certain pathogens, which it can reuse when threatened by future attacks from the same pathogen.

Harvill, who described his alternative viewpoint in the latest issue of mBio, said that some researchers have not yet accepted this broader approach to the immune system.

"Among immunologists or microbiologists this is an alien concept," said Harvill. "It's not part of how we have historically looked at the immune system, but it's a useful viewpoint."

Other researchers who study plant and nonhuman biology are already starting to embrace the concept. For example, plant biologists are beginning to recognize that viruses can help plants resist drought and heat.

"Within nonhuman immunology, this is not an alien concept because they have seen many examples of beneficial relationships between the host and its microbial commensals," Harvill said.

Harvill said adopting this new perspective could be the first step toward new medical treatments.

"This new viewpoint suggests new experiments and results will published," said Harvill. "And, hopefully, the concept becomes more and more mainstream as supporting evidence accumulates."

The National Institute of General Medical Sciences supported this work.

"A compassionate community will not be achieved only through prayer; I pray myself, but I accept its limitations. we need to take action to develop compassion, to create inner peace within ourselves and to share that inner peace with our family and friends. peace and warm-heartedness can then spread through the community just as ripples radiate out across the water when you drop a pebble into a pond."

~ Dalai Lama

The Quanten Theory

COMMON CHILDHOOD DISEASES by Patrick Quanten MD

Patrick Quanten MD

BEFORE we start panicking about the effects of common childhood diseases we might want to take a look at what they are and how much danger they bring into those little lives. We will begin by listing the most common diseases and their known facts.

1. MEASLES

Measles is an endemic disease, meaning that it is continually present within the community and people develop resistance. Scientists believe that there are 21 different strains of the measles virus.

Measles symptoms invariably include fever, together with at least one of the three C's (cough, coryza, conjunctivitis). Symptoms will appear about 9-11 days after infection, and may include the following: coryza (runny nose), dry hacking cough, conjunctivitis (swollen eyelids, inflamed eyes), watery eyes, photophobia (sensitivity to light), sneezing, and fever. The fever may be mild to severe and can reach 105F (40.6C) for a number of days. Fever may drop, and then rise again when the rash appears. Furthermore, there are the typical Koplik's spots, which are very small grayish-white spots with bluish-white centers in the mouth, insides of cheeks, and throat. We have aches generally all over the body and a reddish-brown spotty rash appearing 3 to 4 days after initial symptoms. The rash can last for over a week. It usually starts behind the ears and spreads all over the head and neck. After a couple of days it spreads to the rest of the body, including the legs. As the little spots grow many of them will join together.

Measles is caused by infection with the rubeola virus, a paramyxovirus of the genus Morbillivirus. The virus lives in the mucus of the nose and throat of an infected child or adult. And then again, if measles is an endemic disease it, per definition, will be found in healthy individuals too.

2. SCARLET FEVER

Scarlet fever is a rash that sometimes appears with strep throat - an infection with a bacterium called group A streptococcus. A child with strep throat will usually have a very sore throat and high fever. The scarlet fever rash starts on the chest and abdomen and spreads all over the body. It is bright red like sunburn and feels rough like sandpaper. The color of the rash may be deeper around the armpits. The child's tongue may have a whitish appearance, except for the taste buds, which look bright red, a symptom known as "strawberry tongue." There may be some flushing in the face, with a paler area around the mouth.

Scarlet fever was once a feared and deadly childhood illness, but now scarlet fever is just another kind of rash.

3. HAND FOOT AND MOUTH DISEASE

Hand, foot, and mouth disease is not to be confused with foot-and-mouth disease, which infects only livestock. A common childhood illness, hand foot and mouth disease causes a fever with blisters or sores inside the mouth and on the palms and soles of the feet. The blisters may also appear on the buttocks.

Hand, foot, and mouth disease is caused by a variety of viruses called enteroviruses. In the United States, the disease is usually caused by a virus known as coxsackievirus A16. This virus usually goes around in the summer and early fall. Different groups of viruses that are thought to have been causing this diseases on either side of the big ocean.

Hand, foot, and mouth disease may cause a lot of discomfort, but for most children it isn't very serious and goes away on its own after a week to 10 days.

"There is no treatment for viral infections, so it would be wise simply to encourage the system itself to clear the debris up, and not oppose it"

4. CROUP

Croup is a childhood illness usually caused by a group of viruses called human parainfluenza viruses, which also cause the common cold. The main symptom of croup is a "barking" cough, sometimes likened to the barking sound a seal makes. Croup can be serious enough to require treatment in a hospital. Up to 6% of children with croup are hospitalized, but it is very rarely fatal. For severe cases, treatment helps to keep the sick child breathing normally until the infection ends. A case of croup typically lasts about one week.

Children who get croup tend to be younger than 6 years old, and it's seen most frequently in 2-year-old children.

5. FIFTH DISEASE

Fifth disease has been called the "slapped cheek" disease because it causes a red rash on the face that looks like a slap mark. A lacy red rash may also appear on the child's torso and limbs. Fifth disease doesn't always make a child feel ill, but it can feel like a cold early on, before the rash shows up.

We now know that fifth disease is caused by a virus called human parvovirus B19. Up to 20% of children may get the virus before age 5, and up to 60% have had it by age 19. Infections are usually not very serious and go away in seven to 10 days. Many children infected

with the virus don't show any symptoms. However, sometimes infection with parvovirus B19 can lead to new onset of joint pain and be mistaken for rheumatoid arthritis. These joint symptoms usually go away within three weeks.

6. WHOOPING COUGH

Whooping Cough is a contagious bacterial infection, Bordetella Pertusis. Adults and children can get the disease, but infants tend to become more severely ill with it. It's called whooping cough because it can cause a child to cough so hard and so rapidly that he runs out of breath and must inhale deeply, making a "whooping" sound.

According to the CDC, more than half of babies under 12 months old who get whooping cough have to be treated in the hospital.

Adults who catch whooping cough may not have severe symptoms.

7. GERMAN MEASLES

German measles (rubella) is an illness caused by a virus. Epidemics tend to break out every three to four years, although the illness is less contagious than measles and chickenpox. While most children have measles in their early childhood, a lot do not get German measles until they are quite a bit older: 10 to 20 per cent of 20 to 25-year-olds have never had the disease. In fact, a lot of people have German measles in such a mild form that it's never diagnosed. This is referred to as a subclinical infection.

The patient develops a rash. This typically starts around the ears, from where it spreads all over the body in tiny pink spots. The rash changes almost from hour to hour, and will disappear again after about two to three days, requiring no treatment. Up to one week before the rash appears, the patient can suffer a light cold, consisting of a cough and sore throat and/or swelling in the neck and base of the skull (due to the enlargement of the lymph nodes). Sore red eyes (conjunctivitis) can occur and last for several days.

8. CHICKENPOX

Chickenpox is a common illness that causes an itchy rash and red spots or blisters (pox) all over the body. It is most common in children, but most people will get chickenpox at some point in their lives. Chickenpox usually isn't a serious health problem in healthy children. After you have had chickenpox, you are not likely to get it again. But the virus stays in your body long after you get over the illness.

Chickenpox is caused by the varicella-zoster virus.

The first symptoms of chickenpox often are a fever, a headache, and a sore throat. Your child may feel sick, tired, and not very hungry. The chickenpox rash usually appears about 1 or 2 days after the first symptoms start. Some children get the chickenpox rash without having a fever or other early symptoms.

After a chickenpox red spot appears, it usually takes about 1 or 2 days for the spot to go through all its stages. This includes blistering, bursting, drying, and crusting over. New red spots will appear every day for up to 5 to 7 days.

Only whooping cough and scarlet fever are caused by a bacterial infection. Both of these bacteria are from families that are resident inside our bodies and are known to help the system survive, rather than attacking the system.

Other illnesses can have symptoms like those of chickenpox. For this reason, you may think you have had chickenpox twice when instead you have had two different infections.

9. MUMPS

Mumps is a disease caused by a virus that usually attacks the parotid salivary glands. These glands, which produce saliva for the mouth, are found toward the back of each cheek, in the area between the ear and jaw. In cases of mumps, these glands typically swell and become painful.

After a case of mumps it is very unusual to have a second bout because one attack of mumps almost always gives lifelong protection against another. However, other infections can also cause swelling in the salivary glands, which might lead a parent to mistakenly think a child has had mumps more than once. In some cases, signs and symptoms are so mild that no one suspects a mumps infection. Doctors believe that about 1 in 3 people may have a mumps infection without symptoms.

Cases of mumps may start with a fever of up to 103°F (39.4°C), as well as a headache and loss of appetite. The well-known hallmark of mumps is swelling and pain in the parotid glands, making the child resemble a hamster with food in its cheeks. The glands usually become increasingly swollen and painful over a period of 1-3 days. The pain gets worse when the child swallows, talks, chews, or drinks acidic juices (like orange juice).

Children usually recover from mumps in about 10-12 days. It takes about 1 week for the swelling to disappear in each parotid gland, but both glands don't usually swell at the same time.

GENERAL COMMENTS

Only whooping cough and scarlet fever are caused by a bacterial infection. Both of these bacteria are from families that are resident inside our bodies and are known to help the system survive, rather than attacking the system. Under specific circumstances some bacteria are seen in large numbers at a site of cellular debris. One assumes that they must be the cause of the debris. The truth of course is that we, as investigators, arrive very late on the scene. Only after symptoms have persisted for a while do we take a look at what is going on. The reason for this lack in investigative prowess is the simple fact that the preliminary signs are so vague they don't indicate anything specific.

All other common childhood diseases are caused by viruses. It turns out, there is never just one virus but there is a bunch of possibilities. The consequences are obvious. There is no treatment for viral infections, so it would be wise simply to encourage the system itself to clear the debris up, and not oppose it. If you then want to go down the route of prevention through vaccination how can you do that in an efficient and professional manner if you don't even know which virus will be causing the disease in the future within this particular child? Laughing this problem away by saying that it is better to have some 'immunity' than none, even it isn't

very specific, only illustrates the lack of ability to demonstrate "immunity". It is a word that is used a lot in this context but that is never defined in clear and unmistakable terms. And that problem also arises in the "conformation" of a viral infection.

CONFORMATION OF DISEASE

Not often, but occasionally, the news hands us more information than they were meant to. It may show up like this: "There is a measles epidemic in the Midlands where already 367 cases have been reported. Nineteen of these have been confirmed!"

First you have to realize that these infectious childhood diseases are notifiable. This means that doctors have an obligation to notify the authorities of any of these diseases they come across. They are being paid for the notification! That should be obvious, because why should a very busy doctor waste his time on forms if he could earn money? The notification of the disease is based upon the doctors clinical evaluation. If you put the symptoms of these diseases next to each other and you realize that these symptoms will only be very seldom all in view and you put into the equation that a common cold comes close to most of those disease patterns as well, then you may be keen to forgive the doctor if he doesn't actually know. It is a suspicion. The sum of these suspicions depends on what the grapevine tells us: are there "suspected" cases then we are likely to think about those more readily and suddenly we have a whole bunch of possibles.

In the great majority of cases that is where it stays. Authorities don't need much more to use the fear amongst the population to reiterate their power to help. Dependency increases dramatically during those times and people, fuelled by their own fear, will start to attack each other about whose fault it is that another epidemic has struck.

When we are looking for "confirmation" we, at least, need to be able to spot the offending micro-organism on the site of the crime. For bacterial infections we satisfy ourselves by culturing the said bacteria from the collected debris. As mentioned before, that doesn't actually constitutes guilt, but as we do not have to take these critters to court where they have an opportunity to explain what exactly it is they are doing there, it is a done-and-shut case.

The confirmation with relation to viral infections is a bit more complicated, especially as no-one has ever completely isolated a virus at all. In other words, it has proven to be impossible to extract a single virus from living cell debris. Confirmation for a viral infection is then simply a raised antibody count in the blood. First of all, we know that there is no such thing as a "specific" antibody. It is represented as if there is, but science has known for forty years that there are so many cross-over reactions giving false positives that it has become a very unreliable test. And secondly, under these circumstances a high level antibodies is interpreted as proof that an infection is actually taking place. That same medical profession uses the same test with the same high level result to "prove" that you have immunity against that disease.

"First you have to realize that these infectious childhood diseases are notifiable. This means that doctors have an obligation to notify the authorities of any of these diseases they come across. They are being paid for the notification!"

If, by their own admission, the actual confirmed infections is so low compared with the number of reported diseases; if, on top of that, the confirmation doesn't actually confirm anything and leaves so much room for speculation, the reality then is that we do not have any scientific way to link any virus to any disease, let alone accusing the virus of being the culprit.

TREATMENT

These childhood diseases, apart from whooping cough and croup, all present with a rash at some point. The skin is the largest detoxification organ in the body. A skin rash, of whatever sort, is always a result of the excretion of large amounts of waste through the skin. This very strongly suggests that the common childhood diseases all have some connection to clearing up.

When we look at the natural distribution, where that is still possible, of these diseases then we notice that they come in clusters. There is a natural time and a natural age to show signs of a specific disease, followed by a disease free period. This suggests that at a certain development stage of the young child an internal reorganization takes place, which entails some of the old structure to be taken down for it to become replaced with new. This old debris is specific to the development stage the child is at and therefore shows itself as a particular rash and set of symptoms. Common childhood diseases are the end result of moving to a different stage of development. Can this threaten the life of the child? Only if the child is already weak, has very little growth energy and has been placed under tremendous strain already whereby some of his/her development has been seriously away from the natural path of the child.

Treatment should then consist of allowing the child to be ill. Fever should be encouraged as it helps to burn up waste. Excretion through the skin should be encouraged as the quicker the inner system is emptied of waste the healthier the child will be afterwards. Allow the child not to eat as the digestive process takes up a lot of energy that at this stage can be better used in the big cleanup operation that is underway.

There is hardly ever, only in very rare life-threatening conditions, a need for antibiotics.
Maybe in terms of prevention, we need to consider the stress we are putting the children under. Feeling safe for a child means knowing mum is always there. Food for a child means all that is natural, unadulterated, un-"improved". Stability to a child means knowing that it is okay to love dad as well as mum, and not being forced to chose between them. Prevention of the real kind ensures that your child will be strong enough to make the necessary internal changes when it needs to. Under those circumstances none of the common childhood diseases will form a threat to the long-term health of your child.

June 2013

"MY BABY JUST GOT THE DIABETES VACCINE"

BY ANNA WATSON,
FOUNDER OF THE ARNICA
NATURAL IMMUNITY NETWORK
www.arnica.org.uk

WHY DO WE HAVE SUCH POOR INFORMED CONSENT AROUND VACCINATION?

A mother really did say this after the first set of baby vaccine a few years ago. It was the DTP in case you were wondering, and I can well understand that spoken fast it can sound very much like Diabetes. Those 3 letters, DTP, are pretty meaningless to most new parents. They probably know that it stands for a combination of different vaccines that the Department of Health recommends to protect their baby from deadly diseases, but the detail is possibly not important. I would waiver that most parents will not know what the DTaP/IPV/Hib stands for.

I am so glad that it is not just me who finds this attitude incredulous;

'What really surprises me is the fact that choices are given to parents in this country (honestly, they don't know how lucky they are), yet the majority of them blindly follow the state and what it dictates,' says a Hungarian mum who is able to make a choice in the UK but would not be able to choose in her home country of Hungary where vaccines are mandatory.

Incase we forget that Informed Consent is our legal right, let me include this reminder.

CONSENT TO TREATMENT

Consent to treatment is the principle that a person must give their permission before they receive any type of medical treatment.
Consent is required from a patient regardless of the treatment, from blood test to organ donation. The principle of consent is an important part of medical ethics and the international human rights law.

It continues to define consent, that it must be voluntary and informed with capacity…

- VOLUNTARY: the decision to consent or not consent to treatment must be made alone, and must not be due to pressure by medical staff, friends or family.
- INFORMED: the person must be given full information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead. Healthcare professionals should not withhold information just because it may upset or unnerve the person.
- CAPACITY: the person must be capable of giving consent, which means they understand the information given to them and they can use it to make an informed decision

Anna Watson

"If the person has enough capacity and makes a voluntary and informed decision to refuse a particular treatment, their decision must be respected. This is still true even if their decision would result in their death, or the death of their unborn child"

CAPACITY

"If the person has enough capacity and makes a voluntary and informed decision to refuse a particular treatment, their decision must be respected. This is still true even if their decision would result in their death, or the death of their unborn child"

Strong words indeed from the NHS Choices website. However, many parents find that they have not been respected at all in their decision but instead have been ridiculed and bullied, sometimes shouted down, their child threatened with death or asked to permanently leave the practice!

So why is it then that vaccines fall outside of these noble guidelines?

I suggest that it is because they are just guidelines and there lies a huge conflict between what is seen as the greater good and informed choices.

No parent, as far as I know, has legally challenged the actions of an individual who has failed to provide full information on vaccines. Perhaps we accept that we will not have full information and do not expect it. I was sent from the GP to the pharmacy, back to the GP, only to be told that they didn't have any vaccine inserts! They certainly never told me of any disablement risks from vaccines or told me that there was a vaccine damage payment fund. At least US law demands that a patient be given a VIS (Vaccine Information Statement) before all vaccines.

I wonder what would have happened if this toddler was injured after the MMR and if mum could have sued the health professional who told this whopper. A mum took her toddler into A&E on an unrelated issue and was told that she really should vaccinate with the MMR because several people had died recently in the area. So how can someone make an informed consent with this type of inaccurate risk information? There have not been any deaths in the Brighton area for some time.

After reading several articles about informed consent and vaccines the conflict becomes clear. Parents who exercise informed consent and refuse vaccination damages the public health program so our rights are not respected or welcome. The health professional who talked about measles deaths was clearly over stepping the line with her information but not by her intention. I wonder if, in a court of law, the health professional could claim that the rights

of the child for potentially life saving medicine, and the duty to society from a public health stand, override the duty to give full information to parents? Clearly this ethic is upheld anyway in practice. What do the academics say on the theory?

PARENTS' RIGHTS AND 'FREE-RIDING'

Issues such as parents' rights are considered and balanced against: collective responsibilities for public health; permissibility of 'free-riding';

In this article free riding is also mentioned.

Vaccination polices are an interesting and possibly hybrid case: in so far as we think of them as a matter of public health policy they cannot be based on individual choice, or on informed consent…. sheltering behind protection provided by others' vaccinated children…Public health policies can be undermined if their implementation depends on individual informed consent.

The history of informed consent and free choice for patients has had a very shaky legacy as it has been strongly held that the doctor knows best. Vaccines, the corner stone of modern medicine, and seen as a Public Health matter, are perhaps the most difficult to give up to complete consent.

From The Hippocratic Oath, 500 B.C.E. through to Thomas Percival, a British physician who published a book called Medical Ethics in 1803, the idea was that the doctor knows best. Patients have a right to truth, but when the physician could provide better treatment by lying or withholding information, he advised that the physician do as he thought best. When the American Medical Association was founded in 1847 their ethical guidelines were very much based around Percival's work.(Summarised from Wikipedia on the Medical History surrounding informed consent)

A patient-centred approach is a more recent aim within the last generation, where informed consent is sort and adverse outcomes must be identified with the patient. However, the GMC's new Ethical guidelines still give more weight to the clinician's view of what the patient needs to know. Is it no wonder then that even black triangle drugs, like Gardasil, are treated as established medicines.

"Science lies at the heart of the vaccination controversy, and there can be no substitute for it, The ethical practice of medicine requires full and informed consent. It is not possible to have the informed part of informed consent without the science. That vaccine safety science has been and remains inadequate is not in dispute."

Carol Stott, phd, MSc, CSci, CPsychil and Andrew Wakefield MB, BS, FRCS, FRCPath. From Vaccine Epidemic 2012

RECENTLY UPDATED GMC "ETHICAL GUIDELINES"

From the recently updated GMC "Ethical Guidelines", in a section called Discussing Side Effects and other Risks:
28. …"the amount of information about risk that you should share with patients will depend on the individual patient and what they want or need to know"
29. .. "you MUST identify the adverse outcomes that may result from the proposed options"

Yes, did you too spot the clash here?

We can't just blame the health care providers. Media and society also accepts that vaccines are established and safe medicines. The BBC shares the view that consensus has already been reached on the MMR and that "false balance" between well-established fact and opinion must be avoided. This reply from the BBC around a complaint I made explains much of the media coverage around vaccines.

In response I would draw your attention to the results of a review of the BBC's science coverage commissioned by the BBC Trust and published in July 2011.
http://downloads.bbc.co.uk/bbctrust/assets/files/pdf/our_work/science_impartiality/science_impartiality.pdf

One of the findings in this independent assessment by Professor Steve Jones (Emeritus Professor of Genetics at University College London) was that where there was consensus on scientific matters, providing an opposite view without consideration of "due weight" could lead to a "false balance" and that this might lead viewers to "perceive an issue to be more controversial than it actually is". Professor Jones cited issues including global warming, MMR vaccines and GM foods. The Trust agreed with Professor Jones that, "there should be no attempt to give equal weight to opinion and to evidence" and that a "false balance" between well-established fact and opinion must be avoided.

I suggest that this underpinning philosophy will continue to result in inaccuracies and bias and so will deeply affect informed choice. Toddlers and parents watching CBeebies will have a tough job making informed decisions around vaccination as the BBC consider the safety and efficacy of the MMR a well established fact and so full accuracy is not required.

'I have read your further comments in response to my finding on your complaint about Get Well Soon: Inject to Protect, but while I do understand that the programme could have been more accurate, I'm afraid that I don't agree that the BBC's Guidelines place a requirement on programmes of this kind for the degree of accuracy you describe.' says Alison Wilson, BBC, Complaints Manager

So there you have it, health professionals, academics and the media will not be able to supply such a degree of accuracy as you may require, and indeed may be selective in their disclosures, so I suggest that you operate a 'buyer beware' type of policy on your decision making.

There are a few examples of positive views of the patient that are worth sharing and some practical ideas to help you make an informed decision.

I thought it very responsible of Richard Halvorsen of Baby Jabs, a clinic giving single baby vaccines, with his attempts to give a decent overview of the efficacy and possible ADRs of most of the vaccines and include the risks of

the disease on his website. This is what you would expect perhaps from the NHS. Promoting vaccines but also respecting the individual.

Bill Inman deserves a mention too. 'Don't tell the patient' (1999) is an amazing historical commentary on how slippery things can be when trying to bring about change in policy on informing patients on drug trials under their GP. Bill Inman founded the Drug Safety Unit and Prescription Event Monitoring and is a hero in my eyes. Chapter 7 is an amazing account of the JCVI and the resistance of the Department of Health to his data of whooping cough vaccine damage. Bill could never understand how the patient was so disrespected.

SO TO CONCLUDE

We do have a right to refuse vaccines in the UK without being coerced. However, the UK is still far from supporting fully informed consent on vaccines because history, philosophy, the media, public opinion and health professionals feel that free choice, in the case of vaccines, compromise social duty and public health. The census is that vaccines are good and so information doesn't need to be accurate and side effects don't need to be dwelled upon if the outcome is increased uptake of the vaccine program.

Package inserts are a good start for parents to make an informed decision but they still don't really make it clear that safety and efficacy studies are mostly epidemiological, mostly market funded and that the placebo is never benign!

Anna Watson, founder of the Arnica Natural Immunity Network

www.arnica.org.uk

For your informed consent I hope you will find these abbreviations useful:
BCG= Bacille Calmette Guérin
D=diphtheria
d=low dose diphtheria
T=tetanus
aP=acellular pertussis (whooping cough)
IPV=inactivated polio vaccine
Hib=Haemophilus influenzae type B
Men C=Meningococcus group C

And for the future vaccines... what will the abbreviations be for these 3 strains of meningitis?
Men W-135 (serogroup W-135 meningococcus) and Men X and Men Y
Answers on a postcard please!

Bonus question:
What will the new Hand, Foot and Mouth vaccine be called?
Answers here please:
https://www.facebook.com/groups/arnica/

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AIMS & OBJECTIVES OF THE *informed* PARENT GROUP

1. To promote awareness & understanding about vaccination in order to preserve the freedom of an informed choice
2. To offer support to parents regardless of their decisions
3. To inform parents of the alternatives to vaccinations.
4. To accumulate historical & current information about vaccination & to make it available to members & interested parties.
5. To arrange & facilitate local talks, discussions and seminars on vaccination, childhood illnesses & the promotion of health.
6. To establish a nationwide support network and register (subject to members permission).
7. To publish a newsletter for members.
8. To obtain, collect and receive money and funds by way of contributions, donations, subscriptions, legacies, grants or any other lawful methods; to accept and receive any gift of property and to devote the income, assets or property of the group in or towards fulfilment of the objectives of the group.

THE INFORMED PARENT COMPANY LIMITED. REG.NO. 3845731 (ENGLAND)

THE INFORMED PARENT, PO BOX 4481, WORTHING, WEST SUSSEX, BN11 2WH.
Tel/Fax: 01903 212969 web: www.informedparent.co.uk