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EBOLA, AIDS MANUFACTURED BY WESTERN PHARMACEUTICALS, US DoD?

BY: DR. CYRIL BRODERICK,
PROFESSOR OF PLANT PATHOLOGY
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http://www.liberianobserver.com/security/ebola-aids-manufactured-western-pharmaceuticals-us-dod


Ebola orphans in Liberia. (Photo: USIM/Facebook)

DEAR WORLD CITIZENS:
I have read a number of articles from your Internet outreach as well as articles from other sources about the casualties in Liberia and other West African countries about the human devastation caused by the Ebola virus. About a week ago, I read an article published in the Internet news summary publication of the Friends of Liberia that said that there was an agreement that the initiation of the Ebola outbreak in West Africa was due to the contact of a two-year old child with bats that had flown in from the Congo.

That report made me disconcerted with the reporting about Ebola, and it stimulated a response to the "Friends of Liberia," saying that African people are not ignorant and gullible, as is being implicated. A response from Dr. Verlon Stone said that the article was not theirs, and that "Friends of Liberia" was simply providing a service. He then asked if he could publish my letter in their Internet forum. I gave my permission, but I have not seen it published. Because of the widespread loss of life, fear, physiological trauma, and despair among Liberians and other West African citizens, it is incumbent that I make a contribution to the resolution of this devastating situation, which may continue to recur, if it is not properly and adequately confronted. I will address the situation in five (5) points:

1. EBOLA IS A GENETICALLY MODIFIED ORGANISM (GMO)

Horowitz (1998) was deliberate and unambiguous when he explained the threat of new diseases in his text, Emerging Viruses: AIDS and Ebola - Nature, Accident or Intentional. In his interview with Dr. Robert Strecker in Chapter 7, the discussion, in the early 1970s, made it obvious that the war was between countries that hosted the KGB and the CIA, and the 'manufacture' of 'AIDS-Like Viruses' was clearly directed at the other. In passing during the Interview, mention was made of Fort Detrick, "the Ebola Building," and 'a lot of problems with strange illnesses' in "Frederick (Maryland)." By Chapter 12 in his text, he had confirmed the existence of an American Military-Medical-Industry that conducts biological weapons tests under the guise of administering vaccinations to control diseases and improve the health of "black Africans overseas." The book is an excellent text, and all leaders plus anyone who has interest in science, health, people, and intrigue should study it. I am amazed that African leaders are making no acknowledgements or reference to these documents.

"The World Health Organization (WHO) and several other UN Agencies have been implicated in selecting and enticing African countries to participate in the testing events, promoting vaccinations, but pursuing various testing regiments."

2. EBOLA HAS A TERRIBLE HISTORY, AND TESTING HAS BEEN SECRETLY TAKING PLACE IN AFRICA

I am now reading The Hot Zone, a novel, by Richard Preston (copyrighted 1989 and 1994); it is heart-rending. The prolific and prominent writer, Steven King, is quoted as saying that the book is "One of the most horrifying things I have

Editor's note

Magda Taylor

HERE IS THE LAST ISSUE FOR 2014 – which I trust you will find of interest.
Dr Donegan is focusing on rubella in this edition…the disease and one of the components of the MMR that is often overshadowed by all the attention on measles and mumps.

Dr Donegan also drew my attention to the information regarding 'consent in minors' which is included in the NHS eLearning portal. It reads:

'Different understandings of what constitutes the welfare of the child are not easily resolved.

In cases where competent young people (who are legally under the age of consent) refuse treatment, the respect for autonomy, which underlies all medical care, is a powerful factor in any decision about recourse to the courts.

In general, the law recognises the right of a minor who understands the implications of the decision, to consent to treatment even if the child's parents object.

On the other hand it places limitations on the same person's right to refuse treatment, allowing the parents to override such a refusal.

A clinician could apply to the court to override a refusal by a competent minor.' As Dr Donegan points out - in other words…You can CONSENT but you can't REFUSE - so it's all skewed towards treatment. All the schoolgirls where the parents have not signed the consent form or actually said, "No to the HPV - when these girls go into school they are shown horrific unbalanced videos by school nurses and then decide that they want to have the vaccine because of this. They are allowed to CONSENT as minors as they are deemed 'Gillick competent – even though it is against their parents wishes.

BUT… a judge can ORDER a competent 15yr old - who could consent to underage birth control and sex (and vaccination) to have an MMR vaccine against her will.

WISHING YOU A HEALTHY AND HAPPY NEW YEAR AHEAD. THANK YOU FOR YOUR SUBSCRIPTION AND I HOPE YOU WILL BE RENEWING FOR ANOTHER YEAR – YOUR CONTINUED SUPPORT IS VERY MUCH NEEDED FOR THE CONTINUATION OF THIS PUBLICATION!! - Magda Taylor, December 2014

› *from p01*

ever read. What a remarkable piece of work." As a New York Times bestseller, The Hot Zone is presented as "A terrifying true story." Terrifying, yes, because the pathological description of what was found in animals killed by the Ebola virus is what the virus has been doing to citizens of Guinea, Sierra Leone and Liberia in its most recent outbreak: Ebola virus destroys peoples' internal organs and the body deteriorates rapidly after death. It softens and the tissues turn into jelly, even if it is refrigerated to keep it cold.

Spontaneous liquefaction is what happens to the body of people killed by the Ebola virus! The author noted in Point 1, Dr. Horowitz, chides The Hot Zone for writing to be politically correct; I understand because his book makes every effort to be very factual. The 1976 Ebola incident in Zaire, during President Mobutu Sese Seko, was the introduction of the GMO Ebola to Africa.

3. SITES AROUND AFRICA, AND IN WEST AFRICA, HAVE OVER THE YEARS BEEN SET UP FOR TESTING EMERGING DISEASES, ESPECIALLY EBOLA

The World Health Organization (WHO) and several other UN Agencies have been implicated in selecting and enticing African countries to participate in the testing events, promoting vaccinations, but pursuing various testing regiments. The August 2, 2014 article, West Africa: What are US Biological Warfare Researchers Doing in the Ebola Zone? by Jon Rappoport of Global Research pinpoints the problem that is facing African governments.

OBVIOUS IN THIS AND OTHER REPORTS ARE, AMONG OTHERS:

(a) The US Army Medical Research Institute of Infectious Diseases (USAMRIID), a well-known centre for bio-war research, located at Fort Detrick, Maryland; **(b)** Tulane University, in New Orleans, USA, winner of research grants, including a grant of more than $7 million the National Institute of Health (NIH) to fund research with the Lassa viral hemorrhagic fever; **(c)** the US Center for Disease Control (CDC); **(d)** Doctors Without Borders (also known by its French name, Medicins Sans Frontiers); **(e)** Tekmira, a Canadian pharmaceutical company; **(f)** The UK's GlaxoSmithKline; and **(g)** the Kenema Government Hospital in Kenema, Sierra Leone.

Reports narrate stories of the US Department of Defense (DoD) funding Ebola trials on humans, trials which started just weeks before the Ebola outbreak in Guinea and Sierra Leone. The reports continue and state that the DoD gave a contract worth $140 million dollars to Tekmira, a Canadian pharmaceutical company, to conduct Ebola research. This research work involved injecting and infusing healthy humans with the deadly Ebola virus. Hence, the DoD is listed as a collaborator in a "First in Human" Ebola clinical trial (NCT02041715) which started in January 2014 shortly before an Ebola epidemic was declared in West Africa in March. Disturbingly, many reports also conclude that the US government has a viral fever bioterrorism research laboratory in Kenema, a town at the epicentre of the Ebola outbreak in West Africa. The only relevant positive and ethical olive-

branch seen in all of my reading is that Theguardian.com reported, "The US government funding of Ebola trials on healthy humans comes amid warnings by top scientists in Harvard and Yale that such virus experiments risk triggering a worldwide pandemic." That threat still persists.

4. THE NEED FOR LEGAL ACTION TO OBTAIN REDRESS FOR DAMAGES INCURRED DUE TO THE PERPETUATION OF INJUSTICE IN THE DEATH, INJURY AND TRAUMA IMPOSED ON LIBERIANS AND OTHER AFRICANS BY THE EBOLA AND OTHER DISEASE AGENTS.

The US, Canada, France, and the UK are all implicated in the detestable and devilish deeds that these Ebola tests are. There is the need to pursue criminal and civil redress for damages, and African countries and people should secure legal representation to seek damages from these countries, some corporations, and the United Nations. Evidence seems abundant against Tulane University, and suits should start there. Yoichi Shimatsu's article, The Ebola Breakout Coincided with UN Vaccine Campaigns, as published on August 18, 2014, in the Liberty Beacon.

5. AFRICAN LEADERS AND AFRICAN COUNTRIES NEED TO TAKE THE LEAD IN DEFENDING BABIES, CHILDREN, AFRICAN WOMEN, AFRICAN MEN, AND THE ELDERLY. THESE CITIZENS DO NOT DESERVE TO BE USED AS GUINEA PIGS!

Africa must not relegate the Continent to become the locality for disposal and the deposition of hazardous chemicals, dangerous drugs, and chemical or biological agents of emerging diseases. There is urgent need for affirmative action in protecting the less affluent of poorer countries, especially African citizens, whose countries are not as scientifically and industrially endowed as the United States and most Western countries, sources of most viral or bacterial GMOs that are strategically designed as biological weapons. It is most disturbing that the US. Government has been operating a viral hemorrhagic fever bioterrorism research laboratory in Sierra Leone. Are there others? Wherever they exist, it is time to terminate them. If any other sites exist, it is advisable to follow the delayed but essential step: Sierra Leone closed the US bioweapons lab and stopped Tulane University for further testing.

"Reports narrate stories of the US Department of Defense (DoD) funding Ebola trials on humans, trials which started just weeks before the Ebola outbreak in Guinea and Sierra Leone"

The world must be alarmed. All Africans, Americans, Europeans, Middle Easterners, Asians, and people from every conclave on Earth should be astonished. African people, notably citizens more particularly of Liberia, Guinea and Sierra Leone are victimized and are dying every day. Listen to the people who distrust the hospitals, who cannot shake hands, hug their relatives and friends. Innocent people are dying, and they need our help. The countries are poor and cannot afford the whole lot of personal protection equipment (PPE) that the situation requires. The threat is real, and it is larger than a few African countries. The challenge is global, and we request assistance from everywhere, including China, Japan, Australia, India, Germany, Italy, and even kind-hearted people in the U.S., France, the U.K., Russia, Korea, Saudi Arabia, and anywhere else whose desire is to help. The situation is bleaker than we on the outside can imagine, and we must provide assistance however we can. To ensure a future that has less of this kind of drama, it is important that we now demand that our leaders and governments be honest, transparent, fair, and productively engaged. They must answer to the people. Please stand up to stop Ebola testing and the spread of this dastardly disease.

Thank you very much.

Sincerely,

Dr. Cyril E. Broderick, Sr.

ABOUT THE AUTHOR:

Dr. Broderick is a former professor of Plant Pathology at the University of Liberia's College of Agriculture and Forestry. He is also the former Observer Farmer in the 1980s. It was from this column in our newspaper, the Daily Observer, that Firestone spotted him and offered him the position of Director of Research in the late 1980s. In addition, he is a scientist, who has taught for many years at the Agricultural College of the University of Delaware.

Ebola: Protective clothing

WHY IS CHINA HAVING MEASLES OUTBREAKS WHEN 99% ARE VACCINATED?

BY SAYER JI
20/9/2014
www.greenmedinfo.com

CHINA has one of the most vaccination compliant populations in the world. In fact, measles vaccine is mandatory. So why have they had over 700 measles outbreaks from 2009 and 2012 alone? The obvious answer is the the measles vaccines are simply NOT effective. A recent study published in PLOSone titled, "Difficulties in eliminating measles and controlling rubella and mumps: a cross-sectional study of a first measles and rubella vaccination and a second measles, mumps, and rubella vaccination," has brought to light the glaring ineffectiveness of two measles vaccines (measles–rubella (MR) or measles–mumps–rubella(MMR)) in fulfilling their widely claimed promise of preventing outbreaks in highly vaccine compliant populations.

According to the study, "The reported coverage of the measles-rubella (MR) or measles-mumps-rubella (MMR) vaccine is greater than 99.0% in Zhejiang province. **However, the incidence of measles, mumps, and rubella remains high.**" [emphasis added]

CHINA'S GREAT MANDATORY VACCINE EXPERIMENT FAILURE

Zhejiang is an eastern coastal province of the People's Republic of China and home to 55 million inhabitants. All children there receive a compulsory first dose of MR at 8 months and another dose of the MMR vaccine at 18–24 months.

In the new study researchers analyzed a subset of 1,015 Zehjiang inhabitants and found that despite the recent measles outbreaks 93.6% of them were seropositive for measles antibodies, meaning they had presumably vaccine-induced protective antibodies against measles in their blood serum - more than is required to obtain so-called 'herd immunity' threshold of 88%-92%, which is often claimed to be the solution to extinguishing infectious diseases altogether.[2] And yet despite this theoretical 'protection,' eight-seven (8.6%) of the subjects developed measles anyway.

Another recent study, published in the highly authorative Bulletin of the World Health Organization, looked at recent measles occurrences throughout China and found that there were 707 measles outbreaks in the country recorded between 2009 and 2012, with a steep trend upwards in 2013: "The number of measles cases reported in the first 10 months of 2013 - 26443 - was three times the number reported in the whole of 2012." This is all the more odd considering that since 2009 "…the first dose of measles-virus-containing vaccine has reached more than 90% of the target population." One would expect with increasing measles vaccine uptake there would result in a decrease in measles incidence.

"Injecting aluminum and other highly immunotoxic adjuvants into the body in order to stimulate elevated antibody titers does not in and of itself guarantee their affinity for the antigen they are supposed to be protecting you against."

Clearly the vaccines aren't as effective as claimed, nor is the concept of herd immunity - which is debunked and decimated for example, in papers such as 'Herd Immunity: Myth or Reality?' by Tetyana Obukhanych, PhD - supported unequivocally by the epidemiological evidence.

The failure of vaccine-induced antibody titers to protect against 'vaccine preventable disease' may make more sense when you consider the antibody-based theory of vaccine efficacy - a fundamental tenet of vaccinology/immunology – was recently called into question: Study Calls Into Question Primary Justification for Vaccines. Injecting aluminum and other highly immunotoxic adjuvants into the body in order to stimulate elevated antibody titers does not in and of itself guarantee their affinity for the antigen they are supposed to be protecting you against. To the contrary, it is much like saying you have improved the overall health of the beehive by kicking it with your boot to stir its angry residents and getting them to sting (and hence die) the closest thing around them.

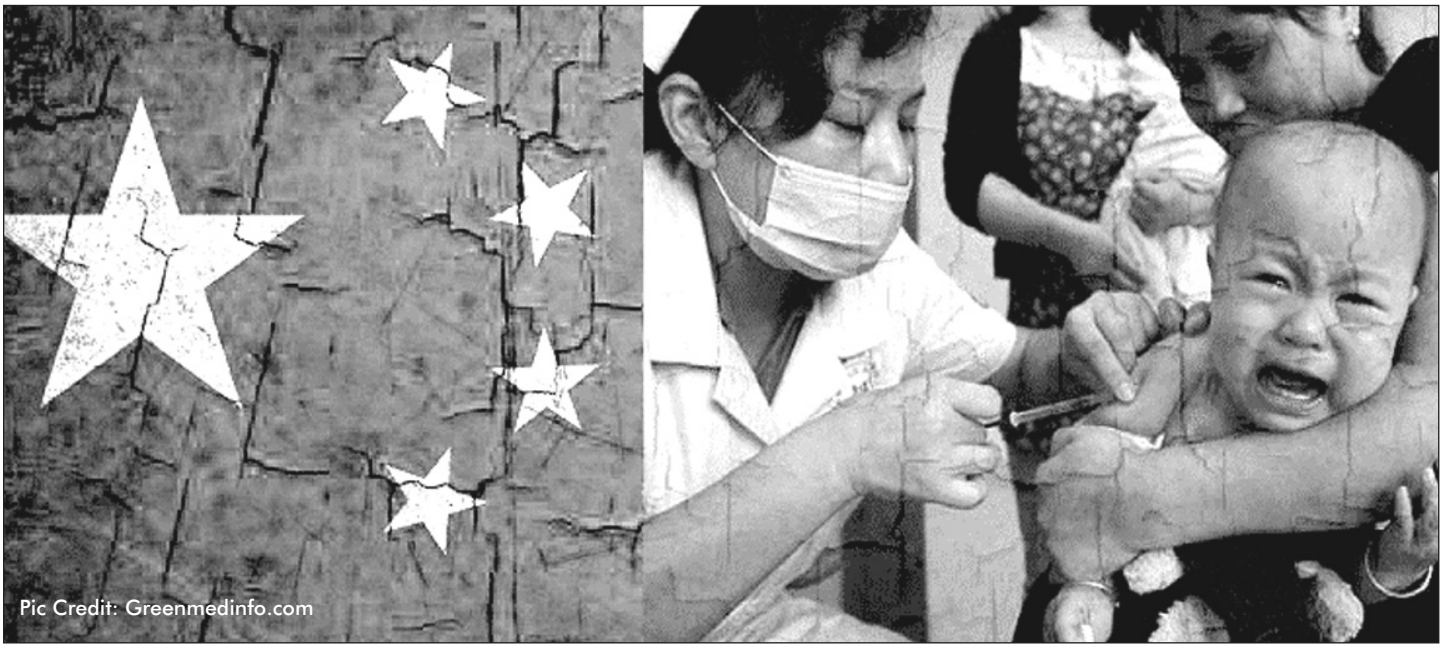
THE WHO'S GOAL OF ERADICATING MEASLES IN CHINA WITH MANDATORY VACCINES HAS FAILED

In 2005, the Regional Committee of WHO Western Pacific Region established 2012 as the target date for the complete regional elimination of measles, and the Chinese Ministry of Health initiated mandatory measles vaccination to accomplish this. A year later, in 2006, China set a goal of accelerating the progress of eliminating measles by 2012, striving to keep measles incidence below 0.1 per 100,000, and then developed a series of vaccination strategies to execute these goals.

And yet, despite the full and near universal implementation of multi-dose vaccines, measles, mumps and rubella outbreaks continued to afflict those receiving them:

"Measles outbreaks continued in 2008, with 12782 cases reported, which translated to 252.61 per million of the population. From 2009 to 2011, the incidence of measles remained high at 3.14-17.2 per million of the population. Similarly, the incidence of mumps increased from 394.32 to 558.26 per million of the population in 2007 and 2008, respectively. Finally, the reported cases of rubella increased from 3284 to 4284 in 2007 and 2011, respectively, representing a 30.45% increase or an increase from 65.94 to 78.71 per million of the population. Therefore, the elimination of measles and control of mumps and rubella are urgent public health priorities in local regions."[1]

As we have explored in a previous article, "Measles: A Rash of Misinformation," the measles vaccine is not nearly as safe and effective as is widely believed. Measles outbreaks have consistently occurred in highly immunization compliant populations. For a more extensive review of the epidemiological literature on measles outbreaks happening within highly vaccine complaint populations read: The



2013 Measles Outbreak: A Failing Vaccine, Not A Failure To Vaccinate

Sadly, the latest study concludes with the recommendation that the MMR vaccine should be increased to two doses with the first dose at 8 months and the second dose at 18-24 months. They further suggest, that in addition to another MMR vaccine, "An MR vaccination speed-up campaign may be necessary for elder adolescents and young adults, particularly young females." As has been the historical response pattern of the medical establishment's pro-vaccine agenda when facing the evidence of their failed vaccine campaigns, instead of acknowledging the folly of relying exclusively on a vaccine-centric view of immunity (what about nutrition, vitamin D, improved sanitation and hygiene?) they default counter-intuitively to increasing the number of vaccines given, adding 1 or 2 'boosters' when the vaccines clearly are not working. This intellectually dishonest and callous approach, in fact, is a primary driver for the expansion of already dangerously high number of vaccines that are presently populating the CDC's arguably insane immunization schedule - a schedule with the highest number of vaccines in the world, and which we are supposed to believe has nothing to do with the exponentially increasing autism rate (1 in 5,000 in 1975; 1 in 65 today) in our country, or its shameful if not outrageous 33rd-worst infant mortality rate in the developed world.

Another highly concerning problem with the new study is its conspicuous lack of mention of the known unintended, adverse effects of vaccination. In fact, earlier this year we reported on another Chinese vaccine study that found that "42% of Drug Reactions Are Vaccine Related, groundbreaking Chinese Study Finds."And of course, we cannot leave out mention of what is likely the greatest medical cover-up of our time: the senior vaccine scientist William Thompson at the CDC blows the whistle on how his agency covered up the autism/vaccine link for over a decade (and likely much more malfeasance still to be uncovered), and which is still ongoing, as no mainstream media group has yet to cover the facts of the story in a serious or honest manner. How many of these Chinese infants and children will undergo neuro-developmental regression or suffer other neurological insults as a result of using the same MMR vaccine the CDC identified as doing harm to African-American boys? We may never know, but we can be certain that they are not immune to the well-documented dangers.

Given the gravity of potential harms associated with routine vaccines, juxtaposed to the perhaps far lesser risk associated with contracting what were once considered normal, immune system building natural infections (measles), the issue here is really about balancing the pro's versus the con's, with the medical literature itself guiding parents decisions, who have the legal right and responsibility to choose what medical interventions their children should succumb to.

Sayer Ji is the founder of GreenMedInfo.com, an author, educator, Steering Committee Member of the Global GMO Free Coalition (GGFC), and an advisory board member of the National Health Federation. He founded Greenmedinfo.com in 2008 in order to provide the world an open access, evidence-based resource supporting natural and integrative modalities. It is widely recognized as the most widely referenced health resource of its kind.

Disclaimer: This article is not intended to provide medical advice, diagnosis or treatment. Views expressed here do not necessarily reflect those of GreenMedInfo or its staff.

NOTES

{1} Zhifang Wang, Rui Yan, Hanqing He, Qian Li, Guohua Chen, Shengxu Yang, Enfu Chen.Difficulties in eliminating measles and controlling rubella and mumps: a cross-sectional study of a first measles and rubella vaccination and a second measles, mumps, and rubella vaccination. PLoS One. 2014 ;9(2):e89361. Epub 2014 Feb 20. PMID: 24586717

{2} Vaccination and herd immunity to infectious diseases. Anderson RM, May RM Nature. 1985 Nov 28-Dec 4; 318(6044):323-9. {PubMed}

WHY MORE VACCINES WON'T TRANSLATE TO BETTER HEALTH

DR JACOB PULIYAL & PROFESSOR BM HEGDE

http://www.moneylife.in/article/why-more-vaccines-wont-translate-to-better-health/38107.html
16/07/2014

EXTRACTS

IF VACCINATION was such a good method of disease prevention we should have been able to eradicate many contagious disease, but alas, records show that except small pox ***(Editor: the eradication of smallpox by vaccination is also debatable!)*** we have not been able to eradicate any contagious disease to date.

When one gets an infectious disease, by and large, one gets immunity against that infection; sometimes the immunity is lifelong, but in many cases for some time after the first infection. However, the hypothesis that artificial vaccination using various laboratory methods gives complete protection against the disease seems to be based on a shaky foundation. Historically, most infectious disease deaths had fallen significantly long before any vaccination for diseases was introduced. The important changes in sanitation, water supply, good nutrition and education seem to have influenced the fall much more than vaccinations. There are now sporadic reports that recent vaccination against measles and mumps seems to have triggered an epidemic of those diseases significantly in the vaccinated group.

Every Indian should be proud of the fact that smallpox eradication was possible using the Indian ancient Ayurvedic vaccination system with attenuated live small pox virus from the previous year's small pox patient's pus. It was in 1767 that Dr TZ Holwell, FRS; FRCP (London) presented a paper on the subject at the Royal College of Physicians at London after having studied this vaccination system for twenty years prospectively in The Bengal where this vaccination was in vogue for "times out of mind" through the five International Universities in India at that time. Edward Jenner of conventional vaccination fame, used cow pox pus, which today we know has nothing to do with small pox. Dr Holwell's paper can be viewed in the Royal College library at Regent's Park campus even today, although partially damaged in the great fire of the 18th century.

"If vaccination was such a good method of disease prevention we should have been able to eradicate many contagious disease, but alas, records show that except small pox we have not been able to eradicate any contagious disease to date."

Indian Prime Minister Narendra Modi has announced four new vaccination programs in the fond hope of preventing, if not eradicating, some diseases as detailed below.

Unfortunately he has been advised wrongly and besides wasting scarce public health resources is likely to result in serious problems for the well-meaning Government.

1. POLICY TO VACCINATE ADULTS IN JAPANESE ENCEPHALITIS (JE) ENDEMIC AREAS.

a) This disease affects children. In endemic areas it does not affect adults as 90% of adults have developed natural immunity by sub-clinical or clinical infection in childhood.

So the vaccine is to be given in the population who are already immune and are not affected by the disease.

A few adults are affected but according to Borah (PMID 21715224 J Clin Virol 2001;52:45-9) these are in areas of new invasion of the disease (and the adult population is not immune) or where the virus has changed over time. In both these cases the new vaccination program is useless. The vaccine is being targeted to endemic areas and NOT areas where the disease is emerging for the first time, and if the virus has changed and natural immunity is not effective, the chances that the vaccine will be effective are untested and unlikely.

b) There is another point that needs to be considered. In childhood immunisation, 80 to 90% coverage is considered excellent coverage. Uptake of adult vaccines is much lower.

For JE prevention in adults, 90% of whom are already immune, if the government hopes to reach the 10% of those who are not immune it will have to vaccinate 100% of the population – an impossible task.

So it is clear that this exercise is a complete waste of resources which is better spent in trying to prevent the disease in children who are the main group affected.

2. POLICY TO INTRODUCE NEW ROTAVIRUS VACCINE IN INDIA.

a) The newly licensed vaccine costs Rs150 per child. According to Bhandari et al (Lancet 2014; 383:2136-43.) it has only 50% efficacy and 55 children will have to be given the vaccine to prevent one case of diarrhoea in those 55. The cost

"IT IS MORE FROM CARELESSNESS ABOUT TRUTH THAN FROM INTENTIONALLY LYING THAT THERE IS SO MUCH FALSEHOOD IN THE WORLD. ~ SAMUEL JOHNSON"

of giving this vaccine to 55 children in order to prevent one case of diarrhoea by vaccination will be Rs8,250.

Rotavirus infection treated with oral re-hydration solutions (ORS) early will cost Rs10 per child. The money is better spent on water and sanitation projects and to make ORS widely available; this will reduce all diarrhoea deaths - not only rotavirus infections.

b) Worse still is the risk of intussusceptions that the vaccine causes. Intussusception is a surgical condition that makes the intestine telescope into itself causing intestinal obstruction and passage of bloody stools. This has to be treated immediately or it can result in deaths. A rotavirus vaccine was introduced previously in the US but it was banned when it produced one case of intussusceptions in every 10,000 children vaccinated.

According to the Lancet paper quoted above, the new vaccine seems to produce one excess intussusceptions case in every 2,000 vaccinated children, meaning it is five-times more dangerous than the vaccine that was banned.

The sample studied is too small to tell the real risk of this dreaded complication. It was studied in 4,500 children whereas the US Food and Drug Administration (FDA) required a study in 30,000 children before the new rotavirus vaccine was granted license.

But it seems the Drug Controller of India has granted license and says that adverse effects can be studied in post license marketing surveillance.

Now with the announcement of introduction in the immunisation program it means this experiment will be conducted on 27 million children, who will act as guinea pigs for a vaccine. In poor rural areas where the vaccine will be given by the government, children will develop intussusceptions, passing blood in stools after a few weeks of immunisation and there will be no doctor available to make the diagnosis of intussusceptions. The parents will assume the child died of dysentery. The death will not even be recorded as an adverse event following immunisation.

"Now with the announcement of introduction in the immunisation program it means this experiment will be conducted on 27 million children, who will act as guinea pigs for a vaccine."

3. RUBELLA VACCINE IN BABIES TO PREVENT CONGENITAL RUBELLA SYNDROME (CRS)

Rubella is a very mild disease, like a cold that lasts for two days and mild fever with a slight transient rash. It is widespread in children and gives lifelong immunity.

However if a girl does not get infected in childhood and is therefore not immune, and she gets the infection in the first three months of pregnancy, the baby in her womb will ***(Editor: Personally I think the word 'will' should read 'may' It is not automatic the CRS will occur - it is very much dependent on the general health of the pregnant women.)*** develop CRS with cataracts, heart disease and mental retardation.

The incidence of CRS is not known and is very low because most children get natural immunity before they reach adolescence.

The best way to reduce CRS is to vaccinate adolescent girls so that if they had escaped natural infection in childhood they can be immune before going into pregnancy ***(Editor: Again this is also debatable)***.

If we vaccinate children the natural immunity that most children get will be stopped and it is documented that there will be more cases of CRS as adolescents may go into pregnancy without immunity.

This is documented in medical literature and any public health doctor will tell you that. The purpose is not to eliminate such mild viruses from the world but avoid CRS. The new policy will increase CRS. (Anderson and May. Infectious disease in humans: dynamics and control. Oxford Press 1992) (Edmunds et al. Epidemiol. Infect 2000;125:635-50)

We earnestly hope that this correct scientific viewpoint reaches our Health Minister and our Prime Minister for them to take the right decision. We should not forget that the industry will push vaccines to every gullible government, as vaccines make better business sense compared to curative drugs.

"Man's mind is so formed that it is far more susceptible to falsehood than to truth." - Desiderius Erasmus

ABOUT THE AUTHOR

Dr Jacob Puliyal is a pediatrician and member of the National Technical Advisory Group on Immunization (NTAGI) of the Government of India. Professor Dr BM Hegde, a Padma Bhushan awardee in 2010, is an MD, PhD, FRCP (London, Edinburgh, Glasgow & Dublin), FACC and FAMS. He is also Editor-in-Chief of the Journal of the Science of Healing Outcomes, chairman of the State Health Society's Expert Committee, Govt of Bihar, Patna. He is former Vice Chancellor of Manipal University at Mangalore and former professor for Cardiology of the Middlesex Hospital Medical School, University of London.)

"IF PEOPLE LET GOVERNMENT DECIDE WHAT FOODS THEY EAT AND WHAT MEDICINES THEY TAKE, THEIR BODIES WILL SOON BE IN AS SORRY A STATE AS ARE THE SOULS OF THOSE WHO LIVE UNDER TYRANNY. ~ THOMAS JEFFERSON (1762-1826)"

FLU VACCINE IS THE MOST DANGEROUS VACCINE IN THE U.S. BASED ON SETTLED CASES FOR INJURIES

HEALTH IMPACT NEWS
29 September 2014
http://healthimpactnews.com/2014/flu-vaccine-is-the-most-dangerous-vaccine-in-the-united-states-based-on-settled-cases-for-injuries/

The last report issued in 2013 by the Department of Justice (Vaccine Court), for compensation made by the Health and Human Services for people injured or killed by vaccines, was released in December 2013, covering the period of 16/8/2013 through 15/11/2013.

There were 139 claims settled during this time period, with 70 of them being compensated. So, just over 50% of the claims filed for vaccine damages were compensated during this period.

Once again, the greatest percentage of damages compensated were for the influenza vaccine, and most of those were for Guillain-Barré Syndrome (GBS). Yet these facts, tucked away in a file on the Department of Health and Human Services website, are never reported in the mainstream media. So we will report them here.

Of the 70 cases compensated, 42 of them were for the flu vaccine, or 60% of the cases settled where compensation was awarded for injury or death due to the vaccine. The combined total of the other 40% of cases settled included the following vaccines: Hep B, Tetanus, HPV, DTaP, MMR, IPV, PCV, Hib, Meningococcal, Varicella, TD.

So injuries and deaths due to the flu vaccine were compensated more than the total compensation paid out to eleven other vaccines. Yet, if you look at the top selling vaccines in the market, the top flu vaccine is only #5, being outsold by Prevnar, Gardasil, PENTAct-HIB, and Infanrix/Pediarix. (Source.)

When you receive your "routine" annual flu shot, are you aware of these statistics?

And this is just for a 3-month period during 2013. When we published the last report back in 2013, for the period covered between 5/16/2013 to 8/15/2013, the numbers were very similar: 77 cases settled for compensation resulting in injury or death due to vaccines, and 50 of those were for the flu vaccine.

"Clearly, the flu vaccine is the most dangerous vaccine in America today, but that fact is not mentioned by the mainstream media, nor is it likely to be reported to you by your doctor.."

Clearly, the flu vaccine is the most dangerous vaccine in America today, but that fact is not mentioned by the mainstream media, nor is it likely to be reported to you by your doctor.

These cases are the ones that were compensated for injuries and deaths due to vaccines, which are only about 50% of the claims filed. The other 50% of vaccine injuries or deaths filed received nothing, because their attorneys were not able to defeat the government attorneys (funded through your tax dollars) fighting to not pay for damages. But even these claims that are filed are admittedly under-reported.

Attorney Howard Gold of Gold Law Firm, who settled a case for GBS due to a flu vaccine in 2011, remarked:

Petitioners have three (3) years from the onset of the injury (or two years from date of death) to file a claim. Gold states that the "Program is not used as much as it could be because the American public is just not aware of it. I receive at least 5 calls a month from individuals who cannot obtain compensation because the deadline has passed. They just found out about it too late. We all need to do a better job in getting the word out to the public that the Program exists."

In November 2013, a healthy 19-year old young man died from a routine exam that included the flu vaccine. Chandler Webb received the flu shot on October 15th, and then died on November 19th, 28 days later. Since the flu shot is considered safe in the medical field, doctors waited too long to suspect that the flu shot was causing Chandler's rapidly deteriorating medical condition, according to his mother. She believes that if they had investigated the adverse reaction to the flu shot immediately, he might still be alive today.

As can be seen by the cases compensated by the vaccine court for injuries and deaths due to the flu vaccine, the majority of them are for Guillain-Barré Syndrome.

What is Guillain-Barré Syndrome?

Here is the definition the CDC gives:

Guillain-Barré syndrome (GBS) is a rare disorder in which a person's own immune system damages their nerve cells, causing muscle weakness and sometimes paralysis. GBS can cause symptoms that last for a few weeks. Most people recover fully from GBS, but some people have permanent nerve damage. In very rare cases, people have died of GBS, usually from difficulty breathing.

Compare this to the CDC definition for Polio:

Polio is an infectious disease caused by a virus that lives in the throat and

intestinal tract. Up to about 72% of susceptible persons infected with polio have no symptoms. However, infected persons without symptoms can still spread the virus and cause others to develop polio. About 24% of infected susceptible persons have minor symptoms such as fever, sore throat, upset stomach, or flu-like symptoms and have no paralysis or other serious symptoms. About 1-5% develop aseptic meningitis with stiffness of the back, back, or legs, and in some persons increased or abnormal sensations a few days after the minor illness resolves. These symptoms typically last from two to ten days, followed by complete recovery. Less than 1% of polio cases result in paralysis of the limbs (usually the legs). Of those cases resulting in paralysis, 5-10% of the patients die when the respiratory muscles are paralyzed.

Of course, the medical community and the mainstream media want everyone to believe that polio was eradicated by vaccines a long time ago. Read Dr. Suzanne Humphries' excellent article, Did Vaccines Really Eradicate Polio?, as well as Dr Viera Scheibner's article, The REAL History Behind the Polio Vaccine, to see how this belief has no merit, based on historical facts and peer-reviewed studies.

Polio, Guillain-Barré Syndrome, and any other names of disease are simply arbitrary names assigned to groups of symptoms and conditions. The symptoms of polio and GBS are so similar, some people feel that Franklin Delano Roosevelt's condition was really GBS and not polio. There were no flu shots in 1921 when FDR contracted polio, but the tuberculosis vaccine was introduced that year.

To understand how vaccine injuries and deaths are all dealt with in a special "vaccine court" that was set up by Congress, after granting legal immunity to pharmaceutical companies in 1986 for any damages caused by vaccines (and which was then upheld by the Supreme Court in 2011), watch the excellent videos below by Emmy Award winning journalist Ben Swann, as well as the video by The Canary Party, narrated by actor Rob Schneider.

There are two other MMR vaccine whistleblowers

BY JON RAPPOPORT
September 24, 2014
NoMoreFakeNews.com

We all know about CDC whistleblower William Thompson now.

On August 27, he released a statement through his lawyer, Rick Morgan, in which he admitted research fraud. Thompson confessed he and his co-authors cooked the data in a key 2004 study, thereby exonerating the MMR vaccine from any connection to autism. But what about Stephen Krahling and Joan Wlochowski?

Who?

They're two former Merck virologists who filed a qui tam suit against Merck, the manufacturer of the very same MMR vaccine.

The suit claims Merck defrauded the US government by selling the vaccine, under a federal contract, when Merck knew the mumps component of the vaccine was far less effective than advertised.

Of course, Merck disputed this claim, but on September 5th, Judge Jones, of the Federal District Court for the Eastern District of Pennsylvania, gave the green light for the suit to move forward. Krahling and Wlochowski assert several levels of Merck fraud:

To achieve a slam-dunk success, Merck tested the effectiveness of the MMR vaccine against the version of the virus in the vaccine, rather than against the natural mumps virus a person would catch in the real world.

Merck irrelevantly and deceptively added animal antibodies to the test results, thus giving the false appearance of strong human immune response to the vaccine.

On top of that, Merck faked the quantitative results of the tests to which the animal antibodies had been added.

Here is where these two Merck whistleblowers and Thompson, the CDC whistleblower, intersect:

In 2004, Thompson wrote a letter to CDC Director, Julie Gerberding, warning her that he was about to present troubling and sensitive data about the MMR vaccine at an upcoming conference on vaccines and autism.

Thompson's meaning was clear. He had found a connection between the MMR vaccine and autism.

Gerberding never answered his letter, and Thompson's presentation at that conference was canceled.

Gerberding left the CDC in 2009.

She is now… the president of Merck Vaccines, the manufacturer of the MMR vaccine. Major media consider this a non-story, on the level of a can of overflowing garbage on a quiet street corner. Well, they have to consider it a non-story. If they reported it and pressed it, they would fracture the pillars of the entire vaccine establishment.

Jon Rappoport - author of three explosive collections, THE MATRIX REVEALED, EXIT FROM THE MATRIX, and POWER OUTSIDE THE MATRIX.

Jon was a candidate for a US Congressional seat in the 29th District of California. He maintains a consulting practice for private clients, the purpose of which is the expansion of personal creative power. Nominated for a Pulitzer Prize, he has worked as an investigative reporter for 30 years, writing articles on politics, medicine, and health for CBS Healthwatch, LA Weekly, Spin Magazine, Stern, and other newspapers and magazines in the US and Europe. Jon has delivered lectures and seminars on global politics, health, logic, and creative power to audiences around the world. You can sign up for his free emails at NoMoreFakeNews.com.

Hazards of setting targets to eliminate disease: lessons from the leprosy elimination campaign

BY ANAND BHOPAL
Final Year Medical Student
University of Manchester
23 February 2014

Editor: The following comments by Anand Bhopal are in response to an article published in the BMJ about a leprosy elimination campaign.

Makes interesting reading regarding what aspect of disease attracts the most money! It reads:

Lockwood and colleagues raise an important issue with regards to the rhetoric surrounding disease elimination.[1]

Disease control catches the imagination of funders and the general public like few areas of medicine. Smallpox eradication - to date the only disease vector successfully eradicated - is lauded as one of the greatest human achievements of the 20th century. Eradication and elimination of other infectious diseases clearly have great potential to improve global health. Most importantly, such campaigns can attract the resources to do so.

Over recent years, global health funding from public-private partnerships and philanthropic foundations has increased.[2] This 'new money has driven the global health agenda away from the likes of 'primary health care for all' as set out in the Alma Ata Declaration 36 years ago.[3] Resources have been shifted towards new vaccines, new diagnostics and new technologies, with relatively little investment in implementation and health systems research.[4,5]

"Disease control catches the imagination of funders and the general public like few areas of medicine. "

Such 'venture capital' has a role in pushing new frontiers of science, however, this risks overlooking the agenda required for sustained improvements to population health. Increased funding has transformed the landscape of neglected tropical diseases in recent years. Driven by rhetoric of 'elimination', 'eradication', 'cures' and so forth, funders have invested in this mission.

Lofty ambitions must be encouraged, however, in the face of a double burden of communicable and non-communicable diseases in low-income countries, care should be taken to ensure priorities are not unduly skewed in search of a legacy. A willingness to ask questions and refine the approach is essential to ensuring we best serve the populations we seek to help.

[1] Lockwood, Diana NJ, Shetty V, Penna, GO. Hazards of setting targets to eliminate disease: lessons from the leprosy elimination campaign. BMJ, 2014; 348.
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[3] Declaration of Alma Ata (1978). Available from: http://www.who.int/publications/almaata_declaration_en.pdf (Last accessed: 21/02/14)
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Competing interests: No competing interests

Study on link between MMR vaccine & Autism redacted from publication

http://www.healio.com
August 28, 2014

A recently published study that assessed timing of measles-mumps-rubella vaccination and autism among young black boys has been removed from the public domain, according to a statement from Translational Neurodegeneration.

The study, penned by Brian S. Hooker, PhD, PE, a biochemical engineer at Simpson University in Redding, Calif., found that young black boys who received the MMR vaccine before age 24 months had an increased risk for autism diagnosis. Hooker used data from a previous study conducted by the CDC, which found no association between age at MMR vaccination and autism diagnosis among children.

According to Hooker, the CDC study limited its cohort of black boys to include only those who had a valid birth certificate, which decreased the statistical significance of their analysis.

In response to these claims, the CDC said the study presented results for two sets of children: all children initially recruited and a subset of children for whom a birth certificate was available, according to a press release.

Frank DeStefano, MD, MPH, director of the CDC's Immunization Safety Office and lead author of the CDC study, said he and colleagues stand by the study findings.

As a result, Translational Neurodegeneration, the journal in which Hooker's study was published, released this statement: "This article has been removed from the public domain because of serious concerns about the validity of its conclusions. The Journal and publisher believe that its continued availability may not be in the public interest. Definitive editorial action will be pending further investigation."

Millions of Children Infected with 'Vaccine Safety Experts' Rotateq Vaccine: Dr. Paul Offit

BY SAYER JI, FOUNDER

Thursday, September 25th 2014

www.greenmedinfo.com

Paul Offit says you can safely administer 10,000 vaccines to infants at once. But he also profits from the patent he holds for the Rotateq vaccine. What's wrong with this picture?

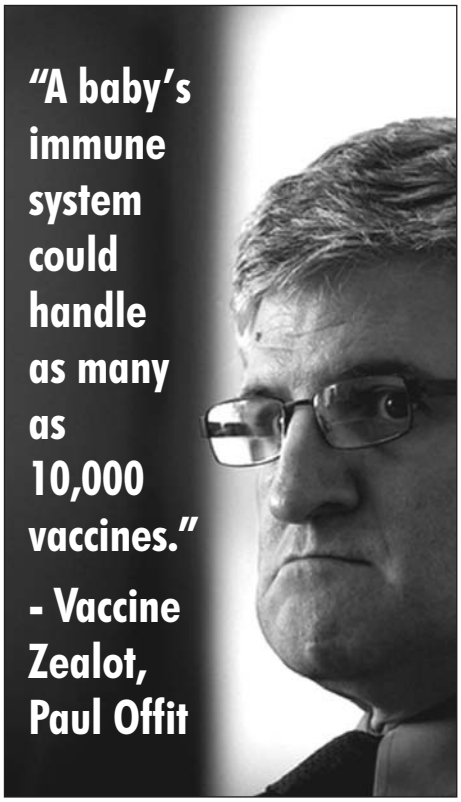
Dr. Paul Offit is a pediatrician who co-invented a rotavirus vaccine (trade name Rotateq), who once stated in interview that a child can be administered 100,000 vaccines safely at once (later revised to 10,000). A professor of Pediatrics at the University of Pennsylvania, he is the darling of the mainstream media and a widely cited self-appointed 'vaccine safety expert,' despite the glaring conflict of interest implied by such a designation.

Unfortunately for Dr. Offit (not so affectionately named Dr. Profit), a 2010 study published in Journal of Virology revealed that his multi-million dollar grossing patent on the Rotateq vaccine contains a live simian retrovirus (with a 96% match of certainty) that has likely infected millions of children over the past few years with a virus that causes great harm. Retrovirus infections are permanent, and can carry on indefinitely into future generations. In other words, once they are inserted into the human genome they can not be removed.

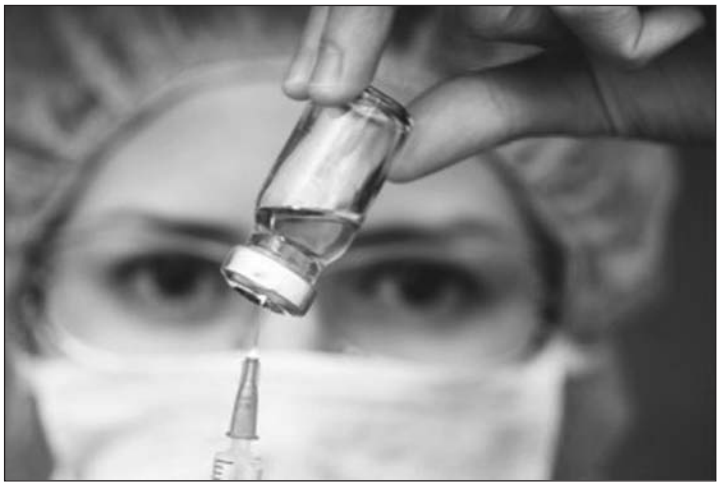
Moreover, a 2014 study published in Advances in Virology found Dr. Offit's vaccine contains a "a baboon endogenous virus strain M7...likely due to the monkey cell line in which RotaTeq was produced from."

In order to grasp the dire significance of these findings, you might want to familiarize yourself with the history of adventitious viruses in so-called attenuated or live vaccines. These contain the actual disease vector they are supposed to prevent. While considered "weakened," their process of manufacture often make them more adaptable to the host within which they are injected. Many rounds of passage through human and animal cells often makes these vaccines far more dangerous than the natural 'wild-type' infections that we encounter naturally. You only have to look to oral polio vaccine to understand the dangers of the vaccine model. In 2011, the Indian Journal of Medical Ethics published a study revealing that vaccine strain polio is twice as lethal as wild-type, and has been identified to cause over 47,000 cases of polio-associated paralysis in 2011 alone. This was the vaccine launched by the Dali Lama himself, who apparently has no clue as to the harm caused by these interventions.

The theory is that by infecting healthy bodies with them you generate an immune response – validated by elevated antibody titers, regardless of their affinity to the pathogen – that results (in theory) in increased protection. Regardless of the justification for using monkey cells for vaccine production, monkey retroviruses contaminate the vaccines nonetheless. By unintentionally infecting healthy infants with these viruses you are making them sick. Retroviruses use reverse transcriptase – a viral enzyme – to insert pathogenic genetic information into healthy cells, effectively converting them into virus-manufacturing factories. And no matter what your medical philosophy is, monkey viruses have no justifiable place in a healthy human body.



IN VACCINES WE TRUST?



BY SUZANNE HUMPHRIES, MD

26 August 2012

http://drsuzanne.net/2012/08/

Millionaire vaccine inventor and mandatory vaccine advocate Paul Offit recently released a short video for doctors on medscape. This statement that outlines Offit's personal belief system could be a prelude to the legal removal of all philosophical and religious vaccine exemptions in the United States of America. This is something that Offit has been working toward for years, and the likely end-purpose of his series of books.

Paul Offit believes that exempting your child from vaccination is morally reprehensible. He considers himself an authority on autism, all infectious diseases, morality, history, every religious system, and infant immunology. You may also recognize Dr Offit as the one who says that all vaccines are perfectly safe and infants can tolerate theoretically 10,000 of them at once:

"A more practical way to determine the diversity of the immune response would be to estimate the number of vaccines to which a child could respond at one time ... each infant would have the theoretical capacity to respond to about 10,000 vaccines at any one time." [1]

The status accorded to him by the pharmaceutical and medical fields permits him to influence the opinions and practice of lower rung physicians regarding vaccine exemptions. Unfortunately, even doctors will simply believe the "expert" [2] without bothering to go and check their own medical literature, to see if the self-proclaimed expertise has a solid scientific foundation. Research shows that when people listen to the expert, the part of their brains that is capable of independent thought goes to sleep.[3]

In Offit's video, he said that religious exemptions do not "make sense" and went on to inform doctors on the chronological age of three religious scriptures, and how they could not possibly have anything to do with vaccination because vaccines are so much newer than those tattered and outmoded scribbles of hundreds or thousands of years ago. Those "outmoded" books, including the Old Testament and the Koran, include specific passages containing principles which obliquely address many health issues. To many people, these scriptures place vaccines amongst many things which are not consistent with scriptural hygiene.

Hindu faith also has restrictions on what is permitted in their bodies, the treatment of cows and monkeys etc. Vaccination is an affront to many Hindus who know the contents of vaccines. The Dalai Lama hopefully does not understand the full impact of his alliances.

God gave Moses core principles on Mt. Sinai that are held in high esteem by both Christians and Jews the world over. Offit misses out on the timelessness of God's words. God's principles don't wear out. Neither do they need continuous repeating and revising.

God could have instructed Moses on how to inoculate the Israelites in the desert when the diseases came upon them. If you take note of the Old Testament books of Exodus, Leviticus, Numbers, and Deuteronomy, you'll see that there were very specific guidelines handed down on everything from worship of God to disease management, with warnings as to what would happen if those guidelines were ignored. The Israelites had highly skilled metal smiths and very sophisticated craftsmen and oil production. They had access to all the tools that Edward Jenner used to invent the smallpox vaccine, which included cowpox (not smallpox) pus scraped directly from infected cow bellies, a crude filter, glycerine, and a sharp prong. Paul Offit may not realize how crude the highly praised first vaccine really was. Still, medical vaccination or inoculation of any sort, was never part of God's instruction.

Hospital-based doctors who consider any disease that is supposedly treatable by pharmaceutical medicine to have a spiritual component, are considered to be quacks. Lip service, however, is given through the tolerance of chaplains and religious representatives, so long as they don't interfere with the use of drugs, vaccines or "medical science."

In the New Testament, did Jesus, the greatest human healer of all time, ever turn to Luke, the physician-apostle, to do any of the healing work of people brought to him? No. Did any of the apostles and disciples ever call on Luke to do God's healing for them? No. Did Jesus instruct Luke to carry on with his old medical practices later? No. Jesus left the Holy Spirit here on earth for any and all to ask for, receive and gain wisdom from.

In medical school, doctors are taught to view the human body as a random mistake-ridden vessel, which is to be forced into submission with antibiotics, antihypertensives, antihistamines, anti-inflammatories, surgery, drugs etc. The natural extension of this paradigm over the past 100 years has been for the medical profession to condition human beings to not trust anyone but certified medical doctors to fix this defective mistake-ridden aberration of creation. Veterinary science has similarly conditioned humans to consider animals as defective, mistake-ridden creation prototypes. The number one successful strategy in creating this industry has been to always implant fear into people's heads. That increases cortisol, undermines the immune system, and creates a self-fulfilling prophecy.

Vaccines are the template for the fear-based belief system that those who don't know their history will easily fall for. The

trajectory of fear removes God from the picture. A fear-ridden populace couldn't possibly credit God with any usefulness once the medical/pharmaceutical industry sets itself up in God's place.

Through the resultant lack of faith in the human creation and the God who does actually have the power to heal all through both the design of the body and miracles, seeps the arrogance (and ignorance) of doctors and scientists who think they can outwit God's nature. While sometimes it might look like it's possible to outwit nature, for example by using antibiotics, the law of "What you sow you will reap" often comes back with a vengeance. Drug-resistant bacteria like MRSA, VRE, and overgrowth of the colitis-causing Clostridium difficile, are prime examples.

Doctors like Paul Offit believe that the slowly maturing immune system of an infant is defective[4] and that vaccinations[5][6], designed to put it into hyper-drive, will fix the defects. On the other hand, Dr Offit doesn't have much faith in his own laboratory creations, since he believes that the anti-vaccination movement "threatens us all," including presumably ... the vaccinated.

Paul Offit makes reference to the two states that have ruled that parents do not have a religious privilege to decide how their children's bodies are treated, citing US Constitutional amendment 14. The 14th amendment was designed to protect newly freed slaves. It is being used for a different purpose in Mississippi and West Virginia. Many people are unaware that the 14th amendment is the most controversial amendment ever proposed, and that according to some legal experts, it was never legally ratified.

If corporate medicine is going to be permitted to over-ride parental philosophical and religious objections, and invade the bodies of our children with dozens of vaccine antigens, chemicals, animal DNA, aborted fetal tissue, and cancer cells, the source of these laws must come under scrutiny.

The impingement on Article I of the First Amendment of the Constitution should also be taken into consideration.

"Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances."

It would appear that the Bill and Melinda Gates foundation has made PLANS that would steamroll right over the protection of our free speech.

"An anti-vaccine surveillance and alert system Seth Kalichman of the http://www.uconn.edu/ in the USA will establish an Internet-based global monitoring and rapid alert system for finding, analysing, and counteracting communication campaigns containing misinformation regarding vaccines to support global immunization efforts."

Only time will tell what is going to be considered "misinformation" and "counteraction." If parents were convinced that vaccines are safe and effective, there would be no anti-vaccination movement. It shouldn't take military action or Internet surveillance to maintain the health of communities or global immunization efforts. This type of action is not new. It is reminiscent of policies found in National Socialist empires, Stalinist countries, or Communist China.

"If parents were convinced that vaccines are safe and effective, there would be no anti-vaccination movement."

Those who push removal of philosophical and religious exemption should at least be free of financial conflicts of interest, and they are not. More importantly, in order to bolster the 30-billion-dollar-per-year-income vaccine industry they consider to be evidence-based science, they should not be proclaiming worldwide expertise in what it takes to have a personal relationship with Jesus, something they appear to have no experience in.

Dr Offit considers "evidence based medicine" to be separate from religion, or spirituality – yet the Christian scriptures, both old testament and new, make it perfectly clear that good health is solely predicated on a living relationship with God.

When it comes to vaccines, these flag bearers of evidence-based medicine use research protocols which involve tight selection and exclusion criteria for vaccine study entrants. They then recommend those same vaccines, assuring safety to concerned parents, to even the children who would have been refused entry to that vaccine safety study.

Instead of placebos, evidence based medicines uses vaccines, and calls them placebos, yet vaccines do not fit their own definition of placebo;

pla·ce·bo/pl s b /Noun:
A harmless pill, medicine, or procedure prescribed more for the psychological benefit to the patient than for any physiological effect.

A substance that has no therapeutic effect, used as a control in testing new drugs. Here are some examples of vaccine trial "placebos":

The hepatitis A vaccine was the placebo for the influenza vaccine in a well publicized study. The study's designer is quoted as saying that he didn't want to withhold a potentially beneficial treatment from the control subjects. "Hepatitis was not studied, but to keep the investigators from knowing which colonies received flu vaccine, they had to offer placebo shots, and hepatitis shots do some good while sterile water injections do not." So, if the placebo is supposed to have no therapeutic effect as the definition that was taken from an ardently pro-vaccine website that criticizes our criticism of their use of placebos, and the study used hepA placebo because "water does no good" ... where on earth is the match up with even their definition of science?

Dr. Suzanne Humphries is a conventionally educated medical doctor who has taken the walk into, around, and out of the allopathic paradigm. She fully and successfully participated in the conventional system for 19 years, witnessing first-hand how that approach fails patients and creates new disease time and again. Prior to medical school, she earned a bachelor's degree in physics from Rutgers University.
Dr. Humphries is on the board of directors of the International Medical Council on Vaccination. She lives in Maine, USA.

Visit her website is drsuzanne.net

CDC EPIDEMIOLOGIST WHISTLEBLOWER CONFIRMS NEW REVIEW SHOWING VACCINE AUTISM LINK

WATCHUNG, NJ
(MARKETWIRED VIA COMTEX)
Published: Sept 11, 2014
www.marketwatch.com

IN RESPONSE to the August 25, 2014 Centers for Disease Control and Prevention (CDC) declaration defending the validity of the 2004 DeStefano et al. study, PhD biochemist Brian Hooker responded and outlines inconsistencies in the agency's research practices and position.

Central to Hooker's response is "the irrefutable fact that valid information about race -- for the entire study sample of 2,448 children -- was available and accessible in school records."

The CDC maintains that birth certificates, which were available for only a smaller portion of the children in the study, were necessary to extract race and other information. However, in the original data Hooker obtained from the CDC through the Freedom of Information Act (FOIA), race information was directly obtainable through school records, which were available for all children in the study.

In addition, Dr. William Thompson, a CDC scientist since 1998, also released a statement on August 27, 2014 that supports Dr. Hooker's assertion that the CDC withheld important data that significantly altered the study's outcome.

According to Dr. Thompson's statement, "Decisions were made regarding which findings to report after the data was collected." Thompson's conversations with Hooker confirmed that it was only after the CDC study co-authors observed results indicating a statistical association between MMR timing and autism among African-American boys, that they introduced the Georgia birth certificate criterion as a requirement for participation in the study. This had the effect of reducing the sample size by 41% and eliminating the statistical significance of the finding, which Hooker calls "a direct deviation from the agreed upon final study protocol -- a serious violation."

Hooker and Thompson both concluded that the study's original data revealed a strong, statistical association between the timing of the MMR (measles, mumps, rubella) vaccine and autism incidence in African-American boys.

"I regret my co-authors and I omitted statistically significant information in our 2004 article published in the journal Pediatrics. The omitted data suggested that African-American males who received the MMR [measles, mumps, rubella] vaccine before 36 months were at increased risk for autism"

"Ten years ago (February 2, 2004), Dr. Thompson expressed concerns about the [MMR] study's findings in an urgent letter to CDC Director Dr. Julie Gerberding," said Dr. Hooker. [Thompson] wrote: 'I will have to present several problematic results relating to statistical associations between the receipt of the MMR vaccine and autism.' Referring to the upcoming Institute of Medicine (IOM) meeting on immunizations and autism.

Dr. Thompson received no reply from Dr. Gerberding but was removed from the IOM speaker schedule just days before the meeting. The 2004 IOM report, which omitted his findings, was cited in the Omnibus Autism decision that denied 5,000 families compensation for vaccine injury claims. The report continues to be widely cited for its position of exonerating vaccines' role in causing autism.

Dr. Gerberding subsequently left the CDC in 2008 and in 2009 became president of Merck's multi-billion dollar vaccine division, a position she still holds today.

Hooker's statement also quoted an internal CDC memo from 2004 which termed Dr. Thompson's role in carrying out statistical analysis for the MMR study "pivotal," it described him as having "excellent statistical skills", "exceptional epidemiological skills", "[an] outstanding reputation within his highly specialized field," and confirmed his leadership of multiple large CDC studies.

Dr. Hooker points out Dr. Thompson's impeccable scientific credentials provide extra weight to his current revelations. Thompson states:

"I regret my co-authors and I omitted statistically significant information in our 2004 article published in the journal Pediatrics. The omitted data suggested that African-American males who received the MMR [measles, mumps, rubella] vaccine before 36 months were at increased risk for autism. Decisions were made regarding which findings to report after the data was collected, and I believe that the final study protocol was not followed."

The CDC has a history of manipulating data in order to achieve a desired outcome and then misleading the public. The agency has been criticized in a number of government investigative reports for its failure to warn and protect the public.

In 2008, the CDC withheld information regarding the toxic formaldehyde found in trailers provided to victims of hurricane Katrina and failed to alert the public that formaldehyde is a carcinogen.

An Office of the Inspector General (OIG) 2009 investigation concluded the CDC was allowing many scientists and medical experts, with significant conflicts of interest, to participate in numerous research studies.

Then in 2010, a congressional investigation found the CDC "knowingly used flawed data to claim that high lead levels in the [DC] District's drinking water did not pose a

health risk to the public." The Washington Post reported, "The committee reveals that the missing data showed clear harm to children from the water and that CDC authors knew the data was flawed."

In addition, former CDC vaccine/autism researcher, Poul Thorsen, who co-authored several studies widely cited as "proof" there is no link between vaccines and autism, has been indicted and charged with 13 counts of wire fraud and nine counts of money laundering awarded to the CDC for autism related research. Thorson is now a fugitive on the Inspector General's most wanted list.

"Given this abysmal track record and the fact that an astonishing 1 in 68 American children have an autism diagnosis, one has to wonder why the revelations made by Drs. Thompson and Hooker hasn't become a major news story or prompted greater congressional scrutiny of the CDC," said Barry Segal, founder of Focus Autism.

The Focus Autism Foundation was founded by humanitarian and philanthropist Barry Segal. The foundation is dedicated to investigating the cause(s) of the autism epidemic and the rise of chronic illnesses in children. A Shot of Truth is an educational campaign sponsored by Focus Autism. Mr. Segal also founded the Segal Family Foundation, which provides approximately $10 million annually to Sub-Sahara Africa to promote education, health, and family planning.

CDC Scientist reportedly claims vaccine linked to Autism in black babies

POSTED BY TAYLOR GORDON

http://atlantablackstar.com/

September 8, 2014

Credit: Joe Raedle/Getty Image

A SENIOR SCIENTIST for the Centers for Disease Control and Prevention claims the federal agency has been hiding results from a test of experimental measles vaccines that increased the likelihood of Black children getting autism, according to reports.

There has been a lot of controversy surrounding MMR (measles, mumps and rubella) vaccinations and whether or not they are linked to autism.

While the CDC assured the public that there was nothing to worry about with the vaccination, senior scientist Dr. William Thompson claims the CDC has been lying for years, according to The Examiner.

Dr. Brian Hooker was doing research for the Focus Autism Foundation and requested some information via the Freedom of Information Act about a 2004 study that claimed MMR vaccinations were perfectly safe.

According to Thompson, those results were false.

The Examiner reported that Thompson, who has been with the CDC for more than a decade, admitted to Hooker that he and several other authors behind the study manipulated and hid data that proved Black babies were more than three times more likely to develop regressive autism if they were given the vaccine before the age of 3.

For more than 10 years, parents of Black children may have been uninformed and unaware that giving their baby the vaccine could drastically increase the likelihood that they could develop autism. According to Age of Autism, "That one lie is responsible for at least 250,000 cases of autism in African-American male children and that number is a gross underestimate of the true extent of the damage."

Thompson's statements come after Congress already has started to suspect something was awry with the CDC's investigation.

U.S. Congressman Bill Posey of Florida requested information from the CDC regarding the study in the past, but the agency refused to hand anything over.

Posey released a public statement saying, "The CDC can't be trusted regarding investigating vaccine safety."

He even went on to say that the "CDC should be investigated."

Posey was absolutely right, according to Age of Autism. The website, which is dedicated to sharing information about autism, reported that about 20 years prior to the controversial study being published, the CDC tested deadly, experimental measles vaccines on African infants before launching another round of tests on inner-city babies in low-income neighborhoods in the U.S.

VACCINE DISCLAIMER LETTERS

ARNICA
UK PARENTS' SUPPORT NETWORK
Promoting Natural Immunity

BY ANNA WATSON

During the summer I was contacted by a mother who had been told by her GP surgery that she either agreed to have her son vaccinated or if not she must sign a disclaimer, otherwise he would be de-registered.

A series of emails and phone calls followed between myself, NHS England and the mother's surgery. Was this legal? Where was the policy detailing this practice? Why were so many GPs asking for disclaimers? What was the significance to the parent signing or not signing?

What followed is the same old chestnut, GPs in different areas of the UK interpreting the NHS policy of mass vaccination in their own way, and NHS England (now called) not knowing fully how their policy is being implemented. You will also see how NHS England is not even clear on what their policy is, and that bias and personal opinion persists throughout.

Here follows the communication I experienced with NHS England - it is interesting to compare their first response with their last one!

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Thank you for your email of the 24th June 2014. Your GP is entitled to ask you to sign a disclaimer regarding the vaccinations, if you have chosen not to immunise your child. The GP does needs written confirmation of your decision. You will need to sign the disclaimer and return it to your GP, to ensure continued care of your child.
Yours sincerely
Karen Jagger
Customer Contact Centre
Case Officer, NHS England

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Thank you for your telephone call of 4th July 2014 to NHS England.
I understand that your friend has been asked to sign a disclaimer by her GP because she has chosen not to accept vaccinations for her child and that you wanted more information regarding this, perhaps in the form of an NHS England policy. I advise that choosing to not vaccinate children is potentially putting the child, and other people, at risk of infection. By asking for the parent to sign a disclaimer, the GP is ensuring that he or she is not legally liable for any harm caused as a result of a parent's decision that is contrary to the GP's clinical advice. It is important that there is trust between both patient and doctor and, by not signing the disclaimer, there is the potential for putting the doctor-patient relationship at risk.
I hope this sufficiently addresses your enquiry.
Kind regards,
Tom Buckley
Customer Contact Centre
Support Officer

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Dear Tom

Many Thanks for your reply - I did try to call you but as I haven't heard back I have emailed you.

I fully understand the vaccine policy, and agree that asking for a decision in writing for patient records is not unreasonable.

I agree that the GP should be entitled to ask. However, the way in which this is presented / demanded, with threats attached, is causing confusion and making the patient / parent bullied.

1. Will older people need to sign disclaimers on not wanting the flu vaccine? For 'potentially putting the (person), and other people, at risk of infection'

Might this mean that smokers and heavy drinkers will have to sign such a disclaimer for not following clinical advice? Is there a move towards this kind of disclaimer / contract in the NHS?

2. I didn't know that doctors were "legally liable for any harm caused as a result of a parent's decision that is contrary to the GP's clinical advice" Can you please give any references or examples of this?

3. I sat on my local PCT board as a lay member, and saw it through to the CCG, and it seems that such a disclaimer is not used and not even heard of in my borough. Is a disclaimer a new policy or a new accepted practice? If so, please direct me to reference or details? Where does it say in the Green Book, on the NHS website or else that "The GP does need written confirmation of your decision" as suggested by the last case worker. Or is it the case that GPs have some freedom to operate their own interpretation of the Vaccine Policy and demanding written confirmation and withdrawal of services is actually supported by NHS England?

4. Legally what are the consequences for a parent who signs a disclaimer or for one who does not sign a disclaimer?

Some GPs are saying that GP services will be withheld if vaccination does not take place, some say services will be with held if the disclaimer is not signed. My first letter from NHS England implied that this was perfectly reasonable practice "Your GP is entitled to ask you to sign a disclaimer regarding the vaccinations, if you have chosen not to immunise your child. The GP does needs written confirmation of your decision. You will need to sign the disclaimer and return it to your GP, to ensure continued care of your child."

5. Finally, you mention the importance of the relationship between GP patient "It is important that there is trust between both patient and doctor and, by not signing the disclaimer, there is the potential for putting the doctor-patient relationship at risk." I agree that the relationship is vital but isn't the GP putting this at risk also by not respecting the patients choice as guided by the GMC 'Consent_-Patients & GPs working together - A GMC Guide.'

There are several references but perhaps this paragraph is most relevant:

'Respecting a patient's decisions'

43 You must respect a patient's decision to refuse an investigation or treatment, even if you think their decision is wrong or irrational.10 You should explain your concerns clearly to the patient and outline the possible consequences of their decision. You must not, however, put pressure on a patient to accept your advice.
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I have heard many stories of GPs shouting and using very emotive and threatening language when a 'discussion' is had about this topic, so to introduce a disclaimer in these circumstances does not seem to be helpful to build bridges. In the last 60 years of operating a vaccine policy, and at a time where uptake is nearly at WHO levels, why is it necessary to operate a disclaimer letter and threaten to withdraw services for non vaccinated children?

There are around 5% - up to 500,000 unvaccinated children in the UK. This seems a large amount to try to chase and potentially not treat. I would like to make an appointment to see someone at NHS England to discuss and clarify these matters

Many Thanks

Anna Watson

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Dear Anna,

Thank you for your reply. I am seeking advice and will respond to you as soon as possible.

Kind regards,

Tom Buckley

Customer Contact Centre

Support Officer

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Disclaimer letters – not policy – says NHS England

Dear Anna,

Thank you for your patience whilst I have sought advice to answer your questions. The positions in relation to parental responsibility is contained in the Children Act 1989 and the legal position on people with parental responsibility giving consent for a child to have vaccinations/immunisations is set out in Chapter 2 of the Green Book and can be set out as follows:

For young children not competent to give or withhold consent, such consent can be given by a person with parental responsibility, provided that person is capable of consenting to the immunisation in question and is able to communicate their decision. Where a person brings a child in response to an invitation for immunisation and, following an appropriate consultation, presents the child for that immunisation, these actions may be considered evidence of consent. A person giving consent on behalf of a child may change his or her mind and withdraw consent at any time. Where consent is either refused or withdrawn, this decision should be documented. If there is disagreement between the people with parental responsibility for the child, then immunisation should not be carried out until their dispute is resolved. A child may be considered "Gillick" competent, this is where the child is able to sufficiently understand the proposed treatment to be able to give consent in their own right.

Those who are capable of giving consent or are doing so on behalf of another (including a child) may do so in writing, orally or by cooperation. Completion of a consent form is not a legal requirement and a signature on a consent form does not itself prove that the consent is valid but it does serve to record the decision that was reached, and the discussions that have taken place. It is important to ensure that the healthcare record for each child – Personal Child Health Record (PCHR) and GP record (either paper or computer) is an accurate account of care planning and delivery. It is good practice for proper records of any discussions to be recorded in the PCHR and completed with the involvement of the parent or guardian.

A GP surgery cannot make signing a disclaimer a condition of treatment for parents or the child, as GP services are available free at the point of delivery. A practice would not be able to take any specific action to force the issue, but would probably document carefully the issue in the records. As independent contractors, GPs and will seek advice regarding documenting the decision from various sources which will help to improve the business and manage risk. Claims against health care professionals are increasing, which means that significant amounts of money are spent every year on indemnifying doctors and paying out compensation. The defence organisations will therefore often provide members with advice on how to manage medico legal risk. Some, though not all GP practices may adopt measures to address these risks. Such guidance, though maybe considered best practice, cannot be mandated.

Regarding a parent refusing to consent to immunise their child, there is not "legal liability" for the GP, as I described below, so please accept my apologies for any misunderstanding. It is better described as being put at risk of a medico-legal challenge if the failure to immunise was later challenged by an absent parent who would have parental responsibility. As an example, if a child is not immunised with MMR and subsequently develops brain damage as a consequence of a measles encephalitis, then a parent - separated from their partner - could quite reasonably challenge, years later, the failure of an effective preventative measure being offered. Formally documenting the parental dissent at the time of the decision, gives some medico-legal protection to the GP and the practice.

Adults who refuse the flu vaccine and people who smoke and drink heavily would not sign a disclaimer to receive treatment. A patient with capacity has the right to make a decision that may not be in accordance with medical advice, but nonetheless it is a responsibility for the doctor to respect a patients informed decision. However, for patients without capacity - children and a minority of adults - the GP has a duty to consider whether the person taking the decision on behalf of the child / incapacitous adult is making a fair and appropriate decision.

If there are doubts, then the health care professional should refer the matter to an Independent Mental Capacity Advocate (IMCA) who would take appropriate measures to assess the best interest of the person without capacity.

Kind regards,

Tom Buckley

Customer Contact Centre

Support Officer

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You should be pleased to know that the sharing of this last email with the GP surgery and with the Immunisation team for that particular North London Borough, was plenty for them to state to the mother that her son was still welcome. A follow up call in November to check that these letters were not being still sent out was also successful….

Keep this handy - one day you or a friend may need the last email in this series to show to your own GP!
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The Quanten Theory

VITAMIN & OTHER SUPPLEMENTATION
Good, bad or indifferent or all of the above?

by Patrick Quanten MD

Patrick Quanten MD

I WOKE up this morning believing a UK government warning had gone out: "Pills are a waste of money and may damage health". Then I realised it had all been a dream. Of course the government wouldn't send out a warning like that. Nevertheless, the government came close enough to the above statement. The statement read: "Vitamin pills are a waste of money and may damage health."

Of course, nobody argues with the fact that most people do not need the supplements as long as they eat a healthy balanced diet. That's good advice, except that "a healthy balanced diet" has never been defined. It is one of those things that we talk an awful lot about without actually knowing what it means.

We generally struggle to define basic principles we continually use and until we do, we can carry on throwing out generalised statements that can't be questioned or put to the test. The real value of those statements, however, is zilch. When you fail to clearly identify what you are talking about, nobody can really understand it or gain any knowledge from it. It easily leads to double standards and confusion.

The Food Standards Agency says that consumers put their health at risk by taking too many vitamins for too long. Does the Pharmaceutical Industry inform us that taking too many prescription drugs for too long puts your health at risk?

A ban on chromium picolinate is just around the corner on the grounds that it can cause cancer. Fair enough. No argument. Other well-known high cancer risk factors are fluoride, HRT, steroids, chemotherapy drugs, X-rays, electromagnetic fields from power cables, a whole range of food additives, preservatives and colorants, hydrogenated vegetable oils, and cigarette smoking. I am looking forward to a Government ban on all these on the same grounds.

"The Food Standards Agency says that consumers put their health at risk by taking too many vitamins for too long. Does the Pharmaceutical Industry inform us that taking too many prescription drugs for too long puts your health at risk?"

Other supplements are named as causing irreversible problems or side effects if taken in large amounts for a long time. Every patient information leaflet of every prescription drug gives a long list of known side effects the drug can cause, when taken in the recommended dosage.

In order to shed some light onto the subject and begin to understand what supplements are and whether or not they have a place in our lives we need to start defining the concepts we will be discussing.

WHAT IS DEFICIENCY?

Before we can evaluate whether or not a particular person in a particular situation could benefit from supplementation, we need to clearly establish what we mean when we say that someone is "deficient" in certain areas of his/her nutrition. How can we "measure" deficiency? What is it?

Health Authorities in the Western world are keen to put out lists of what they call Recommended Dietary Allowances. Let's familiarise ourselves with this concept as the name suggests that these "food allowances", recommended by the authorities, might have something to do with the food requirements needed to avoid deficiency.

The Recommended Dietary Allowances, or RDA's, were established in 1941 in response to the threat of war. They were determined in an effort to define nutrient needs for mass-feeding programmes, in which whole populations might need to be supplied with minimal diets. These recommendations are now being applied for purposes for which they were never intended. They are no guide at all to nutritional values of food ingredients, but are a very basic and rough guide to what is required for minimal food survival packages for an entire population, not any individual in particular.

HOW WERE THESE NUTRIENT REQUIREMENTS ESTABLISHED?

First, the mean quantity of a given nutrient that a population requires was determined according to the standard that half the people eating less than this quantity might show no signs of deficiency, and that half of those with an intake exceeding this quantity may show signs of deficiency. Next, because the mean is an estimate, to allow for variability among individuals the actual RDA is set at two standard deviations above this quantity. This adjustment is supposed to assure that 98% of all healthy persons will have their needs for

a particular nutrient satisfied by the amount specified. This amount obviously exceeds by a large margin the minimal nutrient requirement for most people in the population. On the other hand, even by standards used to determine the RDA's, a full 2% of the population will suffer from a deficiency of some nutrients if they follow the RDA's. Going beyond the question of these figures for our minimal nutrient requirements, we might want to know how much of each nutrient we need for maximum nutrition. Based on clinical, epidemiological and first-hand evidence, the scientists and physicians have noted in their clinical experience that much higher amounts of specific nutrients may be needed to bring some of us to a state of exceptional health.

It obviously isn't down to the RDA's to ensure the health of all of us. There is definitely more to it then that.

LET'S SUMMARISE THE GENERAL KNOWLEDGE GAINED IN THE LAST CENTURY ABOUT HEALTH, DIET AND THE CHANGES MADE.

1. Man's body is a complex, biochemical machine that has specific requirements for health, including specific nutritional requirements. Apart from the ingredients of food, we also need air, warmth, shelter, sunlight and companionship. A deficiency of any of these essential nutrients will result in ill-health. A Western diet is characterised by dietary excesses and shortages, which have devastating effects upon the body's biochemistry and health.
2. Planet-wide dietary variations are enormous and the body's resilience is remarkable. It is amazing that the health and lifespan of those who are underfed, or indeed overfed, are not worse than the average.
3. A truly healthy or optimum diet has never been fully defined. It is true to say that no portion of the human race has lived on a completely healthy or optimum diet for any great length of time, if ever at all.
4. The rapidity of change in Western eating habits is unprecedented and undoubtedly accounts for many diseases affecting Western man. Before the development of modern technology dietary changes only occurred slowly. Botanical research and modern farming methods have made possible the introduction of new types and large quantities of foods into our food supply. Many of these don't reach us in an unadulterated form. Significant quantities of minerals and vitamins are lost in the process of refining and processing of foods. The more we interfere with food, the greater the potential for health risks is.
5. The majority of diets are influenced by market forces and, in the West, by advertising rather than by scientific recommendation. Food manufacturers have to make a profit. This means that they have to put the interests of their shareholders first, rather than altruistically providing the best foods for their customers.

"We are different and things change all the time. Yet our healthcare system is based on the presumption that we are all the same and nothing ever changes. This is, simply put, bizarre."

6. What is a healthy diet for one individual or population may not necessarily be so for other individuals or populations. There is real truth in the old saying, "One man's meat is another man's poison". A failure to appreciate individual variation in biochemistry has resulted in many members of the medical profession dismissing diet as a major factor in disease.
7. An "average" or normal diet is not necessarily a healthy one. Repeated dietary surveys show that in many groups the intake of essential nutrients is low or borderline.
8. Anyone who is ill, or just has symptoms, has a different nutritional requirement from the times when he/she is perfectly healthy. The presence of symptoms or an illness indicates an imbalance in the health status of that individual, changing his/her requirements for nutrition.

SO, STOP BELIEVING THAT THERE IS SUCH A THING AS A HEALTHY DIET, FIXED & UNCHANGEABLE, GOOD FOR EVERY ONE.

Defining a healthy, balanced diet and a nutritional deficiency is proving a bit of an impossible task. Before we go on to where that leaves us in terms of knowing what to consume to support our body in its effort to be healthy, we will need a greater understanding of what actually causes a nutritional deficiency.

GENERAL CAUSES OF DEFICIENCY

Whether or not an individual is deficient in one or more nutrients depends on a lot more than just the amount taken in the diet, let alone the RDA. There are four main factors that influence nutritional status:

- Biochemical individuality
- The quality of the food we eat
- The quantity of the food we eat
- The efficiency of digestion, absorption and utilisation

BIOCHEMICAL INDIVIDUALITY

It is now widely accepted that health is an individual matter. We are all different in many ways and what is good for one today may not be good for another today, nor may it be good for the same person tomorrow. We are different and things change all the time. Yet our healthcare system is based on the presumption that we are all the same and nothing ever changes. This is, simply put, bizarre.

The medical profession fully accepts that such an assumption has to be false, but carries on playing the number-game. Everything they do hinges on statistics. If more people report being better whilst receiving a certain treatment, then it must be good for everybody. Well, we know, and they know, that this isn't true, but at least you feel your "chances" of getting better have increased. But does it make a substantial difference to you personally? Let's look at a fictional risk of getting a mutilating and crippling disease of 1 in 10 million. To doctors that is a very low risk and consequently, to the healthcare system, a low priority. For the individual who gets the disease, the risk

is 1 in 1 as he/she actually has the disease, and the healthcare provisions paramount. So, in order to increase successful healthcare it must be considered on an individual basis. That, however, the medical profession classifies as anecdotal: a friendly term, meaning "meaningless to us". But can we ever know an individual's risk as opposed to a statistical risk for the whole population? Can we with reasonable accuracy predict the likely problems an individual is heading for?

That, I am afraid, will take us far away from vitamins and mineral supplements, and will therefore have to wait. Suffice it to say, don't turn your back on the old knowledge that "nothing is impossible".

THE QUALITY OF FOOD

Dieticians know exactly how many calories there are in a tomato, what the concentration is of all the main ingredients, and how many we all should have as part of our healthy diet. What the Western world seems to have failed to take note of, is that a tomato grown in England is different from one grown in Italy and one from Mexico. Why? Because everything that makes the tomato what it is, is different: the climate, the quality of sunlight, the soil, the water and the air. The most important ingredient in the quality of our food is how and where it is grown. (see article "Healthy Food" on my website).

Next is what we do to our food after we have grown it. Do we eat it fresh from the soil or the plant? Do we send it away to be sterilised, vacuum packed or frozen, to be preserved, so we have time to move the food to a great number of places over vast distances?

Not so long ago scientific research showed that the majority of our fruit and vegetables are seriously devoid of vitamins and minerals. It was reported in the popular press under the heading "There is no vitamin C in your orange!" The main reason for the appalling deficiencies is said to be the harvesting of unripe fruit and vegetables, which are then left to "ripen" either during their long transportation halfway across the world, or in cooling units. The lack of a natural environment prohibits the food to become what it was meant to be. The other reason for the general poor state of our pretty-looking fruits and vegetables is the poor quality soil they are grown in, which is a direct result of many years of artificial fertilisation and forced growth.

THE QUANTITY OF FOOD

Dependency on large amounts of refined foods is known to lead to malnutrition, even when there is no undernutrition. If nutrient-dense foods such as whole grains and unprocessed foods are replaced by processed foods that have been stripped of essential nutrients, there will obviously be an alteration of the nutritional status of the person who eats them.

"As repeated scientific studies have shown the importance of nutritional factors in the prevention and treatment of diseases, it is now taken for granted by doctors and scientists that diet is a major factor in the diseases of the Western world."

DIGESTION, ABSORPTION, UTILISATION

An individual whose digestive system is inefficient is more likely to have a poor nutritional status than someone with an efficient digestive system. This might seem obvious, yet it is widely overlooked by health professionals and the public alike. "A bit of indigestion; … suffer from wind; …bouts of loose stools or constipation", are all mild but definite indications that the digestion is not working properly. Consequently, the food does not get broken down properly; nutrients are lost, resulting in possible nutritional deficiency.

Certain conditions of the intestine reduce the efficiency with which digested foods are absorbed. Examples of these are food allergies such as gluten intolerance, which alters the inner lining of the gut, or polyps, diverticulosis and Crohn's disease. Besides this, the presence of other substances in the diet can prevent certain nutrients from being absorbed properly. For example, tea and coffee reduce the absorption of zinc and iron. Bran fibres can reduce the absorption of calcium, iron and zinc. Foods in their natural status, non-refined, have a combination of substances within them that will aid the process of digestion and absorption. These substances are generally referred to by medical authorities as "impurities".

Some people may also have metabolic abnormalities that prevent the body from efficiently utilising the nutrients that are there. These metabolic problems can be caused by genetic factors, food intolerance, other nutrient deficiencies, food toxins and environmental pollution such as certain pesticides.

Now that we have looked at what constitutes a deficiency, what causes it and how the quality of our food plays a vital role in the nutritional status of the individual, we can move on to the place of supplementation in our diet.

SCIENTIFIC REASONS FOR SUPPLEMENTS

As repeated scientific studies have shown the importance of nutritional factors in the prevention and treatment of diseases, it is now taken for granted by doctors and scientists that diet is a major factor in the diseases of the Western world. However, when it comes to the consequent treatment, we find that this is largely ignored in favour of the drug approach. There is no financial reward for sending people home with advice on dietary habits, herbs and home-made remedies. It also demystifies disease and penetrates the wall of jargon and complexity the medical profession has created around itself in order to claim the sole possession of the wisdom of health and disease patterns.

Some of the commonest diseases of civilisation include heart disease, high blood pressure, dental caries, obesity, diverticulosis, gallstones, appendicitis, gout, varicose veins, strokes, diabetes and cancer. They are all more common in the Western world than elsewhere. We produce more of these diseases than anyone else, yet we claim to know how to combat them!

As well as these very serious conditions, many non-killing diseases

that beset technologically advanced countries may also be linked to food. These include asthma, eczema and other allergies, chronic degenerative diseases such as osteoarthritis and rheumatoid arthritis, and mental illness. There is increasing, indeed, overwhelming evidence that many of these conditions, if not all, can be prevented and treated by nutritional means. Many sectors of the public have been quick to catch on to the importance of nutrition in such conditions, but the medical profession as a whole has been somewhat slower. It is unthinkable that the enormous number of people across the Western world who are using nutritional supplements, and the vast amount of money spent on them, could have developed on the back of nobody finding any benefit from it. As the medical profession has failed to deliver on their promise of eliminating diseases, the population has over the years more and more turned to where it all began; "you are what you eat."

On top of that, ironically it is our own scientific evidence that has given more substance to the knowledge that food and its quality is of vital importance. It is the Western science that discovered the vitamins and, later on minerals and their precise role. In further experiments it was established how individual treatment protocols with these supplements could influence disease patterns. Some of this research resulted in Nobel prizes for individuals such as Linus Pauling (Vitamin C), but in many cases the establishment had to resort to distancing themselves from their heroes when these people started to turn out even more astounding results from vitamin, mineral and essential element research. Linus was a hero when he researched Vitamin C and the Common Cold; he became a muddled, confused geriatric to the establishment when he published his studies on Vitamin C and Cancer.

It is our research that has listed vitamins and crucial elements and has discovered their function, as well as the impact of various concentrations when taken as supplements. A comprehensive list can easily be found in the extensive literature on the subject but it is of interest just to pick some out for the purpose of this dissertation.

- Vitamin A: infection fighter, skin protector
- Carotenoids: cancer and heart protectors, antioxidants
- Vitamin B 12: the vitality shot
- Choline and Lecithin: nerve rebuilder
- Inositol: nature's sleeping pills
- Pantethine/Pantothenic Acid: better than cholesterol pills
- Biotin: diabetes benefactor
- Magnesium: the heart's most important mineral
- Zinc: immune booster, wound healer
- Copper: arthritis reliever
- Chromium: blood sugar balancer

Benefits and effects have long been established and one has to question why all of the sudden these supplements have come under attack.

"Beta-carotene was hailed as the most essential tool in the natural cancer treatment cupboard with well-conducted tests showing a massive reduction in cancer growth and in many cases "cancer-cures". Not only impossible, but also plain ridiculous!"

WHY FIGHTING AGAINST DISEASE BUSTERS?

As research continued into the effects of supplementation of our diet, reports emerged one after the other of fantastic results in areas where not only the medical profession was struggling, but where they categorically had stated that there was no cure. Research showed that high dosages of Vitamin C could stave off cancer, in some cases reverse it. Impossible! Beta-carotene was hailed as the most essential tool in the natural cancer treatment cupboard with well-conducted tests showing a massive reduction in cancer growth and in many cases "cancer-cures". Not only impossible, but also plain ridiculous!

As the pressure was growing on the mainstream medical authorities to take more notice of these studies, they decided to do their own. They did not want to speak to anybody who was involved in this kind of research, but instead set off on their own. Within a short period of time they were happy to announce that each of these reports was rubbish and that their "repeated" experiments had failed to show any improvement at all when using supplements like Vitamin C or Beta-carotene in cancer patients. Complaints from the established researchers in the field about the flaws in the set-up of the official studies and in some cases the use of inferior supplements were ignored and silenced. Massive media campaigns put the medical authorities firmly in control again. And yet, their problem hasn't gone away. It keeps rearing its ugly head. Then there is nothing else to be done but to make the use of these substances totally illegal, which will put an end to any research into this matter and consequently a stop to continual reports of beneficial effects.

You think I am exaggerating? Here are just a few examples, which have been well documented in the literature and are important to us in order to reach sensible conclusions.

When we go back in time and look at Linus Pauling's studies about the effects of Vitamin C on the immune system and, later on, more specifically on the cancer process, we cannot fail to be impressed by the results. Not only did he stand by his results, but many others also replicated his results. Yet, when the medical hierarchy decided it was time to "once and for all" prove that the man was a lunatic, some twenty years after he had rocked the scientific boat, they could only report that Vitamin C made no difference whatsoever in cancer patients. In hindsight, an important factor in all of this is the Vitamin C itself. Have a look on the bottle of your Vitamin C supplement and it will tell you that Vitamin C is ascorbic acid. True Vitamin C, however, is ascorbate! Furthermore, the success of the C complex can be attributed to the fact that the natural resources, which Linus was also using, contain synergistic components, such as rutin and other bioflavonoids, a copper enzyme, and other factors. None of these are found in standard-issue synthetic Vitamin C, which has been in general use since 1934.

Our obsession with finding the one "active ingredient" keeps hindering our

progress in understanding how nature really works. About twenty years ago, even doctors were advising their patients to take Evening Primrose Oil for menstrual problems and it became so popular that it was brought onto the market in our favourite form, a pill. Very popular with patients as well as general practitioners, but disaster was about to strike. The authorities felt that it was essential to find the active ingredient as combination drugs are shunned by the industry regulator. And they found it! The Evening Primrose pill was still sold as Evening Primrose but now only containing one of the ingredients. Effectiveness dropped dramatically, even to the point that as a general practitioner one could not miss the number of women coming back asking to try something else, as this particular supplement did not make any difference. Stripped down to the active ingredient, the ingredient loses its activity.

Hundreds of studies were published demonstrating that people with higher beta-carotene levels had impressive protection against all forms of cancer, heart disease, macular degeneration and a range of other degenerative diseases. Hoffman-La Roche, the leading supplier of the nutrient at that time, confidently funded a series of studies that were expected to make their product, synthetic beta-carotene, a "must" in the lives of everyone who wanted cancer protection. Between 1994 and 1996 the studies were published, and synthetic beta-carotene laid the biggest egg in human history. How could dietary beta-carotene be of such spectacular value, while beta-carotene capsules actually seemed to make cancer prevention somewhat worse? The artificial version is inferior for two primary reasons:

• It does not contain any of the other natural carotenoids.

• Its overwhelming presence interferes with our cells' absorption of the other natural carotenoids in food. For example, the synthetic form lowers the blood's concentration of lutein, another carotenoid with its own unique health-promoting power.

The earlier conclusion that beta-carotene itself shielded us from disease was based in large part on research that didn't involve synthetic beta-carotene, but rather used natural supplements or natural food sources of the nutrient, such as fresh carrot juice. This distinction is usually not mentioned. Equally important is the usually disregarded fact that the carotenoids are fat-soluble nutrients. For optimal absorption and use in the body, they need to be consumed with some fat containing food; a problem in our "fat-free diet society".

"Taking supplements on an on-going basis does not reflect the changing needs of the individual. This will lead to the body having to deal with an overflow of vitamins and minerals, just as if they were toxins."

Similar stories confuse the matter right across the board, leaving the ordinary person totally bewildered as to what is good and not so good for them. Another problem that follows on from the inefficiency of the artificial supplement is the drive to try higher concentrations.

WHAT TO MAKE OF IT ALL?

The arguments will carry on raging for some time to come, but here are some essential points that we can conclude from the above information.

1. Nutritional deficiencies are primarily due to the poor quality of our food products. This is a direct result of detrimental farming practices, which have depleted the natural resources of the soil and added toxic chemicals onto the food chain. Equally to blame is the industry and practice of processing our foods. Processing is only useful from the point of view of delaying the natural decaying processes in order to keep the food appearing fresh so it can be sold over longer periods of time. Refining has a similar objective, added to which is the industry's drive to isolate the "active ingredient" and consequently make the food purer. At least that's the marketing angle.

2. We are all individuals and therefore nutritional needs differ from person to person, throughout the changing seasons, and throughout the stages of life. A blanket approach to dietary requirements and nutritional supplementation must therefore be inadequate.

3. Taking supplements on an on-going basis does not reflect the changing needs of the individual. This will lead to the body having to deal with an overflow of vitamins and minerals, just as if they were toxins. The same occurs when people take very high dosages inappropriately. Even the purest and most needed substance becomes a toxin when over-used or allowed to build up inside the tissues.

4. Most of the side effects mentioned fall into one of two categories. They either relate to the body clearing the supplement out because saturation point has been reached, or they are part of a "healing crisis". The fat-soluble vitamins A, D, E and K are not easily cleared out of the system and have therefore always been used with a maximum known dosage. Water-soluble vitamins and minerals, however, can be easily dealt with even in high dosages. When you take too much Vitamin C, whatever that may mean for the individual, the body will start the clearing process by draining the excess via the urine. If that is inadequate, the gut will provide a powerful alternative and you will have some diarrhoea. Reducing your intake, or stopping it, will stop the symptoms.

As part of a healing crisis, one might see symptoms which result from the body healing itself. The supplement only provides the extra means; it does not have any specific drug-like effects on the system. As the body uses the extra nutrients the cellular metabolism changes and this may show up temporarily as "symptoms" induced by the supplement. From the purely biochemical and mechanistic point of view, which the medical profession holds, it is misinterpreted as a supplement-caused illness. In fact the illness was already there, and the supplement only allowed the body to do something about it. Perseverance will in these instances result in not only the disappearance of the supplement-induced symptoms but also in a significant improvement of the underlying illness.

5. The crucial point about the positive or nil effect of nutritional supplements, as the case may be, is all about quality. To put it in simple terms: artificially made products do not enhance your health, natural products do. But how can you tell the difference, as relying on company's information has proved to be somewhat tricky? I use the following rule of thumb to help me through this one. When the label lists quite clearly all ingredients with their exact concentration, it is very likely this was done in a laboratory. Extracting products directly from natural sources leaves you unaware of "other" possible ingredients in minute quantities and certainly will not give you an exact concentration figure of the substance, as the concentration in the starting product will vary and the extraction process will not produce exactly the same amount all the time either.

Finally, we can conclude that in order to prevent a nutritional deficiency or to rectify it, we need to supplement our diet. The only way to do that effectively is to use extracts from natural sources.

No matter how efficient this process is and how carefully it is done, it remains a form of isolating the active ingredient. The only true supplementation is to change your dietary habits and include a wide variety of fresh, unadulterated foods, chosen for their specific qualities that will support your particular system. Supplementation, even with the highest possible quality product, remains a second best option and will never be a match for the real thing: pure, wholesome foods of the right quality and quantity for the individual's momentary needs.

Dozens of children feared dead after being injected with 'tainted' measles vaccine in Syria

BY DAMIEN MCELROY, REYHANLI

16/09/2014

http://www.telegraph.co.uk

World Health Organisation programme is suspended after reports that up to 36 children have died after receiving the vaccination. As many as 36 children were reported to have died excruciating deaths last night after receiving tainted measles vaccines under a UN-sponsored programme in the rebel-held north of Syria.

The programme was suspended amid rumours of sabotage of a high profile international effort to ensure the brutal civil war does not result in an outbreak of measles. Doctors in clinics in the towns of Jirjanaz and Maaret al-Nouman in the northeastern province of Idlib said children started falling ill soon after the doses were administered. There were conflicting figures of dead and injured last night as a tide of grief swept the front line rural settlements.

Relief organisations just over the border in Turkey said the loss of life was extensive, rising as high as 36 plus more than a dozen other children in a serious condition.

"It's very bad. The figures of dead we are getting go into the 30s.

Children are dying very quickly," said Daher Zidan, the coordinator of the medical charity, Uossm. "We think it will get worse."

The Syrian opposition coalition, which controls the area of Idlib province and had been administering the programme, said it had halted the immunisation project forthwith.

"The Syrian interim government's health ministry has instructed a halt to the second round of the measles vaccination campaign, which began Monday ...following several fatalities and injuries among children in vaccination centres in the Idlib countryside," a statement said.

Medical experts said a contaminated batch of the vaccine was the most likely explanation for the incident.

In what had been a rare hopeful breakthrough, the World Health Organisation (WHO) launched the vaccination drive to ensure 1.6 million children were granted protection from measles this summer.

The WHO said it was urgently checking the reports and could not confirm the toll. Other well-followed Syrian monitoring groups said there had been deaths.

"At least five children have died and 50 others are suffering from poisoning or allergic reactions after measles vaccinations in Jirjanaz, in Idlib province," the Syrian Observatory for Human Rights said.

Many opposition sympathisers circulated images of the dying children on social media sites with suggestions the vaccine had been adulterated with cyanide, possibly by regime agents, to undermine confidence in the opposition.

Idlib is one of the few strongholds of a Western-back rebel movement that has largely been eclipsed by the nihilist Islamic State of Iraq and the Levant (Isil) or al-Qaeda's Jabhat Al-Nusra in non-regime parts of Syria.

Mohammad Mowas, a Syrian doctor working in Turkey, said the reported symptoms were a gradual slowdown in the heart rate as the infants turned blue and were consistent with cyanide poisoning. "This looks like deliberate attempt to spike the vaccines," he said.

Fears that the death toll could rise yet further circulated the exile medical community last night.

Each bottle of the vaccine contains 40 doses and medics believe two bottles were suspect.

Charity Save the Children said it was "appalled and deeply saddened" by the deaths. It said in a statement: "Save the Children is appalled and deeply saddened by the news of the deaths of a number of children and the hospitalisation of many more after receiving vaccinations for measles in northern Syria earlier today.

"The local authorities have launched an investigation. It is clear something has gone badly wrong and Save the Children will help the authorities in any way we can to help find out what has happened."

Rubella: Disease, Vaccine and Congenital Rubella Syndrome Part 1

BY DR JAYNE LM DONEGAN
GP & HOMOEOPATH

DR JAYNE L.M. DONEGAN

Rubella ('Little Red' in Latin), is a Togavirus of the genus RUBIVIRUS. Infection used to be most frequent in 5-9 year-olds. but since the introduction of the vaccine in the 1970s most of the cases are now in 15- 24 year-olds

The incubation period is 10-21 days and the period of infectivity is said to be from 4-7 days before the rash appears. It is accepted that rubella is one of the mildest of the infectious fevers. In cases of children with clinically detectable symptoms, a rash is usually the first sign of being unwell but there may be swollen glands with no rash. Rubella used to be known as 'Three Day Measles'. In older children and adults, there may be a prodrome of 1- 5 days as the body's cell mediated immune response goes into action with:

- low-grade fever
- tiredness
- weakness
- swollen glands
- cough

There may be a rise in temperature just before the rash appears, coinciding with the appearance of antibodies in the blood. The rash, if it occurs, is generally 'maculopapular' - it may be just flat or slightly raised. Older people are more prone to getting swollen joints due to immune complex associated arthritis. One attack confers immunity probably in 90% of cases.

The USA 'Pink Book' on immunisation states that up to 50% of infections may be subclinical or inapparent. Dr Dorothy Horstmann an expert virologist and the first woman appointed as a professor at the Yale School of Medicine, whose research on poliovirus paved the way for the development of polio vaccine, quotes sub-clinical infection in as many as 86% of cases in military recruits. (Horstmann 1965)

The problem with rubella is not the seriousness of the disease itself, but what can happen to the unborn child of someone who has the infection when they are pregnant. This can lead to **Congenital Rubella Syndrome** (CRS which includes:

- Heart defects
- Blindness
- Deafness.

When I was a child in the 1960s, it was regarded as imperative that all girls should get rubella as a child so that this would not happen. Indeed as children we were immediately sent round to the house of anyone whose child had mumps, measles, rubella or chicken pox in the school holidays, in the hopes that we, too, would be ill during the holidays and not miss any school!

CRS was first described by Norman Gregg, a paediatric ophthalmologist in Australia. He noticed an unusually large number of babies in his clinic with cataracts. Treating them was complicated by the fact that many of them had heart problems and so were difficult to anaesthetise. There had been a large rubella outbreak in Australia in 1940 regarding which he noted at the time:

"Within my own experience I have not previously seen German measles of such severity and accompanied by such severe complications as occurred during this epidemic in 1940. The swelling of the glands of the neck, the sore throat, the involvement of the wrist and ankle joints and the general constitutional disturbance were all very pronounced."

In fact he wondered whether the epidemic might not be related in some way to the epidemic of sore throats that started in the military camps and spread to the civilian population at the same time, whether the 'rubella' rash was in fact a rash due to streptococcal toxin

Epidemics originating in military camps always raise the question of whether they occur in some measure due to the cocktails of vaccines and drugs that are given to the recruits (cf 1918 influenza epidemic).

Hearing two mothers in his waiting room discussing how they had both had rubella in early pregnancy set him thinking, culminating in a masterly paper published in 1941 '**Congenital cataract following German measles in the mother**' (Gregg 1941)He described the accompanying heart defects and predicted that the process might continue after birth, not just a one off episode of damage in the womb. Scorn was immediately poured on him from every direction. How could a mere ophthalmologist, not a consultant in infectious diseases - and an Australian at that! - presume to write about virology? It was to be twenty years before the virus was identified, the process elucidated, and he received the recognition outside of Australia that he deserved.

A world-wide rubella epidemic occurred in 1962-1965 The Centers for Disease Control (CDC) wrote:

"An estimated 12.5 million (clinical) cases of rubella occurred in the United States, resulting in 2,000 cases of encephalitis, 11,250 fetal deaths, 2,100 neonatal deaths, and 20,000 infants born with CRS, a constellation of birth defects that often includes blindness, deafness, and congenital heart defects. The economic impact of this epidemic in the United States was estimated at $1.5 billion. The global epidemic spurred development of rubella vaccines and emphasized the need to develop and implement strategies for using these vaccines to prevent this devastating health burden." (CDC 2005)

How many of these cases or rubella or CRS were accurate diagnoses is not known as diagnosis was clinical and not laboratory confirmed. That it is

notoriously difficult to diagnose rubella in the absence of a blood test was shown by Dr Sidney Kibrick of the Evans Memorial Department of Clinical Research, Boston University School of Medicine in a monograph on the subject back in 1964 at the height of the rubella epidemic in the USA. He lists ten other causes for such a rash that were already known even then, measles, scarlet fever, roseola infantum (HHV6&7), slapped cheek (parvovirus), infectious mononucleosis, drug sensitivity, enteroviruses, reoviruses (including rotavirus), adenoviruses, respiratory syncytial virus. (Kibrick, 1964).

"Evidence that erroneous diagnoses are common in this disease is provided by results of a study on 464 pregnant women wherein attempts were made to correlate the patient's history of rubella with presence or absence of antibody. No correlation was observed. This suggests that "**the occurrence of rubella as reported by patients cannot be taken as a reliable index of previous exposure**"

Note also from the CDC data how even a mild, inoffensive illness like rubella can have dire consequences if badly managed, but it provided the impetus to produce a rubella vaccine which was licenced in the USA in 1969 and in the UK in 1970. In the UK it was originally given to teenage girls, and women after giving birth who had been found to be lacking antibodies while pregnant. This was extended 1988 in the UK to be given to 12-15 month-old children in the form of MMR and an additional preschool dose in 1996.

THE VACCINE

Several strains of rubella vaccine were developed in dog kidney and duck embryo but the Wistar RA 27/3 strain is the one used in the USA and UK. It is only available as part of the MMR combination vaccine in the UK Childhood Vaccination Schedule. The formulation in MMRVAXPRO made by Sanofi Pasteur MSD Ltd is a live attenuated viral vaccine produced in WI-38 human diploid lung fibroblasts. The source is lung tissue from a human, male, Caucasian fetus aborted at 14 weeks in September 1966.

VACCINE EXCIPIENTS

The excipients, the 'vehicle' in which the viral antigens are delivered to the person being vaccinated, as listed on the Electronic Medicines compendium are:

- Sorbitol, Sodium phosphate, Potassium phosphate, Sucrose
- Hydrolysed pork gelatin
- Medium 199 with Hanks' salts
- Minimum Essential Medium, Eagle (MEM) (contains iron, glucose & phenol red)
- Monosodium L-glutamate (MSG/ E621)

NB The vaccine may contain traces of recombinant human albumin (rHA).

- Neomycin
- Phenol red
- Sodium bicarbonate, Hydrochloric acid (to adjust pH) Sodium hydroxide (to adjust pH) Solvent: Water for injection

From European Medicines Agency documents: biological reagents used in the manufacture of the vaccine or intermediates include:

- Fetal bovine serum (FBS)
- Porcine pancreatic trypsin
- Porcine-derived hydrolyzed gelatine
- Choline chloride
- Bovine or porcine tallow-derived polysorbate 80
- Fish or sheep wool-derived cholesterol, and amino acids

It is ironic that so many parents try to avoid additives such as MSG in their children's food but unwittingly have them injected with it in the MMR vaccine. The manufacturer advises that allergy to any of the constituents is a contraindication to the vaccine.

ADVERSE REACTION TO THE VACCINE

These are difficult to estimate as it is acknowledged that fewer than one in a hundred adverse reactions are reported for any drug. In the case of vaccines, of those that are reported, there is not much clarity as this whole area is so controversial. However, accepted adverse reactions as listed in the single rubella vaccine: Erevax Rubella Vaccine, Live PhEur (RA27/3 strain SmithKline Beecham 1998, are:

- Mild non-infectious case of rubella a few days after injection of the vaccine with rash, fever, swollen glands and swollen or painful joints with or without joint effusion.
- Extremely rarely, transient polyneuropathy (altered sensation, tingling or muscle weakness) or thrombocytopenic purpura (low platelets causing purple bruising).

These side effects tend to be more marked in adults than in children. Symptoms when they do occur usually begin one to three weeks after vaccination and are normally transient.

- Acute anaphylactic reaction to the vaccine may occur in some people.

DOES THE VACCINE STOP RUBELLA INFECTION?

As with all vaccines, the production of antibodies is used as a measure of whether the vaccine works or not. But as I have emphasised in many previous articles, antibodies are only the tip of the immunity pyramid. The bottom 2/3 of the pyramid, the largest part, is made up of the innate or non-specific immune system which does not use antibodies to protect the body and its functions.

From the beginning it was seen that even in terms of antibodies, the response to rubella vaccines was not so large or long lasting as that from natural infection. Dr Horstman again

"The protective efficacy of vaccine-induced and naturally acquired immunity was compared in a prospective study of a rubella epidemic among military recruits. **80 per cent of those vaccinated and 3.4 per cent of those who were naturally immune were reinfected.** The results of this study point up marked differences in resistance to reinfection between persons who have acquired their immunity to rubella by vaccination and those who have experienced natural infection with wild rubella virus. They illustrate the quantative aspects of immunity and resistance but they also suggest that there may well be a qualitative difference between vaccine-induced and naturally acquired immunity."

AND PROPHETICALLY:

"One might question the degree and quality of protection that the young population with vaccine-induced immunity alone might have in 10-15

years... If rubella virus can spread rapidly through a population in which 86% possess specific .. antibodies as in the present study (ie immune by antibody levels) – the prospects for eliminating circulation of the wild virus are not bright." (Horstmann 1970)

In a discussion of experts in1970, Dr Harry M. Meyer, Jr. National Institutes of Health, Bethesda, Md stated regarding his own similar research:

"None of these observations is particularly surprising since similar findings were made in studies of immunity resulting from live polio and rubeola (measles) virus vaccination. In terms of degree of resistance one expects attenuated viruses, in general, to evoke lower levels of antibody than their virulent counterparts. This is true of all the live vaccines - those for polio, smallpox, rubeola (measles), mumps, yellow fever, and rubella. Lesser antigenic differences often exist between strains of the same virus. For example, attenuated rubella viruses are not identical and these variations can be correlated with relative resistance to reinfection.

Dr Horstman: "**Our whole concern with the problem is that vaccination against rubella is unique, since it is not the vaccinee who is the main target, but the fetus, some 10 or 15 years hence**. It may be that the present vaccination programs will prove effective, but as we gain more experience we tend to be more cautious in predicting an easy victory. The virus turns out to be an unusual agent, virologically and immunologically, and the infection has some strange epidemiologic features."

Later studies were able to give more information on the 'qualitative' differences between rubella vaccination and natural infection:

1974, Dr Margo Honeyman et al (Sydney,Australia) "This study suggests that the magnitude of the cell mediated immune (CMI) response after vaccination is less than after natural infection", 'Not only is the magnitude of the CMI response less after vaccination, but it also becomes undetectable much more quickly than after natural infection', 'Perhaps the lower and more short lived CMI usually stimulated by the rubella vaccine virus may be an important factor in the high reinfection rate frequently observed following rubella vaccine."

1975 Dr Abraham Morag et al (New York USA): "It is significant, however, that the level of cell-mediated immunity in tonsils was conspicuously low after subcutaneous immunization (compared to natural infection)." (Morag 1975)

1981 Dr Linda Ho-Terry et al (London UK) "Antibody to the ribonucleoprotein component of rubella virus occurs in only a proportion of patients with clinical rubella and is rarely present in individuals after administration of RA27/3 live attenuated virus vaccine." (Ho-Terry 1981).

There came a gradual realisation that there is a high degree of rubella reinfection after vaccination.

1981, a UK study: "Immunity against rubella was once thought to be lifelong, but it is now recognised that reinfection is not uncommon. Reinfection is usually subclinical and is especially likely after rubella immunisation, though it also occurs after naturally acquired infection. The presence of high levels of rubella haemagglutination inhibition antibodies does not invariably confer immunity or exclude the possibility of congenital rubella in a subsequent pregnancy." (Partridge 1981)

1982, an Australian study: "Infection with wild rubella virus is known to occur after successful vaccination. This has not been believed to be risk to the fetus, even if the infection occurs in the first trimester of pregnancy." Describing a case of CRS that did, in fact, occur. (Bott 1982)

1989, a UK study: "Reinfection with rubella may occur and has been reported after both naturally acquired and vaccine induced infection. Reinfection is usually subclinical and is detected serologically, most commonly among pregnant women who have had close and prolonged contact with rubella at home. Reinfection in pregnancy has been considered to present a minimal risk to the fetus, and mothers are usually reassured that there is no risk or only a minimal one to the fetus." In a study describing five examples where this was not the case. (Best 1989)

1997, an Israeli study: "The frequency of rubella virus reinfection after vaccination, may vary between 10 and 22%, a 10 times greater rate than naturally immune (ie from naturally acquired rubella disease) individuals with low rubella antibody level." Reporting a baby with CRS whose mother was reinfected after being vaccinated. (Aboudy 1997)

In the 1981 the UK study by Cradock-Watson et al, which is regularly quoted as evidence that reinfection with rubella in pregnancy is not harmful to the fetus, they issue this caveat: "Our general conclusion that re-infection is harmless to the fetus applies to women whose immunity is due to natural infection; **it should not be assumed to include those whose immunity is the result of immunization.**" (Cradock-Watson 1981)

DOES THE VACCINE ERADICATE THE DISEASE?

Reading the 2012 (update of 2005) review of MMR vaccine by the Cochrane Collaboration, a non industry sponsored group from over 120 countries working together to produce reliable, accessible health information, one comes across the surprising statement:

"We did not identify any studies assessing the effectiveness of MMR in preventing rubella."(Demicheli 2012)

In 1999 there was an epidemic of rubella in Greece. When infected Greek students attended British universities, a number of small outbreaks of clinical rubella occurred in the UK, including Aberdeen in Scotland, Although MMR uptake had dipped to below 80% in England and Wales that year, it was in Scotland (Aberdeen) where the vaccine coverage rate had remained in excess of 85%, that the only baby reported in 1999 to have CRS in the UK was born. (Tookey 2004)

DO ANTIBODIES EQUAL IMMUNITY AND CAN YOU TELL IF YOU ARE IMMUNE BY A BLOOD TEST?

1980, UK Public Health study study:

"No level of any antibody tested was invariably associated with protection" (Harcourt 1980). 2000, Belgian study: "Reviewing the last ten years of literature, we were unable to define a cutoff level of antirubella antibodies in case of renewed contact with the wild virus during pregnancy." (Bullens 2000)

However the 2013 Report On 11th World Health Organization Global Measles And Rubella Laboratory Network Meeting quotes the US Advisory Committee on Immunization Practices as concluding: "that detectible (sic) vaccine antibody may decline over time but immunity does not."

"What if you have contact with someone with a rubella like illness when you are pregnant? Because neither antibodies to vaccination, nor natural infection can protect fetus from disease/ damage, Best and her UK team state:

"Until rubella infection is eradicated consideration must be given to testing all pregnant women who have contact with or develop illnesses like rubella, even if they have a history of rubella vaccination and have been reported previously to have rubella antibodies." (Best 1989)

In 1982, Dr Elizabeth Miller and her team at Public Health England reported on their study of over one thousand women with confirmed rubella in pregnancy. 40% continued their pregnancies, those who elected to have their pregnancies terminated (54%) or miscarried (4%) did not appear to have their fetuses examined for rubella. Follow-up was to 2 years of age in 273 children, the findings in infected children being compared with those in children who had escaped infection. The results are displayed in the table below. This table shows results for mothers who has symptomatic infection. In those with asymptomatic infection – subclinical (11), none were infected. It is assumed that all these infections are primary ones, not re-infection, but the immune status of most of the mothers was unknown. Nevertheless, 80% is said to be the risk of fetal damage in the first 12 weeks of pregnancy and 8% the risk due to reinfection. (Morgan-Capner 1991). These results are summarised more simply in 'Guidance on Viral rash in Pregnancy'.

"The risk to the fetus of primary rubella in the first 16 weeks gestation is substantial, with major and varied congenital abnormalities being associated with infection in the first trimester. Rubella infection between 16 and 20 weeks gestation is associated with a minimal risk of deafness only and rubella prior to the estimated date of conception or after 20 weeks carries no documented risk". (HPA 2011)

HAVE CASES OF RUBELLA AND CRS DECREASED SINCE INTRODUCTION OF THE VACCINE?

Yes and No. Some of the decrease in reported cases is because of a reduction in cases, but some of the decrease is because when you have a history of vaccination against a disease, then your illness is diagnosed as 'non-specific-viral-rash' and not rubella, leading to an automatic drop in notifications.

Introduction of the vaccine has been followed in all countries by a decrease in notified cases of rubella in children – when it is a good time to get it - and an increase in adults. Introduction of vaccination programs with low uptakes has lead to massive outbreaks of rubella and CRS in Greece, Poland, Romania, Japan and China, in recent years. (Chen 2013, Panagiotopoulos 2004, Paradowska-Stankiewicz 2013) But again, in many cases (almost 100% in Poland), the diagnosis is only made clinically, which is highly unreliable, and in many cases vaccination status is not recorded. This makes it impossible to know whether rubella vaccination programs, which cost a considerable amount of money to implement, are effective either in terms of diseases reduction or cost.

(Part Two will be featured in TIP Newsletter Issue 1 2015).

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© 2014 Dr Jayne L.M. Donegan MBBS DRCOG DFFP DCH MRCGP MFHom
Telephone/Fax 0044 (0)20 8632 1634
Email: jaynelmdonegan@yahoo.com
Website: www.jayne-donegan.co.uk/

Dr Donegan runs a series of talks and workshops on Vaccination and other health related topics - running between January and May 2015, see website for details: www.jayne-donegan.co.uk
If you are interested in hosting one of these lectures or workshops, please contact Dr Donegan at: tel/fax 0044 (0) 208 632 1634 (ansafone) or email jaynelmdonegan@yahoo.com

Table of Fetal CRS Risk from Symptomatic Maternal Infection in Pregnancy (Miller 1982)

STAGE OF PREGNANCY	0-11W	11-12	13-14	15-16	17-18	19-22	23-26	27-30	31-36
FREQUENCY OF FETAL INFECTION	90%	67%	67%	47%	39%	34%	25%	35%	60%
STAGE OF PREGNANCY	0-11W	11-12	13-14	15-16	17-18	>18			
RUBELLA DEFECTS	100%	50%	17%	50%	0%	0%	0%	0%	0%
	HEART DISEASE / DEAFNESS	DEAFNESS ALONE	DEAFNESS ALONE	DEAFNESS ALONE					
OVERALL RISK	90%	33.5%	11.4%	23.5%	0%	0%	0%	0%	0%

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)

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