THE informed PARENT
ISSUE THREE 2016 A NEWSLETTER ON VACCINATION ISSUES AND HEALTH

COMING SOON: MEDICAL FEMA CAMPS FOR ANTI-VAX AND POLITICAL DISSIDENTS

EXTRACTS FROM AN ARTICLE BY DAVE HODGES, THECOMMONSENSESHOW.COM
http://www.naturalnews.com/
Oct 7 2016

WITH REGARD to self-granted federal regulations, the federally controlled medical management agencies in this country, have granted themselves the right to declare someone a medical threat for an absolutely harmless illness and then ship these people off to a FEMA camp which is operating under the guise as medical detainment facility, however, it operates with no medical personnel. This is a backdoor into mass FEMA camp detentions.

THE DRACONIAN NOTICE OF PROPOSED RULE MAKING

With its Notice of Proposed Rulemaking (NPRM) in the Federal Register on Aug. 15, 2016, the Centers for Disease Control and Prevention (CDC) has greatly expanded the draconian power of the government over the lives of the American people when it relates to health matter or a pseudo-health matter.

Barbara Loe Fisher, the President of the National Vaccine Information Center (NVIC), stated:

"Today, the American people are challenged, as they have never been before, to confront the expansion of government authority over our bodies and the bodies of our children, specifically the exercise of police power to take us into custody and isolate us without our consent whenever public health officials believe we are sick or could become sick."

The CDC, with its NPRM, is seeking to "restrict the freedom of a person entering the U.S. or traveling between states if they believe the person is infected or could become infected with certain kinds of communicable diseases." So, now we are looking at pre-crime as an excuse to incarcerate people related to the controversial issue of vaccinations.

In part, these regulations will be used to impose the emerging mandatory vaccination laws. Are there any limits to the authority of the federal government with regard to vaccinations? According to the aforementioned documents, there are no limits placed in this new authority and the conditions, under the law, this could easily be expanded to the simple cold or the flu. Would this new authority open the way for the U.S. government health officials to eventually restrict travel via automobile, bus and train from state to state?

Amazingly, the NPRM calls for airline and cruise ship personnel to increase surveillance of travelers into the U.S. and those traveling between states, but states have the greatest authority under the Constitution to use police powers to control infectious diseases within state borders. It is all about the money. The CDC currently funds many state initiatives when it comes to health. Subsequently, the federal government, in the form of the CDC will be able to take control of every state health agency.

Fisher stated that medical enforcement authorities could be detaining, isolating and quarantining of people in the U.S., "who appear "unwell" but are otherwise simply going about minding their own business".

When we begin to connect the dots, under Obamacare, all medical records are accessible by the IRS in violation of HIPPA regulations. Since our medical records are part of federally tracked electronic medical records as well as vaccine tracking systems which is also accessible by the IRS, these officials now have the ability to determine from our medical records if we have had all of our vaccinations. If not, you could be subject to medical detainment for not getting your vaccinations, or your children could. Also, please make note of the term "other infections". This is a blank check for the federal government to detain you for any "perceived" condition.

In fact, Fisher goes on to say that the CDC is granting itself the ability to detain and quarantine people without their consent. Fisher is quick to point out, there are "many viral and bacterial infections that occur quite often in our country ." These conditions give the CDC the authority to act upon every infection that has the potential to spread and cause harm or even death to some people (eg flu and bronchitis)."

Editor's note

Magda Taylor

'DO PARENTS WHO REFUSE TO VACCINATE THEIR CHILDREN MAKE YOUR BLOOD BOIL?' this was the question Paddy O Connell (sitting in for Jeremy Vine) put to listeners of BBC R2 on 21st November 2016 just before the discussion started.
I had been invited on to speak as a parent from the 'anti vaccination' movement. The resident doctor on the show, Sarah Jarvis, stated all the usual wonders of vaccination and quoting a number of statistics as regards to diphtheria and measles. Of course there was mention of the 'big problem' – parents who are not getting their children vaccinated and how that will effect 'herd immunity'. I did point out that diseases, such as measles, diphtheria, tuberculosis etc were in major decline BEFORE the vaccines were introduced. However it fell on deaf ears as both the presenter and doctor continued to talk about declines since the vaccines. Paddy then told me the 'reason I am just being a bit pompous there Magda is that FACTS DO COUNT….and then referred back to Dr Jarvis's information as if only her information was factual.
Are you a doctor? I was asked – 'No….which gives me the advantage of taking a wider view', and I also mentioned that doctors were in the straightjacket of established modern medicine so can not speak out.
Dr Jarvis stated 'What you see whenever immunisation is brought in – in every immunisation – in every single country – the line goes along, it may be tailing off very, very gradually, and then suddenly immunisation is brought in and it drops…off…a…cliff!" No mention of the massive declines before….and I got a feeling that she was completely unaware of the bigger picture and all the graphs and figures from mid 1800s.
These programmes are predictably very bias and frustrating but it may have sown some seeds, and I have developed an immunity to their one-sided stance, just wish they would give me longer!
HEALTH AND HAPPINESS AND ALL THE BEST FOR 2017!
MAGDA TAYLOR.

› *Continued from p01*

The previously cited documents specify some of the symptoms that "could get you detained" under the CDC's NPRM include vomiting, diarrhea, and a fever of more than 100 degrees - symptoms that can be caused by everything from "allergic reactions, inflammatory bowel disease, salmonella and norovirus infections to hangovers and the common cold." WHAT THIS CLEARLY STATES IS THAT ANY CITIZEN, AT ONE TIME OR ANOTHER, COULD BE AND WILL BE DETAINED UNDER THESE NEW GUIDELINES.

THE GOVERNMENT HAS JUST GRANTED ITSELF THE AUTHORITY TO ROUND UP PEOPLE WHO ARE NOT "FEELING WELL" AND THEREFORE, POSE A DANGER TO SOCIETY BECAUSE THEY "MIGHT POSE A THREAT".

When health authorities come and arrest you because you have a temperature in excess of 100 degrees, NPRM regulations state that you can be held for up to 72 hours without the right to contact a lawyer to appeal your detention. You would be asked to sign a contract with the CDC agreeing to submit yourself or your minor children to such "public health measures" as "quarantine, isolation, conditional release, medical examination, hospitalization, vaccination, and treatment."

According to Fisher, if you refuse to sign the CDC documents, CDC officials, or their designees, can still do whatever they want because 'the individual's consent shall not be considered a prerequisite to any exercise of any authority' by the CDC. When you are released from medical detention, you can be electronically tracked and monitored. These regulations make a nice addition to the police state surveillance grid.

There are more government documents that talk about the disposition of people who are medically detained that are very disturbing.

When an illness strikes, the changes in the handling of the stricken patients have already been planned for through a series of legal actions, most of them are Executive Orders. For example, the Executive Order, entitled Revised List of Quarantinable Communicable Diseases, amends Executive Order 13295, passed by George W. Bush in April 2003, which allows for the, "apprehension, detention, or conditional release of individuals", and Ebola is specifically mentioned.

Obama took this portion of the Executive Order to a whole new level. Obama has granted his administration the authority to detain, in any manner deemed necessary, any person who demonstrates any degree of respiratory distress. This means people with noninfectious asthma could be detained.

When the forced transport of these patients begins to occur, relatively healthy people will be joining them in this death parade march to camps being run with foreign assets.

Any illness will be the impetus to send people to camps, however, this is by no means the end game. These camps will quickly morph into martial law detainment camps for American dissidents. I would imagine that many alternative media broadcasters will develop asthma over the next several months.

As I have previously reported, I found evidence supporting these claims in a federal document entitled Emergency Support Function #8 (ESF #8) - Public Health and Medical Services Annex.

NICE consults on ways to tackle falling child vaccination rates

1 September, 2016

http://www.thecommissioningreview.com/

THE National Institute for Health and Care Excellence (NICE) has published a draft quality standard on boosting the number of vaccinated children.

Latest figures from NHS Digital show that millions of children are unprotected against potentially lethal diseases, as child vaccination rates in England have been falling for the past two years.

In some areas of the country, fewer than 1 in 10 children are vaccinated against diseases such as polio and diphtheria and, unless uptake rates improve, there is a risk of these diseases resurging.

Last year only a quarter of local authorities met World Health Organization targets to vaccinate 95% of children against measles, mumps and rubella.

NICE has therefore published a new draft quality standard, open for consultation until 29 September, which sets out how to drive up the number of under-19s receiving vaccinations.

Professor Gillian Leng, deputy chief executive at NICE, said: "Around three million children and young people may have missed a mumps, measles and rubella (MMR) vaccine.

"With so many children open to exposure we are at risk of a serious outbreak.

"This variation in uptake across the country is unacceptable and we need to do more to ensure every child across the country gets the vaccinations they are supposed to.

"The standard also notes that young offenders are less likely to be immunised than other young people outside the system and suggests they have their records checked for missed vaccinations on entering prison.."

"We now need peoples' views to make sure we have set the right priorities to tackle this variation.

"Vaccinations don't just protect the people receiving them – vaccination also protects all of us by eliminating infections from the country."

The quality standard includes five statements that set out priorities to drive up the number of immunisations given to children and young people.

It says that parents or carers of children who miss immunisation appointments should be followed up by telephone or with a text as this makes them more likely to rebook.

The standard also notes that young offenders are less likely to be immunised than other young people outside the system and suggests they have their records checked for missed vaccinations on entering prison.

NICE is also encouraging health visitors and nurses to check if children have missed vaccinations during their usual reviews at the start of school or college.

Registered stakeholders are now able to submit their views on the draft quality standard via the NICE website.
The final quality standard is expected in January 2017.

REPORT BACKS PEDIATRICIANS WHO NEED TO DISMISS VACCINE-REFUSING PARENTS

BY ERIC SAGONOWSKY
Aug 30, 2016
www.fiecepharma.com

IN RESPONSE to an upswell of vaccine hesitancy and refusal since 2007, the American Academy of Pediatrics (AAP) is arming pediatricians with another tool to force the issue. In a new report, AAP says as a last resort," pediatricians may dismiss families who don't listen to the science and ultimately refuse vaccines.

It's a reversal from AAP's stance in the past, but one that was justified as practitioners were having problems with parents who wouldn't comply with vaccine schedules, Kathryn Edwards, director of the Vanderbilt Vaccine Research Program and report co-author, told AAP News.

As the report notes, there is anecdotal evidence that when pediatricians give parents the choice between immunizing their child or being dismissed, some parents accept vaccination, even when other efforts at persuasion have failed."

The new position comes as pediatricians are increasingly encountering parents who have doubts about vaccines or who flat-out refuse them. According to a survey cited in the report, 9.1% of parents refused one or more vaccine in 2007; the figure grew to 16.7% in 2013. The parents said they believed vaccines are unnecessary or can cause autism.

The authors made it clear that a pediatrician's decision to dismiss families should not be taken lightly and should be made only after exhaustive efforts to encourage vaccinations.

Pediatricians should keep in mind that many, if not most, vaccine-hesitant parents are not opposed to vaccinating their children; rather, they are seeking guidance about the issues involved, beginning with the complexity of the schedule and the number of vaccines proposed," the report said.

New research on the methods to communicate the importance of vaccines is needed, the authors concluded. The report will be published in Pediatrics.

The clear message parents should hear is that vaccines are safe and effective, and serious disease can occur if your child and family are not immunized, the authors wrote.

Low immunization rates played a role in the 2015 Disneyland measles outbreak, and misinformation continues to plague public health officials and vaccine developers. In HPV vaccines, for instance, developers Merck and GlaxoSmithKline have encountered a sex stigma, safety worries and antivaccine campaigns in their efforts to grow uptake.

Outside of the U.S., the WHO recently said vaccine hesitancy is a global problem, adding that in some cases, strategies to encourage vaccination are inadequate.

ADVERSE EVENTS AFTER ROUTINE IMMUNIZATION OF EXTREMELY LOW-BIRTH-WEIGHT INFANTS

JAMA PEDIATR. AUG 2015
AUTHORS:
DEMEO SD, RAMAN SR ET AL

ABSTRACT:

Importance: Immunization of extremely low-birth-weight (ELBW) infants in the neonatal intensive care unit (NICU) is associated with adverse events, including fever and apnea or bradycardia, in the immediate postimmunization period. These adverse events present a diagnostic dilemma for physicians, leading to the potential for immunization delay and sepsis evaluations.

Objective: To compare the incidence of sepsis evaluations, need for increased respiratory support, intubation, seizures, and death among immunized ELBW infants in the 3 days before and after immunization.

Design, Setting, and Participants: In this multicenter retrospective cohort study, we studied 13,926 ELBW infants born at 28 weeks' gestation or less who were discharged from January 1, 2007, through December 31, 2012, from 348 NICUs managed by the Pediatrix Medical Group.

Exposures: At least one immunization between the ages of 53 and 110 days.

Main Outcomes and Measures: Incidence of sepsis evaluations, need for increased respiratory support, intubation, seizures, and death.

Results: Most of the 13,926 infants (91.2%) received 3 or more immunizations. The incidence of sepsis evaluations increased from 5.4 per 1000 patient-days in the preimmunization period to 19.3 per 1000 patient-days in the postimmunization period (adjusted rate ratio [ARR], 3.7; 95% CI, 3.2-4.4). The need for increased respiratory support increased from 6.6 per 1000 patient-days in the preimmunization period to 14.0 per 1000 patient-days in the postimmunization period (ARR, 2.1; 95% CI, 1.9-2.5), and intubation increased from 2.0 per 1000 patient-days to 3.6 per 1000 patient-days (ARR, 1.7; 95% CI, 1.3-2.2). The postimmunization incidence of adverse events was similar across immunization types, including combination vaccines when compared with single-dose vaccines. Infants who were born at 23 to 24 weeks' gestation had a higher risk of sepsis evaluation and intubation after immunization. A prior history of sepsis was associated with higher risk of sepsis evaluation after immunization.

Conclusions and Relevance: All ELBW infants in the NICU had an increased incidence of sepsis evaluations and increased respiratory support and intubation after routine immunization. Our findings provide no evidence to suggest that physicians should not use combination vaccines in ELBW infants. Further studies are needed to determine whether timing or spacing of immunization administrations confers risk for the developing adverse events and whether a prior history of sepsis confers risk for an altered immune response in ELBW infants.

INCREASED ORGANIC MERCURY EXPOSURE FROM THIMEROSAL-CONTAINING HEPATITIS B VACCINES COULD LEAD TO AN INCREASED RISK OF OBESITY DIAGNOSIS

AUTHORS: GEIER D A, KERN J K, HOMME K G ET AL
N Am J Med Sci. 2016 Jul; 8(7): 297=306. PMID: 27583238

ABSTRACT:
BACKGROUND: Obesity among children and adolescents in the United States has tripled since 1980, and has become a major public health concern.
AIMS: The purpose of this study was to evaluate the potential relationship between exposure to organic mercury from Thimerosal-containing hepatitis B vaccines and the children's subsequent risk of an obesity diagnosis.
MATERIALS AND METHODS: A hypothesis-testing, case-control study was undertaken to evaluate exposure to organic mercury from Thimerosal-containing hepatitis B vaccines, which were administered at specific intervals in the first 6 months of life, among cases diagnosed with childhood obesity and controls by examining automated medical records for children born from 1991 to 2000 who were continuously enrolled in the Vaccine Safety Datalink database.
RESULTS: This study found highly significant associations as follows. Cases diagnosed with obesity were significantly ($P<0.00001$) more likely to have received greater exposure to organic mercury from Thimerosal-containing hepatitis B vaccines administered within the first month of life (odds ratio (OR) =1.511), first 2 months of life (OR = 1.486), and first 6 months of life (OR = 3.795) than the controls. Similar outcomes were observed when the overall data were separated by gender. In a dose-response manner, cases diagnosed with obesity were significantly more likely than controls to have received greater exposure to organic mercury from Thimerosal-containing hepatitis B vaccines, which were administered within the first 6 months of life (OR = 1.0375 per g of mercury, $P<0.00001$).
CONCLUSIONS: In a dose-response manner, the present study associates an increased organic mercury exposure from Thimerosal-containing hepatitis B vaccines with an increased risk of obesity diagnosis, and suggests that Thimerosal is an obesogen. (Foreign chemical compounds that disrupt normal development and balance of lipid metabolism, which in some cases, can lead to obesity.) The results are biologically plausible and future studies are needed to examine this phenomenon.

A CASE REPORT, THE PROGRESSION OF PARKINSON'S DISEASE SYMPTOMS AFTER A RABIES VACCINE LEADING TO LETHAL OUTCOME

AUTHORS: LALOSEVIC D, LALOSEVIC V ET AL
Med Pregl. 2004 Sep-Oct;57(9-10):487-92. PMID: 15675624

ABSTRACT:
INTRODUCTION: In Serbia and Montenegro postexposure rabies vaccination is performed using five doses of rabies vaccine with a potency of 2.5 I.U. It is given on 0, 3rd, 7th, 14th and 28th day, combined with human rabies immunoglobulin with the first dose. Modern rabies vaccines produced in cell cultures rarely cause neurologic complications, among which Guillain-Barre syndrome and parkinsonism.
CASE REPORT: The authors report a case of a 78-year-old woman with a documented five-year history of Parkinson's disease, who was bitten by a rabid cat. Twelve hours later, when the rabies infection of the cat was confirmed by an immunofluorescence test, the patient received the first dose of rabies vaccine Verorab (Aventis), a cell culture vaccine, together with the human rabies immunoglobulin produced in Belgrade. After the third dose of rabies vaccine, the symptoms of Parkinson's disease progressed and vaccination was interrupted. However, one month later, the patient died with predominantly neurological symptoms. As the patient died at the time when incubation of rabies might have been expected, autopsy and rabies diagnostics were performed.
AUTOPSY AND PATHOHISTOLOGIC FINDINGS: The autopsy and pathohistologic findings from the specimens treated with routine hematoxylin and eosin staining, together with immunofluorescence test, excluded rabies as a cause of death and revealed neurodegenerative changes typical for Parkinson's disease. Using two different fluorescent rabies antibodies, we performed a direct immunofluorescence antibody tests, but no rabies antigens were detected. However, in histologic slides of the brain stem, large intracytoplasmic inclusions were found in some neurons, identified as Lewy bodies characteristic for Parkinson's disease.
CONCLUSION: Parkinson's disease, with its complications, was the cause of death of the patient bitten by a rabid cat. Furthermore, the coincidence of the progression of Parkinson's disease symptoms, at the time of postexposure rabies vaccination, points to the vaccine as a possible contributing factor to aggravation of the disease and lethal outcome.

"THE PRIMARY CAUSE OF DISEASE IS IN US, ALWAYS IN US ~ ANTOINE BECHAMP"

VACCINATION AND HEALTH OUTCOMES: A Survey of 6 to 12 year-old Vaccinated and Unvaccinated Children based on Mothers' Report

FRONT. PUBLIC HEALTH | DOI: 10.3389/FPUBH.2016.00270
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http://journal.frontiersin.org/

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Editor: Surprise! Surprise! This study was removed by Frontiers journal after heavy criticism. Frontiers stated that it was 'provisionally accepted' but not published, and will be re-reviewed.

ABSTRACT

BACKGROUND: Vaccinations have prevented millions of infectious illnesses, hospitalizations and deaths among US children. Yet the long-term health outcomes of the routine vaccination program remain unknown. Studies have been recommended by the Institute of Medicine to address this question.
SPECIFIC AIMS: To compare vaccinated and unvaccinated children on a broad range of health outcomes, and to determine whether an association found between vaccination and neurodevelopmental disorders (NDD), if any, remains significant after adjustment for other measured factors.
DESIGN: A cross-sectional survey of mothers of children educated at home.
METHODS: Homeschool organizations in four states (Florida, Louisiana, Mississippi, and Oregon) were asked to forward an email to their members, requesting mothers to complete an anonymous online questionnaire on the vaccination status and health outcomes of their biological children ages 6 to 12.
RESULTS: A total of 415 mothers provided data on 666 children, of which 261 (39%) were unvaccinated. Vaccinated children were significantly less likely than the unvaccinated to have been diagnosed with chickenpox and pertussis, but significantly more likely to have been diagnosed with pneumonia, otitis media, allergies and NDDs (defined as Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder, and/or a learning disability). After adjustment, the factors that remained significantly associated with NDD were vaccination (OR 3.1, 95% CI: 1.4, 6.8), male gender (OR 2.3, 95% CI: 1.2, 4.3), and preterm birth (OR 5.0, 95% CI: 2.3, 11.6). In a final adjusted model, vaccination but not preterm birth remained associated with NDD, while the interaction of preterm birth and vaccination was associated with a 6.6-fold increased odds of NDD (95% CI: 2.8, 15.5).
CONCLUSIONS: In this study based on mothers' reports, the vaccinated had a higher rate of allergies and NDD than the unvaccinated. Vaccination, but not preterm birth, remained significantly associated with NDD after controlling for other factors. However, preterm birth combined with vaccination was associated with an apparent synergistic increase in the odds of NDD. Further research involving larger, independent samples is needed to verify and understand these unexpected findings (my emphasis) in order to optimize the impact of vaccines on children's health.

CITATION: Mawson AR, Ray BD, Bhuiyan AR and Jacob B (2016). Vaccination and Health Outcomes: A Survey of 6- to 12-year-old Vaccinated and Unvaccinated Children based on Mothers' Reports. Front. Public Health 4:270. doi: 10.3389/fpubh.2016.00270
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EDITOR: Larger studies comparing health of the unvaccinated and vaccinated are most certainly needed and are very likely to reveal further 'unexpected findings' for established medicine!

Interesting that the results highlight a number of conditions in the vaccinated group - which many researchers of vaccination have been suggesting for a long time.

The authors also found that the vaccinated were less likely to have been diagnosed with chickenpox and pertussis than the unvaccinated.

Three comments immediately come to mind …firstly 'less likely to have been diagnosed' could mean that some of these vaccinated children may have displayed certain symptoms associated with the 2 illnesses mentioned but due to their vaccination status were not diagnosed with either chickenpox or pertussis.

Secondly – the authors are assuming that all these vaccinated children would have developed chickenpox and pertussis had they not been vaccinated and 'protected'. Whereas you could argue that due to the fact that these childhood illnesses are declining anyway that those children may not have ever developed them anyway regardless of whether they were vaccinated or not.

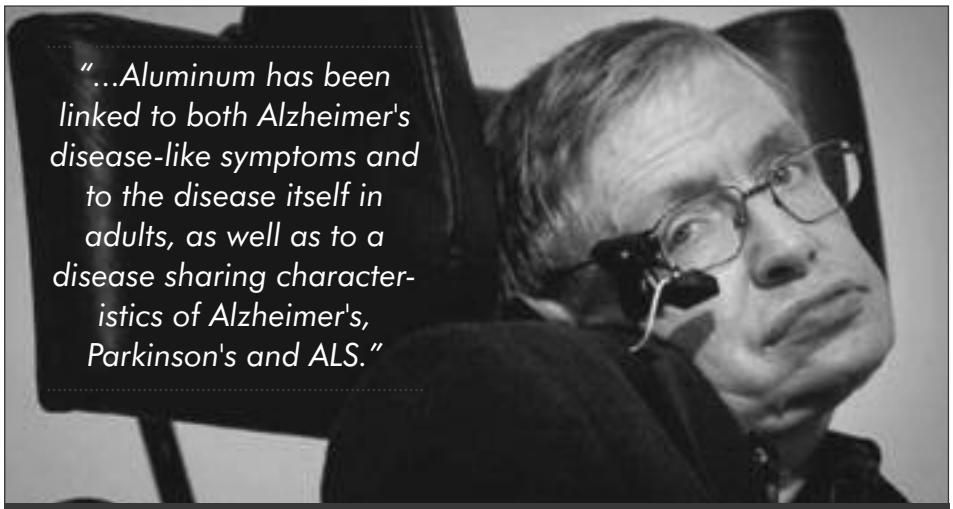
Thirdly, being vaccinated may have skewed their immune system and suppressed their health so that they are unable to throw a fever and have a good clear out in the form of an acute childhood illness?

Aluminum in vaccines causes damage to the brain and nervous system

SEPTEMBER 26, 2016

BY: DAVID GUTIERREZ, STAFF WRITER

http://www.naturalnews.com/



Stephen Hawking, diagnosed with ALS in the year of 1964 age 21

MUCH OF the controversy over additives in vaccines has centered around the mercury-containing preservative thimerosal, which is no longer found in childhood vaccines except for flu shots. But did you know that many childhood vaccines contain potentially toxic, brain-damaging levels of aluminum?

Aluminum is included in vaccines as an "adjuvant," a component that boosts the body's short-term immune response in order to produce antibodies to the vaccine agent faster. This very function may be part of what makes aluminum in vaccines dangerous.

Aluminum is also a neurotoxin that has been linked to various types of brain damage.

HOW ALUMINUM DESTROYS THE BRAIN

Numerous human and animal studies have linked aluminum to brain damage, including Alzheimer's disease. For example, one study found that mice injected with aluminum developed behavioral changes and problems with cognitive and motor function. Autopsies later showed that the motor neurons in their brains and nervous systems showed changes associated with Alzheimer's disease, Parkinson's disease and ALS (Lou Gehrig's disease).

Another study, published by researchers from the University of British Columbia in 2013, found that the risk of autism diagnoses in children was directly correlated with how many aluminum-containing vaccines they had received.

Researchers have speculated that many of aluminum's neurotoxic effects might be due to its immune-stimulating properties. They have speculated that this property might trigger autoimmune reactions in certain people.

In fact, immune adjuvants have been linked with a variety of immune-mediated diseases, including some for which there is still no name. Conditions linked with exposure to immune adjuvants include siliconosis, Gulf War Syndrome, macrophagic myofasciitis syndrome and some post-vaccination phenomena. Notably, all four diseases share certain signs and symptoms with each other. This observation led a group of researchers from Israel's Zabludowicz Center for Autoimmune Diseases to propose a new syndrome in 2011, called Autoimmune (Auto-inflammatory) Syndrome Induced by Adjuvants (ASIA).

In a study published in Immunologic Research in 2013, researchers reviewed the evidence linking aluminum adjuvants to neurotoxic effects. They found that aluminum has been linked to both Alzheimer's disease-like symptoms and to the disease itself in adults, as well as to a disease sharing characteristics of Alzheimer's, Parkinson's and ALS. It has also been linked with Gulf War Syndrome. The researchers suggested that aluminum should be considered a potential trigger of ASIA.

Babies get 10 times the adult dose at birth

SO WHY ARE OUR KIDS BEING INJECTED WITH ALUMINUM, AND HOW MUCH ARE THEY GETTING?

First, it's important to understand that while aluminum occurs naturally in the environment, the body reacts to injected aluminum differently than it reacts to aluminum ingested in food. That's because when the body ingests aluminum, it works to flush it out as quickly as possible to prevent levels in the blood from rising.

The FDA states that for patients being fed intravenous (IV) fluids exclusively, the IV fluids must not contain more than 25 mcg of aluminum per liter (a liter is roughly equivalent to an adult dose). It also notes that as little as 10 mcg of IV aluminum can cause kidney failure in premature infants or those with kidney problems.

So how much aluminum is in the hepatitis B vaccine, which the Centers for Disease Control and Prevention (CDC) recommend giving to babies on the day they are born? A shocking 250 mcg – 10 times the maximum adult dose!

The CDC further recommends that at the age of 2 months, children be given a round of vaccines that collectively contain between 295 mcg and 1,225 mcg of aluminum, depending on the particular combination of shots used.

By age 18 months, a child following the CDC vaccination schedule may have been injected with as much as 4,925 mcg of aluminum.

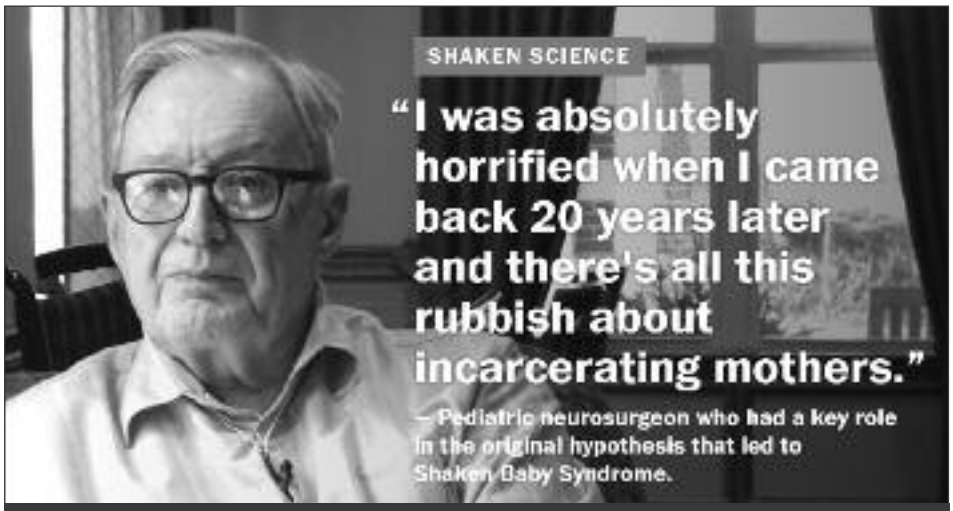
Is it any wonder that people have questioned the necessity of strictly following the CDC's vaccination schedule?

DR A NORMAN GUTHKELCH FOUGHT INJUSTICE TO THE END

SUE LUTTNER
www.onsbs.com
3 August 2016

DR. A. NORMAN GUTHKELCH, the pioneering pediatric neurosurgeon who first proposed in print that shaking an infant could cause bleeding in the lining of the brain, died quietly last week in Toledo, Ohio, a month short of his 101st birthday.

"Until the very end, Norman continued fighting for innocent children and families," said Kim Hart, his caretaker and colleague and the director of the National Child Abuse Defense and Resource Center (NCADRC), who shared her home with Dr. Guthkelch for the last two years of his life. Last year, just before he turned 100, the two of them helped a local mother regain custody of her twins following a hasty diagnosis of abuse that had ignored the children's medical histories.



Dr. A. A. Norman Guthkelch

DR. GUTHKELCH IN 2012

Dr. Guthkelch devoted his final years to working against what he considered a misinterpretation of his work, the model of shaken baby syndrome that has been winning in court for several decades. "I am frankly quite disturbed that what I intended as a friendly suggestion for avoiding injury to children has become an excuse for imprisoning innocent parents," he told me in an interview in 2012.

Dr. Guthkelch published his groundbreaking paper in the British Medical Journal in 1971, proposing that the shaking of infants, considered at that time a reasonable way to calm or discipline a child in northern England where he was practicing, could be triggering subdural bleeding and endangering brain development. The paper did not propose that subdural bleeding proved abuse, but advised physicians faced with unexplained infant subdurals to "inquire, however guardedly or tactfully, whether the baby's head could have been shaken."

When he wrote that paper, Dr. Guthkelch launched an education campaign to stop the practice of infant-shaking in Britain, recruiting the help of case workers who made home visits to new parents. He then pursued other professional interests and didn't revisit the shaken baby discussion until 2011, when law professor Carrie Sperling with the Arizona Justice Project asked him to review the medical records in the case of Drayton Witt, a father convicted of murder in 2002 for the presumed shaking death of his son.

"I want to do what I can to straighten this out before I die," he said in 2012, "even though I don't suppose I'll live to see the end of it.."

"I wasn't too keen on this at first, as I'd retired at least a decade earlier," Guthkelch sighed in a 2012 conversation, but he examined the records and was "horrified" to discover that 4-month-old Steven Witt had suffered a lifetime of medical problems that could easily explain his death. Dr. Guthkelch's affidavit helped convince an Arizona state court to vacate the conviction and free Drayton Witt after a decade in prison.

Sperling, now an associate dean at the University of Wisconsin Law School, describes Dr. Guthkelch as "an amazing, gracious man," who impressed her with "his curiosity, his unassuming nature, and his intellectual integrity." She characterizes his decision to examine the evidence in the Witt case as "an act of true courage for the man whose work was at the root of the diagnosis." Ultimately, Sperling says, "What I found most extraordinary about him was his unwavering and unselfish commitment to justice."

After the Witt case, Dr. Guthkelch made a careful study of the medical records in a series of other shaking convictions in which the defendant still maintained innocence, and in every single case, he told me in a video interview in 2012, he found an obvious, non-abusive medical explanation for the findings. "And I asked myself," he said, "'What has happened here?'"

After exploring the medical literature, he concluded that "dogmatic thinking" had set in among child abuse physicians, who had come to believe that a certain constellation of brain findings, including retinal and subdural bleeding, proved abuse. He began articulating his protestations against the common knowledge, in letters to key players and in an essay to accompany an influential 2012 law journal article by a team of attorneys and physicians concerned that shaken baby theory is convicting innocent parents and caretakers.

Dr. Guthkelch advocated abandoning the terms "shaken baby syndrome" and "abusive head trauma," which incorporate an assumption about mechanism, in favor of the objective term "retino-dural bleeding of infancy."

He tried to encourage communication between the two sides of the debate, he said, "But the arena is much too contentious, and the history too bitter. It's quite tragic."

Dr. Guthkelch began his career at a time of tremendous need. During World War II, right after his residency training, he served as an army neurosurgeon—during the Battle of the Bulge, he once told me, he staffed the operating room for 36 hours straight, breaking for food but not for sleep.

After the war, he returned to his studies under pioneering neurosurgeon Sir Geoffrey Jefferson, who had honed his own skills treating head injury during World War I. Away from the battlefield, Guthkelch found himself specializing in the very young. He became Britain's first physician with the title of pediatric neurosurgeon when he received that appointment at the Royal Manchester Children's Hospital.

Dr. Guthkelch emigrated to the U.S. in the mid-1970s, working at the Children's Hospital of Pittsburgh until 1982. He intended to retire at that time, he said, but when he and his wife moved to Tucson, Arizona, the local hospital recruited him for another eight years of practice.

After the death of his wife in 2011 and his experience with the Witt case, Guthkelch focused his energy on the shaken baby debate. "I want to do what I can to straighten this out before I die," he said in 2012, "even though I don't suppose I'll live to see the end of it."

Moving to Toledo in 2014 gave him the chance to work on the front lines in the fight against the misdiagnosis of abusive head injury. "The 25 months we had with him was an amazing education, an incredible experience, and a true privilege" says NCADRC director Kim Hart. "We are committed to moving forward, championing his desire to correct the misperceptions of his work that have caused so much tragedy for so many innocent families."

GSK EXTRACTING STANDOUT SALES FROM FORMER NOVARTIS VACCINE BIZ

BY ERIC SAGONOWSKY

Aug 31, 2016

http://www.fiercepharma.com/

GLAXOSMITHKLINE had no shortage of critics back in 2014 when it signed the deal to offload its oncology assets and take on Novartis' vaccines business. But the company may be feeling vindicated with projections that this year, the ex-Novartis' vaccines business is set to soar past Novartis' earlier projections.

In speaking with Bloomberg, GSK vaccines chief medical officer Thomas Breuer said last year's sales of Novartis vaccines exceeded the Swiss drugmaker's prior projections by 5 times and that this year GSK looks for it to beat those forecasts by 9 times.

Part of the success has been due to Glaxo's sales abilities and the fact that previously Novartis vaccines were "sub-scale," AXA Framlington Health Funds manager Dani Saurymper told Bloomberg. He added that the Swiss drugmaker "really didn't have the same global reach and breadth of portfolio that Glaxo has" in vaccines.

Novartis vaccines posted a $165 million operating loss in 2013. And immediately following the asset swap in the first quarter of last year, GSK saw its vaccines operating profit fall 31% and operating margin fall 12% versus the prior year on a "higher than anticipated cost base." But since then, turnaround efforts have been paying off. Vaccines outperformed other groups at the drugmaker in Q2, achieving 11% growth and £270 million in profit.

"Vaccines outperformed other groups at the drugmaker in Q2, achieving 11% growth and £270 million in profit"

One big factor was meningitis B outbreaks in the U.S. there have been 7 at universities since 2009, plus a social media furor in the U.K. over the death of a toddler earlier this year, all of which played a part in boosting Bexsero demand, its vaccine for that infection, the news service reports. In fact, demand for the meningitis B vaccine was so high this year that for awhile there was a shortage of the jab in U.K. private clinics. That has since been resolved.

To get the ball rolling following the multibillion-dollar deal close, GSK settled a prior standoff between Novartis and the U.K. over the price of Bexsero for a national immunization campaign. At the time, reports said the parties came to an agreement of £20 per dose.

But the drugmaker doesn't plan to stop there in supporting Bexsero. The U.K. pharma is additionally looking to grow the vaccine's uses, testing whether it could prevent men B carriage in teenagers or protect against gonorrhea. At a conference next month, investigators will present data on Bexsero's ability to prevent the sexually transmitted.

PEDIATRICIANS URGE STATES TO GET TOUGH ON PARENTS WHO DON'T WANT TO VACCINATE THEIR KIDS

BY MELISSA HEALY
LOS ANGELES TIMES
29 Aug 2016

THE NATION'S pediatricians are pushing back against parents who resist having their children vaccinated against a broad range of dangerous diseases by calling on states to stop offering waivers to those with non-medical objections to the practice.

In a policy statement issued Monday, the American Academy of Pediatrics also said that if parents continue to refuse vaccinations despite exhaustive efforts to change their minds, it would be "acceptable" for doctors to exclude these families from their practices.

The pronouncements are intended to guide U.S. pediatricians as they grapple with a rising tide of vaccine "hesitancy" on the part of parents. Among doctors who are members of the nation's largest organization of pediatricians, 87% have been challenged in the last year by parents who refused to have their children immunized, up from 75% in 2006.

Imperturbable in the face of colicky babies, toddlers' tantrums and teen angst, many pediatricians have reached the end of their patience with parents who are unconvinced of vaccines' life-saving benefits. In 2013, 12% of pediatricians routinely asked parents to find another physician if they weren't willing to vaccinate their children. In 2006, only 6% routinely showed such parents the door, according to surveys by the academy.

That step should be a last resort, the group said.

In a lengthy report also released Monday by the AAP, 23 specialists in pediatrics and infectious diseases said doctors should begin discussing the benefits of vaccines as early as the first prenatal visit. In doing so, they should be prepared to explain the scientific evidence supporting vaccines' use.

The panel also urged pediatricians to "personalize" the message that vaccines are safe, effective and powerful by sharing their own decisions to vaccinate their children or grandchildren. This particular advice was prompted by studies showing that skeptical parents tend to value the safety and comfort of their own children over arguments emphasizing the role of vaccines in benefiting the public at large.

Even as it gave physicians its blessing to dismiss vaccine refusers from their practices, the pediatricians' group acknowledged a widely held view among rank-and-file members: that for a profession dedicated to the well-being of children and their families, the decision to show patients the door is often difficult.

"The panel also urged pediatricians to "personalize" the message that vaccines are safe, effective and powerful by sharing their own decisions to vaccinate their children or grandchildren. This particular advice was prompted by studies showing that skeptical parents tend to value the safety and comfort of their own children over arguments emphasizing the role of vaccines in benefiting the public at large.."

"It was gut-wrenching," said Dr. Alison Ziari, chief of pediatrics at the Austin Regional Clinic, a multi-specialty practice with 70 pediatricians in Texas that adopted a vaccinate-or-leave policy in July 2015. "These are our families. We love them and we want to care for them."

After doctors had lengthy conversations with parents reluctant to vaccinate their kids fully by the age of 2, the majority of families chose to get the immunizations and stay with the practice, Ziari said. But the families of about 150 children - a small fraction of the more than 100,000 pediatric patients - persisted in their refusal and were asked to seek care elsewhere, she said.

The survey results released Monday show that parents' concerns about vaccines have shifted in recent years. In 2006, pediatricians reckoned that nearly three-fourths of parents reluctant to vaccinate their children were motivated by fear that some vaccines could cause autism or have other adverse effects on a child's safety.

By 2013, safety concerns and the discredited link between vaccines and autism appeared to be less prominent causes of parental resistance. Instead, physicians attributed a growing number of parental objections to the view that vaccines are an unnecessary discomfort for their young children.

Such complacency is a common, if ironic, response to vaccines' success, doctors and epidemiologists say. Before a measles vaccine was introduced in 1963, virtually everyone got measles as a child, and hundreds of Americans died of the disease each year. Today, few parents of young children have even seen it.

Likewise, once a vaccine for pertussis came into wide use, that disease became a rarity. Pertussis, also known as whooping cough, kills 1% of babies it infects in the first year of life and hospitalizes 5% of teens who get it. In Japan, after pertussis vaccination rates fell precipitously in the 1970s, more than 13,000 people contracted the disease in 1979 and 41 died, according to the U.S. Centers for Disease Control and Prevention.

"In a way, immunization has been a victim of its own success," said Dr. Sydney Spiesel, a pediatrician in Woodbridge, Conn., who has dismissed several families from his practice for refusing to vaccinate their children. "If you don't see terrible things happening, you're not seeing the risks" of failing to vaccinate.

The new guidelines follow a steady uptick in local outbreaks of vaccine-preventable diseases, most notably measles and whooping cough. In 2015, a measles outbreak originating at Disneyland sickened 147 people in the United States, including 131 in California. A study published in the Journal of the American Medical Assn. in March found that people who refused to vaccinate themselves or their children

played a key role in initiating and accelerating those outbreaks.

Although all 50 states and the District of Columbia require that schoolchildren be immunized against a broad range of diseases, most states allow parents to opt out if they have a religious objection to vaccines and 18 allow for "philosophical exemptions" for those who object based on personal, moral or other grounds, according to the National Conference of State Legislatures.

DISNEYLAND OUTBREAK

The Disneyland outbreak helped spark an acrimonious debate over these non-medical exemptions. Last month, a California law removing the state's "personal belief" exemption took effect, making California one of three states - along with West Virginia and Mississippi - that no longer grant non-medical exemptions to vaccines.

"It's clear that states with more lenient exemptions policies have lower immunization rates, and it's these states where we have seen disease outbreaks occur as the rates slip below the threshold needed to maintain community immunity," said Dr. Geoffrey R. Simon, lead author of the medical exemptions policy statement.

"Non-medical exemptions to immunizations should be eliminated," he said.

Physicians on the front lines of patient care say those exemptions have jeopardized the safety of families that do vaccinate their children. They are also a sign of declining trust in a profession that has long enjoyed the confidence of American parents, they add.

As their practice swelled with families moving to Central Texas during the recession, Ziari and her colleagues detected an escalation of parental resistance to vaccination. When outbreaks of measles and whooping cough began making the nightly news, the pediatricians of Austin Regional "began looking at each other and saying, 'That's going to be us, that's going to be our waiting room,'" she said.

That could be life-threatening for their newborn and immunocompromised patients, not to mention dangerous for the unvaccinated children themselves, Ziari knew. Moreover, for parents to challenge doctors on vaccines' health benefits - a matter that is settled within the medical profession - betrayed a "disconcerting" lack of trust, Ziari said.

"It raises flags that they don't trust in the care I'm providing," she said. "That's a cornerstone of the relationship."

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"Physicians on the front lines of patient care say those exemptions have jeopardized the safety of families that do vaccinate their children. They are also a sign of declining trust in a profession that has long enjoyed the confidence of American parents, they add."

TWO DISTINCT EPISODES OF WHOOPING COUGH CAUSED BY CONSECUTIVE BORDETELLA PERTUSSIS AND BORDETELLA PARAPERTUSSIS INFECTIONS IN A FULLY IMMUNIZED HEALTHY BOY

AUTHORS: HEININGER U, SCHLASSA D

Pediatr. Infect Dis J 2016 Nov; 35(11): 1275-1276

ABSTRACT

We describe a 5-year-old, fully immunized boy with polymerase chain reaction-proven consecutive Bordetella pertussis and Bordetella parapertussis infections causing typical whooping cough at the age of 2 and 5 years, respectively.

Neither pertussis immunization nor disease provides reliable immunity against further episodes of whooping cough.

Editor: Interesting how the title of this paper refers to the child in question as a 'fully immunized healthy boy'. Some may question how 'healthy' is a fully immunized individual and also no symptoms of disease do not necessarily equate health. A child who is compromised may not even have the ability to throw a fever or go through an acute illness. There lack of illness may equate to suppression rather than 'health'??

AN ARNICA APPROACH FOR DEALING WITH A CHILD IN HOSPITAL

BY NICOLA ADOLPHE

MOST OF US reading this will be strong advocates for a natural approach to parenting. We've seen the improvement of behaviour and energy, watched as colds disappear, wounds and scars heal over without intervention and fevers are managed safely. Through diligence, study and perseverance, health care is placed firmly in our control with methods that feel intrinsically safe, sustainable and non-invasive. I believe in this approach, I have seen it work many times for our family sustaining me through pregnancy, birth and breastfeeding as well as throughout the childhood years. I feel empowered by the knowledge I have gained over the years for the benefit of our family. I can say with confidence that it works for us.

DESPITE ALL OUR EFFORTS

Despite all our efforts, there are occasions when the medical model is needed. Serious illnesses and hospitalisation are consequences of unforeseen infections, physiological defects and accidents which take us beyond our experience. I had such an experience earlier this year. Out of 5 children, only my youngest and 5th child, a baby of only 7 weeks old at the time (and ironically the only one born in hospital), has ever been admitted to hospital – intensive care – with what could have been a life-threatening condition. Prior to being admitted, she was vomiting and refusing milk, I tried every trick to encourage her to latch but she did not fully respond. On the second day, I reluctantly took her into hospital fearing the worst, likely a drip for rehydrating her, possibly because of an infection. I kept trying to feed her in hope that things would turn around. Instead it spiralled uncontrollably, and became even worse than I ever imagined. I was totally unprepared for the admission; the painful tests, the exclusion of the parent while professionals discussed 'problems' and the lack of consent.

My daughter was fortunate in that she was given a diagnosis and made a recovery, but I feel torn by the medical methods using painful invasive procedures in order to 'treat' a patient. It feels forced and incongruent to say one has been 'treated' leaving a trail of bruising and trauma at the hands of a patriarchal hierarchy that places patients' rights at the bottom of the ladder. As long as lives are 'saved' and the 'battle' against illness has been won, that's all that counts, right? Examine the language we use that places the healthcare professionals on a pedestal for their 'valiant', 'brave' efforts, working tirelessly in an overstretched hospital ward. These wards are the 'frontlines'; an appropriate war analogy to the countless infections and sudden difficulties these highly trained men and women face. Yet, the methods used to 'fight' are torturous and barbaric (this may sound a far too strong an analogy, and I don't mean to cause offence, but – let's say it as it is – sitting in hospital with screaming children having blood taken and knowing your child is up next is the only description that fits). Having a professional tell you "it's fine, she won't remember it…" is firstly totally untrue, and secondly completely unnerving. It feels as though the professionals are entirely immune to the trauma, likely due to the years of working on the 'frontlines', the battle fields, where you would have to be of a strong mind to withstand the pressure. My experience left me emotionally exhausted. All those years of natural health parenting meant that I was deeply in tune to everything she went through, every needle prick, every blood test. The medical model is indeed a paradox. I was left feeling both confused and convicted… There must be a better way…

"Despite all our efforts, there are occasions when the medical model is needed. Serious illnesses and hospitalisation are consequences of unforeseen infections, physiological defects and accidents which take us beyond our experience. I had such an experience earlier this year.."

My daughter was originally treated for sepsis but later it turned out she had a heart arrhythmia (SVT) which was diagnosed at great Ormond Street Hospital (GOSH). She was put under general anaesthetic at our local hospital and several drip lines were put in before being transported via a special incubator by the CATS (Child Acute Transport Service) team from GOSH. One of the drips the surgeon at our local hospital had placed in her damaged a vein. This led to a thrombosis, a dangerous blood clot. Not only was she placed on heart medication, beta blockers 3 times daily, but she was also put on Low Molecular Weight Heparin injections (LMWH) twice daily for 6 weeks. When I was told this regime I was utterly appalled, broken, shocked. I had not been asked to consent to this medication (which was wrong and I should have highlighted this to the staff). I knew the injections were going to be difficult to accept. I knew the beta-blockers were highly questionable in terms of side-effects but I couldn't remember the details. When you are placed under extreme pressure it is difficult to think rationally and I must admit, I really struggled.

At my local hospital I was on the receiving end of scare tactics and threats after I requested that the injections be reduced to once daily. However, a different drug was found and my request was granted. Despite the condescending manner of one of the

consultants I was glad I made this request; it was the best outcome for my daughter and it was the only way I was able to endure the medication regime. I researched anti-coagulation physiology and natural methods to reduce clotting. As breastmilk is low in vitamin K, a clotting factor, and she was fully breastfed, I believed the medication would not need to be continued for the full 6 weeks. The 6 week time frame may have been based on trials for older people or adolescent children rather than babies. I changed my own diet increasing my intake of blood-thinning foods, increased vitamin C and used homeopathic arnica. I committed to the minimum 4 weeks and then threatened to remove consent for further injections. This was not viewed with approval!

COURT ORDER

Perhaps this was not a clever move, as I was threatened with a court order, but I had been waiting for an ultrasound scan for over a week. The injections had been 'below therapeutic level' for the full 4 weeks and the nurses had been gradually increasing the dose. When my daughter began showing side-effects to the medication I wanted to reduce the dosage but was bullied into acceptance. After threatening to remove consent, I received an appointment within 20 minutes of the conversation, for the next working day. The clot was no longer there. I am convinced my research and effort paid off. I saved the NHS two weeks worth of nurses' visits and medication, as well as protecting my daughter from harmful medication.

This article will focus next on the lessons I learned during our hospital experience. In total we stayed for nearly 2 weeks. Only now, after the events have been processed, am I aware of all the things I wish I had asked for but couldn't, all the questions that should have been at the tip of my tongue but I was too overcome with shock. So I have written here a list of 20 ideas that might help reduce trauma, put consent at the heart of treatment, and reduce the likelihood you will be a victim of medical 'coercion' (AKA: bullying and threatening behaviour). I hope you never need this. But if you do, I hope this will prepare you for the unexpected roller-

coaster rides that you may face. As "Arnica" minded parents, practicing alternatives such as homeopathy, home births, non-vaccination and perhaps not visiting a GP for a while could potentially draw attention from a disapproving doctor, so we do need to be careful. At the same time we have rights to do the best for our child, and if we all follow some of these practical tips, we will be raising awareness of those rights in the best possible manner. So do not be put off from following your knowledge and truth. This is your child and not theirs. Keep these suggestions safe for future reference.

(There were difficulties administering the heart medication and it led to a disagreement between ourselves and the hospital, which I shall address in a follow-up article that will focus on examples of threatening behaviour, coercion and bullying. It will also address how to complain if a breakdown in communication occurs. If you have a relevant story, maybe your birth choices were curtailed, or you were forced to accept formula milk against your wishes, maybe you had a threatening letter about vaccines, or you have had social services involvement please send me your stories, spiritual_skater@hotmail.com, or phone 01362 637 609)

20 IDEAS TO DO BEFORE AND DURING AN EMERGENCY HOSPITAL VISIT FOR YOUR CHILD

1) The best advice (from an Arnica mum – thanks Gemma!) was to keep ALL documents relating to the hospital visit. Discharge papers, referrals, letters, leaflets, package inserts, EVERYTHING. Generic leaflets often have complaint addresses and hospital contact numbers, letters have doctors' names, welcome packs often have feedback forms with email addresses. Get a plastic wallet or folder to store it all in.

2) There is usually A LOT of waiting around, before you jump in an ambulance consider grabbing the following items, I've placed these in the order I most valued them:

ESSENTIAL:

- A BOOK (You will absolutely either die (not literally) of boredom or anxiety, without a decent book you are doomed to suffer both)
- Phone/purse
- Kindle/tablet
- Battery chargers
- Breastpump (if relevant – I needed it on the ambulance ride)
- Clothes/nappies for child
- Vitamin C, Arnica, Rescue Remedy
- A pocket notebook

If you have a little more time to pack, consider the optional items below:

- Clothes and towels for yourself, washbag, deodorant (I found the natural ones weren't working, the hospital environment and stress combined to a sticky, sweaty mixture, just warning you…)
- Soft cool shoes (my trainers gave me horrendous athletes foot),

›

- Extra blanket and pillow (the night was a bit cooler and there was a shortage of pillows!),
- Other remedies, vitamins, Epsom salts, etc.,
- Fruit, snacks, herbal tea bags, water bottle and a smoothie or juice.
- A variety of books! Take a puzzle book, fiction, study book etc. A friend lent me a portable DVD player which came in handy too.
- A child's favourite toy or a cuddly teddy/blanket for familiarity. Also consider buying a bright balloon or colourful poster. The clinical atmosphere is bleak and boring and a bit of colour can transform a room.

Keep your mind busy while waiting about. Most hospitals have a multi-faith chapel for quiet reflection and a place to cry. Chaplains of different faiths are around to offer support, Wi-Fi is now commonplace to keep in touch with friends and family. Take an online course, watch that documentary you have been thinking about for months, write letters. Waiting around anxiously does nothing except potentially make you ill – that is the last thing your child needs.

3) You may be wondering why a notebook is included on the essential items above. Use it to document the names of doctors and nurses you meet. Some will be lovely, others might be more difficult. If you know their names it is easy to write accurate feedback. You can also request a change of doctor/nurse/consultant if you find one is treating you unfairly. Record timings of events and what medication was given if you can. You can log your feelings and any other interactions with staff. For those who prefer electronic systems a phone or tablet app could be used instead.

4) Be close to your child. Sing, talk, reminisce, hold and cuddle. Be in the way! Know that your child needs you and yearns for your presence. We know that people hear in their subconscious, and it is also known that babies do have excellent memories. Psychological patterns can be triggered by any separation, pain or anxiety. Your presence, a loving parent, mitigates all of those feelings. Avoid leaving them overnight, even if the hospital is unwelcoming. Ask relatives to help with the care to give you a break.
5) Do seek time out for 15-20 minutes 3 or more times a day. A daily walk outside is important. Explore your surroundings. Perhaps leave some gentle music on while the child sleeps.

"My local hospital had a procedure for asking for consent to medicate in the daytime but ignored any protocol overnight. In my feedback to the hospital I have highlighted this error, that consent should be in place all the time.."

6) Eat properly and drink PLENTY of fluids. Smoothies, coconut water and salads were my nutrition. The hospital meals were actually really good, but my evening meal was sometimes 5pm, so by 9pm (I was fully breastfeeding a baby and occasionally a toddler, so my energy demands were high) I was peckish. I used organic cous cous and a soup mix with salads and dried nuts and fruits to make a healthy hot meal with just boiling water. Both GOSH and my local hospital had a small fridge with a little bit of room to store fresh food. If you are breastfeeding you may be entitled to free meals or discounts so do ask if this applies.

7) Remember the BRAIN acronym to seek information and options:
- B – BENEFITS of a given treatment
- R – RISKS of side effects and harm
- A – ALTERNATIVES to medication regime or use of natural methods
- I – INFORMATION about the condition
- N – DO NOTHING what happens if you don't treat it with drugs?

8) Record any side effects of medication. Take photos and log any observations carefully. Keep note of times and dates and medications that were given that might have caused the side effects in the notebook.

9) Know where PALS is located (Patient Advisory and Liaison Service). They are there to help you request a different clinician if trust and communication breaks down.

10) Request Package inserts of any long term medication your child will be on, and make it clear that you should be allowed to consent to this before they administer the medication to your child. If they do not follow this, try not to be angry or hurt, the doctors working under pressure are not used to parents asking questions, instead try to see it as an opportunity to inform and provide feedback to the hospital that they should follow consent procedures in the future.

11) My local hospital had a procedure for asking for consent to medicate in the daytime but ignored any protocol overnight. In my feedback to the hospital I have highlighted this error, that consent should be in place all the time. I do not know how this compares to other hospitals and I would be interested in finding out more. Find out about consent protocol if you are not there or are asleep. Make sure the staff are aware of your desire to get consent before any medications are given and that it is in place 24/7 unless emergency treatment is necessary. I said to one doctor when my daughter was first presented to the hospital; "I couldn't give informed consent, as I didn't know what you were doing to my child, but I would never prevent you from carrying out your ethical duty to treat".

12) Be clear and honest about your goals of reducing medication, seeking alternatives and using complementary therapies. Some may argue that it might be better not to say anything, but I would say that in the long run we could help raise awareness of alternative lifestyles and gentle parenting and we need to stand up and be counted. Not to mention that if treatment is faster than expected we can tell them what we used and why. Put forward your requests in writing, keep all copies.

13) Be respectful. Doctors are used to people being anxious, but not used to

people who do not rate the medical profession as a noble cause (I prefer to see people equal, there are those who raise the pedestals for a 'doctor', but the real praise goes to the nurses, cleaners and cooks, in my honest opinion). It would have been nice to have felt that my contributions were valid and equally important, but this didn't happen at my local hospital (GOSH were different, and much more accepting of alternatives). Light humour didn't work, and now I would advise never to attempt it. Keep a serious tone over your interactions with health care professionals.

14) Communicate your feelings. If you feel overwhelmed by everything then ask for help. I felt fortunate that I was able to speak to a psychologist at GOSH. Hospitals provision for emotional and mental health is varied, but take up offers of support if it is there.

15) Report bullying behaviour to PALS with specific names and times, and ask to switch any health care professional who you felt was threatening, was not accurate with their diagnosis, was unprofessional and so on. This also goes for a midwife you did not 'gel' with during labour. You have a right to request a change of practitioner, but if they are short staffed it might not be possible to enforce, so make sure you have good grounds to making a request.

16) Invite a friend over for a cuppa. Even in hospital it is possible to gather a sense of normality. If you are without a good support group, place a shout out on the Arnica Facebook page! Someone might come and visit, and the page is good for support and conversation, a reminder that you are not alone!

17) Research, research, research… read about the condition, long-term prognosis, the severity of the illness and/or medications. Learn how to recognise symptoms, you won't automatically be instructed before discharge. Look up PubMed and the Cochrane Library. Local libraries usually have medical text-books to borrow. Often there are medical websites that offer depth. Be aware that it can be harder to find information about the nature of a condition usually referred to in an adult than a child, and the seriousness of an occurrence of an illness might be different for a baby than an older child, so ask about these differences that you might come across in your search.

18) A High quality Vitamin C can be used either via the mother through breastfeeding or directly to a child regardless of diagnosis. (EG: Dr Suzanne Humphries Vitamin C information). Also homeopathic Arnica can be administered for shock, trauma and bruising. There might be other remedies you wish to use. Ask for help on one of the homeopathic helplines (EG www.homeopathyhelpline.com/consultations/telephone).

19) On discharge your child might have ongoing needs and be on medication. If you have not made use of a GP in the past, make use of them now. Be seen regularly; show that you want to be informed and aware of the condition. My experience of GP's have been mixed, but I do feel they are able to give a bit more attention in the surgery than in the hospital ward. It may be possible to have one GP, rather than be seen by 5 different doctors in hospital which makes discussing problems much easier. The same applies as point 15, change GP's and report bullying tactics if you were not listened to. The Clinical Commissioning Group (CCG) may also welcome feedback of GP and hospital services. I will write more on this aspect in my follow-up article.

20) It would be easy for me to write "stay calm" but not easy in practice, so my last point is two-fold:
a) Be self-aware of how you conduct yourself, this is not possible all the time, but just a reminder that the hospital can be a very damaging place emotionally, and your own feelings and desire to do what is best for your child may come across too strongly. If a doctor dislikes what they see they may refer you to social services. Do not be alarmed by this, do not be put off from acting in your child's best interests. Just be aware that it can happen.
b) Ultimately (this point overrides the above (a) to some extent) BELIEVE in what you are doing: YOU have parental responsibility and consent for anything other than risk of death or imminent harm should be through YOU. YOU and YOUR CHILD have human rights upheld by law.

For example:

- Of access to medical care (so they can't turn you away at a doctors surgery for example, or deny you specialist appointments if there are any available);
- Freedom to have beliefs and opinions;
- Right to be free from torture (so the least harmful route in medical care should be everyone's objective);
- Right to privacy – doctors should not be accessing your data without your knowledge, although they can access it to get information, they ought to share with you. If they have concerns about not vaccinating for example, they should tell you if they accessed data to find this out and discuss it with you;
- Rights for justice, fair hearings and equality of treatment (in other words, if you are treated differently because of your beliefs in use of alternatives then you could argue that is discriminatory.)

Nicola Adolphe
23rd November 2016

4 QUESTIONS THAT MAY CHANGE YOUR MIND ABOUT VACCINES

ELLIOT FREED

May 3 2016
http://www.elephantjournal.com/2016/05/4-questions-that-may-change-your-mind-about-vaccines/

SHORT EXTRACT

QUESTION 1:

DID VACCINES SAVE US FROM THE DEADLY PANDEMICS OF THE PAST?

The United Kingdom was the first country to keep data on mortality from infectious diseases in 1838. The U.S. began in 1900. Other countries have other time frames but the trends are roughly similar.

In the U.K. some of the biggest killers of the 19th century were scarlet fever, typhoid, cholera, measles and whooping cough, also known as pertussis. Small pox was statistically more rare.

The only vaccine available in the 19th century was for small pox. Invented by Edward Jenner in 1796, throughout the 19th century it was always associated with outbreaks of small pox. Most of the people who died of small pox in these outbreaks had been vaccinated. In 1885 the city of Leicester turned away from vaccination and embraced quarantine and sanitation. Small pox virtually disappeared in Leicester within a couple years. Within a decade quarantine had replaced vaccination throughout the country and by 1902 small pox was very rare in the U.K.

Quarantine is now the preferred method of containing infectious outbreaks. It is how we dealt with SARS and ebola. It is also how we eradicated small pox around the world. While people credit vaccines, they were only one part of the eradication drive. When cases were identified they were quarantined and vaccinated. Much of the world never had extensive small pox vaccination campaigns.

Cholera, typhoid and scarlet fever are all now very rare in the first world. There are no vaccines or significant vaccine campaigns for any of them.

DDT fumigation of children 1943 through to 1952

"Despite the public victory, by 1952 it was becoming clear that DDT was the likely culprit. Invented in the late 19th century as a nerve gas chemical weapon, in 1938 it was repackaged for use as a mosquito killer. It was applied liberally from 1943 through 1952 on swimming pools and school cafeterias full of children."

They faded for other reasons.

In the U.K. the death rate for whooping cough had declined by 99.74% by the time the vaccine became common in the 1950s. The death rate from measles had declined by 99.96% by the time the vaccine was introduced in 1968.

In the U.S. we see from CDC data, culled from a study published by the AMA, that the death rate from infectious diseases had bottomed out by the time vaccines were being used. It has not changed significantly in the past 65 years, since before the polio vaccine was introduced. [2]

Even the tale of polio is more complicated than first meets the eye. Polio was the diagnosis given to anybody presenting with acute flaccid paralysis (AFP) for 24 hours. There were about a thousand cases a year in the U.S. up until 1943. From 1943 to 1952 cases of AFP skyrocketed. They all received the diagnosis of polio. Most people recovered beginning within one to two weeks of onset. A few did not. In the worst year, 1952, about 3,500 people in the U.S. succumbed to AFP, called polio at the time.

During this time there was a lively debate among the scientific community about what was causing the outbreak of AFP. While there was strong evidence that it was DDT the money and publicity behind the viral theory won out.

Despite the public victory, by 1952 it was becoming clear that DDT was the likely culprit. Invented in the late 19th century as a nerve gas chemical weapon, in 1938 it was repackaged for use as a mosquito killer. It was applied liberally from 1943 through 1952 on swimming pools and school cafeterias full of children.

While there has never been a public admission that DDT was responsible for the outbreak of AFP, in 1953 they stopped spraying it on children. In two years the rate of AFP dropped by one third. The next year the death rate dropped by half. Today DDT is illegal in many countries, including the U.S.

In April, 1955, the polio vaccine

was introduced. Cases of paralysis increased, largely among the vaccinated. But diagnostic criteria were changed for "polio." Instead of 24 hours one had to be paralyzed for 50 to 70 days and the CDC themselves had to find the polio virus in the stool. Cases of "polio" virtually disappeared while cases of AFP went uncounted. Today the CDC does not keep track of cases of AFP. [3] Thus "polio" was eradicated but we still have roughly the same level of AFP as we had before 1943. There are now dozens of known causes of AFP and few people with the symptom have the polio virus.

Many people point to the eradication of polio in India that has been talked of in the media as proof the vaccine is working. Again, we have to look more closely.

According to the WHO, the rate of AFP has increased about 1,000 percent in India since the vaccination campaign began. They call it "non polio" AFP because everybody has been vaccinated. This assumes the vaccine works. As we saw in the U.S. it actually is causing more paralysis.

"According to the WHO, the rate of AFP has increased about 1,000 percent in India since the vaccination campaign began. They call it "non polio" AFP because everybody has been vaccinated. This assumes the vaccine works. As we saw in the U.S. it actually is causing more paralysis."

Dr. Jacob Puliyel is the head of pediatrics at St. Stephens Hospital in Delhi, India and a member of the National Technical Advisory Group on Immunization of the Government of India. In February of 2015 he published a study in the leading pediatric medical journal in the world. He found that the 10 fold increase in paralysis was due to the polio vaccine. Not only that, the case fatality rate was higher as well, so it was a more deadly form of AFP than whatever people had before.

Did we eradicate "polio?" Maybe. But at what cost? We increased paralysis 10 fold and the death rate even higher. This should give one pause.

When people, even the government or the spokespeople for the vaccine manufacturers themselves make declarations that vaccines have saved millions of lives, ask for the hard data. Clearly in the U.K. and in the U.S. and with "polio" in India, this is not the case, even according to the data from the people making the claims. [4]

VACCINATION CONTROVERSY: FRANCE MOST SKEPTICAL OF VACCINES, GLOBAL STUDY FINDS

BY CORTNEY DRAKEFORD
INTERNATIONAL BUSINESS TIMES
http://www.ibtimes.com/
09/09/16

A NEW STUDY shows the French are the most skeptical when it comes to trusting the safety of vaccines. Researchers found that 41 percent of respondents in France believed vaccines were not safe, Science Magazine reported Friday.

The survey found residents in Southeast Asia were the most confident when it comes to vaccine safety. In the U.S., 8.8 percent of respondents questioned the importance of vaccines for children, while 13.5 percent were not confident they were safe. Meanwhile, 9.6 percent of Americans doubted the effectiveness of vaccines and 10.5 percent were concerned with vaccinations because of their religious beliefs.

After recent outbreaks of whooping cough, measles and other infectious diseases in places where confidence in vaccinations are low, the scientist completed the study to help policymakers tackle these problems further, Reuters reported Thursday. The study led by Heidi Larson of the Vaccine Confidence Project at the London School of Hygiene & Tropical Medicine surveyed nearly 66,000 people across 67 countries to find out whether residents considered vaccines important, safe, effective and compatible with the religious beliefs.

"It is vital to global public health that we regularly monitor attitudes towards vaccines so we can quickly identify countries or groups with declining confidence," Larson said of the findings published in the journal EBioMedicine. "This gives us the best chance of preventing possible outbreaks of diseases."

The refusal of vaccinations has been linked to outbreaks of diseases like measles in the Pacific, the United States, Africa, Europe and Asia over the past few years. Other countries that lack confidence in vaccinations include Slovenia, Russia, Ukraine, Armenia, Bosnia, Greece and Herzegovina.

"***This ...shows that vaccine acceptance is precarious,*** **" said Larson, adding that scientists and public health authorities need to "do much better at building public trust."**

"THE MOST SERIOUS DISORDERS MAY BE PROVOKED BY THE INJECTION OF LIVING ORGANISMS INTO THE BLOOD INTO A MEDIUM NOT INTENDED FOR THEM MAY PROVOKE REDOUBTABLE MANIFESTATIONS FOR THE GRAVEST MORBID PHENOMENA ~ ANTOINE BECHAMP"

The Quanten Theory

EVIDENCE-BASED MEDICINE
Where is the science in all that?
by Patrick Quanten MD

Patrick Quanten MD

ON A POPULAR LEVEL, medical authorities grabbed a significant advantage against the growing onslaught of alternative therapies. In the last few decades the pressure to accept different approaches to health increased steadily and more and more alternative therapies were talked about and were judged to be helpful, if nothing else. This threatened the supreme stronghold the profession has on healthcare. In one brilliant move, a heavenly brainwave, they managed to re-establish that advantage, and seemingly for a long time to come.

People were given the idea that all health care surely must be well researched and documented. People have a right to be treated with respect and as intellectual equals. Nobody should be subjected to an approach to health that is riddled with uncertainty, deceit and deliberate lies. In order to protect people from such horror we need to ensure that all therapies are evidence-based. That's it! That is just what is needed. Proof that what you are saying is right, otherwise hold your peace forever. That is what people deserve: evidence underpinning the theory. If we stick to this rule, and we ensure that every healing and curing system shows us their evidence, nothing can go wrong. Everybody can rest assured that we are on the right track.

Indeed, you would like to think so. Especially because you think that evidence equals science. Talking about medicine, surely all evidence is scientific proof. Anything based on that cannot be wrong!

Now here's the thing. Evidence and science are two separate things. They are not the same at all. Truly.

Scientists discovered that light, frequencies that are part of the electromagnetic spectrum in our universe, can behave both like a wave and like a stream of particles. A wave is a continuum and particles are separate entities that together combine to make the whole. More importantly it turned out that light always behaves like a wave unless someone is watching! Scientists proved that the act of watching out for particles - created particles. The harder we look, the more effort we make to look for particles, the more particles appear. Isn't that weird? In science this is known as "the observer influences the observed". It is a well-established scientific fact that all observations are, in part, determined by the way one observes. The manner in which measurements are being made changes the outcome of the measurement. The expected result of a test influences the outcome. All kind of circumstances will have an effect, from the moon cycle, to the weather, the time of day, the mood I'm in, and one can carry on indefinitely. No test or measurement is an absolute truth. The standard meter is kept in Paris under well-controlled conditions to be a true representation of "one meter", the standard as chosen under specific conditions. Allow the conditions to change and the length of the meter changes too. No two "identical" tests or measurements will be strictly comparable; there will always be a number of differences that could possibly interfere with the "clean" result you are after.

Scientists used to measure things, test things, and assume that their results were universal truths. But as scientists take all results into account they started to get baffled by non-matching results. Eventually it became clear that in order to do science they could not work in isolation as each one of them was influencing and steering their own results. Nowadays scientists share their information and results and ask others to repeat the tests in exactly the same way in order to minimalise the interference effect.

"The expected result of a test influences the outcome. All kind of circumstances will have an effect, from the moon cycle, to the weather, the time of day, the mood I'm in, and one can carry on indefinitely. No test or measurement is an absolute truth."

There are two immediate and very important consequences of this scientific knowledge:

1. Any test result depends on who does the test and why. No objective truth.
2. Test results remain wide open to interpretation. No real truth.

MEDICINE IS SAID TO BE EVIDENCE-BASED. HOW DOES THAT WORK?

Somebody comes up with a theory and begins to look for evidence to support the theory. First the theory, then the proof, and proof comes from observations. Hence, the theory that says that smoking causes lung cancer is supported by the fact that the researcher can prove that there are indeed people with lung cancer that are lifelong smokers. Evidence-based medicine! At the same time, scientific research also shows that there are people with lung cancer who never smoked, that there are smokers who never get lung cancer and that there are people who never smoked who also don't get lung cancer. Evidence-based medicine then tells you

that you have an increased chance of getting lung cancer if you smoke. Anybody who attempts to quantify that increased risk is a gambler because it is scientifically impossible to calculate such a percentage. Why? Because thousands of influencing factors, some we know of and the great majority we don't even consider, play a part in life, in living. What evidence-based medicine has done is establishing a link between smoking and lung cancer. A link is a far cry from "the cause", which implies a control function: one controls, guides, the other. Smoking leads you to have lung cancer. No it doesn't! Together with thousands of other factors it has an influence on the lung function. Scientifically, that is all. Science-based research does not allow me to come to cause and effect conclusions in these matters.

Evidence-based research does testing in well-controlled circumstances, even if they only control the composition of the test group, who is in and who is out. Just as is the case with popularity polls where a large part of the population will never be included simply because they refuse or because nobody actually gets to them, it leads to inaccurate results. In a medical test group for a new drug a doctor already has made the choice that you have the right disease in the right expression to be entered into the study. If you agree, that in itself alters your subconscious attitude towards the treatment because you know it is experimental. It is because suggestion has such a high influence on our lives that the placebo effect is "measured" at such alarmingly high rates. Furthermore, the researchers determine the parameters of the study and this may entail people being removed from the end result for a variety of reasons. Vaccination studies commonly remove babies that have become seriously ill in the midst of the trial for the simple reason that they haven't completed the three shots that are needed to study the effect of the vaccination programme. Understanding how studies are being set up and controlled allows you to evaluate the results of evidence-based medicine. And I am not even talking about the millions of test results that end up in the bin because they are the "wrong" kind. If you don't get the results you want you redo the study, slightly altering some of the parameters, until you get what you want. Why do they do it this way? Because right from the onset they have a judgement of a "good" and a "bad" result. This is due to the fact that they are trying to prove something. Science-based medicine is trying to explain something.

In order to explain an observation one needs to include all observations made on the subject. Starting from all that information one needs to distil a theory, an explanation, that encompasses all possible information. No observation is excluded. As far as medicine is concerned it very quickly becomes clear that what is good for one is not good for another, and what is good for me today is not good for me tomorrow. Health is an individual matter, changing in time all the time. But that means that it is impossible to have a health service for the whole population for all time. Indeed, anybody trying to implement a set of health rules on a group of people will always be doing them a disservice.

"So, even if you have a lifetime habit which has eventually made you ill, you can decide to "listen" differently to your environment and your system will start to function differently, clearing up the effects of the previous " listening"."

Now that conclusion does fit in with scientific knowledge we already have. Science has shown that everything changes all the time and no two moments are the same. Science has also shown that every snowflake is unique, has a unique composition, and so it is with every specimen of any kind on earth. Science has also shown that all influences and consequently all changes that occur in matter are induced via the energetic field of that matter. There is no direct matter interference; these are all energetic exchanges. Looking for "causes" within the material part of life is therefore ludicrous. The best you can hope for is that you discover a link between a certain material expression of energy and another. This has nothing to do with cause and effect.

More over, science has established that the individual even has a choice whether to allow energies from the environment to affect him/her or not. We are mostly not aware of the fact that we do have a choice but even on a biological level science has proven that every cell listens to the frequencies of the environment all the time. These impulses then trigger responses from within the cell. It turns out the cells can withdraw some of these antennae, frequency detectors, which results in an ignoring of those specific frequency signals from the environment. In a similar fashion does the whole of the organism have a choice what to take note of and what not. Mostly this choice is a subconscious routine, an automatic reaction. However, we can learn to become aware of this possibility and when we do we can consciously make this work. Indeed, a person can chose not to take in certain vibrations and he/she will notice that the old response that is always felt under the circumstances no longer materialises. When you manage to do this on a more or less continual basis the matter receiving this information, or not, will alter. So, even if you have a lifetime habit which has eventually made you ill, you can decide to "listen" differently to your environment and your system will start to function differently, clearing up the effects of the previous "listening".

Evidence-based medicine keeps you locked into a mishmash of potential influences, for all of which you can find evidence, if only you know how to look for it. Science-based medicine has already proven the individuality of health, has already proven that the way you view the outside information determines the inner outcome.
Evidence-based is not science. It's like your car mechanic finding evidence that the warning light is burning because there is an electrical current running through it. Fixing things solely on the basis of evidence found is dumb. All evidence together makes up science. Evidence leads to a theory and eventually to truth. Evidence leads to science and eventually to knowledge. That is how far evidence is removed from knowledge!

November 2016

FLU VACCINE: Consent, School Immunisation Campaigns and Viral Shedding? Does it matter?

BY DR JAYNE LM DONEGAN
GP & HOMOEOPATH

DR JAYNE L.M. DONEGAN

PART ONE: CONSENT
YOU HAVE REFUSED CONSENT FOR YOUR CHILD TO BE VACCINATED, SO IT'S OK TO SEND THEM TO SCHOOL THE DAY IT IS TAKING PLACE, ISN'T IT?

The Green Books of 1992 & 1996 state: The attendance of a child at school on the day that the parent/guardian has been advised that the child will be immunised, may also be viewed as acceptance that the child may be immunised, in the absence of any reservation expressed to the contrary. However, because of the parent/legal guardian's legal responsibilities in respect of the child's attendance at school, the possibility that immunisation will be offered should be made clear to the parent/ guardian.

This means that sending your child to school on the day of a mass vaccination campaign is a form of implied consent, so you would not have grounds for suing the school or Department of Health for vaccinating your child without your consent. Bearing this in mind and the fact that you cannot get the vaccine out of the child once it has been given, it would be prudent for your child not to be at school that day. Many schools are no longer telling parents which day vaccination will take place for this reason.

3.6 A child under 16 years may give consent for immunisation. Provided he or she fully understands the benefits and risks involved. However, the child should be encouraged to involve a parent / guardian, if possible, in the decision.

3.7 Where a child under 16 who fully understands the benefits and risks of the proposed immunisation wishes to refuse the immunisation, that wish should be respected.

This all seems pretty clear, however by 2006 things are changing and the issue is becoming more tricky. The Green Book 2006 and updates to 2016 state[2] :

'Consent must be obtained before starting any treatment or physical investigation or before providing personal care for a patient.'

However, now children are to be given literature and information in the absence of their parents: in some schools this consists of subjecting them to garish films, for example, about cervical cancer, and then obtaining consent after frightening them. In others it includes singling out the children whose parents have not signed consent forms and deriding them for their parents' choices in front of the other children, employing peer pressure.

'Individuals, or those giving consent on their behalf, must be given enough information to enable them to make a decision before they can give consent. This should include information about the process, benefits and risks of the immunisation(s).' [3] Most parents who have brought their children, or themselves to be vaccinated, will agree that this is honoured more often in the breach.

'Consent is valid if the individual, or person providing consent, is offered as much information as they reasonably need to make their decision, and in a form that they can understand. Case law on this area is evolving – more detail can be found at www.dh.gov.uk/consent'

'There is no requirement for consent to be in writing.'

'Health professionals should ensure that the individual (or those giving consent on their behalf) fully understands which immunisation(s) are to be administered; the disease(s) against which they will protect; the risks of not proceeding; the side effects that may occur and how these should be dealt with; and any follow-up action required. '

I meet numerous women who are upset and bewildered to find that what they were told was a 'whooping cough' vaccine given to them when they were pregnant, was, in fact, a diphtheria, tetanus, polio and whooping cough vaccine, to which they did not consent at all. One informed pregnant mother refused the vaccination on this basis, but was assured by the midwife that it was definitely a single whooping cough vaccine. On being told by said patient that there was no single pertussis vaccine licenced in the UK, the midwife refused to believe her!

"...sending your child to school on the day of a mass vaccination campaign is a form of implied consent, so you would not have grounds for suing the school or Department of Health for vaccinating your child without your consent."

Back to school immunisation programmes: the 2006 and subsequent guidance state that 16-17 year-olds are presumed to be able to consent – this is only right, they are, after all, able to get married and have their own children at this age - and their parents are not allowed to override this consent. However, the case for refusal is much more grey

'If a person aged 16 or 17 or a Gillick-competent child refuses treatment that refusal should be accepted. It is unlikely that a person with parental responsibility could overrule such a refusal. But, "It is possible that the court might overrule a young person's refusal if an application to court is made under section 8 of the Children Act 1989 or the inherent jurisdiction of the High Court. "

So although a parent cannot override the consent of a 16-17 year old, the Court can override the refusal of someone of the same age. How can this be?

The under 16-year-old is no longer mentioned, and we have the ugly spectacle

of the refusal of a Fraser or Gillick competent young person being overruled by a judge who ordered MMR vaccine to be given to a non consenting 15- year-old.[4] That same 15-year-old, from the age of 13 years, could have gone to any doctor or family planing clinic and be prescribed contraception, without her parents consent, so long as she appeared to the doctor to understand what she was doing, refused to involve her parents, and was going to put herself at risk of unwanted pregnancy anyway. The fact that she is way below the age of consent to have sex with anyone and all the factors associated with that seem not to be part of the equation.

Even more concerning is the fact that there seems to have been very little discussion of any actual immunology in this case as the 15 year old girl had, indeed, been given one MMR vaccine as a child. Although the second MMR vaccine is given to everyone, it is only really required in the five percent of 'non-responders' that is, those who do not produce what are regarded as 'protective' levels of antibodies. At the very least antibody levels should have been measured.

Interestingly, the judge declared: 'Obviously in reaching this decision I am aware this is against the girls' wishes, but that it not the only factor. It is of course an important factor, particularly bearing in mind their ages but the court also has to consider their level of understanding of the issues involved and what factors have influenced their views. In this case I do not consider there is a balanced level of understanding by them of the issues involved.' [5]

This is not an issue that seems to overly bother the school nurses and teachers who show the previously mentioned garish films. Please follow the link and read the judgement. When you see measles mumps and rubella described by judges and senior doctors as 'serious' diseases – the ones which, with chicken pox, I was sent out by my parents to catch, in the holidays, so that I would not miss school, then you know that we have lost the plot. Serious or not serious, normal developmental milestone or child killer all hinge on one thing: how you manage childhood fevers.

Do you open the window, put your child to bed, don't feed them unless they are starving and give them lots of pure, clean water to drink? Externalisation (for more details please see reference [6]). Or the opposite? Suppress the fever with paracetamol & ibuprofen; dry up the cough with antihistamines and adrenaline-like compounds; take non indicated antibiotics - wiping out the nice bugs and leaving the nasty ones to overgrow; keep the window closed; stuff your child up with food - especially formula, cow or soya milk - when they are not hungry and push the process in - into the ears: ear infections; into the lungs: pneumonia, into the kidney: nephritis, into the brain: meningitis or encephalitis, or into the blood stream: septicaemia, which is more deadly than meningitis. These are all forms of invasive disease.

"The under 16-year-old is no longer mentioned, and we have the ugly spectacle of the refusal of a Fraser or Gillick competent young person being overruled by a judge who ordered MMR vaccine to be given to a non consenting 15- year-old."

There are no 'killer' bugs or 'nightmare' strains. All bacteria and viruses are potentially pathogenic and capable of causing invasive disease. It is as easy to die from diseases for which there are vaccines as it is to die from diseases for which there are no vaccines. It all hinges on your general level of health when you meet the organism: do you have access to clean water, adequate food, ventilated housing, fresh air and exercise, and someone who loves you? And crucially, how you treat fevers – suppressively or supportively? Do you help the body to externalise disease, or do your suppress all the symptoms (standard medical treatment) and cause invasive disease?

PART TWO: THE LIVE 'FLU VACCINE: FLUMIST QUADRIVALENT (USA) = FLUENZTETRA (UK)

WHAT IS THE 'FLU VIRUS?

Influenza A and B are the two types of 'flu viruses that are associated with human epidemic disease. Influenza A viruses are separated into subtypes on the basis of two surface antigens: hemagglutinin (HA) and neuraminidase (NA). Influenza B viruses are separated into lineages. New 'flu virus variants emerge as a result of point mutations and recombination events that occur during viral replication, resulting in frequent antigenic change or 'drift'. Because the genomes of 'flu viruses are segmented, a second evolutionary process called reassortment can occur, where two viruses infecting one host exchange gene segments. This occurs commonly in humans with both influenza A and B viruses. [7] When new hemagglutinins are acquired from birds or large adaptations occur in humans, larger genetic changes, or antigenic 'shifts', can occur among influenza A viruses, as in the 1918, 1957 and 1968 influenza pandemics.[8]

WHAT DEFENCE MECHANISMS DO WE HAVE AGAINST 'FLU (AND OTHER) VIRUSES?

The vast majority of human pathogens colonize and invade at the mucosal surfaces. Waldeyer's ring forms a protective site at the opening of the pharynx to provide immunity and is an induction site for mucosal responses. It is formed by the lymphoid tissues near the opening of the respiratory and digestive systems. It consists of the adenoid, tubal, palatine and lingual tonsils.[9] This is why it is so important not to let anyone take them out.

The mucous membranes covering the aerodigestive (nose, mouth, pharynx) and the urogenital tracts as well as the eye conjunctiva, the inner ear and the ducts of all exocrine glands are endowed with powerful mechanical and chemical cleansing mechanisms (coughing, sneezing, blinking), mucus and cilia (little hairs to beat it out), that degrade and repel most foreign matter.

The nasal mucosa conditions and cleans inspired air before it enters deeper regions of the body. However, this filtering results in the accumulation of foreign substances in the nose. Since these impurities include both particulate and infectious materials, mechanisms for washing the nasal interior and immune resistance are well developed.[10] There is also a large and highly specialized innate and adaptive mucosal immune system which protects these surfaces, and the

inside of the body, against potential danger from the environment. It includes phagocytic neutrophils and macrophages, dendritic cells which process antigen, natural killer and mast cells (histamine).

In a healthy human adult, this local immune system contributes almost 80% of all immunocytes (immune cells). The cells accumulate in, or move between, various mucosa-associated lymphoid tissues (MALT). Together they form the largest mammalian lymphoid organ system. Protection at the mucosal surface is correlated with secretory immunoglobulin-A (IgA) antibodies which are produced by the mucosa-associated lymphoid tissue. This secretory IgA antibody exerts its immune function by:

- Massive production: more than 50 mg per kg body weight per day
- Specific transport into mucosal secretions
- Resistance to host proteases – that break down protein
- Stopping bacteria sticking to body surfaces
- Stopping absorption of macromolecule (including uptake and binding of allergens to target cells in the mucosa)
- Stopping the inflammatory effects of other immunoglobulins
- Neutralisation of viruses outside and inside epithelial cells and bacterial toxins
- Enhancement of nonspecific defence mechanisms (e.g., lactoperoxidase which kills bacteria, and lactoferrin which kills bacteria, parasites and transports iron)
- Elimination of antigens in tissue through binding and then polyimmunoglobulin receptor (PigR) – mediated transport of immune complexes and IgA through epithelial cells

Unlike the systemic immune system (inner body), which functions in a normally sterile environment and tends to make a vigorous response to invaders, the MALT system guards organs that are full of foreign matter, so the nasal mucosa has evolved a variety of mechanisms to achieve and maintain tolerance against self-antigens and against the many environmental antigens present in the microflora (nice bugs that live in/on body), in food and among airborne matter. It follows that when encountering this abundance of antigens, the MALT must economically select appropriate immune mechanisms and regulate their intensity to avoid bystander tissue damage and immunological exhaustion.[11]

All these obstacles and mechanisms, designed specifically to keep unwanted organisms out of the body have to be overcome in order to make a successful mucosal, non-injectable vaccine. So mucosal vaccines have to overcome formidable barriers in the form of significant dilution and dispersion; competition with many and various live reproducing bacteria, viruses, inert food and dust particles; breakdown by enzymes and low pH before reaching the target immune cells. It has long been known that vaccination through mucosal membranes requires potent adjuvants (helpers) to enhance immunogenicity, as well as delivery systems to decrease the rate of dilution and degradation and to target the vaccine to the site of immune function.[12]

WHAT DOES THE 'FLU VIRUS DO?

Nothing very much unless you are a child needing to go up a developmental step or an adult who is exhausted and needs a rest. Please see 'killer' bugs or 'nightmare' strains, earlier in the text.

What is the Live Attenuated Influenza Vaccine (LAIV) - FlumistQuadrivalent / FluenzTetra being given in our schools?

It is a Genetically Modified (GMO) vaccine containing reassortment wild virus types and viruses that are cold-adapted, temperature-sensitive, attenuated virus reassortant strains adjusted to the viruses circulating for the actual 'flu season in a specific year. These mucosal vaccines are designed to stimulate production of secretory IgA antibodies to 'flu virus surface hemagglutinin and neuraminidase to protect the upper respiratory tract; serum IgG antibodies to protect the lower respiratory tract (lungs) and neutralise virus in the blood stream, and cell-mediated immunity (CMI), mainly against 'flu virus matrix and nucleoprotein antigens.

CMI does not protect against infection, but is important for clearance of virus and recovery from illness.[13] Immune mechanisms conferring protection against influenza following receipt of FluMist Quadrivalent vaccine are not fully understood; it is thought that serum antibodies, mucosal antibodies, and influenza-specific T cells may play a role.[14]

WHAT IS IN THIS VACCINE?[15]

In addition to the 'flu antigens, each 0.2 mL dose contains:

- 0.188 mg/dose monosodium glutamate (MSG)

And residual amounts of:

- 2.00 mg/dose hydrolyzed porcine gelatin ovalbumin (< 0.24 mcg/dose)
- 2.42 mg/dose arginine gentamicin sulfate (< 0.015 mcg/mL)
- 13.68 mg/dose sucrose (sugar) ethylenediaminetetraacetic acid (EDTA) (< 0.37 mcg/dose)
- 2.26 mg/dose dibasic potassium phosphate FluMist Quadrivalent contains no preservatives
- 0.96 mg/dose monobasic potassium phosphate

HOW MANY ANIMALS/ ANIMAL PARTS ARE INVOLVED WITH PRODUCTION OF OR IN THE VACCINE?[16]

Chicken embryo kidney cells (CEKS) SPF (Specific Pathogen Free) Hen's eggs, African green monkey (vervet) kidney cells (VERO), Porcine trypsins, Newborn calf serum. It is tested on ferrets, rats, mice, rabbits (eyes), hamsters, guinea pigs, 21 animal species, not specified, it did not replicate in any bird species (not specified).

TESTING THE VACCINE ON HUMANS

Please read the EMA Assessment report Fluenz Tetra 19 September 2013 EMA/586629/2013.[17] The original trials on efficacy (if it works) were performed on children without high-risk medical conditions. [18]

NASAL MUCOSAL VACCINES AND VAGINAL SECRETIONS

Animal experiments have shown that intranasal immunization induces a specific antibody response in the genital tract, although the mechanisms behind the immunologic connection between such anatomically and functionally remote organs are unknown.[19, 20] I have not found any evidence that this effect of the vaccine has been tested in the pre- and post- marketing trials, nor in any subsequent clinical use of this vaccine.

BIODISTRIBUTION

A biodistribution study of intranasally

administered radiolabelled placebo was conducted in 7 healthy adult volunteers. The mean percentages of the delivered doses detected were as follows: nasal cavity 89.7%, stomach 2.6%, brain 2.4%, and lung 0.4%. The clinical significance of these findings is unknown. [21] (it does not say whether vaginal swabs were taken or examined)

WHO SHOULD NOT HAVE FLUENZ/FLUMIST?

Contraindications: Children and adolescents with hypersensitivity to the active substances or to any of the excipients e.g. gelatin, gentamicin, eggs or egg proteins e.g. ovalbumin. Children and adolescents with clinical immunodeficiency due to conditions or immunosuppressive therapy such as: acute and chronic leukaemias; lymphoma; symptomatic HIV infection; cellular immune deficiencies; and high-dose corticosteroids. Fluenz Tetra is not contraindicated for use in individuals with asymptomatic HIV infection; or individuals who are receiving topical/inhaled corticosteroids or low-dose systemic corticosteroids or those receiving corticosteroids as replacement therapy, e.g. for adrenal insufficiency. [22] Precautions include those who are currently taking oral steroids or who have been prescribed oral steroids in the last 14 days for respiratory disease. There is limited safety data on children who are currently taking a high dose of an inhaled steroid – Budesonide >800 mcg/day or equivalent (eg Fluticasone >500 mcg/day) so such children should only be given Fluenz/Flumist on the advice of their specialist. As these children are a defined risk group for flu, those who cannot receive Fluenz/Flumist should receive an inactivated flu vaccine.[23]

The USA Patient information sheet states: Children younger than 5 years of age with recurrent wheezing and persons of any age with asthma may be at increased risk of wheezing following the administration of FluMist Quadrivalent. If Guillain-Barré syndrome has occurred within 6 weeks of any prior influenza vaccination, the decision to give FluMist Quadrivalent should be based on careful consideration of the potential benefits and risks. FluMist Quadrivalent has not been studied in immunocompromised persons.[24] In 2003 the USA Advisory Committee in Immunization Practices contraindicated FluMist in pregnant women. [25]

Many animal parts are involved with production of or in Vaccines

SHEDDING OF LIVE ATTENUATED INFLUENZA VACCINE (LAIV) FLUMIST/ FLUENZ

In animal studies, LAIV viruses replicate in the mucosa of the nasopharynx, inducing protective immunity against viruses included in the vaccine, but replicate inefficiently in the lower airways or lung. Cold-adapted means that viruses should only be able to replicate at cooler temperatures in the nasal mucosa. Temperature sensitive means that they should be unable to replicate at warmer temperatures of the lower airways and lungs and attenuated means that they should not be able to cause 'flu. The cumulative effect of these properties should be that the viral strains induce protective immunity without causing disease.[26]

Public Health England, 'The National Childhood Flu Immunisation Programme 2016/17 Information for healthcare practitioners' states that the vaccine has a good safety record and unvaccinated contacts are not at risk of becoming seriously ill with the 'flu vaccine virus, either through being in the same room where 'flu vaccine has been given or by being in contact with a recently vaccinated individual. They do not define 'serious'.

They say that excluding children from school during the period when LAIV is being offered or in the following weeks is therefore not considered necessary. The only exception to this would be the tiny number of children who are extremely immunocompromised (for example those who have just had a bone marrow transplant). They say that although vaccinated children are known to shed virus for a few days after vaccination, it is less able to spread from person to person than the natural infection. This is in contrast to natural flu infection, which spreads easily during the flu season.

However, their main rationale for non exclusion appears to be their statement that in schools using vaccine, as 'everyone' is being vaccinated, although there will be shedding, 'everyone' will therefore be 'protected', so the risk of transmission is small.[27] However, if your child has not been vaccinated, this will not necessarily be the case. I would definitely not send my child in to school on the day of a mass vaccination campaign for reasons outlined in 'consent' above.

Does it matter if my child comes into contact with children who are shedding the vaccine? Please see What defence mechanisms do we have against 'flu (and other) viruses? Earlier in the text. Your child will not be having the concentrated targeted dose that the recipients of the vaccine will get and should be well able to cope with meeting it via the normal routes.

DOES THE VACCINE WORK?

The live nasal vaccine induces significantly higher local IgA antibodies in nasal washings and local cell-mediated immunity than injected dead vaccine but not such high serum antibody titres. Despite these differences in immune responses, the two types of vaccine had comparable protective efficacy (60–90%). Live attenuated influenza vaccine (LAIV) was licensed for use in children and adults in the USA in 2003. In 2008 annual influenza immunization was recommended for children aged 5–18 years by the Advisory Committee on Immunization Practices (ACIP), then since February 2010 for everyone ages 6 months and older.[28] In 2016, in a sudden and surprising reversal of current policy, the USA ACIP rejected use of Flumist/Fluenz for the 2016-17 'flu season, stating that it had been ineffective (only about 3% effective) in the 2015-16 'flu season.

That this might occur with the live mucosal 'flu vaccine was predicted back in 2005 by Dr Jan Holmgren, Professor of Medical Microbiology and Immunology at University of Göteborg, Sweden and Dr Cecil Czerkinsky Research Director at INSERM [29]. They said "It remains to be seen to what extent the safety and efficacy profiles established in animal models hold true in genetically diverse human subjects who also may differ significantly in their intestinal flora, nutritional status and previous immunological experience, all of which are factors that have been found to affect mucosal vaccine efficacy." In 2009, Dr Angie Eick-Costa of the US Armed Forces Health Surveillance Center in Maryland sounded a note of caution. Her analysis showed that the live nasal vaccine was more effective in army recruits, many of whom had never been vaccinated against 'flu, than in non recruits, many of whom had been previously vaccinated. She postulated that it might work best in those who had never had a 'flu vaccine before (vaccine naive).

Researchers in Ireland in 2001 pointed out that oral or nasal vaccine delivery eliminates the requirement for needles and can induce immunity at the site of infection, but... "protein antigens are poorly immunogenic when so delivered and can induce tolerance" (ie no immune response to an antigen),[30] as did Drs Vajdy in the USA [31] and Mann and team in the UK [32] This is because tolerance represents the most common and important response of the host to environmental antigens, including food and commensal bacterial components, for the maintenance of an appropriate immunological homeostasis, [33] otherwise we would all be allergic to everything!

"It remains to be seen to what extent the safety and efficacy profiles established in animal models hold true in genetically diverse human subjects who also may differ significantly in their intestinal flora, nutritional status and previous immunological experience, all of which are factors that have been found to affect mucosal vaccine efficacy.."

Public Health England, however, is refusing to change its recommendations and is doggedly pursuing a policy of vaccinating all of the nation's school children with the live AstraZenecaUK nasal vaccine whether it works or not.

'Insanity: doing the same thing over and over again and expecting different results.' (Anon)

MBBS DRCOG DFFP DCH MRCGP MFHom
27 November 2016

REFERENCES:

1 Immunisation Against Infectious Diseases, HMSO London 1992 p5 3.1 (v); 1996 p7 3.5. Immunisation Against Infectious Diseases, HMSO London 1996 can be downloaded at http://webarchive.nationalarchives.gov.uk/20080910134953/http:/dh.gov.uk/en/publichealth/healthprotection/immunisation/greenbook/dh_4097254

2 Immunisation Against Infectious Diseases, HMSO London 2006 http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_113539.pdf

3 Immunisation Against Infectious Diseases, HMSO London 2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/144250/Green-Book-Chapter-2- Consent-PDF-77K.pdf

*4 {2013} EWHC 2683 (Fam)*http://www.bailii.org/ew/cases/EWHC/Fam/2013/2683.html

5 Op cit (4)

6 See free A4 download Dr J Donegan: 'General Measures for Nursing Children' & ebook 'Nursing Children Supportively through Acute Illness http://www.jayne-donegan.co.uk/articles

7 McCullers JA Insights into the interaction between influenza virus and pneumococcus. Clin Microbiol Rev. 2006 Jul;19(3):571-8 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1539103/pdf/0058-05.pdf

8 Grohskopf, LA, Sokolow LZ, Karen R. Broder, KR et al , Prevention and Control of Seasonal Influenza with Vaccines 2016-17 Influenza Season Prevention and Control of Seasonal Influenza with Vaccines Recommendations of the Advisory Committee on Immunization Practices - United States, 2016–17 Influenza Season MMWR Recommendations and Reports / August 26, 2016 / 65(5);1–54 MMWR Recommendations and Reports / August 26, 2016 / 65(5);1–54 http://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6505.pdf

9 Zaman M1, Chandrudu S, Toth I, Strategies for intranasal delivery of vaccines. Drug Deliv Transl Res. 2013 Feb;3(1):100-9. doi: 10.1007/s13346-012-0085-z. Epub 2012 Jul 12 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3539070/pdf/13346_2012_Article_85.pdf

10 Yoshida SH, Gershwin ME. Immunity, infection, and nasal disease. Clin Rev Allergy Immunol. 1998 Spring- Summer;16(1-2):3-24. Review.

11 Holmgren J, Svennerholm AM Vaccines against mucosal infections. Curr Opin Immunol. 2012 Jun;24(3):343-53 http://www.nature.com/nm/journal/v11/n4s/pdf/nm1213.pdf

12 Vajdy M1, Srivastava I, Polo J, Donnelly J,

Nasal Flu vaccine being administered

O'Hagan D, Singh M. Mucosal adjuvants and delivery systems for protein-, DNA- and RNA-based vaccines. Immunol Cell Biol. 2004 Dec;82(6):617-27
http://www.nature.com/icb/journal/v82/n6/pdf/icb200491a.pdf
13 Holmgren J, Czerkinsky C Mucosal immunity and vaccines. Nat Med. 2005 Apr;11(4 Suppl):S45-53
http://www.nature.com/nm/journal/v11/n4s/pdf/nm1213.pdf
14 Medimmune Astra Zeneca FluMist Quadrivalent Myth vs. Fact
https://www.flumistquadrivalent.com/consumer/resources/myths-vs-facts.html *15 Prescribing Information FluMistQuadrivalent 2016*
http://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM294307.pdf
16 Committee for Medicinal Products for Human Use (CHMP) EMA Assessment report Fluenz Tetra 19 September 2013 EMA/586629/2013
http://www.ema.europa.eu/docs/en_GB/document_library/EPAR_-_Public_assessment_report/human/002617/WC500158413.pdf
17 Committee for Medicinal Products for Human Use (CHMP) EMA Assessment report Fluenz Tetra 19 September 2013 EMA/586629/2013
http://www.ema.europa.eu/docs/en_GB/document_library/EPAR_-_Public_assessment_report/human/002617/WC500158413.pdf
18 Medimmune Astra Zeneca FluMist Quadrivalent Myth vs. Fact
https://www.flumistquadrivalent.com/consumer/resources/myths-vs-facts.html
19 Bergquist C1, Johansson EL, Lagergård T, Holmgren J, Rudin A, Intranasal vaccination of humans with recombinant cholera toxin B subunit induces systemic and local antibody responses in the upper respiratory tract and the vagina. Infect Immun. 1997 Jul;65(7):2676-8
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC175378/pdf/652676.pdf
20 Johansson, E-L, Wassén, l, Holmgren, J et al, Nasal and Vaginal Vaccinations Have Differential Effects on Antibody Responses in Vaginal and Cervical Secretions in Humans Infect Immun. 2001 Dec; 69(12): 7481–7486
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC98837/pdf/ii1201007481.pdf *21 Prescribing Information FluMistQuadrivalent 2016*
http://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM294307.pdf
22 Electronic Medicines Compendium Summary of Product Characteristics FluenzTetra
https://www.medicines.org.uk/emc/medicine/29112
23 Public Health England, The National Childhood Flu Immunisation Programme 2016/17 Information for healthcare practitioners © Crown copyright 2016
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/551676/Childhood_flu_programme_information_for_healthcare_practitioners.pdf
24 Prescribing Information FluMistQuadrivalent 2016
http://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM294307.pdf
25 Scott A. Harper, M.D.1 Keiji Fukuda, M.D. Nancy J. Cox, Ph.D. Carolyn B. Bridges, M.D Supplemental Recommendations of the Advisory Committee on Immunization Practices (ACIP) MMWR September 26, 2003 / 52(RR13);1-8
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5213a1.htm
26 Questions and Answers for Health Care Providers Revised October 2016, Manitoba Health, Seniors and Active Living Communicable Disease Control Seasonal Influenza Program updated 2016
https://www.gov.mb.ca/health/flu/docs/flumist_hcp.pdf
27 Public Health England, The National Childhood Flu Immunisation Programme 2016/17 Information for healthcare practitioners © Crown copyright 2016
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/551676/Childhood_flu_programme_information_for_healthcare_practitioners.pdf
28 ACIP votes down use of LAIV for 2016-2017 flu season, Centres for Disease Control 2016
http://www.cdc.gov/media/releases/2016/s0622-laiv-flu.html
29 Institut national de la santé et de la recherche médicale.
30 Ryan EJ, Daly LM, Mills KH. Immunomodulators and delivery systems for vaccination by mucosal routes. Trends Biotechnol.2001Aug;19(8):293-304
https://www.ncbi.nlm.nih.gov/pubmed/11451471
31 Vajdy M Generation and maintenance of mucosal memory B cell responses? Curr Med Chem. 2006;13(25):3023-37
https://www.ncbi.nlm.nih.gov/pubmed/17073644
32 Mann JF1, Acevedo R, Campo JD, Pérez O, Ferro VA. Delivery systems: a vaccine strategy for overcoming mucosal tolerance? Expert Rev Vaccines. 2009 Jan;8(1):103-12. Doi: 10.1586/14760584.8.1.103
https://www.ncbi.nlm.nih.gov/pubmed/19093777
33 Fujihashi K1, Kato H, van Ginkel FW, Koga T, Boyaka PN, Jackson RJ, Kato R, Hagiwara Y, Etani Y, Goma I, Fujihashi K, Kiyono H, McGhee JR, A revisit of mucosal IgA immunity and oral tolerance. Acta Odontol Scand. 2001 Oct;59(5):301-8
https://www.ncbi.nlm.nih.gov/pubmed/11680650

MEDICINES & HEALTHCARE PRODUCTS REGULATORY AGENCY – NEEDS REGULATING!

Model Leah Wood is campaigning for a radical shake-up of the health system to reduce the influence of giant pharmaceutical companies. Leah, daughter of Rolling Stones guitarist Ronnie Wood, believes the public has become too dependent on medication prescribed by doctors.

"People need knowledge to judge for themselves what is out there rather than getting prescribed pills for everything," says the 38-year-old mother of two, who is an organic lifestyle advocate.

"Pharmaceutical companies have too much power and we have become used to medication instead of seeing what else is out there."

Leah is backing a petition launched by the pressure group, the National Health Federation, to restructure the MHRA, claiming it is a 'puppet' of the pharmaceutical industry. The call comes in the week the influential Academy of Medical Royal Colleges warned that doctors were giving too many patient test and drugs they don't need while the British Medical Association called for a dedicated NHS helpline and website where people hooked on prescription drugs can get advice.

"There should be more choice available and we should be able to use alternative ways of healing ourselves providing they are safe," adds Leah. "People should have the freedom to try other avenues when they are ill.

"It is clear that some of these medicines are not vital and we don't need our bodies clogged up with chemicals. But the big pharmaceutical companies have too much influence and other remedies are overlooked or banned. I am really concerned that there is a level playing field so everything can be considered."

Leah's grandmother Rachel Karslake was diagnosed with breast cancer but used an organic lifestyle to combat the condition. Her mum Jo, an organic pioneer who split from the Rolling Stone seven years ago, revitalized her diet by preparing fresh organic food.

"The doctors gave Nan all these treatments and made her do chemotherapy but she wasn't getting any better so she decided to take matters into her own hands. She took homeopathic treatments and supplements and my mum and Auntie prepared organic food for her," says Leah, a fashion model and artist. "We are convinced it helped her. Leah, who lives in north London with her financier husband Jack McDonald and children Maggie, 7 and Otis, 4, adds that the government should also provide more health and dietary information for the public.

"Not enough people know what is inside their food or even if they need the medicines prescribed by doctors," she says. "We need to look after ourselves as much as possible to prevent illness not to rely on doctors once we get ill.

"It is time there was more knowledge out there and for the public to take a bigger interest in their own health"

Leah believes in maintaining a healthy lifestyle and not relying on conventional medicines if healthier alternatives are available. "I was brought up with alternative medicines and homeopathy and have been taught the importance of eating well. You are what you eat. I try and stay healthy. I go to the gym, run and take vitamins. You can often heal yourself through diet and lifestyle and I think it is important not to overmedicate.

'I use homeopathy and alternative remedies a lot with my kids. There are so many alternatives but people do not realise they are available because the pharmaceutical message is so strong."

She is urging the public to sign a petition to reform the MHRA and promote alternative therapies.

Join Leah in support Reform MHRA by signing the petition:
https://petition.parliament.uk/petitions/172576

Follow ReformMHRA
https://twitter.com/ReformMHRA
https://www.facebook.com/MHRAremodel/

Forthcoming Lectures by Dr Jayne Donegan

VACCINATION – THE QUESTION

Is there a question? Isn't it scientifically proved that vaccination is the single most effective cause of improved health in the 20th and 21st Century?

29 January 2017, Sunday afternoon, 1.45 for 2-4pm, North West London NW4. For further information and to book tickets please email jaynelmdonegan@yahoo.com with your post code, contact telephone number and number of tickets required. Tickets cost £11 (£10 per person for couples) and must be booked in advance. Nearest tube: Hendon Central

NURSING CHILDREN SUPPORTIVELY THROUGH ACUTE ILLNESS: FEVER MANAGEMENT

What do you do if you don't vaccinate (and even more so if you do)?

26 February 2017 Sunday afternoon, 1.45 for 2-4pm, North West London NW4. For further information and to book tickets please email jaynelmdonegan@yahoo.com with your post code, contact telephone number and number of tickets required. Tickets cost £11 (£10 per person for couples) and must be booked in advance. Nearest tube station: Hendon Central

See website for further info: http://www.jayne-donegan.co.uk/lecturesworkshops

INCREASED ORGANIC MERCURY EXPOSURE FROM THIMEROSAL-CONTAINING HEPATITIS B VACCINES COULD LEAD TO AN INCREASED RISK OF OBESITY DIAGNOSIS

N AM J MED SCI. 2016 JUL; 8(7):
297=306.
PMID: 27583238
AUTHORS: GEIER D A, KERN J K, HOMME K G ET AL

ABSTRACT:
BACKGROUND: Obesity among children and adolescents in the United States has tripled since 1980, and has become a major public health concern.
AIMS: The purpose of this study was to evaluate the potential relationship between exposure to organic mercury from Thimerosal-containing hepatitis B vaccines and the children's subsequent risk of an obesity diagnosis.
MATERIALS AND METHODS: A hypothesis-testing, case-control study was undertaken to evaluate exposure to organic mercury from Thimerosal-containing hepatitis B vaccines, which were administered at specific intervals in the first 6 months of life, among cases diagnosed with childhood obesity and controls by examining automated medical records for children born from 1991 to 2000 who were continuously enrolled in the Vaccine Safety Datalink database.
RESULTS: This study found highly significant associations as follows. Cases diagnosed with obesity were significantly (P<0.00001) more likely to have received greater exposure to organic mercury from Thimerosal-containing hepatitis B vaccines administered within the first month of life (odds ratio (OR) =1.511), first 2 months of life (OR = 1.486), and first 6 months of life (OR = 3.795) than the controls. Similar outcomes were observed when the overall data were separated by gender. In a dose-response manner, cases diagnosed with obesity were significantly more likely than controls to have received greater exposure to organic mercury from Thimerosal-containing hepatitis B vaccines, which were administered within the first 6 months of life (OR = 1.0375 per g of mercury, P<0.00001).
CONCLUSIONS: In a dose-response manner, the present study associates an increased organic mercury exposure from Thimerosal-containing hepatitis B vaccines with an increased risk of obesity diagnosis, and suggests that Thimerosal is an obesogen. The results are biologically plausible and future studies are needed to examine this phenomenon.

Yellow fever Vaccine may be linked to neurological problems via a molecular mimicry mechanism

FRONT. NEUROL. 2016;7:130
EPUB 2016 AUG 10
PMID 27559330
AUTHORS: R E ROSCH, M FARQUHAR, P GRINGRAS, D K PAL

ABSTRACT:
Narcolepsy with cataplexy is a rare, but important differential diagnosis for daytime sleepiness and atonic paroxysms in an adolescent. A recent increase in incidence in the pediatric age group probably linked to the use of the Pandemrix influenza vaccine in 2009, has increased awareness that different environmental factors can "trigger" narcolepsy with cataplexy in a genetically susceptible population. Here, we describe the case of a 13-year-old boy with narcolepsy following yellow fever vaccination. He carries the HLA DQB1*0602 haplotype strongly associated with narcolepsy and cataplexy. Polysomnography showed rapid sleep onset with rapid eye movement (REM) latency of 47 min, significant sleep fragmentation and a mean sleep latency of 1.6 min with sleep onset REM in four out of four nap periods. Together with the clinical history, these findings are diagnostic of narcolepsy type 1. The envelope protein E of the yellow fever vaccine strain 17D has significant amino acid sequence overlap with both hypocretin and the hypocretin receptor 2 receptors in protein regions that are predicted to act as epitopes for antibody production. These findings raise the question whether the yellow fever vaccine strain may, through a potential molecular mimicry mechanism, be another infectious trigger for this neuro-immunological disorder.

Vaccinations and secondary immune thrombocytopenia with antiphospholipid antibodies by human papillomavirus vaccine

SEMIN. HEMATOL. 2016 APRIL;
PMID 27312165
AUTHORS: BIZJAK M, BRUCK O ET AL

ABSTRACT
A 13-year-old girl developed immune thrombocytopenic purpura (ITP) and concomitant positive antiphospholipid antibodies (aPL) following vaccination with a quadrivalent human papillomavirus (HPV) vaccine. During the course of a disease, she developed clinical manifestation with bleeding and she was treated with intravenous immunoglobulins. Consequently, the number of her platelets remained critically low and she was put on corticosteroids and rituximab. Since then, her platelet count remain within the normal range, but her aPL are still present.

AIMS & OBJECTIVES OF THE *informed* PARENT GROUP

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

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

The views expressed in this newsletter are not necessarily those of The Informed Parent Co. Ltd.
We are simply bringing these various viewpoints to your attention. We neither recommend nor advise against vaccination. This organisation is non-profit making.

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