32 INFORMATIVE YEARS
THE informed PARENT
ISSUE TWO 2024 A NEWSLETTER ON VACCINATION ISSUES AND HEALTH

DR. YEADON: I'M FORMALLY CONFIDENT THAT ACUTE RESPIRATORY ILLNESSES THAT WE CALL COLDS AND FLU ARE NOT CAUSED BY SUBMICROSCOPIC INFECTIOUS PARTICLES CALLED VIRUSES & ARE NOT CONTAGIOUS

BY DR MIKE YEADON AND PUBLISHED ON THE LIONESS OF JUDAH SUBSTACK.
25 April 2024
https://tinyurl.com/2s3d55j9

OVERVIEW & EXTRACTS BY MAGDALENE TAYLOR

Mike Yeadon states: *'For a number of other diseases which are attributed to viruses, such as "HIV/AIDS" & "Polio", I've followed the trail of evidence far enough to also state that there is no evidence that they're caused by such viruses. On the contrary, and like "Covid-19", they are more correctly termed syndromes (since the claimed symptoms vary to an extraordinary extent) and are misattributions of a collection of other illnesses. In each case, people really are ill. It's just that the diagnosis is wrong and not viral, either. I've read of the failures ever to meet reasonable isolation expectations for any virus.'*

Mike continues pointing out that from his non-professional position he thinks virology is fraudulent. From his professional position that he has not *'done enough personal, detailed research to be sure that viruses don't exist, though I suspect that it's true.'*

Mike states that he now holds the opinion *'that global pandemics of severe illnesses are impossible. There haven't been any pandemics. The most famous example, Spanish Flu Pandemic, is a mixture of exaggeration and probable, deliberate poisoning. In recent years, they're "PCR false positive pseudo epidemics", a well-established, real thing, in which 100% of the claimed positive test results are false.'*


Dr Mike Yeadon

> *"Interestingly, one person, years ago, confessed to me that they didn't want to believe what I was telling them, because it was simply too frightening. It's possible that psychological protection mechanisms prevents some of us from accepting new information."*

He dismisses that there is any risk of emerging pandemics regarding it as an obvious lie, and finds it strange that other academics are not interested in looking into it when he attempts to share his findings.

The article continues: *'Interestingly, one person, years ago, confessed to me that they didn't want to believe what I was telling them, because it was simply too frightening. It's possible that psychological protection mechanisms prevents some of us from accepting new information.'*

In the rest of Mike's article, he tries to understand why it seems impossible to 'persuade' or 'convince' others that we're being lied to and *'that the pandemic is a long-planned fraud.'* But does not presently think that all we need to do is expose the virus lie and the battle will be over.

The article ends:

'For avoidance of doubt, both PCR based diagnostics, and tests for what are claimed to be antibodies to certain infectious disease-causing agents, and vaccines (without reservation) are all fraudulent. The underlying illnesses are real, which is why the lies are so effective.

Best wishes, Mike'

TiP Editor: *Very pleased to read that Mike has continued to investigate the virus story unlike others in the 'truth' movement. However, in his article on the same substack, 25 Nov 2023 entitled:* ***Dr. Mike Yeadon: "I'm Being Censored by What I Thought Was Our Own Side"*** *Mike writes about how a very well received presentation he gave, arranged by the party of MEP Christine Anderson – the AfD (Alternative for Germany) was not included in the link to the session. He wrote:*

'I learned yesterday that dissenting voices in AfD had decided my opinions were too extreme and they've excised my presentation from the link to the session, which I understand has now been made public. It's very depressing and frustrating to find I'm being censored by what I thought was our own side.'

It appears that some of the members within this political party are not so 'alternative'? Sadly, political parties do get infiltrated and wrongly influenced and directed away from the basic truths.


Magda Taylor

Editor's note

The last few months have disappointingly been extremely quiet in terms of new subscribers and renewals which has led me to make the decision to halt the paper edition of the newsletter.
I have also discontinued the landline to economise so please email me if you wish to get in touch. My email is now: magdalene@informedparent.co.uk *And just a reminder that there is NO LONGER a Post Box address, letters sent there will not reach me.*

I realise that some of you paid an extra five pounds for the paper editions and obviously if you require a refund then please get in touch. Rather than a refund I am happy to extend your subscription period for an extra 3 months instead of a refund, if that is acceptable to those concerned? Again, please get in touch to discuss further. To reinstate paper option (UK subscribers only) the number of subscribers would need to increase and the annual fee would need to increase from £25 to £30. Feedback welcome. I will try and continue with the newsletter, however if the number of subscribers continue to decline then I will have to reconsider its future. I still have a stock of recent editions (2021-2023) and have made them available at a much lower price.

Also, half price copies of 'Health The Only Immunity' booklets and half price copies of the DVD 'We Don't Vaccinate' are available while stocks last. Please go to SHOP if you are interested in further copies to pass on to interested friends and family. Or perhaps you would like a number of copies for your clinic waiting room? Let me know by email please.

Some of you have been subscribing for more than 3 decades and I expect, like me, have learnt much by navigating through a broad range of data over the years. As you may have noticed during the last few years in particular, I have included more and more articles on the questioning of germ theory, virus, contagion etc as ultimately these foundational theories (unproven) are what the whole concept of vaccination rest upon.

Most people who start to research the subject usually begin with concerns surrounding possible side effects from the vaccines. And yet in essence the most important aspect is 'do germs cause disease?' If not, then there is absolutely no need for any vaccines at all. New parents may start by asking, for example, as to whether some vaccines are safer than others.

Whilst it is true that over the years the authorities have acknowledged that the toxicity of vaccines, even different batches of the same vaccine can vary, the main, most important question still remains, 'Do germs cause disease?' Although I had read 'Pasteur Exposed' by Hume in the early nineteen nineties and realised back then that the established view of disease and what it represents had been completely hijacked for a very long time, it was still hard to let go of the germ narrative after years of indoctrination. Most of us have been taught to view symptoms as a result of the body going wrong, mainly due to being attacked by some kind of germ.

So, when you start to uncover the fraud of germ theory, it is still hard to drop all the concepts of the disease narrative coming from modern pharmaceutical medicine.

Due to the covid story many of us have deepened our knowledge and understanding as to realising the invalidity of virology and the nonsensical methodology that is executed in the name of science which ultimately does not prove any pathogenic, contagious entity called a virus.

If you are a new parent or new to this subject I strongly urge you to head straight for the theories behind vaccination and avoid being side-tracked into looking at 'vaccine safety and efficacy', or what the ingredients are, and so on.

The other very important area to study is what is health? Do we actually have an immune system? Why do we refer to it as an immune system….immune from what, if germs are not the cause of symptoms? Whenever I see the terms immune or immunity I transpose the word health in its place. Also realise that the body is always trying re-correct itself given the chance and return to full health. This may mean a purge, that the body is always trying to re-correct itself, a detox, a rash, vomiting, diarrhea, mucosal discharge, which may mean being uncomfortable, incapacitated, in pain for a short period. However, if the rubbish (the toxicity) is allowed to externalise without interference the outcome will be a much healthier body. Supporting the body through that process of detoxification is in my opinion the best method to regaining health.

I mentioned a new book in the last edition of this newsletter entitled The Final Pandemic by Drs Mark and Sam Bailey. This is a very good place to start in realising that the world population have been misled through unproven scientific assumptions and misconceptions which have been handed down and elaborated on since the time of Pasteur. It is a very informative read, relatively easy to understand, and in my opinion, an ideal place to begin if you are just embarking on the subject.

I have included a few extracts from the epilogue of The Final Pandemic on pages 10 and 16 to give you an example of the content.

As to the latest story – the declaration by the WHO that there is a monkey pox pandemic - my hope is that this will spark off more people to look into the subject in general and increase the scepticism about vaccination which has been growing in recent years!

Magdalene Taylor, Editor, September 2024.

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STATE COVID-19 VACCINE MANDATES AND UPTAKE AMONG HEALTH CARE WORKERS IN THE US

YIN WANG, MA; CHARLES STOECKER, PHD; KEVIN CALLISON, PHD; JULIE H. HERNANDEZ, PHD

14 August 2024
JAMA Network Open.
2024;7(8):e2426847. doi:10.1001/jamanetworkopen.2024.26847

BRIEF EXTRACTS FOLLOWED BY COMMENTARY BY MAGDALENE TAYLOR

OBJECTIVE

To examine the association between state COVID-19 vaccine mandates for HCWs and vaccine uptake in this population.

CONCLUSIONS AND RELEVANCE

This repeated cross-sectional study found that state COVID-19 vaccine mandates for HCWs were associated with increased vaccine uptake among HCWs, especially among younger HCWs and those in states with no test-out option. These findings suggest the potential for vaccine mandates to further promote vaccinations in an already highly vaccinated HCW population, especially when no test-out option is in place.

Pic credit: Wall Street Journal

TiP Editor: These type of studies are not interested in the health and well-being of all the HCW post Covid jabs. The priority is looking at how successful the mandating of these vaccines on HCWs increases uptake amongst that profession. I noticed how incorrect the opening line of the Introduction text is (for those health professionals who even bother to read these published papers). It is no wonder that there are still many medical and scientific professionals 'believing' in the so-called wonders of vaccination. And the reference given for that statement is certainly not published scientific proof but from a book by an historian. How is that acceptable when all the historic books and texts written by critics of vaccination (often doctors and scientists) are dismissed by the present 'experts and academics' as only books not proper science?

The opening line reads:

'Introduction

Since their debut in 1796, vaccines have played a pivotal role in controlling lethal epidemics, such as smallpox, cholera, and bubonic plague.' (1)

(Reference, 1. Foreign Bodies: Pandemics, Vaccines and the Health of Nations by Simon Schama; 2023.)

This is a fine example of disinformation! Controlling lethal epidemics?? My conclusion, after investigating the history of vaccination for over 3 decades, would be quite the opposite. I personally now view this procedure as pivotal in slowing the decline in smallpox symptoms and increasing chronic and debilitating disease symptoms both physically and/or mentally for the vaccine recipients. Additionally, in more recent years, vaccination has played a pivotal role in controlling populations through fear of germs and so-called diseases to justify bringing in mandates, restrictions, lock downs etc. I strongly urge you to read up on the background history of vaccination. A good starting point would be the literature on the Archive section of the Informed Parent website. Downloads are free. https://informedparent.co.uk/archive-literaturebooks-3/

As for claiming bubonic plague was controlled by vaccines it will not take you more than a few minutes to check the accuracy of this statement. Type in bubonic plague vaccine into your search engine.

This is what immediately came up for me:

'…Called the Black Death, it killed millions of Europeans during the Middle Ages. Prevention doesn't include a vaccine….'

And also:

'Was there a vaccine for bubonic plague?

Pestis is one of the most virulent human pathogens, and to this date there are no licensed plague vaccines available.'

As for cholera symptomology - it is quite obviously an environmental issue caused by a breakdown of the environment and living conditions, especially experienced during wars or natural disasters. Raw sewage spilling into the locality, no clean water etc. will obviously affect those populations living in those areas. Clearly, if you simply inject that population with a cholera vaccine but don't clean up the mess and address creating a clean water supply then people will continue to get sick.

When I googled cholera, one of the questions that came up, along with the answer, was:

'What is the problem with cholera vaccines?

Cholera vaccine is not 100% effective against cholera and does not

protect from other foodborne or waterborne diseases. Cholera vaccine is not a substitute for being careful about what you eat or drink.'

Personally, I think they should have put 'other foodborne or waterborne poisons' as they are the cause. In the book Vaccines by Plotkin & Mortimer, Second Edition the following makes interesting reading as they are admitting that other measures taken are more effective! No surprise to those of us who use our common sense – it's crystal clear, and these so-called experts are really just stating the obvious!

It reads (p636):

'Resources were not available in areas that are endemic for cholera and, if mobilized, would have distracted resources from other more effective interventions.

Other factors were also important. For example, the risk of cholera declined substantially for the expatriates and upper class residing in cholera-endemic areas. This decline was due to the improvement in water and quality associated with the boiling and chlorination of water and the more hygienic preparation of food. Similarly, the risk of cholera among soldiers also decreased because of improved standards for water and food in military settings. Thus, cholera vaccine was no longer needed by groups of persons who obviously had felt a strong desire for the vaccine and had the economic capability to pay for it. Use of the vaccine had been strongly encouraged by the requirements for vaccination of international travellers in an attempt to prevent the spread of the organism between countries. When it was appreciated that the vaccine did not prevent carriage of the vibrio, these requirements became inappropriate and harmful by placing unnecessary restrictions on travel. Most important were analyses of the available field trials, which demonstrated that whole cell parenteral vaccine was not cost-effective in cholera control programs. The poor cost-effectiveness was related to the cost and difficulty of requiring injections every 6 months, the poor acceptability of **the relatively reactogenic vaccine,** the potential dangers from spread of needle-borne diseases, the vaccine's failure to prevent spread of the vibrio, and finally the distraction from other potentially more cost-effective interventions.

Furthermore, other methods were found to be more useful in managing cholera epidemics than parenteral vaccination, for example, provision of safe food and water and effective case management of cholera cases as they occur. Also important was the development of effective rehydration fluid therapy, using standardized intravenous and oral solutions, that lowered case-fatality rates to less than 1%, making cholera much less feared that it had been previously.'

'Needle-borne diseases' I think the correct term should be needle-caused diseases! The only way you would observe a 'spread' of cholera to other countries is if other countries have the same conditions. The only transmission occurring is the contaminated food and/or water being taken in by an individual. If lots of people ingest these contaminated foods and drinks then clearly there will be large numbers suffering from different degrees of diarrhea and vomiting etc. depending on their different individual levels of health.

They did not pass it on to each other they simply all experienced the effects of contaminated foods/drinks. In actual fact their body's reaction is actually to try and purge the system of these toxins, and provided they can gain fresh clean water etc they are very likely to recover quickly.

WHO IS AT IT AGAIN: DECLARING FALSE EMERGENCIES WHERE THERE ARE NONE IN THE NAME OF CONTROL AND MONEY

BY JOHN BLAID
https://johnblaid.substack.com/p/who-is-at-it-again
15 August 2024

EXTRACTS

For the people who don't know the history of mpox (monkey pox). In 1958, there was an attempt to create a polio vaccine where a lab used monkeys as their test subjects. After the monkeys were exposed to this vaccine, some of the monkeys started to develop skin symptoms, and that is how mpox was born. It had nothing to do with any alleged "virus" which will be apparent later, it was simply a classic reclassification of existing symptoms into a new label. Historically, they've done this with polio, smallpox, and a myriad of different diseases for various reasons; one reason is to make a vaccine look successful in its alleged "eradication" of a disease. Another reason is to promote the production of new vaccines, I'm sure there are other reasons too.What should be understood here is that the symptoms attributed to mpox are the same symptoms that are attributed to measles, smallpox, and chickenpox.

If one looks at the history of these various diseases, it becomes very apparent that the doctors cannot determine what is what based on the visual symptoms alone since they are non-specific; it requires a test to determine what is what.

People should know that so-called "antibody" tests are non-specific and entirely meaningless regardless of whether a "virus" would exist, which there is no evidence for. A PCR cannot be used for the simple reason that it's not a diagnostic test, it's a research tool to make copies of "genetic" material, just like a Xerox machine makes copies of paper. The PCR cannot determine the origin of the targeted sequence, just like a Xerox machine cannot determine the origin of a paper. Not only that but a PCR cannot determine if you are sick, if you will become sick or if you have been sick, it's totally meaningless.

To get up to speed on the nonsense in "virology," I highly recommend you check out my education package HERE, which has lots of source material in both text and video.

MPOX VACCINE MAKER'S STOCK PRICE SOARS AFTER WHO DECLARES GLOBAL PUBLIC HEALTH EMERGENCY

BY BRENDA BALETTI, PH.D.
THE DEFENDER
August 15, 2024

EXTRACTS

Stock prices for mpox vaccine maker Bavarian Nordic surged after the World Health Organization (WHO) on Wednesday declared mpox a global public health emergency.

The company's share prices jumped 17% in early trading in Copenhagen today, Forbes reported, after climbing 12% yesterday when the WHO made its announcement. In the U.S., shares were up 33% this morning.

The WHO cited recent outbreaks in the Democratic Republic of Congo (DRC) and neighbouring nations in its declaration.

The DRC, where the outbreak is concentrated and most severe, has approved two vaccines — Japan's LC16 and Bavarian Nordic's Jynneos, which is also marketed as Imvamune and Imvanex.

"The WHO is using the monkeypox outbreak in Africa to fast-track, under emergency use, two monkeypox vaccines," Dr. Kat Lindley, a senior fellow at FLCCC Family Medicine and president of the Global Health Project told The Defender.

This is the eighth public health emergency the WHO has declared since 2007, when it substantially revised its International Health Regulations (IHR). Critics have called the process for designating such an emergency "non-transparent and contradictory."

In July 2022, the WHO declared mpox a global emergency after reporting the disease had spread to more than 70 countries, mostly affecting gay and bisexual men. At the time, Tedros made

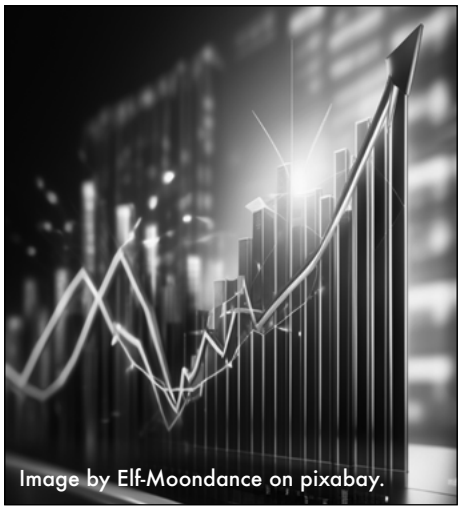


Image by Elf-Moondance on pixabay.

the declaration unilaterally, in direct contradiction to independent review panel advice.

Lindley said health officials are most likely using PCR tests, which were shown during the COVID-19 pandemic to generate false positive results.

"We really have no idea," she said, if the alleged deaths are "complications of people who have depressed immune systems and are dying of other things."

TiP Editor: For those of you who have read, for example: The Final Pandemic by Drs Sam & Mark Bailey you will be well aware that there is no proof of any pathogenic virus of any kind. Virology is an assumption based on the belief that some disease symptoms are caused by a specific virus. The methodology used by virologists actually creates what they observe and claim, and as Stefan Lanka has said numerous times….'they are deceiving themselves.'

I wonder if the focus on DRC has anything to do with the wealth of natural resources there? Giving the powers that be an opportunity to have a strong presence in those areas. Disrupting the lives of the inhabitants of an area or country, causing chaos, displacement, poverty, lack of food etc will result in many expressions of 'disease symptoms' which can then be claimed as monkeypox, in my opinion.

Here follows a couple of extracts from an article which make interesting reading. Link at end.

'DRC is home to some of the world's largest reserves of metals and rare earth minerals used to produce advanced electronics. As the world has become more reliant on cobalt, copper, zinc, and other minerals, local and external groups have become more incentivized to get involved in the Congolese conflict.'

'More than seven million people have been internally displaced due to the constant threat of violence and atrocities, as well as extreme poverty and mining expansion, especially in the North Kivu, Ituri, and South Kivu provinces.

Since the beginning of 2024, nearly 358,000 people have been displaced in DRC, 80 percent of which has been caused by armed conflict.

New UN-verified data also reveals that there has been a 30% increase in grave violations against children in eastern DRC during the first quarter of 2024 compared to the last three months of 2023. A staggering 23.4 million Congolese suffer from food insecurity, making DRC the country most affected by food insecurity in the world. The displaced population urgently needs security support, medical aid, and other humanitarian aid. Approximately 1.1 million Congolese nationals are seeking refuge beyond the Congo's borders.' (20 June 2024, Global Conflict Trigger.
https://www.cfr.org/global-conflict-tracker/conflict/violence-democratic-republic-congo .)

"THE MOST SERIOUS, EVEN FATAL, DISORDER MAY BE PROVOKED BY THE INJECTION OF LIVING ORGANISMS INTO THE BLOOD; ORGANISMS WHICH, EXISTING IN THE ORGANS PROPER TO THEM, FULFIL NECESSARY AND BENEFICIAL FUNCTIONS - CHEMICAL AND PHYSIOLOGICAL - BUT INJECTED INTO THE BLOOD, INTO A MEDIUM NOT INTENDED FOR THEM, PROVOKE REDOUBTABLE MANIFESTATIONS OF THE GRAVEST MORBID PHENOMENA....."
(LES MICROZYMAS BY BÉCHAMP). ~ **Pasteur Exposed by Ethel D Hume. p242**

POISONS by Patrick Quanten MD

Pharmacology is defined as "an experimental science which has for its purpose the study of changes brought about in living organisms by chemically acting substances (with the exception of foods), whether used for therapeutic purposes or not". Pharmacology studies the effects of drugs and how they exert their effects.

In the early 19th century a split developed between apothecaries who treated patients and those whose interest was primarily in the preparation of medicinal compounds. The latter formed the basis of the developing speciality of pharmacology. Pharmacology depends largely on experiments conducted on laboratory animals, but even the human animal may be used as a test subject. Hence, originally pharmacology had nothing to do with treating diseases. It was purely an 'academic' study of substances and their effects on living matter. Pharmacology is held to have emerged as a separate science only when the first university chair was established, which happened in 1847 in Estonia (Russia). However, the main drive into therapeutics came much later. Harry Gold, a Professor of Pharmacology at Cornell University (Ithaca, State of New York), carried out seminal work on the human pharmacology of digitalis glycosides in the late 1930s and early 1940s. An important landmark in 1941 was the publication of the first edition of Goodman and Gilman's very influential textbook The Pharmacological Basis of Therapeutics. Pharmacotherapy or drug therapy is defined as medical treatment that utilizes pharmaceutical drugs to improve ongoing symptoms, treat the underlying condition, or act as a prevention for other diseases. And a pharmaceutical is a compound manufactured for use as a medicinal drug. This means that pharmacotherapy is using man-made, foreign to the body, substances to influence the natural processes within the body.

Patrick Quanten MD

"A poison is defined as 'any substance that is harmful to your body', but they just told me that what turns a poison, a harmful substance to my body, into a medicine, a life-saving substance to my body, is the intention which lies behind the taking of the substance."

The first medicinal drugs came from natural sources and existed in the form of herbs, plants, roots, vines and fungi. Until the mid-nineteenth century nature's compounds were all that were available to relieve man's pain and suffering. The first synthetic drug, chloral hydrate, was discovered in 1869 and introduced as a sedative-hypnotic. It is still available today in some countries. The first pharmaceutical companies were spin-offs from the textiles and synthetic dye industry and owe much to the rich source of organic chemicals derived from the distillation of coal (coal-tar). The first analgesics and antipyretics, exemplified by phenacetin and acetanilide, were simple chemical derivatives of aniline and p-nitrophenol, both of which were by-products from coal-tar. An extract from the bark of the white willow tree had been used for centuries to treat various fevers and inflammation. The active principle in white willow, salicin or salicylic acid, had a bitter taste and irritated the gastric mucosa, but a simple chemical modification was much more palatable. This was acetylsalicylic acid, better known as Aspirin®, the first blockbuster drug. The natural compound, the extract from the bark, was tolerated well by the body, but the pharmaceutical approach is to break up the natural compound and only use one chemical substance from it. It then has to figure out how to administer this so the body will tolerate it. At the start of the twentieth century, the first of the barbiturate family of drugs entered the pharmacopoeia and the rest, as they say, is history. Medical drugs are derivatives, manipulations, of extracts from organisms found in nature.

The medicine cabinet opens and there, sitting on a shelf, is the incriminating object: the ominous dark bottle with the skull and crossbones on the label. Obviously, the one thing that sets the poison bottle apart from all other bottles is the need for prominent and immediate identification, it being a receptacle for toxic material. This was achieved in a number of ways, including shape, colour, embossing and labelling. Poisons were commonly found in the home for the purpose of controlling rodents and other pests, and were sold by grocers and druggists. It was considered very important to warn people about poisons and their uses. The skull and crossbones has long been a standard symbol for poison. It is a symbol consisting of a human skull and two long bones crossed together under or behind the skull. The design originated in the Late Middle Ages as a symbol of death and especially as a memento mori on tombstones. In 1829, New York State required the labelling of all containers of poisonous substances. The skull and crossbones symbol appears to have been used for that purpose since the 1850s. In the 1870s, poison manufacturers around the world began using bright cobalt bottles with a variety of raised bumps and designs (to enable easy recognition in the dark) to indicate poison, but by the 1880s the skull and cross bones had become ubiquitous, and the brightly coloured bottles lost their association.

Image by David Gallie from Pixabay

Warning: the content is poisonous.

Then we ask the question: what is the difference between a poison and a medicine? According to law, the key distinction between a medicine and poison is the intent with which it is given to a person. Therefore, if the substance is administered with the intention to save a life, it is a medicine but it acts as a poison if it is given with the intent to cause harm to the body. Wait! Wait a minute. A substance is a medicine and a poison at the same time! The law only differentiates between the two in terms of what one is trying to achieve. This immediately ensures that, in law, a medical doctor whilst practising can never poison a person. He is protected by law from such accusation as it is assumed his intention is to do good. In his hands the poisonous substance becomes a medicine.

Leaving this aside, it does tell us that the substances used in allopathic medicine, the pharmaceutical products, are all poisons. A poison is defined as 'any substance that is harmful to your body', but they just told me that what turns a poison, a harmful substance to my body, into a medicine, a life-saving substance to my body, is the intention which lies behind the taking of the substance. However, the substance is exactly the same. An obvious example of this is heroin, which in the hands of a medical practitioner becomes morphine. With this substance, it is said that a drug user is killing himself and a doctor is saving your life. Let's be clear about this now: all pharmaceuticals are poisons. Some poisons become medicines simply by believing they are improving health, rather than undermining health.

Hence, the labelling of these medicines becomes extremely important. Drug labelling is also referred to as prescription labelling. It is a written, printed or graphic matter upon any drug or on its container, or accompanying such a drug. Drug labels seek to identify drug contents and to state specific instructions or warnings for administration, storage and disposal. Since 1800s, legislation has been advocated to stipulate the formats of

drug labelling due to the demand for an equitable trading platform, the need of identification of toxins and the awareness of public health. Indeed, as we have seen, warning the public of the poisonous content of a bottle was a primary concern.

In the UK, the Poisons and Pharmacy Act of 1908 stated that the vessel, wrapper, or cover containing them has to bear a label distinctly stating the name of the article as well as the word 'Poison'. The Pharmacy and Medicines Act of 1941 required the nature and amount of all active ingredients (but not all ingredients) to be displayed on the label of a medicine. Instead of the label displaying a message that would be easily understood by the majority of the population (the word 'poison'), legislation had turned its attention to filling the label with names of chemical substances nobody knew the meaning of. It appears as if, suddenly, medicines are no longer poisons, unless you know what effects the chemicals, mentioned on the label, have. The word 'poison' is nowhere to be found on the label of any medicine anymore. Instead you get a load of meaningless information about the content.

Drug labelling plays crucial roles not only in the identification of active ingredients or excipients of a known drug, but also in the provision of guidance for patients to ensure safety and appropriate administration of medicine. In February 1999, the introduction of population pharmacokinetics (PPK) in drug labelling established the significance of dose individualisation in relation to age, gender, concurrent medication, disease state etc. The application of PPK became ubiquitous, particularly in pharmacological agents with a narrow therapeutic index, found in, for example, anticancer and anti-infective medications. Lots of information that is not comprehensible to most people, which makes them rely on their doctor's knowledge of the prescribed medicines. So instead of you knowing the medication you are taking is poisonous, you now have to rely on the doctor and hoping he knows when it is a medicine and when it is a poison. And then it turns out they don't know what is on the 'patient' information leaflet either. They are not aware of the poisonous nature of what they are prescribing for you either. If you don't believe this, go and test it out. Question your GP and be stunned!

The law says that the name of the product should be clearly visible on the packaging. That is another great help to know what is in it. Drug nomenclature is the systematic naming of drugs, especially pharmaceutical drugs.

In the majority of circumstances, drugs have three types of names:

"Instead of the label displaying a message that would be easily understood by the majority of the population (the word 'poison'), legislation had turned its attention to filling the label with names of chemical substances nobody knew the meaning of."

chemical names, the most important of which is the IUPAC name; generic or non-proprietary names, the most important of which are international non-proprietary names (INNs); and trade names, which are brand names. I hope you now know what is in the package as companies can use whichever naming system suits them best. You should now, according to the regulatory body, have all the information you need to take your medication in a safe, non-poisonous, way.

This short journey through part of allopathic medicine's history shows you how the concern about taking medicines, poisons, 'to cure' oneself has faded from stark warnings to a mountain of useless information obscuring the fact that taking medicines, poisons, is a dangerous practice. The explanation we are receiving to justify such behaviour on the part of the experts, the regulatory bodies, is that medicines are nowadays so much safer than they used to be. So you have no reason to worry! They can make a statement like that, because neither you nor I are in a position to prove them wrong. Acknowledging that medicines have side-effects, minor as well as major ones, doesn't prove that, in general terms, they are always poisonous or safe for that matter. Furthermore, how do you rate a poisonous effect? What makes one substance more poisonous compared to another substance? How do you evaluate that? No, modern medicines are less poisonous because the experts tell us they are.

Maybe we can explore the idea of poisons, medicines and toxicity a bit further in order to become a little wiser about what is really going on. We already talked about poisons and medicines. What about toxicity? What is meant by that? The word 'poison' refers to any substance that can make you sick or harm you. A toxin is a specific type of poison. A 'toxin' is a naturally occurring poison produced by metabolic activities of living cells or organisms. So, a toxin is also a poison. The fact that it is said to have a biological origin, as opposed to many other poisons, either naturally occurring or man-made, doesn't make it less of a poisonous substance. Poisons are used as pesticides, herbicides, insecticides, rodenticides as well as drugs. Interesting that all of those products intent to kill, except the last one, as we are told that medicines are not poisons due to the intention behind their use.

I hope you now will remember the difference between toxins and poisons. And I am saying this because I have heard that my health is seriously being threatened by environmental toxins. Besides these environmental toxins being of a biological nature, harmful microorganisms, they also tell me about chemical environmental toxins. Various processes, including industrial activities, agriculture or natural processes, can create environmental toxins, which can pose significant health risks. Environmental toxins can be chemical in nature. Examples of chemical toxins are pesticides, herbicides, volatile organic compounds (VOCs) and heavy metals, in other words man-made 'toxins'. No different from the man-made 'poisons', as far as I can see.

What effects are caused by poisonous substances in living organisms? A complete understanding of the mode of action of an insecticide, for instance, requires knowledge of how it affects a specific target site within an organism.

The target site is usually a critical protein or enzyme in the insect, but some insecticides affect broader targets. Although most insecticides have multiple biological effects, toxicity is usually attributed to a single major effect. It may affect the normal activity of the nervous system. It may affect the endocrine system, slowing down or inhibiting procreation. It may affect specific chemical processes within the cells. The same pathways are used by medicines to interfere with natural processes. Rodenticides are generally anticoagulants, which disrupt the normal clotting process of the blood, resulting in the animal bleeding to death. Anticoagulants are also used as medicines and are commonly known as 'blood thinners', and yes, you can bleed to death as a result of taking these. Medicines are used to either inhibit (anti-inflammatory, antacids, beta-blockers, sedatives, etc.) or to stimulate (diuretics, prokinetic agents, digoxin, etc.) certain natural processes, in the same way as pest exterminators do.

It may be obvious to you by now that using these toxic substances may or may not produce poisonous effects, depending on, on the one hand, the amount of poison you use and, on the other hand, the strength of the organism that is being exposed to it. This explains why poisons can be used as medicines, and why 'the intention' with which you take the poison turns it into a medicine rather than a poison. The effects produced by poisons may be local (hives, blisters, inflammation) or systemic (haemorrhage, convulsions, vomiting, diarrhoea, clouding of the senses, paralysis, respiratory or cardiac arrest). And what effects do we see from ordinary medications? From the homely aspirin to the most sophisticated prescription medicine on the market, all drugs come with side-effects. Many are minor, a few are serious, and some are just plain strange. Perhaps the most common set of side-effects for drugs that work inside your body involves the gastrointestinal system. Nearly any drug can cause nausea or an upset stomach. For drugs used on the outside, skin irritation is a common complaint. So medicines act indeed in the same way as poisons do, causing the same effects.

Hence, leaving aside the intention, which is open to interpretation, we have seen that medicines and poisons follow the same pathways inside the body and cause the same effects. A therapeutic effect is a consequence of the medical treatment of any kind, the results of which are judged to be desirable and beneficial. And a toxic effect is then an adverse effect of a drug produced by an exaggeration of the effect that produces the therapeutic response. What turns a therapeutic effect into a toxic one is the balance between two things: the amount of the substance used and the inner strength of the person taking the substance, the state of his inner being, the internal energy to respond to being poisoned.

All this leads us to some useful conclusions:

Medicines are poisons

- Usage and dosage is individually different
- Medicines (poisons) are never organ or function specific
- Therapeutic effects and side-effects are all poisonous effects
- Therapeutic effects and side-effects are individual
- The major danger of medicines is not that they are poisons.
- The major danger of medicines is that we believe they are not poisons.
- The major threat to your health is a false sense of security.

September 2024

FDA CONFESSES: ZERO SCIENTIFIC EVIDENCE OF "MONKEYPOX VIRUS" OR CONTAGION... NOT EVEN A "GENOME" FOUND BY ANYONE... ANYWHERE

CHRISTINE MASSEY'S SUBSTACK

August 20, 2024

https://tinyurl.com/4aues7b6

Christine Massey sent a FOI as regards to the scientific evidence of a monkeypox virus to the FDA in the US. Here is a brief summary of the response from the Division of Freedom of Information. Please go to Christine's substack to read in full. Link above.

Sarah B. Kotler ("J.D.") acting as Director, Division of Freedom of Information, US Food and Drug Administration (FDA) officially confessed that the people running the FDA have no records authored by anyone, anywhere:

1. that scientifically prove/provide evidence of the existence of any alleged "monkeypox virus", or

2. that even describe the purification of particles that are alleged to be "monkey pox virus" directly from bodily fluid/ tissue/excrement of so-called "hosts", or

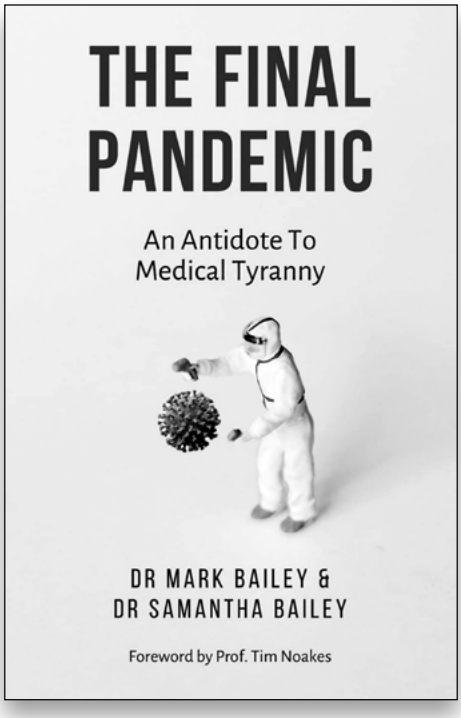
3. that describe the purported "genome" of any alleged "monkeypox virus" being found intact in the bodily fluid/tissue/excrement of a so-called "host" (as opposed to fabricated in silico, aka a computer model), or

4. that scientifically demonstrate contagion of the illness / symptoms that are allegedly caused by purported "monkeypox viruses" [see pg 6].

"…we have no responsive records."

THE FINAL PANDEMIC: AN ANTIDOTE TO MEDICAL TYRANNY

BY DR MARK BAILEY &
DR SAMANTHA BAILEY (2024)



EXTRACTS FROM THE EPILOGUE

EXTRACT ONE: 'When we were trained as doctors we did not learn about health, we learnt about disease. We memorized thousands of terms related to pathology and then almost as many "treatment" protocols in the form of pharmaceuticals and surgical procedures. We were part of the world of allopathic medicine that has been elevated to the status of high reverence amongst the public. It is an undeserved status. While there are certainly occasions of acute limb and life-saving interventions, these episodes are in the tiny minority of interactions with the medical system.

Calling it a "health" system is also a deceptive misnomer. As a friend in Switzerland once remarked to us, "yes, we also have one of those but is should be called the sick system." Indeed, it is a system that can barely cure anyone. It might surprise those outside the system that the word 'cure' is often discouraged from use for doctors in training. Hence, the mindset of the new doctor is corrupted from the start; instead of seeing the body as something that has been created in perfection, they see it as something that is prone to breakdowns. From "bad genes" to "bad luck" or "age-related" problems, the doctor is there to make a diagnosis and patch things up. The public have been trained to accept these 'diagnoses' as legitimate and for many it brings a sense of relief. Unfortunately, such labels all too often feed straight into the allopathic business model of long-term drugs or surgery.'

EXTRACT TWO: 'One does not have to look further than vaccines to see how entrenched in dogma the typical medical practitioner has become. When a doctor proclaims that the vaccines they advocate are evidenced-based, you are witnessing one of the most disturbing frauds in history. As we have said previously, doctors are among the worst people in the world to comment on vaccines. They usually recommend them even though they have not studied the nature of the disease, the historical data including when the vaccine was introduced, and what is actually in the vials. When an adverse event occurs there is typically a cognitive dissonance for the vaccine promoter who does their bit to maintain the "safe and effective" mantra not realizing that it is a marketing slogan invented by the pharmaceutical industry. However, neither should we underestimate their fear of being ostracized from the medical community. Almost every doctor is told about the "fall" of Dr Andrew Wakefield, including the loss of his practicing license and income. Only a minority of us looked at what Dr Wakefield actually said and were all the better for it.'

TiP Editor: An excellent read – I highly recommend this book!
Available in a few different formats.
ISBN-13 978-0473701994

WHAT HAVE WE LEARNED IN THE PAST 4 YEARS?

TiP Editor: I highly recommend these two presentations by Dr Tom Cowan.

PART 01:

https://rumble.com/v5a3p8d-what-we-have-learned-in-the-last-4-years-august-7th-2024.html

PART 02:

https://rumble.com/v5az078-what-we-have-learned-in-the-past-4-years-part-2-81424.html

A SYSTEMATIC REVIEW OF AUTOPSY FINDINGS IN DEATHS AFTER COVID-19 VACCINATION (WITHDRAWN)

NICOLAS HULSCHER A, PAUL E. ALEXANDER B, RICHARD AMERLING B, HEATHER GESSLING B, ROGER HODKINSON B, WILLIAM MAKIS C, HARVEY A. RISCH D, MARK TROZZI E, PETER A. MCCULLOUGH B F 1

Article link HERE

WITHDRAWN: This Article-in-Press has been withdrawn at the request of the Editors-in-Chief. Members of the scientific community raised concerns about this Article-in-Press following its posting online. The concerns encompassed. • Inappropriate citation of references. • Inappropriate design of methodology. • Errors, misrepresentation, and lack of factual support for the conclusions. • Failure to recognise and cite disconfirming evidence. The concerns were shared with the authors, who prepared a response and submitted a revised manuscript for consideration by the journal. In consideration of the extent of the concerns raised and the responses from the authors, the journal sent the revised manuscript to two independent peer-reviewers. The peer-reviewers concluded that the revised manuscript did not sufficiently address the concerns raised by the community and that it was not suitable for publication in the journal. The authors disagree with this withdrawal and dispute the grounds for it.

Here follows the original Abstract before it was withdrawn.

Highlights

• We found that 73.9% of deaths were directly due to or significantly contributed to by COVID-19 vaccination.
• Our data suggest a high likelihood of a causal link between COVID-19 vaccination and death.
• These findings indicate the urgent need to elucidate the pathophysiologic mechanisms of death with the goal of risk stratification and avoidance of death for the large numbers of individuals who have taken or will receive one or more COVID-19 vaccines in the future.
• This review helps provide the medical and forensic community a better understanding of COVID-19 vaccine fatal adverse events.

ABSTRACT

Background

The rapid development of COVID-19 vaccines, combined with a high number of adverse event reports, have led to concerns over possible mechanisms of injury including systemic lipid nanoparticle (LNP) and mRNA distribution, Spike protein-associated tissue damage, thrombogenicity, immune system dysfunction, and carcinogenicity. The aim of this systematic review is to investigate possible causal links between COVID-19 vaccine administration and death using autopsies and post-mortem analysis.

Methods

We searched PubMed and ScienceDirect for all published autopsy and necropsy reports relating to COVID-19 vaccination up until May 18th, 2023. All autopsy and necropsy studies that included COVID-19 vaccination as an antecedent exposure were included. Because the state of knowledge has advanced since the time of the original publications, three physicians independently reviewed each case and adjudicated whether or not COVID-19 vaccination was the direct cause or contributed significantly to death.

Results

We initially identified 678 studies and, after screening for our inclusion criteria, included 44 papers that contained 325 autopsy cases and one necropsy case. The mean age of death was 70.4 years. The most implicated organ system among cases was the cardiovascular (49%), followed by hematological (17%), respiratory (11%), and multiple organ systems (7%). Three or more organ systems were affected in 21 cases. The mean time from vaccination to death was 14.3 days. Most deaths occurred within a week from last vaccine administration. A total of 240 deaths (73.9%) were independently adjudicated as directly due to or significantly contributed to by COVID-19 vaccination, of which the primary causes of death include sudden cardiac death (35%), pulmonary embolism (12.5%), myocardial infarction (12%), VITT (7.9%), myocarditis (7.1%), multisystem inflammatory syndrome (4.6%), and cerebral hemorrhage (3.8%).

Conclusions

The consistency seen among cases in this review with known COVID-19 vaccine mechanisms of injury and death, coupled with autopsy confirmation by physician adjudication, suggests there is a high likelihood of a causal link between COVID-19 vaccines and death. Further urgent investigation is required for the purpose of clarifying our findings.

> YET UPON A THEORY SO CONSTANTLY AT FAULT WHEN THOROUGHLY SIFTED THERE HAS BEEN ERECTED A WHOLE SYSTEM OF INOCULATION. OR, PERHAPS, THE FACTS MAY BE STATED CONVERSELY. HAD IT NOT BEEN FOR THE SALE OF SERA AND VACCINES, NOWADAYS GROWN TO SUCH VAST PROPORTIONS, PASTEUR'S GERM-THEORY OF DISEASE MIGHT BEFORE THIS HAVE COLLAPSED INTO OBSCURITY. ~ **Pasteur Exposed by Ethel D Hume. p211**

VACCINATION CRIMES & FALSE EVIDENCE

BY A J MARRIOT (C1924)

It is very difficult for anyone who has studied the Vaccination Question, and, it may be added, the question of inoculations, to write or speak with restraint on the cruelty with which they have been administered by ignorant magistrates and military martinets in the medical profession. I will first give you two or three examples of the crimes and then proceed to show you that, although vaccination was conceived in honest error by Jenner, he never believed in the vaccination for which he was paid £30,000; that, in fact, he knowingly cheated the country out of that amount. He heard from Gloucester dairymaids that once one had had the cow-pox one could never have the small-pox. This he repeated to his medical friends.

They showed him that such an idea was unwarranted, and he saw they were right. But he believed that when cow-pox was derived, as he believed it could be, from the greasy heels of a horse, passed through a cow it would protect, and protect for life, anyone who had been afflicted with it from small-pox. However, circumstances compelled him to pretend to a belief in what is called vaccination for a time, or he would not have got his reward from Parliament.

His faith should be known as equination, not vaccination. The story is too long to go into here. White's "Story of a Great Delusion" deals with it in full length. The two tragedies I am about to relate are examples of hundreds that have been brought before the Anti-Vaccination League and various Anti-Vivisection Societies.

Gladys Shirley, 16 years of age, 2, Drovers Road, Croydon, died on September 24th, 1920, after a long illness following vaccination. She entered the service of the London Post Office in February, 1912. While in the middle of her duties she was sent by a superior official in the Post Office to be vaccinated, and was told that she must be done or she could not stay. She went to the Public Vaccinator in Bartholomew Close. She reported that this doctor told her that he had not the proper vaccine, and that after thinking a minute he took some stuff from a cupboard and said he would try that. Gladys Shirley was a perfectly healthy girl until she was vaccinated; she never missed a day from school through illness. Her parents and her three sisters have always been in the most robust health.

The arm appears to have healed in the usual way, but then lumps and abscesses developed on the shoulders and chest, under the armpit. She gradually failed in health, like a blight would to vegetation, became white in appearance, and by the end of the summer of 1919 abscesses formed in both legs. She was unable to walk; her temperature rose to 102°. The Post Office doctors patched her up and she returned after a few weeks to duty and the Post Office till February 14th 1920, when she failed entirely, took to her bed, and remained there till her death.

Mr. John Silver saw her on August 20th, a wasting spectacle of skin and bone. An abscess which had formed in her neck and broken and was discharging matter. The Post Office paid her six weeks' part pay since February 14th, and refused to admit further liability or to send any more sick pay.

Here is another case: -

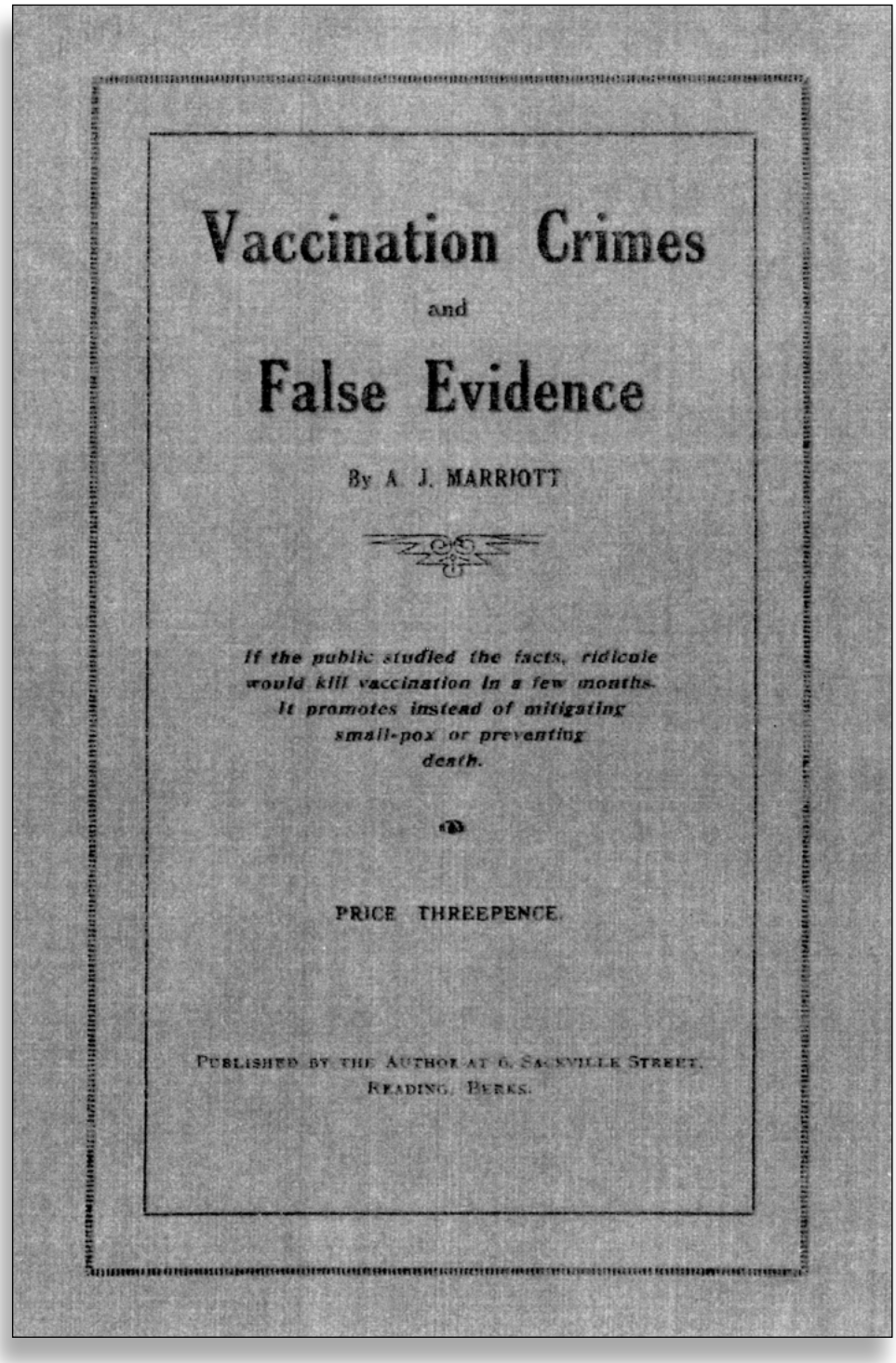
Mr. Gillings, of 4, Emba Street, Bermondsey, had a daughter who had to be vaccinated by order of the firm in whose employ she was – George Payne and Co., Queen Elizabeth Street, Tower Bridge, London, S.E. The particulars of the case you will gather from the following letters:- 4, Emba Street, Bermondsey, S.E.16, 29th October, 1923 Dear Sir, I wish to bring to your notice the case of Miss E. Gillings, an employee of the firm until January last, and who in consequence of vaccination, performed by order of the firm the alternative dismissal having been given, is now suffering from a disease which the doctors pronounce to be incurable and that she has only a few months to live, and I hope you will compensate me for the injury done to my daughter by enforced vaccination. I also desire to point out to you that, prior to vaccination, she was a strong healthy girl, never ill nor in the least bit weakly, and, as has happened in other similar cases, she became ill a few weeks after vaccination and was never well again. I am in straightened circumstances myself, and I consider that any firm that orders its employees, on pain of dismissal, to submit to vaccination, should pay compensation if the operation has injurious results. (Signed) W. H. GILLINGS Addressed to Messrs. George Payne and Co.

The following is the reply:-

George Payne and Co. Limited.
Managing Director's Office,
Queen Elizabeth Street, Tower Bridge,
London, S.E., 1st November, 1923.
Mr. W.H. Gillings, 4, Emba Street,
Bermondsey, S.E.16

Dear Sir, We are in receipt of your letter, but might mention we have never persuaded or requested anyone of the staff to be vaccinated unless they wanted to be done. We engaged the best and most reliable doctor obtainable in the City and we know that every care and precaution was taken. It is quite true that those who did not wish to be vaccinated could not be permitted to continue at work while the epidemic was about, as this would not have been fair to those of the staff who had been vaccinated, but there was no coercion, and any who had to be put off for the time being were promised reinstatement when the risk had been removed.

We are confident the doctor will explain to you that it is not vaccination which was the cause of your daughter's illness. (No doubt they always do.) We are sending your letter on to the doctor who carried out the vaccination.
Yours faithfully,
GEORGE PAYNE & Co. LTD
(Initialled) W.D.
Space prevents me giving cases from the Army and Navy of mischief done by vaccination, but there have been such cases, and it was nothing short of a serious moral crime to inflict



Sir Almroth Wright's inoculation on our men in the late war. There was neither time nor opportunity to fairly test whether it was advisable to use it. Such experience as was obtained in the Boer War distinctly condemned it. As to medical evidence, or to its value, especially Governmental medical evidence, no one who has been engaged in the antivaccination and anti-vivisection movement would dream of paying the slightest attention to it. You can feel quite satisfied of its failure by the fact that Japanese doctors who followed the course of the war by their actual presence condemned it so completely that no inoculation against typhoid was used by the Japanese in their campaign against Russia. The results of its absence was perfectly satisfactory.

I am quite sure that if the public did its duty by itself, instead of trusting to the majority of doctors, they would come to the same conclusion as myself, vaccination should be made a criminal offence, and probably all inoculations of disease also. I can certainly include two, anti-diphtheretic inoculation and Pasteur's inoculation for rabies. In *Truth*, December 19th, 1923, there is an article criticising Pasteur which shows how his statistics, re his wonderful triumph over hydrophobia, were faked. In both hydrophobia and diphtheria, since their alleged wonderful discoveries, both diseases have increased, clearly the result of the alleged remedies. In diphtheria the inoculators have to admit this fact, but they say the case rate has diminished. That is because if you have an ordinary sore throat now, you go to a doctor.

He says "Yes, diphtheria," and often succeeds in foisting inoculation, not only on yourself, but on contacts, with the result of killing somebody amongst them. I have Press cuttings of such cases. Thus is false evidence manufactured, disease spread, and fees improperly obtained. I have often been asked: If you were bitten by a dog would you not go to Paris to receive Pasteur treatment. My answer has always been: No! As a matter of fact, I have been twice bitten. I looked on the matter in this light: if I have got hydrophobia I cannot certainly prevent its development by adding a further dose of hydrophobia to it, but as I note where Pasteur Institutes have been set up, up goes the statistics of hydrophobia and I am not going to them from fright. Common sense is no antagonist to real science, but to sow disease with the expectation of reaping health is neither sense nor science.

What I want to impress on my readers is the imbecility of trusting to a majority in these cases. Have you ever been on a jury? I remember a case that I was on. There were two witnesses for the prosecution, nine for the defence; nevertheless, we convicted. A long list of previous convictions against the prisoner were then put in. And re inquests, what is the evidence usually in cases of death from vaccination. Perfectly healthy subjects (these inquests are principally on children) until vaccinated – then terrible sores, frightful suffering, death. A medical coroner plays impudently into the hands of the medical witness who says:- he vaccinated so many others with same lymph; no ill effects: death from natural causes the verdict. Well, we've heard of the curate's egg that was good in parts. Calf lymph, in a sense, is altogether bad, but it may be, no doubt, specially bad in parts. Besides, it is the state of the blood of the victim that has much to do ›

with it. Anyway, juries would often be justified by returning verdicts of manslaughter in these cases, and should not be humbugged by medical trickery.

Now there has never been the slightest evidence to warrant any belief that vaccination had any beneficial effect in preventing or mitigating small-pox, and vaccination should have been completely discredited when Jenner's dictum that it protects from smallpox for life was to be incorrect, and that would have been the effect had there not been money in it, and had the public been wide awake. Jenner was backed in this claim by the College of Physicians and College of Surgeons. They showed their total ignorance of the subject, nevertheless, when they made the claim that if it did not protect for life it did for some years, an assertion for which they had no more warrant than their first assertion, the public still allowed itself to be victimised. Don't forget, the money vaccination has cost would have settled the housing question.

Many of the talks of the frightful ravages of small-pox before vaccination are put forward in good faith, nevertheless they are untrue. You will hear there were fifty thousand deaths (all sorts of numbers are given) before vaccination. These statements were founded on the number of deaths noted in the London Bills of Mortality, the only statistics pretty nearly that were available up to 1838, and multiplying them by the number of the population. Pure nonsense. There were many country districts where small-pox was entirely unknown, and even in some towns small-pox was unknown for as many as forty years, for small-pox and all other zymotic diseases are proved to be the result in the main of density of population. No mitigation can be produced by anything but sanitation. Here I will say that at the present time there is an agitation to increase the height of the building line in London and other towns. This should be prevented.

The facts against vaccination are simply overwhelming; so much so is this the case that I say no doctor has a right to profess a belief in what is a most degrading superstition, discreditable to the lowest class of savage peoples. The case rate in small-pox outbreaks before vaccination was known was from 14 to 18 per cent, yet modern pro-vaccinist doctors gravely assert that since vaccination the unvaccinated die at from 32 to 60 per cent., vaccinated at 7 to 12½ per cent. And in his dealing with vaccination, "Vaccination a Delusion," Professor Alfred Russell Wallace asks "How is it with so much better sanitary conditions and greatly improved treatment, nearly half the unvaccinated patients die, while in the last century less than one-fifth died." False evidence, my reader – the truth of it is impossible.

The conduct of the medical profession, or that part of it that have been lately trying to reintroduce compulsory vaccination, has been exceedingly indecent, even if they really believe in it. Inspired paragraphs have appeared in all the most powerful organs of the Press of a most untruthful character. Here is one from the Times:- "Most things in medicine are problematical, most theories

"How is it with so much better sanitary conditions and greatly improved treatment, nearly half the unvaccinated patients die, while in the last century less than one-fifth died."

fail, but vaccination is a solid rock. There is no doubt of any sort, nor can there be any doubt, that it is and will remain the way of salvation for mankind whenever small-pox threatens to break out."

Now anything falser than this statement was never printed, but the medical correspondent of the Times may have been responsible when the Times consented to print it. Anyway, I don't object to these false statements if we who know them to be false have a chance to counter them, but we haven't a fair chance. Although the Times printed some letters on the other side we feel the correspondence was nevertheless unfairly wangled. We say if the medical profession were really concerned for the public health, instead of hunting for fees, they would take care all sides should be put before the public.

But what do you think of doctors putting anti-vaccinators down as ignorant and venal?

Just consider that the anti-vaccinator has come into the movement in almost all cases because he, or some relative or friend, has lost a child or other relation from vaccination. He is forced to study the question. He has previously accepted, as all those who are really ignorant do, the current opinion. He soon finds out that the attempt on the part of doctors to make it out as solely a medical question is ignorance of blatherskyte. In fact, we antivaccinists say if we were ignorant on the matter as the doctors we should have no right to an opinion on the subject.

The anti-vaccinist finds that all the doctors know about the matter is how to vaccinate and take their fees – ulterior knowledge can only be obtained by the returns of the Registrar-General. Doctors admit these statistics are manipulated in favour of vaccination, and yet they all are honourable men. In notes on the small-pox epidemic at Birkenhead, 1877 (p.9), Dr. F. Vacher says: "Those entered as not vaccinated were admittedly unvaccinated or without the faintest mark. The mere assertion of the patients or their friends that they were vaccinated counted for nothing." Another medical official justifies this method of making statistics as follows: "I have always classed those as unvaccinated where no scar, presumably arising from vaccination, could be discovered. Individuals are constantly seen who state that they have been vaccinated, but upon whom no cicatrices can be found.

In a prognostic and statistic point of view, it is better, and I think necessary, to class them as unvaccinated," – Dr Gayton's Report for the Homerton Hospital, 1871-2-3. Now all vaccinations are registered, why in the public interest are not the registers searched and the exact truth put before the public.

So much for false statistics as to the vaccinated and unvaccinated; now for the deliberate falsification of vaccination fatalities.

Dr. Henry May, Medical Officer of Health, candidly states as follows:- "In certificates given by us voluntarily, and to the which the public have access, it is scarcely to be expected that a medical man will give opinions which may tell against or reflect upon himself in any way. In such cases he will most likely tell the truth but not the whole truth, and

assign some prominent symptom of the disease as the cause of death. As instances of cases which may tell against the medical man himself, I will mention erysipelas from vaccination and puerperal fever." From 1881 to 1895 pro-vaccinists were obliged to admit an average of 52 deaths caused by vaccination per annum. We anti-vaccinists call them murders. But for the tricks described above we believe the number 52 would be multiplied considerably. Some go so far as to say ten-fold.

Now anti-vaccinists are subjected to gross abuse by many, I think I may say most, medical men. But what is our offence? Simply we want these matters honestly and fairly dealt with. They have even insinuated that anti-vaccination is a paying game. Well, for myself I have sacrificed my holiday money for two years to be able to put my views forward for the public benefit, and all connected with the Anti-Vaccination League are self-sacrificing people. Compulsory vaccination is not likely to be forced on me or my wife, both being very advanced in years; and we have no children.

In the Anti-Vaccination League at most there have never been more than half-a-dozen paid servants. And I fear that our Secretary, at any rate, cannot be so well paid as her industry and services would warrant. Against these facts you have to consider that for the ten years ending 1921 public vaccination alone cost £1,597,000, and private vaccination probably brought the amount up to at least half-amillion a year. But beyond that to discredit vaccination would discredit a score of feehunting impostures of a similar character. I will give you a shameful instance of falsification, of a most discreditable character, which is only a sample of many whereby the public are deceived.

The Bedford Times, October 7th, 1921, chronicles a meeting of the Bedfordshire Rural District Council on October 1st, where the Medical Officer (Dr. Parbury) reported on the hospital cases, twenty-one in number, which included one case of small-pox – a vaccinated boy. Dr. Parbury told the Council: "On the 20th ultimo a letter from the Ministry of Health stated that as the boy, who was thought to have had small-pox, had been successfully vaccinated, it was not officially a case of small-pox. In his opinion it was a case of small-pox, and he did not think vaccination excluded the possibility of small-pox.

The medical man in charge of the case at the hospital was of the same opinion. Small-pox and cow-pox were possible in the same individual. It would have been a serious menace to the public health to treat the case otherwise than he had done." The Ministry of Health have been the prime movers in a plot to bring about the renewal of compulsory vaccination, and severe loss has been inflicted on the public by unnecessary expenditure both for vaccination and printed matter. The City of Gloucester has been put to great expense and its trade much injured by the action of the Ministry of Health and some of the Borough Council in that city. When you see by the foregoing account of the Bedford case what tricks the Ministry of Health can be capable of, I think all will agree that the public health is the last concern the Ministry of Health consider, and that they are under the thumb of people who are pushing vaccination for profit.

"The Ministry of Health have been the prime movers in a plot to bring about the renewal of compulsory vaccination, and severe loss has been inflicted on the public by unnecessary expenditure both for vaccination and printed matter."

There is, unquestionably, a serious danger of an extensive outbreak of small-pox, or some other disease, owing to over-crowding, the result of housing shortage. If our doctors were properly impressed with this fact, what should we expect from them? All their energies thrown into an effort to get houses built, which would protect from small-pox and all other diseases.

But what do they do? All they can to divert the money into their own pockets by starting unwarranted scares. Now, an examination into the figures of the cases in all these scares is a tremendous triumph for the anti-vaccinists. Unfortunately, these figures are not studied by the public, and statements which can only be described as outrageously mendacious are swallowed, and public money is wasted. That is the least part of the evil – the vitality of everyone vaccinated is lowered and, if small-pox were about, liability to it would be increased, and also to disease of any kind.

The position of the pro-vaccinists has been one constant shuffle. Their first tale, as I have said, was protection for life. Next came protection of death, or mitigation. Shown to be frauds they then said you would not be protected without *four injections. (* In the Middlesborough small-pox epidemic, 1897-8, it was found those with four marks suffered more from fatal and severe cases than those with three than those with two. In fact, false evidence again, evidence going to show what we anti-vaccinators contend – the unvaccinated are the safest from small-pox.) But you can never catch these slippery people; if everything else fails they say you have not been properly done. I should have thought paying the doctor for something that was not of the nature of what was professed was being very completely done.

Now, in 1822 and 1825, immense brag was indulged in by the National Vaccine establishment on the triumph of vaccination over small-pox. As a matter of fact, not above a fourth of the people were then vaccinated. The decline in small-pox commenced twenty years before vaccination was discovered, and continued from that date, 1789 to 1820, from then to 1834 the decline was much less; in 1838 there was an epidemic. Although more people were vaccinated than ever, the pro-vaccinists, after bragging in 1822 and 1825 that vaccination had stamped out small-pox, they then said the epidemic was the result of the neglect of vaccination, so they got the law made stringent with the result that in 1871-2 the worst small-pox epidemic (indeed, it was a pandemic) in recorded history took place. Now the evidence from the epidemics prove that the more people are vaccinated the more they suffer from small-pox. In 1838-40 38,833 perished, in 1871-2 42,085. In 1838-40 we do not know the proportion ›

of the population vaccinated, but it could not have been more at a most liberal estimate than 40 per cent. In 1871-2 97½ per cent. we know, were vaccinated. In the period of much less vaccination the deaths were 772 per million, in 1871-2 the deaths were 918 per million. With such facts what right have medical men to-day to be plotting to set it up again in the old strength.

We anti-vaccinators look on vaccination as a most brutal crime, and that clearly those who are pushing it have more concern for profit than the public health. We think that probably cancer is caused by it, that it has caused a recrudescence of leprosy in the East. In *Truth*, December 26th, 1923, strong evidence is given that foot and mouth disease was caused in the States from vaccinated calves. We want honest enquiries made in these matters. We don't want to dogmatise, but we say no doctors may be permitted on these enquiries except as witnesses. Their evidence in such matters is quite unreliable, not always from dishonesty, but from that which is sometimes unconscious bias.

I ask for the prohibition of vaccination under the same penalties as inoculation. In that I am in agreement with the British Union for the Abolition of Vivisection, 32, Charing Cross, London, S.W.1, from whom may be obtained "The Fraud of Vaccination" and the "Fraud of Inoculation," price 4d. each, post free. I am in disagreement on the matter with the majority of the Anti-Vaccination League, 25, Denison House, 296, Vauxhall Bridge Road, S.W.1, from whom may be obtained " An Enquiry into Vaccine Lymph," post free, 5d.; "The Gloucester Small Pox Epidemic, 1895- 6," post free. 2d. or 3d. (I forgot which). If you don't stop the ambition of these medical fanatics or intriguers you will have to have constant inoculations of disease to the utter destruction of your health, and an immense increase in local and national expense.

There are one or two meannesses of the pro-vaccinists I had nearly forgotten. The fact is, the fight they make is founded on meanness, mendacity, greed and bigotry. The bigotry is the most respectable, as it is found on honest ignorance.

When the Act of 1907 was passed they succeeded in confining the right to obtain an exemption to the father, a trick, I am bound to say, which shows that an honest manly confidence in their cause is entirely absent. Lately a doctor has tried to show that the decrease in vaccination is due to the indolence of parents. It was their own trickery that in advance cut this contention off. Instead of allowing vaccination to be optional they compelled a parent to be too industrious and thoughtful if he wanted an exemption to neglect to apply for it.

Reverting to the tale of the ignorance of anti-vaccinists, I would say we are only human; we may therefore be in error. But the pro-vaccinists monopolize all the ignorance. The most comic thing on the face of this earth is a pompous fool on the Bench lecturing a claimant for exemption on ignorance.

Eighty years previous to vaccination, variolation, or the inoculation of small-pox, to produce a mild disease to prevent a serious attack later on prevailed. When vaccination was introduced, pro-vaccinists attacked the variolaters and had an easy job to show how mischievous it was in spreading small-pox. In a very few years the inoculators were able to retaliate and shew small-pox and small-pox deaths after * vaccination. (*The variolaters and vaccinators each proved the folly of their respective superstitions.)

The excuses I have alluded to were made, but, in 1811, Cobbett made a violent attack on the pro-vaccinists and Jenner, and showed the imbecility of these excuses, for it was no use saying they were cases where vaccination was improperly done, several severe cases of disease and deaths were Jenner's own patients.

These facts would have killed vaccination by laughing it to death, but the public never began to trouble till deaths from vaccination became fairly common, and they were never so very common as to awake the interest they should do, but they added to the expense of vaccination, and the threatened immense expense of kindred impostures ought to awake the universe – especially parents – on behalf of their children.

PASTEUR'S RABIES VACCINE

FROM : THE FINAL PANDEMIC BY DR MARK BAILEY & DR SAMANTHA BAILEY (2024), PAGE 79.

After his (Pasteur) long-hidden journals were finally disclosed in the mid-1970s, it was apparent that his public announcements about the successful treatment of rabies in dogs were fraudulent.

In the 1995 book, The Private Science of Louis Pasteur, author Gerald Geison revealed that, "the survival rates for the two sets of dogs fall into the following ranges for the dogs treated by Pasteur, 50 to 78 per-cent, for the untreated control dogs, 57 to 71 percent.

In other words, there was no evidence that his rabies shot was of any use at all. In fact, it was probably even worse.

As Dr Montague Leverson reported in 1909, the widespread use of Pasteur's rabies vaccines in France corresponded with a dramatic increase in the number of cases of the condition that it was supposedly preventing:

During twenty-three years preceding the use of the anti-rabic serum there were 685 deaths from rabies in all France, or an average of 30 per annum.

But since the use of the anti-rabic inoculations the average has risen to 100 per annum, in place of 30, with a continually increasing number each year, so that according to the official returns the number of deaths from rabies in France for the year ending in June, 1907, was just about 300.

In truth, as Professor Peter said, in his address to the Academy of Medicine, Paris, on the 11th of January, 1887, "M Pasteur does not cure rabies he imparts it!"

ALMOST 14,000 SEEK COMPENSATION, SAYING COVID VACCINES LEFT THEM DISABLED

PAYMENTS HAVE BEEN AWARDED FOR CONDITIONS INCLUDING STROKE, HEART ATTACK, BLOOD CLOTS, INFLAMMATION OF THE SPINAL CORD AND FACIAL PARALYSIS

THE TELEGRAPH
17 August 2024
https://www.telegraph.co.uk/news/2024/08/17/covid-vaccine-astrazeneca-sick-victims-compensation-scheme/


Image by Adam from Pixabay

EXTRACTS

Nearly 14,000 people in Britain have applied for payments from the government for alleged harm caused by Covid vaccines, new figures show.

Freedom of Information requests made by The Telegraph show that payments have already been awarded for conditions including stroke, heart attack, dangerous blood clots, inflammation of the spinal cord, excessive swelling of the vaccinated limb and facial paralysis.

Around 97 per cent of claims awarded relate to the AstraZeneca jab, with just a handful of payments made for damage from Pfizer or Moderna.

Since the Vaccine Damage Payment Scheme (VDPS) was founded in 1979 it has had around 16,000 applications, but the Covid jab has made up the vast majority of claims.

Despite warnings and the growing number of clotting cases, the UK government continued to recommend the AstraZeneca jab, even though vaccination had already been halted in Germany, Italy, France, Spain, Denmark, Norway, The Netherlands, Sweden and Latvia by March 2021……

……Thousands of people have been turned down by medical assessors who say there is no concrete proof that the vaccine caused harm, while hundreds of others have been refused payment because they are "not disabled enough".

Those who are successful receive a one-off payment of £120,000, but so far, the government has made payments in just 175 cases, fewer than two per cent of people who have applied. More than 5,500 claims have been rejected, while a further 519 were dismissed before a medical assessment. Despite nearly 1,000 people asking for their cases to be reconsidered, just 12 have been told their decision has been reversed and they will receive a payment.

Nearly 350 claims were rejected because, although assessors accepted the vaccine had caused harm, they ruled it had not "caused severe disablement". Under the rules, applicants must be 60 per cent disabled to qualify. The government insists that the VDPS payment is not a compensation scheme, and the money can be used to help claimants chase damages in court. However, many argue that the VDPS payment is not enough to take on big pharmaceutical companies or compensate for the loss of loved ones……

…..Last year, AstraZeneca officially admitted that in some cases the vaccine can cause VITT and in May it began the worldwide withdrawal of the jab, claiming that it was no longer the most effective now that newer vaccines had been adapted to target Covid-19 variants. However AstraZeneca was granted legal indemnity early in the pandemic, so even if a civil case was successful, UK taxpayers would have to pay compensation.

The number of claims has reached such levels that administrative staff processing claims was increased from four to 80 last year. More than 700 people have been waiting over a year for a decision.

A spokesman for the NHS Business Services Authority, which runs the VDPS, said: "The Department of Health and Social Care (DHSC) is responsible for the policy and legislation that governs the VDPS, including the criteria around severity of disablement

"Since taking over the management of the scheme in 2021, the NHSBSA's dedicated VDPS team works hard to do all we can to support claimants and to actively make improvements to the claim process. We continually review our processes to further develop the way in which we manage claims, and to provide a better service for claimants."

TETANUS

DR JAYNE LM DONEGAN MBBS DRCOG DCH DFFP MRCGP
Naturopath & Homeopath,
Retired NHS GP

TiP Editor: Dr Donegan throughout this article quite rightly emphasises it is the cleaning of the wound which is the most important aspect to prevent possible infection. Also, she highlights the questionable role antibodies may or may not play in the very rare development of what have been coined tetanus symptoms.

Additionally, I would like to point out that as regards the toxins produced by the bacterium, Clostridium tetani, which are deemed to cause tetanus, this is not proven. It is admitted in the medical literature that: 'The diagnosis of tetanus is entirely clinical and ***does not depend*** *upon bacteriologic confirmation. C. tetani is recovered from the wound in only 30% of cases and can be isolated from patients who do not have tetanus.' This means that in 70% of cases there is no sign of the bacterium! In those 30% where C. tetani was recovered were they present to clean up the wound site and not the cause?? Should we refer to bacteria as sometimes nice or sometimes bad? The indoctrination of the germ theory has a lot to answer for in my opinion.*
(Ref: CDC, Pink Book, Tetanus, section Laboratory Testing.)

People are becoming increasingly worried about common or garden childhood cuts and grazes regarding the tetanus risk. It is noticeable that people who have attended my lecture on Holistic First Aid or read my eBook on Tetanus - Safe Treatment of Childhood Injuries, are better prepared, less afraid, and if they contact me at all it is generally to tell me what they have done to check it is correct. As with all potentially serious conditions, it is always best to have some background knowledge of the subject. Unfortunately, even having reliable information to read is difficult for some parents to take in properly because their mind tends to freeze at any description of a worst case scenario and then their ability to make rational decisions is compromised.

Some of the following is from a medicolegal report I prepared for an Australian Court Case in 2012 hence the Australian data:

DR Jayne L.M.Donegan

"It is my opinion and experience that if correct emphasis were placed on the importance of wound toilet, the few cases of tetanus that occur, even in vaccinated individuals, might well be avoided."

Clinical tetanus, as opposed to just carrying it in your gut or having no symptoms, is caused by the toxin from the bacterium, *Clostridium tetani*. This bacterium is present in the gut of many farm animals and can live in spore form in soil and dust for many years. It is highly resistant to heat and drying. Colonisation by the organism does not itself cause symptoms. It is only when the toxin is produced that harmful effects are caused. To make the toxin the organism needs to have anaerobic (no oxygen) conditions. This is why clinical tetanus is classically associated with wounds from rusty nails because this is thought to combine dirt with a deep penetrating wound that it is difficult for oxygen to reach. The need for anaerobic conditions is also why clinical tetanus so rarely occurs despite undoubted frequent contamination of wounds. Other injuries that promote anaerobic infections are severe burns and severe crush injuries with the occurrence of dead, necrotic flesh. However, tetanus infection has also been reported after trivial or no injury (after tonsillitis) or operative procedures (abortion, appendicectomy). [1] (Harrison's, 1987). Clinical tetanus is not an infection. The symptoms occur as a result of the direct action of the toxin blockading neurotransmitter release from spinal inhibitory interneurons. Clinical symptoms when they occur, usually develop five days to eight weeks after the injury, commonly two weeks. A shorter incubation period usually indicates more severe disease. The effects of tetanus disease may remain local to the site of the injury or become more generalised. People tend to remain alert but may exhibit odd behaviour in the early stages. There may be irritability with muscle twitching and spasms, accompanied by a low grade fever. This can progress to grimacing (*risus sardonicus*), back spasms (*opisthotonos*) 'lockjaw' and severe cases may have laryngeal spasm causing difficulty in swallowing saliva, spasm of the respiratory muscles necessitating artificial ventilation, and in some cases, death. Characteristically the symptoms worsen for three days, remain stable for the next 5-7 days and by two weeks may have disappeared all together. Most survivors recover completely in four weeks. All the effects of tetanus toxin appear to be self-limiting because those who recover from the disease have no residual defect. [2] (Harrison's, 1987).

Is the reduction in cases of clinical tetanus entirely brought about by use of the vaccine?
Paul Fine, Professor of Communicable Disease Epidemiology at the London School of Hygiene and Tropical Medicine states:

"There is little doubt that the introduction of routine tetanus toxoid vaccination in the 1940s had an impact upon trends and patterns of disease. However, the fact that the incidence of tetanus was declining prior to widespread vaccination, because of decreasing exposure (fewer people in contact with soil and animal faeces which are the main reservoirs of the tetanus bacillus) and the widespread use of tetanus toxoid in wound management make it difficult to assess the precise extent to which prophylactic vaccination has contributed to the decline in tetanus morbidity." [3] (Fine 1993).

Does being vaccinated with tetanus vaccine mean that the recipient will not contract tetanus the toxin based disease? No.

• The Australian Immunisation Handbook states, *"Individual cases have been reported and clinicians should consider tetanus when there are appropriate symptoms and signs, irrespective of the person's vaccination record"* [4] (AIH 2008)
• Researchers in Finland, reporting six cases of clinical tetanus in immunized children, two of whom had been suspected of having psychogenic symptoms, emphasised that, *"Tetanus should be remembered as a rare cause of neurological symptoms, even in immunized children."* [5] (Luistro & Iivanainen 1993)
• Professor Zvi Shimoni and colleagues described a 34 year old construction worker in Israel developed severe tetanus disease despite no history of injury and whose *"immunisation record showed that he had been immunised against tetanus according to the recommendations of the Israeli Ministry of Health."* He also had boosters at work five and two years before, nevertheless, being admitted to hospital with severe clinical tetanus. Professor Shimoni warned that, *"doctors should entertain the diagnosis of tetanus in the proper clinical setting, regardless of the patient's immunisation record."*

WHY WOULD THAT BE?

The perspicacious Dr David Vinson, an adjunct investigator at the Kaiser Permanente Division of Research and a practicing emergency physician pointed out in a letter to the British Medical Journal in 2000 that the antibody titres – levels – that medical authorities regard as protective are not so and were never designed to be taken as such. By researching the subject and reading studies written in French, he explained that *"The understanding of "protection" was derived from animal studies that correlated serum concentrations of tetanus antibody with symptoms of tetanus. The threshold of 0.01 IU/ml was established* ***because guinea pigs with titres above this level were protected from fatal tetanus, not from clinical tetanus;*** *six of 45 animals with protective levels developed non fatal tetanus. Similarly, in humans, non-fatal tetanus has been described in 10 out of 64 consecutive patients with antitetanus titres greater than 0.01 IU/ml."* [6] Relying on an intervention because it produces antibodies does not guarantee immunity. This is the case with all vaccines.

What do you need to do? 'Wound Toilet' – Hydrogen peroxide H2O2

It is my opinion and experience that if correct emphasis were placed on the importance of wound toilet, the few cases of tetanus that occur, even in vaccinated individuals, might well be avoided.

Profusely bleeding wounds are not tetanus prone – blood equals oxygen.

Superficial grazes are not tetanus prone as they are exposed to air, though grit from the road and foreign bodies should be removed.

Any puncture wound such as a nail, a fish hook or other must be removed as must any dead or dying material. Use 6 inch curved fishing forceps to get a good grip on splinters. These are an essential part of any first aid kit.

The wound should be held under cold running water (or pour out your bottle of drinking water) to reduce the temperature to make the enzyme controlled reaction of clotting or coagulation slow down. You *want* it to bleed. Blood is oxygen and it also removes dirt as it come out.

Squeeze the wound to make more blood come out.

Then drip onto the wound – from a piece of cotton wool or your finger – half diluted 3% hydrogen peroxide. It will 'sizzle.' These are bubbles of oxygen being released. When the bubbling stops, dab dry and drip on more H2O2. Keep doing this until there is no more 'sizzling'. Then leave the area open or cover with gauze smeared with Petroleum Jelly BP (VaselineTM) and tape down with micropore or similar if clothes or shoes will rub. Do *not* use savlon or any other proprietary salves, lotions, creams or antiseptics. They just kill off the nice germs, and have no effect on tetanus. With the exception of gauze soaked in Calendula mother tincture. Dr Dorothy Shepherd's's dilution was 30 drops to one wine glass of water. Iodine can cause an allergic reaction and irritate the skin.

Back in the first World War they knew how important wound toilet was: *"Tetanus tends especially to follow wounds infected by stable dust, or by the deeper soil thrown up by shells on the battle field. All wound exposed to infection in this way should be carefully purified."* [7] (Black's 1944).

A German study from 1967 found that hydrogen peroxide hindered the absorption of tetanus toxin as well as detoxifying it. *"The peroxide was able to penetrate even into jagged wounds. It acted by cleaning the wounds mechanically and killing harmful bacteria and funguses."* The author concluded that peroxide made a valuable complement to active and passive tetanus vaccination.[8] (Ludwig 1967)

Homeopathically, Hypericum and Ledum are given for nerve injury and deep penetrating injuries. I recommend they be given together in the 200c potency, crushed in a bottle of water with a drop of rescue remedy, shaken hard and sipped often for a few days. I have only ever used this once in my time bringing up two boisterous girls as only once did one of them have what I considered to be a tetanus prone wound, but I used hydrogen peroxide on any dirty wound or one with pus.

MEDICAL ADVICE - BE AWARE

1. That tetanus vaccine at the time of injury in an unvaccinated person *makes no difference to this wound.* It is for future wounds as it takes a minimum of 14 days to produce what are said to be 'neutralising antibodies' and then only after three doses.
2. What does make sense is to give tetanus immune globulin (TIG) which gives immediate antibodies. The down side is that, as a human derived blood product, although it is screened for contamination there is no guarantee that potentially harmful agents will not be missed.
3. *There is no single tetanus vaccine available in the NHS,* What is called a tetanus vaccine will be a diphtheria, tetanus and polio vaccine in those over the age of 6 years, with pertussis also if under the age of 6 years and a 6-in-1, including hepatitis B and Hib, in those under the age of one year. This is the case no matter now much the health professional tells you that it is only tetanus vaccine.

Which wounds are tetanus prone?

All of them including no wound at all. Is it likely? - No

The British National Formulary describes as:

Low Risk *"clean cuts less than 6 hours old, non-penetrating (with) negligible tissue damage."* Your child's wounds will be less than 6 hours old if you carry out appropriate wound toilet in a timely fashion.

Tetanus-prone wounds as, *"compound fractures (with the broken bone exposed to the environment), certain animal bites and scratches, puncture-type injuries acquired in a contaminated environment, wounds or burns with systemic sepsis, and wounds containing foreign bodies."*

You will be removing foreign bodies at the time of wound toilet and insisting that health professionals (HP) do the same in more serious injuries – influencing HPs to do the right thing is, admittedly easier said than done.

High-risk tetanus-prone wounds as any *"tetanus-prone wounds or burns that either show extensive devitalised tissue or require surgical intervention that is delayed more than 6 hours, or wounds that are heavily contaminated with material likely to contain tetanus spores (such as soil or manure)."* [9] In these cases, there will be far more pressing concerns than just tetanus.

The Australian Immunisation Handbook states, *"In Australia, tetanus is rare, occurring primarily in older adults who have never been vaccinated or were vaccinated in the remote past and can occur, after apparently minor injury."* [10] (AIH 2008) The figures for Australia on tetanus incidence and death since 2000 show this to be the case.

When I saw that clinical tetanus occurred in a child aged two, it was such a surprising occurrence that I scoured the medical literature to try find the case written up and learn more about what happened. I found it in the Medical Journal of Australia in the section on Medical Ethics.

The child was an unvaccinated two year old from South Australia who contracted clinical tetanus in 2000 – the first case of a child in Australia since 1969. A splinter of wood became embedded in the sole of her foot. Unfortunately it was not removed until 12 days later when it was expelled with a small amount of pus. The child was admitted to hospital two days after that when she developed muscle spasms and inability to open the mouth. *The parent and GP diagnosed tetanus.* The child was given tetanus immune globulin (TIG) intravenously and also had it injected at the site at her parent's request, despite its not being on the protocol, as well as a five day course of metronidazole, an antibiotic. The spasms were managed with midazolam and magnesium sulfate and did not require mechanical ventilation. She was nursed in a quiet, darkened, low stimulation environment throughout her stay and was discharged on sedation after 18 days.

The ethical dilemma for the doctors was whether or not they should have sought a court order to force the parent to vaccinate the child. I recommend you read it in full as it has opinions very relevant to today: *"Our society (and most others) recognises that parents, generally speaking, are in the best position to make decisions for their children, for several reasons."* [12](Goldwater et al 2003) This is all the more poignant as it is exactly what is not recognised by health professionals, the Government and, crucially, the UK Court of Protection where parental opinion is, sadly, ignored in favour of the most obsequious deference by judges to 'experts.'

Tetanus notifications Australia, 2000-2009

Year	Notifications	Age	Deaths & Age of Death
2000	6 (5 female), (1 male)	>50y (5), 2y (1) 1 part immunised, 2 unimmunised, 2 not known	
2001	3 (1 female), (2 male)	>70y (2), adult (1)	
2002	3 (2 female), (1 male)	>64y	
2003	4 (1 female, 3 male)	65-69y (1), >85y (2)	
2004	5 (4 female, 1 male)	>60y	
2005	2 (1 female, 1 male)	74y, 84y	
2006	3 (1 female, 2 unknown)	18y part immunised, 66y, 74y	
2007	3 (1 female, 2 male)	76ym, 79yf	1 male unimmunised 93y
2008	4	>70y	
2009 [11]	3	>34 y	

NB 'NOT KNOWN'/ 'UNCLEAR'/ 'NOT RECORDED' OFTEN MEANS PEOPLE ARE VACCINATED BUT THERE ARE NO RECORDS SHOWING THIS. THIS CAN ALSO OCCUR WITH THOSE RECORDED AS UNIMMUNISED. RECORD KEEPING CAN BE VERY POOR - YOU CAN SEE THAT IN SOME OF THE CASES EVEN THE PATIENT'S SEX IS UNKNOWN.

How did anyone stay alive before there was a tetanus vaccine?

The late Professor Ricardo Veronesi of São Paulo Brasil contributed greatly to the study of tetanus. He was a great supporter of tetanus vaccination but this did not stop him from asking questions. He studied populations that not only had no tetanus vaccination but no injections of vaccines or drugs of any sort. Backing up laboratory studies in animals from earlier years, he found that tetanus spores in the gut causes natural immunisation as was, *"unquestionably demonstrated by presence of protective levels of tetanus antitoxin in the blood…"* This explained to him the previously puzzling facts of:

*"**1.** The relatively small number of cases of overt disease among people and animals born and living in large tetanus-risk regions all over the world.*

***2.** The existence of "poor responders" and "good responders" to the primary tetanus toxoid stimulus.*

***3.** The age distribution of tetanus showing evident prevalence among newborns and children.*

***4.** The wide individual variations in the clinical picture of human tetanus as indicated by the localization and limitation of the symptoms and their severity."* [13]

Prof. Veronesi's research was echoed by Professor Haim Matzkin, Head of Epidemiology in the Israel Defence force when he studied the Falashas, an ancient Jewish population from Ethiopia who migrated to Israel the 1980s. It was his opinion that, *"There is enough evidence today to challenge the axiomatic statement that only active immunization is the key to disease prevention."*

"It may be hypothesized that repeated exposure over many years to the tetanus bacilli (perhaps by growth of the bacilli in the tissue or by colonization of the digestive system), with relatively small amounts of toxin produced, may ultimately both immunize and provide a booster to the individual" .[14]

Is this a surprise? No. Not if you acknowledge that the world is not a series of random bits of chaos, but an intelligently designed, beautiful symphony.

My patients and those who attend my lecturers know how keenly I promote the eating of 'dirt' ie, not keeping your children too clean, letting them pick up food from the floor, not bleaching and sterilising them out of existence. Here we see that if that some of that 'dirt' contains tetanus spores we might be setting up another type of immunity.

This is not to negate the importance of clean water, adequate nutritious and unadulterated food, ventilated housing, someone to love and look after them, fresh air, sunshine and exercise. Also happiness, contentment and gratitude. There is nothing like fear to massively weaken your immune system.

Looking at the table of Australian tetanus cases 2000-2009, are the few cases of tetanus in children because they are all vaccinated?

Tetanus Cases England and Wales, 2000-2009 [19]

Year	Notifications	Age & Vaccination status	Deaths & Age of Death
2013	7 (3 female, 3 male)	Of 3 cases born after 1961 2 had 3-4 doses, 1 not recorded. of 4 born before 1961, 2 not immunised, 2 not recorded	0
2014	7 (4 female, 3 male)	15-87y Born before 1961, four doses, 2 none, 2 not recorded Born after 1961 2 fully immunised. One not recorded.	1 80+ female immunisation not recorded
2015	6 (4 female, 2 male)	50-85 5 born before 1961, 4 not immunised, one unknown. One born after 1961 had 4 doses	1 mid 80s female unimmunised
2016	4 (2 female, 2 male)	25-44y None confirmed to have had 5 doses. One born before 1961 had 2 doses. 3 born after 1961, one 4 doses, one 2 doses, one unknown. One IV drug user	0
2017	5 (4 female, 1 male)	26-81y 3 born before 1961 one severe case had 5 doses but at wrong intervals. 2 born after 1961. One had 5 doses, one unclear	0
2018	7 (4 female, 3 male)	31-88y 2 born before 1961, one thought not vaccinated, One booster, but no record primary 5 thought to be vaccinated not verified. One IV drug user	3 born before1961. One unknown two had booster but no record primary course
2019	4 (1 female, 3 male)	39-70y History of vaccination but not clearly recorded	0
2020	7 (3 female, 1 male)	6 56-87y + One unknown age. 6 born before 1961 or not recorded. One booster but no primary course	2 born before 1961 & uncertain vaccination history
2021	11 (6 female, 5 male)	19 to 87 (6 born before 1961) 10 born before 1961 or uncertain history. One immunised no booster in 10 years, One incomplete primary course.	1 born before 1961 booster within 5 years
2022	4 (3 female, 1 male)	One primary course, booster within 10y, One immunised not confirmed, 2 born before 1961	0

No - A study published in 2015 stated: *[Vaccination] coverage [in Australia] increased rapidly, from an estimated 53% in the 1980s to over 90% (in 12–15 month old infants) by 2000. However, uptake has since remained relatively stable at around 91–92%.* [15]

This means approximately 10% of Australian children are not vaccinated. With a birth rate of about 270,000 per year this means 27,000 children per year are not vaccinated at all. Over 20 years this is over half a million. Why do these children not get clinical tetanus?

In the USA about 3.7 *million* children are born every year, 10% of children are not vaccinated – over 20 years that is about *7.4 million children and young adults.* In addition 20% have not had four doses of a tetanus containing vaccine – an even greater number.[16] In 2019 there were only 26 cases of tetanus reported.[17] Why do all those unvaccinated children not get clinical tetanus?

In the UK, the latest study by the UK Health Security Agency states that there were four cases reported in 2022, 11 in 2021 and seven in 2019. The ages ranged from 23 to 72 years. To explain why cases occur in older people there is an implication that cases born before 1961 when universal childhood vaccination started in the UK were unvaccinated – as if you only have vaccines in the first year of your life – not when you are older, in the work place, you have never cut your hand and gone to A&E or taken a foreign holiday.

Were these cases small unvaccinated children? No.

"All had a history of domestic or work-related injury; two cases were injured while gardening, one case sustained a bite from a feral cat and one had a minor injury from work."

"The mild case believed themselves to be immunised but they were born outside of the UK and therefore vaccination history could not be verified." If this patient had died they would have been classified as unimmunised. It is important to note that almost without exception no-one were recorded as being offered post-exposure prophylaxis with intramuscular Tetanus Specific Immunoglobulin (TIG), despite the recommendation that all exposed

individuals with unknown vaccination status be offered prophylaxis with Tetanus Immune Globulin following a tetanus prone wound.

Please note: in my opinion, only Tetanus immune globulin is effective, not HNIG. They are not equivalent.

In the UK about 7000,000 babies are born each year and 5-10% unvaccinated. This means that over 20 years there are 700,000 to 1.4 million children and young adults unvaccinated against anything. Where are they in these figures and where are the deaths or cases of clinical tetanus? Where, for that matter, are the deaths from polio and diphtheria?

Do all parents carry out scrupulous wound toilet? Do all UK, USA, Australian children not play in the garden? Be exposed to animal faeces and tetanus spores in the soil which are everywhere? You know the answer.

The doctors themselves state: *"Tetanus is extremely rare in developed countries".* [20]

How many doses of tetanus containing vaccine are you said to need to be immune?

The NHS website says five.[21] GOV.UK says five *in toto* and that *"routine boosters every 10 years are no longer recommended."* [22] However it is noticeable in the UK tetanus statistics that no booster within ten years is given as a reason for tetanus occurring in otherwise fully vaccinated individuals. The World Health Organization says you need six doses. [23]

The elephant in the room – Vitamin C

A study in Bangladesh found that there were no deaths in the age group of 1-12 years with clinical tetanus who had 1000mg of intravenous vitamin C added to usual tetanus immune globulin treatment protocol, whereas 74% of those with standard protocol without Vitamin C died.[24] [Jahan 1984).

However a Finish review of this study for the Cochrane Database 24 years (2008) later concluded: *"A single, non randomised, poorly reported trial of vitamin C as a treatment for tetanus suggests a considerable reduction in mortality. However, concerns about trial quality mean that this result must be interpreted with caution and* ***vitamin C cannot be recommended as a treatment for tetanus on the basis of this evidence.*** *New trials should be carried out to examine the effect of vitamin C on tetanus treatment."* [25]

No, let's not use a cheap, safe, readily available product that could save thousands of lives world wide and has almost zero toxicity. 16 years later (2024), have new trials been carried out? Of course not. You should know that every hospital pharmacy stocks Pabrinex for Wernicke's encephalopathy and post operative shock and sepsis. Ampoule 2 contains 500mg vitamin C for intravenous use. Trying to get a health professional to prescribe it is like trying to fly to the moon. Why? I do not know.

Is your child at risk from this disease?

Most cases of clinical tetanus and deaths are over 70 years old in Australia. In the UK they are born before 1961. The WHO states that, *"the majority of reported tetanus cases are birth-associated among newborn babies and mothers who have not been sufficiently vaccinated with tetanus containing vaccine."* [26]

Complacent attitudes regarding the protection afforded by vaccination have resulted in less emphasis being given – both by the general public and health professionals - on the need to undertake strict and appropriate wound toilet, especially removing foreign bodies in the lower limb.

This has lead to both vaccinated and unvaccinated individuals contracting clinical disease. Remember that clinical tetanus is very rare and can occur with no history of wound. Why? Because overall general health is also important.

Is your child at risk from the vaccine?

Yes because every vaccine carries some risk. This is an acknowledged fact. Tetanus and diphtheria vaccine is described as causing, *"brachial neuritis, with an incidence of approximately 1 in 100,000 (adults)."* [27] (AIH 2008) and thousands of vaccine injuries are reported by parents and health professionals per year but not acknowledged as causally related. But the studies to show if they are causally are not done.

Holding on to reality - Risk.

I believe that information is power. When you have information you can make rational decisions based on reality, not those engendered by fear. What is it that you need to know? What is the disease? What is the worst that can happen? How can you reduce the chances of that happening? What are the pros and cons of vaccination? Does it protect you?

Then you can step back and decide what is best for your family according to your own values, culture, beliefs, capabilities and what *you* think is in the best interest of you or your family. However, I find that many people do not want full information. They want to be told, for example if they decide not to vaccinate their children, that they will be fine – that there is no risk, however minute. But being alive is a risk. To vaccinate. To not vaccinate. They both involve your assessment of risk. To make rational decisions about the chance of your child dying of tetanus if they are not vaccinated – or indeed, vaccinated – let's look at some figures.

In 2022, 57 children under the age of 17 died in road traffic accidents (casualties 13,304).[28]

Does that mean you won't put them in a car?

In 2022, 35 children died of drowning.[29] Does that mean you won't live near the sea, go on holiday to the sea, allow them to go swimming, own a hot tub?

1n 2022 at least six children were reported to have died of Group A Strep that they contracted at school.[30] Does that mean that you won't send them to school? (probably a good idea though!)

And now for some real life examples of parental dilemmas and coping strategies.

Q&A

Q - My darling 12 year old son was playing in woods tonight and never saw the rusty barb wire lurking in the undergrowth. He has a small fairly shallow puncture wound on his left shin. I squeezed it at the time to make it bleed and when we got in I squeezed some more. Dripped hydrogen peroxide on it for 45 mins - was still bubbling- and fed him a hypericum 30c tablet.

I am surrounded by folk who think I'm mental for not vaccinating my kids so now at this moment in time I would just like someone on my side. I have been to one of your lectures and have your practical guide to tetanus here. I will continue to give him hypericum for next 3 days and I will drip hydrogen peroxide on it in the morning. I just worry I will miss signs of him becoming very ill. And then the preceding discussions with doctors.....over not vaccinating. Arghhhhh.....his birthday too! :(He's so clumsy!
A - Ledum 200c - next time at same time as Hypericum. You seem to have done just the right thing re wound toilet, well done. Boys will be boys! Tetanus incubation period is 14 to 56 days.

Most people don't get clinical tetanus or we would never have reached the 20th century.

Q - My unvaccinated 16 month old was scratched this morning by a random cat. It was bleeding for a few minutes before I got him home and cleaned it with salt water and put breast milk on it. I am a little concerned about tetanus. My friend sent me pictures from a book of yours and I just wondered where I could buy your books please?
A - Sounds like you did the right things - You can get the tetanus ebook here http://www.jayne-donegan.co.uk/articles
NOTE: Breast milk is an inspired choice, it is full of useful antibodies and is also great for squirting into eyes with bacterial conjunctivitis.

Q - I'm looking for information about the tetanus vaccine which I read when my son was smaller, he's about to go on a farm trip age 8 and I just want to prepare myself and reassure myself in case of incident as he is unvaccinated.
A - That is sensible Please download my ebook Tetanus and Minor Injuries from my website.

Q - I have some concerns about my daughter age 8 years. She stood on a rusty nail on Wednesday afternoon when we were out and this caused a puncture wound to the pad of her right foot. I cleaned the wound (small amount of blood) with alcohol cleaning wipes and stuck a plaster on it until we got home.

Once home I soaked her foot in warm water with salt and doTERRA oils tea tree and oregano.

I contacted a homeopath and she suggested Ledum from my Helios kit so I've began by giving her one 30c pill on the tongue followed by two 30c pills dissolved in water and given every 30 mins for the rest of the day.

Day 2 which is today, I continued but gave it every hour. I noticed one of her toes which is directly above the puncture wound is swollen and suspect an infection.

My homeopath suggested I contact my GP. He was busy but looked at some images I took and confirmed he also suspected an infection. He has advised a course of antibiotics.

He suggested my daughter may be covered for tetanus but I confirmed she was never immunized. I confirmed she was taking Ledum for prevention.

I would love to speak with you to understand if there is something additional I should be doing to help my daughter. I'm starting to doubt my self and am worried that as she is not vaccinated that she is at risk of tetanus. Thanks for taking the time to read.
A - I see you have downloaded my tetanus book.

Follow instructions re wound toilet - what you have done is probably fine but always use hydrogen peroxide. doTERRA oils are very good - given the choice I would always use lavender in preference to tea tree oil. I also recommend Hypericum in addition to Ledum and in a 200c potency

Having said all of that the would is probably not a tetanus risk anyway. Inflammation is always maximum at 48 hours. Hydrogen peroxide takes that down as well. Re vaccination that is a matter for yourself to decide - but it is of no benefit for the current wound only for future wounds.

Q - I was wondering whether it would be possible to have a one to one with you to discuss tetanus please. My daughter was at a friends climbing a ladder to slide into a paddling pool and she's just told me that as she was climbing the ladder something caught her leg. She said she tried to make it bleed when she got out of the pool but it wouldn't bleed. She has no idea if it was a puncture wound or a scrape or if it was rusty and I wasn't at friends house to investigate. Apparently the mum rubbed some cream into it.

Needless to say I'm now worried about tetanus. I find that I'm struggling to cope with the level of anxiety this brings and perhaps speaking with you might help. I'd be so grateful to hear from you. (I have bought your tetanus pamphlet but still find myself unsure of what to do now particularly as it never bled).
A - If I have time I'll call you tomorrow probably evening - follow the instructions - hydrogen peroxide 3% half and half with water.
Q - I do have Lugols iodine - can that help? **A** – It can set off allergies.
Q - Thank you , I now have hydrogen peroxide 3%. **A** - EXCELLENT.

Q - I hope you don't mind me contacting you but I don't know who else to turn to. I've spent this morning in A and E with my daughter in law and my 20 month granddaughter, who has been burned by a hot black coffee. Whilst wearing joggers. In A&E they gave her calpol and nurofen, scraped the blistered skin off, took photos and dressed the wound. The burn was judged to be partial superficial. However it covers a large area, from mid thigh right down the front of her leg. Hence after reviewing the photos the neighbouring Burns Unit asked us to take her in immediately. This is where I am asking for your help, she hasn't had any childhood vaccines and the Dr is saying they need to give her a Tetanus shot. My son has just called to ask what he should do. My instinct is not to give it her, as if the leg is dressed and bandaged, why will she be exposed to tetanus. I know from studying on your courses you are an expert on this and wondered if this is one of those situations where not having it could be more serious than having it.

I've been giving her Cantharis 30c, Hypericum 30c and Calendula 30c hourly since it happened.
A - https://www.nhs.uk/conditions/burns-and-scalds/recovery/

NHS: *"Depending on how the burn happened, you may be advised to have an injection to prevent tetanus, a condition caused by bacteria entering a wound. For example, a tetanus injection may be recommended if there's a chance soil got into the wound."*

NOTE: here is an example of a doctor telling the parents their child needs to have a tetanus containing vaccine for a clean wound that still has a good blood supply when the NHS website also does not even recommend it for a burn that was not in contact with soil.

I have not heard of scraping off blisters - carefully draining them, yes. Blisters cover the area, protect it from rubbing and scratching, keep infection out and allow new skin to develop underneath. Though it seems there is more than one opinion now: https://pubmed.ncbi.nlm.nih.gov/34908785/

"Blisters are characteristic finding of second-degree superficial burns. Varied opinions for the management of burn blisters are available in literature. Most accepted one is to puncture it in a sterile way, keep the overlying skin as a biological cover, and over that put a moist sterile biological dressing. Fluid in the blister is ultrafiltrate of the plasma, which is rich in proteins such as immunoglobulins, various cytokines, prostaglandins, and interleukins.

This fluid is pro-inflammatory, and the evidence regarding its effect on wound healing is varied. Instead of drainage, the burn blister fluid can be aspirated and immediately sprayed over the other areas of the same wound. We found this method feasible as an adjuvant therapy for second-degree superficial burn wounds.

Reply - In my heart I knew the answer, but your information have given me the confidence to stand firm. They have been pushing for us to give her the MMR whilst she in hospital, as, *"they have some bad cases"* but obviously that one was easy to answer! She is due to go to theatre today to have epiprotect applied.

Q - I attended one of your online lectures a few weeks ago on tetanus and first aid. My 10 year old daughter wants to have her ears pierced for her birthday and as always the tetanus risk jumps to mind. I was wondering what your thoughts are on this. All the girls in our family have pierced ears and it's something she has now decided she would like to have. I would be grateful if you could let me know your thoughts on this.

A - Pierced ears – great. If you think tetanus is a risk where she will have it done then that is the LEAST of your worries! - Think about Hepatitis B/C HIV etc. Make sure you go to a regulated place- I think Accessorize do them.

Q - Hydrogen peroxide?

A - Hydrogen peroxide for all cuts/grazes if need to clean more than water.

Q - My 10 year old had a *seemingly very minor skin wound* in the school wildlife garden last Weds. He nicked his finger on a jagged edge of a rusty rake. The wound did penetrate the skin but the metal went into his finger at a sideways angle so it wasn't a really deep wound, and it bled a small amount according to my son.

My son, is only partially vaccinated against tetanus (1 dose at 14months old and 1 dose at 9 years old). I got very worried when we received different medical advice on how to act on his injury, according to different doctors and nurses we spoke to. The first advice was vaccination within 48 hours. The second, third and fourth advice were '*do nothing*.' The fifth advice was intramuscular tetanus immune globulin (TIG) and vaccination at the same time immediately.

Much parental stress followed as we tried to balance risk and benefit. We finally opted for a vaccine yesterday, as having researched how TIG is sourced (we read its sourced from a pool of 1000 non UK donors, screened for big blood borne diseases, but with a caveat of not being able to screen for all disease that could be present) combined with the fact it appears to be very rarely given in the UK, we saw the vaccine as having less unpredictability in terms of a) how his body might react, and b) anaphylactic shock, as he has received two vaccines before.

We are still questioning whether we did the right thing to choose vaccine over TIG....ie the worry that maybe he needs those antibodies right now.

So, for future events, I want to feel more prepared, especially as our younger son has not received any vaccinations (and we are camping next weekend)

The possible side effects of TIG sound very scary as a parent. I understand its possible to have the really rare reaction of anaphylactic shock to any medication (or foreign antibodies) but aside from this reaction, the Patient Information Leaflet found stated that shortness of breath, low blood pressure, chest pain, tremor etc were possible reactions with unknown frequency.

After all of that explanation, I just wanted to ask you how safe is IM-TIG?

A - **1**. the tetanus vaccine was not just a tetanus vaccine - it would have been at a minimum a tetanus, polio and diphtheria vaccine

2. I do not know why the TIG advice included having the vaccine as well.

3. The most important issue regarding tetanus is wound toilet - cleaning it and hydrogen peroxide - irrespective of vaccine status. You may want to download my tetanus and minor injuries ebook from my website https://www.jayne-donegan.co.uk/articles/

4. TIG is as safe as any other blood product - it is screened but only for things we know. It is may or may not be safer that the vaccine.. Wound toilet is the most important issue.

Q - Thank you so much Jayne. We went for the vaccine in the end, with lots of detox aftercare. Hopefully that will be the last vaccine. I have hydrogen peroxide at home but it's a worry when the injury happens when I'm not present (children growing up, more independent) I have been to this lecture previously, and do have the notes somewhere, am I right in thinking the hydrogen peroxide needs to be applied straight away for the oxygenation, and is useless after a time lapse? (ie if the children are injured at school/Park with friends/club etc when general washing with water would likely be extent of cleaning.

A - Most wounds are not tetanus prone anyway as blood is oxygen. Re anaphylaxis, from the summary of product characteristics, the frequency of anaphylaxis with the TIG is unknown, as is the frequency with the vaccine.

Q - My 8 year old had a small accident on Sunday, a rusty nail in our garden pierced her foot, the majority of the nail was caught by her shoe (crocs). I took her to a GP yesterday and they were insistent on a Tetanus shot, I just wanted to double check with you how critical this is and if you can recommend someone who can do it privately if needed. Thank you and kind regards

A - *'I took her to a GP yesterday and they were insistent on a Tetanus shot'*

Yes - well - that is to be expected - one size fits all, no individualisation but crucially, no information about wound toilet - cleaning the wound appropriately - is the most important factor vaccinated or unvaccinated - how else did we all survive before there was a vaccine.

There is a tetanus ebook available on my website for next time, and a lecture next week - forewarned is forearmed

Q - If it's OK I have a question about using hydrogen peroxide on wounds. I have the 3% food grade one like you recommended but have heard some controversial things about using it for wound cleaning - also the packet says it's corrosive to skin… is this just 'precaution' so they don't get sued? Assuming if you have used it for years for wound cleaning (a few sprays of the 3% is that right?!) then it's ok?! Just double checking!!

A - Anything cheap, ordinary, off patent is demonised. A neighbour whose cat had endless courses of antibiotics for a wound with a non healing fistula from a bite and in whom I suggested the use of hydrogen peroxide said, *"I looked it up and it says it destroys flesh!"* I said, *"What do you think anti biotic means? - Anti life."* Suffice to say the cat's wound cleared up with the H2O2 - of course.

Don't use spray, drip on from cotton wool dipped in it 'til fizzing stops. Do you have the tetanus ebook?

Q - From someone who downloaded my tetanus and minor injuries ebook

Thanks Jayne, I've just read through and found it very helpful. What would be the concerning symptoms of tetanus after a cut that you should watch for?

A - strange continual blinking/ eye twitching reflexes like knee jerk occurring withou being hit with a patella hammer.

Q - Would you say it's best for children who live /work in a farm environment to have a tetanus vaccine?

A - You have to decide that - vaccinated or unvaccinated the important factor is 'wound toilet'. It is amazing that anyone managed to reach the 19th century when tetanus vaccination became available if vaccination was the most important factor.

Q - I attended your lecture on tetanus a few weeks ago. You suggested a few products to use in the First Aid kit. Is there a particular website you recommend I buy the supplies from?

As I've been searching for certain items (hydrogen peroxide etc) from my local chemists/shops however, no one seems to stock the items any more.

A - Amazon :-) They sell 3% peroxide. All chemists used to but now they are too busy selling savlon creams that make wounds wet and kill off all the nice bacteria!

Funny story re the First Aid Kit - I do first aid and cook for a summer camp each year. One of the adults hit a log too hard and the axe bounced back and hit his forehead making a big gash (handle side!). I set about sorting it out and his wife brought out her kit – they are usually useless. I looked in it and was amazed. It had everything I needed: hydrogen peroxide, cotton wool, gauze squares, scissors, tape, vaseline, - it was fab. I said to her,

"What a brilliant kit - it has everything I need!"

She said, *"I went to your lecture years ago and I put together the kit you recommended!"*

Ha! ha! – what goes around comes around! - You can download the Kit List from my website for free.

NOTE: Hydrogen peroxide can be applied at any time. The BNF says wound toilet is too late after six hours, the sooner it is undertaken the better. Remember to put the cut/ puncture under running water to slow clotting and to make it bleed for longer even if you have no hydrogen peroxide. You see, above, what can happen with a *'seemingly very minor skin wound in the school wildlife garden.'* A reaction out of all proportion to the injury and the risk. None of the doctors recommended careful 'wound toilet'. This is how mistakes are made and bad outcomes occur. Twenty years ago no-one would have thought twice about such an injury and now we are all hyped up to think death is around the corner.

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To attend her regular online lectures please visit: https://www.jayne-donegan.co.uk

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RESOURCES

Dr Donegan's lecture Holistic First Aid Course - Tetanus and minor injuries next lecture 04 Mar 2025, Tuesday Evening. To book https://www.eventbrite.co.uk/e/1018574031347

Dr Donegan's ebook TETANUS and Treatment of Cuts, Grazes and Minor Injuries - Safe Treatment of Childhood Injuries is available for download at: https://www.jayne-donegan.co.uk/tetanus-and-treatment-of-cuts-grazes-and-minor-injuries-safe-treatment-of-childhood-injuries/

More detailed and scientific information about Tetanus and the other childhood vaccines can be found in: Childhood Vaccinatable Diseases and Their Vaccines is available for download at: https://www.jayne-donegan.co.uk/childhood-vaccinatable-diseases-and-their-vaccines

Dr Donegan's First Aid Kit is available for free download at: https://www.jayne-donegan.co.uk/wp-content/uploads/2024/09/Dr-Donegan-First-Aid-Kit.pdf

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EUROPEAN VACCINATION CARD WILL BE PILOTED IN FIVE COUNTRIES

'A EUROPEAN VACCINATION CARD WILL ENABLE INFORMED VACCINATION, ACCORDING TO EXPERTS WORKING ON THE EUVABECO PROJECT. LATVIA, GREECE, BELGIUM, GERMANY AND PORTUGAL WILL PILOT THE NEW TOOL FROM SEPTEMBER.'

EXTRACTS
22 JULY 2024
https://www.vaccinestoday.eu/stories/european-vaccination-card-will-be-piloted-in-five-countries/

As Europe transitions from emergency measures to long-term COVID-19 management, there is a critical opportunity to strengthen resilience and increase preparedness for future health threats. The European Vaccination Beyond COVID-19 (EUVABECO) project seeks to leverage this momentum by initiating pilot projects to develop and test implementation plans for tools that support both routine and crisis vaccination practices.

INTRODUCING THE EUROPEAN VACCINATION CARD

One key tool that EUVABECO will introduce is the European Vaccination Card (EVC). Scheduled for launch in September 2024, the EVC will initially be piloted in five pilot countries: Latvia, Greece, Belgium, Germany, and Portugal. The card aims to empower individuals by consolidating all their vaccination data in one easily accessible location. It will be available in various formats, including printed cards, mailed copies, and digital versions for smartphones.

Developed during the COVID-19 pandemic for the EU Digital COVID Certificate, the GDHCN is now managed by the World Health Organization, enabling the authenticity of digital vaccination records to be ensured.

EUVABECO's pilot projects aim to pave the way for other countries by harmonising vaccine terminology, developing a common syntax, ensuring adaptability across different healthcare settings, and refining EVC implementation plans.

These plans will be publicly released in 2026, extending the EVC system beyond the pilot phases and enabling broad adoption across all EU Member States.

TiP Editor: I remember reading an article in recent years where the word covid was claimed to really stand for Certificate Of Vaccine ID!

TIP ARCHIVE

AN EXPLOSIVE POINT-SOURCE MEASLES OUTBREAK IN A HIGHLY VACCINATED POPULATION: MODES OF TRANSMISSION AND RISK FACTORS FOR DISEASE

ROBERT T. CHEN, GARY M. GOLDBAUM, STEVEN G. F. WASSILAK, LAURI E. MARKO-WITZ, WALTER A. ORENSTEIN

American Journal of Epidemiology, Volume 129, Issue 1, January 1989, Pages 173–182,
https://doi.org/10.1093/oxfordjournals.aje.a115106

ABSTRACT

In 1985, 69 secondary cases, all in one generation, occurred in an Illinois high school after exposure to a vigorously coughing Index case. The school's 1,873 students had a pre-outbreak vaccination level of 99.7% by school records.

The authors studied the mode of transmission and the risk factors for disease in this unusual outbreak. There were no school assemblies and little or no air recirculatlon during the schooldays that exposure occurred. Contact interviews were completed with 58 secondary cases (84%); only 11 secondary cases (19%) of these may have had exposure to the index case in the classrooms, buses, or out of school.

With the use of the Reed-Frost epidemic model, only 22–65% of the secondary cases were likely to have had at least one person-to-person contact with the index case during class exchanges, suggesting that this mode of transmission alone could not explain this outbreak.

A comparison of the first 45 cases and 90 matched controls suggested that cases were less likely than controls to have provider-verifiable school vaccination records (odds ratio (OR) = 8.1) and more likely to have been vaccinated at less than age 12 months (OR = 8.6) or at age 12–14 months (OR = 7.0). Despite high vaccination levels, explosive measles outbreaks may occur in secondary schools due to
1) airborne measles transmission,
2) high contact rates,
3) inaccurate school vaccination records, or
4) Inadequate immunity from vaccinations at younger ages.

TiP Editor: Another good example of how a highly vaccinated population still experience an outbreak of measles. The authors clearly are unclear and are really at a loss as to understand why this 'outbreak' occurred. They admit that the mode of transmission could not be explained and typically resort to mathematical epidemic models, and use the term 'likely to have', in otherwords their conclusions are very much based on assumptions that fit with their belief in disease and germ theory.

HOMEOPATHY INTERNATIONAL (HINT)

A new homeopathy body supporting the profession has released a position statement regarding vaccination and informed consent. They are looking to engage with government bodies to find out why the NHS has not been keeping doctors up to date about their professional liability regarding informed consent. Their statement can be found at: http://www.hint.org.uk

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.

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