THE informed PARENT
ISSUE ONE 2020 A NEWSLETTER ON VACCINATION ISSUES AND HEALTH

COVID 19: MANY QUESTIONS, NO CLEAR ANSWERS

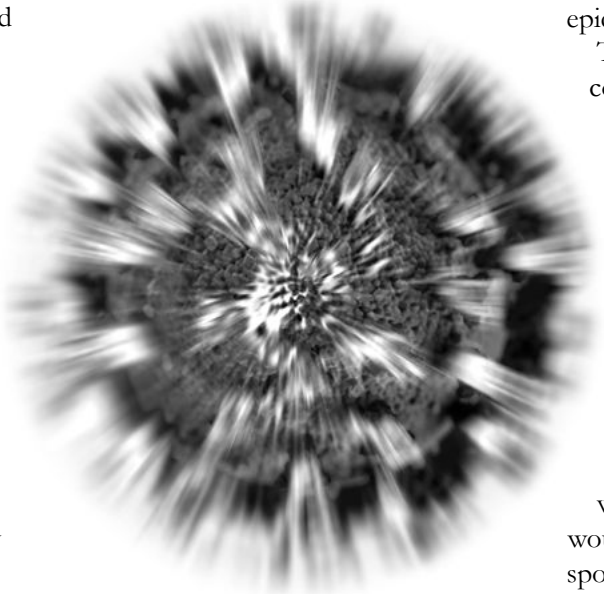
BY TOM JEFFERSON
The BMJ Opinion, March 2, 2020

BECAUSE OF MY background as an epidemiologist and Cochrane researcher, and my involvement in the H1N1 outbreak, I often get stopped in the street, or in a bar, or the gym, and asked about covid-19. The questions are usually: how long does it take for the symptoms to manifest? How can I avoid it? Is it serious?

These are just a few examples, and they are no different to what people would ask, say, in a park in Leeds or a subway in New York. Except that I live in Italy, the third most hit country in the world, my youngest children go to school locally, and my grandchildren are due to come over to Italy soon to see us.

The tone of my answers is usually dismissive. I explain the nature of influenza-like illnesses, the fact that it is a syndrome, there is not a single cause, and the gallery of "culprits" increases as time goes on. But it is mysterious, it comes and goes. That is why it is called influenza, as our forefathers ascribed its waxing and waning to the influenza degli astri, or "influence of the planets." Meaning they had not a clue as to where and how it started and where it went. We are still clueless.

There is, however, one question that my Italian friends often ask me to which I have no answer: how is this different from the seasonal influenza-like illnesses we are used to? Mario, a weight training paramedic, looked to me as the font of all knowledge, but I think his faith is misplaced. To begin with I muttered something about bats, birds, wet markets, a novel virus and so on. I deftly got on with what I was doing, but I was left with a nagging feeling of ignorance. Well, the virus serotype is new, sure, but is that enough to justify the frenetic media attention? Cases increased rapidly in China and then, of all places, here in Italy, and so have the number of deaths.



Coronavirus / Covid-19. Pic Credit: CDC.

At the time of writing there have been 2838 deaths recorded in China and 86 elsewhere in the world, according to the World Health Organization. Even though no one knows for certain how many people die of influenza every year, 2828 deaths in the space of three months compared to the nearly 900 000 deaths a month in China alone for all causes (mainly cancer and cardiovascular accidents) does not sound like much. And how do 86 deaths worldwide (excluding China) compare with deaths from influenza and influenza-like illness? Do not bother looking it up: we do not know.

Perhaps the death rate, the ratio of confirmed cases to deaths, could explain the furore? It seems to be anything between 0.18% to 4.9% (depending on where you look), on average below that of other coronavirus outbreaks. And deaths seem to be concentrated in older age groups and in people with pre-existing morbidities.

So I cannot answer my nagging doubts, there does not seem to be anything special about this particular epidemic of influenza-like illness.

There are, however, two consequences of this situation that bother me. The first is the lack of institutional credibility as perceived by my friends. They range from firefighters, policemen, and even a GP—not the kind of people you would want to alienate in an emergency. A restaurant owner told me he would never report himself to the health authority as that would mean at least two weeks of closure and his business would go to the wall. Jokers and spoofers are doing overtime on the web. The authorities cried wolf in 2005 and 2009 with influenza and see what you get now.

The second is that once the limelight has moved on, will there be a serious and concentrated international effort to understand the causes and origins of influenza-like illnesses and the life cycle of its agents?

Past form tells me not, and we will go back to pushing influenza as a universal plague under the roof of the hot house of commercial interest. Note the difference: Influenza (caused by influenza A and B viruses, for which we have licensed vaccines and drugs), not influenza-like illnesses against which we should wash our hands all the year round, not just now.

Meanwhile, I still cannot answer Mario's question: what's different this time?

Tom Jefferson is an epidemiologist and Cochrane researcher, based in Rome, Italy.


Magda Taylor

Editor's note

WORDS FAIL ME as to the situation we are presently experiencing worldwide! A very interesting short video online entitled: Coronavirus Is Not Covid-19 presented what I consider a very interesting perspective on why this pandemic has come about. The presenter Jerry Day, EMF Help Center firstly reads out a text regarding the virus by a US scientist who wished to remain anonymous (Manufactured Pandemic: Testing People for Any Strain of a Coronavirus, Not Specifically for COVID-19; Julian Rose, Global Research, 27 March 2020). At around 9.50 minutes into the video Jerry Day then states:

'I am going to speculate as to why all the media and our political leaders are whipping up hysteria over this idea of global pandemic. Our central banks and our governments created a financial crisis using unbacked, debt-based, fiat currency, unlimited government borrowing, at impossibly escalating levels of taxation to service all the debt. We are very near now the end of the monetary cycle where debt can no longer be sustained. Currencies everywhere are being overprinted and nearing collapse. Equity markets are irreparably overvalued and our currency systems must undergo a major reset as they desperately issue helicopter money for bail-outs and give-aways the currency will sharply inflate and trillions of dollars of monetary value will simply disappear for most of us as those who control currency will collect that wealth.

In this process many people worldwide will suffer losses, poverty, disruption, and sacrifice. Most people are not aware that this disaster was predictable and inevitable. Bankers and lead officials do know what is coming and they know that people see that they are to blame for the disaster unless they can come up with a scapegoat.

Scapegoats come in the form of things like terrorism, global warming and global viral pandemics. Manufacturing or exploiting some global threat not only allows blame for the economic disaster to be diverted from central banks and government officials but also gives an excuse to impose authoritarian public policies so that riots and civil unrest can be harshly dealt with by state-sponsored violence and force.

We are being suckered to accept a huge new set of restrictions on our lifestyles and personal liberties so we will be powerless against official policy and some kind of new world order can be imposed that without some fabricated crisis would meet violent public opposition. We have been made to believe that we must radically change our lives because of a pandemic but we're actually changing our lives to relieve central banks and our legislators from the blame for what's happening to our economy.

We have seen major stock market crashes. We have seen years of near zero interest rates. We are seeing public debt now multiplying by trillions of dollars per year. Just as central bank and government insiders have expected our corrupt global economic and currency systems are unravelling. We now see that not only is public debt unsustainable, but even corporate and private debt are at levels where that debt can never be paid off. It's a mathematical impossibility. The cause of the collapse, the depression, the austerity, poverty, and social disorder is not a COvid 19 pandemic. The cause of the economic collapse is worthless, unbacked, debt-based currency, bad economic policy, greed and irresponsible conduct by government and central bankers and their belief that they can plunder the world's workers and business owners decade after decade until everything crashes, then past the blame off onto some unrelated calamity that they either create themselves or exploit to their benefit.

In 1913 when the Federal Reserve was created future economic disasters like we are seeing today were unavoidable. But you are being asked to blame a virus for this supposedly unexpected economic meltdown. the lockdowns, the people forced to not work, the companies forced to not produce. The debtors who will be made unable to pay their debts. The quarantines, curfews, martial law tactics imposed. This whole insane reaction to an alleged pandemic WILL cause major economic damage. That is what it is designed to do. So all economic failures and crises from now on can be blamed on a virus, not on the people who created the economic corruption in the first place.

We do not need to beat a virus we need to prevent another fake, unbacked currency from replacing the last one. We need to prevent debt and taxation from accruing to pay for exploding public debt and financial mismanagement.

We need to demand that no one pledge OUR future labour to pay for THEIR greedy indulgences.

As we slather our living spaces with toxic sanitizing chemicals. As we give up our true social context and become even more addicted to our tracked and monitored electronic social media platforms. As we allow idiotic government policies to close our businesses and destroy our jobs.

Would this not be a good time to think for ourselves and consider whether we are being told the truth, whether we are being used and set up by liars and corrupt officials for their own benefit?

Can we do anything to reclaim our lives, our prosperity, and hope?

Or will we simply believe whatever we are told and obey whatever we are told to do?

Obediency and complacency can be good, or it can be a terrible mistake. Trusting media and politicians can be good, or it can be a terrible mistake. I would argue that trusting this pandemic hysteria and participating in economic suicide is a terrible mistake.'

It is time to find courage, speak out, raise concerns and gather reliable information to share far and wide!

Magdalene Taylor, Editor,
April 2020

"LIBERTY IS TO THE COLLECTIVE BODY, WHAT HEALTH IS TO EVERY INDIVIDUAL BODY. WITHOUT HEALTH NO PLEASURE CAN BE TASTED BY MAN; WITHOUT LIBERTY, NO HAPPINESS CAN BE ENJOYED BY SOCIETY. ~ *HENRY ST. JOHN.*"

IATROGENIC PNEUMOTHORAX RELATED TO MECHANICAL VENTILATION

World J Crit Care Med
PMID:24834397
4 February 2014

TiP Editor: Given concerns from some health professionals that putting patients on a ventilator may be inappropriate and lead to fatalities. This may be of interest?

ABSTRACT

PNEUMOTHORAX is a potentially lethal complication associated with mechanical ventilation. Most of the patients with pneumothorax from mechanical ventilation have underlying lung diseases; pneumothorax is rare in intubated patients with normal lungs.

Tension pneumothorax is more common in ventilated patients with prompt recognition and treatment of pneumothorax being important to minimize morbidity and mortality. Underlying lung diseases are associated with ventilator-related pneumothorax with pneumothoraces occurring most commonly during the early phase of mechanical ventilation.

The diagnosis of pneumothorax in critical illness is established from the patients' history, physical examination and radiological investigation, although the appearances of a pneumothorax on a supine radiograph may be different from the classic appearance on an erect radiograph.

For this reason, ultrasonography is beneficial for excluding the diagnosis of pneumothorax. Respiration-dependent movement of the visceral pleura and lung surface with respect to the parietal pleura and chest wall can be easily visualized with transthoracic sonography given that the presence of air in the pleural space prevents sonographic visualization of visceral pleura movements. Mechanically ventilated patients with a pneumothorax require tube thoracostomy placement because of the high risk of tension pneumothorax. Small-bore catheters are now preferred in the majority of ventilated patients.

Furthermore, if there are clinical signs of a tension pneumothorax, emergency needle decompression followed by tube thoracostomy is widely advocated. Patients with pneumothorax related to mechanical ventilation who have tension pneumothorax, a higher acute physiology and chronic health evaluation II score or PaO2/FiO2 < 200 mmHg were found to have higher mortality.

"Mechanically ventilated patients with a pneumothorax require tube thoracostomy placement because of the high risk of tension pneumothorax."

CORE TIP:

Patients with pneumothorax related to mechanical ventilation (PRMV) have a high mortality rate. PRMV often occurs in the early stage of mechanical ventilation and it may recur on the other side of lung in a short period of time. Low compliance is associated with a high incidence of PRMV, with PRMV being more related to the underlying process than the ventilatory setting. PRMV patients with tension pneumothorax, higher acute physiology and chronic health evaluation score or PaO2/FiO2 < 200 mmHg have a higher mortality.

UK HEALTH SURVEY OF UNVACCINATED INDIVIDUALS

Q1: ARE YOU AN UNVACCINATED ADULT, AGED NO MORE THAN 40 AND / OR HAVE YOU ANY UNVACCINATED CHILDREN?

Q2: DO YOU / THEY LIVE IN THE UK?

IF YOU ANSWERED YES TO BOTH QUESTIONS, PLEASE READ ON - WE NEED YOUR HELP!

We are conducting a long overdue strictly confidential UK health survey comparing the incidence of various health conditions in the unvaccinated with those of the general population.

Regardless of whether you have any health conditions or not, we would like to hear from you all equally and from as many of you as possible.

The survey questionnaire takes just minutes to complete and we need a high number of participants to derive meaningful results.

If you are happy to contribute to this survey or have any questions please email Shan at: healthvaxsurv@gmail.com saying where you saw this request.

Please may we also ask your help in passing on this information to other potential participants, but in a manner consistent with it being kept strictly outside the general public domain. Thank you!

PLEASE EMAIL SHAN AT: healthvaxsurv@gmail.com

THE CORONAVIRUS IS COMING: HEAD FOR THE HILLS!

BY TED KOREN

https://korenwellness.com/blog/the-coronavirus-is-coming/

IS IT CORONAVIRUS or déjà vu? I'll never forget the scene. A few years ago, I was in a hotel teaching a KST seminar and during a break I went into the lobby. I was attracted to the large screen TV showing a near-hysterical reporter telling us about the horrible, terrible, no good, scary, killer flu that just appeared in Mexico. This time it could be the "Big one", the swine flu that killed millions. Again.

People all over the world were freaking out. There was a report of baggage handlers in Italy refusing to touch luggage that was in a plane that had come in from Mexico City.

One of the students at the seminar who was watching the "news" with me asked, "What do you think about this?" I answered him honestly. "I don't know, these reporters sound hysterical. Let's wait 'til the dust settles. How do we know that this flu is different from last year's flu?"

I went back to teaching and told everyone to settle down. One person asked me if beer was a good antidote for the flu. I told him I thought brandy was better and we could do research on this later that evening. Then we got back to the seminar.

OOPS!

Guess what was discovered? A month or so later, when things settled down and the reporters started reporting news instead of hysteria, it was revealed that that year's terrible "killer flu" turned out to be even milder than the regular flu.

I wonder, "did the airline passengers eventually got their luggage?"

HYSTERIA IS MORE CONTAGIOUS THAN THE FLU

Media-fueled hysteria, didn't stop millions of people from being distracted with fear. Millions got vaccinated even though the vaccine wasn't tested for safety or effectiveness. "Testing? Lives are at stake for G-d sake. You want us to die? Gimme that shot."

Remember a few years ago when hundreds of elderly people waited on line for "protection" from some flu shot they were scared into getting? Again, we were told, "It's coming, the big one is coming!" The only people who died were those who had accidents and falls while waiting on line for the worthless, dangerous flu shot that has been linked to neurological damage as well as Alzheimer's Disease. [1]

"If you think this is a replay you are correct: coronavirus is just a replay of Ebola, SARS, bird flu. swine flu, MERS and H1N1. It's the latest hysteria; it's all blah, blah, blah. Fake news."

LET'S DISCUSS THE FLU

Let's talk about the flu. You have a fever, you're weak and achy, tired and have other flu-like symptoms. Could it be coronavirus (2019-nCoV)! Or maybe it's...

- Swine flu
- SARS
- MERS
- West Nile Virus
- Zika
- Ebola
- Bird Flu
- H1N1

Weren't we told all of the above were going to spread all over the world and kill millions? Didn't the experts tell us that?

POODLE FLU?

Who knows what else will be coming—Parakeet flu? Chicken flu? Frog flu? Blog flu? Cat flu? Goat flu? Duck flu? Poodle flu? Or perhaps it's an ILI: influenza-like illness that you have. Most cases people consider to be the "flu" are really ILIS. In one study, over 80% of people who thought they had the flu had an ILI.[2]

There is no end to what we can blame an epidemic on since there are thousands, hundreds of thousands and even millions of viri and bacteria and other micro-organisms. They all have one thing in common—the medical profession, health department, "experts" and media love to blame epidemics on them.

DETOXIFICATION AND RESTORING HOMEOSTASIS

What is the flu? A detoxing! All the symptoms—fever, sweating, fatigue—are good for you. You are restoring homeostasis as your body flushes out toxins. It's a wonderful thing, even if you feel like crap. Please rest and take it easy, hydrate [my grandmother used an enema bulb—I dare you (it did work)] and stay comfortable while you heal.

It's been known for centuries that having fevers and so-called infectious diseases of childhood result in a healthier person with less cancer, less heart disease and less chronic illness in adulthood. It's long been known that as a result of the detox children have physical and mental growth spurts after these diseases. That is why, in India measles is referred to as "visitation from a goddess." In China measles symptoms are understood to be how the child detoxes from the poisons it absorbed in the womb. After all, mothers detox into their unborn babies. [3] It must be repeated that symptoms are how your body restores homeostasis, or balance. Symptoms are part of a healing process. As Hippocrates said, "We call them diseases but symptoms are the cure of diseases."

THE END IS COMING, PREPARE TO MEET THY DOOM!

Remember those cartoons of a guy in a white robe walking around holding a sign, telling us to repent or we're going to meet our maker?

Since medicine has replaced religion for many people, "The End is Coming" is no longer from a religious group but from medical organizations telling us that the BIG ONE is coming.

Repent or you're going to die. How do we repent? We get sprinkled, rather

Photo by Cam Adams on Unsplash

injected, with holy water. Vaccines are the modern holy water given by today's doctor-priests.

"Inject me and my wife and our kids with your holy waters! We'll be protected! We'll be among the saved! After all what could be the downside of holy water?"

If you think this is a replay you are correct: coronavirus is just a replay of Ebola, SARS, bird flu. swine flu, MERS and H1N1. It's the latest hysteria; it's all blah, blah, blah. Fake news.

But vaccine stocks are soaring in response. That's what we need, a vaccine against coronavirus. Who has time for safety tests? [4]

ARE YOU WORRIED?

Are you worried about the coronavirus and the monstrous pandemic that it will unleash to kill millions? You needn't be. There are really no such things as "killer bugs" or "killer viri." Infections only arise in fertile soil. Claude Bernard, the father of physiology and one of the world's great scientists, famously said our "milieu interieur"—our internal environment—was the key to health. This flew in the face of Pasteur and Koch's germ theory of disease, that considered the germ to be primary as a cause of disease, irrespective of the individual's health. Intense discord among scientists arose over this issue.

Yet on his deathbed Louis Pasteur, in 1895, said to his friend Professor Renon: "Bernard was right, the germ is nothing, the milieu is everything." [5]

BUT THERE ARE PLENTY OF OTHERS

There are plenty of others to this day that feel that Bernard was wrong, that the germ is everything and individual resistance is nothing. We have experts who use computer simulations (i.e. made up stories) that are truly frightening. One simulation has predicted 65 million deaths from the coronavirus. Even though every prediction ever made based on that premise has never come to pass it makes no difference, people are easily scared. Ignore the facts, head for the hills! [6]

HOW BAD IS IT?

According to the CDC:

While CDC considers this a serious public health concern, based on current information, the immediate health risk from 2019-nCoV to the general American public is considered low at this time. [7]

Don't panic yet!! We'll tell you when to panic. But stay in pre-panic mode, it'll keep you scared. Politicians and medical professionals like that.

WHY CHINA?

Let's put this China coronavirus "pandemic" in perspective: there have been a small number of deaths blamed on the coronavirus in a city of 11 million. Is that more or less than died during the same period last year? The year before? We don't know since nobody is asking the right questions. Reporters that go after politicians with ferocious intensity become typists when someone in a white coat with letters after their name speaks.

Why China? Much of China is filthy. I'll never forget, a couple of years ago my brother and sister-in-law took a 3-week tour of China. They came back having lost weight. Why? They said the food was terrible, the air was barely breathable, the water was polluted, bathrooms were disgusting and they couldn't wait to leave. Many people in their group got sick.

Stop blaming it on bugs—they are scavengers that feed on toxic tissue. It's not some "virus" of which there are thousands if not millions, it's the toxins.

The foul air of dozens of fast-expanding cities across China contains cocktails of toxic contaminants unprecedented in the range of pollutants they contain at high concentrations ... effects that doctors say are cutting five years off the expected lifespan of half a billion people in northern China.

China has the world's most dangerous outdoor air pollution. The

country emits about a third of all the human-made sulphur dioxide (SO2), nitrogen oxides (NOx), and particulates that are poured into the air around the world. The Global Burden of Disease Study, an international collaboration, estimates that 1.1 million Chinese die from the effects of this air pollution each year, roughly a third of the global death toll. [8]

MORE TOXICITY

Let us not forget the poor quality of the food and the malnutrition from food grown in minerally depleted soil. Add to that genetically modified seeds, synthetic chemical fertilizers, herbicides, fungicides and pesticides and you have a toxic population close to the tipping point. Excellent nutrition information is at www.westonaprice.org

THE SAME OLD DANCE

This coronavirus hysteria is the same old dance we see year after year: government officials trying to scare us into spending money on useless vaccines or drugs. Blaming things on a "virus" distracts from the real source of disease—toxicity, pollution, poor waste disposal, poor water, poor nutrition, factory farming and (especially in communist countries) lack of respect for private property – people can pollute with impunity since, if "the people" own the land, then nobody owns the land. Who can sue for violation of property rights if there's no private property? Without private property pollution spews unchecked.

A HISTORY OF PANDEMICS

In the history of human life on this planet there has never been an infection, let alone a plague, that threatened to wipe out humanity; not even the bubonic plague or "black death" that killed so many in Europe in the Middle Ages. As with other plagues it was caused by filth, rats, unsanitary lives. By staying away from polluted water and polluted air, by observing basic hygiene and sanitation practices, a reasonably healthy, reasonably well-nourished person has nothing to worry about.

One of the most powerful immune suppressive things to do is to take

"Those days MDs prescribed aspirin by (literally) the hands-full. Pumped full of aspirin, people were not able to generate a healthy fever and instead became a perfect breeding ground for bacterial infection. It was not the flu virus that caused death but bacterial pneumonia."

medications. Steroids, aspirin, acetaminophen and many other meds weaken one's immune system, make you toxic and get you sick. The medical profession is one of the main causes of death and disease in today's world.

HOW TO STAY HEALTHY

Your immune system works to keep your body in balance or homeostasis; it is more powerful than any drug or vaccine—and much safer. You are not a passive victim. You don't need drugs to live a healthy life. You most certainly don't need vaccines—that'll make you sicker!

WORLD HYSTERIA ORGANIZATION

The WHO— "World Hysteria Organization"—likened the coronavirus to the new "Spanish Flu" that caused millions of deaths. Every time officials wish to terrify the public they tell us that the 1918-1919 Spanish killer flu is coming.

WHAT WAS THE SPANISH FLU ALL ABOUT?

The 1918-1919 "Killer Flu" or "Spanish flu" that supposedly killed millions world-wide was no unusual, terrible, powerful flu. It was a regular flu.

What made it so deadly was the new medical treatment with their new wonder drug—aspirin. Aspirin's use, and especially its dangers, was not understood.

Those days MDs prescribed aspirin by (literally) the hands-full. Pumped full of aspirin, people were not able to generate a healthy fever and instead became a perfect breeding ground for bacterial infection. It was not the flu virus that caused death but bacterial pneumonia.

Under medical care the death rate was as high as 40%. But under homeopathic, chiropractic and osteopathic care the death rate was about 0.25%. These healers did not use aspirin to suppress symptoms and respected the body's need to generate a fever.

CORONAVIRUS IS NO BIG DEAL

A few days before the WHO announcement the world-class Robert Koch Institute (RKI) reported that the threat of the coronavirus is small, noting that its mortality is very, very low with a death rate less than 0.5%. Far less than SARS. [9]

Remember SARS? The severe acute respiratory syndrome outbreak in 2002-2003, which originated in China and world-wide was blamed for 700 deaths? 700 deaths out of over a billion people is not a pandemic.

In fact, we still don't know if it that mortality number was any different from a regular flu-like condition.

To this day there are conflicting reports about the number of people infected because it was so mild and most people were never tested for it. [10]

But the WHO likes to scare people just as it has done in prior flu scares. The WHO continues to discuss coronavirus as a horrible, deadly pandemic spreading all over the world. A few days ago some Americans who had visited China came home with a fever! Oh my!

POLITICIANS LOVE HYSTERIA

As politicians like to say, "Don't let a good crisis go to waste." People turn to our "leaders" during a crisis and this is an opportunity for them to accumulate more power. The freedom of the people will diminish as the power of the elected and unelected bureaucrats will grow.

NATURAL, SAFE, EFFECTIVE AND INEXPENSIVE

Natural ways to deal with colds and flu are healthcare systems or arts that promote proper function and do not suppress symptoms. Included in that list are chiropractic (and of course KST), classical osteopathy, acupuncture (to clear blockages and open up healing channels), homeopathy (to turn on your body's natural healing), herbology, naturopathy, Ayurvedic (Indian) medicine and many other systems including Traditional Chinese Medicine (TCM).

Speaking of China, Steve Schram, DC, LaC, an expert in TCM, mentioned to this author the formula Gan Mao Ling, Zhong Gan Ling, and Yin Qiao San as the "best" Chinese formula for colds and flu. That formula "clears heat toxins, dispels wind-heat, benefits sinus and throat." [(11)]

Of course, the above healing approaches are far from an exhaustive list. We live in a world that has a wealth of natural, safe, effective methods to permit the body to function at its height and promote detoxification, rest and rejuvenation.

HEAD FOR THE HILLS

Please head for the hills—because that's where there are a lot of nice spas, resorts and hot springs. We have so many choices in our great country: the Pocono mountains in Pennsylvania, the Berkshires in Massachusetts, and, in West Virginia there is the Berkeley Springs (enjoyed by George Washington and other founding fathers).

The US is dotted with great hot springs and spas. I'd like everyone on the West Coast to remember this because California, Oregon, Washington and Alaska are closer to China than for example, Hot Springs, Arkansas.

Take it easy and head for the hills! Take a vacation from the news, avoid MDs with their suppressive medications as much as possible and respect your body's natural healing abilities— you and your family will be healthier for it.

REFERENCES

1. Hugh Fudenberg, MD. National Vaccine Information Center, 1st Int'l. Conference on Vaccination, Sept. 1997,

2. Influenza activity United States 2013-2014 Season and Composition of the 2014-2015 Influenza Vaccines Weekly, June 6, 2014; 63(22):483-490

3. https://www.ewg.org/research/body-burden-pollution-newborns

4. https://www.fool.com/investing/2020/01/21/wuhan-coronavirus-hits-the-us-and-vaccine-stock-so.aspx

4. https://www.fool.com/investing/2020/01/21/wuhan-coronavirus-hits-the-us-and-vaccine-stock-so.aspx

5. Gross CG. Claude Bernard and the constancy of the internal environment. The Neuroscientist. 1998;4:380-385.

6. https://news.yahoo.com/health-experts-issued-ominous-warning-170400102.html?guccounter=1

7. https://www.cdc.gov/media/releases/2020/p0124-second-travel-coronavirus.html

8. https://e360.yale.edu/features/how-a-toxic-cocktail-is-posing-a-troubling-health-risk-in-chinese-cities

9. https://thefourthempire.blogspot.com/2020/01/germanys-robert-koch-institute-says-new.html

10. https://www.statnews.com/2020/01/20/who-calls-for-emergency-meeting-on-new-virus-in-china-as-cases- spread-to-health-care-workers

11. https://drjakefratkin.com/product/gzq-formula/

MEDICAL ERRORS DO NOT GO VIRAL by Patrick Quanten MD

THE STORY medical authorities tell about viruses are errors of judgement and study objectives, as well as study methods. I have been advocating this for a long time based on scientific evidence that has repeatedly emerged and has been repeatedly confirmed over the last two hundred years.

Scientists know that the micro-organisms found in infected tissue have emerged from that diseased tissue itself, not from the outside environment. Scientists have also demonstrated that viruses are not alive, are not organisms and do not attack. Viruses are a massive excuse to cover up poisoning. And yet, the public stays mute. They are forced from one panic mode into the next, and they oblige.

The public - and you are part of the public - does not make an effort to acknowledge the truth. You all keep fighting medical authorities on issues they know they control. The question is not whether or not vaccinations are safe and effective. That question is obsolete when we implement scientific knowledge about infections, bacteria and viruses.

When we take notice of the science that tells us that infections are not being passed on as a result of the jumping of a micro-organism from one individual to another then we do not need any 'protection' against such an imaginary attack. When we take notice that science has never isolated or identified a virus then we realise they do not exist as micro-organisms.

There is a tsunami of so-called information, powered by a non-critical media, drowning us daily in a pool of selected lies. Does that same media machine, seeking the truth for our benefit, give you information about anything that opposes the authority's view on vaccinations and infections? Did you hear about the court case that concluded that there is no scientific evidence at all that viruses exist?

Pharmaceutical companies are being challenged, both scientifically and socially, but the media is not really interested in telling you about it. Merck faced two separate class action lawsuits because they lied about the effectiveness of the mumps vaccine in the MMR combination. It was shown they fabricated efficiency studies over the last two decades to maintain the illusion that the vaccine is very protective.

Patrick Quanten MD

"I am looking forward to the day the truth goes viral."

A study conducted by Gary S. Goldman and Neil Z. Miller was published in the Human and Experimental Toxicology Journal. They have been studying the dangers of vaccines for twenty-five years and found a direct statistical correlation between higher vaccine doses and infant mortality rates. ("Infant mortality rates regressed against number of vaccine doses routinely given: Is there a biochemical or synergistic toxicity?")

The US Center for Disease Control and Prevention (CDC) main goal is to protect public health and safety through the control and prevention of disease, injury, and disability in the US and internationally. Brian Hooker published a paper with a comprehensive analysis of the CDC's own data from 2003 revealing a 340% increased risk of autism in African-American children following the MMR vaccine (Translational Neurodegeration Journal). Dr. William Thompson confirmed that the CDC knew about the relationship between the age of first MMR vaccine and autism incidence in African-American boys as early as 2003 but they chose to cover it up.

And what about the measles virus? German biologist Dr. Stefan Lanka initially offered 100,000 euros to anyone who could provide scientific evidence that the measles virus existed. In a long drawn out court battle (ending February 16, 2016) five experts have been involved in presenting the results of scientific studies. All five, including Prof. Dr. Andreas Podbielski, appointed by the preceding court, have consistently found that none of the six publications which were introduced to the trial contained scientific proof of the existence of the alleged measles virus. The so-called genetic fingerprinting of the measles virus was independently examined by two recognised laboratories, including the world's largest and leading genetic institute. The results prove that the authors of the six publications were wrong and as a direct result all measles virologists are wrong. They have misinterpreted ordinary constituents of cells as part of the suspected measles virus. Because of this error they have been building normal cell particles into a model of a measles virus, which now identifies the virus as an illusion. With the results of the genetic tests, all thesis of the existence of the measles virus has been scientifically disproven. The virus is a fabrication, a model that has been created out of normal cellular pieces, and it didn't involve an invasion of foreign material.

The error was not realised by the authors and everybody else because they violated a fundamental scientific duty, and that is to carry out control experiments. Control experiments would have protected the authors and mankind from this momentous error, which became the basis of the belief in the existence of any disease-causing

viruses. It was decided not to do control experiments with these studies, sponsored by the industry, and I leave it up to you to guess the reason behind this decision.

The six publications submitted in the trial are the main relevant publications on the subject of measles virus. As a result of the Supreme Court Judgement any national and international statements on the alleged measles virus, the infectivity of measles, and on the benefit and safety of vaccination against measles are since then deprived of their legal basis.

Upon enquiries the head of the National Reference Institute for Measles at the Robert Koch Institute, Prof. Dr. Annette Mankertz admitted an important fact, namely that the measles virus does contain typical cell's natural components and that vaccination against measles therefore would cause frequent and severe allergies and autoimmune reactions.

"The results prove that the authors of the six publications were wrong and as a direct result all measles virologists are wrong. They have misinterpreted ordinary constituents of cells as part of the suspected measles virus."

"THE VIRUS IS A FABRICATION, A MODEL THAT HAS BEEN CREATED OUT OF NORMAL CELLULAR PIECES, AND IT DIDN'T INVOLVE AN INVASION OF FOREIGN MATERIAL."

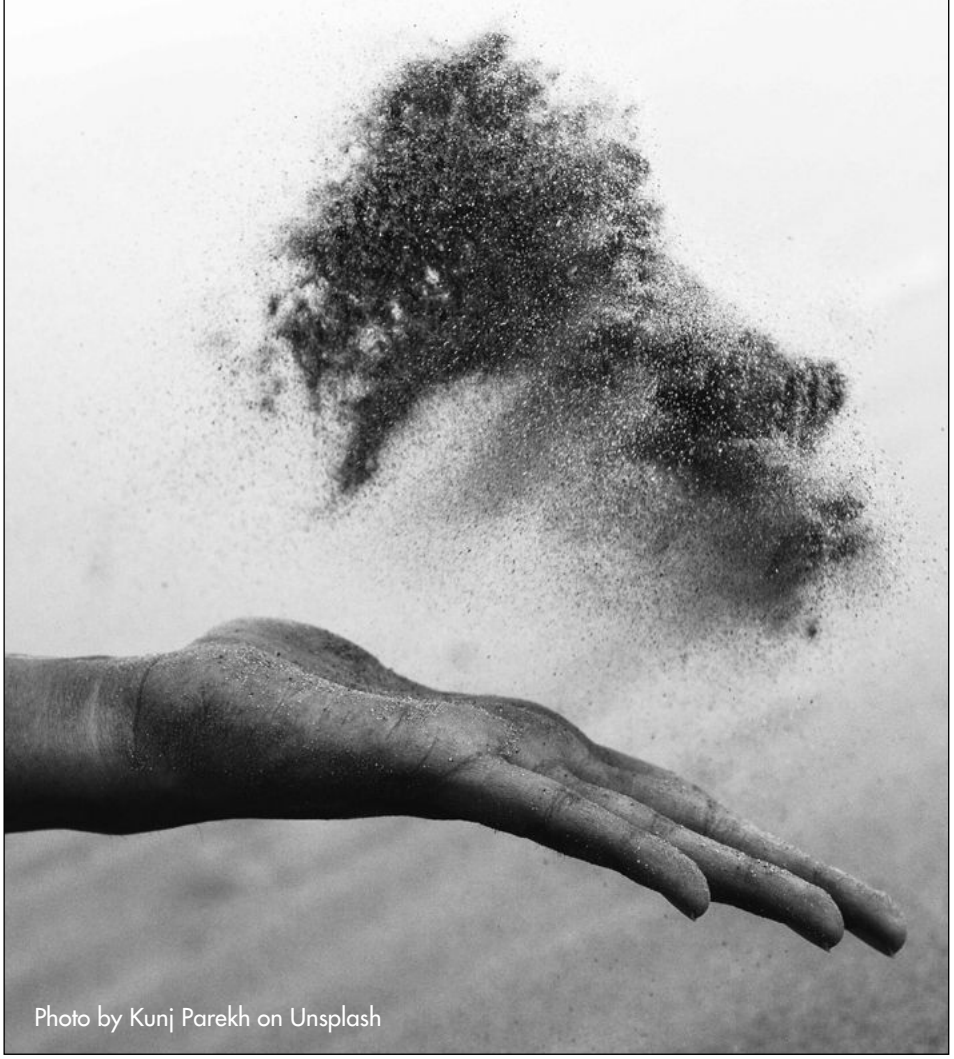


Photo by Kunj Parekh on Unsplash

Prof. Podbielski stated on several occasions that by the assertion of the Robert Koch Institute with regard to the natural cell components in the measles virus the thesis of existence of measles virus has been falsified.

The conclusion cannot be anything else than that the measles virus does not exist. It is a fictional character in a story of fiction and make-belief.

The way the results of this pharmaceutical research is presented makes us believe researchers have identified and isolated the virus they talk about. The truth is that true isolation never happens, not 'without a shadow of a doubt'. The whole HIV and AIDS debacle has made that quite clear, although, once again the media failed to inform us properly. We were told that researchers had isolated the HIV virus and had proven this to be the cause of the AIDS syndrome. In reality there was a thunderous controversy about the scientific papers that had been published on this subject and the claims within them were seriously questioned within the scientific community. None of the objections were ever refuted and most of them were never even addressed. In an interview in 1997 Montagnier, one of the 'discoverers', admitted that he and his colleagues did not carry out purification of the cell particle. He conceded that only an "assemblage of properties" of the cell particle was detected by his team on the cell membrane and that no electronmicroscopic photographs were published to show this cell material. Nevertheless, non-identified proteins were used as substrate for the "HIV test" patented by Montagnier in 1983 with the claim that they were retrovirus proteins of the newly isolated HIV, while in fact they were only cell particles.

This brings into question the entire story of how the immune system works as certain important questions have never been answered.

- Why does the immune system, under certain conditions, attack the body's own proteins?
- Why are cancer cells not recognised by the immune cells as being foreign?
- During pregnancy, why don't the immune cells attack the embryo?
- Why are intestinal bacteria not regarded as foreign?

This touches on the fundamental dogma of immunology, namely the assumption that immune cells can recognise foreign proteins and molecules and can differentiate between the body's own 55,000 odd proteins and

proteins and molecules from other organisms. It is this perception that largely contributes to the seemingly plausible theory that a sophisticated virus has infiltrated the body. The infection-invasion theory is a fallacy. Testing for 'specific' antibodies in order to identify the attacker can only be done by manipulating scientific good practice guidelines.

It could have been a lot easier if notice was taken of all scientific publications, instead of selecting the ones the authority likes. In the mid-seventies it was proven that nitrite poisoning caused a series of physical and mental effects that later were named the AIDS syndrome. The AIDS disease is caused by poisoning and the HIV virus does not exist.

The horrific outbreak of mad cow disease, in the early nineties was caused by poisoning, which induces certain prions within the tissues, mainly the nervous tissue. Consequently, the human variant, Creutzfeldt-Jacob disease is also due to poisoning. In fact, going back in time through the history of viral diseases we continuously find reports proving poison to be the cause of the disease rather than the invisible elusive virus. And this goes all the way back to the beginning, all the way back to polio, which was proven, at that time, to be caused by poisoning through pesticides, and certain medical procedures eg tonsillectomies. Other injections were found to provoke polio in some individuals also.

Scientists have given us real proof of disease causes, but the media does not give a voice to those researchers. If it disturbs the story put out by the medical authorities, which is the industry, then two campaigns are started. One campaign concentrates on bombarding the population with information, promises and/or fears that will keep them mesmerized, and the other is directed towards undermining the credibility of those researchers. When their work, their papers and their conclusions cannot be dismissed as bullshit the campaign becomes very personal. Any old dirt that can be misconstrued, taken out of context or time frame, will be spread in the media, who is more than willing to lend a helping hand to the hand that feeds them, the authority, the industry.

The media, and that includes the social media, controls what we believe. Even facebook has decided what is fake news with regards to vaccinations, and removes it from the ether. It is no longer in people's view. It is no longer available as information to the people. That does not constitute freedom of speech, freedom of publication, freedom of thought.

Authorities that give themselves the "right" to check your conversations and to withdraw them, to annihilate them, are violating the right to freedom of speech. Any government that allows this to happen to their citizens should not consider themselves protectors of freedom. As an authority and a government it would adorn them to make a public and open choice: either they are afraid and need restrictions and controls, or they propagate free speech. Please do not pretend to do both at the same time!

I am looking forward to the day the truth goes viral.
February 2020.

THE INCIDENCE OF LOWER RESPIRATORY TRACT INFECTIONS AND PNEUMOCOCCAL VACCINATION STATUS IN ADULTS IN FLEMISH PRIMARY CARE

De Burghgraeve T, et al
Acta Clin Belg.
2020 Mar 9:1-11. PMID: 32149595

ABSTRACT: EXTRACTS

PNEUMOCOCCAL vaccination coverage of adults at risk for pneumococcal disease is below recommended levels.

There is no observational data on pneumococcal vaccination and the incidence of lower respiratory tract infections in a general adult population.

The current study had the objective to explore the incidence of lower respiratory tract infections and the pneumococcal vaccine coverage in function of age, influenza vaccination status and risk status, in Flanders, Belgium.

First, we divided the population into three groups along the risk status for developing apneumococcal infection according to the recommendations for pneumococcal vaccination in adults by the Belgian High Council of Health.

28.6% from our total adult study population are considered the target group for vaccination.

Second, we found that the average pneumococcal vaccination coverage in this targeted population was 18.7%.

Third, we found a significantly **higher incidence** of LRTI in patients **previously vaccinated against pneumococcal disease and/or influenza across the majority of subgroups.** Pneumococcal vaccination coverage in Flanders is quantitatively low but observed to be qualitatively high in terms of reaching the most at risk population. Our findings are likely to be highly relevant to addressing future vaccination strategies in Flanders. ***(TiP emphasis.)***

"THE DOCTOR OF THE FUTURE WILL GIVE NO MEDICINES, BUT WILL INTEREST HIS PATIENTS IN THE CARE OF THE HUMAN FRAME, IN DIET, AND IN THE CAUSES AND PREVENTION OF DISEASE."

~ THOMAS EDISON. (1847-1931)

DIAGNOSING INBORN ERROR OF IMMUNITY FOLLOWING THE PRESENTATION OF A COMPLICATED ACQUIRED INFECTION AFTER MMRV VACCINE ADMINISTRATION

BY Al Zoebie L et al.

BMJ Case Report 2020;13:e233063.

SUMMARY

LIVE VACCINE-ACQUIRED infection should attest for the occurrence of inborn errors of immunity. Autosomal recessive immunodeficiency 31B, a result of a signal transducer and activator of transcription [1] genetic mutation, results in defected interferon pathways: interferon alpha/beta and interferon gamma.

These interferons are crucial for the defence against viral and mycobacterial infections. Recognition is important for preventive and therapeutic approaches. Herein, we report the presentation of a newly diagnosed 13-month-old child with immunodeficiency 31B after presenting with disseminated measles and varicella infection after Measles, Mumps, Rubella and Varicella vaccination.

DISCUSSION – BRIEF EXTRACTS

Disability and deaths from vaccine-preventable diseases have reduced; however, there has been increased concerns over vaccine safety in immunodeficient patients. In areas without new-born screening for immunodeficiencies, disease-defining infections may lead to a diagnosis.[7]

Deficiencies affecting the innate immune response have been shown to be associated with viral measles vaccine infections. Literature has identified patients developing measles vaccine-associated infection to have defects in either type I interferon, type III interferon, or both.[1] Therefore, further studies and work-ups are needed to identify the genetic aetiology of severe infections accompanying the measles vaccine. In summary, any infection caused by live attenuated vaccine that is sufficiently severe to require medical intervention should raise the suspicion for an immune deficiency disorder and should be attested. Autosomal recessive STAT1 deficiency is characterised by susceptibility to severe disseminated myco-bacterial and viral infections and unfortunately may result into death. As Monafo et al have explained through an infant whom developed a fatal disseminated measles following vaccination.[11] These patients need to avoid all live viral attenuated vaccines and likewise, this finding is of clinical importance to the family for future family planning; this family would also benefit from genetic counselling to prevent any complications associated with live attenuated vaccines. These patients, as shown in the literature, may benefit from bone marrow transplantation.[12] Nevertheless, further studies are still necessary to highlight a better understanding of innate immunity involved in live attenuated vaccines administration to ensure improvements in the preventive and therapeutic approaches in these patients.

ACUTE EXPOSURE AND CHRONIC RETENTION OF ALUMINUM IN THREE VACCINE SCHEDULES AND EFFECTS OF GENETIC AND ENVIRONMENTAL VARIATION

MCFARLAND G, LA JOIE E, THOMAS P, LYONS-WEILER J

Journal of Trace Elements in Medicine & Biology, Vol 58, Mar 2020, 126444

ABSTRACT

LIKE THE MECHANISMS of action as adjuvants, the pharmacodynamics of injected forms of aluminum commonly used in vaccines are not well-characterized, particularly with respect to how differences in schedules impact accumulation and how factors such as genetics and environmental influences on detoxification influence clearance. Previous modeling efforts are based on very little empirical data, with the model by Priest based on whole-body clearance rates estimated from a study involving a single human subject. In this analysis, we explore the expected acute exposures and longer-term whole-body accumulation/clearance across three vaccination schedules: the current US Centers for Disease Control and Prevention (CDC) schedule, the current CDC schedule using low aluminum or no aluminum vaccines, and Dr. Paul Thomas' "Vaccine Friendly Plan" schedule. We then study the effects of an implicit assumption of the Priest model on whether clearance dynamics from successive doses are influenced by the current level of aluminum or modeled by the assumption that a new dose has its own whole-body dynamics "reset" on the day of injection. We model two additional factors: variation (deficiency) in aluminum detoxification, and a factor added to the Priest equation to model the potential impact of aluminum itself on cellular and whole-body detoxification. These explorations are compared to a previously estimated pediatric dose limit (PDL) of whole-body aluminum exposure and provide a new statistic: %alumTox, the (expected) percentage of days (or weeks) an infant is in aluminum toxicity, reflecting chronic toxicity. We show that among three schedules, the CDC schedule results in the highest %alumTox regardless of model assumptions, and the Vaccine Friendly Plan schedule, which avoids > 1 ACV per office visit results in the lowest (expected) % alumTox. These results are conservative, as the MSL is derived from data used by FDA to estimate safety of aluminum in adult humans. These results demonstrate high potential utility of modeling variation in patient responses to aluminum. More empirical data from individuals who are suspected of being intolerant of aluminum from vaccines, evidenced by high aluminum retention, neurodevelopmental disorders and/or a myriad of chronic illnesses would help answer questions on whether the model predictions can be used to estimate parameter values tied to genetic factors including genomic sequence variation and family history of chronic illnesses tied to aluminum exposure.

OLDER VERSION OF WHOOPING COUGH VACCINE COULD PREVENT FOOD ALLERGIES

BY MELISSA CUNNINGHAM

January 20, 2020
https://www.smh.com.au/national/older-version-of-whooping-cough-vaccine-could-prevent-food-allergies-20200120-p53t07.html

A DOSE OF whooping cough vaccine phased out at the turn of the century could hold the key to protecting children from developing food allergies.

A new Australian study published in the Journal of Allergy and Clinical Immunology found that rates of children with food allergies have risen exponentially since the late 1990s – around the same time a new whooping cough vaccine was rolled out nationally.

The older "whole cell" whooping cough vaccine was eliminated in 1999 and replaced with a new version, amid reports Australian babies were suffering minor side effects, including fever and pain where the needle was injected.

Hospital admissions for food-induced anaphylaxis more than doubled between 1998 and 2005, before increasing by a further 50 per cent in between 2005 and 2012, data from the Murdoch Children's Research Institute reveals. This led a group of Australian researchers to test the theory that a "whole cell" vaccine may actually be better at training an infant's immune system to ward off serious allergens. As part of the observational study published in The Journal of Allergy and Clinical Immunology on Tuesday, researchers examined more than 500 cases where children were diagnosed with food allergies in the last 20 years.

Those who had received one or more doses of whole cell vaccine as infants in the late 1990s were found to be 23 percent less likely to be diagnosed with a food allergy than those who didn't.

Experts caution, however, that more research was needed. Researchers have urged parents to continue getting their children immunised against whooping cough with the current vaccination, which has proven extremely effective in preventing the potentially deadly disease.

Lead researcher Professor Tom Snelling, from Curtin University and Telethon Kids Institute, said that while both vaccines were effective in protection against whooping cough, findings pointed to the whole cell vaccine providing the additional benefit of reducing the risk of serious allergies.

"These allergies occur when the immune system reacts to everyday substances such as different types of food," Professor Snelling said.

"We believe that by harmlessly mimicking infections, some vaccines such as the whole-cell whooping cough vaccine have the potential to help steer the immune system away from developing allergic reactions and that a single initial dose of the whole cell vaccine might have the additional benefit of partially protecting young babies against developing life-threatening food allergies."

"The older "whole cell" whooping cough vaccine was eliminated in 1999 and replaced with a new version, amid reports Australian babies were suffering minor side effects, including fever and pain where the needle was injected."

Paediatric immunologist Richard Loh, co-chair of the National Allergy Strategy, said while the results were "promising", more investigation was required as to why one in ten Australian infants are diagnosed with a food allergy.

"A limitation is that it is a retrospective study, rather than a prospective study," he said. "The key message to parents is to keeping vaccinating their children against whooping cough because the current vaccine is life-saving."

Associate Professor Loh suggested changes in national feeding guidelines during the same period, including advising parents to delaying introduction of peanuts until children are three years old, may also be linked to a rise in allergies.

"We know now that information is incorrect and earlier introduction of peanuts before the age of 12 months can actually decrease allergy development by up to 80 per cent," he said. Professor Snelling's research team will further investigate with a follow-up clinical study involving 3000 Australian babies throughout 2020.

After her five-year-old son Jack was diagnosed with allergies to wheat and eggs, Catherine Lax enrolled daughter Ashley, now aged 18 months, into the clinical trial. Jack failed to thrive in the first year of his life, suffered from severe eczema and was wrongly diagnosed with severe reflux. It wasn't until Jack went into anaphylactic shock and was rushed to hospital that doctors determined it was a severe food allergy.

"We wanted to try and find answer as to why this happened to Jack and hopefully prevent a similar thing occurring with Ashley," Ms Lax said. "The latest findings are really promising so that's given us hope."

Infants participating in the next part of study will be randomly assigned to receive either one dose of whole cell whooping cough vaccine followed by two doses of the newer vaccine, which is not made from whole cells, or to just have the usual schedule of three doses of the the newer whooping cough vaccine.

The babies will be followed until they are 12 months old to confirm whether the whole cell vaccine helps to protect against food allergies in infancy.

"If successful, a new vaccine schedule could form part of an effective strategy to combat the rise in food allergies," Professor Snelling said.

Melbourne has previously been deemed the food allergy capital of the world. There are several theories proposed for the reasons why, from the hypothesis that the city is too clean to vitamin D deficiencies in the population to a concentration of families with the genetic predisposition.

TiP Editor: Prof Gordon Stewart would not have agreed that the whole cell version only caused minor side effects! I wonder if these academics have considered that the increase in allergies coincides with more and more vaccines being added into the baby schedule?

WHO'S MALARIA VACCINE STUDY REPRESENTS A "SERIOUS BREACH OF INTERNATIONAL ETHICAL STANDARDS."

BY PETER DOSHI

BMJ 2020;368:m734
doi: 10.1136/bmj.m734 (Pub 26 Feb 2020)

EXPERTS ARE TROUBLED by the apparent lack of informed consent in a large, cluster randomised study of the malaria vaccine.

EXTRACTS:

A large scale malaria vaccine study led by the World Health Organization has been criticised by a leading bioethicist for committing a "serious breach" of international ethical standards. The cluster randomised study in Africa is already under way in Malawi, Ghana, and Kenya, where 720 000 children will receive the RTS,S vaccine, known as Mosquirix, over the next two years.[1-3]

Mosquirix, the world's first licensed malaria vaccine, was positively reviewed by the European Medicines Agency, but its use is being limited to pilot implementation, in part to evaluate outstanding safety concerns that emerged from previous clinical trials.[3]

These were a rate of meningitis in those receiving Mosquirix 10 times that of those who did not, increased cerebral malaria cases, and a doubling in the risk of death (from any cause) in girls.[2]

Charles Weijer, a bioethicist at Western University in Canada, told The BMJ that the failure to obtain informed consent from parents whose children are taking part in the study violates the Ottawa Statement, a consensus statement on the ethics of cluster randomised trials, of which Weijer is the lead author, and the Council for International Organizations of Medical Sciences' International Ethical Guidelines. "The failure to require informed consent is a serious breach of international ethical standards," he said.

"The material lists the increased rates of meningitis and cerebral malaria observed in trials and states that they will be monitored. But the potential for increased risk of death among girls is not mentioned."

Christine Stabell Benn of the University of Southern Denmark, professor in global health and a vaccine expert who recently published concerns about WHO's study in The BMJ,[4] added her concerns: "I think parents should be made aware of this doubled female mortality. Imagine that this mortality was a true finding (and remember that it comes on top of five other non-live vaccines being associated with increased female mortality[5-9]).

If true, then how will this be perceived by the participants—that their children were unknowingly involved in a huge experiment by the authorities? This could be a disaster for public trust in vaccines and health authorities."

What information parents are provided with in practice is hard to judge. WHO sent The BMJ some training information that it says it has shared with country partners about Mosquirix's potential risks. The material lists the increased rates of meningitis and cerebral malaria observed in trials and states that they will be monitored. But the potential for increased risk of death among girls is not mentioned.

In a post hoc analysis of the GlaxoSmithKline phase III trial, WHO reported that the all cause mortality rate was "about twofold higher in females" given malaria vaccine versus those in the control arm.[10]

When asked why the female mortality signal was not included, WHO cited "insufficient evidence to classify gender specific mortality as a known or potential risk."

It is unclear whether any ethical bodies specifically reviewed and signed off on the "implied consent" process already under way. The BMJ asked WHO whether the agency's Research 4 Ethics Review Committee, which approved the study protocol in February 2018, waived the requirement for individual informed consent.

WHO did not answer the question directly, instead referring to the process as one used by the ministries of health in Ghana, Kenya, and Malawi. "The vaccine deployment is led by the countries and it is done in the context of routine vaccinations, where there is no requirement for written individual consent." It said that "care givers are free to decline if they do not wish their child to receive the vaccine."

"THE SECRET OF HEALTH FOR BOTH MIND AND BODY IS NOT TO MOURN FOR THE PAST, NOT TO WORRY ABOUT THE FUTURE, OR NOT TO ANTICIPATE TROUBLES, BUT TO LIVE IN THE PRESENT MOMENT WISELY AND EARNESTLY. ~ *BUDDHA.*"

LAB TESTS CONFIRM CHILD DIED OF DIPHTHERIA DESPITE VACCINATION

https://www.keeptalkinggreece.com/2019/12/06/diphtheria-greece-child-vaccination-confirmed/
6 Dec 2019

RESULTS of laboratory tests conducted in UK's Public Health Laboratory have confirmed that the 8-year-old boy was positive in the strain of diphtheria toxin, the Greek National Public Health Organization (ESA) said in a statement. The child that passed away due to severe respiratory infection in a public children's hospital on November 26 "was found positive on diphtheria (Corynebacterium diphtheriae) toxin in bronchial secretions."

The ESA speaks of a "sporadic incident"and stresses "the importance of vaccination in children and adults for diphtheria."

The orphan boy stayed in two state-run facilities until the age of 5 and later lived in a foster family.

Despite initial reports, the boy had indeed received all five doses of diphtheria vaccine. However, it is not clear - at least in the media reports – whether the child received the vaccine in the essential periods of time and the proper age. ***TiP Editor: ?????*** As the child was suffering from other health issues that may had led his weakened immune system to not respond to the vaccine as expected. Vaccines offer a coverage at 95 percent. The case reveals that although the diphtheria disease has disappeared in the country for the last 30 years, the virus still exists and the child somehow came in contact with it.

Authorities focus now on children without vaccination, although, there is no a data bank. The case became known after a doctor at a private hospital posted about it on social media.

TiP Editor: Virus??? It is a bacteria!

WHO: 257 DEATHS IN YEMEN BY DIPHTHERIA FOR 26 MONTHS

Oct 29 2019
https://www.yemenpress.org/

THE UNITED NATIONS World Health Organization (WHO) has reported 257 deaths from diphtheria in 26 months in Yemen.

The organization said in a tweet published through the official account of its office in Sanaa, on Monday, it has "protected 3.4 million children from diphtheria disease by vaccination against the disease in 186 districts in Yemen."

She pointed out that 4,541 suspected cases of diphtheria have been reported with 257 deaths from the disease during the period from August 12, 2017, to October 12.

Diphtheria is transmitted through a germ called diphtheria, which mainly affects the mouth, eyes, nose, and sometimes the skin. The incubation period is from 2 to 6 days.

The World Health Organization said on Sunday that a quarter of a million Yemenis are on the verge of starvation, stressing that the ongoing conflict and the resulting economic crisis, "are one of the main factors behind food insecurity in Yemen."

"War has destroyed vital civilian infrastructure in the country," FAO said, and an estimated 20 million people are food insecure in Yemen. "Nearly a quarter of a million people are on the brink of starvation, if not. Urgent intervention. "

It is noteworthy that the health sector in Yemen, suffering from a sharp deterioration due to aggression and siege, which led to the spread of epidemics and diseases and the closure of a large number of health facilities. *TiP Editor: Unsurprisingly I was unable to find out what per centage of these cases were vaccinated. However it is quite clear that the cause of this outbreak is due to a severe breakdown in living conditions! When living in war torn regions on the brink of starvation do these academics at the WHO really believe that vaccination can prevent these cases and deaths??*

EIGHT CHILDREN DIE OF DIPHTHERIA IN GUJRANWALA IN LAST 2 MONTHS

December 28 2019
https://www.thenews.com.pk/

GUJRANWALA: As many as eight children have died of diphtheria during the last two months here.

Similarly, 20 children were suffering from the disease during the same period and were under treatment at hospitals.

The increasing number of victims has raised the questions about the performance of the health authorities. The citizens have shown serious concerns over the situation and demanded the higher authorities take action to stop the rising death toll and control the whole situation.

The victim children, including six-year-old Abdul Hassan, seven-year-old Zeeshan Ali, 12-year-old Hassan, 12-year-old Zuhra Batool and three-year-old Arham, died within a few days after contracting the contagious disease.

It was told that all the children had got vaccinated of anti-diphtheria. Citizens criticised the health authorities and said that the children were dying of the disease while the Punjab government was focusing just on dengue eradication.

When contacted, Commissioner Zahid Akthar Zaman said that he himself took notice of the matter and asked the health authorities to furnish a report in this regard.

The commissioner said that he also directed the concerned authorities to produce the actual figures about anti-diphtheria vaccination (EPI) in the district.

WORLD HEALTH ORGANIZATION QUESTIONS VACCINE SAFETY

By AVN admin (Australian Vaccination risks Network). 18 January, 2020.

"IN MEDICAL SCHOOL, you're lucky if you have a half day on vaccines, never mind keeping up to date with all of it." – Prof Heidi Larson, PhD. Director Vaccine Confidence Project.

On December 2nd & 3rd 2019, the World Health Organization (WHO) held a Global Vaccine Safety Summit in Geneva. The event was live-streamed and footage from the summit reveals the intense questioning from top Scientists and Medical professionals on vaccines and the safety of vaccines. Find it here: **https://www.who.int/news-room/events/detail/2019/12/02/default-calendar/global-vaccine-safety-summit**

What this summit has shown to the world is that people who want stronger vaccine safety science and safety studies are not 'anti-vax' – they are rational human beings wanting to ensure the right decisions are being made for the global population. The summit also reveals that 'the science isn't settled'. In fact, the science hasn't been done.

Prof. Heidi Larson, Ph.D., Professor of Anthropology, Director of the Vaccine Confidence Project and staunch supporter of vaccines was the closing speaker for the event. Her talk was to inform attendees on 'how to move forward in addressing communication and behaviours in relation to vaccine safety.'

Dr Larson urges the healthcare community to stop using the derogatory term 'anti-vaxxer.'

"One of our biggest challenges I think now is getting rid of the term "anti-vax', getting rid of the hostile language, and starting to have more conversations, to be open to questions, to make people feel like they shouldn't be judged for asking questions."

She also admits that a lot of the 'vaccine scepticism online' is not 'misinformation' and that there is a lot of ambiguity in the safety field.

"The biggest problem is a lot of it's not misinformation. Our problem is, as we've heard in the last 48 hours, that there's not anything 100%, and what actually can legally without creating a censorship thing, can we actually say is misinformation? We have a lot of ambiguity in the safety field, and we have to come to terms with that, so we have to think about it differently, than 'deleting misinformation' but building trust, so people are willing to put up with a certain amount of risk because they believe in it enough."

"One of our biggest challenges I think now is getting rid of the term "anti-vax', getting rid of the hostile language, and starting to have more conversations, to be open to questions, to make people feel like they shouldn't be judged for asking questions."

Prof Larson also goes on to admit: "There's a lot of safety science that's needed. Without the good science, we can't have good communication. So, although I'm talking about all these other contextual issues and communication issues, it absolutely needs the science as the backbone. You can't repurpose the same old 'science' to make it sound better if you don't have the science that's relevant to the new problems."

She also highlights the unique position in human history that has shifted populations to the very fragile state of vaccine-induced-immunity" https://www.facebook.com/HighWireTalk/videos/1248648795324693/

Dr Bassey Okposen, Nigerian Doctor and Program manager for NEEICC asks a very vital question regarding different antigens, different adjuvants and whether these ingredients are or could be 'cross-reacting' with each other, and where the safety studies are on these interactions. Dr Robert Chen, Scientific Director of Brighton Collaboration, attempts to answer, but fails miserably.

His answer is too long to quote, here is a link https://www.facebook.com/HighWireTalk/videos/2448345268759271/

He takes almost 5 minutes to say – no they aren't looking at that, but maybe they should. We ask that you watch and report on this vital vaccine summit – here is a link to a condensed version of the live stream: https://youtu.be/_1xey8zlyQo

The original stream can be found on the WHO summit event page. It is broken into parts by days, and speakers. Many valid points were raised during the event, such as:

Dr. Soumya Swaminathan, M.D., Chief Scientist, W.H.O., Pediatrician

"I think we cannot overemphasize the fact that we really don't have very good safety monitoring systems in many countries, and this adds to the miscommunication and the misapprehensions because we're not able to give clear-cut answers when people ask questions about the deaths that have occurred due to a particular vaccine…"

Dr. David Kaslow, M.D. – V.P., Essential Medicines, Drug Development program PATH Center for Vaccine Innovation and Access (CVIA). "So in our clinical trials, we are actually using relatively small sample sizes, and when we do that, we're at risk of tyranny of small numbers."

The mantra that vaccines are "safe and effective" is no longer acceptable.

In light of these revelations by the WHO, the AVN demands that the Federal Government fulfil the promise made 6 years ago by Prof Peter McIntyre that they would use the data in the ACIR to compare the overall health of the fully vaccinated, the partially vaccinated and the completely unvaccinated. This needs to be done as a matter of urgency. Until we have real scientific evidence showing that vaccines are safe for everyone, the Federal and State Governments need to immediately withdraw No Jab No Pay and No Jab No Play legislation. When the experts state publicly that they don't know how vaccines work or whether they are safe, it is time for Australia to exercise their duty of care on this issue.

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THE ART OF MEDICINE: POLIO PROVOCATION: SOLVING A MYSTERY WITH THE HELP OF HISTORY

The Lancet, Vol 384; p300-301
July 26, 2014 www.thelancet.com

DURING THE SUMMER of 1951, a medical mystery in the USA erupted into a crisis, stimulating professional debate and public anxiety. The issue was polio provocation, a health risk facing unvaccinated children in polio endemic regions. Leading specialists were at a loss to explain the condition. As the poliovirus was widespread before the discovery of an effective vaccine in 1955, evidence that some paediatric injections could incite polio infection and paralysis led to extraordinary shifts in health policy and calculated efforts to mitigate the risk. At the core of this discussion were physicians and public health researchers, whose efforts to formulate a clinical theory drove both policy and the impetus for scientists to unravel the underlying mechanism.

During the 1940s and 1950s, physicians and public health researchers in the USA, UK, Canada, and Australia sought to understand the nature of polio and how it attacked the grey matter of the spinal cord. Through clinical observation and reporting, older causation theories, which implicated poor sanitation or immigrant populations, were slowly replaced by a range of new possibilities, such as the effect of fatigue, diet, or hygiene. While personal characteristics and precipitating factors were examined, some physicians noticed a correlation between certain medical interventions and polio paralysis.

One of the first medical procedures implicated in the causation of polio was tonsil surgery. A study of more than 2000 case histories in the 1940s by the Harvard Infantile Paralysis Commission concluded that tonsillectomies led to a significant risk of respiratory paralysis due to bulbar polio. Although proponents of the theory did not entirely oppose tonsillectomies, they cautioned that such interventions should be avoided during epidemics. Reflecting the growing body of evidence that tonsillectomies could provoke polio, many doctors in the USA adjusted their surgical procedures to account for disease-endemic factors. "The policy of the United States Army", Major-General E A Noyes acknowledged in 1948, "has been to stop tonsil and adenoid operations during epidemics". Even though laboratory technology at the time was not sufficiently advanced to unravel the mechanism, published evidence affected clinical practice.

Concerns about tonsillectomies coincided with indications that paediatric injections could also incite polio paralysis. Evidence of this correlation was first published by German doctors, who noted that children who had received treatment for congenital syphilis later became paralysed in the injected limb. Although further studies from Italy and France corroborated this link, it was not until the end of World War II that injection-induced polio emerged as a public health concern.

"A report that emerged from Guy's and Evelina Hospitals, London, in 1950, found that 17 cases of polio paralysis developed in the limb injected with pertussis or tetanus inoculations."

The application of epidemiological surveillance and statistical methods enabled researchers to trace the steady rise in polio incidence along with the expansion of immunisation programmes for diphtheria, pertussis, and tetanus. A report that emerged from Guy's and Evelina Hospitals, London, in 1950, found that 17 cases of polio paralysis developed in the limb injected with pertussis or tetanus inoculations. Results published by Australian doctor Bertram McCloskey also showed a strong association between injections and polio paralysis. Meanwhile, in the USA, public health researchers in New York and Pennsylvania reached similar conclusions. Clinical evidence, derived from across three continents, had established a theory that required attention.

Several ideas were posited by health professionals in an effort to understand how immunisations for diphtheria, tetanus, and pertussis seemed to provoke polio infection. One theorist posited that injections injured human tissues and predisposed them to viral infection. A further theory advanced by Harold K Faber of the Stanford University School of Medicine argued that the ubiquitous poliovirus, already present on the skin of many children, was being driven into the body during immunisations and thus seeded deep into the tissue. The lack of certainty heightened anxiety and brought the issue to mainstream attention.

Medical journals and newspapers became sites of contestation. Not all doctors agreed with the alarmist tone and critiqued the findings as either coincidental or based on insufficient data. Meanwhile, American newspapers advised parents to postpone vaccinations during warm weather or epidemics, citing evidence that some children developed polio within a month of injection. As debates swirled and publicity mounted, parents were asked to weigh the potential risks of immunisations with their benefits.

The impressive volume of literature on polio provocation by the 1950s fuelled changes in health policy. US health organisations and charities, including the National Foundation for Infantile Paralysis, the American Academy of Pediatrics, and the American Public Health Association, accommodated the possibility of polio provocation and encouraged health professionals to avoid "indiscriminate" injections and "booster shots" during epidemics.

In New York City, child health stations were closed and laws mandating paediatric vaccinations before school attendance were relaxed. Most health

professionals reformed their immunisation practices and accepted that seasonal factors and cycles of disease were important to consider before immunising children.

Just as anxiety surrounding polio provocation crested, a series of related scientific discoveries fuelled its rapid decline. The introduction of the Salk vaccine in 1955 and the Sabin vaccine in 1962 ushered in an era of polio prevention, which parents and health professionals greeted with a combination of relief and enthusiasm. Once polio vaccination programmes established herd immunity among children and adults, the corresponding risk of toxoid-based injections inciting polio paralysis was effectively eliminated. Orthodox public health and surgical practices were restored. Although medical scientists failed to understand the epidemiological mechanism behind polio provocation, the Salk and Sabin vaccines pushed the issue to the margins of clinical attention.

Concern about polio provocation lay dormant for decades, but resurfaced in the 1980s when large international aid agencies, such as Rotary International and WHO, expanded their immunisation programmes in low-income nations. In some areas of Africa, where polio was endemic, public health workers began to report cases of paralysis after immunisations against common childhood diseases. Since these observations were decades removed from earlier published findings, many health professionals supposed they were witnessing a new phenomenon.

Consultation of archived clinical research helped to bring renewed attention to polio provocation. British microbiologist H Vivian Wyatt became intrigued by the reports emerging from Africa, and turned to archived medical journals in search of a possible explanation. Upon discovering the coverage of polio provocation from the 1950s, Wyatt reasoned that aid workers were witnessing the spectre of a forgotten clinical theory. He published his findings in history and public health journals, arguing that the theory appeared to be scientifically plausible and that the localisation of paralysis could be correlated with injections. Wyatt hoped this work would stimulate a renewed scientific effort to unlock the mechanism of polio provocation and inspire more circumspect immunisation practices in polio endemic regions.

Published historical accounts drew some attention to the matter, but it was not until severe epidemics erupted in India during the 1990s that fresh clinical evidence became available. One study from rural India found that injections seemed to have a role in causing paralytic polio. A subsequent assessment upheld this assertion in concluding that the primary risk factor for paralysis was receiving an injection within 30 days of onset. Health professionals in India struggled to verify the data and weigh its implications. Akin to the debates of the 1950s, some researchers rejected the evidence, whereas others cautioned that injections in endemic countries should be conducted only when all other therapeutic options were exhausted. However, without laboratory findings that showed how injections could provoke polio, the debate continued to rage.

The abundance of historical clinical research on polio provocation combined with indications of its re-emergence roused medical researchers to unravel the cause. The state of virology and immunology were sufficiently advanced by the 1990s to allow for a systematic investigation. In 1998, State University of New York researchers Matthias Gromeier and Eckard Wimmer published a pioneering article on the Hypodermic syringe with bottle of diphtheria vaccine mechanism of injection-induced polio paralysis. Through their laboratory work, they discovered that tissue injury produced by an injection aided the poliovirus to infect the body and readily journey to the spinal cord. For the first time, health professionals working in polio endemic regions had scientific evidence that paediatric injections could incite paralysis.

Substantiation of the theory seemed to vindicate the cautious policies of the 1950s and the importance of maintaining herd immunity against polio. In countries where the virus was controlled through vaccination programmes, the risk of polio provocation was insignificant. However, in regions where polio was endemic, immunisation sequence mattered until eradication of the virus was achieved. The discovery showed that polio vaccination was vital to the wider success of public health programmes and that it needed to be undertaken before other paediatric immunisations to reduce the risk of provoking polio. By resolving a lingering clinical enigma, medical science gave new gravitas to the global polio eradication effort and elevated the vaccine to a pillar of the public health arsenal.

The long history of polio provocation highlights the importance of published clinical evidence in shaping health policy and spurring medical research. Far from being bibliographic curios, archived medical journals contained the remnants of a neglected theory and important observations relevant to a contemporary concern. Historical record and interpretation ultimately grounded conceptions of polio provocation and added weight to fresh discoveries. By building on knowledge, physicians and public health researchers forged a momentum to solve a mystery, which ultimately helped to reduce suffering and save lives.

Stephen E Mawdsley

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TiP Editor: Vaccine-derived polio virus (VDPV) and circulating VDPV (cVDPV) are responsible for the majority of polio cases now!

FURTHER READING

Grob G. The rise and decline of tonsillectomy in twentieth- century America. J History Med Allied Sci 2007; 62: 383–421

Gromeier M, Wimmer E. Mechanism of injury-provoked poliomyelitis. J Virol 1998; 72: 5056–60

Mawdsley SE. Balancing risks: childhood inoculations and America's response to the provocation of paralytic polio. Soc Hist Med 2013; 26: 759–78

Rogers N. Dirt and disease: polio before FDR. New Brunswick: Rutgers University Press, 1992

Wyatt HV. Provocation poliomyelitis: neglected clinical observations from 1914 to 1950. Bull Hist Med 1981; 55: 543–37

ONGOING MUMPS OUTBREAK AMONG ADOLESCENTS & YOUNG ADULTS

Ireland, August 2018 to January 2020
Euro Surveill. 2020;25(4):pii=2000047.
https://doi.org/10.2807/1560-7917.
ES.2020.25.4.2000047


Photo by Papaioannou Kostas on Unsplash

EXTRACTS

BETWEEN 18 August 2018 and 24 January 2020, 3,736 mumps cases were notified in Ireland. The highest numbers of notifications were observed in the age group 15–24 years.

In total, between 18 August 2018 and 24 January 2020, 3,736 mumps cases were notified, including confirmed (n = 2,583), possible (n = 897) and probable (n = 256) cases. Mumps activity, which had declined during the summer months of 2019, increased with the start of the academic year in September 2019, and is continuing to increase through January 2020. The largest number of mumps notifications (n = 302) was reported on week 4 of 2020.

The highest number of notifications and the highest incidence rates were observed in the age groups 15–19 years and 20–24 years. The median age of the cases was 20 years (interquartile range (IQR): 18–26). Of the cases, 53% were male (1,964/3,736).

VACCINATION STATUS OF CASES

Vaccination status was reported for 32% of cases (1,199/3,736). Where vaccination status was reported, 72% (n = 858) had received two doses of MMR vaccine, 16% (n = 187) had received one dose and 12% (n = 142) of cases were unvaccinated. Twelve cases received a third dose of MMR vaccine. Vaccination information was obtained through a number of sources, such as local immunisation databases, general practitioners' records, and case/parental records or recall. Because of recall bias, there may therefore be some inaccuracies in the vaccination status figures reported above. We analysed years since the last dose of MMR for cases with reported vaccination date (17%; 618/3,736). Of 618, 52% (n = 323) received the last dose of the vaccination 13 to 17 years before onset of disease.

DISCUSSION

In recent years, many countries, including the United Kingdom (UK) [8], the Netherlands [9], Czech Republic [10], Israel [11] and the United States (US) [12] have reported large mumps outbreaks involving mainly adolescents and young adults. The high potential for transmission in the crowded social environments of students, e.g. large indoor gatherings and shared housing, only partly explains the ongoing outbreak. Other additional factors need to be considered, such as historical low uptake of MMR vaccine, insufficient effectiveness of the mumps component of the MMR vaccine and the possibility of waning immunity in those appropriately immunised. (TiP emphasis.) This outbreak again highlights the importance of sustained high vaccination coverage of the two-dose MMR schedule for all children and young adults.

In Ireland, immunisation information systems have traditionally been local, and historically, school immunisations have been held in archived hard copy format and are not easy to routinely obtain. Information on having received MMR vaccination is easier to ascertain, compared to having not received the vaccination. Vaccination status was unknown for 68% of the cases (n=2,537) during the ongoing outbreak while only 23% of all cases (n = 858) reported having received two doses of MMR. Such incomplete information on vacci- nation status of cases made it impossible to determine vaccine effectiveness during the outbreak.

With this rapid communication, we would like to con- tribute to the discussion about reasons for large mumps outbreaks involving adolescents and young adults occurring in some European countries. As this outbreak is mainly affecting university and college students, which is a highly mobile international population, we would like to raise awareness for the potential of exportation of cases to other countries.

Finally, while students and employees of colleges and universities were targeted for a free MMR vaccination programme since early 2019, the number of vaccinations administered has been low.

For this reason, from start of January 2020, we are focusing on raising awareness about mumps in Ireland and the importance of high vaccination coverage of the two-dose MMR vaccination.

HPV: WHO CALLS FOR COUNTRIES TO SUSPEND VACCINATION OF BOYS

THIS WAS the headline for an article written by Sophie Arie on 2 December 2019 (BMJ 2019; 367:l6765). The article states that the 'World Health Organization is calling on countries that are vaccinating boys against the human papillomavirus (HPV) to suspend these programmes until all girls who need the vaccine can get it.'

According to the article, the Dept. of Health & Social Care was unable to comment about whether it would consider suspending the UK programme for boys and that these recommendations should be considered at the next meeting of the JCIV in February 2020. Apparently the University of Warwick using a mathematical model estimated that by 2058 in the UK that the HPV vaccine programme currently being used (vaccinating both girls and boys) may prevent up to 64,138 HPV related cervical cancers and 49, 649 other HPV related cancers. May prevent is a useful term when churning out all these predictions. The article comments that since the launch of the programme for boys in the UK in September, there have been growing calls from patient organisations and websites like jabsfortheboys.uk, which is funded by MSD, for older cohorts of boys to be included in the national programme.

Growing calls from organisations and charities who receive funding from the drug companies that produce a HPV vaccine. How very convenient for the vaccine makers! (See additional notes section at the end.)

The article ends with comments by Mark Jit, Professor of Vaccine Epidemiology at the London School of Hygiene and Tropical Medicine, who conducted some of the work to inform SAGE's recommendations to suspend the vaccine programme for boys.

"There are lots of calls for boys to be vaccinated. Those arguments make perfect sense if you're in a world where there is enough for everyone. People making decisions in countries about who to vaccinate need to become more aware that there is currently not enough for all the girls who need it."

ADDITIONAL NOTES:

Follow the money tree...
http://jabsfortheboys.uk/about-us/ Jabs for the Boys is provided by the Oral Health Foundation HPV Action (HPVA), a partnership of about 50 patient and professional organisations that are working to reduce the health burden of HPV. The development of the website was supported by an educational grant to OHF from MSD (Merck, Sharp & Dohme).

In 2019, HPV Action received a Mouth Cancer Foundation charity project award for further work on the site. These funds were paid to the Oral Health Foundation, one of HPVA's members, which is managing the project. Many of these foundations receive funding from Merck and/or GlaxoSmith-Kline eg Throat Cancer Foundation (TCF).TCF is a founding member of HPVAction, and in 2018 the founder of the TCF, Jamie Rae sued Health Secretary Jeremy Hunt for denying boys access to HPV vaccine leaving young men exposed to cancer causing infection according to an article in the Mail on Sunday by David Rose, 27 May 2018.

Also is there a conflict of interest with members of the expert advisory group on the content for Jabs for the Boys site? If we look at one example, Professor Margaret Stanley, Emeritus Professor of Epithelial Biology, Cambridge University. Prof. Stanley serves as an expert on HPV for the HPV subcommittee of the UK's Joint Committee on Vaccines and Immunisation whilst also working as a consultant for companies that market HPV vaccines. Some of these companies include GSK, MSD, and Sanofi Pasteur MSD. (Wikipedia.)

DR. CAMERON KYLE-SIDELL: "WE ARE TREATING THE WRONG DISEASE AND WE MUST CHANGE WHAT WE ARE DOING."

BY JAMES BAILEY
April 9, 2020

CAMERON is an ER and critical care physician at the Maimonides Medical Center in Brooklyn, NY, where he has been working at the bedside of COVID+ patients. Based on his experience treating many patients suffering from the coronavirus, he concluded the entire medical community has been given false information, causing them to operate under a false paradigm that patients are suffering from a pneumonia-like virus when it is not that at all. As a result, physicians are treating patients for respiratory failure when there is nothing wrong with their respiratory system. He explains the real problem is oxygen failure, like being at a very high altitude where the air does not have sufficient oxygen. He says, "We are treating the wrong disease and we must change what we are doing if we want to save as many lives as possible… I fear that if we are using a false paradigm to treat a new disease, that the method by which we program the ventilator, one based on a notion of respiratory failure as opposed to oxygen failure, that this method, and there are a great number of methods we can use with the ventilators, but this method being widely adopted at this very moment in every hospital in the country which aims to increase pressure on the lungs in order to open them up is actually doing more harm than good. The ARDS that we are seeing, that the whole world is seeing, may be nothing more than lung injury caused by the ventilator."

Other reports are coming in from doctors claiming they are being pressured to report the coronavirus as the cause of death in cases where the actual cause was unrelated, showing there is a real effort to inflate the numbers for the sake of fear mongering to manipulate public opinion. Now we have Cameron exposing the entire medical community has been lied to about the nature of the disease, causing them to do more harm than good.

CORONAVIRUS THROUGH THE LOOKING GLASS

BY Dr JAYNE LM DONEGAN,
MBBS DRCOG DFFP DCH MRCGP
MFHOM GP & HOMEOPATH

THE WORLD IS A VERY different place today to the one in which I had thought to be writing this article.

THE CURRENT 'SITUATION'

Why are so many well observed science-based narratives coming from a few newspaper columnists and retired High Court Judges, and not from politicians and the majority of doctors in positions of power? Money usually talks, but not today. Faced with total economic collapse, hysteria is trumping science and money every time.

The members of my own profession appear not to have done any independent investigation of their own, content to follow whatever is the current dogma unquestioningly. Not every one of them but doctors who questions this dogma are accused by their fellows of being conspiracy theorists, or, '*putting people's lives at risk.*'

We were doing a great job in the UK, when we were following the advice of Her Majesty's Government's chief scientific adviser Sir Patrick Vallance; to let the harmless-to-most-people virus spread till we reached a level of natural herd immunity when cases would stop. Sir Patrick is a wise and experienced doctor. He also has common sense - which, unfortunately, is not very common.

I thought we were in safe hands. Sir Patrick's plan to sequester the vulnerable, let the virus spread, and gain natural herd immunity seemed admirable and evidence based. The Prime Minister Boris Johnson, manfully stuck to Sir Patrick's sage advice despite fierce opposition and personal attacks by populist politicians, so called 'experts' and the media going for his and Sir Patrick's throats

'People will die!!' They screamed.

Expert says: *"Herd immunity only applies to children."* Where do they find these 'experts'?

10,000 people die of pneumonia every year, 20,000 in 1999-2000, when

DR Jayne L.M.Donegan

" No-one outside of Ferguson's group even checked the maths. Ferguson announced that hundreds of thousands in the UK and millions in USA would die unless the population was 'locked down' for up to 18 months."

all nurses' leave was cut, all elective operating lists were cancelled, the NHS had to hire refrigerated lorries to put bodies in because mortuaries were full, and London ambulances had to drive people as far afield as Derby to find ITU beds. http://news.bbc.co.uk/1/hi/health/249320.stm

There were 60,000 more NHS beds in 1999 than there are now subsequent to successive government cuts. And the country was not shut down nor bankrupted and our civil liberties were not taken away.

Every year, every winter, NHS hospitals are heaving. All the beds are full. People are left on trolleys in corridors for days some dying on them.

And the country is not shut down nor bankrupted and our civil liberties are not taken away.

On 16 February 2020 Neil Ferguson of Imperial College revealed his report and disease model that he had written based on cherry-picked assumptions and using calculations he devised 13 years ago and which he has refused to share with ANYONE. The report had no peer review. No-one outside of Ferguson's group even checked the maths. Ferguson announced that hundreds of thousands in the UK and millions in USA would die unless the population was 'locked down' for up to 18 months. However long it took to produce a vaccine.

And the Government believed him. The Prime Minister abandoned his prudent course to cheers from the rabid press, as did the USA.

One unreviewed, unchecked report by the man who brought us the wholesale slaughter of British farm animals (foot and mouth) in 2001, took down the 'free' world,.

It was that easy. While experienced, conscientious scientists, epidemiologists and doctors around the world said,
"This must be wrong.
This is not what we are seeing.
It is not how this kind of epidemic behaves."

How many deaths will there be from crime, murder, domestic violence, suicide, unemployment, patients not getting their usual care or chemotherapy and the inevitable toll that real depression and hopelessness from economic collapse bring in their wake? How many?

A week later, Professor Sunetra Gupta of Oxford University produced a much more rational report which predicted far fewer deaths. She reasoned that the peak of cases had probably already been reached, with the virus having started circulating earlier than previously thought.

Professor Gupta remarked how surprised she was at the readiness with which the Imperial College model had been accepted. She was pilloried in the press. It is only acceptable to bring bad news and to increase hysteria, not diminish it. *"It's not published or peer reviewed,"* they screamed." - Neither was the Imperial Report.

In these difficult times there have been some lovely instances of kindness and community spirit, with focus on what is really important in life.

But there have also been people reporting others to the authorities and being abusive to those whom they perceive to be endangering health (due to non evidence-based virus scaremongering) for going on maybe

two walks a day or talking to someone nearer than 2 metres. Also stories of police stopping motorists driving alone in their cars in order to walk alone in national parks.

Where I live in NW London, glass shop doors of several businesses were smashed down as thieves broke in to steal cash boxes last week. In Italy armed police are guarding supermarkets after crowds saying they had no money tried to take food for their families.

The world has spent 80 years blaming the Germans (they might say they didn't, but deep down they did) for murdering all those Jews.

"I would never have done that, I would have spoken out," they say.

Would they?

Would they really?

In just a few weeks almost the whole world has been confined in a form of house arrest, their liberties restricted, free speech curtailed, [https://www.gov.uk/government/news/government-cracks-down-on-spread-of-false-coronavirus-information-online] bodies are allowed to be cremated without a death certificate, for a virus that is wreaking less havoc than 1999/2000 flu.

Would they really have said anything all those years ago when they are not saying anything now?

No, they would not, because the very same tactics were used then as now:

"Those Jews are going to take your jobs, steal the bread from the mouths of your children, rape your women, and along with the Homosexuals, Gypsies and Disabled they will pollute your race. Be very afraid of them."

Now: *"That corona virus is going to kill your parents, kill your grand parents, kill you because you have asthma, diabetes, heart disease and those people out in the sunshine are going to make you DIE and anyone who doesn't agree with this is TRYING TO KILL YOU."*

After being the author of all this devastation, Neil Ferguson of Imperial is now saying, *"Oh, I may have miscalculated . It may be only 20,000 deaths. (And I still won't share my calculations)"*

He might have miscalculated? After the havoc he has wreaked in everyone's lives?

He has blood on his hands, and not just the blood of all those animals.

Has this admission caused any relaxation of the measures currently in force or distancing from Ferguson's original secret calculations?

Photo by Serrah Galos on Unsplash

Not at all. There is now talk of making the isolation arrangements more stringent

It is entirely predictable that Neil Ferguson of Imperial College would produce the model he did and would advise that an 18 month lock down until a vaccine arrives was necessary. His department works in partnership with the World Health Organization. The WHO work hand in glove with The Gates Foundation. The Gates Foundation aims to institute compulsory vaccination programs to all countries in the world. The WHO and Gates Foundation, even now, are targeting Africa for vaccine trials as the World Health Organization (WHO) is said to *"rightly[be] drawing attention to the risks the virus poses to the poorest and most vulnerable nations — particularly in Africa."* There are hardly any cases of people with illness ascribed to coronavirus in Africa, compared to the rest of the world. But people in African countries

›

will be handy and cheap to test the vaccine on. A Nature editorial in February 2020 states:

"It's hard to avoid the feeling of déjà vu. Infectious-disease outbreaks are often accompanied by such pledges to improve disease surveillance, and ***by promises to provide funds for drug and vaccine development. What is less forthcoming is sustainable funding for clinics providing community-level general medicine,*** *and for medical and nursing education,* ***as well as investments to sustain hospitals with supplies, electricity and running water."***

[https://www.nature.com/articles/d41586-020-00379-9 Nature]

The Gates Foundation in the form of its Vaccine Initiative GAVI, along with the Rockerfeller Foundation, and Microsoft are the Alliance behind ID2020 which aims to force everyone to have '*secure digital identities*' that will be used to track people and their vaccination records and stop people travelling or maybe even leaving their home if they have not been vaccinated with an ever increasing and arbitrary number of vaccines for which the manufacturers have no *liability* for any damage caused. Would this pandemic have been able to happen had it not been for the new Director General of the WHO, Tedros Adhanon Ghebreyesus, who took up his post in 2017. We have had SARS, Ebola, Swine 'flu, MERS, Zika pandemic 'scares' but the current scare has been the most successful one of all. It has brought the world to its knees. Not because of any virus but because of the response of the World Health Organization and other countries to the perceived virus.

How much of this current policy of the WHO is dictated by the Gates Foundation?

"Though the WHO is a public institution, the details of… engagements, and Gates's involvement, aren't available in the WHO's budgets or financial statements."

https://www.vox.com/science-and-health/2019/12/13/21004456/bill-gates-mckinsey-global-public-health-bcg

The other partners of Imperial College are AstraZeneka, Merck, Servier, all pharmaceutical companies and Nestlé. Apart from Nestlé, they all make vaccines. If you wear pink-tinted spectacles, everything you see will be pink. Natural immunity, intravenous vitamin C, chloroquine in severe cases – none of the USA Centers for Disease Control scientists, or UK Department of Health experts are interested in using these. Why do they not consider them? Because no pharmaceutical companies are interested in supplying them as they are cheap, cost pennies, and are OFF PATENT.

" The World Health Organization, The Gates Foundation, and governments all around the world are pushing for something new, expensive and patentable. No wonder Bill Gates has left Microsoft to concentrate full time on 'Philanthropy'. How much more money can you make on vaccinating 8 billion people compared to software?"

The World Health Organization, The Gates Foundation, and governments all around the world are pushing for something new, expensive and ***patentable***. No wonder Bill Gates has left Microsoft to concentrate full time on 'Philanthropy'. How much more money can you make on vaccinating 8 billion people compared to software?

As coronaviruses make up 25% of common colds and we haven't managed to make a vaccine against the common cold in 70 years, what chance is there that we will come up with one now?

There have, in fact, been previous coronavirus vaccines - after SARS – a vaccine was developed which produced very good antibody levels in mice. Unfortunately when the mice were exposed to natural coronavirus, this provoked such a large immune response, primed by the vaccine, that the mice died. *Après toi...*

Lack of safety and effectiveness notwithstanding, dependence on vaccines as the only solution to every bodily need, is so pervasive, that doctors are advising people to have a 'flu shot 'as there is no coronavirus vaccine available', even though studies have shown that flu vaccination makes you more susceptible to corona virus.

"The laboratory data in our study showed increased odds of coronavirus and human metapneumovirus in individuals receiving influenza vaccination."

This appears in the results and discussion sections but not the conclusion.

https://reader.elsevier.com/reader/sd/pii/4410X19313647?token=4254FEED-443FA39F11AC9649E9E81C3987E38A-75B75958C702FCB80F932E27F-F46A16CE1DF7798C840CD-31E61DE8714E pdf p352

Dr Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases (NIAID) in America since 1984 and one of the lead members of the White House Coronavirus Task Force., speaks about his *'Ambitious Plan to Scale Up Covid-19 Vaccine'* with government money which will allow him to manufacture the vaccine before there are any results of any trials. So they can *"push it [the vaccine],"* onto the market. He laments that this did not happen with Zika and SARS vaccines:

"That [getting them manufactured and into the market] has been a stumbling block for previous development of vaccines," Fauci said.

"We have a nice Zika vaccine, but we don't have enough to do it because there's no Zika around - same with SARS."

In other words, had there been outside funding to 'push" Zika and SARS vaccines, onto the market, they would have, even in the absence of any need. He added:

"So that's one of the things we're really going to push on is to be able to have it ready if in fact it works." Perhaps a minor consideration.

[https://news.bloomberglaw.com/pharma-and-life-sciences/fauci-outlines-ambitious-plan-to-scale-up-covid-19-vaccine?eType=EmailBlastContent&eId=2ab622d5-9eb7-4590-8b27-561e2d438f2f]

A BETTER APPROACH

Instead of focussing on vaccines, new drugs, shortage of ventilators, respiratory failure, no ITU beds, total organ failure, wouldn't it be better to focus on not getting invasive disease in the first place?

HOW?

Eat well, stop eating lots of sugar and processed foods. Look at the Alliance for Natural Health Food4health plate https://www.anhinternational.org/campaigns/food4health/

If you get symptoms of any acute illness, don't take: paracetamol, ibuprofen, antihistamines, decongestants and opiate cough suppressants which all sabotage the body's innate immune system and increase the incidence of invasive disease. Instead, open the window, stop eating, go to bed, drink lots of hot drinks and sleep. And if you can't sleep, reflect on your life. People also get ill from emotional causes, let them come to the surface. Can't be that simple? Try it.

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06 April
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All References accessed 27March to 06 April 2020

Dr Donegan's free information sheet: 'General Measures for Nursing People through Acute Illness' is available on her website, as well as ebooks on managing fevers, measles, mumps, rubella, avoiding meningitis, tetanus and minor injuries and travel medicine may also be downloaded.

http://www.jayne-donegan.co.uk/articles

DR DONEGAN IS CURRENTLY GIVING ONLINE LECTURES ON:

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LARGE COMMUNITY MUMPS OUTBREAK IN MANITOBA, CANADA, SEPTEMBER 2016–DECEMBER 2018

CCDR, Vol. 46, Iss. 4, April 2, 2020: Respiratory syncytial virus (RSV)

ABSTRACT

BACKGROUND: After routine mumps immunization programs were implemented in Manitoba in the 1980s, incidence was low, with 0–9 cases of disease annually.

In September 2016, a mumps outbreak began in fully vaccinated university students in Winnipeg, Manitoba.

Objective: We describe the investigation of this province-wide mumps outbreak, which lasted between September 2016 and December 2018. We present the details of public health measures implemented and challenges encountered. Possible contributing factors to the sustained transmission are also provided.

Methods: Probable and con rmed cases of mumps were investigated by public health departments using the investigation form developed for this outbreak.

Confirmed mumps cases were linked to the provincial immunization registry. An outbreak response team planned and implemented control measures across the province.

Results: The outbreak began in vaccinated university students in September 2016 and spread across the province. Activity was high and prolonged in the northern remote areas. By the end of 2018, 2,223 cases had been con rmed.

All age groups were affected, and incidence was highest among people aged 18–29 years. Two-dose coverage of mumps-containing vaccine in con rmed cases was close to 70%.

Conclusion: This prolonged outbreak revealed a large vulnerable population likely resulting from under-vaccination and waning vaccine-induced immunity in the absence of natural boosting from exposure to mumps virus.

It is important to maintain high two-dose coverage with mumps-containing vaccines. A third dose of mumps-containing vaccine in future outbreaks may be considered.

PHYSIOLOGICAL CHANGES OF THE VACCINATED ORGANISM: A BASIS FOR THE INTERPRETATION OF THE CLINICAL COMPLICATIONS DUE TO PROPHYLACTIC VACCINES

BY A. DEL CAMPO
Immunological Department, Laboratori Glaxo, Verona. Proc. 10th int. Congr. Permanent Sect. microbioi. Standard. int. Ass. microbial. Soc., Prague 1967; Progr. immunobiol. Standard., vol. 3, pp. 280-284 (Karger/New York 1969)

EXTRACTS

THE METHODS employed everywhere to control the safety of prophylactic vaccines seem to be nowadays sufficient to prevent the reappearance of such tragic accidents as the Lubeck or Cutter incidents.

However, satisfactory safety of vaccines on a mass level does not necessarily coincide with total safety on an individual level: and in fact the use of any vaccine induces, at a varying rate, secondary effects or real complications, which are of a limited epidemiological value but very important from a clinical point of view.

Sometimes these complications can be attributed to previous sensitizations to the administered antigens, or to potential properties of the vaccine -- as in the case of the neurological complications of arising from the use of vaccina virus or of attenuated polio viruses; but most frequently they seem to be quite independent of the known properties of the vaccine -- such as in all the reactions, observed after different vaccinations, concerning the respiratory tract (Cantalini, 1960; Snow and Lewis, 1960), the Endocrine system (Aragona, 1960), the blood coagulation process (Meindersma et al, 1962; Zelakowski et al, 1964; Barghini 1964; Wagner, 1964; Muscolino et al, 1965), the renal function (Sottrup 1961; Baylon et al, 1966), the intestinal tractus [Diesfeld, 1962], the joints (Ed. BMJ, 1963 and 1964; Silby et al, 1965), the eye (Chakravorty, 1963; Scialdone et al, 1963) and, above all, concerning the great number of secondary infections (Stickl et al, 1966).

"Its complexity is, on the other hand, remarkable when the activity of the vaccine manifests itself slowly, involving the appearance of fever or of other inflammatory processes which represent a second stress for the vaccinated organism."

To explain the pathogenesis of this second group of complications it is necessary to admit firstly that vaccination is always a trauma of considerable intensity - though variable from vaccine to vaccine - for the body and therefore its effects are far greater than the functional changes induced by drugs normally used in therapy or prophylaxis; and secondly, that the pre-existence - in a minority of individuals - of special organic conditions (such as anatomical alterations, actual or potential functional defects of different organs or tissues, peculiar predispositions or miopragias which cannot be defined more clearly) can induce an abnormal response to the vaccinal trauma, that is a pathological reaction.

The exact identification of such organic conditions, having to be applied to each case, is of clinical interest. But the intensity and the other functional aspects of the vaccinal trauma are worth being defined experimentally, in order to explain in detail the generic notion of "negative phase", specific and above all aspecific {Raettig, 1964] which has been used for many years, mainly to indicate the lower resistance to infections usually observed after vaccinations.

In a series of investigations performed in the last 5 years on more than 200 children, we have tried to explain the main functional changes which can be observed in the human body after the administration of different antigenic preparations, consisting of toxoids, bacterial viral vaccines.

The results of these surveys show that the functional changes induced by vaccinations are rather marked, and appear both on a biochemical and a cellular level [Del Campo et al, 1965a-c, 1966a-g; Tuvo et al, 1966; Zardini et al, 1966, 1967].

The complex of the physiological changes detected after the various vaccinations corresponds fundamentally to the picture of the general adaptation syndrome and is therefore extended to all the functional activities.

The features of this syndrome vary, however, according to the properties of the various prophylactic vaccines. Namely, its intensity and duration are the highest following the vaccinations with live attenuated vaccines, the lowest following the administration of toxoids, and average following bacterial vaccines.

Its complexity is, on the other hand, remarkable when the activity of the vaccine manifests itself slowly, involving the appearance of fever or

of other inflammatory processes which represent a second stress for the vaccinated organism : this can be easily observed after smallpox and polio vaccination (Sabin type). On the contrary, the syndrome does not modify with the repetition of vaccinal stimuli.

All the remarks here summarized can help give a more precise pathogenetic basis for the interpretation of many complications observed after vaccinations.

Sometimes the functional changes observed are themselves initial stages of some complications (e.g. the lengthening of the prothrombin time).

In other cases, the evident biochemical disorder which takes place in the human body immediately after the administration of a vaccine is a condition sufficient to explain why latent states of functional deficiency in various organs or systems can be increased and actualized to the point of a pathological reaction (as in the case of EEG changes in individuals who are carriers of cortical bioelectric abnormalities).

In yet other cases, the decrease of some important factors of natural resistance - essentially properdin and lysozyme - can explain the easy occurrence of secondary infections following p rophylactic vaccinations.

From a practical point of view, the general picture of this "post-vaccinal syndrome" suggests at least 3 kinds of conclusions :

1. It is necessary to increase our efforts to improve the purity of prophylactic vaccines: the. post-vaccinal syndrome shows in fact the highest grade following the use of live vaccines and is still marked following the use of killed ones, while it is much slighter following the injection of highly purified toxoids. In the latter case, the syndrome is probably of a purely " immunologic" type, and it lacks nearly all the components of a toxic or infectious type.

2. It is absolutely necessary not to discontinue the practice of accurately selecting the individuals to be submitted to prophylactic vaccinations, and of excluding all the subjects showing clinical or anamnestic characteristics which make probable the presence of latent or actual functional abnormalities, especially when very important or delicate parenchymas or systems (like e.g. CNS) are involved.

3. Every effort must be made to prevent individuals just vaccinated from being exposed to a new stress - be this of a physical or infectious type-while weakening of the natural defence and the disorder of the biochemical activities are still operating.

Only in this way does it seem possible on the one hand to reduce the intensity and the duration of this post-vaccinal syndrome, and on the other to limit its consequences and the danger of the real clinical complications which arise from it.

SUMMARY

A series of experiments has been carried out on more than 200 children, to investigate the effects of vaccinations on the physiology of the human body.

The results indicate that artificial immunization induces normally certain physiological changes, which correspond fundamentally to those of the general adaptation syndrome, being therefore extended to many, if not all, organs and systems.

Adrenal cortex, blood cells, serum proteins and electrolytes, intermediate metabolites, enzymes' activities and natural resistance are in fact deeply involved.

This picture can help explain the pathogenesis of the complications consisting of an alteration of the adaptation to the environment (through the involvement of natural resistance) or of changes in the function of different organs or systems (when these were altered by anatomical or functional damage prior to vaccination).

ANAPHYLAXIS AS AN ADVERSE EVENT FOLLOWING IMMUNISATION

Michel Erlewyn-Lajeunesse, Jan Bonhoeffer, Jens U Ruggeberg, Paul T Heath, J Clin Pathol. 2007 Jul; 60(7): 737–739

A REVIEW of the definitions of anaphylaxis and discussion of the challenges for vaccine safety

CONCLUSIONS

Anaphylaxis is a rare adverse event following immunisation. Designing a case definition for use in epidemiological studies is challenging because of the variety and non-specificity of the symptoms.

Despite these difficulties two recent symposia have proposed definitions and the Brighton Collaboration has published a definition to be used specifically for immunisation. We propose that future studies on vaccine safety should use and evaluate this definition as a benchmark for reporting.

Research in this area to date has shown that reliable and well defined incidence rates cannot be derived from passive reporting systems used in post-marketing surveillance. **There is a need for large and prospective multinational studies to arrive at a better understanding of the frequency and true nature of this rare event.** ***(TiP emphasis)***.

Only by providing robust data can we expect to reliably assess vaccine safety and maintain public confidence in our immunisation programmes.

PMID: 17483254

FIRST MALARIA VACCINE ROLLED OUT IN AFRICA - DESPITE LIMITED EFFICACY AND NAGGING SAFETY CONCERNS

BY SCIENCE JOURNALIST,
JOP DE VRIEZE

26 Nov 2019

https://www.sciencemag.org/

EXTRACTS

MALAWI - In a small room at the Phalula Health Centre in southern Malawi's Balaka district, two young mothers are sitting on a wooden bench, each with a 5-month-old baby on their lap. Across from them, behind a desk, sits Alfred Kaponya, a community health worker. A colleague is busy preparing a vaccine, tapping the syringe to dislodge bubbles. Kaponya explains the procedure to the women, writes down the vaccines' serial numbers in the children's vaccination booklets, and copies them onto a spreadsheet in his binder.

Then, one of the mothers bares her son's thigh for the shot; he starts to cry, and she strokes his back. The procedure is repeated for the other baby, a girl.

It may sound routine, but it's not. These two children have just received the first malaria vaccine to move beyond the stage of clinical testing—a landmark event in the battle against a disease that each year takes more than 400,000 lives, most of them children in Africa. Thirty years in the making, RTS,S, also known by its brand name, Mosquirix, targets Plasmodium falciparum, the most common and most lethal of four malaria parasite species. It is an answer to a dire need. After decades of declining numbers of cases and deaths, the fight against malaria has stalled. Parasites resistant to the most widely used treatment, called artemisinin-based combination therapy, are spreading, while malaria mosquitoes are increasingly resistant to insecticides.

And yet the rollout, here and in two other African countries, isn't quite the breakthrough the field has been waiting for. Mosquirix's efficacy and durability are mediocre: Four doses offer only 30% protection against severe malaria, for no more than 4 years. Some experts question whether that is worth the cost and effort.

The biggest concerns, however, are about the vaccine's safety. In the largest trial, children who received Mosquirix had a risk of meningitis 10 times higher than those who received a control vaccine. Mosquirix may not have triggered the meningitis cases—there are other possible explanations—but the possible risk worried the global health community so much that, rather than rolling out the vaccine across Africa, the World Health Organization (WHO) has decided to set up a pilot in Malawi, Ghana, and Kenya in which the vaccine will be given to hundreds of thousands of children.

THE DEBATES ABOUT MOSQUIRIX came to a head at a meeting at WHO headquarters in Geneva in October 2015. Proponents of rolling out the vaccine, including many African representatives, argued that an imperfect vaccine was better than none. Others, mainly vaccine experts, argued that Mosquirix just wasn't safe and effective enough for introduction. A relative outsider at the meeting, Danish anthropologist and vaccine researcher Peter Aaby of the Bandim Health Project in Guinea-Bissau, offered another argument against introduction.

After reanalyzing the data from the biggest trial, Aaby discovered that although the vaccinated children had malaria less often, they did not die less often. Among girls, overall mortality was almost doubled, Aaby told his colleagues at the meeting. "This vaccine is killing girls," he recalls saying. Whereas WHO expects the vaccine to save one life per 200 children vaccinated, Aaby believes one in 200 will die as a result of it; he predicts "a nightmare."

Aaby and Christine Stabell Benn, a global health professor at the University of Southern Denmark, have an explanation. The married couple has studied routine vaccinations in Africa for decades and believes vaccines can "train" the immune system in ways that don't affect just the target disease. Vaccines that contain a living, weakened pathogen—such as the vaccines against measles and tuberculosis—strengthen the immune system generally, Aaby and Stabell Benn say, making recipients better able to fight off other infections. But vaccines that contain a killed pathogen or only bits of it weaken the immune system, their theory goes—especially in girls, because their immune systems seem to respond more strongly to vaccines in general.

Few share Aaby's concerns about Mosquirix. WHO's Mary Hamel, who leads the vaccine pilot from Geneva, says the trial was not designed to study mortality. Just being enrolled in the trial meant children received better care, and their mortality was 70% lower than among children near the study sites who weren't enrolled. "The surprise," Hamel says, was the low mortality in girls who received the rabies vaccine. Tanner says Aaby has "enriched our field" but "has turned a bit into a missionary with regard to the nonspecific immune effects. I am confident that the vaccine will have an overall positive effect on mortality." Yet Aaby's presentation at the meeting intensified the doubts. At one point, it appeared the vaccine might be abandoned altogether, Greenwood says. To address the concerns, the attendees agreed to the three-country pilot. In each country, the WHO team and the national government would randomly select areas where about 120,000 children annually would receive the vaccine between 2019 and 2022. Researchers would monitor how well the rollout went and compare rates of malaria, meningitis, and other diseases, as well as mortality, in vaccinated and control areas.

By September, almost 35,000 children in Malawi had received at least one shot. Getting the vaccine to these children has been straightforward, but collecting follow-up information is a challenge. "In trials, you have a controlled environment. You know where the participants are, keep track of them, if there is an issue you take care of them," says Bernhards Ogutu, a pediatrician and malaria researcher at the University of Nairobi who is involved in Kenya's

vaccine pilot program. "But in the pilot, once you've given the child the vaccine, they go home."

As a first step to monitoring them, researchers in Malawi have set up a surveillance system in four "sentinel hospitals" that treat both vaccinated and unvaccinated children. Comparing data about illness and mortality should show the vaccine's impact, says pediatrician Tisu Mvalo of the University of North Carolina Project–Malawi in Lilongwe. "We had to train hospital staff to collect these data. We hope that the numbers will be big enough to detect potential differences."

Keeping track of children who die outside the hospitals is even harder. "Unfortunately, we still have no death registration in this country," Mathanga says. Instead, the team built a new system based on a cultural practice: In rural Malawi, town chiefs must allocate a place for the dead to be buried. The researchers figured they would know which children have died. Many chiefs are illiterate, however, so they had to be assigned an assistant. Pilot evaluation staff use motorbikes to visit the chiefs regularly and collect the paper files; they also interview relatives of deceased children to identify the most likely cause of death. But these "verbal autopsies" aren't always correct.

MEANWHILE, the pressure to deliver results is rising. In April, WHO's advisory committees said they would assess any impact of Mosquirix on meningitis, severe malaria, and mortality—and determine whether the vaccine can be introduced in the rest of Africa—after just 2 years, instead of the four originally planned. "The evaluation will continue, but we don't want to keep the rest of Africa waiting any longer," says David Schellenberg, who left LSHTM in 2016 to join the team at WHO. Another reason to hasten the decision is that GSK needs to know whether it can continue production, Schellenberg says.

COVID: TWO VITAL EXPERIMENTS THAT HAVE NEVER BEEN DONE

BY JON RAPPOPORT
www.nomorefakenews.com
10 April 2020

WHY NOT? Because they would expose this vicious farce, the criminals perpetuating it, and end the lockdowns. The first experiment would confirm or deny the accuracy of the PCR diagnostic test. The experiment would reveal whether this widespread test for COVID-19 can actually predict illness in the real world, in humans, not in the lab. This experiment has never been done. It should have been done before the PCR was ever permitted to make claims about THE QUANTIY OF VIRUS that is replicating in a patient's body. Quantity is vital, because, in order to even begin talking about whether a virus can cause disease, millions and millions of virus must be actively replicating in a patient's body.

Here is the experiment. Assemble a group of 500 volunteers, some sick, some healthy. Take tissue samples from them, and give the samples to PCR technicians. The technicians will never see or know who the 500 volunteers are.

The techs run these samples through the PCR. For each sample, they report which virus they found, and how much of it they found.

"In patients 34, 57, 83, 165, and 433, we found a great deal of the following disease-causing viruses."

Now we un-blind those specific patients. By the test results, they should all be sick. Are they? Aren't they? Then we would know. We would know how accurate and relevant the test is in the real world. Of course, this is not the end of the experiment. The same samples should have been given to a whole other set of PCR techs to run. Did they come up with the same results the first set of PR techs did?

Several new groups of 500 patients each should be enlisted, and still more sets of lab techs should repeat the experiment, ending up with confirmation or rejection of the initial findings. This is the way the scientific method is supposed to work.

In the absence of this experiment, the quantitative PCR must be looked at as a rogue hypothesis that should never have been foisted on the public. It should never be used as the basis for determining case numbers of any disease. In the "COVID-19 crisis," all case numbers derived from the PCR should be thrown out. The second vital experiment concerns the discovery of a new virus---in this case, COVID-19.

First of all, there is no lab procedure that can climb inside the human body in real time and record the active replication of millions of virus. The closest you can come involves the use of electron microscopy.

Suspecting the existence of a new disease-causing virus, researchers should line up, at the very least, several hundred people who seem to have the new disease. Tissue samples should be taken from them. Using correct steps of centrifuging these samples, specimens of the results should be examined and photographed under the electron microscope. In every one of the several hundred photos, do the researchers see many identical particles of a virus they've never seen before; and do the researchers see that these many particles are the same from photo to photo? If so, and if more than one group of researchers independently carrying out this procedure on the patients' tissue samples achieves the same result...then, this is as close as you can come to saying you've discovered a new disease-causing virus.

Other researchers with other patients should attempt to replicate the above findings. This vital experiment has never been done in the case of COVID-19. Not even close. Therefore, researchers can't make a true claim to have discovered a new disease-causing virus.

In the absence of the two vital experiments I've described in this article, all you're left with, concerning a single "COVID-19" pandemic and a single new cause, are: anecdote, rumor, gossip, conjecture, speculation, bad science, and lies. Plus the horrendous damage from all the consequences of lockdowns based on those lies.

TURN ON THE ECONOMY.

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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