THE informed PARENT
ISSUE TWO 2018 A NEWSLETTER ON VACCINATION ISSUES AND HEALTH

# OUR BRAVE NEW WORLD: PHARMA'S POLITICAL STRAW MEN, LIES AND CENSORSHIP

BY JOHN STONE
April 12, 2018
www.ageofautism.com

WE ARE REACHING a critical point (and historic moment) which resembles in some ways both WMD and the banking crisis of 2008: the burden of scientific evidence and personal testimony weighs heavily against the industry (everyone has been lied to and the products have been over-sold) and what we are seeing is a pre-emptive strike to stop people talking – to stop them at all cost. The evidence is that the industry and governments are afraid of exposure and are going for broke. This was the message of the industry spokeswoman Heidi Larson on 1 January 2018 in her column 'Let Freedom Ring'. It was a very odd kind of freedom – Larson who works closely with the World Health Organization and Bill and Melinda Gates, as well as Merck and GSK – seemed to be trying to trade vaccine compulsion (distancing herself and the Vaccine Confidence Project from moves around the world towards draconian mandates) for silence on vaccine safety.

"The growing challenge in the vaccine landscape is that it is no longer isolated individuals who are thinking twice or refusing vaccination, but that there are growing groups of people who are not only expressing their individual right to question and to choose, but are increasingly connected with others and demanding the right to choose as part of a larger movement. These movements are about principles of freedom and rights, not about specific vaccines, or specific safety concerns."

Larson is not wrong about rights but she is about people not having "specific safety concerns": only a few


months before she had declared on a Johnson and Johnson website:

"Yes, there are potential risks—there will always be potential risks with any medical treatment. And we don't talk enough about that."

Anybody might reasonably be worried about safety of something over which they are being threatened with censorship. And, of course, now there are many people writing and speaking on the web, who want to talk about the risks both from personal experience and published science who are not poorly informed, malicious or engaging in irresponsible talk. Of course, there are clickbait sites that put out deliberately false information but it does not seem likely that they are the ones that industry or government are really scared about.

When the European Parliament balances the bald assertion that vaccines are "safe" with condemning " the spread of unreliable, misleading and unscientific information on vaccination aggravated by media controversies" and calling "on Member States and the Commission to take effective steps against the spread of such misinformation and to further develop awareness and information campaigns, especially for parents…" they are themselves being misleading, naive or worse – and they are trying to forestall public examination of what the industry and surrogate government bureaucracies are doing, and suppress the ever growing body of evidence that vaccines are not safe. They are declaring falsehoods, engaging in innuendo and calling for socially repressive measures. This sadly is all too likely to dovetail with French President Macron's proposed legislation on Fake News, following on his extension vaccine mandates.

Simultaneously, we have the alarming spectacle of Senator Pan who having notoriously piloted the notorious SB277 school vaccine mandates bill through the Californian legislature has now filed SB1424 to censor social media with the appointment of state "fact checkers" to decide which facts are true.

This bill would require any person who operates a social media, as defined, Internet Web site with a physical presence in California to develop a strategic plan to verify news stories shared on its Web site. The bill would require the plan to include, among other things, a plan to mitigate the spread of false information through news stories, the utilization of fact-checkers to verify news stories, providing outreach to social media users, and placing a warning on a news story containing false information.

(a) Any person who operates a social media Internet Web site with physical presence in California shall develop a strategic plan to verify news stories shared on its Internet Web site.

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Magda Taylor

# Editor's note

*WELCOME to the latest 2018 newsletter, Issue Two. A mixture of articles, which will hopefully trigger further lines of enquiry and help towards your informed choice. Things have not just been hotting up regarding the weather in recent times. The vaccine issue continues to rear its head regularly now – in one way or another!*

*Further articles on HPV vaccine safety; the recent announcement for urgent investigation into a Cochrane review that had not included all relevant trials and ignored possible sources of bias; the push and subsequent introduction to offer boys this vaccine in the UK. Also, investigative journalist, Joan Shenton was recently due to travel over to Australia this summer for Q&A sessions after organised screenings of her film documentary Sacrificial Virgins. However Joan was denied a visa to visit Australia.*

*Then there is, and has been, the steady flow of scaremongering articles on measles cases and blaming those who are choosing to not vaccinate. Mainstream media, the mouthpiece for the industry continues to present inaccurate and biased reports. I also wrote to a Public Health doctor (Sussex/Surrey,NHS England) back in June with a number of questions regarding information that had been mailed out to schools and parents on measles outbreaks from earlier this year. No response despite re-emailing a couple of weeks later. Perhaps I will copy in the head of PHE and see if I can get any kind of response with a third attempt? I will publish my questions and any response in the next newsletter.*

*I am presently reading a book written in the 1800s by William White: 'The Story of a Great Delusion'. It is hard work sometimes due to the wording of the past compared to modern day english. However it is an excellent book and I can not emphasise enough how important it is to build up your knowledge about the history of vaccination and Jenner's extremely shaky science. People say today...'oh that is archaic now and modern medicine has moved on...etc'. However modern vaccines and the idea of immunity is based on Jenner's vaccination theory. Also modern medicine rejoices in Jenner's achievements (you might wonder why if you read up on his ideas/experiments) and how vaccination eradicated smallpox when it suits them to quote their 'archaic' information. Personally I prefer to read from a book and find the information activates more brain cell activity than when staring at screens - so I am encouraging you to try and take time to read a few books from the past – there is a vast array to choose from. Check out the Archive Library on my website and also forgottenbooks.com have a list of archive books available if you wish to order a printed copy.*

*If anyone is interested in organising a talk on vaccination in their locality please get in touch via the contact page on the website or phone 01903 212969. I have gathered together a lot of information over the 27 years I have been investigating this issue, and I am keen to share it with those interested.*

*Let's hope more doctors and scientists will have the courage to speak out with their concerns and findings!*

*Magdalene Taylor, Editor, August 2018*

CONTINUED FROM PAGE 1:

(b) The strategic plan shall include, but is not limited to, all of the following:
(1) A plan to mitigate the spread of false information through news stories.
(2) The utilization of fact-checkers to verify news stories.
(3) Providing outreach to social media users regarding news stories containing false information.
(4) Placing a warning on a news story containing false information.
(c) As used in this section, "social media" means an electronic service or account, or electronic content, including, but not limited to, videos, still photographs, blogs, video blogs, podcasts, instant and text messages, email, online services or accounts, or Internet Web site profiles or locations.

Not surprisingly there is already a fine article about this by John Rappoport. The bill does not of course specify vaccine related stories but obviously we can see where this is going – of course it is altogether terrifying to envisage the scale and cost of this new bureaucracy, not to mention its potential for arbitrariness, incompetence and vindictiveness: perhaps above all to stop people talking about their own experiences. Is this so mad, grandiose, so Un-American that even California's legislature might back off? In this brave new world no one could be confident.

These are not of course random events. Our new rulers are the pharmaceutical industry hiding behind men of straw.

***John Stone is UK and European Editor of Age of Autism.***

"TRUST IS A FRAGILE COMMODITY. IN PUSHING HPV AS AGGRESSIVELY AS THEY HAVE DONE, PHARMACEUTICAL COMPANIES RISK BLOWING TRUST IN ALL VACCINES OUT OF THE WATER."

*~ Dr David Healy, from 'In the Name of the BMJ', 7 Aug 2018. www.davidhealy.org*

# BEHAVIORAL STRATEGIES MORE EFFECTIVE THAN PERSUASION WHEN PROMOTING VACCINATIONS

**SUMMARY**: RESEARCHERS SAY VACCINATION CAMPAIGNS FOCUSED ON PERSUASION MAY NOT BE EFFECTIVE. THE STUDY REPORTS INTERVENTIONS FOCUSED ON SHAPING PATIENTS' AND PARENTS' BEHAVIOR MAY BE MORE EFFECTIVE IN PROMOTING VACCINATIONS.

NEUROSCIENCE NEWS, APRIL 4, 2018

https://bmcinfectdis.biomedcentral.com/articles/10.1186/s12879-018-3096-7

***TiP Editor: Sadly the medical establishment spend more time looking at strategies to rein in any individual who dares to question, research and decline vaccines for themselves or their loved ones! Good to be aware of 'their' strategies.***

FACED WITH OUTBREAKS of influenza and other vaccine-preventable diseases, parents, educators, healthcare providers, and policymakers around the world often want to know how to persuade people to get their vaccinations. But a comprehensive review of the scientific findings from research on vaccination behaviour shows that the most effective interventions focus directly on shaping patients' and parents' behaviour instead of trying to change their minds.

"A common myth is that it's easy to persuade people to get vaccinated," says researcher Noel T. Brewer of the University of North Carolina, first author on the report. "But when was the last time hearing a fact one time led you to exercise regularly, lose weight, or quit smoking? It's the same for vaccination."

The findings, published in Psychological Science in the Public Interest, a journal of the Association for Psychological Science, suggest that although vaccination campaigns commonly focus on changing people's perceptions and attitudes about vaccines, there is little evidence that these campaigns are effective.

To understand the factors that underlie vaccination-related behaviour, Brewer and co-authors Gretchen B. Chapman (Carnegie Mellon University), Alexander J. Rothman (University of Minnesota), Julie Leask (University of Sydney), and Allison Kempe (University of Colorado Anschutz Medical Campus) examined the latest findings from a variety of fields, including psychological science, public health, medicine, nursing, sociology, and behavioural economics.

The report is accompanied by a commentary by Victor J. Dzau, President of the United States National Academy of Medicine.

"As Brewer and colleagues note, psychological science offers insight into why people engage in health behaviours including vaccination," Dzau writes in his commentary. In publishing this report, the authors "are performing a service to society by integrating the disconnected literature on psychological theories and vaccination, which can inform practical interventions to address the challenges of vaccination."

One of the challenges of vaccination is that uptake varies across vaccines. Childhood vaccination generally has strong public support, with the majority of infants in most countries receiving recommended vaccines. In contrast, many adults forego vaccines such as the seasonal flu shot.

"Vaccination is one of the greatest public health achievements in the past century. Yet, vaccine uptake is well below optimal for some vaccines, and healthcare providers routinely face parents and patients who are hesitant about receiving vaccines," explains Chapman. "Accessing the full benefits of vaccination entails facilitating behaviour, and the insight for doing that comes from psychological science."

The best available data indicate that the percentage of people who actively refuse all vaccines is incredibly small and that neither vaccine refusal nor delay is on the rise. These findings contradict the media-fueled narrative that an increasing number of people are rejecting immunizations.

In reality, most people receive most vaccines in line with their doctors' recommendations. Many others have favourable attitudes toward vaccination but do not always follow through to receive vaccines in full or on time. The researchers find that the most effective vaccination interventions build on these favourable intentions, employing behavioural strategies to:

- Facilitate action by providing patients with reminders and prompts
- Reduce barriers by setting default orders and appointments
- Shape behaviour by developing incentives, sanctions, and requirements

"Our main message to policy makers and providers is that, surprisingly, the strongest evidence supports impacting vaccination directly by leveraging, but not trying to change, what people think and feel," Chapman says.

In some cases, people encounter false or misleading information about vaccines. Research shows that the best way to correct this misinformation is to reiterate the facts clearly and in a way that fits with people's intuitive beliefs.

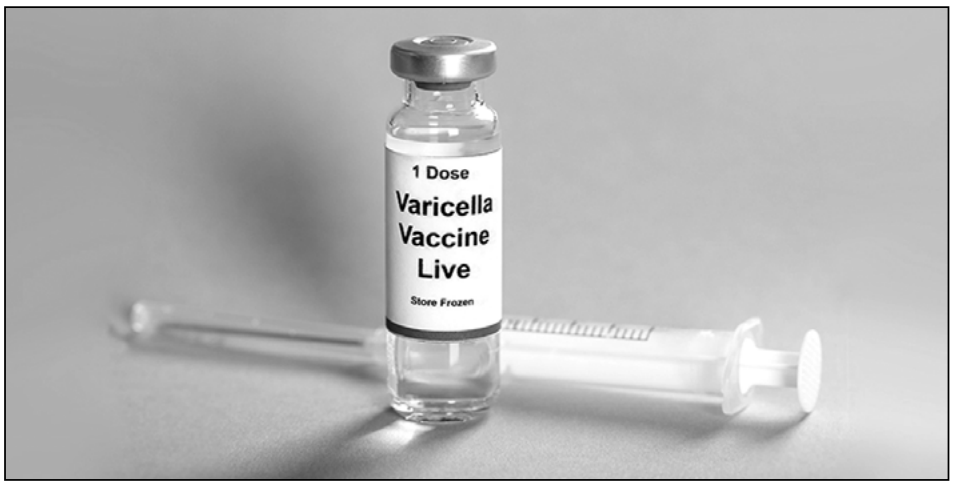
These conclusions are supported by multiple sources of evidence, but the researchers note that much of the available research on vaccination behaviour is limited in quality or quantity. Studies investigating vaccination attitudes and behaviour over time are rare and few studies examine the specific mechanisms or components that make for effective interventions.

Despite these limitations, cross-continent studies are increasingly converging on some common findings. In general, these studies show that vaccine acceptance tends to be high, vaccine hesitancy exists around the world, and the factors that motivate vaccination are similar across countries.

Vaccination is a public health issue, with psychological science providing a lens for understanding the factors that motivate vaccination. The interventions that stand to have the greatest impact are those based on psychological theory and behavioural evidence.

***Source: Anna Mikulak – Association for Psychological Science.***

# THE VARICELLA VACCINE, SKYROCKETING SHINGLES & CDC CHICANERY




Worldmercuryproject.org

May 09, 2018

"COLLUSION" is the word du jour, and the practice's very characteristics—deception, fraud, misrepresentation and secrecy—often prevent collusive acts from coming to light. In the scientific research community, would-be deceivers draw on a variety of tricks to slant their message, including manipulating data, employing other questionable research practices, not disclosing conflicts of interest, harassing whistleblowers and engaging in outright censorship.

The Centers for Disease Control and Prevention (CDC) is no stranger to any of these tactics, but eventually, as Shakespeare once predicted, the "truth will out." Critics and senior scientists, in growing numbers, have been pulling back the veil on the CDC's unethical modus operandi, arguing that questionable practices have become "the norm and not the rare exception." Adding to this emerging picture of a public agency captive to "rogue interests," a March 2018 article in the Annals of Clinical Pathology describes CDC's suppression of inconvenient research findings pertaining to its Universal Varicella Vaccination Program. The author, an independent computer scientist, outlines in morbidly fascinating detail the "collusion" between CDC and its local public health partner to conceal unwanted chickenpox vaccine outcomes from the public.

## ONE VIRUS, TWO DISEASES

Prior to the 1990s, natural chickenpox (caused by the varicella zoster virus) was a nearly universal childhood experience and, in children with normal immune systems, played out as a mild disease that conferred long-term immunity. In 1995, without any compelling medical reason to do so, the CDC added the chickenpox vaccine to the childhood vaccine schedule for 12-to-15-month-olds. In 2006, acknowledging the problem of waning vaccine effectiveness, it indicated that four to six-year-old children needed to get a second (booster) shot.

*"Those authors cautioned that mass chickenpox vaccination was likely to cause a major shingles epidemic and predicted that shingles would affect more than 50% of those aged 10-44 years at introduction of vaccination."*

Following natural chickenpox infection, the virus remains latent in the body. If reactivated later in life (usually in immunocompromised adults), the virus resurfaces in the form of shingles (herpes zoster or HZ). Before introduction of the vaccine, the high prevalence of natural chickenpox in communities served to hold shingles in check for most adults by regularly boosting a type of immunity called cell-mediated immunity. In fact, a 2002 study showed that exposure to natural chickenpox in adults living with children "was highly protective against [herpes] zoster." Those authors cautioned that mass chickenpox vaccination was likely to cause a major shingles epidemic and predicted that shingles would affect "more than 50% of those aged 10-44 years at introduction of vaccination."

Before and after introduction of the vaccine, researchers also warned of the vaccine's potential to shift the average age of chickenpox infection upward—a problematic scenario given that chickenpox is more severe in adults—while shifting downward the average age at which shingles occurs.

## FROM PREDICTIONS TO REALITY

The Annals author was hired as a research analyst in 1995 by the Los Angeles Department of Health through the CDC-funded Varicella Active Surveillance Project. For reasons specific to the project's self-contained geographic locality, the project benefited from unusually high-quality data and "uninterrupted and stable data collection." Thus, the research analyst found himself ideally positioned to monitor the rollout of the chickenpox vaccination program from its inception and assess its outcomes—both positive and negative.

Initially, his sole mandate was to analyze varicella data. In 2000, however, after anecdotal reports began trickling in from school nurses about "unexplainable increases in the number of cases of HZ…among school-aged children," the analyst persuaded the CDC to add active surveillance of shingles to his duties. In short order, this dual surveillance effort revealed two clearly negative consequences of the varicella vaccination program:

1. Widespread chickenpox vaccination had "accelerated the recurrence of shingles in children who had had natural chickenpox" to rates higher than those published "in any historical study." Previously, "such high HZ incidence rates were…associated with older adults, not children."
2. The mass varicella vaccination program also had "increased the likelihood of shingles recurrence in adults."

Neither finding was palatable to the public health agencies eager to publicize their vaccination program as an unmitigated success.

## OBFUSCATION AND MALFEASANCE

From this point until the analyst quit in disgust in 2002, the CDC either sat on or out-and-out forbade publication of any studies "suggesting negative findings or deleterious effects," engaging in at least 23 distinct actions "contributing to obfuscation and malfeasance." In one nonsensical attempt to "bury" the findings, the project investigators "simply and spuriously argued that the [surveillance project] did not provide a suitable platform for which to study HZ incidence rates." When the analyst refuted this argument, the agencies sought to statistically mask the unwanted findings. For example, they improperly averaged shingles rates across the two very different subgroups of children (vaccine recipients and children who had previously had natural chickenpox) to hide the spike in shingles in the second group.

The CDC and local health department also went after the research analyst, both before and after his employment with them. Actions included:

- Directing him "not to pursue further analysis of trends in HZ cases"
- Denying him permission to contact individuals who had reported a second recurrence of shingles within a year of their first reported case
- Attempting to discredit him through ad hominem attacks
- After his resignation, serving notice "to 'cease and desist' publication in a medical journal when he sought to objectively publish all of the data and results" and pressuring journal editors to postpone publication.

*"Case reports likewise refer to "vaccine-strain zoster severe enough to cause neurological complications such as meningitis or encephalitis" in healthy children."*

## HOLLOW PROMISES

More than two decades into universal chickenpox vaccination in the U.S., the program's early promises ring hollow. Instead, the Annals author makes a compelling case that the program has resulted in a "fabricated cycle of disease and treatment" that has a substantial health care cost burden and is "causing distress" to vaccine recipients—and non-recipients—of all ages. Elsewhere, the author quoted a parent whose daughter received the varicella vaccine at age four (having never had natural chickenpox) and then had recurrent and painful episodes of shingles at ages 13 and 16; the parent expressed regret for "a dangerous vaccine with awful side effects that stay with you for a lifetime…far worse than chickenpox in one's youth." Case reports likewise refer to "vaccine-strain zoster severe enough to cause neurological complications such as meningitis or encephalitis" in healthy children.

Recently, Italian scientists suggested that routine varicella vaccination programs may have "perverse public health implications" due to the "intrinsically antagonistic" dynamic between chickenpox and shingles. Likewise, an agency—the CDC—that is in charge of promoting vaccine uptake while being tasked with vaccine safety at the same time has an inherent conflict of interest that does not serve the public.

Over a decade ago, a Nature editorial discussed parents' declining confidence in vaccine safety and concluded that there was a "strong case" to be made for establishing "a well-resourced independent national agency that commands the trust of both the government and the public in matters of health protection." Johns Hopkins University researchers similarly called for an independent National Vaccine Safety Board separate from the CDC or any branch of government in order to "ensure optimal vaccine safety." It's high time to follow through on those vital recommendations.

# THE COCHRANE HPV VACCINE REVIEW WAS INCOMPLETE AND IGNORED IMPORTANT EVIDENCE OF BIAS

LARS JØRGENSEN, PETER C GØTZSCHE, TOM JEFFERSON

BMJ; Evidence Based Medicine;
27 July 2018

## KEY FINDINGS

- The Cochrane human papillomavirus (HPV) vaccine review missed nearly half of the eligible trials.
- The review was influenced by reporting bias and biased trial designs.
- Authors of Cochrane reviews should make every effort to identify all trials and the trials' limitations.

In May 2018, the Cochrane Collaboration published its review of the human papillomavirus (HPV) vaccines. The review primarily assessed the vaccines' effect on precursors to cervical cancer. Cochrane has high standards for its reviews; however, there were important limitations in its HPV vaccine review, which we address in this paper.

## CONCLUSION

Part of the Cochrane Collaboration's motto is 'Trusted evidence'. We do not find the Cochrane HPV vaccine review to be 'Trusted evidence', as it was influenced by reporting bias and biased trial designs. We believe that the Cochrane review does not meet the standards for Cochrane reviews or the needs of the citizens or healthcare providers that consult Cochrane reviews to make 'Informed decisions', which also is part of Cochrane's motto. We recommend that authors of Cochrane reviews make every effort to identify all trials and their limitations and conduct reviews accordingly.

# The Quanten Theory

# VACCINE DRAMA IN CHINA

## by Patrick Quanten MD

www.pqliar.net

BIG WORLD NEWS!!

Vaccine scandal in China. A public outcry. And I'm thinking thousands of children dead, killed by vaccination. I'm thinking, finally it is all coming out. So I start reading with a heart full of excitement for the new future.

And I read that there are no children who have died. Not a single child has even been reported to be harmed by the vaccine drama. Dark clouds dim the light in my soul. No, that apparently is not the scandal! The scandal is that a Chinese Company has not kept to the rules. That is the big, unforgivable, scandal!

One Chinese Company has produced a number of "faulty" vaccines. This was discovered, not by the effects these vaccines had on people but through an official government inspection of the company's facilities in which they found that the company had fabricated production and testing records and had falsified production specifications and equipment.

So, nothing wrong with the vaccine then? Well, it is "substandard". Okay, so it is less effective? Yes, it is less effective. But not harmful? Indeed, it is still perfectly safe.

And now I raise an eyebrow. Why the outcry? Why the public panic? Surely, this is not the first time a manufacturing process is being manipulated? In fact, it happens so frequently that we, as victim citizens, should be used to it by now. The people have not been affected by this "scandal" and yet the world - indeed, a much larger world than simply China - has been rocked to its core. The regulatory body has done its work. Checking manufacturing procedures has proved to be effective. What the hell is the problem then??

Let's go back in time.

*Patrick Quanten MD*

*"...they found that the company had fabricated production and testing records and had falsified production specifications and equipment."*

Since 1987, in China vaccine quality for international procurement has been assured through the prequalification system that is managed by the World Health Organisation (WHO). The "prequalified" stamp of approval means that these vaccines are consistently safe, effective and of high quality and thus recommended for bulk purchase by the United Nations Children's Fund (UNICEF) in 152 low and middle-income countries, and by the GAVI Allience, which funds vaccines in 73 of these countries, as well as purchases by other agencies.

Several Chinese vaccines are licensed by the China Food and Drug Administration (CFDA) that is part of China's National Regulatory Authority (CNRA) which received WHO's total seal of approval in March 2011. In July 2011 this status was renewed and WHO Director-General Dr Margaret Chan welcomed the news, saying : "As a result of this evaluation, WHO is confident in the quality, safety and effectiveness of vaccines that are made in China."

According to the CFDA, China has 34 vaccine manufacturers, of which four are international joint ventures, seven are state run and the rest are private. All 34, it says, have met the most recent Good Manufacturing Practices requirements. And that is wonderful news, especially in the light of the general reputation about the quality that Chinese products have in the eyes of the Western world. Since when is Made in China synonymous for superior quality? People in the West equate it rather with cheap and cheerful. But hey, as far as vaccines are concerned the WHO is happy about the quality. Good news.

Except that persistent safety problems keep raising questions about the industry. Not so long ago, The American Food and Drug Administration announced a voluntary recall of a popular blood pressure medication made in China. But if there are consistent concerns about manufacturing in China, why are Western companies so keen to manufacture in China? Ah I forgot, much bigger profit margins! Well then the rest really doesn't matter anymore, I guess.

So, apart from manufacturing medicines inside China for the global market (UNICEF and GAVI order big time!) what is the Chinese internal market worth? Every year more than one billion vaccines are given to the Chinese in a compulsory vaccination programme. According to the Chinese Centre for Disease Control and Prevention every year more than one thousand children get seriously damaged by the vaccines, ranging from lasting nerve damage to death. This is simply blamed on the old manufacturing techniques used.

Photo by Edu Lauton on Unsplash

Here is another example why in the West campaigners against vaccination will never be able to pin the damage onto the vaccine itself. Manufacturing companies change the way they produce vaccines quickly enough, so whenever it might become clear there is a problem they no longer use that method or ingredient. In China the argument still works but by trying to blame manufacturing we keep chasing the facts all the time and we won't ever close in on them. Not this way!

In the light of China's vaccine production being so profitable for the Western companies it is also worth noting the opinion of Wang Yu, the director of CCDCP, who said that the West is keeping their vaccine technology secret from them. So, basically we want them to fail!!

This latest scandal has put another hole in China's vaccine industry, already tainted with other scandals. Shares went tumbling down. However, the good news, so the economists are saying, is that it may offer an opportunity for multinational vaccine makers to expand their meagre share of the China market. Foreign vaccine producers could make a bigger mark on the local market, but they seem to be having their own problems too. Last year, the National Institute for Food and Drug Control (NIFDC) in China rejected 16 batches of vaccines, of which 14 came from foreign makers. So, we are no damned better than the Chinese!! Never mind, we still believe in ourselves, and that is what counts. The other interesting point about this is that rejecting 16 batches then did not even produce a ripple in the media, whilst rejecting one batch now is blowing up into a massive storm. Who is doing this? And why?

Let's take a closer look at the vaccine market in China in order to figure out what this scandal is all about.

China is the largest vaccine consumer in the world. It is a closed market with a strong local vaccine industry, access to which is challenging for Western players. While state-owned companies dominate the category 1 vaccine market, privately owned and foreign vaccine manufacturers play a significant role in the category 2 vaccine market. GlaxoSmithKline is the biggest multinational vaccine player in China, with 23 million doses of vaccine approved in 2010. The company's most successful vaccines in China are its MMR, hepatitis B and A vaccines. Among domestic vaccine players, CNBG and Sinovac excel in terms of category 1 vaccine supply and strong R&D capacities. In order to penetrate the Chinese market, partnerships with local vaccine companies are crucial for Western vaccine manufacturers.

In 2009, the Chinese vaccine market was valued at $700m–1,520m, growing at a CAGR of around 15%. More than 1 billion doses of human vaccines were registered and approved by the National Institutes of Food and Drug Control in 2010. According to WHO estimates, 200 million doses of the five main vaccines are distributed in China per year. Vaccines are grouped into two categories in China. Different pricing mechanisms apply to category 1 and category 2 vaccines. Prices of category 1 vaccines can fluctuate depending on medical needs. Vaccines from multinational companies enjoy higher prices in China. Local governments have conducted a series of price cuts on category 2 vaccines. Vaccines are fully paid for by the government. The human rabies vaccine was the only category 2 vaccine listed on the 2009 version of the National Reimbursement Drug List (NRDL). Under new regulations, the number of vaccine distribution sites

increased from 143 to more than 700.

Vaccine 1 refers to those free vaccines provided by the government for the public, including vaccines against major epidemic diseases such as hepatitis B, epidemic meningitis and tetanus. Vaccines in this category are all priced by the government and purchased through bidding. Vaccine 2 mainly covers vaccines paid by citizens themselves.

For Vaccine 2, pricing falls into the hand of companies, thus offering a higher profit margin and yet forming a more fiercely competitive market. Some of the commonly used vaccines in the Vaccine 2 catalogue include Pneumonia Vaccine, Varicella Vaccine, Type B Haemophilus Influenzae Conjugate Vaccine, Influenza Vaccine and Rabies Vaccine. In China, Vaccine 1 market is dominated by state-owned enterprises. Foreign and private enterprises gain certain advantages in the Vaccine 2 market.

And the scandal happens to be about the rabies vaccine on the one hand and the DTP vaccine (diphtheria, tetanus, pertussis) on the other. Both happen to be category 2 vaccines, part of the competitive market! Do you think this feels a bit like a mafia war for control and supremacy? Let's list the facts.

1. No child has been harmed. - If you believe in effectiveness of vaccines and you have been given a less effective one, you can simply get another one. Problem solved. No need for panic. No harm done.
2. Who loses? - The local Chinese pharma industry. Damage to their reputation. Serious loss of income with possible bankruptcy to follow. Public is steering away from local produce and demanding foreign made products.
3. Who gains? - The Western pharma industry. Without having to prove it, they are seen to be the best, resulting in an exponential growth in the demand for their product from a market that is worth billions a year.

Here we find a major difference in attitude. In the Western world there is a strong belief that each of us can do it better than anyone else in the world. In the USA they prefer the products that are made in the USA. In Europe, we prefer our own country too but as industry is spread much more across many borders we are more ready to accept products from our friends in the west of Europe than those from the east. African and Asian countries lack far behind on our confidence scale. However, we like their products very much, without expressively stating this, if they are cheap enough. Saving money makes it worthwhile buying, but it doesn't boost our confidence in the product.

*"An industry will lie, manipulate, lobby, rather than tell the truth and be respectful towards the people that provide them with the profits."*

So, the whole drama set up around a mistake in the production of some batches of vaccines, which has done no harm whatsoever to any individual, may well be an opportunity created to achieve a major shift in the market. Follow the money!

Enquiries about problems of vaccine quality in the UK between 2009 and 2011 resulted in 4% error admissions. These were reported incidents to a vaccine advice service. It was commented on by saying that most errors could have been prevented if basic medicine management checks were undertaken. But they clearly weren't. And that wasn't in far away China, a land where they "obviously" are not as good as we are! Furthermore, vaccination error reports to VAERS have increased substantially over the last decade. Here, this is seen as a good thing because at least it is reported and can then be dealt with. I made a similar remark about the China incident earlier but there it was apparently inappropriate as the media turned it into a huge drama, while the same thing happening here, "knowingly", is perfectly acceptable.

As long as we are dependent on an industry we will have to face these mistakes. Industry only has one purpose in life and that is making profit. So, all means to increase the profit are in principle allowed. Governments have pretended they are regulating the possibilities in which the industry is allowed to gain their profit, but the truth is that only after the public has become well aware of dubious practices the industry agrees not to use those practices anymore and to regulate them. Truth has no place in making money. Honesty has no place in making money. An industry will lie, manipulate, lobby, rather than tell the truth and be respectful towards the people that provide them with the profits. In fact, it turns out that a workforce is nothing but trouble and it would be less hassle and more profitable if the work could be fully automated.

Maybe the biggest news story is the fact that the Western world is stepping in to rescue the poor Chinese people from the tyrants of their own inadequate industry. Totally selflessly we flood in to help sorting this out. Now if the Western industry were to do that for their own people, now that would be the biggest news story ever!!

Is the world going to be a better place after this drama has passed over? Are the children going to be safer and better treated? Is the industry going to be a more honest bunch?

Nothing is going to be different unless you and I change it.

This drama is important to the industry and people are being used as bait and cannon fodder. People won't be better off after the drama.

Nothing is going to change unless you and I change it.

***July 2018***

"VACCINATION IS AN ORGANISED CRIMINAL ENTERPRISE, DRESSED UP AS DISEASE PREVENTION, BY MEANS OF JUNK SCIENCE."

*~ ERWIN ALBER 1945–2018*

# WHAT IS WRONG WITH PERTUSSIS VACCINE IMMUNITY? WHY IMMUNOLOGICAL MEMORY TO PERTUSSIS IS FAILING

DIAVATOPOULOS DA, EDWARDS KM
Cold Spring Harbor Perspectives in Biology.
December 2017
https://www.ncbi.nlm.nih.gov/pubmed/28289059

ABSTRACT

Memory responses seen after whole-cell pertussis (wP) and acellular pertussis (aP) vaccine priming are different and reflect better long-term protection against pertussis disease seen with the whole-cell vaccines. Although acellular vaccines generate higher levels of antigen-specific IgG to the antigens included in the aP vaccines, there are many more pertussis antigens included in whole-cell vaccines. Acellular vaccine priming is associated with skewing of the immune response to a more Th2-like response, whereas whole-cell priming is associated with a Th1/Th17 response. Repeated booster doses of acellular vaccine in children primed with acellular vaccine has been shown to result in progressively shorter duration of protection against disease. This may be explained by the generation of higher levels of antigen-specific IgG4, which does not bind complement and leads to a suboptimal inflammatory response and impaired phagocytosis and antimicrobial defense. In contrast, whole-cell priming followed by aP vaccine boosters results in better opsonization, phagocytosis, and complement mediated killing through the preferential induction of IgG1.

# INCREASED INCIDENCE OF CERVICAL CANCER IN SWEDEN: POSSIBLE LINK WITH HPV VACCINATION

LARS ANDERSSON
Indian Journal of Medical Ethics Online
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ABSTRACT

The Centre for Cervical Cancer Prevention in Sweden has noted in its annual report a substantial increase in the incidence of invasive cervical cancer, especially during the two years 2014 and 2015. I have sub-grouped the data according to age, using the same statistical database of the National Board of Health and Welfare as used by the authors of the above-mentioned report. The increase in the incidence of cervical cancer was shown to be most prominent among women 20–49 years of age while no apparent increase was observed among women above 50. The FDA has noted in the clinical trials referred to it for marketing approval that women exposed to the human papilloma virus (HPV) prior to vaccination had an increase in premalignant cell changes compared with placebo controls. I discuss the possibility that HPV vaccination could play a role in the increase in the incidence of cervical cancer by causing instead of preventing cervical cancer disease in women previously exposed to HPV. A time relationship exists between the start of vaccination and the increase in the incidence of cervical cancer. The HPV vaccines were approved in 2006 and 2007, respectively and most young girls started to be vaccinated during 2012–2013.

# HPV Vaccination Syndrome: A Clinical Mirage, or a New Tragic Fibromyalgia Model?

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CONCLUSIONS

Independent investigators have reported the development of a fibromyalgia-like chronic syndrome after HPV vaccination. It is difficult to categorize the condition within a specific diagnosis. Recent advances in our understanding of fibromyalgia could provide diagnostic and therapeutic guidelines for the hypothetical HPV vaccination syndrome. On the other hand, should the veracity of HPV vaccination syndrome be corroborated, it could become a new tragic and undesired model of fibromyalgia. International health authorities deny the existence of such a syndrome. More research will be necessary to define HPV vaccination syndrome as a clinical mirage or as a new clinical entity.

# DEDICATION

*This edition of The Informed Parent is dedicated to Erwin Alber (4 January 1945 – 13 June 2018), a warrior of truth and good. Erwin dedicated much of his life exposing and debating the vaccine myth. He ran Vaccination Information Network (VINE) for numerous years, and he continued to inspire many others to open their eyes to the subject. Erwin also translated all of the German doctor Gerhard Buchwald's books into English – making the data much more accessible for vaccine researchers worldwide. RIP Erwin.*

# MEDICAL DOCTORS CONCERNED WE ARE GIVING AMERICA'S CHILDREN TOO MANY VACCINES TOO SOON

BY JENNY MARGULIS
April 10, 2018
jennifermargulis.net

WHEN MARK ZUCKERBERG POSTED a photo of his baby daughter on Facebook with the chipper caption, "Doctor's visit–time for vaccines!" last January, the post garnered an enormous amount of attention: 36,255 shares, 3.4 million reactions, and 83,000 comments. The extensive comments on the post caught the interest of some scientific researchers, who analyzed over a thousand of them. Their analysis yielded what media outlets described as a "surprising" result: the "anti"-vaccine comments were more scientifically based and carefully worded than the "pro"-vaccine comments.

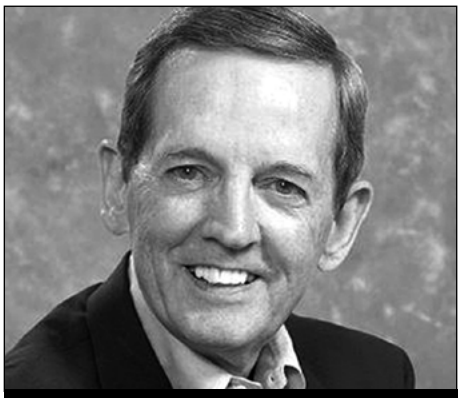
In the words of the researchers: "Although the anti-vaccination stance is not scientifically-based, comments showed evidence of greater analytical thinking, and more references to health and the body. In contrast, pro-vaccination comments demonstrated greater comparative anxiety, with a particular focus on family and social processes."


The problem responsible scientists are faced with right now is that the evidence is accumulating that the CDC's childhood vaccine schedule is not scientifically-based. The medical doctors, academic researchers, citizen scientists, and concerned parents who are taking the time to read the science and educate themselves about what we know and what we don't about vaccines are all coming to the same conclusion: something is very wrong with today's childhood vaccine recommendations. Our current medical recommendations seem to be harming children's bodies and their brains.

Let's hear from a few of those on-the-ground medical doctors themselves. These are not crackpots. These are not crystal-slinging tree-hugging hippies. These are top doctors and thought leaders, physicians who care deeply about the health of our children and our nation. So what do they have to say?

**Dr. Ravenel** is a doctor based in Winston Salem, North Carolina and who has been practicing medicine for over 40 years. He used to be the first to dismiss the idea that vaccines might be contributing to autism. Why? Because he blindly followed the medical establishment and did not bother to do any research for himself. Denying a causal link between vaccines and autism was the most comfortable position to take. He chose his words very carefully when I interviewed him: "to say that 'vaccines cause autism' is an inaccurate, non-nuanced statement. At the same time, to say that 'vaccines don't cause autism' is also inaccurate. In certain conditions, like with mitochondrial dysfunction, vaccines certainly can cause autism or contribute to it."

**Dr. Sutton** has about 3,500 patients in her integrative medical practice in Fair Oaks, California. She is a founding member of Physicians for Informed Consent, a new non-profit made up of doctors and researchers who oppose mandating medical treatments.



*"There is clearly a relationship between vaccines and autism," – Dr. Bose Ravenel, M.D.*

Dr. Sutton is deeply concerned by the poor health of Americans who follow mainstream medical advice: I think that in the 1980s we had a sweet spot with vaccines where most people could be vaccinated and tolerate the vaccines. At that point our health regulators and the vaccine industry could have created studies to understand those existing vaccines better so that the people who were damaged by vaccines, the most sensitive ones, were able to have different schedules. That's totally possible now with the genetic understanding that we have. Unfortunately that didn't happen, and money was spent instead on research and development of ever more vaccines.

It's not a rational thing to think that we can just give an ever-increasing number of vaccines without causing damage. There's a tipping point for many people in terms of the toxins that they can handle and the increase in chronic illness that was demonstrated by this study shows this, and the increase in drastic diseases with acute immediate reactions is also part of the profound neurodevelopmental things that are seen occasionally following vaccines.

I see daily in my practice evidence of vaccine injury and I hear stories almost every day of families that vaccinate children and then decide not to vaccinate and the unvaccinated children within the same family are healthier, more socially adjusted and more capable academically than the siblings who were

born first and were fully vaccinated.

I think we must look at vaccines as a changing picture because nature responds to the impact of vaccines. We should never consider vaccines a fixed item that's a forever part of the medical landscape. An important example is the Hib vaccine. Which now has so little likelihood of happening as a disease that the vaccine damage frequency is at or higher than the likelihood of catching the Hib disease. The vaccine has shifted the structure of that germ enough that the germ is no longer the same aggressive germ that it was in the past. So should we still continue a vaccine that is not needed?

We also have to understand in this fluctuating scene that many things impact infectious disease, not just vaccines. The single most primary one was plumbing and the second, nutrition.

We're making things black and white that really have many many shades to them. We have to get past sound bites and look at a complex picture with more accuracy. It is unethical to not study unvaccinated versus vaccinated. No question about that. There are plenty of parents who would prefer not to vaccinate their children and those can be the first to volunteer to check epidemiologically the health of those voluntarily unvaccinated children and see how that is with voluntarily fully vaccinated children.

Is Dr. Sutton's an "outlier"

*"It's not a rational thing to think that we can just give an ever-increasing number of vaccines without causing damage. There's a tipping point for many people in terms of the toxins that they can handle."*
*– Dr. Kelly Sutton, M.D.."*

position? Does that even matter?

The interesting thing about science–and human health–is that 30,000 people can have one point of view and one person can have another point of view. And that one person with the dissenting point of view can turn out to be the one who is right.

As microbiologist Morten Laane points out, science is not a Democracy.

Consider Galileo whose idea that the Earth moved around the sun was in direct opposition to what the church authorities, and the majority of the people, believed and wanted to be true. However unpopular his theories, Galileo turned out to be right.

Or **Dr. Frances Oldham Kelsey**, who saved U.S. babies from thalidomide despite the fact that the medical establishment believed it was safe and it was given to pregnant women in dozens of places around the world, including Canada, Britain, and the Middle East. Kelsey's skepticism and insistence on erring on the side of caution saved thousands of American babies from devastating health problems. But so many parents and doctors have been seeing vaccines causing health problems with their own eyes–and so many have started speaking up about it and started sharing their stories–that they can no longer be dismissed as "outliers."

Questioning vaccine safety does not make you anti-vaccine. It makes you pro-health, pro-child, and pro safe vaccination.

**Dr. William T. Redwood, M.D**. is one of the most well respected emergency room doctors in the state of Georgia. He, too, is concerned: "If you summarily dismiss the possibility that the increasing rates of childhood illnesses, including ADD, autism, asthma and other auto-immune disorders are connected to vaccines, you can't figure out if our children's health problems are vaccine-related injuries.

**Dr. Paul Thomas**, **M.D.**, my co-author and a pediatrician with over 13,000 children in his practice in Portland, Oregon, has noticed that the children who are the most vaccinated in his practice are also the least healthy.

Anyone who would smugly say, "The science is clear" or "The science is settled" profoundly misunderstands what

*"As unpopular as this observation might be, my unvaccinated children are by far the healthiest."*
*– Dr. Paul Thomas, M.D*

science is. Science is a process of inquiry. Any scientific knowledge that any given generation has is always subject to scrutiny. Science is never settled.

We keep talking about vaccines being a potential trigger for autism because we keep seeing American children being harmed by our current CDC vaccine schedule. If the harm weren't happening, we would not be having this conversation.

- Is it the glutathione-depleting acetaminophen given before and after vaccination that is triggering autism?
- Is it the cumulative toxic exposure, a negative synergy between vaccine ingredients?
- Is the depleted microbiome because of the overuse of antibiotics playing a role?
- Is there an in utero assault with ultrasound exposure and a trigger pulled by aluminum in the hepatitis B vaccine given at birth?

The honest truth is that we simply don't know. But we can't find out if we don't ask the right questions. With 1 in 45 children diagnosed with autism today, we are in the midst of a national health crisis that can no longer be ignored.

**ABOUT THE AUTHOR:**

Jennifer Margulis, Ph.D., is an investigative journalist, book author, and Fulbright awardee. She is the author of Your Baby, Your Way: Taking Charge of Your Pregnancy, Childbirth, and Parenting Decisions for a Happier, Healthier Family and co-author (with Paul Thomas, M.D.) of The Vaccine-Friendly Plan. Follow her on Facebook, Twitter, and Pinterest. Watch her in the series, The Truth About Vaccines.

# Measles outbreak in a tertiary level hospital, Porto, Portugal, 2018: challenges in the post-elimination era

AUTHORS: RITA SÁ MACHADO1, MARIANA PEREZ DUQUE1, SORAIA ALMEIDA2, IVO CRUZ1, ET AL

https://eurosurveillance.org/

Eurosurveillance, Vol 23, Issue 20, 17 May 2018

EXTRACTS:

A tertiary level hospital in Porto with ca 4,400 healthcare workers (HCW) has been affected by a measles outbreak since March 2018, cases were mainly vaccinated HCW.

As measles is a mandatory notifiable disease in Portugal, the confirmation of the first cases on 14 March lead to the prompt implementation of public health control measures.

We present preliminary findings of this outbreak, highlighting public health initial actions and their short-term results. On 13 March, the clinical director of a hospital in Porto reported a probable measles outbreak to the Public Health Regional Department (DSP), with 24 HCW affected. The local public health unit was then notified to assess and manage the situation, and initiated the epidemiological investigation. All cases had a connection to the adult Emergency Department (aED) and their clinical presentation included maculopapular rash, low fever, tachycardia and headache. The National Reference Laboratory, Instituto Nacional Dr. Ricardo Jorge, Lisbon, confirmed the first two cases on 14 March. From 11 February to 22 April, 211 cases linked to the hospital were notified, with 96 confirmed cases.

The mean age for the 211 cases notified was 33.3 (SD: 12.5), 135 cases were female. Preliminary findings showed that all but one confirmed measles cases (n = 96) occurred in adults (≥18 years; 18-39); 60 (62.5%) were female. Confirmed cases included 86 HCW (Table). One hospitalised patient was affected. Of the 96 confirmed cases, 67 (69.8%) were vaccinated with two doses of measles vaccine or measles mumps and rubella (MMR) vaccine. ***(TiP editor:What about the other 30% had they received one dose of MMR??***

***Let's take a look at the figures on their table. If we add those of the 96 confirmed cases that received either one or two doses of MMR then 81.3% were vaccinated. Out of the remaining cases 11.5% unknown? It is quite possible that they may have been vaccinated but cannot remember. The remaining 5.2% - no vaccination or measles history another ambiguous heading. This could mean that the person thought they had been vaccinated but there is no record. Where there is no written history it is often listed as unvaccinated.)***

All cases were advised to remain isolated for 4 days after they developed a rash. Medical clearance to return to work was given 5 days after the rash onset if there were no clinical complications from measles or if there were no continuing symptoms. Post-exposure prophylaxis (PEP) (vaccine or immunoglobulin) was offered within 72 hours to susceptible HCW and patients that had contact with a measles case. The regional stockpile of MMR vaccine and immunoglobulin allowed a rapid supply of these products. Two vaccination posts were created and HCW were advised to get vaccinated if they had not received two MMR doses in the past or a presumptive immunity due to disease; a total of 1,132 vaccines were administered.

For every possible or probable case in a HCW, the infection control and prevention team created a list of susceptible patients with whom the HCW may have had contact during their infectious period. Of more than 500 contacts identified, 73 patients received the MMR vaccine and 68 were immunised with immunoglobulin due to contraindications to vaccination or a high risk of severe illness and complications from being vaccinated.

As the outbreak occurred in a university hospital, medical and nursing schools were contacted and advised to inform students about the outbreak. Students were advised to verify their immunisation status and instructed to immediately report any symptoms within the measles case definition. Daily situation reports were released to HCW employed at the university hospital.

Several efforts have been made globally to eliminate measles, a highly contagious viral communicable disease that has the potential to infect 75–90% susceptible contacts and is spread by airborne transmission.

| | Confirmed cases | | Probable cases | | Total number of notified cases | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| **Total** | 96 | 45.5 | 82 | 38.9 | 211 | 100.0 |
| **Diagnostic site** | | | | | | |
| CHP | 85 | 88.5 | 80 | 97.6 | 196 | 92.9 |
| Other | 11 | 11.5 | 2 | 2.4 | 15 | 7.1 |
| **Sex** | | | | | | |
| Female | 60 | 62.5 | 52 | 63.4 | 135 | 64.0 |
| Male | 36 | 37.5 | 30 | 36.6 | 76 | 36.0 |
| **Age group (years)** | | | | | | |
| 0–17 | 1 | 1.0 | 3 | 3.7 | 5 | 2.4 |
| 18–29 | 50 | 52.1 | 20 | 24.4 | 79 | 37.4 |
| 30–39 | 39 | 40.6 | 32 | 39.0 | 85 | 40.3 |
| 40–49 | 5 | 5.2 | 11 | 13.4 | 22 | 10.4 |
| 50–59 | 1 | 1.0 | 7 | 8.5 | 10 | 4.7 |
| 60–69 | 0 | 0.0 | 3 | 3.7 | 4 | 1.9 |
| 70–79 | 0 | 0.0 | 5 | 6.1 | 5 | 2.4 |
| 80–89 | 0 | 0.0 | 1 | 1.2 | 1 | 0.5 |
| **Vaccination/immune status** | | | | | | |
| No vaccination or measles history | 5 | 5.2 | 12 | 14.6 | 21 | 10.0 |
| One dose of measles vaccine | 11 | 11.5 | 14 | 17.1 | 29 | 13.7 |
| Two or more doses of measles vaccine | 67 | 69.8 | 44 | 53.7 | 126 | 59.7 |
| Presumptive immunity due to disease [c] | 2 | 2.1 | 2 | 2.4 | 5 | 2.4 |
| Unknown | 11 | 11.5 | 10 | 12.2 | 30 | 14.2 |

CHARACTERISTICS OF MEASLES CASES BY CASE CLASSIFICATION, PORTO, PORTUGAL • 11 FEB - 22 APR 2018 (n = 211)

Portugal had its last measles outbreak in 2017 following an imported case. Prior to this, Portugal had 12 years without endemic measles transmission. In the current outbreak, transmission of measles has occurred mainly in the healthcare setting. ***(TiP Editor: Yes mostly in the vaccinated!)*** Proactive control measures were readily instituted which helped to control the outbreak and avoid a higher number of secondary cases in other settings. Measures included notification, isolation of cases, list of susceptible cases, contact tracing, screening for new cases and immunisation of susceptible population.

Vaccination or acquired immunity after illness are considered reliable protections against the disease. Portugal is a country with a high level of reported vaccination coverage for MMR vaccine and in 2017, MMR vaccine coverage at the age of 5 years was 96%. According to the National Plan for Measles Elimination, HCW are highly recommended to receive two doses of MMR vaccine or documented evidence of measles infection, considering they are at a higher risk of exposure to the virus. Nevertheless, we are seeing outbreaks occurring that encompass healthcare settings. The frequency of cases among HCW directs attention to the need of considering interventions to ensure this group is well protected, including vaccination and infection control and prevention measures.

**Strikingly, most cases were in young (18-39 years old) fully vaccinated HCW. This feature has also been documented in other outbreaks.** ***(TiP emphasis).*** The high frequency of cases among vaccinated people, likely due to waning vaccine-derived immunity in a situation where natural boosting is taking place to a very limited extent, points towards the need to further investigate this issue to recommend new approaches. This is especially important for populations that are at a higher risk of being exposed to diseases, such as HCW, and spreading disease to individuals in a vulnerable situation, such as patients.

As we had our first case confirmation on 14 March and three cases started symptoms before March 2018, we had a delay between disease onset and confirmation of the diagnosis. This might have happened because Portugal has a low incidence of measles, therefore, HCW and clinicians do not commonly see measles in clinical practice and thus it may not have been their first diagnosis. In addition, atypical clinical presentation in vaccinated individuals could have been a contributing factor.

The atypical clinical presentation of measles in vaccinated individuals can occur with mild or moderate symptoms similarly to our outbreak (maculopapular rash as the only clinical criteria or low fever). To ensure that as many cases were identified as possible during the outbreak, the case definition was adapted, increasing sensitivity, taking atypical presentation of measles into account.

In a country with low incidence of measles, this outbreak emphasises risks and challenges posed locally, such as infection of fully vaccinated individuals and the sustainability of herd immunity in a healthcare setting.

Further investigation of this outbreak is ongoing, including genotyping of all cases.

***TiP Editor: Infection of fully vaccinated individuals poses challenges? What are the vaccinated doing developing measles? Why do they never ask obvious questions ie. does the vaccine actually work?***

# EVALUATING CLINICAL EFFECTIVENESS OF 13-VALENT PNEUMOCOCCAL CONJUGATE VACCINATION AGAINST PNEUMONIA AMONG MIDDLE-AGED AND OLDER ADULTS IN CATALONIA: RESULTS FROM THE EPIVAC COHORT STUDY

Angel Vila-Corcoles Email author, Olga Ochoa-Gondar Email author, et al.
BMC Infectious Diseases 2018 18:196 https://doi.org/10.1186/s12879-018-3096-7. 27 April 2018

## ABSTRACT

### BACKGROUND

Benefits using the 13-valent pneumococcal conjugate vaccine (PCV13) in adults are controversial. This study investigated clinical effectiveness of PCV13 vaccination in preventing hospitalisation from pneumonia among middle-aged and older adults.

### METHODS

Population-based cohort study involving 2,025,730 individuals ≥50 years in Catalonia, Spain, who were prospectively followed from 01/01/2015 to 31/12/2015. Primary outcomes were hospitalisation for pneumococcal or all-cause pneumonia and death from any cause. Cox regression models were used to evaluate the association between PCV13 vaccination and the risk of each outcome, adjusting for age, sex and major comorbidities/underlying risk conditions.

### RESULTS

Cohort members were observed for a total of 1,990,701 person-years, of which 6912 person-years were PCV13 vaccinated. Overall, crude incidence rates (per 100,000 person-years) were 82.8 (95% confidence interval [CI]: 77.7–88.1) for pneumococcal pneumonia, 637.9 (95% CI: 599.0–678.7) for all-cause pneumonia and 2367.2 (95% CI: 2222.8–2518.7) for all-cause death. After multivariable adjustments we found that the PCV13 vaccination did not alter significantly the risk of pneumococcal pneumonia (multivariable-adjusted hazard ratio [mHR]: 1.17; 95% CI: 0.75–1.83; $p = 0.493$) and all-cause death (mHR: 1.07; 95% CI: 0.97–1.18; $p = 0.190$), although it remained significantly associated with an increased risk of all-cause pneumonia (mHR: 1.69; 95% CI: 1.48–1.94; $p < 0.001$). In stratified analyses focused on middle-aged or elderly persons and immuno-compromised or immunocompetent subjects, PCV13 vaccination did not appear effective either.

### CONCLUSION

Our data does not support clinical benefits of PCV13 vaccination against pneumonia among adults in Catalonia. It must be closely monitored in future studies involving more vaccinated person-time at-observation.

# ERADICATING POLIO WITH A VACCINE WE MUST STOP USING

BY NICHOLAS C GRASSLY

The Lancet Infectious Diseases
Comment; vol 18; issue 6, p590-591

*Photograph: Divyakant Solanki/EPA*

THE GLOBAL PARTNERSHIP working to eradicate polio is dealing with the challenge of how to withdraw oral poliovirus vaccine while completing eradication in the last few endemic countries. Vaccine withdrawal is necessary because the oral vaccine is genetically unstable, rarely reverting to a wild-type phenotype and causing outbreaks of poliomyelitis. These vaccine-derived polioviruses should be responded to like any other poliovirus outbreak requiring substantial resources and threatening the concept of polio eradication.[1] In 2017, for the first time recorded, more children were paralysed by vaccine-derived polioviruses than wild-type polioviruses (95 reported cases vs 22 reported cases). This finding reflects the large outbreaks of serotype 2 virus in Syria and Democratic Republic of the Congo and presents the first test of the eradication strategy of globally synchronised withdrawal of oral vaccines. Withdrawal started with serotype 2 in April, 2016, when trivalent vaccine was replaced with bivalent vaccine in 155 countries following the declaration of global eradication of this serotype of wild poliovirus.

Khalequ Zaman and colleagues provide helpful new information on the performance of serotype 2 monovalent oral poliovirus vaccine (mOPV2).[2] This vaccine is held in a stockpile by WHO and released only for response to serotype 2 vaccine-derived poliovirus outbreaks. Zaman and colleagues show that this vaccine is highly immunogenic in Bangladeshi infants aged 6 weeks and can be given on a short interval schedule without causing significant detriment to overall seroconversion. Two doses of mOPV2 given 1 week apart induced an immune response in 161 (93%) of 173 infants compared with 176 (97%) of 181 infants when given 4 weeks apart. This finding suggests that a rapid response with two doses of this vaccine in mass campaigns could control serotype 2 poliovirus outbreaks if high coverage can be achieved.[3]

The challenge is the achievement of high coverage in a response with appropriate geographical scope. Since the global withdrawal of serotype 2 oral vaccine, seven circulating serotype 2 vaccine-derived polioviruses have been reported from five countries (as of February, 2018), and all but one appear to have been seeded by trivalent vaccine given before withdrawal.[4] Most circulating serotype 2 vaccine-derived polioviruses have required more than two campaigns with mOPV2 because of the challenges in vaccinating children in areas affected by conflict or with poor access to health care. It is also possible that mOPV2 is less immunogenic in poorer communities or among children older than those assessed by Zaman and colleagues.[5, 6]

Some hesitancy exists about the use of mOPV2 in large campaigns because of the risk of creating more vaccine-derived polioviruses. This anxiety has increased because in most countries after April, 2016, serotype 2 immunity has only been provided by a single dose of inactivated poliovirus vaccine (IPV) offered by routine immunisation programmes. This dose is likely to protect about half of those vaccinated and offers insufficient mucosal protection against infection and transmission.[7] Moreover, routine immunisation coverage is low in areas prone to poliovirus outbreaks.8 However, despite concerns about mOPV2 use in these areas, this vaccine is the only vaccine that induces mucosal protection and should be the primary vaccine for responding to confirmed outbreaks. The risk of ongoing vaccine-derived poliovirus circulation clearly outweighs that of new emergences after mOPV2 use.

Zaman and colleagues also report no additional benefit when IPV was administered alongside the first dose of mOPV2 at 6 weeks of age.2 The relevance of this finding to outbreak response is less clear because campaigns with IPV are typically used in older children to boost previous immunity induced by oral vaccine.[9,10] The additional benefit of IPV will also depend on the immune response induced by oral vaccine alone, which was observed in 157 (91%) of 172 infants after just one dose of mOPV2 in Bangladesh.2 A similar study in Pakistan found that 76% (39 of 51) of seronegative infants aged 6 weeks had an immune response following a single dose of mOPV2, which increased to 100% (15 of 15) when monovalent serotype 2 IPV was co-administered.[11] These and other supporting data have motivated IPV use in response to vaccine-derived poliovirus outbreaks despite a shortage of supply.

This study confirms that an effective vaccine exists to control serotype 2 vaccine-derived poliovirus outbreaks.

In a world that is rapidly losing serotype 2 immunity, stopping these outbreaks is crucial to the success of global polio eradication. ***(TiP Editor: Are they patting themselves on the back for having an effective vaccine to control vaccine-caused polio cases? Unbelievable!)***

## COMPETING INTERESTS

I receive grants from WHO and Bill and Melinda Gates Foundation outside the submitted work. I am a member of the WHO Strategic Advisory Group of Experts on Immunization working group on polio.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# RESURGENCE OF WHOOPING COUGH MAY OWE TO VACCINE'S INABILITY TO PREVENT INFECTIONS

September 21, 2017
https://www.bu.edu/sph/2017/09/21/resurgence-of-whooping-cough-may-owe-to-vaccines-inability-to-prevent-infections/

THE STARTLING GLOBAL RESURGENCE of pertussis, or whooping cough, in recent years can largely be attributed to the immunological failures of acellular vaccines, School of Public Health researchers argue in a new journal article. The article, published in F1000 Research, points to the differences in mucosal immunity between whole-cell pertussis (wP) vaccines and the newer acellular pertussis (aP) vaccines, first introduced in the 1990s, as playing a pivotal role in the resurgence of the disease.

"This disease is back because we didn't really understand how our immune defenses against whooping cough worked, and did not understand how the vaccines needed to work to prevent it," said Christopher J. Gill, associate professor of global health and lead author of the article. "Instead we layered assumptions upon assumptions, and now find ourselves in the uncomfortable position of admitting that we may made some crucial errors. This is definitely not where we thought we'd be in 2017."

Up until the 1950s, there were millions of cases of whooping cough around the globe each year, with numerous fatal cases in infants. The introduction of whole-cell pertussis (wP) vaccines led to a 99% reduction in cases. Later, as wP vaccines raised concerns of possible rare neurologic adverse events, aP vaccines were licensed and used in a number of countries starting in the early 1990s. Since then, cases of whooping cough have risen sharply. In 2014, there were more than 32,000 cases reported in the US.

"The resurgence of pertussis in the US to its highest levels since the 1940s emphasizes the need for answers to these questions," the authors wrote.

The researchers examined mathematical models of pertussis transmission, data derived from the aP and wP vaccines responses in animals, and recent insight into the immunology of pertussis and pertussis vaccines. They found that, contrary to existing assumptions, although both vaccines blocked symptomatic disease, wP vaccines blocked also infections in animals while aP vaccines did not. Other differences included wP vaccines' ability to induce a stronger herd immunity and robust TH17 responses, which confer mucosal immunity, while aP vaccines only induced TH2 responses.

Experimental and immunologic data has shown that aP vaccines do not provide herd immunity, while mathematical models imply otherwise. The researchers proposed a hypothesis to reconcile the contradictory findings: Herd effects from aP vaccines may be the result of modifications in disease presentation that lead to reduced possibility of transmission rather than induced resistance to infection.

The researchers also considered the role of several known factors in the rise of whooping cough cases, including detection bias, waning of immunity, and evolutionary shifts in the bacteria's genome. They found that, while contributing to the increase in incidence, these factors alone do not fully explain existing epidemiologic data.

Citing the urgency of the growing health crisis, the authors emphasized the need to go beyond the limitations of animal models and provide human data to further examine the arguments put forth in their article.

"The resurgence of pertussis in the aP vaccine era is evolving into a slow-moving global public health crisis," the researchers wrote. "But, with the public's trust in vaccines waning, this has also become a public relations crisis."

Don Thea, professor of global health, was a co-author on the article.
– Salma Abdalla

***(TiP Editor: Giving the vaccine credit for 99% reduction in cases! Worrying about the public's trust waning? This vaccine has caused many reactions, severe brain damage and fatalities over the years and as with all other vaccines its efficacy is highly questionable!).***

# THE CORRUPTION OF EVIDENCE-BASED MEDICINE: KILLING FOR PROFIT

BY DR JASON FUNG
Nephrologist. Special interest in type 2 diabetes reversal and intermittent fasting. Founder of Intensive Dietary Management Program.
https://medium.com/@drjasonfung/the-corruption-of-evidence-based-medicine-killing-for-profit-41f2812b8704
10 Apr 2018

THE IDEA OF EVIDENCE BASED MEDICINE (EBM) IS GREAT. The reality, though, not so much. Human perception is often flawed, so the premise of EBM is to formally study medical treatments and there have certainly been some successes. Consider the procedure of angioplasty. Doctors insert a catheter into the blood vessels of the heart and use a balloon like device to open up the artery and restore blood flow. In acute heart attacks studies confirm that this is an effective procedure. In chronic heart disease the COURAGE study and more recently the ORBITA study showed that angioplasty is largely useless. EBM helped distinguish the best use of an invasive procedure.

So, why do prominent physicians call EBM mostly useless? The 2 most prestigious journals of medicine in the world are The Lancet and The New England Journal of Medicine. Richard Horton, editor in chief of The Lancet said this in 2015:

"The case against science is straightforward: much of the scientific literature, perhaps half, may simply be untrue"

Dr. Marcia Angell, former editor in chief of NEJM wrote in 2009 that,

"It is simply no longer possible to believe much of the clinical research that is published, or to rely on the judgment of trusted physicians or authoritative medical guidelines. I take no pleasure in this conclusion, which I reached slowly and reluctantly over my two decades as an editor"

This has huge implications. Evidence based medicine is completely worthless if the evidence base is false or corrupted. It's like building a wooden house knowing the wood is termite infested.

*"It is simply no longer possible to believe much of the clinical research that is published, or to rely on the judgment of trusted physicians or authoritative medical guidelines."*

What caused this sorry state of affairs? Well, Dr. Relman another former editor in chief of the NEJM said this in 2002:

"The medical profession is being bought by the pharmaceutical industry, not only in terms of the practice of medicine, but also in terms of teaching and research. The academic institutions of this country are allowing themselves to be the paid agents of the pharmaceutical industry. I think it's disgraceful"

The people in charge of the system—the editors of the most important medical journals in the world, gradually learn over a few decades that their life's work is being slowly and steadily corrupted. Physicians and universities have allowed themselves to be bribed.

The examples in medicine are everywhere. Research is almost always paid for by pharmaceutical companies. But studies done by industry are well known to have positive results far more frequently. Trials run by industry are 70% more likely than government funded trials to show a positive result. Think about that for a second. If EBM says that 2+2 = 5 is correct 70% of the time, would you trust this sort of 'science'?

**Selective Publication**—Negative trials (those that show no benefit for the drugs) are likely to be suppressed. For example, in the case of antidepressants, 36/37 studies that were favourable to drugs were published. But of the studies not favorable to drugs, a paltry 3/36 were published. Selective publication of positive (for the drug company) results means that a review of the literature would suggest that 94% of studies favor drugs where in truth, only 51% were actually positive. Suppose you know that your stockbroker publishes all his winning trades, but suppresses all his losing trades. Would you trust him with your money? But yet, we trust EBM with our lives, even though the same thing is happening.

Let's look at the following graph of the number of trials completed versus those that were published. In 2008, the company Sanofi completed 92 studies but only a piddly 14 were published. Who gets to decide which gets published and which does not? Right. Sanofi. Which ones do you think will be published? The ones that favor its drugs, or the ones that prove their drugs do not work?

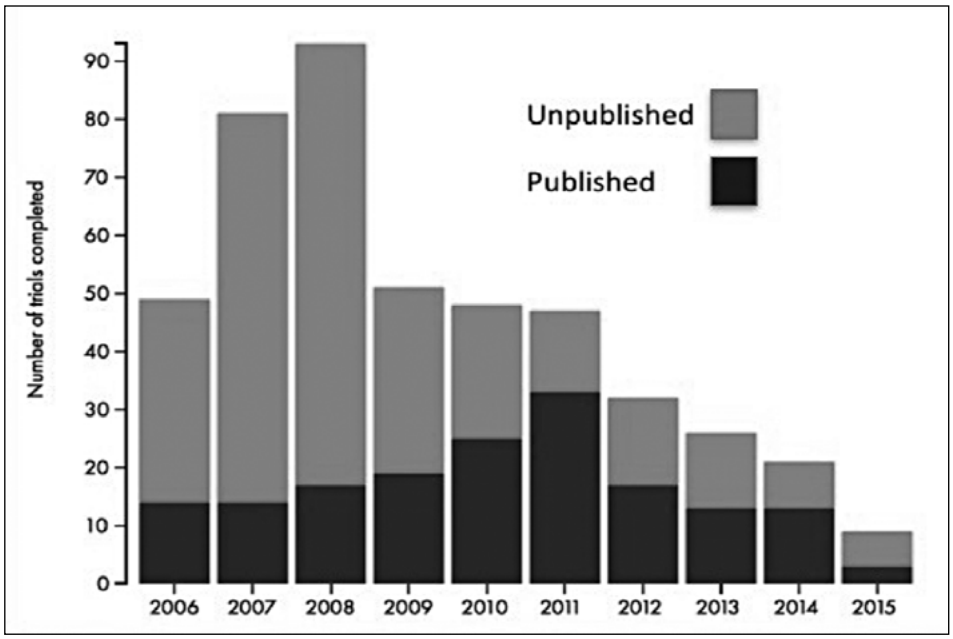

Photo by rawpixel on Unsplash

Right. Keep in mind that this is the only rational course of action for Sanofi, or any other company to pursue. It's idiotic to publish data that harms yourself. It's financial suicide. So this sort of rational behavior will happen now, and it will not stop in the future. But knowing this, why do we still believe the evidence based medicine, when the evidence base is completely biased? An outside observer, only looking at all published data, will conclude that the drugs are far, far more effective than they are in reality. Yet, if you point this out in academic circles, people label you a quack, who does not 'believe the evidence'.

**Rigging of Outcomes**—Or consider the example of registration of primary outcomes. Prior to year 2000, companies doing trials did not need to declare what end points they measured. So they measure many different endpoints and simply figured out which one looked best and then declared the trial a success. Kind of like tossing a coin, looking at which one come up more, and saying that they were backing the winning side. If you measured enough outcomes, something was bound to come up positive. In 2000, the government moved to stop these shenanigans. They required companies to register what they were measuring ahead of time. Prior to 2000, 57% of trials showed a positive result. After 2000, a paltry 8% showed good results. More evidence of the evidence base being completely corrupted by commercial interest, and the academic physicians who were getting rich on it tacitly allowing corruption because they know that you don't bite the hand that feeds you 'Advertorials'—Or this example of a review paper in the NEJM that fracture rates caused by the lucrative bisphosphonate drugs were "very rare". Not only did the drug companies pay lots of consulting fees to the doctors, three of the authors of this review were full time employees! To allow an advertorial to be published as the best scientific fact is scandalous. Doctors, trusting the NEJM to publish quality, unbiased advice have no idea that this review article is pure advertising. Yet, we still consider the NEJM to be the very pinnacle of evidence based medicine. Instead, as all the editors of the journals sadly recognize, it has become lucre-based publishing. Mo money = better results.

**Money from Reprints**—The reasons for this problem is obvious to all—it's insanely profitable for journals to take money from Big Pharma. Journals want to be read. So they all try to get a high Impact Factor (IF). To do this, you need to get cited by other authors. And nothing boosts ratings like a blockbuster produced by Big Pharma. They have the contacts and the sales force to make any study a landmark. A less obvious benefit is the fees that are generated by Big Pharma purchasing articles for reprint.

If a company publishes an article in the NEJM, they may order several hundred thousand copies of the article to be distributed to unsuspecting doctors everywhere. These fees are not trivial. The NEJM publisher Massachusetts Medical Society gets 23% of its income from reprints. The Lancet—41%. The American Medical Association—a gut busting 53%. No wonder these journals are ready to sell their readers (ordinary physicians) down the river. It pays. Who needs journalistic ethics when there's a Mercedes in the driveway? Mo money, baby. Mo money.

**Bribery of Journal Editors**—A recent study by Liu et al in the BMJ shed more light on the problem of crooked journals. Crooked journal editors. Editors play a crucial role in determining the scientific

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dialogue by deciding which manuscripts are published. They determine who the peer reviewers are. Using the Open Payments database, they looked at how much money the editors of the most influential journals in the world were taking from industry sources. This includes 'research' payments, which are largely unregulated. As mention previously, much 'research' consists of going to meetings in exotic locale. It's funny how many conferences are held in beautiful European cities like Barcelona, and how few are done in brutally cold Quebec City.

Of all journal editors that could be assessed, 50.6% were on the take. The average payment in 2014 was $27,564. Each. This does not include an average $37, 330 given for 'research' payments. Other particularly corrupt journals include:

## Industry Payments to Editors

| Journal | General pay ($) | Research ($) |
|---|---|---|
| JAMA | 6331 | 84 516 |
| JACC | 475 072 | 119 407 |
| J Clinical Oncology | 5 957 | 160 304 |
| J Infectious Disease | 44 140 | 17 526 |
| Diabetes Care | 96 688 | 212 426 |
| JAMA Internal Med | 59 | 122 712 |

This is slightly horrifying. Each editor of the Journal of the American College of Cardiology received, on average $475 072 personally and another $119 407 for 'research'. With 35 editors, that's about $15 million in bribes to doctors. No wonder the JACC loves drugs and devices. It pays the private school bills. Mo money = we'll publish your crooked studies for you. Mo money, baby, mo money.

**Publication Bias**—The evidence base that EBM depends upon is completely biased. Some people think I'm really anti-Pharma, but this is not really true. Big Pharma companies have a duty to their shareholders to make money. They have no duty to patients. On the other hand, doctors have a duty to patients. Universities have a duty to remain unbiased. It is the failure of doctors and universities to keep their greedy paws out of the corrupting influence of Big Pharma money that is the problem. If Big Pharma is allowed to spend lots of $$$ paying off doctors and universities and professors, then it should do so to maximize profits. That is their mission statement. Doctors love to blame Big Pharma companies because it takes peoples gaze off the real problem—lots of doctors taking $$$ from anybody who will pay. The pharma industry is not the problem. Bribery of university doctors is the problem—one that is easily fixed if the political will exists.

Consider this study. Looking at studies in the field of neurodegenerative disease, researchers looked at all the studies that were started but never finished or never published. Approximately 28% of studies never made it to the finish line. That's a problem. If all the studies that don't look promising for drug candidates are not published, then it appears that the drugs are way way more effective than they really are. But the published 'evidence base' would falsely support the drug. Indeed, Pharma sponsored trials were 5 times more likely to be unpublished.

Imagine you have a coin flipping contest. Suppose a player call 'Big Pharma" chooses heads, and also pays the coin flipper. Every time the coin flipper pulls up tails, the results don't count. Every time it comes up heads, it counts. This happens 28% of the time. Now, instead of a 50/50 split of heads and tails, it's more like a 66/34 split of heads/tails. So the 'evidence based medicine' lover claims that heads is far more likely to come up than tails, and castigates people who don't believe the results as 'anti-science'.

Evidence based medicine depends entirely upon having a reliable base of evidence (studies). If the evidence base is tampered with, and paid for, then EBM as a science is completely useless. Indeed, the very editors whose entire careers have been EBM have now discovered it to be worthless. Does the CEO of Phillip Morris (maker of Marlboro cigarettes) smoke? That tells you all you need to know about the health risks. Do the editors of the NEJM and the Lancet believe EBM anymore? Not at all. So neither should we. We can't believe evidence based medicine until the evidence has been cleaned up from the corrupting influence of commercial interests.

Financial conflicts of interest (COI), also known as gifts to doctors, is a well accepted practice. A national survey in the New England Journal of Medicine in 2007 shows that 94% of physicians had ties to the pharmaceutical industry. This gravy train only rides in one direction. From Big Pharma to the wallets of doctors. Sure Big Pharma can simply pay doctors directly, and it does plenty of that. It's no surprise that medical students with more exposure to pharmaceutical reps develop a more positive attitude towards them. Many medical schools have limited exposure of medical students in response, but declined to get off the gravy train themselves. There is a simple relationship between how prominent a physician is (more articles published—almost always academic doctors and professors) and how much money they take from Big Pharma. More prominent = more money. Further, there is a 'clear and strong link' between taking industry money and minimizing the risk of side effects of medications. What, you thought people teach at prestigious institutions like universities for the good of mankind? Maybe that's why they went there, but that's not why they stay. They came for the science. They stayed for the money.

**So here's a damning list of all the problems of EBM:**

- Selective Publication
- Rigged outcomes
- Advertorials
- Reprint Revenues
- Bribery of Journal Editors
- Publication Bias
- Financial Conflicts of Interests

When the evidence base of medicine is bought and paid for, people die. That is how doctors have created this opioid crisis that kills thousands of people. Pharmaceutical companies want to pay off doctors, just as drug lord want to pay off judges and police officers. Doctors, being human, should put safeguards against this temptation. Unfortunately, doctors and universities have been willing participants in this game of killing for profit. We need to end it now. End the corruption of the universities. Stop the bribery of doctors.

# A LOWERED PROBABILITY OF PREGNANCY IN FEMALES IN THE USA AGED 25–29 WHO RECEIVED A HUMAN PAPILLOMAVIRUS VACCINE INJECTION

BY GAYLE DELONG

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## ABSTRACT

Birth rates in the United States have recently fallen. Birth rates per 1000 females aged 25–29 fell from 118 in 2007 to 105 in 2015. One factor may involve the vaccination against the human papillomavirus (HPV). Shortly after the vaccine was licensed, several reports of recipients experiencing primary ovarian failure emerged.

This study analyzed information gathered in National Health and Nutrition Examination Survey, which represented 8 million 25-to-29-year-old women residing in the United States between 2007 and 2014. Approximately 60% of women who did not receive the HPV vaccine had been pregnant at least once, whereas only 35% of women who were exposed to the vaccine had conceived.

For married women, 75% who did not receive the shot were found to conceive, while only 50% who received the vaccine had ever been pregnant.

Using logistic regression to analyze the data, the probability of having been pregnant was estimated for females who received an HPV vaccine compared with females who did not receive the shot.

Results suggest that females who received the HPV shot were less likely to have ever been pregnant than women in the same age group who did not receive the shot.

If 100% of females in this study had received the HPV vaccine, data suggest the number of women having ever conceived would have fallen by 2 million. Further study into the influence of HPV vaccine on fertility is thus warranted.

Photo by Ewout Paulusma on Unsplash

# RECONSIDERATION OF THE IMMUNOTHERAPEUTIC PEDIATRIC SAFE DOSE LEVELS OF ALUMINUM

BY JAMES LYONS-WEILER, ROBERT RICKETSON

Journal of Trace Elements in Medicine and Biology 48 (2018) 67–73
26 February 2018

## ABSTRACT:

FDA regulations require safety testing of constituent ingredients in drugs (21 CFR 610.15). With the exception of extraneous proteins, no component safety testing is required for vaccines or vaccine schedules. The dosing of aluminum in vaccines is based on the production of antibody titers, not safety science. Here we estimate a Pediatric Dose Limit that considers body weight.

We identify several serious historical missteps in past analyses of provisional safe levels of aluminum in vaccines, and provide updates relevant to infant aluminum exposure in the pediatric schedule considering pediatric body weight. When aluminum doses are estimated from Federal Regulatory Code given body weight, exposure from the current vaccine schedule are found to exceed our estimate of a weight-corrected Pediatric Dose Limit.

Our calculations show that the levels of aluminum suggested by the currently used limits place infants at risk of acute, repeated, and possibly chronic exposures of toxic levels of aluminum in modern vaccine schedules. Individual adult exposures are on par with Provisional Tolerable Weekly Intake "limits", but some individuals may be aluminum intolerant due to genetics or previous exposures. Vaccination in neonates and low birth-weight infants must be re-assessed; other implications for the use of aluminum-containing vaccines, and additional limitations in our understanding of neurotoxicity and safety levels of aluminum in biologics are discussed.

*"...tissue samples from post-mortem brains of patients diagnosed with autism spectrum disorder (ASD) were found to contain high concentrations of aluminum."*

## DISCUSSION (EXTRACT – FINAL PARAGRAPH):

While the effect of our proposed reduction on the final antigenicity of the vaccine is unknown, the full effects of the high injected doses of aluminum on the developing brain are also unknown. Indications of accumulation of aluminum associated with autism were recently published [42] in which the majority of tissue samples from post-mortem brains of patients diagnosed with autism spectrum disorder (ASD) were found to contain high concentrations of aluminum.

Many samples contained extremely high concentrations, and the study also localized aluminum in glial cells in the brain, consistent with aluminum-induced gliosis models of neurodevelopmental disorders.

# HPV VACCINE AND FERTILITY • PART 02

BY Dr JAYNE LM DONEGAN,
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MFHOM GP & HOMEOPATH

## PRIMARY OVARIAN INSUFFICIENCY

The first published case of primary ovarian insufficiency after HPV vaccine, was published by Dr Deirdre Little, a GP in Bellingen New South Wales (NSW) and Dr Harvey Ward an obstetrician affiliated to the University of NSW. This was in the British Medical Journal of 2012. A 16 year-old girl who started her periods at the age of 13 years was given three doses of HPV vaccine.

One year after the first dose her periods became scanty and then absent. Blood tests showed that her hormones were at menopausal levels and she had no genetic or other abnormalities herself or in her family history that would have accounted for it.[39]

In 2014 Little and Ward published two more cases. The second case was of an 18 year-old woman whose periods had started aged 11 year-of-age. She has cerebral palsy and Asperger's syndrome with anxiety and depression and found it hard to cope with the periods so she was started on the oral contraceptive pill (OCP) the age of 12 years. She was given the first of three HPV vaccines when aged 12 years and nine months along with a hepatitis B vaccine in the other arm. Apart from three months when she was 14 years-of age when she took a break from the pill, she stayed on it until she was 18 years. During the break and after she stopped for good aged 18, she had no periods. When investigated six months after stopping this, her blood tests showed her hormones were in the menopausal range. All other tests including genetic were normal. Her anti-Müllerian hormone level, a marker of ovarian reserve - giving an estimate of the remaining egg supply,[40] was unrecordable.

The third patient started her periods aged 10 years and they were regular until after the third of three HPV vaccine dose at the age of 15

*DR Jayne L.M.Donegan*

years. Again, her hormones were in the menopausal range. There was nothing in her personal, genetic or family history to account for this. Anti-Müllerian hormone level was unrecordable indicating no egg reserve.

On the other side of the world a team of researchers in Israel, Canada and Italy published three more cases of patients whose periods had previously been normal, stopping after HPV vaccinations.[41] The first girl started her periods at the age of 14 years and had the first of three HPV vaccines six months later. Her last period occurred shortly after the third vaccine. She also reported burning, nausea and stomach pains with headache and cramps, later going on to experience night sweats, insomnia progressing to joint pain and symptoms of depression. Her hormones were at menopausal levels and she had no other predisposing factors in personal, genetic and family history.

The second girl was the sister of the previous case. She was given the HPV vaccine at the age of 13 years, at the same time as her sister, before she started her periods. She did not have her first period until she was 15 years-old. This was followed by one more and then they stopped. She also had of symptoms of depression, insomnia, anxiety, panic attacks and difficulties in focusing/concentrating on school work. She was again hormonally menopausal with no obvious predisposing factors. She was tested for anti-ovarian antibodies and these were positive.

The last of this series of patients did not have her first HPV vaccine until she was 21 years-of-age. Her periods had started when she was 13 years-old and had been normal. Her periods became irregular and scanty a few months after her third dose of HPV vaccine. She was prescribed the pill for two years to try to regulate her periods but there was no improvement. She stopped when 23 years-old. Blood tests were menopausal and in addition she had antithyroid peroxidase antibodies.

This team includes Professor Yehuda Schoenfeld who with Professor Nancy Agmon-Levin in 2011, first described the autoimmune/inflammatory

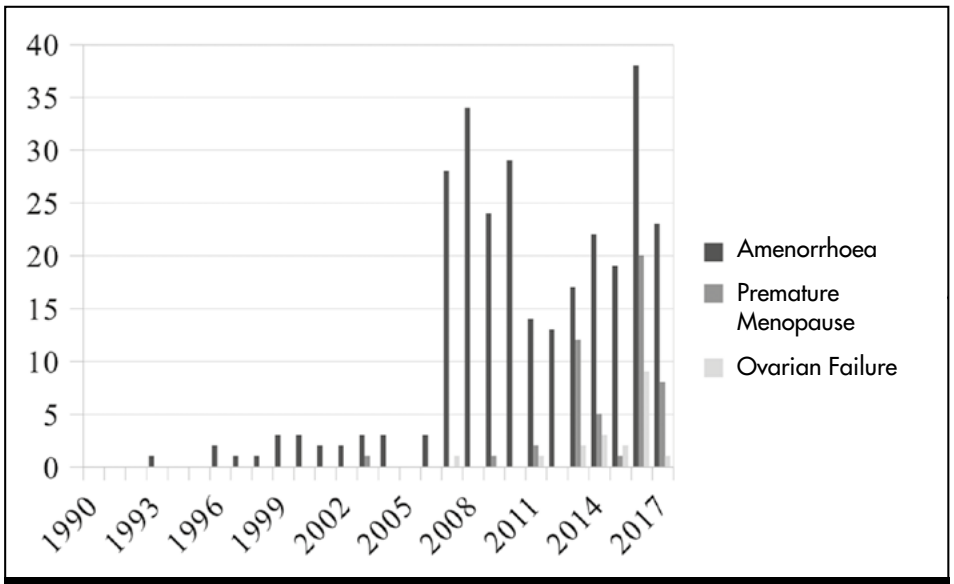



*Fig.3 Reported incidence of Amenorrhoea, Premature menopause and Ovarian Failure to VAERS Data base 1990- 2016 50*

syndrome induced by adjuvants (ASIA), linking conditions previously described separately, but sharing similar autoimmunity manifestations, such as the post-vaccination phenomena, the macrophagic myofasciitis syndrome (MMF), the Gulf war syndrome (GWS) and siliconosis (after silicon cosmetic implants).[42] These events can be very low grade initially and may occur a long time after the vaccination (i.e. months to years), which makes it very difficult to identify a definite causal link between the intervention - the HPV vaccine, and the auto-immune event occurring afterwards: primary ovarian insufficiency. It is thought that certain individuals are more susceptible to such auto-immune events occurring, especially if there is a familial susceptibility to autoimmunity and/or an adverse response to a prior dose of HPV or other vaccine. In other cases of primary ovarian insufficiency, not known to be associated with HPV vaccination, ovarian auto-antibodies are frequently present and may occur in the presence of other auto-immune disease. HPV vaccine has already been reported as an important factor in cases of Guillain-Barré syndrome and other neuropathies, such as systemic lupus, vasculitis, idiopathic thrombocytopenic purpura (low platelet auto-immune syndrome), and autoimmune hepatitis.[43]

## HPV VACCINE AND FERTILITY - WHAT IS PRIMARY OVARIAN INSUFFICIENCY?

Primary ovarian insufficiency is the preferred term for the condition that was previously referred to as premature menopause or premature ovarian failure. It is thought to affect 0.5-3.0% of women in childbearing age [44] and is considered to be present when a woman who is less than 40 years old has had amenorrhoea, or no periods, for 4 months or more, and has two Follicle Stimulating Hormone (FSH) levels, at least one month apart, in the menopausal range.[45] Autoimmunity is an important mechanism for premature destruction of the ovarian follicles and Zhen and co-investigators in Beijing, China found that those women who suffered from primary ovarian insufficiency had antibodies to many

*"It is thought that certain individuals are more susceptible to such auto-immune events occurring, especially if there is a familial susceptibility to autoimmunity and/or an adverse response to a prior dose of HPV or other vaccine."*

other organs and endocrine glands in the body and this was despite the fact that, apart from having no ovulation and no periods, the women had no symptoms of autoimmune disease, making it difficult to screen them out of, for example, vaccine programs without extensive blood screening for immune markings.[46]

The interplay of autoimmunity with the endocrine system is complex and incompletely understood.[47] If a woman does not ovulate, she cannot become pregnant. In addition if she has no ovarian reserve she cannot use her own eggs for IVF (in vitro fertilisation). She is also at risk to low bone density, osteoporosis, cardiovascular disease and premature aging.

| YEAR | Amenorrhoea | Premature | Ovarian |
|---|---|---|---|
| 1990 | 0 | 0 | 0 |
| 1991 | 0 | 0 | 0 |
| 1992 | 0 | 0 | 0 |
| 1993 | 1 | 0 | 0 |
| 1994 | 0 | 0 | 0 |
| 1995 | 0 | 0 | 0 |
| 1996 | 2 | 0 | 0 |
| 1997 | 1 | 0 | 0 |
| 1998 | 1 | 0 | 0 |
| 1999 | 3 | 0 | 0 |
| 2000 | 3 | 0 | 0 |
| 2001 | 2 | 0 | 0 |
| 2002 | 2 | 0 | 0 |
| 2003 | 3 | 1 | 0 |
| 2004 | 3 | 0 | 0 |
| 2005 | 0 | 0 | 0 |
| 2006 | 3 | 0 | 0 |
| 2007 | 28 | 0 | 1 |
| 2008 | 34 | 0 | 0 |
| 2009 | 24 | 1 | 0 |
| 2010 | 29 | 0 | 0 |
| 2011 | 14 | 2 | 1 |
| 2012 | 13 | 0 | 0 |
| 2013 | 17 | 12 | 2 |
| 2014 | 22 | 5 | 3 |
| 2015 | 19 | 1 | 2 |
| 2016 | 38 | 20 | 9 |
| 2017 | 23 | 8 | 1 |

*Cases of amenorrhoea, premature menopause and ovarian failure from 1990*

## HPV VACCINE AND FERTILITY - HOW MANY GIRLS AND WOMEN ARE AT RISK?

This is unknown as can be seen from above, however there is still another method of collecting adverse events - the United States (USA) Vaccine Adverse Event Reporting System (VAERS). VAERS is a national early warning system to detect possible safety problems in US-licensed vaccines. Events occurring after vaccination are added to the database by health professionals, patients or parents if they think that a medical adverse event they have had may be linked to a vaccine.

The data from what is described as a 'passive' surveillance system are subject to the acknowledged limitations of under-reporting, reporting bias, and lack of incidence rates in unvaccinated comparison groups. Establishing causal relationships between vaccines and adverse events requires additional scientific investigation. A report to VAERS does not mean that the vaccine caused the adverse event, only that the adverse event occurred at some point after the vaccination.[48] Although the data from VAERS are often dismissed for this reason, the Scientific Advisory Group of the European Medicines Agency agrees that despite the known weakness and limitations of spontaneous passive reporting systems, it remains a sensitive tool to pick up unexpected rare signals, which are not predicted at the time of introduction of a vaccine.[49]

Doing a very simple search for cases of amenorrhoea, premature menopause and ovarian failure from 1990 when VAERS was first established to the latest year figures are currently available, after any vaccine (removing amenorrhoea due to pregnancy), it can be seen in the graph below that though there were cases reported in the 1990's (after measles, MMRII, Varivax (chicken pox) and Anthrax vaccines), there is a very sharp rise in cases of

amenorrhoea reported after 2006. Gardasil vaccine was introduced in 2006. With few exceptions the cases are after administration of Gardasil vaccine. Cervarix was not introduced until 2009 and never had much of a share of the USA market. Irrespective of whichever vaccines the cases of amenorrhoea occurred after, it is possible to see after 2006 that there was a clear signal that something unusual was happening regarding amenorrhoea and vaccines in the USA. This occurred long before the first cases were published online or taken up by social media groups.

Reports to databases like VAERS in the USA and the Medicines and Healthcare products Regulatory Agency (MHRA) in the United Kingdom (UK) are often criticised for being biased by people who, 'jump on the bandwagon' and decide they have an adverse drug reaction just because they read or heard about it in the media. A study by Dr. Preciosa Coloma and colleagues at the Erasmus University Department of Informatics in the Netherlands, collected publicly accessible data from Facebook, Google+ and Twitter from when these groups started until September 2014 to see if 'mining' social media networks could be used for medicines safety surveillance. One of their case studies was HPV vaccine and infertility. It can be seen quite clearly from their Figure (4. below) that the sharp increase in cases of amenorrhoea reported to VAERS after Gardasil vaccination started long before social media became occupied with the topic.

## HPV VACCINE AND FERTILITY - IS THERE BIOLOGICAL PLAUSIBILITY FOR GARDASIL/ GARDASIL 9 OR CERVARIX TO CAUSE OVARIES TO STOP FUNCTIONING?

Points to consider:

• Human ovaries are common targets of autoimmune attack. [52]

• The HPV vaccine over-activates the immune system, producing antibody levels as much as 36 -78 times higher than after natural infection.[53] It is the cell mediated immunity of the innate immune system, not the specific antibody mediated immune system, which is associated with regression of cervical lesions. This hyper-stimulation of the antibody based immune system could increase the likelihood of antibodies being made to body structures (auto-antibodies), which include the vulnerable ovaries.

• Aluminum compounds. Gardasil/ Gardasil 9 and Cervarix contain an aluminium adjuvant. A study exposing rats to sub-chronic aluminium chloride (AlCl3) showed disruption of the structure of the ovary and disturbance of metabolism at the level of cell respiration and energy formation. The authors thought this could lead to inhibition of ovulation and corpus luteum development, leading to infertility in female rats [54]

• It is thought that the autoimmune/ inflammatory syndrome induced by adjuvants (ASIA) described above may include primary ovarian insufficiency under its umbrella, particularly as other auto-immune events have been reported as triggered by HPV aluminum adjuvant containing vaccines

• Polysorbate 80 or Tween 80. Gardasil and Gardasil 9 but not Cervarix, contain Polysorbate 80. Researchers in Bratislava in 1993 found that injecting very young (neonatal) rats with Polysorbate 80 led to rapid maturation and then degeneration of the ovaries.[55]

• European public assessment reports for both Gardasil and Gardasil 9 say that both vaccines can give rise to auto-antibodies, meaning antibodies against oneself: Gardasil: "Theoretically, the vaccine could give rise to antibodies, which cross-react to self-structures, resulting in autoimmune events. Such possibility is not readily studied in experimental animal models, but can only be studied in the clinical situation." [56] Gardasil 9: "Theoretically, lymphoid stimulatory effect seen in repeat-dose toxicity study might cause/ exacerbate autoimmune diseases, but such a risk can only be characterized in post-marketing setting in humans." [57] As has been shown above, such auto-immune disease has not been studied or characterised in the clinical situation. This does not occur as trial design and monitoring systems are not set up to detect anything other than gross disease. Even if this is detected it is dismissed as 'not biologically plausible', or 'not raised above back ground rate.' As Little and Ward pointed out, in the case of ovarian failure in girls and young women, the background rate is not known, only for the entire incidence up to 40 years-of-age. The incidence increases with age.[58]

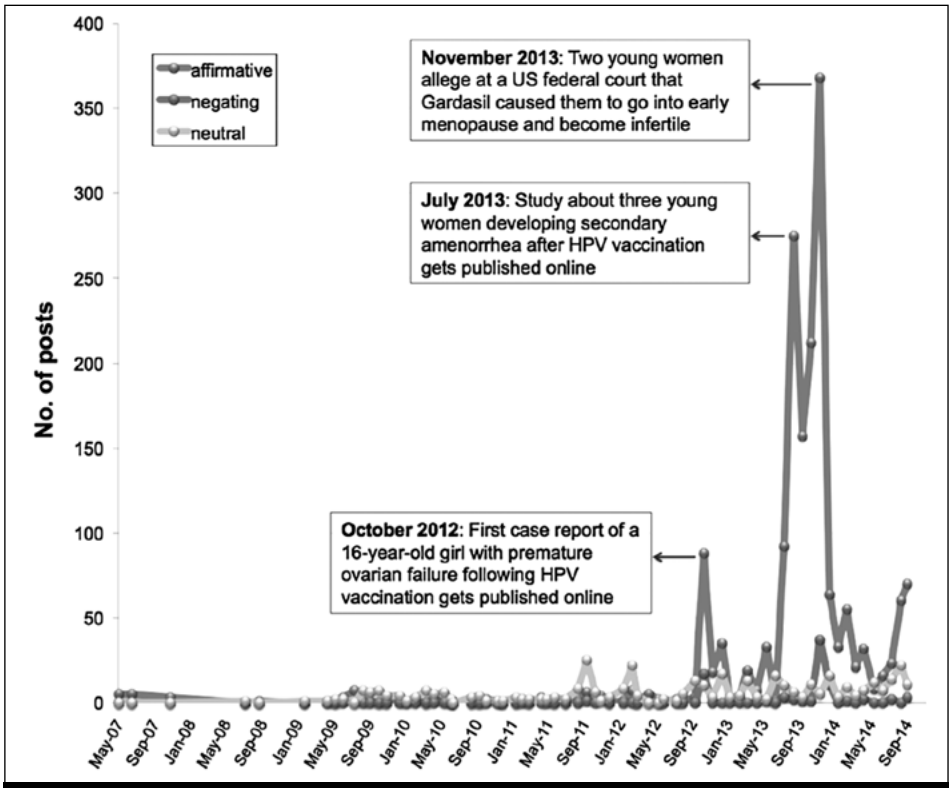



*Fig.4 Trend of assertions of HPV vaccine/infertility-related posts over time. HPV human papilloma virus.[51]*

• HPV DNA fragments in the vaccines are another source of possible immune disruption that may provoke long-term slow grade stimulation or over stimulation of the immune system acting as a possible trigger to auto-immunity. Although, the World Health Organization (WHO) HPV vaccine information states "These vaccines do not contain viral genetic material or live biological product, so they cannot multiply and are not infectious." [59] And Merck's own scientists say "The VLPs (virus like particles) contain no viral DNA and therefore the vaccine is non-infectious,"[60] Dr Sin Lee, pathologist and Director of Milford Molecular Diagnostics, Milford, Connecticut found that all 16 Gardasil samples she tested contained fragments of HPV DNA.[61] After severe criticism and attempts to discredit Dr Lee and her methods, Professor Laurent Belec, Chef du laboratoire de Virologie, Hôpital Européen Georges Pompidou, in Paris found the same in all the different batches of French Gardasil that he tested, thus confirming Dr Lee's findings. It is possible that these viral fragments if bound to the aluminium adjuvant may cause unintended biological consequences. The significance of HPV viral DNA in the vaccine is unknown. Instead of urgent studies being ordered to find out what effects this might have on people's health, or even withdrawing the vaccine, the FDA issued a statement saying it was known the DNA fragments were there all along and the vaccine is safe, "The presence of DNA fragments is expected in Gardasil and not evidence of contamination. Based on the scientific information available to FDA, Gardasil continues to be safe and effective, and its benefits continue to outweigh its risks."[62]

HPV Vaccine and Fertility – are HPV vaccines linked to premature menopause of primary ovarian insufficiency in girls and women?

This is a hard question to answer, because we do not have the data. We do not have the data from preclinical trials on the effect of the vaccine on the ovaries of rats nor on the subsequent fertility of those that have been vaccinated, only data on male rats. Clinical trials in humans have been inadequately designed and implemented, with follow up of only 14 days after each dose, and then only recording what the researcher regarded as significant, dismissing an ocean of severe ill health they did not consider related. As reports have been published from all over the world about adverse reactions that have occurred after administration of Gardasil and other HPV vaccines, particularly auto-immune reactions, drug safety regulators have dismissed them as "also occur[ing] in individuals who have not been exposed to HPV vaccines and were described long before introduction of the HPV vaccines[63], ignoring the fact that autoimmune conditions usually require triggers to develop. When people have had their symptoms recorded they have been separated into single items rather than grouped together as a clinical entity, so that syndromes – a group of symptoms occurring together as part of a condition - are missed. Last of all is the old chestnut (a subject, idea, or joke that has been discussed or repeated so often that it is not funny any more[64]) - Causality. As Peter Schönhöfer, Professor of clinical pharmacology, Zentralkrankenhaus, Bremen, Germany said in a letter to

## WHO MAKES GARDASIL AND GARDASIL 9?

Merck, Sharpe & Dohme/ MSD. They also make MMRVAXPRO, an MMR vaccine, and Vioxx, an anti-arthritis drug.

### ARE THEY A TRUSTWORTHY COMPANY?

When concerns were raised about the safety of Merck's drug, Vioxx in 1999, whether those taking it had a higher risk of heart attacks and strokes, Merck protested for five years that it was safe, until they withdrew it in 2004[70], admitting no liability. In 2007 though, Merck paid $4.85 billion to settle the first batch of law suits. In 2011, they agreed to pay $950 million more to resolve allegations from the USA Department of Justice that they improperly marketed Vioxx by making false statements about the drug's cardiovascular safety. In 2012, Merck settled a consumer class action suit over the medication for $220 million and in 2016, they paid approximately $830 to conclude a multi-district class action lawsuit in a New Jersey federal court, in addition to legal fees and expenses.[71] From 1999, when doctors and researchers first started raising safety concerns about Vioxx, internal Merck emails shown in an action in the Australian Court in 2009 revealed that Merck employees had drawn up a list of doctors critical of Vioxx, who were marked as needing to be 'neutralised' or 'discredited' for raising safety concerns.[72] This is similar to the discreditation both of people who say they have been damaged by Gardasil and clinicians who try to raise safety concerns.

Throughout this sorry tale Merck, the USA regulators, the Federal Drug Administration (FDA) did nothing to protect patients except to ask Merck to add a warning that patients with a history of heart disease should use the drug with caution. When Merck eventually withdrew Vioxx, voluntarily, in 2004, Dr. Sandra Kweder, deputy director of the FDA's office of new drugs at that time, said she was "stunned," that they had taken that step, despite a study by one of the FDA's own scientists, Dr. David Graham, estimating that Vioxx was associated with more than 27,000 heart attacks or deaths linked to cardiac problems.[73] His findings were not regarded as relevant by his bosses..

This is the same company that manufactured and tested Gardasil and Gardasil 9, saying they are extensively tested and that the illnesses from which thousands of girls and women say they have been suffering since taking Gardasil are nothing to do with the vaccine. The regulators who agree with them are the same ones that did nothing about Vioxx.

the BMJ in 1997: "Drug companies and their experts use lack of causality in defending a product and to discredit reports of adverse effects. There is no causal explanation for the antidepressant effect of tricyclic agents, the antipsychotic effect of neuroleptics, or the sedative effect of barbiturates; there is only an association between the drug and the desired result. This is sufficient to grant therapeutic efficacy...(the) association does not simply disappear because experts declare that the events are not related causally. Such causality is misused as a bureaucratic safety measure."[65]

Alcina Nicol, PhD at the Instituto Oswaldo Cruz in Rio de Janeiro, states in her independent overview of HPV vaccine that controversy still exists over whether the benefits of the available HPV vaccines outweigh the risks and this has suppressed uptake of the HPV vaccines in comparison to other vaccines. "Concerns about HPV vaccine safety have led some physicians, healthcare officials and parents to withhold the recommended vaccination from the target population." Then she complains that, "immunisation programs can be seriously compromised by safety ... concerns. [66] This is true. Unfortunately her message appears to be that the people should continue to be vaccinated irrespective of safety concerns about vaccines because immunisation programs are more important than the health of the recipients of the vaccines.

## IS A VACCINE THE ONLY WAY OF DEALING WITH HPV?

For a virus which occurs worldwide, everyone gets infected with in one or other of its forms in their life time and generally clears by mounting an effective cell mediated immune (CMI) response, it is more logical to find out what it is that stops some people being severely affected by human papilloma virus, rather than vaccinate every one on the planet with a vaccine of questionable safety and that does not perform better than the cervical screening program which is proven to be safe and effective. If we look we will find that it is the same factors that have always supported health and which were responsible for the massive drop in deaths from infectious disease since the nineteenth century in what are known as 'developed countries': Good food[67], clean water, fresh air, sunshine, ventilated, dry housing, adequate sleep and someone who loves you. Vitamin E[68] and red grape skins[69] are said to specifically stimulate cell mediated immunity, but be careful to keep looking at the big picture and not be distracted by people who call themselves scientists discovering more and more about less and less.

Specific factors for avoiding HPV infection associated with cervical cancer include avoiding early age at first sexual intercourse which is also good from an emotional point of view, using condoms which prevent other sexually transmitted diseases and having regular cervical screening.

***28 February 2018 © 2018***
***Dr Jayne LM Donegan MBBS DRCOG DCH DFFP MRCGP MFHom***

**REFERENCES***: All references were accessed by JLMD between 23 January and 28 February 2018. Please contact The Informed Parent for complete article (part 1&2 with references). Links to all references are provided for which there is free access to the full manuscript. Others have been received from the authors of the studies.*

**Recommended further reading:**

*Adolescent Premature Ovarian Insufficiency Following Human Papillomavirus Vaccination: A Case Series Seen in General Practice by Drs. Deirdre Little & Harvey Ward. published in the Journal of Investigative Medicine High Impact Case Reports October-December 2014: 1–12. Available free at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4528880/*

*What the Gardasil Testing May Have Missed by Frederik Joelving, investigative journalist for Slate, Slate is an online general-interest publication offering analysis and commentary about politics, news, business, technology, and culture. Available free at: https://slate.com/health-and-science/2017/12/flaws-in-the-clinical-trials-for-gardasil-made-it- harder-to-properly-assess-safety.html*

## PONDERING THE EFFECT OF GARDASIL AND GARDASIL 9 ON FERTILITY:

1. Why did Merck do any fertility studies on Gardasil at all? Glaxo Smith Klein (GSK) did not do any on Cervarix. Teenagers in the 'catch-up' program and women who need rubella vaccine are given MMR vaccine. The two brands licensed in the UK, Merck's MMRVXPRO[74] and GSK's Priorix[75] both state in their Summary of Product Characteristics (SPC) that the vaccines have not been evaluated in fertility studies. For preclinical animal safety data the Merck MMRVAXPRO product data states, "Non-clinical studies have not been conducted." Giving an MMR vaccine to children, teenagers and women of childbearing age is no different to giving them an HPV vaccine. Sometimes what people don't say is more important than what they do say. Did someone at Merck flag up possible problems with Gardasil vaccine early on and decide to neutralise them specifically carrying out tests on fertility to show that Gardasil and by extension Gardasil 9 (no new tests were carried out, just comparisons with Gardasil), putting normal results in their product information and licensing applications and omitting abnormal? (see Vioxx above)
2. Why did Merck carry out tests on fertility, sperm count, and sperm motility as well as vaccine-related gross or histomorphologic (when looked at under a microscope) changes in the testes and not carry out the same tests in the female rat, or any tests on the fertility of female vaccinated rats? Or did they indeed do these tests, not like the results and bin them, hoping nobody would notice? (see Vioxx above)
3. Why did the regulators not require that these tests be done before ever giving permission to proceed with clinical trials in human beings? (see Vioxx above)
4.And why do regulators still allow' placebo' controlled vaccine trial that use biologically active, 'placebos' that are not placebos by definition?

# HORRORS OF VACCINATION EXPOSED AND ILLUSTRATED

BY CHAS M HIGGINS, Brooklyn US, 1920

EXTRACT; PAGE 23-24

**Deaths from vaccination greater than deaths from smallpox. Shocking denial and concealment of vaccination deaths by our departments of health and vital statistics.**

It will be seen from the last quotation that Dr Millard is one of those honest doctors who are not afraid to tell the truth about vaccination, its great dangers and frequent fatalities, the evils and barbarities of compulsion, the superior value of sanitation, and the stinging fact that the inflicted disease, vaccine, frequently causes more deaths per year than the natural disease, smallpox! To confirm these startling facts I will now quote a few figures, during the period to which Dr Millard refers, from the record of the Registrar General of England which, as you know, is one of the highest statistical authorities in the world.

| YEAR | TOTAL DEATHS FROM SMALLPOX | TOTAL DEATHS FROM VACCINATION |
|---|---|---|
| 1906 | 21 | 29 |
| 1907 | 10 | 12 |
| 1908 | 12 | 13 |

| | | |
|---|---|---|
| Total deaths from smallpox for six years | 1905 to 1910 | 199 |
| Total deaths from vaccination for six years | 1905 to 1910 | 99 |
| Deaths from smallpox in said period | under 5 years old | 26 |
| Deaths from vaccination in said period | under 5 years old | 98 |

From these remarkable figures we will see that for the six years from 1905-1910, in England and Wales, the total deaths from vaccination from all ages were about half the total deaths from smallpox, but that in the same period the total deaths from vaccination, in the child ages of five years and under, were nearly four times the deaths from smallpox in the same age group!

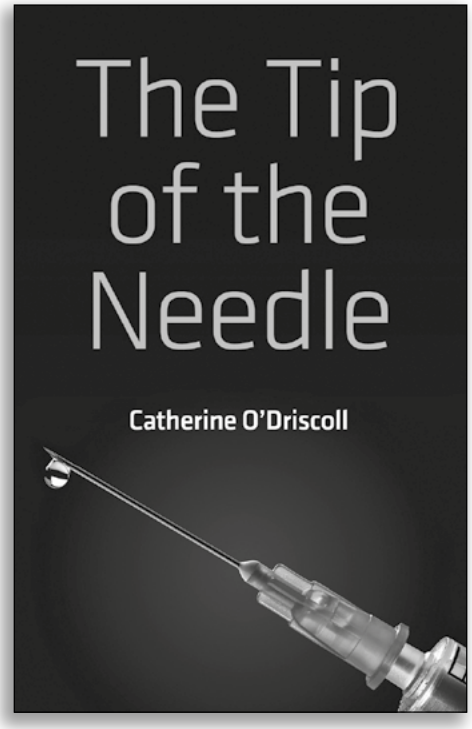
The report of the English Registrar General for the three years, 1911,1912, and 1913, tell a similar story of vaccinal fatality, as follows:

| | | |
|---|---|---|
| Total deaths from smallpox | for six years | 42 |
| Total deaths from vaccination | for six years | 31 |
| Deaths from smallpox in said period | under 5 years old | 8 |
| Deaths from vaccination in said period | under 5 years old | 30 |

Here it will be noted that for the three years stated the total deaths from vaccination are three-quarters of the total deaths from smallpox, whereas the deaths from vaccination in children five years old and under are over three times more than the deaths from smallpox in the same age group!

This awful record of fatal vaccinations thus speaks very clearly for itself and forms a strong indictment of the whole barbarous and dangerous system of compulsory vaccination, whether for child or adult, and must condemn the evil practice in every rational mind.

# BOOK NEWS: THE TIP OF THE NEEDLE




BY CATHERINE O'DRISCOLL

https://www.catherineodriscoll.com

ANOTHER BOOK exposing the world of vaccines for pets - as well as humans. "Her scope is wide. By the time you finish the last chapter, you will have a global understanding of the complex interests controlling the health and well-being of your animals, your children, and yourself – and perhaps the beginning of an inkling of an answer to the question, 'Why?'

***Dr Jayne LM Donegan, MBBS DRCOG DCH DFFP MRCGP MFHom***

Here's an extract from Chapter 75:

## MARKETING A PANDEMIC

So many people are encouraged by their doctors to get their flu shots each year, but it turns out there's no proof that they work, although they do represent a health risk. So once again we need to ask if flu shots are about profits or health?

To determine the value of flu vaccines for children, Tom Jefferson, MD, and colleagues at the respected Cochrane Collaboration looked at over a thousand studies. The results were reported in The Lancet. Here's the conclusion: "We recorded no convincing evidence that vaccines can reduce mortality, hospital admissions, serious complications, and community transmission of influenza. [1] Doctors read the Lancet, so they must know this.

"Though the US Centers for Disease Control (CDC) and Prevention advises flu vaccines for babies 6-23 months because they tend to suffer more complications once they get the flu, no evidence supports the recommendation."

Lone Simonsen, PhD, and colleagues at the National Institute of Allergy and Infectious Diseases conducted a review of 33 consecutive flu seasons, from 1968 to 2001. Simonsen and colleagues found that the number of flu-related deaths among elderly Americans increased steadily during the 33-year-period, despite the fact that their acceptance of flu vaccinations also steadily increased.

Another study showed that the flu vaccine does not appear to be effective in preventing influenza-related hospitalisations in children, especially children with asthma. In fact, children who get flu vaccine are three times more at risk for hospitalisation than their peers who do not get the vaccine. Of 48 reports involving more than 66,000 adults, "Vaccination of healthy adults only reduced risk of influenza by 6% and reduced the number of missed work days by less than one day. It did not change the number of people needing to go to hospital or take time off work." [2,3]

I'm just a dog owner with no scientific training. If I can read a report and see that flu vaccines provide little or no benefit but do pose risks, why can't governments, which pay out billions for these virtually useless shots? It's difficult to understand why the flu vaccine, with such poor performance and poor evidence of efficacy, could become such a worldwide phenomenon. And it's even more difficult to understand why the UK government should instigate a nationwide flu vaccine programme for children in 2014, after the publication of the Cochrane Review.

I got in touch with Tom Jefferson from the Cochrane Collaboration and asked him this very question: why?

"I would have thought that the motivation for canine vaccines is very much the same as the motivation for human vaccines," he said. "It's a very complex issue. I think it would be wrong to assume that everyone who supports vaccines is on the payroll of the pharmaceutical industry. That's not the case. They believe in it. They're believers."

It would, it seems, be safer to believe in fairies or, indeed, archangels.

In 2009, according to the Telegraph, the UK government was preparing to offload millions of unwanted swine flu vaccines as officials predicted there would be no third wave of the 'pandemic'. Fewer than 5,000 people in Britain were thought to have contracted swine flu by January 9th [4].

Ministers had signed contracts worth £100 million to deliver 90 million vaccines to Britain. The government was considering exercising a break clause in its contract with Baxter, which supplied vaccines used by the NHS. There was no such clause in the GSK contract but ministers were in discussions with the company about future supplies. David Salisbury, the Department of Health's director of immunisation, admitted that this still left the problem of vaccines which had already been delivered, but added that the government would keep a stock in case the virus returned. A number of other countries also announced plans to sell off their surplus vaccines. Who to? Who in their right mind would want them?

India was luckily in the midst of an alleged H1N1 pandemic by February 2015. Maybe they were persuaded to buy the unwanted vaccines?[5]

According to the Toronto Star, more than 11,000 cases had been reported since mid-December. However, a report the next day by the Times of India [6] stated that the number of H1N1 positive cases touched 241 on Sunday, 22 February. That's a big discrepancy, and not very scientific, making me wonder whether the tabloid media has a reason to inflate the numbers.

An Indian friend told me: "A few years back there was this scare of bird flu and millions of birds were culled and a warning was given to take Tamiflu in case anyone contracted bird flu symptoms. So they are at it again and since they failed miserably with bird flu, the scare of swine

flu has appeared and we are seeing daily news of people dying of swine flu. They have got wiser this time hence the deaths being reported. I asked at a lab if people were coming for testing for swine flu and the reply was negligible. This is very wise marketing as our country is a fertile field for selling any drugs or medicines."

Meanwhile the vaccine manufacturers did quite well out of inaccurate pandemic predictions for the fourth quarter of 2009. GSK made $1.7 billion, Novartis got $700 million, and Sanofi-Aventis pocketed a cool $500 million. Apparently you have more chance of being struck by lightning than winning the lotto, but it seems investing in vaccines offers better odds, no matter how dodgy they are.

According to Pharma News, the Parliamentary Assembly of the Council of Europe (PACE) planned to hold an emergency debate and inquiry into the influence exerted by drug makers on WHO's global H1N1 flu campaign. The text of the PACE resolution [7] approved by the Assembly stated: "In order to promote their patented drugs and vaccines against flu, pharmaceutical companies influenced scientists and official agencies responsible for public health standards to alarm governments worldwide and make them squander tight health resources for inefficient vaccine strategies, and needlessly expose millions of healthy people to the risk of an unknown amount of side-effects of insufficiently tested vaccines."

The WHO's "false pandemic" flu campaign was "one of the greatest medicine scandals of the century," according to Wolfgang Wodarg, chairman of the PACE Health Committee, who introduced the parliamentary motion.

"The definition of an alarming pandemic must not be under the influence of drug-sellers," he said.

In June 2010, Fiona Godlee, editor-in-chief of the British Medical Journal, published an editorial [8] which criticised WHO, saying that an investigation had disclosed that (here we go again) some of the experts advising WHO on the pandemic had financial ties with drug companies which were producing antivirals and vaccines. For goodness sake – when are they going to get the people with financial ties to the pharmaceutical industry off government committees? And until they do, why should we trust a word they say? Margaret Chan, Director-General of the WHO, replied stating, "Without question, the BMJ feature and editorial will leave many readers with the impression that WHO's decision to declare a pandemic was at least partially influenced by a desire to boost the profits of the pharmaceutical industry. The bottom line, however, is that decisions to raise the level of pandemic alert were based on clearly defined virological and epidemiological criteria. It is hard to bend these criteria, no matter what the motive". Nevertheless, the criteria were wrong, and many people paid for it with their lives; the rest of us paid via our taxes. Once again, we pay for this and they give us that.

# LETTER TO THE EDITOR: NEW PENTAVALENT ROTAVIRUS VACCINE SHOWS LITTLE EFFICACY AGAINST DIARRHEA

LALIT KUMAR: DRLALITNARWAT@GMAIL.COM - CORRESPONDING AUTHOR. JACOB PULIYEL, DEPARTMENT OF PEDIATRICS, ST STEPHENS HOSPITAL, DELHI 110054, INDIA

Vaccine, 13 June 2018

ROTAVIRUS VACCINE is recommended as a means of reducing diarrheal morbidity and deaths in developing countries [1]. The original efficacy studies with the presently licensed vaccines were done in the USA and Europe. Efficacy against severe rotavirus infection was around 90% (95% confidence interval (CI) : 85. ·1–94. ·1) and against all-cause severe gastroenteritis it was about 50% (CI: 39. ·8–57. ·8) [2]. Efficacy was less in Africa and Asia. In Africa it was 61% (CI: 44.0 0–73.2) 2) against severe rotavirus diarrhoea and 30% (CI: 15.0–42.6) against all-cause severe diarrhoea [3].

The journal Vaccine has now published the results of a Phase-III randomized-control-trial, of a newly developed pentavalent rotavirus vaccine (BRV-PV). Vaccine efficacy against rotavirus diarrhoea, (39.5% efficacy against severe rotavirus gastroenteritis (SRVGE) in the per protocol analysis) is emphasized in the report. However, the incidence of 'all-cause severe gastroenteritis' was not reduced by vaccination – vaccine efficacy was reported as 4.6% (95% CI: -5.1 to 13.4) [4].

From the standpoint of the scientific record, additionally highlighting the clinically relevant aspect of their findings - namely efficacy against all-cause diarrheal morbidity, would enable decision makers to make choices about the vaccine, considering costs and benefits. The same vaccine was studied in Niger. An efficacy of 66.7% against severe rotavirus gastroenteritis was reported in the per protocol population[5]. However severe gastroenteritis due to any etiology was not significantly lower among the vaccinated (difference in rate 1.97 cases per 100 person years confidence interval [CI](CI: –- 1.,28 to –5.22) [6]. The authors did post-hoc analysis of efficacy against 'very severe diarrhoea' (which they defined as Vesikari score of 15 or more) and reported a difference in rate of 3.08 per 100 person years (CI: 1.79 to –4.36) among the vaccinated. As efficacy against 'very severe diarrhea' has not been studied previously, comparable data for other rotavirus vaccines is not available.

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## AIMS & OBJECTIVES OF THE *informed* PARENT GROUP

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

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