THE informed PARENT
ISSUE TWO 2019 A NEWSLETTER ON VACCINATION ISSUES AND HEALTH

GOVERNMENT DOCTORS MAKE GROSS ERRORS CONCERNING MEASLES STATISTICS, MISINFORM SENATORS, THREATEN PUBLIC HEALTH

PHYSICIANS FOR INFORMED CONSENT DOCTORS AND SCIENTISTS SOUND ALARM AS LEGISLATORS CONSIDER BANNING PHYSICIANS FROM MAKING PERSONALIZED VACCINE RECOMMENDATIONS IN CALIFORNIA.

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PHYSICIANS FOR INFORMED CONSENT (PIC), an organization of doctors and scientists who encourage using statistics to safeguard public health, recently flew in doctors from across California to educate members of the Senate Committee on Health about the risks of measles vs. the risks of the measles, mumps, and rubella (MMR) vaccine—which are explained in PIC's opposition letter [1] to California SB 276, a bill that would allow only state public health officers the right to grant or approve vaccine exemptions to children at-risk of vaccine injuries.[2] PIC's doctors included Dr. Shira Miller, Dr. Lionel Lee, Dr. Edmond Sarraf, Dr. Melanie Gisler, and Dr. Charles Penick.

At the Senate Committee on Health hearing for SB 276, on April 24, 2019, Dr. Erica Pan, interim health officer at Alameda County Public Health Department, testified to senators that 1 in 1,000 measles cases result in death, a figure that contradicts measles death statistics by 10-fold from the pre-vaccine era.[3] As Dr. Alexander Langmuir, director of the epidemiology branch of the Communicable Disease Center (now Centers for Disease Control and Prevention) for 21 years, explained in his seminal 1962 paper,[4] measles is a "self-limiting infection of short duration, moderate severity, and low fatality," and "…in the United States measles is a disease whose importance is not to be measured by total days disability or number of deaths."

Between 1959 and 1962, before the introduction of the measles vaccine, about 400 measles deaths among approximately 4 million measles cases occurred every year in the United States, which results in a 1 in 10,000 (0.01%) chance of a child dying from measles, not 1 in 1,000. This information is explained in detail in the PIC educational documents, the Measles Disease Information Statement (DIS)[3] and Vaccine Risk Statement (VRS),[5] which were provided to all California legislators.

"...design and reporting of safety outcomes in MMR vaccine studies, both pre- and post-marketing, are largely inadequate."

By comparison, over 23,000 infant deaths occur every year in the U.S. from all causes and the chance of a child dying in his or her first year of life is currently 1 in 170 (0.6%)[6]—which is 60 times the risk of a child dying from measles in 1962, a time period when almost every child had measles by age 15.[3]

Now, misinformation concerning measles data is rampant. On April 29, 2019, Dr. Robert Redfield, director of the Centers for Disease Control and Prevention since 2018, stated in a CDC telebriefing that, "There are no treatment and no cure for measles and no way to predict how bad a case of measles will be."[7] However, Dr. Redfield's statement is erroneous. High-dose vitamin A and immunoglobulin (passive immunization) are available for the treatment of measles upon exposure,[3] there is evidence that the antiviral ribavirin is beneficial in the treatment of measles,[8-10] and 99.99% of measles cases fully recover.[3] Additionally, 75–92% of hospitalized measles cases are low in vitamin A, and vitamin A status is a known factor that can be used to predict the severity of measles.[3]

"Misrepresenting the measles death rate by 10-fold is dangerous because it prevents one from accurately comparing the risk of measles vs. the risk of the MMR vaccine," said Dr. Shira Miller, PIC founder and president. "If a doctor doesn't know the true risk of serious harm from measles and doesn't know that effective measles treatments are available, how can he or she determine which children are more at-risk of vaccine injury than being harmed by a measles infection?"

One of the risks of the MMR vaccine is seizure, which occurs in up to 1 in 641 vaccinated children, 1 in 252 vaccinated siblings of children with a history of febrile seizures, and 1 in 51 vaccinated children with a personal history of febrile seizures;[11] with 5% of febrile seizures resulting in epilepsy.[12] Furthermore, a review of more than 60 MMR vaccine studies conducted for the Cochrane Library states, "The design and reporting of safety outcomes in MMR vaccine studies, both pre- and post-marketing, are largely inadequate."[13]

"There are more ethical solutions to the rare complications that occur from measles in the United States than banning physicians from making personalized vaccine recommendations for their patients," said Dr. Miller.

Physicians for Informed Consent is a nationally recognized 501(c)(3) nonprofit educational organization representing doctors and scientists whose mission is to safeguard informed consent in vaccination. In addition, PIC's Coalition for Informed Consent consists of more than 150 U.S. and international organizations. Visit **physiciansforinformedconsent.org** for more information/references.

Magda Taylor

Editor's note

BUSY TIMES INDEED!

Following on from my last editorial the push for more and more vaccines, threats of mandatory vaccines, and strategies to convince any 'vaccine-hesitant' parents, continue to be broadcast via mainstream channels. More and more emphasis is on vaccine acceptance. Exaggerating the dangers of, for example, measles, blaming outbreaks on the unvaccinated, along with silencing or censorship strategies by the media.

The Salzburg Statement of Vaccination Acceptance (July 2019) from concerned scientists, public health professionals, physicians, and child health advocates issued this in collaboration with the International Working Group on Vaccination and Public Health Solutions, proclaiming their unwavering commitment to universal childhood vaccination, and their pledge to support the development, testing, implementation, and evaluation of new, effective, and fact-based communication programs. (TiP Editor: Even though I personally view vaccination as having no benefits for health and with potential dangers it would have been far more preferable if they had used the word vaccination instead of communication in the previous sentence!)

Those involved are committed to:

• Support laws that mandate childhood vaccination, when they are likely to improve the public's health, and to support more systematic qualitative and quantitative research on behavioural and social determinants of vaccination integrated with long-term, evidence-based communication programs that will build vaccine literacy in support of these laws.

• Widely disseminate reliable, accurate vaccine information in plain language through mass and social media, and delivered by trusted sources at all levels of society, including celebrities, faith-based leaders and parents.

• Promote "community protection" in public health law and communications to reinforce the equivalence of vaccination with other essential public services like law enforcement, firefighting and sanitation and restore broad societal trust in vaccination as a foundation of public health progress.

This kind of rhetoric should send a shiver down everyone's spine. These 'established' bodies are openly attempting to take away your freedom of choice. There is NO indication of independent study, debate or investigating concerns or first hand experiences from questioning parents and academics worldwide.

On 21 July The Guardian published an article 'Anti-extremism software to be used to tackle vaccine disinformation' which opens: "Technology used to counter violent messages online from Islamic State and the far right is being adapted to counter the spread of "anti-vax" conspiracy theories."

Further in the piece it reports: 'While its founders expect a focus on extremism to always be at its heart, most recently it has been examining how to adapt the model to respond to what it described as "other destructive communities online" such as those spreading anti-vaccination theories, those involved in human trafficking, and people who are vulnerable to gang violence.' Clubbing vaccine-concerned parents with issues such as human trafficking and the likes is totally unacceptable. Having recently read Orwell's '1984' it has become very apparent to me that either he had a very reliable crystal ball or he had been made aware of the future plans for humanity.

Back in May the BMJ published an editorial: ***'Information wars: tackling the threat from disinformation on vaccines'*** *which the authors end by stating:*

'Those involved in the battle against infectious disease understand that they must always strive to be one step ahead of constantly evolving microorganisms. Exactly the same principle applies in what is now a rapidly evolving information environment.'

I had 2 Rapid Responses published in response to this article, which can be viewed online. Here is my second one published on 19 May 2019:

'In response to William Flynn: I would suggest he questions why there have always been concerns surrounding vaccination, since its inception? If a procedure is very effective and very safe then it will, most certainly, be whole-heartedly accepted by the public. This has never been the case as regards to vaccination due to the array of vaccine injuries or deaths and also the vast numbers of vaccinated who go on to develop the disease they were supposedly protected from.

Those of us who have spent years studying this subject are deeply concerned about the mainstream media coverage and statements made by medical doctors or public health officials, which generally go unchallenged due to heavy bias. The recent censorship on this matter has increased, and even if a voice of concern is invited to participate on a broadcast or programme the amount of time they are given is usually minuscule compared to the health professional.

Regarding 'emotional' social media comments I have observed, and also experienced, numerous times that it is generally the individuals who are calmly questioning or raising concerns about vaccination that are met with over-emotional and often hostile and aggressive verbal attack. In particular by those with limited knowledge on the subject that have been misled by mainstream media, or even mainstream medical education, to fearfully

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look upon the unvaccinated as spreading disease.

In the 28 years I have been involved in the subject I have met or corresponded with numerous health professionals who would have shared the same opinion as William Flynn initially. Why did their position change? They took on the task of INDEPENDENTLY studying the wide range of vaccine literature and data over the last two centuries.
They started to listen to the concerns of their patients.
They started to consider the anecdotal evidence.
Some even started to study health.

Yes, I thoroughly agree mainstream media should be held to higher standards when reporting or sharing health-related content as their support adds great weight to its claims. A proactive rather than reactive approach is needed to help protect the public from the ever-increasing health disasters that are occurring now and will worsen if one of the potential causes continues to be protected from independent investigation.'

There have been a number of Rapid Response debates in the BMJ over the last few months and it is good to see that the BMJ are still publishing many good and challenging responses. I do hope this will continue!

The invitations for radio or TV interviews have lessened greatly over the last couple of months. A recent proposed interview on BBC London TV news was cancelled – however this was not unexpected as I have experienced this many times over the years. The enthusiastic researcher is given the cold shoulder from their producer and the item is dropped. The epidemic of censorship is rife!

If you value your freedom of choice in medical matters please become more active. A conversation or two with friends and family may trigger their curiosity. Or organise a talk in your area or even in your front room.
Please get in touch for more details.

Due to more people waking up on this serious subject the industry-led health departments, medical establishment and media are flooding the trusting public with propaganda and more and more mandates. We all need to get involved in any way we can – however small.

Stay healthy, stay strong and calmly state your case.

Magdalene Taylor, Editor, July 2019

A QUESTION OF DISEASE EPIDEMICS

BY DON HOUSTON

Don Houston BSc, and parent, started to look into the subject due to the doctors being unable to give any answers to health problems his children had. Don started to look into it himself and just about everything he discovered led back to vaccines. The following text is Don's response to a question he was asked by one person:
'*When an epidemic or outbreak is in progress, what is it that stops it in it's tracks? Your explanation would answer the question if I were talking about what has stopped epidemics from occurring but I am asking what was it that caused each passed epidemic to stop when they did?*'

Don's response: Can't say there are many examples of an outbreak coming to a sudden stop, rather they tend to peter out as the conditions that favour the outbreak abate. Perhaps the closest example would be the plague in 1666 ending suddenly in England. By 1666 the plague was pretty close to fading out naturally so by then it had become basically a disease of London, capital of filth, overcrowding, poverty and rats. What it wasn't was well designed, especially for fire control so when a fire started it spread to the other side of the wall and lit up the neighbouring home and again, and again until it was totally out of control. The street burnt, the next street burnt and so it went until most of London had suffered a serious case of urban redevelopment. With enough roast rats for a feast.

The houses were gone, the filth was gone, the rats were gone and so too was the plague. Never to be seen again, except as sporadic cases here and there. And this brings up another factor of disease. Epidemic diseases have a natural life, like an organism, they come, ravage the land for some time then fade naturally and eventually disappear. By the time of the great fire, the plague in Britain was fading away naturally leaving London as the last repository of this disease with the fire wiping out the animal vector, the rat.

SO WHAT MAKES DISEASES BECOME EPIDEMIC AND WHY DO THEY JUST DISAPPEAR?

Disease comes from within the body, not from the outside as modern medicine believes. Basically disease is a product of malnutrition and toxicity, both of which were in abundant supply in times past when disease ruled. For students of disease epidemics and dynamics outbreak years can be predicted simply with some knowledge of agriculture, a year of poor crops is followed by disease outbreaks thus demonstrating the nutrition link.

YOU CAN BE NUTRITIONALLY DEFICIENT AND STILL REMAIN HEALTHY, UNTIL...

Disease is the result of several factors working together to overwhelm your body and drive it into a disease state. Stress is a very significant factor in disease, add stress to an already stressed body and it becomes too much to manage. An excellent example of this is influenza. It is a disease of winter because to develop influenza you must first be seriously deficient in vitamin D. Then all it takes is a stressor to trigger the development of disease, influenza, such as a cold weather front move across bringing cold, rain or snow. In these days of disease fearogenesis and paranoia you can see the effects as news reports begin reporting the outbreaks of ›

influenza within 24 hours.

So in this case the factors associated with the disease is nutritional deficiency, vitamin D and something that adds stress to an already stressed body. Developing influenza requires the precursor condition of vitamin D deficiency but how serious you develop the disease is dependent on vitamin C levels. Vitamin C is a universal detoxifying agent, it has the capability of clearing most toxins and viruses from the body. Very few viruses can even get established if you have adequate intake of vitamin C and if you do develop a virus-mediated disease, like influenza, then a large dose is generally adequate to clear the infection in as little as two hours.

Basically disease has been part of the human condition for several thousand years, primarily it is in centres of civilisation (cities), centres of crowding, poverty and filth, places where conditions favour disease. We have largely created epidemic disease as a product of our civilisation, particularly urbanisation and so it has been basically unchanged since Roman times.

History tells us that disease has dominated human civilisation because of the ignorance of medical treatment and ideas of times past. This is not quite so, disease conditions have been constantly changing, changes in rule from despotic to reasonable, each bringing its own societal conditions. However the one that that has remained constant is food. Periods of good food tend to be marked by good health, conversely periods of poor crops, famine, poverty are always punctuated with rampant disease. Thus in the past general health has been very much associated with agriculture, not advances in medicine but the advent of the industrial revolution brought changes that have had great impact on overall health.

Industrialisation brought its own problems that for over a hundred years added to the disease load; pollution and coal replacing wood in the home. Poorly designed and constructed dwellings lead to inefficient heating complete with excessive use of timber for heating with its tendency, due to poor chimney design, to fill the home with smoke, an added stressor to add to rampant poverty and concomitant poor food. Industrialisation brought cheap coal to replace wood but unknown then was that coal had vastly higher amounts of toxic contaminants in its smoke. Coal fires in the home was, for over a century, a major factor in disease, mortality and morbidity.

Places like London stank so badly that on several occasions parliament was closed due to the stench. That should give some idea of living conditions, not pleasant. Combined with severe overcrowding (notable after about 1840 with rail and rapid urbanisation) disease of this time is not hard to link to living conditions ie: food that often was rancid by the time it got to market, overcrowding and foul air from coal for all heating and cooking in home, and pollution from the growing factories. What is truly amazing about this time is the number of healthy people despite the conditions. Disease, under these conditions, is only to be expected.

"If you source genuine, official data from this time the story they tell is contrary to modern interpretations, medicine had no impact on disease, ever."

If you source genuine, official data from this time the story they tell is contrary to modern interpretations, medicine had no impact on disease, ever. Vaccines ushered in a period of massive smallpox epidemics, especially following mandatory vaccination, a disaster of monumental proportions. Antibiotics came into widespread use around 1945 to cause absolutely no change in death rates anywhere. Antibiotics do appear to definitely save many lives but there is the other side, for every life saved by antibiotics is balanced by one taken as a direct result of antibiotic toxicity or unexpected effects on the body.

So we find that the real death of disease is quite mundane and unglamorous, sanitation, sewerage, clean water supply, transport so food gets to market before going rotten, electricity (refrigeration, washing machines, vacuum cleaners) and industrialisation.

Industrialisation has brought us ever-bigger machines to apply to all industries, including farming. Machines that do in one day what a hundred men with the biggest of plough horses would need a week to do. More food through more reliable produced has rendered outbreak years largely a thing of the past.

Today disease is mostly a product of modern, scientific, evidence based medicine and massive industrialisation and the toxic environment that it creates. More recently, and increasingly damaging, communications through electromagnetic pollution saturating our environment.

ELECTRICITY, THE IGNORED FACTOR OF DISEASE

Electromagnetic radiation needs no vector to carry disease, no seed to alter the body mileau in favour of a disease state. Electromagnetic radiation will find you no matter where you may hide and the effect it has on the body is very much like that of disease organisms.

So with disease we need nutritional deficiency to leave the body in a state of compromise, weakened and thus susceptible, a trigger factor, a stressor that hits the body with added stress to switch it over to favour disease and you get sick.

Disease organisms do not directly cause disease but they can trigger it in susceptible people, just like a stress factor. Viruses have an electrical field, a signal that has the potential to trigger antibodies or other sensitive biological molecules. Once the right molecules have been triggered they pass on the signal to other cells via surface proteins/antibodies, which initiates immune cascades which lead to inflammation, altered blood vessel permeability, migration of leucocytes, elevation in temperature, in short your immune system has created the symptoms of disease. At this stage no actual germ is needed, the immune reaction can be self-sustaining. In fact, in a susceptible person with sufficient sensitivity all they need for disease to develop is to come close enough to the triggering agent to detect its specific electrical signal.

This is an area almost totally ignored in modern medicine but there is evidence for such a system to exist,

crystals and how precipitation in a saturated solution can be triggered by a seed crystal or coming close to a crystal. This is an example of sympathetic resonance. Another is striking a tuning fork and bringing it close to a complementary tuning fork. The still tuning fork will soon start resonating in concert with the struck fork through sympathetic resonance.

In immunology studies into allergies have revealed people so sensitive that they do not need to come into contact with certain allergens, they only need to come into the presence of the allergen to react. Place the vial of allergen into an aluminium tube and no reaction but as soon as the vial is removed the patient reacts. The only feasible explanation is sympathetic resonance. The aluminium tube is a Faraday cage that prevents any electrical signals being transmitted beyond the cage.

In immunology there is a thing called specificity, one antigen, one complimentary antibody. The antigen and antibody are exact complimentary molecules, much like the tuning forks or the crystals and as such have complimentary electrical resonances so can resonate simply by being in the same room. No contact is required.

This principle applies to disease states as well. During an epidemic disease can be spread by sympathetic resonance, not just direct contact. This is a factor not well known but with plenty of indirect evidence to show it may exist. Rupert Sheldrake has investigated this concept in a paper, 'A New Science of Life' and a book of the same name, but his findings and evidence are mostly ignored by mainstream medicine and science. Which is a pity as his theories explain much that those who scorn him cannot, and a better understanding of electrophysiology would be of immense use in treating disease conditions. We do have some pretence at electric therapy, such as, tens machines, magnetic mats, electric pain treatment so even though electrophysiology is mostly ignored obviously enough is known to make money out of electrical and magnetic based therapies.

Bacteria are very much opportunistic and can live happily outside host cells. To have adverse effects bacteria must find favourable conditions in which they can multiply unrestricted. Bacteria produce some very nasty toxins as internal components that are released when the bacteria die (like tetanus toxin, botulinis toxin) or as exudates either to digest food substrate externally or as capsular glycoproteins (eg, salmonella poisoning/typhoid). The bacteria are not actively pathogenic but opportunistic pathogens. They live quite happily on and in us all the time but only cause disease when there is a breakdown in health leading to some sort of bodily malfunction that changes the body mileau in favour of the bacteria. This often results in massive increase in available food for the bacteria and massive overgrowth of bacteria as a result. Then you get overloaded with toxic by-products of bacterial proliferation which makes you sick through poisoning.

"Epidemics arise with widespread stress situations, insufficient food due to crop failure, environmental events such as flooding, snow, earthquake and such like."

Factors conducive to active infection is inflammation of mucus membranes, physical damage to tissues, nutritional deficiencies weakening tissues sufficiently to result in some degree of breakdown, stress (stress is a huge factor in disease promotion), and poisoning/toxic effects. All these things can lead to exudation of serum, free food time for bacteria due to inflammation. Bacteria are opportunistic, not invasive.

Epidemics arise with widespread stress situations, insufficient food due to crop failure, environmental events such as flooding, snow, earthquake and such like. This causes a common stress factor affecting many people. Being in a situation common to many people when disease breaks out it will be mostly the same disease across most affected people. Similar disease conditions result in similar disease so we get a significant number of people developing the same symptoms, the same disease. We do not actually need a germ for this to happen. Anton Bechamp discovered something he called mycrozymas in pretty much all things and discovered that in response to disease states in the body will develop into bacteria in accordance with the affected tissue.

Bechamp's theories fit observed fact far better than Pasteur's germ theory and explain disease outbreaks where medical explanations tend to fail.

In an outbreak situation we have a widespread disease promoter, such as famine or natural disaster with excess of contaminated water, sympathetic resonance and mycrozymas that together will initiate very rapid disease generation and spread. Far faster than person to person transmission can happen. Reversal of outbreak is generally not as rapid or easily achieved as the initial propagation of disease but basically what is required is to reverse the base cause of disease. For famine that is food, for natural disaster that is cleaning up the mess and establishing sources of clean water and adequate food. Once this is done then the outbreak situation generally clears up quickly.

In all this germs actually have very little, if anything, to do with causing an outbreak. That requires stress to the body that leaves it in a weakened state and thus open to developing, not catching, disease. Ending an epidemic requires an understanding of the underlying causes of disease and removing or reversing them. Vaccines do not work so will have no effect on ameliorating disease at all (been demonstrated several times), instead vaccines are another serious stress factor that is more likely to affect your body in favour of disease. Antibiotics have limited benefit as they come with their own dangers so should only be used sparingly and with thought as an adjunct to treating disease rather than the mainstay (only) treatment.

Understand the basic underlying causes of disease and you will know how to prevent outbreak situations and how to treat disease if it should manage to get established. This was known to the ancient Greek philosophers - good food, clean water and clean air. Nothing has changed since then, we still need good food, clean water and clean air as a foundation for health.

Magic in Immunization by Patrick Quanten MD

MISDIRECTION, manipulating the spectator away from the cause of a magic effect, is widely considered a central element of the practice of magic, but it is much more widely used than that. Misdirection is a principle element in the art of deception. Misdirection is sometimes defined "as the intentional deflection of attention for the purpose of disguise". As such, it would encompass anything that prevents you from noticing the secret method. It has also been suggested that misdirection is not simply about directing attention away from the cause of a magic effect, but toward something interesting, which again prevents the spectator from noticing the method.

Whilst some misdirection principles involve manipulating what people pay attention to, real misdirection deceives not only the eye of the spectator, but his mind as well. More precisely, successful misdirection might manipulate not only people's perceptions, but their memory for what happened, or their reasoning about how the effect was created.

If, however, people become aware of the misdirection, the impossible becomes possible, and the magic disappears. So that needs to be avoided at all cost.

Whilst central to magic, misdirection is also used in many other domains. Politicians are often accused of misdirecting the attention of the public away from bad news, and military generals occasionally use misdirection to gain advantage over their enemies. Although misdirection is not used in these examples to create a magical effect, many of the principles are the same, and that is mainly making sure that there is no awareness of the misdirection itself.

Besides the physical misdirection there is also the psychological misdirection used in all parts of life. Broadly speaking, there are three categories of misdirection.

Patrick Quanten MD

"Maybe by taking a back seat and shining a different light on the performance we can unveil a few of the misdirection procedures used by our governments."

1. Perceptual misdirection.
This refers to misdirection that manipulates the perception of an event.
• Attentional misdirection: focus - what you are attending to timing - when you pay attention resources - how much attention is given.
• Non-attentional misdirection: masking - no perception because of an occluder grouping - no perception because of blending.

2. Memory misdirection.
• Forgetting: delay – after some time we forget about many details confusion - complexity makes us forget many details distinctiveness - less distinctive makes us forget it.
• Misremembering: recollection - remembered as a similar event suggestion – influence the content of a memory time lap increase between encoding and retrieval - makes misremembering more likely.

3. Reasoning misdirection.
• Ruse: an action that misdirects the spectator's reasoning as to why an action was carried out.
• Feigning actions: pretending to do one thing when in fact he does something entirely different false transfer – things are perceived as being present even when they no longer are convincers – using additional effects to support the observational error.
• Wrong assumptions: pre-existing assumptions can be manipulated and exploited.

You don't have to pay money to go and see a magic show. In the media there are magic shows going on all the time, for free. At least it is free to watch but you will be fooled and you will pay, sometimes even with your life. Let's focus our attention on the magic of immunization and how the tricks learned at the School of Magic are employed to entertain us. Maybe by taking a back seat and shining a different light on the performance we can unveil a few of the misdirection procedures used by our governments.

First of all, it is good to remember that everything is done for a purpose. So, even if the real reason is hidden or is presented as being something else rest assured that there is a serious purpose behind every move and every word.

In the story of how infections spread from one organism to another via air, water or direct contact, we are shown that the incriminated germ is present in the diseased tissues of two separate organisms. Now you see it here, and then you see it there. It is made out to look as if the germ is somehow magically transferred from one totally separate enclosure to another, a bit like a coin being magically moved from one closed hand into another without touching. The magic lies in the fact that the germ is present in both separate tissues and that we are made to believe a transfer has taken place. Misdirection. Science has never proven a transfer of a germ from one organism to another. In fact, over the last two hundred years science has repeatedly shown that there is no transfer, that such a

transfer would be almost impossible to achieve and that there are, indeed, two identical germs present in two different organism at the same time. The coin does not transfer, the magician uses two coins and deception to make it look like there has been a transfer.

This has more recently been completely underpinned by the quantum theory where it was demonstrated that all matter lies at the centre of its own energy field and has originated from that field through the process of densification, compression of energy. The material organism therefore originates from the field, the environment, it is in. Hence, it belongs to the tissues it has been found in and only can be in that spot. No germ has ever been caught in the midst of a journey from one organism to another.

The theory that we are being attacked by an alien force that is set to destroy us has been perpetuated over two centuries and is still holding strong. Misdirection. This focuses your attention to the outside, away from the real cause of your health problem, the inside. It is the tissue becoming diseased that gives rise to occurrence of the germ and thus the reason why you become ill lies inside yourself, not outside. Science has established this two centuries ago and has reconfirmed it on many occasions since. Why would an authority be interested in misdirecting your attention? If the illness originates from the inside then it is pretty obvious that you are the only one who can heal it. If it comes from the outside you can be made to believe you will need protection. In the history of mankind we have, up till now, always believed that our troubles are caused by something on the outside. It is not difficult to deceive people in this way because it is something they want to believe. Nevertheless it is misdirection, exploiting a wrong assumption.

In order to find out whether your protection, in this case vaccination, is actually protecting you you could simply take note of the fact that there are people who have been fully vaccinated and still become ill with the disease they thought they had protection against. When that occurs you can simply conclude that either there is no protection at all or only limited protection, depending on how many cases you have observed. The medical profession measures protection in observing the changing effects vaccination has on certain proteins that they chemically isolate from a blood sample. They call it a measure of an immune response. They convince you that that shows you that you have protection. Misdirection. The magician tells you you are holding

Whilst some misdirection principles involve manipulating what people pay attention to, real misdirection deceives not only the eye of the spectator, but his mind as well.

Photo by Ashley Bean on Unsplash

a unique card in your hand whilst he knows that not to be true. The changed results in the laboratory test have not been proven to have any connection to your protection. In fact, life shows us that this is definitely not the case.

Since vaccination does not give you a 100% protection we are being told we need herd protection so the germ has nowhere to go and will disappear off the face of the earth. Misdirection. First of all, remember that you already have been misdirected about the germ moving from one individual to another. Secondly, don't you find it strange that the medical profession tells us that in order for the germ to be eradicated we need to achieve 95% vaccination rate?

This germ, apparently, does not know it can survive in 5% of the population. Again misdirection. Vaccinating everybody is going to ensure the extinction of the germ because it can no longer infect anybody. However, the reason we need herd immunity is because the vaccinations are not actually protecting the vaccinated. If it did, then people would not need to worry whether the germ was around or not because it would not affect their personal health at all.

Germs can lay dormant in your body, hidden away in undetectable places, for them to surface and attack you even decades later. Misdirection. The magician tells you the effect you are experiencing is due to a bite from a tick many many years ago. You start to believe it because it is said with authority. This is memory misdirection. You believe the germ must have been there all along because that is what you are being told. The proof they show you is not the germ that has come to life but only a change in laboratory results of some proteins in a blood sample.

Focusing on the ingredients of the vaccine is a misdirection too. After decades we are able to show the detrimental effects of one ingredient only to find out that the "act" has been changed and they are now using a different ingredient. Diversion of attention because science has long ago proven that there never is an immune response (a change in the laboratory results of certain proteins in a blood sample) unless there is a toxic substance present in the mix.

The naming of the diseases is a misdirection too. Whether it is called non-paralytic poliomyelitis or viral meningitis only aids to divert attention in a different direction whilst talking about the same thing. Not noting a disease as measles because it can't be measles in a vaccinated person is exploiting and manipulating a wrong assumption. Whether an action is called variolation, vaccination or immunization only adds to the confusion the authority needs in order to guide you away from the reality of what is happening, and to make you believe these are three different actions. The collection of statistical data is a misdirection because how you collect the data and in which category you put it is not what you say you are doing.


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Then the question arises as to why would a government put on this fantastic magic show for us? What are they gaining? What does the magician gain? When he performs we are mesmerised. We are in his power. He can make us believe anything he wants. It is the same thing that governments are after, power over us. The truth allows everybody to make up their own mind. Deception and misdirection puts the government in the driving seat. They have the power. And why would they need that power?

An authority only remains an authority for as long as their members see them as an authority. So, either they have to prove themselves to be an authority, time and time again, or they have to force their authority upon the members. It is up to you to decide how our politicians day in day out prove how they truly know what is best for us. If you feel they are failing that test, then wonder how on earth you are going to carry on seeing them as an authority and respect them as an authority? They make sure they remain in power by mesmerising you and deceiving you.

Now, obviously if an authority were to force their power onto you by ways of physical force, as has happened in the past, resistance against this enforcement would grow very quickly and visibly. People know these methods and reject them. We live in a developed society, I have you know!

But what if the government is able to wrench the freedom of choice, which they have handed to you as a great privilege, a present we should be humbly grateful for until our dying day, out of our trembling unsure hands? Which magic trick, which slide of hand are they going to use in order for us not to even notice that they are taking away from us the very thing they have given to us, the greatest gift ever? And it is a magic trick that does it for them. It is called deception, misdirection. It is simple. Make the audience look elsewhere and they won't see what you are actually doing. Hide the truth and they believe what you show them. Make them believe they have seen something or they know something.

Governments have known these tricks for a long time and use them regularly. Make a big deal out of

something quite small or innocent and you can pass legislation, take action, enforce laws, to your heart's content. And with all those small measures and "improvements" we really have lost sight of what is truly going on.

None of these measures are important to us, whether they do or they don't make our lives better, safer, more prosperous. The real reason lies hidden behind the rhetoric that diverts our attention and behind the actions that fool us into believing in a particular outcome. We willingly hand back our independent mind.

We think it is perfectly fine for the government to know what I buy, which TV programmes I watch, what websites I visit, whom I talk to on the phone, what treatments I use, whom I vote for, and the list goes on into what we believe to be private areas of our life. Why are we okay with this? Because we feel threatened. By whom or by what? By something the government, an authority, tells us is threatening us. It is a stark warning and it is on your head if you ignore the warning, if and when it goes wrong. It might and it might not, but who is now going to take the risk? Better safe than sorry. Indeed, is there such a risk? And if so, how serious is it? Ask Tony Blair and the people in Iraq!

It always has been and still is the threat from the outside that binds us all together and that convinces us to hand over our mind, our thinking and our knowledge in exchange for protection. We are afraid, and only the magician knows how to avert the danger of the approaching chain saw.

The terrorist act has an equivalent in healthcare. When the Secretary of State believes the health of the nation to be threatened he can take any action he likes. He can do anything he believes to be of benefit to counteract the believed threat. The government can encourage everybody to get vaccinated because they believe the coming flu is going to be bad, or because they believe a measles epidemic is going to sweep the country.

Just as the war on Iraq could not be stopped by ten thousand people openly demonstrating they did not believe what the government was telling them, none of us can stop our government taking measures to "protect" us when they feel the need for it. This is not a scientific discussion. It should be but your attention is, once again, being misdirected. The government is not interested in finding out whether what the industry is saying is actually correct or not. All they are interested in is gaining more power over the population. Reducing the freedom of choice of the people, and preferably with the consent of the people, is the highway to power. The government is not taking it back forcibly. No, you are handing it to them willingly.

And that is the real challenge we are all facing, both as individuals and as a group. Arguing over who is right and who is wrong is not going to get us anywhere. Searching desperately for the truth in data and statistics is not going to get us anywhere. There is just one way forward and that is to stick with absolute scientific truth. A basic known fact is that every individual has his or her own truth. This is a direct consequence from the scientific fact that an observer influences the observed. The person who observes, the method that is being used to make a measurement, the circumstances surrounding the observation, all of it - and more than this - changes the results of the observation. In other words, the observation is dependent on the observer and the truth that an observer sees is dependent upon his or herself. So we all see things differently.

"The truth allows everybody to make up their own mind. Deception and misdirection puts the government in the driving seat. They have the power. And why would they need that power?"

Circumvent the entrenched discussions by altering the focus. No longer argue about whether something should be called variolation, vaccination or immunization. No longer argue about whether herd immunity is a fabrication of the medical authority or not.

No longer argue about whether statistics show that vaccination has lowered problems with infectious diseases or not. Instead of focussing on fighting fake news and arguing about what the truth actually is, go and ask your government to give you what they so proudly tell you they have provided you with. Liberty and Equality are the basic concepts of this magic show. Go and claim them instead of accepting what you are told they should look like.

I want the freedom to make up my own mind. And whether or not I make an approved decision is not a criteria for judging my choice. The only thing that matters is that it is a free choice, and allows me to implement my freedom of choice. Without the remark, as long as it doesn't harm or threaten to damage a fellow citizen. And right there you are violating my freedom of choice. At the same time it would also undermine the second demand I have.

All choices should be treated equally. There are no good or bad choices. Things are what they are, and it is simply our point of view, our personal reaction to the choices that deem it to be good or bad. Whether an election result is good or bad depends on your point of view. The actions of a person make that person a terrorist in certain eyes and a freedom fighter in others.

If intrinsically there is no difference between good and bad choices then we should treat them equally and allow them all to manifest.

Equality does not mean the same numbers or the same amount of money or the same chances. Equality means that if I have the opportunity to be myself and to express myself then everybody else has that same, equal, opportunity. What he does with that or how he expresses that is not up to me to demand. True equality allows individuals to be who they want to be and to do what they need to do.

In this magic show you have a free choice as long as you pick what the magician allows you to pick. It is up to the audience to stop the magic and to focus on truth and reality.

June 2019

WHO IS MOST LIKELY TO HAVE SIDE EFFECTS TO FLU VACCINATION?

BY RICHARD SMITH

March 13, 2019

thebmjopinion

A simple question that seems to be unanswered but should be answered, says Richard Smith. I don't think that I've ever had the flu, certainly nothing that affected me for more than a day, but last year I had the influenza vaccine for the first time. Three factors influenced me: two tough friends who had each for the first time spent a week in bed with the flu; the doctor telling my wife that she should have the vaccine "for the sake of others"; and an Australian critical care doctor telling me on Twitter that they had in their winter that precedes ours seen more severe cases of flu than usual. Unfortunately I developed flu-like symptoms within a few hours of my vaccination, leaving me wondering who is most likely to have side effects from the vaccine. Could it be that I was having it for the first time? Will I be likely to get them again if I'm vaccinated next year?

I have deliberately delayed in posting this blog because I don't want to put people off having the flu vaccine. The flu season is now largely over, and I have not had the flu. Indeed, I haven't had any illness at all since my flu vaccine. By the autumn when the time will come again for the influenza vaccine my blog will be forgotten and not discourage anybody for being vaccinated–but the research questions I'm posing will still be valid. I had both the influenza vaccine and the pneumococcal vaccine at the same time through the same needle in the morning. I hadn't gone to get the pneumococcal vaccine, but the nurse suggested that I have it as well. Immediately afterwards I cycled seven miles to and from a lunch with a friend on a delightful sunny day. We even ate our lunch out of doors, which is unusual for London in December. It wasn't until the evening when I began to shiver and feel cold. My arm was red, hard, and sore where I'd been vaccinated. I went to bed but slept badly, unable to sleep on the side vaccinated, and becoming feverish

Richard Smith

during the night. The next morning I felt grotty and looked up the symptoms of adverse effects from influenza vaccination on NHS Choices. The side effects are said to occur in between one in 10 and one in 100 people, so I'd been unlucky. The side effects includes headache, aching muscles or joints, fever, feeling generally unwell, sweating, shivering, fatigue, and pain, swelling, redness, bruising or at the injection site. I had a full house. None of the symptoms were severe, but they were enough to stop me having an effective day. I went to bed early, slept soundly, and the next morning I was fine. (Illogically I didn't when this happened look up the side effects of the pneumococcal vaccine, but I have now and they are similar and seem to be commoner.).

Perhaps in retrospect I reacted to it rather than the flu vaccine; and perhaps reactions are commoner if they are given together. That's another research question. Despite my illogicality I think that my suggestions for research still apply—and to the pneumococcal vaccine as well as the flu vaccine.) I wondered if I could find an answer to the simple question of "Who is most likely to experience adverse effects of influenza vaccination?" Might it be related to age, gender, having the vaccine for the first time, having reactions in the past, being pregnant, a history of not having the flu, or other factors? The first paper I found, from JAMA, seemed to conclude that there are no side effects; I had imagined them or, as my wife correctly pointed out, it might be coincidence that I had the vaccination and then symptoms from some other cause. That was hard for me to believe, but I knew that she could be right. Perhaps she was. The JAMA authors randomised 336 people to either the vaccine or placebo ***(Tip Editor: An important question to ask is what did the placebo group receive?)*** and found the same incidence of side effects in the two groups, suggesting that there were no side effects attributable to the vaccine. But if side effects occur only in, say, one in 20 or even fewer people the study is clearly underpowered (meaning there aren't enough people in the study to reach a confident conclusion).

Another study looked at the frequency of side effects in 816 people, of whom 650 (80%) responded to a telephone survey. About one in 20 reported fever, and one in 10 "disability." One in seven of those called after seven days reported a "flu-like illness" (although many of them without fever presumably) within two days of being vaccinated compared with one in 12 phoned after three weeks, suggesting that some of the people called later had not been much incapacitated or they would have remembered their flu-like symptoms. The overall conclusion is that: "These symptoms did not result in a decreased ability to perform usual daily activities." I would, I think, have struggled with my flu-like illness to go to work if I had to, even though in seven years at school I missed not a day and only two days in 25 years at The BMJ.

So I couldn't find an answer to my simple question of who was most likely to get side effects from influenza vaccination despite hundreds of millions being vaccinated every year. I was also left with the conclusion that researchers are much more interested in efficacy than side effects, which fits with the observation that adverse effects are poorly collected and poorly reported in randomised trials. Indeed, I found two systematic reviews of multiple trials of effectiveness. It's understandable that researchers, particularly those who develop vaccines, will be much more interested in efficacy than side effects,

particularly in the context of antivaccinationists making a tremendous amount of noise about mostly false adverse effects of vaccines. The researchers, who will rightly believe in the great effectiveness of vaccines, will not want people to be put off from being vaccinated. But patients are interested in both efficacy and side effects, and if they are to give genuinely informed consent they need high quality evidence on both. The nurse who vaccinated gave me no information at all (perhaps because she knew I was a doctor, and I didn't ask) and told my wife there were no side effects (perhaps she'd read the JAMA trial).

I'd like some young researcher to do a simple case control study to answer my question of who is most likely to have an adverse reaction to influenza vaccination.

Richard Smith was the editor of The BMJ until 2004.

A REVIEW OF FACTORS AFFECTING VACCINE PREVENTABLE DISEASE IN JAPAN

KUWABARA N, CHING MS
Hawaii J Med Public Health.
2014 Dec;73(12):376-81
6 Oct 2015 https://www.today.com/health/secrets-worlds-healthiest-children-6-longevity-lessons-japan-t48251

ABSTRACT

Japan is well known as a country with a strong health record. However its incidence rates of vaccine preventable diseases (VPD) such as hepatitis B, measles, mumps, rubella, and varicella remain higher than other developed countries. This article reviews the factors that contribute to the high rates of VPD in Japan. These include historical and political factors that delayed the introduction of several important vaccines until recently. Access has also been affected by vaccines being divided into government-funded "routine" (eg, polio, pertussis) and self-pay "voluntary" groups (eg, hepatitis A and B). Routine vaccines have higher rates of administration than voluntary vaccines. Administration factors include differences in well-child care schedules, the approach to simultaneous vaccination, vaccination contraindication due to fever, and vaccination spacing.

Parental factors include low intention to fully vaccinate their children and misperceptions about side effects and efficacy. There are also provider knowledge gaps regarding indications, adverse effects, interval, and simultaneous vaccination. These multifactorial issues combine to produce lower population immunization rates and a higher incidence of VPD than other developed countries. This article will provide insight into the current situation of Japanese vaccinations, the issues to be addressed and suggestions for public health promotion.
PMID: 25628969

TiP Editor: Japan has the highest "healthy life expectancy" in the world, with Japanese boys and girls expected to live to 73 without any major illness or disability, according to a recent study published in The Lancet. Their overall life expectancy is in the 80s.

And yet the paper above is concerned that they have a poor vaccination uptake and they are looking at ways of increasing the uptake? Perhaps they should consider that the lower vaccination uptake may be a factor in why they have better health than the highly vaccinated developed countries? But that would be too obvious!

UN AGENDA 2030: ADULT VACCINATIONS AS A PUBLIC HEALTH INTEREST FOR HEALTHY AGEING

BY C. STUEN, J. BARRATT, K. BLUESTONE, AND E. DHAR
Innov Aging. 2017 Jul; 1(Suppl 1): 407.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6244389/
30 June 2017

ABSTRACT

The United Nations adopted a 15 year Sustainable Development Agenda for 2016–2030 (Agenda 2030).

The prior agenda, known as the Millennium Development Goals, made no reference to older persons, however a Stakeholder Group on Ageing advocated so that Agenda 2030 has an overarching principle of "leaving no one behind."

There are 17 Goals and 169 Targets and accompanying indicators that contain specific and implied references to older persons. Specific attention will be given to Goal 3 of Agenda 2030-" to ensure healthy lives and promote wellbeing for all at all ages."

The implementation of one of its targets such as "Achieve universal health coverage...access to safe, effective, quality, and affordable, essential medicines and vaccines for all" provides a global opportunity to develop and seek ways to promote healthy ageing including adult vaccinations. Research has shown that adult immunizations can drive healthy ageing initiatives however obstacles still remain to successful implementation.

This poster presents the opportunities and strategies to convince policymakers to adopt a lifecourse approach to healthy ageing including adult immunizations. The Stakeholder Group on Ageing members from across the globe will identify programmes to influence policies on ways to promote healthy ageing and reablement in this poster.

TiP Editor: Whatever age we are we're all potential targets!

"NOTHING IS MORE FATAL TO HEALTH, THAN AN OVER CARE OF IT."
~ BENJAMIN FRANKLIN.

FOCUSING ON RUBELLA & CHICKEN POX

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

Following on from Dr Donegan's articles in the last 2 editions of the newsletter - this article looks at rubella and chickenpox.
All references for the complete text are available by request from The Informed Parent.

DR Jayne L.M.Donegan

RUBELLA: GERMAN MEASLES

Normal course of the disease
Incubation Period: 14-28 days, usually 18 days.
'Infectious': 1 day before symptoms to 10 days after all swelling gone (minimum 14 days)
Symptoms:
Rubella is one of the mildest of the infectious childhood fevers. Up to 50% of infections may be subclinical or inapparent.
It was known as '3 DAY MEASLES'
Day 1 The rash consists of pink macules (flat) and papules (raised) starting on the forehead and spreading to the face, trunk and extremities
Day 2 The rash fades from the face.
Day 3 The rash fades from the rest of the body.
There may be small red spots on the roof of the mouth.

In young children: the rash is usually the first sign of being unwell but there may be swollen glands with no rash. The glands are classically at the back of the neck – suboccipital.
In older children & adults: there may be two stages:
1st stage: Prodrome 1-5 days of low fever, tiredness, weakness, swollen glands, cough, then a rise in temperature to produce the
2nd Stage: Rash Adults are more prone to swollen joints and joint pain, as with the vaccine.

WHAT DO YOU DO?

Generally, nothing much. More than 50% have no symptoms anyway
General Measures and **Fluids**.
Fluids will sort out >95%
Simple Homeopathic Treatment of Fever will probably do the rest.

Homeopathic Specifics
Rubella 30c is the nosode. I would just leave it. It is unnecessary in this context.

Rubella – German Measles is a **Togavirus** of the genus **Rubivirus**.
One episode of rubella confers immunity in about 90% of cases.
Spread is by direct contact with mucus from people's noses or coughs or via the respiratory route from breathing in droplets in the air from coughs, splutters and sneezes. Rubella used to be most frequent in 5-9 year olds but since the rubella vaccine was introduced in 1971 in the UK the number of cases in teenagers has risen, as have cases in 12-15 month olds and preschoolers. Of these cases the proportion occurring in 15-24 year olds is much greater.

COMPLICATIONS

Complications occur when the normal course of the disease – externalisation – is blocked so invasive disease occurs.

Make sure you attend to THE BASICS (TiP Issue 3 - 2018) to stop this happening.
Arthritis - swollen or painful joints as above, which also occur with the vaccine, particularly in adults.
Idiopathic Thrombocytopenic Purpura (ITP) - when the platelet levels drop and bruising starts to appear in the skin. It is very rare. The incidence given for ITP in the Immunisation against Infectious Diseases Handbook, UK, is one per 3000 cases of rubella. However, these figures are from hospitalised cases of rubella in the 1930's. As >50% of cases of rubella cases have no symptoms, and of those that do, rubella is still described as the 'mildest of all exanthems', those admitted to hospital with a diagnosis of rubella must have been a very small fraction of total cases, and they must have been pretty badly managed or lived in dire social circumstances to get that ill - and even of these hospitalised cases, only one in 3000 had ITP.

ITP can also be caused by the rubella and MMR vaccines.

Congenital Rubella Syndrome (CRS)
The importance of Rubella infection is due to the fact that if you get it for the first time when you are in the early stages of pregnancy, because you did not get it as a child or because you were vaccinated and the vaccine immunity has worn off, your unborn child may develop Congenital Rubella Syndrome. This comprises:
• Heart defects
• Blindness
• Deafness
Norman McAlister Gregg Australian ophthalmologist noticed a series of babies with cataracts who were difficult for anaesthetists to anaesthetise because of heart problems. He heard many of their mothers in the waiting room talking to each other about having had rashes or rubella when they were pregnant. He was clever enough to link these together. However when he published his findings in 1941 [27], he was laughed at, especially outside of Australia, as he was
a) from the other side of the world and
b) not an infectious disease doctor, so how would he know?

We see this time and time again in science, people who make astute observations, being dismissed because they are not part of whatever is regarded as the conventional view.

In 1947 a U.S. consultant in Infectious Diseases, Dr Conrad Wesselhoeft, published a review of the disease, but it was not until 20 years later in 1961, when the virus was identified in a lab, that Gregg received the universal recognition he deserved.

What happens if you get rubella in pregnancy because you are not immune?

A study carried out in the UK and published in 1982 looked at more than 1000 pregnant women with confirmed rubella infection [28]. 40% of women elected to continue with their pregnancy.

The frequency of congenital infection (not rubella syndrome) after maternal rubella with a rash was:

- >80% in first 12 weeks of pregnancy
- 54% at 13-14 weeks
- 25% at the end of the second trimester.

The **infection** rate then rose again to reach a high figure in the last month.
Defects attributable to **congenital rubella syndrome** occurred in:

- 100% infants infected before the 11th week (principally congenital heart disease and deafness)
- 35% infants infected at 13-16 weeks (deafness alone).
- **0% infants infected after 16 weeks** (63 children)

So 16 weeks from the date of the last menstrual period is the risk period.
Has Rubella vaccine made any difference to CRS? It is hard to know.

There was **no national surveilance for CRS** before rubella vaccine was introduced in the UK in 1971. The data we have, relied on spontaneous reports by paediatricians and, there was **no requirement for serological diagnosis**: a blood test to check that the baby did, indeed, have rubella. Rather, any baby born with an abnormality whose mother was asked, "Did you have a rash in pregnancy?" and replied, "Yes," was counted as a baby with CRS.

That it is notoriously difficult to diagnose rubella in the absence of a blood test was shown by Dr Sidney Kibrick of Boston Medical School as early in 1964. He listed ten other causes for such a rash which were known even then..... measles, scarlet fever, roseola infantum/ 6th disease (HHV6&7), Erythema infectiosum/ slapped cheek syndrome/ 5th disease (parvovirus, erythrovirus), infectious mononucleosis, drug sensitivity, enteroviruses, reoviruses (including rotavirus), respiratory syncytial virus.
So not surprising that:

- In the 5 years before rubella vaccine was introduced, there were 39 cases of CRS reported, relying on haphazard voluntary reporting,
- In the 10 years after rubella vaccine was introduced there were 454 cases, relying also on passive reporting and without serological diagnosis.
- 1980-89 330 cases
- Only in the 10 years after 1990 did the cases reported drop to 46. These were said to be mainly due to mothers being born or acquiring the disease abroad, plus 60 rubella-associated abortions.
- 12 of these cases were reported in 1996, 8 born and raised in the UK so eligible for the school girl rubella vaccination programme.

It is not said that they were unvaccinated. CRS data are to a large extent meaningless as before serological diagnosis was required, it is not known how many cases were actually due to rubella infection. After serological diagnosis was used, this would automatically reduce number of cases as much of what was called CRS might not have actually been due to rubella in the first place and would inflate what appeared to be the effect of the vaccine.

"We see this time and time again in science, people who make astute observations, being dismissed because they are not part of whatever is regarded as the conventional view."

Cases are said to be acquired from abroad, because vaccinated women are believed to be protected. However, with a maximum MMR uptake of 90% and 500-700 thousand babies born annually in England & Wales over this time, if 10% are not vaccinated it means there are over one million not vaccinated over 20 years, over one and a half million over 30 years.

Where are all the cases of CRS occurring in this population?
If they were protected by 'herd immunity', this would protect the mothers born abroad as well.

There must be some additional factors in operation.

WHAT HAS HAPPENED TO RUBELLA THE DISEASE SINCE THE VACCINE WAS INTRODUCED?

1980: "Since licensure of rubella vaccine in 1969, policy in the United States has emphasized immunization of pre-pubertal children beginning at 12-15 months of age. Although this approach has resulted in a 70 per cent reduction in rates of reported rubella, most of the reduction has occurred in children younger than 15 years of age, with **little change in the attack rate for persons 15 years and older. Over 70 per cent of all reported cases now occur in this age group [29].**

This is exactly the time that women need to be protected, and would have been had they had rubella the disease.
2012: "More than 90% of vaccinated persons have protection against both clinical rubella and viremia [virus in the blood] for at least 15 years……."

"Several reports indicate that viremic reinfection following exposure **may occur in vaccinated persons who have low levels of detectable antibody.** The frequency and consequences of this phenomenon are unknown, but it is believed to be uncommon. **Rarely, clinical reinfection and fetal infection have been reported among women with vaccine-induced immunity. Rare cases of CRS have occurred among infants born to women who had documented serologic evidence of rubella immunity before they became pregnant."**[30]

What does this mean? It means that congenital rubella syndrome is very rare. You can have a baby with CRS even if you have been vaccinated. The vaccination campaign first aimed at teenage girls and now administered in a minimum of two MMR vaccines in childhood has pushed rubella disease into adulthood, exactly the same as with mumps and measles, the time when it is most problematic both in terms of symptoms - arthritis - and congenital rubella syndrome.

"Small amounts of rubella vaccine virus are detected in the noses or throats of most rubella susceptible persons 7 to 28 days post-vaccination,

No documented confirmed cases of transmission of rubella vaccine virus have been reported." [31]

- To document it, you would have to look for it. How much has this been looked for? Not much.

What is the answer? I do not know.
1. Looking at the evidence, I think the best option is for your daughter to get rubella in childhood. Antibodies from neither vaccination or infection are guarantees of immunity, though those from natural immunisation (getting the disease) are better quality and longer lasting – remember, antibodies are not the whole story.
Vaccinating in childhood almost guarantees that any vaccine-derived immunity will have worn off by the time your daughter is likely to become pregnant.
2. Keep pregnant women away from **vaccinated children** who are excreting the virus!
3. Something to think about: The Cochrane Collaboration, which until recently, was regarded as the worldwide gold standard in unbiased and objective reviews of medical evidence, stated in their 2012 review of MMR vaccine:

"We did not identify any studies assessing the effectiveness of MMR vaccine in preventing rubella." [32]

Advantages of getting rubella as a child
You don't get it for the first time when you are pregnant.

CHICKEN POX: VARICELLA-ZOSTER

Normal course of the disease
Incubation Period: 10-21 days, usually 18 days.
'Infectious': 2 days before rash until the last vesicle scabs over.
Symptoms: The rash starts off as small raised bumps on the face and scalp that you might not notice. Then the vesicle forms on top, then dries up and crusts, sometimes there is a bit of pus before this happens. The rash then spreads to the trunk, arms and legs. The vesicles heal without scarring if your child does not scratch them, this is difficult to achieve.

WHAT DO YOU DO?

General Measures and **Fluids**.
Fluids.
Simple Homeopathic Treatment of Fever
Specifics:

For itching - a lukewarm bath with a cup of bicarbonate of soda – pat dry +/- run bath water through oats in nylon stocking and a pot of chamomile tea poured in the water (also good for drinking). I do not advise calamine lotion as it is alcohol based and once it has evaporated, it just leaves an itchy powder. If you want to use calamine use Calamine Cream BP. It is best to leave the spots uncovered.

Homeopathic Specifics:
Rhus toxicodendron 30c This is the only homeopathic remedy I have ever used in chickenpox (over and above THE BASICS TiP Issue 3 - 2018). Take 1 three times daily for 1-3 days. It helps the rash come out, the vesicles to scab over quicker, seems to reduce the duration of the disease.

"We did not identify any studies assessing the effectiveness of MMR vaccine in preventing rubella."
The Cochrane Collaboration

There are other remedies if the pustules become pus filled, very red and boil like or your child becomes unwell with a secondary bacterial infection. I have never seen this happen in any child who has had chicken pox managed with THE BASICS and Rhus tox.

NB Do **NOT** use ibuprofen/ NSAIDS (non steroidal anti-inflammatory drugs) in chicken pox because this has been associated with severe skin reactions.[1]

NB > 15 year olds and pregnant women: do not accept a prescription for antivirals. I have seen terrible complications occurring after this. (They are only currently offered to these categories of people.)

CHICKEN POX-VARICELLA -ZOSTER is a DNA virus of the herpes family. One episode of clinical or subclinical chicken pox confers lasting immunity and second attacks are most unusual. Spread is by fluid from the vesicles via the respiratory route from breathing in droplets in the air from coughs, splutters and sneezes.

COMPLICATIONS

Complications occur when the normal course of the disease – externalisation – is blocked so invasive disease occurs. Make sure you attend to THE BASICS (TiP Issue 3 - 2018) to stop this happening.

It is dangerous to get chicken pox when you are pregnant – you can get chicken pox pneumonia which can be fatal.

It is dangerous to get chicken pox as you are being born as this can lead to chicken pox encephalitis - which has a high fatality rate.

Get chicken pox when you are young. A vaccine will wear off, as does all vaccine-acquired immunity. Then you will get it when it is really dangerous.

Shingles - Herpes zoster
Natrum muriaticum 6x (tissue salt) 6x. One dose twice daily for 10 days is thought to reduce likelihood of persistence of the chicken pox virus which leads to shingles.

Advantages of getting chickenpox
Dr Jonathan Silverberg and team at the North Western School of Medicine, Chicago, found: "Wild type varicella zoster virus disease WTVZV (chickenpox) in childhood protects up to 10 years of age against atopic dermatitis (eczema) AD, delays onset of AD symptoms, and decreases AD severity and office visits."

'Nonspecific' Viral Rash
What is a 'nonspecific' viral rash?
A 'nonspecific' viral rash is what doctors call a rash when they don't know what it is.
• Sometimes this is because it does not have a classic pattern and symptoms like measles, mumps and chicken pox.
• Sometimes it is because of the location – if you are in Swansea in the middle of a measles outbreak, your child's rash will be called measles (one of the reasons that only about a third of such cases notified as measles are confirmed); if you are in London, it will be called a 'nonspecific' viral rash.
• Sometimes it is because we are just not very good at diagnosing rashes. Does it matter? No.
The treatment is the same for all of

them.
• General Measures and Fluids. Fluids. Fluids +/-
• Simple Homeopathic Treatment of Fever.

Some examples:
Hand, foot and mouth disease (HFMD) Has rash, sores, blisters on palms, soles, inside mouth. Spread, direct and by mucus, saliva, faeces. Triggered by coxsackievirus. Be sure to have good Vitamin A intake.
5th Disease Slapped Cheek Syndrome Erythema Infectiosum Half of children have no symptoms. Redness of face looks like child has been slapped, later a lacy rash on trunk arms and legs.
Triggered by Human Parvovirus B19 (DNA virus) DNA.
6th Disease Roseola infantum/ Exanthem subitum
There may be convulsions with the fever.
Triggered by Human Herpes Virus 6 (HHV6 / HHV7). The virus is shed throughout life in saliva.
Primary Herpes Simplex Infection May be no symptoms or high fever and swollen gums. Failure to clear the virus can leave your child with a tendency to cold sores (rather like chicken pox with shingles).

Soreness or itches can be managed as in the measles and chicken pox. For example, Rhus tox can be quite useful in HFMD.

CONCLUSION

Keep in mind the old immunological adage:
'Autoimmunity is the price paid for eradicating infectious diseases. (34)
Are childhood diseases nice to have? No.
Are they hard work for the parents? Yes.

Do you have to know how to support your child through these illnesses rather than suppress them with paracetamol, ibuprofen, antihistamines, decongestants and non-indicated antibiotics so that they come out of them stronger rather than weaker? Yes.

Is it worth it in the long term? I believe so.

We cannot escape these illnesses. They have been with us too long. They are part of why we are who we are.

We can run but we can't hide. The more we try to fight them with vaccines and antibiotics instead of living with them and strengthening ourselves the more we weaken our immune system and become susceptible to a whole host of pathogens – listeria, legionella, Lyme's disease, cyclospora, Norwalk virus not to mention AIDS, EBOLA, ZIKA and SARS that no-one had heard of a few decades ago.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST MAKES VACCINATION MANDATORY FOR RECRUITMENT

By Rebecca Thomas
9 April 2019

A WEST MIDLANDS TRUST will no longer recruit staff who have not had an immunisation for mumps, measles and rubella. Sandwell and West Birmingham Hospitals Trust has decided to make the MMR vaccination a requirement for any future clinical staff, following an "alarming" increase in measles cases across the West Midlands.

According to Public Health England data, there were 82 confirmed cases of measles in the West Midlands between January and December 2018.

However, London, the South East and the South West, had higher numbers of confirmed cases with 388, 181 and 139 identified respectively. Overall, 966 cases were reported.

Sandwell and West Birmingham Hospitals Trust's chief nurse, Paula Gardner, said: "With an alarming rise in cases of measles, we need to ensure our staff and patients are appropriately protected so we have been exploring how best to ensure strong vaccination coverage among employees.

"We have decided to tighten our recruitment process in some high risk areas, by offering roles to clinical staff conditional on their immunisation status. This would mean they would not be appointed unless they have been appropriately vaccinated.

"I understand that many of our neighbouring trusts are also considering a similar approach."

HSJ asked what the new policy meant for the trust's existing staff who had not been vaccinated but did not receive a response.

A PHE spokeswoman said: "Measles reports have declined from the high numbers seen last year but ongoing outbreaks in Europe leave the UK at risk. By ensuring they're vaccinated, healthcare professionals will benefit themselves and also protect their patients, who in some cases will be particularly vulnerable."

She added: "All staff should be up to date with their routine immunisations but how that is done is a decision for each trust."

"WITHOUT FREEDOM OF THOUGHT, THERE CAN BE NO SUCH THING AS WISDOM - AND NO SUCH THING AS PUBLIC LIBERTY WITHOUT FREEDOM OF SPEECH ~ *BENJAMIN FRANKLIN*"

HOW TO PREPARE FOR EXPERT TESTIMONY ON THE SAFETY OF VACCINATION

TiP editor: The following article was published online March 2019 and written by Stanley A. Plotkin, MD, a prominent figure in the history of vaccinology. Dr Plotkin, the inventor of the rubella vaccine, is widely regarded as a leading authority on vaccines.

THIS ARTICLE MAKES interesting reading due to the fact that obviously Plotkin was not expecting to be presented with such a challenge.

There are videos online of the actual testimony if you want to hear Plotkin's responses under oath.

Plotkin S A; Pediatrics. 2019;143(4): e20183578

The Centers for Disease Control and Prevention has recently announced that vaccine coverage in American children has begun to decline as more parents seek medical, religious, and so-called philosophical exemptions. The proportion of unvaccinated American children has now reached 1.3%.1 This was a depressing announcement but not surprising in view of the increase in anti-vaccinationism, or as it is euphemistically called, "vaccine hesitancy." One of the reasons for the decline in vaccination became clear to me in January 2018, when I was asked to do a pro bono deposition in a case in which a father who wanted his daughter vaccinated before entering kindergarten was suing his divorced wife, who opposes vaccination. I accepted because I viewed it as a public service, and I thought I merely had to testify about the benefits of vaccination and its overall safety.

However, when I arrived at the conference room where the deposition was to be conducted, I found 2 lawyers representing the mother. I later learned that 1 of the lawyers was a partner at a New York City law firm that specializes in vaccine injury and anti-vaccination suits. The firm represents those opposed to mandatory vaccination. As an example, it opposed a regulation in New York that would allow a child with a sexually transmitted disease to be vaccinated against human papillomavirus without parental permission.2,3

That lawyer grilled me for 10 consecutive hours on subjects ranging from putative vaccine reactions, the potential dangers of adjuvants in vaccines (including aluminum), the causes of autism, possible contaminants in vaccines, and other anti-vaccination tropes. I was also confronted with vaccine package inserts that describe hundreds of supposed reactions and asked details about the oral polio vaccination in what was then called the Belgian Congo that I was involved in during the 1950s. **Table 1** includes a sampling of the subjects about which I was questioned. The opposing attorney was clearly skilled

TABLE 1

Some of the subjects on which I was questioned by an anti-vaccination Lawyer during a deposition

- Money I have received from vaccine companies
- Have I done any consulting for the government despite having consulted for the industry?
- Is the pertussis vaccine effective?
- What royalties have I received for vaccine invention?
- Do vaccines have nonspecific effects, such as increased mortality after DTP (shown by Dr Peter Aaby)?
- Some package inserts seem to say subjects in vaccine trials were only managed for 4–5 d.
- According to the package insert, Salk IPV reactions were only managed for 2 d.
- How was MMR safety documented? Where are safety data? Was there an unvaccinated group managed at the same time?
- A Gardasil safety study used the Alum adjuvant as a control, not a placebo, so how can you exclude reactions? Of the control group, 2%–3% had reactions said to be autoimmune; so did Gardasil.
- The National Academy of Medicine published a book that says many reactions may have been caused by vaccines.
- What proof is there that DTaP doesn't cause autism?
- Is there a study comparing vaccinated and unvaccinated children for health later in life?
- Can Alum travel to the brain and cause autism?
- IL-6 is induced by vaccination and can cause autism.
- Package inserts mention encephalopathy as a possible reaction to influenza and pertussis vaccines.
- Some vaccines were produced in monkey cells; therefore, monkey DNA and protein are in the vaccine.
- Human diploid cell proteins are in vaccines made in MRC-5. Can adjuvants increase responses to non-vaccine antigens in vaccines?
- What about my work with the oral polio vaccine in the Belgian Congo in the 1950s?
- Did I vaccinate anyone without permission?
- What's the evidence that receiving multiple vaccines at the same time is safe?

DTaP, diphtheria-tetanus-acellular pertussis; DTP, diphtheria-tetanus toxoids-pertussis vaccine; IL-6, interleukin-6; IPV, inactivated polio vaccine; MMR, measles-mumps-rubella vaccine; MRC-5, Medical Research Council cell strain 5.

and knowledgeable about vaccination practices. He came armed with numerous articles on the subject of vaccine safety. As someone who has been working in vaccinology since the 1950s and who is the chief editor of the textbook Vaccines, I think I know something about the subject, but I did not have articles at my fingertips and had to depend on my memory.

In his questioning, the lawyer constantly referred to articles of doubtful scientific quality, and I was reminded that an appreciation of the differences between valid studies and those of poor quality is understood by scientists, but judges and lawyers may be misled by some of the thousands of articles published each year, many of which are published for profit and lack scientific integrity. This makes it difficult for lawyers and judges to distinguish truth from misrepresentation.

Therefore, I am concerned about future expert witnesses in cases involving vaccine safety. It is important that they have the latest data from scientifically reliable studies. With the help of Dr Paul Offit and Heather Bodenstab, we have created a library at the Children's Hospital of Philadelphia that contains references on vaccine safety from reliable medical literature. The library is accessible through the hospital's Web site (vaccine.chop.edu/ safety- references). This resource is designed to help expert witnesses but will also serve pediatricians who wish to inform themselves about vaccine safety.

Another aspect of the questioning was related to package inserts for vaccines. On this topic, I had to agree with the opposing lawyer that they are incomplete documents written primarily (although imperfectly) to protect the manufacturers from legal attack. In addition to pertinent safety information, the package inserts list numerous putative reactions to each vaccine, as reported by physicians to the Vaccine Adverse Events Reporting System from empirical experience. The inserts say nothing about the overall safety record, which may be based on millions of subjects. The description in the inserts of crucial trials seem to imply that safety was observed only over a few days post-inoculation, and they ignore the reality of longer follow-up in safety trials plus data accumulated through years of use. More should be said in the package insert about the efficacy of the vaccine. I am campaigning with the Food and Drug Administration and vaccine manufacturers to add the missing information to the package inserts. It would help if organizations such as the American Academy of Pediatrics actively supported those changes in the package circulars.

Although in this case the judge ruled in favor of vaccination, I am convinced that the anti-vaccination movement is much better organized than the pediatric community, and if nothing is done to correct this imbalance, vaccine coverage will decrease further. It is crucial that future expert witnesses be better prepared with scientific information enabling extensive rebuttals. Just as important, they should be prepared by defense lawyers (which I was not) about how to handle questions that are not grounded in accepted science.

In addition, organizations such as the American Academy of Pediatrics and the Pediatric Infectious Diseases Society should provide training to vaccine experts on how to give testimony. If possible, it would be useful to identify and train a panel of experts who would agree to present the science in vaccine-related legal contests. Moreover, they will need training to deal with the legal concept of reasonable doubt, by which a poor-quality study is used to question the overall data in favor of safety. If this is not done, lawyers such as the one I faced will have a significant negative impact on vaccination, raising costs and diminishing coverage. We must not allow our child patients to be unprotected as a result of the anti-vaccination movement's specious and unfounded objections or otherwise unsound positions transmitted through the legal system like an infectious disease.

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POTENTIAL CONFLICT OF INTEREST: Dr Plotkin is a paid consultant to Sanofi Pasteur, GlaxoSmithKline, Merck, Pfizer, Inovio Pharmaceuticals, Variations Bio, Takeda Pharmaceutical Company, Dynavax Technologies, Serum Institute of India, CureVac, Valneva SE, Hookipa Pharma, and NTxBio. Vaxconsult gives advice to vaccine developers.

"A WISE AND FRUGAL GOVERNMENT, WHICH SHALL RESTRAIN MEN FROM INJURING ONE ANOTHER, SHALL LEAVE THEM OTHERWISE FREE TO REGULATE THEIR OWN PURSUITS OF INDUSTRY AND IMPROVEMENT, AND SHALL NOT TAKE FROM THE MOUTH OF LABOR THE BREAD IT HAS EARNED. ~ *CALVIN COOLIDGE*."

CDC'S 'UNIVERSAL' RECOMMENDATIONS FOR INFANT HEP B VACCINE NOT BASED ON SCIENCE, BUT ASSUMPTIONS

BY JEREMY R. HAMMOND
Contributing Writer,
Children's Health Defense
April 02, 2019

PUTTING THE MAJORITY of U.S. children at unnecessary risk of neurodevelopmental injury with incalculable costs to society.
[Note: This is the last installment of a three-part Hep B series examining the CDC's rationale for its universal infant hepatitis B vaccination recommendation. Part 1 explores the risk to infants of a Hepatitis B infection. (The vast majority of children in the US today are not at significant risk of hepatitis B infection.) Part 2 reveals how the agency began recommending vaccination for pregnant women and infants despite a complete lack of randomized, placebo-controlled trials demonstrating that these practices are safe. Part 3 examines the CDC's 1991 policy shift to recommending that infants be 'universally' vaccinated, typically on the first day of their lives, thus placing millions of children at unnecessary risk of neurodevelopmental harm from the vaccine.]

Given the low risk to most newborns of Hepatitis B infection, the routine screening during pregnancy to identify at-risk newborns and the availability of HBIG treatment for exposed infants (that is 75 percent effective at preventing chronic infection), coupled with the lack of studies to determine the safety of vaccinating pregnant women and infants, what was the scientific medical rationale underlying the CDC's decision in 1991 to recommend that all newborn babies be vaccinated? The simple answer is that there wasn't one. The ACIP's recommendation was not based on science, but on the CDC's desire to achieve its goal of eliminating transmission of HBV by achieving high vaccination rates. Indeed, the CDC was actually quite explicit about this at the time.

The CDC's "rationale for a comprehensive strategy to eliminate transmission of hepatitis B virus in the United States" was published in its journal Morbidity and Mortality Weekly Report (MMWR) on November 22, 1991. The new strategy included "making hepatitis B vaccine part of routine vaccination schedules for all infants." The stated reason why the CDC wanted to vaccinate all infants was not because all infants were at risk of infection, but simply because its strategy to vaccinate high-risk populations was failing.

In the CDC's own words, "In the United States, most infections occur among adults and adolescents. The recommended strategy for preventing these infections has been the selective vaccination of persons with identified risk factors. However, the strategy has not lowered the incidence of hepatitis B, primarily **because vaccinating persons engaged in high-risk behaviors, life-styles, or occupations before they become infected generally has not been feasible**." (Emphasis added.)

> *"The CDC acknowledged that no long-term studies had been done to determine the effectiveness of the new vaccine."*

As the CDC reiterated, "Efforts to vaccinate persons in the major risk groups have had limited success." Furthermore, "Educational efforts alone are not likely to fully eliminate the high-risk behaviors responsible for HBV transmission."

Infants, of course, do not engage in those high-risk behaviors. The CDC's reasoning was simply that, since adults tended for various reasons to not get the vaccine, it would eliminate the choice by vaccinating everyone at birth, regardless of individual risk.

It would be cheaper and easier, the CDC argued, just to vaccinate everyone at birth than to continue targeting high-risk populations. "In the long term," the CDC judged, "universal infant vaccination would eliminate the need for vaccinating adolescents and high-risk adults."

Continuing, the CDC noted that the older, plasma-derived vaccine was no longer produced in the US, having been replaced by the recombinant vaccine technology. Like the older vaccine, both brands of the newer HepB vaccine contained aluminum and mercury.

The CDC acknowledged that no long-term studies had been done to determine the effectiveness of the new vaccine. Instead, its effectiveness was judged on the basis of studies done for the older, plasma-derived vaccine. With the older vaccine, protective antibody levels were initially provoked in most subjects, but waned over time so that after nine years as many as 60 percent of subjects no longer had detectable antibodies. However, the vaccine seemed to induce immunologic memory so that subjects remained immune despite waning antibody titers. For children vaccinated at birth, the protective effect of the vaccine persisted for "at least 5 years".

Hence, the CDC's recommendation was not based on scientific studies demonstrating that the recombinant HepB vaccine administered in early childhood would confer immunity throughout adulthood. Instead, the CDC's policy was faith-based, resting on the mere assumption that it would do so.

The CDC's new policy was even more faith-based when it came to the question of the new vaccine's safety. It produced no studies demonstrating that exposing fetuses and infants to these neurotoxins was safe. Instead, citing its own unpublished data, the CDC judged on the basis of "limited experience" that there was "no apparent risk" to developing fetuses of vaccinating pregnant women. Of course, it's very easy to say that there is no apparent evidence of harm when studies to determine the risk have not been done.

The CDC also once again employed the non sequitur fallacy that, since the viral antigen particles in the vaccine were noninfectious, the vaccine "should

cause no risk to the fetus"—thus once again demonstrating the institutionalized failure to consider the potential for neurodevelopmental harms from mercury and aluminum.

Beyond that, the best the CDC could do to reassure the public about the vaccine's safety was to add that "Hepatitis B vaccines have been shown to be safe when administered to both adults and children. Over 4 million adults have been vaccinated in the United States, and at least that many children have received hepatitis B vaccine worldwide."

Of course, this, too, was a non sequitur fallacy, as the conclusion that the vaccine is safe does not follow from the premise that it had been injected into four million children globally. (Consider how many cigarette smokers there must have been in the world already before the government and tobacco industry finally acknowledged that smoking can cause lung cancer.)

In the CDC's faith-based judgment, the benefit of possibly preventing an estimated 2,000 to 5,000 annual deaths from HBV-related liver disease outweighed any potential harms, including the risks of unnecessarily exposing millions of fetuses and newborn babies to the neurotoxic effects of mercury and aluminum.

In 1999, the decision was made to eliminate the mercury-based preservative thimerosal from most vaccines routinely recommended for children. This was done because it had become known that the CDC's schedule was exposing children to cumulative levels of mercury that exceeded the safety guidelines of the US Environmental Protection Agency (EPA). However, thimerosal is still used in multi-dose vials of influenza vaccines, and both hepatitis B vaccines licensed for use in infants still contain aluminum.

EVIDENCE OF NEUROLOGICAL HARM FROM THE HEPB VACCINE

Despite widespread concerns about the possibility of neurodevelopmental harm from the HepB vaccine, which is administered to more than 70 percent of newborns worldwide, still twenty-five years after the CDC implemented its universal infant vaccination regimen, as a team of Chinese researchers noted in a study published in the journal Psychoneuroendocrinology, "Whether this neonatal vaccination affects brain development is unknown."

A previous study by the same team, published in the Journal of Neuroimmunology a year prior (2015), was the first to examine the question of "whether neonatal vaccination could influence brain development in a physiological manner." Studying the effects of vaccination in rats, among their findings was that it triggered an increase in "pro-inflammatory cytokines, such as IL-1β, IL-6, and TNF-α", which research had focused on "as having a detrimental effect on neuronal function and synaptic plasticity." The increase in pro-inflammatory cytokines was part of "a neurotoxic expression profile" exhibited by HepB-vaccinated rats. Their data confirmed "that altered immune status induced by vaccination modulates hippocampal synaptic plasticity during early life". The vaccine induced a bias toward an antibody response, or humoral immunity, in relation to cell-mediated immunity. This skewing of the immune system, they concluded, "exerted detrimental effects".

"Therefore, early vaccination with [hepatitis B vaccine], which induces strong immune activation, is suspected to influence brain development and behavior."

In their study the following year, the researchers elaborated: "Perinatal immune activation has been demonstrated to influence brain development and behavior. The brain is still developing in the early postnatal time period and thus immune activation can impact the developmental programming of the brain. . . . Therefore, early vaccination with [hepatitis B vaccine], which induces strong immune activation, is suspected to influence brain development and behavior."

Furthermore, the balance between cell-mediated (Th1) and humoral immunity (Th2) "serves as an important mediator for the effects of immune activation on the central nervous system (CNS)." The HepB vaccine, as previously reported, induced a Th2 bias, which "is regarded as neurodetrimental" and "has been reported to be associated with cognitive deficits". Their new study demonstrated that early HepB vaccination impaired the behavior, the synaptic plasticity of the hippocampal part of the brain, and the growth of nerve tissue of mice in early adulthood. These detrimental outcomes were all possible effects of "the alterations in the brain neuroimmune milieu following the systemic Th2 bias."

The researchers concluded that early HepB vaccination "induces impairments in behavior and hippocampal neurogenesis", with their data "supporting the long suspected potential association of [hepatitis B vaccine] with certain neuropsychiatric disorders such as autism and multiple sclerosis."

In a third rodent study published in the journal Cytokine in October 2018, the researchers highlighted how HepB vaccination "induced an instant anti-inflammatory cytokine response and a subsequent proinflammatory cytokine response in the hippocampus." Notably, behavioral impairment appeared in mice vaccinated on the day of their birth at eight weeks of age, coinciding with "the delayed hippocampal neuroinflammation". A dramatic increase in pro-inflammatory cytokine levels (IL-1β, IL-6, and TNF-α) as compared to controls was observed between thirty-five to forty-two days post-vaccination.

Naturally, such evidence of delayed neurological harm couldn't possibly have been detected in the uncontrolled clinical trials with only four or five days of follow-up that were used by Merck and GlaxoSmithKline to obtain the FDA's stamp of approval for getting their products to market.

As Children's Health Defense contributing writer J.B. Handley has remarked with respect to this series of studies, "It's reasonable to say that the way Hepatitis B vaccine was tested and

the way Hepatitis B causes brain damage (on a delayed schedule) means our health authorities have no idea how much brain damage Hepatitis B vaccine is causing our children. None."

CONCLUSION

While public health officials and the corporate news media mock and scorn anyone who dares to question the wisdom of vaccinating children strictly according to the CDC's recommended childhood schedule, including vaccination of newborn babies on the very first day of their lives, what the science is telling us is that there are very legitimate reasons for concern. At the very least, there ought to be open discussion and debate about the practice of vaccination, yet instead we are witnessing a concerted effort to silence critics and more strictly enforce vaccine mandates required for school entrance.

While we're told that the hepatitis B vaccine is a "crucial shot" for infants, the reality is that the vast majority of children are not at significant risk of infection. The CDC's recommendation to vaccinate newborns universally was not based on science, but on the assumptions that the vaccine would effectively reduce HBV-related liver disease mortality and—to paraphrase the words of FDA microbiologist Richard Daemer—would be incapable of causing harm to pregnant women's developing fetuses or newborn babies.

Instead, what science is telling us is that the CDC's recommendation to universally vaccinate newborns at birth puts the majority of children in the US at a completely unnecessary risk of neurodevelopmental harm from the hepatitis B vaccine, with incalculable costs to society.

HPV-RELATED CANCER RATES AFFECT VACCINE UPTAKE IN ALABAMA, USA HEALTH STUDY SAYS

BY UNIVERSITY OF SOUTH ALABAMA
March 24, 2019
https://www.alabamanewscenter.com/2019/03/24/hpv-related-cancer-rates-affect-vaccine-uptake-in-alabama-usa-health-study-says/

USA HEALTH RESEARCHERS studying HPV vaccination rates in Alabama have made a surprising discovery: Counties with higher rates of HPV-related cancers also showed higher HPV vaccination rates, according to research presented at the Society of Gynecologic Oncology's Annual Meeting on Women's Cancer.

"It was exactly the opposite of what we expected," said Dr. Jennifer Young Pierce, who heads Cancer Control and Prevention at USA Health Mitchell Cancer Institute. "We found that the higher the rate of cancer in the county, the higher the rate of vaccination."

The research was one of 12 studies accepted for oral or poster presentations at the national meeting. The study sought to explore the reasons why vaccination rates for human papillomavirus (HPV) vary so widely among counties in Alabama, from 33 percent to 66 percent. Researchers expected to find lower vaccination rates in rural counties with fewer physicians and in counties with low incomes, which would have been consistent with national reports from the U.S. Centers for Disease Control and Prevention.

However, the data showed little difference in HPV vaccine uptake between urban and rural counties, and between affluent and poor ones. The seven counties with the highest HPV vaccination rates were both rural and low income, Pierce said. "The main takeaway is that perception of high cancer risk overcomes traditional disparities that can affect HPV vaccine uptake."

Meanwhile, the study also found higher HPV vaccination rates among residents who receive government-funded health care and the highest HPV rates in some counties that have no pediatricians.

The HPV vaccine protects against a variety of cancers in men and women, including cervical, vulvar, vaginal, penile, anal and head and neck.

The vaccine is recommended for boys and girls ages 11-12, with catch-up to age 26.

INFLUENZA VACCINATION IN PREGNANCY: CAREFUL ASSESSMENT CONFIRMS SAFETY CONCERNS FOR THE OFFSPRING

Hum Vaccin Immunother. 24 April 2019
doi: 10.1080/21645515.2019.1605818.
[Epub ahead of print]. Donzelli A

ABSTRACT

Valid evidence doesn't support universal influenza vaccination for pregnant women, the LTE objections are unfounded. The observational evidence is less valid than that from RCTs: important safety signals in all the RCTs require high consideration.

In RCTs, influenza vaccinated women have mostly local adverse effects, while their offspring show a nonsignificant excess of deaths, and a significant excess of serious presumed/neonatal infections in the larger RCT.

Several Authors have financial relationships with vaccine producers, several conclusions omit the safety signals. A cited systematic review has methodological problems and excluded important published RCTs.

Pending new independent RCTs, the precautionary principle suggests avoiding to promote pregnant women vaccination.

Health services could offer it highlighting existing uncertainties, with balanced informations allowing informed choices. PMID:31017837

UK SECOND WORST IN EUROPE FOR VACCINATING AGAINST MEASLES

BY HIBA MAHAMADI

22 July 2019

http://www.pulsetoday.co.uk/

TiP Editor: An example of what is presented to health professionals.

THE NUMBER OF CHILDREN getting measles vaccinations in the UK is the second lowest in Europe, according to new figures.

Data published by Unicef shows the global uptake for measles vaccines in 2018, in which the UK has lagged behind the rest of Europe.

WE NEED TO CHANGE HOW WE TACKLE THE ANTI-VAX MOVEMENT

Over 20% of unvaccinated children in Europe live in the UK, according to Unicef. It follows claims from Public Health England that the lack of appointment availability is to blame for large numbers of missed vaccinations.

The measles vaccine is given in two doses and requires 95% coverage in order to protect against outbreaks, according to Unicef. The national uptake for the first dose of the vaccine, MCV1, decreased from 93% in 2013 to 92% in 2016 and has stagnated up to 2018. The number of children who did not receive the vaccine in 2018 was 62,000, up 6,000 (1%) from 2013. This represents 21% of the total unvaccinated children in Europe, second only to France who have 25% (73,000). The next highest is Italy with 11% (32,000) of unvaccinated children.

Uptake for the second dose of measles vaccine, MCV2, had previously increased but has now stalled. It rose from 88% in 2013 to 89% in 2014. But this figure dropped to 88% in 2017 and 2018. In comparison, France's MCV2 coverage has steadily increased over the past five years, from 75% in 2013 to 80% in 2018. The number of children not getting the MCV2 vaccine in the UK is again the second highest in Western Europe at 97,000, after France at 149,000. In Western Europe as a whole, the number of unvaccinated children, MCV1, has decreased from 295,000 in 2013 to 288,000 in 2018. And for MCV2, it dropped from 756,000 in 2013 to 616,000 in 2018.

However, Unicef estimated that the number of cases of measles around the world more than doubled between 2017 and 2018. The research found disparities in measles vaccination across countries of all income levels, not just the developing world, and even those countries where overall vaccination rates are high.

Alastair Harper, director of advocacy at Unicef UK, said: 'While availability, cost and access to vaccinations remains the biggest global obstacle, in high-income countries like the UK, the proliferation of vaccine-related misinformation on digital and social platforms is one of the key factors associated with vaccine hesitancy. Anti-vaccination groups are exploiting parents, creating confusion and stoking their fears in order to disrupt regular childhood vaccination schedules.

'No child should die a preventable death, and every child has the right to lifesaving vaccinations. It is the responsibility of Government and health professionals to educate the public about the urgent need for vaccinations to protect not just their own children, but also the whole population – including babies under 6 months old, who are too young to be routinely given the MMR vaccine.'

Timing, availability and location of appointments have been identified as barriers to vaccination by parents are healthcare professionals.

Earlier this year, the BMA called the number of missed measles doses in the UK 'incredibly concerning'.

BETA-TRYPTASE AND QUANTITATIVE MAST-CELL INCREASE IN A SUDDEN INFANT DEATH FOLLOWING HEXAVALENT IMMUNIZATION

Forensic Sci Int.
2008 Aug 6;179(2-3):e25-9.
D'Errico S, Neri M, Riezzo I, Rossi G, Pomara C, Turillazzi E, Fineschi V

ABSTRACT

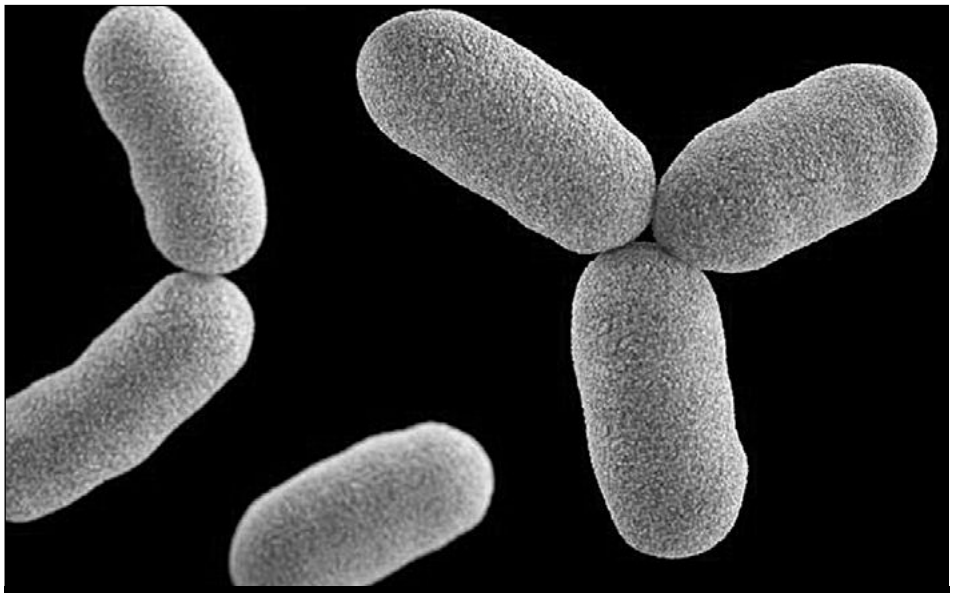
The association between sudden infant death syndrome and immunization is frequently discussed. Serious adverse events following vaccination have generally been defined as those adverse events that result in permanent disability, hospitalization or prolongation of hospitalization, life threatening illness, congenital anomaly or death. They are generally referred to the inherent properties of the vaccine (vaccine reaction) or some error in the immunization process (programme error). The event could also be totally unrelated but only temporally linked to immunization (coincidental event). A fatal case of a 3-month-old female infant, who died within 24 h of vaccination with hexavalent vaccine is presented.

Clinical data, post-mortem findings (acute pulmonary oedema, acute pulmonary emphysema), quali-quantitative data collected from immunohistochemical staining (degranulating mast cells) and laboratory analysis with a high level of beta-tryptase in serum, 43.3 microg/l, allows us to conclude that acute respiratory failure likely due to post hexavalent immunization-related shock was the cause of death.

PMID: 18538957

ASYMPTOMATIC CARRIERS OF DIPHTHERIA IDENTIFIED IN CANADIAN SCHOOL

BY KATE RAINES
Published 10 July 2019
https://thevaccinereaction.org/2019/07/asymptomatic-carriers-of-diphtheria-identified-in-canadian-school/



Three-dimensional (3D) computer-generated image of a group of Gram-positive, Corynebacterium diphtheriae, bacteria. Source: CDC.

A RARE CASE OF DIPHTHERIA was identified at an elementary school in Edmonton, Alberta, Canada—the third case in that school district since 2017.[1] Public health officials subsequently identified three other people, who are asymptomatic carriers of the bacterial disease and are being treated in isolation. The Alberta Health Services (AHS) is monitoring and treating the patient, carriers and all potential contacts.

According to the AHS, "People who have been fully vaccinated, or immunized for their age, **can become carriers** (TiP emphasis) when they come into contact with the bacteria that causes diphtheria. They often don't show symptoms." To protect them, as well as those they may come into contact with, those asymptomatic carriers are being treated and "are subject to the same isolation protocols as someone who is identified as symptomatic."[2]

FULLY VACCINATED ASYMPTOMATIC CARRIERS OF INFECTION

Diphtheria is not, by any means, the only infection that may be transmitted by fully vaccinated, asymptomatic carriers. Pertussis, measles, polio and influenza are among the infections that have been implicated in transmission of infective pathogens from asymptomatic, vaccinated hosts. (TiP emphasis). According to the Centers for Disease Control and Prevention (CDC), "Acellular pertussis vaccines may not prevent colonization (carrying the bacteria in your body without getting sick) or spread of the bacteria."[3] Evidence shows that pertussis—including new strains that have adapted to evade the vaccines—may be carried and transmitted by fully vaccinated individuals who are infected but express no symptoms of disease.[4 5] Two referenced reports published by the National Vaccine Information Center in 2016 and 2018, provided evidence for the fact that children and adults who have received whole cell pertussis vaccines (DPT) and acellular pertussis vaccines (DTaP, Tdap) are capable of being infected with and transmitting pertussis without showing any symptoms and that the pertussis microbe has also evolved to evade the vaccines.[6 7]

In 1973, it was recognized that the live attenuated virus measles vaccine did not always prevent infection with wild type measles, and public health officials also were "not sure about whether some vaccinated children could still transmit wild type measles to others."[8] Even the attenuated (weakened) MMR vaccine used today does not always prevent wild strain measles virus from infecting and being transmitted by asymptomatic, vaccinated carriers, whose cases are never identified or reported like cases of measles in unvaccinated children and adults fully displaying symptoms of measles. It is a little known fact that the MMR vaccine can suppress symptomatic expression of disease but fail to block transmission of the infection to susceptible individuals. In fact, it has been suggested that when it comes to measles outbreaks, "**Most transmissions in highly vaccinated populations are from the vaccinated, asymptomatic carriers with subclinical infections**."[9] (TiP emphasis).

It is the same story with poliovirus infection. Noting that the live attenuated polio vaccine (OPV), which is not used in the U.S. anymore but is used in other countries, does not prevent asymptomatic infection and further spreading of polioviruses. In a 2018 report, the CDC warned of several possible scenarios.

For example, "a vaccinated worker could still become infected, or re-infected, while working with poliovirus and shed live virus for weeks, leading to possible infection of others." The CDC report also suggests, "A person who has an asymptomatic poliovirus infection could travel to a place where vaccine coverage is low. Shedding of virus in that setting could potentially result in re-introduction to a susceptible population, further transmission and cause polio disease."[10]

The invisible threat of disease transmission by fully vaccinated, asymptomatic carriers of infection is important to recognize given the potentially serious nature of some of these diseases and the fact that often

unvaccinated persons are blamed for causing disease outbreaks when there are undiagnosed and unreported cases occurring in fully vaccinated persons.

CHARACTERISTICS OF DIPHTHERIA

Diphtheria is a highly contagious bacterial infection that may seem at first like any other upper respiratory tract infection. In all but the mildest cases, however, the disease progresses to produce a toxin that invades the lining of the respiratory tract and attacks healthy tissue. The dead tissue accumulates as a thick, gray, green or blackish web-like coating of the nose, tonsils, voice box, and throat that can make it difficult to breathe or swallow.

The toxin can also enter the bloodstream and cause damage to the heart, nerves, kidneys and brain.[11] Diphtheria occurs less in a "cutaneous form," as a skin infection characterized by painful lesions that may be covered by the signature gray membrane. The cutaneous form of diphtheria is most often seen in tropical climates but may develop anywhere there are non-hygienic, crowded conditions.[12]

The disease is spread most commonly through direct contact with saliva or respiratory droplets, as through coughing or sneezing, which may spread the disease efficiently in crowded conditions. It also may be transmitted via contaminated personal items such as used tissues or unwashed drinking glasses or, rarely, through contact with toys or clothing used by infected people. Diphtheria may also spread from someone who carries the bacteria, but has no symptoms for it, as may occur when a vaccinated individual picks up the bacteria but does not show symptoms.[13]

DIPHTHERIA VACCINE

Vaccination against diphtheria is only available as part of a combination vaccine that also includes vaccines against tetanus (TD) or tetanus and pertussis (whooping cough) (DTaP). The combination vaccines are typically given to children in the United States at two, four, six and 15-18 months and between four and six years. Boosters are recommended every 10 years thereafter.[14]

It is generally recognized that much of the reactivity of DTaP/Tdap vaccines, including injuries and deaths, is caused by the pertussis component of the combination shots. However, it is not possible to get diphtheria vaccine alone without also being injected with either tetanus vaccine or, more often, both tetanus and pertussis vaccines combined with diphtheria vaccine.[15]

As of July 31, 2018, MedAlerts data show that, since 1990, more than 174,000 adverse reactions, hospitalizations, injuries and deaths were reported to the federal Vaccine Adverse Events Reporting System (VAERS) following one of the combination vaccines that includes diphtheria.[16] Those adverse events have included 2,992 related deaths, 20,106 hospitalizations, and 2,946 related disabilities, the majority among children under age six. In the federal Vaccine Injury Compensation Program (VICP), a total of 5,514 claims had been filed prior to November 28, 2017 for injuries and deaths following vaccination with DTaP or Tdap. That number included 84 deaths and 4,660 serious injuries.[17]

> *"...a vaccinated worker could still become infected, or re-infected, while working with poliovirus and shed live virus for weeks."*

Like most vaccines, the effectiveness of the diphtheria vaccine is known to wane over time. The CDC recommends booster doses of Td (tetanus-diphtheria) vaccine every 10 years. Unlike many infectious diseases, even natural infection with diphtheria does not confer life-long protection. People can have diphtheria more than once. The prognosis for diphtheria has changed little over the past 50 years, despite improvements in treatment options: Between 5-10 percent of cases are fatal, and mortality may reach 20 percent for those under age five or over age 40.

In past centuries, before the development of antibiotics and an antitoxin, the death rate for diphtheria was closer to 50 percent.

The risk of acquiring diphtheria infection in the U.S. or other developed countries is extremely remote, unless travelling to "an impoverished country or a location of a natural disaster that has compromised the sanitation infrastructure."[18] There were only two reported cases in this country between 2004 and 2016. The disease, however, continues to present a challenge in other parts of the world, with over 7,000 cases reported to the World Health Organization (WHO) in 2016 alone.[19]

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DR CONGO HEALTH MINISTER RESIGNS AFTER REPLACED AS EBOLA SPEARHEAD

MENAFN - AFP
July 24 2019
www.thehindu.com

DR CONGO'S HEALTH MINISTER resigned Monday, citing his removal as the head of his country's Ebola response and concerns over a proposed "experiment" with a new, unlicensed vaccine.

"As a result of your decision to place the response to the Ebola outbreak under your direct supervision... I hereby submit my resignation as health minister," Oly Ilunga wrote in a resignation letter to President Felix Tshisekedi.

"As in any war, because that is what this is, there cannot be several centres of decision-making for risk of creating confusion," said the letter. Ilunga also objected to suggestions "by actors who have demonstrated a clear lack of ethics" to introduce a second vaccine to the country's fight against the highly-infectious haemorrhagic virus disease. "Strong pressure has been exerted for several months to roll out a new experiment in the DR Congo," he wrote.

Tshisekedi on Saturday replaced Ilunga as the head of the country's response to the latest Ebola epidemic, which has killed more than 1,700 people. Nearly 170,000 people have been given an Ebola vaccine manufactured by German pharma giant Merck since the outbreak started in Democratic Republic of Congo a year ago. The World Health Organization (WHO) has been pushing for the introduction of a second vaccine produced by a subsidiary of US company Johnson & Johnson, but the health ministry under Ilunga has resisted such a move, citing the risks of introducing a new product in communities where mistrust of Ebola responders is already high. The Merck vaccine is tested but unlicensed, while the second drug is still in the trial investigation stage.

"It would be unrealistic to believe that the new vaccine, proposed by actors who have demonstrated a clear lack of ethics by voluntarily hiding important information from health authorities, could have a decisive impact on the control of the epidemic," said Ilunga, a medical doctor. He did not refer to anyone by name. On Saturday, the presidency announced that coordination of the anti-Ebola campaign would now fall under Tshisekedi's direct supervision.

This came shortly after the WHO gave the outbreak the high-alert status of "public health emergency of international concern". Reporting to Tshisekedi would be Jean-Jacques Muyambe Tamfum, director of the National Institute for Biomedical Research in Kinshasa. He was a member of the team that investigated the first known Ebola outbreak in then-Zaire 1976. Since August last year, Ebola has infected more than 2,500 people in DR Congo, killing more than 1,700 of them, in the second-biggest epidemic since more than 11,300 people died in Liberia, Guinea and Sierra Leone between 2014-2016.

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RAJASTHAN VACCINATION DRIVE STARTS AMID PROTESTS

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PARENTS IN BHARATPUR prevented health officials from vaccinating children. A measles-rubella vaccination campaign, targeted to cover 2.26 crore children up to 15 years of age, has started in Rajasthan amid protests by parents in some parts of the State.

The drive met with resistance on its opening day on Monday at a school in Bharatpur district's Nagar block where the parents of 600 students prevented the health officials from vaccinating the children.

At least 15 children, who were administered the vaccine in Jhunjhunu district's Kakoda village, were shifted to a hospital when they complained of vomitting and nausea. On Tuesday, half-a-dozen girls at Vaidik Kanya Vidyalaya in Jaipur were admitted to Sir Padampat Mother & Child Hospital when they felt dizzy after vaccination. They were kept under observation till late in the evening.

'WITHOUT CONSENT'

While the Medical & Health Department maintained that the vaccination was voluntary, the local officials tried to convince the villagers of its benefits. Some parents alleged that the vaccination was being done without taking their consent and it would have an "adverse impact" on their future generations.

Inaugurating the month-long campaign at Mahaveer Public School here, Medical & Health Minister Raghu Sharma said it would be the biggest vaccination drive in the world, as India accounted for 36% of deaths of the world's children by measles.

The campaign's first phase will cover all schools across the State and the second phase will involve outreach to local communities. About 17,000 trained personnel will undertake vaccination activities at 61,000 Anganwadi centres, while 2.11 lakh principals and nodal teachers, 51,000 accredited social health activists (ASHAs) and 59,000 Anganwadi workers and volunteers will assist in the task. The arrangements for vaccination have been made in 65,000 government schools and 40,000 private schools. Dr. Sharma said his department was paying the highest attention to reduction in infant mortality rate and maternal mortality ratio, as a result of which the health indicators had depicted a continuous improvement.

The infant mortality rate in the State had registered an improvement by 4 digits, showing a decline from 32 to 28 per 1,000, he said. Besides, the World Health Organization has reported that Rajasthan has carried out 90% vaccination in 2018-19. The measles-rubella vaccination drive is set to cover all pre-school children, government and private school children and out-of-school children.

MYALGIA AND CHRONIC FATIGUE SYNDROME FOLLOWING IMMUNIZATION: MACROPHAGIC MYOFASCIITIS AND ANIMAL STUDIES SUPPORT LINKAGE TO ALUMINUM ADJUVANT PERSISTENCY AND DIFFUSION IN THE IMMUNE SYSTEM

GHERADI RK, CREPEAUX G, AUTHIER FJ

4 May 2019

Autoimmunity Reviews

https://www.ncbi.nlm.nih.gov/pubmed/31059838

HIGHLIGHTS

• ME/CFS is multifactorial but Al-containing vaccines may constitute a trigger.
• ME/CFS may be associated with intracellular Al adjuvant persistency assessed by MMF.
• Animal models revealed issemination and neurotoxic effects of Al adjuvants.
• Al adjuvant toxicokinetics and long-term safety now need appropriate investigations.
• Identification of susceptibility genes, co-factors and safer adjuvants is underway.

ABSTRACT

Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) is a multifactorial and poorly undersood disabling disease. We present epidemiological, clinical and experimental evidence that ME/CFS constitutes a major type of adverse effect of vaccines, especially those containing poorly degradable particulate aluminum adjuvants.

Evidence has emerged very slowly due to the multiplicity, lack of specificity, delayed onset, and frequent medical underestimation of ME/CFS symptoms.

It was supported by an epidemiological study comparing vaccinated vs unvaccinated militaries that remained undeployed during Gulf War II.

Affected patients suffer from cognitive dysfunction affecting attention, memory and inter-hemispheric connexions, well correlated to brain perfusion defects and associated with a stereotyped and distinctive pattern of cerebral glucose hypometabolism.

Deltoid muscle biopsy performed to investigate myalgia typically yields macrophagic myofasciitis (MMF), a histological biomarker assessing longstanding persistency of aluminum agglomerates within innate immune cells at site of previous immunization. MMF is seemingly linked to altered mineral particle detoxification by the xeno/autophagy machinery.

Comparing toxicology of different forms of aluminum and different types of exposure is misleading and inadequate and small animal experiments have turned old dogma upside down.

Instead of being rapidly solubilized in the extracellular space, injected aluminum particles are quickly captured by immune cells and transported to distant organs and the brain where they elicit an inflammatory response and exert selective low dose long-term neurotoxicity.

Clinical observations and experiments in sheep, a large animal like humans, confirmed both systemic diffusion and neurotoxic effects of aluminum adjuvants.

Post-immunization ME/CFS represents the core manifestation of "autoimmune/inflammatory syndrome induced by adjuvants" (ASIA).

NEONATAL AND EARLY LIFE IMMUNE RESPONSES TO VARIOUS FORMS OF VACCINE ANTIGENS QUALITATIVELY DIFFER FROM ADULT RESPONSES: PREDOMINANCE OF A TH2-BIASED PATTERN WHICH PERSISTS AFTER ADULT BOOSTING

BARRIOS C, BRAWAND P, BERNEY M, BRANDT C, LAMBERT PH, SIEGRIST CA.

Eur J Immunol. 1996 Jul;26(7):1489-96.

ABSTRACT

Induction of neonatal immune responses to vaccine antigens is believed to be of limited efficacy because of immune immaturity and particular susceptibility to tolerogenic signals during this period of life.

To characterize particular features of neonatal immune responses to vaccine antigens, we assessed the capacity of BALB/c mice at different stages of immunological maturation to respond to a selection of vaccine antigens and presentation systems.

Significant B and T cell responses to vaccine antigens (tetanus and measles virus peptides, tetanus toxoid, live viral attenuated measles virus, canarypox recombinant measles vector or bacillus Calmette-Guérin) were obtained as early as the first week of life.

However, these neonatal responses differed qualitatively from adult responses by a decreased IgG2a/IgG1 ratio of vaccine-specific antibodies, the secretion of significantly higher interleukin-5 and lower interferon-gamma levels by vaccine-specific T cells and an impaired induction of cytotoxic T cell precursors. This pattern of biased Th2 versus Th1 responses induced upon early exposure to vaccines was not reversed by decreasing the doses of vaccine antigens.

It did not disappear with aging and was still reflected in adult responses to booster immunization with the corresponding antigen.

Thus, neonatal immunization can induce significant vaccine specific responses with a predominance of a Th2 pattern which can persist in boosted adult mice.

PMID: 8766551

DTP VACCINE ASSOCIATED WITH INCREASED RATE OF TOTAL MORTALITY IN LOW-INCOME COUNTRIES SAYS PETER GØTZSCHE IN NEW EXPERT REPORT

PR NEWSWIRE
SHERIDAN, Wyo., PRNewswire
August 16, 2019

DTP IS ONE of the most common vaccines used in the world. In 2012, SAGE requested that the WHO review the evidence concerning the possible effects of DTP vaccines on mortality[1]. In a new expert report, Peter C. Gøtzsche, Professor, DrMedSci, MSc analyzed the WHO systematic review as well as any studies published after the WHO report that assessed the effect of DTP vaccine on total mortality. This new expert report concludes that the "evidence tells us that it is likely that the DTP vaccine increases total mortality in low-income countries."[2]

This echoes the conclusion by Peter Aaby – a highly acclaimed scientist renowned for studying and promoting vaccines in Africa - that "all currently available evidence suggests that DTP vaccine may kill more children from other causes than it saves from diphtheria, tetanus or pertussis. Though a vaccine protects children against the target disease it may simultaneously increase susceptibility to unrelated infections." [3] Dr. Aaby's recent study, the first ever naturally randomized comparison of mortality between children receiving DTP and those that are unvaccinated, found that children vaccinated with DTP were 10 times more likely to die in the first 6 months of life than the unvaccinated.[3]

One of the five goals of the WHO's Global Vaccine Action Plan (GVAP) is to exceed the UN Millennium Development Goal [4] target of reducing child mortality.[4] A strategy for achieving this goal is to reach 90% national vaccination coverage on DTP containing vaccines worldwide.[4] According to Gøtzsche's conclusions, this strategy would be counterproductive toward the goal of reducing child mortality. Gøtzsche offers several suggestions for potential next steps. As stated by UNICEF, "the percentage of children receiving the diphtheria, tetanus and pertussis vaccine (DTP) is often used as an indicator of how well countries are providing routine immunization services"[5]. Gøtzsche recommends that the indicator be changed to something that is "known to be positively associated with better child survival."[2] Gøtzsche then explains that "it is the duty of a manufacturer of a drug or vaccine to demonstrate in randomized trials that it works and has a positive benefit to harm balance. This has not been done for the DTP vaccine." [2] As such, he advocates for the initiation of randomized trials and considers the need for them "an urgent ethical imperative."[2]

Gøtzsche concludes with a call for the re-evaluation of current DTP vaccination practices. "No one should be offered this vaccine without full informed consent that includes information that the vaccine is likely to increase total mortality. I also believe that the vaccine should not be recommended and that, if anyone wants to use it, it must be as part of a large randomized trial."[2]

ABOUT THE VACCINE SCIENCE FOUNDATION

The Vaccine Science Foundation aims to equip the scientific community, healthcare professionals, and the general public with the tools and information necessary to increase their knowledge of vaccine science. **Please email via TiP website for a list of references.**

LATEST NEWS

TiP Editor: Shortly before this edition of the newsletter was being sent to the printers the UK prime minister, Boris Johnson announced that urgent action was needed to boost the number of children receiving the measles, mumps, and rubella (MMR) vaccine after the UK lost its measles-free status with the World Health Organization.*

Official statements, alongside a major mainstream media campaign began on Monday 19 August 2019. It goes without saying that no voices of concern were invited to participate in the coverage. Programmes such as the BBC Radio 2 Jeremy Vine Show chose to censor callers with vaccine concerns, and the last few days there has been coverage promoting only the official narrative. The usual inaccurate statements have been made to mislead the trusting public and frighten them into viewing any person who questions vaccination as a danger to the community. As with other issues one of the well-used techniques is to try and divide the public. I would urge you to avoid confrontation when participating in any social media. Staying calm and polite goes a long way alongside encouraging people to investigate. As most of us have experienced, on opening our eyes to this subject, the vaccine story is so unbelievable that is why many, including many health professionals, can not contemplate that they may have been misled.

*measles-free status does NOT mean that there were NO cases of measles. The following text is from fullfact.org: Many of the articles mentioned that the measles virus was eliminated in the UK three years ago. This seems to have come directly from the announcement published by the Department of Health and Social Care, which says the same thing. In 2017, the WHO announced that the UK, along with a number of other countries, had eliminated measles as of 2016. The word 'eliminated' might make it sound like there were no cases of measles that year, but that's not what it means—the way the WHO uses it has a technical meaning that's a bit different to what you might expect. At the time the WHO said "Elimination of measles or rubella can be verified once a country has sustained interruption of endemic transmission for at least 36 months." According to Public Health England: "WHO defines measles elimination as the absence of circulating measles, in the presence of high vaccine coverage, along with good systems to identify cases of the disease. "In countries that have eliminated measles, measles can still occur, but these will be isolated cases that only have limited spread within the community."

TIP ARCHIVE

FAILURE TO REACH THE GOAL OF MEASLES ELIMINATION: APPARENT PARADOX OF MEASLES INFECTIONS IN IMMUNIZED PERSONS

Arch Intern Med.
1994 Aug 22;154(16):1815-20.
Poland GA, Jacobson RM

ABSTRACT

BACKGROUND:
Measles is the most transmissible disease known to man. During the 1980s, the number of measles cases in the United States rose dramatically. Surprisingly, 20% to 40% of these cases occurred in persons who had been appropriately immunized against measles. In response, the United States adopted a two-dose universal measles immunization program. We critically examine the effect of vaccine failure in measles occurring in immunized persons.

METHODS:
We performed a computerized bibliographic literature search (National Library of Medicine) for all English-language articles dealing with measles outbreaks. We limited our search to reports of US and Canadian school-based outbreaks of measles, and we spoke with experts to get estimates of vaccine failure rates. In addition, we devised a hypothetical model of a school where measles immunization rates could be varied, vaccine failure rates could be calculated, and the percentage of measles cases occurring in immunized students could be determined.

"The apparent paradox is that as measles immunization rates rise to high levels in a population, measles becomes a disease of immunized persons. ."

RESULTS:
We found 18 reports of measles outbreaks in very highly immunized school populations where 71% to 99.8% of students were immunized against measles. Despite these high rates of immunization, 30% to 100% (mean, 77%) of all measles cases in these outbreaks occurred in previously immunized students. In our hypothetical school model, after more than 95% of schoolchildren are immunized against measles, the majority of measles cases occur in appropriately immunized children.

CONCLUSIONS:
The apparent paradox is that as measles immunization rates rise to high levels in a population, measles becomes a disease of immunized persons. Because of the failure rate of the vaccine and the unique transmissibility of the measles virus, the currently available measles vaccine, used in a single-dose strategy, is unlikely to completely eliminate measles. The long-term success of a two-dose strategy to eliminate measles remains to be determined.
PMID: 8053748.

TiP Editor: What has been determined since this paper in 1994 that even with 2 doses the vaccinated can still develop measles. In fact on a recent Australian news item Sunrise.com.au entitled 'Measles Immunity Concerns' the reporter mentions how researcher are desperately trying to understand why, and are looking at whether a third booster shot is needed.

THE FUTURE OF MEASLES IN HIGHLY IMMUNIZED POPULATIONS: A MODELING APPROACH

LEVY DL.
Am J Epidemiol. 1984 Jul;120(1):39-48.

ABSTRACT
Little is known about how an intensive measles elimination program changes the overall immune status of the population.

A computer model was created to study the effect of the measles elimination program in the United States on the number of susceptibles in the population.

The simulation reveals that in the prevaccine era, approximately 10.6% of the population was susceptible to measles, most of whom were children less than 10 years of age. With the institution of the measles immunization program, the proportion of susceptibles in the population fell to 3.1% from 1978 through 1981, but then began to rise by approximately 0.1% per year to reach about 10.9% in the year 2050.

The susceptibles at this time were distributed evenly throughout all age groups. The model did not consider the potential effect of waning immunity. The results of this study suggest that measles elimination in the United States has been achieved by an effective immunization program aimed at young susceptibles combined with a highly, naturally immunized adult population.

However, despite short-term success in eliminating the disease, long-range projections demonstrate that the proportion of susceptibles in the year 2050 may be greater than in the prevaccine era.

Present vaccine technology and public health policy must be altered to deal with this eventuality.
PMID: 6741921

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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