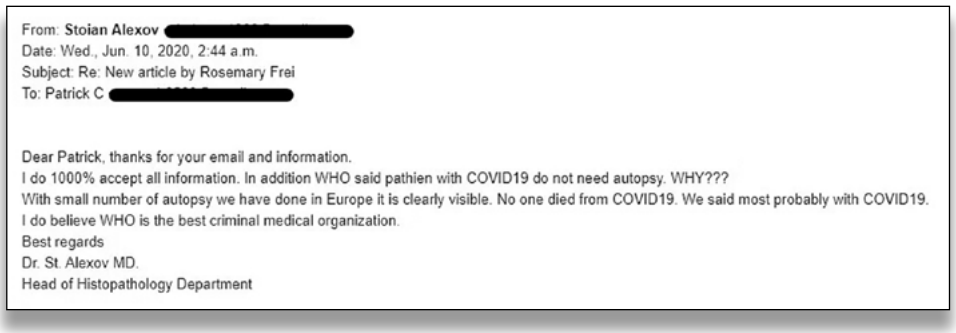
THE informed PARENT
ISSUE TWO 2020 A NEWSLETTER ON VACCINATION ISSUES AND HEALTH

"NO ONE HAS DIED FROM THE CORONAVIRUS"

IMPORTANT REVELATIONS SHARED BY DR STOIAN ALEXOV, PRESIDENT OF THE BULGARIAN PATHOLOGY ASSOCIATION


From: Stoian Alexov [redacted]
Date: Wed., Jun. 10, 2020, 2:44 a.m.
Subject: Re: New article by Rosemary Frei
To: Patrick C [redacted]

Dear Patrick, thanks for your email and information.
I do 1000% accept all information. In addition WHO said pathien with COVID19 do not need autopsy. WHY???
With small number of autopsy we have done in Europe it is clearly visible. No one died from COVID19. We said most probably with COVID19.
I do believe WHO is the best criminal medical organization.
Best regards
Dr. St. Alexov MD.
Head of Histopathology Department

BY ROSEMARY FREI
AND PATRICK CORBETT

https://off-guardian.org
Jul 2, 2020

A HIGH-PROFILE European pathologist is reporting that he and his colleagues across Europe have not found any evidence of any deaths from the novel coronavirus on that continent. Dr. Stoian Alexov called the World Health Organization (WHO) a "criminal medical organization" for creating worldwide fear and chaos without providing objectively verifiable proof of a pandemic.

Another stunning revelation from Bulgarian Pathology Association (BPA) president Dr. Alexov is that **he believes it's currently "impossible" to create a vaccine against the virus.** He also revealed that **European pathologists haven't identified any antibodies that are specific for SARS-CoV-2.** These stunning statements raise major questions, including about officials' and scientists' claims regarding the many vaccines they're rushing into clinical trials around the world.

They also raise doubt about the veracity of claims of discovery of anti-novel-coronavirus antibodies (which are beginning to be used to treat patients).

Novel-coronavirus-specific antibodies are supposedly the basis for the expensive serology test kits being used in many countries (some of which have been found to be unacceptably inaccurate).

And they're purportedly key to the immunity certificates coveted by Bill Gates that are about to go into widespread use— in the form of the COVI-PASS — in 15 countries including the UK, US, and Canada.

Dr. Alexov made his jaw-dropping observations in a video interview summarizing the consensus of participants in a May 8, 2020, European Society of Pathology (ESP) webinar on COVID-19.

The May 13 video interview of Dr. Alexov was conducted by Dr. Stoycho Katsarov, chair of the Center for Protection of Citizens' Rights in Sofia and a former Bulgarian deputy minister of health. The video is on the BPA's website, which also highlights some of Dr. Alexov's main points.

Among the major bombshells Dr. Alexov dropped is that the leaders of the May 8 ESP webinar said **no novel-coronavirus-specific antibodies have been found.** The body forms antibodies specific to pathogens it encounters. These specific antibodies are known as monoclonal antibodies and are a key tool in pathology. This is done via immunohistochemistry, which involves tagging antibodies with colours and then coating the biopsy- or autopsy-tissue slides with them. After giving the antibodies time to bind to the pathogens they're specific for, the pathologists can look at the slides under a microscope and see the specific places where the coloured antibodies — and therefore the pathogens they're bound to – are located.

Therefore, in the absence of monoclonal antibodies to the novel coronavirus, pathologists cannot verify whether SARS-CoV-2 is present in the body, or whether the diseases and deaths attributed to it indeed were caused by the virus rather than by something else.

It would be easy to dismiss Dr. Alexov as just another crank 'conspiracy theorist.' After all many people believe they're everywhere these days, spreading dangerous misinformation about COVID-19 and other issues. In addition, little of what Dr. Alexov alleges was the consensus from the May 8 webinar is in the publicly viewable parts of the proceedings. But keep in mind that whistleblowers often stand alone because the vast majority of people are afraid to speak out publicly.

Also, Dr. Alexov has an unimpugnable record and reputation. He's been a physician for 30 years. He's president of the BPA, a member of the ESP's Advisory Board and head of the histopathology department at the Oncology Hospital in the Bulgarian capital of Sofia.

On top of that, there's other support for what Dr. Alexov is saying. For example, the director of the Institute of Forensic Medicine at the University Medical Center Hamburg-Eppendorf in Germany said in media interviews that there's a striking dearth of solid evidence for COVID-19's lethality. "COVID-19 is a fatal disease only in

CONT/. PAGE 2 >

Magda Taylor

Editor's note

WELCOME to the latest edition. I am keeping my editorial short to free up more space for articles that I feel are well worth a read. Due to the alleged pandemic since the spring I have included further articles on covid-19. Sadly the msm continues to present very bias, one-sided reports to keep the public in a state of fear resulting in them obediently complying with the roll out of more and more regulations and restrictions. Despite the official narrative dominating many people's screens on a daily basis, more and more public are waking up and asking questions. Contradictory and ever-changing messages from our politicians and leaders have led more people to seek information outside the controlled mainstream doublespeak.

One doctor, in particular, who has emerged this year challenging the Covid story is medical doctor Andrew Kaufman. He has been exposing both virus and germ theory, highlighting the shoddy science surrounding these theories, which are based mostly on scientific assumptions over the last century or more. I would highly recommend visiting his website or find him on facebook, there's a wealth of links to many of his presentations and interviews. ***https://www.andrewkaufmanmd.com/***

Censorship has been rife these last few months. Youtube and facebook with their 'fact checkers' have been taking down informative videos and links as fast as they can. However in many ways this is backfiring as it is making people more curious as to what equates to misinformation. It is also noticeable how many more scientists, doctors etc. are having the courage to voice their concerns worldwide. Here is a list of some of them: Dr Ioanidis, Dr Kettner, Dr Katz, Dr Wodarg, Dr Peter Gøtzsche, Dr Bhakdi, Dr Jensen, Pablo Goldschmidt, Dr Kohnlein, Dr Muhammed Iqbal Adil, Dr Bruce Scott – check out on-line what concerns they have on this so-called pandemic.

In July the new film documentary by Andrew Wakefield was released. ***'1986 – The Act'*** *follows a couple's awakening on the vaccine issue and features archive data and footage bringing into question the methods of the vaccine makers and the unhealthy influence they have with their government bodies. Well worth a watch!*
https://1986theact.com/

Very informative programmes such as The High Wire with Del Bigtree every Thursday and UK Column News continue relentlessly to bring you the news that msm denies the public. Also Brian Rose of London Real continues to broadcast many eye-opening interviews with eg Icke, Tenpenny, Kaufman, Wakefield, to name a few. More recently Rose premiered an excellent new documentary 'Plandemic – Indoctornation' by Mikki Willis on his freedom platform. ***https://freedomplatform.tv/***

Please continue to encourage your family and friends to start investigating! The race to fast track a Covid vaccine and target the world population should ring alarm bells, especially the new vaccine technology (mRNA) that is involved. Stay positive, be courageous, and let's hope that a great awakening will unfold to challenge what I would consider to be 'the greatest crime against humanity!'

Magdalene Taylor, Editor, August 2020.

exceptional cases, but in most cases it is a predominantly harmless viral infection," Dr. Klaus Püschel told a German paper in April. Adding in another interview:

In quite a few cases, we have also found that the current corona infection has nothing whatsoever to do with the fatal outcome because other causes of death are present, for example, a brain hemorrhage or a heart attack […] [COVID-19 is] not particularly dangerous viral disease […] All speculation about individual deaths that have not been expertly examined only fuel anxiety."

Also, one of us (Rosemary) and another journalist, Amory Devereux, documented in a June 9 Off-Guardian article that the novel coronavirus has not fulfilled Koch's postulates.These postulates are scientific steps used to prove whether a virus exists and has a one-to-one relationship with a specific disease. We showed that to date no one has proven SARS-CoV-2 causes a discrete illness matching the characteristics of all the people who ostensibly died from COVID-19. Nor has the virus been isolated, reproduced and then shown to cause this discrete illness. In addition, in a June 27 Off-Guardian article two more journalists, Torsten Engelbrecht and Konstantin Demeter, added to the evidence that "the existence of SARS-CoV-2 RNA is based on faith, not fact."

The pair also confirmed "there is no scientific proof that those RNA sequences [deemed to match that of the novel coronavirus] are the causative agent of what is called COVID-19."

Dr. Alexov stated in the May 13 interview that: "the main conclusion [of those of us who participated in the May 8 webinar] was that the autopsies that were conducted in Germany, Italy, Spain, France and Sweden do not show that the virus is deadly."

He added that: "What all of the pathologists said is that there's no one who has died from the coronavirus. I will repeat that: no one has died from the coronavirus."

Dr. Alexov also observed there is no proof from autopsies that anyone deemed to have been infected with the novel coronavirus died only from an inflammatory reaction sparked by the virus (presenting as interstitial pneumonia) rather than from other potentially fatal diseases.

Another revelation of his is that: "We need to see exactly how the law will deal with immunization and that vaccine that we're all talking about, because I'm certain it's [currently] not possible to create a vaccine against COVID. I'm not sure what exactly Bill Gates is doing with his laboratories – is it really a vaccine he's producing, or something else?"

As pointed to above, the inability to identify monoclonal antibodies for the virus suggests there is no basis for the vaccines, serological testing and immunity certificates being rolled out around the globe at unprecedented speed and cost. In fact, there is no solid evidence the virus exists.

Dr. Alexov made still more important points. For example, he noted that, in contrast to the seasonal influenza, SARS-CoV-2 hasn't been proven to kill

youth: [With the flu] we can find one virus which can cause a young person to die with no other illness present […] In other words, the coronavirus infection is an infection that does not lead to death. And the flu can lead to death."

(There have been reports of severe maladies such as Kawasaki-like disease and stroke in young people who were deemed to have a novel-coronavirus infection. However, the majority of published papers on these cases are very short and include only one or only a small handful of patients. Moreover, commenters on the papers note it's impossible to determine the role of the virus because the papers' authors did not control sufficiently, if at all, for confounding factors. It's most likely that children's deaths attributed to COVID-19 in fact are from multiple organ failure resulting from the combination of the drug cocktail and ventilation that these children are subjected to.)

Dr. Alexov therefore asserted that: "the WHO is creating worldwide chaos, with no real facts behind what they're saying." Among the myriad ways the WHO is creating that chaos is by prohibiting almost all autopsies of people deemed to have died from COVID-19. As a result, reported Dr. Alexov, by May 13 only three such autopsies had been conducted in Bulgaria. Also, the WHO is dictating that everyone said to be infected with the novel coronavirus who subsequently dies must have their deaths attributed to COVID-19.

"That's quite stressful for us, and for me in particular, because we have protocols and procedures which we need to use," he told Dr. Katsarov. "… And another pathologist 100 years from now is going to say, 'Hey, those pathologists didn't know what they were doing [when they said the cause of death was COVID-19]!' So we need to be really strict with our diagnoses, because they could be proven [or disproven], and they could be checked again later."

He disclosed that pathologists in several countries in Europe, as well as in China, Australia and Canada are strongly resisting the pressure on them to attribute deaths to COVID-19 alone: "I'm really sad that we need to follow the [WHO's] instructions without even thinking about them. But in Germany, France, Italy and England they're starting to think that we shouldn't follow the WHO so strictly, and [instead] when we're writing the cause of death we should have some pathology [results to back that up] and we should follow the protocol. [That's because] when we say something we need to be able to prove it."

He added that autopsies could have helped confirm or disprove the theory that many of the people deemed to have died of COVID-19 in Italy had previously received the H1N1 flu vaccine. Because, as he noted, the vaccine suppresses adults' immune systems and therefore may have been a significant contributor to their deaths by making them much more susceptible to infection. Drs. Alexov and Katsarov agreed that yet another aspect of the WHO-caused chaos and its fatal consequences is many people are likely to die soon from diseases such as

"The WHO is creating worldwide chaos, with no real facts behind what they're saying."

cancer because the lockdowns, combined with the emptying of hospitals (ostensibly to make room for COVID-19 patients), halted all but the most pressing procedures and treatments. They also observed these diseases are being exacerbated by the fear and chaos surrounding COVID-19. We know that stress significantly suppresses the immune system, so I can really claim 200% that all the chronic diseases will be more severe and more acute per se. Specifically in situ carcinoma – over 50% of these are going to become more invasive […] So I will say that this epidemic isn't so much an epidemic of the virus, it's an epidemic of giving people a lot of fear and stress."

In addition, posited Dr. Alexov, as another direct and dire result of the pandemic panic many people are losing faith in physicians. "Because in my opinion the coronavirus isn't that dangerous, and how are people going to have trust in me doing cancer pathology, much of which is related to viruses as well? But nobody is talking about that."

We emailed Dr. Alexov several questions, including asking why he believes it's impossible to create a vaccine against COVID-19. He didn't answer the questions directly. Dr. Alexov instead responded: (see image on p01).

We also emailed five of Dr. Alexov's colleagues in the European Pathology Society asking them to confirm Dr. Alexov's revelations. We followed up by telephone with two of them. None responded. Why didn't Dr. Alexov or his five colleagues answer our questions?

We doubt it's due to lack of English proficiency. It's more likely because of the pressure on pathologists to follow the WHO's directives and not speak out publicly. (And, on top of that, pathology departments depend on governments for their funding.) Nonetheless, pathologists like Drs. Alexov and Püschel appear to be willing to step out and say that no one has died from a novel-coronavirus infection.

Perhaps that's because pathologists' records and reputations are based on hard physical evidence rather than on subjective interpretation of tests, signs and symptoms. And there is no hard physical evidence that COVID-19 is deadly.

Rosemary Frei has an MSc in molecular biology from the Faculty of Medicine at the University of Calgary, was a freelance medical writer and journalist for 22 years and now is an independent investigative journalist. You can watch her June 15 interview on The Corbett Report, read her other Off-Guardian articles and follow her on Twitter.

Patrick Corbett is a retired writer, producer, director and editor who's worked for every major network in Canada and the US except for Fox. His journalistic credits include Dateline NBC, CTV's W-5 and the CTV documentary unit where he wrote and directed 'Children's Hospital', the first Canadian production to be nominated for an International Emmy. You can follow Patrick on Twitter.

STORING MEDICAL INFORMATION BELOW THE SKIN'S SURFACE: Specialized dye, delivered along with a vaccine, could enable "on-patient" storage of vaccination history

ANNE TRAFTON, MIT NEWS OFFICE

December 18, 2019
https://news.mit.edu/2019/storing-vaccine-history-skin-1218

TiP Editor: This is what officialdom wants to roll out!

EVERY YEAR, a lack of vaccination leads to about 1.5 million preventable deaths, primarily in developing nations. One factor that makes vaccination campaigns in those nations more difficult is that there is little infrastructure for storing medical records, so there's often no easy way to determine who needs a particular vaccine.

MIT researchers have now developed a novel way to record a patient's vaccination history: storing the data in a pattern of dye, invisible to the naked eye, that is delivered under the skin at the same time as the vaccine.

"In areas where paper vaccination cards are often lost or do not exist at all, and electronic databases are unheard of, this technology could enable the rapid and anonymous detection of patient vaccination history to ensure that every child is vaccinated," says Kevin McHugh, a former MIT postdoc who is now an assistant professor of bioengineering at Rice University.

The researchers showed that their new dye, which consists of nanocrystals called quantum dots, can remain for at least five years under the skin, where it emits near-infrared light that can be detected by a specially equipped smartphone. McHugh and former visiting scientist Lihong Jing are the lead authors of the study, which appears today in Science Translational Medicine. Ana Jaklenec, a research scientist at MIT's Koch Institute for Integrative Cancer Research, and Robert Langer, the David H. Koch Institute Professor at MIT, are the senior authors of the paper.

AN INVISIBLE RECORD

Several years ago, the MIT team set out to devise a method for recording vaccination information in a way that doesn't require a centralized database or other infrastructure. Many vaccines, such as the vaccine for measles, mumps, and rubella (MMR), require multiple doses spaced out at certain intervals; without accurate records, children may not receive all of the necessary doses.

"In order to be protected against most pathogens, one needs multiple vaccinations," Jaklenec says. "In some areas in the developing world, it can be very challenging to do this, as there is a lack of data about who has been vaccinated and whether they need additional shots or not."

To create an "on-patient," decentralized medical record, the researchers developed a new type of copper-based quantum dots, which emit light in the near-infrared spectrum. The dots are only about 4 nanometers in diameter, but they are encapsulated in biocompatible microparticles that form spheres about 20 microns in diameter. This encapsulation allows the dye to remain in place, under the skin, after being injected.

The researchers designed their dye to be delivered by a microneedle patch rather than a traditional syringe and needle. Such patches are now being developed to deliver vaccines for measles, rubella, and other diseases, and the researchers showed that their dye could be easily incorporated into these patches. The microneedles used in this study are made from a mixture of dissolvable sugar and a polymer called PVA, as well as the quantum-dot dye and the vaccine. When the patch is applied to the skin, the microneedles, which are 1.5 millimeters long, partially dissolve, releasing their payload within about two minutes. By selectively loading microparticles into microneedles, the patches deliver a pattern in the skin that is invisible to the naked eye but can be scanned with a smartphone that has the infrared filter removed. The patch can be customized to imprint different patterns that correspond to the type of vaccine delivered.

"It's possible someday that this 'invisible' approach could create new possibilities for data storage, biosensing, and vaccine applications that could improve how medical care is provided, particularly in the developing world," Langer says.

EFFECTIVE IMMUNIZATION

Tests using human cadaver skin showed that the quantum-dot patterns could be detected by smartphone cameras after up to five years of simulated sun exposure.

The researchers also tested this vaccination strategy in rats, using microneedle patches that delivered the quantum dots along with a polio vaccine. They found that those rats generated an immune response similar to the response of rats that received a traditional injected polio vaccine.

"This study confirmed that incorporating the vaccine with the dye in the microneedle patches did not affect the efficacy of the vaccine or our ability to detect the dye," Jaklenec says.

The researchers now plan to survey health care workers in developing nations in Africa to get input on the best way to implement this type of vaccination record keeping. They are also working on expanding the amount of data that can be encoded in a single pattern, allowing them to include information such as the date of vaccine administration and the lot number of the vaccine batch. The researchers believe the quantum dots are safe to use in this way because they are encapsulated in a biocompatible polymer, but they plan to do further safety studies before testing them in patients.

"Storage, access, and control of medical records is an important topic with many possible approaches," says

Mark Prausnitz, chair of chemical and biomolecular engineering at Georgia Tech, who was not involved in the research. "This study presents a novel approach where the medical record is stored and controlled by the patient within the patient's skin in a minimally invasive and elegant way."

The research was funded by the Bill and Melinda Gates Foundation and the Koch Institute Support (core) Grant from the National Cancer Institute. Other authors of the paper include Sean Severt, Mache Cruz, Morteza Sarmadi, Hapuarachchige Surangi Jayawardena, Collin Perkinson, Fridrik Larusson, Sviatlana Rose, Stephanie Tomasic, Tyler Graf, Stephany Tzeng, James Sugarman, Daniel Vlasic, Matthew Peters, Nels Peterson, Lowell Wood, Wen Tang, Jihyeon Yeom, Joe Collins, Philip Welkhoff, Ari Karchin, Megan Tse, Mingyuan Gao, and Moungi Bawendi.

LANCET EDITOR SPILLS THE BEANS AND BRITAIN'S PM SURRENDERS TO THE GATES VACCINE CARTEL

June 5, 2020
https://ahrp.org/lancet-editor-spills-the-beans-and-britains-pm-surrenders-to-the-gates-vaccine-cartel/

PHILIPPE Douste-Blazy, MD, a cardiologist and former French Health Minister who served as Under-Secretary General of the United Nations; he was a candidate in 2017 for Director of the World Health Organization. In a videotaped interview on May 24, 2020, Dr Douste-Blazy provided insight into how a series of negative hydroxychloroquine studies got published in prestigious medical journals. He revealed that at a recent Chatham House top secret, closed door meeting attended by experts only, the editors of both, The Lancet and the New England Journal of Medicine expressed their exasperation citing the pressures put on them by pharmaceutical companies. He states that each of the editors used the word "criminal" to describe the erosion of science.

He quotes Dr Richard Horton who bemoaned the current state of science:

"If this continues, we are not going to be able to publish any more clinical research data because pharmaceutical companies are so financially powerful; they are able to pressure us to accept papers that are apparently methodologically perfect, but their conclusion is what pharmaceutical companies want."

Dr Douste-Blazy supports the combination treatment –hydroxychloroquine (HCQ) and azithromycin (AZ) for Covid-19 recommended by Dr Didier Raoult. In April, 2020 Dr Douste-Blazy started a petition that has been signed by almost 500,000 French doctors and citizens urging French government officials to permit physicians to prescribe hydroxychloroquine to treat coronavirus patients early, before they require intensive care. The issue has become highly politicized; the left-leaning politicians and public health officials are adamantly against the use of HCQ, whereas those leaning toward the right politically are for the right of doctors to prescribe the drug as they see fit.

"No one knew when they were electing Johnson that they were electing Gates and putting the vaccine industry at the heart of the British nation's future."

The journal SCIENCE described the response to French President Emmanuel Macron trip to Marseille to meet Dr Raoult who prescribes the combination drug regimen and he has documented their effectiveness. However, public health officials, academic physicians and the media – all of who are financially indebted to pharmaceutical companies and their high profit marketing objectives – vehemently oppose the use of HCQ, and use every opportunity to disparage the drug by derisively referring to President Trump as its booster.

John Stone, UK Editor of Age of Autism, posted the following today (5 June 2020): **British Prime Minister Channels Churchill As He Surrenders To Gates And The Vaccine Cartel.**

This is the moment of national humiliation that we somehow did not see on our television sets last night: British Prime Minister Boris Johnson surrendering to Bill Gates and the vaccine cartel, GAVI, hailed by him as the new NATO – while he speaks from a nation on its knees like Vichy France. While British news after months of wall to wall Coronavirus suddenly, mysteriously became obsessed with the 13 year old saga of Madeleine McCann almost no one saw Johnson's insipid, but rhetorically overblown speech at the end of the global summit he hosted in London yesterday and chaired with Gates. No one knew when they were electing Johnson that they were electing Gates and putting the vaccine industry at the heart of the British nation's future. It was particularly galling to see him extol the already failed Oxford COVID vaccine as an example of British innovation. This is presumably where we were headed from the moment lockdown was announced. The meeting elicited a short mention at the end of the BBC 10 o'clock news and was not mentioned on the front pages of any of the national newspapers this morning.

If GAVI is the new NATO, and the focus of British national destiny perhaps the moment should not have been news managed out of existence. Now everything that our lives were worth has to be surrendered in an endless war against disease long ago devised by Mr Gates. In Gates's brave new world everyone will have to have vaccines like computer patches every five minutes, and when they don't work – if we are still standing – we will have to have another.

PREVENTING PARALYTIC POLIO CAUSED BY VACCINE-DERIVED POLIOVIRUS TYPE 2

www.thelancet.com/infection
Vol 20; p21; Jan 2020

GRACE MACKLIN and colleagues reported the results of a systematic review on the effect of polio vaccine schedules on induction of humoral and intestinal immunity and concluded that the addition of one dose of inactivated poliovirus vaccine (IPV) for all birth cohorts protects against paralytic polio caused by poliovirus type 2.[1]

We concur with the authors on introducing IPV for all birth cohorts to protect against paralytic polio given that IPV induces a humoral response that blocks access of polioviruses into the CNS.[2] The Global Polio Eradication Initiative has reported weekly cases of human paralytic polio occurring during outbreaks of circulating vaccine-derived poliovirus type 2 (cVDPV2) in multiple countries, including some African countries and the Philippines, as well as an upsurge of cases of wild poliovirus type 1 in Pakistan and Afghanistan. Introducing IPV in these settings and other areas with low poliovirus immunisation coverage offers a long-term solution but does not address the critical short-term need to rapidly halt existing outbreaks of cVDPV2.[3] Therefore, we should reassess previous achievements of polio control activities—for example, the containment of outbreaks with supplemental immunisation using trivalent oral poliovirus vaccine (OPV) in Egypt (cVDPV2 from 1983 to 1993)[4] and of circulating vaccine-derived poliovirus type 1 (cVDPV1) in Hispaniola in 2000.[5] In the Hispaniola case, both Haiti and the Dominican Republic implemented up to 3 national vaccination days per year that halted the transmission of cVDPV1.[5] These interventions demonstrate that the use of trivalent OPV might rapidly promote the required intestinal mucosal immunity to stop viral shedding during outbreaks of cVDPV2, which is not offered by the use of IPV at birth.

Furthermore, using trivalent OPV boosts mucosal immunity to wild poliovirus type 1 and other vaccine-derived polioviruses, thus fostering the goals of WHO's Polio Endgame Strategy. To achieve immunisation of children residing in districts with polio vaccine coverage of less than 95% with more than three doses of trivalent OPV, we suggest supplemental immunisation activities in addition to introducing routine IPV at birth.

The biggest challenge facing the Global Polio Eradication Initiative is that health services in several countries have not maintained the required levels of polio immunity in children. If no political will supports routine immunisation to improve vaccination coverage, **circulating vaccine-derived polioviruses will continue to be a threat and other vaccine-preventable diseases might return to cause unnecessary suffering.**

We declare no competing interests.

*Carlos Franco-Paredes, Jose I Santos-Preciado, Andres F Henao-Martinez, Alfonso J Rodriguez-Morales, Peter Carrasco
carlos.franco.paredes@gmail.com

References

1. Macklin GR, Grassly NC, Sutter RW, et al. Vaccine schedules and the effect on humoral and intestinal immunity against poliovirus: a systematic review and network meta-analysis. Lancet Infect Dis 2019; 10: 1121–28.
2. Parker EPK, Molodecky NA, Pons-Salort M, O'Reilly KM, Grassly NCC. Impact of inactivated poliovirus vaccine on mucosal immunity: implications for the polio eradication endgame. Expert Rev Vaccines 2015; 14: 1113–23.
3. Pons-Salort M, Burns CC, Lyons H, et al. Preventing vaccine-derived poliovirus emergence during the polio endgame. PLoS Pathog 2016; 12: e1005728.
4. Yang CF, Naguib T, Yang SJ, et al. Circulation of endemic type 2 vaccine-derived poliovirus in Egypt from 1983 to 1993. J Virol 2003; 77: 8366–77.
5. Pan American Health Organization. Poliomyelitis. https://www.paho.org/hq/ index.php?option=com_content&view=article&id=7069:2012-poliomyelitis&Itemid= 1712&lang=en (accessed Nov 10, 2019).

VACCINATION DE RIGUEUR

Taken from: The Vaccination Inquirer; Vol. V, No. 58, Jan 1884, page 209.

117 Albany Street, Regent's Park
October 22, 1883.

SIR,- Respecting the death of Mrs Darling's infant, vaccinated on Sept 12, and dying on Sept 19, you say, "Dr Whitefoord refused to certify the cause of the child's death without an inquest."

Kindly allow me to state that in my communication to the Coroner for Central Middlesex, I only said that I was "***unable to certify.***" It was therefore a matter of surprise to receive a letter from the Coroner's clerk, suggesting that I should certify to death "as from Diarrhoea." I did not take the liberty of suggesting to the Coroner that I considered it ***his*** duty to hold an inquest; and I cannot see that it was any part of the Coroner's duty to suggest that ***I*** should give a fanciful return to the Registrar. There was no doubt whatever in my mind that the infant Darling died of Acute Meningitis set up by vaccination. From my experience in Central Middlesex I do not think the abuses of vaccination will be submitted to the light of truth in the Coroner's Court. The ***modus operandi*** in vaccination inquiries seems to be the selection of some medical witness who, after making a ***post-mortem*** examination, will unblushingly ascribe death to starvation, sunstroke, or any cause foreign to the case. Better far, I think, to bury under a Coroner's order, leaving the facts untouched. – Your truly, Dr C E Whitefoord.

INFLUENZA VACCINATION AND RESPIRATORY VIRUS INTERFERENCE AMONG DEPARTMENT OF DEFENSE PERSONNEL DURING THE 2017–2018 INFLUENZA SEASON

BY GREG G. WOLFF

Vaccine 38 (2020) 350–354

ABSTRACT

PURPOSE:

Receiving influenza vaccination may increase the risk of other respiratory viruses, a phenomenon known as virus interference. Test-negative study designs are often utilized to calculate influenza vaccine effectiveness. The virus interference phenomenon goes against the basic assumption of the test-negative vaccine effectiveness study that vaccination does not change the risk of infection with other respiratory illness, thus potentially biasing vaccine effectiveness results in the positive direction. This study aimed to investigate virus interference by comparing respiratory virus status among Department of Defense personnel based on their influenza vaccination status. Furthermore, individual respiratory viruses and their association with influenza vaccination were examined.

RESULTS:

We compared vaccination status of 2880 people with non-influenza respiratory viruses to 3240 people with pan-negative results. Comparing vaccinated to non-vaccinated patients, the adjusted odds ratio for non-flu viruses was 0.97 (95% confidence interval (CI): 0.86, 1.09; p = 0.60). Additionally, the vaccination status of 3349 cases of influenza were compared to three different control groups: all controls (N = 6120), non-influenza positive controls (N = 2880), and pan-negative controls (N = 3240). The adjusted ORs for the comparisons among the three control groups did not vary much (range: 0.46–0.51).

CONCLUSIONS:

Receipt of influenza vaccination was not associated with virus interference among our population. Examining virus interference by specific respiratory viruses showed mixed results. **Vaccine derived virus interference was significantly associated with coronavirus and human metapneumovirus;** however, significant protection with vaccination was associated not only with most influenza viruses, but also parainfluenza, RSV, and non-influenza virus co-infections.

RATES OF VACCINE HESITANCY

VACCINE HESITANCY: AMONG GENERAL PRACTITIONERS IN SOUTHERN FRANCE AND THEIR RELUCTANT TRUST IN THE HEALTH AUTHORITIES

INTERNATIONAL JOURNAL OF QUALITATIVE STUDIES ON HEALTH AND WELL-BEING 2020.
VOL. 15, 1757336 https://doi.org/10.1080/17482631.2020.1757336

Rose Jane Isobel Wilson, Chantal Vergélys, Jeremy Ward, Patrick Peretti-Watel and Pierre Verger

ABSTRACT

Purpose: Vaccine hesitancy is common in France, including among general practitioners (GPs). We aimed to understand vaccine hesitant GPs' views towards vaccines.

Method: We conducted in-depth interviews that were thematically analysed.

Result: We found that, facilitated by health scandals and vaccine controversies—that according to participants were not effectively handled by health authorities—the implicit contract existing between health authorities and GPs has been ruptured. This contract implies that health authorities support GPs in making vaccine recommendations by addressing GPs' own concerns, providing them with adequate and up-to-date information and advice, and involving them in vaccine decision-making. In turn, GPs encourage vaccination to reach vaccine coverage targets.

Conclusion: The rupture of this implicit contract has led to a breach in trust in the health authorities and the vaccines that they recommend.

VACCINE ADHERENCE: THE RATE OF HESITANCY TOWARD CHILDHOOD IMMUNIZATION IN KAZAKHSTAN

ZYLKIYA AKHMETZHANOVA, VITALIY SAZONOV, DIETER RIETHMACHER AND MOHAMAD ALJOFAN

EXPERT REVIEW OF VACCINES
https://doi.org/10.1080/14760584.2020.1775080.
Published online: 04 Jun 2020.

ABSTRACT

Objectives: Vaccines are considered one of the most important inventions of human history that enabled the containment of several infectious diseases. However, there is a global decrease in the rate of vaccination and an increase in outbreaks of vaccine-preventable diseases. The aims of the current study are to determine childhood vaccine hesitancy and its influencing factors in Kazakhstan.

Methods: This cross sectional online-based study was conducted between Sep until Nov of 2019.

Results: A total of 387 participants of which 70% were females with the majority under the age of 40 years and having one child or more. More than a third (35%) of the participants identified themselves as vaccine hesitant, 71% believed that vaccines are effective, and 65% believed that vaccines are good. Vaccine source of information appears to be an influential factor as those who receive information from healthcare providers have no concerns about vaccination.

Conclusion: This is the first study to identify factors associated with vaccine hesitancy in Kazakhstan. There is a high rate of vaccine hesitancy and low rate of vaccine knowledge identified in the participant group. Healthcare providers have a unique position in improving parents' vaccine knowledge and acceptance.

WHAT CAN I TELL YOU ABOUT... Causes of Death?

by Patrick Quanten MD

ESTABLISHING the cause of death is a doctor's prerogative. Only a qualified doctor is allowed to fill in the form, which officially makes his statement the true cause of death for that individual. Originally these documents were a legal requirement for the State, who apparently 'owns' the body of any deceased person, to release the body for burial.

It was a document that stated that the person died of a natural cause and the cause was a legally accepted one. That was all these documents were for: establishing written proof of a natural death. Then the medical profession decided they could use this information for statistical purposes to publish figures about death rates for a variety of diseases. They treated this information as if the named causes of death were indeed the actual causes of death, while in fact hardly any of those believed causes have been scientifically proven to be correct.

It is what the doctor believes his patient died of but without him having any real proof for such a conviction and indeed without even the need for any supporting evidence. The only thing the document states is that the person died of one of the established natural death causes, in the opinion of the doctor. He never had to worry about whether the cause he writes down is or is not scientifically correct. And yet, this information, based on the doctor's beliefs, is now being used as 'true' information about real causes of death in order to manipulate government policy and finances.

Occasionally, either for medical, scientific or for legal purposes, autopsies have been carried out in an attempt to establish the 'real' cause of death. Post-mortems lead to identifying a single cause of death, mainly in young people and in criminal investigations, but generally speaking it

Patrick Quanten MD

only turns up a number of possible causes. In fatalities, diseases usually have undermined the function of several vital organs and systems, which makes it extremely difficult, near to impossible, to determine the 'exact' cause of death.

Using these documents to create statistical data about demographic diversity and about changing death rates for specific diseases over time in truth only show differences of doctor's opinions about the cause of death. So cultural and propaganda differences will dominate these statistical data throughout, without ever providing a true picture about death rates for any known and unknown causes. Alter the belief of the physician about what he is treating and his 'understanding' about what has caused a specific individual to die has changed too.

The true cause of any death is almost impossible to establish and no statistics on this matter contain any information of value. It only shows us what doctors believe to be the case.

SPREADING INFECTIOUS DISEASES?

If diseases are to be passed on from one living form to another the element carrying the disease will have to be able to leave the body of the infector before it could possibly enter the body of the infectee. Since the inside of all bodies is well protected by a defensive lining of either skin or membrane in a complete and uninterrupted manner it requires a physical breakdown of this barrier in at least one, preferably multiple locations before a successful invasion can take place. So the disease carrier has to be present inside the body and the defensive lining has to be broken somewhere in order for the carrier to pass into the outside world where it possibly can be picked up by another living organism. For this to happen it needs to break free from the first infected person and survive in the outside world.

HOW THE FIRST PERSON BECAME INFECTED REMAINS A MYSTERY

When the defensive lining has been broken it means a disturbance of the normal function of that system, be it the skin or the membrane. Through this opening leakage of fluids and chemicals will occur, changing the outside equilibrium in the immediate surroundings of the broken defence. This will be noticeable through signs of either excessive fluids such as phlegm, blood, swelling, or signs of inflammation, the reaction of the body trying to repair the breakdown. Without such signs it becomes very unlikely that any carrier of disease is able to leave the body in sufficient numbers. When only miniscule numbers escape in a similar way that a few drops of blood may 'leak' out of the blood vessel, which restores itself very quickly, no damage whatsoever will occur and no change in the environment will take place.

From being present on top of the skin or the membranes - the inner lining of mouth, nose, throat, lungs or the digestive tract - the carrier now needs to leave the confines of the body in order to be able to meet another body. This requires the leaked elements, mainly carried within fluids, to be expelled from the body into the outside atmosphere where it could possibly encounter another body. The way this happens is generally regarded as disease

symptoms. There are, indeed, signs of a malfunction within the body of the carrier of the infection.

Without any disease symptoms science has not been able to establish proof for a way out of the enclosed body of the infector in order to spread the disease carrier.

In order for an infectee to be contaminated by an infector the latter must release the said carrier of that disease into his or her immediate environment.

Science has established that the concentration of infectious material in the environment has to be of a certain level before a transmission of disease can take place, but it never established an exact figure for this. In truth, science has only been using the argument of the concentration in order to explain a failure in transmitting the infection. When no transmission of disease takes place medical researchers proclaim that the concentration of infected material was too low, but they never established the minimum threshold for transmission to actually take place.

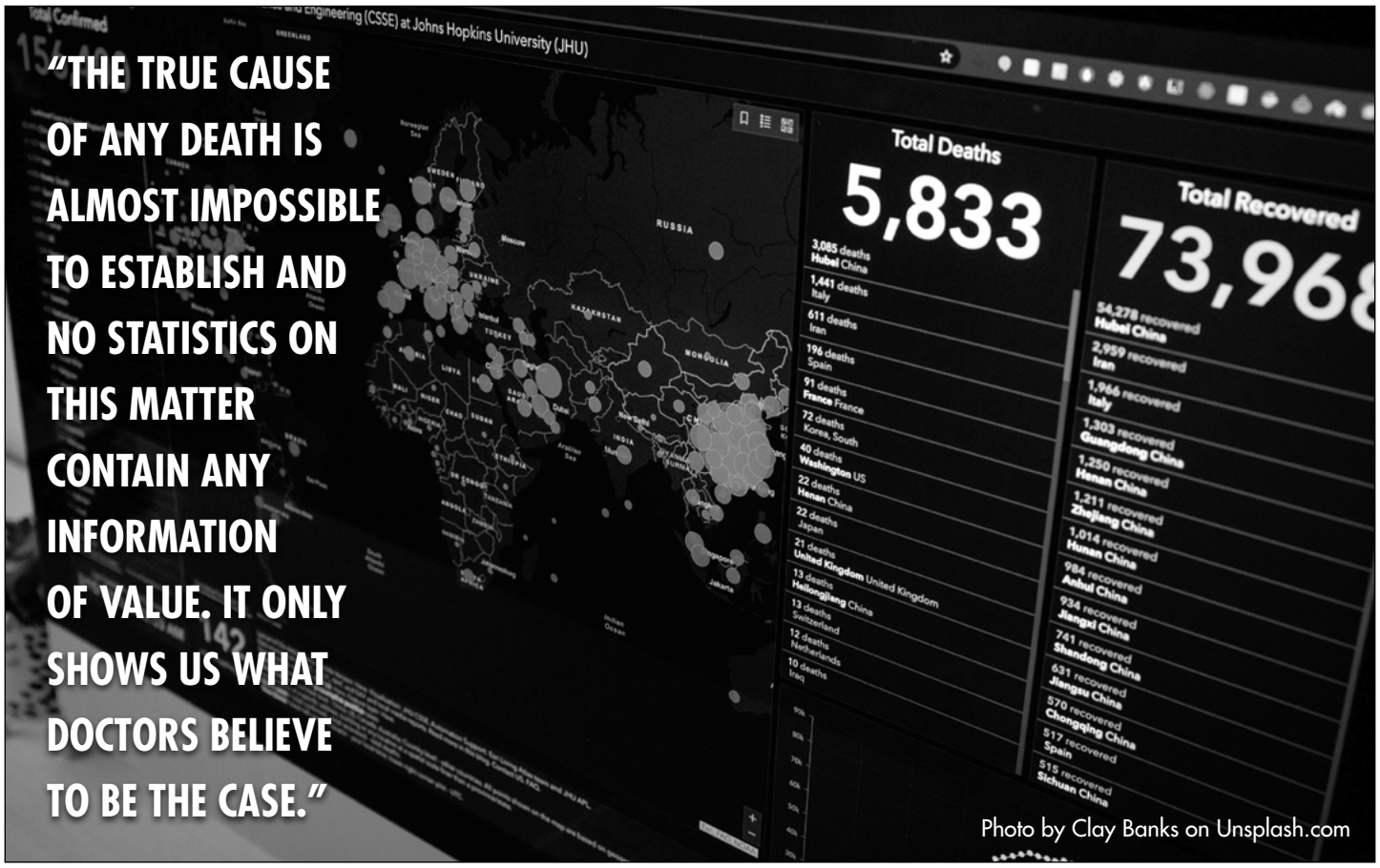
Micro-organisms such as bacteria and fungi can be detected in expelled fluids from ill persons when these fluids are being collected on the body surface itself or very close to it. Living micro-organisms have only been detected in a space of about half a metre away when the fluids have been projected with an extreme force such as sneezing or violent coughing or projectile vomiting. Nowhere else in the immediate surroundings of an ill person have micro-organisms actually been shown to exist and survive as a direct result of the disease process which is developing inside a person.

"And yet, this information, based on the doctor's beliefs, is now being used as 'true' information about real causes of death in order to manipulate government policy and finances."

For a transmission of a disease to take place between two individuals the 'infector' has to have a certain amount of "breakdown" in the tissues before anything can be released. Outwardly the person may still think they are okay but soon it will start to show. In other words, it may be at the very beginning of the illness but in effect they are already ill. Equally the 'infectee' would need to be susceptible also.

Supposing that is the case – in real terms of everyday life science has never established this! There needs to be enough of these carriers attacking the body of the infectee in order to create or find a breakdown in the lining defences of the person who is said to become infected. Scientific studies have established that this cannot happen in people that are healthy at the time of the encounter. It appears as if the carrier on the outside of the body is only able to enter when there is already an existing weakening of the membranes, suggesting a pre-existing illness. Now, supposing a person gets ill with comparable symptoms to the person he or she has been in contact with, that in itself is no proof that a transmission of a disease-carrying substance has taken place.

At the most, one can say that there appears to be a correlation between the two ill people but in order for causation to be proven one has to be much more specific. If a disease-carrying substance, a germ for instance, is found ›



to be present at the same time as a specific disease it is not evidence that that specific micro-organism has caused the disease.

To prove this one has to find that everybody who is carrying that disease-producing organism has to have that specific disease and that nobody else, either a symptom-free person or a person with a different disease, is found to harbour that specific organism. It should also be demonstrated that when that organism is introduced into a healthy system it should always produce that very specific disease and never any other disease. It turns out that science has never established a causal relationship between any organism accused of carrying a disease and that specific disease! At the same time it turns out that all organisms held responsible for specific diseases can, at one point or another, be demonstrated to be resident within a symptom-free body. This is the truth about living micro-organisms that we do find within diseased tissue and that we can easily show to be alive at the time of identification. Medicine says these 'germs' are responsible for the disease but testing this hypothesis scientifically (Koch's postulates) fails every time. Medicine is not science! Being present at the scene of a crime does not make you the perpetrator.

Once science began to run into these problems of not being able to demonstrate a causal link between a living organism and a specific disease the profession invented another invisible 'cause', one that is so small it cannot be seen in living conditions at all. It is supposed to 'reside' within a cell, ignoring the fact that all cells have a very short lifespan, which poses the question as to why any residing substance within such a cell is not being eliminated at the death of its host cell. Science does admit that this tiny blob, which they have named 'a virus', is not a living creature. It is far too small for that and it lacks all organelles (internal organs and structures) to have a metabolism. In spite of the fact that it does not feed itself, it does not metabolise, and it does not excrete anything, it is still said

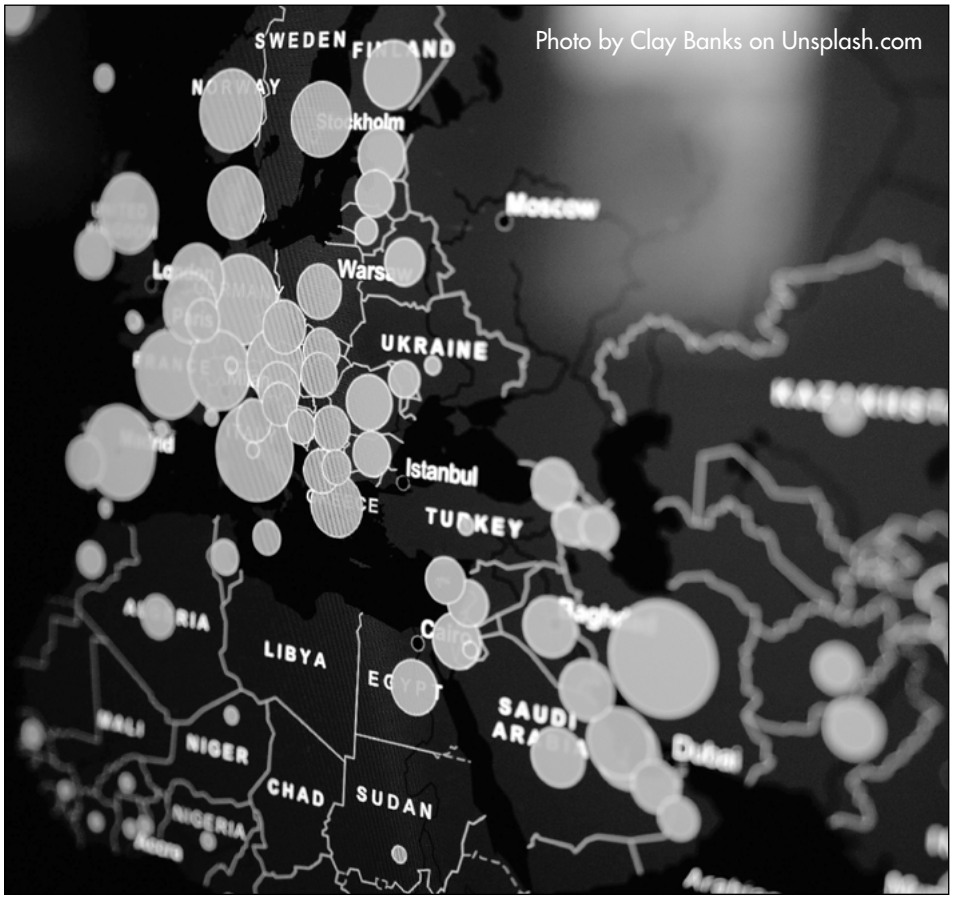


Photo by Clay Banks on Unsplash.com

to replicate; mind you, not of its own accord but by utilising the host cell's DNA, by hijacking the reproductive capacity of the cell and turning the entire cell into a single-minded virus production line. The medical profession fails to explain how a blob which has no metabolism, and is in fact not even alive, is able to make the journey throughout the interior of the cell, in a similar fashion the micro-organisms are said to invade the body from the outside.

Furthermore, this unbelievably tiny blob that doesn't do anything must still be capable of not only fighting off the defence mechanisms of the body, designed to keep foreign material out, but also it must find its way past the cell defences in order for it to arrive at the core of life, the cellular nucleus. Apparently, no bodily defence mechanism, great or small, is capable of detecting and destroying this non-living entity!

Science has tried on many occasions to introduce such viruses into the body of healthy people in order to study the effects of the invasion. Across time and across the world they never managed an effective rate higher than 13%, even when they already introduced it past the defensive membrane. And the effect we are talking about is not even seeing the disease occur, it only means that in blood tests they have established what they have called 'an immune reaction' to the introduction of the virus. It means that in a small percentage of people they measure slightly higher levels of either specific cells or specific proteins they have determined to be linked to a stimulation of the defences of the body.

Science has never established that a disease can be introduced by contact with a virus. It failed to do so in contact with a microbe and it certainly has failed to do so with regards to viruses. So even if a virus is present in the immediate environment of a sick person, which is scientifically impossible to prove, and even if whatever the virus is said to be carried in (water droplets, air, skin, bodily fluids, surfaces) has entered another body, maybe via the airway or the digestive system, there is no scientific evidence it creates any effect whatsoever.

Can one establish the presence of a

tiny particle like a virus in the air or a water droplet? The answer is hardly. It is a very complicated, time consuming and an extremely costly business involving electron microscopic imagery. Bypassing the only true way of visualising what they call a virus, the medical profession has made it easy on itself by chemically 'isolating' the virus instead of demonstrating the true presence of the virus. Although there have been several claims about isolating viruses, none has ever been accepted by the scientific community as purification of the sample or purification of the cellular growth they are using in order to 'amplify' the number of viruses.

These claims are littered with scientific faults, they are assumptions rather than facts. It appears impossible to filter such a tiny blob out of general cellular debris. The 'identification' tests the medical profession is using are not identifying a virus but are identifying a very small DNA sequence or even simply a protein structure. As every living cell is made up of these kind of structures it is potentially possible to 'identify' these structures within specific debris of any cellular organism. There is nothing specific about any viral test the medical profession is using in their research. The presence of 'a virus' cannot be demonstrated by chemical analysis of cellular debris.

If, on so many levels, proof in support of a theory is not forthcoming and so many observations contradict the theory it is scientific nonsense to continue using the theory to set up prediction models and treatment plans. In the case of infectious diseases it would make scientific sense to switch to another germ theory. A two-century old theory is available that so far has never failed to explain infections. In line with the new physics of the twentieth century we would do well in medicine too, to switch from a physical to an energetic approach.

EPIDEMICS?

The spread of diseases on a large scale throughout the population have happened all the time and are part of nature. In fact, just as inflammation occurs as a natural phenomenon it happens the same way with infections. They arise without any obvious reason within every living organism. It is up to us to find that reason and within that answer should lay an understanding why so many people fall prey to the same disease at more or less the same time. In order to progress towards finding that answer we would do well to step away from a theory about the spread of infectious diseases that is so obviously not true.

Observation of epidemics show us some interesting facts. At the very beginning of an epidemic it is almost impossible to find a material source of infection, which has attacked and invaded the body of a person who came into contact with the possible source. So under the conditions of contact transmission most of the time proof is not being provided. Plenty of stories are being generated around words such as "probably" or "most likely" but these don't count as scientific evidence.

"Nowhere else in the immediate surroundings of an ill person have micro-organisms actually been shown to exist and survive as a direct result of the disease process which is developing inside a person."

A CAUSAL LINK BETWEEN AN APPARENT SOURCE OF INFECTION AND A FIRST INFECTEE IS MISSING

Furthermore, at the very beginning of an epidemic, when the first few cases in a specific community or area are being diagnosed, one fails to find anything that connects the persons involved in any physical way. No physical contact, neither directly nor via surfaces they all use, can be demonstrated, which would be a necessity if an outside source of the infection needs to be passed on. Here, stories of explanation involve germs that have lingered somewhere for a while, not infecting anybody who frequented that area except that one case, or the germ has been 'delivered' into the neighbourhood and must have, somehow, been transferred to another specific site without showing any signs in the body of the person 'responsible' for the transfer.

A CONFIRMED TRANSFER LINK BETWEEN EARLY VICTIMS IS MOSTLY NOT PRESENT

Once the epidemic has established itself properly and everybody, or at least everybody within a certain community or area, will come in contact with the said source of the infection it is noted that not everybody becomes infected. Testing for evidence of infection has become a popular pastime but has scientifically been proven to be of little value as whatever test method is being used it always falls far short of establishing a link between a positive result and the person showing signs of infection. The number of people getting ill with symptoms that relate to a specific disease which is said to be causing an epidemic is always much smaller than the number of people having been in contact with the disease.

The most amazing fact about an epidemic spreading through an entire population is the very large number of people who don't become ill.

It turns out that it is scientifically impossible to establish how many people have become infected and whom, but what we do know is that most people who are coming in contact do not become ill. History provides us with striking examples if we care to look. The leprosy colony on Molokai became famous within the Catholic congregation because of Father Damien's work there, and whose work was continued by Sister Marianne Cope who, together with two other nurses, agreed to live there in 1888 and care for the sick. She remained on the island until her death in 1918, aged 80. Despite constant direct contact with sufferers, neither Cope nor the sisters under her direction ever contracted leprosy.

In line with the discovery that as far as transferring diseases is concerned it is time to shift our understanding from the physical matter to the energetic, it would also be wise to view the spread of an epidemic as the expression of an energetic phenomenon.

IMMUNITY?

The medical profession likes to inform us about the status of our immune system, how it protects us but also how it can attack us. They do not give any reason as to what would anger the immune system of an individual so much that it would decide no longer to protect but instead to try and kill. This is, however, a complete U-turn in its functionality and for this to happen without the expertise of the professionals providing us with an obvious reason is a real pity. This must be very frustrating for them, not knowing who the enemy is and what its tactics are, until it happens.

Looking at how they measure immunity it turns out that none of the available tests are actually a measure for resistance against diseases. Instead they test changes in various cells and protein levels which they link to a foreign invader, without actually being able to tell who the attacker might be or even being able to establish a causal link between rises in their measured levels and specific invaders. When they decide they have found a high level of whatever parameter they are testing for they simply say 'it must be caused by an invader.'

None of their test methods have been proven to be a reliable measure for protection against any disease. Lots of people with high levels turn out to be vulnerable to the disease and lots of people with low or non-existing levels turn out to be fully protected against many diseases.

None of their test methods are specific for any disease and even they admit that there are plenty of crossover positive reactions, whereby a detected high level against a so-called specific disease might also protect you against some other diseases. But they can't tell you with certainty which diseases nor can they guarantee you protection either. They notice the inaccuracies within the theory but they do not use those observations to further their understanding. Since apparently the medical profession does not know what it is exactly they are testing and what it means, it doesn't sound much like a scientific method.

"Science has established that within a very short space of time all the same species trees within that forest, even the ones on the outskirts of the forest, are producing that specific protective protein."

However, science did establish how protection against diseases works. In the midst of a small forest they infect one tree with a very specific disease, a disease in which they have identified the protein that the tree produces in order to protect itself against that specific disease. Within minutes, indeed, the tree begins to produce the specific anti-dote, as was expected. Science has established that within a very short space of time all the same species of trees within that forest, even the ones on the outskirts of the forest, are producing that specific protective protein.

Even without there being a possibility of a physical transmission – no direct contact and too short a time (the infected tree hasn't even become ill) – similar trees are protecting themselves as if they know that this specific disease is in the neighbourhood.

Protection against specific diseases occurs even before physical contact with the disease has been established. If it isn't physical contact with the disease that stimulates 'an immune response' then the organism must somehow smell or sense the presence of danger in its neighbourhood. That is, in effect, an energetic exchange.

WHAT CAN I SAY ABOUT THE SCIENCE THAT OUR MEDICAL ESTABLISHMENT IS USING?

These are all outdated models, some of which were even obsolete at the time allopathic medicine was invented by John Rockefeller two centuries ago. But as the inventors and investors of our medical system are business people they opted, and still do, for the most profitable system and one that would make people become totally dependent upon their services. For this dream to become reality one has to stick to the same stories and the same tactics of trashing the opposition, which can easily be done if you own the entire media and governments too.

The reality is far more shocking and far more unbelievable than where human imagination can take you. That is all I can say about medicine.

I am done with it!

No explanation that involves the physicality of matter can even be considered to contain any useful truth in the scientific quest for answers to the fundamental questions of life.

You may believe anything you want, but remember that even that won't change the truth. No matter how great your numbers are. No matter how democratic you want to be. History has shown us that the majority is always wrong!

I close all connecting doors to medicine and I open all doors to open-minded science.

July 2020

"THE ONLY THING WE HAVE TO FEAR IS FEAR ITSELF

~ PRESIDENT ROOSEVELT, 4th MARCH 1933."

DETERMINING FACTORS FOR PERTUSSIS VACCINATION POLICY: A STUDY IN FIVE EU COUNTRIES

VACCINES 2020, 8, 46;
DOI:10.3390/VACCINES8010046

BRIEF EXTRACT

3.3.4. Other Important Discourse: Policy Implementation

During the interviews, some experts (n = 2) expressed that pertussis vaccination was not a frequently debated topic in the country as vaccination debates focused on other vaccines, such as HPV vaccines. Some experts (n = 3) offered a discussion on the paradigm of vaccination policy process. In Poland, there was recently a vote in parliament about abolishing mandatory vaccination, which was triggered by citizens' petition; and in France, there had been a citizen consultation before the country expanded mandatory vaccination in 2018 from 3 vaccines to 11 vaccines. Those events led countries to discuss themes related to public-professional and public-authority relationship.

Some experts shared that they were concerned about how policy was made would have an impact on the perception, attitude or behavior of the general public regarding vaccination or towards HCP: (Health Care Professional).

"And something that might fuel distrust towards the expert professionals, in Poland at least, is the strength and unquestionability of the consensus already existing among professionals." (Poland expert)

"The use of mandatory vaccination may lead some people to be more radical: that doesn't mean they were against vaccines, it just means that they were against mandatory vaccination."

The use of mandatory vaccination may lead some people to be more radical: "....that doesn't mean they were against vaccines, it just means that they were against mandatory vaccination... is it going to push part of the people who are hesitant towards a more radical stance, you know, going to very private schools, where they look the other way and don't really check whether the children are vaccinated? And the issue is whether it's going to create small pockets of severely under-vaccinated people..." (France expert)

According to the some experts, mandatory vaccination may be seen as a way to restore public confidence in vaccines in France and as the consensus or approval of the authority and professionals in Poland.

Other countries found voluntary vaccination based on national recommendation a better suiting strategy. Some experts also expressed doubts about the message or implication conveyed by vaccine mandates:

"I can't see a reason for introducing a compulsory element to this because it's a program that's already very well delivered and very well received. So I can't see a role for mandating in our population at this time. And I doubt it would improve uptake, and it could be counterproductive." (UK expert)

"...but if the results speak for themselves and the health authorities recommend something, people tend to do that. And I believe, and I know I'm not alone in believing that, if we were to make mandatory vaccination, it would actually spark this hesitancy, it would spark distrust. And I think it would be detrimental for our program to do that." (Denmark expert)

THE INFLUENCE OF MATERNAL MENTAL ILLNESS ON VACCINATION UPTAKE IN CHILDREN: A UK POPULATION-BASED COHORT STUDY

EUR J EPIDEMIOL. 2020 APR 24.
DOI: 10.1007/S10654-020-00632-5

ABSTRACT

REDUCED VACCINATION uptake is a growing and global public health concern. There is limited knowledge about the effect of maternal mental illness (MMI) on rates of childhood vaccination. This retrospective cohort study examined 479,949 mother-baby pairs born between 1993 and 2015 in the Clinical Practice Research Datalink (CPRD GOLD), a UK-based, primary health-care database.

The influence of MMI on children's vaccination status at two and five years of age was investigated using logistic regression adjusting for sex of the child, child ethnicity, delivery year, maternal age, practice level deprivation quintile and region. The vaccinations were: 5-in-1 (DTaP/IPV/Hib) and first dose MMR by the age of two; and all three doses of 5-in-1, first and second dose of MMR vaccines by the age of five. Exposure to MMI was defined using recorded clinical events for: depression, anxiety, psychosis, eating disorder, personality disorder and alcohol and substance misuse disorders. The likelihood that a child completed their recommended vaccinations by the age of two and five was significantly lower among children with MMI compared to children with mothers without mental illness [adjusted odds ratio (aOR) 0.86, 95% CI 0.84-0.88, $p < 0.001$]. The strongest effect was observed for children exposed to maternal alcohol or substance misuse (at two years aOR 0.50, 95% CI 0.44-0.58, $p < 0.001$).

In the UK, an estimated five thousand more children per year would be vaccinated if children with MMI had the same vaccination rates as children with well mothers. Maternal mental illness is a hitherto largely unrecognised reason that children may be missing vital vaccinations at two and five years of age. This risk is highest for those children living with maternal alcohol or substance misuse.

TiP Editor: Introducing yet another label to target the vaccine 'hesitant'. Will a mother who raises concerns about vaccines eg anxieties, fall into this new mental health category?

CORONAVIRUS AND FACE COVERINGS

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

IT IS IMPORTANT in the circumstances in which we find ourselves today to be informed of the issues: the science and the law.

I am indebted to Mr Nicholas Wells who took it upon himself to make a freedom of information request of the Department of Health and Social Care, asking them to provide the evidence they held in support of the use of face masks and face coverings to prevent the transmission of the SARS-CoV-2 coronavirus [1]. His original request was made on 06 June 2020. The requested information not being provided, he asked for an internal review of the DHSC's handling of the request, on 04 July 2020, which produced an answer two days later:

"Your request has been handled under the Freedom of Information Act (FOIA).

DHSC does not hold the information you have requested."

In the light of current legislation this is a revealing piece of information.

The Scientific Advisory Group for Emergencies (SAGE) says it provides '*scientific and technical advice to support government decision makers*'. The committee discussed mask wearing at their 21 April 2020 meeting under the heading: '*Community face mask use*'.

WHAT DO THEY SAY ABOUT FACE COVERINGS?

*"The **evidence on effectiveness of masks** for source control is **weak**…. Overall, the evidence that exists is **marginally** positive for the use of masks... The effect of wearing a mask is **likely to be small but not zero**…. On balance, there is evidence to recommend the use of cloth masks in certain higher-risk settings as a precautionary measure where masks could be at **least partially effective**... In enclosed spaces where social distancing is not possible evidence would support a policy where cloth masks could be used for short durations. Working environments vary in many respects and where there is a risk of close social contact with multiple parties the person does not usually meet, use of masks may offer **some benefit.**"*

DR Jayne L.M.Donegan

"The 239 scientists say that evidence for airborne transmission of COVID-19 is 'currently incomplete'."

SAGE also worry that wearing a mask may encourage people to break quarantine arrangements but feel that they may be useful in **reducing anxiety** as the lockdown is reduced. [2]

There is no strong evidence for wearing face coverings there.

On 22 July 2020 (published 07 August 2020), a paper on the *Role of aerosol transmission in COVID-19*, prepared by Public Health England (PHE) and the Joint Biosecurity Centre (JBC) presented evidence from the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) and the Environmental and Modelling group (EMG) that prompted the Government to extend mask-wearing to many more scenarios. [3]

The authors state that the **possibility** of aerosol transmission of SARS-CoV-2 had now been formally acknowledged by World Health Organization, "*hence interest in airborne transmission has increased.*"

They say a factor in the decision of the WHO to take more account of aerosol transmission was a letter signed by 239 scientists and published in Clinical Infectious Diseases 27 May 2020 [4]. I wonder how much influence a letter signed by 240 scientists stating the opposite would have had? There are at least that many scientists around the world who disagree with the current public health narrative.

The 239 scientists say that evidence for airborne transmission of COVID-19 is '*currently incomplete*' but that several hospital-based studies have performed air-sampling. They quote one published paper, one early released paper and five in pre-print and state that four studies found '*several*' positive samples for SARS-CoV-2 genome (RNA) in air, using polymerase chain reaction (PCR) testing. Two found '*very small numbers*' and one found '*none*'. The most they deduce from this data is that "*This evidence* **at least demonstrates a potential risk for airborne transmission** *of SARS-CoV-2*", before going on to enumerate the many ways buildings need to be modified to improve ventilation or kill microbes and where this is not possible masks should be worn.

This extremely non definitive paper is nevertheless said to have prompted the WHO to change its guidance from advising that it was not necessary for the general public to wear masks outside of a healthcare setting to saying that masks should now be worn.

A letter to the New England Journal of Medicine regarding laboratory studies carried out under aerosolisation in a closed chamber at 21°C determined that SARS-CoV-2 was stable in air for over 3 hours with very little loss of viability. Estimates of how long SARS-CoV-1 and SARS-CoV-2 (Covid-19) aerosols lasted on various surfaces were said to be longest on stainless steel and plastic and shortest on copper and cardboard. The results were said to indicate that aerosol and fomite (inanimate objects) transmission of SARS-CoV-2 was **plausible**, not definitive [5].

Further support for the complete about-face by the WHO regarding the wearing of face coverings by the general public was a study from 2019 looking at '*Aerosol emission and superemission during human speech increase with voice loudness*' where the authors concluded that speech can release dramatically larger numbers of particles compared to coughing. We had all better stop talking.

These studies, which are extreme in


Photo by Matt Milligan on Unsplash.com

their vagueness are quoted as if they were definitive. Most of them were not even peer reviewed. But they have been used as evidence for totally changing the way people are now allowed to live.

They actually say at the end:

"*While there is no conclusive evidence for airborne transmission of SARS-CoV-2, it should be noted that there is no robust proof for close-range droplet or surface contact transmission either.*"[6]

So there is not really much evidence at all regarding transmission of SARS-CoV-2l – no wonder the Department of Health and Social Care said it, "*does not hold the information you have requested.*" - ie, the *evidence that mask wearing prevents the transmission of the SARS-CoV-2 coronavirus.*

WHAT DO WE KNOW?

There is a temptation amongst researchers to look more and more at less and less.

How big is the particle? How far does it spread? How long does it persist? Talking is worse than coughing. For goodness sake don't sing.

That is why it is so important to step back and look at the bigger picture.

In all these deliberations of acronyms: SAGE, NERVTAG, PHE, JBC, EMG, there is no mention of the fact that 80% of our immune system is the Mucosal Associated Lymphoid Tissue (MALT) - the shiny pink surface that lines our mouth, nose, gut and breathing tubes, from the mouth to the other end (the anus). Nor that this is designed to have, in fact relies on having streams of microbes – bacteria, funguses, viruses and everything else - streaming across it on a daily, hourly, minutely basis in order to stimulate our lymphocytes and prime our cell mediated immune system to keep it up to date.

If it were not for continual exposure to these microorganisms our immune system would be unable to keep us healthy, immune and alive. It would collapse. Similar to what people who have been locked in their houses, afraid to even use their gardens, will be at risk of when they do eventually emerge. And remember – it is the cell mediated immune system, not the humoural/ antibody immune system that we rely on mostly in illnesses associated with viral particles

Dr. Mitchell Kronenberg who was elected Distinguished Fellow by the American Association of Immunologists in 2019, and colleagues say in their February 2020 paper:

"*Innate lymphoid cells (ILCs) are a lymphocyte population that is mostly resident at mucosal surfaces. They help to induce an appropriate immune response to the microbiome at homeostasis. In healthy people, the mucosal immune system works symbiotically with organisms that make up the microbiota. ILCs play a critical role in orchestrating this balance, as they can both influence and in turn be influenced by the microbiome. ILCs also are important regulators of the early response to infections by diverse types of pathogenic microbes at mucosal barriers. Their rapid responses initiate inflammatory programs, production of antimicrobial products and repair processes.*" [7].

These facts are emphasised by collaborating scientists from the USA and Australian Centers for Disease control who were puzzled as to why individuals not exposed to SARS CoV-2 (Covid-19) nonetheless had T-cells indicating an immune reaction to it. They used human blood samples that were collected before the SARS-CoV-2 virus was discovered in 2019 and found.

"*A range of pre-existing memory CD4+ T cells that are cross-reactive with comparable affinity to SARS-CoV-2* ***and the common cold coronaviruses.***" [8] Science 04 Aug 2020 ie, being exposed to all the seasonal microbes gives us immunity to future ones. The scientists suggest this may be

one of the reasons for the vast difference in disease severity in different individuals. Certainly - as do vitamin D levels and other lifestyle factors.

The microbially dead environment towards which scientists directing public health policy in the UK and around the world are pushing us towards will lead to total immune destruction. This knowledge is not new. Professors Wilson and Duff stated in their British Medical Journal editorial, in 1995:

"*Autoimmunity is the price paid for eradicating infectious diseases.*" [9].

If hiding ourselves from the microbes with which we are designed to interact is not helpful to our collective and individual immune systems, are there any problems associated with the wearing of masks *per se*?

Masks can interfere with breathing in and breathing out. One of the reasons we breathe out is to remove waste gases, blocking their removal with a mask and re-breathing them is unlikely to be helpful.

In terms of oxygen, the concentration has been said to drop rapidly after putting the mask on. To test this I used a pulse oximeter to monitor my blood oxygen concentration before and after putting on a face covering. This did not lower my oxygen level to what are regarded as dangerous levels. However, I do not suffer from chronic respiratory or cardiac conditions.

WHAT ABOUT OTHER PROBLEMS?

Wearing a mask heats people up considerably, it makes some people claustrophobic and others get palpitations, hot flushes, feel faint and giddy or get headaches, as well as steaming up glasses so they cannot see. For some this is enough to set off a panic attack or cause them to fall.

From a psychological point of view the cutting off of facial expression severely interferes with human social interactions. This was said to be one of the reasons Muslim women were banned from wearing the *niqab* in France. Now masks which also remove all facial expression, are mandatory in France: on public transport, in museums, casino, tourist attractions, some parks, markets and shops [10] – but the *niqab* is still banned. Why?

The Government advice on wearing a face covering is that you should:

• *wash your hands thoroughly with soap and water for 20 seconds or use hand sanitiser before putting a face covering on*
• *avoid wearing on your neck or forehead*
• *avoid touching the part of the face covering in contact with your mouth and nose, as it could be contaminated with the virus*
• *change the face covering if it becomes damp or if you've touched it*
• *avoid taking it off and putting it back on a lot in quick succession (for example, when leaving and entering shops on a high street)*

The guidance is saying, in effect, that you should leave the mask on for duration – whether you are in a shop or not. As you will recall from earlier, the SAGE committee stated: *cloth masks could be used for* ***short durations***. Another instance of statements of specifics being used for generalities.

Anyone who has spent any time watching people wearing masks will see them pulling them, tugging them, adjusting them, pushing them up and down, scratching their noses and of course, in the hot weather, getting them damp with sweat and hot breath. I have not seen anyone take their mask off under these circumstances and replace it with a fresh one.

> *"Under the Equality Act 2010 it is illegal to discriminate against someone with a protected characteristic, which includes a disability; as a consumer, when using public services and in other situations. You are not obliged to say what disability you have to anyone."*

When removing the face covering the Government advises that you: [11]

• *wash your hands thoroughly with soap and water for 20 seconds or use hand sanitiser before removing*
• *only handle the straps, ties or clips*
• *do not give it to someone else to use*
• *if single-use, dispose of it carefully in a residual waste bin and do not recycle*
• *if reusable, wash it in line with manufacturer's instructions at the highest temperature appropriate for the fabric*
• *wash your hands thoroughly with soap and water for 20 seconds or use hand sanitiser once removed"*

These conditions are more often honoured in the breach, particularly mask disposal. Footpaths, roads and parks are now littered with used masks and "*a glut of discarded single-use masks and gloves is washing up on shorelines and littering the seabed.*" [12]

Those with respiratory, cardiac and other chronic medical conditions may be at risk from wearing a mask especially in the very hot conditions on public transport in the UK. There are many people with psychiatric, and psychological conditions, also learning difficulties, who become severely distressed or bewildered when told to wear a mask. This includes as many as one million people in the UK with dementia, though there may be far fewer of them alive now after the tragic deaths of people in care homes following the policy of discharging elderly patients with coronavirus into care homes to empty the hospitals for the deluge of inpatients that never came.

If you are at risk from wearing a mask do you have to wear one anyway? No. The Government has produced very sensible rules regarding who is exempt from wearing a mask and it is best to look at the Government website itself rather than other people's interpretations:

https://www.gov.uk/government/publications/face-coverings-when-to-wear-one-and-how-to-make-your-own/face-coverings-when-to-wear-one-and-how-to-make-your-own [11]

WHEN YOU DO NOT NEED TO WEAR A FACE COVERING

In settings where face coverings are required in England, there are some circumstances where people may not be able to wear a face covering. Please be mindful and respectful of such circumstances, noting that some people are less able to wear face coverings, and that the reasons for this may not be visible to others.

This includes (but is not limited to):

• *children under the age of 11 (Public Health England do not recommended face coverings for children under the age of 3 for health and safety reasons)*
• *people who cannot put on, wear or remove a face covering because of a physical or mental illness or impairment, or disability*

• *employees of indoor settings (or people acting on their behalf, such as someone leading part of a prayer service) or transport workers - although employers may consider their use where appropriate and where other mitigations are not in place, in line with COVID-19 Secure guidelines*
• *police officers and other emergency workers, given that this may interfere with their ability to serve the public*
• *where putting on, wearing or removing a face covering will cause you severe distress*
• *if you are speaking to or providing assistance to someone who relies on lip reading, clear sound or facial expressions to communicate*
• *to avoid harm or injury, or the risk of harm or injury, to yourself or others - including if it would negatively impact on your ability to exercise or participate in a strenuous activity.*"

It is very important that everyone reads these exemptions carefully to determine whether they meet one of the exemption categories.

The Government is not requiring people to wear masks to damage their health. That is why these exemption categories exist and they should be used. Many people have been misinformed that they must have a letter from their doctor to prove that they are exempt. This is also untrue. The .gov website *clearly* states:

"*Those who have an age, health or disability reason for not wearing a face covering* ***should not be routinely asked to give any written evidence of this, this includes exemption cards."***

"No person needs to seek advice or request a letter from a medical professional about their reason for not wearing a face covering."

Indeed doctors have been told by the Department of Health that they are not to issue medical exemption letters for the very reason that they are not necessary.

"*Some people may feel more comfortable showing something that says they do not have to wear a face covering. This could be in the form of an exemption card, badge or even a home-made sign.*"

Under the Equality Act 2010 it is illegal to discriminate against someone with a protected characteristic, which includes a disability; as a consumer, when using public services and in other situations. You are not obliged to say what disability you have to anyone. Even asking if you have a disability can be seen as a breach of the law [13]. That is why many shops, such as Sainsbury's, are specifically not asking people why they are not wearing a mask, if that is the case, and are reminding their customers that '*not every disability is visible*'.

As the Government advises, if you are exempt, you might feel happier wearing a lanyard with a card stating this – to avoid potentially distressing situations. Wearing a card helps shopkeepers and public transport officials know that you are complying with the law so they do not feel the need to interrogate you. It also reduces the likelihood that members of the public who have become terrified, will attack you, which I have seen happen in my local shops.

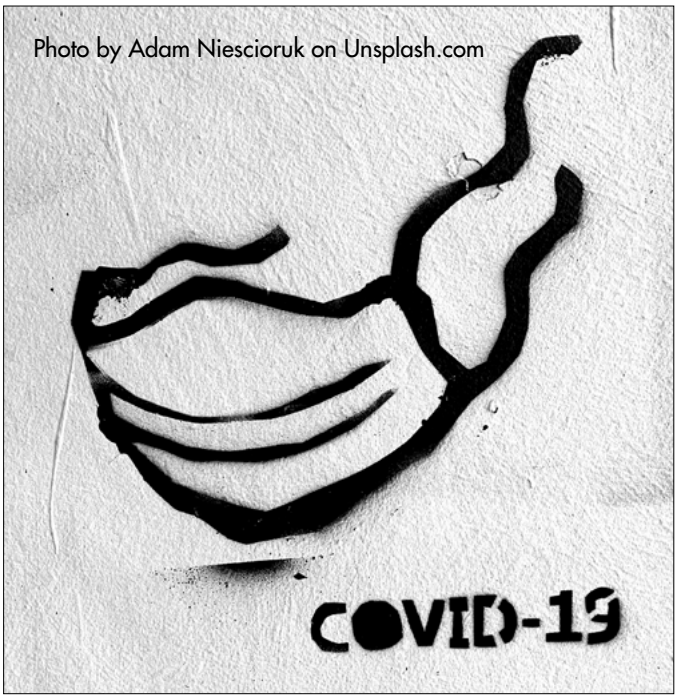


Photo by Adam Niescioruk on Unsplash.com

You can buy a card and lanyard from Disability Horizons for £4-95 plus postage:

https://shop.disabilityhorizons.com/products/ppe/mask-exemption-travel-card-lanyard-or-clip-badge/ [14]

This provides drivers and staff with immediate and simple-to-understand information regarding your mask exemption. The bright red lanyard has 'MASK EXEMPT' written in white capital letters so it is easy to see. The credit card-sized ID badge further explains your mask exemption as being due to a "disability/health condition". Both can be shown and read at a safe distance. These cards are only designed for people with a genuine 'legitimate or reasonable reason' for not wearing a mask, as listed under Government guidelines (above).

Recently on a South Eastern train service, the train manager told the passengers repeatedly, via the public address system, that they had to wear masks to be nice people and if they decided not to do so they could get fined £100 by plain clothes policemen patrolling the train. He said anyone exempt would have to prove it to the police. At the terminus a member of the public gently explained the Government regulations to him, and pointed out the he and the company could find themselves in breach of the relevant legislation. He was very grateful for this information.

To learn how to boost your immune system and manage fever correctly please attend my webinar: Nursing People Supportively Through Acute Viral Illness including COVID-19 Illness – Fever Management. Lectures are listed below.

© Dr Jayne LM Donegan MBBS DRCOG DCH DFFP MRCGP MFHom 16 Aug 2020
jaynelmdonegan@yahoo.com www.jayne-donegan.co.uk/

All References accessed July and August 2020

Dr Andrew Kaufman's has made some informative presentations on the reliability of PCR ampification. Here is one example: https://youtu.be/3TWLuo-8H98

Dr Andrew Kaufman's website: https://www.andrewkaufmanmd.com/

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

References available on request.

YET MORE ON MASKS: USAGE IN SURGICAL SETTINGS

BY ARTHUR FIRSTENBERG.
Update on August 11, 2020
https://www.checktheevidence.com/

INSTEAD OF acknowledging the harm from radio waves, society is tearing its fabric apart by instituting measures that are protecting no one and are instead sickening and killing people. I will mention just one of those measures here: facial masks. As a person who went to medical school, I was shocked when I read Neil Orr's study, published in 1981 in the Annals of the Royal College of Surgeons of England. Dr. Orr was a surgeon in the Severalls Surgical Unit in Colchester. And for six months, from March through August 1980, the surgeons and staff in that unit decided to see what would happen if they did not wear masks during surgeries. They wore no masks for six months, and compared the rate of surgical wound infections from March through August 1980 with the rate of wound infections from March through August of the previous four years. And they discovered, to their amazement, that when nobody wore masks during surgeries, the rate of wound infections was less than half what it was when everyone wore masks. Their conclusion: "It would appear that minimum contamination can best be achieved by not wearing a mask at all" and that wearing a mask during surgery "is a standard procedure that could be abandoned." I was so amazed that I scoured the medical literature, sure that this was a fluke and that newer studies must show the utility of masks in preventing the spread of disease. But to my surprise the medical literature for the past forty-five years has been consistent: masks are useless in preventing the spread of disease and, if anything, are unsanitary objects that themselves spread bacteria and viruses.

• Ritter et al., in 1975, found that "the wearing of a surgical face mask had no effect upon the overall operating room environmental contamination."

• Ha'eri and Wiley, in 1980, applied human albumin microspheres to the interior of surgical masks in 20 operations. At the end of each operation, wound washings were examined under the microscope. "Particle contamination of the wound was demonstrated in all experiments."

• Laslett and Sabin, in 1989, found that caps and masks were not necessary during cardiac catheterization. "No infections were found in any patient, regardless of whether a cap or mask was used," they wrote. Sjøl and Kelbaek came to the same conclusion in 2002.

• In Tunevall's 1991 study, a general surgical team wore no masks in half of their surgeries for two years. After 1,537 operations performed with masks, the wound infection rate was 4.7%, while after 1,551 operations performed without masks, the wound infection rate was only 3.5%.

• A review by Skinner and Sutton in 2001 concluded that "The evidence for discontinuing the use of surgical face masks would appear to be stronger than the evidence available to support their continued use."

• Lahme et al., in 2001, wrote that "surgical face masks worn by patients during regional anaesthesia, did not reduce the concentration of airborne bacteria over the operation field in our study. Thus they are dispensable."

• Figueiredo et al., in 2001, reported that in five years of doing peritoneal dialysis without masks, rates of peritonitis in their unit were no different than rates in hospitals where masks were worn.

• Bahli did a systematic literature review in 2009 and found that "no significant difference in the incidence of postoperative wound infection was observed between masks groups and groups operated with no masks."

• Surgeons at the Karolinska Institute in Sweden, recognizing the lack of evidence supporting the use of masks, ceased requiring them in 2010 for anesthesiologists and other non-scrubbed personnel in the operating room. "Our decision to no longer require routine surgical masks for personnel not scrubbed for surgery is a departure from common practice. But the evidence to support this practice does not exist," wrote Dr. Eva Sellden.

• Webster et al., in 2010, reported on obstetric, gynecological, general, orthopaedic, breast and urological surgeries performed on 827 patients. All non-scrubbed staff wore masks in half the surgeries, and none of the non-scrubbed staff wore masks in half the surgeries. Surgical site infections occurred in 11.5% of the Mask group, and in only 9.0% of the No Mask group.

• Lipp and Edwards reviewed the surgical literature in 2014 and found "no statistically significant difference in infection rates between the masked and unmasked group in any of the trials." Vincent and Edwards updated this review in 2016 and the conclusion was the same.

• Carøe, in a 2014 review based on four studies and 6,006 patients, wrote that "none of the four studies found a difference in the number of post-operative infections whether you used a surgical mask or not."

• Salassa and Swiontkowski, in 2014, investigated the necessity of scrubs, masks and head coverings in the operating room and concluded that "there is no evidence that these measures reduce the prevalence of surgical site infection."

• Da Zhou et al., reviewing the literature in 2015, concluded that "there is a lack of substantial evidence to support claims that facemasks protect either patient or surgeon from infectious contamination."

Schools in China are now prohibiting students from wearing masks while exercising. Why? Because it was killing them. It was depriving them of oxygen and it was killing them. At least three children died during Physical Education classes — two of them while running on their school's track while wearing a mask. And a 26-year-old man suffered a collapsed lung after running two and a half miles while wearing a mask.

Mandating masks has not kept death rates down anywhere. The 20 U.S. states that have never ordered people to wear face masks indoors and out have dramatically lower COVID-19 death rates than the 30 states that have mandated masks. Most of the no-mask states have COVID-19 death rates below 20 per 100,000 population, and none have a death rate higher than 55. All 13 states that have death rates higher 55 are states that have required the wearing of masks in all public places. It has not protected them. "We are living in an atmosphere of permanent illness, of meaningless separation," writes Benjamin Cherry in the Summer 2020 issue of New View magazine. A separation that is destroying lives, souls, and nature.

COVID19 PCR TESTS ARE SCIENTIFICALLY MEANINGLESS THOUGH THE WHOLE WORLD RELIES ON RT-PCR TO "DIAGNOSE" SARS-COV-2 INFECTION, THE SCIENCE IS CLEAR: THEY ARE NOT FIT FOR PURPOSE

TORSTEN ENGELBRECHT
AND KONSTANTIN DEMETER
Jun 27, 2020
https://off-guardian.org/2020/06/27/covid19-pcr-tests-are-scientifically-meaningless/

EXTRACTS

LOCKDOWNS and hygienic measures around the world are based on numbers of cases and mortality rates created by the so-called SARS-CoV-2 RT-PCR tests used to identify "positive" patients, whereby "positive" is usually equated with "infected." But looking closely at the facts, the conclusion is that these PCR tests are meaningless as a diagnostic tool to determine an alleged infection by a supposedly new virus called SARS-CoV-2. At the media briefing on COVID-19 on March 16, 2020, the WHO Director General Dr Tedros Adhanom Ghebreyesus said: "We have a simple message for all countries: test, test, test."

The message was spread through headlines around the world, for instance by Reuters and the BBC. Still on the 3 of May, the moderator of the heute journal — one of the most important news magazines on German television— was passing the mantra of the corona dogma on to his audience with the admonishing words: "Test, test, test—that is the credo at the moment, and it is the only way to really understand how much the coronavirus is spreading."

So to start, it is very remarkable that Kary Mullis himself, the inventor of the Polymerase Chain Reaction (PCR) technology, did not think alike. His invention got him the Nobel prize in chemistry in 1993. Unfortunately, Mullis passed away last year at the age of 74, but there is no doubt that the biochemist regarded the PCR as inappropriate to detect a viral infection. The reason is that the intended use of the PCR was, and still is, to apply it as a manufacturing technique, being able to replicate DNA sequences millions and billions of times, and not as a diagnostic tool to detect viruses. How declaring virus pandemics based on PCR tests can end in disaster was described by Gina Kolata in her 2007 New York Times article *Faith in Quick Test Leads to Epidemic That Wasn't.*

LACK OF A VALID GOLD STANDARD

Moreover, it is worth mentioning that the PCR tests used to identify so-called COVID-19 patients presumably infected by what is called SARS-CoV-2 do not have a valid gold standard to compare them with. This is a fundamental point. Tests need to be evaluated to determine their preciseness — strictly speaking their "sensitivity"[1] and "specificity" — by comparison with a "gold standard," meaning the most accurate method available. Jessica C. Watson from Bristol University confirms this. In her paper "*Interpreting a COVID-19 test result*", published recently in *The British Medical Journal,* she writes that there is a "*lack of such a clear-cut 'gold-standard' for COVID-19 testing*." But instead of classifying the tests as unsuitable for SARS-CoV-2 detection and COVID-19 diagnosis, or instead of pointing out that only a virus, proven through isolation and purification, can be a solid gold standard, Watson claims in all seriousness that, "pragmatically" COVID-19 diagnosis itself, remarkably including PCR testing itself, "*may be the best available 'gold standard'*." But this is not scientifically sound.

Apart from the fact that it is downright absurd to take the PCR test itself as part of the gold standard to evaluate the PCR test, there are no distinctive specific symptoms for COVID-19, as even people such as Thomas Löscher, former head of the Department of Infection and Tropical Medicine at the University of Munich and member of the Federal Association of German Internists, conceded to us [2]. And if there are no distinctive specific symptoms for COVID-19, COVID-19 diagnosis — contrary to Watson's statement — cannot be suitable for serving as a valid gold standard.

NO PROOF FOR THE RNA BEING OF VIRAL ORIGIN

Now the question is: What is required first for virus isolation/proof? We need to know where the RNA for which the PCR tests are calibrated comes from.

The reason for this is that PCR is extremely sensitive, which means it can detect even the smallest pieces of DNA or RNA — *but it cannot determine where these particles came from*. That has to be determined beforehand. And because the PCR tests are calibrated for gene sequences (in this case RNA sequences because SARS-CoV-2 is believed to be a RNA virus), we have to know that these gene snippets are part of the looked-for virus. And to know that correct isolation, and purification of the presumed virus has to be executed. Hence, we have asked the science teams of the relevant papers, which are referred to in the context of SARS-CoV-2 for proof whether the electron-microscopic shots depicted in their in vitro experiments show purified viruses. But not a single team could answer that question with "yes" — and NB, nobody said purification was not a necessary step. We only got answers like "*No, we did not obtain an electron micrograph showing the degree of purification*" (see below). We asked several study authors "Do your electron micrographs show the purified virus?", they gave the following responses:

Study 1: Leo L. M. Poon; Malik Peiris. "Emergence of a novel human coronavirus threatening human health" *Nature Medicine*, March 2020
Replying Author: Malik Peiris
Date: May 12, 2020
Answer: "*The image is the virus budding from an infected cell. It is not purified virus.*"

Study 2: Myung-Guk Han et al. "Identification of Coronavirus Isolated from a Patient in Korea with COVID-19", *Osong Public Health and Research Perspectives*, February 2020
Replying Author: Myung-Guk Han
Date: May 6, 2020
Answer: "*We could not estimate the degree of purification because we do not purify and concentrate the virus cultured in cells.*"

Study 3: Wan Beom Park et al. "Virus Isolation from the First Patient with

›

SARS-CoV-2 in Korea", *Journal of Korean Medical Science*, February 24, 2020
Replying Author: Wan Beom Park
Date: March 19, 2020
Answer: "*We did not obtain an electron micrograph showing the degree of purification*."
Study 4: Na Zhu et al., "A Novel Coronavirus from Patients with Pneumonia in China", 2019, *New England Journal of Medicine,* February 20, 2020
Replying Author: Wenjie Tan
Date: March 18, 2020
Answer: "*[We show] an image of sedimented virus particles, not purified ones.*"

Regarding the mentioned papers it is clear that what is shown in the electron micrographs (EMs) is the end result of the experiment, meaning there is no other result that they could have made EMs from. That is to say, if the authors of these studies concede that their published EMs do not show purified particles, then they definitely do not possess purified particles claimed to be viral. (In this context, it has to be remarked that some researchers use the term "isolation" in their papers, but the procedures described therein do not represent a proper isolation (purification) process. Consequently, in this context the term "isolation" is misused). Thus, the authors of four of the principal, early 2020 papers claiming discovery of a new coronavirus concede they had no proof that the origin of the virus genome was viral-like particles or cellular debris, pure or impure, or particles of any kind. In other words, the existence of SARS-CoV-2 RNA is based on faith, not fact. We have also contacted Dr Charles Calisher, who is a seasoned virologist. In 2001, *Science* published an "*impassioned plea…to the younger generation"* from several veteran virologists, among them Calisher, saying that: "[modern virus detection methods like] sleek polymerase chain reaction […] tell little or nothing about how a virus multiplies, which animals carry it, [or] how it makes people sick. [It is] like trying to say whether somebody has bad breath by looking at his fingerprint." [3]

And that's why we asked Dr Calisher whether he knows one single paper in which SARS-CoV-2 has been isolated and finally really purified. His answer: "I know of no such a publication. I have kept an eye out for one." [4] This actually means that one cannot conclude that the RNA gene sequences, which the scientists took from the tissue samples prepared in the mentioned in vitro trials and for which the PCR tests are finally being "calibrated," belong to a specific virus — in this case SARS-CoV-2.

In addition, there is no scientific proof that those RNA sequences are the causative agent of what is called COVID-19.

In order to establish a causal connection, one way or the other, i.e. beyond virus isolation and purification, it would have been absolutely necessary to carry out an experiment that satisfies the four Koch's postulates. But there is no such experiment, as Amory Devereux and Rosemary Frei recently revealed for OffGuardian. The necessity to fulfill these postulates regarding SARS-CoV-2 is demonstrated not least by the fact that attempts have been made to fulfill them. But even researchers claiming they have done it, in reality, did not succeed.

One example is a study published in *Nature* on May 7. This trial, besides other procedures which render the study invalid, did not meet any of the postulates. For instance, the alleged "infected" laboratory mice **did not show any relevant clinical symptoms** clearly attributable to pneumonia, which according to the third postulate should actually occur if a dangerous and potentially deadly virus was really at work there. And the slight bristles and weight loss, which were observed temporarily in the animals are negligible, not only because they could have been caused by the procedure itself, but also because the weight went back to normal again. Also, **no animal died except those they killed to perform the autopsies.** And let's not forget: These experiments should have been done before developing a test, which is not the case.

IRRATIONAL TEST RESULTS

It is also certain that we cannot know the false positive rate of the PCR tests without widespread testing of people who certainly do not have the virus, proven by a method which is independent of the test (having a solid gold standard). Therefore, it is hardly surprising that there are several papers illustrating irrational test results. For example, already in February the health authority in China's Guangdong province reported that people have fully recovered from illness blamed on COVID-19, started to test "negative," and then tested "positive" again. A month later, a paper published in the *Journal of Medical Virology* showed that 29 out of 610 patients at a hospital in Wuhan had 3 to 6 test results that flipped between "negative", "positive" and "dubious".

So how can it be that those who claim the PCR tests are highly meaningful for so-called COVID-19 diagnosis blind out the fundamental inadequacies of these tests—even if they are confronted with questions regarding their validity?

Certainly, the apologists of the novel coronavirus hypothesis should have dealt with these questions before throwing the tests on the market and putting basically the whole world under lockdown, not least because these are questions that come to mind immediately for anyone with even a spark of scientific understanding. Thus, the thought inevitably emerges that financial and political interests play a decisive role for this ignorance about scientific obligations. NB, the WHO, for example has financial ties with drug companies, as the *British Medical Journal* showed in 2010.

Finally, the reasons and possible motives remain speculative, and many involved surely act in good faith; but the science is clear: The numbers generated by these RT-PCR tests do not in the least justify frightening people who have been tested "positive" and imposing lockdown measures that plunge countless people into poverty and despair or even drive them to suicide. And a "positive" result may have serious consequences for the patients as well, because then all non-viral factors are excluded from the diagnosis and the patients are treated with highly toxic drugs and invasive intubations. Especially for elderly people and patients with pre-existing conditions such a treatment can be fatal, as we have outlined in the article "Fatal Therapie."

Without doubt eventual excess mortality rates are caused by the therapy and by the lockdown measures, while the "COVID-19" death statistics comprise also patients who died of a variety of diseases, redefined as COVID-19 only because of a "positive" test result whose value could not be more doubtful.

NOTES:-
[1] Sensitivity is defined as the proportion of patients with disease in whom the test is positive; and specificity is defined as the proportion of patients without disease in whom the test is negative.
[2] E-mail from Prof.Thomas Löscher from March 6, 2020
[3] Martin Enserink.Virology. Old guard urges virologists to go back to basics, Science, July 6, 2001, p. 24
[4] E-mail from Charles Calisher from May 10, 2020
[5] Creative Diagnostics, SARS-CoV-2 Coronavirus Multiplex RT-qPCR Kit

Torsten Engelbrecht is an award-winning journalist and author from Hamburg, Germany. In 2006 he co-authored Virus-Mania with Dr Klaus Kohnlein, and in 2009 he won the German Alternate Media Award. He has also written for Rubikon, Süddeutsche Zeitung, Financial Times Deutschland and many others.
Konstantin Demeter is a freelance photographer and an independent researcher. Together with the journalist Torsten Engelbrecht he has published articles on the "COVID-19" crisis in the online magazine Rubikon, as well as contributions on the monetary system, geopolitics, and the media in Swiss Italian newspapers.

HOW TO GET VACCINATED WITHOUT PARENTAL CONSENT ...

FROM UPDATED VERSION
25 AUGUST 2020

https://www.wikihow.com/Get-Vaccinated-Without-Parental-Consent?

TiP Editor: Here are some extracts from Wikihow directed to the younger generation! Personally I find this extremely disturbing. Another method of division? Turn the child against the parent? Encourage the child to follow the system rather than their own loving parents? Encourage the child to become deceitful?

EXTRACTS:

There's a lot of misinformation about vaccines online, and sometimes well-meaning parents fall into rabbit holes of conspiracy theories and made-up "facts." While they often intend to protect their children, not vaccinating has the opposite effect, and leaves kids more vulnerable to dangerous and even deadly diseases.

Look at your options. Some areas let you get vaccinated without parental consent if you're a minor, and others don't. Potential options include:

• Get vaccinated in secret (if your local laws allow it). Run the risk of your family finding out.
• Try asking for your family to let you be vaccinated. You may be able to convince them.
• Try asking your doctor, your school nurse, or another responsible adult to help convince your family.
• Petition the court for emancipation if your parents are really bad.

"I'm autistic. I can't be turned autistic twice. But I could die of polio, and I'd really rather not."

• Wait until you're 18 if you think that your parents would severely punish or abuse you if they learned that you disobeyed them.

Try talking to your parents. Explain your own worries, and let them voice theirs. Make sure that it's a two-way conversation, and you show respect for their perspectives (even when they frustrate you). It takes time, and often good listening skills, to change people's minds. Try saying things like:

• "Why did you choose not to vaccinate me? Were you afraid something bad would happen if you did?"
• "I've found some research on vaccine safety. May I show it to you?"
• "I understand that people are saying a lot of scary things, and that it can be hard to figure out what's true and what isn't true. I know it must be difficult for you."

Ask your parents for information on what vaccines you have and haven't received. This lets you know what you're already vaccinated against. If your parents really hate vaccines, you could pretend that you want to know if you're at risk for "vaccine injury," or that you think a health problem you have might be caused by vaccines.

• You are allowed to lie to your parents if it's the only way you can get the information you need to protect your health. Later, you can say that you researched it and realized you don't have a vaccine injury.

HANDLING ANY AFTERMATH

Rest after your vaccine, especially if you don't feel well.
You can tell your family that you're feeling under the weather, and you can say "I think I might be fighting off some type of illness" if you don't feel safe telling them about the vaccine.

Remember that you don't have to tell your parents about getting vaccinated, especially if they are controlling or abusive. You can keep your health choices to yourself, especially if they would be mean to you or make you feel unsafe as a result of your choices. You're allowed to keep a secret if it's necessary to promote your health and well-being.

Know what to say if they do find out somehow. Show respect for their position (however illogical it may be), while emphasizing that this is important to you.

• "I read about meningitis, and how quickly it can kill someone. It was scary. I don't want to live with that fear hanging over my head. I know that you may not approve. I did this to give myself peace of mind."
• "I'm autistic. I can't be turned autistic twice. But I could die of polio, and I'd really rather not."
• "I want to be a mom someday. Vaccine-preventable diseases can kill a baby in the womb. I did this to protect my ability to have children in the future."

INFECTIOUS DISEASES: DISPELLING THE MYTHS

BY DAWN LESTER
6th May 2020
https://whatreallymakesyouill.com/infectious-diseases-dispelling-the-myths/

OUR PREVIOUS ARTICLE, entitled The Germ Theory: A Deadly Fallacy, (Dawn Lester, April 19th 2020) revealed that there is no scientific basis for the idea that 'germs' cause disease.

This revelation raises a fundamental question about the transmission of diseases claimed to be infectious; a question that is answered by the statement that because diseases are not caused by germs, they cannot be transmissible.

The vast majority of people will consider this statement to be highly controversial as it contradicts their everyday experience of seeing people with the same symptoms at the same time; an experience that is invariably interpreted to provide 'proof' that those people have all 'caught' the same disease that has been spread by germs. Although a popular interpretation of simultaneous ill-health, it is nevertheless an erroneous one.

This statement will inevitably raise yet further questions in people's minds, the main ones being: why do diseases appear to be infectious; and what causes them if not germs? The answer to the first question is that appearances are deceptive. The answer to the second question is that people are exposed to complex combinations of harmful substances and influences that induce the symptoms associated with disease. Furthermore, as we explain in our book What Really Makes You Ill? Why Everything You Thought You Knew About Disease Is Wrong, symptoms represent the body's innate self-healing processes; they are the body's efforts to expel toxins, repair damage and restore health. The reason that people in close proximity to each other experience similar symptoms is because they have been exposed to similar combinations of harmful substances and influences.

The best way to expand on these explanations is through an example: the most pertinent example, in view of the current alleged 'pandemic', is the 1918 Flu.

Influenza is defined on the November 2018 WHO fact sheet entitled Influenza (Seasonal) as a seasonal illness that is said to be characterised by certain symptoms, especially fever, cough, headache, muscle and joint pain, sore throat and runny nose. Although not regarded as inherently dangerous, influenza is said to be potentially fatal for people 'at high risk', which refers to children under 5, adults over 65, pregnant women and people with certain other medical conditions.

"It was a common expression during the war that more soldiers were killed by vaccine shots than by shots from enemy guns."

It is claimed that the pandemic of 1918 was responsible for the deaths of 20 to 100 million people. However, unlike the 'seasonal' variety, the 1918 flu affected a completely different demographic; the majority of deaths occurred in adults in the 20 to 40 age range. In addition, the symptoms they experienced are reported to have been very different from those described by the WHO. A Stanford University article entitled The Influenza Pandemic of 1918 refers to physicians' reports and states that,

"Others told stories of people on their way to work suddenly developing the flu and dying within hours."

Nevertheless, this illness is claimed to be merely a variation of ordinary influenza; as indicated by a 2006 CDC article entitled 1918 Influenza: the Mother of All Pandemics that claims,

"All influenza A pandemics since that time, and indeed almost all cases of influenza A worldwide…have been caused by descendants of the 1918 virus…"

It should be emphasised that viruses are not alive; they cannot therefore have descendants.

A significant aspect of the 1918 'pandemic' is that it occurred towards the end of WWI. Although military personnel are usually amongst the fittest and healthiest members of the population, it is reported that soldiers were often the most severely affected, especially in the US; as indicated by a 2014 article entitled Death from 1918 pandemic influenza during the First World War that states,

"Pandemic influenza struck all the armies, but the highest morbidity rate was found among the Americans as the disease sickened 26% of the US Army, over one million men."

The article also claims that: "The origin of the influenza pandemic has been inextricably linked with the men who occupied the military camps and trenches during the First World War."

There are reasons that these men became ill or died; one key reason is the use of medicines and vaccines, both of which have been directly linked to morbidity and mortality. In her booklet entitled Swine Flu Exposé, Eleanor McBean refers to the 1918 Flu and explains that,

"It was a common expression during the war that 'more soldiers were killed by vaccine shots than by shots from enemy guns.' The vaccines, in addition to the poison drugs given in the hospitals, made healing impossible in too many cases. If the men had not been young and healthy to begin with, they would all have succumbed to the mass poisoning in the Army."

The medicine commonly prescribed for the treatment of influenza during the early 20th century was aspirin, the dangers of which were unknown at the time, but have since been recognised to include respiratory problems; as indicated by a November 2009 article entitled Salicylates and Pandemic Influenza Mortality, 1918-1919 Pharmacology, Pathology and Historic Evidence that states,

"Pharmacokinetic data, which were unavailable in 1918, indicate that the aspirin regimens recommended for the 'Spanish influenza' predispose to severe


Photo by Mateus Campos Felipe on Unsplash.com

pulmonary toxicity."

The disease was originally believed to be caused by a bacterium, against which a number of vaccines were developed; as discussed in a 2009 article entitled The fog of research: Influenza vaccine trials during the 1918-19 pandemic which states that,

"Bacterial vaccines of various sorts were widely used for both preventive and therapeutic purposes during the great influenza pandemic of 1918-19."

In his book, The Hygienic System: Vol VI Orthopathy, Herbert Shelton refers to epidemics as 'mass sickness' and adds that,

"In the training camp where the writer was stationed, hundreds of cases of mumps developed during the influenza pandemic. But these did not make the front page. During this pandemic there were as many or more colds as ever, but almost nobody had a cold. Colds were influenza. Influenza was a blanket term that covered whatever the patient had."

The similarity to the 2020 'pandemic' is striking!

Although the vaccines of the early 20th century differed from those of the early 21st century, their ingredients share many characteristics, most notably toxicity and neurotoxicity. The 20th century vaccines were associated with many adverse effects, including lethargic encephalitis; as described by Annie Riley Hale in her book entitled The Medical Voodoo,

"In the British Journal of Experimental Pathology August 1926, two well-known London medical professors, Drs Turnbull and McIntosh, reported several cases of encephalitis lethargica – 'sleeping sickness' – following vaccination which had come under their observation."

Post-vaccination encephalitis is a recognised phenomenon; as indicated by a September 1931 article entitled Post-Vaccination Encephalitis that states,

"Post-vaccination encephalitis is a disease of unknown etiology that has appeared in recent years and which occurs without regard to the existence of known factors other than the presence of a recent vaccination against smallpox."

The adverse effects of medicines and vaccines are unsurprising, considering the toxic nature of their ingredients; as explained by the authors of Virus Mania,

"Additionally, the medications and vaccines applied in masses at that time contained highly toxic substances like heavy metals, arsenic, formaldehyde and chloroform…"

Medicines and vaccines were not the only hazardous material to which soldiers were exposed. In his book entitled Pandora's Poison, Joe Thornton discusses chlorine, which, in its natural state within a chloride salt, is stable and relatively harmless. Chlorine gas, by comparison, is highly reactive, destructive and deadly; as he explains,

"If released into the environment, chlorine gas will travel slowly over the ground in a coherent cloud, a phenomenon familiar to World War I soldiers who faced it as a chemical weapon, one of chlorine's first large-scale applications."

Survivors of a chlorine gas attack would have suffered respiratory

problems for the rest of their lives; Joe Thornton describes the effects,

"Chlorinated chemicals were particularly effective chemical weapons because they were highly toxic and oil soluble, so they could cross cell membranes and destroy the tissues of lungs, eyes and skin, incapacitating soldiers and causing extreme pain."

There were other toxic chemicals that could induce respiratory problems that may have been mistakenly identified as 'influenza', such as Nitroglycerin, which was manufactured in large quantities and used extensively during WWI. Its significance is explained by Nicholas Ashford PhD and Dr Claudia Miller MD in their book entitled Chemical Exposures: Low Levels and High Stakes, in which they state that, "Nitroglycerin, used to manufacture gunpowder, rocket fuels and dynamite, may cause severe headaches, breathing difficulties, weakness, drowsiness, nausea and vomiting as a result of inhalation."

The 'war effort' inevitably created a substantially increased demand for the industrial manufacture of machinery, equipment and weapons, many of which needed to be welded; welding is a hazardous occupation as the authors explain, "Welding and galvanised metal causes evolution of zinc oxide fumes that, when inhaled, provoke an influenza-like syndrome with headaches, nausea, weakness, myalgia, coughing, dyspnea and fever."

Dyspnoea refers to breathing difficulties.

Influenza of the seasonal variety is said to affect millions of people worldwide every year; as the WHO fact sheet states, "Worldwide, these annual epidemics are estimated to result in about 3 to 5 million cases of severe illness and about 290,000 to 650,000 respiratory deaths."

Many countries were affected by the 1918 'pandemic', although India is claimed to have been the most severely affected; a 2014 article entitled The evolution of pandemic influenza: evidence from India 1918-19 states that, "The focal point of the epidemic in terms of mortality was India, with an estimated death toll range of 10-20 million…"

"Another particularly interesting circumstance that would have affected the health of large numbers of people is the 'crippling drought' that India experienced in 1918-19, which is said to have been the result of the El Niño."

In 1918, India had an established pharmaceutical industry and a growing vaccination programme; as described in a 2014 article entitled A brief history of vaccines and vaccination in India that states, "The early twentieth century witnessed the challenges in expansion of smallpox vaccination, typhoid vaccine trial in Indian personnel, and setting up of vaccine institutes in almost each of the then Indian states."

Cholera and plague vaccines were also used in India. The article also refers to one of the common explanations for the alleged 'spread' of the flu throughout the population in the comment that, "The pandemic is believed to have originated from influenza-infected World War I troops returning home."

There is little, if any, evidence to support this claim; but there is a major flaw in the idea that returning troops were responsible for the spread of the '1918 Flu'. This disease is claimed to have been so deadly that it could kill within days, or even hours.

It is clear therefore that Indian soldiers afflicted by this deadly form of 'influenza' would not have survived the long journey from a European war zone back to their home country.

Another particularly interesting circumstance that would have affected the health of large numbers of people is the 'crippling drought' that India experienced in 1918-19, which is said to have been the result of the El Niño Southern Climatic Oscillation (ENSO). This is reported in a December 2014 article entitled Malaria's contribution to World War One – the unexpected adversary that states,

"The ENSO for 1918-1919 was one of the strongest in the twentieth century."

India is not the only country to have been affected by the strong ENSO of 1918-19; many regions in the southern hemisphere were also affected. Parts of Australia, for example, are reported to have experienced severe droughts between 1918 and 1920. Other regions known to have been affected by the ENSO of 1918-19 include Brazil, Central America, Indonesia and the Philippines, as well as parts of Africa.

Yet adverse health problems in these countries during that period are invariably attributed to influenza; as indicated by a July 2013 article entitled Mortality from the influenza pandemic of 1918-19 in Indonesia, which states that, "For Indonesia, the world's fourth most populous country, the most widely used estimate of mortality from that pandemic is 1.5 million."

The article makes no reference to the ENSO of 1918-19 and only discusses the decline in the population due to influenza. WWI also involved men drawn from African countries that were colonies of European countries; as discussed in an article entitled War Losses (Africa) that refers to the, "… vast mobilization of African soldiers and laborers for service in Europe between 1914 and 1918…"

It should be noted that soldiers and labourers were not the only casualties; the article also states that, "…very large, but unknown numbers of African civilians perished during the war."

The article refers to some of the reasons that African civilians died and these include, "…famine prompted by a lack of manpower to till the fields, and diseases exacerbated by malnourishment…"

Famines throughout the regions of the southern hemisphere are likely to have been triggered by the droughts that are frequently associated with an ENSO, and especially the strong ENSO of 1918-19.

It is abundantly obvious that the 'pandemic' referred to as the 1918 Flu occurred during a unique time in history. The refutation of the 'germ theory' means, however, that the high levels of morbidity and mortality experienced during that time cannot be attributed to an 'infectious virus'.

Instead, as we have shown in this article and as we show in depth in our book, that worldwide phenomenon can be explained by a number of causal factors that include, but are not restricted to: the stresses of war and combat; multiple toxic vaccinations; toxic medicines; the appalling conditions in which soldiers lived and fought; exposures to deadly chlorine gas and other toxic materials; and the effects of a strong ENSO.

These factors, occurring simultaneously and acting synergistically, provide a far more compelling explanation for the morbidity and mortality suffered during 1918 than that of an infection by a non-living particle of genetic material in a protein coating that has been labelled 'virus'.

REFERENCES:

BOOKS

ASHFORD, N & Miller, C – Chemical Exposures: Low Levels and High Stakes.
ENGELBRECHT, T & Köhnlein, C – Virus Mania
MCBEAN, E – Swine Flu Exposé.
RILEY, A – The Medical Voodoo
SHELTON, H. – The Hygienic System: Vol VI Orthopathy.
THORNTON, J. – Pandora's Poison: Chlorine, Health, and a New Environmental Strategy.

ARTICLES

WHO fact sheet Influenza (Seasonal) https://www.who.int/news-room/fact-sheets/detail/influenza-(seasonal)
The Influenza Pandemic of 1918 https://virus.stanford.edu/uda/
1918 Influenza: the Mother of All Pandemics https://wwwnc.cdc.gov/eid/article/12/1/05-0979_article
Death from 1918 pandemic influenza during the First World War http://onlinelibrary.wiley.com/doi/10.1111/irv.12267/abstract
Karen M. Starko, Salicylates and Pandemic Influenza Mortality, 1918–1919 Pharmacology, Pathology, and Historic Evidence, Clinical Infectious Diseases, Volume 49, Issue 9, 15 November 2009, Pages 1405–1410, https://doi.org/10.1086/606060
The fog of research: Influenza vaccine trials during the 1918-19 pandemic https://www.ncbi.nlm.nih.gov/pubmed/19525296
Post-Vaccination Encephalitis http://annals.org/aim/article-abstract/669860/post-vaccination-encephalitis
The evolution of pandemic influenza: evidence from India 1918-19 https://bmcinfectdis.biomedcentral.com/articles/10.1186/1471-2334-14-510
Lahariya C.A brief history of vaccines & vaccination in India. Indian J Med Res. 2014 Apr;139(4):491-511. PMID: 24927336; PMCID: PMC4078488.
Malaria's contribution to World war One – the unexpected adversary https://malariajournal.biomedcentral.com/articles/10.1186/1475-2875-13-497
Chandra S. Mortality from the influenza pandemic of 1918-19 in Indonesia. Popul Stud (Camb). 2013 Jul;67(2):185-93. doi: 10.1080/00324728.2012.754486. Epub 2013 Jan 23. PMID: 23339482; PMCID: PMC3687026.
War Losses (Africa) https://encyclopedia.1914-1918-online.net/article/war_losses_africa

CHANGING HEARTS AND MINDS

BY ELIZABETH LODER,
HEAD OF RESEARCH, THE BMJ

BMJ 2019;367:l6601
doi: 10.1136/bmj.l6601
(Published 21 November 2019)

EXTRACT

THE UK IS NO LONGER measles free, and other vaccine preventable childhood illnesses are on the rise. What is the best way to counter the claims of the antivaccination movement?

Not with papers, peer reviewed studies, or symposiums, say Kathryn Perera and colleagues (doi:10.1136/bmj.l6447). "Don't bring a fact to a narrative fight," they advise. The "we know best" approach is not effective in a world that is sceptical of the "old power" represented by medical experts and institutions. Instead, those who hope to change minds must embrace "new power" approaches that take into account the emotional explanations for beliefs and attitudes.

The success of the antivaccination lobby is "based on tactics and thinking that can and should be deployed against it." These strategies rely on stories and context that are created and shared in the peer to peer communities that thrive on social media platforms.

Meanwhile, the Daily Mail has launched a campaign to "end the MMR vaccine ignorance" and encourage parents to inoculate their children. The newspaper expresses "profound regret" for the credence it gave to the now retracted paper by Andrew Wakefield and colleagues linking the MMR vaccine to autism. But is the Mail's apology too late? Ingrid Torjesen examines charges of hypocrisy levelled at the paper (doi:10.1136/bmj. l6487).

It is widely viewed as having contributed to vaccine hesitancy with articles that were heavily slanted towards antivaccination arguments. A new editor has come in and taken a fresh look, and this as much as the resurgence of disease may have contributed to the Mail's change of heart.

TiP Editor: Rather than consider more conversation and open discussion with those raising concerns the focus is to increase further tactics on how to change the hearts and minds of critical thinkers!

MUMPS ANTIBODY RESPONSE IN YOUNG ADULTS AFTER A THIRD DOSE OF MEASLES-MUMPS-RUBELLA VACCINE

OPEN FORUM INFECTIOUS DISEASES (2014)
DOI: 10.1093/OFID/OFU094

EXTRACTS

BACKGROUND

MUMPS outbreaks in populations with high 2-dose measles-mumps-rubella (MMR) vaccine coverage raise the question whether a third dose of MMR vaccine (MMR3) is needed. However, data on the immunogenicity of MMR3 are limited. We assessed mumps virus neutralizing antibody levels pre- and post-MMR3 in a nonoutbreak setting.

CONCLUSIONS

Very few subjects had negative or low baseline mumps titers. Nonetheless, mumps titers had modest but significant increases when measured 1 month and 1 year post-MMR3. This temporary increase in titers could decrease susceptibility to disease during outbreaks, but may have limited value for routine use in vaccinated populations.

INTRODUCTION

Mumps is an acute viral disease that classically presents with parotitis. Serious complications include orchitis, deafness, and encephalitis. A monovalent mumps vaccine was licensed in 1967, and in 1977, the Advisory Committee on Immunization Practices (ACIP) recommended universal childhood vaccination with 1 dose. In 1989, the ACIP recommended that school-aged children receive 2 doses of measles-mumps-rubella (MMR) vaccine for improved measles control, with the first dose at age 15 months (high-risk areas) or 12 months (non-high-risk areas) and the second dose at age 4–6 years. Vaccine coverage against mumps increased, which was associated with a >99% decline in disease incidence compared with the prevaccine era. Following this success, the Healthy People 2010 goal of mumps elimination was established. However, unlike measles and rubella, mumps elimination in the United States was never documented. The current Healthy People 2020 mumps goal is to reduce the number of US-acquired cases, rather than elimination.

"Between 2006 and 2013, several large mumps outbreaks occurred in the United States and abroad, primarily among 2-dosed vaccinated school-aged children and young adults in high-contact settings."

Between 2006 and 2013, several large mumps outbreaks occurred in the United States and abroad, primarily among 2-dosed vaccinated school-aged children and young adults in high-contact settings. Although current MMR vaccination recommendations are for the first dose at age 12–15 months and the second dose at 4–6 years, a third dose of MMR vaccine (MMR3) was offered at school-based immunization clinics during 2 of these outbreaks as part of a public health response.

However, serologic response was not measured. Although attack rates declined after administering MMR3 in both school-based studies, in one study, statistical significance could not be established due to the small number of cases, and in both studies, the possibility of the declines being unrelated to the intervention could not be excluded.

A third dose of mumps-containing vaccine is also administered in some nonoutbreak settings. Healthcare personnel, military recruits, international travelers, and college students who may have been vaccinated as children but who lack documentation are routinely given an additional dose, which is often the third dose.

Pregnant women with a negative rubella titer are revaccinated after delivery even if they have had 2 previous MMR doses.

Despite mumps outbreaks occurring in communities with high 2-dose MMR vaccine coverage and third doses being routinely administered in some settings, data on the immunogenicity of MMR3 are limited. The objective of this study was to assess the magnitude and duration of aggregate mumps virus neutralizing antibody responses after MMR3 in a healthy, young adult population.

TiP Editor: They are good at establishing elimination goals but when they fail to achieve them they just move to new elimination dates. A measles eradication goal was originally set at 1980, yes fifty years ago! Or sometimes they drop the idea of elimination and start talking about reducing cases as they describe with mumps in this paper. I would have thought that their main objective would be to study why mumps outbreaks continue to occur in communities with high 2 dose MMR coverage, and sometimes even with 3 doses? In the UK mumps was not even a notifiable disease until 1988, the year the MMR was introduced. It was previously considered that mumps complications were very rarely serious and therefore there eis little indication for the routine use of a mumps vaccine. (BNF, No 10, 1985, page 385).

MEASLES, MUMPS, AND RUBELLA ANTIBODY PATTERNS OF PERSISTENCE & RATE OF DECLINE FOLLOWING THE SECOND DOSE OF THE MMR VACCINE

SEAGLE EE, BEDNARCZYK RA, HILL T, FIEBELKORN AP, HICKMAN CJ, ICENOGLE JP, BELONGIA EA, MCLEAN HQ

Vaccine. 2018 Feb 1;36(6):818-826. doi: 10.1016/j.vaccine.2017.12.075.

ABSTRACT

BACKGROUND:

ANTIBODIES TO MEASLES, mumps, and rubella decline 3% per year on average, and have a high degree of individual variation. Yet, individual variations and differences across antigens are not well understood. To better understand potential implications on individual and population susceptibility, we reanalyzed longitudinal data to identify patterns of seropositivity and persistence.

METHODS:

Children vaccinated with the second dose of measles, mumps, rubella vaccine (MMR2) at 4-6 years of age were followed up to 12 years post-vaccination. The rates of antibody decline were assessed using regression models, accounting for differences between and within subjects.

RESULTS:

Most of the 302 participants were seropositive throughout follow-up (96% measles, 88% mumps, 79% rubella). The rate of antibody decline was associated with MMR2 response and baseline titer for measles and age at first dose of MMR (MMR1) for rubella. No demographic or clinical factors were associated with mumps rate of decline. One month post-MMR2, geometric mean titer (GMT) to measles was high (3892 mIU/mL), but declined on average 9.7% per year among those with the same baseline titer and <2-fold increase post-MMR2. Subjects with ≥2-fold experienced a slower decline (≤7.4%). GMT to rubella was 149 one month post-MMR2, declining 2.6% and 5.9% per year among those who received MMR1 at 12-15 months and >15 months, respectively. GMT to mumps one month post-MMR2 was 151, declining 9.2% per year. Only 14% of subjects had the same persistence trends for all antigens.

CONCLUSIONS:

The rate of antibody decay varied substantially among individuals and the 3 antigen groups. A fast rate of decline coupled with high variation was observed for mumps, yet no predictors were identified. Future research should focus on better understanding waning titers to mumps and its impacts on community protection and individual susceptibility, in light of recent outbreaks in vaccinated populations.

CONTAGIOUS DISEASES IN THE UNITED STATES FROM 1888 TO THE PRESENT

N ENGL J MED.
NOVEMBER 28, 2013
369(22): 2152–2158. doi:10.1056/NEJMms1215400.

BRIEF EXTRACT

RECENT RESURGENCES

DESPITE SUCCESSFUL vaccination programs, multiple resurgences of measles, rubella, mumps, and pertussis have occurred since the 1980s. Measles outbreaks were continuously reported throughout the country during the 1980s, and a major resurgence in 1989–1990 affected the entire country.

Since the early 1980s, the rubella incidence rate has been elevated in California, and a large outbreak occurred in 1990–1991. A major resurgence of mumps occurred in 1986–1987 in multiple states, and the incidence rate has continued to be elevated in some of those states ever since. Pertussis is the only vaccine-preventable disease that has been consistently on the rise in the United States, with yearly incidence rates increasing since 1976. In 2003–2005 and again in 2010, there were resurgences of pertussis throughout the country, with the highest incidence rates in the Midwest to Northwest and in the Northeast.

Last year (2012), the largest pertussis outbreak since 1959 was reported in the United States with over 38,000 cases nationwide.

TiP Editor: When we read 'successful vaccination programs' what it actually means is that they successfully gave large numbers of individuals a vaccine.

That is all. How do these 'experts' know how many of those recipients would have developed measles if they had not been vaccinated, given that the number of cases had been falling throughout the 1900s?

And when they use the word 'despite' it is also possible that it could be 'because of' – meaning are the vaccines causing some cases? If their vaccine programmes were successful then they would not be having all these resurgences surely??

AIMS & OBJECTIVES OF THE *informed* PARENT GROUP

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

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

THE INFORMED PARENT, PO BOX 4481, WORTHING, WEST SUSSEX, BN11 2WH.
TEL: 01903 212969 web: www.informedparent.co.uk