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

THE BELIEF THAT VIRUSES ARE PATHOGENIC INVADERS IS CRUMBLING: New study says 'Exosomes' can't be distinguished from Viruses

BY DR. TOM COWAN
October 26, 2020
https://truthcomestolight.com/

IN THE WORLD of science, beliefs typically die a long, slow death. Such is the case with the germ theory, which really took off in the late 1800s.

At that time, the main proponents of the germ theory, including the Frenchman Louis Pasteur and the German Robert Koch, ardently believed that all the bacteria in living organisms, including human beings, were invaders from the outside. In other words, from our skin inward, we were sterile, except if we had been invaded by a pathogen. Today, 150 years later, this idea seems laughably incorrect and naïve.

Almost everyone now knows that trillions of bacteria live in and on every surface of our bodies. Some people have even attempted to demonstrate that most of our genetic material is bacterial rather than human in origin. We now have conclusive evidence that these trillions of bacteria living in us help digest our food, synthesize crucial nutrients, participate in detoxification functions, help regulate and control our emotions and, in some ways, participate in every normal human function.

The early proponents of the germ theory were not only completely inaccurate in their conclusions about the role of bacteria in the human organism, but, more important, they established a framework that postulated that human beings were somehow separate from nature. This insidious and unscientific conclusion, which continues to the present time, has caused grave harm to all living systems.

In the case of viruses, a similar shift is just beginning to happen in the scientific community. The old paradigm about viruses is that we are essentially "virus-free" in our healthy, natural state, and the only viruses that are inside us must be pathogens that came from the outside. This belief was, of course, never proven; it was just stated as dogma, and it dovetailed nicely with the narrative of "nature is out to get us."

"The conclusion, then, is that these internally generated exosomes (EVs) are the agent of adaption for living beings. They are not pathogens."

If we fast forward to modern virology, we now know that these particles called viruses can be exosomes, also called extracellular vesicles (EVs), which are generated from the tissues as a way of detoxification and communication. The way it works is that when a tissue is exposed to a certain toxin, especially one that breaks down the genetic material (i.e., EMF poisoning), the tissue packages this broken-down genetic material into vesicles so they can be excreted from the body. This is what I mean when I say a virus is the body's way of "pooping out poisons."

This excreted package of poisons is not only a vital detoxification strategy, but it also serves as a communication vehicle that can be sent out to the world. Through a kind of resonance, exosomes communicate from one part of the body to another, or from one organism to its community of friends, that a poison has been encountered, so prepare to make a defensive response.

The conclusion, then, is that these internally generated exosomes (EVs) are the agent of adaption for living beings. They are not pathogens. Unfortunately, the medical/scientific community has mistaken these detoxification-communication messengers for pathogenic viruses. But that narrative is starting to crumble. Consider this quote from a recent paper published in the journal Viruses 2020 May; 12(5). 571. The paper was written by Gianessi, F et al and is titled: "The Role of Extracellular Vesicles as Allies of HIV, HCV and SARS Viruses." Here is a quote from Section 3 of the paper:

The remarkable resemblance between EVs and viruses has caused quite a few problems in the studies on the analysis of EVs released during viral infections. Nowadays, it is an almost impossible mission to separate EVs and viruses by means of canonical vesicle isolation methods, such as differential ultracentrifugation, because they are frequently co-pelleted due to their similar dimension. To overcome this problem, different studies have proposed the separation of EVs from virus particles by exploiting their different migration velocity in a density

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Magda Taylor

Editor's note

WHEN I FIRST STARTED to investigate vaccination back in September 1991, after previously believing without question that it was safe and effective, I had absolutely no idea what a huge role vaccines would be playing three decades later on the people of this planet!

Obviously the world population's attention has been directed towards the virus since the spring. Our lives have been greatly disrupted and our freedoms increasingly restricted. Any scientist, doctor or parent attempting to raise concerns – are met with hostility and labelled 'anti vaxxers' or 'vaccine denier' or the novel term covidiot (an insulting term for someone who ignores health advice about Covid-19). Government officials are warning the public to beware of these people, as they may attempt to radicalise you. Any individuals who attempt to question covid and the official policies being implemented are being deemed terrorists, an enemy of the people!

Mainstream media continues to shut down the freedom of speech and freedom of enquiry, although there have been a few questioning articles emerging, for example, the Daily Mail online. Talk Radio have also had some very good interviews - some of their presenters have been delivering exceptionally good questions to their guests, especially pulling them up over the lack of evidence and the conflicting data etc.

Even the British army's information warfare unit has been instructed to counter 'an alarming rise in propaganda and conspiracy theories' online regarding coronavirus. The 77th Brigade, which has previously been used against Isis and extremist political groups, is part of the government operation against a coalition ranging from anti-vaccine and anti-5G activists to hard-right libertarians, who have been claiming that the pandemic threat is bogus and organising protests against lockdowns. (The Independent, 30 May 2020).

These measures are unbelievable and the extreme behaviour by many governments worldwide could easily be described as tyrannical.

The many shocking video footages of the heavy-handed policing towards individuals peacefully protesting about what is going on has left many stunned by the inhumane actions taken. All forms of separation are being promoted, in particular the dehumanising wearing of masks (the new fashion accessory) with no mention of the potential health hazards from constantly restricting proper breathing.

However despite attempts to erase freedom of speech we are seeing a growing number of articles, interviews and data appear daily online that are casting many doubts on all the official narrative. More and more concerned scientists, doctors and other academics are collaborating, resulting in more alliances being formed, such as:

World Doctors Alliance

https://worlddoctorsalliance.com/

UK Medical Freedom Alliance

https://www.ukmedfreedom.org/

The UK MFA have produced many vaccine documents and templates, including an informed consent form, which can be downloaded. Also simple, easy-to-understand leaflets on the two main vaccines due to be available for UK citizens this month and onwards.

Children's Health Defense are now producing a free online newsletter 'The Defender' to expose the corrosive impact of corporate power on democracy, particularly on health and environmental issues.

There are numerous uncertainties surrounding what these fast-tracked vaccines will achieve let alone the effects of this new vaccine technology.

A paper published by the New and Emerging Respiratory Virus Threats Advisory Group (4/12/20) states, for example:

- *the length of immunity conferred by natural infection or vaccination is currently not known*
- *that individuals with some immunity could become silently infected and still contribute to onward transmission of virus*
- *the duration of protection from the vaccine is not yet known (they are moderately confident that it is likely to persist for at least three months)*
- *reinfection upon re-exposure to SARS CoV2 does occur, but seems rare. Most reported reinfections are mild, but some are severe; these require further investigation.*

All sounding rather vague and government ministers here, and overseas, are indicating that social distancing and mask wearing must continue even after receiving the vaccine. I would encourage you all to do your best to ignite family and friends into questioning the contradictory and often nonsensical policies that are being dictated to us presently.

Here's hoping for the light to shine on the truth!

Magdalene Taylor, Editor, December 2020

gradient or using the presence of specific markers that distinguish viruses from EVs. However, to date, a reliable method that can actually guarantee a complete separation does not exist.

Read the final line again: A way to distinguish external "pathogenic" viruses from particles generated from our own tissues to help us adapt to a novel toxin does NOT exist, period. Perhaps the reason virologists can't find any method to distinguish these particles from each other, in spite of the fact that they can pull a single molecule out of virtually any complex solution, can only be because there is nothing to distinguish. I submit that all viruses are exosomes/EVs. They are all generated from our tissues. None are pathogens. See you later, close up shop, it's time to get honest work.

This change in how we view viruses (exosomes) will happen, but possibly only when the old guard dies out. Paradigms are hard to change. This one, however, is threatening to destroy the world, and we don't have time for the virologists to fade away. We must understand this shift ourselves. It's not that complicated once you remove the veil. It's obvious: We humans are part of the joyous dance of life, viruses and bacteria are our dance partners, and without them we will trip on our own two feet and fall flat on our collective faces.

ISOLATION OF THE VIRUS

IN A RECENT VIDEO PRESENTATION DR TOM COWAN, AUTHOR OF **THE CONTAGION MYTH**, DISCUSSED A FEW PAPERS PUBLISHED ON THE ALLEGED ISOLATION OF THE CORONAVIRUS (2019-NCOV). HERE ARE A COUPLE OF THE PAPERS HE HIGHLIGHTED WHERE IT IS OPENLY ADMITTED THAT THE VIRUS IN QUESTION WAS NOT ISOLATED. THE BOLD TYPE WITHIN THE TEXTS IS TO EMPHASIZE COWAN'S OBSERVATIONS.

DETECTION OF 2019 NOVEL CORONAVIRUS (2019-NCOV) BY REAL-TIME RT-PCR

www.eurosurveillance.org

23 January 2020

BACKGROUND: The ongoing outbreak of the recently emerged novel coronavirus (2019-nCoV) poses a challenge for public health laboratories **as virus isolates are unavailable** while there is growing evidence that the outbreak is more widespread than initially thought, and international spread through travellers does already occur.

AIM: We aimed to develop and deploy robust diagnostic methodology for use in public health laboratory settings **without having virus material available.**

METHODS: Here we present a validated diagnostic workflow for 2019-nCoV, its design **relying on close genetic relatedness of 2019-nCoV with SARS** coronavirus, making use of synthetic nucleic acid technology.

The second paper Dr Cowan comments on is as follows:

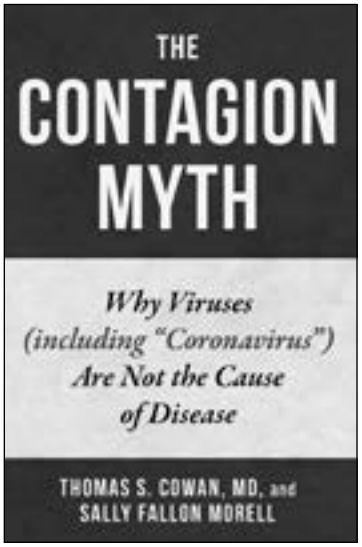
CDC 2019-NOVEL CORONAVIRUS (2019-NCOV) REAL-TIME RT-PCR

https://www.fda.gov/media/134922/download

Diagnostic Panel.

13 July 2020

Page 39: 'Since **no quantified virus isolates of the 2019-nCoV are currently available**, assays designed for detection of the 2019-nCoV RNA were tested with characterized stocks of in vitro transcribed full length RNA (N gene; GenBank accession: MN908947.2) of known titer (RNA copies/µL) spiked into a diluent consisting of a suspension of human A549 cells and viral transport medium (VTM) to mimic clinical specimen.'



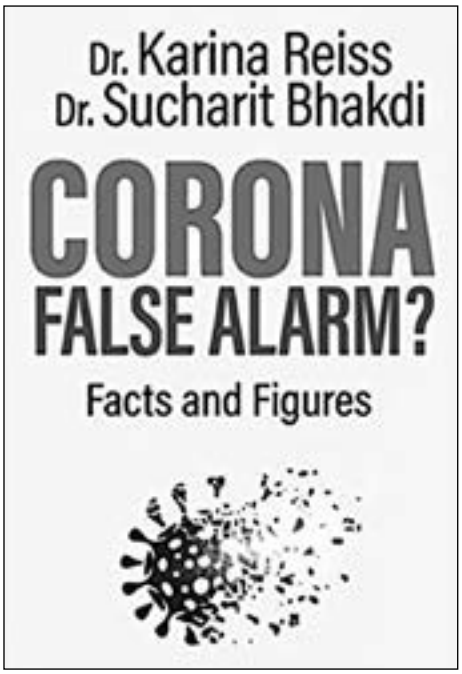
Dr Cowan points out that they are admitting that there are NO virus isolates available to go about developing these PCR tests. In other words they have never actually found the virus and instead they are using/testing sequences that are based on stocks of in vitro (laboratory-created transcribed full length RNA made in petri dishes) samples. That is what they are using as the blueprint, the template of the virus to develop the PCR tests.

NEW BOOK: CORONA FALSE ALARM? FACTS AND FIGURES

BY KARINA REISS & SUCHARIT BHAKDI (SEPT 2020)
ISBN 978-1-64502-057-8 (paperback)
Edited comments by the authors taken from an online article 15 Sept 2020 on
www.organicconsumers.org/blog

THE FIRST MONTHS of the year 2020 were characterised worldwide by a single nightmare: Corona. Dreadful images took wing from China, then Italy, followed by other countries. Projections on how many countless deaths would occur were coupled with pictures of panic buying and empty supermarket shelves. The media in everyday life was driven by Corona, morning, noon and night for weeks on end. Draconian quarantine measures were established all over the world. Civil rights were restricted as never before since the end of the Second World War. The collapse of social life and the economy were generally accepted as being inevitable. Was the country under threat of such a dreadful danger to justify these measures? Had the benefits that could possibly be gained by these measures been adequately weighed against the subsequent collateral damage that might also be expected? Is the current plan to develop a global vaccination programme realistic and scientifically sound?

The intent of this book is to provide readers with facts and background information, so that they will be able to arrive at their own conclusions. Statements in the book should be regarded as the authors' opinions that we submit for your scrutiny. Criticism and dissent are welcome. In scientific discussions, postulation of any thesis should also invite antitheses, so that finally the synthesis may resolve potential disagreement and enable us to advance in the interest of mankind. We do not expect all readers to share our points of view. But we do hope to ignite an open and much needed discussion, to the benefit of all citizens of this deeply troubled world.



PORTUGUESE COURT RULES PCR TESTS AS UNRELIABLE & UNLAWFUL TO QUARANTINE PEOPLE

November 18, 2020
https://greatgameindia.com/portuguese-court-pcr-tests-unreliable/


Photo by Josh Hild on Unsplash

THE COURT STATED, the test's reliability depends on the number of cycles used and the viral load present. Citing Jaafar et al. 2020, the court concludes that "*if someone is tested by PCR as positive when a threshold of 35 cycles or higher is used (as is the rule in most laboratories in Europe and the US), the probability that said person is infected is less than 3%, and the probability that said result is a false positive is 97%.*"

The court further notes that the cycle threshold used for the PCR tests currently being made in Portugal is unknown. The threshold cycles used in PCR tests in India is between 37 and 40, which makes the reliability of the PCR test less than 3% and the false positive rate as high as 97%. This case concerned the fact that four people had been quarantined by the Regional Health Authority.

Of these, one had tested positive for COVID using a PCR test; the other three were deemed to have undergone a high risk of exposure. Consequently, the Regional Health Authority decided that all four were infectious and a health hazard, which required that they go into isolation. The court's summary of the case to rule against the Regional Health Authority's appeal reads as follows:

"*Given how much scientific doubt exists — as voiced by experts, i.e., those who matter — about the reliability of the PCR tests, given the lack of information concerning the tests' analytical parameters, and in the absence of a physician's diagnosis supporting the existence of infection or risk, there is no way this court would ever be able to determine whether C was indeed a carrier of the SARS-CoV-2 virus, or whether A, B and D had been at a high risk of exposure to it.*"

It is also important to remember PCR was invented as a way to create copies of genetic material. It was never intended to be a diagnostic tool. The standard coronavirus tests are throwing up a huge number of positive cases daily. These tests are done based on faulty WHO protocols which are designed to include false positives cases as well. This fact about false positives of PCR Tests was first noted in public by Dr. Beda M. Stadler, a Swiss biologist, emeritus professor, and former director of the Institute of Immunology at the University of Bern. *So if we do a PCR corona test on an immune person, it is not a virus that is detected, but a small shattered part of the viral genome. The test comes back positive for as long as there are tiny shattered parts of the virus left. Correct: Even if the infectious viruses are long dead, a corona test can come back positive, because the PCR method multiplies even a tiny fraction of the viral genetic material enough [to be detected].*

Earlier, the WHO's testing protocol was even questioned by Finland's national health authority. WHO had called on countries to test as many patients as possible for coronavirus.

Finland ran out of testing capacity and began limiting coronavirus tests to the most vulnerable groups and healthcare personnel only. Finland's national health authority said that testing people with mild symptoms would be a waste of healthcare resources. In a startling disclosure, Finland's head of health security, Mika Salminen dismissed WHO advisory saying the WHO doesn't understand pandemics and that their Coronavirus testing protocol is illogical and doesn't work. So, if the WHO's testing protocols are indeed based on the most reliable, accurate and well sourced technologies and research methodologies available worldwide, shouldn't they have known about its negligible effectiveness and its impact in causing panic and chaos? Indeed the WHO knows it doesn't work and moreover this is not the first time such criticisms have been voiced. In the past in 2010, the WHO was caught faking a pandemic and was forced to admit that its methodology of measuring the virality or the spread of the disease, instead of its severity was incorrect.

CHALLENGES IN CREATING HERD IMMUNITY TO SARS-COV-2 INFECTION BY MASS VACCINATION

www.thelancet.com
https://doi.org/10.1016/S0140-6736(20)32318-7
Published online November 4, 2020


Photo by Judith Prins on Unsplash

EXTRACTS

Vaccines to protect against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) have risen up the agenda of most policy makers and individuals as the second wave of COVID-19 in northern hemisphere countries grows and there is increasing pressure on health-care systems. For any licensed vaccine, efficacy and duration of protection are key issues. Vaccine efficacies to protect against infection above 80% are desirable, but duration of protection will remain uncertain for a number of years post licensure of COVID-19 vaccines. Preliminary evidence suggests waning antibody titres in those who have recovered from SARS-CoV-2 infection, but antibodies are only one part of the human immune response and acquired immunity to reinfection or the prevention of disease when reinfected. Data on immunity to other coronaviruses suggest that immunity to SARS-CoV-2 might be short lived, perhaps 12–18 months in duration. Whether past infection will prevent severe COVID-19 on re-exposure to SARS-CoV-2 is not known at present.

Developing the structure of a within-country immunisation programme will be crucial, including defining priorities for receiving vaccination, solving distribution challenges, and encouraging public acceptance of vaccination. Addressing vaccine hesitancy will require good communication strategies on the value of being protected as an individual and the benefits for the community in reducing viral transmission.

There is less clarity about the main priority of mass vaccination in the shorter term. Is it to minimise net mortality per year, or is it to maximise the average number of years of life gained by an individual receiving the vaccine? What happens if countries do not reach high vaccine coverage levels? First, SARS-CoV-2 will become endemic but at a low level, the precise level depending on the degree of vaccine uptake, with peaks in winter and troughs in summer in the northern hemisphere. Second, policy makers will have to consider whether to mandate vaccination and to create a certificate to record immunisation for school, college, or university, and the workplace. Given vaccine hesitancy, the creation of herd immunity by vaccination is likely to be challenging in many countries. A further problematic issue for policy makers and vaccine producers is to carefully track the molecular evolution of SARS-CoV-2. Vaccine efficacy will depend on a stable virus target, unless we move to a situation such as that for influenza. A vaccination where vaccine composition varies depending on which strains are predicted to be dominant in any given year. Research shows continued viral evolution of SARS-CoV-2 and this aspect needs to be tracked carefully. Taking novel vaccines successfully through phase 1 to phase 3 trials within a year has been an outstanding achievement, but equally challenging over the coming year will be persuading governments and populations to use COVID-19 vaccines effectively to create herd immunity to protect all.

OPERATION MOONSHOT: What do the leaked documents say?

BY ELISABETH MAHASE
11 Sept 2020
BMJ 2020;370:m3558

EXTRACTS:

Operation Moonshot is the name of the UK government's newly proposed covid-19 mass testing scheme. The plan, revealed by The BMJ, involves an expansion of testing from the current hundreds of thousands of tests each day to 10 million a day by early 2021. But how does the government propose to do this?

From December the plans propose increasing daily capacity to between two and four million. This would involve mass testing of all homes in local areas or whole cities when prevalence rises (430 000 tests a day), testing high contact professions such as teachers every week (100 000 a day), and testing people to allow them to enter high risk settings, such as visitors to hospital and care homes. The plan then states that there would be "full rollout" in early 2021 to 10 million tests a day, to "enable people to return to and maintain normal life."

At this stage, weekly testing would be made available progressively to the whole population to allow people to go to high risk events by using a "digital passport" to show they have tested negative for the virus. Are there any plans to get the public on board? The documents show that there have been discussions over how to incentivise people to be tested. They point to enforcing testing "via a sanction-based model" or through "offering individuals opportunities/access from being tested," such as being able to attend events.

HOW A COVID-19 VACCINE COULD END UP HELPING THE VIRUS SPREAD: IT MAY BE POSSIBLE TO INFECT OTHERS EVEN AFTER GETTING A SHOT

BY PETER COY,
BLOOMBERG BUSINESSWEEK
11 November 2020
www.bloomberg.com

A VACCINE THAT protects against symptoms of Covid-19 could contribute to the spread of the disease if—and this is still just an if—the people who get vaccinated remain capable of carrying and transmitting the virus. That's a risk that's gotten little attention amid the deserved jubilation over a Nov 9 report from Pfizer Inc. and BioNTech SE that their vaccine candidate appears to be highly effective.

It's a matter of timing. If everyone in the world is vaccinated, or has developed antibodies through exposure to the disease, there will be no problem. But in the early going, when only some people are protected, they could unwittingly spread the disease to people who are still vulnerable. The vaccinated people might stop wearing masks and social distancing since they aren't themselves at risk anymore. They could be carrying the SARS-CoV-2 virus, even if they're not getting sick from it.

How big a problem this might be is hard to say, because we don't know for sure if immunized people are capable of shedding infectious virus. It's possible that their antibodies will eradicate any infection pretty quickly, so they might just shed viral debris. Pfizer and the Centers for Disease Control and Prevention did not immediately respond to requests for comment.

It's also not yet clear how much protection the Pfizer-BioNTech vaccine and others would provide. The gold standard is to achieve sterilizing immunity, which is so strong that the virus can't get a grip in the body at all—meaning that vaccinated people are safe to others. The human papillomavirus vaccine provides sterilizing immunity, for example. But sterilizing immunity is hard to achieve with viruses such as SARS-CoV-2, which enter through the respiratory system. The only sure way to know if the vaccine provides sterilizing immunity would be to check whether trial subjects who remain free of Covid-19 have been exposed to it, by tracing their contacts.

The Pfizer-BioNTech vaccine and others might provide just functional immunity—protecting people from the full-blown disease but not from carrying the virus. Functional immunity may also be what people get from being infected by the disease itself. They can catch it again, but will have fewer, if any, symptoms. We already know that people who are asymptomatic can spread Covid-19. In fact, that's one of its scariest characteristics.

Bloomberg's Jason Gale raised this issue with Paul Griffin, a professor in the faculty of medicine at the University of Queensland in Australia. Griffin, who is an investigator on four Covid-19 vaccines that do not include the Pfizer-BioNTech one, said that while it might turn out that vaccinated people can transmit the disease, transmission is far more likely if people are coughing and sneezing. "So if we are preventing clinical disease, then that will go a long way to reducing transmission as well, even if it's not precisely a transmission-blocking vaccine," Griffin said on Nov. 10. In other words, under the right conditions, a vaccine can and should suppress the transmission of Covid-19. But if people who get

Photo by Daniel Schludi on Unsplash

vaccinated throw caution to the winds, it's possible they could get a lot of other people sick.

TiP Editor: All rather confusing – they are not sure about whether vaccinated people are capable of shedding infectious virus – antibodies MAY eradicate infection –unclear about how much protection the vaccine will provide. Then a term we are not familiar with arrives 'functional immunity' which is claimed to only protect people from full- blown disease. How would they know to what level an individual might have developed this so-called disease if they had not received a vaccine? How do they know that if people 'catch' covid again it will be less of an issue second time round? That was not the case back in the days of smallpox. A secondary case could be fatal. Regarding antibodies – apart from the fact that antibodies do not equal immunity - a BBC report: 'Covid: Antibodies 'fall rapidly after infection' (27 Oct 2020) it states: 'The researchers say their findings do not scupper hopes of a vaccine, which may prove more effective than a real infection. One of the researchers, Prof Graham Cooke, said: "The big picture is after the first wave, the great majority of the country didn't have evidence of protective immunity.'

THE BEST DOCTORS GIVE THE LEAST MEDICINE.

~ *BENJAMIN FRANKLIN*

LETTER TO THE HEALTH SECRETARY

BY DR MICHAEL YEADON

6 Sept 2020

RESPONSE TO THE VACCINE CONSULTATION:

Dear Mr Hancock,
I have a degree in Biochemistry & Toxicology & a research based PhD in pharmacology. I have spent 32 years working in pharmaceutical R&D, mostly in new medicines for disorders of lung & skin. I was a VP at Pfizer & CEO of a biotech I founded (Ziarco - acquired by Novartis). I'm knowledgeable about new medicine R&D.

I have read the consultation document. I've rarely been as shocked & upset. All vaccines against the SARS-COV-2 virus are by definition novel. No candidate vaccine has been in development for more than a few months.

If any such vaccine is approved for use under any circumstances that are not EXPLICITLY experimental, I believe that recipients are being misled to a criminal extent.

This is because there are precisely zero human volunteers for whom there could possibly be more than a few months past-dose safety information.

My concern does not arise because I have negative views about vaccines (I don't).

"I don't trust you. You've not been straightforward & have behaved appallingly throughout this crisis. You're still doing it now, misleading about infection risk from young children. Why should I believe you in relation to experimental vaccines?"

Instead, it's the very principle that politicians seem ready to waive that new medical interventions - at this, incomplete state of development- should not be made available to subjects on anything other than an explicitly experimental basis. That's my concern.

And the reason for that concern is that it is not known what the safety profile will be, six months or a year or longer after dosing.

You have literally no data on this & neither does anyone else.

It isn't that I'm saying that unacceptable adverse effects will emerge after longer intervals after dosing. No: it is that you have no idea what will happen yet, despite this, you'll be creating the impression that you do.

Several of the vaccine candidates utilise novel technology which have not previously been used to create vaccines. There is therefore no long term safety data which can be pointed to in support of the notion that it's reasonable to expedite development & to waive absent safety information on this occasion.

I am suspicious of the motives of those proposing expedited use in the wider human population. We now understand who is at particularly elevated risk of morbidity & mortality from acquiring this virus. Volunteers from these groups only should be provided detailed information about risk / benefit, including the sole point I make here. Only if informed consent is given should any EXPERIMENTAL vaccine be used.

I don't trust you. You've not been straightforward & have behaved appallingly throughout this crisis. You're still doing it now, misleading about infection risk from young children. Why should I believe you in relation to experimental vaccines?

Dr Michael Yeadon

Short BIO: Dr. Michael Yeadon is an Allergy & Respiratory Therapeutic Area expert with 23 years in the pharmaceutical industry. He trained as a biochemist and pharmacologist, obtaining his PhD from the University of Surrey (UK) in 1988.

Dr. Yeadon has published over 40 original research articles and now consults and partners with a number of biotechnology companies. Before working with Apellis, Dr. Yeadon was VP and Chief Scientific Officer (Allergy & Respiratory Research) with Pfizer.)

BRITAIN'S GCHQ TO WAGE CYBER WAR ON ANTI-VACCINE PROPAGANDA

REPORTING BY REBEKAH MATHEW IN BENGALURU; EDITING BY DANIEL WALLIS.

9 November 2020 The Times

https://uk.reuters.com

BRITAIN'S GCHQ has begun an offensive cyber-operation to tackle anti-vaccine propaganda being spread online by hostile states, The Times reported.

This latest move by GCHQ, which gathers communications from around the world to identify and disrupt threats to Britain, is an attempt to counter disinformation activities linked to Russia, the report said.

The British government considers tackling false information about immunization as a high priority as the prospect of a reliable vaccine against the coronavirus draws closer, the Times said.

A vaccine is seen as the world's best bet for beating the COVID-19 pandemic that has led to more than 1.2 million deaths, roiled economies and disrupted billions of lives.

GCHQ is Britain's main eavesdropping agency and has a close relationship with the U.S. National Security Agency, as well as the eavesdropping agencies of Australia, Canada and New Zealand in an intelligence alliance known as the "Five Eyes".

"GCHQ has been told to take out antivaxers online and on social media," the Times said, citing a source.

The report said the focus of the operation is taking down hostile state-linked content and disrupting the communications of the cyberactors responsible.

The Quanten Theory www.pqliar.net

What is Health? by Patrick Quanten MD

TO ANSWER THIS simple question, let's go straight to the horse's mouth. Let's get it over and done with quickly. Let's make this crystal clear, so there is no ambiguity whatsoever. Let's ask the people who run the show and whose specialism this is.

For a very long time, the medical profession defined health as 'the absence of disease'. More recently they have realised that that is no longer appropriate, not because they no longer believe it, but because it no longer covers their activities. Prevention of diseases is what they promote so much nowadays and which has become an enormous source of income for the medical industry. However, preventative treatment would not be necessary when they go by the definition of absence of disease.

They would then, in effect, be treating healthy people and billing these people for it. The World Health Organisation (WHO) – amazingly health needs to be organised globally – currently gives the following definition: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Can anyone, by this definition, be really sure they are healthy?

It turns out that nobody, including the WHO, defines 'well-being'. And yet, somebody must use some kind of definition for this term as people are defined to be ill, meaning they are no longer in total well-being. So the question remains the same: who defines 'well-being'? You might want to. You might want to consult a doctor because you don't feel well, thereby defining yourself as being unwell. You have decided you are not well. Indeed, but that doesn't make you ill yet. The doctor has to examine you, run some tests, do whatever he decides is required before he makes a declaration about your well-being or your not so well-being. The doctor decides whether

Patrick Quanten MD

"In a free society, an individual has no right to decide for himself if he is healthy or not."

or not you are ill. You don't. You don't have the right qualifications to make that definition! The medical profession is the only profession that has the legal right to pronounce a person ill or healthy. The legal right!!!

In a free society, an individual has no right to decide for himself if he is healthy or not. And yet, what is traditionally understood by the term 'healthy'? As long as there have been people on this earth, there has been a sense of a difference between a well person and a not well person.

If we take the Ayurvedic texts, we find the following description, not a definition, of health. It defines a healthy person as someone whose doshas (bio-psychic forces) are all in equilibrium, the digestive fire (Agni) is in a balanced state (called sama), in addition to the body's tissues (dhatus) and waste products (mala) being in balance. The quote also states that the mind (mana), sense organs (indriyas), and the person's soul (atma) must be also in a pleasant state (prasanna). When a person is balanced in all of those areas, he or she is considered healthy by Ayurvedic standards. Three key words stand out here: equilibrium, balance, and a pleasant state.

The health concept of Traditional Chinese Medicine includes the holistic view of unison between man and universe, the harmonious unity of fusion of shape and soul, the people-oriented view of values and the balance of qi-blood-yin-yang in the human body. This too makes it a harmony between a single individual and his or her environment. Here too, there is no concept of a 'general' set of rules that delivers a healthy state. Both traditional descriptions of the state of health refer to a balance within an individual, within a single person. Neither deliver a set of rules for conduct, eating habits or anything applicable to the entire population, suggesting that such rules would deliver a balance, health, to all individuals.

In order to know if something is in balance or not, one ought to know what kind of balance one is referring to. Is this the balance between the average of a population and the individual? Is this the balance between an artificially set standard and the individual? Is this the balance between what has been decided to be the right thing and the individual? As we all are unique individuals, every one of us has a different combination of the same forces, of the same tissues, of the same mind products.

Crucial here is the fact that we are all made out of the same stuff, but we are all different. There is no 'group' balance that will provide you with a monitoring device of balance that suits each and every individual. No blood test or imagery will tell you what that individual balance should be, even if you believe to know what the 'right' level or the 'right' picture should look like. It will remain a choice you have made, to which you demand that everyone adheres. 'The average' is not the individual's balancing point. Health is described as a balance, and every balance is an individual matter, changing throughout life according to varying circumstances. So, the balance for one individual is not only specific to

that individual, but it is also shifting during his lifetime as well. This means, not only is a comparison with an average or any set standard for all not an indication for individual health but keeping that standard constant throughout life is also a mistake. Both are guidelines the medical profession sticks to rigidly.

Health is an individual matter and can, in fact, only be determined by that individual himself. It is the individual who receives the signals that something is no longer 'right', has shifted out of the ordinary, out of the usual. It is the individual who can, through personal observation of the altering signals, increase his knowledge about the driving forces that move the signals. By noticing how things change, how and when the signals of body and mind differ, the individual is able to determine the interactions that unsettle the balance in his or her life. It is the individual who can, through careful interpretation of the signals, get to know what exactly it is that creates the imbalance.

That information provides him with the necessary ideas about what needs to be done to rectify the situation. It is, therefore, only the individual who can correct the imbalance and who can, in fact, perform a healing. In spite of the doctor being the authority who legally determines whether or not you are ill, it is you, and only you, who has the natural authority to understand your own imbalance. This goes hand in hand with the power and the necessary choices to rectify the problem.

Giving that power away to an outside authority, like the medical profession, exposes us to all kinds of 'wrongs'. When that authority decides to lower their own standards by which disease is measured suddenly a lot more people will be diagnosed as being ill, not healthy. By lowering the 'normal' blood pressure standard there are suddenly a lot more heart patients. By lowering the default level of normal blood sugar there are suddenly a lot more diabetic patients. By choosing to name slight and temporary alterations to the shapes of cells cancer, there are suddenly a lot more cancer patients. An outside authority who has the power to decide who is ill and who isn't, while at the same time being the authority that drives the illness industry, is handing that industry carte blanche to create as many ill people as they want to. This is another example of what can go horribly wrong when there is no separation of power, when the diagnostic and the remedial powers are all in the same hands.

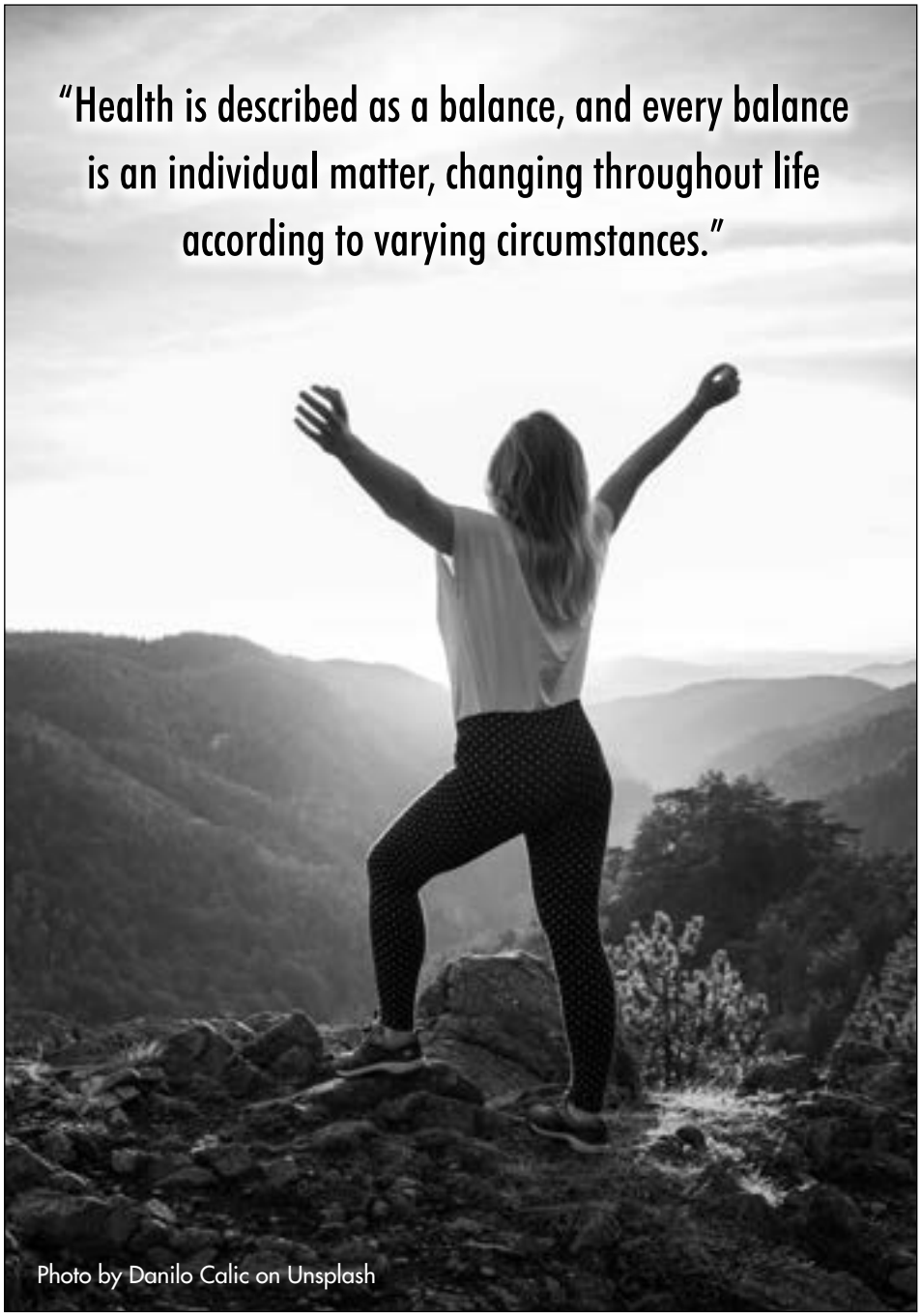


Photo by Danilo Calic on Unsplash

Now you could argue that the solution then is to simply split them up. Create diagnostic centres whilst allowing other therapists to provide treatments. Sadly that is not going to work. How do I know? Because this system is already being used. By whom? The medical profession! In the first line medical care system (GP's surgeries) physiotherapists, acupuncturists, osteopaths, massage therapists, dieticians, and many others have been adopted within the system. They work alongside the doctors in the same practice. How do they work? Well, the doctor makes the diagnosis – remember he is the only one that can do this! – and then tells the therapist what treatment, how to treat and how long for. The power remains firmly in the hands of the diagnostician and the others are merely unwitting accomplices in this seemingly more wholesome – I wouldn't say: holistic – setup. It is an extension of the system that forms the backbone of modern

medicine. The specialist service will provide an accurate diagnosis and will tell doctors how and when to treat.

I have a different proposition for you with regards to a future healthcare system. The only diagnostic power lies in the hands of the individual who decides what's wrong with him/her. Obviously, making a good diagnosis – knowing what is wrong with you – requires a lot of observation and information gathering from your own system.

But once you know what the imbalance in your life is and why it occurred, you can decide what help it is you need. So, the individual, should he or she choose to do so, tells a specific therapist, be it doctor or osteopath or massage therapist or any other, what exactly it is the individual requires that therapist to do. The therapist becomes the hired handyman who is contracted to do a very specific job. The person in charge is the individual who hires him and the therapist will be judged on the result he achieves, on how good a job he does.

But there is another aspect to disease that needs highlighting. In traditional philosophies and health systems there is clarity about the natural order in which forces are contributing towards imbalances. Without a shadow of a doubt, they all perceive the mind to rule the body. They all see the non-material as superior, meaning having more influence, over the material. The mind regulates the body and is responsible for its health, in other words for its balance.

It is stated that an imbalanced, a troubled, mind is causing ill physical health, and that every physical signal of malfunctioning is the result of a disturbance of mind. So these old traditions teach balance of mind and their most powerful therapies are mind exercises for the individual to practise. Most of the time, they use physical

"It is stated that an imbalanced, a troubled, mind is causing ill physical health, and that every physical signal of malfunctioning is the result of a disturbance of mind."

practices to help focus the mind of the individual on making specific alterations in their lives. Doing differently from before is a major tool on the road back to health.

Not only does our modern, sophisticated, medical system make a fundamental mistake by forcing every individual to fit into an artificially chosen health norm – group over individual – but it also has chosen to focus on the body, on the material exchanges, instead of on the mind. Even when they do acknowledge that a very specific ailment is caused by the mental state of the individual the main treatment approach is a chemical one, a physical one.

So, if the health of a person is the balance that individual manages to maintain for him/herself by him/herself, and if the real instrument by which this can be achieved is the mind of the individual, what would then be the value of a healthcare system that strives to make every individual adhere to the same pre-set standards and that ignores that the body is only an expression of the balance that person holds in his/her mind?

Let's, just for a moment, free ourselves from our preconceived ideas of who is and who isn't knowledgeable about health. The medical profession focuses on disease, analyses it, dissects it, and splits it up into millions of pieces, exceptions and special cases. Traditional human knowledge tells us that disease, every disease, is simply a lack of balance and that the basic physiology behind these processes is always the same. This knowledge also includes the acknowledgment of the power of the mind over the body. The ruler and the executer. If something doesn't go to plan in execution, go and complain to the ruler, to the boss. If you notice an imbalance, if you are becoming ill, know that it is caused by pressure somewhere in your mental state, the kind of pressure your system finds difficult to cope with. Inspect your life. Observe your signs, mental as well as physical. Find the pressure that pushes you out of your natural balance. Now you have a diagnosis!

Want a treatment? Reduce the pressure. Life is simple! Basically, it will come down either to finding a way not to become weighted down any longer by the situation or to finding a way to change the environment that is responsible for that kind of pressure. Which doctor do you need to consult for this? Exactly, a doctor called "I".

When you are concerned about your health you need to train yourself, through observation, in the art of listening to your own mind and body. Close the door on outside information channels and sit quietly and at peace with yourself. Once you have established contact in that way, you practise the first rule of proper communication: you quieten your mind and you listen. Don't allow your mind to chitchat. Don't allow your mind to judge. Simply listen to the inner voice.

And once you have listened, you stay still and listen some more.

Every time you listen, you learn more about who you are and what you need to do in your life in order to be balanced, to be healthy.

Then you don't need a self-proclaimed expert in whose hands to put your life. You put your own hands together and give thanks to the life you have been blessed with.

November 2020.

WHEN HEALTH IS ABSENT, WISDOM CANNOT REVEAL ITSELF, ART CANNOT MANIFEST, STRENGTH CANNOT FIGHT, WEALTH BECOMES USELESS, AND INTELLIGENCE CANNOT BE APPLIED. ~ *HEROPHILUS*

WILL COVID-19 VACCINES SAVE LIVES? CURRENT TRIALS AREN'T DESIGNED TO TELL US

PETER DOSHI REPORTS

the bmj | BMJ 2020;371:m4037 |
doi: 10.1136/bmj.m4037

Peter Doshi associate editor

THE WORLD HAS BET the farm on vaccines as the solution to the pandemic, but the trials are not focused on answering the questions many might assume they are.

EXTRACTS

As phase III trials of covid-19 vaccines reach their target enrolments, officials have been trying to project calm. The US coronavirus czar Anthony Fauci and the Food and Drug Administration leadership have offered public assurances that established procedures will be followed. Only a "safe and effective" vaccine will be approved, they say, and nine vaccine manufacturers issued a rare joint statement pledging not to prematurely seek regulatory review.

But what will it mean exactly when a vaccine is declared "effective"? To the public this seems fairly obvious. "The primary goal of a covid-19 vaccine is to keep people from getting very sick and dying," a National Public Radio broadcast said bluntly.

Peter Hotez, dean of the National School of Tropical Medicine at Baylor College of Medicine in Houston, said, "Ideally, you want an antiviral vaccine to do two things . . . first, reduce the likelihood you will get severely ill and go to the hospital, and two, prevent infection and therefore interrupt disease transmission."

Yet the current phase III trials are not actually set up to prove either. None of the trials currently under way are designed to detect a reduction in any serious outcome such as hospital admissions, use of intensive care, or deaths. Nor are the vaccines being studied to determine whether they can interrupt transmission of the virus…..

Yet until vaccine manufacturers began to release their study protocols in mid-September, trial registries and other publicly released information did little to dispel the notion that it was severe covid-19 that the trials were assessing. Moderna, for example, called hospital admissions a "key secondary endpoint" in statements to the media. And a press release from the US National Institutes of Health reinforced this impression, stating that Moderna's trial "aims to study whether the vaccine can prevent severe covid-19" and "seeks to answer if the vaccine can prevent death caused by covid-19."

"None of the trials currently under way are designed to detect a reduction in any serious outcome such as hospital admissions, use of intensive care, or deaths."

But Tal Zaks, chief medical officer at Moderna, told The BMJ that the company's trial lacks adequate statistical power to assess those outcomes. "The trial is precluded from judging [hospital admissions], based on what is a reasonable size and duration to serve the public good here," he said.

Hospital admissions and deaths from covid-19 are simply too uncommon in the population being studied for an effective vaccine to demonstrate statistically significant differences in a trial of 30 000 people. The same is true of its ability to save lives or prevent transmission: the trials are not designed to find out.

Zaks said, "Would I like to know that this prevents mortality? Sure, because I believe it does. I just don't think it's feasible within the timeframe [of the trial]—too many would die waiting for the results before we ever knew that."

"Our trial will not demonstrate prevention of transmission," Zaks said, "because in order to do that you have to swab people twice a week for very long periods, and that becomes operationally untenable."

He repeatedly emphasised these "operational realities" of running a vaccine trial. "Every trial design, especially phase III, is always a balancing act between different needs," he said. "If you wanted to have an answer on an endpoint that happens at a frequency of one 10th or one fifth the frequency of the primary endpoint, you would need a trial that is either 5 or 10 times larger or you'd need a trial that is 5 or 10 times longer to collect those events. Neither of these, I think, are acceptable in the current public need for knowing expeditiously that a vaccine works."

Still, it's fair to say that most of the general public assumes that the whole point of the current trials, besides testing safety, is to see whether the vaccine can prevent bad outcomes. "How do you reconcile that?" The BMJ asked Zaks.

"Very simply," he replied. "Number one, we have a bad outcome as our endpoint. It's covid-19 disease." Moderna, like Pfizer and Janssen, has designed its study to detect a relative risk reduction of at least 30% in participants developing laboratory confirmed covid-19, consistent with FDA and international guidance.

Number two, Zaks pointed to influenza vaccines, saying they protect against severe disease better than mild disease. To Moderna, it's the same for covid-19: if its vaccine is shown to reduce symptomatic covid-19, it will be confident it also protects against serious outcomes.

But the truth is that the science remains far from clear cut, even for influenza vaccines that have been used for decades. Although randomised trials have shown an effect in reducing the risk of symptomatic influenza, such trials have never been conducted in elderly people living in the community to see whether they save lives.

Only two placebo controlled trials in this population have ever been conducted, and neither was designed to detect any difference in hospital admissions or deaths. Moreover, dramatic increases in use of influenza vaccines has not been associated with a decline in mortality.

DISMANTLING THE VIRUS THEORY: The "measles virus" as an example

DR. STEFAN LANKA
WISSENSCHAFFTPLUS – Das Magazin
June 2015
https://wissenschafftplus.de/

WHY SHOULD we doubt the existence of viruses? What are viruses and what are they not? How are viruses being scientifically demonstrated to exist?

EXTRACTS:

Scientists must question everything and especially what they love the most, i.e. their own discoveries and ideas. This basic rule of scientific research helps avoid erroneous developments and reveals the ones that already exist. Also, we must all be allowed to question the status quo, otherwise we would live in a dictatorship. Moreover, science cannot be limited to a selected number of institutions and experts. Science can and must be conducted by anyone who has the necessary knowledge and the appropriate methods. Science can be considered science only if its claims are verifiable, reproducible and if they allow predictions. Science also needs external control, because, as we will see, a part of the medical sciences has lost touch with reality for quite some time. Anyone who has knowledge of biology and the genesis of life, of the development and functions of the tissue, of the body and of the brain, will automatically question the assumptions about viruses.

In the reality of the body and of its mechanisms, there is no place for hypothetical malignant processes. All biological processes, including those that can end in suffering, pain and death, are originally meant to be useful.

A different approach to the virus phenomenon is possible and necessary: any layman with some background knowledge reading scientific papers about pathogenic viruses can realize that such viruses do not exist and what is being described are only typical components and characteristics of cells. This background knowledge will be provided in this article.

THE ORIGINS OF THE IDEA

The present notion of a virus is based on the ancient ideas that all diseases were caused by poisons ("toxins") and that people would regain their health by producing "antitoxins" as an "antidote". Indeed, a few diseases are caused by poisons. The subsequent idea, that the body can restore its health by producing or being given "antidotes", was born when it was observed that people survived bigger amounts of poison (such as alcohol) when their body was trained by consuming slowly increasing amounts of that poison. However, in reality there are no antidotes, instead the body produces enzymes, which neutralize and eliminate the poisons (alcohol).

"Any layman with some background knowledge reading scientific papers about pathogenic viruses can realize that such viruses do not exist and what is being described are only typical components and characteristics of cells."

In 1858, Rudof Virchow, the founder of modern medicine, plagiarized the findings of other scientists, suppressed their essential discoveries and thus a false view on the cause of diseases was born and imposed as a dogma, which is in fact still in effect to date. According to this dogma, all diseases supposedly originate inside the cells. Virchow's cellular pathology re-introduced into medicine the ancient and refuted the humoral doctrine and claimed that diseases develop from pathogenic poisons (in Latin: virus).

The search for these pathogenic poisons remains to date fruitless, however, when bacteria were discovered, it was assumed that they were producing the pathogenic poisons. This supposition, called "the germ theory", was immediately accepted and remains very successful up to the present time. This theory is so successful that the majority of the people are still not aware of the fact that the so-called bacterial toxins are actually normal enzymes, which either cannot appear in a human being, or, if they do, they never appear in such an amount as to make them dangerous.

Then it was discovered that, when they slowly begin to die, bacteria create tiny, apparently lifeless forms of survival, the so-called spores. It was then suspected that these spores were toxic and that they were the so-called pathogenic poisons. This was then refuted, since the spores are rapidly developing into bacteria when their vital resources are being restored. When scientists in the laboratory observed that the weak, highly inbred bacteria perished very quickly while turning into much smaller structures than the spores, it was first believed that the bacteria were being killed by the alleged pathogenic poisons, called viruses, and that the viruses were thereby replicating.

Due to the belief that these - at the time of their discovery still invisible - structures were killing the bacteria, they were called phages/bacteriophages, "eaters of bacteria". Only later it was determined that merely highly inbred and therefore almost non-viable bacteria can be made to turn into phages, or bacteria which are being destroyed so fast that they do not have time to form spores.

The introduction of the electron microscopy led to the discovery of the structures resulting from the transformation of bacteria when these were suddenly dying or when the metabolism of the highly inbred germs was overwhelmed by processes triggered by the adding of "phages". It was also discovered that there are hundreds of types of different-looking "phages". The discovery of phages, the so-called bacterial "viruses", reinforced the wrong assumption and the belief that there were human and animal viruses that looked the same and had the same structure. This is not and cannot be the case, for several different reasons.

After introducing chemical


Photo by Liz Red on unsplash

examination techniques in biology, it was discovered that there are thousands of types of phages and that phages of one type always have the same structure. They consist of a particular molecule, made of nucleic acid, which is covered in a shell of proteins of a given number and composition. It was only later discovered that merely the bacteria which had been highly inbred in the test tube could turn into phages themselves, by contact with phages, but this never applied to natural bacteria or bacteria which had just been isolated from their natural environment. In this process, it was discovered that these "bacterial viruses" actually serve to provide other bacteria with important molecules and proteins, and that the bacteria themselves emerged from such structures.

Before it could be established that the "bacterial viruses" cannot kill natural bacteria, but they are instead helping them to live and that bacteria themselves emerge from such structures, these "phages" were already used as models for the alleged human and animal viruses. It was assumed that the human and animal viruses looked like the "phages", were allegedly killing cells and thereby causing diseases, while at the same time producing new disease poisons and in this way transmitting the diseases. To date, many new or apparently new diseases have been attributed to viruses if their origin is unknown or not acknowledged. This reflex found an apparent confirmation in the discovery of the "bacterial viruses".

ABOUT THE ALLEGED PROOF OF PATHOGENIC VIRUSES

The "bacteriophages", correctly defined as incomplete mini spores and building blocks of the bacteria, have been scientifically isolated, while the supposed pathogenic viruses have never been observed in humans or animals or in their body fluids and have never been isolated and subsequently biochemically analysed. To date, none of the researchers involved in this kind of work seems to have realised this.

The use of the electron microscope and the biochemistry were very slowly returning to normal after 1945 and no one had realised that not one pathogenic virus had ever been isolated in humans or animals; thus, as of 1949 researchers started applying the same idea used for the (bacterio) phages, in order to replicate the human and animal "viruses". John Franklin Enders, born in 1897 into the family of a rich financier, was active in various fraternities after having finished his studies, then he worked as a real estate agent and studied foreign languages for four years before turning to bacterial virology, which fascinated him.

He then simply transferred the ideas and concepts that he learned in this area of research to the supposed pathogenic viruses in humans. With his unscientific experiments and interpretations that he had never confirmed through negative controls, Enders brought the entire "viral" infectious medicine to a dead end. It is important to note at this point that Enders, like many infectious diseases specialists, worked for the U.S. military, which had always been and remains to date a huge victim of the fear of contagion. It was mainly the U.S. military which spread its erroneous belief that besides chemical weapons

there were also biological weapons in the form of bacteria and viruses. In 1949, Enders announced that he had managed to cultivate and grow the alleged polio virus in vitro on various tissues.

The American expert opinion believed everything immediately. What Enders did was to add fluids from patients with poliomyelitis to tissue cultures which he claimed to have had sterilized, then he alleged that the cells were dying because of the virus, that the virus was replicating in this way and that a vaccine could be harvested from the respective culture. At that time, summer polio epidemics (polio = flaccid paralysis) were very frequent during summer and they were believed to be caused by polio viruses. A vaccine was to help eradicate the alleged virus. After the polio vaccine was introduced, the symptoms were then re-diagnosed among other things as multiple sclerosis, flaccid acute paralysis, aseptic meningitis etc. and later polio was claimed to have been eradicated.

During his experiments, Enders et al. sterilised the tissue cultures in order to exclude the possibility of bacteria killing the cells. What he didn't take into consideration was that the sterilisation and the treatment of the cell culture when preparing it for the alleged infection was exactly what was killing the cells.

Instead, he interpreted the cytopathic effects as the existence and the action of polio viruses, without ever having isolated a single virus and described its biochemistry. The necessary negative control experiments, which would have shown that the sterilisation and the treatment of the cells prior to the "infection" in the test tube was killing the cells, have never been performed. However, for this "performance" Enders received the Nobel prize in 1954.

1954 is also the year in which Enders applied and introduced the same technique in order to allegedly replicate the measles virus. As he had been awarded the Nobel prize for the alleged polio virus the same year, all researchers believed his technique to be scientifically valid. Thus, to date, the entire concept of measles has been based upon this technique. Thus, the measles vaccines do not contain viruses, but particles of dead monkey kidney tissue or human cancer cells.

"Instead, he interpreted the cytopathic effects as the existence and the action of polio viruses, without ever having isolated a single virus and described its biochemistry."

To date, no negative control experiments have been done with respect to the so-called measles virus either, which would have shown that it is the laboratory procedures that lead to the cytopathic effects on the cells. Additionally, all claims and experiments made by Enders et al. and the subsequent researchers lead to the only objective conclusion that in fact they were observing and analyzing dying cellular particles and the activity thereof in the test tube, misinterpreting these as particles and characteristics of the alleged measles virus.

THE MEASLES VIRUS AS AN EXAMPLE

The following explanations apply to all the so-called (human or animal) "pathogenic viruses".

The six papers provided by Dr Bardens in the course of the "measles trial" as proof for the existence of the measles virus describe in a didactically ideal way the various steps of the chain of misinterpretations up to the belief in the existence of a measles virus.

The first paper was published in 1954 by Enders et al.: "Propagation in tissue cultures of cytopathogenic agents from patients with measles" (Proc Soc Exp Biol Med. 1954 Jun; 86 (2): 277–286). This publication can be found on the internet, like all the other publications presented at the measles trial.

In that experiment, Enders et al. cut down dramatically on the nutrient solution and added cell-destroying antibiotics to the cell culture before introducing the allegedly infected fluid. The subsequent dying of the cells was then misinterpreted as presence and also isolation of the measles virus. No control experiments were performed to exclude the possibility that it was the deprivation of nutrients as well as the antibiotics which led to the cytopathic effects.

Enders' and his colleagues' blindness can be explained by the fact that he truly wanted to help people, while the virus hysteria was intensifying after the war and during the cold war. It can also be explained by the fact that Enders and many of his colleagues had no idea about medicine and they were competing with the Soviet Union for the development of the first measles vaccine.

Such a pressure for success can also explain why Enders and his colleagues ignored their own reservations and cautions expressed in 1954, when they had observed and noted that many cells also died after being treated normally (i.e. without being "infected"), which they thought to have been caused by unknown viruses and factors. All these facts and cautions were subsequently disregarded.

The second paper presented by the claimant in the measles trial was published in 1959 and, for the reasons presented above, the authors concluded that the technique introduced by Enders was not appropriate for the isolation of a virus. This rebuttal is not only NOT being discussed by all the other researchers, but it is being ignored.

In the third paper, the authors photographed typical cellular particles inside the cells and misinterpreted these as measles virus. They did not isolate

any virus. For unexplained reasons, they failed to determine and describe the biochemical structure of what they were presenting as a virus in a separate experiment. In the short description of the methods used, one can read that the authors did not apply the standard isolation technique for viruses, i.e. the density gradient centrifugation.

They simply centrifuged fragments of dead cells at the bottom of a test tube and then, without describing their biochemical structure, they misinterpreted the cellular debris as viruses. From the way the experiments were performed, one can only conclude that cellular particles were misinterpreted as viruses. We find the same situation in the fourth and the sixth publication put forward by the claimant as proof of the existence of a measles virus.

The fifth publication is a review describing the consensus process as to which nucleic acid molecules from the dead cells would represent the so-called genome of the measles virus. The result is that dozens of researchers teams work with short pieces of cell-specific molecules, after which - following a given model - they put all the pieces together on paper. However, this jigsaw puzzle made of so many pieces was never scientifically proven to exist as a whole and was never isolated from a virus, for a measles virus has never been seen, neither in humans nor in a test tube.

Referring to this publication, the court-appointed expert stated that it described the gold standard, i.e. the entire virus genome. It is obvious that the expert did not read this paper, whose authors stated that the exact molecular composition and functions of the measles virus genome will have to be the object of further research, which is why they had to rely on other virus models in order to achieve a consensus on the structure and functions of the measles virus genome.

The easiest thing for anyone to notice is that in all these publications, as well as in all other publications on the "measles virus" and other pathogenic viruses, no control experiments were ever performed. No researchers used the density gradient centrifugation technique; instead, they only centrifuged cellular debris at the bottom of a test tube. This technique, used to collect all the particles from a fluid, is called pelletising. From a logical and scientific perspective, it can be said that in all publications on so-called "pathogenic viruses", the researchers demonstrated in fact only particles and characteristics of cells.

We also recommend Prof Lüdtke's relevant review (1999). He noted that at the early beginnings of virology, the majority of virologists always concluded that the structures they had mistaken for viruses turned out to be components of the cells and thus, they were only the result of the experiment and not the cause of the changes observed. After the discovery and characterization of the phages and after introducing the dogma that the nucleic acid was the genome of all cells and viruses, the consensus was born, according to which such viruses must exist in humans and animals as well.

ANTI-VAXXERS MAY BE BARRED FROM PUBS AND OFFICES: SENIOR TORY MP

BY MICHIEL WILLEMS
https://www.cityam.com/
Sunday 15 November 2020

PEOPLE WHO REFUSE to take a Covid-19 vaccine may be barred from restaurants, pubs and offices, a senior Conservative MP has suggested. Tom Tugendhat, MP for Tonbridge, Edenbridge and Malling and chair of the Foreign Affairs Committee, told HuffPost UK he could "certainly see the day" when people are refused entry into pubs and restaurants, and they may not be allowed to return to their work place until they have had the vaccine.

"If vaccination works and if we are confident it's safe, and all indications so far are good, then I can certainly see the day when businesses say:

'Look, you've got to return to the office and if you're not vaccinated you're not coming in'."

Tugendhat added that the use of 'vaccination certificates' may also become standard practice as employers and venues could demand to see such documentation before people are allowed to entering their premises. As a result, people who refuse the vaccine may find it hard to return to normal life, he added.

OPTIONAL, ALSO FOR CHILDREN

Health secretary Matt Hancock said earlier this week that any vaccine will be optional and children will not be forced to get a vaccination.

His comments followed reports that a vaccine from Pfizer and BioNTech is more than 90% effective. The news led to a spike in financial market activity worldwide.

The UK government has asked the NHS to be ready to deploy any Covid-19 vaccine from early next month.

Once it starts rolling out the medication, the most vulnerable will be first in line, Hancock said. The UK anticipates to have 10m doses of the vaccine available by the end of the year.

VACCINE REFUSERS

The UK government said earlier this week it is actively fighting anti-vaxxers. Prime minister Boris Johnson revealed that money splurged by vaccine taskforce chief Kate Bingham on private PR companies was necessary to combat anti-vaccine conspiracy theories.

Johnson, who has labelled vaccine refusers as "nuts", told the House of Commons that the spending was necessary to reassure people vaccines were safe and to encourage participation in trials.

"The expenditure [helps to] raise awareness of vaccines, to fight the anti-vaxxers and to persuade the people of this country – 300,000 – to take part in trials without which we can't have vaccines," Johnson told MPs.

TiP Editor: Very sad to read the rhetoric of MP Tugendhat. Why hold such extreme views - I wonder what research he has done on the subject? If he is your MP you could write and ask him?

CONSENT AND VACCINATION IN ENGLAND

BY Dr JAYNE LM DONEGAN,
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THE FIRST Covid-19 vaccine has arrived and is to be administered to millions of people in what has been described as one of Britain's largest peacetime logistical exercises. While there may be mixed opinions about accepting the vaccine what is not in dispute is the requirement for informed consent with all medical or surgical interventions. The General Medical Council (GMC) published its updated Consent Guidance for doctors, effective from 09 November 2020. The new Guidance replaced that of 2008. In the interim the Montgomery Ruling 2015 [Montgomery v. Lanarkshire Health Board] made into law what was already GMC Guidance. The Montgomery ruling established that,

"*rather than being a matter for clinical judgment to be assessed by professional medical opinion, a patient should be told whatever they want to know, not what the doctor thinks they should be told.*"

How does the 2020 GMC guidance compare to the old 2008 version regarding giving people information about adverse reactions?

GMC 2008 (32) You **must** tell patients if an investigation or treatment *might result in a serious adverse outcome, even if the likelihood is very small.* You should also tell patients about less serious side effects or complications if they occur frequently, and explain what the patient should do if they experience any of them.

The phrase '*you must*' has a formal meaning defined in the preamble as an *overriding duty or principle.*

The new guidance states:
GMC 2020 Discussing benefits and harms:
(21) **You must** give patients clear, accurate and up-to-date information, based on the best available evidence, about the potential benefits and risks of harm of each option, **including the option to take no action.**
But the requirement to tell people about serious outcomes, even if the likelihood is small, has been downgraded in importance to **you should.**
The formal meaning of which is used in two ways:
1. When explaining how to meet an overriding duty or
2. *Where the duty or principle doesn't apply in all situations or circumstances, or there are factors outside your control that affect whether or how you can follow the guidance.*
We can see in GMC 2020 the Consent guidance only states:
(23) **You should usually** include the following information when discussing benefits and harms.
a) Recognised risks of harm that *you believe* anyone in the patient's position would want to know. *You'll know these already from your professional knowledge and experience.*
b) The effect of the patient's individual clinical circumstances on the probability of a benefit or harm occurring. If you know the patient's medical history, you'll know some of what you need to share already, but the dialogue could reveal more.
c) Risks of harm and potential benefits that *the patient would consider significant for any reason.* These will be revealed during your discussion with the patient about what matters to them.
d) **Any risk of serious harm, however unlikely it is to occur.** This is likely to be easier to discuss in advance if possible,
e) Expected harms, including common side effects and what to do if they occur.


DR Jayne L.M.Donegan

"My generation of doctors had it drummed into them that it was the professional and ethical duty of a doctor to always act in the best interests of their patient, including being their advocate, along with 'first do no harm', and 'to cure occasionally, to relieve often and to comfort always."

The idea that the doctor or health professional will '*already know...recognised risks of harm that they believe anyone in the patient's position would want to know from their professional knowledge and experience*, is an interesting one and presumes a lot on the part of the doctor and the patient.

In describing **Seven principles of decision and consent** the GMC 2020 states:
Three: All patients have the right to be listened to, and to be given the information they need to make a decision and the time and support they need to understand it.
Four: Doctors must try to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action.

These sentiments though praiseworthy are not rooted in the reality of medical practice in 2021

Whereas an overworked and overstretched junior or senior hospital doctor may find time to sit at the person's bedside to discuss for example a surgical procedure or a cancer treatment, their colleagues in general practice have appointment slots of only ten minutes, it is often hard if not impossible to see the same doctor consistently and many practices are run on locum doctors. So in the ten minute consultation the doctor is supposed to be able to listen to why the person came, take a history, examine them, decide on further investigations, work out a prognosis and plan of action while at the same time eliciting the persons values, hopes fears, *Weltanshauung*, along with fulfilling all the messages that pop

up on the computer screen such as smoking, blood pressure, statin and flu vaccine reminders, never mind having the administrative staff knocking on your door to say you are running late and people are complaining.

I have worked in the NHS for 37 years, 32 of these in General Practice. It still never fails to amuse me what people who have the luxury of three and four hour meetings drinking cups of coffee think up for us GPs to do in ten minutes. I remember being laughed at by a presenter at a post graduate conference when I suggested that GPs should get what used to be called their average net remuneration (AVN) for a list size of 1000 patients rather than the usual 2000.

"*What*?" He said, "*Get paid the same for doing half the work*!"

"*No*," I said, "*We would do the same amount of work but it would be better work. We would be able to have 20 minute appointments: time to listen, consider and examine; time to explain properly and not try to solve every problem with a medication because it is quicker to send someone off with a prescription than to explain how they can fix it without drugs.*"

Twenty-five years later it is even worse, examination has decreased so much. People are sent off for scans and referred to hospital consultants without even having examined the area in question. For my generation of GPs it was regarded as a breach of professional etiquette to write a referral without including a full examination in the referral, plus my surgical bosses always said, "*If you don't put your finger in it - you put your foot in it.*" Very true.

So despite the Montgomery 2015 ruling making it law that,

"*Rather than being a matter for clinical judgment to be assessed by professional medical opinion, a patient should be told whatever they want to know, not what the doctor thinks they should be told.*"

which, as we have said, was merely making a legal requirement that was already GMC 2008 guidance, that the doctor has an "*overriding duty or principle to tell patients if an investigation or treatment might result in a serious adverse outcome, even if the likelihood were small.*"

GMC 2020 has watered this down to where it "*doesn't apply in all situations or circumstances, or there are factors outside your control that affect whether or how you can follow the guidance.*"

What are these factors outside the control of the doctor that would affect whether or how they could follow the Guidance?

I do not know. But I do know that I was told last year by a senior NHS England official that if the *best interest* of the patient clashed with *NHS Policy*, a doctor working in the NHS had to follow *NHS Policy*. To be clear this was not in the context of funding or rationing issues where such difficult decisions do have to be made. It was a case of, if the patient's best interest clashes with *NHS policy,* the NHS doctor 'had' to follow *NHS policy*.

My generation of doctors had it drummed into them that it was the professional and ethical duty of a doctor to always act in the best interests of their patient, including being their advocate, along with '*first do no harm*', and '*to cure occasionally, to relieve often and to comfort always.*'

I am sure there are some situations where, despite the time pressure and work load this guidance is put into practice, but vaccination is not one of them, as anyone who has gone to a vaccine appointment for themselves or their babies, children or elderly relatives will know. Please see examples of this on page 19.

GMC 2020 is nonetheless optimistic that:

(6) *Obtaining a patient's consent needn't always be a formal, time-consuming process. While some interventions require a patient's signature on a form, for most healthcare decisions you can rely on a patient's verbal consent, as long as you are satisfied they've had the opportunity to consider any relevant information (see paragraph 10) and decided to go ahead.*

What else has changed?

The two others that leapt out at me are: Refusal of treatment . In GMC 2008 this is listed under 'Partnership':

5(c) The patient weighs up the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which one. **They also have the right to accept or refuse an option for a reason that may seem irrational to the doctor, or for no reason at all**.

This is a really important point. People may refuse treatment for reasons that may seem irrational to the doctor **or for no reason at all**. Many people get terribly anxious and have sleepless nights wondering how they can acquire the encyclopedic knowledge of an intervention that they will need to convince their doctor to agree to their refusing it. Totally not necessary. That is why it is called a 'consultation'. You go to the doctor to get their opinion, not to be told what to do.

GMC 2020 is completely different. Under the heading 'If you disagree with a patient's choice of option' there is no longer unquestioning respect for personal autonomy.

(48)**You must respect your patient's right to decide**. If their choice of option (or decision to take no action) seems out of character or inconsistent with their beliefs and values, **it may be reasonable to check their understanding of the relevant information (see paragraph** 10) and their expectations about the likely outcome of this option and reasonable alternatives.

If it's not clear whether a patient understands the consequences of their decision, **you should offer more support to help them understand the relevant information. But you must not assume a patient lacks capacity simply because they make a decision that you consider unwise.**

People are no longer allowed to be irrational or have no reasons at **all when they** refuse treatment for themselves or their family. Now they are expected to be consistent in whatever beliefs or character the doctor, who may have only met the person on one occasion, has decided they have. It may sound quite unobjectionable, in fact supportive, to say "*it may be reasonable to check their understanding of the relevant information,*" or, "*you should offer more support to help them understand the relevant information*,

until you see what happens in practice, and if you have not had the task of trying to help people regain their trust in the medical profession after they have been shouted at, ganged up upon by two, three, four other medical professional shouting at them and disrespecting them, in fact doing the exact opposite of the any GMC guidance on consent.

Other actions which people perceive as bullying, intimidatory, and just plain frightening are being told they must attend an appointment with a hospital consultant which they did not ask for, and continually being sent letters, emails and phone calls telling them to come to appointments that they do not want and did not make. The most traumatic is being threatened with referral and actual referral to social services for making health decisions that people are legally allowed to make about themselves and their children, all the worse when one of the accusations is 'non engagement with the health services' when this just means not attending the appointments they did not make, while ignoring appropriate contacts the family may have had with other members of the health services – not that there is a legal requirement to interact with any part of the health service at all.

The worst thing about all of this is that people become so traumatised by what health professionals have done to them that they no longer want to present for medical help when they actually need it. What may look like an innocent change in language is being used as the vehicle to carry out a psychological agenda. This unfortunately worded section ends with the patronising statement

"*But you must not assume a patient lacks capacity simply because they make a decision that you consider unwise.*"

It is a shame it needs to be said. Such paternalistic attitudes in medicine are supposed to be long past but unfortunately are becoming more and more common, even entrenched, as the practice of medicine is reduced to the following of algorithms enforced as law because the doctor believes they will be medico-legally protected from claims if they do so. People who do not conform become perceived as a threat to the doctor.

CONFLICTS OF INTEREST

Both GMC 2008 and 2020 state that you should tell people about any conflicts of interest that you, or your organisation, may have, which may include financially benefiting from the intervention that is being promoted

A sad loss from GMC 2008 is the word *balanced*.

(33) You must give information about risk in a *balanced way*. You should avoid bias, and you should explain the expected benefits as well as the potential burdens and risks of any proposed investigation or treatment.

"But you must not assume a patient lacks capacity simply because they make a decision that you consider unwise."

Balanced is a nice friendly word which most of us understand the intent - doctors and the general public. It has been replaced by the word *objective*, a much more 'psychological' word and more difficult to define – one persons' objective is another person's harangue.

GMC 2020

(11) You must try to make sure the information you share with patients about the options is *objective*. You should be aware of how your own preferences might influence the advice you give and the language you use. When recommending an option for treatment or care to a patient you must explain your reasons for doing so, and share **information about reasonable alternatives, including the option to take no action. You must not put pressure on a patient to accept** your advice.

There are many kind, considerate, humane and helpful doctors who act whenever they can in what they see as their patients' best interest and when they do not agree with what the patient has to say will nonetheless, á la Voltaire, "*fight to the death for their right to say it.*" Sadly there are some, and they seem to be increasing in number, who do not conduct themselves in this way.

A welcome addition to the GMC 2020 guidelines is the encouragement of patients who wish to make audio and visual recordings of the consultation.

Visual and audio recordings

27 (c) accommodate a patient's wishes if they would like to record the discussion

(53) Recordings made by patients are owned by them and do not have to be stored with their medical records, which, if taken up by large numbers of the public will go a long way to moderating some of the excesses of consultations regarding consent and may go some way towards restoring people's faith in the medical profession where it has been lost. So the billion dollar question – are you going to have the vaccine if you are lucky enough to be one of the groups to whom it is being offered? That is up to you but *do not* have the vaccine until you have :

a. downloaded the information sheet for recipients and the one for health professionals and read them both and **b.** downloaded the excellent Covid 19 consent form written by **UK Medical Freedom Alliance**, read all the links and download the form to take with you to your vaccine appointment so that you can go through it together with the health professional and both sign it. Please see links on page 19. Remember – the manufacturers of the vaccine have no liability for any adverse reactions, neither do the health professionals. But the health professionals – doctors, nurses, pharmacists, dentists, veterinary surgeons – *are* liable if they have not followed the law on informed consent and can be sued and found liable on that account. It is for the benefit of the health professional as well as yourself that consent for the vaccine is correctly carried out.

Don't be like the man who went to a London Teaching Hospital for an outpatients appointment, was offered the Covid-19 vaccine because he was there (once diluted and opened to be used up within a certain time frame) and only given the 4 page package insert to read after he had been given the vaccine.

I strongly recommend downloading, reading and keeping as references the following links:

2020 UKMFA Covid-19 vaccination consent form. This can be found on the UK Medical Freedom Alliance website:
CLICK HERE

UK Medical Freedom Alliance UKMFA:
CLICK HERE

2020 Pfizer Covid-19 vaccine Reg 174 information for UK recipients:
CLICK HERE

2020 Pfizer Covid-19 vaccine Reg 174 information for UK healthcare professionals:
CLICK HERE

GMC 2020 Consent: patients and doctors making decisions together:
CLICK HERE
GMC 2008 Consent: patients and doctors making decisions together:
CLICK HERE

GMC 1998 Seeking patients' consent: The ethical considerations:
CLICK HERE

GMC 2007 Updated 2018 0–18 years: guidance for all doctors:
CLICK HERE

Public Health England 2013 Immunisation against infectious diseases handbook; Chapter 2 Consent:
CLICK HERE

2015 Montgomery Ruling further reading: BMJ 2017 Analysis Montgomery and informed consent: where are we now? BMJ 2017;357:j2224:
CLICK HERE

MDU 2020 Montgomery and informed consent Explaining informed consent and the significance of Montgomery vs Lanarkshire Health Board:
CLICK HERE

Dr Donegan's forthcoming 2021 lectures - please share with others who might be interested.
https://www.eventbrite.co.uk/

A SMALL SELECTION OF QUOTES FROM HEALTH PROFESSIONALS AS REPORTED BY PARENTS:

The GP said, "No. There are no side effects of the HPV vaccine besides perhaps soreness at the site of the injection." The A&E doctor later said, after carrying out tests for severe and complex symptoms, "Doctors are not supposed to really say this, but I believe it was the vaccine."

My mum took my daughter, her granddaughter, to the GP when she was unwell, but was totally bullied from the young doctor about her not being vaccinated. She was in utter shock about how he spoke to her, he even said "what is wrong with this child's mother, is she stupid?"

My GP phrased it as "Some doctors think that not vaccinating your child is close to child abuse... but of course I respect your choice". I was told I was an irresponsible parent and my 6-week-old daughter would die because I declined vaccines. A doctor told me there is no mercury or any other harmful chemicals in any of the vaccines and that they are 99.9% effective against the disease.

My GP couldn't answer concerns about the Prevenar so referred me to Public Health who passed on my concerns to Pfizer who sent copies of two papers; one Cochrane report that I'd cited to the GP that didn't prove safety and one in Spanish. Public Health enclosed a letter telling me if my baby ever went into A&E he would have to be vaccinated anyway. This ridiculous set of responses clinched things for me!

My GP was very surprised with my decision to decline vaccines. I explained that I had concerns about the ingredients, and he explained they only contain a bit of protein…He had no idea what was in a vaccine!

GP said: "If you're not vaccinating I'll inform Social Services." [which he did].

GP said: "You Eastern European people are brain washed because you all don't want to vaccinate."

GP said: "You are an irresponsible parent for not vaccinating."

GP said: The father doesn't have the right to decide if the child gets vaccinated or not as you gave birth to the child not him."

GP said: "You have the obligation to give her all the vaccines not only the Hep B." And he didn't want to give her the package insert of any vaccine as he said she [the mother] is: "Not superior to any other mother that she should be begging to read it."

MISSING AND UNPROVEN VIRUSES: THIS IS NOTHING NEW

BY JON RAPPOPORT

https://nomorefakenews.com/

30 October 2020

AS I KEEP making the case that the SARS-CoV-2 virus has not been proven to exist, I'm also making this point:

There is no honest and prolonged mainstream debate on this issue, and there has to be. Reputable journals should be opening up their pages to such a debate from all comers, and they aren't. They're ignoring, side-stepping, and suppressing a debate. This is not science. It's not even a shadow of science.

And the COVID virus is not the first time the issue of existence has arisen. If more people understood that, they wouldn't be so shocked. Here are several cases from recent history:

In the early part of the 20th century, a very nasty skin disease called pellagra took hold in the American South, affecting several million people.

The elite medical view, of course: a germ was the cause. But no one could find it in the ensuing decades. Finally, a small group of independent researchers, relentlessly pursuing a different course, convinced the establishment that the true cause was a niacin deficiency.

In the 1960s and 70s, Japan experienced a strange nervous-system affliction labeled SMON. Again the clarion call was: find the virus, it must be a virus. But no, in a landmark court case, the cause was shown to be a gastrointestinal drug, clioquinol, manufactured by Ciba-Geigy. The company apologized and paid out damages. Since then, some research has suggested that clioquinol fails to explain all the SMON cases.

SARS, 2003. During the height of hysteria in Canada about this flu-like illness, famous WHO researcher, Frank Plummer, wandered off the reservation and told the press that fewer and fewer SARS patients showed any sign of having the virus---in fact, the percentage was shrinking to zero.

Therefore: what virus?

Swine Flu, 2009. As I detailed in a recent article, CBS investigative reporter Sharyl Attkisson uncovered the fact that the CDC had secretly stopped counting cases, because the overwhelming percentage of patients' samples coming back from testing labs showed no sign of the Swine Flu virus or any other flu virus.

HIV, first announced as the cause of AIDS in 1984, has been challenged by a number of independent researchers. I have published Christine Johnson's explosive and detailed interview with Eleni Papadopulos, "a biophysicist and leader of a group of HIV/AIDS scientists from Perth in Western Australia." The subject? Does HIV exist? I'm reprinting my article and the Papadopulos interview below.

There are other illnesses in which the existence of the virus has been challenged: for example, polio and the Swine Flu of the 1970s.

"Is there an open and honest prolonged debate about this stunning situation in the psychiatric literature? Absolutely not."

Mainstream and independent investigators should also be aware there are analogous "missing causes" within the medical framework. The most egregious example is certainly psychiatry. Following the breakthrough work of psychiatrist Peter Breggin, I've written extensively on this subject. In a nutshell, there are NO defining lab tests for ANY of the 300 so-called mental disorders. Every one of these disorders is arbitrarily assembled by committees of psychiatrists, from menus of behaviors. This is about as far from science as you can get.

Is there an open and honest prolonged debate about this stunning situation in the psychiatric literature? Absolutely not.

Here is my article, Does HIV Exist? Buckle up:

Before we get to Christine Johnson's interview, a bit of background.

My first book, AIDS INC., was published in 1988. The research I engaged in then formed a foundation for my recent work in exposing the vast fraud called COVID-19.

In 1987-88, my main question eventually became: does HIV cause AIDS? For months, I had blithely assumed the obvious answer was yes. This created havoc in my investigation, because I was facing contradictions I couldn't solve.

For example, in parts of Africa, people who were chronically ill and dying obviously needed no push from a new virus. All their "AIDS" conditions and symptoms could be explained by their environment: contaminated water supplies; sewage pumped directly into the drinking water; protein-calorie malnutrition; hunger, starvation; medical treatment with immunosuppressive vaccines and drugs; toxic pesticides; fertile farm land stolen by corporations and governments; wars; extreme poverty. The virus cover story actually obscured all these ongoing crimes.

Finally, in the summer of 1987, I found several researchers who were rejecting the notion that HIV caused AIDS. Their reports were persuasive.

I'm shortcutting a great deal of my 1987-8 investigation here, but once HIV was out of the picture for me, many pieces fell into place. I discovered that, in EVERY group supposedly at "high-risk" for AIDS, their conditions and symptoms could be entirely explained by factors that had nothing to do with a new virus.

AIDS was not one condition. It was an umbrella label, used to re-package a number of immunosuppressive conditions and create the illusion of a new and unique and single "pandemic."

Several years after the publication of AIDS INC., I became aware of a quite different emerging debate going on under the surface of research: DOES HIV EXIST?

Was the purported virus ever truly discovered?

And THAT question led to: what is

the correct procedure for discovering a new virus?

The following 1997 interview, conducted by brilliant freelance journalist, Christine Johnson, delves into these questions:

How should researchers prove that a particular virus exists? How should they isolate it? What are the correct steps?

These questions, and their answers, reside at the heart of most disease research---and yet, overwhelmingly, doctors never explore them or even consider them.

Johnson interviews Dr. Eleni Papadopulos, "a biophysicist and leader of a group of HIV/AIDS scientists from Perth in Western Australia. Over the past decade and more she and her colleagues have published many scientific papers questioning the HIV/AIDS hypothesis…"

Here I'm publishing and highlighting excerpts from the interview. Technical issues are discussed. Grasping them is not the easiest exercise you've ever done, but I believe the serious reader can comprehend the vital essentials.

Christine Johnson: Does HIV cause AIDS?

Eleni Papadopulos: There is no proof that HIV causes AIDS.

"These questions, and their answers, reside at the heart of most disease research - and yet, overwhelmingly, doctors never explore them or even consider them."

CJ: Why not?

EP: For many reasons, but most importantly, because there is no proof that HIV exists.

CJ: Didn't Luc Montagnier and Robert Gallo [purportedly the co-discoverers of HIV] isolate HIV back in the early eighties?

EP: No. In the papers published in Science by those two research groups, there is no proof of the isolation of a retrovirus from AIDS patients. [HIV is said to be a retrovirus.]

CJ: They say they did isolate a virus.

EP: Our interpretation of the data differs. To prove the existence of a virus you need to do three things. First, culture cells and find a particle you think might be a virus. Obviously, at the very least, that particle should look like a virus. Second, you have to devise a method to get that particle on its own so you can take it to pieces and analyze precisely what makes it up. Then you need to prove the particle can make faithful copies of itself. In other words, that it can replicate.

CJ: Can't you just look down a microscope and say there's a virus in the cultures?

EP: No, you can't. Not all particles that look like viruses are viruses.

CJ: My understanding is that high-speed centrifugation is used to produce samples consisting exclusively of objects having the same density, a so-called "density-purified sample." Electron microscopy is used to see if these density-purified samples consist of objects which all have the same appearance -- in which case the sample is an isolate -- and if this appearance matches that of a retrovirus, in terms of size, shape, and so forth. If all this is true, then you are three steps into the procedure for obtaining a retroviral isolate. (1) You have an isolate, and the isolate consists of objects with the same (2) density and (3) appearance of a retrovirus. Then you have to examine this isolate further, to see if the objects in it contain reverse transcriptase [an enzyme] and will replicate when placed in new cultures. Only then can you rightfully declare that you have obtained a retroviral isolate.

EP: Exactly. It was discovered that

retroviral particles have a physical property which enables them to be separated from other material in cell cultures. That property is their buoyancy, or density, and this was utilized to purify the particles by a process called density gradient centrifugation.

The technology is complicated, but the concept is extremely simple. You prepare a test tube containing a solution of sucrose, ordinary table sugar, made so the solution is light at the top but gradually becomes heavier, or more dense, towards the bottom. Meanwhile, you grow whatever cells you think may contain your retrovirus. If you're right, retroviral particles will be released from the cells and pass into the culture fluids. When you think everything is ready, you decant a specimen of culture fluids and gently place a drop on top of the sugar solution. Then you spin the test tube at extremely high speeds. This generates tremendous forces, and particles present in that drop of fluid are forced through the sugar solution until they reach a point where their buoyancy prevents them from penetrating any further. In other words, they drift down the density gradient until they reach a spot where their own density is the same as that region of the sugar solution. When they get there they stop, all together. To use virological jargon, that's where they band. Retroviruses band at a characteristic point. In sucrose solutions they band at a point where the density is 1.16 gm/ml.

That band can then be selectively extracted and photographed with an electron microscope. The picture is called an electron micrograph, or EM. The electron microscope enables particles the size of retroviruses to be seen, and to be characterized by their appearance.

CJ: So, examination with the electron microscope tells you what fish you've caught?

EP: Not only that. It's the only way to know if you've caught a fish. Or anything at all.

CJ: Did Montagnier and Gallo do this?

EP: This is one of the many problems. Montagnier and Gallo did use density gradient banding, but for some

"And so… as I've reported these past few months, there is every reason to doubt and reject the existence of the COVID virus, since correct large-scale electron microscope studies have never been done."

unknown reason they did not publish any EMs [photos] of the material at 1.16 gm/ml…this is quite puzzling because in 1973 the Pasteur Institute hosted a meeting attended by scientists, some of whom are now amongst the leading HIV experts. At that meeting the method of retroviral isolation was thoroughly discussed, and photographing the 1.16 band of the density gradient was considered absolutely essential.

CJ: But Montagnier and Gallo did publish photographs of virus particles.

EP: No. Montagnier and Gallo published electron micrographs of culture fluids that had not been centrifuged, or even separated from the culture cells, for that matter. These EMs contained, in addition to many other things, including the culture cells and other things that clearly are not retroviruses, a few particles which Montagnier and Gallo claimed are retroviruses, and which all belonged to the same retroviral species, now called HIV. But photographs of unpurified particles don't prove that those particles are viruses. The existence of HIV was not established by Montagnier and Gallo -- or anyone since -- using the method presented at the 1973 meeting.

CJ: And what was that method?

EP: All the steps I have just told you. The only scientific method that exists. Culture cells, find a particle, isolate the particle, take it to pieces, find out what's inside, and then prove those particles are able to make more of the same with the same constituents when they're added to a culture of uninfected cells.

CJ: So before AIDS came along there was a well-tried method for proving the existence of a retrovirus, but Montagnier and Gallo did not follow this method?

EP: They used some of the techniques, but they did not undertake every step including proving what particles, if any, are in the 1.16 gm/ml band of the density gradient, the density that defines retroviral particles.

CJ: But what about their pictures?

EP: Montagnier's and Gallo's electron micrographs…are of entire cell cultures, or of unpurified fluids from cultures…"

---end of interview excerpt---

If you grasp the essentials of this discussion, you'll see there is every reason to doubt the existence of HIV, because the methods for proving its existence were not followed.

And so…as I've reported these past few months, there is every reason to doubt and reject the existence of the COVID virus, since correct large-scale electron microscope studies have never been done.

I kept the Christine Johnson interview, and other similar information, in mind when, for example, I explored the dud epidemics called SARS and 2009 Swine Flu.

How many viruses have been named as causes of disease, when in fact those viruses have never been isolated or proved to exist?

Of course, conventional-consensus researchers and doctors will scoff at any attempt to raise these issues. For them, "the science is settled." Meaning: they don't want to think. They don't want to stir the waters.

After 30 years working as a reporter in the area of deep medical-research fraud, I've seen that false science occurs in levels.

The deeper you go, the stranger it gets. To put it another way: the deeper you go, the worse it gets.

DR WODARG AND DR YEADON REQUEST A STOP OF ALL CORONA VACCINATION STUDIES AND CALL FOR CO-SIGNING THE PETITION

https://2020news.de/en

EXTRACTS:

On December 1, 2020, the ex-Pfizer head of respiratory research Dr Michael Yeadon and the lung specialist and former head of the public health department Dr Wolfgang Wodarg filed an application with the EMA for the immediate suspension of all SARS CoV 2 vaccine studies, in particular the BioNtech/Pfizer study on BNT162b. Dr Wodarg and Dr Yeadon demand that the studies – for the protection of the life and health of the volunteers – should not be continued until a study design is available that is suitable to address the significant safety concerns expressed by an increasing number of renowned scientists against the vaccine and the study design. On the one hand, due to the known lack of accuracy of the PCR test in a serious study, a so-called Sanger sequencing must be used. This is the only way to make reliable statements on the effectiveness of a vaccine against Covid-19. On the basis of the many different PCR tests of highly varying quality, neither the risk of disease nor a possible vaccine benefit can be determined with the necessary certainty, which is why testing the vaccine on humans is unethical per se. Furthermore, they demand that it must be excluded, e.g. by means of animal experiments, that risks already known from previous studies, which partly originate from the nature of the corona viruses, can be realized. The concerns are directed in particular to the following points:

• The formation of so-called "non-neutralizing antibodies" can lead to an exaggerated immune reaction, especially when the test person is confronted with the real, "wild" virus after vaccination. This so-called antibody-dependent amplification, ADE, has long been known from experiments with corona vaccines in cats, for example. In the course of these studies all cats that initially tolerated the vaccination well died after catching the wild virus.

• The vaccinations are expected to produce antibodies against spike proteins of SARS-CoV-2. However, spike proteins also contain syncytin-homologous proteins, which are essential for the formation of the placenta in mammals such as humans. It must be absolutely ruled out that a vaccine against SARS-CoV-2 could trigger an immune reaction against syncytin-1, as otherwise infertility of indefinite duration could result in vaccinated women.

• The mRNA vaccines from BioNTech/Pfizer contain polyethylene glycol (PEG). 70% of people develop antibodies against this substance – this means that many people can develop allergic, potentially fatal reactions to the vaccination.

• The much too short duration of the study does not allow a realistic estimation of the late effects. As in the narcolepsy cases after the swine flu vaccination, millions of healthy people would be exposed to an unacceptable risk if an emergency approval were to be granted and the possibility of observing the late effects of the vaccination were to follow.

Nevertheless, BioNTech/Pfizer apparently submitted an application for emergency approval on December 1, 2020.

SOUTH KOREA'S FLU VACCINE DEATH TOLL APPROACHES 100

7 November 2020

https://news.cgtn.com/

THE DEATH TOLL in South Korea after getting seasonal flu shots has risen to nearly 100, the Korea Disease Control and Prevention Agency (KDCA) said Saturday, which raises concerns over the vaccine's safety.

The death toll rose to 97 as of midnight Friday, and most of the fatalities are elders, the agency noted, adding that it has found no direct link between flu shots and deaths. Despite the growing number of flu vaccine recipients' deaths, KCDA still urges the citizens to get vaccinations amid the COVID-19 pandemic. In October, South Korean Prime Minister Chung Sye-kyun expressed condolences to the families of the deceased, calling for a thorough investigation to verify the exact cause of deaths. As for now, more than 19.6 million South Koreans have received the vaccine shots, around 11.6 million of which got the shots for free under the state-run program, according to Yonhap News Agency. Earlier, Singapore has temporarily halted the use of two influenza vaccines as a precaution after some people who received them in South Korea died, becoming among the first countries to publicly announce a halt of the vaccines' usage. The Korean Agency for Disease Control reported on October 31 that as of 0:00 on the same day, the number of deaths after influenza vaccination in Korea had risen to 83.

The Korean Agency for Disease Control notified on October 31 that as of 0:00 on the same day, after Korea was vaccinated with the flu vaccine The number of deaths rose to 83. After investigating the cause of death of 72 of them, the Korean Agency for Disease Control decided that the correlation between the cause of death and vaccination was very low, so it decided to continue to promote Influenza vaccine vaccination plan. According to a report from the Korean Agency for Disease Control, among the 83 deaths, 71 were elderly over 70 years old and 46 were men. Looking at the time from flu vaccination to death, 50 people died within 48 hours of flu vaccination and 13 people died less than 24 hours after vaccination.

The Korean Department of Disease Management held a related meeting on the 30th to analyze and discuss the relevant situation of a new death case. The experts at the meeting agreed that the cause of death in this case was related to influenza vaccination.

The correlation between them is very low, and there are no reports of abnormal reactions among vaccinators who received the same batch of vaccines in the same medical institution on the same day as the death. The Korean Agency for Disease Control therefore decided to continue its influenza vaccination plan. (Headquarters reporter Zhang Yun). Source:CCTV News Client.

COVID-19: GPS ARE TOLD TO BE READY TO DELIVER VACCINE FROM NEXT MONTH

BMJ 2020; 371:m4291
Published 04 November 2020

Here follows a Rapid Response published on BMJ website by Jackie Fletcher (JABS) to the article entitled above.
https://www.bmj.com/content/371/bmj.m4291/rapid-responses

JACKIE FLETCHER,
WARRINGTON, CHESHIRE.
JABS a voluntary support group for parents of vaccine-damaged children & 24/7 carer. 11 November 2020

Dear Editor
The Medicines and Healthcare products Regulatory Agency (MHRA) is the executive agency of the Department of Health and Social Care. This body is responsible for issuing an emergency licence to allow the use of Covid-19 vaccines in the UK if the licence is required urgently.

The MHRA should NOT authorise Covid-19 vaccines when the agency is already anticipating 'high volume of Covid-19 vaccine Adverse Drug Reactions (ADRs)'. [1]

Neither should the agency authorise Covid-19 vaccines when the agency admits that it does not have the technology in place to process ADRs and '...it will be unable to process these ADRs effectively. This will hinder its ability to rapidly identify any potential safety issues with the Covid-19 vaccine and represents a direct threat to patient life and public health....'. [1]

In my opinion, the MHRA has already been failing the public; on its website it states that: '..It is estimated that only 10% of serious reactions and between 2 and 4% of non-serious reactions are reported...'. [2] I cannot find any information to show that they are addressing this potentially dangerous finding.

During a meeting with the MHRA which I have attended, officers have stated that the reports that they do receive are not routinely followed-up by contacting the reporting health professional, six months to 12 months later, to determine if the individual fully recovered from the reaction or has further deteriorated.

"A recent example is the H1N1 vaccine which was introduced quickly into the population in 2009 and was found to be linked with narcolepsy and Guillain Barre syndrome."

Without this information neither the MHRA nor doctors have any accurate safety data on vaccines. A point that has been raised with the Government time and time again. [3] [4]

Currently anyone who takes a Covid-19 vaccine may not be aware that the procedure is loaded with risks for the above reasons and also because there is no financial safety net for anybody harmed in the process.

The vaccine manufacturers have sought and been given indemnities to protect them from potential vaccine damage claims. [5] I understand that health professionals who administer the vaccines will also be protected against claims.

The proposed Covid-19 vaccine, as with all vaccines, will carry a risk of serious injury or death. Vaccine manufacturers' product information sheets attest to this with other vaccines. A recent example is the H1N1 vaccine which was introduced quickly into the population in 2009 and was found to be linked with narcolepsy and Guillain Barre syndrome [6] [7]

Contrary to how most MPs and the Prime Minister presents people who complain of vaccine damage and labels them as: 'anti-vaxxers are nuts' [8], the Government is fully aware of the risks that vaccines pose to the public. Vaccine damage payments of over £74 million have been awarded to people severely damaged.

However, Covid-19 vaccine is not listed on the eligible to claim section. [9] The Vaccine Damage Payment Act 1979 would need to be amended to include all people over the age of 21 years and the awards should be made appropriate to the damage sustained on a par with current product liability claims.

As it stands, the Covid-19 vaccine is being promoted as the saviour of the country and according to the media reports, no serious concerns have shown up in the trials.

The MHRA, with the authority to licence this vaccine, admits in tender documents that they are expecting a high volume of ADRs but don't have the technology to cope which they say is a direct threat to patient life and public health. Meanwhile, the only people taking any risk whatsoever are the people holding their arms out.

Competing interests: Mother of MMR vaccine-damaged son.

REFERENCES
Please go to Rapid Response article for the reference details.

THERE IS A HIGHER COURT THAN COURTS OF JUSTICE AND THAT IS THE COURT OF CONSCIENCE. IT SUPERCEDES ALL OTHER COURTS. ~ *MAHATMA GANDHI*

RE: COVID-19: WHERE IS THE VIRUS?

BY JANET MENAGE.
GP RETIRED. WALES, UK.
BMJ 2020;370
https://www.bmj.com/content/370/bmj.m3379/rr-2
12 October 2020

RAPID RESPONSE TO COVID-19: WHERE IS THE VIRUS?

Dear Editor
We are told that the virus is everywhere – in the air, in our breath, on fomites, trapped in masks - yet public health authorities seem not to be in possession of any cultivable clinical samples of the offending pathogen. In March 2020, the World Health Organisation instructed authorities not to look for a virus but to rely instead on a genome test, the RT-PCR, which is not specific for SARS-CoV-2 [1] [2]. A Freedom of Information request to Public Health England about cultivable clinical samples or direct evidence of viral isolation has no information and refers to the proxy RT-PCR test, quoting Eurosurveillance [3].

"It appears, therefore, that we have public health bodies without clinical samples, a test which is non-specific and does not distinguish between infectivity and non-infectivity."

Eurosurveillance states: "Virus detection by reverse transcription-PCR (RT-PCR) from respiratory samples is widely used to diagnose and monitor SARS-CoV-2 infection and, increasingly, to infer infectivity of an individual. However, RT-PCR does not distinguish between infectious and non-infectious virus. Propagating virus from clinical samples confirms the presence of infectious virus but is not widely available (and) requires biosafety level 3 facilities" [4]. The CDC admits that, "no quantified virus isolates of the 2019-nCoV are currently available", and used a genetically modified human lung alveolar adenocarcinoma cell culture to, "mimic clinical specimen"[5].

It appears, therefore, that we have public health bodies without clinical samples, a test which is non-specific and does not distinguish between infectivity and non-infectivity, a requirement for biosafety level 3 facilities to even look for a virus, yet we are led to believe that it is up all our noses. So, where is the virus?

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Competing interests: No competing interests

ANALYSIS OF HEALTH OUTCOMES IN VACCINATED AND UNVACCINATED CHILDREN: DEVELOPMENTAL DELAYS, ASTHMA, EAR INFECTIONS AND GASTROINTESTINAL DISORDERS

BY BRIAN S HOOKER AND NEIL Z MILLER.
SAGE Open Medicine, Vol 8: 1-11
PMID: 32537156
First Published May 27, 2020

ABSTRACT

Objective: The aim of this study was to compare the health of vaccinated versus unvaccinated pediatric populations.

Methods: Using data from three medical practices in the United States with children born between November 2005 and June 2015, vaccinated children were compared to unvaccinated children during the first year of life for later incidence of developmental delays, asthma, ear infections and gastrointestinal disorders.

All diagnoses utilized International Classification of Diseases–9 and International Classification of Diseases–10 codes through medical chart review.

Subjects were a minimum of 3 years of age, stratified based on medical practice, year of birth and gender and compared using a logistic regression model.

Results: Vaccination before 1 year of age was associated with increased odds of developmental delays (OR = 2.18, 95% CI 1.47–3.24), asthma (OR = 4.49, 95% CI 2.04–9.88) and ear infections (OR = 2.13, 95% CI 1.63–2.78). In a quartile analysis, subjects were grouped by number of vaccine doses received in the first year of life.

Higher odds ratios were observed in Quartiles 3 and 4 (where more vaccine doses were received) for all four health conditions considered, as compared to Quartile 1.

In a temporal analysis, developmental delays showed a linear increase as the age cut-offs increased from 6 to 12 to 18 to 24 months of age (ORs = 1.95, 2.18, 2.92 and 3.51, respectively).

Slightly higher ORs were also observed for all four health conditions when time permitted for a diagnosis was extended from > 3 years of age to > 5 years of age.

Conclusion: In this study, which only allowed for the calculation of unadjusted observational associations, higher ORs were observed within the vaccinated versus unvaccinated group for developmental delays, asthma and ear infections.

Further study is necessary to understand the full spectrum of health effects associated with childhood vaccination.

TIP ARCHIVE

INVESTIGATING VIRUSES IN CELLS USED TO MAKE VACCINES; AND EVALUATING THE POTENTIAL THREAT POSED BY TRANSMISSION OF VIRUSES TO HUMANS

Principal Investigator: Arifa S. Khan, PhD Office / 1 Feb 2018
https://www.fda.gov/

TiP Editor: Texts such as this example should raise alarm bells! Given the years of vaccine manufacture using living cells, whether using human, monkey and other mammalian tissue you would have thought that the investigation of such an important matter, ie using cancer-causing material and the threat of transmission to the vaccine recipient, would have been done BEFORE the use of vaccines worldwide?

GENERAL OVERVIEW

THE EMERGENCE of pathogenic virus infections like influenza and HIV have created an urgent need for new vaccines. Virus-based vaccines are made in living cells (cell substrates). Some manufacturers are investigating the use of new cell lines to make vaccines. The continual growth of cell lines ensures that there is a consistent supply of the same cells that can yield high quantities of the vaccine.

In some cases the cell lines that are used might be tumorigenic, that is, they form tumors when injected into rodents. Some of these tumor-forming cell lines may contain cancer-causing viruses that are not actively reproducing. Such viruses are hard to detect using standard methods. **These latent, or "quiet," viruses pose a potential threat, since they might become active under vaccine manufacturing conditions.** Therefore, to ensure the safety of vaccines, our laboratory is investigating ways to activate latent viruses in cell lines and to detect the activated viruses, as well as other unknown viruses, using new technologies. We will then adapt our findings to detect viruses in the same types of cell substrates that are used to produce vaccines. We are also trying to identify specific biological processes that reflect virus activity.

These methods will enable FDA scientists to help manufacturers to determine whether their specific cell substrate is safe to use for vaccine production. The methods our laboratory are developing and testing will help to ensure the production of safe and effective vaccines in two ways: 1) FDA will be able to develop testing guidelines for manufacturers who use new cell substrates for producing vaccines; and 2) FDA will publish the new methods it develops in peer-reviewed scientific journals, thus making them readily accessible to all manufacturers.

We are also evaluating the risk of retrovirus infections in humans. (Retroviruses are RNA viruses that use an enzyme called reverse transcriptase (RT) to replicate; RNA is the de-coded form of DNA). Simian foamy virus (SFV) can be transmitted from nonhuman primates (e.g., monkeys) to humans. **Although there is no evidence that SFV causes disease, the virus can remain in a lifelong quiet state in the DNA after infection**. Moreover, two individuals in Africa were recently found to be infected with both HIV-1 and SFV. Therefore, it is important to determine if SFV poses a threat to human health and to understand how the virus spreads in order to create strategies for controlling human infections. Such work will also help FDA to develop a new policy regarding blood donation by individuals working with nonhuman primates and implementing formal safety guidelines for people working with SFV-infected animals. We are also investigating the consequences of dual SFV and HIV-1 infection in the monkey model. *(Bold type TiP emphasis.)*

VACCINE-INDUCED ENHANCEMENT OF VIRAL INFECTIONS

Huisman W, Martina BEE, et al.
PMID: 19022319

ABSTRACT

Examples of vaccine-induced enhancement of susceptibility to virus infection or of aberrant viral pathogenesis have been documented for infections by members of different virus families. Several mechanisms, many of which still are poorly understood, are at the basis of this phenomenon. Vaccine development for lentivirus infections in general, and for HIV/AIDS in particular, has been little successful. Certain experimental lentiviral vaccines even proved to be counterproductive: they rendered vaccinated subjects more susceptible to infection rather than protecting them.

For vaccine-induced enhanced susceptibility to infection with certain viruses like feline coronavirus, Dengue virus, and feline immunodeficiency virus, it has been shown that antibody-dependent enhancement (ADE) plays an important role. Other mechanisms may, either in the absence of or in combination with ADE, be involved. Consequently, vaccine-induced enhancement has been a major stumble block in the development of certain flavi-, corona-, paramyxo-, and lentivirus vaccines. Also recent failures in the development of a vaccine against HIV may at least in part be attributed to induction of enhanced susceptibility to infection. There may well be a delicate balance between the induction of protective immunity on the one hand and the induction of enhanced susceptibility on the other. The present paper reviews the currently known mechanisms of vaccine-induced enhancement of susceptibility to virus infection or of aberrant viral pathogenesis.

THE EFFECT OF TIME SINCE MEASLES VACCINATION AND AGE AT FIRST DOSE ON MEASLES VACCINE EFFECTIVENESS – A SYSTEMATIC REVIEW

Vaccine 2020 Jan 16;38(3):460-469
PMID: 31732326

ABSTRACT

Background: In settings where measles has been eliminated, vaccine-derived immunity may in theory wane more rapidly due to a lack of immune boosting by circulating measles virus. We aimed to assess whether measles vaccine effectiveness (VE) waned over time, and if so, whether differentially in measles-eliminated and measles-endemic settings.

Methods: We performed a systematic literature review of studies that reported VE and time since vaccination with measles-containing vaccine (MCV). We extracted information on case definition (clinical symptoms and/or laboratory diagnosis), method of vaccination status ascertainment (medical record or vaccine registry), as well as any biases which may have arisen from cold chain issues and a lack of an age at first dose of MCV. We then used linear regression to evaluate VE as a function of age at first dose of MCV and time since MCV.

Results: After screening 14,782 citations, we identified three full-text articles from measles-eliminated settings and 33 articles from measles-endemic settings. In elimination settings, two-dose VE estimates increased as age at first dose of MCV increased and decreased as time since MCV increased; however, **the small number of studies available limited interpretation**. In measles-endemic settings, one-dose VE increased by 1.5% (95% CI 0.5, 2.5) for every month increase in age at first dose of MCV. We found no evidence of waning VE in endemic settings.

Conclusions: The **paucity** of data from measles-eliminated settings indicates that additional studies and approaches (such as studies using proxies including laboratory correlates of protection) are needed to answer the question of whether VE in measles-eliminated settings wanes. Age at first dose of MCV was the most important factor in determining VE. More VE studies need to be conducted in elimination settings, and standards should be developed for information collected and reported in such studies. ***(Bold type - TiP emphasis)***

IMMUNOCONTRACEPTIVES: HOW FAR FROM REALITY?

Lekhwani S, Vaswani N, Ghalaut VS et al. Adv Biomed Res 2014;3:247. PMID: 25590025

EXTRACTS

ABSTRACT

Despite high expectations of safer, effective, economical, longer acting contraceptives, to date, there are no licensed contraceptive vaccines available in the market. Nevertheless, a role for vaccines undoubtedly exists as an aid to birth spacing and as a nonsurgical means of generating sterility. The research concerned in the area so far has been successful on the feline population, with room still for exhaustive studies on humans.

The future of contraceptive vaccines holds great promise in terms of comfort, price, efficacy, rare complications, and possibly nonselective action on animal populations as well as on humans. This brief review deals with the basic aspects of immuno-contraceptives along with the efforts done so far. There is a need for further research in aspects involving the rate of evolution of contraception resistance based on genetics, resistance phenotypes, or cross generation effects.

Gonadotropin releasing hormone and luteinizing hormone have not been investigated in humans, as both reported impotency in animals; the follicle stimulating hormone has been shown to cause oligospermia; zona pellucida has also not been studied in humans as it causes irreversible oophoritis, while the sperm has the potential for success in humans based on the data from immunoreproductive studies. Even as the position of the human chorionic gonadotropin vaccine looks hopeful, research on other possible targets continue with an eventual aim of discovering a vaccine that is more immunogenically effective.

CONCLUSION

The development of contraceptive vaccines is still at the research stage. The WHO records suggest that over 120 million pairs still have an unmet need for contraception and about 45 million pregnancies are terminated every year worldwide. The future of contraceptive vaccines holds great promise in terms of comfort, price, efficacy, complications, and possibly non selective action in animal populations as well as in humans.

This possibility comes as a result of development in the technology of recombinant DNA and creating new microorganisms, which may express certain antigens. GnRH and LH have not been investigated in humans, as both have reported impotency in animals; FSH has been shown to cause oligospermia; ZP also has not been studied in humans, as it causes irreversible oophoritis, while the sperm has a potential for success in humans, based on the data from immuno-reproductive studies. Even as the position of the hCG vaccine looks hopeful, research on other possible targets continue with an eventual aim of discovering a vaccine that is more immunogenically effective.

TiP Editor: Given the concerns over the years surrounding the alleged vaccines laced with hCG and also recent concerns raised regarding the fast- tracked covid 19 vaccines in relationship to the effects on fertility and pregnancy I would urge anyone considering this new vaccine to research it thoroughly. In a recent BBC interview Jonathan Van-Tam, deputy chief health minister stated that none of the trials for the covid vaccines included pregnant women knowingly… and also stated 'right now do we have the data in pregnant women?… no we don't… we don't have the data.'

AIMS & OBJECTIVES OF THE *informed* PARENT GROUP

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

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