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MEASLES: NEITHER GONE NOR FORGOTTEN

Antivaccine sentiment isn't the only problem

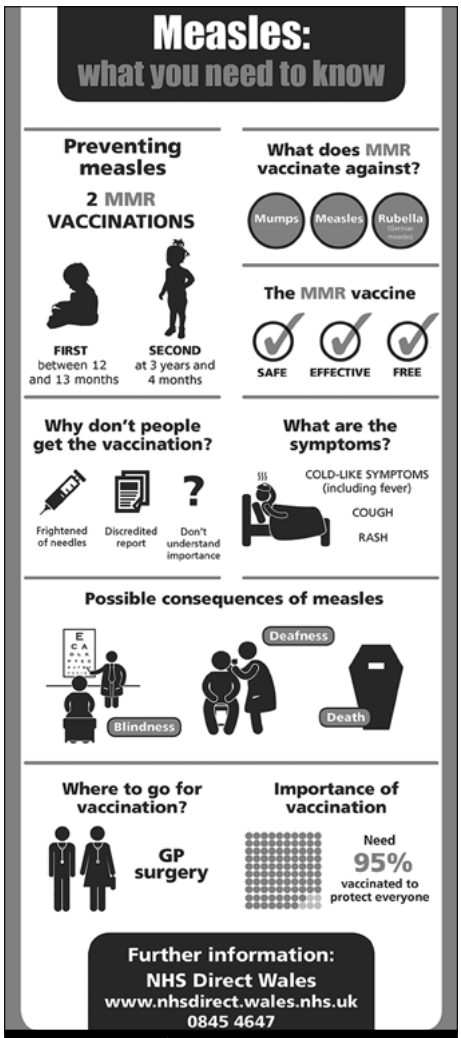
THE HEADLINE ABOVE was the title of a recent article published in BMJ (25 Sept 2018) by Elliman and Bedford. The opening paragraphs state:

'It is 50 years since measles vaccine was introduced in the UK and 30 years since it was replaced with the highly effective measles, mumps, and rubella (MMR) vaccine. In 2017, the World Health Organization declared that measles had been eliminated from the UK; this means that measles is no longer endemic, not that it has disappeared.

Another 42 of the 53 member states in the WHO European region have been reported as having interrupted the endemic spread of measles, yet epidemics of measles are occurring across Europe. The region saw more cases of measles (over 41,000, including at least 37 deaths) in the first six months of 2018 than in any other complete year of the decade. In England, three times as many cases of laboratory confirmed measles have been recorded up to 10 September 2018 than in the whole of 2017 (876 v 267).

Why is this happening? Detailed examination of the cases occurring in the European Economic Area (EEA) in the 12 months from July 2017 to June 2018 showed that in the 90% of cases where immunisation status was known, 82% had received no measles-containing vaccine and only 2% had received at least two doses. In 2017, only four EEA countries recorded an uptake of 95% or more for two doses of a measles-containing vaccine, and even countries with a current high uptake overall may have gaps in immunity because of variation within the country or earlier lower uptake.

The uptake of one dose at 2 years of age has steadily fallen from a high of 92.7% in 2013-14 to 91.2% in 2017-18; the reasons for this small decline are not clear. Uptake of MMR shows regional variation, with a 19% difference between the English local authorities with the highest and lowest uptakes for one dose at age 5 years and about 30% difference for two doses. Some of this variation is likely to be due to inaccurate data collection, but the different reasons for non-immunisation will require tailored actions to improve uptake.'



An example of how measles is being portrayed by the NHS

The authors then state that when children are not fully vaccinated it is usually due to accessing problems rather than the parents actively declining – not sure how they arrived at that conclusion? I have never had any parents complaining that they could not access the vaccines. However, I have heard from a lot of parents complaining about the never-ending reminders and strongly worded letters sent from their GP surgery for them to bring in their child to be vaccinated.

Elliman and Bedford then embark on 'countering misinformation'. They talk about the fall in uptake in the early years of this century after the 'now discredited' (their words not mine) Lancet paper was published.

'Although uptake has now recovered, many older children and young adults remain unprotected, and this partly explains the age distribution of current measles cases, with a large proportion in people older than 15 years. In England, 42% of cases reported between January and March 2018 occurred in the over 20s and rates of hospital admission were high, showing the severity of this infection in older age groups. '

The narrative used in their final paragraphs I read in disbelief. Once again they start portraying anyone who has concerns, or declines vaccines, as being politically extreme. Similar to the script from the Newsnight programme (I now refer to it as Newsfright). It reads:

'Unfortunately, vaccines have become even more of a political issue recently and are now on the agenda of right wing populist groups in Europe—for example, the National Rally party in France and the Five Star party in Italy. Before he was elected US president in 2016, Donald Trump tweeted on numerous occasions that MMR vaccine causes autism. Antivaccine sentiment on social media undoubtedly plays a part in some distrust of

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Magda Taylor

Editor's note

WHAT AN AVALANCHE of written attacks we have seen during 2018 on anyone who dare mention the 'V' word in a questioning or critical manner! Whether it be a parent questioning their health visitor or practice nurse on the issue or a scientist flagging up potential safety concerns – they are mostly met with disapproval and dismissal. The media's involvement to attempt to divide public opinion and create an 'us and them' – anti-vax/pro-vax situation is also a disgrace. Programmes such as Newsnight have presented extremely bias and misleading coverage talking about addressing vaccine hesitancy, and how people think they are smarter than doctors and find out their own truth from the 'disinformation' on the internet. The narrative was shocking… the presenter stated with a concerned voice…'Let's not pretend… the anti-vaxxers are a movement now… just like the Russian bots who try to move people away from vaccination.' One guest commented that 'when people buy into these conspiracy theories' - which in his opinion – 'is essentially what anti-vax movements do.' That this results in anti-vaxxer's feeling empowered with a form of 'know-it-all-ism' and they then spread public health scares..and so on. I listened with disbelief at the contents of the programme, the producers of Newsnight should be ashamed of their one-sided propaganda. Good investigative journalism is heading for extinction. We have more to save than just the bees!

Some of you may be aware of the expulsion of Peter Gøtzche from the Nordic Cochrane group. In an article in the BMJ Opinion blog, 8 November 2018, Gøtzche discusses his removal from Cochrane and his concerns that the organisation has embraced new ethics and has become a 'highly centralised business' where 'academic freedom has gone, scientific debates are unwelcome, and transparency a thing of the past'. He goes on to highlight how he had tried to uphold Cochrane's original values of publicly challenging science and yet when his team challenged a Cochrane HPV vaccine review, they came under heavy attack and censorship. Gøtzche states that if questioning the leadership, holding the drug industry to account and criticising bad science qualifies as 'seriously bad behaviour', which was the excuse Cochrane gave to expel him, then he is proud to own that title. He has submitted a complaint to the Charity Commission and is calling for the present Board and CEO to resign and that there is an independent investigation into his dismissal. Earlier in September the BMJ Evidence Based Medicine featured a blog entitled Cochrane – A sinking ship? By Maryanne Demasi, PhD. The article states that there are concerns that Cochrane has become preoccupied with 'brand promotion' and 'commercial interests', placing less importance on transparency and delivering 'trusted evidence'. Demasi, a researcher working with Prof. Gøtzche, stated that Gøtzche was well-known for his blunt criticisms over breast cancer screening, the overuse of psychiatric drugs, his description of the drug industry as 'organised crime', but it was his stinging critique of the quality of a Cochrane HPV vaccine review and their under-reporting of the harms of the vaccine that resulted in Gotzche's dismissal. The following day four other members resigned from the Governing Board in solidarity. The author of the article also includes the following sentences that should trigger alarm bells into people's minds: '"Cochrane has become too sensitive to criticism of the pharmaceutical industry", says one board member. Insiders say a 'possible concern' might be that Cochrane fears that Gøtzsche's criticism of the HPV vaccines review would negatively impact its sponsorship from the Bill & Melinda Gates Foundation.' You can read the full articles online. Obviously he crossed the line when he mentioned the 'V' word!

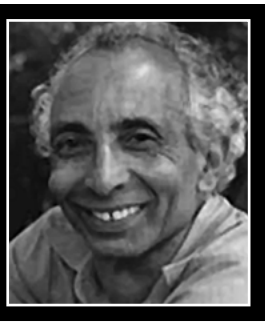
Another good example of this kind of behaviour from the medical establishment features in part one of the film documentary 'Sacrificial Virgins' regarding HPV vaccine. An Austrian government forensic scientist, Dr Johan Missliwetz was ordered to do a second autopsy regarding a particular death as the first autopsy could not establish a cause of death. He reported back that it was either a genetic disorder of the heart or had been caused by a recent vaccine the girl had received. He suddenly started to receive many calls from senior members of the Austrian medical establishment and he was advised to stop talking about the vaccine as a potential cause. Dr Missliwetz stated on the video interview that he had done thousands of autopsies throughout his career – and no one called him in this manner – he was very surprised at the extraordinary reaction he received. This is the typical reaction when you mention the 'V' word. He went on to take early retirement – I wonder if he was encouraged to?

Wishing you all good health, happiness and the freedom of choice!

Magdalene Taylor, Editor, December 2018

DEDICATION: Keki Sidhwa (1926-2018)

An inspirational figure and one of the leading lights in natural health and fasting. I was fortunate to know Keki and learnt much over the years from his lectures, writings and conversations. Keki was given up for dead at the age of 14 and was helped back to health by his mother and aunt who kept him alive with tiny amounts of coconut water to keep him hydrated – he was in a deep coma and could not swallow. After 16 days he suddenly came out of the coma free of the double pneumonia, typhus and heart condition. This later inspired Keki to study naturopathy and osteopathy and he went on to help many, many people regain health by fasting and allowing the body to self-heal. RIP dear Keki.



vaccines, but how much it contributes is unknown. In August 2018, it transpired that Russian backed bots and trolls have been spreading misinformation about vaccines. Countering such activities effectively presents challenges. Government information is a useful adjunct but cannot replace discussion with knowledgeable, trusted healthcare professionals who are equipped to respond to parents' specific questions and concerns.'

At least the authors admitted that most of the deaths in the UK and France in the last 10-15 years have been in the immune-compromised. However they end the article encouraging medical professionals to take every opportunity in vaccinating – whatever age.

'Whenever a healthcare professional has contact with a patient, child, or adult, in whatever setting, the opportunity should be taken to check their immunisation status and offer any missing immunisations. (It is never too late to have the MMR vaccine.) This provides a real opportunity to ensure that herd immunity is attained and endemic disease banished to the history books.'

Elliman and Bedford's article prompted me to send in two Rapid Responses, both of which were published. I have reproduced my responses here, along with another one by Bernadette Pajer, USA. If you want to read all the responses then go to bmj.com and search for 'Measles: neither gone nor forgotten' – there are many good ones to read!

RAPID RESPONSES: 3 EXAMPLES

RAPID RESPONSE: 1

Re: Measles: neither gone nor forgotten.
Fuelling divisions and a lack of public debate are the main problems.
Magda Taylor, The Informed Parent. 3 November 2018

It is 50 years since we, the trusting public, have been led to believe that a particular medical product introduced in 1968 would eradicate measles. Twenty years on, in 1988, a new bigger and better product came along. The, then, health minister Edwina Curry announced 'one jab – lifelong protection'. However a few years later a booster dose was introduced? No mention of lifelong protection that time round.

According to the data on the PHE site, which starts from 1940, it is very clear that a large fall in measles mortality occurred in the first decade and a half, well BEFORE any medical attempt to eradicate measles was introduced. According to McKeown [1]: 'less than a quarter of all children had been protected by the end of 1972', and yet still the measles cases and deaths continued to fall despite the low uptake. In a DoH book [2] it states that 'from 1968 to 1980 the uptake remained between 50-60%', and yet still the measles cases and deaths fell despite the fact that the uptake was nowhere near the, now claimed, required figure of 95% uptake of 2 doses of MMR.

"According to the data on the PHE site, which starts from 1940, it is very clear that a large fall in measles mortality occurred in the first decade and a half, well BEFORE any medical attempt to eradicate measles was introduced."

At the end of the 1950s you will find the description of measles by medical doctors very different to the doctors of today. Why would that be? It was because measles had been declining over the centuries, alongside other zymotic diseases, mostly due to social improvements, and by the late fifties was generally viewed as a straightforward childhood illness in the majority of cases. For example, regarding a measles epidemic in early 1959 the BMJ published [3]: 'the writers (the reporting GPs) agree that measles is nowadays normally a mild infection….' If in 1959 it was referred to as 'normally a mild infection' why are today's public (including a good proportion of health professionals) being presented a very different image? We are constantly being told of the threat of serious complications and deaths if herd immunity (another questionable theory) is not achieved via high MMR uptake.

HAS MEASLES EVOLVED INTO A MORE DEADLY DISEASE?

Why are parents being made to fear a 'normally mild infection' of the 1950s? You would think that by now it should have evolved into an extremely mild infection or almost non-existent? Perhaps Elliman has an explanation? Does he consider measles more dangerous than back in the 1950s? And if so, why?

Quoting figures regarding immunisation status, I wonder if Elliman can be more detailed in his comment. In my experience it is very difficult to obtain the status, as it is not generally recorded. Stating that in the 90% of cases where the status was known is rather vague. For example, if there were only 10 cases with known status out of hundreds of measles cases with unknown status, then that would mean you are only talking about 90% of 10.

Good that the authors admit that 'inaccurate data collection' occurs regarding the variations in uptake. If it can occur in this area how accurate is the collection of data on other aspects of this subject?

Measles was predominantly a childhood illness and yet a worrying trend is appearing with the age of incidence now high in the 20-39 year olds? MMR uptake has generally been reasonably high since it's introduction and it is very likely that many of those cases in the older age group received at least one MMR and/or the MR during the campaign targeting all 5-16 year olds back in Nov 1994. Has the MMR programme shifted the age of incidence to an age where there may be more complications? As one Public Health doctor pointed out to me recently: 'The case–fatality ratio for measles is age-related and is high in children under one year of age, lower in children aged one to nine years and rises again in teenagers and adults' [4]

Has the MMR suppressed the individual's system - resulting in a delay in their ability to develop measles at the appropriate age? A medical paper [5] reporting on a measles outbreak in a tertiary level hospital in Portugal states that strikingly most cases were in the 18-39 year old fully vaccinated health care workers. They indicate this may be due to waning immunity.

Given that 'immunity' is not understood – what does CONT/. PAGE 4

the future hold regarding number of MMR doses? Shifting a 'normally mild infection' into an age bracket where there is an increased chance of serious problems is not a very productive achievement in my opinion.

Right-wing political parties? Russian trolls? Associating anyone who dare mention the 'v' word in any critical form with particular groups or individuals is sadly a growing trend. It is an attempt to alienate the general public towards those who are asking questions. People from all walks of life have many concerns and it is much more than just a sentiment.

We all share the same goal – good health for all. Those who speak out have nothing to gain and yet they are met with hostility or are demonized. As the scientist Wallace stated back in 1898 in his book Vaccination A Delusion [6]:

"Why this effort at secrecy in such a matter if there is nothing to hide? Surely it is to the public interest that official statistics should be made as correct as possible; and private persons who go to much trouble and expense in order to correct errors should be welcomed as public benefactors and assisted in every way, not treated as impertinent intruders on official privacy, as it is too frequently the case."

The health of the recent generations concerns me. We are long overdue for an independent critical overview before health is gone and forgotten.

REFERENCES:

1. The Role of Medice, McKeown T. p.106
2. Immunisation Against Infectious Disease 1990; p52
3. Measles Epidemic; BMJ; 7 Feb 1959 p354
4. Plotkin and Orenstein, 2004, Chapter 19
5. Measles outbreak in a tertiary level hospital, Porto, Portugal, 2018: challenges in the post-elimination era. Machado et al; Eurosurveillance, Vol 23, Issue 20, May 2018
6. Vaccination A Delusion (1898); Wallace A R, p.27

RAPID RESPONSE: 2

ACCESS? Re: Measles: neither gone nor forgotten

Magda Taylor, The Informed Parent
Published 3 November 2018

I AGREE WITH Dr Spitzer's comment that the cause of the poor immunisation uptake is NOT due to access problems. Vaccine access problems? This is not something I have heard about from all the parents I have come into contact with over the last 27 years. I am however experiencing more and more parents with doubts over the MMR trying to ACCESS more information on the subject. Especially since many of the research papers are being archived and hard to access. As Dr Spitzer points out that 'Even when offered on-the-spot immunisation during a consultation the refusal rate is high.' This is a clear example that it is not about accessing the MMR.

RAPID RESPONSE: 3

Wild vs Artificial Exposure to Measles Are Not Equal

Bernadette Pajer
Co-president Informed Choice Washington State. USA
Published 6 November 2018

THERE IS A FACT rarely considered by public health officials: vaccination is not an intervention that eliminates disease exposure for individuals. Vaccination replaces wild exposure with artificial exposure, and they are not equal. We are many decades into mass vaccination campaigns, and it is alarming that instead of the medical and scientific community stepping back to examine the overall impact on public and individual health to see if current strategies should be reevaluated, the focus is on those who question or refuse vaccination. Experts have acknowledged that the current measles vaccine cannot eradicate measles because of primary and secondary failure.[1] Studies have found that the concentration and duration of maternal antibody protection for infants with vaccinated mothers is lower and shorter than protection provided by non-vaccinated mothers [2] , and it has been found that a third dose of MMR cannot boost protection for any length of time [3], leaving most adults unprotected. We have entered a vaccine-era of vulnerable infants and vulnerable older adults—populations that were protected when measles circulated naturally. It's a messy conundrum, and it cannot be laid at the feet of those who opt out of vaccination. For the vast majority of healthy children who can easily handle a case of measles in childhood, vaccination provides no personal benefit and exposes them only to vaccine injury risk and vulnerability to measles in adulthood.

Since industry does not make a single measles vaccine available, that leaves just the controversial MMR that appears to not have had any clinical trials. MMR contains fragmented fetal DNA in the rubella portion, which some find morally objectionable and others medically problematic because of the potential for autoimmunity and insertional mutagenesis [4] . As well, the vaccine is highly contaminated with glyphosate from the gelatin [5] , and there are no studies showing injecting glyphosate to be safe or how it may alter the immune response to the other ingredients. Add that Merck has been accused of falsifying the efficacy of the mumps portion of their vaccine [6] and, Houston, we have a problem.

100% vaccination uptake would not alter the dilemma of vaccine failure or risk. The WHO chose a goal of global eradication before they had a safe tool able to achieve it. Rather than pushing for higher uptake, time and money would be far better spent on implementing rapid diagnosis and notification programs using new technologies to utilize good old-fashioned detection & isolation, researching best and safest measles treatments, and building the basics of healthy immunity in poor communities: clean water, proper sanitation, and adequate nutrition.

[1] Poland, Gregory A and Robert M Jacobson. "The re-emergence of measles in developed countries: time to develop the next-generation measles vaccines?" Vaccine vol. 30,2 (2012): 103-4.

[2] Waaijenborg, et al. "Waning of Maternal Antibodies Against Measles, Mumps, Rubella, and Varicella in Communities With Contrasting Vaccination Coverage." OUP Academic, Oxford University Press, 8 May 2013,

academic.oup.com/jid/article/208/1/10/796786.
[3] Fiebelkorn AP, Coleman LA, Belongia EA, et al. Measles virus neutralizing antibody response, cell-mediated immunity, and IgG antibody avidity before and after a third dose of measles-mumps-rubella vaccine in young adults. The Journal of infectious diseases. 2016;213(7):1115-1123. doi:10.1093/infdis/jiv555.
[4] Deisher, T A, et al. "Epidemiologic and Molecular Relationship Between Vaccine Manufacture and Autism Spectrum Disorder Prevalence." Issues in Law & Medicine., U.S. National Library of Medicine, 2015, www.ncbi.nlm.nih.gov/pubmed/26103708.
[5] Honeycutt, Zen. "Glyphosate in Childhood Vaccines." Moms Across America, www.momsacrossamerica.com/glyphosate_in_childhood_vaccines.
[6] Solomon, Lawrence. "Merck Has Some Explaining To Do Over Its MMR Vaccine Claims." HuffPost Canada, HuffPost Canada, 27 Nov. 2014, www.huffingtonpost.ca/lawrence-solomon/merck-whistleblowers_b_5881914.html.

Competing interests:
No competing interests.

PUBLIC HEALTH ENGLAND WITHHOLDING VACCINES RESULTS MAKING IT IMPOSSIBLE TO ESTABLISH IF DRUGS COULD BE HARMFUL

BY HENRY BODKIN
15 September 2018
https://www.telegraph.co.uk/

THE FAILURE OF England's public healthy body to publish results of three major studies into vaccines for children makes it impossible for experts to establish whether the drugs could be harmful, scientists have claimed.

Hundreds of children took part in three potentially risky Government drug trials, but Public Health England (PHE) breached the law by failing to add the findings to the official register set up to allow the scientific community to scrutinise the outcomes.

Experts have accused PHE of an "incomprehensible" violation of the trust of parents who gave their consent for their children to take part in the tests.

The largest trial involved 640 participants under the age of 16 whose parents gave consent for them to be selected at random to try a new meningococcal and whooping cough booster vaccine.

While dangerous side-effects in a trial at this stage are rare, a risk does exist. Participants also take a gamble by offering themselves up for selection for a new drug which might not protect them as well as the standard therapy.

The trial concluded in 2016, but the results have not yet appeared on the EU Clinical Trials Register (EUCTR), in breach of EU law which requires registration within 12 months, nor published anywhere else.

The failure to register means there is currently no way for the public to know how those children fared.

Last night Dr Ben Goldacre, the Oxford academic whose analysis revealed the PHE omission, told The Sunday Telegraph: "It is incomprehensible to me that Public Health England of all the trials it could leave unreported to have failed to comply with the legal requirements to report trials of vaccines.

"When patients participate and they take a risk with their own health. We have to respect their contribution by publishing the results properly. If we don't, that is a betrayal of trust."

The EUCRT was set up partly to counter the tendency of many scientific journals, which is the traditional mode of publication, to polish the results, downplaying the therapies that failed.

The transparency it affords is supposed to promote confidence in science at a time where the "anti-vax" movement, those who argue vaccines are useless and actually cause disease, is buoyant.

Andrew Wakefield, the discredited British doctor whose fraudulent research prompted a scare that the MMR vaccine causes autism, is enjoying widespread support in the US and a boost sympathetic comments by President Trump.

"Withholding the results of a clinical trial makes a mockery of all our efforts to promote trust in medicine, and I'm particularly sad to see vaccine trials going unreported," said Dr Goldacre.

A second PHE trial, which concluded in 2010, investigated effectiveness of a meningitis C vaccine in a group of 130 one-year-olds, while a third, which concluded in 2011, involved 75 adults trialing a meningitis B vaccine.

PHE said the results of these studies had been published in academic journals, while results of the larger 640-patient trial are "still being analysed".

The omissions by PHE forms part of a bigger picture of widespread disregard for the registration law.

Dr Goldacre's research via his EU.trialstracker.net website shows that over the 7,274 trials where results have been due, only 49.5 per cent reported the results. However, no organisation has ever been sanctioned for breaching the law.

The research showed that pharmaceutical companies tend to comply more than academic institutions, with 68 per cent of company-sponsored trials reporting their results, compared to 11 per cent from universities.

Fergus Sweeney, Head of Inspections at the European Medicines Agency, said: "We need to reflect on how we can improve our communication with academic sponsors and smaller sponsor organisations.

"This study helps to spread the word on how important it is to post trial results once a clinical trial is over.

"We at EMA are firm believers that transparency and public availability and scrutiny of clinical trial information and results are fundamental for the protection and promotion of public health."

Vaccines - what now? by Patrick Quanten MD

WITH THE ONGOING discussion surrounding vaccination programmes and vaccine safety and/or efficacy and in particular because of the yes-no type of discussions whereby one group is not listening at all to the opposition, I feel that it might be time to take stock of what has been achieved so far. Where do we stand on the vaccination controversy and can there ever be any progress in one or the other direction, preferably towards truth? In order to pinpoint the position we have arrived at it might be worthwhile to step back into the history of vaccinations first in order to evaluate this new growing opposition against vaccinations which is said to be a direct result of misinformation and scaremongering.

Health and medical scholars have described vaccination as one of the top ten achievements of public health in the 20th century. Yet, opposition to vaccination has existed as long as vaccination itself (indeed, the pre-vaccination practice of variolation came under criticism as well). Critics of vaccination have taken a variety of positions, including opposition to the smallpox vaccine in England and the US in the mid to late 1800s, resulting in various anti-vaccination leagues evolving. Then the more recent vaccination controversies, such as those surrounding the safety and efficacy of the diphtheria, tetanus, and pertussis (DTP) vaccine, the measles, mumps, and rubella (MMR) vaccine, and the use of a mercury-containing preservative called thimerosal.

Widespread smallpox vaccination began in the early 1800s, following Edward Jenner's questionable cowpox experiments, in which he claimed that vaccinating using lymph from a cowpox blister would offer immunity against smallpox. Jenner's ideas were novel for his time, however, they were met with immediate public criticism. The rationale for this criticism varied, and included sanitary, religious,

Patrick Quanten MD

scientific, and political objections, but most importantly they were based on the growing number of reports of vaccine injuries and fatalities.

The Vaccination Act of 1853 ordered mandatory vaccination for infants up to 3 months old in the UK, and the Act of 1867 extended this age requirement to 14 years, adding penalties for vaccine refusal. The laws were met with immediate resistance from citizens who demanded the right to control their bodies and those of their children, especially whey they had witnessed first hand either a vaccine death or injury. The Anti-Vaccination League and the Anti-Compulsory Vaccination League formed in response to the mandatory laws, and numerous anti-vaccination journals sprang up. An early "**The Informed Parent**"!

The town of Leicester was a particular hotbed of anti-vaccine activity and the site of many anti-vaccine rallies. The local paper described the details of a rally: "An escort was formed, preceded by a banner, to escort a young mother and two men, all of whom had resolved to give themselves up to the police and undergo imprisonment in preference to having their children vaccinated… The three were attended by a numerous crowd…Three hearty cheers were given for them, which were renewed with increased vigour as they entered the doors of the police cells." The Leicester Demonstration March of 1885 was one of the most notorious anti-vaccination demonstrations. There, 80,000-100,000 anti-vaccinators lead an elaborate march, complete with banners, a child's coffin, and an effigy of Jenner.

Such demonstrations and general vaccine opposition lead to the development of a commission designed to study vaccination. In 1896 **the commission ruled that vaccination protected against smallpox**, but suggested removing penalties for failure to vaccinate. The Vaccination Act of 1898 removed penalties and included a "conscientious objector" clause, so that parents who did not believe in vaccination's safety or efficacy could obtain an exemption certificate.

Toward the end of the 19th century, smallpox outbreaks in the US lead to vaccine campaigns and related anti-vaccine activity. The Anti-Vaccination Society of America was founded in 1879, following a visit to America by leading British anti-vaccinationist William Tebb. Two other leagues, the New England Anti-Compulsory Vaccination League (1882) and the Anti-Vaccination League of New York City (1885) followed. The American leagues waged court battles to repeal vaccination laws in several states including California, Illinois, and Wisconsin.

In 1902, following a smallpox outbreak, the Board of Health of the city of Cambridge, Massachusetts, mandated all city residents to be vaccinated against smallpox. City resident Henning Jacobson refused vaccination on the grounds that the law violated his right to care for his own body how he knew best. In turn, the city filed criminal charges against him. After losing his court battle locally, Jacobson appealed to the U.S. Supreme Court. In 1905 the Court found in the state's favour, ruling that the state could enact compulsory laws to protect the public in the event of a communicable disease. This was the first U.S. Supreme Court case concerning the power of states in public health law.

Anti-vaccination positions and

vaccination controversies are not limited to the past. In the mid 1970s, an international controversy over the safety of the DTP immunization erupted in Europe, Asia, Australia, and North America. In the UK opposition resulted in response to a report from the Great Ormond Street Hospital for Sick Children in London, alleging that 36 children suffered neurological conditions following DTP immunization. Television documentaries and newspaper reports drew public attention to the controversy. An advocacy group, The Association of Parents of Vaccine Damaged Children (APVDC), also piqued public interest in the potential risks and consequences of DTP.

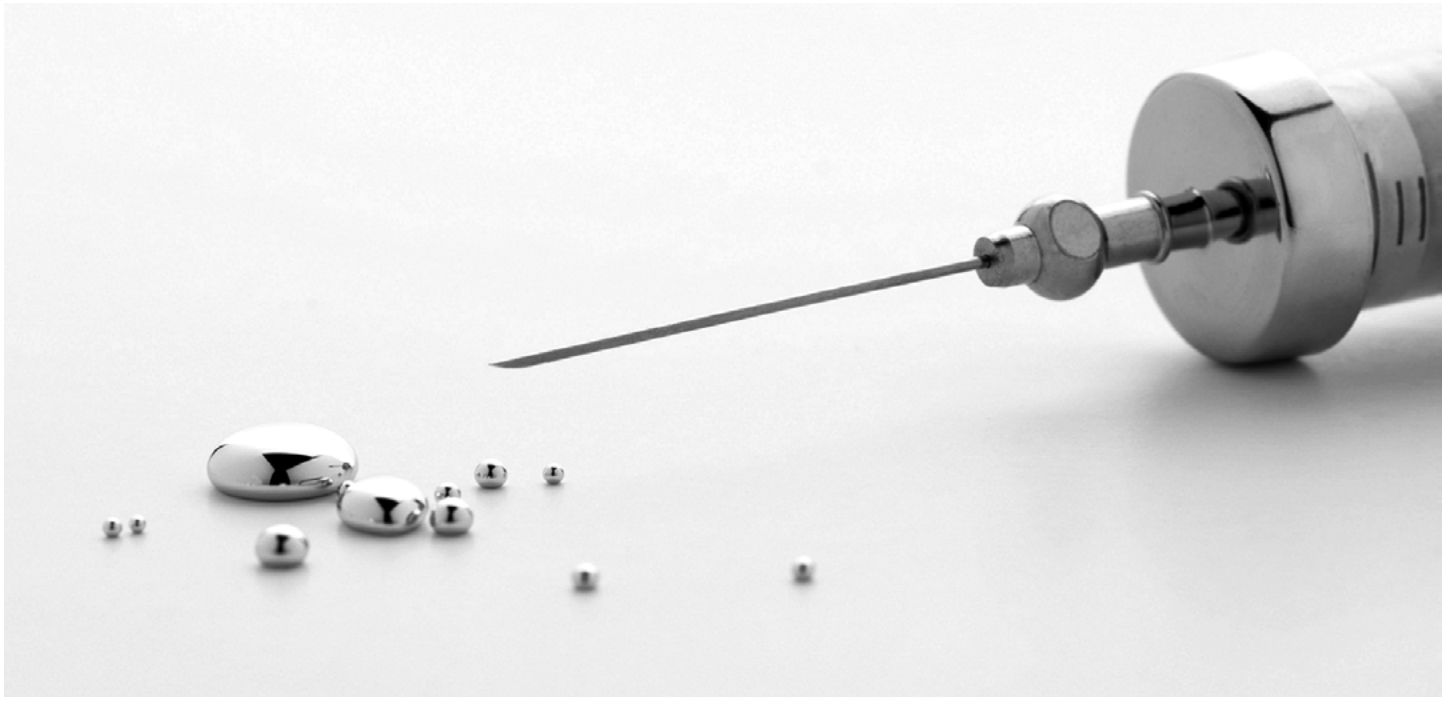
In response to decreased vaccination rates the UK Joint Commission on Vaccination and Immunization (JCVI), **confirmed the safety of the immunization**. Nonetheless, public confusion continued, in part because of diverse opinions within the medical profession. For example, surveys of medical providers in the UK in the late 1970s found that they were reluctant to recommend the immunization to all patients. Additionally, an outspoken critic of the whooping cough vaccine, Prof. Gordon Stewart, published a series of case reports linking neurological disorders to DTP, sparking additional debate. In response, the JCVI launched the National Childhood Encephalopathy Study (NCES). The study identified every child between 2 and 36 months hospitalized in the UK for neurological illness, and assessed whether or not the immunization was associated with increased risk. NCES results indicated that the risk was very low, and this data lent support to a national pro-immunization campaign.

"City resident Henning Jacobson refused vaccination on the grounds that the law violated his right to care for his own body how he knew best. In turn, the city filed criminal charges against him."

The U.S. controversy began with media attention on the alleged risks of DTP. A 1982 documentary, DPT: Vaccination Roulette, described alleged adverse reactions to the immunization and minimized the benefits. Similarly, a 1991 book entitled A Shot in the Dark outlined potential risks. As in the UK, concerned and angry parents formed victim advocacy groups, but the counter response from medical organizations, like the Academy of Paediatrics and the Centres for Disease Control and Prevention, was stronger in the US. Although the media storm instigated several lawsuits against vaccine manufacturers, increased vaccine prices, and caused some companies to stop making DTP.

Nearly 25 years after the DTP controversy, England was again the site of anti-vaccination activity, this time regarding the MMR vaccine. In 1998, British doctor Andrew Wakefield recommended further investigation of a possible relationship between bowel disease, autism, and the MMR vaccine. A few years later, Wakefield alleged the vaccine was not properly tested before being put into use. The media seized these stories, igniting public fear and confusion over the safety of the vaccine. The Lancet, the journal that originally published Wakefield's work, stated in 2004 that it should not have published the paper. The General Medical Council (GMC), an allegedly independent regulator for doctors in the UK, concluded that Wakefield had a "fatal conflict of interest." In 2010, the Lancet formally retracted the paper after the GMC ruled against Wakefield and he was struck off from the UK medical register in Great Britain. Wakefield is constantly being blamed for every measles outbreak since, and the growth of 'anti-vaxxers.'

Thimerosal, a mercury containing compound used as a preservative in vaccines, has also been the centre of a vaccination and autism controversy. Although the authorities insisted on the safety of the use of small amounts of thimerosal in vaccines, in July 1999, leading U.S. public health and medical



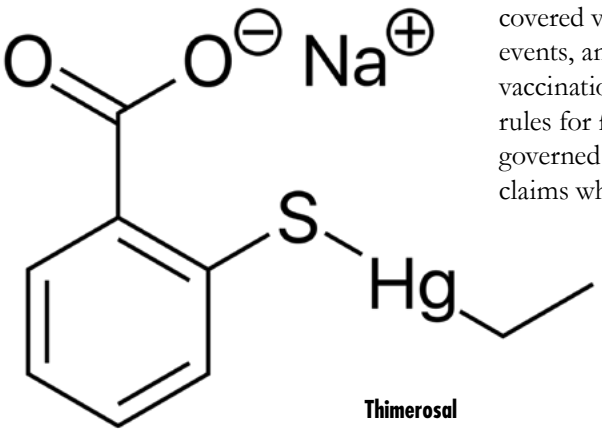
organizations and vaccine manufacturers agreed that thimerosal should be reduced or eliminated from vaccines as a precautionary measure. In 2001, The Institute of Medicine's Immunization Safety Review Committee issued a report concluding that there was not enough evidence to prove or disprove claims that thimerosal in childhood vaccines causes autism, attention deficit hypersensitivity disorder, or speech or language delay. A more recent report by the committee "favours rejection of a causal relationship between thimerosal-containing vaccines and autism". Even with this finding, some researchers continue to study the possible links between thimerosal and autism. Today, thimerosal is no longer used in most childhood vaccines, though some forms of influenza vaccine available in multi-dose vials may contain the preservative.

We can draw two immediate conclusions from this brief scan of historical facts. The first is that studies "proving" the efficacy and /or the safety of vaccines have been used by authorities over and over again to implement more restrictive rules, whilst at the same time these studies never settled the minds of the anti-campaigners. The second conclusion is that eventually, without admitting to have been wrong, the industry "voluntarily" alters their attitude in manufacturing or administering vaccinations.

1. Why are only "official" studies (government and industry) proving safety and efficacy?
2. Why are certain controversial vaccine components altered/ removed when they had been claimed to be harmless?

A rift between words and deeds we also find in the setting up of National Vaccine Injury Compensation Programmes. Vaccines are perfectly safe to use - no admission of any wrong-doing - and yet there is a need for compensation. We have discussed the ins and outs of such schemes in another issue of this very magazine but let's remind ourselves here of some important points in respect to the knowledge about the safety of vaccines.

Always first have a look at the reason why authorities say they introduce anything new. In this case it is to ensure that people who have a genuine claim of unfortunately having been damaged by vaccination to spare them the trouble and the difficulty of getting a court judgement. The authorities felt that it would be unjust for people who had already suffered a great deal to have to go through the other traumatic experience of a court case in order to get justice. How generous of them to consider the poor suffering people and to embrace their plight fully! In reality the rules are a lot less emotional. When



Thimerosal

the medical profession agrees that the vaccine has caused definite damage then you will be compensated and the manufacturer will not and can not be blamed for that damage. You don't have to go to court; we admit you are right and that the damage was caused by the vaccine. This is a no-fault alternative to the traditional legal system for resolving vaccine injury petitions. Because this is a medical judgement the entire procedure is carried out behind the closed doors of the medical judiciary. When they themselves feel this to be a punishable offence, you will get your compensation. The industry gets off scot-free. The case is closed and can never be talked about or re-opened. In fact, the case has never seen daylight. It never even existed. The industry can happily carry on and the medical profession is not even being told there was a problem. Nobody knows about it, and those that do are sworn to secrecy. The result is a resounding "**vaccines are safe**" statement.

The National Vaccine Injury Compensation Program (NVICP) was created in the 1980s in the USA, after lawsuits against vaccine companies and health care providers threatened to cause vaccine shortages as the industry blackmailed government vaccination programmes by stopping production if they were going to have to be responsible for "mishaps" and to have to pay out large sums of compensation. So together with governments in the Western world they worked out a no-fault compensation scheme which allowed governments to continue with their propaganda that they were saving the population from terrible diseases. The National Childhood Vaccine Injury Act Reporting and Compensation Tables (VIT) list each covered vaccine, its associated adverse events, and the allowable interval from vaccination to onset of event. The rules for filing a petition are strictly governed and exclude many potential claims which would force the authority to look at the much wider picture. Keep it as narrow as you possible can and stick to it rigidly! But show you care!

The VIT is subject to review by DHHS, and vaccine injuries may be added to and removed from the tables depending on the best available evidence. Seizure disorder after DPT vaccination, which was the cause of many successful lawsuits against vaccine manufacturers before the NVICP, was removed from the list of compensable events in 1995 because of lack of evidence supporting a link. Don't forget that in this setup the medical authority finances and promotes the industry and sits in judgement over who will be compensated for the damage caused by the same industry. The medical profession has been given the power to protect its industry in spite of potent evidence of wrong-doing at the same time as it is upholding the claim to only care for the wellbeing of the population. Has anybody ever pointed out this constitutes a conflict of interest?

The perpetrator is the appointed judge.

Since 1988, over 20,018 petitions have been filed with the NVICP. Over a 30-year time period, 17,536 petitions have been adjudicated, with 6,276 of

those determined to be compensable, while 11,260 were dismissed. Total compensation paid during that time period of the programme is approximately $4 billion, which is roughly on only one third of the petitions accepted for judgement by the medical authority.

Figures from the UK Dept. of Works & Pensions show the total amount of money awarded under the Vaccine Damage Fund since 1979 to 2017 £74,130,000. A far cry from money spent in the US. However, in 2005 there was a problem with the Pandemrix swine flu vaccine causing narcolepsy, which lead to the quiet and spontaneous withdrawal of the vaccine from the market. Although no link was "proven" and no link was admitted it was the medical profession themselves who took this step and surely this points in the direction of "Houston, we have a problem". In Norway they admitted paying out $13 million. You would have thought that would be it, but guess what? In 2009 there was a problem with a flu vaccine against Mexican flu. The problem was narcolepsy and the vaccine was Pandemrix!! In 2014 the Dutch government set aside 5 million euro to fund the compensation claims for this disaster, although they mentioned it could easily become double that figure. And just to show how medical authorities are carrying on as if nothing has happened, in 2011 Swedish researchers found that Pandemrix caused a 4x increase in the number of children with narcolepsy, but to this day no blame goes to the industry.

Children's Health Defence recently called attention to a glaring example of the NVICP's pro-industry and anti-vaccine-injured bias. In 2007 and 2008, DOJ attorneys exhibited "highly unethical and appallingly consequential official misconduct" during an Omnibus Autism Proceeding (OAP) orchestrated to determine the fate of 5,400 families who had filed claims for vaccine-induced autism. The potential value of the claims exceeded $100 billion - an amount that "would have bankrupted the compensation programme many times over." HHS's Department of Justice lawyers, under pressure to deprive petitioners of their rightful relief, successfully achieved that aim through allegedly fraudulent means. In September 2018, Children's Health Defence Chairman, Robert F. Kennedy Jr. and Rolf Hazlehurst (parent of one of the vaccine-injured children involved in the OAP) requested that the DOJ Inspector General and Congress investigate this fraud and obstruction of justice by HHS and DOJ officials.

By anyone's accounting, the **$4 billion** paid out to date by the NVICP is an attention-getting amount of money. However, that amount pales in comparison to the billions of dollars' worth of autism claims that the vaccine court unfairly dismissed. According to HHS, moreover, "fewer than 1% of vaccine adverse events are reported," and studies confirm that many health providers are unfamiliar with the system for reporting vaccine injuries. The shocking underreporting of vaccine injuries also fails to account for the fact that one in six individuals who experience an adverse event following immunization (AEFI) have a recurrence with subsequent vaccination, often rated as more severe than the initial AEFI. If even a small percentage of these unreported and recurrent vaccine injuries were brought forward for compensation, the entire NVICP house of cards - and the CDC's deceptive claims of unassailable vaccine safety - would crumble.

"In 2011 Swedish researchers found that Pandemrix caused a 4x increase in the number of children with narcolepsy, but to this day no blame goes to the industry."

Instead, whether intended or not, the end result of the 1986 Act and the NVICP has been to create a "gold rush" environment that encourages manufacturers to develop even more vaccines, while conveniently exempting them from liability for the injuries and deaths that result from their powerful immune-system-altering products. With no incentive to make vaccines safe and a large and lucrative market guaranteed by the CDC's childhood vaccine schedule - as well as a growing effort to foist unnecessary and dangerous vaccines on adults - vaccine manufacturers appear to have it made. The public and vaccine safety advocates must continue to remind the government that the approximately 6,300 claims that have been compensated over the NVICP's 30-year history represent the very tip of the iceberg.

But the truth is you can say whatever you want. As long as the medical system is allowed to operate outside the law of the land nothing will change!

Industry without liability towards the people is nothing but a loose cannon.

How can anybody know what is the truth in a world where so much conflicting evidence is being brought forward? Well, just ask yourself the question: When vaccines are perfectly safe, why does the authority need a scheme that pays out compensation money for serious damage caused by vaccines?

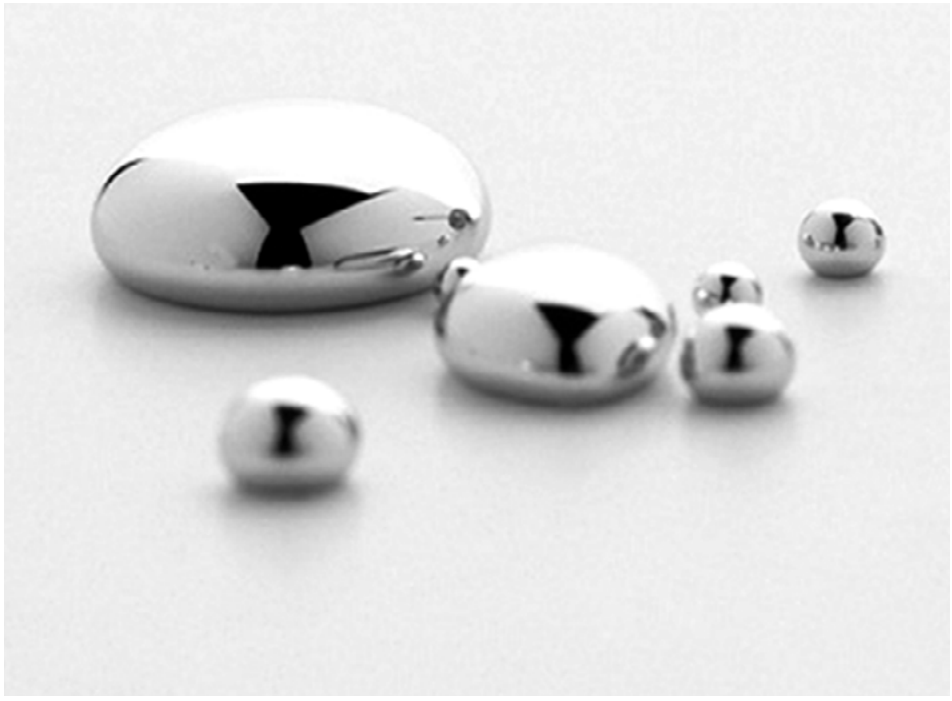
But all of this could still be justifiable if vaccines were effective in reducing and ending infectious diseases. They tell us they are, but how do they know? They test them rigorously. How do they know what to test and how to test it?

- It all starts with assuming there is a good chance the vaccine works against a certain disease. It all starts with the dogma vaccines prevent diseases.
- In the preclinical trials the vaccine gets tested on tissue culture and on animals. Scientists know that animal testing doesn't provide any answers on human reactions to the same exposures as various species have various reaction patterns and there is no extrapolation possible between the different animals and between animals and humans. Nor does in vitro provide answers for in vivo.
- Furthermore, the industry will study which preservatives or stabilizers to add so that the vaccine doesn't break down and whether any adjuvants are necessary to generate a strong enough immune response. In truth, vaccine researches have known for sixty years that when they do not add any irritant, a toxic substance, no immune response can be demonstrated!

• When these tests are satisfactory, a sponsor applies for the right to set up clinical trials. Human researchers test the vaccine in what is called human trials. Selected healthy adults are hand-picked to become vaccinated in very controlled conditions, so nobody gets ill. If you do, those results will be excluded from the trial because there already "was something wrong" with you.
• Once these tests have "proven" the vaccine is safe, hundreds of volunteers will now be inoculated and information about side-effects is gathered. Here we talk about immediate side-effects that show up within the testing period which is generally about two weeks.
• After this testing phase the vaccine is compared with older and different vaccines on efficiency in the public domain. If vaccines are supposed to protect against diseases, how long is your observation period in this testing phase? How long do you keep watching to see whether the disease occurs or not? Three months? Three years? Or should it be ten years or a lifetime?
• Medical authorities check the test results themselves. They inspect the factories and in doing so ensure safety and potency of the vaccine. No independent authority gets a look in.
• They say the whole process can take up to 10 years. When this entire process can take up to ten years and the testing and trial periods are said to take anything between eight and ten years, I wonder how long they take to observe the effects of the vaccine in comparison with other existing vaccines?

The effects of vaccines are tested on the public, just like other drugs and procedures are, and there is never a problem with it unless you actually no longer can hide the problems. First it is perfectly safe, and then it gets taken off the market. Have you ever wondered why no vaccine is said to give you a lasting immunity? Does this mean that in time they always record the vaccinated person as becoming infected?

The standard benchmark for scientific testing is the double-blind trial whereby one group is given the medicine and the other group a placebo and neither the doctor nor the patient knows which has been used. In vaccine testing the medical profession has abandoned the double-blind trials on the basis that it is ethically indefensible not to vaccinate. Hence, the dogma vaccines prevent diseases rules the entire procedure. In fact, they are allowed to begin using vaccinations without knowledge of long-term effects and possible dangers, whereby vulnerable human beings are being used to find out this information.



In vaccine testing the medical profession has abandoned the double-blind trials on the basis that it is ethically indefensible not to vaccinate.

Passing through the entire development and production stages following their own official guidelines it is estimated that the time required for this process is not ten years but more likely around twenty years and the financial investment needed is at least one billion dollars. It might serve you to look at how quickly the latest vaccines come onto the market. How much time elapses between the idea of the vaccine and the vaccine actually becoming available?

The first HPV vaccine became available in 2006, after it had been "proven" to be safe. Apart from all the stories about serious and dangerous side-effects and the discussions about whether or not these are real side-effects or coincidental disease occurrences, there are a few other facts that we can draw your attention to.
• A conservative watchdog organisation in the US, Judicial Watch, received documents from the Dept. of Health and Human Services (HHS) "revealing that its National Vaccine Injury Compensation Program (VICP) has awarded $5,877,710 dollars to 49 victims in claims made against the highly controversial HPV (human papillomavirus) vaccines".
• In 2010 in India, the Indian Council of Medical Research (ICMR) ordered the country's health ministry to suspend the HPV vaccine programme after reports of four deaths and 120 complications.
• In Japan, the vaccine is no longer recommended by the government, although it is still available. There is also a lot of controversy around the subject in Denmark, with many parents and doctors raising questions.
• An eight-month investigation by Slate found the major Gardasil trials were flawed from the outset, and that regulators allowed unreliable methods to be used to test the vaccine's safety.
• In an internal 2014 EMA report about Gardasil 9 obtained through a freedom-of-information request, senior experts called the company's approach "unconventional and suboptimal" and said it left some "uncertainty" about the

safety results. EMA trial inspectors made similar observations in another report, noting that Merck's procedure was "not an optimal method of collecting safety data, especially not systemic side effects that could appear long after the vaccinations were given."
• Merck, the manufacturer of the HPV vaccine Gardasil, has stated in their Gardasil Product Information Leaflet, that there are over 45 side-effects which may be experienced after Gardasil injections and that this occurs in 3.2% of those injected and that one third of these are serious (life-threatening) side effects.

Scientifically what is required is to demonstrate a causal link between the alleged disease cause, the germ, and the actual disease. Both being present in the same person at the same time establishes a link but not a cause. If there is a causal link, one of the features is that both occurrences happen every time. One doesn't go without the other. It might interest you to know that a causal link has never been found in any of our known infectious diseases!

SO, WHAT HAVE WE LEARNED?

1. Opposition against vaccination has been present since the very beginning and the war is still waged on the same issues: safety and efficacy.
What makes you think you are going to stop vaccinations now when you haven't managed it in two hundred years? Unless, you change tactics. Unless science could prove that there never is a need for protection against an infectious attack from the outside.
It's your lucky day! Science has established time and time again over the last two hundred years that germs occur spontaneously inside the diseased tissue in an effort by the organism to clean up the disease and get back to health.
2. Anecdotal information about individual reactions surrounding vaccinations are creating fear amongst the population and are being dismissed by the authorities. By making a successful claim, which is a rare event, you help the authorities to suppress reports of serious problems.
When the perpetrator is appointed judge over the claim, the outcome is pretty predictable. By no longer allowing the medical profession to operate outside the law you can hold them directly responsible for their actions and the procedures they use. This will ensure that the industry will become accountable as well, and just as it is for every ordinary citizen, doctors and the pharmaceutical industry will have to carry their punishment personally.
3. Test results depend on the way the test has been set up as well as on many other variables such as choosing the participants, deciding on the rules of the testing, how to collect the data, how to interpret the data, what conclusions must be drawn. The medical profession does not accept the scientific truth (discovered a hundred years ago) that the observer influences the observed and that no test can ever give an "objective" result.
Testing, in the laboratory as well as on animals, brings us no useful information about the truth for humans. No testing on one human being can give us any information about the effects of the same procedure on another human being. Every observation is valid and is directly linked to the individual and the circumstances. Hence, no procedure can ever be effective or safe for all.
Giving people the right to validate their own lives and making whatever is available subject to the decision of the individual is the only real way forward in the direction of health. Freedom of choice is all that is required. Hand people the right to make their own decisions and give them the freedom to decide what they believe is best for them. Physics has proven this to be the truth. Shall I compress it into the three demands we need to put forward?
1. Make medical science part of science. - Matter is energy, in its material substance and in its function. Germs are a result of the disease not the cause.
2. Everyone is equal in the eyes of the law.
3. Freedom of choice.

Or as the French may say: Liberté, Egalité, Fraternité. (Freedom, Equality, Brotherhood)

December 2018

"EVERY INTELLIGENT PERSON WHO TAKES THE TIME TO INVESTIGATE VACCINATION, WILL FIND ABUNDANT EVIDENCE IN THE PUBLISHED WRITINGS AND PUBLIC RECORDS OF THE ADVOCATES OF VACCINATION, TO PROVE ITS UTTER WORTHLESSNESS, WITHOUT READING A LINE OF ANTI-VACCINATION LITERATURE. AND IF WE COULD ADD TO THIS ALL THE SUPPRESSED FACTS, WE WOULD HAVE A MASS OF EVIDENCE BEFORE WHICH NO VACCINATOR WOULD DARE TO HOLD UP HIS HEAD."

~ Dr Robert A Gunn, MD, "Vaccination: Its fallacies and Evils", 1882.

PARENT'S LETTER TO HEAD TEACHER: NASAL FLU VACCINE IN SCHOOLS

REPRODUCED HERE is a letter written by a UK parent regarding the nasal flu vaccine that is now being annually administered at schools during the first term after the summer. You may find this helpful in composing your own letter- should you decide to decline having your child receive the vaccine.

Dear Mrs X

I am writing to you regarding the upcoming flu vaccination program taking place at school this year. I have been told by the Local School Nurse team that in our school it will take place on Wednesday 21st November.

I would like to express my genuine concerns about this program taking place at school. I am well aware that you are following NHS and Ofsted guidelines, however I do not feel this is the best environment for such a campaign, and here are my main concerns:

the Fluenz Tetra is a drug that is part of the Government Black triangle scheme. Medicines with a black triangle status have not been comprehensively studied for safety and require continued monitoring and active surveillance to identify potentially serious adverse events. In my view, such procedures should take place at GP surgeries or other medical establishments where the appropriate safeguarding and monitoring measurements can be taken by trained staff.

The parental NHS leaflet states there is no risk of transmission of the vaccine flu virus and yet in the vaccine package insert the risks of shedding and possible transmission are very real and clear. Manufacturers report that shedding is seen up to 28 days post vaccination, with the highest peak being on days 2-3 post vaccination.

The vaccine contains 4 strains of genetically modified viruses among which is H1N1 (Swine flu). It also contains porcine ingredients, as well as MSG (monosodium glutamate)

This vaccine has been withdrawn in the USA in 2016/17 and 2017/18 (called Flumist there but is the same vaccine) due to being ineffective. It has also been withdrawn in Belgium. Indeed, as of now the UK is one of the very few countries to administer this live vaccine en masse in schools.

While this is just a brief summary of my concerns, I have expanded and referenced my research further below.

Like I mentioned before, I realise that the flu vaccination campaign takes place across the vast majority of primary schools in the country and that you are only following the equivalent guidelines. However, I wonder if it is possible at all to reschedule the date just before half term, thus allowing most of the shedding to happen outside school environment, potentially minimising the transmission to other children, staff and parents.

I would like to request for……. to be absent on the vaccination day as well as the following two days. If the date remains as it is now - Wednesday 21st November, then I would also like …….. to be absent on Thursday 22nd November and Friday 23rd of November, in order to avoid the peak shedding period (days 2 and 3 post vaccination). I will of course liaise with Mrs ……. and Mrs …….. for homework to make up for the time lost in the class room.

Best Regards,…….

BRIEF SUMMARY OF MY CONCERNS

The topic of vaccination is a huge and complex one but in the interests of keeping this as brief as possible, here are my chief objections to the nasal flu vaccination, particularly its administration during school hours and why I feel the need to remove my child from the environment:

1. FLUENZ TETRA IS A DRUG THAT IS PART OF THE GOVERNMENT BLACK TRIANGLE SCHEME

(1). Medicines with a black triangle status have not been comprehensively studied for safety and require continued monitoring and active surveillance to identify potentially serious adverse events. All Influenza vaccines are developed ahead of each Flu season, meaning that each year, it is a 'best guess' as to whether the vaccine will cover the strains that emerge. It also means that as it is constantly changing it can never be thoroughly tested for safety and will always remain a black triangle drug and require monitoring as, in essence, they cannot know if it is safe or effective. We do know that the vaccines are made in March and it does *not* cover the strain of Flu they have experienced in Australia.

By administering it to children in schools, the Nasal Spray Flu Vaccine Programme directly violates the Secretary of State's declaration in The Health Protection (Vaccination) Regulations 2009 which states there is no provision for imposing or enabling any restriction or requirement which has, or would have, a significant effect on a person's rights. (2) I do not wish my child to be exposed to a GM virus so therefore I feel that this program affects my rights. Furthermore, are the people administering the vaccination at school going to screen children for the following issues first?

"You should not get FluMist Quadrivalent if you have a severe allergy to eggs; have ever had a life-threatening reaction to influenza vaccinations; or are 2 - 17 years old and take aspirin or medicines containing aspirin – children or adolescents should not be given aspirin for 4 weeks after getting FluMist Quadrivalent unless your healthcare provider tells you

otherwise. Children under 2 years old have an increased risk of wheezing (difficulty with breathing) after getting FluMistQuadrivalent. Tell your healthcare provider if you or your child are currently wheezing; have a history of wheezing if under 5 years old; have had Guillain-Barré syndrome; have a weakened immune system or live with someone who has a severely weakened immune system; have problems with your heart, kidneys, or lungs; have diabetes; are pregnant or nursing; or are taking Tamiflu®, Relenza®, amantadine, or rimantadine. Your healthcare provider will decide if FluMist Quadrivalentis right for you or your child." [3]

The prescribing information says: 'Inform vaccine recipients or their parents/guardians that FluMist Quadrivalent is an attenuated live virus vaccine and has the potential for transmission to immunocompromised household contacts'. [4]

2. SAFETY

The nasal spray flu vaccine (Fluenz Tetra or FluMist Quadrivalent) currently recommended for Early Years children in the school flu vaccination programme contains genetically modified strains of influenza with no long-term safety studies. The nasal flu spray is a new vaccine so it is yet unclear what the long-term effects are but medical experts in the UK are already saying that it can cause narcolepsy(constantly falling asleep) and cataplexy (seizures triggered by giggling). [5] In addition, the packaging leaflet included with the vaccine lists Guillain-Barré syndrome and exacerbation of symptoms of Leigh syndrome (mitochondrial encephalomyopathy) as possible side-effects. [6]

This vaccine has been withdrawn in the USA [7] in 2016/17 and 2017/18 due to being ineffective. It has also been withdrawn in Belgium. Indeed, the UK is one of the only countries to administer this live vaccine en masse in schools. In point of fact, the potential consequences of NOT receiving this vaccine are… less flu:

"Using recently observed low LAIV (live attenuated influenza vaccine) effectiveness values, fewer influenza cases will occur if LAIV is not used compared with having LAIV as a vaccine option.[8]

The vaccine contains genetically modified organisms, which are, by their very nature, unpredictable.

"Genetically modified (GM) viruses and genetically engineered virus-vector vaccines possess significant unpredictability and a number of inherent harmful potential hazards." [9]

"Appropriate risk management is the key to minimizing any potential risks to humans and environment resulting from these GM vaccines."[9]

One of these GM viruses is H1N1 – swine flu.[10]

Reassortant influenza virus* (live attenuated) of the following four strains**:
A/Michigan/45/2015 (H1N1) pdm09 - like strain (A/Slovenia/2903/2015, MEDI 279432) 10 FFU***
A/Hong Kong/4801/2014 (H3N3) -like strain (A/New Caledoina/71/2014, MEDI 263122) 10 FFU***
B/Brisbane/60/2008 - like strain (B/Brisbane/60/2008, MEDI 228030) 10 FFU***
B/Phuket/3073/2013 - like strain (B/Phuket/3073/2013, MEDI 254977) 10 FFU***…….per 0.2 ml dose.
* propagated in fertilised hens' eggs from healthy chicken flocks.
** produced in VERO cells by reverse genetic technology. This product contains genetically modified organisms (GMOs).
*** fluorescent focus units.
This vaccine complies with the WHO recommendation (Northern Hemisphere) and EU decision for the 2017/2018 season.

The vaccine may contain residues of the following substances: egg proteins (e.g. ovalbumin) and gentamicin. The maximum amount of ovalbumin is less than 0.024 micrograms per 0.2 ml dose (0.12 micrograms per ml).[10]

The vaccine also contains MSG which arguably is a neuro toxin. Another ingredient is gentamicin - an antibiotic which has an incredibly long list of potential side effects ranging from agitation to coma through hallucinations to wheezing. [11]

3. SHEDDING (SPREADING OF THE VIRUSES IN THE VACCINE)

The nasal spray flu vaccine is a live attenuated vaccine that uses a weakened pathogen to illicit an immune response/reaction. It contains four strains of live influenza virus designed to replicate in the nasal passages of the recipient [4]. This means that recently vaccinated children can easily 'shed' (spread) the same weakened pathogens to others (who have chosen NOT to receive the vaccine).

Dr Graham Downing has found several studies that prove shedding is a serious issue. One study found that the viruses in live vaccines are shed at levels similar to infection, with children being infectious for longer than adults. Another says that 44% of children vaccinated with the live influenza vaccine were shedding the virus and putting others at risk. He concludes that although viral transmission is complex it has been demonstrated that infection from one person to another occurs at viral shedding levels similar to those of children post vaccination. [12-19]

The issue of shedding is of particular concern to those classed as 'at risk' and 'immune compromised' such as dialysis patients, chemo and radiotherapy patients, those with rare genetic immune disorders, and anyone more susceptible to cross infection. Are you aware of any such children in the school? If so, their parents should be specifically warned in advance.

Given that the 'virus has the potential for transmission' peaking at 'two to three days post vaccination in clinical studies' it would be sensible to administer the vaccination on a Friday, or before half term. Then those children who would prefer to avoid the worst of the shedding will not be absent for more than a day or two from school. However, the GM virus will sit in children's noses for up to 28 days meaning that some parents may consider longer absences. [10] Scheduling an afternoon administration or allocating a venue away from the main building of the school may reduce absences from children whose parents want to avoid the actual administration period.

Table 5: Characterization of Shedding with FluMist in Specified Age Groups by Frequency, Amount, and Duration (Study MI-CP129[a] and Study FM026[b])

Age	Number of Subjects	% Shedding[c]	Peak Titer ($TCID_{50}$/mL)[d]	% Shedding After Day 11	Day of Last Positive Culture
6-23 months[e]	99	89	< 5 log_{10}	7.0	Day 23[f]
24-59 months	100	69	< 5 log_{10}	1.0	Day 25[g]
5-8 years	102	50	< 5 log_{10}	2.9	Day 23[h]
9-17 years	126	29	< 4 log_{10}	1.6	Day 28[h]
18-49 years	115	20	< 3 log_{10}	0.9	Day 17[h]

[a] NCT00344305; see www.clinicaltrials.gov
[b] NCT00192140; see www.clinicaltrials.gov
[c] Proportion of subjects with detectable virus at any time point during the 28 days.
[d] Peak titer at any time point during the 28 days among samples positive for a single vaccine virus.
[e] FluMist and FluMist Quadrivalent are not approved for use in children younger than 24 months of age *[see Adverse Reactions (6.1)]*.
[f] A single subject who shed previously on Days 1-3; $TCID_{50}$/mL was less than 1.5 log_{10} on Day 23.
[g] A single subject who did not shed previously; $TCID_{50}$/mL was less than 1.5 log_{10}.
[h] A single subject who did not shed previously; $TCID_{50}$/mL was less than 1.0 log_{10}.

US package insert. Table 5 page 4

4. RISK TO OTHERS OF FLU TRANSMISSION

By sneezing and touching door handles, etc, recently vaccinated children will spread the viruses around the school putting the health of staff, other pupils, and their families at risk. They may not all show symptoms of the flu and therefore will not be absent as flu patients usually would be. Public Health England claims that shedding from a recently vaccinated person is negligible but it has been proven, in both school and laboratory settings, that flu vaccine strains have been transmitted to other children and staff. (20) Even the manufacturers advise that people who are immune-compromised should not come into contact with a recently vaccinated child (21) which suggests that there is indeed a risk of transmission.

It can be argued that due to the weakened nature of the virus the risk of contracting flu from the vaccine is low. It cannot however be stated as zero risk and I feel it's disingenuous to state as the NHS's parental leaflet does that "No, the vaccine cannot cause flu because the viruses in it have been weakened to prevent this from happening.". The package insert (10) describes a study where one placebo subject had mild symptomatic Type B virus infection confirmed as a transmitted vaccine virus. They estimate the risk of contracting the vaccine virus at 2.4%. Note this was a small study on healthy children. Again from the package insert (10) under Warnings and Precautions it says 'FluMist Quadrivalent has not been studied in immunocompromised persons.' and 'Safety and effectiveness of FluMist Quadrivalent have not been established in pregnant women, nursing mothers, geriatric adults, or children less than 2 years of age'. It has not been studied whether or not the transmission rate is higher in susceptible individuals, for example to the very young, the very old or seriously sick.

5. ADVERSE REACTIONS ASSOCIATED WITH FLUENZ

The list of side effects and the probability of the very common ones (1 in 10 recipients) seems to beg the question is there a net benefit to the child or the school if attendance will inevitably suffer.

List of adverse reactions (10):
Adverse reaction frequencies are reported as:
Very common (≥ 1/10)
Common (≥ 1/100 to < 1/10)
Uncommon (≥ 1/1,000 to < 1/100)
Rare (≥ 1/10,000 to < 1/1,000)
Very rare (< 1/10,000)

• Immune system disorders
Uncommon: Hypersensitivity reactions (including facial oedema, urticaria and very rare anaphylactic reactions)
• Metabolism and nutrition disorders
Very common: Decreased appetite
• Nervous system disorders
Very common: Headache
• Respiratory, thoracic and mediastinal disorders
Very common: Nasal congestion/rhinorrhoea
Uncommon: Epistaxis
• Skin and subcutaneous tissue disorders
Uncommon: Rash
• Musculoskeletal and connective tissue disorders
Common: Myalgia
• General disorders and administration site conditions
Very common: Malaise
Common: Pyrexia

I have also managed to obtain a product analysis compiled by the MHRA (Medicines and Healthcare products Regulatory Agency), the UK's regulator of medicines, medical devices and blood components for transfusion. This 33-page document contains all the reactions post the vaccine administration from the beginning of its introduction dating October 2012 till March 2018.
Please email via The Informed Parent for full list of references.

"THERE DOES NOT EXIST ONE SINGLE FACT, IN ALL THE EXPERIMENTS AND IMPROVEMENTS MADE IN SCIENCE, WHICH CAN SUPPORT THE IDEA OF VACCINATION. A VACCINATED PEOPLE WILL ALWAYS BE A SICKLY PEOPLE, SHORT LIVED AND DEGENERATE."

~ Dr Alexander Wilder, MD from "Vaccination: A Medical Fallacy", editor of the New York Medical Tribune, 1879.

THE NON-POLIO ILLNESS THAT "LOOKS JUST LIKE POLIO"

BY LYN REDWOOD,
RN, MSN, PRESIDENT,
Children's Health Defense
October 16, 2018

OVER THE PAST FIVE YEARS, a rare and serious "polio-like" illness—called acute flaccid myelitis (AFM) or acute flaccid paralysis (AFP)—has been cropping up in "unusual" clusters around the U.S., mostly in children. AFM/AFP cases have also been reported in Europe, India and other countries. AFM targets one area of the spinal cord (the gray matter) and can cause permanent disability and sometimes death.

Public health experts view acute flaccid paralysis as "the most common clinical manifestation of paralytic poliomyelitis"—and when laboratory analysis points to poliovirus as the cause of those symptoms, that person is diagnosed with "polio." However, when there is no confirmed poliovirus involvement, health providers instead diagnose the condition as "AFM" or "AFP," even though the clinical picture is identical to polio. A Stanford neurologist admits that AFM "looks just like polio, but that term really freaks out the public-health people."

The current uptick in AFM cases in the U.S. seems to have begun around August 2014, with 362 cases confirmed by the Centers for Disease Control and Prevention (CDC) since that time. Sixteen states have reported dozens of cases in 2018 in infants and children, including Pennsylvania (3 cases), Minnesota and Washington (6 cases each), Illinois (9 cases) and Colorado (14 cases). Epidemiologists believe that the number of identified cases likely underestimates the number of actual cases. In 2014, a speaker asked several hundred pediatric neurologists attending a conference how many had seen a recent case of AFM: "About one-third raised their hands [and] dozens kept their hands up when asked if they had seen two, three, five or more [cases]." Given that the chances of AFM are ordinarily pegged to be "about one in a million," a CDC neuroepidemiologist pronounced this show of hands "remarkable"—but what is "remarkable" is that public health officials are studiously ignoring possible environmental triggers that include vaccination.

THE CHECKERED HISTORY OF "POLIO"

Poliovirus is an enterovirus—a virus that inhabits the gastrointestinal tract but is capable of traveling to the nervous system. From the CDC's blinkered perspective, only poliovirus is capable of causing the paralytic condition labeled "polio." However, early polio researchers (publishing not long after the introduction of the first polio vaccine) painted a different picture. In a study describing a 1958 polio outbreak in Michigan (published in the Journal of the American Medical Association or JAMA), the authors reported that "in a large number of paralytic as well as nonparalytic patients poliovirus was not the cause". The JAMA researchers also noted that their laboratory analyses had not only identified two different "immunological types of the poliovirus" but also other types of enteroviruses and "there were no obvious clinical differences" among them.

Dr. Suzanne Humphries, who cites the JAMA study, has observed that poliovirus existed as a "common" and "trivial" bowel inhabitant for millennia—not causing paralysis until the 20th century. Humphries suggests that dietary and environmental factors (including exposure to toxins such as arsenic, lead and DDT) as well as the advent of "invasive medical procedures" (such as "intramuscular injections of many types, including…vaccines") weakened 20th-century individuals' innate immunity and were capable of fostering the paralysis "uniformly attributed to poliovirus infections."

PREFERENTIAL FOCUS ON VIRAL EXPLANATIONS

Unlike the one-cause-one-outcome view of paralytic polio, the CDC and other contemporary researchers agree that AFP has a "broad array of potential etiologies." Some news reports have touched on the likely role of environmental toxins, but virtually all of the published research on AFM has stayed away from that possibility. Instead, researchers have been busy making the case that two non-polio enteroviruses—enterovirus D68 (EV-D68) and enterovirus A71 (EV-A71)—are primarily to blame, even though neither one has shown itself to be a consistent pathogen. Studies out of Colorado published in Lancet Infectious Diseases (2018) and the CDC's Morbidity and Mortality Weekly Report (2016) not only posit a link between the two enteroviruses and AFM but also describe other mysterious neurologic outcomes "of unknown etiology" that have appeared of late in Colorado children.

A perplexing aspect of EV-D68 (an enterovirus first identified in the 1960s) is that, like the millennia-old poliovirus, the genetically older strains of EV-D68 "had never been known to cause paralysis" before 2014, being primarily associated in otherwise healthy individuals with mild cold-like symptoms. Post-2014, researchers who isolated never-previously-encountered strains of EV-D68 from pediatric AFM cases speculated that "recent genetic virus evolution" might be responsible for EV-D68's sudden "neurovirulence."

THE CASE OF THE ORAL POLIO VACCINE

"Neurovirulence" is a term very familiar to those who have studied the occurrence of vaccine-associated poliomyelitis in countries that use the live oral poliovirus (OPV) vaccine. The OPV vaccine is acknowledged to be "genetically unstable" and capable of evolving "in the human intestine to regain the neurovirulence and replication characteristics of its parental wild-type strains." Studies in countries such as Ghana and China have identified vaccine-derived poliovirus in children with paralysis in regions with high OPV coverage—while labeling the children's illness AFP rather than polio. ›

Indian researchers recently described the relationship between rates of "non-polio acute flaccid paralysis" (NPAFP) and the country's practice of "pulse polio immunisation" (periodic OPV vaccination of all children under age five). The number of polio rounds "had a high correlation with the NPAFP rate," and the mortality rate in NPAFP patients was "twice the mortality rate for wild polio." When the researchers calculated "the number of paralyzed children each year which exceeded the expected numbers" for the period from 2000–2017, they found that there were "an additional 491,000 paralyzed children" above the expected number of 149,000. Given the strong association of non-polio paralysis "with the number of OPV doses delivered," the researchers intriguingly speculated that:

"…repeated doses of the live vaccine virus delivered to the intestine may colonize the gut and alter the viral microbiome of the intestine, and this can result in strain shifts of enteropathogens. It is possible that new neurotropic [i.e., preferentially attacking the nervous system] enteroviruses colonizing the gut may induce paralysis."

Avoiding the "P" word and the "V" word. The United States uses the inactivated poliovirus (IPV) vaccine, which does not colonize in the gut. IPV, therefore, cannot cause viral strains to shift in the manner hypothesized by the Indian researchers in connection with the OPV vaccine. However, there are many other reasons to suspect vaccine-related mechanisms of causation for AFM in the U.S., a primary one being that the scientific literature has documented paralysis as an adverse reaction to vaccination for decades! A 1950 report in The Lancet describing a poliomyelitis outbreak in Australia observed a relationship between paralytic polio and prior pertussis vaccination, and a "considerable increase in the severity of the paralysis in the last inoculated limbs of those children under three who received an injection…within thirty-five days of the onset of poliomyelitis." A survivor of the outbreak who learned of the Lancet paper discovered that the report had been buried due to "fears of a backlash against immunisation."

"Studies in animals have shown that aluminum-containing vaccines contribute to "a neurodegenerative process… of the gray matter of the spinal cord" and to "hindlimb paralysis" and other neuropathological changes."

In a recent eNewsletter, retired family physician Dr. Gary Kohls painstakingly outlines studies describing post-vaccination paralysis, several published quite recently (1998, 2003, 2013, 2014, 2016). He also quotes retired pediatrician Allan Cunningham, who discussed the well-known phenomenon of paralytic polio following intramuscular vaccination in a letter to The BMJ in 2015—and, apropos of AFM, stated, "If a polio-like virus is circulating in the U.S., the possibility of its provocation by one or more vaccines has to be considered." Cunningham explained: "It is taboo to suggest a role for vaccines, but some old-timers remember 'provocation poliomyelitis' [PP] or 'provocation paralysis'… following intramuscular injections, typically with vaccines. PP was most convincingly documented…during the 1949 British polio epidemic when the risk of paralytic polio was increased 20-fold among children who had received the DPT injection…. Similar observations were made…in New York City; their literature review cited suspected cases as far back as 1921."

A 2018 case report of a five-year-old AFP patient in Taiwan noted that the child "experienced sudden onset of acute flaccid paralysis (AFP) involving left arm after fever and respiratory symptoms for 3 days". However, the case report—and the many news stories about AFM—have all omitted any mention of the sick and deceased children's recent vaccinations.

A decade ago, Chinese virologists described the brain stem as a major target of infection with EV71 (one of the two enteroviruses suspected of causing polio-like paralysis), but they noted that prior research had not defined the enterovirus's "neurotransmission route." In their research with mice, these investigators found that intramuscular injection of EV71 "resulted in brain infection, flaccid paralysis, pulmonary dysfunction, and death of 7-day-old mice." The study, which compared intramuscular injection to oral administration of EV71, also observed that the mice were "remarkably more susceptible" to intramuscular versus oral inoculation. Building support for a "retrograde axonal transport theory," the researchers hypothesized that EV71 spreads "from muscle to [central nervous system] through neuronal pathways as well as the bloodstream at certain times during infection." Retrograde axonal transport could also explain how injections given at the time of an infection can create an opportunity for bacteria or viruses to enter into the brain.

Most IPV vaccines in the U.S. are aluminum-containing combination vaccines. French researchers have shown that aluminum particles in vaccines play a key role in another mysterious on-the-rise condition called macrophagic myofasciitis (MMF). The MMF researchers have stated that when "poorly biodegradable aluminum-coated particles [are] injected into muscle," they can subsequently "disseminate…throughout the body and slowly accumulate in [the] brain." Studies in animals have shown that aluminum-containing vaccines contribute to "a neurodegenerative process…of the gray matter of the spinal cord" and to "hindlimb paralysis" and other neuropathological changes.

"…instead of asking hard questions about post-vaccination paralysis, the pharmaceutical industry is developing more vaccines."

Disturbingly, AFM seems to display a unique pattern of weakness and a stubborn lack of response to standard treatments as compared with more "traditional" forms of spinal cord inflammation. In a 12-country study by European researchers of 29 cases of AFM, two of the 29 patients died and full recovery was "rare" in those who survived. Yet instead of asking

hard questions about post-vaccination paralysis, the pharmaceutical industry is developing more vaccines. Buttressed by a rushed consensus that EV-D68 and EV-A71 are the dangerous viruses du jour and "the principal causes of AFP," the industry has already developed an "effective" EV-A71 vaccine, while "an EV-D68 vaccine could be on the horizon." If the vaccines that children are already receiving are found to be playing a causal role in helping these enteroviruses to get into the brain or causing paralysis via other mechanisms, the pharmaceutical industry and public health officials might find themselves in a public relations quandary. Instead, therefore, we get linguistic games that go so far as to describe AFM as "polio-like" but dare not utter the word "polio" or "vaccine."

VACCINATION BOTH A THEORETICAL AND A PROVED CAUSE OF EPIDEMICS

FROM CHARLES HIGGINS, HORRORS OF VACCINATION (1920) PAGE 26

IN A PREVIOUS LETTER to the Secretary of War, dated October 14, 1918, I have pointed out the dangerous nature of vaccination, particularly during epidemics, and the hygienic importance of suspending all vaccination during our recent epidemic of influenza and pneumonia, and the further desirability of making all vaccination strictly free and voluntary. I also then called attention to the probability that the repeated and multiple vaccinations of millions of men, in this country and Europe, with various septicemic infections for the last two years, may have had some relation to this epidemic, which seems to have been more severe among the vaccinated men in the military camps and hospitals than among the rest of the population. And I would now like to repeat here some of the important facts which I have stated in said letter as to both the probable and the proved relation of vaccination to many deadly epidemics.

GRAVE NATURE OF RECENT EPIDEMIC OF INFLUENZA AND PNEUMONIA, AND POSSIBLE RELATION OF VACCINATION THERETO

From the rapidity, severity, and mortality of this disease, it would seem not to be a true influenza, as heretofore known, and as its worst cases are characterized by a rapid and fatal ending, with a few days' sickness, in malignant or septic pneumonia, with abscesses in the lungs, it seems more related to the very fatal "Pneumonic Plague? Which raged in Manchuria after the Japanese war. This suspicion is strengthened by the fact that the chief germ found in the fatal cases is the "streptococcus," which is found in the worst forms of "blood poisoning" or "septicaemia," and also in vaccination. Now, the act of ordinary vaccination, as already proved, is, in itself, an act of blood poisoning, pure and simple, and it is so classed in medical statistical works as a form of "septicaemia" or "pyaemia" and as this infecting process has been repeated at wholesale in the bodies of thousands and tens of thousands of men closely massed in camps, should it be any wonder if an epidemic of some sort of "septicaemia" should crop out at some time under such conditions?

"...this infecting process has been repeated at wholesale in the bodies of thousands and tens of thousands of men closely massed in camps, should it be any wonder if an epidemic of some sort of "septicaemia" should crop out at some time under such conditions?"

In leading medical and statistical works, both influenza and pneumonia and typhoid fever and vaccination are all classed as different forms of "septicaemia", and while I do not, of course, know, and do not say, that the recent epidemic of influenza and pneumonia was actually caused by vaccination, yet I repeat that when the body and blood of millions of men all over this country and Europe are deliberately impregnated with various septic diseases, or septicemic infections, can any reasonable person, whether doctor or layman, be surprised if such world-wide, and million times repeated, acts of septicemic infection should be ultimately proved to have some causative or conditional relation to the recent world-wide epidemic of septicemic disease?

Is it physically or medically possible to go on sowing and spreading some known and unknown septic diseases at wholesale, within human bodies, without reaping some big harvest of deadly septic diseases as a necessary consequence? In the words of Scripture, can we keep on "sowing" the "winds" of infection without ultimately "reaping" the "whirlwind" of epidemics?

TiP editor: Another article on this subject that is worth reading – Did a Vaccine Experiment on US Soldiers Cause the 'Spanish Flu'? by Kevin Barry, 7 Nov 2018. www.firstfreedoms.org.

IT IS HEALTH THAT IS REAL WEALTH AND NOT PIECES OF GOLD AND SILVER.

~ Mahatma Gandhi

ONE FLU OVER THE TOP

BY SUSAN MCFIE
Hastings Independent
www.hastingsindependentpress.co.uk/
19 October 2018

THE FLU SEASON IS BACK *along with annual vaccination campaigns. But controversy builds as the British Medical Journal (BMJ) questions if flu vaccines are effective and whether patients are given enough information to make an informed choice. In the light of past history Susan McFie asks who can we trust?*

It's that time of year. Waiting at the doctor's surgery you will doubtless be bombarded with cautionary tales of failing to get an annual flu jab. There's no escaping the message: local pharmacies, primary schools and supermarkets are in on the act. You may even be offered a complimentary balloon. People are falling over themselves to inject us, squirt us with nasal vaccines or prescribe anti-viral drugs. Is this necessary? Is it effective? Is it safe?

ASK YOUR DOCTOR

You might assume that medical professionals would be first to get the shots; not so. 45% of NHS staff in England and 60% in Scotland remain unvaccinated. Yet GP practices receive payments of around £10.00 per shot administered. Could the push to vaccinate be associated with these target payments? A BMJ report last October revealed that some GPs were effectively threatening patients! One surgery even withheld repeat prescriptions from people declining vaccines. But in some cases payments are vital, compensating for lacking funds.

If doctors had fewer financial concerns and more time to research, what might they discover? In last month's BMJ, editor Peter Doshi described how governments internationally have taken unsafe shortcuts getting flu vaccines marketed. He details how in Europe licenses were granted for products based on studies of entirely different vaccines containing different viruses. Other countries including the UK and the USA gave manufacturers indemnity from liability for vaccine injuries.

Doshi says the 2009 swine flu vaccines were 'even more controversial than normal'. Senior German physicians expressed concern over GlaxoSmithKline's Pandemrix vaccine, which contained a controversial 'adjuvant', a substance added in order to 'turbo-charge' immune response. Then it was discovered that top politicians and government employees were to receive a different vaccine, one without the suspect adjuvant! The European Medicines Agency stressed the 'Unpredictability of adjuvant effects in humans'.

SLEEPING SICKNESS

Doctors' fears appeared justified as health authorities from China, Sweden, France and Japan reported serious injury and death following the experimental Pandemrix vaccine. The most serious adverse effects were narcolepsy and cataplexy following injection. In narcolepsy the brain switches off, often without warning, while in cataplexy there is sudden loss of muscle function. Many also developed sleep apnea, paralysis, night terrors and hallucinations. By 2010 new cases were being diagnosed daily across Europe. Some doctors spoke of an epidemic. As a result the vaccine was withdrawn.

History reveals the swine flu vaccination campaign of 1976 was cut short when hundreds of people developed paralysing Guillain-Barré syndrome. Then in 2005 the UN and the World Health Organization warned that bird flu was imminent and would kill up to 150 million people. Images of the 1918 'Spanish flu' pandemic were used to reinforce the message. This resulted in global stockpiling of a new anti-viral drug called Tamiflu. The UK spent £473m on it; the US purchased 20 million doses at $100 dollars each.

BIRD FLU OFF, PIG FLU BACK IN

The panic diminished, the world breathed a collective sigh. Tamiflu began to slip from blockbuster status. But in 2009, just when we thought it was safe to visit the farmyard, the World Health Organisation warned that the world was once more in the midst of a swine flu pandemic. Just four months later the vaccines appeared. The US National Institutes of Health advised that the shots were safe. In the UK a joint statement from the Department of Health, British Medical Association, and Royal Colleges of General Practitioners announced full support for the vaccine program saying it had been 'thoroughly tested.' The problem was that it hadn't, and many people now live with the results.

RISK VERSUS BENEFIT

From a public health perspective vaccination is about risk versus benefit – the risk of catching a disease versus the risk of adverse events from the vaccine. Against this we need to know if the drug actually works. Pandemrix was given to 6 million people in the UK and 30 million people across Europe. Numbers of serious side-effects are difficult to ascertain: the Irish Times had to resort to the Freedom of Information Act to discover that swine flu vaccines in Ireland had resulted in almost 1,000 injury reports in 2009 alone, more than any other drug or vaccine over the previous five years.

Over 1,300 cases of narcolepsy were reported in UK and Europe following Pandemrix. Researchers in Finland found a 12 fold increase in narcolepsy in adults and British research identified 'at least' 14-fold increase in the condition in UK children given the vaccine. EU regulators were already investigating 12 conditions 'of special interest' associated with flu vaccines including anaphylaxis, Bell's palsy, auto-immune hepatitis, convulsions, Gullain-Barré Syndrome and sudden death.

NO BETTER THAN PARACETOMOL

But do the drugs even work? In 2012 Labour MP Paul Flynn described the 2009 flu vaccine campaign as 'one of the most expensive confidence tricks in history'. The campaign, he said, 'made billions for Big Pharma, frightened the world witless and wrecked the priorities

of health services worldwide. All for a mild illness that was less dangerous than seasonal flu.'

Flynn detailed how when 60% of Sweden's population was vaccinated (that's 5.4 million shots) just 6 lives were saved, and the flu death rate sat at 0.31 per 100,000. Poland, which hardly vaccinated anyone, had a flu death rate only marginally higher at 0.47 per 100,000. In the same period the UK had double Poland's rate of flu fatalities despite mass vaccination costing £1.2 billion.

Flu treatments also have major problems. In 2014 the global Cochrane Collaboration concluded that the anti-viral drug Tamiflu was no better than paracetamol and didn't stop the disease spreading or prevent dangerous complications, concluding 'there is no credible way these drugs could prevent a pandemic.'And Tamiflu has side effects. Oxford Professor of Evidence-Based Medicine Carl Heneghan, speaking to the BBC, said for every 10 million doses of Tamiflu, about 10,000 people report serious psychiatric events. Suicidal behaviour, hallucinations, seizures and delirium have been reported in young people in the UK and USA.

Hastings Independent Press spoke to Dr C. Benton, a US physician and formerly keen proponent of vaccination. In a meeting with a medical director at the Centre for Disease Control, Benton was told that there would never be a good flu vaccine because there are over 200 viruses causing flu and flu-like symptoms. Manufacturers have to guess a year ahead which ones might be circulating.

• Only around half of all NHS staff take flu vaccines. Two NHS Trusts reported a take-up of only around one fifth of staff. In Yorkshire just 18.4% of frontline ambulance crew chose to be vaccinated last year.

• Flu vaccines were not recommended for healthy children until 2000 but Flu Mist, a nasal spray, is now being administered in UK schools. The US Centre for Disease Control stopped recommending Flu Mist following a reported 97% failure rate in 2015/16.

• 43% of people studied by the journal Vaccine believed the flu shot could give you the flu. Manufacturers say it's a 'killed virus' and cannot cause flu. However many people develop so-called flu-like symptoms.

• Flu Mist spray is live containing 4 genetically modified flu viruses including Swine flu.
Experts say it causes a mild flu infection and may infect others for up to 3 weeks.

• The projected Bird flu and Swine flu pandemics never arrived. Neither virus passes easily to humans. But thousands experienced serious effects from vaccines and anti-viral drugs. Fortune magazine described Avian flu as 'very good news' for investors.

• Research suggests that vitamin D is more effective at preventing flu than vaccines, particularly in cases of deficiency.

SAFETY CONCERNS AROUND ALUMINIUM ADJUVANTS

BY PROF. CHRIS EXLEY,
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10 November 2018.
Hippocraticpost.com

IT IS APPROXIMATELY 10 years since we began our investigations into aluminium adjuvants and specifically their mode of action. We have reviewed the field in our new publication in Allergy, Asthma and Clinical Immunology and in particular in the light of what are known as serious adverse events immediately following vaccination. What might be the cause of such events, ranging from health issues directly associated with the injection site to brain encephalopathy and death? Arguably, they are unrelated to the vaccine antigen, the reason for the vaccine, and aluminium adjuvants, unsurprisingly are recognised as prime suspects in initiating these events. I say, unsurprisingly, since there is no requirement to demonstrate that aluminium adjuvants are safe for human use. There is no approval mechanism. Only vaccines are approved for human use. There are two commonly used aluminium adjuvants, Alhydrogel® and AdjuPhos®, and a sulphated version of the latter, which is included in Gardasil, a vaccine against the human papilloma virus (HPV). To my knowledge, to date Merck has not given permission for independent study of its proprietary adjuvant.
Merck's own safety'trial data suggest a frequency of adverse events for the vaccine of approximately 2.5% and similarly 2.5% for their 'placebo group' who received their proprietary adjuvant. So, even though 25000/1,000,000 perfectly healthy recipients become ill on receiving Gardasil it is safe since the same number become ill on only receiving the adjuvant alone. In a very small true control group where the placebo was reported as saline, there were zero (none) adverse events. This raises some serious questions about adjuvants themselves.
We know that aluminium adjuvants are toxic at the injection site, and this toxicity is essentially their mode of action, and evidence is burgeoning that this toxicity is also being manifested away from the injection site. New and important research on sheep and recently published in the journal Veterinary Pathology now provides direct evidence of the fate of aluminium adjuvants following sub-cutaneous injection. The research confirms the accumulation of aluminium adjuvant in lymph glands. However, it also shows that while lymph glands are a target destination for aluminium adjuvant for the whole vaccine this is not the case when only the aluminium adjuvant is injected. Essentially the handling by the body of aluminium adjuvant is different between whole vaccine and that which is mainly used as the control or placebo in vaccine safety trials. These seminal data for sheep raise new and important questions about how vaccine safety trials are conducted in humans and offer further insight into the role of aluminium adjuvants in serious adverse events following vaccination.

ACUTE ILLNESS & FEVER MANAGEMENT

BY Dr JAYNE LM DONEGAN,
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INTRODUCTION

JUST A COUPLE OF DECADES ago our parents and grandparents considered these diseases part of normal childhood, to the extent that they used to send their children – and I was one of them – to mumps, measles, rubella and chicken pox parties in the holidays, so they could 'catch' the disease in the holidays, and not miss any time off school! (this was a real form of 'child abuse' in my eyes). The school we would be missing in those days was nursery or primary school, not secondary school or university as in so many vaccinated people today. Parents have become understandably worried about their ability to manage these childhood illnesses due to the alarmist information they are given about complications and death. Information that does not include, for example, that measles is a killer in countries where people drink sewage; suffer from malnutrition; live in damp, under-ventilated, overcrowded housing, in the street or in refugee camps; may be orphans or their parents might be suffering from HIV. Or that in developed countries, when children die, it is from the complications of such disease which are in every case invasive, not the normal course of the disease. Invasive disease occurs when the normal action of the body to externalise the disease is blocked, most particularly by the suppression of the fever, even though the National UK Guidelines no longer recommend doing this. Childhood diseases do not strengthen the population by killing off the weak ones. A well-managed childhood fever makes that individual child stronger and healthier. The World Health Organization states that giving Vitamin A to children with measles reduces death by 50% in developing countries.

Conventional medicine bases its management of infection on:

The Germ Theory of Disease as promulgated by the French chemist Louis Pasteur; When you meet the microorganism, you become infected

DR Jayne L.M.Donegan

unless:

• You met the disease before, survived it, and have antibodies or

• You have been vaccinated and have antibodies that way.

However, we know this is not the case as, on a bus where someone has this year's 'flu, not everybody gets it, even though it is new each year, that's why we have new vaccines every year. Not everybody gets 'flu because not everybody needs to get 'flu.

In my experience: children get infectious diseases because they need to have a clean out, learn what to do with their immune system, and go up a developmental step.

Adults get them because they are exhausted, and if they could go to bed for a couple of days in advance, they would not have needed to get ill (try telling that to your boss!)

What actually happens when you meet a micro-organism is that there are seven possible outcomes:

1. You do not become infected at all.
2. You have a subclinical infection i.e you have no symptoms of disease, but develop antibodies to the organism.
3. You have a mild form.
4. A moderate form.
5. A severe form.
6. You become disabled or
7. You die

Which one of the seven you get depends on:

• The state of your immune system when you meet it and

• How you treat the illness.

Whatever the state of your immune system, you get complications from not treating infectious diseases correctly.

The first step in this process is to recognise that the infection is not your enemy but your friend. From an holistic point of view, diseases causing fever, loss of appetite, diarrhoea and vomiting and rashes are encountered as detoxifying processes, enabling the body to clean itself out.

In the short term, suppression of these processes leads to complications, which mean, invasive disease: ear infections, pneumonia, nephritis, meningitis, encephalitis, septicaemia and in some cases, failure to clear the organism. In the long term, suppression leads to chronic disease.

The most important part in this process is fever. There is a substantial body of medical evidence indicating that fever is a beneficial response to infection and improves the ability of the immune system to carry out its function, and that reducing fevers can increase morbidity (complications) and mortality (death) in severe infection.

As Heinz Eichenwald, Professor of Paediatrics at the South Western Medical School, University of Texas, states in the Bulletin of the World Health Organization [(1)]: "Fever represents a universal, ancient, and usually beneficial response to infection, and its suppression under most circumstances has few, if any demonstrable benefits. On the other hand, some harmful effects have been shown to occur as a result of suppressing fever. It is clear, therefore, that the widespread use of antipyretics should not be encouraged either in developing countries or in industrial society."

Antipyretics are anti-fever agents (Greek piros – fever): paracetamol (acetaminophen) and ibuprofen, and previously aspirin but this is no longer recommended in children under the age of 12 years due to its association with Reye's disease.

The UK National Guidelines (National Institute for Clinical and Healthcare Excellence) state: 'Antipyretics do not prevent febrile convulsions and should not be used specifically for this purpose.' 'Give paracetamol/ ibuprofen to children with fever for distress. Only for as long as there is distress. Do not give both together but consider giving the other if distress returns before next

dose of the first drug is due.' [2]

'Do not use ibuprofen/ NSAIDS (non steroidal anti-inflammatory drugs) in chicken pox because this has been associated with severe skin reactions.' [3]

Holistic practitioners have been teaching people about the importance of allowing your body to have its fevers and not to interfere with the eliminative processes for centuries. The evidence that fever reduction worsens the outcome of infectious diseases has been published in the medical literature for decades.

Now that NICE have eventually caught up, regarding fever, has this made any difference to the advice from doctors? Sadly, it seems not. Parents all over the country are sent away with prescriptions for paracetamol and ibuprofen instead of advice on how to nurse their child. Parents with a child in hospital for observation after a febrile convulsion have been threatened with being referred to social services or having a Court Order taken out against them because they do not consent to their children having ibuprofen or paracetamol when their child has a fever but is otherwise well: drinking or breast feeding, lots nice wet nappies, wet mucous membranes, alert, a nice pink colour, responding normally to social cues and having no breathing or other problems.

Have these medical professionals not read the guidelines:

'Antipyretics do not prevent febrile convulsions and should not be used specifically for this purpose.' One consultant paediatrician on being presented with the guidelines, rather than appreciating the rationale for the parents behaviour became even more intransigent and threatening (see past issue of The Informed Parent).

In 2018, the Oxford Vaccine Group's, Vaccine Knowledge Project which says it gives 'Authoritative Information for All' lists diarrhoea as a serious complication of measles. Diarrhoea is a normal part of the eliminative process focusing on the bowel. The Oxford Vaccine Group also state, in the UK,

"Around one in every 15 children with measles will develop more serious complications." They certainly will when they are treated with the 'Standard Medical Management', which in the UK is no longer the standard.

THE BASIC MANAGEMENT OF CHILDHOOD DISEASE

The most important thing to remember is: that it doesn't matter what the organism or name of the disease is, the management is the same for all of them.

This is obvious, when you think about it. It often takes some time for you to diagnose, if you ever do, which particular childhood illness your child is demonstrating. So you need to treat what you see, what your child is showing you, at the time they are showing you, not wait for them to be in some condition or state in the future when everything will become clear with the benefit of hindsight.

TAKING THE TEMPERATURE

It is extremely important that you look at your child, not the numbers, as the numbers can lead you astray. You may become over-alarmed by a 'high' temperature when your child is drinking, sleeping, has lots of wet nappies, wet mouth, tears, responds normally to seeing or hearing you. On the other hand, you may not follow your instincts about a floppy, pale weak child with a mewling cry who has a minimally raised, normal or even low temperature, not wanting to be judged as an 'over anxious parent'. You may not seek help. And that child has meningitis and is too weak to produce a fever.

How to most usefully take your child's temperature is with the back of you hand on the back of their neck. That tells you if they have a fever or they don't. If they have a fever, go to the next step.

INITIAL MANAGEMENT OF ALL CHILDHOOD FEVERS

The NICE Traffic Light

This is a tool for assessing complications formulated for health professionals. It is a very useful guide for parents. The only thing you cannot do is measure the blood pressure, and you do not need to (I do not recommend measuring the temperature either, except as above). If you are worried about your child, assess them looking at each section and decide whether they are in the green, OK, amber, be a bit worried, red, be already in hospital section. It is useful for you as a parent and even more, if you have to access medical help, that you will be able to describe your concerns to the doctors in their own language/algorithms so they will take what you report more seriously. [4] Print it with your best ink and put it on the fridge along with the General Measures and Simple Homeopathic Treatment information.

	Green – low risk	Amber – intermediate risk	Red – high risk
Colour (of skin, lips or tongue)	• Normal colour	• Pallor reported by parent/carer	• Pale/mottled/ashen/blue
Activity	• Responds normally to social cues • Content/smiles • Stays awake or awakens quickly • Strong normal cry/not crying	• Not responding normally to social cues • No smile • Wakes only with prolonged stimulation • Decreased activity	• No response to social cues • Appears ill to a healthcare professional • Does not wake or if roused does not stay awake • Weak, high-pitched or continuous cry
Respiratory		• Nasal flaring • Tachypnoea: RR > 50 breaths/minute, age 6–12 months RR > 40 breaths/minute, age > 12 months • Oxygen saturation ≤ 95% in air • Crackles in the chest	• Grunting • Tachypnoea: RR > 60 breaths/minute • Moderate or severe chest indrawing
Circulation and hydration	• Normal skin and eyes • Moist mucous membranes	• Tachycardia: > 160 beats/minute, age < 1 year > 150 beats/minute, age 1–2 years > 140 beats/minute, age 2–5 years • CRT ≥ 3 seconds • Dry mucous membranes • Poor feeding in infants • Reduced urine output	• Reduced skin turgor
Other	• None of the amber or red symptoms or signs	• Age 3–6 months, temperature ≥ 39°C • Fever for ≥ 5 days • Rigors • Swelling of a limb or joint • Non-weight bearing limb/not using an extremity	• Age < 3 months, temperature ≥ 38°C • Non-blanching rash • Bulging fontanelle • Neck stiffness • Status epilepticus • Focal neurological signs • Focal seizures

NICE Traffic Light

Treating a child without giving them medicines to suppress their symptoms does not mean doing nothing, it means you are supporting the body's processes of elimination by making sure that there is plenty of fresh air and fluids. This will

allow the liver, the major detoxifier, the kidneys and lungs to work efficiently.

A child's ability to regulate their temperature is immature. If the room is hot, the child cannot radiate their excess heat into their surroundings. It is important, therefore, that the temperature in the room is low enough to provide a temperature gradient to allow this to happen. While this elimination is occurring, it makes sense not to fill the child with food that they then need to process. Much of the 'picture' that we see on a screen has to be filled in by our cognitive processes as comparatively little information is supplied with visual electronic media. It can therefore be very tiring to watch TV or computer screens. Reading and studying are also tiring and are best avoided when ill.

VITAMIN D

Vitamin D is essential to the correct functioning of your child's immune and other systems. Every one can get it from safe sunshine although everyone spends so much of their time indoors these days it is hard. They can get it from butter, eggs, fatty fish, cheese and cod liver oil – fermented or cold pressed. If you do not eat animals or their products, then better you have a good quality synthetic form for babies, children and adults.

GENERAL MEASURES FOR MANAGING ACUTE FEVER

• **Fresh air** – open the window, during mild weather, lie outside if possible. At night, make sure that the window is open even if only a little in the winter.

• **No dairy produce** – no milk (including soya) yoghurt, cheese, eggs until well on the mend. Dairy increases mucus, upsets stomachs and may increase fever

• **Plenty of clear fluids** – for example, water with Rescue Remedy, half diluted apple juice. Ginger (fresh root grated or chopped, one god pinch), honey* (2 tsp) & lemon (¼ squeezed) in a mug of boiling water, stir & sip hot. This may be a made in quantity, sieved, cooled and used as a fluid replacement in cases of diarrhoea and vomiting. Ginger helps to sweat the fever OUT unlike paracetamol and ibuprofen which reduce fever but push it IN, often making the illness last longer. See NICE Guidelines below.

If squash, make sure it contains no aspartame or saccharin. No orange juice. Fluids are best taken frequently, small frequent sips are more useful than occasional large gulps , especially if there is vomiting.

• **No food unless hungry** – this is VERY important.

Do not force your child to eat if they are not hungry. When any fever is down, and they are hungry have light food – starch, minimal fat chew it well, for example:

• peeled sliced apple.

• wholemeal toast scraped with Marmite or honey

• mashed potato made with cooked potato, boiling water and a pinch of salt,

• vegetable soup, or stock home made, hot tomato juice with a squeeze of lemon +/- a little Tabasco (for adults and older children)

• fruit or cooked vegetables all in very small quantities

• **Honey*** on a teaspoon is very good for sore throats and stops harmful bacteria from multiplying. [*Government Health Warning: not for infants less than 1-year of age]

• **REST** – this is extremely important most adults only get infectious diseases because they are tired and need a rest – f they had a rest first, they probably wouldn't get the infection.

• **Loose clothing** – made of soft, natural fibres.

• **No TV**/ computer/ books/ tablets – Listening is OK, so radio is OK, no ipods plugged into ears.

• **Room temperature** – between 15ºC and 18ºC

• **No meat**, fish, fatty food or dairy until two days after better; up to a week if after diarrhoea and vomiting. If dairy or normal diet is introduced and symptoms start again, especially after diarrhoea and vomiting, go back to fasting or light diet until symptom free.

SIMPLE HOMOEOPATHIC TREATMENT OF ACUTE FEVER

1**. Acute fever previously COMPLETELY well.** (may have come on after cold north east wind)
ACONITE 30c
- one dose every 15 minutes for up to three doses.

2. Acute fever previously COMPLETELY well + red (may have dilated pupils, heat with dry skin)
BELLADONNA 30c in ADDITION to **ACONITE 30c**
- one dose every 15 minutes for up to three doses.

3. Acute fever previously NOT completely well (may have been whiney with mucus and clingy)
PULSATILLA 30c
- one dose every 15 minutes for up to three doses.

ONE DOSE = one globule, or, if tablets, crush one tablet between two teaspoons, put powder into eg an egg cup. To give the dose, lick your finger tip, dip into powder, put powder on your child's tongue.

You may wish to give the dose in liquid form. In this case, put the powder into a 500mls bottle of mineral water, add a drop of rescue remedy, replace the lid tightly, bang the bottle hard twice on a firm surface to potentise the water, then give a sip, teaspoon or a few drops as a dose.

For lingering symptoms or recurrent fevers, it may help to consult a homoeopath or other holistic practitioner who can asses your child and treat them constitutionally.

TO FINISH IT ALL OFF

SULPHUR 30c three doses 12 hours apart can be useful when the illness seems to have ended but your child continues with low grade, lingering remnants that they don't seem to be able to shake off.

Homeopathic guide for dosing

The more intense the symptoms, the smaller the interval between between doses for example, for fever, as above, give one dose every 15 minutes, up to three times per episode.

What is an episode? If your child is hot and uncomfortable, give a dose.

If your child then appears to be more comfortable, drinks or falls into peaceful sleep, stop. You may only need one dose. If they later appear restless or uncomfortable, start again with your 3 doses, but do not just keep giving doses if there is no improvement. The remedies for fever are NOT to bring down the fever. If the fever goes down it is because the remedy has reduced the need for it by helping support the body in its externalis-

ing disease process by another way.

For the **disease specifics**, depending on the intensity of the symptoms on which you are basing the choice of remedy, the remedy may need to be given hourly, 2-8 hourly or daily.

But always keep three dose maximum. Let the remedy work and then reassess. 'Less is more.'

It is not possible to overemphasise that the most important part of the management of your child's fever are the GENERAL MEASURES.

You often do not need to do anything else. Naturopaths get very good results by simply opening the window, putting the child to bed, starving them and giving them plenty of clean pure water. Parents contact me distraught that their child is not improving despite all the remedies they are giving them. Then I find out, on questioning, that the window is closed, the room temperature is 22 and they can, "Only get them to eat yoghurt….."

Or parents message me telling me how worried they are about the temperature. To which I always answer: "Don't look at the temperature. - **Look at your child not the numbers.** That's what we need to know." (Most of the methods used for measuring temperatures in children are inaccurate anyway). I use homeopathic remedies for fever as I have seen children feel more comfortable, more able to drink and to sleep peacefully after taking them. Sleep is the great healer.

General Measures +/- Homeopathic Fever Treatment are THE BASICS

NOSODES - What are they?

Nosodes are homoeopathically potentised preparations of part or parts of the disease process. They are energetic preparations designed to stimulate the vital force of the individual and support the innate healing power of the body when it encounters the microorganisms from which it has been made. In potencies above 12c, no molecules of the original substance remain. Nosodes differ from vaccination, the name applied generally to the process of introducing into the body, by injection or orally or nasally in drop or spray form, a substance of the nature of dead or attenuated living infectious material and other ingredients, like aluminium salts and formaldehyde, with the object of increasing the body's power to resist or moderate disease.

Nosodes are neither vaccination nor a substitute for vaccination. In my paediatric practice I use the nosode in the 30c potency in two ways.

1. If the disease is circulating in your locality, you can give one dose 12 hourly for three doses.

One dose 12 hourly x3 – morning, evening & the next morning.

Some people do this because they would like to try to stop their child getting the disease. I do it because children have many fewer chances to encounter these organisms or disease states circulating normally these days so the body is not 'familiar' with them, so to speak. Unlike in the past. My rationale for giving what is called a 'split single dose' of the nosode is to 'introduce' it to the body so when the body comes across it again in their environment they will not be strangers. If meeting the organism provokes your child to get the disease it is because your child needs to go up that developmental step.

2. If you think your child actually has the disease, then you give the nosode three times in one day.

One dose 6-8 hourly x3 – morning, afternoon, evening.

And then treat your child as you would otherwise – the BASICS +/- the specifics as you see fit. Some homeopaths would argue that nosode use should be restricted to the end of the disease process if it is not resolving or in the case of what homeopaths call the never well since scenario. I agree that this may have been the case decades ago when the organisms or disease states were circulating normally and at a time when a child is designed to meet them. However, nowadays when this is not the case, I find that an introduction, as in 1. above, helps stimulate the body's vital force to move the case along in a satisfactory way.

INVASIVE vs NON-INVASIVE DISEASE

Crucial to understanding the interplay between bacteria, viruses, fungi and ourselves is understanding the difference between the invasive and the **normal/ non-invasive** form of a disease. No-one dies or becomes disabled due to the normal course of an infectious disease. They die or become disabled from the complications of an infectious disease and these are all **invasive**. The normal course of an acute childhood infection is: FEVER to speed up the chemical reactions in the body, LOSS of APPETITE – no point filling yourself up with more chemicals that need processing when you are trying to clean yourself out, perhaps DIARRHOEA and VOMITING and/ or a RASH. These are all pushing out or externalising processes. Fever is the fast way, lasting a few days, mucus production is the slow way and may take weeks or months.

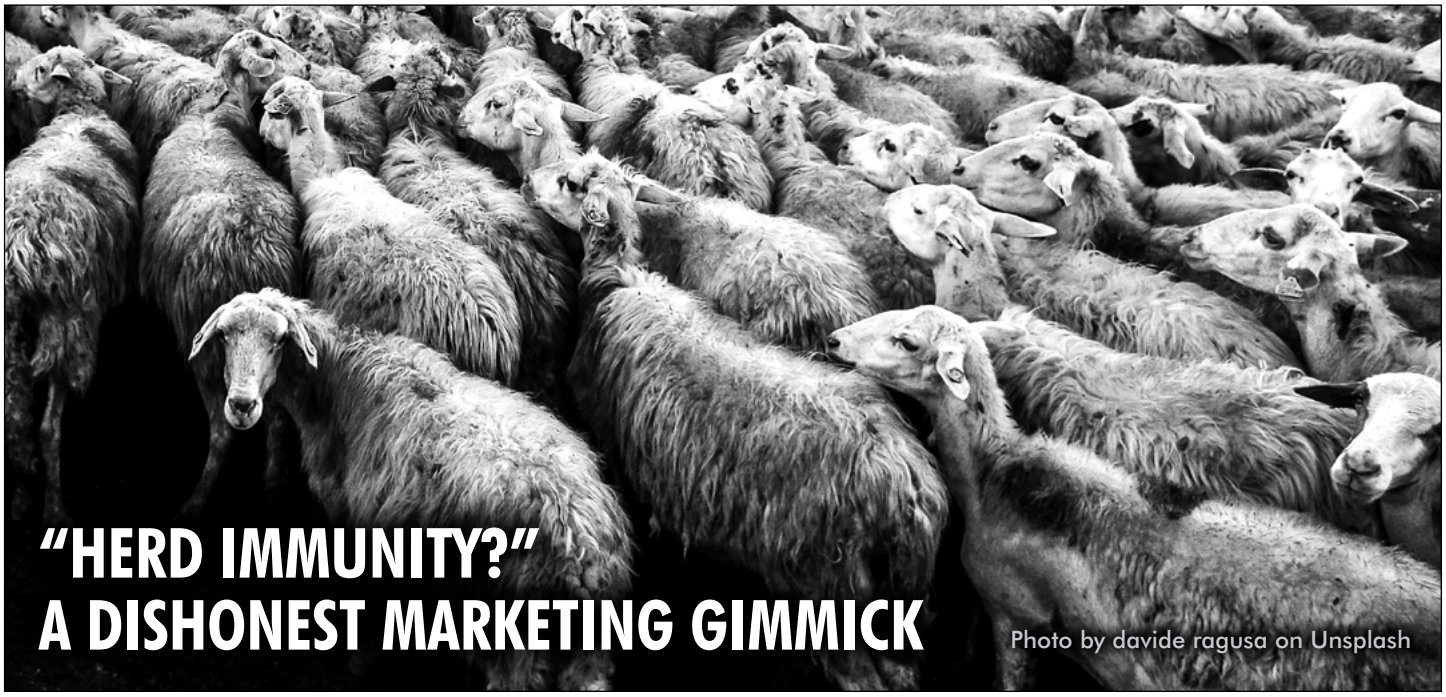
A QUICK RECAP - To manage childhood fevers in a nut shell:

Open the window, put your child to bed, don't feed them unless they are starving and give them lots of pure, clean water to drink. The opposite of this externalising process is suppression. Suppress the fever with paracetamol & ibuprofen; dry up the cough with antihistamines and adrenaline like compounds; take non indicated antibiotics – which wipe out the nice bugs and leave the nasty ones to overgrow; keep the window closed; stuff them up with food - especially formula, cow or soya milk - when they are not hungry and you push the process in: into the ears causing ear infections, into the lungs causing pneumonia, into the kidney causing nephritis, into the brain causing meningitis or encephalitis, or into the blood stream causing septicaemia, which is worse. These are all forms of **invasive** disease.

There are no 'killer' bugs or 'nightmare' strains.

All bacteria and viruses are potentially pathogenic and capable of causing **invasive** disease. It is as easy to die from diseases for which there are vaccines as it is to die from diseases for which there are no vaccines. It all hinges on your general level of health when you meet the organism and crucially, how you treat fevers – suppressively or supportively. Do you help the body to externalise disease, or do your suppress all the symptoms and cause invasive disease?

Please email via The Informed Parent for full list of references.



"HERD IMMUNITY?" A DISHONEST MARKETING GIMMICK

Photo by davide ragusa on Unsplash

BY J.B. HANDLEY
June 8, 2018
https://jbhandleyblog.com/home/2018/6/7/herd-immunity-a-dishonest-marketing-gimmick

WASHINGTON, District of Columbia—Hiding in a non-descript office building in Washington, D.C., Every Child By Two ("ECBT") poses as a nonprofit organization with a seemingly noble goal: getting as many children vaccinated as possible. Of course, a quick Google search or perusal of the nonprofit's 990 forms reveals a different truth: ECBT is a front group for vaccine makers, the primary source of their funding. Don't take my word for it, the prestigious British Medical Journal ran an expose of many groups like Every Child By Two titled, "The unofficial vaccine educators: are CDC funded non-profits sufficiently independent?"

The BMJ was pretty unsparing:

IAC, ECBT, and AAP have a few things in common. They are all non-profit organizations with large online presences that promote themselves as sources of reliable information on vaccines. They also receive funding from both vaccine manufacturers and the Centers for Disease Control and Prevention. And, in their advocacy for compulsory vaccination, they all have in common a goal that pushes beyond official governmental policy and, in the case of influenza vaccines, the evidence.

Amy Pisani, ECBT's director, maintains a twitter account for the organization where she recently encouraged parents to do their part in maintaining "community immunity" through an infographic that was part gentle reminder, part guilt-induced obligation, and 100% founded on nonsense.

WHAT, EXACTLY, IS "COMMUNITY IMMUNITY"?

"Community Immunity" is the term du jour and an apparently more palatable synonym for the oft-invoked concept of Herd Immunity, the idea that unless enough people are vaccinated against a certain disease, everyone is at risk. Find the right doctor to come on TV, and they'll be happy to explain the magic of vaccine-derived Herd Immunity, and what a scientific process it really is, according to them. Fall below Ms Pisani's 95% vaccination rate number in her infographic? We return to the Dark Ages!

There's just one problem with the Community/Herd Immunity math and the shaming and pressure that goes along with it: we've never come close to achieving "Herd Immunity" through vaccination, and we never will. In order for Herd Immunity to be a real thing, you need two things to be true (and neither have ever been):

1. Adult vaccination rates would also have to be very high, just like rates for children

Ms. Pisani's infographic above mentions the 95% threshold needed to achieve herd immunity for measles, but she fails to mention one thing: the vaccination rate of all the adults. According to the CDC, adult vaccination rates have been, and remain, woefully low, as the CDC's 2016 survey-- Vaccination Coverage Among Adults in the United States, National Health Interview Survey-- explained:

"Many adults in the United States have not received recommended vaccinations..."

HOW LOW ARE ADULT VACCINATION RATES?

According to the CDC, it appears that adult vaccination rates for most vaccines ARE BELOW 50%. But, wait a minute, how do we achieve "community immunity" if less than half the adults are playing along? We don't, as some simple 8th grade math can show you.

Let's make some assumptions. Let's assume the child (18 and under) vaccination rate is 100%. It's not, so this is a conservative assumption. Also, let's assume the overall adult vaccination rate is 60%. It's not that high, so this is also a conservative figure. If we blend those two numbers, what do we get? Well, children 18 and under represent 24% of the US. Population, so here you go:

(24% x 100%) + (76% x 60%) = 69.6%

So, the actual "community" vaccination rate in this example is 69.6%

(the children's rate plus the adult rate equals the total rate), and this is probably a high figure, so the real number in the United States right now is probably somewhere around 65%. Nowhere near Herd Immunity thresholds.

But, it's actually worse, you also need to believe that:

2. Vaccinations provide lifetime protection. The mid-60 percent "community" vaccination rate above is enough to mathematically disprove that we've ever attained herd immunity all by itself, but it's actually way worse than that. You see, vaccinations don't confer lifetime immunity. In fact, many vaccines "wane" (meaning you lose the protection they provided you with) in under ten years. An eighteen year-old who received their last Hepatitis B vaccine at 4 years old? They probably have no more "protection" from the Hepatitis B vaccine. The "real" rate of vaccine protection in our society? Because of vaccine waning, it's certainly well below 50%, just look at the "Duration of Protection" provided by some routine vaccines:

The last vaccine I received was my senior year of college, in 1991. That was twenty-six years ago. And, I NEVER received many of the new vaccines on the childhood schedule that have all been introduced in the past 10-15 years. It's safe to say that I have no vaccine-derived immunity from any disease right now, which raises an obvious question: If it's mathematically true that we have never achieved herd immunity through vaccination because of adult vaccination rates and the fact that vaccines wane over time, where are all the epidemics?

I'm not the first person to ask this question. It gets asked all the time by educated people who understand this topic and bristle at the ongoing discussions about herd immunity that take place in the mainstream media. One of the better articles I have read on this topic was in the The Hill, the daily newspaper of the U.S. Congress: 'If only half of America is vaccinated, where are the epidemics?' written by Gretchen DuBeau, the Executive Director of the Alliance for Natural Health. Ms. DuBeau destroys the myth of herd immunity in one short editorial, here's just an excerpt:

'Vaccines may have a place in our medical arsenal, but they are not the silver bullet they're portrayed to be. Year after year the pharmaceutical industry, looking for lucrative new profit centers, churns out new vaccines. They use pseudo-science to convince the public that these products are safe and effective, and they use public shaming to convince the citizenry that non-compliance is a public health threat. This entire racket completely falls apart with a close examination of the herd immunity myth. Until we are honest in our assessment of both the safety and efficacy of vaccines, kids will continue to be hurt, rights will continue to be trampled, and mythology will continue to trump science.

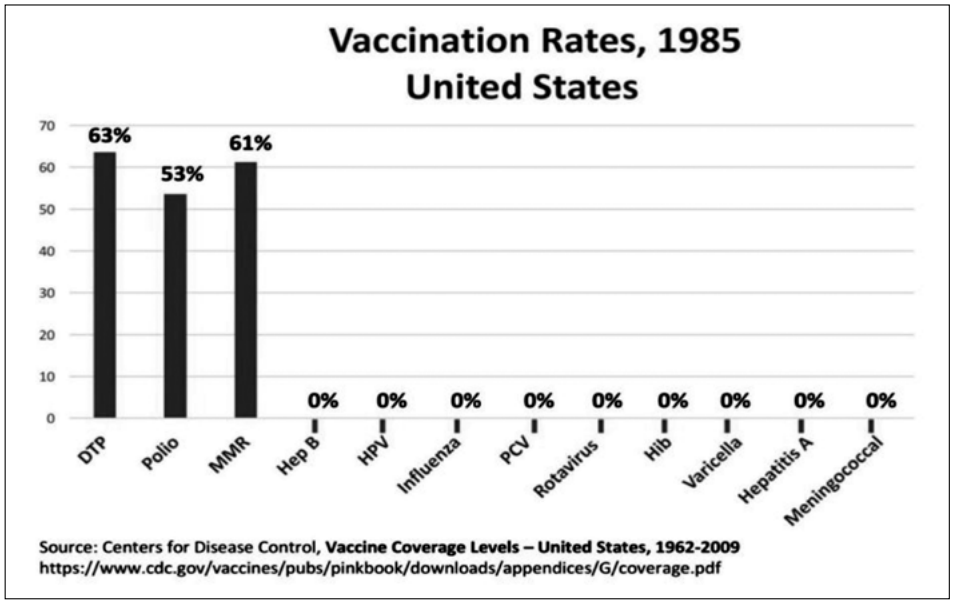
"What this means is that at least half the population, that is the baby boomers, have had no vaccine-induced immunity against any of these diseases for which they had been vaccinated very early in life."

Ms. DuBeau's article quotes a doctor, Russell Blaylock, M.D., who has also been an outspoken critic of the herd immunity mythology, he writes:

That vaccine-induced herd immunity is mostly myth can be proven quite simply. When I was in medical school, we were taught that all of the childhood vaccines lasted a lifetime. This thinking existed for over 70 years. It was not until relatively recently that it was discovered that most of these vaccines lost their effectiveness 2 to 10 years after being given. What this means is that at least half the population, that is the baby boomers, have had no vaccine-induced immunity against any of these diseases for which they had been vaccinated very early in life. In essence, at least 50% or more of the population was unprotected for decades. If we listen to present-day wisdom, we are all at risk of resurgent massive epidemics should the vaccination rate fall below 95%. Yet, we have all lived for at least 30 to 40 years with 50% or less of the population having vaccine protection. That is, herd immunity has not existed in this country for many decades and no resurgent epidemics have occurred. Vaccine-induced herd immunity is a lie used to frighten doctors, public-health officials, other medical personnel, and the public into accepting vaccinations.' The school-specific vaccination rate argument is really absurd. I live in Oregon. Like many states, our state publishes vaccination rates by school. If your child attends a school with "low" vaccination rates, the message is that it's a time bomb waiting to explode! But, wait a minute. What's the vaccination rates of the teachers in that school? No one knows. What's the vaccination rate of the administrators? No one knows. What's the vaccination rate of the parent volunteers, the janitors, the delivery people, and the parents who walk inside the school every day to pick up their children? That's right: no one knows. And yet, we're encouraged by the media to panic.

HISTORY

Perhaps you're still confused. Yes, my math seems pretty airtight and direct. Ms. DuBeau's article seems to support my argument, as does Dr. Blaylock. But could all these people screaming about the importance of herd immunity really be that far off base? What if I told you that banging the table about the importance of herd immunity is actually a very recent development, and one instigated by vaccine makers? What if our own history of vaccines and vaccination rates disproved the herd immunity myth all by itself? Let's go back to the 1980s right here in the U.S. and see what the data says. Vaccination Rates: 1985 (see chart on p26). No one can believe this chart when they first see it. They demand to see my data source. I got it from the CDC. We only gave three vaccines in 1985. These are vaccination rates for children in the United States in 1985. Does anything stand out to you? Yes, nine of the vaccinations we routinely give to children today didn't exist in 1985. Yes, vaccination rates for the three vaccines we did give were dramatically below the "herd immunity" threshold that experts today like Ms. Pisani (who is funded by vaccine makers) tells us we need to hit. Well...where were all the epidemics? Feel free to Google "polio epidemic, United States, 1985." I was alive in 1985. I was a sophomore in High School. No one was having a panic attack. No one was screaming herd immunity, or community immunity. Do I need to keep going?



FINAL THOUGHTS

I've kept the arguments here very simple. I've just done some simple math and showed you some data from the mid-1980s. Herd immunity is an interesting theory, but it's a myth that we've ever achieved it through vaccination. I could have gone down a few more levels. I could have asked why anyone should worry about vaccination rates if they themselves have been vaccinated? In turns out, the failure rate is probably way higher for vaccines than we think, way higher than even the numbers I quoted you above. Dr. Blaylock addresses this:

In the original description of herd immunity, the protection to the population at large occurred only if people contracted the infections naturally. The reason for this is that naturally-acquired immunity lasts for a lifetime. The vaccine proponents quickly latched onto this concept and applied it to vaccine-induced immunity. But, there was one major problem – vaccine-induced immunity lasted for only a relatively short period, from 2 to 10 years at most, and then this applies only to humoral immunity. This is why they began, silently, to suggest boosters for most vaccines, even the common childhood infections such as chickenpox, measles, mumps, and rubella.

It actually gets even more confusing. As one simple example, it turns out the pertussis vaccine (whooping cough) doesn't keep you from carrying and spreading the disease. Why do we always read about whooping cough outbreaks? Boston University researchers explain:

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

Like I said, the story is quite a bit uglier than just basic math. Did you know there are employees of one vaccine maker--Merck--who filed a whistleblower lawsuit arguing that the company hid data that showed the mumps vaccine was losing efficacy: The suit charges that Merck knew its measles, mumps, rubella (MMR) vaccine was less effective than the purported 95% level, and it alleges that senior management was aware and also oversaw testing that concealed the actual effectiveness. According to the lawsuit, Merck began a sham testing program in the late 1990's to hide the declining efficacy of the vaccine. The objective of the fraudulent trials was to "report efficacy of 95% or higher regardless of the vaccine's true efficacy."

I could also share with you some other data from the CDC, some data that destroys the myth that vaccines saved us all from infectious disease. I could quote CDC scientists from a study published in Pediatrics in 2000 who said this: "Thus vaccination does not account for the impressive declines in mortality seen in the first half of the century...nearly 90% of the decline in infectious disease mortality among US children occurred before 1940, when few antibiotics or vaccines were available." I could keep going, but I won't. Herd immunity is a myth. It's a bully club planted in the media by vaccine makers to scare parents into vaccinating in order to "protect" others. The math doesn't add up, and never has. The next time you hear someone invoke the importance of herd immunity, send them this article and ask them to refute it! And, ask yourself a question: "If they're lying about herd immunity, what else might they be lying about?" Can't get enough information about the myth of herd immunity? Here's some other articles and links.

Do high rates of vaccination make us safe? Let's talk about herd immunity. TruthSnitch

Community Immunity? (From Informed Choice WA)

Herd Immunity: Fact or Fiction? By Dr. Kelly Brogan

HERD IMMUNITY: CAN MASS VACCINATION ACHIEVE IT? By Tetyana Obukhanych, PhD

There is no Herd Immunity By The Outliers

Let's talk about herd immunity By Levi Quakenboss

Immunologist Tetyana Obukhanych: Unvaccinated Children Pose "No Extra Danger to the Public"

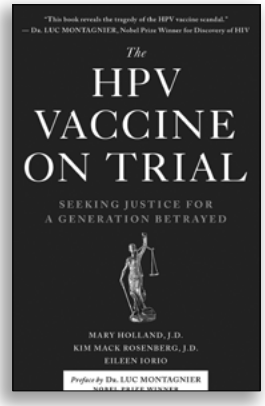
Great video from Dr. Suzanne Humphries (only 6 minutes long):

Dr Humphries - Herd Immunity: A False Sense of Security

ABOUT THE AUTHOR:

J.B. Handley is the proud father of a child with Autism. He and his wife co-founded Generation Rescue, a national autism charity, in 2005. He spent his career in the private equity industry and received his undergraduate degree with honors from Stanford University in 1991. His first book, How to End the Autism Epidemic, will be published in September 2018 by Chelsea Green Publishing and is available for pre-order on Amazon. He is also the author of "A lone FDA scientist could end the autism epidemic." and International scientists have found autism's cause. What will Americans do?

BOOK NEWS: THE HPV VACCINE ON TRIAL - Seeking Justice for a Generation Betrayed



THIS BOOK PAINTS a devastating picture of corporate and government conflicts of interest, negligence, and malfeasance in approving and promoting human papillomavirus (HPV) vaccines, touted to prevent cervical and other cancers. Coming out on the heels of recent New York Times revelations about astounding financial conflicts of interest at Memorial Sloan-Kettering Cancer Center, this groundbreaking book highlights the lack of transparency, manipulated science, and abuse of state power to market this medical juggernaut, already raking in over $2.5 billion per year. Authors Holland, Rosenberg, and Iorio conclude:

• HPV vaccines have never been proven to prevent cancer of any kind.
• No participants in the original HPV clinical trials received true saline placebos.
• The clinical trials never investigated the vaccine's possible effects on human fertility or potential to cause cancer.
• The clinical trials show that the vaccines contribute to HPV lesions, and potentially cancer, in some women. Despite this, neither the manufacturers nor government agencies recommend prescreening to eliminate those with clear risk factors.
• Although the vaccine is targeted for 11-12-year-old children, only a small fraction of clinical trial subjects was in this age range.
• Lawsuits against HPV vaccine manufacturers and government health agencies are progressing around the world, including the US, India, Japan, Colombia, Spain, and France.
• The US government earns millions in royalties from Merck and GSK, the vaccine manufacturers, for its role in the invention of HPV vaccine technology.
• Although the US government proclaims HPV vaccines safe and effective, it has paid out millions of dollars to compensate families for death, brain injury, multiple sclerosis, ulcerative colitis, and other severe, debilitating conditions.

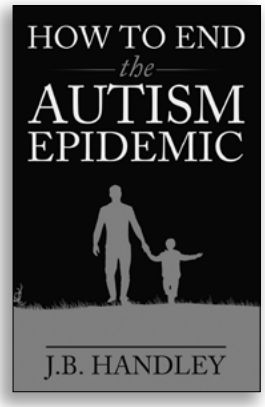
With praise from some of the world's leading scientists on aluminum, autoimmunity, and vaccines, this book fills a critical void, giving people information they need to make commonsense decisions about this vaccine. Written in plain language, The HPV Vaccine on Trial ultimately is about how industry, government, and medical authorities may be putting children in harm's way.

ABOUT THE AUTHORS

Mary Holland, M.A., J.D., is on the faculty at NYU School of Law, directs its Graduate Lawyering Program, and lives in New York City. Kim Mack Rosenberg, J.D., is a lawyer in private practice and lives in New York City. Eileen Iorio has practiced in the financial and health fields and lives outside New York City.

HOW TO END THE AUTISM EPIDEMIC: by J B Handley - Another highly informative and highly recommended read!

ONE BOOK REVIEW of Handley's book by Bernadette Pajer (co-president of Informed Choice WA a Washington based organisation) states: As a reader, and professionally as a published author, I have written many book reviews. Never have I written one so personal. I'm 55 years old. When I was growing up in the 1960's, 70's, and even early '80's (I graduated high school in 1981), I didn't know anyone with food allergies. I vaguely recall hearing about asthma, but no one I knew personally had it. I didn't know anyone with autism, ADHD, or any of the many chronic immunological or neurological conditions children have today. The most common lunch in my era was a peanut butter and jelly sandwich washed down with a carton of milk. That lunch would put my son in the hospital. I didn't know anyone, or of anyone, who died of or were harmed by any infection now targeted by vaccines. I, and my classmates had been given a couple shots in our toddlerhood, and that's it. There were no school mandates for vaccination, no talk of a need for them. My favourite sitcoms, like The Brady Bunch, used common childhood illnesses as plot devices. But all that has changed. Perceptions of infection, of history, of vaccines, has dramatically changed since the 1986 National Childhood Vaccine Injury Act was passed, removing liability not only from vaccine makers but from those who administer them, setting in motion the most successful, most highly funded, global marketing campaign in history . . . and the corporate capture of our public health agencies. Everyone is in partnership to push vaccines in this dangerous 'regulatory vacuum' as Justices Sotomayor and Ginsberg described it in 2011, in which nobody is responsible to see that current science is included in vaccine design, administration, and policies. But now we have JB Handley's book. His brilliant, honest, highly-cited book that rips away the marketing veil away and reveals the truth about autism, and what we need to do to stop the epidemic. This is the most important book to be published in my lifetime. JB didn't write this book to profit from it (he's donating all profits to organizations dedicated to healing those with autism), he wrote it to educate, to awaken, and to inspire. I hope everyone reads this book and ensures their doctors, friends, family, elected officials, and those in public health read it, too. Bernadette Pajer, ICWA, https://informedchoicewa.com/



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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