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

'UNETHICAL' CLINICAL TRIALS OF VACCINES POSE THREAT TO HUMAN LIVES

BY JACOB PULIYEL
https://www.sundayguardianlive.com/news/unethical-clinical-trials-vaccines-pose-threat-human-lives
11 November 2019

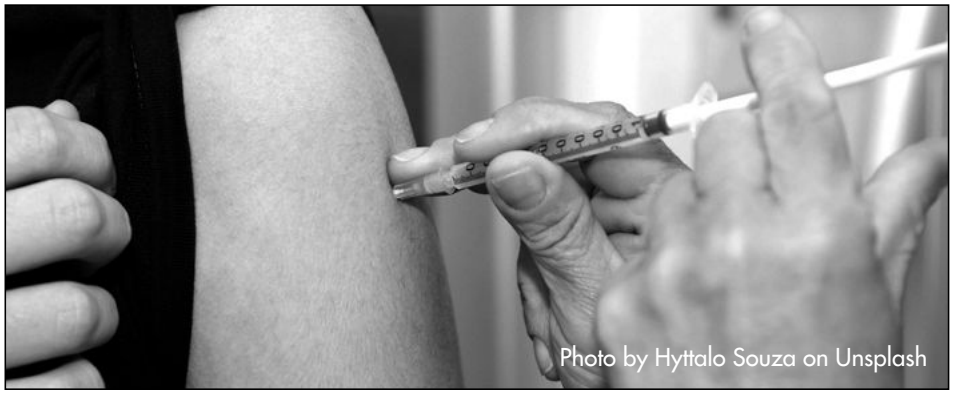


Photo by Hyttalo Souza on Unsplash

PRIMUM NON NOCERE—"first, do no harm"—is a basic tenet of medical ethics. That is about to change in India. "Controlled Human Infection Method" (CHIM) studies are planned to be introduced here. Humans are to be deliberately infected with diseases to test the efficiency of experimental vaccines. It will provide a shortcut to vaccine licencing and reduce costs to manufacturers.

At Hotel Taj Palace, from 19 -21 November, under the rubric of the "World Conference on access to medicinal products", the ICMR and the DBT plan to introduce CHIM studies. According to the Economic Times, even vaccine manufacturers are advising caution before allowing such a radical departure from standard practice.

The Translational Health Science and Technology Institute (THSTI), under the DBT, is spearheading the efforts under the banner of a mysterious "India Volunteer Infection Research Consortium". Dr Y.K. Gupta, principal advisor, THSTI, has said that "initially, such studies should only be allowed in high-quality academic institutions… Similarly, at least initially, only healthy, educated adults should be included in a CHIM study". The promoters are clear that such concessions are needed only initially.

So, the "initial" studies are to be done on drug-responsive malaria, typhoid and flu (which is self-limiting). It is claimed that CHIM volunteers are to be infected with a weakened strain of the pathogen. However according to biologics development consultant Dr K.B. Walker "a safe, well characterised strain will lose some semblance to the real "challenge" organism and so weaken the relevance of CHIM in informing further clinical development". This defeats the main objective of doing such studies.

Also, what is the use of doing studies on easily treated disease? The real need is for vaccines against dangerous diseases like Ebola. After the initial human revulsion against CHIM has been overcome, we can expect trials with Ebola infection and similar plagues. After the "initial" stages, we can expect these studies will not be limited to academic institutions and contract research organisations (CROs) will do these studies more efficiently. This is a slippery slope. Once the Rubicon is crossed, there may be no coming back.

The country remembers what happened when the government tried to encourage the inflow of foreign exchange for clinical trials from abroad with tax cuts and relaxing local laws. The cost of doing clinical trials in India was half of what it cost in other countries in the West, even counting kickbacks to local doctors. There was a spurt in such trials. However, lax governmental regulation had to be tightened after 1,725 deaths among trial participants were reported. Justice R.M. Lodha commented about these trials saying, "human beings are being treated like animals".

Writing in Business Standard, a group of ethicists and legal experts have raised a number of questions about these CHIM that need to be answered. Who are the industry collaborators? Who are the funders? Who will own patents obtained through CHIM? Will there be disclosure about the incentive paid to volunteers? Will there be an open registry of adverse events and results?

In a country, where adverse events during a government-funded rotavirus trial are yet to be disclosed despite repeated appeals going up to the Supreme Court, open disclosures regarding CHIM trials seems very unlikely. The poor in India are known to enter studies not for altruism, but for healthcare, better healthcare services for themselves—or for money. Even in developed countries, participants are known to join multiple trials for the high payments, despite the discomfort and the risks posed by repeated infections, according to the article in Business Standard.

The Alliance for Human Research Protection (AHRP) is presided over by Vera Sharav, a survivor from Hitler's holocaust. The AHRP has called the proposed studies on human volunteers in India, "a vaccine experiment atrocity".

CHIM studies cannot be done in countries like India where research regulation is poor and research transparency is non-existent. One must prevent exploitation of the public by vested interests.

Jacob Puliyel is a paediatrician. The opinions expressed are his own.


Magda Taylor

Editor's note

SINCE THE LAST EDITION *in the summer an onslaught of vaccine propaganda from officialdom has continued. The Daily Mail, in early October, launched a campaign to encourage parents to inoculate, calling for the NHS to introduce an alert system to remind busy parents to take their children to be vaccinated. Since then the Mail, Telegraph and Times have been on the attack of some who question vaccination. Articles with headlines such as 'Antivax GP shows how to avoid jabs', 'Homeopaths warning mothers not to have children vaccinated, investigation reveals' and 'NHS leaders have gone to war on homeopathy by attempting to have the practice blacklisted amid fears it is fuelling anti-vax propaganda,' featured in these mainstream newspapers.*

Even the BMJ published 'Homeopathy should have professional accreditation revoked, NHS leaders urge' (29/10/19; https://www.bmj.com/content/367/bmj.l6248). The article comments that some practitioners are spreading misinformation about vaccines. A letter sent to the Professional Standards Authority by Simon Stevens, CEO of NHS England and Stephen Powis, National medical director, expressed 'serious concerns about the possible reaccreditation of the Society of Homeopaths given the 'spread of misinformation about vaccine safety'.

I submitted a response to the BMJ article however it was not selected for publication. This was my response:

Simon Stevens and Stephen Powis need to address the 'serious concerns' by more and more people worldwide about the vaccine science, vaccine injuries and vaccine deaths. The public have been given 'a false impression' that vaccines have been clinically and scientifically established for far too long. The theories behind vaccination remain fundamentally flawed and as Alfred R Wallace stated in 1898, when there was only the smallpox vaccine:

'And all these horrors on account of what Dr. Creighton has well termed a "grotesque superstition," which has never had a rational foundation either of physiological doctrine or carefully tested observations, and is now found to be disproved by a century's dearly bought experience. This disgrace of our much–vaunted scientific age has been throughout supported by concealment of facts telling against it, by misrepresentation, and by untruths.'

And so it continues over a century later except that now we have an ever-increasing vaccine schedule and at that same time we are witnessing an ever-increasing number of children and young adults with an array of mental health disorders, ASD, allergies, juvenile diabetes, autoimmune disorders and so on.

What is going on with our health?
Sadly homeopaths are now being targeted with such fury, and I see that the present method being employed is to link them in with the vaccination issue. Stevens should be grateful that some practitioners are trying to help those who have been affected by vaccination as the NHS are not interested and just turn parents away dismissing their experiences as a coincidence.

More and more people are turning to other health practitioners, such as homeopaths, osteopaths, chiropractors etc and are very happy with the results. These methods focus on HEALTH, strengthening the constitution, looking at the whole body and listening and learning about the patient in a much more thorough way than you will receive with your GP. One minute homeopaths are being accused of giving sugar pills that are just placebos, the next minute they are being accused of using potentially harmful therapies? And why would, for example, the Royal family use homeopathy when they can have access to any form of treatment they wish? I am deeply concerned and saddened by the direction Stevens et al are moving our NHS towards. Limiting our choices and trying to de-regulate any other form of therapy is a disgrace. It would not surprise me if privatization is next on their 'to do' list.'

I would urge you to respond to articles, especially the BMJ as they do publish some responses by those concerned about vaccination unlike mainstream media.

Other recent BMJ articles you can look up are: David Robert Grimes: Vaccines—how can we counter misinformation online?

New power versus old: to beat antivaccination campaigners we need to learn from them—an essay by Kathryn Perera, Henry Timms, and Jeremy Heimans.

Reading other responses may be useful and inspire you to submit a comment. Your response may act as a trigger to others, even medical professionals, to start questioning the subject.

Due to being ostracised or worse by the medical establishment most medical doctors prefer to keep a low profile if they become doubtful about the proclaimed benefits of vaccination. However Dr Malcolm Kendrick, who describes himself as a Scottish doctor, author, speaker and sceptic, has raised his head above the parapet and recently voiced concerns about the science behind vaccination. He was one of the speakers at an International Conference on Informed Consent held in Tel Aviv, Israel on 21 November 2019. Dr Kendrick highlighted the uncertainties surrounding theoretical concepts like herd immunity, lack of research on safety and efficacy, rate of adverse effects, and called for more debate and open discussion.

Other speakers included Dr Jayne Donegan (UK), Mary Holland, Kim Mack Rosenberg and Del Bigtree (US) and Dr Loretta Bolgan from Corvelva (Italy). Videos of the conference are online on The HighWire with Del Bigtree.

What will 2020 bring? Let's hope that as more cracks appear on this procedure an informed and united public will emerge to challenge the so-called settled science and bring about positive changes for our future health.

Magdalene Taylor, Editor, December 2019

FLU VACCINE SELECTIONS SUGGEST THIS YEAR'S SHOT MAY BE OFF THE MARK

BY HELEN BRANSWELL
STAT on September 30, 2019
https://www.scientificamerican.com/

THE STRAINS CHOSEN for the Southern Hemisphere vaccine suggest the Northern Hemisphere one may not provide optimal protection

It's never an easy business to predict which flu viruses will make people sick the following winter. And there's reason to believe two of the four choices made last winter for this upcoming season's vaccine could be off the mark.

Twice a year influenza experts meet at the World Health Organization to pore over surveillance data provided by countries around the world to try to predict which strains are becoming the most dominant. The Northern Hemisphere strain selection meeting is held in late February; the Southern Hemisphere meeting occurs in late September. The selections that officials made last week for the next Southern Hemisphere vaccine suggest that two of four viruses in the Northern Hemisphere vaccine that doctors and pharmacies are now pressing people to get may not be optimally protective this winter. Those two are influenza A/H3N2 and the influenza B/Victoria virus.

The strain selection committee concluded the H3N2 and B/Victoria viruses needed to be updated because the ones used in the Northern Hemisphere vaccine didn't match the strains of those viruses that are now dominant. Influenza epidemiologist Dr. Danuta Skowronski described the significance of those two changes in one word: "mismatch."

"I think the vaccine strain selections by the WHO committee are obviously important for the Southern Hemisphere but they're also signals to us because they're basing their decisions on what they see current predominating on the global level," said Skowronski, who is with the British Columbia Center for Disease Control in Vancouver.

Flu vaccine is a four-in-one or a three-in-one shot that protects against both influenza A viruses—H3N2 and H1N1—and either both or one of the influenza B viruses, B/Victoria and B/Yamagata. Most flu vaccine is made with killed viruses, and most vaccine used in the United States is quadrivalent—four-in-one.

There was great uncertainty around which version of H3N2 to choose for the Northern Hemisphere vaccine when the committee met last February—there was a lot of variation between the strain the U.S. was seeing and the H3N2 viruses sickening people in Canada and Europe. There was so much uncertainty, in fact, that the committee delayed making the choice of the H3N2 strain for a month to try to get a clearer picture. In the end, the committee selected a version of the virus that was causing a wave of late season illness in the United States. (Canada also had a late season surge of H3N2 activity, but caused by a different version of the virus.)

"That H3N2 wave was late and it was evolving at the time that they met in February," Skowronski said of the strain selection committee. "And there was a diverse mix of H3 viruses. And it wasn't clear to them, I guess, [which strain] … would emerge the clear winner."

It appears the virus that was ultimately selected is not the H3N2 that dominated during the Southern Hemisphere's winter 2019 season. Scott Hensley, an associate professor of microbiology at the University of Pennsylvania, said the variant of H3N2 viruses that just swept through the Southern Hemisphere is more likely to be the main cause of H3N2 infections for the Northern Hemisphere this winter than was the case in the U.S. late last winter and into the early spring.

But that version of H3N2 is difficult to grow in eggs, which is the way the vast majority of flu vaccines is made, he noted, suggesting that fact may have influenced the thinking

In recent years the H3N2 component has generally been the least effective part of the vaccine. If H3N2 viruses predominate this coming flu season, a vaccine mismatch could add to the severity of the season. But if those viruses play a smaller role this winter, the impact of a mismatch will be less significant, making it hard to predict if this choice is going to turn out to be a problem. **Flu circulation "remains difficult to predict and flu viruses are constantly breaking rules that we try to establish for them,"** (***TIP emphasis in bold***). Hensley said, adding that flu vaccines "often protect against severe disease even when … mismatched."

The selection of a new B/Victoria virus for the Southern Hemisphere 2020 shot also concerns Skowronski. There was almost no influenza B activity in the 2018-2019 flu season and it's been several years since B/Victoria viruses have caused much illness. As a result, there may not be a lot of immunity to those viruses in the population, she said. B/Victoria flu viruses are especially hard on children, Skowronski said.

Given the possibility that a couple of the components of the vaccine might not be well-matched to circulating flu viruses, Skowronski said it will be important for doctors to realize vaccinated patients may still contract influenza. For those who are at high risk of developing severe illness, rapid treatment with flu antiviral drugs should be considered. She also suggested older people or people who have underlying health problems—in other words, those who are likely to develop a severe case of flu if they contract the virus—should take steps to avoid being around sick people. The sliver of good news: The officials meeting at the WHO last week concluded that the H1N1 and the flu B/Yamagata components of the Southern Hemisphere vaccine didn't need to change, suggesting they are representative of the strains of those viruses we're likely to encounter this winter.

TiP Editor: As usual lots of uncertainties.'Flu viruses especially hard on children'?? Growing up in the 60s I never heard of any concerns about children developing flu?

ORAL POLIO VACCINE CAUSING PARALYSIS IN KIDS: STUDY

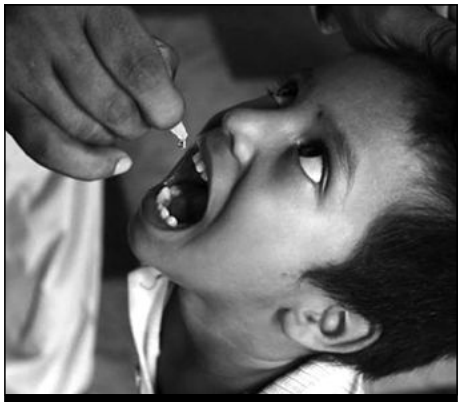
EXPERT CALLS FOR REVIEW OF INDIA'S ORAL POLIO VACCINATION PROGRAMME, BUT HEALTH MINISTRY OFFICIALS SAY OPV BENEFITS FAR OUTWEIGH THE RISKS

BY SUMI SUKANYA DUTTA
Express News Service
Published: 23rd October 2019
https://www.newindianexpress.com/

NEW DELHI: At least 400 children in India would have developed polio after receiving the oral polio vaccine (OPV) over the past five years, a top Indian paediatrician has revealed in a just published scientific paper that questions the ethics of the continued use of OPV.

T Jacob John, who has earlier advised the World Health Organisation and the Indian government on polio eradication policies, has described the continued use of OPV as an "ethical anomaly" that is causing avoidable polio to children. India has been free from wild polio virus since 2011, but the Ministry of Health and Family Welfare has never released data on vaccine associated polio paralysis (VAPP), a rare adverse effect of OPV that causes infantile paralysis. All children under 6 in the country have been receiving multiple doses of OPV — that contain live polio viruses — since 1994, through pulse polio programme while the government also launched injectable polio virus schedule for children in 2015.

John challenged the current policy saying the government has continued



Pic: EPA WIRES

"For the sake of convenience, ethical issues have been ignored by several poor countries like India; the existing programme needs to be reviewed."

with OPV because "it's easy and commercially more viable". "For the sake of convenience, ethical issues have been ignored by several poor countries like India; the existing programme needs to be reviewed," added John, an emeritus professor at Christian Medical College, Vellore. He has published the analysis jointly with Mumbai-based paediatrician Dhanya Dharmpalan in the Indian Journal of Ethical Issues. John has pointed out that in nearly 40 countries, governments had long stopped OPV due to risk of polio associated with it.

In the OPV given to children worldwide, Type 2 vaccine viruses was withdrawn from use in 2016; it continues to contain Type 1 and 3 strains of viruses that can cause VAPP. Children in India are given two intradermal fractional doses of IPV at 14 weeks and 6 years in lieu of the recommended one full dose intramuscular IPV at 14 weeks.

The paper has highlighted that in last five years, globally, cases of polio caused by vaccine viruses have outnumbered those of polio caused by wild polio viruses.

Top officials in the health ministry, however, said the benefits attached with OPV far outweighed the risks. "We have relied on OPV because of the results it has shown in last 25 years in eradicating wild polio," said an official. "Moreover, we have following WHO guidelines on polio eradication programme and do not have the technical expertise to go beyond its recommendation."

Another official said unless neighbouring countries like Pakistan and Afghanistan stopped reporting cases of wild polio, it would be difficult to withdraw OPV from India.

MEASLES-RUBELLA VACCINATION: PARENTS TO SUE HEALTH MINISTRY

KAMPALA, UGANDA
THE INDEPENDENT
19 Oct 2019
https://www.independent.co.ug/

PARENTS OF TWO CHILDREN from Greenhill Academy are suing the Ministry of Health for illegally vaccinating their children during the on-going mass vaccination campaign that is immunizing children against Polio, Measles and Rubella-MMR.

According to a notice to sue that was delivered to both Green Hill Academy and the Ministry of Health by the two parents of pupils identified as Allan Mulindwa and Annet Damba through their lawyers Mulindwa Associates & CO Advocates, the Health ministry is accused of forcefully immunizing the two children without getting consent from their parents.

The two children are identified as Kelly Mirembe Mulindwa and Amber Ruth Mulindwa.

The immunization exercise took place at the school on October 17, 2019. The delegation that carried out the immunization exercise was led by the Minister of Health, Dr. Ruth Aceng who was present as her daughter was also being immunised.

The parents are going to seek legal redress for their children being immunised without consent from their parents. The letter goes ahead to state the people who carried out the immunization exercise ignored pleas from the two children who informed them that their parents refused them to get immunised because they were already immunised.

AUTOANTIBODIES AGAINST AUTONOMIC NERVE RECEPTORS IN ADOLESCENT JAPANESE GIRLS AFTER IMMUNIZATION WITH HUMAN PAPILLOMAVIRUS VACCINE

IKEDA, HINENO, SCHEIBENBOGEN ET AL. ANNALS OF ARTHRITIS AND CLINICAL RHEUMATOLOGY; 2019

Volume 2, Issue 2, Article 1014,

10 Sep 2019.

ABSTRACT

In Japan a significant number of adolescent girls complain of unusual symptoms after Human Papillomavirus (HPV) vaccination, and these symptoms, composed of orthostatic dysregulation, Chronic Regional Pain Syndrome (CRPS) and cognitive dysfunction are considered adverse effects of HPV vaccination.

However, a causal link between HPV vaccination and these adverse effects has not been demonstrated. In the present study, we investigated autoantibodies against diverse G-protein coupled receptors in the serum of girls who complained of possible adverse effects after HPV vaccination.

Fifty five girls with HPV vaccination and 57 girls without HPV immunization were enrolled in the study. e serum levels of autoantibodies against the adrenergic receptors α1, α2, β1and β2, muscarinic acetylcholine receptors 1, 2, 3, 4, 5; and endothelin receptor A was significantly elevated in girls with HPV vaccination, compared with those in the controls. The serum levels of these autoantibodies tended to decrease with the time course of the illness, but there was no statistically meaningful association between the clinical symptoms and elevated serum levels of these autoantibodies.

This preliminary study provides evidence that post-vaccination abnormal autoimmunity plays an important role in the development of unique symptoms after HPV vaccination. *(TiP emphasis).*

INFECTIOUS VACCINE-DERIVED RUBELLA VIRUSES EMERGE, PERSIST, AND EVOLVE IN CUTANEOUS GRANULOMAS OF CHILDREN WITH PRIMARY IMMUNODEFICIENCIES

PLOS PATHOG. 2019 OCT 28;15(10):E1008080. DOI: 10.1371/JOURNAL.PPAT.1008080. [EPUB AHEAD OF PRINT]

PERELYGINA L1, CHEN MH1, SUP-PIAH S1, ADEBAYO A1, ABERNATHY E1, DORSEY M2, BERCOVITCH L3, PARIS K4, WHITE KP5, KROL A5, DHOSSCHE J5, TORSHIN IY6, SAINI N7, KLIMCZAK LJ8, GORDENIN DA7, ZHARKIKH A9, PLOTKIN S10, SULLIVAN KE11, ICENOGLE J1.

ABSTRACT

Rubella viruses (RV) have been found in an association with granulomas in children with primary immune deficiencies (PID). Here, we report the recovery and characterization of infectious immunodeficiency-related vaccine-derived rubella viruses (iVDRV) from diagnostic skin biopsies of four patients. Sequence evolution within PID hosts was studied by comparison of the complete genomic sequences of the iVDRVs with the genome of the vaccine virus RA27/3. The degree of divergence of each iVDRV correlated with the duration of persistence indicating continuous intrahost evolution. The evolution rates for synonymous and nonsynonymous substitutions were estimated to be 5.7 x 10-3 subs/site/year and 8.9 x 10-4 subs/site/year, respectively. Mutational spectra and signatures indicated a major role for APOBEC cytidine deaminases and a secondary role for ADAR adenosine deaminases in generating diversity of iVDRVs. The distributions of mutations across the genes and 3D hotspots for amino acid substitutions in the E1 glycoprotein identified regions that may be under positive selective pressure. Quasispecies diversity was higher in granulomas than in recovered infectious iVDRVs. Growth properties of iVDRVs were assessed in WI-38 fibroblast cultures. None of the iVDRV isolates showed complete reversion to wild type phenotype but the replicative and persistence characteristics of iVDRVs were different from those of the RA27/3 vaccine strain, making predictions of iVDRV transmissibility and teratogenicity difficult. However, detection of iVDRV RNA in nasopharyngeal specimen and poor neutralization of some iVDRV strains by sera from vaccinated persons suggests possible public health risks associated with iVDRV carriers. Detection of IgM antibody to RV in sera of two out of three patients may be a marker of virus persistence, potentially useful for identifying patients with iVDRV before development of lesions. Studies of the evolutionary dynamics of iVDRV during persistence will contribute to development of infection control strategies and antiviral therapies.

MENINGOCOCCAL SEROGROUP B DISEASE IN VACCINATED CHILDREN

J Pediatric Infect Dis Soc. 2019 Oct 21

PMID: 31634404

CONCLUSIONS

We present 4 children who developed MenB-associated IMD (invasive meningococcal disease) despite previous vaccination with 4CMenB.

In 2 cases, the antibodies induced by 4CMenB likely were not effective against the isolated strains.

A high level of suspicion for IMD seems advisable regardless of the patient's vaccination history.

The Quanten Theory www.pqliar.net

FOCUS ON HEALTH by Patrick Quanten MD

WHEN YOU GROW UP in a system that is obsessed with avoiding illness as a way of staying healthy it is no wonder we are becoming more and more frightened. As the medical profession, our experts and pool of knowledge, shows us more and more things that may make us ill, we feel the noose tightening around our necks. There isn't much that seems a safe bet anymore. Nothing left that will guarantee our good health. We need to exercise, and then we hear about young fit and sporty adults that just drop dead.

We need to eat healthily, and then they tell us that new information has emerged to highlight concerns with the things they had previously advised us were safe. Health advice twists and turns every few years and seems to fold back unto itself after the passing of time. Regular radiographic breast screening for the random population was stopped all together because of clear signs it was creating more cancers. Years later, when we have all forgotten about it, it is brought back as the absolute lifesaver.

Fear of becoming ill rules our life. The continual search for the right remedy and the perfect prevention occupies our thought processes. Panic occurs when we no longer know what is right and what is wrong, what to do and what not to do. Experts are constantly contradicting one another, but luckily only the right information is being released to the public by the authorities. This in itself is a wonderful statement from a free society, proud of the freedom of speech. Yes, we are free to think what we want and free to speak about it. As long as nobody hears us!

By now, we should have understood that it is impossible to maintain health, to prevent illness, by focusing on details, by trying to measure life to a pre-set standard, introduced by human beings 'in the know'. Time is proving to us constantly that keeping your blood cholesterol level to the set standard does not prevent any heart and circulation diseases, nor does keeping your blood pressure under control. Eating healthy food does not ensure me a disease-free life. Protecting myself against the sun rays does not protect me from getting skin cancer. Indeed, it very much looks like the said protection is actually causing skin cancer. Vaccination does not prevent infectious diseases. In general, protection and prevention don't seem to have the predicted effect of guaranteeing my health. Why would this be?

Patrick Quanten MD

"Health is your balance in life. How easy is it to live your life, to get through the day, to perform the tasks you need to complete? When you are in balance your life flows and hits very few obstacles."

From human history and taking into account how other people, other than the Western civilisation, both present and past have described disease and have defined health, it should be immediately clear that health is not dependent upon small details of life. Health is being described as maintaining a balance in life. Not just a balance in the blood sugar level or the hormone cycle, but in life. Life means all aspects in life, large and small. And every aspect has an influence on that balance. Disease occurs when life gets out of balance. Restoring the balance then becomes the prime objective of life itself. It has a built-in restoration mechanism, a natural healing process, which automatically gets activated when a serious imbalance occurs. When you have been burning a lot of energy and there has been too little time for the system to clean up the resulting waste that is left behind after the energy has been burned, you may get a fever, a sore throat and 'the flu'. You don't feel so well. You want to lie down, close your eyes, not think about anything, stay home from work, and you don't feel hungry. All of these are daily activities that are being shut down so the system saves energy and creates time to do the very necessary clean-up. While you are not feeling so well, you are actually healing. You don't need to 'rebalance' your temperature; your system requires the fever to quickly and efficiently burn up the mountain of waste you have accumulated. The system is making a serious effort to bring you back into balance, and if you let it, you will feel refreshed as soon as this episode spontaneously passes.

Health is your balance in life. How easy is it to live your life, to get through the day, to perform the tasks you need to complete? When you are in balance your life flows and hits very few obstacles, and when it does they pass very quickly. You will never be held up for a long time.

The balance in your life is personal. What you require for your life to flow will be different from what your neighbour needs or what I need. Hence, there is no expert who can tell you what will prevent you becoming ill or what is guaranteed to keep you healthy. There is no 'this is good for everybody' protocol in life. The better you understand your own life, your own real requirements in life, the better you will be able to maintain your balance and the healthier your life will be.

A healthy life is not related to the age

at which you die. A healthy life is about the easy flow of energy during your life, for as long as your life lasts. And yes, the less energy one spends on performing the tasks in life the more there will be left in the tank and the further we can go. However, nobody really knows how big your tank is! Not everybody in this life has the same type of engine. We are all, as human beings, constructed in very different ways. Some of us may only have a short life because that was all that life was destined for. The only thing we can say in relation to this point is that when you keep your life in balance you will be able to get the most out of it. No guarantee for a long life, but a guarantee of a life with less struggles, less conflict.

The balance in life is dependent upon all aspects of life. Everything counts. Everything has a role in maintaining that balance. That role is not a constant either. Aspects may be very important during a certain period in life. They may weigh heavily upon life and some time later their influence has diminished drastically. For instance, the importance of keeping warm as part of staying alive will be far greater during a severe winter than it would be during the summer. Also the accumulation of aspects that deliver a similar message to the system, that put similar strains upon the system, is an important factor in maintaining balance. Maintaining the functional temperature of your system depends on the temperature of the environment. However, it will become even more difficult to survive when at the same time of it being cold there is a chilling north-easterly wind blowing and you are eating ice cream all the time. Again this shows that no expert can give you a list of circumstances and living patterns for you to adhere to in order to avoid illness. You can never determine all facets of somebody's life. The end result, balance or imbalance, is the result of an accumulation of factors. We can spend the rest of the life span of this universe trying to figure out which combination is making us ill.

Let's focus on what health is, on what disturbs the balance in life. Before we can understand what is getting me out of balance I need to understand what is keeping me in balance. What is this balance we talk about?

The balance of everything that is part of life, of my life, has to involve everything that my system is connected to. But I am connected with everything in the universe because I am part of the entire universe! Indeed, and that means that everything in the universe is potentially interfering with my balance. So, from now on you can blame it on the moon or on the sun activity or on whichever star you fancy that could be shouldering the blame for your mishap in life. Nobody can actually prove that you are wrong. The real question here is: "Am I getting better when blaming the stars?"

Everything has an influence but the state of your immediate environment, close to home, has a louder voice in your life than the cosmic background noise. In the larger picture of your life, when we draw the plan of your living space, there are components that loom large around you and others that are present in the background. And yes, as we said, these positions do change over time but for a situation further away from your life to have a real noticeable effect on your life its power, its strength, has to increase to power its way to the frontline of your life. Just as we see with natural disasters, some of which clearly affect the entire globe, it is much worse when it happens right where you are. The further you move away from the site the more the impact (the power of the event) diminishes. It takes up less space, time and energy, in lives elsewhere.

This means that when we want to examine our own imbalance in life it would be wise to consider the largest parts of our lives in the first place. Rather than trying to blame your stomach upset on the tomato you ate at lunchtime it would be much more enlightening if you first were to examine situations and influences that play a much larger role in your life in general terms than the poor tomato. What are some of these things then?

Have a look at where and how you spend most of your time. The more time you spend in a certain situation the

Photo by Casey Horner on Unsplash

more likely it is to have a big impact on your life. Well, there are things such as home life, work life, family life. A lot of our energy is invested in our family, whether we are conscious of this fact or not. Growing children are supposed to break free from the family ties or at least push their family influence to the back. Why? To become an individual. As long as you are very close to the family you originated from the influence of automatic unconscious family reaction patterns in the way you live remains very high. It is our duty to break free, to take the family patterns and mould these into a new life, adapting these to an ever-changing world. Changing old patterns into a new format is adapting to a changing environment and helps to maintain the individual's balance within that environment. When your jacket is pinching you in various places it is because you have outgrown it. You will need a new one. And yes, you may prefer one that has a similar style and design but, for sure, it needs to be a different size. Life has to fit you!

When we have set up our own life, when we have started our own family, we need to adjust to that new and different situation and we need to adapt our skills to fit our new needs. However, this situation changes all the time too. Think about children growing up and having different needs. Again there is a demand for change, for adaptation. And sometimes our old patterns, our old choices, our old wishes, are no longer worth the same they were. Sometimes the balance between what I require at this stage in my life is so different from what I required a few years back that it brings me out of balance. I am struggling to keep going. I am struggling to keep my balance. I am struggling to keep living – this way. Relationships become strained. When the pressure is on it is because of changing circumstances, changing needs and fulfilments in life. This will have a big impact on your daily functioning and thus on your health. Is the partnership you have formed filling you with joy and allowing your energies to flow freely? Does that partnership need an update, a review? Is it time to do some work on the structure of our relationships and how we have allowed these to develop? Do I need to bring them in line with the new requirements in my life? Working on something does not necessarily mean chucking it away and replacing it.

We have chosen a particular career. Or have we? Was it truly our own choice or did it come out of a family pattern rather than out of my own heart? We have a job. We have a career. We are building our future. We are spending a lot of time and energy on this project. Even a meagre thirty-six hour week still makes me spend a lot more time in a work environment. So the impact of work and career on my life, on my balance, will be vast and cannot be dismissed as an insignificant

influence on my health. Consider both parts of work: there is the subject of the work and there is the framework in which the work is being done. In other words, what is the job itself doing to you and what are the circumstances of the job doing to you? The job is an expression of who we are, of what our talents are, of where our commitment lies in life. It is very important to us and if the coat does not fit anymore we seriously need to consider changing it, in some way.

So, when we are taking responsibility for the balance in our own lives we need to consider all aspects, all influences, on that life. However, it makes a lot of sense to pay most of the attention to the parts that occupy the largest time, space and energy in that life. You want to lead a balanced life, which will 'protect' you from disease, you definitely need to take a closer look at the basic construction of your life.

Here are the three main fields to explore:

1. How much impact in my life have family patterns had on my decision-making?
2. Is my life in balance with my life partner?
3 Is my job/career a true reflexion of the ingredients of my life?

These are the main fields we need to put our attention to if we want to remain in balance, if we want to remain healthy. All other influences, although they exist and have an impact, only truly show once the above are in balance.

This is how life has been constructed and how it functions. You may not like it and you may prefer the root of your problem to lie elsewhere, but just remember that nature existed a long time before humans appeared and that nature has been functioning for a long time according to its own laws. Human beings are part of nature. We have sprouted from nature. And we obey the same natural laws. Nobody is asking for our consent. It just happens that way. We are free to believe anything we want to but that will never change the course nature follows. And it takes us with it. Kicking and screaming blue murder will not alter that.

Whatever the environment you are surrounded by, just remember you do not need to allow all of it to upset you, to influence you. You can choose to ignore certain messages because they are too disturbing for you. I would urge you to take notice of the messages that nature is bringing you. Put your attention there. It will give you less time, plus you will have less need, to pay attention to messages from other human beings. I'd rather listen to the old master himself than to the new kid on the block.

Nature has been operating according to simple laws since the beginning of time. Human beings are little know-it-all's who still have most of it to learn but who like to show off how knowledgeable they think they are.

I have made my choice of master.

November 2019

MEASLES AND MALNUTRITION IN SAMOA

25 November 2019
https://www.garymoller.com/post/measles-and-malnutrition-in-samoa

EXTRACTS

THERE HAVE BEEN an alarming number of deaths in Samoa from measles (38 and rising). This is an absolute tragedy. For such a small population, how come the death rate has been so high?

Low rates of immunisation do not fully explain this high rate of mortality and it never will. There is more at play than the experts are telling us.

When you travel the islands by bicycle and make a point of living with the natives you see, time and again, the displacement of native populations by foreign tourist developments and farming operations that take over the best arable land and reef.

Young men and women leave the villages and congregate in the towns seeking a better life. Traditional ways of living, including food production and food preparation, are being seismically disrupted.

The displacement and impoverishment of native populations are best seen in the dramatic way that food has changed in just a few generations.

Traditional foods such as whole fish, seaweeds, shellfish, crabs, coconut, taro and breadfruit have been displaced by white rice, flour, soft drinks, sugar, margarine, pork belly and, of course, KFC.

Diseases of "modern day malnutrition" are now rampant in the islands. Tooth decay, obesity, thyroid disease, diabetes, heart disease and arthritis to name some.

Poverty in the Pacific Islands suits New Zealand and Australia. Without having thousands of desperately poor people on our doorsteps who else is there to do our seasonal labour-intensive and back-breaking horticultural work in places like our vineyards and orchards?

NZ and Australian workers won't do it. It is hard labour, repetitive, weather-dependent and sometimes isolated.

The pay is so little per hour and unreliable that nobody in their right mind will do it. Pacific Islanders will do it because they are desperate for any kind of work. They'll do it for next to nothing. Seasonal labour from the islands enables NZ and Australia to cheaply produce food and wine to sell to rich consumers. If there was no poverty in the islands our horticulture industry would be in trouble. Food prices would climb while export profits would decline.

With this displacement and impoverishment of island populations comes things like overcrowding, poor sanitation and malnutrition, sometimes affecting thousands of natives on a single island.

This produces the perfect conditions for the transmission of diseases such as typhoid and measles.

According to the World Health Organisation, "The impact of malnutrition on Samoa, and particularly on the children of Samoa, is shocking."

Read more about what the World Health Organisation has to say about the conditions in Samoa to understand why measles has gone like wildfire through Samoa and why it has killed so many (You don't see these things in the travel brochures do you?):
https://thevaccinereaction.org/2019/11/samoas-measles-outbreak-and-response/

In New Zealand, as with the islands, diseases like measles and their worst impact are closely related to poverty, hence the current measles outbreak in NZ is mostly confined to places and ethnic populations with the lowest socioeconomic status, like Polynesian people living in South Auckland. Refer here: https://surv.esr.cri.nz/PDF_surveillance/MeaslesRpt/2019/WeeklyMeasles25112019.pdf

If we are really serious about promoting good health then we would be doing much more to address poverty in all of its forms - and the exploitation that goes with it. Not just here in New Zealand but also in our Pacific neighbourhood.

For more reading about how to protect your family from measles and other viruses, in addition to vaccination, here is some reading that I have prepared for you:
https://www.garymoller.com/post/how-to-protect-your-family-from-measles-and-other-viruses

Currently, there is not a vaccine for poverty.

Oh, and about the myth that measles can give you immunity amnesia?
https://www.tetyanaobukhanych.com/blog/should-you-be-afraid-that-measles-gives-you-immune-amnesia

TiP Editor: Go to Dr Tenpenny's article The Real Crisis in Samoa for further analysis.
https://vaxxter.com/the-real-crisis-in-samoa/

POLIO OUTBREAK: THE PHILIPPINES

DISEASE OUTBREAK NEWS
24 September 2019
https://www.who.int/

ON 19 SEPTEMBER 2019, the Philippines declared an outbreak of polio. Two cases have been reported to date, both caused by vaccine-derived poliovirus type 2 (VDPV2). Environmental samples taken from sewage in Manila on 13 August and a waterway in Davao on 22 August have also tested positive for VDPV2.

TiP Editor: The New York Times, reported on 'More Polio Cases Now Caused by Vaccine Than by Wild Virus.' (25 Nov 2019). Four African countries have reported new cases of polio linked to the oral vaccine, as global health numbers show there are now more children being paralyzed by viruses originating in vaccines than in the wild.

This is a problem that has been going on since the polio vaccine was introduced. Let's hope this problem will be highlighted more and more in mainstream media.

And what about provocation polio which can be caused by any intramuscular injection, meaning any injectable vaccine.

VACCINE MISINFORMATION AND SOCIAL MEDIA

BY TALHA BURKI

www.thelancet.com/digital-health Vol 1 October 2019

A FEW EXTRACTS

ON AUG 19, 2019, British Prime Minister Boris Johnson outlined plans for a summit of social media firms to discuss how to promote accurate information about vaccination.

WHO defines vaccine hesitancy as a "delay in acceptance or refusal of vaccines despite availability of vaccination services". The effect has been around for as long as vaccination. But the advent of social media has offered an unprecedented opportunity to amplify and spread anti-vaccination messages. "What was previously a fringe opinion is becoming a transnational movement", said David Broniatowski (School of Engineering and Applied Science, George Washington University, Washington, DC, USA). "The unique thing about social media is that they allow messages to propagate very quickly and for communities to form."

Vish Viswanath (Harvard TH Chan School of Public Health, Boston, MA, USA) points out that the general public can be split into three groups. There is a minority of staunch opponents of vaccination who are unlikely to shift their opinion. There is a larger group of people who have been ***persuaded (TIP emphasis)*** of the importance of vaccines and are just as unlikely to shift their opinion. And then there are those in the middle. "These people are trying to do the right thing but they have doubts and they have questions, and they can be vulnerable to anti-vaccination messages", said Viswanath. "That is where you see the damage."

The social media networks have started to take action. In August 2019, Pinterest announced that searches on its site for vaccine-related topics, such as measles or vaccine safety, will only turn up links to reputable public health organisations.

The results will not be accompanied by recommendations, comments, or advertisements. The move was welcomed by WHO's director-general Tedros Adhanom Ghebreyesus. "We hope to see other social media platforms around the world following Pinterest's lead", he stated. More than 300 million people visit the Pinterest website or access its app every month. A large number but nowhere near the reach of Facebook, which has 2.4 billion users every month. Earlier this year, Facebook stated that it would no longer recommend content that included misinformation about vaccines and it would reject advertisements that carried misinformation. Youtube has removed advertisements from anti-vaccination videos, meaning that the posters will not make any money. Twitter ensures that when users search for vaccine-related topics in the UK, the first result is for the National Health Service. In the USA, the same search first turns up a link to the Department of Health and Human Services.
But scroll down the page and anti-vaccination messages abound.

"Social media is not all the same", adds Broniatowski. "The platform matters a great deal." Facebook, for example, has administrators and content is largely shared within groups, whereas Twitter is full of bots.

So Facebook might be best advised to focus on setting standards for its administrators, whereas Twitter could turn its attention to making it harder for automated accounts to be promoted.

"Some of the issues are transitional", said Larson. "Social media platforms opened their doors relatively recently; I think we are still deciding where to draw the boundaries." She believes that the medical community needs to be proactive. "Official websites could be far more responsive; parents complain about not being able to find answers to the questions they have", said Larson.

"A lot of public health officials have been anxious about going into social media, especially the older generation, but that is where the public are to be found these days.

We are facing this growing gap between where the scientific and official information lives and where the public is going. That has to change."

TiP Editor: I reproduce these kind of articles so you have an idea of the kind of strategies they are looking at to eradicate vaccine hesitancy.

DECREASED HUMORAL IMMUNITY TO MUMPS IN YOUNG ADULTS IMMUNIZED WITH MMR VACCINE IN CHILDHOOD

Proc Natl Acad Sci U S A. 2019 Sep 3
PMID: 31481612

EXTRACT

In the past decade, multiple mumps outbreaks have occurred in the United States, primarily in close-contact, high-density settings such as colleges, with a high attack rate among young adults, many of whom had the recommended 2 doses of mumps-measles-rubella (MMR) vaccine.

Waning humoral immunity and the circulation of divergent wild-type mumps strains have been proposed as contributing factors to mumps resurgence.

MEASLES GENOTYPE B3 IS SPREADING THE WORLD, IT HAS NOW BECOME THE PREDOMINANT GENOTYPE. STUDIES SHOW THE MMR VACCINE DOESN'T HAVE THE CAPACITY TO EFFECTIVELY NEUTRALIZE MEASLES B3

BY IWB
August 17, 2019
https://www.investmentwatchblog.com/

WHILE WE ARE TOLD that measles is having a resurgence due to vaccine hesitancy, when one looks closer at the data, it shows clearly that it is the vaccine that is not working. The major outbreaks are from one specific genotype, while the other genotypes have been reducing year on year. Let's keep this simple, below are the references, in the first one the WHO say that B3 is the predominant measles virus genotype circulating around the globe. The second study found that the MMR vaccine had difficulty neutralizing the B3 genotype compared to other strains. The third study concludes that B3 is significantly more transmissible, which of course makes sense if the vaccine can't stop it. The fourth and final study calls for more research to see if B3 can overcome vaccine-induced immunity, as it would explain why B3 is spreading while other genotypes aren't. Or if you prefer just use logic, ask yourself why are all the other genotypes dying out, while B3 has been spreading like wildfire. The obvious answer is that B3 can evade the vaccine. If anti-vaxxers were the reason, you would expect all genotypes to be having a resurgence, not just one. It is likely that TPTB (the powers that be) are taking advantage of this situation, by falsely placing the blame on anti-vaxxers to increase vaccine sales and lobby to take away medical freedoms. Whereas if they simply admit that the vaccine doesn't work against genotype B3, then they have to invest in a new vaccine, so lose money instead of making money.

The mainstream media has been attacking anti-vaxxers on a weekly basis, the blame is being placed on their shoulders for the resurgence of measles. In reality, the data shows that the measles resurgence is only for one genotype, a genotype which studies show cannot effectively be neutralized by the vaccine. So hence it is vaccine failure that is behind the resurgence.

REFERENCES

1. World Health Organization EpiBrief – Measles B3 is predominant genotype www.euro.who.int/__data/assets/pdf_file/0009/370656/epibrief-1-2018-eng.pdf

2. Comparison of neutralizing antibody titers against outbreak-associated measles genotypes (D4, H1 and B3) in Iranacademic.oup.com/femspd/article/74/8/ftw089/2632698

Extract "The geometric mean titer (GMT) rates of the sera against D4, H1, B3 and A genotypes were 95.9, 90.5, 32.0 and 76.1, respectively. Low GMTs of antibody against the B3 genotype compared with the other genotypes were indicated. Based on the current study results, the MV antibody titers in the sera of vaccinated cases are sufficient to neutralize all circulating genotypes in Iran; however, neutralizing antibody titers were lower for the B3 genotype than for the H1, D4 and A genotypes. The heterogeneous nature of MV, for instance the nucleotide sequence diversity between different strains, necessitates the evaluation of the protective efficacy of the vaccine against measles B3 genotype in countries where this virus has been the most commonly identified circulating genotype."

3. (2017) Genotype-Specific Measles Transmissibility: A Branching Process Analysis www.ncbi.nlm.nih.gov/pubmed/29228134

Extract "Genotype B3 is found to be significantly more transmissible than other genotypes (P = .01) with an R of 0.64 (95% confidence interval [CI], .48–.71), while the R for all other genotypes combined is 0.43 (95% CI, .28–.54)."

4. Measles Outbreak Among Previously Immunized Healthcare Workers, the Netherlands, 2014 academic.oup.com/jid/article/214/12/1980/2631197

Extract: "Also, it may be that differences in the capacity to neutralize different genotypes only become apparent at relatively low levels of vaccine-induced IgG, particularly when there is intense exposure, such as reported here for the measles virus B3 strain. It is striking that, during the large outbreak of infection due to measles virus strain D8 in the Netherlands during 2013–2014, 181 patients with measles were admitted to the hospital, and only 2 cases of measles in vaccinated hospital HCWs were reported (T. Woudenberg, personal communication). This may indicate differences between the D8 and B3 strains in terms of pathogenicity or capacity to overcome vaccine-induced immunity. B3 strains are now globally the most common genotype found [5]. Further research into the correlates of serological protection against distinct wild-type strains is required, especially in the context of low levels of vaccine-acquired antibodies."

EFFECTIVENESS OF REPEATED INFLUENZA VACCINATION AMONG THE ELDERLY POPULATION WITH HIGH ANNUAL VACCINE UPTAKE RATES DURING THE THREE CONSECUTIVE A/H3N2 EPIDEMICS

VACCINE, 2 NOV 2019: PMID: 31690467

CONCLUSION

During consecutive influenza A/H3N2 epidemics, poor influenza vaccine effectiveness may be more pronounced among the elderly population with a high annual vaccine uptake rate.

IS THERE A CORRELATE OF PROTECTION FOR MEASLES VACCINE?

TIP EDITOR MAGDA TAYLOR
- A BRIEF OVERVIEW

THE MAIN HEADLINE above was the title of an article published in The Journal of Infectious Disease (PMID:31674645) 1 November 2019. Written by the modern father of vaccination Stanley A Plotkin it was interesting to observe how many admissions of uncertainty Plotkin made regarding level of protection from measles vaccine. The public are continuously given the message that the 'science is settled' regarding all aspects of vaccination, and yet this short article revealed a number of uncertainties.

Plotkin comments:
'To define a correlate of protection by a vaccine is not easy, as I have learned over the years. In 2001, I first wrote about the subject, attempting to simplify it with certain definitions and criteria. Subsequently I realized that nothing is simple, as has been noted from times immemorial! The reasons for this lack of simplicity are manifold, including lack of standardization of critical immunologic tests, the multiplicity of antibody and cellular immune functions, and the many ways in which those functions interact. In addition, challenge dose and number of challenges also figure into estimations of correlates.'

Plotkin then moves to the assumed protective antibody level (120mIU) from measles vaccine based on conclusions drawn from a study by Chen et al. (Chen RT, Markowitz LE, Albrecht P, et al. Measles antibody: reevaluation of protective titers. J Infect Dis 1990; 162:1036–42.)

Referring to this study Plotkin states:
'Whereas that was, and is, a useful number, its accuracy has not been confirmed for several reasons.'

He briefly discusses that antibodies have multiple functions, and how cellular responses to measles are 'ill-defined.' Plotkin states that the measles vaccine 'gives an attenuated infection, and it is not the case that antibody levels remain permanently elevated in vaccinees. The current situation is responsible for reevaluation of the long-term efficacy of measles vaccine.'

Plotkin continues:
'Although the great majority of measles vaccinees remain seropositive indefinitely, as in the case of mumps vaccine the circulation of new measles virus genotypes may be important. Genotypes B3 and D8 are now circulating, and these viruses are not as well neutralized by antibodies to the vaccine genotype (ie, genotype A) as by antibodies raised against the new strains.'

"The public are continuously given the message that the 'science is settled' regarding all aspects of vaccination, and yet this short article revealed a number of uncertainties."

He then highlights how some vaccinees – he suggests a 'minority,' lose antibodies with time and become susceptible to measles infection, and refers to a few studies showing outbreaks of measles in vaccinated individuals. One study he mentions published in 2017 'Epidemiology of measles in vaccinated people, Spain 2003–2014'. This original study reported how 138 measles cases were observed in 2-dose vaccine recipients, although Plotkin indicates 132.

Another study he highlighted was an outbreak in Dutch medical staff suggesting that low levels of neutralizing antibodies in vaccinees correlated with failure of protection. Plotkin states that 'unfortunately, the fully protective level of neutralizing antibodies is not known.'

It was good that he also drew attention to another factor that must also be considered, ie the possibility that subclinical (no symptoms) or paucisymptomatic (presenting few symptoms) infection with measles virus does occur in vaccinees. And whilst Plotkin states he is not aware of any evidence that show that vaccinees with some symptoms of measles excrete virus he does suggest that 'virus isolation from such patients should be attempted.'

He ends the article with:
'Moreover, the reasons for waning of antibodies in some vaccinees are not known, and the establishment of new correlates of protection based on neutralizing antibodies or other immune functions may be needed. The measles epidemics occurring in Europe and the United States could serve a useful purpose if specimens were obtained from exposed contacts before they are or are not infected. The scientific community should take advantage of the current situation brought on by vaccine resistance and vaccine ignorance to better define the correlates of measles immunity.'

A disappointing last line from Plotkin suggesting that the present number of measles cases have been brought on by vaccine resistance and ignorance. I would have thought that Plotkin should be sounding alarm bells to the scientific community regarding the questionable science surrounding a supposedly protective vaccine - given all his admissions throughout his article?

Members of the scientific and medical bodies should be asking a lot more questions about the uncertainty of antibody protection, full blown measles in highly vaccinated populations, asymptomatic and paucisymptomatic measles in the vaccinated, the potential spreading of disease by vaccinees, and the waning of the vaccine immunity – all of which Plotkin briefly highlights in this short article. Vaccination should be based on a full understanding of immunity before it is even considered as a procedure and implemented worldwide. There are so many anomalies regarding vaccination, not forgetting all the vaccine injuries and deaths that are continually dismissed or ignored.

The science is very far from settled!

THE REAL REASON FOR VACCINE MANDATES

BY TED KUNTZ
October 16, 2019
https://thevaccinereaction.org

THE ARGUMENT MADE for denying a public education to children who are selectively vaccinated or unvaccinated is the risk they pose to the immune-compromised who can't be vaccinated. It's a heart-warming story motivated out of compassion for those children who are medically fragile.

Or is it? If we take these pro-mandate advocates at their word, then it would follow that we also cannot allow any child or adult to attend our public schools and daycares who isn't fully immunized. This means not just being vaccinated, but rather genuinely immunized against infectious diseases.

So, this begs the question(s):

- Are immune-compromised children who can't be vaccinated allowed to attend school and daycare?
- Is the 10% of the population who are non-responders to vaccination allowed to attend schools and daycares?
- Is the significant percent of the population whose antibody levels have waned allowed to attend school and daycare?
- Is any titre testing being conducted to determine who has adequate antibody levels and therefore safe to attend school and daycare?
- And, if disease transmission is really what the proponents of vaccine mandates are worried about, then shouldn't those children recently vaccinated with live-virus vaccines also be excluded from schools and public spaces until the viral shedding has ceased?

If mandate proponents aren't demanding all of these individuals be excluded from schools, daycares and other public spaces, then one has to wonder whether the transmission of disease really is their primary concern.

"These mandates are not about making the public space safe, but rather are a crude and heartless means to coerce families to vaccinate against their wishes by creating hardship and threatening the future of their children."

IT'S NOT ABOUT MEDICAL RISK

I think we all know the answers to these questions. None of the unvaccinated immune-compromised children are denied access to a public education. None of the non-responders to vaccination are denied a public education. None of the significant number of children and adults whose immunity has waned are denied a public education. We know there is no required titre testing to determine who is actually immune and who is not. And there is no acknowledgement given, much less consideration of the viral shedding from the recently vaccinated. A child can be vaccinated with a live virus vaccine and be back in their classroom within minutes. This means that the restrictions being imposed upon selectively vaccinated or unvaccinated children is not about medical risk. It is not about the transmission of disease. It is not about the safety of the public space. If it really was about medical risk and the transmission of disease, these other unvaccinated and unimmunized children and adults, as well as those recently vaccinated with live virus vaccines would also be deprived of a public education and access to public spaces. But that will never happen.

What is obvious, if we dare to think, is that vaccine mandates for school attendance is really about punishment for challenging vaccine ideology. These mandates are not about making the public space safe, but rather are a crude and heartless means to coerce families to vaccinate against their wishes by creating hardship and threatening the future of their children. When you examine the justification given for eroding parental rights, medical rights and legal rights, it isn't what they claim it is. It isn't about medical risk. It isn't about compassion for the medically fragile. This is the sham of the medical industry. This is the deception of the vaccine lobbyists. They purport to be about health and compassion, but it isn't health they are concerned about. It isn't about medical risk. It isn't compassion for the immune-compromised. It's all about power, control, and the removal of the right of parents to say no to unwanted and unsafe medical products.

This is a corporation that has been captured by greed, arrogance and willful ignorance. This is a corporation that purports to have compassion for the vulnerable but has no compassion for the vaccine injured or those made medically fragile as a result of vaccination. This is all about selling vaccine products, with or without your consent. Period. So, when a politician, medical professional, or vaccine industry lobbyist tells you that school mandates are necessary to protect the vulnerable, let them know that you see through their fraud and deception. Tell them that if they really had compassion for the vulnerable, they would have compassion for the vaccine injured. Tell them that 'the emperor has no clothes' and you see their naked greed and callous disregard. Tell them you do not consent and never will.

This article was reprinted with the author's permission. It was originally published by Vaccine Choice Canada.

AMONG ALL DISEASES MEASLES HAS STOOD AS THE CLASSIC EXAMPLE OF SUCCESSFUL PARASITISM. THIS SELF-LIMITING INFECTION OF SHORT DURATION, MODERATE SEVERITY, AND LOW FATALITY HAS MAINTAINED A REMARKABLY STABLE BIOLOGICAL BALANCE OVER THE CENTURIES.

From: The importance of measles as a health problem (1962) PMID: 14462171.

BENEFITS OF CONTRACTING MEASLES

BY VIERA SCHEIBNER, PH D

https://unpeudairfrais.org/

31/3/18

WELL-MANAGED NATURAL INFECTIOUS DISEASES ARE BENEFICIAL FOR CHILDREN

WHEN INFECTIOUS DISEASES of childhood are not mismanaged by the administration of antibiotics, or by suppressing fever, the diseases prime and mature the immune system and also represent developmental milestones. Having measles not only results in life-long specific immunity to measles, but also in life-long non-specific immunity to degenerative diseases of bone and cartilage, sebaceous skin diseases, immunoreactive diseases and certain tumours as demonstrated by Ronne (1985).

Having mumps protects against ovarian cancer (West 1969).

This is the area that should be researched and the results heeded instead of trying the impossible: to eradicate infectious diseases.

APPROACHING CHILDHOOD DISEASES WITH COMMON SENSE AND WISDOM

The already quoted large group of Swiss doctors that formed a working committee questioning the Swiss' Health Department's policy of mass vaccination with the MMR (measles, mumps and rubella) vaccine, wrote that up to 1969, at the Basel University Paediatric Clinic, artificial infection with measles was used to treat successfully the nephrotic syndrome (Albonico et al. 1990).

ASTHMA AND ALLERGIES PREVENTED BY NATURAL MEASLES DISEASE

As shown by Shaheen et al. (1996), even in a developing country having measles is beneficial: it prevents atopy: "After adjustment for breastfeeding and other variables, measles infection was associated with a large reduction in the risk of skin-prick test positivity to household dustmite . . . 17 (12.8%) of 133 participants who had had measles infection were atopic compared with 33 (25.6%) of 129 of those who had been vaccinated and not had had measles".

Alm et al. (1999) wrote that increased prevalence of atopic disorders in children may be associated with changes in types of childhood infections, vaccination programmes, and intestinal microflora.

They found that at the Steiner schools in Sweden, "52% of the children had had antibiotics in the past, compared with 90% in the control schools…18% and 93% of children respectively, had had combined immunisation against measles, mumps, and rubella, and 61% of the children at the Steiner schools had had measles".

"Having measles not only results in life-long specific immunity to measles, but also in life-long non-specific immunity to degenerative diseases of bone and cartilage, sebaceous skin diseases, immunoreactive diseases and certain tumours."

"Fermented vegetables, containing live lactobacilli, consumed by 63% of the children at Steiner schools, were compared with 4.5% at the control schools….Skin-prick tests and blood tests showed that the children from Steiner schools had lower prevalence of atopy than controls".

ENGINEERED MEASLES VIRUS USED IN ANTI-CANCER THERAPY

Carmona Mota (1973) described a remission of infantile Hodgkin's disease after natural measles. They wrote, "A 23-months-old Caucasian male was seen for the first time in April 1970 with a large mass in the neck due to hypertrophy of the left cervical lymph nodes. Before radiotherapy could be started the child developed measles. Much to our surprise the large cervical mass vanished without further therapy."

Many others started researching and writing about the oncolytic (cancer-destroying) effect of measles virus.

Msaouel et al. (2009) conducted clinical testing of engineered oncolytic measles virus strains in the treatment of cancer. Even though the virus they used was a vaccine-type virus, the research was done in vitro with a virus directly injected into the tumour. They wrote, "It is of note that a number of viral strains, including certain derivatives of the attenuated live measles virus Edmonston (MV-Edm) vaccine strain, demonstrate a propensity to preferentially infect, propagate in, and destroy cancerous tissue. The reason for using modified viruses was given as "concerns regarding the potential of wild-type-viruses to cause serious side effects, technical limitations in manufacturing viral lots of high purity for clinical use, as well as the overwhelming excitement and fervent support for the, at the time, newly emerging chemotherapy approaches that slowed down research on alternative strategies".

One can reasonably speculate that there were also political reasons for using a vaccine measles virus (an engineered measles virus), and not the wild measles virus, because the next question to answer would be why not simply let children have the natural measles and thus achieve the long-term non-specific immunity to a number of cancers.

THE DANGERS OF MEDICAL INTERFERENCE IN DISEASE MANAGEMENT

It is disconcerting that as in the past, even today's doctors still relentlessly suppress fever and administer antibiotics as part of the standard practice ignoring well-documented published research which demonstrated that suppressing fever at the same time as administering antibiotics (and other medications) encourages the growth and general viability of the pathogens and their ability to develop resistance to such medications and may lead to their increased virulence (Mackowiak (1981)).

I end with an important message from history, which unfortunately fell on deaf ears and which has not lost its relevance to modern medical practice.

In a letter to the Duchess Sophia, mother of the future George I of England, Princess Elizabeth Charlotte (Liselotte) von der Pfalz, Duchess of

Orleans and widow of the younger brother of Louis XIV, wrote:

Our misfortune continues. The doctors have made the same mistake treating the little Dauphin as they did ministering to his mother, the Dauphiness. When the child was quite red from the rash and perspired profusely, they [the doctors] performed phlebotomy and administered strong emetics; the child died during these operations. Everybody knows that the doctors caused the death of the Dauphin, since his little brother who had the same sickness, was hidden away from the 9 physicians who were busy with his older brother, by the young maids, who have given him a little wine with biscuits.

Yesterday, when the child had high fever, they wanted also to perform phlebotomy but his two governessess were firmly opposed to the idea and instead kept the child warm. This one also would have certainly died if the doctors had had their way.

I do not understand why they don't learn by experience. Had they no heart, when they saw the Dauphiness die after phlebotomy and emetics, not to dispose of her child?

Koprowski (1962) summarised the still relevant historic message, "Avoid physicians and thou will be cured."

SUMMARY

Despite their long history of failures and tragedies arising from their observed derailing effects on the immune system, outdated procedures for both disease prevention, i.e. vaccination, and disease management, i.e. treatment hostile to the body's defences, such as antibiotics and anti-pyretics, remain standard practice to this day. The damage already done will continue to affect future generations for some time to come.

The unscientific standard procedures should be abandoned and the natural processes and the innate intelligence of the immune system respected. Medicine should adopt a common sense attitude to natural infectious diseases and their vital role in priming and maturing the immune system, for children's long-term benefit.

REFERENCES

Ronne T. 1985. Measles virus infection without rash in childhood is related to diseases in adult life. Lancet; 5 Jan: 1-5.

West RO. 1966. Epidemiologic studies of malignancies of the ovaries. Cancer; 1001-1007.

Albonico H et al 1990. Vaccination campaign against measles, mumps and rubella, A constraining project for a dubious future? Working group of doctors for selective MMR vaccination. 18 pages, self-published.

Sheheen et al. 1996. Measles and atopy in Guinea-Bissau. Lancet; 347: 1792-1796.

Alm et al. (1999). Atopy in children of families with an anthroposophic lifestyle. Lancet; 353: 1485-1488.

Carmon Mota H. 1973. Infantile Hodgkins'disease: remission after measles. BMJ; 19May: 423.

Msaouel P, et al. 2009. Clinical testing of engineered oncolytic measles virus strains in the treatment of cancer: An overview. Curr Opin Mol Ther; February; 11(1): 43-53.

Mackowiak PA. 1981. Direct effects of hyperthermia on pathogenic microorganisms: teleologic implications with regard to fever. Rev Infect Dis; 3(3).

Koprowski H. 1962. The role of hypergy in measles encephalitis. Am J Dis Child; 103:103-108.

AGAINST COMPULSORY MMR VACCINATION AND FOR LOOKING AFTER NEW MOTHERS

BY PROF ARNE AKBAR, PRESIDENT, BRITISH SOCIETY FOR IMMUNOLOGY

https://www.theguardian.com/society/2019/sep/13/against-compulsory-mmr-vaccination-and-for-looking-after-new-mothers

THE RECENT DROP in childhood vaccination uptake is a cause of concern for all of us, as your article rightly points out (No MMR should mean no school place, say GPs, 9 September), with only 87.2% of children in England receiving two doses of the MMR vaccine by age five. However, the factors that have led to this are complex and multifactorial. In such a situation, which has the potential to significantly affect our nation's health, our policy decisions must be guided by evidence.

Compulsory vaccination is a blunt tool and there is no current evidence that it would increase the UK's immunisation rate, but rather concerns that it could increase current health inequities and alienate parents with questions on vaccination. However, there are lots of other actions that the government can take to positively influence vaccine uptake, many of which were outlined in the No 10's recent announcement, such as strengthening the role of local immunisation coordinators, promoting catch-up vaccinations and improving information provision on vaccination.

Healthcare professionals are the most trusted information source on vaccination, so we should encourage positive and educated conversations between them and parents, based on mutual trust.

With the correct funding available, we at the British Society for Immunology believe that our country can make changes to significantly increase vaccine uptake without resorting to the extreme measure of compulsory vaccination.

Photo by Jenna Norman on Unsplash

DECREASED HUMORAL IMMUNITY TO MUMPS IN YOUNG ADULTS IMMUNIZED WITH MMR VACCINE IN CHILDHOOD

BY MOHAMMED ATA UR RASHEED, CAROLE J. HICKMAN, MARCIA MCGREW, SUN BAE SOWERS, SARA MERCADER, AMY HOPKINS, VICKIE GRIMES, TIANWEI YU, JENS WRAMMERT, MARK J. MULLIGAN, WILLIAM J. BELLINI, PAUL A. ROTA, WALTER A. ORENSTEIN, RAFI AHMED, AND SRILATHA EDUPUGANTI


Photo by Jens Johnsson on Unsplash

ABSTRACT

IN THE PAST DECADE, multiple mumps outbreaks have occurred in the United States, primarily in close-contact, high-density settings such as colleges, with a high attack rate among young adults, many of whom had the recommended 2 doses of mumps-measles-rubella (MMR) vaccine. Waning humoral immunity and the circulation of divergent wild-type mumps strains have been proposed as contributing factors to mumps resurgence. Blood samples from 71 healthy 18- to 23-year-old college students living in a non-outbreak area were assayed for antibodies and memory B cells (MBCs) to mumps, measles, and rubella. Seroprevalence rates of mumps, measles, and rubella determined by IgG enzyme-linked immunosorbent assay (ELISA) were 93, 93, and 100%, respectively.

The index standard ratio indicated that the concentration of IgG was significantly lower for mumps than rubella. High IgG avidity to mumps Enders strain was detected in sera of 59/71 participants who had sufficient IgG levels. The frequency of circulating mumps-specific MBCs was 5 to 10 times lower than measles and rubella, and 10% of the participants had no detectable MBCs to mumps. Geometric mean neutralizing antibody titers (GMTs) by plaque reduction neutralization to the predominant circulating wild-type mumps strain (genotype G) were 6-fold lower than the GMTs against the Jeryl Lynn vaccine strain (genotype A).

The majority of the participants (80%) received their second MMR vaccine ≥10 years prior to study participation. Additional efforts are needed to fully characterize B and T cell immune responses to mumps vaccine and to develop strategies to improve the quality and durability of vaccine-induced immunity.

From: https://www.doctorslounge.com/index.php/news/pb/90938

POPULATION DYNAMICS AND ANTIGENIC DRIFT OF BORDETELLA PERTUSSIS FOLLOWING WHOLE CELL VACCINE REPLACEMENT, BARCELONA, SPAIN, 1986–2015

EXTRACT

'DESPITE EXTENSIVE vaccination campaigns and high immunization rates (86% for global primary vaccination in 2018), the incidence of whooping cough significantly re-emerged during the first decade of the twenty-first century, not only in Spain and Europe but also worldwide.

This unfavourable situation has led to pertussis becoming the leading vaccine-preventable disease in industrialized countries, and hence, a global public health problem [2–5].'

(Published 26 Nov 2019).

Link to full article:

https://doi.org/10.1080/22221751.2019.1694395

EFFECT OF SEASONAL INFLUENZA VACCINATION ON INFLUENZA SYMPTOM SEVERITY AMONG CHILDREN IN HUTTERITE COMMUNITIES: FOLLOW UP STUDY OF A RANDOMIZED TRIAL

INFLUENZA OTHER RESPI VIRUSES. 2019;00:1–9. DOI: 10.1111/IRV.12689. 12 September 2019.

CONCLUSIONS

Seasonal influenza vaccine did not consistently attenuate symptom severity in the context of vaccine failure; however, TLAIV offered superior severity attenuation compared to TIV. Our results challenge the dictum that influenza vaccine reduces the severity of symptoms even when the vaccine fails to prevent influenza.

MUMPS IN THE VACCINATION AGE: GLOBAL EPIDEMIOLOGY AND THE SITUATION IN GERMANY

BY A. BELENI & S. BORGMANN
International Journal of Environmental Research and Public Health, Review
31 July 2018

CONCLUSIONS

THE PRESENT STUDY shows that vaccination against mumps was successful in reducing its incidence, although outbreaks occurred in various countries and eradication of the disease did not happen. The main reason for this is waning immunity, while genetic divergences of vaccine and wild-type strains are a matter of discussion.

In Germany, vaccination against mumps resulted in a marked decrease in incidence. In Western Germany, incidence was higher due to local/regional outbreaks. In Eastern Germany, incidence was lower, possibly due to higher vaccination rates. Although the initiation of the vaccination campaign resulted in a low incidence, the age of affected individuals increased, as shown by an analysis of Eastern German notification data. As the probability to suffer from complications increases in older individuals, lack of vaccination increases the risk of complications over-proportionally, when living in a vaccinated population. ***(TiP Editor:***

"Given that many mumps cases are occurring in the previously vaccinated at a later age, why do they state 'lack of vaccination increases the risk of complications'?"

Given that many mumps cases are occurring in the previously vaccinated at a later age, why do they state 'lack of vaccination increases the risk of complications'? Waning immunity is leading to mumps at a later age in the vaccinated which can also increase the chances of complications.)

Although the benefit of a third MMR dose is temporally limited the authors feel that application of a third dose to adolescents might be appropriate to prevent mumps outbreaks since young adults become affected the most.

As shown before, in Germany the second MMR vaccine is applied early in childhood (age of 15–23 months). Therefore, in Germany this measure might be more efficient compared to countries in which individuals are vaccinated later in life.

CLINICAL AND EPIDEMIOLOGICAL ASPECTS OF DIPHTHERIA: A SYSTEMATIC REVIEW AND POOLED ANALYSIS

BY SHAUN A TRUELOVE, LINDSAY T KEEGAN, WILLIAM J MOSS, LELIA H CHAISSON, EMILIE MACHER, ANDREW S AZMAN, JUSTIN LESSLER

Clinical Infectious Diseases, ciz808, https://doi.org/10.1093/cid/ciz808
Published: 19 August 2019
https://academic.oup.com/cid/advance-article-abstract/doi/10.1093/cid/ciz808/5551532

ABSTRACT

METHODS

WE CONDUCTED nine distinct systematic reviews on PubMed and Scopus (March to May 2018). We pooled and analyzed extracted data to fill in these key knowledge gaps.

RESULTS

We identified 6,934 articles, reviewed 781 full texts, and included 266. From this, we estimate the median incubation period is 1.4 days.

On average, untreated cases are colonized for 18.5 days (95% CI, 17.7-19.4), and 95% clear Corynebacterium diphtheriae within 48 days (95% CI, 46-51).

Asymptomatic carriers cause 76% (95% CI, 59-87%) fewer cases over the course of infection than symptomatic cases. The basic reproductive number is 1.7-4.3.

Three doses of diphtheria toxoid vaccine are 87% (95% CI, 68-97%) effective against symptomatic disease and reduce transmission by 60% (95% CI, 51-68%). Vaccinated individuals can become colonized and transmit; consequently, vaccination alone can only interrupt transmission in 28% of outbreak settings, making isolation and antibiotics essential.

While antibiotics reduce the duration of infection, they must be paired with diphtheria antitoxin to limit morbidity.

CONCLUSION

Appropriate tools to confront diphtheria exist; however, accurate understanding of the unique characteristics is crucial and lifesaving treatments must be made widely available.

This comprehensive update provides clinical and public health guidance for diphtheria-specific preparedness and response.

DOCTORS WON'T MAKE YOU HEALTHY. NUTRITIONISTS WON'T MAKE YOU SLIM. TEACHERS WON'T MAKE YOU SMART. GURUS WON'T MAKE YOU CALM. MENTORS WON'T MAKE YOU RICH. TRAINERS WON'T MAKE YOU FIT. ULTIMATELY, YOU HAVE TO TAKE RESPONSIBILITY. SAVE YOURSELF. ~ *NAVAL RAVIKANT*.

MEASLES VIRUS NEUTRALIZING ANTIBODIES IN INTRAVENOUS IMMUNOGLOBULINS: IS AN INCREASE BY REVACCINATION OF PLASMA DONORS POSSIBLE?

BY MODROL J; TILLE B; FARCET M R; MCVEY J; ET AL. J Infect Dis 2017 Nov 15; PMID:28968738

DISCUSSION

MEASLES VACCINE was first licensed in the United States in 1963 and was implemented in all states by the mid-1980s. By 1989, the 2-dose measles vaccination program was introduced, which resulted in a high level of herd immunity and limited the spread of wild-type measles virus in the population, giving fewer natural opportunities for antigenic boosting, which would also contribute to lower measles virus antibody titers in the general population.

The investigation of measles virus antibody titers in the plasma donor population in 2007 indicated a sharp decline in antibody titers for age cohorts born after 1963, which correlated well with the first introduction of measles vaccination in the United States.

An additional decline was seen in the snapshot study of 2015, **which indicated that the introduction of the 2-dose regime resulted in an even more pronounced reduction of measles virus antibody titers.** ***(TiP emphasis)***

In age cohorts born after 1990, antibody titers seem to have leveled off, which might indicate that through vaccination of essentially all younger US plasma donors a "steady state" has been reached.

These low levels of measles virus antibody titers in plasma donations translate to lower levels of titers in IVIG, which might ultimately endanger the consistent supply of this important therapeutic in the United States, because the minimum potency requirement for measles virus antibodies, as defined in regulation 21 CFR 640.104, has become increasingly difficult to meet. This potency requirement does not apply in Europe or most other parts of the world.

To respond to the observed decline in measles virus antibodies in the plasma donor population, the study in 2015 evaluated the feasibility of revaccination as a means to elicit higher anti-body levels in plasma donors.

The initial 2-fold increase in antibody titers after revaccination was short-lived, as titers dropped back to similar levels seen just before revaccination approximately 6 months after the booster vaccination.

These findings from a plasma donor population 18–58 years of age are consistent with findings of a recent study in which young adults 18–28 years of age showed an overall modest measles virus antibody titer increase 1 month after revaccination. After 1 year, titers had declined to near-baseline levels.

In conclusion, the current screen of plasma donations provided further evidence for the continued decline in measles virus antibody titers in the US plasma donor community, which has by now reached a critical level for the supply of IVIG. The current study findings showed that an attempt to boost antibody titers through revaccination cannot be expected to result in a sustainable increase of measles virus antibody titers in plasma donors.

It is therefore urgently necessary to consider and investigate alternative measures that will permit a consistent supply of this important therapeutic.

A reduction of the measles virus antibody titer required for lot release of IVIG products has already been proposed.

With the success of the measles vaccination program and the ongoing World Health Organization efforts to eliminate and ultimately eradicate measles worldwide, a replacement of the measles virus antibody titer as a functional potency requirement for IVIG seems inevitable in the long term.

PERI-CONCEPTIONAL OR PREGNANCY EXPOSURE OF HPV VACCINATION AND THE RISK OF SPONTANEOUS ABORTION: A SYSTEMATIC REVIEW AND META-ANALYSIS

BY TAN ET AL.

BMC Pregnancy and Childbirth (2019)

Published online: 19 August 2019

CONCLUSION

Evidence of the association between peri-conceptional or pregnancy exposure of HPV vaccination and spontaneous abortion was limited, however, a real association cannot totally be ruled out. Additional research is warranted to assess the impact of exposure of 2vHPV or 9vHPV vaccination on spontaneous abortion.

Considering the insufficient evidence, women at childbearing age should preferably avoid unintended HPV vaccination during pregnancy.

OPTIMISING INFORMED CONSENT IN SCHOOL-BASED ADOLESCENT VACCINATION PROGRAMMES IN ENGLAND: A MULTIPLE METHODS ANALYSIS

BY CHANTLER, LETLEY, PATERSON ET AL

Vaccine; Volume 37, Issue 36 23 August 2019, Pages 5218-5224

ABSTRACT

THE PROCESS OF OBTAINING informed consent for school-based adolescent immunisation provides an opportunity to engage families. However, the fact that parental consent needs to be obtained remotely adds complexity to the process and can have a detrimental effect on vaccine uptake.

We conducted a multiple methods analysis to examine the practice of obtaining informed consent in adolescent immunisation programmes. This involved a thematic analysis of consent related data from 39 interviews with immunisation managers and providers collected as part of a 2017 service evaluation of the English adolescent girls' HPV vaccine programme and a descriptive statistical analysis of data from questions related to consent included in a 2017 survey of parents' and adolescents' attitudes to adolescent vaccination. The findings indicated that the non-return of consent forms was a significant logistical challenge for immunisation teams, and some were piloting opt-out consent mechanisms, increasing the proportion of adolescents consenting for their own immunisations, and introducing electronic consent. Communicating vaccine related information to parents and schools and managing uncertainties about obtaining adolescent self-consent for vaccination were the main practical challenges encountered.

Survey data showed that parents and adolescents generally agreed on vaccine decisions although only 32% of parents discussed vaccination with their teenager. Parental awareness about the option for adolescents to self-consent for vaccination was limited and adolescents favoured leaving the decision-making to parents. From the interviews and variability of consent forms it was evident that health professionals were not always clear about the best way to manage the consent process. Some were also unfamiliar with self-consent processes and lacked confidence in assessing for 'Gillick competency'.

Developing pathways and related interventions to improve the logistics and practice of consent in school-based adolescent immunisation programmes could help improve uptake.

MUTATIONS ASSOCIATED WITH EGG ADAPTATION OF INFLUENZA A(H1N1)PDM09 VIRUS IN LABORATORY BASED SURVEILLANCE IN CHINA, 2009–2016

BY YANG, CHENG, ZHAO ET AL

Biosafety and Health, Vol 1, Issue 1, March 2019, Pages 41-45

MUTATIONS OF INFLUENZA virus associated with adaptation occurring during passage in embryonated chicken eggs could result in antigenic change or reduced vaccine effectiveness. In this study, we investigated the mutations of influenza A(H1N1)pdm09 egg isolates from the Chinese National Influenza Surveillance Network between 2009 and 2016. Thirteen mutations were identified in the hemagglutinin (HA) protein from viruses passaged in eggs, in comparing to those in cells. After scanning public database, four mutations, D127E, L191I, D222G/N and Q223R in HA1, which may alter the receptor-binding specificity, were observed frequently. Although the A(H1N1) pdm09 virus has evolved in human for nearly ten years, most egg-cultured viruses acquired one or more further mutations.

Using the egg isolates for influenza surveillance requires extra caution because of these selected mutations, and their impacts on antigenicity and receptor-binding property need further evaluation. *(TiP emphasis).*

Currently, most of the influenza vaccines are produced using egg isolates, particularly in China. Thus, there is an urge to promote the establishment of an alternative influenza vaccine production platform.

SETTLEMENT REACHED IN SWINE FLU VACCINE CASE

19 Nov 2019
RTE News. https://www.rte.ie/news/

BRIEF EXTRACT

A HIGH COURT ACTION for damages by a student who claimed she developed the sleep disorder narcolepsy after receiving the swine flu vaccine has been settled. However, she is to receive compensation and the High Court was told all her costs are to be paid by the Minister for Health and the Health Service Executive. It was seen as a test case for up to 100 more and the court had been asked to determine if any or all of the defendants, including the vaccine maker and the State, were liable for damages. The defendants in the case were GlaxoSmithKline Biologicals, the Health Service Executive, the Minister for Health and the Health Products Regulatory Authority, formerly the Irish Medicines Board. All claims made in the case were denied and the settlement was made without admission of liability. No orders were made against the HPRA or GSK. Ms Bennett was 16 when she was given the Pandemrix vaccine at school as part of a vaccination programme administered by the HSE. The court heard she was later diagnosed with an incurable, life changing sleep disorder narcolepsy, excessive daytime sleepiness and episodes of sudden weakness known as cataplexy.

VACCINES ARE SAFE & EFFECTIVE AND THEY SAVE LIVES – IS THIS TRUE?

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

PART 01


DR Jayne L.M.Donegan

MANDATORY VACCINATION is being touted by politicians as the answer to what they call '*vaccine hesitancy*' which they describe as due to '*misinformation*,' '*fake news*', or '*junk science*'. Homeopaths are being targeted for warning parents to be cautious of vaccination while the chief executive of NHS England, Simon Stevens, states, "*Anything that gives homeopathy a veneer of credibility risks chancers being able to con more people into parting with their hard-earned cash in return for bogus treatments which at best do nothing, and at worst can be potentially dangerous*," in an effort to force the Professional Standards Authority to revoke the Society of Homeopaths' accreditation. Any doctor who supports informed consent for vaccination is harassed by the media and regulatory bodies and the Secretary of State for Health continues to parrot the non evidence based mantra, "*The science is beyond doubt: vaccines are safe. They are effective and they save lives and there is no alternative. Vaccines are a miracle of modern medicine...*"

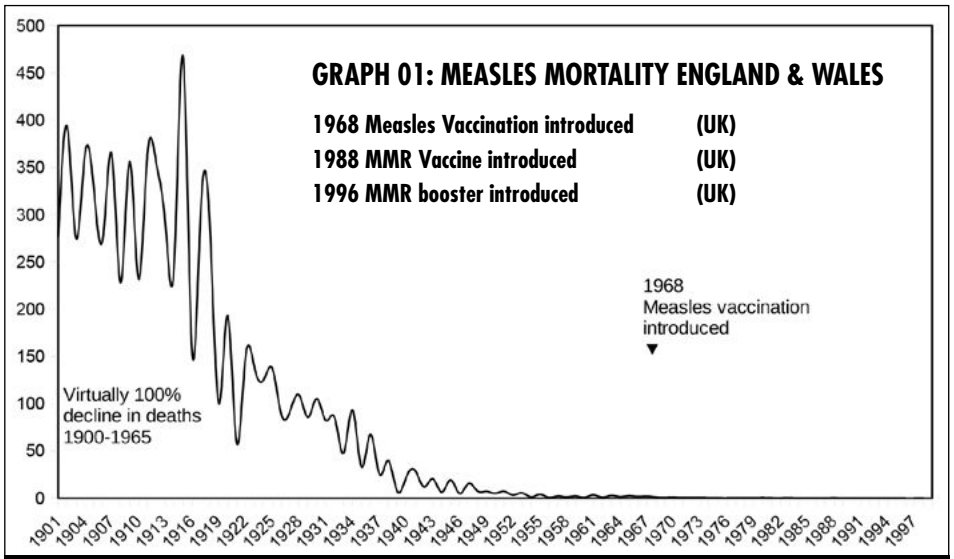
That this is manifestly untrue is born out by the fact that there are approximately 900 known cases of children and adults who developed narcolepsy following Pandemrix 'flu vaccination in 2009. The British Medical Journal in 2018 published a highly critical peer reviewed paper asking why the narcolepsy was not spotted earlier by the Medicines and Healthcare products Regulatory Agency.[i] In the same issue another study was highly critical of the methodological problems with the safety studies of the HPV vaccine administered to girls at school. Lars Jørgensen and colleagues found the so-called 'transparency' policies not fit for their purpose. After reports of potential harms associated with HPV vaccines appeared in the media, the European Medicines Agency (EMA) eventually carried out an investigation in 2015. However the EMA did not do the assessment itself but relied on the *vaccine manufacturers*' analyses of the underlying harm data, the conclusion being that there was no evidence of harm.[ii] The Editor-in-chief of the BMJ, Fiona Godlee wrote, "*Public trust in vaccination programmes is crucial to their success. History tells us that trust is easily undermined by misinformation, but this should not prevent an open and informed debate on the evidence for the effectiveness and safety.*" [iii]

The UK has a Vaccine Damage Payment Unit. From 1978 to 2017 the VDPU paid out £74 million, to vaccine-injured children (freedom of information response). Only those 60% or more disabled qualify and they must not have died before two years of age. Those less than 60% disabled or dead before age 2 receive nothing. The £74 million is all the more significant because it is *almost impossible* to prove that a vaccine caused the damage – even if it is an adverse reaction listed by the manufacturer in the package insert. Vaccine manufactures with research laboratories, teams of staff and billions of dollars at their disposal do not have to show that the injuries they list are *caused* by the vaccine. But the parents with none of these facilities and no money, in addition to trying to care for a disabled child, are required to do this or their case will be thrown out.

In the USA approximately US$ 4.2 billion has been paid to children injured by vaccines since 1988. All major countries have compensation schemes because vaccines are capable of causing considerable harm.

The US Supreme Court has ruled that vaccines are, '*unavoidably unsafe*' even when given appropriately.[iv]

Vaccine manufacturers have never carried out, or been required to carry out, a study to compare the health and well-being of vaccinated versus unvaccinated children. No vaccine in the routine childhood vaccination program has been tested against a biologically inactive placebo, only against other vaccines or vaccine 'vehicles' containing aluminium, polysorbate 80, formaldehyde, neomycin, phenol red, calf fetal protein, porcine gelatine, MSG, to name a few.



Measles - Deaths Per Million All Ages - England & Wales 1901 - 1999.
Source: "20th Century Mortality" Office for National Statistics England.

The vaccine manufacturers have no liability for their vaccines. Unlike any other drugs, you cannot sue the pharmaceutical companies for the injuries their vaccines have caused. These companies therefore have no incentive to care much about safety. It does not cost them anything when things go wrong. The truth about asbestos in talcum powder (Johnson & Johnson) and mesothelial cancer; or heart attacks and deaths caused by Vioxx (Merck) the anti-inflammatory drug came out because people sued the manufacturers and in this process got disclosure of important documents. This is not possible with those same manufacturers' vaccine products, so they can hide the data of adverse reactions studies. This data never sees the light of day as it would adversely affect sales of their products, and departments of health can continue telling the public that vaccines are safe and effective.

Regarding yellow fever vaccine, Prof. Martin Gore of the Royal Marsden Hospital, a leading British oncologist, was reported to have died of total organ failure after receiving a yellow fever vaccine in January 2019. R.I.P. He would not have died had he read my Travel Medicine book – or even the package insert of the vaccine. Being a professor of medicine will not help you if you do not take steps to fully inform yourself of the risks and benefits before going ahead with any medical procedure, as I am sure he would have counselled his own oncology patients. According to peer reviewed research in the Journal of Emerging Infectious Diseases 2011, women aged 19 to 34 years of age have a higher than expected number of deaths from yellow fever vaccine adverse reactions. Cambridge University student Alana Cutland threw herself out of an aeroplane over Madagascar in August of this year following yellow fever vaccination. The British Society for Immunology acknowledged that yellow fever vaccination could have been the cause of death. Former BBC journalist, Malcolm Brabant lost his job after temporary psychosis following yellow fever vaccination, about which he has written a book and made a documentary.[v]

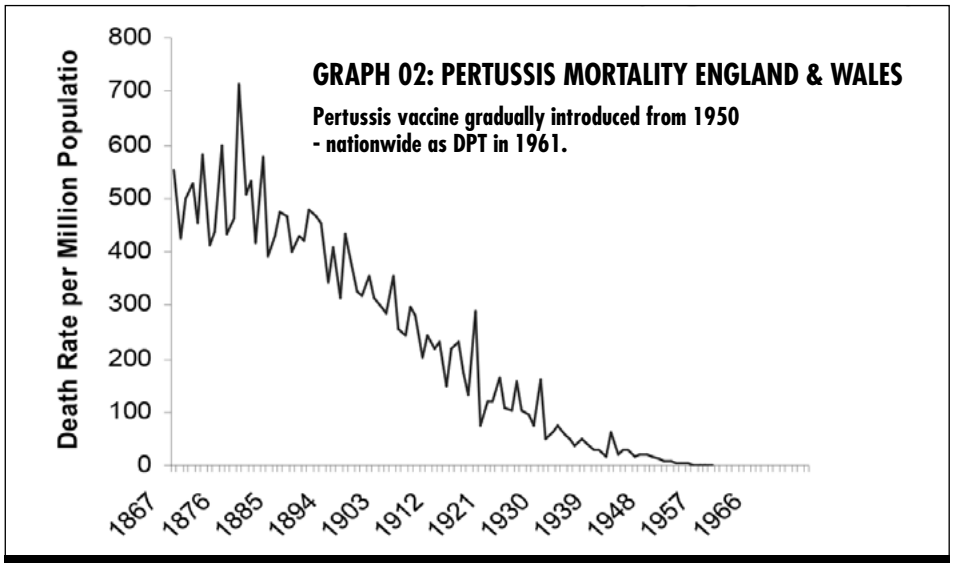
"Figures from the UK Office for National Statistics show that approximately 99% of the people who used to die from measles and whooping cough had stopped dying before the vaccines against these diseases were introduced."

Yellow fever vaccine is not in the childhood vaccination schedule. This is the only reason that Professor Gore's death and these other mishaps have been reported. Had it been a childhood vaccine, the press would have been silent. The risks from infectious diseases have dramatically declined but are grossly exaggerated to frighten parents. Figures from the UK Office for National Statistics show that approximately 99% of the people who used to die from measles and whooping cough had stopped dying before the vaccines against these diseases were introduced. See graphs 1 & 2. It has long been known that making people afraid makes them easier to manipulate.

The big push towards compulsory vaccination, with many US states losing all exemptions, even medical ones, appeared to start after the 2014-2015 outbreak of measles in Disneyland, California. This started a frenzy of disease-mongering with accusations that unvaccinated children were putting vaccinated children and those unable to be vaccinated at risk.

LOOKING AT THE FACTS, HOWEVER, THE PICTURE IS A LITTLE DIFFERENT

ORIGINALLY, THERE WERE said to be 110 cases of which 49 were not vaccinated, 12 of these were below vaccination age. Out of the remaining 61, 47 were said to be of *unknown* or *undocumented vaccination* status. In a country where vaccinations must be logged with Health Maintenance insurance Organisations, Medicare or Medicaid to be re-imbursed, it is disingenuous to suppose that the vaccination status could really be unknown. It would be unsurprising if these 47 cases were not, indeed, vaccinated. There were five measles cases definitely known to have had one dose of measles-containing vaccine, seven who had had two doses and one who had had *three* doses.[vi] The 12 too young to be vaccinated who contracted measles are also not really 'unvaccinated'. The reason children are not vaccinated before the age of 12-15 months is because in the days when mothers all had real measles, the antigens that crossed the placenta to the baby protected that baby for the first 12 to 15 months of their life. The reason that babies below that age are now contracting measles, and in Europe some of them are dying, is entirely *because* of the measles vaccination program. Measles vaccinated mothers pass on lower quality antibodies that last for a shorter length of time. These



Source: "20th Century Mortality" Office for National Statistics England. CD-ROM, Registrar Generals Returns 1837-1900 Office for National Statistics London.

vaccine-induced antibodies may only protect their babies for the first six months of life, leaving the babies unprotected after this time and susceptible to measles when it is not optimal for them to contract it.

But the facts of the USA measles outbreak are even more complicated than this. In a study published in 2017 by Centers for Diseases Control scientists described new molecular tests for different virus strains which are necessary because, ***"approximately 5% of recipients of measles virus-containing vaccine experience rash and fever which may be indistinguishable from measles"***, they go on to quote unpublished data which showed that of the 194 cases of measles confirmed in the USA in 2015, 73 (38%) of the cases were *measles from the measles vaccine virus!* Not 'vaccine failures' where someone was vaccinated but then got the real measles anyway, *but measles from the vaccine i.e measles-vaccine-virus measles!* Therefore 38% of all measles cases in the USA in 2015, about which there was such a hue and cry with clamping down on peoples civil liberties and religious freedoms, were *caused* by the vaccine. And these CDC scientists knew it.[vii] And the CDC knew it. Yet they watched all the measles hysteria, the massive political rhetoric, the doctors and senators calling for an end to vaccine exemptions and the massed vaccination campaigns, some of which were the direct cause of these cases of measles, and they said..... not a word. How honest is that? How scientific? How moral and how ethical? Why did they say nothing? Perhaps because it would have interfered with the plan to vaccinate everyone from womb to tomb and beyond. Doubtless even now some pharmaceutical company executive is trying to come up with a way to convince doctors and politicians that money can be made from vaccinating people after death to reduce a future contagion of pandemic importance – the dead are, after all, a great untapped market and there will be more and more of them.

In response to what is termed the global problem with 'vaccine hesitancy', the World Health Organization produced a 'Best Practice' document in 2017 entitled, '*How to respond to vocal vaccine deniers in public*.' Relying on techniques based on psychological research on persuasion, its stated aims are to "*make the public audience more resilient against anti-vaccine statements and stories and to support the vaccine hesitants in their vaccine acceptance decision*." It does not seek to persuade what it terms '*vaccine deniers*' whom it describes as having "*characteristics that are similar to religious and political fanatics in that he or she adheres to a belief that is impossible to challenge, whereas challenge is the fundamental tenet of scientific progress*." This is an interesting concept as anyone who has tried to engage a health professional with questions such as: **why** there have been no comparison of the health and well-being of vaccinated and unvaccinated children; **why** it is that vaccines are developed using antibody production as a surrogate for immunity when it is not; **why** there are no trials of vaccine safety and efficacy against non biologically active placebos (except BCG vaccine which showed that more people who had the vaccine got tuberculosis than the ones who didn't); **why** long term safety tests are regarded as 14 days; **why** none of the vaccines currently given to pregnant women or young children have been tested for their effect on fertility; **why** the HPV vaccine originally intended for girls has only histology available for testicles and not ovaries post vaccination (except corpus luteum counts); **why** the girls and young women in the 'One Million' Scandinavian HPV vaccine study were told that it was not a vaccine safety trial, just an efficacy trial and that the placebo would be saline when it was the whole vaccine minus the HPV portion, and included the aluminium adjuvant?

*"Therefore 38% of all measles cases in the USA in 2015, about which there was such a hue and cry with clamping down on peoples civil liberties and religious freedoms, were **caused** by the vaccine."*

The reaction to any of these questions is the opposite to, "*challenge is the fundamental tenet of scientific progress*". There are no answers. There is only denial, aggression or dismissal. One young man of my acquaintance who went with his wife to see a GP about vaccination to appease his mother-in-law, armed with facts, figures and questions, was told after a very short while, "*Get out of my office!*"

Back to the document and its core message:

• Prepare three key messages you really want the public to know and remember.
• The audience will not be able to recall or even transfer the provided knowledge when confronted with too much information.

'*The receptive powers of the masses are very restricted, and their understanding is feeble. On the other hand, they quickly forget*.'

• Keep your three key messages as simple as possible.

'*Such being the case, all effective propaganda must be confined to a few bare essentials and those must be expressed as far as possible in stereotyped formulas*.'

• Repeat your key messages as often as reasonably possible. '*These slogans should be persistently repeated until the very last individual has come to grasp the idea that has been put forward*.'

*(words in italics are not in the WHO document)

• Emphasize high safety instead of low risk (framing)
• Underline scientific consensus with regard to vaccine safety and efficacy.
• Emphasize the social benefits of vaccines. Psychological research shows that emphasizing the social benefit of vaccines increases an individual's intention to vaccinate.

HAS THIS GUIDANCE HAD AN IMPACT?

It would seem so. In 2003 Dr John Clements of the Department of Vaccines and Biologicals, World Health Organization was putting across the message that,"***vaccines are safe and effective and save millions of lives***" but this was not a universal slogan. However, after the publication of the WHO document the mantra started to appear more regularly. In 2017, Johns Hopkins public health expert Daniel Salmon was stating, "***The science is clear: Vaccines are safe, effective, and do not cause autism.***"[viii] By 2018 Solano County, California pediatrician Judy Yang was repeating,

"The science is VERY clear that vaccines are safe, effective, and do NOT cause autism."[ix] But in 2019 on the back of swingeing changes in United States vaccine laws, and with legislators on both sides of the Atlantic talking about forcing vaccination on unwilling citizens by mandatory measures, it became a veritable storm. In April, Senator Marsha Blackburn (Republican, Tennessee) co-introducer of the bipartisan 'Vaccines Save Lives Resolution recognizing the importance of vaccines and immunizations in the United States' said, "***Doctors have told us time and time again that the science is clear: vaccines save and improve lives***." [x] In the same month Jean Gough, Regional Director of UNICEF in South Asia stated, "***The scientific evidence is clear: vaccines are effective and help save lives.***" [xi] Senator Amy Klobuchar signed onto a Senate resolution in April 2019 noting ***the scientific consensus that vaccines are effective and safe***. In May 2019 USA Presidential Candidates were asked their views: "***Pete believes vaccines are safe and effective and are necessary to maintaining public health***,"said Mayor Pete Buttigieg's spokesman. Senator Elizabeth Warren said, "***Medical data proves (sic) vaccines are not linked to autism, that they are safe, effective, and our best chance of protecting people from diseases***." Governor Jay Inslee said, "***I believe in science — and the science on vaccines is crystal clear: vaccinations are safe and protect public health***." In May 2019 The American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association, and American Psychiatric Association issued a joint statement supporting vaccination claiming, "***The science is resoundingly clear: Vaccines are safe, effective, and save lives***." [xii] and by November the UK Secretary of State for Health and Social Care, Matt Hancock had taken it up: "***The science is beyond doubt: vaccines are safe. They are effective and they save lives and there is no alternative***." [xiii]

Does learning the psychological technique of repeating three simple points, ***until the very last individual has come to grasp the idea that has been put forward,'*** actually answer any questions about vaccine safety and efficacy? No.

The UK Department of Health says in the Immunisation against infectious diseases handbook (the Green Book), ***"There is now overwhelming evidence that MMR does not cause autism,"*** quoting a long list of studies. However, almost all of these studies were analysed by the Cochrane Collaboration reviews of 2005 and 2012, with the authors' conclusion stating: ***"The design and reporting of safety outcomes in MMR vaccine studies, both pre- and post-marketing, are largely inadequate."***[xiv] *If they are* ***'largely inadequate,' how can there be, "overwhelming evidence that MMR does not cause autism"?***

The studies quoted in the 'Green' Book but not included in the Cochrane Review were omitted because they were even more unsuitable than the ones that were reviewed (personal communication from author).** This is hardly a ringing endorsement of MMR vaccine safety. In addition the authors ***"identified no studies assessing the effectiveness of MMR vaccine against clinical or laboratory-confirmed rubella".***

Vaccines: safe and effective? The science is settled? I don't think so.

© Dr Jayne LM Donegan MBBS DRCOG DCH DFFP MRCGP MFHom
02 December 2019
jaynelmdonegan@yahoo.com
www.jayne-donegan.co.uk/

PART 02 WHAT'S NEXT?

The European Union has set as a target electronic ID card health records for recording vaccination status by 2022. See the next issue of The Informed Parent.

*Perceptive readers will recognise the quotes in italics (not in the WHO document) as being from 'Mein Kampf' (translation by J. Murphy).[xv]

**The next Cochrane, no longer a Collaboration, Review will be including some of these discarded studies and is likely to avow that the MMR is safe and effective.

REFERENCES

All References accessed 01 November – 02 December 2019

i https://www.bmj.com/content/362/bmj.k3948

ii https://www.bmj.com/content/362/bmj.k3694

iii https://www.bmj.com/content/363/bmj.k4152

iv https://nft.nu/sites/default/files/93104.pdf

v https://smile.amazon.co.uk/s?k=Malcolm+Brabant&ref=nb_sb_noss

vi https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4584705/pdf/153-154.pdf

vii https://www.ncbi.nlm.nih.gov/pubmed/27852670

viii https://hub.jhu.edu/2017/01/11/vaccines-autism-public-health-expert/

ix https://www.northbay.org/blog/your-wellness/2018/vaccines-save-lives.cfm

x https://www.blackburn.senate.gov/blackburn-duckworth-alexander-resolution-recognizing-importance-vaccines-passes-senate

xi https://www.unicef.org/rosa/stories/saying-no-vaccines-risking-childs-life

xii https://www.acog.org/About-ACOG/News-Room/Statements/2019/ACOG-Statement-Vaccines-Act?IsMobileSet=false

xiii https://www.telegraph.co.uk/news/2019/11/01/homeopaths-warning-mothers-not-have-children-vaccinated-investigation/

xiv https://www.cochrane.org/CD004407/ARI_using-combined-vaccine-protection-children-against-measles-mumps-and-rubella

xv http://www.greatwar.nl/books/meinkampf/meinkampf.pdf

DR DONEGAN'S FORTHCOMING LECTURES:

For more details please see: Lectures/Workshops at: www.jayne-donegan.co.uk/

TIP ARCHIVE

MEASLES VIRUS-SPECIFIC ANTIBODY LEVELS IN INDIVIDUALS IN ARGENTINA WHO RECEIVED A ONE-DOSE VACCINE

ARGUELLES, ORELLANA, CASTELLO ET AL

JOURNAL OF CLINICAL MICROBIOLOGY, Aug. 2006, p. 2733–2738 Vol. 44, No. 8

DISCUSSION

THIS SEROLOGICAL STUDY examined the prevalence of antibodies to measles in vaccinated children and teenagers following the national measles vaccination program in Argentina before 1998, which used a one-dose regimen.

Both cellular and humoral responses [7, 54–56] are involved in immunity to MV. Although passive administration of anti-bodies protects an individual against natural infection even in the absence of a cellular response [2], the importance of cellular immunity in clearing infection has been well established for immuno-deficient children [38]. The relevance of serum antibodies to susceptibility or immunity remains **an unsettled issue**. For this reason, the limit of 200 mIU/ml, although conventionally accepted as a protective level [3, 6, 13, 17, 22, 31, 35, 41, 48, 50], **should not be taken as an absolute**. However, determination of MV neutralizing antibodies closely correlates with protection from infection and disease [14].

Antibodies have traditionally been used as markers of vaccine-induced immunity because they are easier to measure and quantify than cell-mediated immunity [38]. Monitoring of humoral immunity is based upon detection of specific IgG anti-bodies, assessed mainly by immunoassays using the whole virus or recombinant proteins [10, 12, 20, 26, 49]. Neutralizing MV antibodies can be measured in vitro by standard neutralization test and more accurately by its enhanced version, the plaque reduction neutralization test [3, 14, 47]. However, the plaque reduction neutralization test is currently carried out in only a few laboratories in the world because of technical difficulties.

"Another important issue to consider is primary vaccine failure, which can increase the number of susceptible individuals in vaccinated populations."

The performances of the in-house methods described herein (EIA and NT EIA) were quite satisfactory with respect to sensitivity and specificity compared to a certified commercial EIA, indicating that these methods can be used as alternatives to estimate IgG levels in vaccinated populations. Although the discrepancies between these methods were low (1.43% for the in-house EIA and 4.6% for the NT EIA), samples considered negative by in-house methods were retested with a certified method to avoid misclassification of the specimens being evaluated.

Approximately 84% of children included in this study had measles antibody levels exceeding those values (200 mIU/ml) that are believed to confer protection [3, 6, 13, 17, 22, 31, 35, 41, 48, 50], whereas only 32% of teenagers showed IgG levels above 200 mIU/ml. Accordingly, the antibody levels to MV, expressed in mIU of IgG, showed a marked decrease with increasing age. These results are in agreement with previous observations [15, 19, 37] showing that vaccination-induced MV antibodies decline with time in the absence of natural booster infections or a second dose of vaccine. This indicates that a single-dose strategy at an early age results in IgG levels that vanish in adolescence, making this group at high risk of acquiring a milder or subclinical form of the infection [36, 45].

Although revaccination is advisable for all of those individuals, it should be taken into account that priming of T-cell immunity may have resulted because of vaccination, but very little neutralizing antibody could have been made [21]. However, upon exposure to wild-type measles those individuals may have mounted a memory response, sparing clinical disease [1].

On the contrary, antibody responses to the TT (tetanus toxoid) component of the trivalent vaccine were satisfactory in both 1- to 4-year-old children and teenagers. This difference might be explained by the fact that MV vaccine was given as a single dose, in contrast to the diphtheria, tetanus, and pertussis vaccine, which was given in four repeated doses according to the Argentine schedule.

Another factor that perhaps could have contributed to these results is the characteristic features of these vaccines. Attenuated MV vaccines are easily inactivated when the cold chain required for vaccine maintenance is discontinued [4], whereas the inactivated TT component of trivalent vaccines has a remarkable stability independent of storage temperature. Interruption of cold-chain facilities might represent a problem in temperate regions of low socioeconomic income, like suburban Buenos Aires neighborhoods [4].

Another important issue to consider is primary vaccine failure, which can increase the number of susceptible individuals in vaccinated populations [43]. Primary vaccine failures or failure to seroconvert may account for variable proportions of children without detectable MV antibodies after vaccination. Our data ›

indicate that about 16% of children from 1 to 4 years old might have undergone primary vaccine failures, since antibodies were not detected after vaccination. Failures to sero-convert have been shown to be dependent on several factors, including the number of doses, the strain included in the vaccine used, the geographical region, and the age of first vaccination because of persistence of maternal antibodies [8, 44]. However, a previous report showed that as many as 80% of Argentine infants were susceptible to MV infection at 9 months [39], indicating that they did not have maternally derived measles antibodies by the age of vaccination.

The susceptibility profile for a particular country can be estimated from vaccination coverage and disease incidence data, but the most direct evidence comes from seroprevalence studies [24].

Although the conclusions outlined here were based on a restricted number of individuals, they have provided some indication of the prevalence of antibody levels in vaccinated individuals with a single-dose monovalent vaccination schedule. In 1998, an epidemic outbreak of measles occurred in Argentina, where an 80 to 100-fold increase in the number of reported cases was registered [42]. Although no direct link can be drawn between the seroprevalence data from 1997 reported here and that outbreak, the absence of new epidemics in the country for the past 8 years could be related to the implementation of the two-dose schedule after 1998. A second dose with the trivalent formulation MMR II (Merck, Sharp & Dome) has been included at the age of 6 years. This vaccine has been used for the first immunization at 12 months, replacing the monovalent vaccine. Including a second dose will not only provide a new opportunity to vaccinate children who did not receive the first dose but also reduce the number of primary vaccine failures. Additionally, it will boost the titers in already-vaccinated individuals.

The information obtained from the present study may be useful in future years to evaluate and compare immune statuses achieved with the two-dose regimen introduced in Argentina in 1998.

WE NEED AN INFORMED VACCINATION DEBATE


Photo by Shelagh Murphy on Unsplash

WALESONLINE
Western Mail letters:
Tuesday, 8 October 2019

LETTER FROM:
DR NOEL THOMAS, MAESTEG

YOUR EDITORIAL (October 5) states that "'Anti-vaxxers' are a menace to heath".

On the contrary, many of those who raise questions about vaccination are emphatically pro-child health and pro-informed consent to vaccination, as I am.

The questions we raise are concerned with the increasing vaccine load, the timing of vaccinations, and their many adverse effects, which are detailed in the Patient Information Leaflets for each vaccine (PILs).

How often are those PILs shown to parents and discussed in detail, as UK law demands ?

Recent correspondence in the British Medical Journal confirmed that there have been no valid safety studies on any vaccines in the UK childhood schedule.

This remarkable fact has not been mentioned in the public media, which adds to the concern of informed observers. Your editorial mentions a recent rise in reports of mumps, an inevitable result of the poor protection that is conferred by the mumps component of the MMR vaccine, a problem that has been recognised for many years. Mumps, a trivial infection of childhood in the past, has been postponed by vaccination until young adulthood, when artificial immunity has waned. The illness is then more unpleasant, complications are more common and sometimes serious.

The official advice to repeat the MMR, in young adults, neglects to mention that the immune response wanes with repeated vaccinations, which will presumably have to be continued throughout life?

Your editorial mentions a drop in uptake of the "six in one" vaccine. Given thrice in the first year, this vaccine contains Hepatitis B vaccine. Hepatitis B is a very rare problem in childhood in the UK, unless the mother is already infected, when prenatal screening will ensure protective postnatal vaccination.

The main risk factors for Hepatitis B are IV drug use and multiple sexual partners; both are unlikely in childhood.

Research suggests the immunity from Hepatitis B vaccine will be of little use, by the age of 18 years, when those habits become more likely.

These are only a few of the many issues which concern informed parents, and unless their concerns are addressed, then online comment and discussion, with understandable vaccine hesitancy, are inevitable.

We need an informed debate and greater awareness about vaccination policy. Professionals, the media and the vaccine industry must recognise that parents have a legal right to know all the information that is available about vaccine safety and effectiveness.

To deny parents that right, and to label them "anti-vaxxers" when they speak up, is perhaps a sign of weakness, rather than strength.

A SERIOUS LAWSUIT: "AN EXPERIMENTAL VACCINE WAS GIVEN TO HUNDREDS OF THOUSANDS BABIES IN ISRAEL"

DR. YAFFA SHIR-RAZ

Full text can be accessed online at ageofautism.com (Published 27 Nov 2019). The following text are just a few extracts.

EXTRACTS

AN EXPERIMENTAL, FLAWED, dangerous and harmful vaccine was given to newborns and infants in Israel, without informing their parents and without obtaining their informed consent. These serious allegations were raised last Wednesday in a lawsuit filed by Attorney Dr. Ahuva Ticho against the Israeli Ministry of Health and Scivac, the manufacturer of Sci-B-Vac. Between 2011 and 2015, Sci-B-Vac, a Hepatitis B vaccine made in Israel, was given, to 428,000 newborns and infants in Israel.

The lawsuit, for bodily injuries allegedly caused as a result of the vaccine, was filed on behalf of two children and their parents. At the same time, a motion for certification of a class action was filed against Scivac last Thursday, by attorneys David Or-Chen and Ahuva Ticho, in the amount of NIS 1,879,500,000. The class action alleges misrepresentation, loss of autonomy, exploiting distress and breach of duty to inform consumers.

The motion for certification of a class action was filed on behalf of the two children and their parents. According to an opinion that accompanies the statement of claim, by Prof. Avinoam Shofer, a pediatric neurologist, there is a reasonable basis to determine that Sci-B-Vac is the cause of the functional-developmental impairment in the two children for whom the lawsuit was filed, in the absence of any other known possible cause. With respect to plaintiff A, the statement of claim alleges that he suffers from a severe seizures disease, epilepsy, and a developmental delay. He has multiple seizures, up to 40 a day. At the age of four, he does not speak yet, and apart from the word "father", he does not even make syllables, only sounds. As for plaintiff B, according to Prof. Shofer's opinion, his symptoms and test results indicate that he suffered from a vaccine-associated encephalitis, and today suffers from a developmental delay.

"Over the past three years, in an attempt to find answers, dozens of documents that reveal additional details regarding the decisions to approve the vaccine and include it in the immunization schedule, and regarding the recall, were collected."

THE TIP OF THE ICEBERG

The Sci-B-Vac story was exposed three years ago, on Ynet, an Israeli news website, following the Israeli Ministry of Health announcement of a recall of the Sci-B-Vac vaccine. The recall was announced on July 29, 2015, and applied to all the batches distributed since 1.1.2012. According to the recall notice, the reason for the recall, was "a technical failure in packaging". The notice emphasized that the recall was conducted as a precautionary measure only and that there were no reports of concerns regarding the efficacy and safety of the vaccine. Two weeks later, in response to Ynet's investigation, the Ministry of Health issued a clarification notice, stating that the nature of the problem was "a concern about possible cracks in the vials, claimed to be the result of "a problem of a lack of synchronization at the rate of feeding the vials and labels into the machine." However, the later explanation did not reassure parents. In fact, the clarification notice may have increased parents' anxiety, especially given a recall announcement published online at the same time, by the Hong Kong Ministry of Health, where several hundred batches of the vaccine were sold. The latter announcement warned of a risk of infection and sepsis, and instructed the public to consult their healthcare professional, if in doubt or feeling unwell.

It was later revealed that the defect leading to the recall was only the tip of the iceberg. To date, Scivac has not received approval from any Western regulatory agency, such as the FDA or EMA. The company's documents show that the company's clinical studies, which the Israeli Ministry of Health relied upon to approve the vaccine and introduce it into the routine immunization schedule for infants, included only two phase III studies in neonates, with a scant number of participants.

THE STUDIES ARE A "TRADE SECRET"

Following the publication of the Ynet's report on the recall, Ynet and the Movement for Freedom of Information in Israel, and later on lawyers and parents whose children received the vaccine, submitted numerous requests under the Freedom of Information Act. They sought access to documents, protocols and company's clinical trials that would allow the public and clinicians to understand the basis for the vaccine's approval for marketing and its inclusion in routine immunization schedules for infants, as well as understanding the cause of the recall.

However, all Freedom of Information requests were refused. The Ministry of Health has repeatedly claimed that the clinical trials were "the manufacturer's trade secret" and that the protocols of committee discussions in which the vaccine was approved and included in the routine immunization schedule for infants " were not in the possession" of the Israeli Ministry of Health.

Scivac did not provide any answers either. In response to a request by Attorney Ticho, which was forwarded to Scivac's attorneys, Perl Cohen et al, it was claimed that "Sci-B- Vac marketed by our client was not defective. The reason for conducting the recall... was a specific failure in the vaccination package - which does not affect the

Photo by Irina Murza on Unsplash

efficacy and / or safety of the vaccine; and without any implications for those vaccinated in the past and / or in the future. Your request for information and documents is rejected."

Over the past three years, in an attempt to find answers, dozens of documents that reveal additional details regarding the decisions to approve the vaccine and include it in the immunization schedule, and regarding the recall, were collected.

HOW MANY NEWBORNS WERE INCLUDED IN PHASE 3 TRIALS?

In a response to Ynet's investigative report, the Israeli Ministry of Health stated that "the State of Israel is a sovereign state and has an advanced drug registration system, at a level that is not inferior to large and well-respected health authorities, such as the FDA and the EMA, and therefore is able to examine and evaluate the data submitted to it". Even if this were true, the question is why, in this particular case, when it came to immunizing neonates and infants – the most vulnerable population, the Ministry of Health found it appropriate to stray from its policy? This is particularly puzzling when a vaccine which did have both FDA and EMA approval and a recognized safety profile was available, and had been in use for years, in Israel and throughout the world. Furthermore, the question arises whether the safety and efficacy studies were indeed carried out in accordance with the FDA and EMA standards. The lawsuit alleges that, the decision to introduce the vaccine into the routine immunization schedule for infants was made "without the defendant 2 (Scivac) conducting safety studies worthy of Phase III, in infants and newborns, prior to its approval and introduction for use, as opposed to what is required by its procedures".

Phase 3 is the crucial stage in clinical trials, designed to ensure the efficacy and safety of drugs and vaccines in a large number of patients. According to scientific sources attached to the statement of claim, "the FDA requires phase III studies involving thousands, if not tens of thousands of subjects". The Ministry of Health has argued in response to Ynet that "Phase III trials of the vaccine included more than 3,000 people. Of these, more than 1,000 were infants".

However, based on a May 1, 2015 official Scivac document, this claim seems to be incorrect. A table in the document, summarizes the main clinical studies carried out by the company. The table shows that four studies were defined by the company as Phase 3, of which only two were in newborns, totaling 276 newborns only.

GENERIC OR "NOVEL" VACCINE?

In response to Ynet's inquiring why the company was not required to provide large-scale safety studies before the vaccine was approved, the Ministry of Health claimed that there was no need for them, since "this is a vaccine similar to the existing vaccine."

BUT IS THAT IN FACT SO?

In its studies, the company calls Sci-B-Vac an "a novel" vaccine, and presents it as a "third-generation vaccine". This is in contrast to hepatitis B second-generation vaccines, such as Engerix B. According to the lawsuit, Sci-B-Vac "is a new vaccine, which is not an alternative and/or not a generic and/or not an improved vaccine, compared to Engerix" and is "substantially different by a number of technological-scientific parameters, each of which in itself increases the risk for contamination and/or morbidity".

The writer holds a Ph D in Health Communication from the University of Haifa, Israel, and is a health communication researcher and health journalist.

AIMS & OBJECTIVES OF THE *informed* PARENT GROUP

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

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

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