THE informed PARENT
ISSUE THREE 2021 A NEWSLETTER ON VACCINATION ISSUES AND HEALTH

EVALUATING COVID-19 VACCINE EFFICACY AND SAFETY IN THE POST-AUTHORISATION PHASE

PRUGGER C, SPELSBERG A, KEIL U, ERVITI J, DOSHI P.
FULL ARTICLE: BMJ 2021;375:E067570

WHEN covid-19 vaccines were first authorised, regulators required post-authorisation studies to tackle important uncertainties about efficacy and safety. But these studies may have little practical value unless there is greater engagement and scrutiny from the wider scientific community, argue Christof Prugger and colleagues

A BRIEF OVERVIEW BY TIP EDITOR, MAGDALENE TAYLOR

This article, published in the BMJ December 2021, evaluates the quality of post-authorisation studies relating to the covid-19 vaccines. The authors begin by stating that to achieve earlier access to new medicines the reliance on less robust forms of evidence at the time of approval is used. They point out that there is a long history of concerns about the wisdom of shifting clinically important efficacy and safety assessments from before to after authorization.

'Post-authorisation studies often fail to deliver—lots of studies are never started, many take years longer than planned, and some fail to confirm pre-authorisation results. Evidence on relevant outcomes often remains inconclusive for several years….'

The Covid-19 vaccines are used as an example of expedited regulatory approval and the authors call for 'independent scrutiny' of the studies alongside the right questions being asked and answered. They also comment that 'extra scrutiny would help improve the historically poor track record of required post-authorisation studies.'

According to the authors, regulators and drug companies currently negotiate post-authorisation requirements behind closed doors. The authors argue for an open review of proposed study designs by independent scientists and patients, especially important in view of emerging reports of "poor research conduct, lax data management, and a lack of regulatory oversight" at one of the companies involved in a pivotal covid-19 vaccine trial.

To illustrate the need for third party scrutiny the authors compiled a list of 21 studies specified in risk management plans after conditional authorisation by EMA of Pfizer-BioNTech and Moderna vaccines. Only five of the 13 Pfizer-BioNT and five of the 8 Moderna studies had study protocols or summary information available, the authors could not locate the information for the other 11 studies.

The authors state: 'The post-authorisation studies being prioritised by manufacturers seem to be those aimed at developing new vaccines or obtaining approval for additional doses of the current vaccines. The need for data on hard outcomes such as hospital and intensive care admissions or death in moderate or high risk populations is being overlooked.'

The EMA is the only regulator that provides access to data and documents from mandated post-authorisation studies, which allows public access. To the authors knowledge the UK MHRA does not have any plans for proactive release of data. They also point out that there is a great lack of funding regarding regulatory studies and that both the scientific community and the public increasingly perceive the urgent need for independent evaluation of regulatory requirements.

The article ends with 5 key

messages from the authors:

- Expedited approval of medicines by regulatory authorities often postpones the evaluation of important efficacy and safety endpoints until after medicines are widely available
- For such medicines, well designed, conducted, analysed, and reported post-authorisation studies are vital to ensuring confidence that benefits actually outweigh risks
- Covid-19 vaccines were widely administered following "conditional" authorisation based on short clinical trials, when important questions remained unanswered
- Regulators require sponsors to carry out post-authorisation safety and efficacy studies, which often remain relatively unknown outside of specialist circles, and there is a history of insufficient compliance and regulatory oversight
- Independent researchers must help scrutinise the design, conduct, data reporting, and overall transparency of post-authorisation studies mandated by regulators, particularly for global public health interventions such as covid-19 vaccines.


Magda Taylor

Editor's note

MY APOLOGIES for this very delayed edition (Iss.3 2021). Thank you for your patience and the first edition for this year is due out in April.

As we head for the 2-year anniversary of this highly questionable pandemic which we have been told has been taking place, I have included further articles which continue to bring into question aspects on the existence of the virus and the questionable safety and efficacy of the mRNA products. Everyday news and data emerges and sifting through what appears to be trustworthy and then attempting to check out the source or reference is very time consuming. Each and every one of us has to decide what we perceive as reliable, especially as we are warned by officialdom of the increased circulation of misinformation, disinformation and stories by conspiracy theorists or extreme right-wing anti-vaxxers. It appears however, that a growing number of people may consider that it is our authorities who are the experts in the field of questionable data.

When I first became involved in setting up The Informed Parent back in September 1992 I had absolutely no idea that this subject would unfold into what has taken place since March 2020. There has hardly been mention of the childhood diseases from msm as the covid story has eradicated the measles scare stories or alarming reports on other childhood acutes, it seems. However we are seeing a huge contradiction now in regards to the health of the children worldwide. Children aged 5-11 are now being targeted to receive this gene therapy product (labelled a mRNA vaccine) in some parts of the world.

Why do I say contradiction? For nearly 2 years we have been told that children are not at risk from this alleged disease and most of the attention has been on the adults with a number of restrictions brought in, lockdowns, masks, the jabs and boosters. Now we are told that we can go back to normal life, go back to work, learn to live with this alleged virus, no masks needed etc. And yet at the very same time the age group that were always considered the least at risk have suddenly become the target group. Will this jab and boosters find its way into the recommended immunisation schedule, an annual dose alongside the flu nasal spray vaccine given in the early part of the school term to the vast majority of schoolchildren? Flu was never viewed as an issue when I was at school in the 1960s and early seventies. Nor was it seen as an issue in the late 1980s and nineties when my daughters attended school. Parents were not worrying about whether their child would get through the year without developing flu. It was not an issue then, why should it be an issue now? If children are supposedly benefitting from all the vaccines introduced into the schedule over the last few decades, then shouldn't they be healthier? Why would they be developing the flu?

For those of you who are just embarking on your investigation of vaccination I strongly urge you to first research the background story ie the history and the theoretical foundations this procedure is based on. After all, theories are theories not facts, and science should be ever-evolving not set in stone, never to be questioned. Follow the science we are told - as if the science is a thing. But what about the other scientific theories and hypothesis out there? One thing that is a fact and not a theory is that you do not need to be a scientist or read scientific papers to be healthy!

***Magdalene Taylor**, **Editor**. January 2022.*

BREAKING THE SPELL: THE SCIENTIFIC EVIDENCE FOR ENDING THE COVID DELUSION

BY THOMAS S COWAN MD, 2021

PDF booklet available at:

www.drtomcowan.com

EXTRACT

IT IS INSTRUCTIVE to examine carefully one of the most influential papers written about the isolation and characterization of SARS-CoV-2 (1). The importance of this paper is that it claims to document the isolation of SARS-CoV-2 from the first patient diagnosed with COVID-19 in Australia. Therefore, it takes its place as one of the most critical papers published regarding the emergence of SARS-CoV-2 outside of its supposed country of origin, China.

As you will see, the authors of this paper (Caly et al.) follow the same script as the one used by Enders more than six decades ago. In the first section, they describe the clinical situation of the affected patient. Then comes the hunt for the virus. As always:

"Material from the initial nasopharyngeal swab was used to inoculate a Vero/hSLAM cell line" (1).

Translated, this means that an unpurified sample of the mucus from the patient's nose and throat was inoculated onto a culture of monkey kidney cells. The researchers made no attempt to look for the actual virus or to test for the genome of the virus in the swab sample from the patient. Only a RT-PCR (reverse transcription polymerase chain reaction) analysis was done, which I will discuss in the next chapter.

In the body of the paper, there is no description of the actual culture methods, but in the supporting material, the authors describe the usual use of a minimal nutrient medium and the addition of two antibiotics (gentamicin and amphotericin) to the growth medium. Predictably, this starvation and poisoning of the cells results in the cells' breaking down (the CPE) and the production of "viral" particles liberated into the culture medium. This process also means that, along with extracellular vesicles/viruses, numerous sources of genetic material will be present in the final culture. These include any potential exogenous viruses that might have infected the patient (if such viruses even exist), genetic particles from the unpurified swab sample from the patient, fetal calf serum and the monkey kidney cells. Yet Caly and colleagues make no attempt to determine where the genetic material that was tested for originated. The authors then describe the electron micrographs done on the resulting culture fluid:

"Electron micrographs of sectioned Vero/hSLAM cells showed cytoplasmic membrane-bound vesicles containing coronavirus particles (Box 5, B). Following several failures to recover virions with the characteristic fringe of surface spike proteins, it was found that

adding trypsin to the cell culture medium immediately improved virion morphology". In other words, the particles the Australian researchers call "coronaviruses" included the characteristic halo of spike proteins only after the investigators added trypsin to the culture medium. Trypsin is a protein-digesting enzyme; viruses are alleged to have a protein "coat." It would be reasonable to assume that if one adds protein-digesting enzymes to particles with a protein coating, some of the protein coating will be eaten away, leaving a final particle that might look in an electron micrograph as if it has spikes. This lab-induced result obviously would bear no relationship to what such a particle might look like inside a live person. There is only one rational, logical and scientific conclusion that one can draw from this paper: These researchers had no idea what made the Vero/hSLAM cells break down. Moreover, they had no idea where any genetic material they subsequently tested for originated. Finally, they did not find any particle with the characteristic morphology of a coronavirus until they manufactured its appearance. In sum, there is no evidence in this paper that any particle known as SARS-CoV-2 was found, or that any virus had anything to do with this Australian person's illness.

In every paper published on the "isolation" and characterization of SARS-CoV-2, the first step in the experiment is to do the viral culture. Every analysis of the genome of the "virus" has been done on the results of these culture experiments, not on fluid taken directly from any sick person. Conventional virologists present the CPE (cytopathic effect) as THE proof that the virus exists AND causes disease.

Thus, our next step is to look at the recent experiments of Stefan Lanka as he attempted to do proper scientific studies to understand exactly how the CPEs that virologists are reporting come about. Stefan Lanka, a virologist who is credited with discovering the first "giant" virus living in an organism in the ocean, decided to put the cytopathic-effect phenomenon to a rigorous test. The question he tried to answer is a simple one: Is the CPE caused by the presence of a pathogenic virus, or is it the result

Thomas Cowan MD

of the culturing process?

Here is the essence of Lanka's experiment, done by an independent professional laboratory that specializes in cell culturing. As seen in this series of photographs, each of the four vertical columns is a separate experiment. The top photo in each column was taken on day one, and the bottom photo was taken on day five. (For images see full PDF document).

In vertical column one, normal cells were cultured with normal nutrient medium and only a small amount of antibiotics. As you can see, on neither day one nor day five was any CPE found; the cells continued their normal, healthy growth. In vertical column two, normal cells were again grown on normal nutrient medium and a small amount of antibiotics, but this time, 10% fetal calf serum was added to enrich the medium. Still, the cells in the culture grew normally, both on day one and day five.

The third vertical column shows what happened when Dr. Lanka's group used the same procedures that have been used in every modern isolation experiment of every pathogenic virus that I have seen. This included changing the nutrient medium to "minimal nutrient medium"—meaning lowering the percentage of fetal calf serum from the usual 10% to 1%, which lowers the nutrients available for the cells to grow, thereby stressing them—and tripling the antibiotic concentration. As you can see, on day five of the experiment, the characteristic CPE occurred, "proving" the existence and pathogenicity of the virus—except, at no point was a pathogenic virus added to the culture. This outcome can only mean that the CPE was a result of the way the culture experiment was done and not from any virus.

The fourth and final vertical column is the same as vertical column three, except that to this culture, a solution of pure RNA from yeast was added. This produced the same result as column three, again proving that it is the culture technique—and not a virus—that is causing the CPE. The reason for adding the yeast RNA is because of the way that the genome of a "virus" is found, a computerized process called "alignment."

The alignment process starts with fragments of RNA and constructs a theoretical genome—one that never exists at any point in the actual sample. This genome never exists in any person, and it never exists intact even in the culture results; it exists only inside the computer, based on an alignment process that arranges these short pieces into an entire "genome." It is for this reason that every complete genome of SARS-CoV-2 is referred to as an "in silico" genome, meaning a genome that exists only in the computer. As long as you have enough of these RNA fragments and provide the template, the computer can recreate any genome. Knowing how the alignment process works, we can now understand what Dr. Lanka's fourth experiment actually showed. He was able to show that any RNA virus genome can be found in the results of the cell culture from the fourth experiment. Yet at no time were any of these viruses added or present in the experiment. At this point, it should be clear that the existence of SARS-CoV-2 has never been scientifically proven. And because the virus has never been shown to exist, there is no way we can conclude that this virus causes any disease, has any "variants," contains any particular protein—in particular, the now famous spike protein—or has any other characteristics. In addition, we can now turn our attention to the COVID tests. If the virus hasn't been shown to exist, and if the main researchers who came up with the tests for the virus admit in writing that they never worked with or had possession of an actual virus, what, actually, is a COVID test looking for? This question also points to an important corollary, which is to understand how COVID testing has been manipulated to implement governmental measures that have done great harm to the peoples of the world.

A NEED TO QUESTION FURTHER: Extracts from Dr Andrew Kaufman interview with Jason Liosatos

EXTRACT FROM VIDEO INTERVIEW (AROUND 53 MINS IN)

https://www.bitchute.com/video/2kqobF0QlMYv

DR ANDREW KAUFMAN – "But I'll tell you, Jason, what's really been frustrating me lately is that there are a lot of doctors and scientists who are trying to promote freedom, and they're on our side, of course, and I'm happy to have more team mates, but they're purposely trying to ignore the research, the fundamental research on viruses and biology, they don't want to question it, they want to just kind of pretend that it's true and stick with that, even though when they've examined the things about the pandemic, they can see it's not true, right?

They say it's just a mild disease, right? Or they say it should be treated with anti-parasitic drugs instead of with ventilators and vaccines, but they're unwilling to actually look deeper even though they've seen okay, it's false at this level, they don't say to themselves, hey maybe it's false at the next level too, let me take a look, right? And part of this is maybe an unwillingness to change your profession.

I couldn't keep practicing medicine once I realised that it was based on false conclusions, I had to change what I did"…"now if you look at the actual science where this comes from, which it seems that I'm one of the few people who have done because many of them say, well in the animal studies all the animals died, you must have heard that all the ferrets died, right? That is a complete falsehood, it's a lie actually, I've looked at every single study and not one study did any animals die, they didn't even get sick, the ferrets didn't even show any symptoms, and of course they weren't exposed to a virus either, they were exposed to a toxic cell culture that was forced up their nose under pressure, like with a pneumatic pressure gun, which is not how things work in nature, but if you didn't look at the actual proof of the virus and realise there was no proof and there was no virus, and ("there's still a million dollar reward for someone who can show it, yes,") yes of course, but if you realise that fact, then you'd know right off the bat that there can't be any antibody dependent enhancement (ADE) because there's no virus to enhance it against, right?

And you realise that if there's any bad reactions it's just from the vaccine because the vaccines have poison that's what they're pretty much made of, not that you should even call them vaccines, these covid genetic injections, but you see that people in the freedom movement are mongering fear that this winter that lots of people are going to die from this false theory, right? Totally made up and what is the result if we really do see people dying?

It will be blamed on the virus, which doesn't exist and it will perpetuate the idea that viruses are dangerous right?"…"and this is the problem that we could get into that a lot of people who are fighting for freedom and aware of some degree of truth, if they don't know the full truth, they could get manipulated back into compliance of some sort, and it's really difficult to see people out there doing something good but not willing to look at the whole truth."

FOR NEW PARENTS

WHEN The Informed Parent newsletter was first published back in September 1992 the articles were predominantly looking at the different vaccines and their relating diseases.

Due to the wide range of people subscribing from all walks of life, including those with medical or science backgrounds I have tried to include texts that would stimulate a desire to investigate the subject further from a variety of angles.

Some individuals have been reading TiP newsletter for almost 30 years, whilst others are new to the subject and are only just getting started.

I realise that since March 2020 the editions have been dominated by the covid narrative, which whilst of interest for those more familiar with the subject, is not the primary reason to subscribe to the newsletter.

When contacted directly by new parents I always encourage them to firstly investigate the procedure itself.

Is vaccination a procedure based on sound science and scientific facts? Is the science settled? What are the

EVIDENCE FOR A CONNECTION BETWEEN CORONAVIRUS DISEASE-19 AND EXPOSURE TO RADIOFREQUENCY RADIATION FROM WIRELESS COMMUNICATIONS INCLUDING 5G

J CLIN TRANSL RES. 2021 OCT 26; 7(5): 666–681. PMID: 34778597
BEVERLY RUBIK & ROBERT R. BROWN
https://pubmed.ncbi.nlm.nih.gov/34778597/

ABSTRACT

Coronavirus disease (COVID-19) public health policy has focused on the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus and its effects on human health while environmental factors have been largely ignored. In considering the epidemiological triad (agent-host-environment) applicable to all disease, we investigated a possible environmental factor in the COVID-19 pandemic: ambient radiofrequency radiation from wireless communication systems including microwaves and millimeter waves. SARS-CoV-2, the virus that caused the COVID-19 pandemic, surfaced in Wuhan, China shortly after the implementation of city-wide (fifth generation [5G] of wireless communications radiation [WCR]), and rapidly spread globally, initially demonstrating a statistical correlation to international communities with recently established 5G networks.

In this study, we examined the peer-reviewed scientific literature on the detrimental bioeffects of WCR and identified several mechanisms by which WCR may have contributed to the COVID-19 pandemic as a toxic environmental cofactor. By crossing boundaries between the disciplines of biophysics and pathophysiology, we present evidence that WCR may: (1) cause morphologic changes in erythrocytes including echinocyte and rouleaux formation that can contribute to hypercoagulation; (2) impair microcirculation and reduce erythrocyte and hemoglobin levels exacerbating hypoxia; (3) amplify immune system dysfunction, including immunosuppression, autoimmunity, and hyperinflammation; (4) increase cellular oxidative stress and the production of free radicals resulting in vascular injury and organ damage; (5) increase intracellular Ca2+ essential for viral entry, replication, and release, in addition to promoting pro-inflammatory pathways; and (6) worsen heart arrhythmias and cardiac disorders.

CONCLUSIONS

There is a substantial overlap in pathobiology between COVID-19 and WCR exposure. The evidence presented here indicates that mechanisms involved in the clinical progression of COVID-19 could also be generated, according to experimental data, by WCR exposure. Therefore, we propose a link between adverse bioeffects of WCR exposure from wireless devices and COVID-19.

Specifically, evidence presented here supports a premise that WCR and, in particular, 5G, which involves densification of 4G, may have exacerbated the COVID-19 pandemic by weakening host immunity and increasing SARS-CoV-2 virulence by (1) causing morphologic changes in erythrocytes including echinocyte and rouleaux formation that may be contributing to hypercoagulation; (2) impairing microcirculation and reducing erythrocyte and hemoglobin levels exacerbating hypoxia; (3) amplifying immune dysfunction, including immunosuppression, autoimmunity, and hyperinflammation; (4) increasing cellular oxidative stress and the production of free radicals exacerbating vascular injury and organ damage; (5) increasing intracellular Ca2+ essential for viral entry, replication, and release, in addition to promoting pro-inflammatory pathways; and (6) worsening heart arrhythmias and cardiac disorders.

WCR exposure is a widespread, yet often neglected, environmental stressor that can produce a wide range of adverse bioeffects. For decades, independent research scientists worldwide have emphasized the health risks and cumulative damage caused by WCR [42,45].

The evidence presented here is consistent with a large body of established research. Healthcare workers and policymakers should consider WCR a potentially toxic environmental stressor. Methods for reducing WCR exposure should be provided to all patients and the general population.

benefits and what are the risks? Are we a much healthier world population post vaccination? Did smallpox vaccine rid the world from smallpox?

There is a suggested reading list on my website in the drop-down menu under INFO. Even though many more publications and videos continue to emerge on the internet I highly recommend reading widely.

Books written in the 1980s and nineties still contain many relevant texts, and personally I have found some of the historical books from the 1800s a great eye-opener on the subject.

In the past I produced a Special Edition – a selection of articles from 1993 – 2005 featured in TiP newsletters. For a number of years this has only been available as a downloadable pdf once paper copy stocks were depleted.

I will be aiming to produce another special edition featuring articles from 2006 to the present time that particularly focus on aspects newcomers to the subject may find beneficial.

I intend to include it with the initial mail out for all new subscribers and also made available to all existing subscribers if interested.

COVID-19: STIGMATISING THE UNVACCINATED IS NOT JUSTIFIED

BY GÜNTER KAMPF, THE LANCET
Volume 398, Issue 10314, 20–26 20 November 2021, Page 1871.

IN THE USA and Germany, high-level officials have used the term pandemic of the unvaccinated, suggesting that people who have been vaccinated are not relevant in the epidemiology of COVID-19. Officials' use of this phrase might have encouraged one scientist to claim that "the unvaccinated threaten the vaccinated for COVID-19".[1] But this view is far too simple.

There is increasing evidence that vaccinated individuals continue to have a relevant role in transmission.

In Massachusetts, USA, a total of 469 new COVID-19 cases were detected during various events in July, 2021, and 346 (74%) of these cases were in people who were fully or partly vaccinated, 274 (79%) of whom were symptomatic. Cycle threshold values were similarly low between people who were fully vaccinated (median 22·8) and people who were unvaccinated, not fully vaccinated, or whose vaccination status was unknown (median 21·5), indicating a high viral load even among people who were fully vaccinated.[2] In the USA, a total of 10 262 COVID-19 cases were reported in vaccinated people by April 30, 2021, of whom 2725 (26·6%) were asymptomatic, 995 (9·7%) were hospitalised, and 160 (1·6%) died.[3] In Germany, 55·4% of symptomatic COVID-19 cases in patients aged 60 years or older were in fully vaccinated individuals,[4] and this proportion is increasing each week. In Münster, Germany, new cases of COVID-19 occurred in at least 85 (22%) of 380 people who were fully vaccinated or who had recovered from COVID-19 and who attended a nightclub.[5] People who are vaccinated have a lower risk of severe disease but are still a relevant part of

the pandemic. It is therefore wrong and dangerous to speak of a pandemic of the unvaccinated. Historically, both the USA and Germany have engendered negative experiences by stigmatising parts of the population for their skin colour or religion. I call on high-level officials and scientists to stop the inappropriate stigmatisation of unvaccinated people, who include our patients, colleagues, and other fellow citizens, and to put extra effort into bringing society together.

I declare no competing interests.

Günter Kampf
guenter.kampf@uni-greifswald.de
University Medicine Greifswald, Institute for Hygiene and Environmental Medicine, 17475 Greifswald, Germany.

REFERENCES

1 Goldman E. How the unvaccinated threaten the vaccinated for COVID-19: a Darwinian perspective. Proc Natl Acad Sci USA 2021; 118: e2114279118.

2 Brown CM, Vostok J, Johnson H, et al. Outbreak of SARS-CoV-2 infections, including COVID-19 vaccine breakthrough infections, associated with large public gatherings—Barnstable County, Massachusetts, July 2021. MMWR Morb Mortal Wkly Rep 2021; 70: 1059–62.

3 US Centers for Disease Control and Prevention COVID-19 Vaccine Breakthrough Case Investigations Team. COVID-19 vaccine breakthrough infections reported to CDC—United States, January 1–April 30, 2021. MMWR Morb Mortal Wkly Rep 2021; 70: 792–93.

4 Robert Koch Institut. Wöchentlicher Lagebericht des RKI zur Coronavirus- Krankheit-2019 (COVID-19) — 14·10·2021— aktualisierter Stand für Deutschland. Oct 14, 2021. https://www.rki.de/DE/Content/InfAZ/N/Neuartiges_Coronavirus/Situationsberichte/Wochenbericht/Wochenbericht_2021-10-14.pdf?__blob=publicationFile (accessed Oct 18, 2021).

5 Von Dolle F. Münster: Inzwischen 85 Infizierte nach 2G-Party im Club. Sept 20, 2021. https://de.mirroronline.net/party/infizierte-nach-party-0648662 (accessed Sept 23, 2021).

EPIDEMIOLOGY OF ACUTE MYOCARDITIS/PERICARDITIS IN HONG KONG ADOLESCENTS FOLLOWING COMIRNATY VACCINATION

CLIN INFECT DIS. 2021 NOV 28
PMID: 34849657
HTTPS://PUBMED.NCBI.NLM.NIH.GOV/34849657

ABSTRACT

Results: Between 14 June 2021 and 4 September 2021, 33 Chinese adolescents who developed acute myocarditis/pericarditis following Comirnaty vaccination were identified. 29 (87.88%) were males and 4 (12.12%) were females, with a median age of 15.25 years. 27 (81.82%) and 6 (18.18%) cases developed acute myocarditis/pericarditis after receiving the second and first dose, respectively. All cases are mild and required only conservative management. The overall incidence of acute myocarditis/pericarditis was 18.52 (95% Confidence Interval [CI], 11.67-29.01) per 100,000 persons vaccinated. The incidence after the first and second doses were 3.37 (95%CI 1.12-9.51) and 21.22 (95%CI 13.78-32.28 per 100,000 persons vaccinated, respectively. Among male adolescents, the incidence after the first and second doses were 5.57 (95% CI 2.38-12.53) and 37.32 (95% CI 26.98-51.25) per 100,000 persons vaccinated.

Conclusions: There is a significant increase in the risk of acute myocarditis/pericarditis following Comirnaty vaccination among Chinese male adolescents, especially after the second dose.

CHARACTERISTICS AND OUTCOMES OF PATIENTS WITH CEREBRAL VENOUS SINUS THROMBOSIS IN SARS-COV-2 VACCINE–INDUCED IMMUNE THROMBOTIC THROMBOCYTOPENIA

ORIGINAL INVESTIGATION

September 28, 2021

JAMA NEUROL, 2021; DOI:

10.1001/JAMANEUROL 2021.3619

https://tinyurl.com/2t8jba8d

ABSTRACT

Importance: Thrombosis with thrombocytopenia syndrome (TTS) has been reported after vaccination with the SARS-CoV-2 vaccines ChAdOx1 nCov-19 (Oxford–AstraZeneca) and Ad26.COV2.S (Janssen/Johnson & Johnson).

Objective: To describe the clinical characteristics and outcome of patients with cerebral venous sinus thrombosis (CVST) after SARS-CoV-2 vaccination with and without TTS.

Design, Setting, and Participants: This cohort study used data from an international registry of consecutive patients with CVST within 28 days of SARS-CoV-2 vaccination included between March 29 and June 18, 2021, from 81 hospitals in 19 countries. For reference, data from patients with CVST between 2015 and 2018 were derived from an existing international registry. Clinical characteristics and mortality rate were described for adults with (1) CVST in the setting of SARS-CoV-2 vaccine–induced immune thrombotic thrombocytopenia, (2) CVST after SARS-CoV-2 vaccination not fulling criteria for TTS, and (3) CVST unrelated to SARS-CoV-2 vaccination.

Exposures: Patients were classified as having TTS if they had new-onset thrombocytopenia without recent exposure to heparin, in accordance with the Brighton Collaboration interim criteria.

Main Outcomes and Measures: Clinical characteristics and mortality rate.

Results: Of 116 patients with postvaccination CVST, 78 (67.2%) had TTS, of whom 76 had been vaccinated with ChAdOx1 nCov-19; 38 (32.8%) had no indication of TTS. The control group included 207 patients with CVST before the COVID-19 pandemic. A total of 63 of 78 (81%), 30 of 38 (79%), and 145 of 207 (70.0%) patients, respectively, were female, and the mean (SD) age was 45 (14), 55 (20), and 42 (16) years, respectively. Concomitant thromboembolism occurred in 25 of 70 patients (36%) in the TTS group, 2 of 35 (6%) in the no TTS group, and 10 of 206 (4.9%) in the control group, and in-hospital mortality rates were 47% (36 of 76; 95% CI, 37-58), 5% (2 of 37; 95% CI, 1-18), and 3.9% (8 of 207; 95% CI, 2.0-7.4), respectively. The mortality rate was 61% (14 of 23) among patients in the TTS group diagnosed before the condition garnered attention in the scientific community and 42% (22 of 53) among patients diagnosed later.

Conclusions and Relevance: In this cohort study of patients with CVST, a distinct clinical profile and high mortality rate was observed in patients meeting criteria for TTS after SARS-CoV-2 vaccination.

TERRAIN – THE MOST IMPORTANT QUESTION

https://terrainthefilm.com

DR ANDREW KAUFMAN and filmmaker, Marcelina Cravat have produced a film entitled 'Terrain' that looks at the cause of disease and challenges the theory that pathogenic microbes or particles are responsible for this. A subheading to this 2-part film makes it crystal clear as to their conclusions: The End of the Germ Theory.

I am delighted that the terrain theory is finally coming into the conversation. Personally I have been waiting for over 30 years for Pasteur's germ theory, and all that came since based on his theory, to be scrutinised. This is long over due in my opinion and so very crucial to the investigation of the cause of disease. This is especially important since we now live at a time when the world population is being led to believe we are living at the mercy of ever-increasing virus strains, with more pandemics on the horizon!

The pharmaceutical world now dominates the world of medicine and science, in particular the area of funding. The industry devotes one hundred per cent of its funding to research that falls into the germ theory model of disease paradigm. Even then findings that are either unexpected or unwelcome are very likely to remain unpublished to preserve the established models by modern medicine.

Part one of this film premieres on 5 February 2022 and part 2 the following week. I would consider it essential viewing and hope you will add it to your To Watch list!

INFECTIONS: NOMENCLATURE & CAUSATION by Patrick Quanten MD

How do they do it?

TO AN ORDINARY PERSON, that is you and me, it looks like magic how doctors know what the name of the disease is we are suffering from and what has caused it. If we take infectious diseases as an example then it is really clever stuff how they manage to keep them all separate and how they can tell us so much about every single one of them. It is something we bow down to in veneration. Mouths fall open. We nod. We become believers. We forget to ask how it is done.

We manifest a number of symptoms and signs and doctors seem to know how to put them together, how to 'read' them and what the name is for the collection each of us presents with. There are local symptoms such as swelling, redness, pain, dryness, itching, spots, and more general signs such as fever, coughing, tiredness, loss of appetite, diarrhoea, headache, feeling unwell. None of these are specific for a particular disease. A disease consists out of a number of symptoms, pulled together under a certain name. But when we look into it a bit further then we notice that not even every single symptom mentioned under the disease heading needs to be present for a doctor to already know what is wrong with you. They, magically, can fill in the blanks themselves to complete the picture and to declare your specific illness a fact.

Overlapping symptoms, those that occur in several infectious diseases, don't seem to throw them off the scent either. They know! They are able to make the correct analysis in spite of the fact that the symptoms are so similar or even exactly the same. How do they do that?

While you are not looking they consider many other factors that help to eliminate the various potential diagnoses. They take into account your age. Certain diseases are described in the medical textbooks as occurring mostly within a certain age group. Attention is being paid to what they have diagnosed recently in other patients and they remember what the medical profession has informed them of *what is going around*. Infectious diseases are said **to do the rounds.** When you have been informed of a certain disease outbreak in your neighbourhood your alertness for symptoms that are mentioned as part of that disease description heightens. You are on the lookout, and anything that resembles it can quickly be named by the doctor. When they have been informed that a specific disease is now showing up under slightly different symptoms then they know to call the combination of symptoms the disease, as prescribed by the medical authority. The doctor also takes into account the fact that it *definitely* can't be the possibility against which you have been vaccinated as they believe that that person is now protected against that specific disease. So it must be something else. This in itself has led to many new diseases, 'variants' of existing diseases, to emerge. Let's then summarize how they come to know what disease you are suffering from when all you are displaying are non-specific symptoms and signs.

Patrick Quanten MD

"It is the authority that rules the belief systems of their trainees. It is the authority that lays down connections 'to force' a specific diagnosis."

- Their textbooks lump together a number of non-specific symptoms to call it a specific disease.
- The medical authority tells them which disease is coming their way, how to recognize it, even if it doesn't quite fit the description they have learned by heart.
- Based on their belief of what medical treatment does, they eliminate possible diagnoses to reach their verdict.

So, what once looked like an almost impossible task – to identify a specific disease out of non-specific signs – becomes a lot easier now that the medical authority, combined with the belief system they have developed in their trainees, tells them what it will be as soon as they get somewhere in the neighbourhood, following the non-specific signs. An infectious disease which has fever, general malaise and a skin rash as the main symptoms can still be very confusing to the public, even when they are armed with a dermatology book. Comparing skin rashes on standardized pictures is a nightmare as the rash you are presented with very seldom matches the rash of just one of the diseases mentioned in the book. And yet the doctor knows which one it is! How do they do that when the symptoms in a real person are not exactly as the book describes them to be?

But when in doubt, if the doctor is not quite convinced, there are tests he can do in order to confirm the suspicion, the hunch. There are blood tests in which the elevation of certain elements such as white blood cell count, sedimentation rate, 'specific' antibodies and others will allow the medically trained person to believe the diagnosis has been confirmed. There are images, various scanning techniques, in which the doctor will be looking for things the medical authority has decided confirms a specific disease. For instance, these could be plaques of some sort, internal swelling, indication of high activity, and many others. The medical authority also

encourages doctors to look for signs of other diseases, which they have decided 'very often' go together with a specific infectious disease, which means that if you can establish that one is present then the other must be present too. If you believe it then this is 'confirmation' of the diagnosis of your disease.

Hence, by a process of elimination, starting with an almost entire book of possibilities the doctor has been able to whittle it down to one specific infectious disease with the help and guidance of the medical authority who makes them believe in certain connections, such as if a person in the vicinity has it you must have it too, or if you have one disease you must have the other too. It is the authority that puts a number of non-specific symptoms together and calls them a specific disease. It is the authority that rules the belief systems of their trainees. It is the authority that lays down connections 'to force' a specific diagnosis.

Confirmation of a diagnosis is done using medical tests. These give us, so the authority tells us, specific absolute results. And that is just as well otherwise nobody would be able **to be sure** about any diagnosis. Unfortunately science has taught us that an absolute test does not exist! It tells us that the circumstances of each test, as well as the intention with which the test is performed, is part of the outcome, determines the test result. Hence, medical tests will provide you with outcomes that will be influenced by **all** surrounding factors, both those of the patient and those of the doctor and medical facilities. Not taking these factors into account, so science tells us, renders the test result completely useless and any interpretation of such a result a complete fantasy. But this means that there are no specific antibodies (which the medical profession admits to, if you look long and hard), no specific healthy levels of anything you measure in the blood, no particular way the images have to look in order to be called healthy or diseased. All of that is nothing more than an interpretation, which is someone's, or a group's opinion. It is not fact. It is an opinion, based on the way they have chosen to look at measurements, at data, at test results. Hence, when

Photo by Mikita Karasiou on Unsplash

the authority, and by extension the representatives of the authority (the doctors), is of the opinion that you have a certain specific infectious disease then that is only their opinion, not a fact. Scientifically speaking, one cannot distinguish between the various infectious diseases, whether they are childhood diseases or adult infectious diseases. One can have an opinion about how to name this particular presentation of symptoms but one can never know whether the same diagnosis made in different people also means that these people indeed suffer the same disease or have the same underlying problem.

A diagnosis is the opinion of the medical authority. In this respect it is good to remember that by law, written by the medical authority, only people that have been trained by them and have been given a licence to practise by them are allowed to make a diagnosis. This means that only the opinion of the medical authority has any value in naming a disease as the result of the presentation of symptoms. In human society, one group of people, one school of thought, has grabbed the power to determine the disease

anybody is suffering from and to outlaw any other thought on the matter. A diagnosis is the prerogative of the medical authority. A disease, however, is the prerogative of nature.

Furthermore, the reach of the medical authority stretches a lot further than claiming the right to make a diagnosis. They also tell us what the cause of the disease is they have identified. For every infectious disease they have named, they have given us **the** cause. The causes are to be found within these categories:

• Bacteria. – examples are: certain types of throat infections, certain types of ear infections, certain types of meningitis, certain types of digestive tract infections, certain types of respiratory infections, gonorrhoea (*whooping cough, scarlet fever, impetigo*)

• Fungi. – examples are: certain nail infections, certain vaginal infections, ringworm, certain respiratory infections (including mouth), certain digestive tract infections

• Parasites. – examples are: certain types of digestive tract infections, certain types of hair infections, certain types of blood infections, certain types of brain infections

• Viruses…

What do we learn from the first three categories?

They are all living creatures of which their presence can be demonstrated.

Infections of parts of the body, systems and organs, can be caused by a great variety of living microorganisms.

The same infection, with the same symptoms, can be classified in any of these three categories depending on the microorganism that can be identified as being present in the diseased tissue.

The medical profession *blames* the cause of the disease depending on the presence of a microorganism as being a bacterial, a fungal or a parasitic infection, even though these can all affect the same system of the body. In practise it would take up a lot of time and a lot of resources to investigate every single 'diagnosis' of an infectious disease. Hence, the medical authority has *authorized* their trainees **to diagnose without evidence**. Basically, if it looks like it, it must be it. In effect, that is an opinion. The medical diagnosis without any proof that the said causative agent is even present within the diseased tissue is a pure guess. When they do bother and investigate, very often they do not identify the said causative agent within the diseased tissue.

This is a good time to remember that every test result depends on **all** circumstances surrounding the test, the method used, the time of testing, the reason for the test, and many, many more. So, the outcome of the test, done in a standardized way, differs very often from the expected result.

"Science tells us that the medical profession has never, in its two hundred years of existence, proven a causal link between any of the known infectious diseases and the microorganism they claim causing that disease."

And then we arrive at the next failure of the medical authority. The presence of a microorganism in diseased tissue is no proof that that microorganism has actually caused the disease. Wherever there is a fire you will be able to identify firemen. However, it would seem like a ludicrous suggestion that this is all the proof you need to state with certainty that all fires are caused by firemen. Science tells us that the medical profession has never, in its two hundred years of existence, proven a causal link between any of the known infectious diseases and the microorganism they claim causing that disease. Let me repeat this. **No proof has ever been submitted for any known microorganism to have caused any known infectious disease.**

And what about viruses? When the medical profession was unable to demonstrate the presence of a disease-causing microorganism within diseased tissue they decided that this particular infection, no different in signs and symptoms, must have been caused by an invisible microorganism. This being the reason why they have failed to detect it! It is scientific reasoning upside down. Science would observe that there are no microorganisms present and yet the tissue is clearly diseased, leading to the conclusion that in this specific incidence the disease cannot be caused by a microorganism. The medical authority has decided that an infectious disease must be caused by a micro-organism, leading to the conclusion that, if none can be demonstrated the causative agent must be an invisible relative of the microorganism. This they have named it to be a virus. Science sticks to observation, while the medical profession is built on assumptions. In principle, an assumption may be true or it may not, but it certainly can never be seen as an absolute truth. Unless you can convince everybody not to adhere to basic, fundamental, scientific principles, in which case they will all believe your opinion without questioning it. Not questioning an assumption is not scientific. It is the role of science to question all and every theory, and every 'belief system'. But the medical authorities do not bother with this.

• Viruses. – all infections everywhere in the body that cannot be demonstrated to have any microorganisms present within the diseased tissue must be caused by a virus, or, in other words, every infection that is believed to be caused by a virus

(*chickenpox, erythema infectiosum or fifth disease, roseola infantum, mouth hand and foot disease, croup, respiratory syncytial virus RSV, Reye's syndrome, measles, mumps*)

If infections are not what the medical profession proclaims them to be, what are they then? Well, follow the observation. Whether any microorganism can be demonstrated to be present or not, the initial stages of becoming ill with an infection, or 'going down' with an infection, always includes these symptoms, either locally, generally or both: swelling, redness, heat and pain. These are the symptoms the medical profession has called **an inflammation**. When asked what the cause of an inflammation is, which organisms are responsible for it, the medical profession falls silent. What we observe is that an inflammation occurs spontaneously, without any obvious outside trigger. Hence, the

driving force for an inflammation comes from inside the organism that produces the inflammation.

What is 'an inflammation'? Well, the symptoms as mentioned in the medical books are swelling, redness, heat and pain. Indeed; exactly the same as the symptoms of an infection. Those symptoms basically indicate an elevation of the temperature of the tissues, which causes those four signs to occur. Elevating the temperature is what one does in order 'to burn' something. So essentially it is a fire within the tissues. One that happens spontaneously. In other words it has been orchestrated by the organism, by the tissues themselves. Why would you start a bonfire? Only for one of two reasons: to keep you warm or to get rid of waste. The tissues do not need the fire to keep warm as they already are at their normal temperature. The temperature is raised because they need to burn off waste material that has been gathering dust within the cells and the tissue. So whenever the tissue is loaded with waste products that it can't get rid of quickly enough it will start a bonfire, an inflammation. Once the fire dies down and the waste has been removed, the tissues can pick up their normal activities again, having more space and more energy flowing than they had when the waste products were piling up. An inflammation is a clearing process and hence it is a big help in restoring 'normality', which we call health.

When inside such an inflammation some microorganisms can be demonstrated, the medical profession declares them to be the cause of the illness, which they have identified as an inflammation plus microorganisms, otherwise called an infection. Without microorganisms the inflammation has now become 'a viral infection', which is simply an inflammation, an attempt to heal the tissues. So the disease is the inflammation, which has been caused by the infection, which is the result of the invasion of a microorganism, visible or otherwise. Through observation, we can detect easily that the inflammation comes first, not last, and that no point of invasion or no trajectory of an invading force has ever been demonstrated. It shows us a complete reversal of events, not starting from the outside but starting from the inside. It shows us that the entire 'infectious process' is linked to a clearing out mechanism to restore the system back to health. What has been called a disease is in fact a spontaneous healing action from the system, from the living organism. The real disease is the piling up of waste products within the tissues.

In childhood infectious diseases such waste products can be the result of the growing process. A child moving through a development stage whereby it no longer shall function as a baby, from hereon in will get a breakdown of some tissue structure it will no longer need in that format. If that happens quickly then a lot of waste, cellular debris, comes together very quickly causing 'an infection'. At each milestone of the growing up process this similar reaction shows itself, even right up to the acne of a teenager. The higher the waste mountain, combined with the lower the recycling power, it will all result in serious inflammation and waste disposal as we recognize in respiratory mucus, in skin eruptions, in diarrhoea, in fever, and so on. In such a case the doctor gets really worried because he thinks the disease is really bad. In reality the healing process is really hefty! And as it is difficult to imagine that a system with the sole purpose in life of keeping itself alive, irrespective of the outside circumstances, is going to blow itself up, we can relax, no matter how hefty the symptoms. This process is a spontaneous body reaction in order to heal itself and so a previously healthy and strong system will always recover completely and feel so much better for having a good clear-out.

When a name is just a name and doesn't really hold any truth or knowledge, when a story does not tell the truth, why is knowing the name of the bacteria or virus that, according to the doctor, has caused my problem so important? None of that adds anything to my understanding of the true story of an infectious process. None of that makes me any wiser as to how I can improve my health. None of that makes me any more independent of a healthcare system in which my sole role is to play the victim, a victim of a vicious attack from my environment on my person.

Asking for proof of the stories they tell is laughed away. Of course, there is proof! They are experts. What do you take them for? They are doing proper research and all the rest are charlatans and conspiracy theorists. Hence, no need to show you the proof. And anyway, you are too dumb to understand this. Just trust them.

Or be free and find out for yourself. Have a free mind. Ask questions all the time. Find your own answers. Believe what you know.

January 2022

OH! I AM NOT AT ALL AFRAID OF HER DYING.
PEOPLE DO NOT DIE OF LITTLE TRIFLING COLDS.

~ Quote from Jane Austen's 'Pride & Prejudice', chapter 7.

I FOUND the above comment made by Mrs Bennet in the Austen novel Pride & Prejudice rather interesting. Written in the early nineteenth century when there were more cases of disease due to the social conditions at that time, it seems that some back then did not fear what might now be considered by mainstream medicine as a disease caused by a potentially deadly coronavirus. Some now might be more inclined to consider the mismanagement, the trifling treatments and protocol embraced by our present health system as the cause of fatal outcomes, rather than a cold or flu itself?

THE CHANGING EPIDEMIOLOGY OF DIPHTHERIA IN THE UNITED KINGDOM: 2009 TO 2017

BRIEF OVERVIEW BY
MAGDALENE TAYLOR, TIP EDITOR

This paper was a listed reference in the UK diphtheria report for 2020 and I decided to take a read - out of interest. It is often said that many health professionals will only read the Abstract of a paper, that is, if they even read any medical papers at all.

I noticed in this particular Abstract under the heading Results, it stated: 'Two thirds (23/33) of cases were inadequately immunised.'

What does inadequately mean and were the other 11 cases vaccinated? I finally arrived at the paragraph within the full text regarding vaccination status. It reads:

'Overall, 22 of 33 cases were inadequately vaccinated for their age (including those with unknown or unclear vaccination status), 13 of 18 C. diphtheriae cases and nine of 15 C. ulcerans cases (Table 2). Of the 11 appropriately vaccinated cases ***(TiP editor: why not just state fully?)***, five presented with cutaneous disease, four had mild respiratory disease, one had a combination of respiratory and cutaneous symptoms and one had an 'other' presentation (Table 2).

Vaccinated cases were more commonly from younger age groups. There was an increase in fully vaccinated cases following the change in the surveillance programme, with only two of 12 cases being fully vaccinated before April 2014 compared with nine of 21 cases after.

Table 2 actually indicates that there were only 2 unvaccinated amongst the 33 toxigenic cases. The 11 that are under the column 'Unknown or unclear' may all have received some doses, this we will never know. Earlier in the same paper there is some comment about this unknown/unclear status:

'Cases where there was no record of vaccination were considered as inadequately vaccinated. It may be, particularly for older individuals who had moved practices during their life, that they had received vaccinations as children but these doses were not recorded in current records, but in general, primary care records are very detailed, and it is more likely that individuals without recorded vaccinations were under-immunised.'

In my opinion many medical or scientific articles are inadequately worded and often confusing – whether that is deliberate or not - one can only speculate.

Full article:

https://pubmed.ncbi.nlm.nih.gov/32209165/

	Fully vaccinated for age	Partially vaccinated	Not vaccinated	Unknown or unclear vaccination status	Total
Toxigenic *Corynebacterium diphtheriae*	**5**	**7**	**1**	**5**	**18**
Cutaneous	4	5	0	5	14
Respiratory (no membrane)	0	1	1	0	2
Respiratory (no membrane)/cutaneous	1	0	0	0	1
Respiratory (with membrane)	0	1	0	0	1
Toxigenic *Corynebacteriumulcerans*	**6**	**2**	**1**	**6**	**15**
Cutaneous	1	1	0	3	5
Other/unspecified	1	0	0	1	2
Respiratory (no membrane)	4	1	0	1[a]	6
Respiratory (with membrane)	0	0	1[a]	0	1
Respiratory (with membrane)/cutaneous	0	0	0	1	1
Total toxigenic cases	**11**	**9**	**2**	**11**	**33**
***Corynebacterium diphtheriae* NTTB**	**4**	**0**	**0**	**6**	**10**
Asymptomatic	1	0	0	0	1
Cutaneous	1	0	0	3	4
Respiratory (no membrane)	2	0	0	1	3
Unknown	0	0	0	2	2

NTTB: non-toxigenic toxin gene-bearing.

Table 2: Diphtheria cases by species, clinical presentation & vaccination status, United Kingdom, 2009–2017 (n = 43)

EPIDEMIOLOGICAL UPDATE: DIPHTHERIA - PAHO Pan American Health Organisation 22 September 2020 Diphtheria in the Americas - Summary of the situation

EXTRACT

In Brazil, between 2010 and 2019, 662 suspected cases of diphtheria were reported, of which 77 (12%) were confirmed, including 8 deaths. The federal units that reported the highest numbers of confirmed cases during the same period were Maranhão (28 cases) and Pernambuco (16 cases). The Northeast Region reported the highest proportion of confirmed cases (58%), followed by the Southeast (18%) and South (10%) regions.

The 77 confirmed cases of diphtheria reported between 2010 and 2019 had a median age of 10 years, 51% were male, **64% received 3 or more doses of the vaccine**, and 22% had an unknown vaccination status. The most frequent signs and symptoms among confirmed cases were: pseudomembrane (90%), fever (71%), and lymphadenopathy (69%). Overall, 27% of the confirmed cases developed at least one complication; the most frequent complications, either associated or not associated with diphtheria, were palatal paralysis (17%), myocarditis (4%), and bilateral and symmetric paralysis of the extremities (4%). Overall, 80% of the confirmed cases required hospitalization. Regarding outcome among confirmed cases, 82% recovered without sequelae and 10% died. Of the 77 confirmed cases, 78% had nasopharyngeal secretion samples collected, and overall, 80% were confirmed by clinical-epidemiological criteria and 20% by laboratory criteria.

In the Dominican Republic, between 14-17 February 2020, 2 confirmed cases of diphtheria were reported, both fatal. The first case is a 9-year-old Haitian female resident of Guanito Municipal District in San Juan Municipality who had symptom onset on 12 February 2020. The case had no travel history and had **received 2 vaccine doses** administered in Haiti. The case died on 24 February 2020. The second case is a 14-year-old Dominican male resident of the Capotillo Sector in the National District who had symptom onset on 9 February 2020. The case had no travel history and an unknown vaccination history. The case died on 14 February 2020. Both cases were laboratory-confirmed, and Corynebacterium diphtheriae biotype mitis was isolated from both samples. No epidemiological link was identified between these cases.

TiP Editor: 64% of 77 confirmed cases = 49 had received 3 or more vaccine doses. 22% (17) 'unknown vaccination status' – meaning that they could have also have been vaccinated but there is no paperwork. This has occurred in the past when parents have had their children vaccinated but there is no record – unknown status is recorded.

And what about the remaining 11 confirmed cases. Did they receive 1 or 2 vaccine doses? If they were completely unvaccinated you would think that this would be stated, wouldn't you? The reports from Haiti and Venezuela included in this paper do not even mention the vaccination status in confirmed cases, which may lead you to consider that perhaps all cases had received one or more vaccine doses and it was better left unsaid? Looking at diphtheria cases in the UK in 2020 (Health Protection Report, Volume 15, Number 7, 13 April 2021) there were only 2 confirmed (using PCR!) cases. One case considered a toxigenic case the other termed as a non-toxigenic toxin gene-bearing strain (NTTB). In the report it states: 'The pathogenesis and clinical significance of isolation of this organism are **not yet well understood;** NTTB are **not thought to cause diphtheria** but owing to their potential **but unknown risk** of becoming toxigenic through a genetic event, it is currently recommended in the UK that they are managed in the same way as fully toxigenic (that is, Elek-positive, toxin-expressing) diphtheria cases and eliminated using antibiotics from patients and contacts.' (Bold type TiP emphasis.) **Further in the report there is finally a mention of the vaccination status of the one NTTB case in 2020 – 'a partially immunised male aged 42.' I have to say that reading these kind of texts the public health officials appear rather vague – which is far from reassuring!**

THE REVOLT AGAINST COMPULSORY VACCINATION IN INDIA – 1892

FROM: 'THE RECRUDESCENCE OF LEPROSY & ITS CAUSATION' BY WILLIAM TEBB (1893)

EXTRACTS FROM P360-61

The first triennial report of the working of the vaccination department in Bengal has been recently published, and the Commissioner says that the Acts in the rural districts are practically a dead letter; vaccination is rejected by all the higher class of Hindus – the Brahmins, Marwaries, Rajputs, and Burmahs – while among Mahommedans, the Ferazis display the utmost repugnance to the Jennerian rite. In nearly every village, reports the Commissioner, there are families who persistently refuse vaccination, and secrete their offspring to escape the vaccinators....The Times of India, July 14th , 1892, says:-

"The prejudice against vaccination in Burmah seems to be growing to quite a remarkable extent….At Katha, Mohayou, and Mobin so strong is the prejudice against arm-to-arm vaccination that the vaccinators appear to have narrowly escaped violence at the hands of the villagers, who organised an open resistance to the system"….. "There has been a falling off of nearly two hundred thousand, or about 11 per cent in the numbers of vaccination operations performed during the past year in Bengal, as compared with the record for 1890-91….."

THE VIRUS HAS BEEN ISOLATED? WHERE?

THERE HAVE BEEN MANY ARTICLES AND DISCUSSIONS OVER THE LAST COUPLE OF YEARS REGARDING VIRUS ISOLATION. AS WITH OTHER ASPECTS OF THE VACCINATION AND GERM THEORY STORY IT IS AN AREA WHERE TO EVEN RAISE QUESTIONS INCREASES YOUR CHANCES OF BEING LABELLED A VIRUS DENIER OR A FLAT-EARTHER OF BIOLOGY AND DISMISSED AND RIDICULED.

VERY DISAPPOINTING that there are those who choose to name call individuals who raise concerns and findings that bring into question the official scientific narrative rather than investigate the concerns raised.

The following letter by Christine Massey is a response to an article by Steve Kirsch ('a serial entrepreneur who has started multiple high tech companies' as described by Steve himself) entitled **'Has the virus been isolated? Yes.'** Steve has become a vocal critic of how dangerous the current Covid vaccines are, he does however hold the view that virus isolation has been achieved and is critical of Drs Kaufman, Cowan and microbiologist Stefan Lanka's findings and presentations.

To read Kirsch's article you can find it here https://tinyurl.com/ycx437ue

Christine Massey's response reads:

Hi Steve,

You've published a blog titled "Has the virus been isolated? Yes"

You go on to clarify that you actually have no idea if this is true, and that your title is based on faith in certain individuals.

'I rely on expert opinions of people who I trust for certain issues like whether or not the virus has been "isolated." It's a reasonable approach if you are careful about which experts you trust. All of the expert friends I've asked (including Robert Malone and Li-Meng Yan) tell me that "the virus has been isolated." So it has been "isolated" according to their belief in what the term means.

Hmm. Well I personally don't rely on other people's beliefs - especially people with a long history involving many millions of dollars with the so-called "vaccine" industry that claims to protect us from alleged "viruses".

Now to your credit, you did disclose that "isolate" means different things to a virologist versus a regular man or woman, or a scientist. But you didn't explain to your readers what "isolate" actually means to a virologist. I think it's important for the public to know. Don't you agree?

"Nothing is isolated as per the meaning of the word to regular humans, not even from the monkey/cow/human mixture."

Here's an example, from researchers at the CDC:

"We used Vero CCL-81 cells for isolation and initial passage. We cultured Vero E6, Vero CCL-81, HUH 7.0, 293T, A549, and EFKB3 cells in Dulbecco minimal essential medium (DMEM) supplemented with heat-inactivated fetal bovine serum (5% or 10%) and antibiotics/antimycotics... We used both NP and OP swab specimens for virus isolation. For isolation, limiting dilution, and passage 1 of the virus, we pipetted 50 µL of serum-free DMEM into columns 2–12 of a 96-well tissue culture plate, then pipetted 100 µL of clinical specimens into column 1 and serially diluted 2-fold across the plate.

We then trypsinized and resuspended Vero cells in DMEM containing 10% fetal bovine serum, 2× penicillin/streptomycin, 2× antibiotics/antimycotics, and 2× amphotericin B at a concentration of 2.5 × 105 cells/mL. We added 100 µL of cell suspension directly to the clinical specimen dilutions and mixed gently by pipetting. We then grew the inoculated cultures in a humidified 37°C incubator in an atmosphere of 5% CO2 and observed for cytopathic effects (CPEs) daily. We used standard plaque assays for SARS-CoV-2, which were based on SARS-CoV and Middle East respiratory syndrome coronavirus (MERS-CoV) protocols...

When CPEs [Cytopathic effects aka harm to the monkey cells] were observed, we scraped cell monolayers with the back of a pipette tip. We used 50 µL of viral lysate for total nucleic acid extraction for confirmatory testing and sequencing. We also used 50 µL of virus lysate to inoculate a well of a 90% confluent 24-well plate."

I've had to submit a FOIA request to the CDC for details of the vaguely referenced "mock infected cells" used in this study. But the Methods that are available from Harcourt et al. (and all other "SARS-COV-2 isolation" studies) make clear that "isolation" to Robert Malone and anyone else who insists "yes, the virus has been isolated" means combining monkey kidney cells (aka "Vero" cells, or some other cell line) with fetal bovine serum, patient specimens and toxic drugs, and then irrationally, unscientifically attributing any resulting harm to the poisoned monkey cells (which are typically also malnourished by the researchers) to "the virus".

Nothing is isolated as per the meaning of the word to regular humans, not even from the monkey/cow/human mixture.

And since no one on the planet has managed to cite or provide any record describing isolation/purification of the alleged "virus" or any "variant" from any patient sample, by anyone, anywhere, ever (which you seem to realize based on your repeated references to the FOIA collection that is publicly available on my website and now contains failures from 156 institutions in roughly 30 countries) it's quite clear that no science has ever been carried out with the theoretical "virus".

No one, including Sabine Hazan and the CDC researchers, has ever extracted genetic material from a purified sample of the alleged "virus" so that they could sequence "it" and characterize "it" to find out if the alleged RNA genome of 30,000 base pairs with a spiky protein shell actually exists. And no one, including Sabine Hazan and the CDC researchers, has performed fully controlled experiments to see if the alleged "it" actually spreads disease via natural modes of exposure. Because virology is not a science.

Since you brought up the curious "science" of Dr. Sabine Hazan, I'll share with you the bizarre email exchange I had with Sabine that went off the rails as soon as I pointed out the blatant flaws in her same paper that you have cited.

Steve, I have a question for you. Regarding the expensive products that you promote and refer to as "virus" to your readers, have you ever read the descriptions of these products to find out what they actually contain?

From your EVA product description: "Infectious cell culture supernatant containing BetaCoV/France/IDF0372/2020, clade 19A.... Unit definition: one vial.. 2 000,00 € (Cost per access for Academics)."

Regarding the ATCC and other products that you've promoted, Dr. Saeed A. Qureshi, PhD, who spent 30+ years with Health Canada conducting hands-on and multi-disciplinary laboratory research in pharmaceuticals regulatory assessment and is an internationally recognized expert in pharmacokinetics, biopharmaceutics, drug dissolution testing, and analytical chemistry, felt the need to publish a warning: Buyer Beware!

"For $1200, what's the customer really buying? A diluted human mucus/phlegm/mucus from swab samples with all kinds of added chemicals (30+), including African green monkey kidney cell (Vero cells) broth. In short, they are faking it and lying all the way with confidence and authority!"

Steve, last year I tracked down the origin of the so-called "SARS-COV-2 isolate" that is referred to as "MUC-IMB1" aka "BavPat1" and sold by companies like EVA (also for 2 000,00 € per vial). It turned out to be just more of what I call "monkey-business fraud", in this case courtesy of the infamous team of Corman and Drosten. Never shown to have anything to do with "a virus".

Maybe it's time you do your own due diligence instead of repeating the wild unsubstantiated claims of your trusted experts, none of whom can prove the existence of any alleged virus in the complete and utter absence of any purified samples of such.

Best wishes,
Christine Massey, M.Sc.

Peterborough, Ontario, Canada

No one, including Sabine Hazan and the CDC researchers, has ever extracted genetic material from a purified sample of the alleged "virus" so that they could sequence "it" and characterize "it" to find out if the alleged RNA genome of 30,000 base pairs with a spiky protein shell actually exists.

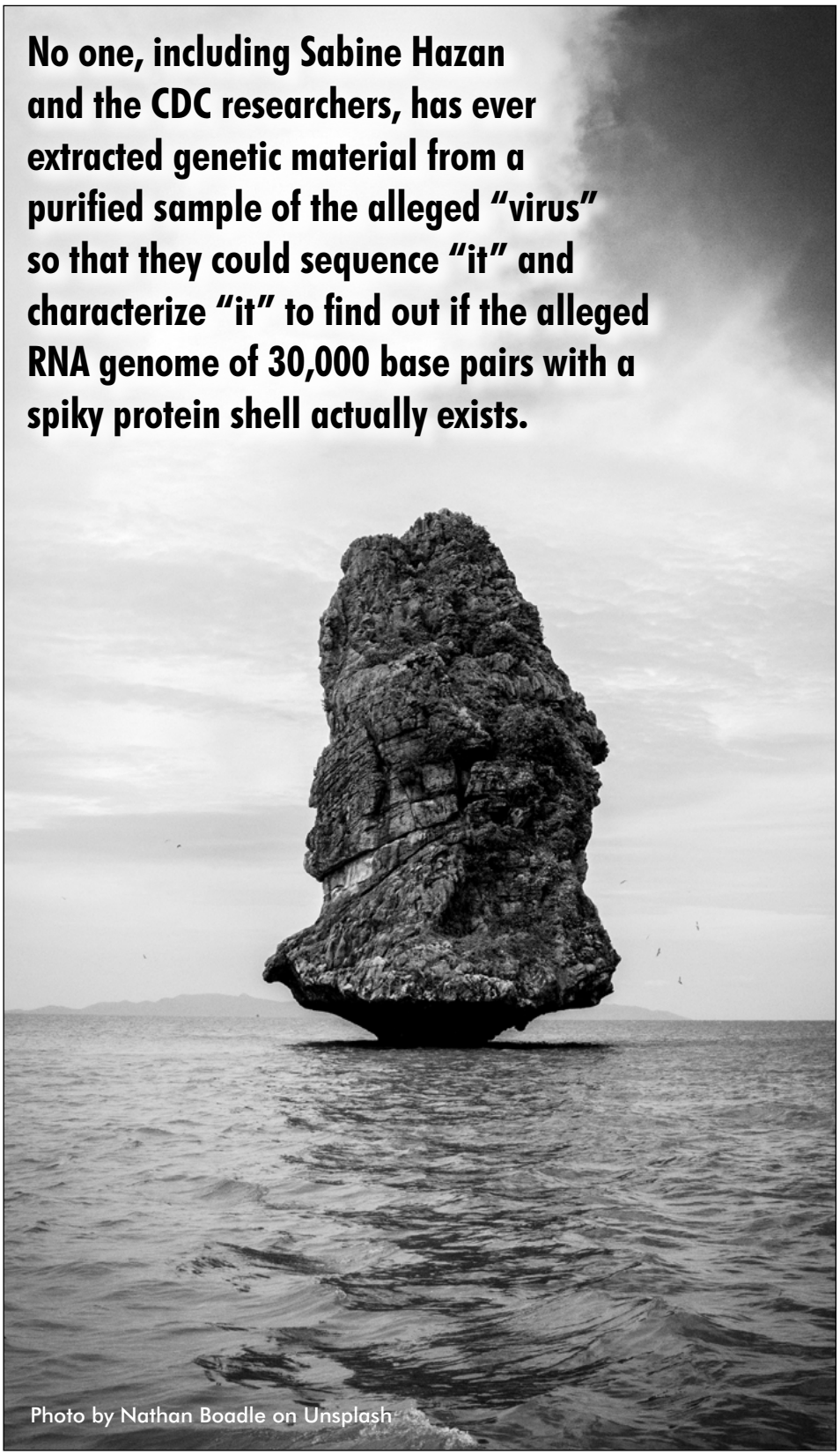


Photo by Nathan Boadle on Unsplash

THE R NUMBER

MAGDALENE TAYLOR, EDITOR OF THE INFORMED PARENT.
JANUARY 2022

WE ARE CONSTANTLY TOLD how contagious some diseases are. How often do we read that, for example, measles is a highly contagious disease?

How is the alleged contagiousness established with these alleged infectious diseases?

An article in Science News, 28 May 2019, entitled: 'One number can help explain why measles is so contagious' by Helen Thompson caught my eye recently. What is this number? The subheading made it clear – it is the R number:

'A disease's R_0 is the average number of people a person can infect in an unvaccinated population'

In the pre-covid era many of the public would not have been familiar with R numbers. However over the last 22 months we have heard Boris Johnson and the various health ministers talk about the R number in relation to the alleged pandemic and the alleged transmission when they attempt to justify new regulations.

Featured in this Science News article is an explanation for the R number. (See diagram below).

The article continues with comment from epidemiologist, David Smith at the University of Washington in Seattle:

"*With measles, if you're anywhere near someone with the disease, you could get it. It's considered to be highly infectious, if you're not vaccinated against the disease.*"

Where are the references to scientific evidence demonstrating that his statement is accurate? I have noticed these reference-free claims on many occasions, including on the WHO website: *'Measles is one of the world's most contagious human viruses but is almost entirely preventable through vaccination. In the last 20 years, the measles vaccine is estimated to have averted more than 30 million deaths globally.'*

'One of the world's most contagious human viruses'? 'Almost entirely preventable'? 'Averting millions of deaths globally'? These are the typical claims made by authorities across the world and much of the population simply believe these claims to be proven scientific truths - without question.

These diseases were declining over the centuries due to improved living conditions, clean water, sanitation, better nutrition etc coming into play. A vaccine 'averting' more than 30 million deaths is an assumption, a hearsay. Especially as the measles death rate underwent a major and dramatic downward trend from the mid 1850s to mid 20th century in the developed world BEFORE the introduction of the measles vaccine. Improved social conditions averted the deaths, and had these improvements been introduced into the developing world it is highly likely that the same declines would have been experienced there also. In relation to claims that measles is the 'most contagious' human virus other health practitioners have formed a different view. One example is naturopath Herbert Shelton whose book first published in 1931, The Hygienic Care of Children discusses many aspects of health and disease in childhood. In Chapter 24, The Acute 'Infectious' Diseases of Childhood Shelton comments on the alleged contagiousness of measles. He writes (p289):

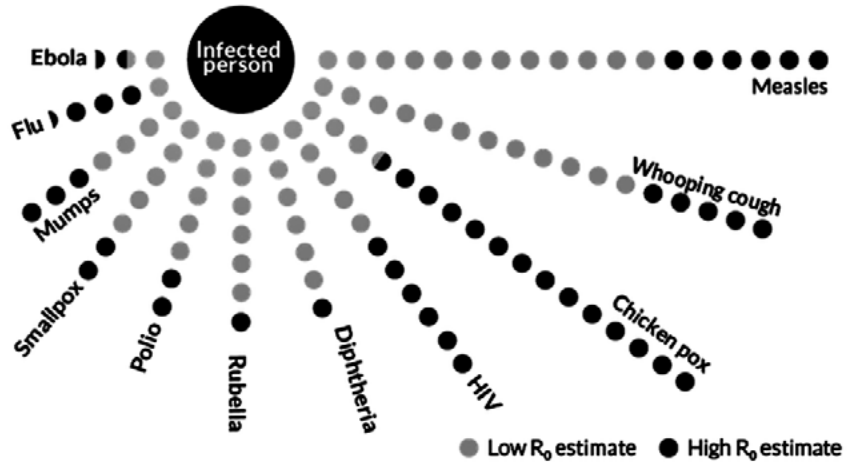
'This statement is false, as every informed person well knows. My children were repeatedly in contact with measles, scarlet fever and whooping cough. On one occasion they were visiting, for over a week, with a cousin who had measles. They were in the room with him daily, even on the bed. They did not develop it."

From first hand experience as a child my two younger sisters were both diagnosed with whooping cough, although one sister was not particularly poorly. We shared the same small bedroom - two cots and a single bed in a row. We were sleeping at close proximity, sharing the same air, and yet I never developed a cough at all. Also later, as a mother myself, a neighbour's

Revealing ratio

The basic reproduction number, R_0, of an infectious disease is the number of people on average that would catch the pathogen from one infected person in a population without any immunity against the disease. Each dot in this graphic represents a person who would catch the disease from an infected individual. R_0 is usually expressed as a range because the factors that go into this ratio vary depending on the time and place of an outbreak.

Basic reproduction number (R_0) range for selected infectious diseases



T. TIBBITTS

Source: P. Fine/Epidemiol. Rev. *1993; S. Hay* et al/Philos. T. R. Soc. B *2013; G. Chowell and H. Nishiura*/BMC Med. *2014*

child played on numerous occasions with my daughters during the time they both had the allegedly highly infectious chickenpox. This child never went on to 'catch' chickenpox from them.

Back to the article and the R number. Thompson continues with a quote from David Smith:

'R_0 can also be used to determine the fraction of the population that needs to be vaccinated to prevent a disease from spreading, known as herd immunity. Textbooks boil the relationship down to a simple equation: 1-(1/R_0). But for real outbreaks, the math gets a lot more complicated. "It's a nasty computation," Smith says.'

The article ended with these last 3 paragraphs:

'While the R_0 range might be able to tell you a lot about a disease or a case, it's fallible. Researchers recently outlined R_0's faults in the January 2019 Emerging Infectious Diseases. Inconsistencies in its definition can result in misinterpretations among researchers and the public. And R_0 can't tell you how well a vaccine or another control method is working in an ongoing outbreak — for that you'd need to look at another reproduction number, R effective or Rt, which changes over the course of an outbreak.

"R_0, as a descriptor of an epidemic, isn't great," Smith acknowledges, because it assumes pristine conditions. And in an epidemic, that's rarely the case. R_0 has its limitations, but measles' high number emphasizes why it's good that there's a vaccine for the potentially life-threatening disease.

Before the vaccine (measles) was widely used starting in the 1960s, millions were infected each year, and hundreds died.'

To summarise the previous 3 paragraphs you might conclude that the R number is fallible, faulty, results in misinterpretations, unable to establish how well a vaccine is doing, isn't great as a descriptor of an epidemic, assumes pristine conditions which is rarely the case in epidemics, and has limitations. Sounds rather similar to those computer-generated mathematical models produced by Neil Ferguson at Imperial College, London back in 2020, doesn't it? The last line of the article is a most familiar and well-used comment that continues to be claimed over and over again:

'Before the vaccine (measles) was widely used starting in the 1960s, millions were infected each year, and hundreds died.' If anyone took the time to look at the measles cases and deaths before the vaccine was widely used it is clear that both had been falling greatly in the 'developed' countries due to social improvements over the previous century as I pointed out earlier in this text.

I would highly recommend investigating this area for all diseases. My version of the R number would be the 3Rs. R_3 = Research, Research, Research!

ROTAVIRUS: DEADLY DIARRHOEA

MAGDALENE TAYLOR, TIP EDITOR

IN 2013 the rotavirus vaccine was introduced into the UK vaccination schedule and it was claimed to prevent infant diarrhoea, deemed to be caused by the 'rotavirus'. As the vaccine became part of the combination vaccine normally given in the early months of an infant's life, not too much attention was drawn to the justification of this additional vaccine. It seemed to have been quietly added as generally most parents would not have looked upon infant diarrhoea as a great concern. Certainly there was no discussion about it when I had my daughters over 30 years ago or before when I was growing up. Talking to other parents over the decades it seems they also shared similar experiences to me. There was no great fear of this condition. From a naturopathic view diarrhoea is one of the body's methods to speedily remove toxins and it is not surprising that in the developing world there continues to be severe cases and deaths from this condition. Poor quality water and food, alongside inadequate living conditions and sanitation are the obvious reasons as to why there would be high levels of toxicity (poisoning) leading to diarrhoea. However we are led to believe that a rotavirus is to blame. Bouts of diarrhoea in these poor infants will exhaust the body's attempt to cleanse itself, especially when they are unable to rehydrate properly due to the lack of clean water. If all the social conditions were improved as they have in the developed countries diarrhoea would lessen greatly and deaths very unlikely. This seems very obvious but not so for authorities such as the WHO it seems. In a FOI letter sent to Public Health England in 2015* requesting statistics on hospitalisations and deaths on rotavirus in UK pre- and post- the introduction of the vaccine only limited figures were provided. Figures from 2010 to 2013 regarding hospitalisations were 1165, 1135, 1214 and 424 respectively, and regarding deaths PHE stated 'they did not hold any data in relation to infants deaths as a result of rotavirus.'

According to very recent articles a study has been published in the Lancet Infectious Diseases journal as regards to a new rotavirus vaccine to address the problems in Africa and Asia. Extracts can be found in this edition on page 21.

* https://www.gov.uk/government/publications/rotavirus-statistics

"THE SECRET OF HEALTH FOR BOTH MIND AND BODY IS NOT TO MOURN FOR THE PAST, NOT TO WORRY ABOUT THE FUTURE, OR NOT TO ANTICIPATE TROUBLES, BUT TO LIVE IN THE PRESENT MOMENT WISELY AND EARNESTLY. ~ *BUDDHIST SAYING*"

KOCH'S POSTULATES

A BRIEF AND SIMPLIFIED OVERVIEW. BY MAGDALENE TAYLOR, EDITOR OF THE INFORMED PARENT.

IN THE LATE 19th century microbiologist Robert Koch formulated four rules that had to be met in order to confirm that a specific germ was the cause of a specific disease. However were these 4 conditions ever satisfied for any disease? It is sometimes claimed that they were but where is the evidence? In the latter part of the 1800s, after the germ theory had been embraced and established, there arose an issue when no bacteria could be seen in some disease presentations. This puzzled the scientists wedded to the germ theory, as there had to be a microbe to blame, a germ-causing organism must be responsible.

Before electron microscopy came into use it was claimed that when a bacteria could not be found in a diseased individual then it must be an invisible agent at play, too small to be seen. In the 1930s, with the development of the electron microscope, it was then claimed that in some diseases, where no bacteria was present, that the disease was caused by pathogenic nano-particles. These particles were labelled virus, and a new branch of science emerged under the title of virology. However virus-causing particles did not meet with all the conditions required by Koch's postulates. This was indicated in a 1937 published paper entitled 'Viruses and Koch's Postulates' by Thomas M Rivers. For example, viruses could not be cultivated on ordinary lifeless media and Rivers commented on how the blind adherence to Koch's postulates may act as a 'hindrance' especially for viruses.

Rather than thoroughly investigating and re-evaluating both the germ theory and Koch's postulates (more theory) the world of 'established' science appear to prefer the idea of revising the postulates or discarding them altogether if they are seen as a hindrance to the established scientific narrative. Here follows a brief extract from a 2016 paper by Antonelli & Cutler entitled 'Evolution of the Koch Postulates: Towards a 21st-century understanding of microbial infection'. Whilst these authors appear, and are highly likely to, embrace the germ theory of disease they do at least highlight that there is doubt regarding infectious disease causation:

'In light of the above considerations, it is tempting to speculate that, finally, we have still failed to achieve a consensus by which infectious disease causation can be established without doubt. This dilemma largely arises from the continuum of interactions demonstrated among microbes and their host, necessitating our understanding of this complex interplay and underpinning factors that influence whether this will manifest as asymptomatic carriage or development of life-threatening pathologic consequences.'

From: Clinical Microbiology and Infection, ISSN: 1198-743X, Vol: 22, Issue: 7, Page: 583-584 (2016)

Lastly here are some extracts from the abstract of a more recent published paper entitled 'The necessity to revise Koch's postulates and its application to infectious and non-infectious diseases: a mini-review' by Hosainzadegan H et al. (PMID: 31440916):

'Advances in the science have promoted all aspects of human's life; these, in turn, have changed many principles and scientific postulates. Koch's postulates, since the beginning of their implementation, have been one of the important subjects involving complications and misinterpretations regarding the causal relationship of microbe-hosts. These postulates have been shown not to be correct in some cases including the inability of some microbes to grow in the culture medium, viruses, or anaerobic bacteria. Today, due to some new scientific facts like the social behaviours of bacteria, such as quorum

KOCH'S POSTULATES

1. THE MICROORGANISM MUST BE FOUND IN ABUNDANCE IN ALL ORGANISMS SUFFERING FROM THE DISEASE, BUT SHOULD NOT BE FOUND IN HEALTHY ORGANISMS.
2. THE MICROORGANISM MUST BE ISOLATED FROM A DISEASED ORGANISM AND GROWN IN PURE CULTURE.
3. THE CULTURED MICROORGANISM SHOULD CAUSE DISEASE WHEN INTRODUCED INTO A HEALTHY ORGANISM.
4. THE MICROORGANISM MUST BE RE-ISOLATED FROM THE INOCULATED, DISEASED EXPERIMENTAL HOST AND IDENTIFIED AS BEING IDENTICAL TO THE ORIGINAL SPECIFIC CAUSATIVE AGENT.

'Life has changed since the 1880s when Robert Koch elucidated his guidelines, later to be called Koch's postulates, for determining whether a microorganism is the cause of a disease. The horse-drawn buggy bumping over dirt roads has been replaced by the computer-assisted automobile speeding along paved highways. It would be absurd to expect modern cars to abide by traffic rules and standards designed for horse-drawn carriages. Yet, many continue to hold Koch's postulates as the unchanging standard for determining causation in medicine, despite a revolution in bio-technology and leaps in medical knowledge. Recent findings based on the application of new technologies, especially in the fields of micro-biology and infectious disease, demand a renewed dialogue on proof of causation and revised guidelines for defining a causal relationship between a microbe and a disease.'
David N. Fredricks and David A. Relman
Sequence-based identification of microbial pathogens: a reconsideration of Koch's postulates.
Fredericks DN, Relman DA
Clin Microbiol Rev9p18-33(1996 Jan)

sensing, there are serious problems regarding the definition of whole microbial effects; ...the application of Koch's postulates to explain the causal relationships between host-microbes could be difficult. Therefore, nowadays, even the molecular Koch's postulates are not accountable. Also, according to the new scientific discoveries, various criteria such as changes in the immune system, pathology, and clinical findings, along with the results of daily laboratory tests, should be used to apply Koch's postulates in the etiologic studies. Otherwise, the possible etiologic relationships between the host-microbes cannot be verified due to numerous complications; certainly, the relationship between the doctor and the lab is ultimately weakened. Therefore, public health, prevention, and much of the antimicrobial treatments will also remain in a state of ambiguity.'

There is certainly a state of ambiguity with many aspects of germ theory in my opinion!

REPLETION AND EXHAUSTION?

THE HYGIENIC CARE OF CHILDREN BY HERBERT M SHELTON (1931).

TiP Editor: This naturopathic text from ninety years ago makes interesting reading. Naturally those who only value the modern 'established' science will dismiss such texts as alternative, out-dated nonsense. However as a growing number of people are coming to realise 'the science' we are constantly told to follow is only the well-funded, accepted, settled science that the authorities have deemed to be so!

CHAPTER XXIV, COMMON DISORDERS OF INFANTS AND CHILDREN

EXTRACT:

COLDS: (rhinitis, coryza) represent processes of vicarious elimination. They are not caused by cold feet, damp air, night air, exposure to cold, eating your gruel out of a damp bowl, exposure to heat, etc., nor are they caused by germs. The two great causes of colds are repletion and exhaustion. Anything and everything that tends to tax and lower the vital or nervous powers, impairs digestion, checks elimination and tends to bring on disease.

• Repletion or plethora, (overeating with surcharged blood vessels) tends to overtax the functions of life, poison the body and necessitates a process of compensatory elimination, which is disease.

• Eating when exhausted, when worried, or over excited, or under any similar circumstance, when the digestive powers are low, also poisons the body and calls for an unusual house-cleaning process.

• Excesses of sugar, starch and milk are the chief causes of colds and other catarrhal conditions.

We do not "catch" colds; we develop them within ourselves. The cold, per se, is a life saving measure, a process of elimination. Many so-called diseases begin with a cold and others develop after recurring colds and this has given rise to the theory that colds prepare the way for "other diseases;" that they weaken the body and prepare it for attack by some other and more virulent disease. Nothing can be farther from the truth. If the prevailing theory that colds and other so-called diseases are due to germs is correct, there seems to be no reason why the less virulent germs (of colds) must first break down the resistance of the body before the more virulent germs (of infantile paralysis, measles, tuberculosis, etc.) can cause disease therein. I do not accept the germ theory and I have no patience with those who use this superstition as a means of frightening people out of their wits. Mr. Harter, of the Defensive Diet League, lists an array of troubles which, he says are "all spread by what is technically known as 'spray infection,' " and that the "common cold" is responsible for "a tremendous amount of sickness and many fatalities" from these diseases. He says "The germ laden spray from such a person carries up to five feet when he talks or laughs; up to ten feet when he coughs or sneezes without covering his nose and mouth with handkerchief, or mask or hand. Venture within five or ten foot limits unprotected at your own peril." This is just voodooism. The germ theory is a theory of chance and lawlessness. We are here by accident. How we managed to escape annihilation, during the ages of ignorance and stupidity that elapsed before Louis Pasteur came upon the scene, is inexplicable. Without bacteriologists and serologists we would all soon perish. The medical profession is satisfied to have every disease caused by a germ and in those diseases for which a germ has not been discovered, the profession assumes that germs cause them just the same and treat these conditions accordingly. Assuming the truth of this theory, there are several important questions that need answering. Dr. Tilden has well put them as follows:

"What prevents sporadic cases of disease from kindling endemics? And why do not endemics create epidemics? And epidemics create pandemics? Why is it that in families of children one or two may have diphtheria, scarlet fever, or typhoid fever, and no other member of the family takes the disease? The answer may be that as soon as the disease breaks out those who are not sick are rendered immune. But I must meet this statement with the very stubborn fact that this was true before the alleged discovery of immunisation; and it is as true of scarlet fever today as in all past time. It must not be forgotten that the germ of scarlet fever has not yet been discovered; hence its cure and prevention are still in the maze of obscurity. But, in spite of this fact, scarlet fever has declined as rapidly; if not more rapidly; than diphtheria, which disease has been *almost entirely wiped out by the great discoveries in the line of immunisation."*

Coming back to colds, instead of laying us liable to "other diseases," they tend just the other way. That condition of the body that makes the cold, or a series of colds necessary, may and often does, due to the persistence of its causes, demand other forms of eliminating crises (disease) to remedy. But tuberculosis no more develops out of a cold than the hair on a man's face develops out of the hair of his head. A cold may be and usually is part of an acute disease, like measles or scarlet fever, and it may be the first part of this marvellous process of systemic purification to develop.

VACCINE MANDATES HARM LONG-TERM PUBLIC HEALTH

BHASKARAN RAMAN AND
KAMESWARI CHEBROLU
SUNDAY, SEP 12, 2021
https://www.outlookindia.com/website/story/opinion-vaccine-mandates-harm-long-term-public-health/394359

TiP Editor: Whilst the authors appear to be in favour of vaccination they raise reasonable concerns.

COVID-19 has dominated the lives of every human on the planet since March, 2020. Unprecedented measures have been taken by various countries, such as lockdowns and school closures. Also unprecedented is the speed with which vaccines have been developed, which holds hope for many for ending the pandemic. Thankfully, data so far indicates that vaccines are effective at reducing the chance of severe disease and hospitalization. However, a rather unsavoury aspect of vaccine
administration has been the use of various coercive techniques including vaccine mandates. In India, various e-commerce delivery personnel, shop owners, staff at various private companies, school teachers and staff, etc. have been mandated to take the vaccine. Since August 15, only "fully vaccinated" passengers are allowed to travel in Mumbai local train, called the "lifeline of Mumbai". In other words, various aspects of living itself is being conditioned upon taking the Covid-19 vaccine. Such extreme coercion and mandating are counter to the principle of "informed consent", a cornerstone of public health. This principle is so foundational that there is a separate section on "consent" in UNESCO's Universal Declaration on Bioethics and Human Rights which begins: "Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information."

Further, the very first point of the Nuremberg Code, a code written after Hitler's crimes against the Jews, says "voluntary consent of the human subject is absolutely essential".

While certainly many have lost loved ones to Covid-19, is that a reason to relegate foundational principles of medical ethics to the back seat? Let us examine the rationale being offered for vaccine mandates to see if they hold water.

> *"Iceland's top epidemiologist has said that vaccination has not led to herd immunity and Iceland is currently facing a huge surge in Covid cases, despite having 75% of its population fully vaccinated."*

THE FALSE CLAIM OF "NO ONE IS SAFE UNTIL EVERYONE IS SAFE"

The foremost claim which many think favours vaccine mandates is: "no one is safe until everyone is safe". However, this claim is false on multiple counts.

BREAKTHROUGH INFECTIONS AND TRANSMISSION

It is important to realize that while the current vaccines have proven to be effective against severe disease, fully vaccinated individuals can get infected and also transmit the disease. These are the so-called breakthrough cases which have been observed throughout the world, including in highly vaccinated populations. The country of Iceland is a stark example. Iceland's top epidemiologist has said that vaccination has not led to herd immunity and Iceland is currently facing a huge surge in Covid cases, despite having 75% of its population fully vaccinated. A detailed study of vaccinated healthcare workers in Vietnam found that viral loads of breakthrough Delta variant infections were 251 times higher than with old strains in 2020. Breakthrough cases have been reported in Kerala too. The HART group, a group of doctors and medical professionals in the UK, have rightly called vaccination preventing transmission as a myth for Covid19.

This aspect is a crucial difference from other vaccines such as for measles. The current Covid vaccines are non-sterilizing, i.e. vaccinated people can also get infected and transmit: the case for vaccine mandates thus breaks down.

STRONG AND LONG-LASTING NATURAL IMMUNITY

The claim "no one is safe until everyone is safe via vaccination" implicitly assumes that natural immunity from exposure to Covid is insufficient. This is also scientifically false. Known science prior to the pandemic as well as recent research indicate that natural immunity is robust. For instance, a recent study of over 52,000 employees of the Cleveland Clinic Health System (Ohio, USA) found not a single instance of reinfection among the unvaccinated. In the strongest sign of long-lasting and robust immunity from natural exposure, a study found that individuals exposed to SARS-Cov-1 17 years ago showed immunity to SARS-Cov-2 ! This indicates long-lasting natural immunity and also robustness to variants, as SARS-Cov-2 variants are far less different from one another than from SARS- Cov-1. Robustness of natural immunity can also be easily deduced from official data on Mumbai slums: only about 5% of the cases in Mumbai's 2nd wave were from its slums, well before vaccination was underway. It is worth noting that the sero-positivity as measured in Mumbai slums in Jun 2020 was about 57%, while India currently has a sero-positivity of 67.6%. If a vast majority of Indians already have robust natural immunity, this is an additional strong reason against vaccine mandates.

OVERWHELMING HOSPITALS

A related argument made in favour of vaccine mandates is that unvaccinated people can overwhelm hospitals, thus putting others in danger. But by this logic, significant comorbidities of Covid, such as obesity and diabetes should be mandated against, since these contribute significantly to Covid hospitalization. Surely, it would be absurd to think of mandated diet or exercise for such people. Likewise, vaccine mandates are

also illogical. Yet another reason this argument falls apart in India is that much of India already has robust natural immunity, and a third wave itself is unlikely.

"EVERYONE IS FULLY SAFE" IS A SCIENTIFIC IMPOSSIBILITY

Covid will never go to zero, even with 100% vaccination. We must learn to live with Covid. Israel is finding out that even a 3rd booster shot is insufficient to prevent Covid infection. Thus the stated goal itself appears Utopian.

THE ISSUE OF RARE SIDE-EFFECTS

While the side effects of the vaccine are rare, it is not nil. Changes to women's menstrual cycle have been reported in the UK. Blood clotting from the AstraZeneca vaccine is rare but can be devastating, causing even death in rare cases. A study of healthcare workers in Northern India reports that adverse effects requiring hospitalization was observed in 1 in 730 participants (0.1%).

How will a poor person leading a hand-to-mouth existence seek hospital care? Neither the government nor the vaccine makers are being held liable for rare side-effects. Surely, despite this, the risk of Covid is much higher, certainly in older age groups, and the vaccine is advisable. But the presence of even rare side-effects means that taking the vaccine should be an individual decision; there is no room for a mandate or coercion.

THE VARIOUS DRAWBACKS OF COERCION AND MANDATES

Human psychology is that the more you force, the more one wants to resist. Even if coercion works, it leads to loss of trust in public health. Such loss of trust would be disastrous with respect to vaccines for other deadly diseases such as polio, smallpox, measles, etc. and also in the context of people following guidelines should a next pandemic come in the future. There is also the practical issue of accessibility. If the government is mandating vaccines for basic services, then the question arises: has it made sure that all individuals can easily avail free vaccines? Surely, even this has not happened. Last but not the least, vaccine mandates can be an easy tool for oppression and corruption due to issues of accessibility and implementation obstacles. Vast sections of the population, especially the poor and marginalized, can be denied basic rights of livelihood, education, etc if such mandates for "fully vaccinated" become the norm. What does "fully vaccinated" even mean, if it is going to require booster doses? Even USA is planning on booster doses every 5-8 months! Recently, Israel changed the definition of "fully vaccinated" to mean those who have received the booster dose. Will Indians be coerced into taking a booster dose every few months, and people denied basic rights like public transportation or education based on this?

NEED FOR TRUTHFUL MESSAGING

For an effective vaccine, the person who has taken the vaccine is protected, so the statement "no one is safe until everyone is safe" is indirectly conveying to the public that the current vaccines are not effective. Such false messaging is doing great disservice to vaccine uptake. Scientifically truthful messaging, based on open safety and efficacy data is necessary to both reduce vaccine hesitancy as well as to avoid loss of public trust through coercion based on false claims.

(Bhaskaran Raman and Kameswari Chebrolu are faculty in the Department of Computer Science and Engineering at IIT Bombay. Views expressed here are their personal opinion).

DOSE-FINDING TRIAL PAVES WAY FOR NEW ROTAVIRUS VACCINE TO PREVENT A DEADLY DIARRHEAL DISEASE FROM BIRTH

https://www.sciencedaily.com/releases/2022/02/220204093118.htm
4th February 2022

EXTRACTS:

WASHINGTON [US], February 5 (ANI): A team of researchers have found that an Australian developed neonatal rotavirus vaccine RV3-BB was safe and produced a robust immune response in African babies. The study has been published in the 'Lancet Infectious Diseases Journal'. The immune response generated was similar in the group given a reduced dose of the vaccine compared to the high dose, providing an opportunity to reduce vaccine manufacturing costs. Rotavirus vaccines reduce rotavirus-related deaths and hospitalisations **but are less effective in high child mortality countries**... (TiP emphasis).

Researchers from the Murdoch Children's Research Institute (MCRI), the Malawi Liverpool Wellcome Clinical Research Programme and the University of Liverpool have found a reduced dose of an Australian-developed rotavirus vaccine produced a robust immune response in children at risk from deadly diarrheal disease in Africa. Rotavirus vaccines reduce rotavirus-related deaths and hospitalisations but are less effective in high child mortality countries. Although 114 countries have now introduced a rotavirus vaccine, there are still over 80 million or 45 per cent of children less than 5 years of age that do not receive a rotavirus vaccine...

Professor Cunliffe said, "While currently used rotavirus vaccines have significantly reduced illness and death from rotavirus disease, in Malawi and other African countries with high child mortality, rotavirus is still the leading cause of diarrheal deaths in these settings. Our data from Malawi offer new hope that the RV3-BB neonatal rotavirus vaccine can further reduce the high burden of the disease still attributed to this diarrheal pathogen...

"Deputy Director of Global Health at the Bill Melinda Gates Foundation Dr Duncan Steele said, "Despite being preventable with safe and effective vaccines, rotavirus remains a leading infectious killer of young children worldwide."

TiP Editor: With all the money available from foundations such as the Bill and Melinda Gates one - if they are truly concerned about this deadly diarrhoea why not recognise the true cause and give these populations clean water, better housing, better nutrition etc – that would be truly philanthropical, wouldn't it??

VIRUSES: THE LONG AND WINDING ROAD FROM INFECTION TO DETOX REACTION - ONE DOCTOR'S JOURNEY

DR JAYNE LM DONEGAN
MBBS DRCOG DCH DFFP
MRCGP MFHOM

Doctor Practicing Homeopathic
and Naturopathic Medicine

WHAT IS A VIRUS? When I was at school and medical school I was taught that a virus was a smaller than microscopic particle that infected people. Unlike all the other infectious agents this one didn't do anything itself – except infect you. It didn't eat, grow, breathe, or reproduce. We were told that all these functions were carried out for the virus by the cell it infected. The virus was just DNA or RNA and this viral DNA or RNA took over the cell and commanded the cell to produce more genetic material like the virus – a bit like a driver and a car – the virus/driver entered the cell/car and then took command of all the cellular functions.

After I had qualified as a doctor and continued training in orthopaedics, trauma, general medicine, ear, nose and throat medicine, dermatology, paediatrics, obstetrics and gynaecology, like my colleagues, I fought these viruses as well as the bacteria, fungi and parasites that seemed to be everywhere, with antiseptics, disinfectants, antibiotics, antifungals, antivirals and anything else we could get our hands on. There were said to be some beneficial bacteria but no-one had a good word to say for viruses. In addition to the permanent war against microbes, I also fought against my patients' symptoms, like fever, pain, diarrhoea, vomiting, rash, mucus and other manifestations of acute disease, with strong drugs designed to get rid of them. Bodies were really not very clever, I thought. Without my armamentarium of 'anti'-medications and vaccines it had to be wondered how any child would ever manage to reach adulthood.

The only problem with this schema was that people kept coming back with more infections, more sore throats, more glue ears, endless coughs and chest infections – it really was like the little

DR Jayne L.M.Donegan

"Gradually I began to understand that symptoms are not the problem, they are actually the attempts of the body to detoxify itself – to fix the problem. ."

Dutch boy keeping the ocean flood waters back by putting his finger in the hole in the dyke - although it seems this story of my childhood is apocryphal - an urban myth – rather like a lot of my medical training!

In an effort to find a better way of alleviating my patients' suffering I started to look at what is termed complementary medicine. We GPs like to think that we are practicing holistic medicine when we realise there is a link between stress and for example, stomach ulcers or headaches, or perhaps when we ask how things are at home. But that is about where it ends. I started to study homeopathy, naturopathy and terrain theory in an effort to try and understand health from a wider perspective.

Gradually I began to understand that symptoms are not the problem, they are actually the attempts of the body to detoxify itself – to fix the problem. I began to appreciate that the body has its own innate intelligence – just like it has its own innate or non specific immune system which is separate, more basic to survival, and more important in many ways than the specific or antibody dependent arm of the immune system. When I talk about the body having innate intelligence, I don't mean the brain and its ability to think. I mean the innate intelligence present in every one of the different cells, tissues and organs that make up the body. The intelligence that conducts every one of the approximately three billion cells like a symphony rather than a cacophony (*kakos* is Greek for bad). The intelligence that maintains our temperature, glucose and hormone levels, our heart and breathing rate, our digestion, and all the other functions of the body at the appropriate level.

Hahnemann the father of modern homeopathy described it as the Vital Force (Dynamis or Lebenskraft) saying:

"In the healthy condition of man, the spiritual vital force, the dynamis that animates the material body, rules with unbounded sway, and retains all the parts of the organism in admirable, harmonious, vital operation, as regards both sensations and functions, so that our indwelling, reason-gifted mind can freely employ this living, healthy instrument for the higher purpose of our existence." 1849 Dudgeon translation.

I realised in my paediatric training that we prescribed too many antibiotics. The guidelines through the 1980s and 1990s told us to stop prescribing antibiotics for sore throats as most of them are not bacterial. This guidance then extended to ear infections, and even to telling us not to swab throats at all as it became apparent that merely growing Strep from someone's sore throat did not mean that the Strep was causing the sore throat. In fact, you could swab the throats of a hundred healthy people in the street and maybe 90% of them would grow Strep but would not have any symptoms. The presence of the organism in someone with symptoms does not mean the organism is *causing* the symptoms, in the same way that finding gall stones on a scan in someone with abdominal pain does not mean the gall stones are causing the pain. Indeed, lack of appreciation of this vital point has led

quite a few people to go through the trauma of having their gall bladder removed only to find that after recuperating from their surgical operation they *still* had the original abdominal pain. The fact that something is there does not mean it is causing the problem.

The same with viruses. We do not *catch* viruses and more than we catch bacteria. A dustbin filled with rotting meat attracts flies, rats, bacteria and fungi. We do not say the dustbin 'caught' any of these. We say the dustbin is full of rotting meat that is why all those microbes and animals are there - to eat it or transform it over time into compost. Indeed if it were not for these scavengers and transformers we would be drowning in our own waste products. Of course, we know that if we do not like the flies and microbes, including the bad smell, in our bin, we can just clean it out. No flies or microbes then. Same with us. When we build up a certain level of toxins a *healthy* person will initiate a clean out reaction. It will produce a fever to speed up the chemical reactions in the body, there will be loss of appetite – no point filling yourself up with more chemicals that need processing when you are trying to clean yourself out, perhaps diarrhoea and vomiting and/or a rash or endless mucus. These are all pushing out or externalising processes. Once the process is finished a child will go up a developmental step. An adult will get rid of toxins that would otherwise accumulate causing fibrosis or long lasting structural change.

The Germ Theory of disease states that when we meet a microbe we will 'catch' it unless we already 'caught' it before so we have antibodies (if we survived) or we have had a vaccine which gave us antibodies. That the Germ Theory of disease is wrong and we all know it, is obvious if we only stop and think. We all know that on a bus when one person has this year's 'flu, not everybody 'catches' it even though it's new each year so they cannot be 'immune'. That is the reason there is a new 'flu vaccine each year. SARS COV-2 is the first time in history we gave a seasonal respiratory virus vaccine from the *previous* year. The 2019 Wuhan version 'vaccine' was administered in 2020 when it was already one year old. By 2021 and now in 2022 we are still giving boosters of a 'vaccine' that was current – if it was even then – in 2019. This is unheard of.

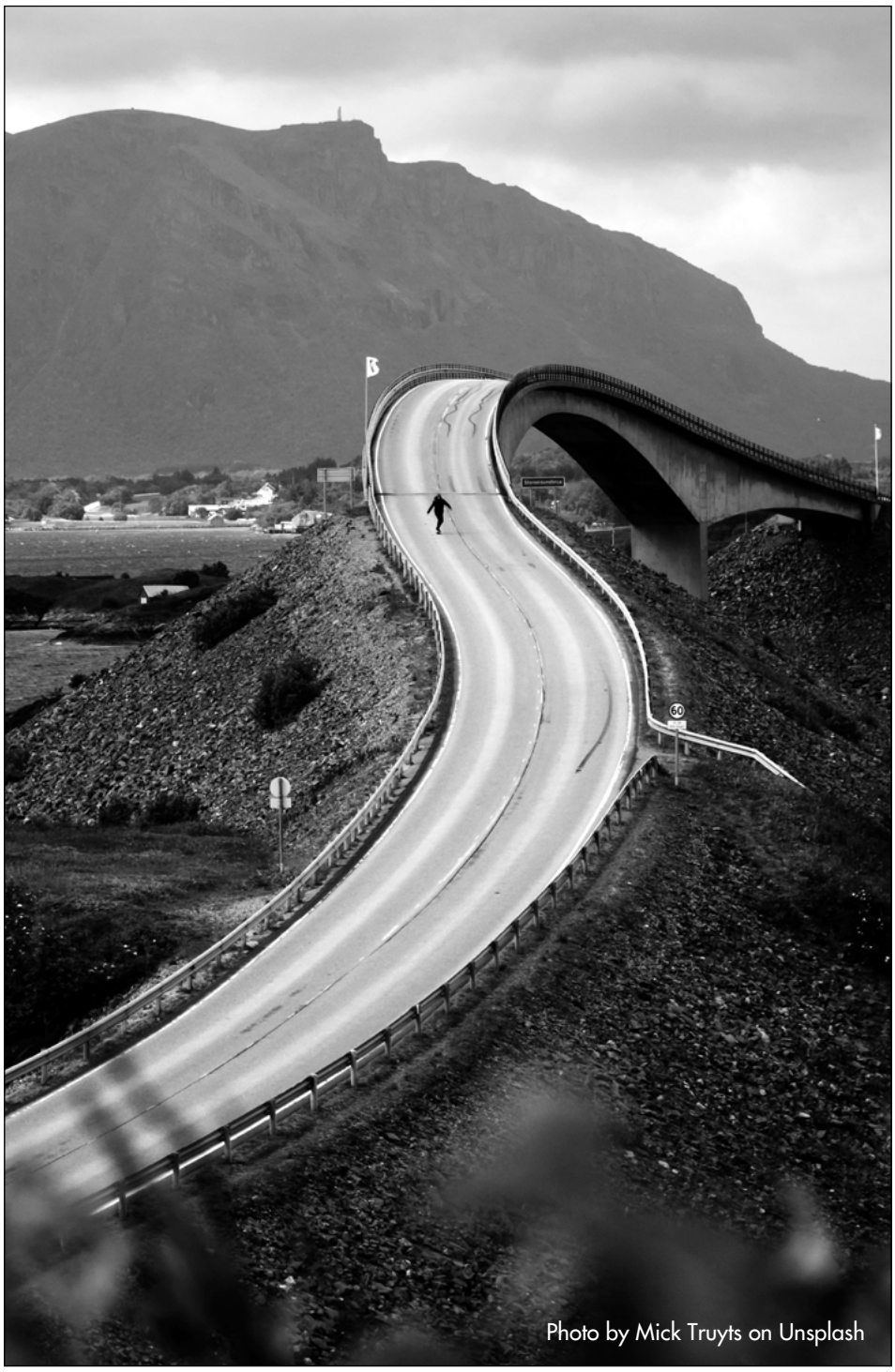


Photo by Mick Truyts on Unsplash

The paediatric guidelines that told us to stop prescribing unnecessary antibiotics also told us to give paracetamol instead. This is what I did with my own children for their first few years. So no unnecessary antibiotics nor creation of antibiotic allergy or resistance nor disruption of the gut biome, but they did have endless snot. Fever is the fast way of getting rid of toxic accumulation. Mucus is the slow way, so it takes a lot longer to do the job – it may be months instead of days.

As I understood more about homeopathic and naturopathic philosophy and learned about the natural intelligence of the body and the reason for symptoms – the body's way of correcting problems and imbalances – I found out that fever was *crucial* to the process – suppress it at your peril. So out went the bottle of paracetamol. I never used ibuprofen. It is a terrible drug. I would not recommend that any

of you do either. It has been banned in France in conventional management of viral respiratory infection since 2019. Treatment, they say, *"repose sur le paracétamol"* – relies only on paracetamol and even that is at a lower dose that in the UK – maximum 3g in 24 hours for adults.

So I understood that children did not 'catch' viral infections – we are surrounded by viruses all the time – but I did think they *used* viral infections to initiate a clear out.

Then in 2004 I read an article by Dr Patrick Quanten MD about viruses: http://www.activehealthcare.co.uk/index.php/literature/science/98-viruses

He said that viruses were not disease causers, they were genetic material, DNA or RNA, produced during the process of cell breakdown and wrapped in a 'bag,' so they could be thrown out. Well, that was a challenging idea – that they came from the inside, not the outside. How could that be? This idea required a lot of pondering and contemplation on my part. How could viruses be anything other than potentially infectious particles even if they only infected you when you needed it? How was it that groups of people got similar illnesses one after the other or all together?

Eventually I came to realise that he was probably correct but I couldn't really explain it to myself properly so I wasn't able to explain it to my patients. As time went by, however, it became more and more obvious and then, rather like the invention of the wheel – it became so self-evident I wondered how it had taken so long to grasp the idea in the first place. Let's look at the some of the accepted 'science' about viruses.

- Viruses are not alive because they do not fulfil any of the criteria for being alive.
- They reproduce by deviously taking over the machinery of the cell and using it to make lots and lots of virus babies which usually 'kill' the cell in the process.
- Many of the symptoms of viral 'infection' such as fever, mucus, swollen glands – are actually caused by the body's immune system in response to the virus.

These statements are based on observation. It requires little shift from this conventional 'scientific' view of viral 'infection' to explain the same observations in quite a different way using holistic principles.

The body with its innate intelligence sets in motion a process of detoxification that results in the breakdown of old and poorly functioning cells and their constituents. The immune or detoxifying system sets up a fever, produces inflammation and mobilises white cells to gobble up rubbish (macrophages – Greek – 'big eaters').

Inside cells are cellular material, organelles and nucleic acids – DNA and RNA – in the nucleus and elsewhere. Some of the products of cellular breakdown produce free oxide radicals that need to be mopped up by vitamin C and glutathione on the way out so they do not produce too much damage. What happens to the nucleic acids – DNA and RNA? Well, they get wrapped in a protein or a lipo (fat) protein coat – or a bin bag in Dr Quanten's words – and chucked out of the cell.

The conventional 'scientific' explanation is that the virus taking over the cell causes it to make new viruses and that this kills the cell. But what if a dying cell packaged up its defective or aberrant genetic material in a protein coat or capsid and threw it out into the blood stream. The more cells that died, the more viral particles would be seen.

Are worsening 'symptoms' and cell death due to a detoxification process the *cause* of increasing numbers of viral particles being seen in the blood stream [holistic view] or are larger number of viral particles responsible for 'killing' increasing numbers of cells [conventional view]?

It is already accepted that most of the symptoms are caused by the body's immune system. What if it were the immune/ detoxifying response that started the cell breakdown in the first place?

In the same way, does the Strep *cause* the sore throat? Or is it just there? Many people have Strep in their throat with no illness. Do gallstones always cause the abdominal pain. Or are they just there? Many people have gallstones with no abdominal pain.

I am at the bus stop when the bus hits a car. Did I cause the crash or am I just there?

Being there and not being the cause is called the 'Innocent Bystander Effect'

When you have worked *with* the body rather that *against* it for decades and seen the great leaps forward the body makes after it is allowed to have, and is supported in its detox process you see which explanation is correct.

Working *with* the body rather than suppressing the symptoms (the body's attempts to fix itself) results in health – vibrant health.

The opposite, the invasion-infection conventional hypothesis results in repeated 'infections' as the body attempts time and again to detox itself but is thwarted at every step by having the healing symptoms blocked. If this continues for long enough the body eventually gives up, toxins accumulate then fibrotic change occurs. This leads to chronic ill health and ultimately to premature death. Remember, we are all going to die, you can't stop that, but you can aim to fulfil or surpass your allotted span.

All OK so far, but how do you explain one child having an illness which spreads to several others, or several people in an office getting the same illness if viruses are not infectious agents??

Well, we have to look deeper into the cosmos to understand that. Understanding life and its phenomena (Greek meaning 'what appears and can be seen') is a complex task. If one child has measles, why do some other children get measles too and other people, for example adults who have already had it not get measles again?

Answering the second part first. Measles, mumps, rubella, chicken pox and all the other viral associated diseases that doctors call 'non specific viral illness' are all developmental steps, which involve the shedding of particular items in the body that no longer serve a purpose. When you go through the measles process you shed the measles detritus. The Chinese call measles 'the visitation of the goddess' and see it as ridding the body of 'fetal toxins'. So measles is a cleansing process that allows you to go up a particular developmental

"But what if a dying cell packaged up its defective or aberrant genetic material in a protein coat or capsid and threw it out into the blood stream. The more cells that died, the more viral particles would be seen."

step – the measles step. So once you have had it, you don't need to have it again. You have done that detox. Why do some children who are in contact with someone with measles not get it? Because they do not need or are not ready for the measles detox at that time. Why do some children get measles when they have been in contact with another child with measles? These are children who do need to go up the measles step. So why didn't they do it last week or the week before? Why is it only after child A gets the measles?

Though we are all individual we are also all interconnected. If there are a lot of children who need to do the measles detox and one of them starts it, this can be the tipping point to set all the rest into doing this as well.

'No man is an island, entire it self.'

One breaks the ice so to speak and the rest follow. If this sounds far fetched, just think about 'menstrual synchrony', the phenomenon whereby women living in the same house or dormitory synchronise their hormones such that after a few months they start to all have their periods at the same time. The interconnectedness of living beings – and probably others - has been described by Dr Rupert Sheldrake of Cambridge University in his theory of morphic fields which can also be used to explain seemingly telepathic occurrences like when an animal in one part of the world is taught a new trick and this is followed by other animals in different countries or continents manifesting the same new trick without anyone having taught them.

Why do several, not necessarily all, people in an office get, for example, what is called viral gastroenteritis if it is not infectious? The people in the office are all subjected to fairly identical conditions for forty or more hours per week, like, non-opening windows, recirculated air, fluorescent lighting and the same mad boss who imposes impossible deadlines, endless coffees, no time for a proper lunch. Some of the workers will compensate for this perhaps by having a calmer or more nurturing life outside of the office or a different response to these stressors. But the others who do not will come down with the illness. Instead of looking at this as a disaster, they should be very happy that it is happening. Adults are far less good at detoxing than children because their systems are less tuned, less vital – less young. Any opportunity to have a vigorous fever, aching muscles and joints (that is what toxins feel like when they are on the move) and to feel lousy – specially designed to make you go to bed and rest which supports the process – should be embraced with enthusiasm and gratitude. What a great opportunity to get rid of dead wood to allow new growth, reducing the tendency towards cancer and heart disease. What is not to like?

The ancients understood the effect of our surroundings on our bodies, including the movements of the heavenly orbs. The word 'influenza' is short for *'influenza delle stelle'* the influence of the stars. We may scoff at such notions from the vantage point of our twenty first century scientism but as R. Dr. Gunther Plaut said in his introduction to 'The Torah, A Modern Commentary':

"To be sure, our knowledge of science is vastly greater than that of the ancients. But that does not necessarily make our world view… based on such scientific insights, any more advanced"

The more you study different types of healing, religion and philosophy, the more you realise how what we know is so tiny compared to what we don't know that it behoves us all to be a little bit humble.

There is a lot of talk about SARS COV-2 being a virus weaponised in a lab in Wuhan. The fact is that you cannot weaponise a virus – it's dead. But you *can* weaponise the environment – pollution in the air, oestrogens and fluoride in the water, petrochemical pesticides sprayed on our crops. People worry a lot about 5g – and they should – but even the regular electricity in the house causes magnetic fields around the rolled steel joists with which modern houses and extensions in older houses are constructed. WIFI and the environmental pollutants with which we are surrounded at unprecedented levels are massive enzyme disrupters. Enzymes determine the speed of all the reactions in the body – or if they happen at all. The breakdown products of these proteins include highly toxic free oxide radicals, also known as reactive oxygen species (ROS) (visualise a five year old running round the sitting room with a blow torch). We neutralise or mop them up with Vitamin C and glutathione.

What can you do to help? High dose vitamin C. There are those who condemn 'megadosing' with vitamins, but desperate times call for desperate measures. I recommend adults take a minimum of 2 grams (2000mg) twice daily of slow/ timed/ medium release vitamin C. The vitamin D level in your blood should be 120-150 nmol/l UK [USA 40-60ng/l], and take steps to reduce your exposure to EMFs - email me for resources.

If you want more in depth information about the particles found in human bodies that are called viruses I highly recommend presentations by Stefan Lanka PhD, Andrew Kaufman MD and Thomas Cowan MD.

jaynelmdonegan@yahoo.com

01 Feb 2022.

TIP ARCHIVE

Maternal & early postnatal immune activation produce sex-specific effects on autism-like behaviors & neuroimmune function in mice

CARLEZON JR WA, KIM W, MISSIG G ET AL
NATURE.COM (2019) 9:16928
https://doi.org/10.1038/s41598-019-53294-z

A FEW BRIEF EXTRACTS:

"There is increasing evidence that the immune system is involved in neuropsychiatric illnesses. There are higher rates of autism spectrum disorder (ASD) in families with a history of autoimmune disorders, and maternal infection or fever during pregnancy increases the risk that offspring will develop ASD,"

"Animal models involving early-life immune activation provide support for a causal role of immune dysregulation in ASD. While the contribution of genetics to ASD is well-established, studies in laboratory animals demonstrate that environmental factors such as those that trigger early-life immune system activation (EIA) can be sufficient to cause phenotypes that resemble ASD or co-morbid conditions. Immune system activation during pregnancy—maternal immune activation (MIA)—in rodents and non-human primates can result in off-spring that exhibit three core behavioral features of ASD, including decreased social interaction, aberrant communication, and increased repetitive or focused behavior." "Our findings suggest that immune system activation during critical periods of development is sufficient to produce persistent alterations in behavior and brain biology". "Implications. These findings provide support for the utility of MIA, PIA (postnatal immune activation), and combined treatment for the study of ASDs on several levels. First, the patterns of behavioral changes, together with their prevalence in males, fit well with the condition as it occurs in humans. The observation that both males and females mount persistent pro-inflammatory responses, whereas only females mount accompanying anti-inflammatory responses, represents a new and potentially important discovery that might aid in understanding sex differences in prevalence and tailoring new treatments. Together, these findings add to accumulating evidence for an immune subtype of ASD, and suggest that immune-related pathophysiologies can differ between sexes. The ability to better identify subtypes of this syndrome will facilitate care and perhaps provide a justification for investigations into treatment strategies (e.g., immune-modulating agents) that might not otherwise be considered for ASDs." *TiP Editor: Has anyone investigated whether the vaccines given during pregnancy and/or the early baby vaccines administered in the first year may create or contribute to early or maternal immune activation?*

Smallpox among the vaccinated

P691–693. THE LANCET
25 November 1944

A COUPLE OF BRIEF EXTRACTS:

'A disturbing feature of this outbreak was that it occurred in a highly vaccinated military population – 96% had been vaccinated at some time, a vaccinal state about three times as good as that of the non-military population of Great Britain. Is, then, vaccination less efficient than it was? If it is, does the fault lie with the lymph, the vaccinator or both? Stevenson, in another paper in this issue, exonerates the lymph. He reminds us that for the last 60 years those conversant with the disease have recognised that vaccination and revaccination, however carefully performed, do not confer absolute immunity.' The last paragraph reads: 'The limitations of vaccination must be clearly stated despite the mighty pens ready to exaggerate every failure. But we shall continue to regard it as the surest safeguard against a loathsome and fatal disease and seek "to fence off as many of the pitfalls and signpost as many of the right roads "as possible.'

Testimonies concerning vaccination & it's enforcement: Classic reprint pamphlet from 1880s

EXTRACTS FROM PAGE 11

MR JOHN MCCLAREN, MP, LORD ADVOCATE FOR SCOTLAND

"I should not have thought it advisable to enforce Vaccination by compulsory legislation, because it is a principle of common law that no man should be compelled to submit himself or family to a medical or surgical operation without his own consent." January 24th, 1881.

GEORGE W MALLONY, MD, NEW YORK, USA

"I am opposed to Vaccination for several reasons:

1st - It is introducing into the human system a deleterious matter, which acts as a permanent poison, which cannot be eradicated by any process known to science.

2nd - It degenerates the human family, by developing syphilis, scrofula, and consumption," – From New York Medical Tribune, September 15th, 1879.

The Recrudescence of Leprosy and its Causation

BY WILLIAM TEBB, 1893

THIS BOOK investigated the resurgence of leprosy during the 1800s and contains many testimonies from doctors around the world pointing to the mandatory smallpox vaccination procedure as the main cause, especially when the arm-to-arm procedure was performed in some parts of the world. However this aspect was continually dismissed and ignored by the authorities. A fascinating read for those who are interested in the likely contribution smallpox vaccination made as regards to the rapid growth of leprosy cases during the latter half of the nineteenth century. In 1889 a committee was brought together for the purpose of investigating the causes of this increase. As you might have guessed the smallpox vaccination as a cause was considered only to be 'so slight a degree that the danger might be disregarded.'

Here follows a couple of brief extracts from Chapter XVI - The Leprosy Investigation Committee.

p308: 'On the contrary the danger from malaria, overcrowding, impure water, unwholesome food, filthy deposits, has, under the instructive teachings of the late Dr Southwood Smith, Sir Edwin Chadwick, and their followers, been gradually and sensibly diminishing, and it is triumphantly claimed that various diseases due to these causes have been decreasing also. It is obvious therefore, that some other factor or factors, peculiar to this century and previously unknown, are at work. This factor, as high authorities now reluctantly avow, has been omitted by the Commission from the list of causations in their summary of conclusions – the latest and most daring official effort, to use a classic phrase, "to preserve vaccination from reproach." '

p309: 'The Leprosy Commissioners (all ardent supporters of the Jennerian practice) have searched far and wide for a rational theory that will account for the recent spread of leprosy in certain countries, but have utterly failed to discover one, and are almost driven to the conclusion that touches closely upon the facts collected in this volume.'

'To the present writer, vaccination seems to be the only intermediary host that passes direct into the blood (except in rare instances of accidental inoculation), and which covers all the facts of the case. It appears that of the £7000 collected £800 remains, part of which it is suggested should be devoted to further investigation. It is to be hoped, if this is adopted, that less prejudiced and more competent inquirers will be appointed, and that in the future numbers of the Journal the accumulation of evidence, so shamefully ignored, showing how leprosy has been spread at the point of the vaccinator's lancet will find a place.'

Poliomyelitis

LETTER TO THE EDITOR,
THE LANCET, 19 MAY 1951 P1127

SIR, - I should like to add the following experience to that recorded by Dr Harrington in your issue of May 5.

In each of the four cases of poliomyelitis encountered by me in 1947 the site of paralysis appeared to be related to trauma, as follows:

Case 1. - Tonsillectomy, followed a fortnight later by bulbar palsy.

Case 2. - Injury to the left thumb, followed about a fortnight later by paralysis of the left forearm and shoulder. This man's wife had a two months' abortion at the same time as the acute disease that preceded his paralysis.

Case 3. - Injury to left hand, followed about a fortnight later by paralysis of the left arm

Case 4. - Impetigo of the left thigh, much scratched, followed by mild poliomyelitis with left quadriceps paresis. The time interval could not be assessed in this case because of the chronicity of the skin lesion.

At about the same time we encountered an old case of poliomyelitis which we regarded as belonging to the same series.

Case 5. – A little later a girl, aged 9 years, attending for some other trouble, was found to have paralysis of the left arm; and inquiry elicited the fact that paralysis had occurred about a fortnight after an injection of A.P.T. on Nov. 2, 1942.

This was our first encounter with post-inoculation poliomyelitis, and we included it in the traumatic series. It was possible to trace most of the other children inoculated at the same time, and none of these had suffered ill effects from their inoculation.

R E Hope Simpson
Public Health Laboratory Service,
Epidemiological Research Unit,
Cirencester.

"A PEOPLE WITHOUT THE KNOWLEDGE OF THEIR PAST HISTORY, ORIGIN AND CULTURE IS LIKE A TREE WITHOUT ROOTS."
~ MARCUS GARVEY.

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 views expressed in this newsletter are not necessarily those of The Informed Parent Co. Ltd. We are simply bringing these various viewpoints to your attention. We neither recommend nor advise against vaccination. This organisation is non-profit making.

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