FREEDOM
OF CHOICE
NO JAB, NO PAY? NO WAY !

NO JAB, NO PAY? Penalizing the "free" exercise of the right to refuse a medical procedure???

The Australian Government has proposed, in its 2015 Budget childcare package, to end the conscientious and religious exemption on children's vaccination for access to the Child Care Benefit, Child Care Rebate and FTB Part A end-of-year supplement, from 1 January 2016. Only the medical exemption would be available, where the child has certified childhood-acquired natural immunity or a medical contraindication.[1] Most past adverse effects, even serious, to the child or other family members would not qualify easily, if at all.[2]

NO WAY! - to pressuring or forcing injections that can cause serious medical conditions, even death!

(Ab)using its power from **needy** families' dependence, the Government threatens to withhold **needed** funds to **PRESSURE OR FORCE**[20] thousands of parents to allow their children to be directly injected and, by its own admission after only very limited testing[3], with **ALL** of...

- **86 antigen doses:** 8 injections (74 antigen doses) before 12 months of age, and 2 more injections by 4 years of age.[4] **plus**
- **foreign organism components, neurotoxins and multiple chemicals:** such as aborted foetal & animal cell line components & DNA, aluminium, polysorbate 80[5], genetically engineered yeast, MSG, antibiotics and potentially animal viruses and/or other contaminants.[6]

Adverse effects, on the brain & nerves[7], immune system, lungs, heart, liver, blood, kidneys, glands, gut, eyes, ears, muscles, joints, skin, etc are frequently reported in trials.[6] The Government admits[8] serious effects such as paralysis, sepsis, meningitis, autoimmune disease[9], toxic shock and death. In 2000-11, it gave a 'certain'/'probable' causality rating to 16% of assessed serious event reports (the rest left as 'possible').[10] Medical research has also linked several ingredients, when injected, to disorders[11] such as cancer[12] and DNA changes.[13]

The Government has not explained how it would compensate for harm done by these injections when given only under this pressure.[14]

You may decide that these injections are right for your child, but should other parents be pressured or forced to permit them?

Can the Government force injections it admits can KILL? NO WAY!

NO WAY! - to adding insult to injury, breaking families already stressed, some already harmed!

Some parents refuse/delay only one vaccine dose.[4] Most/many whose conscientious choice is refusal have seen their previously healthy child harmed after vaccination. Many already struggle financially and emotionally due to such damage and would be burdened further.

If denied much needed childcare benefits, parents whose consciences prevent them from exposing their vaccine damaged child and/or their other children to the risk of further harm would be forced to stop work and/or study and instead claim unemployment benefits.

The "devil's choice" that would be imposed by such legislation may break up many families due to disagreement between each parent.

NO WAY! - to discriminating against the educated needy. Refusal is a right, not a 'privilege' for the rich!

The Government itself has found the highest vaccination refusal rates in the "*highly educated*" and "*well informed*" who have "*often… deliberated extensively over the question*".[15] This includes medical doctors,[16,17,18] who are in frequent contact with those most vulnerable to infectious diseases. The proposed legislation does not target politicians' own right to refuse vaccines for their children.

NO WAY! - to disregarding inalienable human rights!....

Individuals have inalienable rights to life, bodily security, equality, and **free** exercise of thought, conscience and religion. Provisions for these rights are **NOT** "*loopholes*". They are expressed in the Constitution, common and statute law and international human rights instruments.[19] Accordingly, the High Court (1949) has ruled that "*any form*" or "*extent*" of "*compulsion*" of *medical services*, "*whether legal, by… penalties, or… by any other means, direct or indirect, could not be authorized.*"[20] So whatever 'law' the Government enacts, vaccination will remain **illegal** unless parents give valid consent. The Government itself instructs that consent to vaccination is valid only if given:-

- "*voluntarily in the absence of undue pressure, coercion or manipulation*" AND
- "after the *potential risks and benefits of the… vaccine, risks of not having it and any alternative options have been explained*".[21]

Otherwise vaccination may constitute battery, negligence, malpractice, professional misconduct and/or fraud by the administrator.

NO WAY! - to claiming that any special circumstances apply, to justify an invasively totalitarian law!

A medical procedure may reasonably be given to a child without informed consent in an exceptional situation: IF (1) the parents are unavailable to give timely consent AND (2) the purpose is to avert significant danger to the targeted child AND (3) safer alternatives are unavailable AND (4) it is effective for the purpose, demonstrably significantly outweighing the procedure's risks.[22] Do these apply?

(1) Are the parents unavailable? NO! And it is mainly because parents most reliably "*have the child's best interests in mind*",[23] that they are vested with legal "*authority and responsibility*" for such decisions. Also notably, it extends to their own children only.

(2) Is the purpose to protect the targeted children from a significant danger? NO!

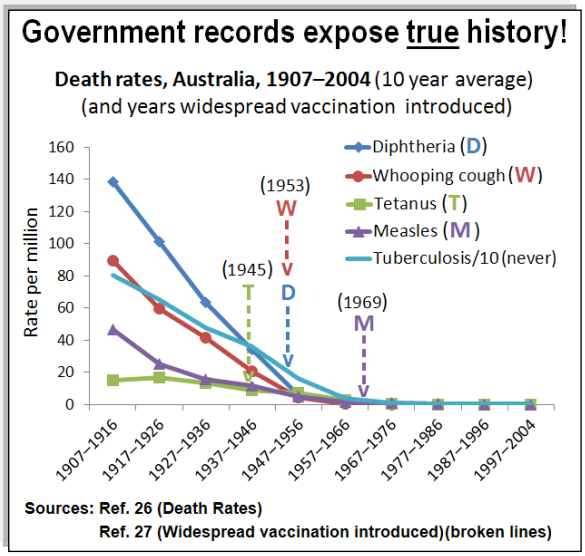
In stating its purpose, the Government fails to allude to any danger to the children it is targeting for vaccination. Its expressed concern is only at the alleged risk, not even substantiated,[24] "*to other* (unidentified) *young children and the broader community*." Any law requiring individual children's rights to be sacrificed on the pretext of serving the government-decreed 'greater good' is totalitarian and irreconcilable with the principles of democracy and freedom, even if the majority vote for it.[25] Nonetheless, regarding the risk to any group…

- Infectious diseases dramatically declined in importance in the 19th and 20th centuries, almost all of it **BEFORE** vaccination.[26,27] (See graph, right).

  For example, already by 1950, the Government no longer considered whooping cough (WC) and measles important enough to be notifiable,[28] and in 1956 it was declared that "*as causes of infant mortality in Australia all the infective diseases have been overcome*".[29] How? See **(3)** below.

- The decline continued to the extent that over the last 20 years (10 million unvaccinated child years[30,31]), notifications of **diphtheria, polio and tetanus** (which is not even contagious) have totalled in children zero, zero and two respectively.[32] Australia has been certified polio-free ever since 2000.[33,46]

  Similarly, other diseases' annual average notifications in Australia include:
  - 1 in 600,000 for **hepatitis B** (similar to before widespread vaccination)[34,33]
  - 1 in 150,000 for **Hib** in the targeted (highest incidence) ages, 0 to 4 years[34,33]
  - zero for **meningococcal C** in under 15-yr-olds since 2011.[33]



- Australia was declared '**measles** free' in 2009[35] and by a stricter definition in 2014[36]. The Government states "*transmission... due to locally acquired cases has not occurred… for some time*"[37]. Outbreaks still occur, but briefly with limited reach and no deaths in 20 years,[34,33] despite vaccine-induced antibodies' limited duration.[38] **Mumps and rubella** notifications are similarly infrequent.[34] Hence reported rates of cited disease complications, listed on the vaccine insert also, are over 500 times higher from the vaccine.[39,34,33]

(3) Are safer alternatives unavailable? NO!

- The Government itself gives credit to improved nutrition, sanitary reform, breastfeeding, improved fitness, reduced family size, less overcrowding and general health for the past dramatic decline in infectious diseases[40] and continued protection against them.[41]
- The WHO[42] and scientific research now inform how to prevent and manage infectious diseases, eg Vitamin A halves measles risks.[43]
- Properly managed natural exposure to some targeted diseases, eg **chickenpox,** measles, mumps & rubella (MMRV), has been found to prevent (by up to 93%[44]) and resolve[45] some cancers & other chronic conditions. It also brings reliable lasting immunity, unlike vaccines.

(4) Would vaccination of these children protect others, and enough to significantly outweigh its risks? NO!

- Government information is that other than the "childhood diseases" (WC, MMRV), the targeted diseases are very difficult or impossible to develop from day-to-day contact. Other factors are important.[34,46] Note that only WC and chickenpox are commonly reported.
- The Government "*has determined that there is no clinical effectiveness*" of the **whooping cough** vaccine for reducing disease spread.[47] Even the manufacturers do not claim it will reduce it![48] Instead, with fully vaccinated rates at record highs: 97% in these families[1] and 90% in under 19 year olds[49] (goal, just reached), plus many adults now vaccinated, whooping cough notifications & deaths have risen in vulnerable age group(s).[34,50] Medical research finds vaccination may result in "*silent reservoirs*"[51] of "*readily transmitted*"[52] infection.
- The Government has frequently found the vaccination rate amongst reported cases to be 90% to 100%, similar to, or higher than, the vaccination rate in the population, including whooping cough, mumps, chickenpox, Hib and **pneumococcal**.[34,53,51]
- When original sources are identified in disease cases, they are almost always found to be vaccinated, and often recently.[54]

NO JAB, NO PAY? NO WAY! - PLEASE SUPPORT OUR PROTEST movement!

For next protest, go to https://www.facebook.com/nojabnopaynoway or http://nojabnopaynoway.weebly.com/

Visit or **post** a brief expression of your concerns to your local Federal Member of Parliament and/or The Hon Scott Morrison MP, Minister for Social Services, PO Box 6022, House of Representatives, Parliament House, Canberra ACT 2600.

For references numbered herein, send an email to freedomofchoicevacc@mycg.org or Ph: 0432 194 204

REFERENCES for "Freedom of Choice. No Jab No Pay? No Way!" protest flier

The purpose of this document is to

1) pass on as faithfully as possible referenced information that is sourced primarily from publications authored or endorsed by the Government, plus fill in, also reliably, gaps in the information provided by the Government, in relation to:
   - whether or not the Parliament of the Commonwealth Government has been delegated the power by the people to pass legislation of the nature that the Government has proposed, and
   - what consequences, beneficial and/or adverse, could reasonably be predicted from the proposed legislation.
2) explain why we conclude that the Commonwealth Government has not been empowered to enact such legislation and that notwithstanding it has not been demonstrated to advance the "greater good", and hence must not be enacted.

The reader is encouraged to do any further research that he/she sees fit and form his/her **own** informed conclusion, and also to pass on to us any errors identified in the information contained herein so that we can correct them for others' benefit.

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1 "*No jab - no play and no pay for child care*" media release by PM Tony Abbott, 12 April 2015 https://www.pm.gov.au/media/2015-04-12/no-jab-no-play-and-no-pay-child-care-0;

"*Government ends religious 'No Jab No Pay' of benefits exemption*" media release by Mr Scott Morrison, 19 April 2015 http://scottmorrison.dss.gov.au/media-releases/government-ends-religious-no-jab-no-pay-of-benefits-exemption;

Budget 2015 - "*Supporting Australian Families*": http://budget.gov.au/2015-16/content/highlights/families.html;

"*Strengthening Immunisation for Young Children*", Australian Government Department of Social Services https://www.dss.gov.au/our-responsibilities/families-and-children/benefits-payments/strengthening-immunisation-for-young-children

2 Medical exemptions

The present "Immunisation Exemption Medical Contraindication" form lists only the following as grounds for a medical exemption:

- unstable neurological disease, or
- encephalopathy within 7 days after a previous vaccination, or
- immediate severe acute allergic or anaphylactic reaction after any previous vaccination, or
- malignant disease and/or immunosuppressive therapy and/or immunosuppression, or
- allergy to preservative or antibiotic contained in the vaccines, or
- other non-permanent contraindication and vaccination is only deferred to a later date.

http://www.humanservices.gov.au/spw/health-professionals/forms/resources/immu11-1310en.pdf

– For more information about contraindications, see
The Australian Immunisation Handbook 10th edition (2013), *2.1.4 Pre-vaccination screening*
http://www.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home~handbook10part2~handbook10-2-1#2-1-4 (page last updated 16 July 2015)

It is evident from the information in Reference 3 about adverse effects and their frequencies reported that almost all of those reported, even resulting in permanent damage, including many that may be given a "certain" or "probable" (rather than "possible") causality rating by the TGA (see Reference 10), would not fall under any of the above listed categories of contraindication for future vaccination.

One example of note is that there are no scientific grounds for the assumption that if a condition that is ultimately recognised as vaccine encephalopathy were to develop, all symptoms would appear within 7 days after vaccination, especially when observing infants, who cannot talk. Longer periods have also been documented post-vaccination for symptoms to appear in such types of conditions.
e.g. in the case of post-vaccine acute disseminated encephalomyelitis, "neurologic symptoms typically appear 4 to 13 days after a vaccination." (http://myelitis.org/symptoms-conditions/acute-disseminated-encephalomyelitis/)

3 How the Government admits the lack of testing, in effect the experimental nature, of its vaccination program…

Acknowledged limits of testing prior to vaccines' release for use on the general public

The Government in its official Australian Academy of Science booklet "*The Science of Immunisation*" (2012), (https://www.science.org.au/publications/scienceofimmunisation-q-and-a-2012/safe)

provides the information that there are 3 phases of vaccine development (after it is tested on animals) before it is approved for widespread community use, with only Phase 1 and Phase III involving any safety assessment.

"In phase I clinical trials, the vaccine candidate is given to small numbers (25–50) of healthy adults with the primary goal of assessing safety". Such a trial would obviously be extremely limited in its ability to detect risks.

Phase III, it states, "*usually requires administration of the vaccine to many thousands of potentially susceptible people*".

However, not only are the trials conducted by the vaccine manufacturers themselves (not an independent investigator), but their product information (which can be accessed here for each available vaccine: https://www.ebs.tga.gov.au/), reveals:

i. The monitoring periods in clinical trials range from a limited period of a few days to only 6 weeks, and

ii. Rather than "*usually… many thousands",* the total number of subjects in the relevant trials range from less than 300 to approx. 5000, and are usually nearer the **lower** end of that range. An exception is 12,000 in the case of the Priorix MMR vaccine. (Is it further possible that even in the case of one or more of these small trials, they have been selected by manufacturers from a number of trials on the basis of having yielded the most favourable results?).

iii. Vaccine manufacturers almost invariably select as trial subjects only those who they define as "healthy", but fail to include how they define "healthy", e.g.

- Priorix-Tetra® vaccine (for measles, mumps, rubella and chickenpox): "In a study with an earlier formulation of the GSK MMRV combination vaccine (with a reduced mumps content) a total of 300 **healthy** infants aged 9 to 10 months, without previous history of varicella…*PRIORIX-TETRA* given in a 2-dose schedule in healthy children in the second year of life…"
- H-B-VAX II vaccine (for hepatitis B): "1636 doses of H-B-VAX II were administered to 653 **healthy** infants and children (up to 10 years of age) who were monitored for 5 days after each dose."

Indeed "*The Science of Immunisation*" also proceeds to admit that the pre-licensure testing is **insufficient** to rule out a significant risk of adverse events that are infrequent but are sufficiently common and/or serious to render the vaccine unfit for use in the community. It cites an example, being the Rotashield rotavirus vaccine which was initially administered to the public but subsequently withdrawn within only 1 year of use due to the unacceptable rate at which it was found to be causing intussusception. Then, with the replacement vaccine, **again** it was only after it had been used on the public that a higher number of cases of intussusception was detected with that replacement vaccine also.

Accordingly, the Government's Therapeutic Goods Association (TGA) admits:

> *"When a medicine (or vaccine) is first registered and made available in Australia, information about its safety and efficacy is usually available only from clinical trials",*

but that

> "*Clinical trials…do not detect all possible adverse events because:*
>
> *i. they usually do not continue for long enough to detect adverse events that take a long time to develop, and*
>
> *ii. they do not include enough subjects to detect adverse events that occur (more) rarely, and*
>
> *iii. they do not include all of the… types of people who might… use the medicine and... be more susceptible to some adverse events...*"
>
> *(Reporting medicine and vaccine adverse events*, Aust. Govt. Dept Health and Ageing TGA http://www.tga.gov.au/safety/problem-medicine.htm#why)

Hence the pre-release testing is too limited to determine the rate and strength of vaccines' association with serious adverse effects that may not even be rare. It follows that the administration of the vaccines to the general public is experimental to the extent, at the minimum, to which the clinical trials are thus limited.

Inadequacy of testing subsequent to vaccines' release to the general public demonstrated by product recalls

The Government's claim that vaccines "comply with strict manufacturing and production standards" appears to be contradicted by vaccine recalls that have occurred. For example:

- *Meningitec meningococcal serogroup C conjugate vaccine suspension for injection, single dose syringe - Recall - potential for particulate contamination*. 29 September 2014. TGA

  The announcement that *"Emerge Health has advised that a review of batches manufactured since October 2012 found a small number of syringes had been contaminated with iron oxide (rust) and oxidised stainless steel"* and consequent recall did not occur until 29 September 2014, which was 2 years after the said detected contamination was found to have begun.

  Why did it take 2 years after the release of these potentially contaminated vaccines to the public before the testing occurred that detected that contamination?

  https://www.tga.gov.au/alert/meningitec-meningococcal-serogroup-c-conjugate-vaccine-suspension-injection-single-dose-syringe

- "*MSD has recalled lots of PedvaxHIB and Comvax, because it has been unable to guarantee sterility.*" (7 Jan 2008)

  http://www.kiallamedical.com.au/Home/patient-information/infectious-diseases/hib

Lack of investigation of vaccine detoxification

Menkes and Kinsbourne (1990) in published the results of a Workshop on Neurologic Complications of Pertussis and Pertussis Vaccination in 1990:

"Vaccines are not standard from one batch to the next… In fact, the whole question of vaccine detoxification has never been systematically investigated."

(J. H. Menkes, M. Kinsbourne· Workshop on Neurologic Complications of Pertussis and Pertussis Vaccination. Neuropediatrics 1990; 21(4): 171-176. https://www.thieme-connect.com/DOI/DOI?10.1055/s-2008-1071488)

Even subsequent to vaccines' release to the general public, testing remains seriously inadequate

The TGA explains that it is due to the three types of limitations it lists to the testing (see quote of the TGA above and accompanying reference), that it relies upon **passive** surveillance of adverse events **subsequent** to the release of vaccines to the public to *"provide important information for the TGA's safety monitoring program" "to contribute to a better understanding of their possible adverse effects when they are used outside the controlled conditions of clinical trials".*

However, even after this surveillance has occurred for some time, it does not pretend to have the nature of scientifically conducted research, because it has its own serious limitations from a scientific perspective:

- It is passive, unenforced, arbitrary (in practice), unmonitored itself, and susceptible to medical doctors' bias and limited knowledge. The resulting reporting rate can hence be up to 100 or more times lower than in clinical trials.

  (Reference: product information available here https://www.ebs.tga.gov.au/ compared to

  Adverse events following immunisation annual reports (2003 thru 2011), CDI, Aust. Govt. Dept Health http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-aefi-anrep.htm and

  "Surveillance of adverse events following immunisation: Australia, 2000–2002" report http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-pubs-cdi-2003-cdi2703-htm-cdi2703a.htm The causality ratings are also defined in the latter report above.)

- **The reporting rate for serious adverse events linked to medications has also been estimated by the U.S. FDA to be 1%.**

  (Kessler D, *Introducing MEDWatch - A New Approach to Reporting Medication and Device*, JAMA, June 2, 1993-Vol 269, No. 21 http://www.fda.gov/downloads/Safety/MedWatch/UCM201419.pdf

Hence undeniably, the giving of these vaccines essentially remains experimental to the extent, at the minimum, of the afore listed limitations to clinical trials. Other countries also rely upon passive surveillance.

The additional experimental aspect arising from the Government's vaccination program…

It could be argued further that inadequacies of testing in relation to administration aspects of the Government vaccination programs add to the experimental nature of vaccines' administration, such as

- the potential additional toxicity, of a synergistic nature, of the simultaneous injection of the numerous toxic ingredients in vaccines, when several vaccinations are administered simultaneously (in addition to the synergistic toxicity arising from multiple components being delivered simultaneously in a single vaccination), and
- the potential cumulative toxicity, and/or cumulative adverse effect(s) on the body, of the numerous toxic ingredients in vaccines, arising from the multiple vaccinations that are administered, and on multiple occasions.

However this document is focusing primarily on information that is conceded or recorded by government.

Hence, considering all of the above, claims of vaccine safety are, indisputably, scientifically groundless.

Failure to demonstrate safety more significant given low tolerance for risk for healthy with minimal disease risk

The lack of scientific demonstration of safety can be seen to be especially significant in view of the fact that, as stated by the US Department of Health and Human Services' Food and Drug Administration (FDA):

"In contrast to most drugs and biological products that are predominantly developed to treat ill patients, vaccines primarily are given to large numbers of healthy people, oftentimes predominantly healthy infants and children. And this places significant emphasis on their safety. Also, for several vaccines the incidence of the infectious diseases that they are intended to prevent is quite low... Therefore, a high percentage of… people will never be exposed to the infectious agent… Thus, there is low tolerance for significant adverse events… caused by vaccines."

(Food and Drug Administration (FDA). Workshop on Non-clinical Safety Evaluation of Preventative Vaccines: Recent Advances and Regulatory Considerations. 2002. http://www.fda.gov/downloads/biologicsbloodvaccines/newsevents/workshopsmeetingsconferences/transcriptsminutes/ucm054459.pdf (pages 12-13), last accessed July 30 2015.)

The said "quite low" "incidence of the infectious diseases that they are intended to prevent" and the lower still chance of any permanent adverse outcome arising from them is described and referenced in the paragraph numbered **(2)** on the second page of this flier.

View that vaccine safety testing is inadequate has received support from the Cochrane Library.

The prestigious Cochrane Library recently did an independent review of MMR vaccine trials and the author's conclusion was, "*The design and reporting of safety outcomes in MMR vaccine studies, both pre- and post-marketing, are largely inadequate."* (Cochrane Database Syst Rev. 2012 Feb 15;2. http://www.ncbi.nlm.nih.gov/pubmed/22336803)

4 Vaccines proposed to be linked to the government benefits are those for diphtheria, tetanus, polio, pertussis, Hib, Hepatitis B, pneumococcal, meningococcal, measles, mumps, rubella and chickenpox. The linked vaccines and doses are listed in the *Standard vaccination schedule for family assistance* here: http://www.humanservices.gov.au/customer/subjects/immunising-your-children

Does your child need all of those vaccines and doses in order to be protected from the targeted diseases?

The Government says that there is an at least 95% chance that he/she does **not**. In particular…

- **2 doses needed of measles-mumps-rubella containing vaccine (scheduled at 12 and 18 months of age)?**

The *Australian Immunisation Handbook* (see Reference 6) states (in *Section 4.9.4 (Measles) Vaccines*),

> *"Measles immunity induced by 1-dose vaccination provides long-term immunity in most recipients.[2,27] However, approximately 5% of recipients fail to develop immunity to measles after 1 dose.[28]"*

It is easy to do a blood test for the presence of antibodies to measles, mumps or rubella.

The second measles-mumps-rubella containing vaccine dose (MMRV) does also target chickenpox. However:-

- it is also easy to do a blood test for the presence of antibodies to chickenpox, to which immunity may have developed asymptomatically by the time chickenpox vaccination is considered

  (Boulianne N, Duval B, et al. *Most ten-year-old children with negative or unknown histories of chickenpox are immune*. Pediatr Infect Dis J.2001;20:1087–1088. http://www.ncbi.nlm.nih.gov/pubmed/11734718), and

- chickenpox vaccination, if desired, is available separately, without the measles, mumps or rubella components.

5 Polysorbate 80

Polysorbate 80 is an ingredient in Infanrix hexa, Infanrix IPV and the pneumococcal vaccine Prevenar, all standard vaccines on this schedule.

- **anaphylactoid reactions**

Polysorbate 80 has been identified as the causative agent for the **anaphylactoid** reaction of nonimmunologic origin (polysorbate specific IgE antibodies were not identified) in the human.

(Coors EA, Seybold H, Merk HF, Mahler V. Polysorbate 80 in medical products and nonimmunologic anaphylactoid reactions. Ann Allergy Asthma Immunol 95:593-599, 2005 http://www.ncbi.nlm.nih.gov/pubmed/16400901).

- **reproductive damage?**

In sexually mature rats, a study in 1956 saw a reproduction decrease with Polysorbate 80 at 20% of their diet.

(Oser BL and Oser M. Nutritional studies on rats on diets containing high levels of partial ester emulsifiers. J Nutr 60:489-505, 1956. http://jn.nutrition.org/content/60/4/489.full.pdf)

Delayed effects of neonatal exposure to Polysorbate 80 on female reproductive organs in rats have also been documented. Polysorbate 80 accelerated the maturation of the female rats, damaged the vagina and womb lining, caused significant hormonal changes, severe ovary deformities and ultimately rendered the young female rats infertile.

(Gajdova M, Jakubovsky J, Valky J. Delayed effects of neonatal exposure to Tween 80 on female reproductive organs in rats. Food Chem Toxicol 31:183-190, 1993. (http://www.ncbi.nlm.nih.gov/pubmed/8473002)

6 Vaccine ingredients and adverse effects reported, as listed on vaccine product inserts

All of the specific vaccines that are available in Australia and may be given are named in *The Australian Immunisation Handbook* 10th edition (2013), in the chapters relating to the various respective diseases in *Part 4 Vaccine-Preventable Diseases* here: http://www.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home~handbook10part4 (page last updated 16 July 2015)

The Australian Government Department of Health TGA here https://www.ebs.tga.gov.au makes available the manufacturers' product information for each vaccine. The product information for each vaccine includes:

- ingredients of the vaccine (though not all ingredients are required to be listed), and
- adverse effects reported in previously healthy recipients.

Ingredients include as (apart from viral antigens, bacterial toxoids and cell components):

- 2-phenoxyethanol, aluminum hydroxide, aluminum phosphate, amino acids, ammonium sulfate, bovine derived materials, calf serum protein, casamino acids, chick embryo cell culture, Eagle MEM modified medium, EDTA, embryonic guinea pig cell cultures, Fenton medium (containing bovine extract), foetal bovine serum, formaldehyde, gelatin, glutamate, glutaraldehyde, human embryonic lung culture and WI-38 human diploid lung fibroblasts, lactose, Latham medium derived from bovine casein, Minimum Essential Medium, modified Latham medium (derived from bovine casein), modified Stainer-Scholte liquid medium, monkey kidney cells, monosodium L-glutamate, neomycin, phosphate, phosphate buffers, polymyxin B, polysorbate 80 (Tween 80), potassium chloride, potassium chloride, potassium phosphate monobasic, recombinant human albumin, recombinant yeast protein, residual components of MRC-5 cells including DNA and protein, semi-synthetic medium, sodium chloride, sodium dihydrogen phosphate dehydrate, sodium hydroxide, sodium phosphate dibasic, sodium phosphate monobasic, sorbitol and hydrolysed gelatine, soy peptone broth, streptomycin, succinate buffer, sucrose, trometamol, yeast.

  All ingredients in this list are classified as "inactive" so **can be in "placebos" in vaccine trials** (See Reference 10).

Adverse effects reported in total (i.e. sourced from product inserts of **all** of the subject vaccines, with most appearing on several vaccine product inserts) include *inter alia,* **apart from** the neurological and other effects included in References 2 and 7, the following, in previously healthy recipients (cited frequencies are per dose or primary course):

- from clinical trials
  - **each** at a frequency of more than 0.1% and some more than 10%:
    circulatory collapse, dizziness, syncope (fainting), pain in extremity, hypersensitivity reaction (including bronchospasm), **haematoma**, lymphadenopathy, hyperhidrosis (excessive perspiration) (0.4%), restlessness, nervousness, insomnia, injury, pain, asthenia, upper respiratory tract infection, bacterial infection, viral infection, influenza-like illness, fungal injection, **asthma**, pneumonia, bronchitis, respiratory disorder, rhinitis, pharyngitis, laryngitis, stridor, cough, **allergy,** sinusitis, epistaxis, otitis media, conjunctivitis, eye complaints, dysphonia, stomatitis, stomatitis aphthous, toothache, parotid gland enlargement, pruritis, dermatitis, dermatitis contact, dermatitis allergic, **eczema**, rash erythematous, urticaria, dyspepsia, hiccup, constipation, candidiasis, gastrointestinal disorders, colitis, enteritis, gastroenteritis, gastro-oesophageal reflux, flatulence, pyelonephritis, joint stiffness, musculoskeletal stiffness, anaemia, herpes simplex, herpes zoster (chickenpox),
  - additionally each at a frequency of more than 0.01% and less than 0.1%:
    abnormal liver function tests, chills, flushing, paraesthesia,
  - additionally from clinical trials but without frequencies cited:
    death, diabetes mellitus, **atypical measles** (a more severe form, which lends itself to misdiagnosis: http://www.medterms.com/script/main/art.asp?articlekey=6593), measles inclusion body encephalitis (MIBE), pancreatitis, vasculitis**,** pneumonitis, parotitis, leukocytosis, thrombocytopenia, purpura, subacute sclerosing panencephalitis (SSPE); Guillain-Barré Syndrome (GBS); acute disseminated encephalomyelitis (ADEM); ataxia; polyneuritis; polyneuropathy; ocular palsies; optic neuritis; papillitis; retrobulbar neuritis; nerve deafness, lymphadenitis, myocarditis, exanthema, Henoch-Schönlein purpura, hypoesthesia, brachial radiculitis, secondary bacterial infections of the skin and soft tissue, including impetigo, agitation, septic shock, sepsis, bronchiolitis, urinary tract infection, roseola, aspiration, breath holding, influenza, inguinal hernia, viral syndrome, croup, thrush, wheezing, choking, colic, congestive heart failure.

    (A few of these are sourced from the US product inserts for two of the same vaccines, M-M-R II and Prevenar13.

    U.S. Food and Drug Administration, Vaccines, Blood & Biologics, Complete List of Vaccines Licensed for Immunization and Distribution in the US
    http://www.fda.gov/BiologicsBloodVaccines/Vaccines/ApprovedProducts/ucm093833.htm)

- additionally from post-marketing surveillance:
  - each at a frequency of up to 0.01%:
    allergic reactions (including rash, pruritus, urticaria and other anaphylactic and anaphylactoid reactions), **delayed** hypersensitivity reactions, mimicking serum sickness, collapse or shock-like state (hypotonic-hyporesponsiveness episode), cyanosis, vasovagal syncope, dyspnoea (breathing difficulty), apnoea, wheezing, meningism, polyarteritis nodosa, **ecchymoses**, **granulocytopenia**, increased erythrocyte sedimentation rate, transverse myelitis, Kawasaki syndrome, thrombocytopenic purpura, aplastic anaemia, cellulitis, angioneurotic oedema, facial oedema, angioedema**,** aseptic meningitis, paralysis, paresis, neuropathy, peripheral neuropathy including Bell's Palsy, Guillain-Barré syndrome, peripheral neuritis, bronchial neuritis, neuritis, multiple sclerosis, exacerbation of multiple sclerosis, neuropathy, cerebrovascular accident, cerebellitis, cerebellitis like symptoms, transverse myelitis, seizure, hypersomnia, sleep disorder, disturbed sleep**,** hypotension**,** vertigo, tinnitus**,** uveitis, erythema, severe skin disorders such as erythema multiforme, petechiae, Stevens-Johnson syndrome, arthritis, orchitis, epididymitis, dysuria, alopecia, IgA nephropathy, relapse of nephrotic syndrome, tachycardia, palpitations, migraine, visual disturbances, keratitis, lichen planusm, earache, pallor.

    .

7 Neurological disorders

Meningitis or encephalitis symptoms

Adverse effects reported include many symptoms that are possible symptoms of some degree of meningitis or encephalitis, and are reported quite commonly within 48 hours after the vaccination. Those symptoms include various symptoms that:

- are directly identifiable as neurological in nature:
  convulsions, abnormal crying, irritability, somnolence, headache, neck stiffness, and
- are of a more general nature:
  fever (>38°C), fatigue, reduced appetite, malaise, abdominal pain, diarrhoea, vomiting, arthralgia, myalgia & rash).

(James F. Bale Jr, MD, Current Management in Child Neurology, Third Edition, © 2005 Bernard L. Maria, Chapter 79, Meningitis and Encephalitis
http://web.squ.edu.om/med-Lib/MED_CD/E_CDs/CHILD%20NEUROLOGY/docs/ch79.pdf;

H Schmidt et al. Sleep disorders are long-term sequelae of both bacterial and viral meningitis. Neurosurg Psychiatry. 2006 April;77(4): 554–558. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2077506/;

J. H. Menkes, M. Kinsbourne Workshop on Neurologic Complications of Pertussis and Pertussis Vaccination. Neuropediatrics 1990; 21(4): 171-176. https://www.thieme-connect.com/DOI/DOI?10.1055/s-2008-1071488)

A young child with encephalitis or meningitis may have only 2 or 3 of the above symptoms.

- small children with meningitis "*may only be irritable and look unwell*"

(Sáez-Llorens X, McCracken GH *Bacterial meningitis in children.* Lancet, June 2003. 361 (9375): 2139–48. http://www.thelancet.com/journals/lancet/article/PIIS0140673603136938/abstract)

- young children or infants with encephalitis may present only "*irritability, poor appetite and fever*"

(*Symptoms of Encephalitis. NHS.* Retrieved 5 Jan 2015.
http://www.nhs.uk/Conditions/Encephalitis/Pages/Symptoms.aspx)

These symptoms themselves will usually be temporary, but that does not mean that there has been no lasting effect.

In the case of several of these symptoms, when they are seen in circumstances other than vaccination, they meet with a concerned response by doctors. However, when seen after vaccination they are considered "normal" or "expected" and dismissed with no investigation or explained reason. Doctors' usual only response is to advise the parent to give the child an antipyretic.

Gerhard Buchwald, MD stated (in 2002):

"For every vaccination, minimal encephalopathy (does not lead to clinically overt cognitive dysfunction, but can be demonstrated with neuropsychological studies) destroys brain cells. As a result, in Germany, there are 1.2 million children who have contracted hyperkinetic syndrome who are then treated with Psychopharmeca (a drug similar to Ritalin) used to calm them down... We have hundreds of thousands of so-called minimal cerebral dysfunction cases and millions of neurodermatitis patients"

(Testimony of Dr Gerhard Buchwald MD before the Quebec College of Physicians Medical Board. Extracted to here: http://www.doctorbob.com/vd--dr-buchwald-testimony.html from *The Trial of the Medical Mafia,* by Jochim Schafer, ISBN 2921783029, with permission of *Here's The Key Inc.,*CP309, Waterloo, Qc JOE 2NO, Canada.)

In addition to these symptoms frequently reported after vaccination, encephalitis, meningitis and encephalopathy are explicitly included on several vaccine manufacturer product inserts in their lists of adverse effects reported (e.g. Engerix B hepatitis B vaccine, pertussis vaccines, Priorix MMR vaccine and Priorix Tetra MMRV vaccine – Reference 6 provides the location of these product inserts).

Some medical researchers have named a syndrome "Autoimmune Syndrome Induced by Adjuvants (in vaccines)" (http://www.biomedcentral.com/1741-7015/11/118/), after they concluded that,

"*in some cases, vaccination may be the triggering factor for autoimmune and neurological disturbances in genetically predisposed individuals, and physicians should be aware of this possible association.*"

(de Carvalho J.F., Shoenfeld Y. Status epilepticus and lymphocytic pneumonitis following hepatitis B vaccination. *European Journal of Internal Medicine* 2008;19(5):383-385.
http://www.sciencedirect.com/science/article/pii/S0953620507002944)

A finding published in April 2013 concluded that the aluminum adjuvant in vaccines can penetrate the brain:

"Nanomaterials (in vaccines) can be transported by monocyte-lineage cells to DLNs, blood and spleen, and, similarly to HIV, may use CCL2-dependent mechanisms to ***penetrate the brain****. This occurs at a very low rate in normal conditions explaining good overall tolerance of alum despite its strong neurotoxic potential. However, continuously*

*escalating doses of this poorly biodegradable adjuvant in the population may become **insidiously unsafe**, especially in the case of overimmunization or immature/altered blood brain barrier or high constitutive CCL-2 production."*

(Khan Z, Combadière C et al. Slow CCL2-dependent translocation of biopersistent particles from muscle to brain, *Biomed Central Medicine.* 2013, 11:99
http://www.biomedcentral.com/1741-7015/11/99)

Medical research publishes known and possible mechanisms by which vaccine-induced neurological damage occurs. For example, Menkes and Kinsbourne (1990) suggested this mechanism for how the whooping cough vaccine is able to cause brain damage, suggesting that the **pertussis toxin** itself has a central role:

*"In implicating pertussis vaccination in the evolution of subsequent neurologic residua, a careful consideration of the mechanism for **vaccine-induced brain damage** plays an important supporting role. Pertussis toxin has been shown to alter cellular signalling. It also affects the catecholaminergic and GABAergic systems in brain. Although normally a protein of the size of pertussis toxin would not be able to cross the blood-brain barrier, factors known to disrupt the blood-brain barrier include brief hypertensive episodes such as might occur during a coughing paroxysm, hypoxia, and prolonged seizures, whether or not they are accompanied by hypoxia. In addition, a direct, endotoxin-mediated attack on the endothelial cells could create a local defect of the blood-brain barrier."*[7]

(J. H. Menkes, M. Kinsbourne· Workshop on Neurologic Complications of Pertussis and Pertussis Vaccination. Neuropediatrics 1990; 21(4): 171-176.
https://www.thieme-connect.com/DOI/DOI?10.1055/s-2008-1071488)

This research in effect states that the attempt to inactivate or suppress the toxicity of pertussis toxin vaccine ingredient has limited success. It remains relevant to the currently used acellular pertussis vaccine.

8 Government lists of serious effects that it acknowledges may occur as a result of vaccination:

The Australian Commonwealth Government admits a number of serious effects that may occur, which include among others: **death**, paralysis, meningitis, encephalitis, encephalopathy, lymphadenitis, orchitis, osteitis, osteomyelitis, parotitis, arthritis, arthralgia, sepsis, **thrombocytopenia**, subacute sclerosing panencephalitis (SSPE), seizures, brachial neuritis, anaphylaxis, toxic shock syndrome and polyarteritis nodosa.

(The Australian Immunisation Handbook 9th edition (2008), especially but not limited to *Appendix 6 – Definitions of Adverse Events Following Vaccination.*http://www.nevdgp.org.au/info/immunisation/handbook-9.pdf, p360-363)

One form of the forms of thrombocytopenia that the Government admits that vaccination, at least the MMR vaccine, can cause, is idiopathic thrombocytopenic purpura (ITP), which is an **autoimmune disease**.

("*The Science of Immunisation*", Australian Academy of Science, 2012)
https://www.science.org.au/publications/scienceofimmunisation-q-and-a-2012/vaccine-safety

The Government proceeds to attempt to play down this risk by comparing it to the "10 times greater" risk of developing the same condition as an outcome from measles, but the comparison misleadingly fails to take into account the minimal chance of contracting measles. From Reference 39, the latter chance can be estimated for an unvaccinated child aged from 1 to 19 years, based upon the Government's assumption of vaccine effectiveness, to be approximately 1 in 1600 (annually 1 in 30,000). The resultant ITP risk for the relevant 19 years is then **160 times greater from the vaccine**.

The Government also admits that the influenza vaccine can cause the **autoimmune disease** Guillain–Barré syndrome, though this is not one of the vaccines directly relevant to the presently proposed legislation.

The Government's concession, in principle, that vaccines can cause autoimmune diseases is a concession of the biological plausibility of other vaccines causing other autoimmune diseases also. Such other links have been made in medical research (See Reference 9).

The US Government Vaccine Court awards claims for death, anaphylaxis and anaphylactic shock, **encephalopathy,** seizure and convulsion, chronic arthritis, brachial neuritis, thrombocytopenic purpura, vaccine-strain measles viral infection, vaccine-strain polio viral infection, and "any acute complication or sequela (including death) of an illness, disability, injury, or condition referred to above which illness, disability, injury, or condition arose within the time period prescribed", as set out in the *U.S. National Childhood Vaccine Injury Act Vaccine Injury Table*.

(*U.S. National Childhood Vaccine Injury Act Vaccine Injury Table*.
http://www.hrsa.gov/vaccinecompensation/vaccineinjurytable.pdf)

Autism: Whilst not making any broad concession that vaccination can cause autism (the repercussions of doing so would obviously be considerable), the US Government:

- has conceded that vaccination can cause autism in a child with an underlying mitochondrial disorder

  (J.S. Poling. *Vaccines and Autism Revisited*. N Engl J Med 2008; 359:655-656, August 7, 2008
  http://www.nejm.org/doi/full/10.1056/NEJMc086269

  The Vaccine-Autism Court Document Every American Should Read, by David Kirby, 27/2/2008,Huffington Post
  http://www.huffingtonpost.com/david-kirby/the-vaccineautism-court-d_b_88558.html), and

- has "compensated cases in which children exhibited an encephalopathy, or general brain disease" including where that illness has been "accompanied by a medical progression of an array of symptoms including autistic behavior, autism, or seizures."

  (Email from Cheatham, Tina (US Government HRSA) to journalist Sheryl Attkisson https://childhealthsafety.files.wordpress.com/2011/01/attkisson-cbs-hrsa-email-exchanges-autistic-conditions-vaccines.pdf), and

- has quietly been **underwriting autism treatments** such as ABA (applied behavioural analysis) **for children in its vaccine-injury program**

  (*Vaccine Court Awards Millions to Two Children With Autism.* David Kirby, Huffington Post. 15/01/2013 04:03 AEST Updated: 16/03/2013 20:12 AEST http://www.huffingtonpost.com/david-kirby/post2468343_b_2468343.html), and

- has employed (and continues to employ) US CDC Senior Scientist researcher Dr. William Thompson who made a statement that was read into the US Congress record on 29 July 2015 by Congressman Rep. Bill Posey (R-Florida), that his CDC research team had **attempted to hide research data that had indicated a causal link of vaccination to autism**. He stated that:

  "the omitted data suggested that African American males who received the MMR vaccine before age 36 months were at increased risk for autism"…"The…co-authors… [put the relevant documents]…into a huge garbage can. However,… I kept hardcopies of all documents in my office, and I retain all associated computer files. I believe we intentionally withheld controversial findings from the final draft of the Pediatrics paper".

  (http://www.c-span.org/video/?327309-1/us-house-morning-hour&live. Some extracts of the transcript are in:

  CDC Scientist: 'We scheduled meeting to destroy vaccine-autism study documents' by Sharyl Attkisson. July 29, 2015. https://sharylattkisson.com/cdc-scientist-we-scheduled-meeting-to-destroy-vaccine-autism-study-documents/)

  Dr. Thompson was referring to this paper that had been published in 2004 and had claimed to debunk the link:

  DeStefano et al. *Age at first measles-mumps-rubella vaccination in children with autism and school-matched control subjects: a population-based study in metropolitan Atlanta*. Pediatrics. 2004;113:259–266

  (http://www.ncbi.nlm.nih.gov/pubmed/14754936.)

Autism has increasingly become an enormous burden for public health. The rate has recently reached an alarming **1 in 40** four and five year olds. The "experts say Australian schools need to prepare for an increase in autistic students", admitting that it is "probably" genuinely increasing, rather than merely an apparent increase caused by more effective diagnosis.

(*Autism cases among younger children on the rise, but reason why still unclear,* by Lucy Carter, 25 Aug 2015, http://www.abc.net.au/news/2015-08-25/autism-cases-among-younger-children-on-the-rise/6723904).

9 Autoimmune disease

Autoimmunity is the destruction by the immune system of the host's own tissue.

Because autoimmune disease progresses gradually, the symptoms are likely to not appear immediately.

However, there is significant evidence of a link between vaccines and autoimmune diseases.

The first disease to be recognized as an autoimmune disease was Hashimoto's thyroiditis or chronic lymphocytic thyroiditis. It was not recognised and described until 1912, which was after vaccination had been implemented on a large scale. We now have an epidemic of autoimmune diseases.

(Nakazawa, Donna (2008). *The Autoimmune Epidemic*. New York: Simon & Schuster. pp. 32–35. ISBN 978-0-7432-7775-4.)

The Government admits vaccines can cause thrombocytopaenic purpura, and also that Guillain-Barré syndrome may occur as an effect of the influenza vaccine, but that vaccine is not (yet) included on the childhood vaccination schedule).

Here are some examples of evidence of the effect of autoimmunity extending to other autoimmune diseases:

Injection of antigen, repeatedly - autoimmunity evidenced to become inevitable

An "antigen" is any substance that when introduced into the body stimulates the production of an antibody.

The result of research published in 2012 on mice was that:

"Repeated immunization with antigen causes systemic autoimmunity in mice otherwise not prone to spontaneous autoimmune diseases."

In all mice tested, their being vaccinated with an antigen at least 8 times was sufficient for autoimmunity to become not just possible, but inevitable. It found:

"Systemic autoimmunity appears to be the inevitable consequence of over-stimulating the host's immune 'system' by repeated immunization with antigen, to the levels that surpass system's self-organized criticality."

(Tsumiyama K, Miyazaki Y, Shiozawa S. *Self-Organized Criticality Theory of Autoimmunity*. PLoS ONE, 2009; 4(12): e8382. http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0008382)

A.S.I.A. Syndrome (Autoimmune Syndrome Induced by vaccine Adjuvants)

Some medical researchers have named a syndrome "Autoimmune Syndrome Induced by (vaccine) Adjuvants" (http://www.biomedcentral.com/1741-7015/11/118/), having concluded that "*in some cases, vaccination may be the triggering factor for autoimmune and neurological disturbances in genetically predisposed individuals, and physicians should be aware of this possible association*."

(de Carvalho J.F., Shoenfeld Y. *Status epilepticus and lymphocytic pneumonitis following hepatitis B vaccination*. *European Journal of Internal Medicine*, 2008. 19 (5) , pp. 383-385. http://www.sciencedirect.com/science/article/pii/S0953620507002944)

Insulin-dependent Diabetes (Type 1)

The autoimmune disease diabetes mellitus type 1 has been linked to various vaccines, including, *inter alia,* the hepatitis B and Hib vaccines.

(Classen JB. *The diabetes epidemic and the hepatitis B vaccines*. N Z Med J. 1996 Sep 27;109(1030):366. http://www.ncbi.nlm.nih.gov/pubmed/8890866

Classen JB, Classen DC. *Association between type 1 diabetes and hib vaccine.* Causal relation is likely. BMJ. 1999 Oct 23;319(7217):1133. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1116914/);

Classen JB, Classen DC. *Clustering of cases of insulin dependent diabetes (IDDM) occurring three years after hemophilus influenza B (HiB) immunization support causal relationship between immunization and IDDM*. Autoimmunity. 2002 Jul;35(4):247-53. (http://www.ncbi.nlm.nih.gov/pubmed/12482192)

"Diabetes mellitus" is also listed on the US product insert for the M-M-R II vaccine (for measles, mumps and rubella)

Multiple Sclerosis

Multiple sclerosis (MS) has also been associated with various vaccines and is listed on the Hepatitis B vaccine product inserts.

MS-like symptoms have been reported multiple times after HPV vaccinations. A 2009 study found that five cases of MS patients who had such symptoms within 21 days of receiving the Gardasil (HPV) vaccine "may be explained by the potent immuno-stimulatory properties of HPV virus-like particles which comprise the vaccine."[9]

(http://www.realfoodhouston.com/2012/07/30/gardasil-and-cervarix-whats-the-controversy-about-the-hpv-vaccine/

Sutton I, Lahoria R, Tan I, Clouston P, Barnett M. CNS demyelination and quadrivalent HPV vaccination. Mult Scler. 2009 Jan;15(1):116-9. http://www.ncbi.nlm.nih.gov/pubmed/18805844)

Multiple sclerosis is also listed on the product insert for both Hepatitis B vaccines (Engerix B and H-B-Vax-II)

Injection of genetically-engineered yeast linked to autoimmune diseases

Research highlighting the danger or uncovering of adverse effects of bypassing the digestive process have accumulated over decades. Research published in 2013 highlighted that one such example, **yeast**, (*Saccharomyces cerevisiae)* which, in genetically-engineered form, is in the Hepatitis B-containing vaccines, may be a significant factor in causing the enormous rise in the rate of incidence of autoimmune diseases, such as rheumatoid arthritis, Crohn's disease, inflammatory bowel disease, systemic lupus erythematosus, anti-phospholipid syndrome, multiple sclerosis, diabetes mellitus type 1 and heart disease.

(Rinaldi R, Perricone R, Blank M et al. Anti-Saccharomyces cerevisiae Autoantibodies in Autoimmune Diseases: from Bread Baking to Autoimmunity; *Clinical Reviews in Allergies and Immunology*. October 2013, Volume 45, Issue 2, pp 152-161. http://link.springer.com/article/10.1007%2Fs12016-012-8344-9)

Of additional significance is that the study found that "ASCAs (anti-*S. cerevisiae* autoantibodies) may be present years before the diagnosis of some associated autoimmune diseases", which is obstructive to the recognition or acceptance of any causal link that may exist. A recent review of this subject cited a temporal relationship of 2 to 3 months between vaccines and autoimmune reactions.

(Shoenfeld Y & Aron-Maor A, Vaccination and autoimmunity-'vaccinosis': a dangerous liaison? J Autoimmunity, Feb 2000;14(1):1-10 http://www.sciencedirect.com/science/article/pii/S0896841199903463)

Injection of mycoplasma, other bacteria and pathogens, linked to autoimmune disease

The injection process allows dangerous mycoplasma (which are resistant to antibiotics) and other bacteria and pathogens in vaccines to enter the bloodstream, which in normal, natural circumstances is sterile, free from such organisms (even though there is a great proliferation of normally friendly bacteria in other parts of the body, especially the gut).

> (Harrison C. Stetler, Paul L. Garbe, Diane M. Dwyer, Richard R. Facklam, Walter A. Orenstein, Gary R. West, K. Joyce Dudley, and Alan B. Bloch. Outbreaks of Group A Streptococcal Abscesses Following Diphtheria-Tetanus Toxoid-Pertussis Vaccination. Pediatrics 1985; 75:299-303. http://pediatrics.aappublications.org/content/75/2/299.short)

One example is the contaminant *Campylobacter J* bacteria in egg. The said report provides the information that this contamination is one of the theories for the acknowledged causal link of the influenza vaccine to Guillain-Barre syndrome, an autoimmune attack of the nerve ganglia rendering the patient partially or fully paralysed, and that this "contamination, coupled with allergy to eggs, has prompted the switch to manufacture flu vaccines in a different manner". Children have a right not to be the subject of what is, in effect, ongoing experimentation with vaccines.

Injection of aluminium, linked to autoimmune and other disorders

Aluminium compounds are also included in vaccines deliberately as "adjuvants", meaning to invoke a significant enough immune response in the form of the production of antibodies, which does not occur naturally with injections. Immunologist Tatyana Obukhanych (PhD) explains:

> "*It appears that alum's adjuvant effect depends on its ability to kill cells, its 'cytotoxic' property. This cellular damage releases intracellular contents, such as DNA and uric acid into the extracellular space, which is now accessible to the cells of the immune system to act upon. This cellular damage is sensed by the immune system, which then initiates the immune response against a "foreign" protein that showed up in the context of such damage. Without alum and without damage that it creates, the immune system would simply disregard the injected foreign protein as innocuous and not make any antibodies against it. But since the whole point of vaccination is to induce antibody production, then whatever alum is doing to induce antibody production, is considered favorable*."
>
> (http://www.vaccinationcouncil.org/2012/06/13/interview-with-phd-immunologist-dr-tetyana-obukhanych-by-catherine-frompovich/)

So it appears that it may be due only to its cytotoxic effect that aluminium achieves the "purpose" of its inclusion in vaccines – to provoke an antibody response, i.e. sensitise the immune system. It is not inconceivable that it may provoke an antibody response to proteins that the body makes itself, after it causes them, as a result of such cytotoxic damage, to be released into different parts of the body where they do not belong. Aluminium salts are increasingly being identified, along with some other vaccine ingredients, as a contributing cause of autoimmune disease and other disorders in vaccinated populations.

> (http://www.greenmedinfo.com/toxic-ingredient/aluminum-hydroxide)

Genes in those genetically susceptible to autoimmune disease may be switched on by vaccine ingredients

The role of pre-existing risk factors including genetic predisposition and environmental factors in autoimmunity is largely accepted. "Vaccination could enhance the risk of autoimmunity in genetically susceptible individuals when exposed to certain environmental chemicals", and many such triggers are themselves found in vaccines - heavy metals, chemicals, viruses and bacteria.

> (Ravel G[1], Christ M, Horand F, Descotes J. Autoimmunity, environmental exposure and vaccination: is there a link? Toxicology. 2004 Mar 15;196(3):211-6. http://www.ncbi.nlm.nih.gov/pubmed/15036747)

Also see Reference 11

10 Causality - "certain" or "probable" rating given to 16% of serious effects assessed

Adverse events following immunisation annual reports (2003 thru 2011), CDI, Aust. Govt. Dept Health
http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-aefi-anrep.htm

Virtually all of the remaining adverse events the TGA left with a causality rating of "possible".

Causality ratings are defined as follows:

Certain

A reaction in association with a single drug/vaccine which is confirmed by re-challenge; or

a. reaction in association with a single drug/vaccine which is confirmed by laboratory data specifically implicating that drug/vaccine; or
b. reaction whose onset is immediately following the administration of a single drug/vaccine (within five minutes if injection was the method of administration); or
c. reaction with a precise spatial correlation with the administration of a single drug/vaccine (e.g. at the exact site of injection).

Probable

a. A reaction with a close temporal or spatial (e.g. skin) correlation with the administration of a single drug/vaccine; or
b. reaction is in reasonable temporal association with a single drug/vaccine and recovery on withdrawal of the drug/vaccine if no other drug/vaccine is withdrawn and no therapy given; or
c. an uncommon clinical phenomenon associated with the administration of a single drug/vaccine and the reasonable exclusion of other factors.

Possible

a. An alternative explanation exists; or
b. more than one drug/vaccine is suspected; in association with the adverse event; or
c. data are incomplete; or
d. recovery follows withdrawal of more than one drug/vaccine; or
e. the time relationship is not clear; or
f. the outcome of the reaction is not recorded; or
g. recovery follows therapy in addition to withdrawal of the drug/vaccine.

(*Surveillance of adverse events following immunisation: Australia, 2000–2002* report http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-pubs-cdi-2003-cdi2703-htm-cdi2703a.htm)

TGA finds serious adverse effects to occur far more frequently than publicly stated

Even without taking into account the underreporting of adverse effects by a factor of up to 100 or more (See Reference 3), the above *Adverse events following immunisation annual reports* indicate that serious adverse events are reported in approximately 1 in 1,300 recipients (taking into account all doses of all vaccines that are received by an individual).

The Government's attempt to cast doubt on causality relies upon a study that does not use a true placebo

The Government asserts in its *The Science of Immunisation* booklet (2012): "*many common symptoms that occur after a vaccine is given are not caused by the vaccine, but occur by chance at that time*".

However it relies only upon a "valuable" "placebo"-controlled 1986 Finland study of the M-M-R II vaccine, which study (not the Government) informs us that the so-called "placebo" group received "*the same product including neomycin and phenol-red indicator but without the viral antigens*", i.e. neomycin, sorbitol and hydrolysed gelatine, Medium 199 (vitamins, amino acids, foetal bovine serum, sucrose, glutamate), Minimum Essential Medium, phosphate, recombinant human albumin, chick embryo cell culture and WI-38 human diploid lung fibroblasts. (See Reference 6.)

The study was also limited to only 10 types of solicited reactions other than local reactions and fever, and the monitoring period before the crossing over of the two compared groups was only 3 weeks (the clinical trial for the Priorix MMR vaccine was 6 weeks). Nevertheless, the M-M-R II group after one to two weeks still suffered significantly more reactions of almost all types than the group that received the incomplete vaccine (the so-called "placebo").

("*The Science of Immunisation*", Australian Academy of Science, 2012 https://www.science.org.au/publications/scienceofimmunisation-q-and-a-2012/vaccine-safety)

11 Disorders that have been linked to vaccines. Note that these are not limited to neurological disorders (Reference 7 herein), autoimmunity, cancer and DNA changes. Nor is the research that has linked to those conditions them limited to the examples cited herein under those headings. For more information and references, email freedomofchoicevacc@mycg.org.

12 Cancer

Some examples of the mechanisms and evidence of vaccines causing cancer include:

Injection of animal cells considered cancerous

Viruses used in vaccines require the use of (human foetus and/or) animal tissue culture 'cell lines' in which to grow the vaccine virus. Hence, one vaccine can include multiple types of serum and tissue proteins from several types of animals, such as bovine (cow), avian (chicken), porcine (pig) and monkey (simian)..

The three strains of poliovirus in the polio vaccine IPOL (Sanofi Pasteur S.A.) and vaccines that contain a polio component (the relevant vaccines here being Infanrix hexa and Infanrix IPV), are grown in cultures of VERO cells, a continuous line of monkey kidney cells, as stated on the manufacturer's product insert (See References 6 and 4).

Vero cells are cells that were extracted from the African Green Monkey kidney epithelial cells. The lineage was created in 1962 in Japan. They are immortalized cells such as the HELA cells of the famed book on Henrietta Lacks, and are considered neoplastic (cancerous cells).

There has long been concern regarding Vero cells and tumor or carcinogenicity. Certain Vero cell lines are known to cause cancer.

(Barrett PN, Mundt W, Kistner O, Howard MK. Vero cell platform in vaccine production: moving towards cell culture-based viral vaccines. Expert Rev Vaccines. 2009 May;8(5):607-18. doi: 10.1586/erv.09.19 http://www.ncbi.nlm.nih.gov/pubmed/19397417
Refers to "*fears regarding… potential oncogenic properties*" of "*continuous cell lines (CCLs)*".

http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/BloodVaccinesandOtherBiologics/VaccinesandRelatedBiologicalProductsAdvisoryCommittee/UCM319573.pdf

"*Deliberations of a WHO Study Group in 1997*
The value of 100 pg of host cell DNA per vaccine dose remained the recommended standard for a decade. However, the issue was revisited in 1997 for several reasons. First, vaccine manufacturers could not always meet this level of residual cell-substrate DNA for some viral vaccines... The outcome of the 1997 WHO meeting was that the amount of residual cell-substrate DNA allowed per dose in a vaccine produced in a continuous cell line and one administered by the parenteral route was raised from 100 pg to 10 ng."
and "*at a VRBPAC meeting in 2000… Some members expressed the concern that Vero cells had the capacity to become tumorigenic with prolonged passage in culture*"

Injection of animal viruses known to be cancerous

Because of the vaccine viral culturing method, one vaccine can potentially include not just one contaminant animal virus, but many. The most well documented example is the SV40 monkey virus, which has been implicated in many increasingly common cancers, such as mesothelioma and multiple myeloma.

A risk has also been identified of bovine serum being contaminated with viral species or prions and the cancer-causing (or cancer-"associated") SV40 virus contaminant in monkey kidney tissue, with admitted resultant risks including cancers, such as hepatocellular carcinoma which is the fifth leading cause of all cancer deaths around the world.

It is assumed by many that the process used to inactivate viruses is 100% effective. However, due to the process being subject to the (mathematical) asymptotic factor, the inactivation of the virus is incomplete.

(Gerber et al. 1961. Inactivation of vacuolating virus (SV40) by formaldehyde, Proc Soc Exp Biol & Med; 108: 205-209. http://ebm.sagepub.com/content/108/1/205.short)

Further, the inactivation is limited in duration, as the inactivated virus is able to revert to its former virulence

(Fenner. Reactivation of animal viruses. BMJ 1962; July 21: 135-142.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1925408/)

Even when the Australian Commonwealth Government was aware, in the 1960s, of batches being produced of the polio vaccine being contaminated by the **cancer-causing SV40** monkey virus, it withheld this information from the unsuspecting public and **it continued releasing these batches**. This was unlike the US authorities who "adopted the policy of not releasing any new batches of vaccine until it had been shown to be free of SV40."

(*Deadly shots: the polio vaccine saga*, SMH October 23, 2004
http://www.smh.com.au/articles/2004/10/22/1098316860457.html)

Vaccines causing cancer in non-humans is fully acknowledged

Wilcock B, Wilcock A, Bottoms K. Feline postvaccinal sarcoma: 20 years later. *The Canadian Veterinary Journal*. 2012;53(4):430-434. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3299519/

Also see References 11 and 13

13 DNA modification

Injection of foreign DNA – ability to contaminate recipient's DNA

The injection process may allow the foreign human and/or animal and/or viral DNA in vaccines to contaminate the DNA of the recipient.

The body has never before, in its natural history, needed to protect itself from an invasion of its integrity by way of a direct injection of foreign DNA. Therefore it cannot be expected to be very effective at doing so, and have more than limited defences against it.

In 1967, geneticist Joshua Lederberg stated, "we already practise biological engineering on a rather large scale by use of live viruses in mass immunisation campaigns." (*Science* magazine, 20 October, 1967, p.13)

After Japanese bacteriologists had discovered that bacteria of one species transferred their own specific antibiotic resistance to bacteria of an entirely different species, Dr. Maurice Stroun and Dr. Philip Anker at the University of Geneva began to accumulate evidence that the transfer of genetic information can also occur between bacteria and higher plants and animals. In 1971, according to an article in *World Medicine* (22 Sep 1971), they became "convinced that normal animal and plant cells shed DNA, and that this DNA is taken up by other cells in the organism. If they are

right, the consequences to virtually every aspect of a cell's metabolism would be considerable. The growth and development, diseases, and even the evolution of an organism would be affected."

Evidence has continued to accumulate that vaccinations may be able to contaminate the genes of recipients with foreign DNA.

- The Ultimate Gamble: Do Childhood Vaccines Result in Genetic Hybridization from Alien Human and Animal DNA Contents? Mar 13th, 2012 | By Harold E. Buttram, M.D. (http://vactruth.com/2012/03/13/vaccines-human-animal-dna)

Gerhard Buchwald, MD, Specialist in Internal Medicine, Germany, testified (in 2002):

"In Germany, there are millions of people with allergies. We don't just produce minimal encephalopathies in the brain, but we also produce modifications of the genetic code."

(Testimony of Dr Gerhard Buchwald MD before the Quebec College of Physicians Medical Board. Extracted here: http://www.doctorbob.com/vd--dr-buchwald-testimony.html from *The Trial of the Medical Mafia,* by Jochim Schafer, ISBN 2921783029, with permission of *Here's The Key Inc.,*CP309, Waterloo, Qc JOE 2NO, Canada.)

Ph.D Immunologist and Researcher Helen V. Ratajczak, states:

"*The theory about the harm caused by growth in human tissue of viruses to be used in vaccines is that human DNA will be in the resultant viruses. (When a virus grows, it must be inside a cell, and as the virus matures, it takes part of the cell – in this case, DNA – with it.) And that human DNA will be from a different individual that the recipient of the vaccine. When DNA from one human is introduced into another human, there is the possibility of homologous recombination…, with the new DNA being incorporated into the recipient's DNA. Now the recipient of the vaccine would have altered DNA (altered self) in his body. The immune system kills altered self or this altered DNA. This constitutes an autoimmune situation*."

(http://vactruth.com/2011/06/06/part-1-of-3-an-interview-about-vaccines-with-helen-v-ratajczak-phd/)

Spontaneous Integration of Human DNA Fragments into Host Genome

K. Koyama, T. A. Deisher, Sound Choice Pharmaceutical Institute, Seattle, WA. May 17, 2012
Conclusion: Not only damaged human cells, but also healthy human cells can take up foreign DNA spontaneously. Foreign human DNA taken up by human cells will be transported into nuclei and be integrated into host genome, which will cause phenotype change. Hence, residual human fetal DNA fragments in vaccine can be one of causes of autism spectrum disorder in children through vaccination. Vaccine must be safe without any human DNA contaminations or reactivated viruses, and must be produced in ethically approved manufacturing processes.
http://s3.amazonaws.com/soundchoice/soundchoice/wp-content/uploads/2012/08/DNA_Contaminants_in_Vaccines_Can_Integrate_Into_Childrens_Genes.pdf

References to substantial additional relevant information are listed here:
http://www.vacfacts.info/vaccine-production-with---human-diploid-cells-aborted-fetal-cell---tissue.html

The U.S. DoD is already deliberately modifying DNA using potential vaccine ingredients

"The biotechnology and pharmaceutical sectors are heavily reliant on the ability to rapidly manipulate and introduce DNA into human cell lines." and

"Advanced Tools for Mammalian Genome Engineering
"The ability to deliver exogenous DNA to mammalian cell lines is a fundamental tool in the development of advanced therapeutics, vaccines…. Current approaches to genetic engineering of mammalian cells rely on gene transfer methods such as plasmids, adenovirus-, lentivirus-, and retrovirus-vectors, cDNA, and minigene constructs. While these tools do provide the basic ability to deliver DNA to mammalian cells, there are several shortcomings associated with these state-of-the-art techniques. These include random DNA insertion into the host genome… and immunological responses to foreign DNA.
One recently developed method for gene transfer that has the potential to address many of these shortcomings is the use of human artificial chromosomes (HACs). HACs possess several ideal properties, including very large DNA delivery capacities, stable, episomal maintenance within the cell, and lack of immunogenicity"

(DEFENSE ADVANCED RESEARCH PROJECTS AGENCY (DARPA), 13.B Small Business Technology Transfer (STTR) Program, Proposal Submission Instructions, DARPA STTR 13.B Topic Descriptions**,** ST13B-001 http://www.acq.osd.mil/osbp/sbir/solicitations/sttr2013B/darpa13B.htm)

Activation of genes

In addition to, and perhaps occurring more easily and frequently than, actual modifications to genes is the phenomenon of ingredients in vaccines, such as heavy metals (aluminium), chemicals, viruses and bacteria triggering the expression, or activation of existing genes, and this in turn leads to a chronic condition.
(See **Genes in those genetically susceptible…** in Reference **9**)

Also see References 12 and 11

14 Compensation

The Government gives a contradictory message in relation to who would be responsible for vaccine injuries that occur as a result of the proposed legislation.

On the one hand,

- The Minister for Social Services, Mr Scott Morrison, appears to confirm that the purpose of the legislation is to pressure parents into vaccinating:

  "Government policy is that children should be immunised. It is good health policy, it is important for the health of our children, for families, for communities particularly if they are going to be put in child care centres and in contact with other children." (See Reference 1)

  and

  "*My aim (with this legislation) is that… all children would be vaccinated"*.

  (26 May at 12:44 on Facebook forum: https://www.facebook.com/malcolmturnbull/posts/10153417449386579)

  The Government also states as a reason for the legislation that parents "*need to consider their obligation to the whole community*" (http://www.health.gov.au/internet/main/publishing.nsf/Content/MC14-004203-Immunisation)

  As detailed in Reference 20, the "*economic pressure*" suffered by welfare-receiving families compels them to apply for the relevant benefits, and hence would cause compulsion upon to them to meet any such condition tied to their receipt of the benefits.

  Even the lowest form of compulsion or pressure by the Government brings upon it a responsibility at common law for adverse effects that arise from it.

Yet, on the other hand, the Government appears to contradict itself…

- Mr Morrison asserts that the Government "respects" parents' "*right to choose not to vaccinate*"[1] and the Government continues to state that it "*respects parents' rights to make decisions about immunisation on behalf of their children*" (http://www.health.gov.au/internet/main/publishing.nsf/Content/MC14-004203-Immunisation)

These statements appear, nonsensically, to imply a refusal to accept that any such legislation **tying needed** welfare benefits to vaccinating would result in any form or degree of compulsion upon welfare-receiving parents to vaccinate.

Combining this apparent denial with the Government's failure to provide any accompanying explanation as to how it would meet its responsibility to compensate for any harm caused by giving of these injections under any such compulsion can only lead one to wonder if the Ministers responsible for this legislation, personally, and the Government itself, intend to seek to avoid liability for compensation for damage. This is especially the case considering that the proposed date for the legislation to come into effect would be as soon as 1 January 2016 and there has still been no public announcement in relation to compensation.

15 Highest vaccination refusal rates in "*highly educated*", "*well informed*" who have "*often… deliberated extensively"*

Childhood Immunisation, the role of parents and service providers – A review of the literature, Aust. Govt, (2004),pg 15

16 Medical doctors found to have highest rubella vaccine refusal rates, most of those susceptible in hospital refusing

Orenstein, W A; Heseltine, P N; LeGagnoux, S J; Portnoy, B. *Rubella vaccine and susceptible hospital employees*. *Poor physician participation*. JAMA, 245(7): 711-713; 1981. http://www.ncbi.nlm.nih.gov/pubmed/7463660

17 Most (52%) medical doctors surveyed had not had hepatitis b vaccine

Kinnersley P. *Attitudes of general practitioners towards their vaccination against hepatitis B*. BMJ 1990 January 27; 300(6719): 238. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1662042

18 Almost twice as many medical doctors found to be refusing than accepting swine flu vaccine

GPs urged to have swine flu vax. Australian Doctor 4 Sep 2009.

Of the 222 doctors surveyed during the swine flu vaccination campaign, almost twice as many (46%) said that they would not have the vaccine than those who said that they would (29%).

19 Individuals' inalienable rights expressed in the Constitution, common and statute law and human rights instruments

Founding principles in the Constitution of the Commonwealth of Australia

The Annotated Constitution of the Commonwealth of Australia (Quick & Garran, 1900):

- "The… laws passed by the Parliament of the Commonwealth, subordinate Parliament, must be within the limits of the delegation of powers or they will be null and void. To be valid and binding they must be within the domain of jurisdiction mapped out and delimited in **express** terms, or by necessary implication, in the Constitution itself. What is not so granted to the Parliament of the Commonwealth is denied to it. What is not so granted is either reserved to the States,

as expressed in their respective Constitutions, or remains vested but dormant in the people of the Commonwealth." (page 346)

- "the truth is, the supreme absolute and uncontrollable authority remains with the people" (page 286).
- "116. The Commonwealth shall not make any law for… prohibiting the **free** exercise of any religion..." (pgs 1027-1031)

  Mr. Higgins had stated in the Constitution Convention Debates (Hansard, Official Record of the Debates of the National Australasian Convention, 7 Feb 1898) "religion is ever a matter between God and the individual; the imposing of religious tests hath been the greatest engine of tyranny in the world" and on 2 March 1898, "The point is that we are not going to make the Commonwealth a kind of social and religious power over us."

  The proposed legislation would prohibit the free exercise of any religion that forbids the administration of all of the linked vaccines. Even if the Government permits in the future the exercise of such a religion on the condition that it is registered, the requirement itself to "register" a religion before it can be exercised constitutes a denial of free exercise of religion.
- incorporation of Imperial Acts and of the Bill of Rights 1688 (by way of the Table of Imperial Statutes on page xiii)

Right to bodily security

- the High Court in *Secretary, Department of Health and Community Services v JWB and SMB* [1992] HCA 15 (hereafter "Marion's Case") stated (quoting Blackstone from 1830):

  '"(T)he law cannot draw the line between different degrees of violence, and therefore totally prohibits the first and lowest stage of it; every man's person being sacred, and no other having a right to meddle with it, in any the slightest manner".'

  (High Court in *Secretary, Department of Health and Community Services v JWB and SMB* [1992] HCA 15 http://www.austlii.edu.au/au/cases/cth/HCA/1992/15.html, quoting the Commentaries of Blackstone (9) 17th ed. (1830), vol 3, p 120)

Right to wholly voluntary, fully informed consent

- **Any consent must be wholly voluntary**

It follows from the above that consent to a medical procedure can be valid only when given wholly voluntarily.

By way of Section 51 Part xxiiiA of the Constitution of the Commonwealth of Australia (hereafter "Federal Constitution"), the 1946 Referendum empowered the Commonwealth Government to make laws for the provision of medical services "*but not so as to authorise any form of civil conscription*".

As stated by Prof. Danuta Mendelson (Chair in Law (Research) at Deakin University) in "Devaluation of a Constitutional Guarantee: The History of Section 51(xxiiiA) of the Commonwealth Constitution" [1999]:

*"it was clear from the referendum debates that Australians… **recognised the importance of… the right to personal autonomy in a doctor–patient relationship**. Section 51(xxiiiA) guarded against the possibility of the reduction of these rights by the Federal Government."*

(Devaluation of a Constitutional Guarantee: The History of Section 51(xxiiiA) of the Commonwealth Constitution [1999] MelbULawRw 14; (1999) 23(2) Melbourne University Law Review 308 http://www.austlii.edu.au/au/journals/MULR/1999/14.html)

Accordingly, it can be argued that a number of High Court rulings, which Prof. Danuta Mendelson discusses in detail therein, support the position that a policy such as "No Jab, No Pay" would be a "form of civil conscription" in the meaning of Section 51 Part xxiiiA and hence constitute a direct and blatant breach of the Federal Constitution. A couple of examples are in Reference 20.

- **Any consent must be fully informed**

Consent cannot be truly voluntary unless fully informed, because it is not true consent if one does not know and understand the nature and implications of the procedure to which one is consenting.

Accordingly, the High Court in *Rogers v Whitaker* [1992] ruled that a medical practitioner must exercise his/her legal duty to warn a prospective patient, even if the patient does not ask, of risks that are 'material', meaning those to which, in those particular circumstances, the medical practitioner is or should reasonably be aware a reasonable (or 'ordinary') person in the patient's position would be likely to attach significance, based upon their likelihood and/or their seriousness.

(Rogers v Whitaker [1992] HCA 58; (1992) 175 CLR 479, 19 Nov 1992 http://www.legalanswers.sl.nsw.gov.au/hot_topics/pdf/health_64.pdf)

Also see citations provided by the Government itself in Reference 21.

Relevant international human rights instruments. These and relevant Articles therein include, *inter alia*:

- The 1948 *Universal Declaration on Human Rights* which states, *inter alia*, that

  "*Everyone has the right to life, liberty and security of person*" (Article 3),

  "*All are equal before the law and are entitled without any discrimination to equal protection of the law*," (Article 7):

  "*Everyone has the right to freedom of thought, conscience and religion; this right includes freedom… to manifest his religion or belief in teaching, practice, worship and observance*" (Article 18). http://www.un.org/en/documents/udhr/

- The *International Convention on Civil and Political Rights* (which is incorporated into Commonwealth of Australia law in the *Australian Human Rights Commission Act 1986* (Cth) ('AHRC Act') (Schedule 2)) which guarantees that:

  - "*all peoples have the right of self-determination. By virtue of that right they… freely pursue their economic, social and cultural development."* (Article 1),
  - *"any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwith-standing that the violation has been committed by persons acting in an official capacity."* (Article 3(a)),
  - *"any person claiming such a remedy shall have his right thereto determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy"* (Article 3(b));
  - *"Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life."* (Article 6),
  - "*Everyone has the right to liberty and security of person.... No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law*." (Article 9),
  - "*No one shall be… subjected without his free consent to medical or scientific experimentation*." (Article 7)
  - *"1. Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching*…. 2. *No one shall be subject to coercion which would impair his freedom to have or to adopt a religion or belief of his choice*" (Article 18)
  - "*Everyone shall have the right to hold opinions without interference*." (Article 19)
  - *"All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."* (Article 26)
  - *"In those States in which ethnic, religious or linguistic minorities exist, persons belonging to such minorities shall not be denied the right, in community with the other members of their group, to enjoy their own culture, to profess and practise their own religion, or to use their own language."* (Article 27)

  and with all of these rights to be recognized…

  - "*without distinction of any kind, such as… political or other opinion, national or social origin, property… or other status."* (Article 2)
  - *"The above-mentioned rights shall not be subject to any restrictions* ***except*** *those which are provided by law, are necessary to protect national security, public order, public health or morals or the rights and freedoms of others, and are consistent with the other rights recognized in the present Covenant."* (Article 12)

  http://www.austlii.edu.au/au/legis/cth/consol_act/ahrca1986373/

Exceptions do not, or may not, apply to such a situation - legal advice given to NSW Parliament in 2013

Re the last article listed above, Article 12, describing circumstances that would be considered acceptable exceptions,

the NSW Parliamentary Secretary, The Hon. MELINDA PAVEY stated before the NSW Legislative Council on 20 June 2013 that she had received legal advice that a court would not, or might not, consider an unvaccinated child, who is **not** presently suffering from a "vaccine preventable" disease, as not presently posing a risk to public health, even if attending a childcare centre, as constituting a reasonably significant threat. In view of this advice, the NSW Parliament rejected an amendment that had been moved to exclude the option for conscientious or religious exemption in the Public Health Amendment (Vaccination of Children Attending Child Care Facilities) Bill 2013.
http://www.parliament.nsw.gov.au/prod/parlment/hansart.nsf/V3Key/LC20130620006
(See speech by The Hon. MELINDA PAVEY (Parliamentary Secretary) [10.50 a.m.])

20 The High Court's prohibition against "any form" or "extent" of "compulsion" of medical services

In *British Medical Association v Commonwealth* [1949] HCA 44; 79 CLR 201 (7 October 1949), the High Court ruled (with respect to Section 51 Part xxiiiA of the Federal Constitution and the words "(but not so as to authorise any form of civil conscription)" therein):

> *"The words 'any form' are important. They show that the Parliament intended that* ***any service*** *to which the limitation applied should be completely voluntary and not procured by compulsion of law… and that compulsion, to* ***any extent or of any nature****, whether legal, by the* ***imposition of penalties****,* ***or practical, by any other means, direct or indirect, could not be authorized****. If Parliament cannot lawfully do this directly by legal means it cannot lawfully do it* ***indirectly*** *by creating a situation… in which the individual is left no* ***real*** *choice but compliance."*[20]
> http://www.austlii.edu.au/au/cases/cth/HCA/1949/44.html

Similarly in *General Practitioners Society v. The Commonwealth* [1980] HCA 30; (1980) 145 CLR 532,

> Murphy J: "*In my opinion,* ***practical compulsion****, as distinct from legal compulsion, is enough to satisfy the concept of "civil conscription*". (at p565) and
> Aickin J: "***Other forms of "practical compulsion" are easy enough to imagine, particularly those which impose economic pressure such that it would be unreasonable to suppose that it could be resisted****. The imposition of such pressure by legislation would be just as effective as legal compulsion, and would, like legal compulsion, be a form of civil conscription.* ***To regard such practical compulsion as outside the restriction placed on this legislative power would be to turn what was obviously intended as a constitutional prohibition into an empty formula, a hollow mockery of its constitutional purpose.*** *(at p566)*"
> http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/HCA/1980/30.html

Are the above rulings relevant to, and hence prohibitive of, the proposed legislation?

- These rulings reflect the Constitutional principle that for the people to authorise any form of compulsion (be it with respect to medical services or anything else), such authorisation must be "*mapped out and delimited in* ***express*** *terms, or by necessary implication, in the Constitution itself. What is not so granted to the Parliament of the Commonwealth is* ***denied*** *to it.*" (See Reference 19, first paragraph). No such authorisation has been given.

Would "*the individual (be) left with no real choice but compliance*", or would the "*economic pressure (be) such that it would be unreasonable to suppose that it could be resisted*"?

- Not only does the Government acknowledge that the proposed legislation involves the imposition of a penalty, but the very families it targets are those who have already shown suffer "*economic pressure) such that it would be unreasonable to suppose that it* (when it means "receipt of these benefits"*) could be resisted*." So the Government recognises that these families are *"left no* ***real*** *choice", i.e.* **compelled,** by their "*economic pressure*" to apply for and receive these benefits in order to pay for life's necessities. It follows that if it were to tie any condition to their receipt of these benefits, then meeting of that condition must automatically become **just as compulsory** for them.

Hence, for this Government "*to regard such practical compulsion as outside the restriction placed on this legislative power would be to turn what was obviously intended as a constitutional prohibition into an empty formula, a hollow mockery of its constitutional purpose." (*quoting Aickin J above)

21 The Government itself instructs that patients' right to informed consent must be upheld

The Australian Immunisation Handbook 10th edition (2013) Aust. Govt Dept of Health, *2.1.3 - Valid Consent*
http://www.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home~handbook10part2~handbook10-2-1

22 Consent to medical procedure for a child

Secretary, Department of Health and Community Services v JWB and SMB [1992] HCA 15 especially MASON C.J., DAWSON, TOOHEY AND GAUDRON JJ. paragraphs 14, 26, 74, DEANE J. paragraph 22, McHUGH J. paragraph 4
http://www.austlii.edu.au/au/cases/cth/HCA/1992/15.html

23 Parents accepted as the most appropriate repositories of power over medical procedures for children

Secretary, Department of Health and Community Services v JWB and SMB [1992] HCA (McHUGH J.)

Paragraph 11: "Blackstone asserted that the "power of parents over their children is derived from ... their duty…He contended that the duty:

> *'to provide for the maintenance of their children, is a principle of natural law; an obligation ... laid on them not only by nature herself, but by their own proper act, in bringing them into the world: for they would be in the highest manner injurious to their issue, if they only gave their children life, that they might afterwards see them perish. By begetting them, therefore, they have entered into a voluntary obligation, to endeavour, as far as in them lies, that the life which they have bestowed shall be supported and preserved.'*

Paragraph 16: "the common law gives this power (to give a valid consent to the medical treatment of their children) to parents simply because it perceives them to be the most appropriate repository of such a power… In the case of children(294) Bromley and Lowe, Family Law, 7th ed. (1987), p 254:

'Apart from a public authority, the most obvious candidates are one or both of the child's parents and it is in such persons that English law, in keeping with most other societies, has vested such authority and responsibility.'

…the case for making the parents the repository of such authority is… supported by strong sociological, psychological and administrative considerations... these grounds include respect for the family as the decision making unit, the appropriateness of giving the power to those who possess a moral duty to protect the child and who are, therefore, likely to have the child's best interests in mind, and the cost and inconvenience of vesting the power in others such as government officials." http://www.austlii.edu.au/au/cases/cth/HCA/1992/15.html (See also Reference 22)

24 The "Greater Good"?

"No Jab No Pay" allegedly to avert risk "*to other* (unidentified) *young children and the broader community*."
No jab - no play and no pay for child care, Media release by PM Tony Abbott, 12 April 2015 (See Reference 1)

The Government's legislation would involve it denying, unless a particular condition is met, certain welfare payments to families that it acknowledges to have **need** of welfare.

Notwithstanding the issue of whether or not the Government is **authorised** at law to impose this particular type of condition, the only way that such legislation could possibly be in the best interests of the country, would be if the said need of funds that it would refuse to provide can reasonably be judged to be counterbalanced by another **need** just as significant or more significant, that can **only** be fulfilled, and can reliably be fulfilled, if the imposed condition is met.

Therefore for the legislation to make any practical sense, there must firstly be a benefit, but not only that, a **need**, for vaccination rates to increase beyond their present record high levels. This need would have to be great enough to match or outweigh the financial and/or other resultant suffering that will be inflicted upon the targeted families. It would also have to be unable to be met by any **alternative measure(s)** that would cause less suffering, especially to families that are already struggling. So has the Government demonstrated such a **need** to be so significant and one that cannot otherwise be met?

So the Government needs to demonstration of (A) a benefit, (B) a need, and (C) a lack of alternative measure(s)…

(A) Would vaccination of the targeted children bring an overall benefit for the "greater good"?

Firstly, the Government has **failed to cite a single case having occurred of the circumstance that this intrusive legislation is purported to seek to prevent**, i.e. a single case of harm having been occasioned to any person as a result of that person contracting any of the targeted "vaccine-preventable" diseases due to transmission by a child who has been identified and has been determined to be unvaccinated and "vaccine eligible", let alone the transmission occurring in a setting that could have easily been a child care centre.

The Government does not claim there to have been a fall in vaccination coverage. Nor does it claim that there is any prediction of a future fall. The Government's stated purpose is only to **increase** vaccination rates to even higher than their already record high levels.

So what the Government is in effect claiming is that in relation to its ultimate objective of the **"**greater good" of public health as a whole (as distinct from that of the individual), then in the case of each vaccine (and dose),

(1) An increased vaccine uptake would decrease the present burden or risk from the targeted infectious diseases, and

(2) Said decrease in risk would outweigh any resulting increase in the present burden or risk to public health.

Let us examine the validity of these implied claims (laying aside any issue about individuals' rights or benefits):

(1) An increased uptake would decrease the present burden or risk from the targeted infectious diseases?

i. How important are infectious diseases overall?

With respect to overall public health, amongst the numerous causes of illness and death today, the Government has stated that it considers infectious diseases one of the least important. The diseases that are targeted by the relevant vaccinations are only a small proportion of those again.
("*Long term mortality trends*", Australian Bureau of Statistics Year Book 2001
http://www.abs.gov.au/ausstats/ABS@.nsf/Previousproducts/1301.0Feature%20Article192001)

(Paragraphs (2) and (3) on page 2 of this flier show also that vaccination cannot be assumed to be the reason for the dramatic decline in their importance throughout the 20th century.)

ii. In relation to which targeted infectious disease(s) would the risk to overall public health be reduced?

Looking in turn at each vaccine and the diseases that it targets (accepting that some diseases cannot be vaccinated against separately by way of any vaccines currently available in Australia), the maximum degree of risk that could reasonably be posed by transmission from an unvaccinated child can easily be seen from the following, noting that the birth cohort has been about 275,000 to 280,000, of whom about 8% to 10% or more, i.e. over 22,000 children in each year group, have been unvaccinated:

(NB: Information herein that relates to the chance, **once** a person is infected, of transmission to **another** person **and** disease then developing in that other person is included mostly in summary form below - see Reference **46** for more detail and references thereof)**:**

(a) **Diphtheria-tetanus-pertussis** (these components are not available separately in any childhood vaccine)

- **Tetanus**. "Tetanus is not passed on from one person to another." (This disease is NOT contagious at all.)
- **Diphtheria**.
  - There have been ZERO notifications in children since June 1992 (See Reference 32). Approximately **10 million unvaccinated child years** have transpired since then.
  - **If**, in spite of this, a case **were** to occur in an unvaccinated child, **then** for transmission to occur, "prolonged contact (eg sleeping in the same room as a case rather than casual contact) is usually required" (See Reference 46). Such contact does **not** occur in the setting of a child care centre.
- **Pertussis**. Summarising what is covered elsewhere herein (especially in References 47 through 54),
  - The vaccine manufacturers do not claim that the vaccine will prevent infection or transmission.
  - The Government (PBAC) itself "*has determined that there is no clinical effectiveness*" of vaccination for preventing transmission of whooping cough to vulnerable infants.
  - The percent of cases vaccinated in outbreaks – 100% or close to it, further confirms the PBAC's conclusion that it is not effective.

  Hence, how can it be expected that ensuring that all children who attend childcare centres (which are not likely to be attended by such young infants) are vaccinated will have any more chance of being effective?

(b) **Polio**:

- Not only has Australia been certified polio-free for 15 years, but the Government reports that "the **last** reported case of locally acquired wild-type polio in Australia was in **1972**" and that "**local transmission** of wild polio virus in Australia probably ceased in **1962**."
  Over 20 to 25 million unvaccinated child years have transpired since then.

It would be reasonable to conclude from this that the **only** possible original source for transmission, other than the vaccine itself (as occurred when this vaccine was used in the 1950s and 60s), is importation from overseas.

So what is the chance of **importing** the wild polio virus?

- **Of the many hundreds of millions** of travellers entering Australia over the past half century, **only 2 cases** have been reported of imported wild polio virus since the **1950s or 1960s**. They were in 1977 and 2007.
- Further, the WHO informs us that polio notifications overseas have declined over 99.9% since 1988. This means that from the **already obviously negligible risk in 1988**, the chance now is a **1000 times less still**.

Nevertheless, accepting that a risk exists of a third importation, what is the chance of **transmission**?

- The Government informs us that an important factor preventing transmission is "adequate treatment of sewerage and provision of safe drinking water and foods", which we enjoy, especially in urban areas. It cites only "rural and remote areas of Australia" as areas where "faecal contamination of the water supply", which it states to be the "primary source of transmission", "remains a possibility".

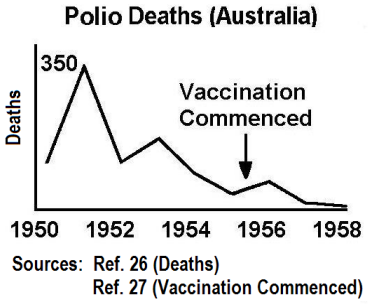
It would be reasonable to conclude from this that the chance of transmission would be even more negligible, especially from one child to another in a child care centre.

Nevertheless, if we accept that there is a chance of transmission, what is the chance of resultant **paralysis**?

- The Government informs us that if a child to become infected with the polio virus, there is only 1 in 1000 chance of paralysis developing.

Finally, if in spite of all of the above significant facts, unvaccinated children are still seen as posing a risk, it ought to be noted that, as has been the case with other targeted diseases, the threat from polio had also declined by 90% by the time the vaccine was introduced in 1956. (See graph below)

Note that polio deaths also declined by almost 90% before vaccination commenced



Sources: Ref. 26 (Deaths)
Ref. 27 (Vaccination Commenced)

(c) **Hepatitis B.**

- The annual notification rate in children is approximately 1 in 600,000 (See References 33 and 34).
- This very low risk is similar to that before widespread vaccination (See Reference 33, 34).
- If, in spite of this, a case were to occur in child due to their not having being vaccinated, then for transmission to occur, "The virus must be introduced through broken skin or the placenta or come in contact with mucous membranes… Faecal-oral and vector-borne modes of transmission have not been demonstrated. Hepatitis B is not transmitted by kissing on the cheek, coughing or sneezing, sharing food or sharing eating utensils." (See Reference 46). It is almost impossible for the circumstances necessary for transmission to exist in the setting of a child care centre, and this is borne out by the above figures.

(d) ***Haemophilus Influenzae type b* (Hib*)***

- *Haemophilus Influenzae* "is a normal part of upper respiratory tract flora" (See Reference 46).
  The bacteria lives harmlessly in the throat of healthy people (be they vaccinated or unvaccinated)
- Hib **disease** itself is very uncommon. The annual notification rate is approximately 1 in 150,000 in the targeted (highest incidence) age group, which is the 0 to 4 year age group (See Reference 33,34).

Since the Hib bacteria, whilst common, is hence not inherently harmful, it follows that transmission of this bacteria is not one of the significant factors that lead to the development of disease associated with Hib.

Further to that,

- The vaccination status amongst cases has been found to be similar to or higher than the vaccination rate in the broader community (See Reference 53).

(e) **Pneumococcal.** Like Hib:

- "The bacteria often live harmlessly in the throat of healthy people" (See Reference 46).
  "In a large majority of hosts, pneumococci are carried with no apparent symptoms."
- Pneumococcal disease is also uncommon. The latest recorded (2012) annual notification rate was approximately 1 in 35,000 overall in under 20 year olds (See Reference 33) for the targeted serotypes**.**

Hence it can be seen that transmission of this bacteria is not one of the significant factors leading to the development of pneumococcal disease itself.

Further to that,

- The vaccination status amongst cases has been found to be similar to or higher than the vaccination rate in the broader community (See Reference 53).

(f) **Meningococcal C.** Like Hib:

- "Asymptomatic respiratory tract carriage of meningococci occurs in 5%–10% of the population."
- Yet meningococcal disease is very rare. Since 2011, there have been 2 notifications reported children under 5 years of age, zero cases in 5 to 14 year olds and 2 cases in 15-19 year olds, with no age group exceeding 1 case per 500,000 (See Reference 3332).

Hence it can be seen that transmission of this bacteria is not one of the significant factors leading to the development of meningoococcal disease itself.

If nevertheless, we accept that there is a risk, be it ever so remote, of an unvaccinated child with a meningococcal C infection attending a child care centre,

- Similar to diphtheria, "meningococcal bacteria are **not** easily spread from person to person and the bacteria do not survive well outside the human body. The bacteria are passed between people in the secretions from the back of the nose and throat. This generally requires close and prolonged contact with a person carrying the bacteria." (See Reference 46)

(g) **Measles, mumps, rubella**

- **Measles**

  - Australia was declared *'*measles free' in 2009 and by a stricter definition in 2014.
  - The Government states "*transmission... due to locally acquired cases has not occurred… for some time"*. Outbreaks still occur, but not transmission due to locally acquired cases.
  - This reported absence of *transmission* is in the face of the fact that vaccine-induced antibodies have limited duration – they have been found to decline by 50% within 20 years, so a large percentage of the adult population cannot possibly be assumed to be immune.
  - Measles and its transmission have been documented to occur as a direct result of vaccination and many past such occurrences may have gone undiagnosed due to the inadequate testing available and used.

  (See References 4, 33 to 38, 54)

- **Mumps**

  - Mumps notifications are similarly infrequent to measles.
  - The vaccination status amongst mumps cases has been found to be similar to or higher than the vaccination rate in the broader community.

  (See References 33, 34, 53)

- **Rubella**

  - The Australian Government states:

    "*The principal aim of (rubella) vaccination campaigns worldwide is to prevent CRS." (*congenital rubella syndrome)

  - However, rubella notifications are similarly infrequent to measles, congenital rubella infection notifications rarer still, and congenital rubella syndrome especially rare.

    The Australian Government reports that:

    "There was 1 notification of CRS between 2008 and 2012: a male aged less than 1 year of age notified in 2012 from the Northern Territory. The place of acquisition was recorded as Indonesia."

    (*Australian vaccine preventable disease epidemiological review series: rubella 2008–2012,* CDI Vol 39 No 1 - March 2015*,* Aust. Govt. Dept Health http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi3901c.htm)

    The average annual number of (CRS) cases notified annually is usually ZERO (amongst the almost 300,000 births), otherwise one. This has been the case since in fact for the past 10 years except in 2007 when 2 cases were notified (one case was acquired overseas and the vaccination status of neither mother was available).

  - The Australian Government also reports that:

    "Statistical Divisions with slightly lower than average childhood vaccination coverage do not correspond with those that have had high rubella notification rates."

    (Rubella in Australia: can we explain two recent cases of congenital rubella syndrome? Gidding HF, Young M, Pugh R, Burgess M, CDI Vol 27 No 4 - 2003*,* Aust. Govt. Dept Health *http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-2003-cdi2704-pdf-cnt.htm/$FILE/cdi2704v.pdf)*

  (See References 33 and 34 for other sources of all of the above statements)

(h) **Chickenpox**

- In the latest period **prior** to any vaccination in Australia (mid 2000 to mid 2002), the average annual chance of chickenpox complications of encephalitis or pneumonitis per age year group (of approximately 270,000 children) for 1½ to 19 year olds was **1 in 73,000**. (See Reference 34).

  Because chickenpox notifications are much more common than most other diseases (other than whooping cough), it is evidently in relation to chickenpox that there is the highest risk of a cited complication.

  However…

- Subsequent to vaccination commencing, the vaccination status amongst cases has been found to be similar to or higher than the vaccination rate in the broader community. For example in 2012, of those cases

where the vaccination status was available, 87% cases had been vaccinated and 13% not vaccinated. (See Reference 53)

- Up to 2006, chickenpox, which the Government describes as "*generally a benign, self-limiting illness in children*" (Reference 34), had not been a nationally notifiable disease, and it is **still** not considered important enough to be notifiable in NSW (Reference 33).
- The UK Government has decided that it is safer for individuals **and** the community **not** to routinely vaccinate, let alone be pressured into vaccinating, against chickenpox because:
  - "*the vast majority of children recover quickly and easily*", after which they have natural, lifelong immunity, whereas "*in adults, chickenpox is more severe and the risk of complications increases with age."* and
  - "*If you vaccinate children against chickenpox, you lose this natural boosting so current levels of immunity in adults will drop and more shingles will occur*."

    (*Why isn't the chickenpox vaccination part of the routine childhood immunisation schedule?* Chickenpox vaccine FAQs. National Health Service (NHS) (UK)

    http://www.nhs.uk/Conditions/vaccinations/Pages/chickenpox-vaccine-questions-answers.aspx#routineschedule)

The Australian Government itself also reports that, if a vaccination coverage of 90% and vaccine effectiveness of 93% were to be assumed:

> *"An Australian study, performed to assess **the potential impact of universal varicella vaccination** based on this hypothesis, suggested that total morbidity due to varicella and herpes zoster in Australia would decrease for the first 7 years of a population program, but, for 8–51 years after vaccination commenced, **total morbidity was predicted to be higher** than pre-vaccination levels."*

(Reference 34 – see *Vaccine Preventable Diseases in Australia, 2005 to 2007)*

iii. Summary

- **Increased chance of infectious disease(s) being transmitted?**

In the case of all of the diseases other than whooping cough and chickenpox, even the risk of the unvaccinated child contracting the disease in the first place evidently ranges from zero, to negligible, to minimal. The chance of another person contracting the disease (especially in its clinical form), as a result of transmission from that child is more remote still.

In the case of all of the diseases, the above documented facts evidence that the chance of another person contracting the disease, especially by way of a child care centre, would not decrease on account of the targeted child being vaccinated. Indeed, some of the documented facts indicate that the chance may, on the contrary, even be **increased**, e.g. the higher rates of chickenpox and whooping cough in the vaccinated than the unvaccinated (especially than the vaccine-eligible unvaccinated).

- **After an infectious disease develops – what then?**

Notwithstanding, various further criteria would have to be met for any harm to result to the person who were to thus become infected.

The Government tells us that, in relation to many or all of the targeted infectious diseases:

- other factors such as nutrition and breastfeeding are important factors for preventing and overcoming clinical (symptomatic) disease (See References 40 to 43)
- disease management measures are undertaken, from which it follows that the quality of disease management must be believed to make a difference. Hence, on the rare occasions that any harm arises from a targeted infectious disease, how can we know that more informed or competent management by the medical staff involved could not have prevented that harm?
- Medical research tells us that, as long as the disease management is sufficiently competent, the infectious disease can be not just harmless, but in some cases extremely beneficial (References 44 and 45)

The Government can be seen from the above to reveal in its own publications that in the case of EACH of the vaccine-targeted diseases, the belief or assumption is misconceived that any child would, on account of being unvaccinated, pose an increased "*risk to other young children and the broader community",* especially by way of the casual contact that occurs in a child care centre. Further, whatever risk there may be, can be seen no more than in theory, because the Government has failed to cite any case to date of any adverse outcome having demonstrably occurred as a result of any of the targeted children not being vaccinated.

Hence there is a lack of evidence that criteria (1) for such legislation being introduced can be met.

(2) Said decrease in risk would outweigh any resultant <u>increase</u> in the present burden or risk to public health?

Whilst part (1) leads one to question whether there would indeed be any said decrease in risk, it is worth examining the counter side - in what respect(s) if any, might the present burden or risk to public health **increase** if the targeted children are vaccinated.

The burden of serious adverse outcomes arising from the vaccines

Multiple documented risks from vaccines, many admitted by Government, have been described in References 5 through 13. It can be seen from Reference 6 that it is not rare even for a serious adverse event to be reported in clinical trials, and from Reference 10 that the Government's own causality assessments indicate that at least 16% of serious adverse effects reported are "certainly" or probably" related to vaccination.

These documented, and not rare, serious adverse outcomes, which are observed hard facts, contrast highly with the evidently remote, at best theoretical, risk that may arise as a consequence of the targeted children remaining unvaccinated, as demonstrated in (1) above.

(a) Calculable numerical difference in risk

This high contrast in risk is highlighted most clearly, perhaps, by the direct numerical risk comparisons that can be made based upon government publications – References 8 and 39 show us that the cited risks of measles outcomes is outweighed by the same risks from measles vaccination by a factor in the order of about 160 to 5000 times, once the small chance of contracting measles in the first place is taken into account.

(b) Burden of cancer and other chronic diseases have been observed to be reduced by targeted diseases

To whatever extent vaccines achieve their purpose of preventing infectious diseases or at least their natural clinical expression, which notably is almost always brief and with no ongoing adverse outcome, medical research suggests the likelihood of a corresponding increase in the burden from cancer, heart disease, stroke and other life-threatening diseases. See Reference 44.

(c) Government-described increase in complex disorder burden is associated with intensified vaccination

It can be seen that unlike infectious diseases, which almost always, after limited duration (usually short), are fully resolved by the immune system with no lasting adverse effects, many of the adverse events reported from vaccines are complex disorders, involving persisting chronic dysfunction. In the case of most such disorders it is clear that they involve, or arise from, dysfunction of the immune system. Apart from the ongoing, and in many cases increasing, adverse effect on the quality of life, the dysfunction can be lifelong and indeed likely to lead to or contribute to earlier death.

Amongst the examples of complex disorders that are reported after vaccination, as listed on vaccine product inserts, are **asthma** and **insulin dependent diabetes.**

Both of these as well as many other complex diseases, have been linked by some medical researchers to vaccination (as discussed further below). Asthma and insulin-dependent diabetes have not themselves to date been acknowledged by the Government or other vested interests to be linked to vaccines, but given the weight of their burden upon community health and mortality itself, any such acknowledgment would have far-reaching political, legal and financial implications.

There are also many complex disorders that are not directly named in the lists in the References 5 through 13 but are known to follow vaccine adverse effects that are listed therein. For example, psychiatric disorders, behaviour problems and learning disabilities can be outcomes of encephalopathy or encephalitis. (See Reference 7).

Professor Fiona Stanley, on behalf of the Government, described in 2001 the then burden on public health of chronic diseases:

> "*asthma and juvenile diabetes, both of which have increased considerably,… head a list of complex disorders which* ***have taken over from infectious diseases*** *as the most serious threats to the health of our young people…*
>
> ***Asthma*** *is now the* ***leading*** *cause of hospital admission in children and is* ***costly*** *to treat. It was the leading problem (present in* ***nearly 20% of children aged 4-16 years****) reported in the WA Child Health Survey in 1992 (Zubrick, Silburn et al. 1995)…*
>
> ***Insulin dependent diabetes*** *mellitus has also increased. In 0-14 year old Western Australian children the rate rose from around 12 per 100,000 (in 1985-91) to 22 in more recent years (Kelly, Russell et al. 1994). Many other centres are now reporting similar increases…*
>
> *Both asthma and diabetes are lifelong illnesses with significant morbidity and need for complex treatments…*
>
> *Increases in* ***autism, behaviour problems and learning disabilities*** *in children have been reported over the 1980s and 1990s (Alessandri, Leonard et al. 1997)"*

("CHILD HEALTH SINCE FEDERATION" by Australian of the Year, Professor Fiona J Stanley, for the 2001 Australian Bureau of Statistics Year Book.
http://www.abs.gov.au/ausstats/ABS@.nsf/Previousproducts/1301.0Feature%20Article212001)

Asthma alone kills 1 person per day, according to *Asthma Australia.* This effectively indicates that more than 1 in 1000 people per birth cohort ultimately is killed by this disorder.

Insulin-dependent diabetes also kills 1 person per day, according to the ABS (3303.0 *Causes of Death, Australia*, 2013.

The precise degree to which vaccines contribute to the burden upon public health, including as causes of "complex disorders", is difficult to determine, because almost all medical research is funded by entities with a very powerful vested interest in **not** wanting to determine this. The Government would have the resources to collect relevant data in order to make such study possible, but chooses not to do so. The necessary resources are not available to all, or virtually all, other entities.

In relation to asthma and insulin-dependent diabetes, however, some significant points of note include:

- **Asthma.** After the high frequency of reports of previously healthy children and adults developing asthma, and existing asthma cases being exacerbated, immediately after vaccination, significant expenditures have been made by vaccine manufacturers on research denying any link. However some researchers have published findings that point to a very strong link. Odent (1994) found the frequency of asthma in a group of fully vaccinated children to be 11%, while a 1997 NZ study found 23%. Both found the frequency in the unvaccinated children to be only 0 – 1%.
(Odent M. JAMA 1994;272(8):592-593; Lancet 1994:344:140; Epidemiology 1997 Nov 8(6)678-80)
- **Insulin-dependent diabetes.** This disease belongs to a major category of complex diseases, **autoimmune diseases**, which were not recognized and described at all until **after** mass vaccination of any kind began. The first to be described was Hashimoto's thyroiditis in 1912. This was after mass smallpox vaccination programs had been instituted in the late 19th century.

Several studies have found the asthma rate to be higher after vaccines that use aluminum hydroxide as adjuvants in the postnatal period. (J Allergy Clin Immunol 1999,104:1128-30). The aluminium ingredient (*inter alia*) has also been linked to autoimmune disease developing after vaccination. (See Reference 9)

Considering that the purpose of vaccination itself is to **sensitise** the immune system, with the adjuvant being necessarily included in order achieve that, is it really surprising that asthma (especially in case of allergic asthma) and autoimmune diseases, both of which are recognised as a manifestations of a **hypersensitised** immune system, are frequently reported to develop, and/or be exacerbated, after vaccination? (See Reference 9)

Given that the early 1970s was when the measles vaccine was first given (from 1969), and perhaps with the added factor that many children then began to be born to vaccinated parents (and hence potentially affected by their parents' vaccines), nor might it be surprising that Professor Stanley stated in this same article, which was published in 2001, three decades later, that:

> "*Similar to other developed countries, we have observed increases in 'complex' diseases in the cohorts of children born in the last three decades*."

Even if vaccines cause only a small proportion of the cases of complex (and other) disorders observed after vaccination, these disorders constitute such a major public health burden that whatever burden can be theorised to be averted by the targeted children being vaccinated evidently pales into insignificance in comparison.

iv. Summary

Given the difficulty in establishing any benefit of vaccinating the children targeted by this legislation with respect to the risk or burden to public health posed by infectious diseases, there is an extremely low tolerance for the risks or burden to public health from vaccination. An analysis of the vaccination risks demonstrates that:-

(a) If the measles vaccine provides a typical or average example for comparison, it can be estimated that there is about a 160 to 5000 times greater risk of the same disease complications from the vaccines themselves than from the disease, given the rarity of disease notifications.

(b) Given the evidence that natural clinical expression of infectious diseases protect against cancer, heart disease, stroke and other life-threatening diseases, targeting these children with vaccines may increase this burden.

(c) Added to the burdens resulting from (a) and (b) are the many complex disorders (such as asthma and type 1 diabetes) that have not been linked to the targeted infectious diseases but have been linked to vaccines. Weight must be given to those disorders in relation to which the causal link to vaccines is not confirmed but remains possible, because the risk (i.e. the chance) of a risk is a still a risk.

Hence it is evident from the balance of risk that the introduction of such legislation cannot meet criteria (2), of demonstrating a overall **benefit** to public health from increasing vaccination rates, **quite to the contrary**.

(B) Is it necessary to increase vaccination rates in the targeted families?

If in spite of the above evidence, a benefit from increasing vaccination rates were to be nevertheless accepted as at least possible, could a **need** to increase vaccination rates be demonstrated? Since vaccination rates, which have steadily increased, have only **just** reached their record highs, it is arguable that it is too soon to determine whether or not the present uptake levels would be sufficient to achieve whatever public health outcome is sought. Further, with the 97% uptake already achieved in the targeted families (Reference 1), the very limited increase that is possible by way of this measure could hardly make any difference to meeting any "herd immunity" threshold.

(C) Are there no alternative measures for increasing vaccination rates?

If in spite of the above evidence, a need from increasing vaccination rates were to be nevertheless accepted as at least possible, there is no demonstration of a lack of alternative measures for doing so that could be implemented without causing the inevitable degree of suffering to these families, who are already the most disadvantaged and struggling families in the community, by denying them welfare funds that the Government itself has accepted that they need (otherwise they would not be eligible for them anyway).

Indeed, some pro-vaccine academics (such as Prof. Raina McIntyre and Assoc. Prof. Julie Leask) have argued that not only are there alternative measures for increasing vaccination rates, but that the proposed "No Jab No Pay" legislation would increase rates only 1% at best (Assoc. Prof. Leask) or may even decrease them (Prof. McIntyre)

(*Abbott government vaccination plan won't work: expert*. SMH. April 14, 2015 http://www.smh.com.au/federal-politics/political-news/abbott-government-vaccination-plan-wont-work-expert-20150413-1mjyhw.html)

(*Opinion: Taking the big stick to vaccine conscientious objectors might backfire*. 13 Apr 2015. Raina Macintyre https://newsroom.unsw.edu.au/news/health/taking-big-stick-vaccine-conscientious-objectors-might-backfire)

How could a law that would cause so much suffering without being shown to be needed (B), has the potential to be counterproductive for its very purpose of increasing vaccination rates (C), and which arguably will not even be in the interests of public health (A), be a law that meets the Constitutional requirement, pursuant to Section 51 Part xxiiiA, for "peace, order and good government"?

25 Respect for inalienable rights of individuals and minorities is integral to a democracy:

http://www.democracyweb.org/node/36

http://www.ipu.org/PDF/publications/DEMOCRACY_PR_E.pdf

http://www.democracybarometer.org/concept_en.html

http://www.slideshare.net/Durham0021/gment-chapter-1-principles-of-government-ppt

http://www.un.org/en/globalissues/democracy/human_rights.shtml

26 Death rates from diphtheria, tetanus, whooping cough, measles and tuberculosis, 1907 – 2004

Australia's Health 2006, The tenth biennial report of the Australian Institute of Health and Welfare, pg 115 (http://www.aihw.gov.au/publication-detail/?id=6442467855);

Commonwealth Year Books, ABS (www.abs.gov.au)

The Commonwealth Year Books from the early 1900s also show that those diseases that are being targeted by vaccines are only some of the infectious diseases that used to plague mankind, and they were not even the most important. The death rate from tuberculosis was about 5 to 50 times higher. Deaths from typhoid were also more common and scarlet fever and dysentery also caused many deaths. These and other infectious diseases dramatically declined well prior to any significant medical interventions such as antibiotics, and have disappeared from developed countries without widespread vaccination or any vaccine being used;

Child Health Since Federation, by Prof. Fiona J Stanley, Australian Bureau of Statistics Year Book 2001 http://www.abs.gov.au/ausstats/abs@.nsf/0/3CE0381F7CBAB608CA2569DE0024ED6D

27 Dates widespread vaccination introduced

The Australian Immunisation Handbook 10th edition (2013), Aust. Govt Dept of Health, *Appendix 7*: *Overview of vaccine availability in Australia* http://www.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home~handbook10-tools~handbook10-appendices~handbook10-appendix7

28 Whooping cough (WC) and measles not notifiable from 1950

Commonwealth Year Book, Jan 1953, Chapter 8, pg 289.
http://www.ausstats.abs.gov.au/ausstats/free.nsf/0/6D34CFB7F684C572CA257AF30015A5C3/$File/13010_1953%20section%208.pdf

29 "As causes of infant mortality in Australia all the infective diseases have been overcome"
Lancaster, H.O. 1956a, "Infant Mortality in Australia". The Medical Journal of Australia, 2:104.

30 POPULATION estimates: *National notifiable diseases: Australia's notifiable diseases status: Annual report of the National Notifiable Diseases Surveillance System*. Aust. Govt Dept of Health (years 1994 - 2012)
Appendix 1: Mid-year estimate of Australian population, … *by state or territory*.
http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-pubs-annlrpt-nndssar.htm

31 VACCINE COVERAGE estimates: *Vaccine Preventable Diseases and Vaccination Coverage* reports, 1993 through 2005 - Supplements, CDI, Aust. Govt Dept of Health.
http://www.health.gov.au/internet/main/publishing.nsf/content/cdisupplements-1-lp

Immunisation coverage annual reports, CDI, Aust. Govt Dept of Health
http://www6.health.gov.au/internet/main/publishing.nsf/Content/cda-immunanrep.htm reports for 2007 to 2012

32 Diphtheria, polio and tetanus - notifications in children zero, zero and two respectively
National Notifiable Diseases Surveillance System summary tables, NNDSS Annual Report Writing Group, CDI, Aust. Govt Dept of Health (http://www9.health.gov.au/cda/source/cda-index.cfm)

33 Disease incidence, especially after 2007

National notifiable diseases: Australia's notifiable diseases status: Annual report of the National Notifiable Diseases Surveillance System. NNDSS Annual Report Writing Group, CDI, Aust. Govt Dept of Health.
http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-pubs-annlrpt-nndssar.htm
(annual reports from 1994 to 2012)

34 Disease incidence, 1993 to 2007

Vaccine Preventable Diseases and Vaccination Coverage reports, 1993 through 2007 - Supplements, CDI, Aust. Govt Dept of Health. http://www.health.gov.au/internet/main/publishing.nsf/content/cdisupplements-1-lp

35 Australia declared measles free in 2009

Australia declared measles free, Wednesday, 11 February 2009, by Dani Cooper for the ABC *News in Science* http://www.abc.net.au/science/articles/2009/02/11/2487452.htm;

Heywood AE, Gidding HF, Riddell MA, McIntyre PB, MacIntyre CR & Kelly HA. *Elimination of Endemic Measles Transmission in Australia.* Bull WHO 2009;87:64-71.
http://www.who.int/bulletin/volumes/87/1/07-046375/en/index.html

36 Australia declared measles free in 2014

Four Western Pacific countries and areas are the first in their Region to be measles-free. WHO news release. Seoul 20/4/14. http://www.wpro.who.int/mediacentre/releases/2014/20140320/en/

37 *"(Measles) Transmission... due to locally acquired cases has not occurred… for some time":*
Immunisation Myths and Realities, 5th edn, 2013. Australian Govt Dept Health.
http://www.health.gov.au/internet/immunise/publishing.nsf/content/uci-myths-guideprov

38 Measles vaccine-induced antibodies' limited duration - found to fall to 50% within about 20 years

Chen et al. *Waning population immunity to measles in Taiwan*. Vaccine Vol 30, No. 47, 19 Oct 2012:6721–7.
http://www.sciencedirect.com/science/article/pii/S0264410X12007207.

39 Reported rates of cited disease complications are over 500 times higher from the vaccine

Risk comparison calculation

Based on measles notifications in 1 and 19 year olds in Australia in 2001-'07 (when there was an annual average of 29 measles cases in that age group), the overall chance of a child during that 19 year period contracting measles is approximately 1 in 10,000 (an annual chance of about 1 in 200,000).

To calculate the assumed higher chance for an unvaccinated than vaccinated child, then based further upon

- an assumption that the induction of antibodies from the MMR vaccine is assumed to provide immunity, and hence that the vaccine's age-weighted effectiveness is 90% for measles (taking into account the degree to which antibody levels wane after vaccination (Reference 38), and
- an average 22000 unvaccinated children per year from average of 92% coverage of a 275000 birth cohort, and

- measles complication rates from Miller (1964) (*Frequency of Complications of Measles*, 1963. BMJ Jul 11, Vol 2: 75 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1815949/pdf/brmedj02558-0019.pdf),

then…

(1) Risk of convulsions, pneumonia, diarrhoea or otitis media from measles in an unvaccinated child

- of the annual average of 29 measles cases, approximately 13.5 occurred in unvaccinated children, and hence…
- the chance of an unvaccinated child contracting measles in the 19 years between 1 and 19 years of age is 1 in 1600,
- the average chance of a measles-infected child in that age group suffering convulsions, pneumonia, diarrhoea or otitis media are 1 in 200 (0.5%), 1 in 27 (3.7%), 1 in 13 (7.7%) and 1 in 43 (2.3%) respectively.
- Hence, the chances of a child suffering convulsions, pneumonia, diarrhoea or otitis media from measles in those 19 years are **1 in 320000**, **1 in 43200**, **1 in 20800** and **1 in 68800** respectively.

(2) Risk of convulsions, pneumonia, diarrhoea or otitis media from the measles vaccine

The Priorix (MMR) vaccine product insert (TGA – Vaccine Product Inserts: https://www.ebs.tga.gov.au/)
provides the frequencies of these same complications from the MMR vaccine reported in clinical trials to be as follows:

- the chances of a previously healthy child suffering convulsions, pneumonia, diarrhoea or otitis media from the Priorix vaccine, within 6 weeks afterwards, totalled for the 2 doses, are reported as**: 1 in 2000 to 1 in 1000, 1 in 1000 to 1 in 100; 1 in 50 to 1 in 5 and 1 in 50 to 1 in 5 respectively**.

(3) Result of comparison of risks in (1) versus (2) above

Based upon the frequencies in (1) and (2) above and comparing them,

- the differences in the chances of a previously healthy vaccinated child developing convulsions, pneumonia, diarrhoea or otitis media within 6 weeks after 2 measles vaccine doses, compared to an unvaccinated child developing these complications from measles, are respectively: 160 to 320, 43 to 430; 416 to 4160 & 1376 to 13760 times greater from the vaccine. Totalling the risks, the difference is **500 to 5000 times greater from the vaccine**.

The cited rate for **encephalitis** from measles including (in the Miller (1964) study referenced above) is 1 in 1,000 cases, which, combined with the above calculated chance of 1 in 1,600 of an unvaccinated child contracting measles between 1 and 19 years of age, works out as a chance of 1 in 1,600,000. (With the unvaccinated children per birth cohort numbering 22000, it can be estimated that only once every 75 years might a child suffer encephalitis from measles as a result of not being vaccinated.)
The rate of encephalitis from vaccination may be greatly in excess of this, given that common vaccine reactions, which include what may be symptoms of encephalitis, are routinely disregarded by doctors as "normal" rather than being investigated for that possibility. (See Reference 7)

40 Factors credited by Government for overcoming infectious diseases

"Improvements over time in the general health of the population and in medical care are also important factors."
Immunisation Myths and Realities 5th edition (2013) (page 43)
(http://www.health.gov.au/internet/immunise/publishing.nsf/content/uci-myths-guideprov) (page

Coercive and Mandatory Immunisation, by Judy Wilyman. Australasian College of Nutritional & Environmental Medicine 10/2008; Vol 27(No 2):p 6-9, quoting

- Gillespie J.A., 1991, "The Price of Health: Australian Governments and Medical Politics 1910 – 1960", Cambridge University Press, Cambridge, UK.
  (re impact of **sanitary reform,** greater emphasis placed on **social** medicine and public health officials becoming aware that **malnutrition** increased the susceptibility of children to disease by weakening the immune system)

- O'Connor K., 1989, "A History of 75 years of baby health services in NSW". NSW Department of Health
  (re impact of the medical profession's increased support for **breastfeeding** in 1929 and new relief policies regarding the **minimum nutritional requirements** in food provisions for the unemployed)

- Lancaster, H.O., 1956, "The Mortality of childhood in Australia: Part 1 Early Childhood", Medical Journal of Australia, 2: p. 889-894.
  (re decline of pertussis before routine immunisation programs were implemented, and its high sensitivity to **social conditions and hygiene**)

- Lancaster, H.O. 1956a, "Infant Mortality in Australia", The Medical Journal of Australia, 2: p.100-108;

- Burnet, M., 1952 and Lewis MJ. (ed.), 1989.
http://www.researchgate.net/publication/228389163_Coercive_and_Mandatory_Immunisation

41 Factors credited by Government for continued protection against infectious diseases

Australia's Food & Nutrition 2012. Australian Government AIHW 2012.

"Good nutrition contributes to quality of life, helps maintain healthy body weight, protects against infections, and reduces the risk of chronic disease and premature death" etc (pages 9 and 103 and 184 - nutrition, 141 – breastmilk) http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737422837

42 *Joint WHO/UNICEF statement on vitamin A for measles*. Expanded Programme on Immunization. Wkly Epidemiol Rec 1987;62:133-134. Measles fact Sheet for tsunami affected populations (WHO) (http://www.searo.who.int/entity/emergencies/documents/general_information_measles100105.pdfhttp://www.searo.who.int/LinkFiles/General_Information_Measles100105.pdf);

Sudfeld CR, Navar AM, Halsey NA; Effectiveness of measles vaccination and vitamin A treatment. Int J Epidemiol. 2010 Apr;39 Suppl 1:i48-55. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2845860/)

43 Scientific research now informs how to prevent and manage infectious diseases

Stephens D, Jackson PL, Gutierrez Y. *Subclinical vitamin A deficiency: a potentially unrecognized problem in the United States*. Pediatr Nurs. 1996 Sep-Oct;22(5):377-89, 456. http://www.ncbi.nlm.nih.gov/pubmed/9087069;

Beck M. *The role of nutrition in viral diseases*, Nutritional Biochemistry 7:683-690, 1996;

McCormick WJ, *Vitamin C in the Prophylaxis and therapy of Infectious Diseases*, *Archives of Pediatrics*, Vol 68:1, Jan 1951, pp. 1-9, 1951, http://www.seanet.com/~alexs/ascorbate/195x/mccormick-wj-arch_pediatrics-1951-v68-n1-p1.htm;

Levy T, "*Vitamin C, Infectious Diseases, and Toxins: Curing the Incurable*", 2002 p30;

Note also that Dr Frederick Klenner published and presented a paper to the American Medical Association in 1949 detailing the complete cure of 60 out of 60 of his patients with polio using high doses of intravenous sodium ascorbate (Vitamin C)

(Klenner, FR. *The Treatment of Poliomyelitis and Other Virus Diseases with Vitamin C.* Southern Medicine & Surgery; Volume 111; No. 7, July 1949:209-214. http://www.seanet.com/~alexs/ascorbate/194x/klenner-fr-southern_med_surg-1949-v111-n7-p209.htm)

44 Properly managed natural exposure to some targeted diseases prevents some cancers and other chronic conditions

Some examples include:

- Rønne T. *Measles virus infection without rash in childhood is related to disease in adult life*. The Lancet 1985, Vol 325, Issue 8419:1-5 http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2885%2990961-4/abstract

  "*Rønne could associate a missing history of measles in childhood with increased cancer risk for a variety of tumors in a historical prospective study. Out of 353 individuals with a negative history of measles 21 developed cancer versus only 1 case out of 230 controls with a positive history of measles (p < 0.001)*."

  (Kleef R, Dieter Hager E. *Fever, Pyrogens and Cancer. In: Madame Curie Bioscience Database [Internet]*. Austin (TX): Landes Bioscience; 2000 (http://www.ncbi.nlm.nih.gov/books/NBK6084/)

- Kondo N et al. *Improvement of food-sensitive atopic dermatitis accompanied by reduced lymphocyte responses to food antigen following natural measles virus infection*. Clin Exp Allergy 1993; 23: 44-50.

- Shaheen SO et al. *Measles and atopy in Guinea-Bissau*. Lancet 1996; 347: 1792-96.

- Albonico HU, Braker HU, Husler J. *Febrile Infectious Childhood Diseases In The History Of Cancer Patients And Matched Controls,* Dept of Mathematical Statistics, University of Berne, Switzerland. Medical Hypotheses 1998 Oct; 51(4):315-20.

- Wrensch M et al. *Prevalence of antibodies to four herpesviruses among adults with glioma and controls*. Am J Epidemiol. 2001;154:161–165. (http://aje.oxfordjournals.org/content/154/2/161.full.pdf)
  "*Glioblastoma cases were (*60%) *less likely than controls to have immunoglobulin G antibodies to varicella-zoster virus*"

- Cramer et al. *Mumps and ovarian cancer: modern interpretation of an historic association* Cancer Causes Control. 2010 Aug; 21(8): 1193–1201 10.1007/s10552-010-9546-1
  (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2951028/pdf/nihms235805.pdf)
  "…suggesting a 19% decrease in risk of ovarian cancer associated with history of mumps parotitis."

- M L Newhouse, *A case control study of carcinoma of the ovary*. Br J Prev Soc Med. 1977 Sep; 31(3): 148–153. PMCID: PMC479015. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC479015/
  Infective disease histories were found to reduce the risk of ovarian cancer by 39% for measles, 53% for mumps, 38% for rubella, and 34% for chicken-pox (Table 10).

- Kubota et al. *Association of measles and mumps with cardiovascular disease: The Japan Collaborative Cohort (JACC) study*. Atherosclerosis. 2015 Jun 18;241(2):682-686

  http://www.atherosclerosis-journal.com/article/S0021-9150%2815%2901380-5/abstract

  Highlighting the most significant results, men who had had mumps had a **48%** reduced risk of **total stroke** and **79%** reduced risk of **hemorrhagic stroke**. Men who had had both measles and mumps had a **20%** reduced risk of **cardiovascular disease, and 29%** reduced risk of **myocardial infarction**.

- Maletzki et al. Cancer Immunology, Immunotherapy. August 2013, Vol 62, Issue 8, *Table 1 Anti-correlation between acute, cured infections, and the likelihood to develop cancer*, on pages 1284-1285.

45 Properly managed natural exposure to measles resolves some cancers

- Pasquinucci G. *Possible effect of measles on leukaemia*. Lancet. 1971 Jan 16;1(7690):136.
- Bluming A, Ziegler J. *Regression of Burkitt's lymphoma in association with measles infection*. Lancet. 1971 Jul 10; 298(7715):105–106
- Ziegler JL. *Spontaneous remission in Burkitt's lymphoma*. Natl Cancer Inst Monogr. 1976 Nov;44:61-5.
- H C Mota. *Infantile Hodgkin's disease: remission after measles*. Br Med J. 1973 May 19; 2(5863): 421.
- Taqi et al. *Regression of Hodgkin's Disease After Measles* (Letters to the Editor) Lancet,16 May 1981; 317(8229): 1112.
- Stephen J. Russell, M.D., Ph.D. and Kah Whye Peng, Ph.D. *Measles virus for cancer therapy*. Curr Top Microbiol Immunol. 2009; 330: 213–241.

46 Most of the targeted diseases – very difficult or impossible to develop from day-to-day contact. Other factors important.

NSW Health Fact Sheets: www.health.nsw.gov.au/Infectious/factsheets/Pages/default.aspx

NSW Health Control Guidelines: http://www.health.nsw.gov.au/Infectious/controlguideline/Pages/default.aspx

Diphtheria: not very contagious - "The probability of spread depends on the closeness and duration of contact. Prolonged contact (eg sleeping in the same room as a case rather than casual contact) is usually required."
(http://www.health.nsw.gov.au/Infectious/controlguideline/Pages/diphtheria.aspx)

Tetanus: "Tetanus is not passed on from one person to another."
(http://www.health.nsw.gov.au/Infectious/factsheets/Pages/Tetanus.aspx)

Haemophilus Influenzae B (Hib): *"Haemophilus influenzae* is a Gram-negative coccobacillus that is a normal part of upper respiratory tract flora… Before Hib immunisation, invasive disease caused by Hib **rarely** occurred **after** the age of 5 years. This was because the prevalence of antibody to Hib progressively increased from the age of 2 years, thought to be related to exposure to Hib (or cross-reacting organisms) colonising the nasopharynx or other sites." (In other words, by 5 years of age natural immunity will develop in an unvaccinated child, normally asymptomatically.)
(*The Australian Immunisation Handbook* 10th edition (2013), *4.3.1 Bacteriology*
http://www.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home~handbook10part4~handbook10-4-3,)

and "Hib bacteria can live harmlessly in the throat of healthy people."
(http://www.health.nsw.gov.au/Infectious/factsheets/Pages/Haemophilus_Influenzae_B.aspx)

Yet Hib disease itself is very uncommon. Hence it can be seen that transmission of this **already** ubiquitous bacteria is not one of the significant factors leading to the development of disease associated with Hib.

Meningococcal C: Like Hib, "Asymptomatic respiratory tract carriage of meningococci occurs in 5%–10% of the population." (http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi3901g5.htm#other)

Yet meningococcal disease is rare. Hence it can be seen that transmission of this bacteria is not one of the significant factors leading to the development of meningococcal disease itself.

Further, "meningococcal bacteria are not easily spread from person to person and the bacteria do not survive well outside the human body. The bacteria are passed between people in the secretions from the back of the nose and throat. This generally requires close and prolonged contact with a person carrying the bacteria."
http://www.health.nsw.gov.au/Infectious/factsheets/Pages/Meningococcal_disease.aspx

Pneumococcal: Like Hib, "The bacteria often live harmlessly in the throat of healthy people."
(http://www.health.nsw.gov.au/Infectious/factsheets/Pages/Pneumococcal-Disease.aspx)

"In a large majority of hosts, pneumococci are carried with no apparent symptoms."
(http://www.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home~handbook10part4~handbook10-4-13).

Yet pneumococcal disease is uncommon. Hence it can be seen that transmission of this bacteria is not one of the significant factors leading to the development of pneumococcal disease itself.

Hepatitis B: "is usually transmitted by contact with bodily fluids (such as blood, semen, vaginal secretions or saliva) of an infected (HBsAg positive) person… The virus **must** be introduced through broken skin or the placenta or come in contact with mucous membranes for infection to occur… Faecal-oral and vector-borne modes of transmission have **not** been demonstrated. Hepatitis B is **not** transmitted by kissing on the cheek, coughing or sneezing, sharing food or sharing eating utensils." (http://www.health.nsw.gov.au/Infectious/controlguideline/Documents/hepatitisB.PDF)

Polio: Not only has Australia been (officially) certified polio-free ever since 2000 (See Reference 33) but the Government reports that "The last reported case of locally acquired wild-type polio in Australia was in 1972."

(Poliomyelitis vaccines for Australian children, NCIRS Fact sheet: December 2009 http://www.ncirs.edu.au/immunisation/fact-sheets/polio-fact-sheet.pdf)

However, that case was "not confirmed virologically… Virological investigations of stored viruses from Victoria indicate that the last wild poliovirus was isolated from a patient with clinical poliomyelitis in 1967…. it is possible that wild poliovirus may have disappeared from Australia in the 1960s and that cases notified later were all VAPP or imported cases, as were all the cases notified after 1972."

(http://www.health.gov.au/internet/main/publishing.nsf/content/cda-pubs-cdi-2002-cdi2602-cdi2602l.htm)

Hence, the Government reports: "**Local transmission** of wild polio virus in Australia probably ceased in **1962**."
Vaccine–associated paralytic poliomyelitis, Margaret A Burgess, Peter B McIntyre, NCIRS, Vol 23, No 10, 30 Sep 1999

http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-pubs-cdi-1999-cdi2303-cdi2303g.htm

Since 1972, more than 20 million, and since 1962, about 25 million, unvaccinated child years have transpired.

Based upon this, it is reasonable to conclude that the **only** possible sources for transmission are:

- vaccination itself. The Government has not admitted, though, the possibility of that occurring from the currently used vaccine, IPV (in spite of it acknowledging that vaccine associated paralytic polio (VAPP) occurred when the IPV vaccine was formerly the vaccine recommended and funded, which was between 1956 and 1966), or
- importation from overseas. In spite of the many millions of people who have entered Australia from overseas in the past half century, there have been **only 2** cases reported of imported wild polio virus **since the 1950s or 1960s** – they were in 1977 (assumed acquired in Turkey) and 2007 (acquired in Pakistan). No secondary clinical cases, i.e. no transmission resulted. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2857217/)

  The WHO states, e.g. in its most recent update (2014), that with the number of cases having globally declined by an estimated 99.9% from 1988 (27 years ago) when it was endemic in more than 125 countries, polio remains endemic in only 3 countries. Hence the risk of importation could be estimated to be about 1000 times less still than in 1988. Further, of the 3 strains of wild poliovirus (type 1, type 2, and type 3) included in the vaccine, wild poliovirus type 2 was considered globally eradicated in 1999.
  (Poliomyelitis Fact sheet N°114 Updated October 2014. World Health Organisation
  http://www.who.int/mediacentre/factsheets/fs114/en/)

  If a third case **were** to occur of importation of wild polio virus, the Government itself states: "Transmission occurs primarily from person to person via the faecal-oral route" and that the "likelihood of local transmission following importation will be dependent upon… the living conditions, primarily relating to the likelihood of faecal contamination of the water supply." It cites only "rural and remote areas of Australia" as areas where "such contamination remains a possibility". (See References 33 and 34). It states that elsewhere, i.e. in urban areas, "adequate treatment of sewerage and provision of safe drinking water and foods" is an important factor for preventing the disease from spreading. (http://www.health.nsw.gov.au/Infectious/factsheets/Pages/Poliomyelitis.aspx)

Even if polio virus transmission were to occur, the Government admits that "*There may be… up to **1,000** cases of asymptomatic infection for each paralytic case in children*":

(*Immunisation Myths and Realities, 5th edition* (2013). Aust. Govt Dept of Health
http://www.health.gov.au/internet/immunise/publishing.nsf/content/uci-myths-guideprov)

47 Government PBAS: "no clinical effectiveness" of whooping cough vaccine for preventing transmission to the vulnerable
States ending free parent whooping vaccine, Australian Associated Press, 8/5/12.0

http://www.dailytelegraph.com.au/states-ending-free-parent-whooping-vaccine/story-e6freuyi-1226350174856

> *"PARENTS across Australia will no longer receive free whooping cough vaccinations because it is not effective in protecting newborns from the potentially deadly illness, a parliamentary committee has heard… 'The PBAC (Pharmaceutical Benefits Advisory Committee), which is totally independent and very expert, has determined that there is no clinical effectiveness of this strategy,' Professor Brook said. He said this had made it clear the cocooning strategy should not be continued. 'So all jurisdictions who have been in this program will be effectively ceasing the cocooning strategy as of the end of June this year'… 'There has been a national committee meet to look at this and to make decisions on the basis of the best scientific evidence available ... the evidence is that the strategy has not been effective.'* "[47]

Consequently, upon apparent acceptance of the whooping cough vaccine's ineffectiveness for preventing infection or transmission, the various states' and territories' funding of the "cocooning" program was terminated in May 2012, just 3 years after it began, with the exception of NSW which initially scaled it down but has since fully ceased the funding, and the NT which continues to provide free vaccines to "all fathers and carers in the same household of an infant under the age of 7 months".

Such unprecedented and rapid reversal of a policy may be another indication that the vaccine had been found to be not just ineffective in preventing infection or transmission but found to increase the risk of transmission to newborn infants, though that conclusion was not stated.

A newly available article (accepted on 19 August 2015 for publication in *Vaccine,* and available online since 29 August 2015) studied the effect (if any) of the cocooning program in Western Australia during 2011-2012, further confirmed that "*vaccinating parents with dTpa during the four weeks following delivery did* ***not*** *reduce pertussis diagnoses in infants*."

(Carcione D. et al. *The impact of parental postpartum pertussis vaccination on infection in infants: A population-based study of cocooning in Western Australia*. Vaccine. Received 7 May 2015, Revised 10 July 2015. Available online 29 August 2015. doi:10.1016/j.vaccine.2015.08.066
http://www.sciencedirect.com/science/article/pii/S0264410X15012049)

(An article in Australian Doctor magazine describes the same research:
Cocooning ineffective against pertussis. Australian Doctor. Michael Woodhead, 31 August 2015
http://www.australiandoctor.com.au/news/latest-news/cocooning-ineffective-against-pertussis)

48 The pertussis vaccine **manufacturers** themselves do **not** claim the vaccines will reduce risk of infection or transmission

Infanrix hexa, Infanrix IPV, Boostrix and other pertussis-containing vaccines' product inserts, available from Aust. Govt Dept of Health, Therapeutic Goods Administration www.ebs.tga.gov.au/

The pertussis vaccine manufacturers themselves do **not** claim that the vaccine prevents infection, transmission, cough severity, total duration of any chronic cough (which may come and go), or any longer term adverse outcomes) They claim only that the vaccine has been successfully tested for reducing, on average, the duration of a "typical" cough (which is "considered over when the child had had no cough for two full days.").

(Greco et al. A Controlled Trial of Two Acellular Vaccines and One Whole-Cell Vaccine against Pertussis. N Engl J Med 1996; 334:341-349
(http://www.nejm.org/doi/full/10.1056/NEJM199602083340601), referenced by Boostrix product insert)

Even if this claim (of reducing, overall, the duration of a "typical" cough) is scientifically valid, a cough is not a complication. It is a symptom that normally arises from the **defences** that the immune system may need to mount in order to protect the body from a complication or harm at a deeper level, and to develop lasting immunity. It is less desirable for the longer term to have a chronic cough, coming and going due to difficulty the body has fully resolving the infection.

It is acknowledged by vaccine manufacturer GlaxoSmithKline on its US Boostrix (pertussis-containing) vaccine product insert (page 15), that "*The role of the different components produced by B. pertussis in either the pathogenesis of, or the immunity to, pertussis is not well understood*".

(BOOSTRIX (Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed)
http://www.fda.gov/downloads/BiologicsBloodVaccines/UCM152842.pdf)

49 Fully vaccinated rates at record high of 90% in under 19 year olds

Immunisation coverage, 2012, Communicable Diseases Intelligence Sep 2014;38(3)
http://www6.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi3803e.htm (See Figures 2, 3 and 4 for whooping cough in particular). It can be seen that references made by the Government and the media to "concern" about an increased number of **registered** "conscientious objectors" is misleading. In response to numerous Government measures implemented over the past 20 years, vaccination coverage itself has only increased, not decreased, and is now at a record high.

50 Rise of whooping cough notifications and deaths in vulnerable age groups with higher vaccination coverage

A record number of 38,750 notifications had occurred in 2011 (see Reference 32), and nine infant pertussis deaths occurred between 2008 and 2011, which was well up from the previous rate of less than 1 death per year.
(http://www.abc.net.au/health/thepulse/stories/2012/08/14/3567495.htm)

51 Medical research finds vaccination may result in "*silent reservoirs*" of infection

Srugo et al. *Pertussis Infection in Fully Vaccinated Children in Day-Care Centers, Israel*. *Emerg Infect Dis*. Oct 2000;6(5). http://wwwnc.cdc.gov/eid/article/6/5/00-0512_article: "The whole-cell vaccine for pertussis is protective only against clinical disease, **not against infection**…. Our results indicate that children ages 5-6 years and possibly younger, ages 2-3 years, play a role as **silent reservoirs** in the transmission of pertussis in the community."

Study:Is the whooping cough resurgence due to vaccinated people not knowing they're infectious? 24 Jun 2015 BMC Medicine (http://www.santafe.edu/news/item/althouse-scarpino-whooping-cough-asymptomatic/);

52 Medical research finds infection "*readily transmitted*" by vaccinated

Warfel, Zimmerman and Merkel. *Acellular pertussis vaccines protect against disease but fail to prevent infection and transmission in a nonhuman primate model* PNAS 2014 111 (2) 787-792.
(http://www.pnas.org/content/111/2/787.full

Does the vaccine increase susceptibility to infection with the targeted *B pertussis* strain?

Researchers have identified a flaw in relation to the whooping cough vaccines, referred to as "Original Antigenic Sin". It not only provides an explanation for the ineffectiveness of the vaccines, but explains why the vaccines may, on the contrary, increase susceptibility to the disease.

(*Vaccinating pregnant women "halves the risk of pertussis in infants' first four months" ~ A critique by Dr Suzanne Humphries.* 21 March 2013 (http://www.vaccinationcouncil.org/2013/03/21/vaccinating-pregnant-women-halves-the-risk-of-pertussis-in-infants-first-four-months-a-critique-by-dr-suzanne-humphries/)

Does the vaccine increase susceptibility to infection with **non**-targeted, and widespread, *B pertussis* strain(s)?

A 2010 study published in the Proceedings of the Royal Society B concluded that vaccination resulted in an approximately **40-fold** increase in *B. parapertussis* lung colony-forming units (CFUs).

(Long et al. *Acellular pertussis vaccination facilitates Bordetella parapertussis infection in a rodent model of bordetellosis*. Proc. R. Soc. B, 2010; published ahead of print March 3, 2010, doi:10.1098/rspb.2010.0010 1471-2954. http://www.ncbi.nlm.nih.gov/pmc/)

Research in Australia published in 2012 has further found that the *B pertussis* strains that have been predominant in Australia in recent times, circulating in this country since at least 2000, are **not** amongst those targeted by the vaccine.

(L Ruiting. *Newly Emerging Clones of Bordetella pertussis Carrying prn2 and ptxP3 Alleles Implicated in Australian Pertussis Epidemic in 2008–2010*. J Infect Dis. 2012
(http://jid.oxfordjournals.org/content/205/8/1220.full.pdf)

Research in the US has made a similar significant finding. A key antigen component of the acellular pertussis vaccine is pertactin (PRN). The CDC findings have indicated that **85%** of the *B. pertussis* strains isolated in 2012:

"*were PRN-deficient and vaccinated patients had significantly higher odds than unvaccinated patients of being infected with PRN-deficient strains. Moreover, when patients with up-to-date DTaP vaccinations were compared to unvaccinated patients,* ***the odds of being infected*** *with PRN-deficient strains* ***increased****, suggesting that PRN-bacteria may have a selective advantage in infecting DTaP-vaccinated persons.*"

(http://www.cdc.gov/maso/facm/pdfs/BSCOID/2013121112_BSCOID_Minutes.pdf page 6)

Has use of (either old or new) whooping cough vaccines increased susceptibility to infection with *B pertussis* overall?

Pertussis notifications have been rising significantly in the United States ever since 1978-80, which was when vaccination was mandated for school entry.

(CDC *MMWR: Summary of Notifiable Diseases* http://www.cdc.gov/mmwr/mmwr_nd/)

In Australia also, since pertussis became a notifiable disease in 1991, and along with several Government incentives instituted on a number of occasions since that have increased vaccination uptake, pertussis notifications have also sustained a significant persistent overall rise in Australia.

(National Notifiable Diseases Surveillance System summary tables
http://www9.health.gov.au/cda/source/cda-index.cfm)

Immunisation Coverage Annual Reports
http://www6.health.gov.au/internet/main/publishing.nsf/Content/cda-immunanrep.htm)

53 Vaccination rate amongst reported cases 90%-100%, similar to, or higher than, the vaccination rate in the population

There are numerous examples of this, but here are a few recent ones:

Chickenpox

In 2012 (the latest year assessed) in Australia, 87% cases of chickenpox cases had been vaccinated (where vaccination status was known), which was **higher** than the vaccination coverage, especially given that the vaccine was only introduced in November 2005 and initial uptake was slow - 20% for the March 2006 cohort (as at March 2008), 71% for the September 2006 cohort, 79% for the March 2008 cohort, and still only 84% in the most recently vaccinated cohort in 2012
(See Reference 33 and *Immunisation coverage annual reports* for 2007 (Fig 8) and 2012 (Fig 3) in Reference 31)

Hib (Haemophilus Influenzae b)

In the 3 years 2009 through 2011, there were just 21 to 23 Hib notifications in vaccine eligible children under 5 years of age. Of those cases, at least 19, and potentially 100%, were vaccinated, and 18 were fully vaccinated for their ages. (See Reference 33)

Mumps

"During the 2006–2007 period, there were 371 notifications of individuals born after 31 December 1980.… Of the 92 cases with vaccination status validated, 72 (78%) had been fully vaccinated, 16 (17%) partially vaccinated, 2 were unvaccinated and 2 had an unknown status." (Reference 34)

Pneumococcal

Notifications in 2006-2007 in vaccine-eligible children aged over 6 months whose vaccination status was known, 78% were reported to be fully vaccinated, and only 10% unvaccinated (Reference 34).
The full vaccination coverage in the wider population nationally (with 3 doses given to infants at 2, 4 and 6 months) was only 90% for those eligible over 12 months in the same period. (See Reference 31)

Pertussis (examples are ordered chronologically)

1) In a 1997 pertussis outbreak in the Bonner County of the Panhandle Health District in North Idaho (US), 85% cases had 4 out of 4 doses and 15% had 3 out of 4 doses (100% vaccinated). Among those who had 2 out of 4, 1 out of 4 or even no doses there were no reported cases. The CDC concluded: "*The myth of vaccine refusal played no role in this outbreak*."
(Testimony before Idaho Legislature, by Angie Vasquez, Director, South Idaho Chapter, Vaccination Information and Liberation. Burley, Idaho, Feb. 26, 2003 http://www.vaclib.org/news/boise.htm)

2) De Serres G, Shadmani R et al. *Morbidity of Pertussis in Adolescents and Adults*. J Infect Dis. (2000) 182 (1): 174-179. doi: 10.1086/315648
(http://jid.oxfordjournals.org/content/182/1/174.full. Table 1 shows that 78% + 19% = 97% of the 280 cases of whooping cough in 12 - 17 year olds were believed to be in the vaccinated)

3) Chuk et al, *Pertussis in infants: how to protect the vulnerable?* CDI 2008;32;4:449-456.
http://www.health.gov.au/internet/main/publishing.nsf/content/cda-cdi3204h.htm

This study, published by Commonwealth Government of Australia, was conducted in relation to 55 infants hospitalised with pertussis between 1997 and 2006 in the Royal Children's Hospital, Brisbane.
In summary, the results were as follows:

1. Of the 30 hospitalised infants who had been old enough to be eligible for vaccination

   - 93% (28/30) infants had been vaccinated. Only 2 were unvaccinated, and one of those, a 3 month old, was only a little older than when the first dose is scheduled in Australia (between 2 and 2½ months). In some countries (e.g. Japan, Italy and all in Scandinavia) the first dose is not scheduled before 3 months of age[53]. The other unvaccinated infant was 5 months of age. The disease in neither unvaccinated infant was serious enough to require admission to intensive care (unlike 5 infants who had been vaccinated), and

   - 83% (25/30) had been vaccinated "on time", meaning within 2 weeks after reaching the scheduled age. In the population at large, on average only 69% infants are given the 3rd vaccine dose "on time".[53]

2. The single death among the "vaccine eligible" was in an infant aged less than 2 months who had, in fact, **been vaccinated** at just 6 weeks of age, a week before presenting with clinical pertussis.

   The infection source, which was not identified, may have been the vaccine that the infant had just been given. This would appear to be a reasonable possibility because:

   - pertussis is a toxin-mediated disease

     (Pittman M. *The concept of pertussis as a toxin-mediated disease*. Pediatr Infect Dis. 1984 Sep-Oct;3(5):467-86. http://www.ncbi.nlm.nih.gov/pubmed/6093069)

   and

   - the pertussis "toxoid" in the vaccine (both the old and new vaccines) can remain pathogenic.

     (J. H. Menkes, M. Kinsbourne· *Workshop on Neurologic Complications of Pertussis and Pertussis Vaccination.* Neuropediatrics 1990; 21(4): 171-176. https://www.thieme-connect.com/DOI/DOI?10.1055/s-2008-1071488)

   The infant's susceptibility may have been further increased by the mother having been vaccinated herself in the past, as it may weaken an infant's transplacental immunity

   (Mullholland K, *Measles and pertussis in developing countries with good vaccine coverage*. Lancet 1995.; 345: 303-307)

3. Of the 15 hospitalised infants aged 2 months, 9 (60%) had received the 1st (2 month) dose and in 7 of those 9 cases no contact was identified, so some or all of those also may have contracted pertussis from the vaccine.

4. Of the 20 infants older than 3 months, the only one who required admission to intensive care was a 9 month old who had been fully vaccinated, and on time. He also required ventilation. The generally accepted upper age

limit today for the potential danger period from pertussis may therefore be higher than 6 months for the vaccinated.

5. Only one of the 6 infants who were at least 7 months of age had not had the 3rd dose (he was just 7 months, and had received the other 2 doses). The other 5 (83%) had received the 3rd dose on time.
6. In the cases of those 5 who were more than 2 weeks "overdue", the average period of time that they were "overdue" was less than 1½ months.

There have been no deaths (or other complications) **recorded in any of the around** 400,000 **unvaccinated** "vaccine-eligible" infants born in Australia since pertussis became a notifiable disease in 1991, according to government publications.

4) In an outbreak in the Triad (North Carolina) in 2012, it was reported in February (2012) that **100%** of confirmed cases to date had received the pertussis vaccine.
(*Whooping Cough Is In The Triad*, WFMY News 2 (Mark Geary), Feb 24, 2012
http://www.digtriad.com/news/article/216176/57/What-You-Need-To-Know-About-Whooping-Cough)

5) *15 Falmouth High Students Diagnosed With Whooping Cough.* November 14, 2014 8:29 PM
http://boston.cbslocal.com/2014/11/14/whooping-cough-outbreak-on-cape-cod/
"A school official tells WBZ that all the students had been immunized."

6) In January 2015 it was published that in Parana, Brazil, in 2007-2013, of the cases where vaccination status was available, 98% of the 1-9 year olds, and 96% of the 1-19 year olds were vaccinated, and 91% and 90% respectively had had 3 or more doses.
(Torress et al. *Resurgence of pertussis at the age of vaccination: clinical, epidemiological, and molecular aspects.* Jornal de Pediatria. Received 2 June 2014, Accepted 8 September 2014, Available online 23 January 2015. doi:10.1016/j.jped.2014.09.004 http://www.sciencedirect.com/science/article/pii/S0021755715000066)

7) *19 kids in Summit Co. (Utah) diagnosed with whooping cough despite being up to date on vaccinations.* March 27, 2015, by Kiersten Nuñez
http://fox13now.com/2015/03/27/19-kids-in-summit-co-diagnosed-with-whooping-cough-despite-being-up-to-date-on-vaccinations/ "all of the children infected are up to date on their vaccinations."

8) *70 diagnosed with Whooping Cough in Reno County* (Kansas) Eyewitness News, Jul 30, 2015
http://www.kwch.com/news/local-news/70-diagnosed-with-whooping-cough-in-reno-county/34378784
"Hutchinson Schools' spokesman, Ray Hemman… says the cases the district has heard about were people who've been vaccinated"

Many more examples, in relation to both chickenpox, pertussis and **other** targeted diseases, can be found, *inter alia*, in References **33** and **34** and by emailing freedomofchoicevacc@mycg.org.

It is not being asserted by the citing of these examples that in all outbreaks the vaccination rate amongst **reported** cases is as high as (or higher than) the vaccination rate in the population. However, it is important to note that:

- with respect to cases that are reported as unvaccinated, the reason for their not having been vaccinated is not included. Those who suffer from **pre-existing health conditions** are less likely to be vaccinated (whether or not officially medically contraindicated), and ill health itself is known to increase susceptibility to infectious diseases, and
- doctors diagnose diseases based primarily upon a historically determined checklist of disease symptoms. Any alteration by vaccination of how the body subsequently expresses a disease will hence reduce the likelihood of diagnosis (e.g. **atypical measles** – see adverse effects in Reference 6), and
- doctors are taught that vaccines are effective, and hence have been found to be consequently affected by **bias.** This also leads to misdiagnosis and underreporting of disease cases in the vaccinated.

(Harnden A. *Whooping cough in school age children with persistent cough: prospective cohort study in primary care. BMJ* 22 July *2006; 333:174* http://www.bmj.com/content/333/7560/174)

54 Sources of infection found to be vaccinated. Infection and transmission can occur as a direct result of vaccination

A couple of publicised examples of original sources having been, or most likely been, vaccinated, and recently:

1) *Travel brings fatal return of diphtheria*. Janelle Miles. The Courier-Mail May 03, 2011:
http://www.couriermail.com.au/news/fatal-return-of-diphtheria/story-e6freomx-1226048663339
"Because her friend had been vaccinated, he carried the bacteria… and unknowingly infected the woman."
(Further information is available from *Australia's notifiable disease status, 2011: Annual report of the National Notifiable Diseases Surveillance System - Part 3 -* http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi3704b2.htm#vpd)

2) In the case of the recent (March 2015) tragic death of 4 week old Riley Hughes in Western Australia from whooping cough, his mother "Catherine told Mamamia that her whole family is immunised and that they had also asked their

friends and families to have boosters. The Department of Health says it does not know how the child contracted the respiratory disease, also known as pertussis." (http://www.dailymail.co.uk/news/article-3007109/Grieving-parents-baby-died-whooping-cough-forced-defend-anti-vaxxers.html)

The advice from Catherine's doctor had been that her vaccination "just three years earlier" would protect her during her pregnancy but she herself now believes that advice to be incorrect (http://www.mamamia.com.au/parenting/whooping-cough-vaccine-in-pregnancy/#myUsAEch0fHxBZ7Z.99), which appears to indicate that she herself contracted whooping cough during her pregnancy. "Research has found that… the single most common source of infection seems to be their mother if she has whooping cough herself." (http://www.health.nsw.gov.au/news/Pages/20120622_00.aspx).

This indicates that, ironically, Riley appears to have contracted whooping cough from his fully vaccinated mother or, given that she had ensured that the only people with whom he came into contact were vaccinated, by way of carriage from an asymptomatic, recently vaccinated, family member or friend. (See References 51 and 52)

Measles (and other?) vaccines as causes of infection and potentially transmission also:

The US Government already pays compensation for "**vaccine-strain** measles viral infection in an immunodeficient recipient", and complications from vaccine-associated measles have been documented also in immune-competent individuals. The US Government acknowledges, in effect, that acquiring measles from the vaccine may be much more common than previously assumed, and may have been going misdiagnosed. It recently stated that:

"Because of limitations due to testing and viral properties, in most cases it is difficult to characterize wild-type versus vaccine-strain measles."

(National Vaccine Injury Compensation Program: Revisions to the Vaccine Injury Table https://www.federalregister.gov/articles/2015/07/29/2015-17503/national-vaccine-injury-compensation-program-revisions-to-the-vaccine-injury-table)

With new technology now available, recent investigations of some children with measles, mumps or rubella have indeed revealed them to be excreting, i.e. infected with, the vaccine strain of the virus.

(*Spotlight on measles 2010: excretion of vaccine strain measles virus in urine and pharyngeal secretions of a child with vaccine associated febrile rash illnes*s, Croatia, March 2010. Croatian Institute of Public Health, Department of Infectious Disease Epidemiology, Zagreb, Croatia. Eurosurveillance, Volume 15, Issue 35, 02 September 2010. http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=19652.
This child had been given the Priorix vaccine, which is also given in Australia.
"In a patient recently MMR-vaccinated, only molecular techniques can differentiate between wild type measles or rubella infection or vaccine-associated disease")

(Differentiating the wild from the attenuated during a measles outbreak. Communicable Disease Control, Alberta Health Services. Pediatricians and Child Health, Apr. 2012; 17(4)
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3381670/
This child had been given the M-M-R II vaccine, which is also given in Australia)

(Case of vaccine-associated measles five weeks post-immunisation, Eurosurveillance, Volume 18, Issue 49, 05 December 2013 http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20649
This child appears to have been given the Priorix vaccine, which is also given in Australia)

Dr Suzanne Humphries M.D., comments: "in the past, we would have never known this. It would have either been considered a different disease… or.. a wild type virus that the person was infected with before they had a chance to mount an immune response (to the vaccine), but because we now… can distinguish between strains, we are finding that… those people have the potential to shed virus and be infective."

(Dr. Suzanne Humphries, M.D. – *Vaccine Strain of Measles Virus Found in Measles Outbreaks*
http://healthimpactnews.com/2015/dr-suzanne-humphries-m-d-vaccine-strain-of-measles-virus-found-in-measles-outbreaks/#sthash.n3tOx28t.dpuf)

This possibility should be considered especially in the light that notifications of measles in the unvaccinated are rare.

Could the vaccine be the cause of the disease outbreaks, which are still being reported from time to time?

Transmission from vaccine-associated measles has been documented.
(Hau M, Schwartz KL, Frenette C, Mogck I, Gubbay JB, Severini A, et al. Local public health response to vaccine-associated measles: case report. BMC Public Health. 2013;13:269. http://dx.doi.org/10.1186/1471-2458-13-269)