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Wednesday, 29 August 2012

Introduction

Following this introduction page is this reviewer's analysis of an article titled, "**Vaccination fears are only upping danger**", which was written by Annette Meeks, CEO of the Freedom Foundation of Minnesota[a]. This reviewer originally downloaded this article on August 13, 2012 from: http://www.startribune.com/opinion/commentaries/165792176.html?refer=y.

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This analysis, titled "**Draft Review of: *'Vaccination fears are only upping danger'***", begins on the next page.

Introductory Remarks

First, to simplify this analysis, each portion of the article being reviewed is first quoted in its original "Arial" font.

Further, when some specific sentence, clause, phrase, or word is being addressed within the review, it is quoted in an *italicized* "*Times New Roman*" font.

Second, this reviewer's assessments are written in a "Verdana" font, follow each quoted portion of the article, and are indented to clearly separate the review remarks from the preceding portion of the document that is being addressed.

Third, when other sources are quoted or referenced, the text is in an "Arial Narrow" font.

Finally, should anyone find any significant factual error in this review for which they have independent[b], scientifically sound, peer-reviewed published substantiating documents, please submit that information to this reviewer so that he can improve his understanding of factual reality and, where appropriate, revise his views and this analysis.

Respectfully,

<S>

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[To whom all responses should be directed]

[a] "an independent, non-profit, education and research organization that develops and actively advocates the principles of individual freedom, personal responsibility, economic freedom, and limited government" [from review page "**23**", emphasis added].

[b] To qualify as an independent document, the study should be published by researchers who have no direct or indirect conflicts of interest from their ties to either those commercial entities who profit from the sale of vaccines or those entities, academic, commercial or governmental, who directly or indirectly, actively promote vaccines, the development of vaccines, and/or inoculation programs using vaccines.

Draft Review of
"Vaccination fears are only upping danger"

Main Review Topics

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Draft Review of
"Vaccination fears are only upping danger"

"Vaccination fears are only upping danger

Article by: ANNETTE MEEKS   Updated: August 13, 2012 - 1:55 PM

They are their own epidemic, a result of the spread of misinformation."

First, the title of this article and the "lead in" do not clearly identify the source of the claimed "*[v]accination fears*" nor whose claimed "*danger*" they are increasing.

Second, the lead in claims that "*[v]accination fears*" are "*their own epidemic*" and that this epidemic is "*a result of the spread of misinformation*".

Based on the title and the lead in, this article is but another one in a never-ending stream of fear-mongering articles published by vaccine apologists and acolytes.

Often, as here, these articles are simply disinformative propaganda pieces used to defend those who directly and indirectly profit from the vaccines that are developed, produced for, and sold and administered to the public.

Thus, the title and the lead in plainly identify the writer of this article, "*ANNETTE MEEKS*", as a vaccine apologist, who plainly believes that she can tell any story and that her story must be believed simply because that story supports the Establishment's propaganda-based view of the ersatz realities from which it profits.

Given this basis, this reviewer notes that this article actually exceeds his expectations because this article continually bombards the reader with fabrications, unsubstantiated cant, and misleading vaccination rhetoric.

Polio Vaccines: The Writer's Fiction and Historical Fact

"April 12 almost became a national holiday. On that day in 1955, virologist Jonas Salk announced that his polio vaccine was a success.

Salk's vaccine effectively ended one of the worst epidemics in our nation's history. Polio was killing and paralyzing ever more children in the United States and was considered the most dangerous communicable disease. Salk's vaccine allayed the fears of millions of American parents. With one dose, their children were safe.

Two years and 100 million doses later, polio was virtually eradicated in the United States."

The only aspect of the preceding rewrite of factual history that is accurate is that "*virologist Jonas Salk announced that his polio vaccine was a success*" on April 12, 1955.

Since the peak in "polio" cases had actually occurred in the United States of America (USA) in 1950 with an national incidence of less than 25 cases per

100,000 population (< 1 case in 4,000 population) and had declined to < 1 case in 5,500 persons before the "polio" vaccination program was introduced in 1955[1], "polio" never reached the historical national "epidemic" threshold of 1 case in every 3,000 persons even though the incidence rate in several states did surpass this threshold.

Moreover, the pre-1950 increase in a "polio" cases was apparently connected to the introduction of the prophylactic combined diphtheria and pertussis (DP) vaccines in the 1940s[2] (where the per 100,000-persons incidence level of "polio" in the USA was found to have increased from an average of "5.8" in the period 1935-1939 (before the DP vaccine was introduced) to "8.4" in the period from 1940-1944 when the DP vaccines were being introduced to "16.8" in 1945-1949 and, after the diphtheria, tetanus, pertussis (DTP) vaccines were introduced, "24.8" in 1950-1954, when the time-local increase in "polio" cases peaked[3].

Further, when the mass vaccination campaign was announced in 1955, the incidence of "polio" deaths in the USA had been declining from the historical peak incidence level in 1920 for more than 34 years and, by 1955, there was an overall decline of 47% from the 1920 level.

Likewise, the United Kingdom (UK) experienced a similar "polio"-case-decline pattern[4], without the time-local increase in the period from 1940 to 1955.

Worse, when the polio vaccination campaign was launched in April of 1955, the Salk vaccine inoculations caused significant increases in the number of "polio" cases with serious "polio" cases in more than 40,000 inoculated children and some "polio" deaths in children given these live-virus-containing Salk inactivated-poliovirus vaccines (this disaster came to be known as the infamous "Cutter Incident"[5] – named after the corporation, Cutter Laboratories, that

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1 Hearings Before the Committee on Interstate and Foreign Commerce, House of Representatives, 87th Congress, 2nd Session on HR 10541 (May 1962), pages 94-112.

2 McCloskey BP. The relation of prophylactic inoculations to the onset of poliomyelitis. ***Lancet*** 1950 Apr 8; **255**(6606): 659-663 [Originally published as Volume 1, Issue 6606].

3 Miller, NZ. The polio vaccine: a critical assessment of its arcane history, efficacy, and long-term health-related consequences. ***Med Veritas*** 2004; **1**: 239-251.

4 Anderson M. **International Mortality Statistics** (Washington, DC, ISBN 0-87196-514-3 [1981]) . Facts on File: 177-178.

5 http://en.wikipedia.org/wiki/Cutter_Laboratories:

"The Cutter incident

In 1955, Cutter Laboratories was one of several companies licensed on April 12 by the United States government to produce Salk polio vaccine. In what came to be known as the Cutter Incident, some lots of the Cutter vaccine – despite having passed the required safety tests – contained live polio virus in what was supposed to be an inactivated-virus vaccine. Cutter withdrew its vaccine from the market on April 27 after vaccine-associated cases were reported. Drs. William Tripp and Karl Habel, both from NIH, were sent by Surgeon General Scheele to Berkeley to inspect Cutter's facilities, question their workers, and examine their records. After a thorough investigation nothing was found wrong with Cutter's method of production.[2] A congressional hearing was held in June 1955 and it concluded that the problem was primarily the lack of scrutiny from the NIH Laboratory of Biologics Control (and its excessive trust in the National Foundation for Infantile Paralysis reports).[3]

A number of civil lawsuits were filed against Cutter Laboratories in subsequent years, the first of which was Gottsdanker v. Cutter Laboratories. The jury found Cutter not negligent, but liable for breach of implied warranty & monetary awards were made to the injured parties. This set the precedent for later lawsuits. All five companies that produced the Salk vaccine in 1955 – Eli Lilly, Parke-Davis, Wyeth, Pitman-Moore, and Cutter – had difficulties in completely inactivating the polio virus, and three companies other than Cutter were sued but the cases were settled out of court.[4]

The Cutter incident was one of the worst pharmaceutical disasters in U.S. history and caused several thousand children to be exposed to live polio virus upon vaccination.[5] The NIH Laboratory of Biologics Control, which had certified the Cutter polio vaccine, had received advance warnings of problems: in 1954, staff member Dr. Bernice Eddy had reported to her superiors that some of the inoculated monkeys had become paralyzed (pictures were sent as well). William Sebrell, the director of NIH wouldn't hear of such a thing.[3]

Numbers affected

The mistake resulted in the production of 120,000 doses of polio vaccine that contained live polio virus. Of the children who received the vaccine, 40,000 developed abortive poliomyelitis (a form of the disease that does not involve the central nervous system), 56 developed paralytic poliomyelitis and of these 5

produced many of the first doses of the Salk polio vaccines including lots in which all of the polio virus was not inactivated, even though other manufacturers' had similar poliovirus inactivation problems).

Thus, the result from these initial live-virus-contaminated inoculations was that the incidence of polio initially increased after the Salk vaccines were introduced in April of 1955.

However, later in 1955, the medical establishment made certain that the polio vaccine would be seen as a success.

All it needed to do, and did, was to change the diagnostic definition of "polio" to: **a)** exclude cases of aseptic meningitis and Coxsackie viruses that had previously counted as "polio" cases, and **b)** increase the duration-of-paralysis requirement from: **i)** any paralysis lasting for 24 hours to: **ii)** paralysis lasting for an extended period of time (6 months).

Thus, the "polio" epidemic was ended by replacing the "polio" definition with the diagnostic criteria for "paralytic polio", which separated out cases of aseptic meningitis and Coxsackie viruses, and required that there must be an extended period of paralysis before a paralytic-polio case could be diagnosed (from 24 hours previously to 180 days)[6] – essentially changing the diagnostic criteria to create a new disease, paralytic polio.

Thus, by this sleight-of-hand definition change, the Establishment created a new disease, paralytic polio, for which it still used the name "polio", whose diagnostic definition ensured that more than 95% of the cases, which were previously diagnosed as "polio", would now be classified as aseptic meningitis or as Coxsackie-virus cases.

Armed with these new definitions, the Establishment snatched 'victory over polio' from the almost certain demise of its vaccination plans, which was threatened by polio vaccines that were increasing the number of cases of "polio".

'Overnight', the "polio" epidemic was stopped by this diagnostic change, which resulted in a rapid 20-fold decline "polio" cases in the mind of the American people, who were not told that "polio" and "paralytic polio" were entirely different disease diagnoses with an overlap of about 5%, and not by the ongoing propaganda that "polio" was stopped by "*Salk's vaccine*".

When these sleight-of-hand diagnostic revisions were fully integrated into the practice of medicine in the USA in 1966, these changes in the diagnostic criteria

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children died as a result of polio infection.[6] The exposures led to an epidemic of polio in the families and communities of the affected children, resulting in a further 113 people paralyzed and 5 deaths.[7]

Administrative consequences

The director of the microbiology institute lost his job, as did the equivalent of the assistant secretary for health. Oveta Culp Hobby stepped down. Dr Sebrell, the director of the NIH, resigned.[3]

References

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3. Edward Shorter, **The Health Century**, Doubleday, New York, 1987, pp 68–70 ISBN 0-385-24236-0
4. Offit, Paul A. **The Cutter Incident: How America's First Polio Vaccine Led to the Growing Vaccine Crisis**, Yale University Press, 2005, pp. 100, 116–19, 133. ISBN 0-300-10864-8
5. Offit PA (2005). "The Cutter incident, 50 years later". ***N. Engl. J. Med.*** **352** (14): 1411–1412. doi:10.1056/NEJMp048180. PMID 15814877. http://content.nejm.org/cgi/reprint/352/14/1411.pdf.
6. Nathanson N. and Langmuir AD. (1963). "The Cutter incident. poliomyelitis following formaldehyde-inactivated poliovirus vaccination in the United States during the spring of 1955. II. Relationship of poliomyelitis to Cutter vaccine". *Am. J. Hyg.* **78**: 29–60. PMID 14043545.
7. Template: NEJM

[6] Hearings Before the Committee on Interstate and Foreign Commerce, House of Representatives, 87th Congress, 2nd Session on HR 10541 (May 1962), pages 96-97.

reduced the reportable cases of "polio" by more than 95%[7].

Moreover, though the Establishment intentionally hid the facts from the public, some, if not most, of the increase in old-definition "polio" cases from the 1940s through the early 1950s were probably aseptic-meningitis cases attributable to post-inoculation adverse effects caused by the "pertussis"-component-containing vaccines, which would have been recognized as such had the post-1955 definition of "polio" been introduced in 1940[8].

Additionally, as other countries replaced the diagnostic definition used to diagnose "polio" with the diagnostic criteria used to diagnose paralytic polio, the "polio" epidemic also disappeared even in those European countries that did not systematically inoculate their children[9] – while – *especially in those countries that introduced vaccination programs using whole-cell-pertussis-component-containing vaccines* – the number of medical cases in very young children that could have been diagnosed as aseptic meningitis soared.

Furthermore, not only did the "polio" vaccines not stop the "polio" epidemic but also – *through the adventitious viral contaminants in them* –the polio vaccines were and, *to a lesser extent, probably still ar*e, the vectors for the inoculation of our children and ourselves with a wide range of animal viral diseases and prions from the tissues and growth medium supplements used in the growth of the suitably attenuated live polio viruses that were subsequently converted into either the attenuated live-poliovirus vaccines or the inactivated-poliovirus vaccines, which we and our children were and/or are being given[10].

Factually, the diseases that polio vaccines have definitely introduced into humans include, but are not limited to,

- Cancer-causing Simian (monkey) virus 40 (SV-40), which has not only infected those who were inoculated with either the inactivated- or live-poliovirus vaccines contaminated with it but it has also been shown to pass from human to human and mother to child[11];
- Simian Immunodeficiency viruses, which some researchers have linked to the corresponding HIV types in humans[12,13];
- The brain-wasting CJD (Creutzfeldt-Jacob disease) and vCJD conditions

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[7] Los Angeles County Health Index: Morbidity and Mortality, Reportable Diseases

[8] This Diphtheria-Pertussis-(DP)-vaccine-associated reality clearly establishes the fact that D-P inoculation and, by extension, DPT inoculation is harmful to some percentage of those developing children inoculated with them at a level of roughly 16 instances per 100,000 vaccinated with a DP (or, by inference, a whole-cell DTP vaccine) or roughly 1 in 6,250.

[9] Mendelsohn R. **How to Raise a Healthy Child… In Spite of Your Doctor** (Ballantine Books, 1984): ['Chapter 19'] Immunization against Disease: A Medical Time Bomb?, pages 230 – 253. [**Note:** This section of the book discusses, "The risks of immunization; is immunization beneficial and necessary?; when to seek treatment for childhood diseases; symptoms and home treatment of chicken pox, mumps, measles, rubella, whooping cough, diphtheria, scarlet fever, meningitis, tuberculosis, SIDS, poliomyelitis, infectious mononucleosis".]

[10] Miller NZ. **Vaccine Safety Manual for Concerned Families and Health Practitioners – 2nd Edition** (New Atlantean Press, 2010, 2012 [updated; ISBN: 978-188121737-4], pages 53-62.

[11] Kim JYH, Koralnik IJ, LeFave M, Sega IRA, Pfister L-A, Pomeroy SL. Medulloblastomas and Primitive Neuroectodermal Tumors Rarely Contain Polyomavirus DNA Sequences. ***Neuro-Oncol*** 2002; 4: 165-170.

[12] Hooper E. Sailors and star bursts, and the arrival of HIV. ***BMJ*** 1997; **315**:1689-1691.

[13] Lemey P, Pybus OG, Wang Bin, Saksena NK, Salemi M, Vandamme A-M. Tracing the origin and history of the HIV-2 epidemic. ***PNAS*** 2003 May 27; **100**(11): 6588-6592.

in humans[14] that have been linked to bovine-spongiform-encephalopathy-(BSE)-contaminated fetal calf serum used in growing polio and other vaccine components; and

- Respiratory syncytial virus (RSV) in children that has been linked to RSV in chimpanzees used in various vaccine research, development and production processes[15].

In addition, cultures of the monkey kidneys used to grow polioviruses for the vaccines have been found to harbor the simian "B" virus, foamy agent virus, haemadsorption viruses, Lymphocytic choriomeningitis (LCM) viruses, and arboviruses[16].

Once-eradicated[17] Childhood Diseases? The Writer's Story and Factual Truth

"Today, nearly six decades after our country celebrated the lifesaving work of this noble scientist, once-eradicated childhood diseases are making a comeback. Diseases like measles and whooping cough are reoccurring because parents choose to ignore decades of scientific research and delay or forego lifesaving vaccinations for their children. The health of Minnesota schoolchildren is at risk because of some parents' misguided fears.

There is a growing epidemic in America -- an epidemic of fear, borne of misinformation about the safety and importance of vaccines.

According to some public health estimates, in parts of the United States, 'vaccination rates have dropped so low that occurrences of some children's diseases are approaching pre-vaccine levels for the first time ever,' as Amy Wallace put it in a 2009 article. Minnesota's Department of Health has reported more than 1,000 cases of pertussis (whooping cough) since Jan. 1, double the total number of cases reported during 2011.

Pertussis has made a comeback in the United States, especially among unvaccinated children who, according to health officials, are 23 times more likely than those vaccinated to contract this sometimes fatal bacterial infection.

In 2010, California officials declared whooping cough an 'epidemic' as they dealt with the worst outbreak in 60 years, including 10 deaths. After waging an intensive vaccination campaign, last year California public health officials reported no cases of pertussis."

Since, *as this writer admits in her initial statement*, certain "*childhood diseases are making a comeback*" – where, in this context, writer apparently means to convey the reality that the number of reported disease cases are significantly increasing over some low rate previously experienced for some period in the USA – it is clear that these childhood diseases were never eradicated in the first place.

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14 USDA Animal and Plant Health Inspection Service (APHIS) **Bovine Spongiform Encephalopathy** Fact Sheet, 2002 Feb: 3 pages.

15 Chidgey SM, Broadley KJ. Respiratory syncytial virus infections: characteristics and treatment. ***J Pharmacy Pharmacol*** 2005 Nov; **57**(11): 1371–1381.

16 Rustigan R, Johnston P, Reihart P. Infection of monkey kidney tissue cultures with virus-like agents. ***Exp Biol Med*** 1955 Jan; **88**(1): 8-16. doi: 10.3181/00379727-88-21478.

17 Based on the definition of the transitive verb, "eradicate" in the "Encarta" dictionary embedded in Microsoft Word 2007®, which reads, "**get rid of something completely** to destroy or get rid of something completely, so that it can never recur or return", no vaccine inoculation program can factually be claimed to have eradicated diseases that "*are making a comeback*".

Measles Realities

Based on this reviewer's most recent review and his analysis of the reported non-vaccine-related measles cases[18], this reviewer understands that mostly isolated outbreaks of "wild" measles infections are occurring in the USA, where the principal causes of these outbreaks appear to be failures of:

a. Public health officials to identify and quarantine all of those who have visited an area where, for whatever reason, measles is still endemic and/or

b. Healthcare providers to identify those who have the onset symptoms of what may be measles and appropriately quarantine those individuals from public contact until the appropriate testing can be conducted.

In addition, the constant background level of the annual MMR-vaccine-associated measles cases is generally being concealed from the public.

Moreover, given the inherent limitations to the duration of protection provided by the current "2 dose" MMR-vaccine inoculation program recommended by the US Centers for Disease Control and Prevention (CDC) and the nature of the injected live-virus measles-containing vaccines currently licensed in the USA by the US Food and Drug Administration (FDA) and available for use[19], increasingly all that is preventing the USA from experiencing a surge in measles cases comparable to those seen recently in several European countries[20] are: **a)** the low number of measles-infected persons entering the USA who are actively shedding the measles virus, and **b)** the somewhat delayed but still effective identification and quarantining of those who are infected coupled with a population where more than a third of the residents of the USA probably still have adequate levels of immune system protection from having been naturally exposed to the measles virus shed by others, contracting measles, and recovering from that exposure[21].

Thus, for measles, both:

♦ History (where: **a)** measles outbreaks have repeatedly occurred in populations that were "100%" vaccinated; **b)** there are increasing instances where a person who has received two or more doses of a measles-containing vaccine still "contracts" a clinical measles case when he or she is exposed to a contact who has a measles diagnosis and/or is actively shedding the measles virus but has not yet been

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[18] Review at "http://dr-king.com/docs/120127_RevisdDrft_RevuOfAutsmControvrsyNeedForResponsbleScienceJournlsm_b.pdf," pages 16-20 and 21-33.

[19] Currently, the available FDA-licensed live measles-containing vaccines are Merck's: **a)** MMR II® [a three-component measles-mumps-rubella combination vaccine] and **b)** ProQuad® [a four-component measles-mumps-rubella-varicella combination vaccine].

[20] Where, in 2011, France was the poster child used by the fear-mongerers shilling for ever higher uptake of vaccines to "frighten" the American people of what could happen to them and to gin up support or tightening the restrictions placed on those who want to "opt out" of the current programs.

[21] This "third" of American residents (see: http://2010.census.gov/news/releases/operations/cb11-cn147.html) currently consists of: **1)** almost everyone over 49 years of age, **2)** those who, though vaccinated against measles still contracted measles when exposed to it, and **3)** those younger residents who were not inoculated with: **a)** a measles-only vaccine or **b)**, when only the combination MMR vaccine was available, an available MMR vaccine and subsequently developed immunity to measles.

diagnosed; and **c)** there are isolated cases of measles where there was no identifiable contact person who was shedding measles virus near the persons who contracted measles) and

- ♦ This reviewer's science-based analysis

have clearly established that the increase in the number of measles cases in a given year is not occurring "*because parents choose to ignore decades of scientific research and delay or forego lifesaving vaccinations for their children*".

"Whooping Cough" Disease and "Pertussis" Vaccine Realities

First of all, the childhood disease is "whooping cough", which can be clinically diagnosed after an infection by *Bordetella pertussis* (*B. pertussis*), *Bordetella parapertussis*, *Bordetella holmesii*, and other organisms.

Strictly, "pertussis" refers to both: **a)** a case of "whooping cough" caused by *B. pertussis* and **b)** vaccine components that are intended to only induce antibody protection against an infection by *B. pertussis* in most of those who are "fully inoculated"[22] with a vaccine containing a "pertussis" component[23].

For the recent outbreaks of "whooping cough" that were labeled "epidemics" in California in 2010 or in Washington state in 2011, even Dr. Anne Schuchat, CDC director of the National Center for Immunization, has admitted in 2012 that parental vaccination resistance is not the reason for the current jump in "whooping cough" cases[24].

Obviously, the problem with current outbreaks of "whooping cough" is that inoculation with the "pertussis"-component-containing vaccines does not protect those inoculated from contracting clinical cases of "whooping cough".

Further, this reviewer has recently completed another review[25], in which he clearly established that:

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[22] In this review and generally, the terms "fully inoculated" and "fully vaccinated" mean that these persons were at least up to date as far as the mandated doses of the vaccine or vaccines in question.

[23] In reality the protection is only provided in about 70% to 80% of those so inoculated and that protection tends to decline such that adequate protection in those who are protected is only assured for 3 years and, after about 12 years following the last "pertussis"-component-containing vaccine dose, the "pertussis"-related antibody protection is generally no longer reliably detectable.

[24] See the transcript of a June 19, 2012 briefing titled, "Pertussis Epidemic in Washington State- 2012 Telebriefing", that is posted at http://www.cdc.gov/media/releases/2012/t0719_pertussis_epidemic.html. In response to a question by "**ELIZABETH WEISE**" who asked (emphasis added), "Hi, thanks for taking my question. You say the rates of illness are going up. You say they are cyclical. Is this part of the cycle or is it related to efforts by some to encourage people not to be vaccinated?", Dr. Anne Schuchat, CDC director of the National Center for Immunization, stated (emphasis added), "Yes, thank you for that question. We think there are many things going on. Pertussis is a cyclical disease and the vaccines are not perfect. So even with increasing vaccination coverage, we expect to still have cycles. We think there are some unusual epidemiologic features that have caused us to launch a more detailed investigation in Washington State. Waning of immunity or a weakening of the time or waning of protection over time may be part of the story that we're seeing. On the other hand, we know that people who are not vaccinated have about an eight times higher risk of disease than people who are vaccinated. We know there are places around the country where there are large numbers of people who aren't vaccinated. However, we don't think those exemptors are driving this current wave. We think it is a bad thing that people aren't getting vaccinated or exempting, but we cannot blame this wave on that phenomenon. Next question."

[25] See http://dr-king.com/docs/120806_PGKDrftRevu_Anti_vaccineMovementCausesTheWorstWhoopingCoughEpidemicIn70Yrs_fnlr2b.pdf, where the 2012 data was that available in mid-July of 2012. This review clearly established that the current outbreaks are related to the numerous problems with having a vaccine component that: **a)** never provided any protection from the minor disease organisms (*Bordetella parapertussis*, *Bordetella*

a. Inoculating developing children with the "pertussis"-containing vaccines does not provide adequate protection against "whooping cough" disease to even those who are fully vaccinated against "pertussis" and

b. Even the current DTaP vaccination program for infants may be causing higher death rates than were reported in the 1940s for "whooping cough" — before the widespread use of "pertussis"-containing serums and vaccines and "penicillin" antibiotics.

In addition, for a variety of proven reasons, the current "pertussis"-containing vaccines are the "cause" of the current case-incidence increases seen in recent years in various states in the USA (e.g., the designated "poster child" states, California in 2010 in and, in August of 2012, Washington state [with a case incidence of "49.2" per 100,000][26].

Moreover, the comments of the writer of the article being reviewed,

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holmesii, *Mycoplasma pneumoniae*, *Chlamydophila pneumoniae*, and in young children, RSV [respiratory syncytial virus] and adenoviruses) that have the ability to infect the developing child respiratory system in manner that may generate the symptoms used to diagnose "whooping cough", **b)** never provided long-term protection to the organism for which it is supposed to provide protection (*B. pertussis*), **c)** creates silent "pertussis" carriers who actively spread "pertussis" in some percentage of those who are vaccinated with it; **d)** causes the targeted organism, "pertussis", genetically adapt to evade the growth-interfering effects of the vaccine, and **e)** is highly toxic to those inoculated with vaccines containing a "pertussis" component to the point that on an incidence bases, more than an order to two orders of magnitude higher levels of "pertussis"-associated sudden deaths that die from "whooping cough" and may be causing deaths at a higher incidence rate than the "whooping cough" death incidence rate in the 1940s before there was widespread use of either the "penicillin"-type antibiotics or a DPT vaccine.

[26] The Establishment apparently choose to use Washington state as its 2012 'poster child' for "whooping cough" cases because of the recent conflict over conscientious exemptions from vaccination. That this is a reality can be seen in its decision to choose Washington state as its 'poster child' for "whooping cough" even though the reported "whooping cough" incidence rate in Wisconsin through 11 August 2012, where there is currently no vaccination exemption controversy, was 37-plus % higher ["67.5" per 100,000] than Washington state's "49.2" "whooping cough" incidence rate (see http://www.cdc.gov/pertussis/outbreaks.html#trends, visited 23 Aug 2012):

States with incidence of pertussis the same or higher than the national incidence (as of August 11, 2012), which is 7.36/100,000 persons [and the 2011-2012 CDC-reported % Coverage for 3–5 DTaP/DT Doses Required for Entering Kindergarten – DTaP Except in PA, where DT**]

State	Rate	% Coverage	State	Rate	% Coverage	State	Rate	% Coverage
Wisconsin	67.5	87.7 (4 doses)	Utah	22.7	97.7 (4 doses)	New York State	10.2	97.9 (3 doses)
Washington	49.2	90.9 (5 doses)	New Mexico	17.1	96.9 (4doses)	Kansas	9.4	88.0 (5 doses)
Montana	39.5	94.8 (4 doses)	Oregon	16.3	93.7 (5 doses)	Pennsylvania	9.2	91.1 (4 DT doses)
Minnesota	38.4*	95.5 (5 doses)	North Dakota	15.9	91.2 (4 doses)	Missouri	8.9	97.1 (4 doses)
Iowa	31.4	91.1 (4 doses)	Alaska	12.5	96.0 (4 doses)	Illinois	8.2	96.4 (4 doses)
Vermont	31.3	92.7 (4 doses)	Colorado	10.5	85.5 (4 doses)	Idaho	8.0	89.0 (5 doses)
Maine	25.9	96.6 (4 doses)	Arizona	10.3	94.9 (4 doses)	New Hampshire	7.4	Not reported to CDC

* Minnesota pertussis cases have not yet been reported through NNDSS and are not included in MMWR pertussis counts for 2012 (data accessed from Minnesota Department of Health web site

** See Vaccination Coverage Among Children in Kindergarten — United States, 2011–12 School Year. *MMWR* 2012 Aug 24: 61(33): 647-652 Last visited in 26 Aug 2012.

For some unstated reason, Wisconsin's 37-plus-percent higher incidence rate for "whooping cough" cases is being ignored. If Wisconsin had been made the 2012 "poster child" for the "whooping cough" epidemic instead of Washington state, perhaps an in-depth review of the deficiencies in Wisconsin's estimation of vaccination coverage and/or exemption rates would have more clearly established that the problems are with the "pertussis"-containing vaccines and not with the level of parental choice to "opt out" from inoculation with these "pertussis"-containing vaccines. Finally, Pennsylvania's "no Kindergarten mandate for any DTaP vaccine" would have shown that a state with no mandate for the "DTaP"-containing vaccines also has a low incidence of "whooping cough".

> "*According to some public health estimates, in parts of the United States, 'vaccination rates have dropped so low that occurrences of some children's diseases are approaching pre-vaccine levels for the first time ever,' as Amy Wallace put it in a 2009 article. Minnesota's Department of Health has reported more than 1,000 cases of pertussis (whooping cough) since Jan. 1, double the total number of cases reported during 2011.*"

only serve to confirm the reality that the problem is with the vaccine because:

a. Minnesota's August-2012 whooping-cough incidence rate (now "38.4" per 100,000) is still about 22 % lower than Washington state's as well as 43-plus-percent lower than Wisconsin's, and

b. *Contrary to the writer's assertions*, the most-recently-published inoculation coverage level for the "pertussis"-containing ("DTaP") vaccines in the state of Minnesota (nominally, 87.5% for four [4] or more DTaP doses in children 19-35 months of age) exceeded the national average (84.4)[27] and, *for those states reporting coverage levels for 2011-12 Kindergarten entry*[28], Minnesota's level for 5 doses of a "DTaP"-containing vaccine ("95.5"%) was higher than the national "*Median*" ("*95.2*"%) for the mandated 3 to 5 DTaP doses or, in Pennsylvania, 4 DT doses.

Further, the writer's unreferenced assertion,

> "*Pertussis has made a comeback in the United States, especially among unvaccinated children who, according to health officials, are 23 times more likely than those vaccinated to contract this sometimes fatal bacterial infection.*"

is at odds with the July 19, 2012 statement made by Dr. Anne Schuchat, CDC director of the National Center for Immunization (<u>see</u> footnote "**24**"),

> "On the other hand, we know that people who are not vaccinated have about an eight times higher risk of" [whooping cough] "disease than people who are vaccinated".

Further, if the pertussis-component-containing vaccines were truly effective in preventing "whooping cough" cases and providing long-term protection, then, the risk for unvaccinated children and adults should be essentially 'infinite' because there would be virtually <u>no</u> ("0") cases of whooping cough in the writer's unreferenced "*those vaccinated*" and Schuchat's "*people who are vaccinated*" groups.

In addition, apparently since 2002[29], *if <u>not</u> earlier*, and clearly in the 2012 "whooping cough epidemic" in Washington state[30], at least 75% of the confirmed childhood cases of "whooping cough" in those 3 months to 19 years of age in Washington state have occurred in those who were fully vaccinated.

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[27] http://www.health.state.mn.us/divs/idepc/immunize/stats/coverdata.html, last visited on 15 August 2012.

[28] Vaccination Coverage Among Children in Kindergarten — United States, 2011–12 School Year. ***MMWR*** 2012 Aug 24; **61**(33): 647-652.

[29] Hanson MP, Kwan-Gett TS, Baer A, Rietberg K, Ohrt M, Duchin JS. Infant pertussis epidemiology and implications for tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccination: King County, Washington, 2002 through 2007. ***Arch Pediatr Adolesc Med*** 2011 Jul ; **165**(7): 647-652.

[30] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6128a1.htm, a 20 July 2012 ***MMWR*** 2012 Jul 20; **61**(28): 517-522 article which is titled, "**Pertussis Epidemic — Washington, 2012**" (last visited on 26 July 2012) and which, among other things, states:

> "Valid vaccination history was available for 1,829 of 2,006 (91.2%) patients aged 3 months–19 years. Overall, 758 of 1,000 (75.8%) patients aged 3 months–10 years were up-to-date with the childhood diphtheria and tetanus toxoids and acellular pertussis (DTaP) doses."

Based on the preceding facts, obviously, the reader should ignore the original article's misleading and inaccurate statements.

Finally, in the passage being reviewed, the writer's closing remark concerning "whooping cough"/"pertussis" cases in California "*last year*" [2011] (with emphasis added),

> "*In 2010, California officials declared whooping cough an 'epidemic' as they dealt with the worst outbreak in 60 years, including 10 deaths. After waging an intensive vaccination campaign, last year California public health officials reported no cases of pertussis.*"

is simply false.

Factually, the California "Pertussis" reports for 2011[31] ("*last year*"), including the one dated "November 11, 2011", which, among other things, stated (with emphasis added),

> "**2011: 2,734 cases with onset in 2011** have been reported to CDPH" [California Department of Public Health] ". The state rate is **6.9 cases/100,000**."[32]

proves that there were > 2,700 reported "pertussis" cases in California in 2011.

"Prophylactic Inoculation" — Disinformation versus Fact

"Why are parents ignoring scientific evidence and allowing their children to go unvaccinated?"

Here, the writer, Annette Meeks, "*CEO of the Freedom Foundation of Minnesota*", has asked an obvious disinformative question, which must be addressing parents and their children who live in some alternate universe.

Clearly, those parents who have studied the actual scientific evidence about the disease, "whooping cough", and the "pertussis-component-containing vaccines" understand that these vaccines are not effective in protecting their children from getting "whooping cough" and may present a significant adverse health risk to their children (see the article in footnote "**25**"; especially, its review pages numbered "25" through "28" [file pages 27 – 30]).

Then, based on that understanding, the parents are affirmatively declining to inoculate their children with vaccines that are not effective in preventing their child from contracting "whooping cough": **a)** because the theoretical short-lived "protection" benefits their child may receive do not outweigh the very real risk of serious harm, including death and permanent disability, to their children **or b)** because their personal religious beliefs, *for example*, simply preclude the intentional pollution of their children's blood with unclean or poisonous substances.

Moreover, **a)** having studied the successful treatment of "whooping cough" in the pre-vaccine era with supplementary vitamin C dosing **and b)** understanding that those with a 25-hydroxy vitamin D blood level above 55 nanograms (ng) of 25-hydroxy-vitamin-D per milliliter (ml) of blood (138 nanomoles [nm] per liter

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[31] See http://www.cdph.ca.gov/programs/immunize/Pages/PertussisSummaryReports.aspx.

[32] See http://www.cdph.ca.gov/programs/immunize/Documents/PertussisReport2011-11-10.pdf that states (emphasis added),

> "Pertussis Report
> November 10, 2011
> **New in this report:** While disease activity in 2011 is still at relatively increased levels throughout the state, the number of new cases reported in recent months has declined.
> **2011: 2,734 cases with onset in 2011** have been reported to CDPH. The state rate is **6.9 cases/100,000**."

[I]) produce their own antibiotic polypeptides in the area of the body that has an infection, these parents know to appropriately supplement their sick child's diet with increased doses of vitamin C and vitamin D-3 whenever their children have a respiratory or other infection (see the article in footnote "**25**"; especially, the text and footnotes in the pages numbered "3" through "5" [file pages 5 – 7]).

Based on the available studies, we know that giving higher doses of these supplements leads to a milder, shorter case of "whooping cough" with no serious complications and, after recovery, *when the disease-causing organism is identified as a Bordetella species*, conservatively, a 10- to 50- year period of protection from re-infection by any of the *Bordetella species* that infect humans[33].

"Some families raise concerns with their pediatricians about the Centers for Disease Control's (CDC) suggested schedule of immunizations. The perceived rapid succession of immunizations that begins at birth frightens some parents who fear their children's developing immune system will be "overwhelmed." This grass-roots parental movement to alter the CDC's recommended schedule has caught fire in recent years as it has spread via the Internet and social media."

Given:

- The 2012, on-line, peer-reviewed article by Goldman GS and Miller NZ in the journal ***Human & Experimental Toxicology***[34], "Relative trends in hospitalizations and mortality among infants by the number of vaccine doses and age, based on the Vaccine Adverse Event Reporting System (VAERS), 1990-2010";
- The fact that postponing the start of the DTP vaccination series by as little as two (2) months significantly reduced those infants' subsequent risk of developing asthma[35]; and
- The finding that vaccination before children are 2 years of age carries with it increased risks for their developing chronic diseases[36],

there is a growing body of evidence that the parents' concerns are supported by the little sound science published about such inoculation issues.

Based on articles such as the ones cited by this reviewer and the fact that several of the vaccines or vaccine-components in the current CDC "*suggested schedule of immunizations*" have been shown to be ineffective (e.g., the "pertussis"-component vaccines) and/or not cost effective (e.g., the "varicella" vaccines[37]), the CDC's recommended disease-preventive inoculation schedule is not based on scientifically sound immunological, epidemiological and/or fiscal studies.

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[33] Wearing HJ, Rohini P. Estimating the Duration of Pertussis Immunity Using Epidemiological Sciences. ***PLoS Pathol***. 2009 Oct: **5**(10): e1000647 (11pgs).

[34] Goldman GS, Miller NZ. Relative trends in hospitalizations and mortality among infants by the number of vaccine doses and age, based on the Vaccine Adverse Event Reporting System (VAERS), 1990-2010. ***Hum Exp Toxicol***. 2012 Apr 24. [Epub ahead of print]

[35] McDonald KL, Huq SI, Lix LM, Becker AB, Kozyrskyj AL. Delay in diphtheria, pertussis, tetanus vaccination is associated with a reduced risk of childhood asthma. ***J Allergy Clinical Immunol*** 2008; **121**: 626-631.

[36] http://www.ecomed.org.uk/wp-content/uploads/2011/09/2-halvorsen.pdf, last visited on 25 July 2011:

[37] Goldman GS, King PG. Review of the United States universal varicella vaccination program: Herpes zoster incidence rates, cost-effectiveness, and vaccine efficacy based primarily on the Antelope Valley Varicella Active Surveillance Project data. ***Vaccine*** 2012 May 31.

"Parents who go online to research the safety and efficacy of innoculation [sic; inoculation] will also encounter myriad myths, half-truths and outright lies about vaccine safety."

Here, this reviewer must agree that those who search online about any aspect (e.g., the safety, efficacy, effectiveness, cost effectiveness, risks, and the duration of protection) of the CDC's current recommended prophylactic inoculation programs and the FDA's approved vaccines that are available in the USA probably will "*encounter myriad myths, half-truths and outright lies about vaccine safety*".

Unfortunately, many, ***if not most***, of these "*myriad myths, half-truths and outright lies about vaccine safety*" will be found on Internet web sites maintained by the CDC, FDA, the vaccine makers, pro-vaccine organizations and vaccine-maker front groups.

In addition, these same sites will also contain "*myriad myths, half-truths and outright lies about*" vaccine efficacy, in-use vaccine effectiveness, the cost effectiveness of the current vaccination dosing and timing program for each vaccine, vaccination risks, and the duration of each vaccine's protection for each of its active components when the vaccine is given separately or with some combination of the possible combinations of other vaccines that are permitted to be given at the same time.

For some measure of the preceding realities, this reviewer could, at one time, rely on the information supplied in a vaccine's "package insert" ("leaflet") as a sound starting point for learning about the specific composition of each vaccine's dose and the vaccine's safety.

However, with the non-science-based decision to allow other than a "true placebo"[38] to be used as a "placebo" in vaccine safety studies, this reviewer can no longer rely on much, *if not all*, of the safety study information provided.

In addition, since there are usually no carcinogenicity, mutagenicity, teratogenicity and reproductive toxicity studies nor are there NOAELs (no-observed-adverse-effect-level) studies in the vaccine or reconstituted vaccine matrices to prove that each component in the vaccine formulation is safe, the requisite scientific proofs of safety for these factors clearly are not provided.

Given:

a. The use of antibody titers without proof of there being a direct connection between the observed antibody levels and the protection provided by the vaccine from the disease,

b. The substitution of animal antisera for human antisera for the measurement of the "antibody level" (titer [titre]), and

c. The reliance of the FDA scientists on the test methods used by and the results submitted by the vaccine's producers,

the purported proofs of efficacy of each "vaccine component" active are, at best, favorably biased and, at worst, apparently knowingly fraudulent[39].

Worse, the in-use effectiveness in preventing disease for each disease-preventive component in each vaccine is not determined using direct natural dis-

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[38] In science, for injected biological drug products, a "true placebo" is a sterile, pH-balanced isotonic saline solution (with or without a small amount of glucose matching the mass of the actives added) that, when injected, produces no adverse injection-related effects other than a slight reddening and transient pain at the injection site.

[39] http://www.courthousenews.com/2012/06/27/47851.htm, "**Class Says Merck Lied About Mumps Vaccine** By REUBEN KRAMER"

ease-agent exposure in an appropriate group of appropriately inoculated volunteer subjects or, *failing that*, direct natural disease-agent exposure in an appropriate animal model system that faithfully tracks human disease resistance.

Finally, though most cost-effectiveness studies are:

- Incomplete (e.g., the costs of the adverse events are not properly considered),
- Optimistic in their assumptions (e.g., a single dose will provide 'lifetime immunity'), and
- Less than appropriately influenced, conducted, and/or sponsored by those seeking vaccine approval,

after receiving FDA approval and the CDC's recommendation for population-wide use, the vaccine makers are still allowed to price their vaccine at levels that significantly exceed the "per dose" costs used to justify the vaccine's approval.

The result is that most all of today's vaccines lack scientifically sound and appropriate data on safety, efficacy, effectiveness, cost-effectiveness and/or chronic-disease risk.

Against this background, it is obvious that the parents' and the independent researchers' concerns have arisen because the vaccine makers have failed to conduct the requisite studies, and the regulatory agencies, which oversee vaccine licensing and the licensed vaccine's usage recommendations, continue to approve such vaccines even though such approvals violate the applicable vaccine statues and laws (regulations) (i.e., the FDA and the Secretary of the Department of Health and Safety [DHHS]) and to make recommendations for their use (i.e., the CDC) knowing that all the requisite scientifically sound and appropriate safety, effectiveness and/or cost-effectiveness studies have not been conducted.

Intent on masking the preceding approval deficiencies, the vaccine makers and the FDA have colluded to reduce the amount of information about the detailed composition of each vaccine dose that is provided to the public, where, for example, the labeling (package insert [leaflet]) in the USA is supposed to provide the full name of the exact components in each dose and, *except for water and the components used to adjust pH or ionic strength*, the nominal amount of each component in the injected dose.

In recent instances, the presence of potentially dangerous DNA fragments was concealed in both the rotavirus vaccines and the HPV (human papilloma virus) vaccines.

This concealment of vaccine-dose composition information has escalated to the point that, *for Novartis' recently approved MenVeo® meningococcal meningitis vaccine*, the package insert only provides the names and amounts for the active antigens and the amount of residual formaldehyde in each dose.

The specific names, and amounts, of each of the other components are concealed behind a "trade secret" façade that clearly violates the legally binding labeling requirements for injected vaccines (which are parenteral drugs) as set forth in 21 C.F.R. 201.100 Prescription drugs for human use.

Given all of the preceding realities, this reviewer is surprised that, relatively speaking, more parents are not "opting out".

"Measles Outbreak" – Blame Those Who Seek Safer Vaccines?

Blame A Non-existent Group and Twist the Historical Records

"It has been nearly two decades since Hollywood and television personalities, with the help of a since-discredited British physician, began scaring parents into bypassing immunizations altogether -- especially the measles, mumps and rubella (MMR) vaccine -- by spreading misinformation about a perceived link between autism and vaccines. What began as the autism movement's campaign against a vaccination preservative has morphed into a vicious and destructive campaign against vaccines."

First, in 1994 or 1995, which would be the time frame for a valid "*nearly two decades since*" claim, neither "*Hollywood and television personalities*" nor "*a since-discredited British physician*" "*began scaring parents into bypassing immunizations altogether*".

As far as this reviewer can tell, "*Hollywood and television personalities*" were not involved in the "*autism and vaccines*" issues until after the start of the 21st century and not openly involved until 2005 (7 years ago), when Jenny McCarthy began speaking her mind about her son's case.

Further, in 1998 (14 years ago), Dr. Andrew Wakefield, the obvious "*since-discredited British physician*" about whom the writer is speaking, recommended that the single measles, mumps and rubella vaccines – then available in the UK – be given instead of the UK-available combined MMR vaccines.

Wakefield made this recommendation because his research into the safety studies for the combination MMR vaccines had found that there were no studies showing that the combination MMR vaccines were safe – a fact that no one seems to be disputing.

Further, in the UK, in 1998, the parents of children who had severe bowel disease and in some instances also had a diagnosis of "autism" – not Dr. Wakefield – had linked their children's severe bowel disease to the MMR inoculation that their children had received just before these parents had noticed the beginnings of their children's symptoms of severe bowel disease.

Ironically, it was media reporters and a few parents– not Dr. Wakefield – who linked the MMR vaccine to "autism" (technically, to the children's diagnoses for pervasive developmental disorders [PDDs], including "autistic disorder").

Thus, in the late 1990s, it was a media reporter and a few parents– not Dr. Wakefield – who, if anyone, were apparently "*spreading misinformation about a perceived link between autism and vaccines*".

Therefore, *at a minimum*, the writer of the article being reviewed is clearly guilty of being a party to the blatant attempt to distort and rewrite the history concerning the probable causal linkage between the MMR vaccine and instances of severe bowel disease in certain UK children.

Not content to 'rest on her revisionist laurels', the writer next changes the target of her concern about "*autism*" and proclaims,

> "*What began as the autism movement's campaign against a vaccination preservative has morphed into a vicious and destructive campaign against vaccines*",

which introduces a fabricated "*autism movement's campaign against a vaccination preservative*".

In fact, the actual movement in the USA, and elsewhere, is the cooperative

action of groups who, based on safety concerns, are seeking to ban all use of mercury and its compounds, including the highly toxic, human reproductive toxicant, carcinogen, mutagen, teratogen and immune-system disruptor, sodium ethylmercurithiosalicylate (commonly known by its trade names, Thimerosal, Thiomersal, Timerosal, Tiomersal and, *in the early literature*, Merthiolate), in medicine.

In dentistry, this coalition also seeks to ban all use of the mercury-containing metal alloys (amalgams) in dental cavity repair.

This coalition is seeking these bans because these are the principal iatrogenic mercury sources that have been proven to be linked to central and peripheral degenerative neurological disorders including causally linked post-exposure instances of the neurodevelopmental and other medical conditions, including, but not limited to:

- The autism spectrum disorders, attention-deficit hyperactivity disorder (ADHD), tics, and language delay in developing children;
- Alzheimer's disease and other dementias in adult humans;
- Causally linked post-mercury-exposure peripheral neuropathies that slowly develop; and
- The chronic proximal-tubule kidney disease to which any type of repeated or chronic mercury exposure contributes in addition to
- Other chronic medical conditions in which mercury exposure has been shown to be a causal factor.

As a founding director, current Secretary for, Science Advisor to, and long-time member of, one of these organizations, this reviewer can reassure the writer that this "coalition to stop the use of mercury in medicine and dentistry" is still focused on pressuring the United Nations, all individual nations, and the regulators and manufacturers of vaccines to stop using Thimerosal as a preservative in vaccines.

Moreover, one of this "coalition's" arguments for Thimerosal's removal from medicine is that removing it from the vaccines recommended for use in children and pregnant women in a given country would help to restore the public's eroding support for that country's current vaccination programs.

Further, while this reviewer is strongly opposed to the mass use of vaccines that lack:

a. The requisite scientifically sound and appropriate proofs of safety,

b. Proof of the vaccine's in-use long-term effectiveness in preventing a disease in those who are fully vaccinated against that disease and/or

c. Verification of the vaccine's cost effectiveness for mass use in a given country,

he supports the use of vaccines that have been properly proven, in scientifically sound and appropriate safety studies using only a "true placebo" as the control for comparison, to be reasonably safe and, in appropriate efficacy and challenge studies, long-term in-use effective in preventing those inoculated from contracting and/or spreading the disease(s), which the vaccines are claimed to prevent.

Finally, this reviewer is a supporter of prophylactic population-wide inoculation programs that use the vaccines that meet the preceding criteria for being reasonably safe and providing long-term protection provided the recommended or mandated inoculation programs are truly cost-effective when all of the costs are appropriately considered.

Since, other than her unsupported words, Ms. Meeks provides no evidence that the coalition to eliminate mercury's use "*morphed into a vicious and destructive campaign against vaccines*", this reviewer must advise the readers of the original article to ignore this unwarranted attempt to slander the good names of those who are opposed to any use of mercury in medicine and dentistry because of the proven toxicities of Thimerosal and dental amalgam filings.

A Measles Outbreak — The Writer's Distortions and Factual Reality

"This campaign of fear has had real consequences. In 2011, Minnesota had the largest measles outbreak in the nation, with 23 children infected and 14 hospitalized. Those 23 measles cases were more than had been reported during the previous 14 years combined.

Based on the population demographics of Minnesota[40] and the reported information that for the 23 individuals with a confirmed non-vaccine-related measles infection: **a)** 7 of the 23 were *not more than* 1 year of age, **b)** 11 of the 23 were between 1 and *not more than* 4 years of age, **c)** 1 was 11 years of age, **d)** 4 were 27 to *not more than* 51 years of age, **e)** the 27-year-old had received 2 doses of the MMR vaccine, and **f)** there were four (4) returning-traveler source cases (2 of which did not infect anyone else; 1 of which only infected 1 other person; and 1 of which was directly and indirectly the source case (case "0") for 18 others in the mostly Somali areas of the Minneapolis-Saint Paul community[41], these 23 cases plus the three other reported Minnesota "wild" measles cases in 2011 collectively translate into an incidence rate in Minnesota of 26 cases per 5,344,861 people or about 1 case per 205,600 – or 0.0005% of Minnesota's population – meaning that about 99.99995% of Minnesotans did not have a "wild" case of measles in 2011.

Further, "Case 15", that of a 27 year-old returning traveler who had had 2 doses of the MMR vaccine, indicates that even 2 doses of the measles component in the combination MMR vaccine does not appear to be fully protective against subsequent measles exposures in a foreign country in which measles commonly occurs.

Examining the recent vaccination uptake/coverage records for MMR in children 18 to 35 months of age, Minnesota has a 92.7% coverage level for the

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[40] http://quickfacts.census.gov/qfd/states/27000.html,

People QuickFacts	Minnesota	USA
Population, 2011 estimate	5,344,861	311,591,917
Persons under 5 years, percent, 2011	6.6%	6.5%
Persons under 18 years, percent, 2011	23.9%	23.7%
Persons 65 years and over, percent, 2011	13.1%	13.3%

[41] http://www.conferences.und.edu/immunization/documents/Gahr-MeaslesinMinnesota.pdf, last visited on 16 August 2012, including the chart on the last page.

state-mandated MMR vaccination in 2010 when the average coverage level for the USA was only 91.5%[42] — indicating that Minnesota state had a coverage level that was higher than at least 25 states in the USA although the coverage level for Minneapolis' Somali residents was somewhat lower.

By contrast, in France[43] where, in 2010, the MMR vaccination coverage level for 1 dose of MMR exceeded 93% and the second dose's coverage level was slightly less than 75% and increasing, there were 15,206 confirmed measles cases in 2011[44] in a population of about 65 million[45] — an incidence level of about 1 measles case per 4 300 French residents — or about 0.023%, a percentage that is more than 45 times higher than the USA incidence percentage in the same year – but 99.977% of the French residents did <u>not</u> get measles in 2011.

Thus, in 2011, France had comparatively serious measles disease outbreak while the USA experienced only "222" cases of measles, and Minnesota happened to be the state that had the most reported cases in 2011.

In 2012, the CDC's "Traveler's Health Outbreak Notice" (<u>see</u> footnote "**44**") for the first part of the year reports, "As of May 23, 2012, in France, 358 cases of measles have been reported in 2012", which indicate that the cases of measles reported there in 2012 will probably be less than 1,000 or more than 15 times lower than the number of cases reported in 2011 and 5 times lower than the number of cases reported in 2010.

These findings show that, in France, most of those who could easily be infected by measles probably were infected in the period from 2009 – 2011.

Based on the available information, it seems that the major differences in the magnitude of the peak in the cyclical ebb and flow of the measles cases in the USA and France is probably the difference in the level of infected "travelers" from other countries that entered the two countries in the 2009-through-2011 period and <u>not</u> the level of vaccine uptake per se.

This is the case because, *even in Minnesota*, one of the 23 Minnesota cases in the outbreak upon which the writer focused, "Case 15", indicates that even two (2) doses of the MMR vaccine does <u>not</u> fully protect all inoculees from contracting a clinical case of measles when some are exposed to (or, as we shall see, inoculated with) the "measles" virus.

"According to the Minnesota Department of Health, as of January 2011, only 58.1 percent of Minnesota children aged 24 to 35 months had received the full recommended vaccine series. Dangerously low vaccine coverage is not limited to any geographic region of the state. By the time these children enter school, parents of more than one in 20 public schoolchildren are seeking exemptions from some shots."

Here the writer again duplicitously focuses on the "*full recommended vaccine series*", by which, given <u>no</u> cited reference, she meant either the CDC's or

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[42] http://www.health.state.mn.us/divs/idepc/immunize/stats/coverdata.html, last visited in 16 August 2012.

[43] See http://www.measlesinitiative.org/mi-files/Tools/Presentations/Annual%20Measles%20Partners%20Meeting%202010/Situation%20of%20Measles%20in%20France.ppt.

[44] http://wwwnc.cdc.gov/travel/notices/outbreak-notice/measles.htm, where the information provided by the CDC was last updated on 25 June 2012 (emphasis added), "As of May 23, 2012, in France, 358 cases of measles have been reported in 2012. <u>There were 15,206 cases reported in France in 2011</u>" (as compared to "222" measles cases in the USA in 2011).

[45] http://www.indexmundi.com/france/demographics_profile.html, after appropriately reducing the mid-2012 population estimate.

Minnesota's vaccination recommendations in 2011, and not, *as she should have*, the mandated vaccination schedule for "*Minnesota children aged 24 to 36 months*"[46].

After reviewing the Minnesota vaccination mandates, where, *at most*, 4 DTap doses, 3 Polio doses, 1 MMR dose, 1 Hib dose and 1 varicella dose are required for a child under 3 years of age in "Preschool", *as opposed to the CDC's recommendation for 4 DTaP doses, 3 Polio doses, 1 MMR dose, 3 or 4 Hib doses, 1 varicella dose, and 3 Hepatitis B doses, 4 Pneumoccal (PCV) doses, 2 or 3 Rotavirus doses, 1 to 2 Hepatitis A doses* and *4 or 5 Influenza doses*, this reviewer finds that the writer's "*only 58.1 percent*" is knowingly misleading because it improperly includes CDC and/or Minnesota recommended vaccines and vaccine doses for children in this age group that are not even mandated by the State of Minnesota for "Preschool" attendance.

Based on the coverage reported for the Minnesota-required vaccines and vaccine doses[47], it appears that coverage for the state-mandated vaccines and

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[46] http://www.educationminnesota.org/en/community/mnschools/immunizations.aspx, which reads (emphasis added),

"Required immunizations

The chart below, from the Minnesota Department of Health Immunization Program, will help you determine whether your child has had the necessary shots to attend school.

To find the number of shots your child needs, find your child's age or grade level for this fall and read across the table. Read each row separately. (Don't add up the totals for each column.) Note that because of changing requirements, the number of shots differ for the various rows. Read only the row for your child's current age/grade level.

To attend school, Minnesota students must show they've had the shots below or have a legal exemption filed with the school. Parents may file a medical exemption signed by a health care provider or sign and have notarized a conscientious objection.

The Health Department recommends shots for pneumococcal disease for children under 5 but the shots aren't required for school.

Note: The Minnesota Department of Health recommends that all children be protected by hepatitis B shots, not just those required by law to have them. The department also recommends that children ages 2 and up with chronic health conditions such as asthma and diabetes have a yearly influenza shot, as well as children 6 to 23 months old and anyone 23 months or older. Contact your doctor for more information.

	DTaP/Td/Tdap diphtheria, tetanus, pertussis (whooping cough)	Polio	MMR measles, mumps, rubella	Hib Haemophilus influenzae type b	Hepatitis B	Varicella* Chickenpox
Preschool	4 shots	3 shots	1 shot	at least 1 shot	0	1 shot
Kindergarten	5 shots (5th shot not needed if 4th was after age 4)	4 shots (4th not needed if 3rd was after age 4)	2 shots	0	3 shots	1 shot
Age 7 through 6th grade	at least 3 shots	at least 3 shots	1 shot	0	0	0
7th through 12th grade	at least 3 shots (and 1Td or Tdap shot required at age 11 or older**)	at least 3 shots	2 shots	0	3 shots, 7th grade only***	1 shot, 7th grade only

* Varicella shot not required if child already had chickenpox. By fall 2008, two doses will be required for all entering kindergarteners and seventh graders.

** Unless a Td (tetanus and diphtheria) was given after the 7th birthday; then it must be repeated 10 years after the last dose. Tdap (tetanus and diphtheria toxoids and acellular pertussis, for adolescents) or Td is recommended at age 11-12.

*** An alternate two-dose schedule of hepatitis B may also be used for children ages 11 through 15."

[47] http://www.health.state.mn.us/divs/idepc/immunize/stats/coverdata.html, last visited 15 August 2012 — which reported:

"Childhood Immunization Rates

Childhood Immunization Coverage in Minnesota

Current state rates from the National Immunization Survey (NIS) and the Minnesota Immunization Information Connection (MIIC). The NIS is a Centers for Disease Control and Prevention (CDC) survey and MIIC is an immunization information system operated by the Minnesota Department of Health (MDH). Updated 7/12 ...Download PDF version formatted for print: Childhood Immunization Coverage in Minnesota (PDF: 287KB/2 pages)

National Immunization Survey (NIS), CDC

Vaccination coverage among children age 19 through 35 months. 2010 data, as reported September 2011.

	Vaccination coverage among children age 19-35 months, NIS										
	DTaP	Polio	MMR	Hib	HepB	Var	PCV	Series	Series (no Hib)	Rota	HepA
MN	**87.8**	**93.7**	**92.7**	63.4	89.5	**91.1**	88.7	52.5	75.7	67.4	49.3
+/-	**5.2**	**3.6**	**4.0**	7.3	4.3	**4.1**	4.9	7.3	6.4	7.2	7.4
Nat	84.4	93.3	91.5	66.8	91.8	90.4	83.3	56.6	72.7	59.2	49.7
+/-	1.0	0.7	1.3	0.7	0.8	1.0	1.3	1.3	1.2	1.4	1.4

+/-: 95% confidence interval [**Note:** Mandated vaccines' coverage for Minnesota children 19-35 months of age: >91.3 % on average.]

vaccine doses is probably about 91% and, *based on the first table provided in the cited reference*, the Minnesota coverage percentage exceeds the national average coverage level for DTaP, Polio, MMR and Varicella.

In addition, the writer's, "*Dangerously low vaccine coverage is not limited to any geographic region of the state*", falsely portrays the status of the vaccination coverage in Minnesota because Minnesota's vaccine coverage is not "*[d]angerously low*" but, for Minnesota's mandated vaccines, apparently higher than the national average.

Further the writer's closing remark is not only intentionally misleading but also fails to note that some of this "5%" of Minnesota parents may actually be "*seeking exemptions from some shots*" that are <u>not</u> even recommended and/or <u>not</u> required by the State of Minnesota for their child to attend school.

Obviously, given the reality that the media, public officials, governmental agencies and others are purposely, *as this writer has done*, pushing the "*full recommended vaccine series*" instead of focusing, as they should, on the vaccines and vaccination doses mandated by each state, the public should be demanding that: **a)** such intentional misrepresentations be stopped and **b)** their state's laws be changed to make all vaccination a voluntary, "opt in" reality in which, like Japan, the state provides vouchers to each child at birth for those vaccines and vaccine doses that each state's public health scientists have proven to be reasonably safe, in-use effective in preventing disease, and cost effective for mass use and, in 2005, these vaccine-dose vouchers were generally valid for use until that child was 90 months (7.5 years) of age <u>except</u> for the BCG, which was valid until child was 4 years of age[48,49].

Thus, for the vaccines and vaccine doses mandated by Minnesota vaccination

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NIS Vaccine Coverage Definitions
4+ DTaP: 4 or more doses of diphtheria, tetanus, and pertussis vaccine.
3+ Polio: 3 or more doses of poliovirus vaccine.
1+ MMR: 1 or more doses of measles, mumps, and rubella vaccine.
Full Series Hib: 3+ or 4+ doses of *Haemophilus influenzae* type b vaccine, depending on product type received (primary series plus the booster dose).
3+ Hep B: 3 or more doses of hepatitis B vaccine.
1+ Varicella (chickenpox): 1 or more doses of varicella vaccine, unadjusted for history of varicella illness.
4+ PCV: 4 or more doses of pneumococcal conjugate vaccine.
Vaccine Series: receipt of all doses listed above (4+ DTaP, 3+ polio, 1+ MMR, full series Hib, 3+ hep B, 1+ varicella, and 4+ PCV).
Series (no Hib): receipt of all doses listed above, with Hib excluded (4+ DTaP, 3+ polio, 1+ MMR, 3+ hep B, 1+ varicella, and 4+ PCV).
Complete Rotavirus: 2+ or 3+ doses of rotavirus vaccine, depending on product type received.
2+ Hep A: 2 or more doses of hepatitis A vaccine.".

48 <u>See</u>, for example, http://www.scribd.com/doc/15081355/Immunization-Schedule-Japan-Vaccination-Japon for 2005.

49 This reviewer cites this Japanese "vaccination system" because, based on the health measures that were available to him after the mercury-poisoning "Minimata" incidents were resolved and before the Fukushima nuclear reactors melted down (i.e., 1980 – 2010), a higher percentage of Japanese children survived to reach their first and fifth birthdays, "SIDs" deaths were virtually non-existent and Japanese children, *even after adjusting for the differences in their caloric intakes and life styles*, were healthier, on average, than the children in the USA. Moreover, the Japanese health officials seem to genuinely place the physical health of Japan's children and the financial health of the public above the fiscal health of the pharmaceutical manufacturers and the healthcare providers.

In Japan, no vaccines are mandated, but Japan's "routine" (highly recommended and subsidized) vaccines for children under 5 years of age are the BCG vaccine for tuberculosis, and the DTaP, the Oral polio vaccine, the Japanese Encephalitis vaccine, the Measles vaccine and the Rubella vaccine or Measles-Rubella combination vaccine.

In 2011, while Japanese suggested childhood vaccination schedule's complexity has increased, all of the other vaccines licensed in Japan (for Hepatitis A, Hepatitis B, Hib, HPV, Influenza, Mumps, *S. pneumoniae* [7- or 23- valent], and Varicella [chickenpox]) are either completely voluntary or "routine" for some small population sub-group (e.g., Hepatitis antiserum and Hepatitis B vaccine for children whose mothers are infected with Hepatitis B)[<u>see</u> http://idsc.nih.go.jp/vaccine/dschedule/Imm11EN.pdf, last visited on 21 August 2011].

laws, the published vaccination coverage levels in Minnesota exceed the corresponding national coverage average levels and clearly show that, by Minnesota and US standards, vaccination coverage is not "*[d]angerously low*".

Moreover, *though the writer of this article chose to ignore this reality,* each year there are some who have a case of MMR-vaccine-associated measles from being infected by the "measles" virus in the live-virus MMR II vaccine (see pages "14" and "15" of the reference in footnote "**41**" which reported, "Vaccine-associated cases (n=10)" cases of measles in 2011).

Thus, in the years before 2011, where the writer reports,

> "*Those 23 measles cases were more than had been reported during the previous 14 years combined*",

it would seem that those who vaccinate their children with the live-virus MMR vaccine are, in a typical year before or after 2011, responsible for almost all of the cases of measles in Minnesota (where the about 10 cases of vaccine-associated measles reported in 2011 is driven by the relatively constant MMR-vaccination level in Minnesota and, on average, less than 2 cases of "wild" measles were reported each year).

Of course, these 'unnoticed' (by the mainstream media) and generally unreported (by state health officials) ten cases of MMR-vaccine-associated measles annually in Minnesota must be 'no big deal' because:

- The Establishment would rather: **1)** feed the myth that 'vaccines do not cause disease'; **2)** ignore the chronic disease epidemics for which one or more vaccines or some component or components in them are a causal factor; and **3)** not – *as required by law* – provide the factual information on the risk of MMR-vaccine-associated measles that is needed for any parent or other person to be able to make an informed-consent decision and, instead, conceal the fact that the live-virus MMR inoculations: **a)** infect all who are administered an MMR vaccine with live measles, mumps and rubella viruses and **b)** sometimes do cause some inoculated child, or a close contact of that child, to contract a clinical case of vaccine-associated measles.
- The MMR-vaccine-associated clinical measles cases – *unlike the live-virus polio-vaccine-associated "paralytic polio" cases* – may have no short-term acute adverse health effects for most all of those who have a diagnosed case of MMR-vaccine-associated measles – *given the lack of information available about such cases*.

In addition, even in 2011, the "10" vaccine-associated measles cases represented about 28% of the total of 36 measles cases – 26 wild and 10 vaccine-associated cases – reported in Minnesota.

Therefore, there is no significant vaccination-coverage problem for the MMR vaccine in Minnesota and, generally, MMR inoculation causes more cases of MMR-vaccine-associated measles each year in Minnesota than the number of wild measles cases unless – *as happened in Minnesota in 2011* – one or more the wild-measles-infected travelers escape the healthcare systems' intercept and quarantine programs and infect several others with whom they have contact and these secondary contacts spread the infection to others, as happened in 2011.

Of Beliefs, Propaganda and Other Vaccine Nonsense (Non-science)

"Ironically, some pediatricians believe the emergence of the anti-vaccine movement is due to the success of vaccines in America. People born in the latter half of the 20th century now comprise the vast majority of American parents. Most of these post-baby boom parents grew up in a world without small-pox, polio, pertussis and other once-fatal childhood diseases."

Since the writer admits that her comments are based on "belief" rather than fact, this reviewer agrees (emphasis added),

"*Ironically, some pediatricians believe the emergence of the anti-vaccine movement is due to the success of vaccines in America*".

In contrast, *as this reviewer has repeatedly established*[50], the facts are,

- There is no "*anti-vaccine movement*" per se.
- The Establishment's 'success' has been the selling of the myth of "*the success of vaccines*" to the American public by:
  - Rewriting the history of vaccination,
  - Suppressing the fundamental science that does not support the Establishment's view of vaccines and immunology,
  - Suppressing the dissemination of those science-supported publications that are at odds with vaccine mythology,
  - Attacking those scientists and medical professionals who dare to point out obvious flaws in the studies supporting a given vaccine's safety, efficacy, effectiveness and/or cost effectiveness — studies that directly or indirectly threaten the vaccine advocates' income, profits and/or stature,
  - Flooding the media and the peer-reviewed journals with Establishment-supported biased reports and fraudulent studies that support the Establishment's customer-base growth and profit-enhancement goals,
  - Downplaying and disregarding the reality that humanity has survived and, absent wars and societal breakdowns, thrived for thousands of years before the first 'successful' vaccine,
  - Ignoring the facts that improvements in sanitation, clean drinking water, hygiene, environmental quality, adequate nutrition, housing and clothing have been the principal drivers for the reductions in the incidence of diseases for which we have an FDA-approved vaccine,
  - Introducing vaccines when the disease is already waning and claiming that all of the subsequent decline in disease cases was 'caused' by the vaccine,
  - Burying the failed vaccines,

[50] See all of the applicable citation-supported articles posted on this reviewer's web site, http://dr-king.com.

- Inflating the theoretical benefits of each vaccine,
- Minimizing or concealing the risks and the magnitude (chance) of each risk associated with each vaccine,
- Replacing the scientific tenet that "plausible time-correlated events must be considered as causal unless there is sound scientific evidence that disproves a causal linkage" with their jingoistic mantra "correlation is not proof of causation", and/or
- Blatantly misrepresenting the nature, level and/or duration of the protection provided by a given vaccine.

"Dr. Paul Offit, a respected pediatrician and vaccine expert, believes that by sharing the dramatic history and devastating effects of anti-vaccine movements throughout time, we will educate families and help eradicate what he calls 'the virus of fear.'"

This reviewer does *not* dispute that:

- The writer considers Dr. Paul Offit to be "*a respected pediatrician and vaccine expert*" or
- Offit "*believes*" what the writer states he does.

In addition, this reviewer recognizes that, "*What*"[51] Offit "*calls the virus of fear*", which Offit wants to "*help eradicate*", are the truths that he and the rest of the vaccine apologists and acolytes are feverishly working to suppress.

However, as a scientist, this reviewer is compelled to reject Offit's personal beliefs and his revisionist agenda items because neither are supported by the factual historical record nor by the sound science addressing the human immune system and how its various elements have functioned for centuries to attain and maintain long-term immunity to the non-vector-borne childhood communicable diseases in the absence of any interference by a vaccine inoculation.

Reviewer's Concluding Remarks

First, this reviewer wishes to thank Annette Meeks for her article on "vaccination fears" because this reviewer's response will help some who read it to:

a. Truly recognize the unscientific, disinformative and fictional assertions that were made in Meeks' article;

b. Understand the facts about polio, the polio vaccines, and polio's 'elimination' by changing the diagnostic criteria for "polio" into the much more restrictive diagnostic criteria for paralytic polio;

c. Realize the truth that, when clinical or sub-clinical cases of a given disease are occurring anywhere in the world, then that disease has not been eradicated — , whether the cases are being 'caused' by a wild or native strain, or by a vaccine-related strain or a vaccine strain, of that disease;

d. Know the difference between the disease, "whooping cough" and one of its causative bacteria, *Bordetella pertussis*, which has led to the disease's

[51] Clearly, "*What*" Offits "*calls the virus of fear*" is the dissemination of the actual historical facts and the scientific evidence that vaccines are not the "gods" which Offit believes them to be.

inappropriately being called "pertussis" and against which the whole-cell and the acellular "pertussis"-component-containing vaccines provide, at best, limited protection;

e. Recognize: **i)** the fallacy in blaming those who seek safer vaccines for the continuing low-level of "wild" measles cases in the USA; **ii)** the distorted historical 'measles outbreak' and 'vaccine coverage' records reported by Meeks, a vaccine apologist; and **iii)** the concealed background level of MMR-vaccine-associated measles cases occurring annually in the USA; and

f. Notice: **i)** the writer's distorted, science-less, belief-driven perspective, and **ii)** the person she apparently credits for shaping her views.

Finally, this reviewer expects that the open-minded readers of this appraisal will verify the validity of this reviewer's assertions for themselves and share what they find to be valid with their friends and neighbors around the world.

End of the Reviewer's Appraisal

Acknowledgements

For contributing valuable insights and providing their personal experience-based knowledge in various areas, this reviewer thanks Mark R. Geier, MD, PhD, David A. Geier, BA, Gary S. Goldman, PhD, and the book writers, Neil Z. Miller and Walene James.

In addition, this reviewer thanks Dr. F. Edward Yazbak, MD, FAAP, Susan Kreider, MS, RN, CPC, Gary S. Goldman, PhD, and Melissa R. Troutman, MA, BS, R.T. (R)(CT), for their support, suggestions, corrections and alternative word-ings, which have helped this reviewer to finalize this assessment.

Postscript

Recent articles have continued to suggest that the DTwcP vaccines were more effective than the current DTaP vaccines.

A quick review of the literature finds that, in the UK, the DTwcP vaccines were not effective in providing long-term protection from whooping cough just as today's DTaP vaccines are not effective in providing long-term protection, and "in children living in non-deprived circumstances in Britain, the risk of pertussis vaccine during the period 1970-83 exceeded those of whooping cough"[52].

Therefore, today's *ineffective* DTaP vaccines are *no less ineffective* than the DTwcP ones were, and the DTaP vaccines are safer based on the relative number of pertussis-related-vaccine-death reports attributed to each type of vaccine in VAERS[53].

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[52] Stewart GT. Whooping cough and pertussis vaccine: a comparison of risks and benefits in Britain during the period 1968-83. ***Dev Biol Stand*** 1985; 61:395-405.

[53] In children under 1 year of age: During the 4-year period, 1997 through 2000, where 71.75 per-tussis-vaccine-related death instances were reported on average (the range was 62 – 75) in VAERS when only the "DTaP"-containing vaccines were used as compared to an earlier 4-year period, 1991 through 1994, when only the "DTwcP"-containing vaccines being administered to those under 1 year of age and, on average, 124.5 pertussis-vaccine-related death incidents were reported in VAERS (the range was 114 – 140).

For an in-depth review of the historical realities concerning the switch from DTwcP to DTaP vaccines in the USA, this reviewer suggests that those having an interest in this area should get a copy of the relevant article[54] that won the 2003 "Stanley W. Jackson Prize", which is given in recognition of the best article published in the ***Journal of the History of Medicine and Allied Sciences*** in the previous three years.

About the Writer, Annette Meeks, CEO of the Freedom Foundation of Minnesota[55,56]

From footnote "55"

"Annette Meeks

Annette Meeks is founder and CEO of the Freedom Foundation of Minnesota, an independent, non-profit, education and research organization that develops and actively advocates the principles of individual freedom, personal responsibility, economic freedom, and limited government. Prior to founding the Freedom Foundation, Meeks spent nine years at another Minnesota think tank, first as director of government affairs and public programs and the final two years as president/CEO.

Annette's previous experience was in Washington, D.C. where she was appointed by Congressman Newt Gingrich to serve as a Deputy Chief of Staff upon his historic swearing in as the 50th Speaker of the U.S. House of Representatives. Prior to serving in the speaker's office, Meeks worked with Gingrich for seven years in a variety of leadership positions in Washington, D.C. and Georgia.

Meeks has a wide range of demonstrated dynamic and creative leadership. She has served as a congressional chief of staff, managed a multi-million dollar congressional campaign, and was involved in the earliest discussions of what would eventually become known as "The Contract with America."

Meeks has assumed various leadership positions throughout Minnesota, including serving on Governor Tim Pawlenty's transition advisory committee; the Governor's Stadium Screening Committee; the Governor's Commission to End Long-Term Homelessness; and, the Board of Directors of Citizens Against Gambling Expansion.

On March 3, 2003, Governor Pawlenty appointed Annette to serve a four-year term as the Seventh District representative to the Metropolitan Council. The Minnesota Senate confirmed her appointment to this position on May 16th, 2004. In 2007, she was re-appointed by Governor Pawlenty to serve another four-year term on the Metropolitan Council. Meeks served as chair of the Council's Transportation Committee and also served on the Community Development Committee.

On April 30, 2010, Meeks received Republican endorsement at the State GOP convention to serve as their candidate for Lieutenant Governor. Her running mate was Representative Tom Emmer. The Emmer/Meeks ticket lost the November 2nd general election by less than ½ of one percent, the second closest gubernatorial election in Minnesota.

A frequent and popular public speaker throughout the state of Minnesota, she also frequently provides political commentary on local television and radio shows.

She is married to Jack Meeks, CEO of The Walker Group," "Inc [a private telemarketing firm]". They live in downtown Minneapolis.

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[54] Geier DA, Geier MR. The true story of pertussis vaccination: a sordid legacy? ***J Hist Med Allied Sci*** 2002 Jul; **57**(3): 249-284.

[55] Taken from http://freedomfoundationofminnesota.com/annette-meeks on 17 August 2012.

[56] Taken from Wikippedia (http://en.wikipedia.org/wiki/Annette_Meeks), "3 July 2012 at 20:36", on 17 August 2012.

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From footnote "56"

"Annette Meeks (born April 12, 1960) is a Minnesota Republican politician, a member of the state's Metropolitan Council, and was the 2010 endorsed Republican candidate for lieutenant governor, running with gubernatorial candidate Tom Emmer.

Biography

Meeks pursued a degree at the University of Minnesota in Minneapolis, and graduated from the American Campaign Academy in Washington, D.C., an educational organization that specialized in teaching campaign tactics to members of the Republican Party.[**1**] She served as deputy chief of staff for House Speaker Newt Gingrich during his time in office. She later served as chief executive officer of the Center of the American Experiment, a conservative think tank, and as the vice chair of the Republican Party of Minnesota. She is the founder and president of the Freedom Foundation of Minnesota [**1**],[**2**]

Meeks was appointed to Minnesota's Metropolitan Council in 2003 by Governor Tim Pawlenty. She was re-appointed to a second four-year term in 2007. She serves as vice chair of the Council's Community Development and Transportation Committees, with transportation being one of her major interests.[**2**]

On April 28, 2010, state representative and gubernatorial candidate Tom Emmer named Meeks as his running mate. It was noted that she had previously argued that the position of lieutenant governor should be abolished.[**3**]

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2. "Biography of Council Member Annette Meeks, District 13". Metrocouncil.org. 2010-06-22. Archived from the original on 25 November 2010. http://www.metrocouncil.org/about/CouncilBios/MeeksBio.htm. Retrieved 2010-11-04.
3. "GOP's Emmer picks Meeks, ironies withstanding". Minnpost.com. Archived from the original on 3 November 2010. http://www.minnpost.com/dailyglean/2010/04/28/17709/gops_emmer_picks_meeks_ironies_withstanding. Retrieved 2010-11-04."

About this Reviewer, Paul G. King, PhD

In addition to the general information available on his Internet web site, http://www.dr-king.com/, Paul G. King, PhD Analytical Chemist, is the Science Advisor to, and current Secretary for, the Coalition for Mercury-Free Drugs (CoMeD, Inc., which is a 501(3)(c) not-for-profit corporation that maintains an Internet web site at http://www.mercury-freedrugs.org/).

As a scientist and student of the federal regulations and statutes that govern drugs, including vaccines, Dr. King has led CoMeD, on two (2) separate occasions, in the drafting and submission of a "Citizen Petition" seeking to have the federal government comply with the law, and, based on the improper denial of the Citizen Petition submitted, a federal lawsuit seeking to have the Federal District Court for the District of Columbia compel the Secretary of the Department of Health and Human Services (DHHS) and the Commissioner of the FDA to comply with the statutes, laws (regulations) and policies that regulate the lawful conduct of the Secretary of the DHHS, the FDA commissioner and CDC and FDA official's. The second civil suit, 1:2009-cv-00015, is still being litigated.

In addition, Dr. King has, *on several occasions*, drafted legislation for submission to the Congress of the USA as well as to the legislatures of various States, submitted cogent comments in opposition to proposed changes to federal and state regulations that are not in the public interest or appear to be at odds with the law, reviewed numerous documents, and written articles on a variety of vaccine-related and other issues.

Further, Dr. King has provided diverse groups with his analysis of various Congressional bills, resolutions and treaty documents as well as federal and state judicial proceedings.

In addition, he been an author of several papers bearing on issues related to the toxicity of Thimerosal and other compounds and, if any, their connection to a range of chronic neurodevelopmental, other developmental and behavioral abnormalities that appear to be well-above (> 1 in 10 children; asthma), above (> 1 in 100 children; the autism spectrum disorders), at (> 1 in 1000 children; non-genetic childhood type 1 diabetes), or approaching (life-threatening peanut allergy) epidemic childhood levels in the USA.

Most recently, Dr. King was the co-author of a paper in the journal ***Vaccine*** with Dr. Gary S. Goldman, which reviewed the United States universal varicella vaccination program and found that the current CDC-recommended vaccination program was neither effective in preventing those who are vaccinated from getting chickenpox nor, *since it greatly increases the public's risk of having clinical cases of shingles*, cost effective for universal use (see footnote "**37**").