

No Forced Vaccines

Statement Regarding Measles Cases

May 24, 2016

Introduction

No Forced Vaccines is an organisation that opposes forced or coercive vaccination. No Forced Vaccines members respect the absolute right of adults to make decisions about vaccination for themselves and for parents to make decisions about vaccination on behalf of their minor children.

Current Measles Cases and Government Response

There have been recent measles cases reported in a number of areas in New Zealand, including in the Waikato, Horowhenua and Northland.

The Ministry of Health is encouraging people in these areas who are unlikely to be immune to be vaccinated with two doses of the measles, mumps and rubella (MMR) vaccine. This vaccine is free to people who would like to be vaccinated and in some areas of New Zealand, special vaccination clinics have been set up to allow people who would like to be vaccinated to receive the MMR vaccine at a convenient location.

The manufacturers' datasheets for the MMR vaccines available in NZ can be found on Medsafe's website at the following link:

<http://www.medsafe.govt.nz/profs/Datasheet/DSForm.asp>

These datasheets are a useful source of information about most of the potential adverse effects of the vaccine.

Measles and Vaccination Programmes

No Forced Vaccines has been informed that "The Ministry of Health says this outbreak shows the importance of widespread vaccination, and that the virus is currently able to spread due to pockets of the population where vaccination rates are lower."

Without access to up-to-date data about whether the recently reported measles cases are occurring in people who have been vaccinated or not, it is difficult to know whether or not the Ministry of Health's assertion is correct.

Measles is generally a cyclical illness, with the virus spreading throughout the community as numbers of susceptible people increase. People born before 1969 are generally assumed to

be immune to the virus as prior to vaccination programmes, measles was regarded as a normal childhood infection like mumps and chickenpox and quarantine of people of who had developed measles was not normal practice. (In fact, some older New Zealanders will remember attending “measles parties” where they visited someone who had the measles in order to be exposed to the virus, get a dose of measles and thereafter develop lifelong immunity.)

However, while most people in developed countries who develop measles make a full recovery with no long term effects, measles is a significant cause of death for children in countries where poverty deprives children of adequate nutrition and access to medical care. Moreover some nutritionally deficient children who survive the illness may become blind. (Temporary blindness can occur during the acute phase of the measles in vitamin A deficient patients and if this deficiency is not treated corneal scarring may thereafter cause permanent blindness.)

In 2010, the World Health Organisation set a goal of reducing measles cases and deaths, and specifically reducing the “global annual measles incidence to fewer than five cases per million population.”

The WHO strategy to reduce measles incidence includes 1) increasing “routine coverage with the first dose of measles-containing vaccine (MCV1) for children aged 1 year to $\geq 90\%$ nationally” <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6444a4.htm>

In New Zealand, The Ministry of Health encourages people to have two doses of MMR vaccine. (According to the Ministry of Health, “Two doses of measles vaccine are recommended because nearly all of the 5–10 percent who fail to be protected by the first dose will be protected by the second.”)

<http://immunisation.book.health.govt.nz/11+Measles/11.5+Recommended+immunisation+schedule>

A high (95%) vaccination rate is hoped to prevent transmission of the virus and thereby prevent measles cases.

However, historically, measles transmission has occurred even in communities with very high measles vaccination rates.

<http://archinte.jamanetwork.com/article.aspx?articleid=619215>

Moreover, relying on high vaccination rates to prevent measles transmission within a community (and thereby measles cases and complications) may not work in the long term.

While immunity from a natural measles infection is almost always lifelong, the duration of protection from the MMR vaccine is not yet known. What research has been done suggests that antibody levels, and presumably resistance to the infection, wane over time.

<http://archpedi.jamanetwork.com/article.aspx?articleid=569784>

This has personal and public health significance because measles is generally more serious in adults than it is in children and some mothers who were vaccinated in childhood may not

have sufficient antibodies to pass on immunity to their babies in the first year of life. Babies under one year of age are one of the groups that are at a higher risk of developing complications from measles than are older children. (Prior to the widespread use of measles vaccines, cases of measles in babies were extremely rare because almost all mothers had had measles themselves in childhood and could pass on sufficient protective antibodies through the placenta and/or through breast milk so that their baby would not be vulnerable to this disease in his or her first year of life.)

While re-vaccination is potentially an option, for women, there is a higher risk of developing painful joints after MMR vaccination than for prepubescent children or men, and a small proportion of affected women develop chronic arthritis following the vaccination. (This risk is disclosed in the datasheet for the MMRII vaccine which may be accessed at this link: <http://www.medsafe.govt.nz/profs/Datasheet/m/MMRIinj.pdf>)

Quarantine

Quarantine of people with measles provides a means of preventing the spread of the virus through the community, provided that contacts of cases are traced early enough. (People with measles are infectious to others at the stage of the illness which may not be recognised as measles, because their predominant symptoms are “cough and cold” type symptoms, and people who have these sorts of symptoms may continue with their usual routines if they do not have a high temperature or are not otherwise feeling unwell.)

While quarantine of measles cases has the advantage of providing a way of preventing transmission of the virus, it also has a disadvantage.

The disadvantage is that by isolating people who have measles from others, people who have not yet had measles may not be exposed to the virus. An effective quarantine programme may thus have the disadvantage of increasing the number of people who lack immunity to measles because they have not been exposed to the virus and/or they decide against being vaccinated or have a medical condition that means that the vaccine is not recommended for them.

Given that measles is generally more serious in adults than in children, quarantine of people who have measles during outbreaks in order to prevent transmission of the disease may ultimately be a poor decision from a public health perspective. This is because by decreasing the opportunities for children to develop measles in childhood, such a policy could create a significant population of adults who lack immunity to measles who could become seriously ill with the disease if they developed it in adulthood. Moreover, the children of these adults may be more vulnerable to developing measles in infancy.

MMR Vaccine Ethics and Safety

While MMR vaccination is an option, a minority of parents choose not to vaccinate their children with this vaccine. Some parents who otherwise support vaccination object to the MMR vaccines because they are manufactured using abortion-derived ingredients. (WI-38 human diploid cells from an aborted foetus are used as a culture medium for the rubella viruses in MSD's MMRII while the other MMR vaccine on the NZ market, GSK's Priorix vaccine uses MRC 5 human diploid cells from an aborted foetus as the culture medium for the rubella viruses. The use of human diploid cells is disclosed on the respective products datasheets here <http://www.medsafe.govt.nz/profs/Datasheet/m/MMRllinj.pdf> and here <http://www.medsafe.govt.nz/profs/Datasheet/p/Priorixvac.pdf> on Medsafe's website although the datasheets do not mention the cells' origins.)

There is also the ongoing controversy regarding the MMR-autism link. Despite what most people are told, Dr Andrew Wakefield's initial research has been vindicated.

There is now a major new documentary about how scientists at the US Centers for Disease Control covered up research that showed an increased risk of autism after MMR vaccination for some children. The film is called *Vaxxed from Cover-up to Catastrophe*. (You can see the trailer here <https://www.youtube.com/watch?v=EdCU2DfMBpU> or find out more information about the film may be found here: www.vaxxedthemovie.com.)

Investigative journalist Sharyl Attkisson (formerly of CBS) has information about the CDC autism cover-up at this link: <https://sharylattkisson.com/cdc-scientist-we-scheduled-meeting-to-destroy-vaccine-autism-study-documents/>

New Zealand does not keep statistics on how many children have autism, so it is impossible to properly assess whether autism rates have increased here since the introduction of MMR vaccines. However, in the USA, one child in 45 now has an autism spectrum diagnosis. <https://www.autismspeaks.org/science/science-news/new-government-survey-pegs-autism-prevalence-1-45>

While MMR vaccination is not the only potential cause of autism, however, many parents have reported that their previously happy and healthy children developed autism following MMR vaccination.

The decision to use the MMR vaccine in NZ (rather than try to source a single measles-only vaccine which may be safer) appears to have been made on the assumption that MMR does not cause autism. Unfortunately, the evidence provided by whistleblower Dr. William Thompson and some papers in the medical literature [1] suggests that the belief (that MMR vaccine does not cause autism in some children) is untrue.

For most people in NZ, the risks from a natural measles infection are very low (and could be made lower if the example of the doctors who have used intravenous vitamin C to successfully treat complications of measles such as viral pneumonia and encephalitis were adopted in NZ.) [2]

A public health policy that risks causing autism (a chronic, usually lifelong condition) in an attempt to prevent a viral illness which generally lasts only a week or two and usually has no long term consequences – beyond inducing life-long immunity thereafter, could be considered to be a very poor decision by families of children who have become autistic following MMR vaccination.

[1] A few papers supporting an autism-MMR link:

<http://www.ncbi.nlm.nih.gov/pubmed/12849883>

<http://www.jpands.org/vol9no2/bradstreet.pdf>

http://www.wesupportandywakefield.com/documents/man796_802.pdf

[2] Measles is listed in *Curing the Incurable* by Thomas Levy, MD (ISBN 1-4010-6963-0) as being “Curable and Preventable” with vitamin C and includes some of Klenner’s case histories including that of an uneventful recovery of a child suffering from measles encephalitis (inflammation of the brain – which according to the NZ Ministry of Health occurs in one in 1000 people who get measles.) Prompt treatment of encephalitis, regardless of the cause is important since the condition may result in death or survivors may be brain damaged.

See also: <http://orthomolecular.org/library/jom/1999/articles/1999-v14n03-p143.shtml>