Submission to Consultation on NSW Public Health Act

Contributed by No Forced Vaccines
www.noforcedvaccines.org

Introduction:

No Forced Vaccines is a diverse group. Members include young people who have not yet had children, parents who have children of different ages (including adult children) and grandparents. Some members are parents of children whose health has been damaged by vaccination. Members have a variety of different ethnicities and professional backgrounds. A large range of health professionals are members.

No Forced Vaccines members hold a variety of opinions about vaccination; some are supportive of vaccination; some are opposed to vaccination. However, regardless of their personal opinions about vaccination, all members support the human right to choose whether or not to be vaccinated, and for parents to make decisions concerning vaccination on behalf of their minor children.

No Forced Vaccines was started in April 2011. It is a New Zealand-based group but it also includes members in other countries, notably Australia, hence this submission. (Other members are primarily in North America and Europe.)

No Forced Vaccines was formed in response to the "Report of the [New Zealand] Health [Select] Committee Inquiry into How to Improve Completion Rates of Childhood Immunisation". This report included a number of recommendations that sought to coerce parents into vaccinating their children, or forcing parents to "choose" between their child either having all recommended vaccinations or none. (The coercive policies recommended in the Report were rejected by the NZ government on the grounds that they were incompatible with human rights. See: http://www.noforcedvaccines.org/news/prime-minister-john-key-to-be-congratulated-for-support-for-parental-and-human-rights/)

Since its inception, No Forced Vaccines has contributed a submission to a NZ parliamentary inquiry into "Improving health outcomes and preventing child abuse with a focus from preconception until three years of age". (See:

http://www.noforcedvaccines.org/submissions/no-forced-vaccines-contributions-to-the-health-select-committee-inquiry/.

The submission to the NZ parliamentary inquiry is well worth reading as it includes a number of evidence-based recommendations on how vaccination programmes can be made safer as well as recommendations about how support for vaccine-injured children and their families could be improved.

No Forced Vaccines also contributed a submission on the "No Jab No Pay" law.

The No Forced Vaccines submission is number 323 on the bill and may be seen on the Australian website government website via this link:
http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/No_Jab_No_Pay/Submissions

The spokeswoman for No Forced Vaccines has also put out occasional press releases when there have been events of concern to members, such as the vaccination of minor children in NZ without their parents' consent. (Press releases are archived on No Forced Vaccines website: www.noforcedvaccines.org)

Given that No Forced Vaccines members are a diverse group (in terms of individual opinions about vaccination) this submission will not debate the merits or otherwise of vaccination, but will address the questions in the Public Health Act 2010 Statutory Review Discussion Paper that are relevant to vaccination and vaccination policy.

In addition this submission will provide information about vaccines and vaccination to assist committee members understand current concerns about vaccinations, as well as discuss ethics related to vaccination policy.

Vaccination can have serious adverse effects, including, unfortunately, reactions that can cause death or lifelong disability in some vaccine recipients. Vaccination policies therefore deserve serious consideration.

Question 1) Are the objectives of the Public Health Act valid and appropriate?
2) Should s3 include a new objective relating to monitoring by NSW Health of diseases and conditions affecting the people of NSW?

Response to Question 1:

No Forced Vaccines understands the objectives of the NSW Public Health Act to be as follows:

a) To promote, protect and improve public health, b) To control the risks to public health, c) To promote the control of infectious diseases, d) To prevent the spread of infectious diseases, e) To recognise the role of local government in protecting public health.

On the face of it, these objectives have merit.

Basic public health measures such as legal requirements for Councils to supply safe water (for drinking, bathing and washing of clothes and bedding), and to dispose of sewage responsibly are vital for public health. These measures are vital in preventing cases of many infectious diseases, especially those spread by the faecal-oral route, and when they do occur, good hygiene and sanitation to prevent further spread of these conditions.

Vaccination provides a way to attempt to control infectious diseases that are spread through droplet infection (coughs and sneezes) and fomites (infectious microbes on surfaces).

Vaccination is a medical procedure that entails the risk of adverse reactions so while this procedure can be made available for people who want to be vaccinated as part of a strategy to control some infectious diseases, the human rights of people who do not want to be vaccinated need to be respected. Likewise, the rights of parents to make vaccination decisions on behalf of their minor children should also be respected.

Question 2) Should s3 include a new objective relating to monitoring by NSW Health of diseases and conditions affecting the people of NSW?

Response to Question 2) No Forced Vaccines had very little notice of the closing date for submissions so has not yet been able to consider Question 2 but will address this question in a supplementary submission.

Question 25) Should the current provisions in the Act relating to vaccine preventable diseases be extended to apply to high schools?

The description of the current state of law relating to enrolment of children in schools in NSW appears to designed to infringe on parents' rights to make free

and informed decisions about their children's vaccinations (unless they plan to home-school their children).

Requiring parents to either have their child be fully vaccinated, or be on a recognised catch up schedule or have a signed conscientious objector form essentially forces parents (whose children do not have underlying medical conditions that qualify them for a medical exemption from vaccination) to choose between their child having *either **all** recommended vaccinations or **none***.

This is a very heavy-handed approach to vaccination policy.

In New Zealand, the current system is that regulations governing primary schools mean that the onus is on school staff to ask for a child's "Immunisation Certificate" when a child is enrolled at school. Parents of children who have received one or more vaccinations that are routinely recorded on a special page of a health and development booklet (the Well Child/Tamariki Ora) book which is supplied free of charge to parents.

The school staff member enrolling the child can then record all the vaccinations that a child has had in the school vaccination register. (it is a legal requirement under [add regulation] for primary schools to keep an "Immunisation Register". This register can be supplied to a Medical Officer of Health so that children who have not been vaccinated against a certain disease can be excluded from school temporarily if they have been in contact with someone who has a given disease (for example, measles) so that the unvaccinated child will not attend school while s/he could be infectious.

The current NZ system is not perfect but it does have the following advantages:

1) It respects parents' rights to make whatever vaccination decision they think are in their child's best interests, whether that is having all recommended vaccinations, some of the recommended vaccinations, or none.

   (This policy may be helping NZ with its record high vaccination rates, because parents feel confident that they do not have to make an "all or nothing" choice regarding vaccinations, but can choose for their child to have vaccinations that are acceptable to them but avoid others. For

example, some parents do not want their children vaccinated with the MMR vaccine because they are concerned about the possibility that their child may become autistic and some parents do not want their daughters to have HPV vaccinations because they do not think it appropriate for children to be vaccinated against a sexually transmitted virus. (Please see the appendix to this document "Current Controversies in Vaccination" for information about the MMR-autism issue, and other health and/or ethical concerns about vaccination.)

2) Children at a primary school or early childhood centre who may be susceptible to a particular infectious disease (because they have not been vaccinated) can be readily identified so that they can be asked to stay at home if they have been in contact with someone who has, for example measles or pertussis, and can be asked to stay home during a period when they may be infectious.

The NZ policy has applied to primary schools (and early childhood centres) so the effects of unnecessary absences (such as a case when a child was excluded because a classmate was believed to have measles, but the measles diagnosis was incorrect) have not had huge impacts on children's learning, although they can be an organisational and financial strain for working parents who would need to find alternative childcare for their well child.

Recently there have been cases of measles in NZ and schools in which have been attended by someone with measles have been temporarily closed, high school students have been asked for vaccination records and those who have not had two doses of MMR vaccine excluded while they were considered to be possibly infectious.

Students at New Zealand schools who have been "exposed to the infection of an infectious disease specified from schedule 2" can be legally excluded from school in a temporary basis under the.

Health (Infectious and Notifiable Diseases) Regulations 1966

http://www.legislation.govt.nz/regulation/public/1966/0087/latest/DLM24238.html

http://www.legislation.govt.nz/regulation/public/1966/0087/latest/DLM24271.html#DLM24271

It is not clear why two doses of MMR vaccine has been used as a surrogate for immunity in these recent measles outbreaks considering the NZ Ministry of Health materials state that 90% of people should be immune after single dose, making a second dose of the vaccine not actually necessary for most people who have had one MMR vaccination.
http://immunisation.book.health.govt.nz/11+Measles/11.5+Recommended+immunisation+schedule

A policy of excluding healthy, unvaccinated high school students from school has the potential to impact badly on the education of unvaccinated students.

Currently, in New Zealand, and to the best of my knowledge, the same is true in Australia, families in which the parents choose not to vaccinate their children (or are selective about the vaccinations that they allow their children to have) and generally very well integrated into society. They tend to be middle income families that prioritise their children's needs.

Any policy that singles out unvaccinated children and their families for special negative treatment (such as exclusion from school, lack of access to a family tax credits and childcare subsidies etc.) does run the risk of alienating these families from the mainstream of Australian society.

Question: 26) Should the Act be amended to allow a public health officer to direct an unvaccinated child whom the officer reasonably believes has been in contact with a case of a vaccine preventable disease be excluded from child care or school, regardless of whether there is an outbreak at the school or child care the child attends?

Response to Question 26:

This is a very broad question and partly depends upon what definition of "contact with a case of a vaccine preventable disease" is used by the Medical Officer of Health.

If a very broad definition of "contact" is used (for example, having gone to the same shopping centre) then it would not be reasonable to exclude a child from school or childcare.

If on the other hand, an unvaccinated sibling had measles and the child attended a school in which they had a classmate on maintenance chemotherapy for

leukaemia, exclusion of the unvaccinated child from school while s/he might be infectious would be reasonable.

Based on the actions of Medical Officers of Health in NZ over the last few years, blanket exclusion of unvaccinated students (or those who are consider under-vaccinated, regardless of the fact that they are most likely to be immune) seems to be the rule, even in cases where the actual exposure and hence infection risk may have been minimal. This type of practice amounts to a form of discrimination against unvaccinated children.

Therefore, if the NZ experience is anything to go by, amending the NSW Public Health Act to allow a public health officer to direct an unvaccinated child whom the officer reasonably believes has been in contact with a case of a vaccine preventable disease be excluded from child care or school, regardless of whether there is an outbreak at the school or child care the child attends, risks introducing a new form of de-facto discrimination against unvaccinated children.

Question 28) Should the Public Health Act be amended to remove the conscientious objector exemption to enrolment in a childcare facility from the Act, such that children who are not vaccinated due to their parents' conscientious objection cannot enrol in child care?

29) If the exemption is not removed from the Act, should other options be pursued to strengthen the requirements to obtain a conscientious objection exemption for enrolment in child care in NSW?

Response to Questions 28 and 29:

No Forced Vaccines asserts that any policy that prevents the enrolment of unvaccinated children in childcare centres is a form of frank discrimination and suggests that the NZ model of recording vaccination information at enrolment (as described earlier in this document) provides a model in which vaccination records can be recorded and children excluded from childcare only if this is necessary to reduce the risk of transmission of an infectious disease.

Current Controversies in Vaccination

The Australian Department of Health and Ageing appears to be very confident of the safety and efficacy of its vaccination programme. This confidence is not shared by many health experts.

The purpose of the following is to present some of the reasons why some parents choose against vaccinating their children, or decide for their children to have some vaccinations but not others.

MMR vaccine and autism

The MMR (measles, mumps, rubella) vaccine has been controversial since the publication of a case series of 12 children (most of whom had been vaccinated with MMR vaccine and subsequently developed symptoms of autism) in *The Lancet* in 1988.

In 2014, fresh controversy arose about the MMR vaccine when a scientist (Dr. William Thompson) employed the Centers for Disease Control in the USA stated that he had been party to the publication of a study which had omitted data that showed that African American boys who had been vaccinated with the MMR vaccine prior to the age of three years were at higher risk of autism. (For more information on this issue, please see the following link: http://www.morganverkamp.com/august-27-2014-press-release-statement-of-william-w-thompson-ph-d-regarding-the-2004-article-examining-the-possibility-of-a-relationship-between-mmr-vaccine-and-autism/

He later gave a statement about how some of the data from the study was destroyed by CDC scientists. (Dr. Thompson retained his personal copies of the data because he knew that its destruction was illegal.) Congressman Posey entered the statement by Dr. Thompson into the records and you can read it here: https://sharylattkisson.com/cdc-scientist-we-scheduled-meeting-to-destroy-vaccine-autism-study-documents/

There are now two documentaries about the CDC's MMR-autism cover-up. One may be viewed online at the following link: https://www.facebook.com/BenSwannRealityCheck/videos/1043476625717287 (this is a short film), while the other, a full length documentary is not yet available online but has been screening in cinemas in the USA and its trailer may be seen at this link: https://www.youtube.com/watch?v=EdCU2DfMBpU . The documentary website is: http://vaxxedthemovie.com/

Thimerosal in vaccines

Controversy also remains about the potential for the preservative thimerosal, (which is approximately 50% ethyl mercury) to cause neurological damage. A recent contributor to this debate is the film, *Trace Amounts* which chronicles the story of a man who developed autism-like symptoms following a tetanus vaccine that he received as an adult. http://traceamounts.com/

The trailer (approximately 2 minutes) is here https://www.youtube.com/watch?v=sqqiy8DhyH0&feature=youtu.be

NB: A thoughtful discussion of the general vaccine-autism controversy by a veteran investigative journalist may be read at this link:

https://sharylattkisson.com/what-the-news-isnt-saying-about-vaccine-autism-studies/

It is salutary to note that despite the fact that Australian parents have been told for many years that paediatric vaccines are now free from mercury, a paper published in 2010 showed that Infanrix-hexa (a combined diphtheria, tetanus, (acellular) pertussis, hepatitis B, polio and *Haemophilus influenzae* type b vaccine) contained approximately 10 parts per billion mercury. http://www.ncbi.nlm.nih.gov/pubmed/20391108

While the amount of mercury is small compared to vaccines that contain added thimerosal, at approximately 10ppb the amount detected in this vaccine is almost five times the FDA limit for mercury in bottled water (2ppb), and delivered through an injection rather than an oral route. https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?fr=165.110

The fact that Infanrix-hexa contained this amount of mercury at a time when vaccines were being promoted to parents as mercury free raises the concern that the version of Infanrix-hexa on the market today may still contain mercury.

Aluminium adjuvants in vaccines

Some vaccines, including many that do not contain added thimerosal, contain aluminium salts as adjuvants. This is a concern because baby rodents injected with human-equivalent dosages of aluminium adjuvants developed brain damage.
http://www.sciencedirect.com/science/article/pii/S0162013413001773

Aluminium adjuvants in vaccines have also be postulated as a possible cause of autism in children.

http://www.ncbi.nlm.nih.gov/pubmed/22099159

Concerns about the efficacy of modern pertussis (whooping cough) vaccines

There is concern that the modern acellular pertussis vaccines may be insufficiently protective.

While modern vaccines against pertussis may protect recipients from becoming ill with whooping cough; if recently vaccinated people come into contact with someone who has pertussis, the *Bordatella pertussis* bacteria may nonetheless colonise the lungs of the vaccinated person, albeit without causing symptoms. This means that the vaccinated individual may unknowingly spread pertussis to others as s/he would lack the cough and other symptoms of pertussis that would usually cause infected people to isolate themselves at home.

A non-technical discussion of this issue is below:

http://articles.mercola.com/sites/articles/archive/2013/12/10/whooping-cough-pertussis-vaccine.aspx

Vaccines and other conditions

Links to other studies about vaccines and health may be found at the website of another documentary *The Greater Good* (http://www.greatergoodmovie.org/)

http://www.greatergoodmovie.org/learn-more/science/

International push to restrict freedom of choice regarding vaccination

Over the last several years, there have been a number of attempts in democratic countries to erode traditional freedom of choice.

While attempts to institute a coercive vaccination policy at government level of in NZ have been defeated, there are currently many different proposals to restrict freedom of choice regarding vaccination in many states of the USA.

This link has up-to-date information on this issue:
https://nvicadvocacy.org/members/Home.aspx

In the USA, a lobby group that is financially supported by the pharmaceutical industry has been identified as a player in the push for coercive vaccination policies. (For details, please see http://www.naturalblaze.com/2015/07/alec-behind-recent-push-for-mandatory.html)

The "No Jab No Pay" Proposals

The "No Jab No Pay" proposals are of concern to No Forced Vaccines members because the intent of the proposals appears to be to coerce parents into vaccinating their children in order to be able to access childcare payments and a family tax credit.

Coercive vaccination policies are undesirable for a number of reasons.

- **They are incompatible with the right to make a free and informed decision about a medical procedure (in this case vaccination) for oneself (in the case of adults) or one's children (when children are minors).**

  A coercive vaccination policy puts health professionals responsible for administering vaccinations to children in a very difficult position as the health professional cannot be sure that financial pressures have not played a significant role in the parents' decision to consent to their child having the vaccinations. Consent for vaccination is supposed to be given "given voluntarily in the absence of undue pressure, coercion or manipulation." See:
  http://www.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home~handbook10part2~handbook10-2-1

Would a parent who has agreed for their child to be vaccinated because their family cannot survive financially without the childcare payment and family tax credit be considered to have given consent "in the absence of undue pressure, coercion or manipulation"?

- **Coercive vaccination policies are incompatible with the traditional democratic value of freedom of religion.** (Some parents who are generally supportive of vaccination do not want their child(ren) to be vaccinated with vaccines that used cell lines derived from aborted human foetal tissue as a culture medium for the viruses in the vaccines.

  For example, the rubella viruses in the MMR vaccine are cultured on such a cell line (which may be variously known as "human diploid cells" or by the name of the actual cell line, such as WI-38) making this vaccine unacceptable to Catholic, Muslim, Buddhist and some Protestants whose religious beliefs oppose abortion. Some people who have no particular religious affiliation may also consider the use of abortion-derived ingredients in vaccines to be unethical and abhorrent. Another cell line of human foetal origin (MRC-5) is used to culture chickenpox viruses.

- **Coercive vaccination policies that use financial blackmail to force reluctant families to vaccinate their children (because they cannot afford to go without the childcare payments and family tax credit) are unjust.**

  One reason that the "No Jab No Pay" proposals are unjust is because they are inequitable. Whether intentionally or not, the "No Jab No Pay" proposals target children in lower income families for a medical intervention (vaccination) which in rare cases can cause devastating adverse effects. *If a child does suffer a devastating side effect, there is no compensation programme available in Australia to affected families; the only option for compensation is to sue the company that manufactured the vaccine which is time consuming, stressful and has no guarantee of success.* (For example, in the case of Saba Button who was severely brain damaged and became tetraplegic following an influenza vaccination, it took four years before her family received a settlement to provide funds for Saba's ongoing 24 hour/day care.
  http://www.perthnow.com.au/news/western-australia/parents-of-saba-button-who-was-victim-of-flu-vaccine-debacle-receive-payout-from-wa-government/story-fnhocxo3-1226945651845

  By contrast, children in wealthier homes may have parents who are able to make whatever vaccination decision(s) that they think are appropriate

for their children without coercion because they are not dependent on the government childcare subsidy and family tax credit in order to provide an adequate standard of living for their families. If they think that one or more vaccines have unacceptable risks, then under the “No Jab No Pay” proposal wealthier parents would be able to decide against certain vaccinations for their child.

In the same spirit, the “No Jab No Pay” proposal can be seen to be inequitable because it potentially interferes with the right of parents in lower income families to follow the precepts of their religion, while parents in higher income families for whom the loss of the childcare subsidy and family tax credit would not be an undue financial burden would not be hindered in exercising a conscientious objection to vaccines that contain abortion-derived ingredients, for example.

Another way in which the “No Jab No Pay” proposal is unjust is because if parents decide against vaccinating their child/ren (who do not qualify for medical exemptions) their parents may need to stop working, reduce their hours and/or rely on *ad hoc* childcare arrangements within the family circle because a child care centre may no longer be an affordable option.

For a child who has been enjoying the opportunities offered for structured and unstructured learning and developing friendships with other children (and warm relationships with teachers) at a good quality childcare centre, having to withdraw from childcare centre may have a significant impact on the child. In such a situation, the “No Jabs No Pay” policy would be effectively punishing a child for his/her parents’ decision regarding vaccination.

Medical Exemption from Vaccination

While the “No Jab No Pay” proposals do allow for medical exemption from vaccination, in practice, based on overseas experience, many children who are at risk of vaccine-injury may not quality for a medical exemption. This link has a good discussion of the issue of medical exemptions: http://www.nvic.org/NVIC-Vaccine-News/May-2015/blackmail-and-the-medical-vaccine-exemption.aspx

Concluding Comments

While the "No Jab No Pay" proposal may have been genuinely conceived as an initiative to improve children's health by increasing vaccination rates, the policy is inherently unethical because it is coercive.

There is also a risk that, if instituted, the "No Jab No Pay" policy could undermine children's health by putting vulnerable children at risk of adverse reactions and/or causing financial stress to families in which parents choose for their children to remain unvaccinated (or not to have certain vaccines) even though such a decision would deprive their families of the childcare subsidy and family tax credit.

In NZ, there is a very strong relationship between poverty and increased ill health in children, and death in childhood.

- The majority of hospital admissions with a social gradient were due to infectious and respiratory diseases among children aged 0–14 years. During 2009–2013, 82% of these admissions were for asthma and wheeze, acute bronchiolitis, acute upper respiratory infections, gastroenteritis, viral infection of unspecified site, skin infections or pneumonia (bacterial, non-viral).

- The rate of hospitalisation from medical conditions with a social gradient for 0–14 year olds was 45 per 1,000 for 2009–2013 with an annual average of over 40,000 admissions. Rates of hospitalisations for children living in the most deprived areas (NZDep deciles 9–10) were nearly 3 times higher than for those in areas with the least deprivation (NZDep deciles 1–2).

- SUDI continued to be the single largest contributor (43%) to children's deaths with a social gradient in 2011, with a rate of 6 per 100,000 (excludes babies <28 days and see below for further detail).

- Rates for deaths from medical conditions with a social gradient were 6 times higher for those in NZ Dep deciles 9–10 areas than for those in the areas with the least deprivation (NZDep deciles 1–2). Rates were more than

3 times higher for Māori and over 4 times higher for Pacific than for European/Other children.

- Vehicle occupant injuries were the leading cause of injury-related deaths and pneumonia was the leading reason for deaths from medical conditions. Traffic related vehicle occupant events are the most common cause of children's injury related deaths, followed by drowning.

- The overall rate of child deaths from injury with a social gradient has been decreasing since 2000.

- Those living more deprived areas (NZDep deciles 9–10) were more than 3 times more likely to die from injury with a social gradient than those living in the least deprived areas (NZDep deciles 1–2). Rates for Māori children were over twice those of European/Other children.

SOURCE: http://www.nzchildren.co.nz/introduction.php

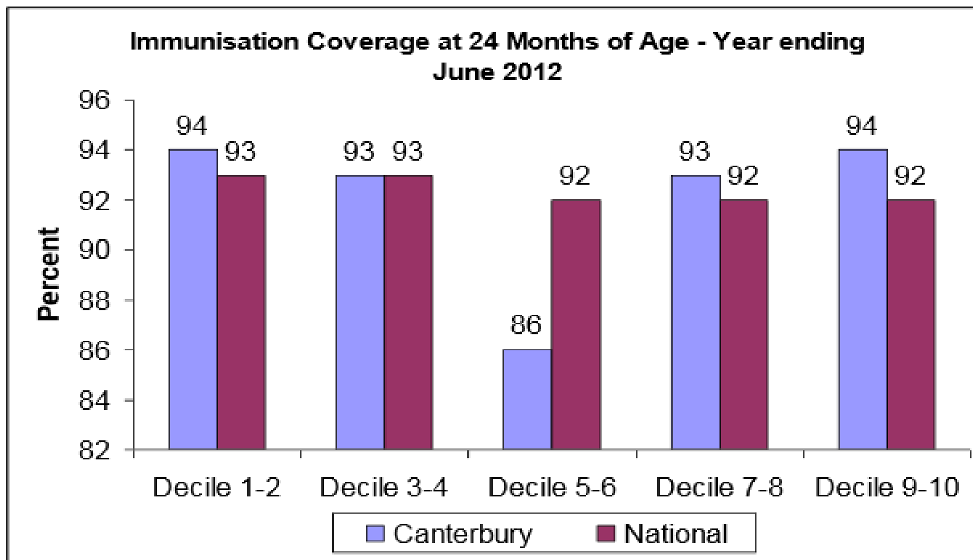
You can see from the graphic on the next page that national vaccination rates for babies in NZ are very similar despite family income levels. (Decile 1-2 are the wealthiest families; Decile 9-10 are the most economically deprived families.) The very similar vaccination rates probably reflect the fact that all vaccines recommended for NZ children on the "National Immunisation Schedule" are free to parents.

Impact on inequalities

National coverage[8] of Maori and Pacific two-year-olds is 91% and 95% respectively. Coverage of Maori two-year-olds in Canterbury is 93% and Pacific two-year-olds is 95%.

Coverage by deprivation index (decile 1 is least deprived through to decile 10 most deprived) over the past 12 months shows no strong pattern with the lowest rates of coverage in the middle decile groups (decile 5-6).

Figure 1 Immunisation coverage rates at 2 years of age, by decile[9], Canterbury and National, year ending June 2012.[10]



Reference: http://www.healthychristchurch.org.nz/media/27258/childhoodimmunisations.pdf

You can see from the graph and comments above that NZ national vaccination rates of Maori children and those of Pacific Island descent are very similar to those of other ethnicities; however Maori and Pacific Island children are more likely to die from medical conditions with a social gradient (notably pneumonia) than children of other ethnicities.

It seems difficult to escape the conclusion that the stresses and disadvantages (such as over-crowded housing, inadequate heating of homes in winter, greater difficulties in purchasing adequately nutritious foods etc.) of living in poverty are more important to children's health than vaccination, given that vaccination rates in NZ are so similar between wealthy and deprived families – yet illness and mortality rates are so much worse among NZ's poorest children.

NZ currently has record high vaccination rates even though vaccination remains voluntary and is not linked to any sort of welfare payment, childcare access or school attendance.

NZ has achieved its record high vaccination rates through developing strategies to enable parents who want their children to be vaccinated to be able to access services more easily and developing new resources (including web-based resources) to promote vaccination.

It is the hope of No Forced Vaccines that members of the Senate Committee will consider this information carefully and recommend against the "No Jab No Pay" policy in favour of a policy that respects people's rights to make a free and informed decision about vaccination for themselves and their children, without coercion.