Commentary

Survey on vaccinations in Europe: adverse effects, epidemiology, laws, and EFVV proposals

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Abstract

In 1998, during the *Biocultura* trade fair in Barcelona, members of the Spanish group *Liga para la Libertad de Vacunaciones* met with members of the French association *ALIS*. They were aware that the Catalan group of doctors *Grup Médic de Reflexió sobre les vacunes*, had already initiated an investigation into the adverse effects of vaccinations and had begun collecting data. They felt strongly that this valiant project deserved attention and expansion so they decided to join forces for this purpose.

A Franco-Spanish *alliance* was therefore formed. As time went by, the alliance grew to include all the European countries where the two founding associations already had established relationships with groups and people prepared to work on this same issue.

In 1999, a venue was chosen for meetings and the structure was determined for a European forum researching the vaccination issue. Since then, the group has gathered every July for an annual meeting in the town of Yenne in France. The project was initially called ***Strasbourg 2004***, later to become the European Forum for Vaccine Vigilance (EFVV).

Over a six-year period, the EFVV conducted a study of the secondary effects of vaccinations, using a questionnaire translated into five languages, which was made available to health practitioners and members of the public.

The analysis of the collected data is published in a report, available in five languages (English, French, Spanish, German, Dutch), and also on a CD which contains our complete work in all five langauages. The report shows that, contrary to official information, secondary effects of vaccinations are much more frequent, serious, numerous with successive vaccinations, responsible for the onset of new and more complex degenerative pathologies (fibromyalgia, diabetes, autism, many different auto immune illnesses …), and usually dismissed by medical staff, remaining unreported.

***Medical Veritas*® Editorial Note**

Please be advised that this is a "Report" and not a sophisticated epidemiological study. The intention of the report was to raise awareness, through the words of the people who shared their cases and experiences, that many thousands of people experience a decline in their health closely associated with vaccination. The aim was not to create a rigid table of specific ailments that could be attributable to one specific vaccine or another, but more so to bring into the light the fact that vaccinations destabilize immune systems in a wide variety of ways. The issues the authors were looking at were not simply those of "Which vaccines cause which problems?" (which is what scientists expect from studies of vaccine reaction), and the report was not generated from the standpoint of statisticians. The authors were questioning the politics behind vaccination, the fact that laws differ tremendously throughout Europe, the fact that in some countries Human Rights seem forgotten where vaccination is concerned, and that babies can die within a few hours or days of vaccination, or adults' health can be so devastated by vaccines that they have to be medically retired, but the system is set up so that vaccination is never brought to account.

Keywords: vaccine adverse effects, epidemiology

1. ACKNOWLEDGEMENTS

We would like to express our deep appreciation to Mr. Paul Lannoye, who in April 2002, during his term as Belgian MEP, organised an international colloquium on vaccination, at the European Parliament in Brussels. This conference became not only a forum for the expression of several different schools of thought but it also strengthened our resolve to continue the EFVV project.

We would also like to thank everyone, both near and far, who has contributed to the work of our group, particularly the victims who in spite of the harsh reality of their everyday lives, have been generous enough to write about their experience.

2. HISTORY OF THE EFVV

The EFVV delegates attending these meetings between 1999 and 2005 represented ten different countries: France, Spain, Great Britain, the Netherlands, Belgium, Germany, Italy, Luxembourg, Israel and Switzerland. Many of the participants are doctors.

The driving force of this group is a common consciousness, a search for truth, a concern for the preservation of human health and a desire to see respect for human rights. It is for this purpose that we have collected a large number of testimonies from people who have suffered undesirable effects following vaccination. To obtain these testimonies, we circulated a questionnaire in the different countries concerned. This resulted in the creation of a database whose analysis is presented in this report.

The different associations who took part in this EFVV project are as follows:

- La Liga para la Libertad de Vacunación (Spain)
- Association Liberté Information Santé (France)
- The Informed Parent (Great Britain)
- The Society of Homeopaths (Great Britain)
- The Alliance of Registered Homeopaths (Great Britain)

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- Nederlandse Vereniging Kritisch Prikken (The Netherlands)
- Stichting Vaccinatieschade (The Netherlands)
- Groupe Médical de Réflexion sur les Vaccins (Switzerland)
- COMILVA (Italy)
- Associazione Vittime dei Vaccini (Italy)
- Preventie Vaccinatieschade (Belgium)
- AEGIS (Luxembourg)
- LiSa (Germany)

(A list of these associations and addresses is found at the end of this report.)

3. EPIDEMICS, INFECTIOUS DISEASES & VACCINES

Routine vaccination has always been construed to be one of the most outstanding victories in the history of preventative medicine. This belief is deeply rooted in our collective consciousness, and especially in the minds of those in the medical profession. As such, it has created and continues to fuel what could, from a critical standpoint, be called the *vaccination myth*. This myth revolves around three basic concepts: the widespread conviction that it was vaccination which eradicated all the deadly epidemics of the past; the notion that vaccination is harmless, only causing rare and minimal adverse effects; the belief that the benefits of vaccines far outweigh the risks. In addition, the actual practice of vaccination is based entirely on consideration of the infectious pathology as a function of only micro organism and host, without taking any other variables into account.

At the same time, careful study of the epidemiological development over several decades of most of the diseases for which there is routine vaccination reveals that the bases of this belief are unsound, and when it comes to the adverse effects of vaccines, common beliefs are not supported by fact here either. Indeed, consideration of the infectious and contagious pathology as a function of only micro organism and host requires complete rethinking. Vaccination coverage figures are in fact derived from a mathematical formula based on a model designed to recreate the life cycle of the infectious disease; sadly, this precludes consideration of certain basic biological variables and relationships between living organisms in a specific habitat.

3.1 Epidemics

It is a well-known fact that during the 18th and 19th centuries, as a result of the Industrial Revolution, European lifestyles changed dramatically. In fact, there are a large number of literary classics whose plots develop against the background of Victorian families living cheek by jowl in the appalling conditions of those crowded city streets. One of the repercussions of Colonialism and the accelerated lifestyle changes imposed by Industrialisation was the emergence, in the form of epidemics, of illnesses previously unknown on our continent (e.g. Cholera, Yellow Fever), the intensification of existing diseases (Smallpox, Diphtheria, Scarlet Fever, Whooping Cough, Tuberculosis), some also in epidemic proportions, and the appearance of diseases brought on by the extremely harsh working conditions endured by the working classes, subsequently called ***pauperism***. Later, this term would be replaced by ***diseases of underdevelopment***, a phrase which clearly describes the situation in which extensive areas of the Third World can now be found. The social, economic and sanitary conditions in which the people in these areas live take us back to our 19th century ancestors who had to cope with malnutrition, promiscuity, unsanitary housing, poor hygiene, illiteracy, high birth and death rates, etc.… all of which heralded the birth of a totally new concept: disease as a fact of life.

Certainly, disease already existed as a social concept in the centuries preceding the Industrial Revolution (*De Morbis Artificum*, the first systematic treatise on occupational diseases by the father of industrial hygiene, B. Ramazzini, was published in 1700) but it was only during the 19th century that the relationship between poverty and disease started to take hold in the minds of the medical profession, and was reinforced by the Cholera epidemics. The first statistical studies revealed distinct inequalities between the social classes when it came to disease. The emergence and rapid expansion of ***hygiene*** as a movement, leading to the concept of ***Public Health*****,** was the logical corollary of these observations. The economic assessment of disease by hygienists in different countries, along with the class struggle and the philanthropic tradition, were all contributing factors in the improvement of hygiene and health infrastructures and also in the development of national health systems. As a result of these briefly mentioned measures, and also of economic development, living conditions changed dramatically throughout the 20th century. Simultaneously, there were also radical changes in the epidemiological profiles of the ailments which had decimated the populations of Europe during the 19th century. Infectious diseases were undoubtedly the main cause of morbidity and mortality in 1900, but by the year 2000, degenerative and cardiovascular diseases had taken the lead. In spite of this, the rapid expansion of Jennerian Smallpox vaccines and the discovery of Microbiology with its subsequent medical applications in the fields of both treatment and hygiene, made it possible to develop new vaccines and serums. Most of the medical profession was therefore encouraged, according to Serotherapy pioneer Emil von Behring, to focus on *"direct research into infectious diseases, without allowing themselves to be distracted by matters of social policy."* This trend was then only reinforced by the subsequent discovery of antibiotics and the search for *magic bullets* capable of eradicating the germs then, and still to this day, considered to be 100% responsible for infectious pathologies. Throughout the 20th century therefore, there were always two schools of medical thought with philosophical roots dating back to the time of Hippocrates. From time to time the two would merge but their views of health, life, disease and epidemiological reality were still totally different. Roughly, one school believed that the most efficient and positive way of fighting disease and epidemics was to make dramatic changes in living conditions. The other school believed first and foremost, without any contempt for the beliefs of the first school, that medical intervention was required to deal with health problems, and specifically, when it came to infectious diseases, the institution of large-scale and routine vaccination programs was crucial.

Vaccinology then developed hand-in-hand with the chemical and pharmaceutical industry which has now become all-powerful. The debate over which was the most desirable health strategy has therefore always, right from the start, been heavily charged with both ideology and emotions. Why? Because vac-

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cinology has always been tightly linked, also from the start, with massive vested interests, both scientific and commercial. The purely "objective and aseptic" scientific discussion was plainly and simply hijacked and replaced with marketing and propaganda. In such a context, vaccines were construed to be the only weapon capable of eradicating and controlling infectious and contagious diseases. Closer examination of the epidemiological life cycle of most of the diseases against which we vaccinate, and even of the diseases for which vaccines do not yet exist, reveals, however, that this is simply not the case. Take for example, and for brevity's sake, only three legendary diseases: Diphtheria, Whooping Cough and Measles. Others like Tuberculosis, Influenza and German measles could in fact just as easily prove the point.

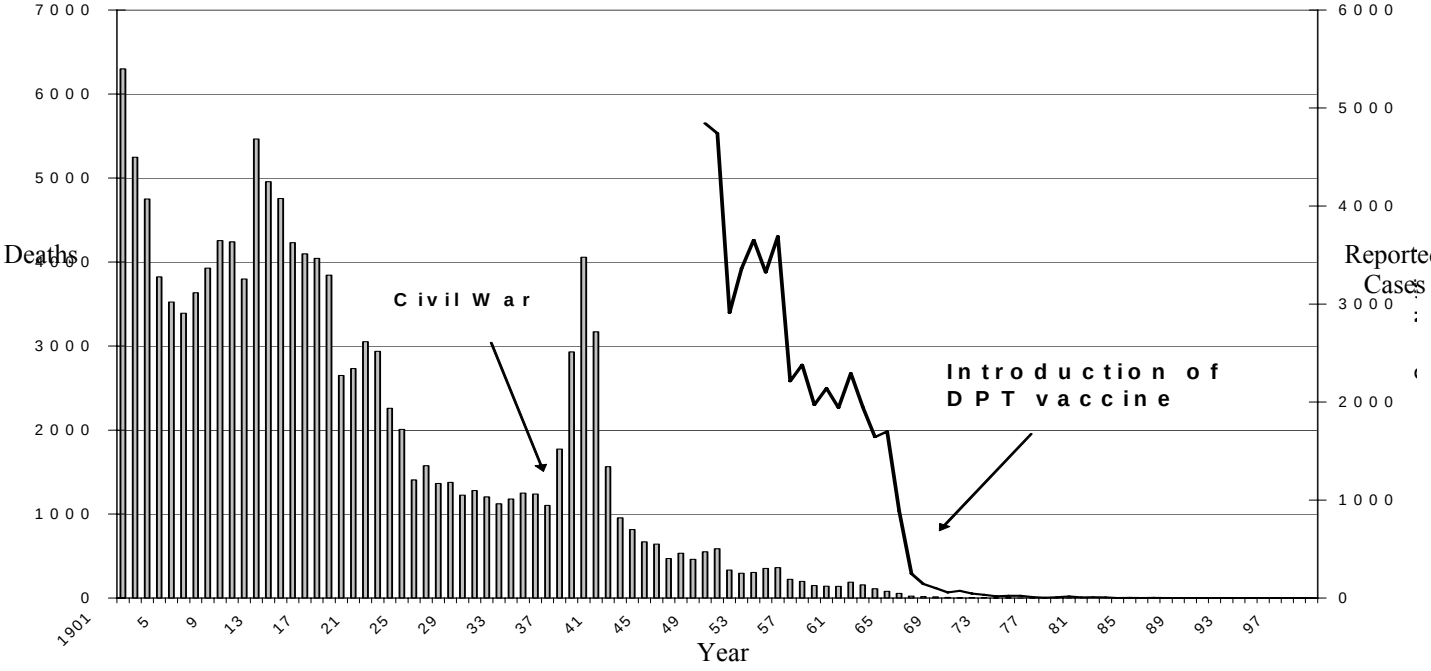
Diphtheria is a disease against which we have been vaccinating for decades, although the vaccination programme start dates vary widely from country to country. The vaccine was first administered during the 20th century, in the Twenties. It has been mandatory in France, one of the first countries to adopt this vaccine, since 1938, and in Germany, it was used on a large scale during the Nazi era and in the occupied zones of World War II. During the pre-war years in France, there were around 15,000 cases of Diphtheria per year but during the war years there were three times as many, and twice as many deaths. In Germany, the incidence in 1940 amounted to 12.4 per 100,000. In Norway, there were 17,000 cases in 1919 but only around 54 in 1939; in 1908 there were 555 Norwegian deaths from Diphtheria compared with only 2 in 1939. Vaccination became mandatory however in 1941 (Norway was occupied by the Germans). In 1942, the records show 22,787 cases and close to 700 deaths.

It is estimated that in Spain, at the beginning of the 20th century, there were 60,000 cases and nearly 5,000 deaths from Diphtheria. The actual records for the year 1901 reveal 6,299 deaths. In 1936 (beginning of the civil war) there were 1,100 deaths, but in 1939 (end of the civil war), the number of deaths had risen to 4,058. In 1950, after the disasters of the war, only 297 deaths were recorded and in 1964 there were only 81. Over the period from 1901 to 1964 therefore, the death rate from Diphtheria dropped by 98.7% and the morbidity rate by 97.2%.

According to these figures, and the fact that the DPT vaccination was only introduced in Spain in the late Sixties, it is clear that vaccination played only a minor role in the decline of the epidemiological impact of Diphtheria. The gradual disappearance of the disease could be observed in all countries as living conditions improved. In fact, the number of Diphtheria cases actually rose sharply in high vaccination areas during World War II; which was also the case in Spain during the civil war, but without vaccination. Germany is another even more significant example. In 1918, during World War I, cases of Diphtheria numbered 100,000; during the Twenties 25,000 cases were reported and in 1945, after five years of mandatory vaccination, the figure swelled to 250,000. The number of cases then dropped off dramatically, without vaccination, after World War II: in 1950 there were 42,500, in 1960 there were around 2,500, in 1962 around 800 and in 1972 there were only 35. It is clear therefore, that the vaccination campaigns implemented between 1970 and 1980 had no impact at all on the life cycle of this disease.

Epidemiological similarity can be observed between Diphtheria and **Typhoid.** While a vaccine for typhoid has been available, it was not routinely administered. Typhoid is transmitted the same way as Diphtheria. This only substantiates the points made above and highlights the fundamental and irreplaceable role of improved living conditions on the emergence and development of infectious and contagious diseases.

Diphtheria in Spain
Deaths 1901-1999 and Cases Reported 1949-1999



Source: Graph generated by author from Spanish Statistics Annual data.

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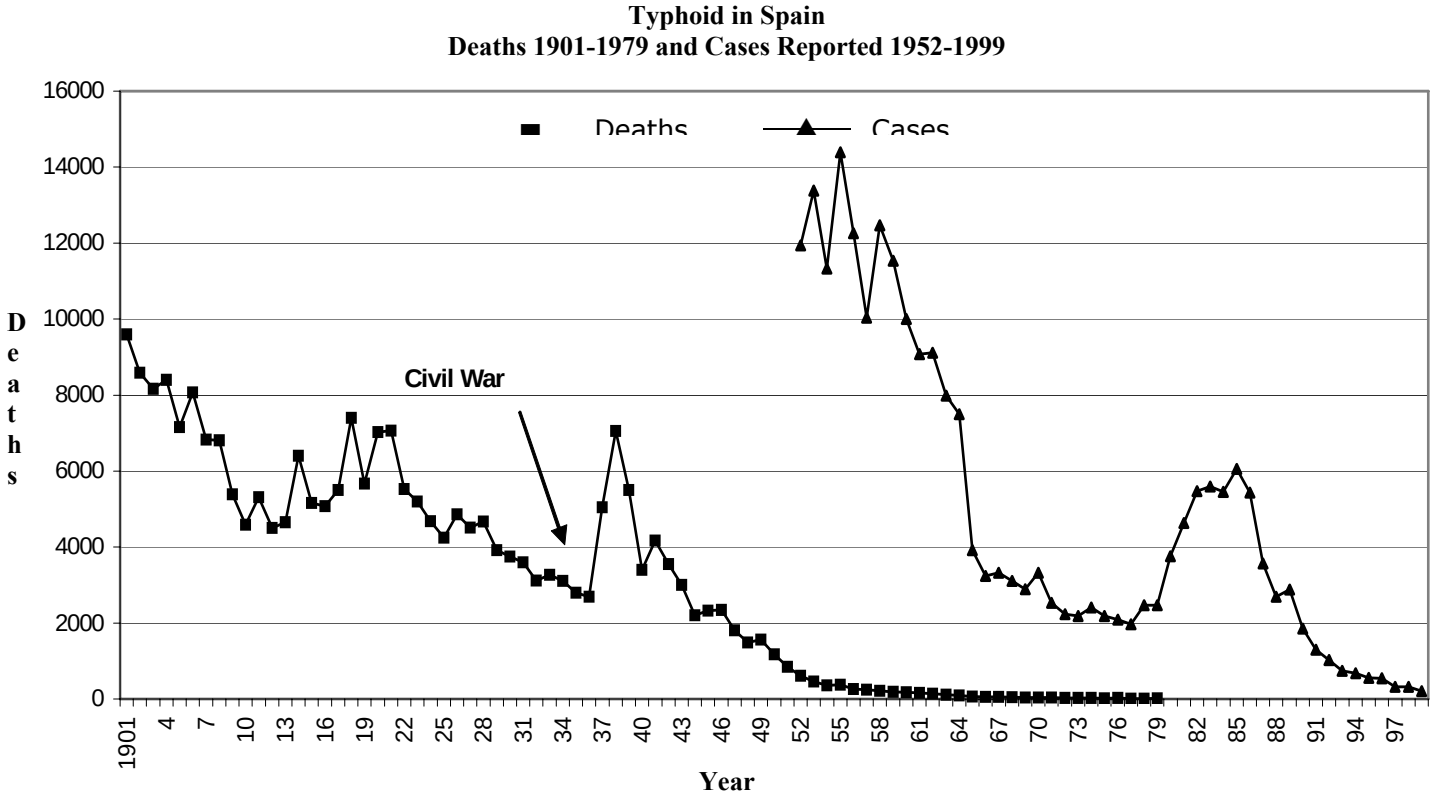
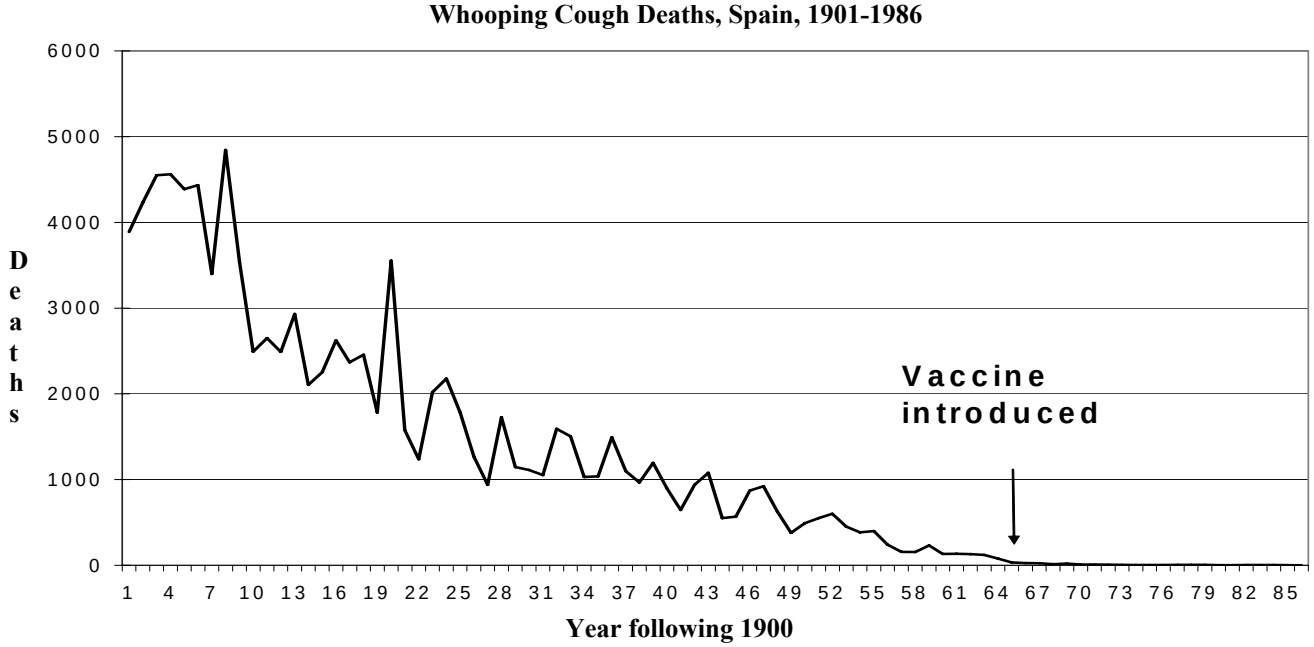


Source: Graph generated by author from Spanish Statistics Annual data.

The **Whooping Cough** vaccine has been in use for a long time now. The first vaccines were administered on a small scale, in the United States, in the Forties. Marketing of this vaccine in England was approved in 1953 but widespread uptake was very slow. In the middle of the 19th century, in England and Wales, the mortality rate from this disease amongst children between birth and age 15 was nearly 1,500 cases per million, while in 1953, nearly a century later, the number of deaths was only 25 per million. Incidence of the disease therefore dropped by 98.5% between 1868 (date of the first census figures) and 1953 (when the vaccine was introduced).



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In 1906, in France, total mortality from Whooping Cough amounted to around 3,500 deaths, whereas in 1959 (the year the vaccine was launched), there were only 280 deaths. This represents a drop of 92% ***before*** the vaccine was even introduced. As in a large number of other countries, vaccination against Whooping Cough only became widespread in France, in the form of a multiple vaccine (Tetracoq, then Pentacoq), after 1966. Taking the period from 1906 to 1966, the decrease in the mortality rate is even greater: 96%.

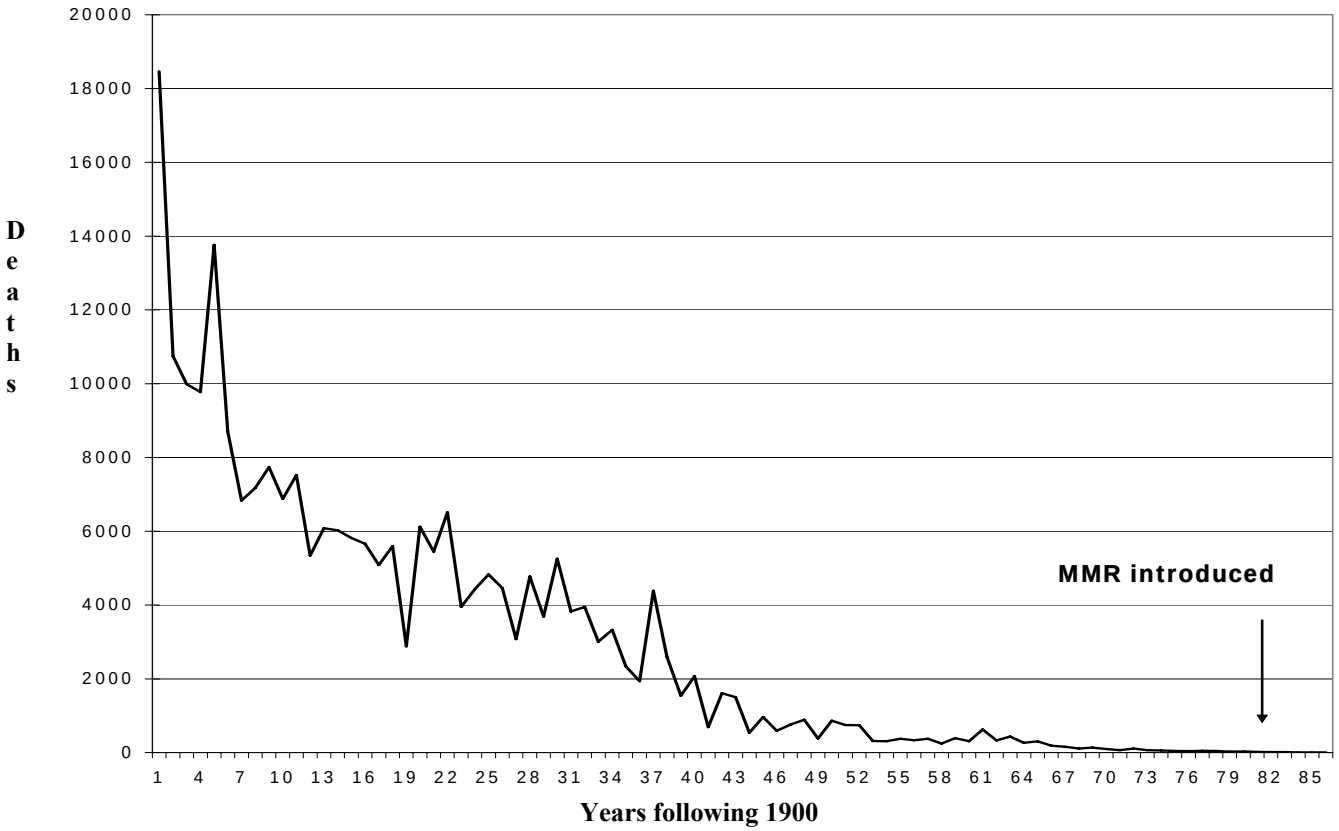
In Spain, at the beginning of the 20th century, yearly deaths from Whooping Cough exceeded 4,000. By 1931 the figure had dropped to 1,114; it was 491 in 1950 and only 33 in 1965, the year the DPT (Diphtheria, Pertussis, Tetanus) vaccination campaigns were launched. The Spanish mortality rate from Whooping Cough therefore dropped by 99.15% between 1901 and 1965, which means that the mortality rate in 1965 was 147 times lower than in 1901. This drop becomes all the more significant when one considers that in 1965, the Spanish population had virtually doubled since the beginning of the century (this was also the case in France and Germany).

Measles is a disease for which there has been routine vaccination in certain countries for only around twenty years, usually in combination with Rubella and Mumps (it is called ROR in France, MMR in English-speaking countries, and TV in Spain). Taking the case of Measles alone, in the middle of the 19th century, the mortality rate amongst children age 15 and under in England and Wales amounted to 1,100 deaths per million; by 1960 there were virtually no deaths at all. The first Measles vaccines were introduced in the United States during the Sixties. This precipitous drop in the mortality rate in England and Wales cannot therefore in any way be attributed to the vaccination campaigns.

In France, large-scale ROR (MMR) campaigns were launched in 1983, despite warnings in 1977 by Professor Bastin who stated, "*Routine vaccination would be difficult to implement in our countries where the disease is harmless; out of 100 hospitalisations, the mortality rate is only 0.17%*". In France, there were exactly 3,756 deaths from Measles in 1906, compared with only 20 in 1983, revealing a 99.5% drop in mortality rate between 1906 and 1983.

In Spain, the National Statistics Annual reports 18,463 deaths from Measles in 1901, and in 1907 the figure revolved around 14,000. In 1981, there were only 19 deaths caused by Measles and the vaccination campaigns started in 1982. The decrease in mortality from Measles in Spain, between 1901 and 1981, was therefore 99.9%, ***without*** vaccination. As stated above, these figures are all the more striking when one considers the fact that the populations of most European countries doubled between the beginning of the century and the Eighties.

Deaths from Measles, annually 1901 - 1986, Spain



Source: Spanish Statistics Annual

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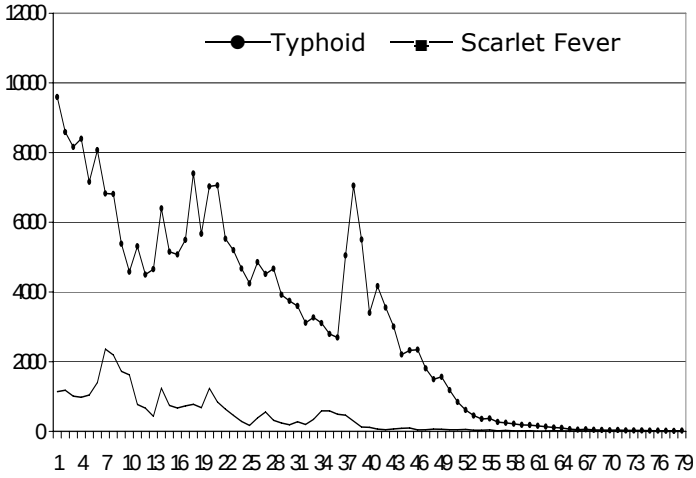
3.2 Epidemics and Vaccinations

The examples above demonstrate clearly that the role played by vaccinations in the epidemiological life cycle of these diseases was insignificant. This observation also applies to other diseases: Tuberculosis, Mumps, Measles, Rubella, Hib, etc…. With the sole exception of **Polio**, a disease which requires a study of its own, the impact of these diseases decreased gradually over the 20th century as European living conditions were totally transformed by social and economic progress.

Typhoid and Scarlet Fever , Spain, 1901-1979

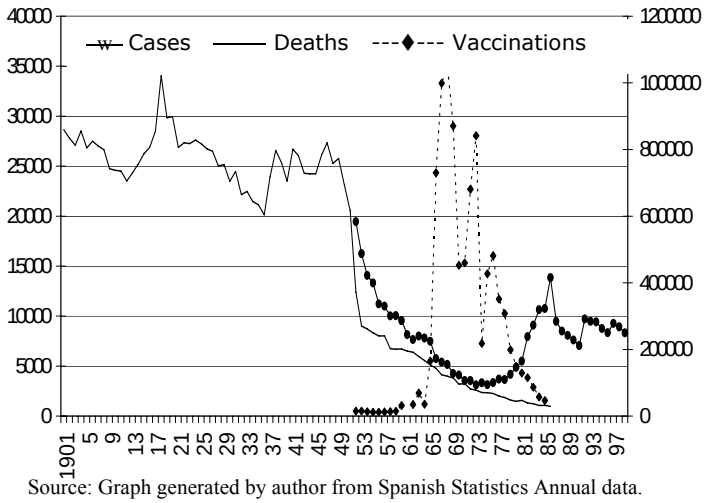


Source: Graph generated by author from Spanish Statistics Annual data.

All of the above is again reinforced and confirmed by the nearly complete eradication of Typhoid (for which there has never been routine vaccination of the general public) and the eradication of Scarlet Fever, another deadly disease for which there has never been a vaccine. In spite of the evidence of the data presented here, we continue nonetheless, in complete and utter ingenuousness, to use and believe in vaccines with almost religious fervour.

The case of Tuberculosis is particularly poignant: almost all European countries stopped using the BCG vaccine during the 1970s and 1980s because it was ineffective and caused a large number of serious side effects.

Tuberculosis in Spain
Cases 1952-1999, Deaths 1901-1986, Vaccinations 1952-1985



Source: Graph generated by author from Spanish Statistics Annual data.

The entirely **official** conclusions of the controlled trials conducted on the BCG include a list of observations explicit enough to need no comments:

1. Efficacy ranges from 80% to 0%. There is even a study which speaks of negative efficacy (-57%), meaning that there were more cases of Tuberculosis among the vaccinated than among the non-vaccinated.
2. This (negative efficacy) phenomenon remains a mystery.
3. The vaccine does not protect against either infection or transmission.
4. The vaccine apparently protects by limiting dissemination in the blood and would probably be effective in cases of endogenous reactivation during the early years of life but not in cases of reactivation in adults or in cases of recent reinfections. N.B. The italics have been added to highlight the extremely hypothetical aspect of these observations. It is important to mention here that in Barcelona (Spain), after the BCG was withdrawn, there was a **very significant decrease in the number of tubercular meningitis cases** in infants, a condition the BCG vaccine was specifically used to eradicate.
5. Protection only lasts a maximum of 10-15 years and revaccination is not advised (latest recommendations).
6. The BCG does not protect infected individuals and these are precisely the ones who run the greatest risk of contracting the disease.
7. Assuming total vaccination coverage, the reduction in overall mortality from Tuberculosis would only be, at most, **6%**.
8. The BCG vaccination was not a contributing factor in the reduction of the annual risk of infection.
9. The BCG is a live vaccine, which poses a worrisome risk of serious or even fatal complications amongst children or adults who are HIV positive. These are in fact the maximum risk group for Tuberculosis.
10. Post-BCG hypersensitivity to tuberculin makes it impossible to distinguish between a positive reaction to the vaccine and the presence of a natural infection. As a result:
    - the Heaf test has no predictive value
    -vaccination interferes with the implementation of other prevention strategies,
    -vaccination also makes it difficult to diagnose non-bacillary forms of TB,
    -vaccination precludes the use of epidemiological infection indicators.

Considering all of the above, it appears utterly appalling that BCG vaccines might still be used in certain autonomous communities in Spain and that it might still be mandatory in France. Indeed, it is just as incomprehensible that the WHO might include this vaccine in its EPV (Expanded Programme of Immunization) when its own officials blame famine, misery, malnutrition, etc. for the emergence of Tuberculosis in the world. How can you then explain that 1/3 of the world's population has been vaccinated against TB?

The **Rubella** vaccine only highlights all the more this virtually religious belief in the benefits of vaccination programmes. Again however, we come up against a paradox: those who advocate vaccination put forward data supporting the irrationality

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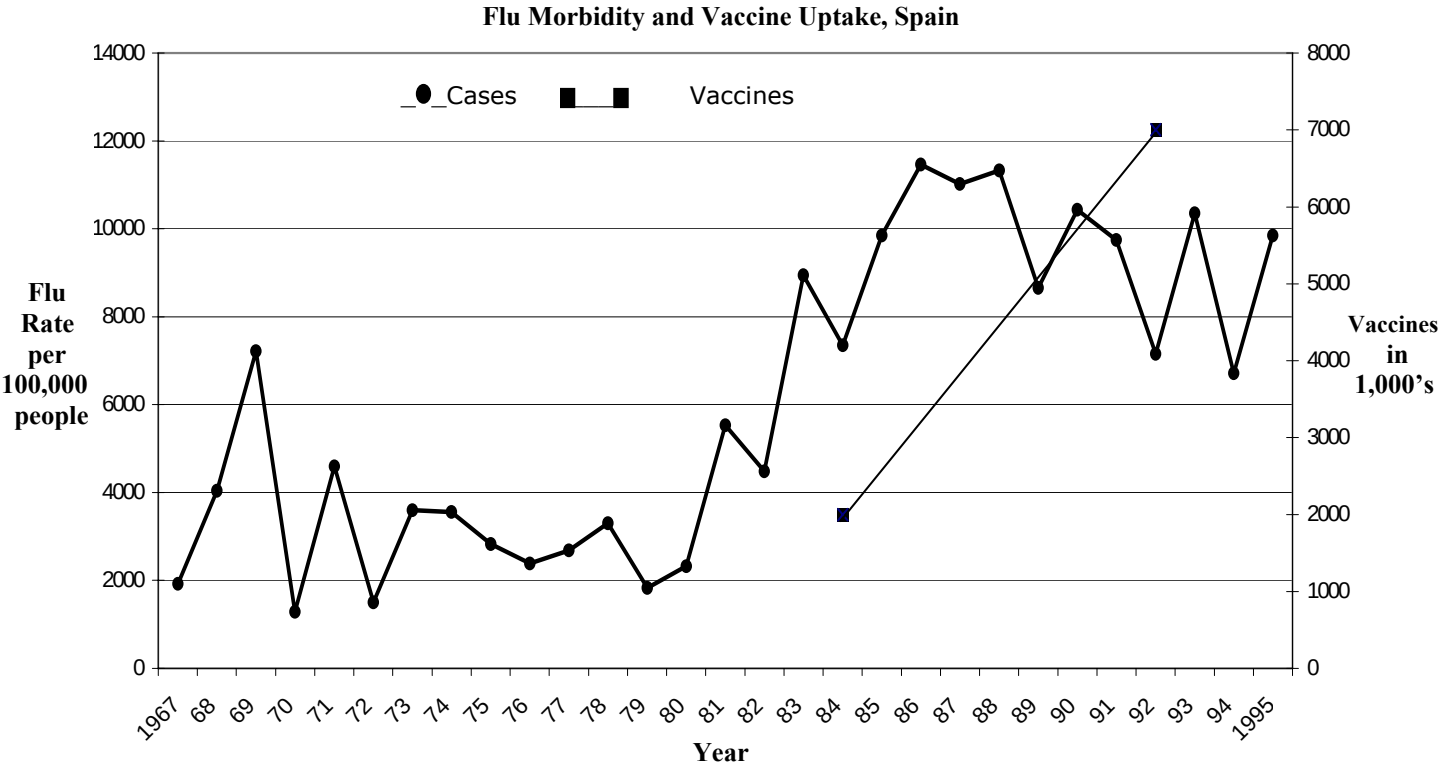
of the so-called preventative measures. In Catalonia, Spain, pro-vaccination groups claim that during the Seventies, when the vaccination campaigns started, 90% of European women of childbearing age were immunised against Rubella. According however to a study by Pumarola & Coll, today, 97% of Catalonian women of childbearing age are immune, not due to vaccination but because the virus is still circulating wildly! They also recognise that 50-80% of artificially immunised women are susceptible to contamination with the disease if exposed to it, whereas only 5% of naturally immunised women would run the same risk. The result is that we are left with a totally counter-productive sense of security, only making it easier for pregnant women to catch the disease from infected people. Add to this statements made at the Glasgow conference in 1993, revealing a higher incidence of osteoarthritis and neuritis in adult women vaccinated against Rubella and one begs the question: why do we persist in administering this vaccine which not only has undesirable side effects but also gives a false sense of security? All of this might explain the cases of congenital Rubella syndrome reported amongst vaccinated women.

When it comes to **Influenza,** the Spanish morbidity figures, obtained from the Department of Health itself, are indisputable. They reveal that alongside the large-scale vaccination campaigns, the incidence of the illness per 100,000 members of the Spanish population *increased* by 400%! In spite of this, the vaccination lobbyists continue to insist that flu jabs are a good way to reduce morbidity from the flu. In fact, this was just what the pro-vaccination contingent maintained, *precisely* when Spain was the country with the highest flu vaccine uptake rate in Europe, based on number of doses per capita.

In conclusion, we feel that the data presented in this chapter is sufficient proof of the fact that vaccines have had only a minor, if not totally insignificant, role in the control and eradication of the epidemics which once decimated the populations of Europe.



Source: Graph generated by author using Spanish National Epidemiological Centre data.

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4. THE VACCINATION LAWS IN EIGHT EUROPEAN COUNTRIES: Belgium, France, Germany, Italy, Luxembourg, Netherlands, Spain, UK

COUNTRY: **Belgium**

Mandatory Vaccines

. Polio (IPV): at 2, 3, 13/18 months
. Heaf test at school
. Hepatitis B is mandatory for all hospital employees working in a medical capacity

Penalties

- Exclusion from school
- Fines
- Lawsuit

Recommended Vaccines

. Infanrix hexa (Polio, Diphtheria, Tetanus, acellular Pertussis (whooping cough), Hib, Hepatitis B), Pneumococcus (pneumonia): at age 2, 3 and 4 months
. MMR, Meningococcus (meningitis): at age 12 months
. Infanrix hexa, Pneumococcus: at age 15 months
. Polio, Diphtheria, Tetanus, acellular Pertussis: at age 6 years
. MMR, Meningococcus: at age 12 years
. Diphtheria, Tetanus: at age 15 years

Special Situations

Exemptions

COUNTRY: **France**

Mandatory Vaccines

For school

- DTPolio (IPV): before age 18 months
- BCG: at or before age 6 years for entry to day nursery. Only a single injection, no boosters, required.

For health workers

- DTPolio: every 10 years
- Hepatitis B with booster if antibody level is lower than 10 IU/ml: every 5 years
- Typhoid (laboratory workers): every 4 years
- BCG: only a single injection, no boosters, required

For other occupations

- Firemen: BCG + Tetanus
- Sewage workers in Paris: Leptospirosis
- Armed Forces (for duty in the tropics): DTPolio, Hepatitis A and B, Meningitis A and C, Typhoid and Yellow Fever

Penalties

- Fines
- Exclusion from school
- Withdrawal of parental authority

Recommended Vaccines

- Pertussis (Whooping Cough): before age 18 months. boosters every 10 years with acellular Pertussis.
- Hib: before age 18 months
- Hepatitis B: before age 18 months
- Hepatitis A: persons at risk
- MMR: between ages 3 and 6, and at age 11/13 years
- Varicella (chicken pox): persons at risk
- Pneumococcus (Pneumonia): between ages 2 months and 2 years
- Influenza (flu): yearly for persons at risk and senior citizens over age 60

Special Situations

Yellow Fever vaccine is mandatory in French Guyana

Exemptions

All vaccines: only with a medical certificate specifying a contra-indication.

COUNTRY: **Germany**

Mandatory Vaccines

Recommended Vaccines (July 2004 by STIKO – Ständige Impfkommission at Robert Koch Institut, Berlin)

For children

At birth: Hepatitis B, ONLY if exposed
At 2 months: DTaP, Hib, Hep B, Polio (IPV)
At 3 months: same as 2 months
At 4 months: same as 3 months
Between 11 and 14 months: same plus MMR and Varicella (Chicken Pox)
Between 15 and 23 months: MMR booster
At age 5-6: Tetanus and Diphtheria for children / adults (Td)
At age 9 to 17: Td, aP, IPV, Hep B

For adults

From age 18 on, yearly: Td
60 years and over: Influenza (flu) yearly
60 years and over: Pneumococcus (Pneumonia) every six years

Special Situations

Exemptions

No exemptions

COUNTRY: **Italy**

Mandatory Vaccines

For children

. Tetanus, Polio, Diphtheria, Hepatitis B: first jab at 3 months, second 6/8 weeks later, third 6/12 months after that. In the event of non-completion of the schedule the whole programme is repeated

For adults

. Tetanus (hospital workers)
. BCG if negative Heaf test (health workers, school staff, armed forces, persons at risk)
. Meningitis, Typhoid, Diphtheria, Tetanus, MMR (armed forces)

For animals

. Rabies (for all animals in high risk areas in the north of Italy)

Penalties

- Fines
- For compulsory education: non-vaccinated children have been accepted at school since 1998 (Circolare Ministeriale del 24/09/1998)

Recommended Vaccines

. Hib, Pertussis (Whooping Cough), together with DTPolio
. MMR: at age 15/18 months
. Diphtheria, Tetanus, Polio (IPV) booster: at age 5/6 years
. BCG: during the first 10 days of life for babies at risk and for school children with negative Heaf test
. Influenza: yearly for those at and over age 65
. Tetanus: pregnant women between 4 and 8 months if no booster received
. Leptospirosis: sewage workers, fishermen, water sportsmen …
. Hepatitis B booster: for people at risk
. Typhoid: for those working in the catering trade

Special Situations

Tetanus: vaccine and serum recommended for injured people

- before age 6 if the person has not received all recommended vaccines
- after age 6 if the person has not received boosters

Exemptions

For medical reasons only (cancer treatment, anaphylactic shock …)

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COUNTRY: **Luxembourg**

Mandatory Vaccines

Recommended Vaccines

For children:

. Diphtheria, Hib: at age 2, 3/5, 4/6, 18/24 months and booster at age 5/6 years
. Tetanus: at age 2, 3/5, 4/6, 18/24 months and at age 5/6, 15 years
. Acellular Pertussis (Whooping Cough): at age 2, 3/5, 6, 18/24 months
. Polio: at age 10/12, 18/24 months and at age 5/6, 15 years
. MMR: at age 15/18 months
. Hepatitis B: at age 11/12 years

Specific groups

- Influenza (flu)
- Pneumococcis (Pneumonia)
- Tuberculosis (Heaf test)
- Hepatitis A
- European Tick Encephalitis
- Rabies
- Typhoid
- Meningitis
- Japanese Encephalitis
- Varicella (Chicken Pox)

Special Situations

Exemptions

COUNTRY: **The Netherlands**

Mandatory Vaccines

For the armed forces

Recommended Vaccines (National Vaccination Pro-gramme)

Phase	Age	1st injection	2nd injection
Phase 1	2 months	DKTP-Hib	Hepatitis B*
	3 months	DKTP-Hib	
	4 months	DKTP-Hib	Hepatitis B*
	11 months	DKTP-Hib	Hepatitis B*
	14 months	MMR	Meningitis C
Phase 2	4 years	DTP	Acellular Pertussis (Whooping Cough)
Phase 3	9 years	DTP	MMR

(D: Diphtheria; T: Tetanus; K: Pertussis (whooping cough); P: polio (IPV); Hib: Haemophilus Influenzae b)

* Only for children with at least one parent born in a country where Hep. B is prevalent and for children whose mother is a carrier.

Special Situations

Exemptions

COUNTRY: **Spain**

Mandatory Vaccines

Recommended Vaccines

. Diphtheria, Tetanus: at age 2, 4, 6, 18 months, at age 6/7 and 13/14 years
. Pertussis (Whooping Cough): at age 2, 4, 6 months
. Acellular Pertussis (Whooping Cough): at age 18 months, at age 6/7 years
. Polio (IPV): at age 2, 4, 6, 18 months and booster at age 4/6 years
. MMR: at age 15 months and at age 3, 10/11 years
. Hib: at age 2, 4, 6, 18 months
. Hepatitis B: at age 2, 4, 6 months, and at age 12/13 years
. Meningitis C: at age 2, 4, 6 months
. Influenza: at age 65 and over

Special Situations

The schedule can be different in some communities, but only

Exemptions

COUNTRY: **United Kingdom**

Mandatory Vaccines

Recommended Vaccines

. Diphtheria, Tetanus, Polio (IPV), Hib, acellular Pertussis (Whooping Cough), Meningitis C: at ages 2, 3 and 4 months
. MMR: at or around age 13 months
. Diphtheria, Tetanus, Polio (IPV), acellular Pertussis (Whooping Cough), and MMR: at age 3-5 years.
. BCG: at age 10-14 years and sometimes given shortly after birth in high risk areas
. Tetanus, Polio (IPV): at age13-18 years.

Special Situations

Exemptions

5. VACCINE ADVERSE EFFECTS AND PHARMACOVIGILANCE

The American authorities have acknowledged that although reporting of the adverse effects of pharmaceutical drugs is theoretically mandatory in the United States, only 1 to 10% of these events are actually reported by practitioners. It is therefore highly probable that when it comes to vaccines, which the medical profession virtually never questions, the reporting rate is even lower, both in the United States and in Europe. This widespread under-reporting highlights basic flaws in the vaccination system: we are in fact totally ignorant of the truth underlying the vaccine "damage" issue. In addition, vaccinated individuals are not monitored over time, and there is no thorough investigation into a patient's medical history prior to vaccination, all of which makes vaccination a very risky and dangerous practice.

In fact, nearly all the patients who sent us testimonies specified that their cases had not been reported to the pharmacovigilance authorities. How therefore can the figures published by these authorities be considered reliable? In an attempt to go to the source, we wrote several letters, in 2002, 2003 and 2004, to various regional pharmacovigilance authorities, as well as to the European unit which is located in Uppsala, Sweden. Most of these letters remained unanswered. We are attaching herewith the responses received, which demonstrate the attitude of these departments. Clearly, they do not seem inclined to divulge comprehensive information on vaccine damage to the general public. This same public is nonetheless coerced, either legally or indirectly, into vaccination. Does this refusal to communicate vital information not constitute a serious breach of our democratic rights?

Taking France as an example, the case files of the Hepatitis B vaccine victims have been "buried" by the AFSSAPS (Agence Française de Sécurité Sanitaire des Aliments et Produits de Santé, or French Health Food and Product Safety Agency), leaving these sufferers unable to obtain recognition of their pathologies which all developed following vaccination. Most of the time, the pharmacovigilance authorities, which are inextricably linked to the large pharmaceutical groups, only report the adverse effects which are benign and transitory. It is not as if the medical profession were totally unaware of the more serious risks of vaccines. These risks are well-known but never revealed to the general public. What are the reasons for this silence?

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In 1998, a dedicated pharmacovigilance department for vaccines was set up in the United States, under the name Vaccine Adverse Event Reporting System, or VAERS (P.O. Box 1100, Rockville, Maryland 20849–1100 USA Tel: +1 301 827 3974; Fax: +1 301 827 3529; www.fda.gov/cber/vaers.html). Nothing of this nature exists in Europe. Sadly, due to the under-reporting mentioned above, VAERS does not reflect the reality of this problem. In addition, it is not easy for a member of the general public to consult these data. The situation appears to be the same worldwide: those required to be vaccinated do not have access to in-depth information on the undesirable effects of vaccines. The fact that this dark side of vaccinology is deliberately hidden casts suspicion on all acts of vaccination.

6. COST OF ONE MONTH'S TREATMENT AND CARE FOR A CHILD WHO BECAME AUTISTIC FOLLOWING VACCINATION

(Testimony from a Spanish family)

. Intensive one-to-one behavioural therapy at home: 20 hours per week.
€ 1000 / month (US $850/mo.)

. Special needs assistant in a private school (in Spanish state schools, children are not allowed to have their own therapist, making it impossible for autistic children to attend state schools):
€ 300 (private school) + € 500 (special needs therapist) =
€ 800 / month (US $650/mo.)

. Training for the whole family in the therapy:
€ 350 / month (US $300/mo.)

. Organic food supplements + doctors' appointments + lab work:
€ 300 /month (US $250/mo.)

. Opportunity cost of either the mother or the father stopping work since one parent has to stay at home to look after the child and take him to school:
€ 2000 / month (US $1,700/mo.)

. TOTAL: 2450 + 2000 = **€ 4450 / month (US $3,800/mo.)**

The consequences of vaccination can be a considerable burden not only on the family of a victim but also on society. They far exceed the cost of the actual disease itself but this additional expense is never taken into account. If it were factored into the equation, it might bankrupt the national health service of any country. Consideration of these costs would in fact make vaccination seem far less idyllic and would tend to favour a much more realistic approach towards public health than the current system.

7. VACCINE ADVERSE EFFECTS: Analysis of Data from Six European Countries, compiled by the EFVV, Sept. 2005

OBJECTIVES AND METHODOLOGY

The group started by preparing a questionnaire (copy attached as Appendix 4) geared to the collection of data on any adverse effects observed after vaccination, whether in the short- or in the long-term. The questionnaire could be completed either by individuals who felt that they had experienced vaccine damage of any kind themselves or by practitioners who had observed such damage in their practice.

The objective was to obtain personal testimonies directly from victims. The top of the questionnaire was designed to be detached and filed with an independent overseer so that all information submitted and the identity of the victims would remain confidential. The questionnaire was translated into six different languages (English, Spanish, German, Italian, Portuguese, Dutch) and was circulated in nine different European countries (Belgium, France, Germany, Great Britain, Italy, Luxembourg, the Netherlands, Portugal and Switzerland), along with a cover letter (copy attached as Appendix 3).

The database which resulted from this questionnaire provided us not only with food for thought, but also with the groundwork for further more detailed analysis and processing. It is not a "scientific" study like those conducted internationally with far greater resources. It was however our modest intention to come up with a review of post-vaccination problems, an assessment which has **never** been attempted prior to this by the health authorities who have, nonetheless, been advocating routine vaccination for more than a century. Our aim was to draw the attention of scientists, politicians and the media to the hidden face of vaccination so that the truth about the undesirable effects of these injections would **finally** be taken into consideration. This information is vital if we are to put an end to this game of Russian roulette in which certain individuals are sacrificed under the pretext of protecting others.

The responses we received were all codified to enable computer processing (using Word, Access, Excel). The delegates in each country then analysed their respective responses and condensed them into tables (the British tables are included here as appendix 5, as well as on the CD-Rom accompanying this report). Analysis of questionnaires from only five countries appears in this report, amounting to a total of around 1000 cases. The returned questionnaires often came with weighty legal and/or medical documentation substantiating the painful experiences of these people who had become victims of the adverse effects of vaccination. We have considered all data concerning the type of vaccine, the type of pathology, including death, the length of time between the vaccination and the reaction, as well as the number of vaccines received, to be highly significant.

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Case Analysis: GREAT BRITAIN

1. Cases analysed: 278

Number of Cases by Age

Age ► Sex ▼	0-2 mths	2-4 mths	5-6 mths	7-12 mths	13-15 mths	16-24 mths	2-5 yrs	6-10 yrs	11-16 yrs	17-25 yrs	26-45 yrs	46-75 yrs	N/A	Total
M	3	56	28	26	12	13	9	2	1	2	5	8	3	**165**
F	0	25	14	17	9	8	3	11	4	11	4	7	0	**113**
Total	3	81	42	43	21	21	12	13	5	13	9	15	3	**278**

According to these figures, the adverse effects reported are heavily weighted amongst very young children and infants. This correlates with the demands of the British vaccination schedule which recommends administration of all the routine vaccines between the ages of birth and 24 months. The statement that infants react well to vaccinations is therefore simply not true.

2. Length of time before problems arose

Reaction	No.
4 hours	120
2-4 days	40
5-7 days	42
1-2 weeks	26
2-4 weeks	18
4 weeks +	14
Gradual	9
Unspecified	9
Total	**278**

As a general rule, adverse effects manifested rapidly. Where deterioration was gradual, it was usually evident within one month of vaccination. N.B.: only 22 of these 278 cases were officially reported by doctors as "adverse effects of vaccination", and in one fatal case a parent was imprisoned for murder.

3. Pathologies by type of vaccine

Type of vaccine	No.
PT	16
DPT+Polio	7
DPT+Polio+Hib	53
DPT+Polio+ Hib+Men C	22
DPT+Men C	4
Men C	17
Polio	7
Hib	4
MMR	67
MR	4
Measles	9
Rubella	7
BCG	4
Hep B	19
Influenza	2
Rare combinations*	36
Total	**278**

- It is widely known that there is a large group of parents who believe their children have been affected by the MMR. However, we did not use data from this group.
- It should be borne in mind that vaccine combinations have changed over the years. It should not therefore be concluded that eg: DPT+Polio+Hib is more likely to cause an adverse effect than DPT+ Polio+Hib+Men C. It is simply that the latter is a newer combination and has therefore been administered less per capita.
- It should be noted that there was no indication as to whether the polio vaccine was oral or injected.

4. Pathologies observed

Type of pathology	Case Number	No.
ADHD/ADD/Hyperactivity	85,99,117,181,248,276,277	7
Allergies	7,13,31,39,57,59,121,134,146, 162,212,265	12
Anaphylaxis	18,29,85,249	4
Appetite disturbance	25,39,45,58,75,83,103,126, 141,143,182,196,226,269,274	15
Asthma	15,31,37,59,120,124,145,186, 199,212,222	11
Autism/Aspergers	1,2,43,68,77,88,99,118,126, 150,151,155,160,166,179,180, 184,202,231,232,237,246, 247,251,256,278	26
Autoimmune (e.g., alopecia, purpura, etc)	53,58,80,174,274,252,253,	7
Central Nervous System	1,4,10,13,19,24,29,30,33,34,35 ,36,43,49,68,71,7278,85,88, 89,99,105,117,120,131,142, 149,151,170,173,182,183,248, 249,255	36
Chronic fatigue/M.E.	24,27,29,33,34,35,36,38,42, 47,48,55,74,100,138,146,173, 185,188	19
Deafness	220,232	2
Death	3,123,152	3
Developmental/ learning disorders	1,4,13,19,41,71,77,85,88,99, 111,151,172,201,223,228,231, 248,266,257	20
Digestive/constipation/ Diarrhoea/ stomache aches	13,14,32,34,37,39,50,51,65,67, 76,85,86,97,99,104111,112, 122,126,134,150,151, 152,153,164,176,180,187,193, 200,203,204,205,223,226,228, 246,247,248,250,268	42
Ear/nose/throat/colds/sinusitis/ tonsilitis/ recurring	5,7,10,21,34,37,52,69,76,82,83 ,101,105,110,114,116,124,139, 141,155,156,157,158, 162,164,199,207,209,210,211, 215,270,277	33

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Type of pathology	Case Number	No.
Eczema/urticaria/rash	5,11,15,31,52,54,56,57,61,63, 84,87,101,102,104,106,108, 110,114,121,122,127,129, 140,143,161,169188,190,194, 197,198,200,205,208,209,213, 214,217,218,219,226,243, 252,253,254,265,269, 270	48
Encephalitis	10,19,41,123	4
Epilepsy	1,41,78,227,235,236,255	7
Fever, high or chronically recurring	1,2,4,8,12,14,21,23,25,37,46, 58,63,64,66,68,74,76,86,90, 91,96,98,103,108,113,121, 126,127,139,141,152,155,157, 167,175,176,181,184,189,191, 196198,200,202,204,206,207, 208,211,215,261,262,263,264, 265,267,268,271,229,238,239, 240,244,251252,253	67
Floppy, listless, excessive sleeping	3,4,6,8,19,24,54,58,65,66,74, 91,116,141,156,171,178,183, 196, 202,208,241,271	23
Flu / flu-like symptoms/malaise	20,26,27,30,35,40,47,79,137, 138,166,174,175,200238,239, 240, 241,272	19
Glands swollen/glandular fever	58,109,188,189	4
Headaches recurring	10,30,60,61,74,76,136,171, 173,183	10
Immune function compromised	7,42,43,141,148,176	6
Leukaemia	43	1
Measles/German measles	19,56,60,64,68,80,92,93,113, 234,242,246,247,	13
Meningitis	6,10,167	3
M.S.	36,47	2
Mumps	94,273,234	3
Musculo-skeletal, fibromyalgia ./joint pain/juvenile arthritis	24,27,28,30,33,38,40,42,45,47, 59,63,64,73,79,95,106,132, 133,135,149,185,216,230,249	25
Persistent/ inconsolable or high pitch/ cephalic screaming	1,3,4,6,9,15,16,19,22,23,25, 32,37,46,54,75,77,88,89,91, 96,98,103,104,105,115,119, 143,152,156,165167,168,171, 175,178,180,189,193,204,229, 244,245252,253,256,259, 260,261,262,267,269	52
Paralysis of parts or total	8,95,107,168,183,235,	6
Respiratory: coughs, chest inf.s, bronchitis, pneumonia	7,8,12,17,20,21,22,59,70,82, 108,112,124,128,129,145,147, 154,190,192,195,198, 199,211,212,221,222,255	28
Rheumat arthritis/ rheumatism	27,28,125,133	4
Seizure/convulsions	10,15,44,63,64,70,89,123,155, 165,170,177,182,207,224,227, 257,266	17
Sleep disturbance	13,49,74,83,89,112,114,126, 204,219,226	11
Stroke/subdural haemorrhage	107,144	2
Swollen injection site	4,23,32,40,46,50,53,73,81,98, 102,111,121,144,146,147,159, 163,168,172,189,206,229, 233,275,258,265,266	28
T.B.	225	1
Urinary – infections etc	59,130	2
Vomiting	15,21,26,70,86,104,146,182, 204,206,233,246,247,268,277	15
Developed disease from vaccine.	19,56,60,64,68,80,92,93,94, 113,225,234,242,246,247,273	16
	TOTAL	**654**

- It would be appropriate to group some of the above categories together. Were that to be done, the largest category would be that of neurological symptomatology/pathology. Such a category would include the sub categories of ADHD/ADD, Autism/Asperger's, central nervous system, developmental/ learning disorders, epilepsy and seizures. These sub categories give a total of 113.
- Other striking categories are: fever, inconsolable (etc.) screaming, skin eruptions and digestive system disturbance. All of these are very marked symptoms of acute illness and represent significantly challenged immune systems.
- Our attention is also drawn to an interesting observation: there are two pairs of twins who received the exact same vaccinations and then went on to develop the very same adverse effects at precisely the same time interval. (see cases 246, 247, 252, and 253.)

5. Outcomes

Full recovery		Chronic	Death
Rapid (<5 Days)	Slow (<5 years)		
25	111	139	3

It should be noted that the majority of cases in the “full recovery” section only recovered after medical intervention. Many of the cases in the “slow recovery” section only recovered after homeopathic treatment, often involving the administration of the relevant vaccine as a homeopathic remedy. It is to be speculated that without this intervention the weighting would be far greater in the "chronic" section.

6. Conclusions

The conclusions that can be drawn from this collection of 278 cases are similar to those of the other European countries involved in our research:

- A very broad range of pathologies was observed, ranging from a simple fever lasting several days, to death.
- Symptoms are often noticed within 24 hours or shortly thereafter.

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- The vaccination is not usually acknowledged by medical authorities as being causative.
- There are more instances of adverse effects from multiple vaccinations than single ones.
- Many chronic conditions, allergies and neurological pathologies are observed to begin in close temporal relationship to vaccination.

Case Analysis: BELGIUM (Flemish-speaking)

Preliminary Comments

The cases studied were merely casual notifications, and in no way represent the total number of vaccine damage cases in Flanders over the period studied (1999-2004).

Cases were however collected at random, so we presume that the analysis reflects a reliable picture of the distribution of vaccine damage in our population.

Many questionnaires were incomplete, and there were no interviews with the respondents, so some data (such as breastfeeding or cure) are not reliable enough to draw any conclusions.

In total, 100 cases were analysed using the following parameters:

- age at time of reaction
- gender
- blood group
- breastfeeding
- presence of contraindications
- vaccine(s) involved
- vaccine adverse effects
- interval between vaccination and vaccine reaction
- outcome

1. Age at time of vaccine reaction (100 Cases)

0 – 6 months	7 – 12 months	1 – 5 years	5 – 12 years	13 – 18 years	19 – 50 years	< 50 years	Unk
34	5	16	9	6	23	4	3

According to this table, most reactions occur in the very young. Many reactions were observed during the first 24 hours after vaccination, even a few hours to minutes after vaccination. The table shows clearly however that older people are susceptible to vaccine reactions as well: 23 cases in the 19 – 50 age group. In addition, different vaccines appear to be responsible in different age groups. Whereas reactions to DPT were common in infants, reactions to the Hepatitis B and Tetanus Toxoid vaccinations played a more important role in adults.

2. Gender Distribution

Male	Female	Unknown
57	43	0

The gender distribution shows only a slightly heavier weighting for males compared with females.

3. Blood Type

A+	A-	B+	B-	AB+	AB-	O+	O-	Unknown
16	1	2	1	2	0	14	1	63

Only a limited number of files specified blood type. As expected, A+ and O came out more frequently as they are the most common blood groups in men.

O+ was present in five males compared with nine females. Considering the overall ratio of males to females in our population, this could suggest that O+ females are more susceptible to adverse reactions. More specifically, five of the nine females were adult women reacting to HBV-vaccination. Again, the reach of this analysis is too limited to draw definitive conclusions, but this observation is significant. The possible greater susceptibility of O+ females to adverse effects from the (HBV) vaccination should be investigated, and such women treated with more caution in order to prevent serious side effects.

Funding is needed to telephone and/or visit respondents at home, and thereby to acquire better insight into the possible role of blood type in the susceptibility of individuals to vaccine adverse reactions.

4. Breastfeeding

Yes	No	Unknown
12	0	88

Very limited data were available on this aspect, and no age analysis was made. Therefore, no conclusions can be drawn from these data.

5. Contraindications

Most reports make no mention of vaccination taking place in spite of a contraindication being present. There are, however, 15 reports which do. Clearly, this number should have been zero. No overlooking of contraindications can ever be tolerated. Contraindications constitute a very definite risk which is easy to avoid for the vaccine recipient.

The following contraindications were specified:

- family history (1)
- incubation time (1)
- infection at the time of vaccination (7)
- general malaise (1)
- eczema (1)

6. Vaccines Involved

Polio	6
DT	2
DPT	24
DPT + IPV	4
MMR	8
Tetanus	11
Hib	4
Meningitis C	6

The entire spectrum of currently used vaccines is represented in our analysis. The most frequent reactions were noticed after the DPT (generally in infants and children) and after the Hepatitis B vaccination (more often in adults). Also, reactions to the Tetanus vaccination were not infrequent.

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Hepatitis B	19
Hepatitis A	1
Hepatitis A+B	4
Smallpox	1
Influenza	3
BCG	2
Yellow Fever	2
Pneumonia	1
Polio + DPT + Hib	2
Polio+ DPT+ Hib+ HBV	6

It is clear that the use of combined vaccines sometimes makes it very difficult, if not impossible, to estimate the role of a particular vaccine in the pathogenesis of a specific vaccine reaction. From the safety and damage control perspective, this speaks against the use of combined vaccines. Far too often, the responsibility for vaccine reaction is attributed more by guesswork than by direct clinical link.

7. Adverse Effects

Fever >39°C	19	Flu-like syndrome	5
Inconsolable crying	11	Eczema	7
Refused food/drink	3	Urticaria	3
Unquenchable thirst	1	Loss of hair	1
Coma	2	Erysipelas	1
Epilepsy	10	Dyspepsia	4
Mental handicap	3	Vomiting	5
Behavioural changes	8	Diarrhoea	6
Psychomotor retardation	5	Recurrent cystitis	1
Arrested physical growth	2	Asthma	3
Fears	1	Lower respiratory tract infections	24
Inability to concentrate	2	Sinusitis	2
ADHD	1	Pneumonia	1
Autism	2	Whooping Cough	1
Headache / migraine	4	Otitis media	13
Apathy	3	Conjunctivitis	2
Encephalitis	2	Arthritis	9
Sleeplessness	7	Diabetes	4
Multiple Sclerosis	1	Polyarteritis Nodosa	2
Impaired vision	2	Leukaemia	1
Impaired hearing	1	Urinary incontinence	3
Subdural haematoma	1	Faecal incontinence	1
Increased cranial pressure	2	Liver function disturbed	2
Optic Neuritis	1	Liver cirrhosis	1
Paresthesia	1	Weakness	10
Peripheral Neuritis	2	Chronic fatigue	4
Chorea	1	Angor pectoris	1
Viral meningitis	1	Blood pressure unstable	1
Vertigo	3	Palpitations	2
Febrile convulsions	2	Collapse	1
Local swelling / pain	10	Epistaxis	2
Dysfunction of injected limb	1	Exitus	3
Swollen glands	1		

8. Time interval between vaccination and first symptoms

0–3 d	3– d	7–14 d	3rd week	4th week	> 4 weeks	Unk.
40	8	11	4	12	15	9

The figures here indicate that the number of delayed reactions is not insignificant. This is all the more important considering the fact that these late reactions often related to deeper neurological pathologies or systemic diseases. In order therefore to be interpreted correctly, observation of possible vaccine adverse reactions must extend at least over the three months following vaccination.

9. Outcome

Cure	Chronic	Death	Unknown
26	43	3	30

Apparently, many cases, even a majority of the serious adverse reactions, developed into chronic pathologies. This is very distressing, as many of these chronic conditions cannot be cured and constitute a major financial cost to society and a lifelong burden for the victim. Considering these figures, we cannot help but question how vaccination complies with Hippocrates' famous words, "First, do no harm."

Case Analysis: BELGIUM (French-speaking)

1. Cases Returned: 51

2. Age Distribution

0-2 mos	2-4 mos	4-6 mos	6-12 mos	12-16 mos	16-24 mos	2-5 yrs	5-10 yrs	10-15 yrs	15-25 yrs	25-45 yrs	45-75 yrs	+75 yrs
5	4	13	8	2	0	1	3	1	2	5	7	0

3. Worsening of pathologies after further vaccines or booster shots: 20

4. Deaths: total 4

Sudden infant death after the first vaccination: 1
Sudden infant death after the second vacccination: 1
9 years after an initial reaction, relapse three months after a booster shot followed by death 15 months later: 1

5. Onset of reactions (number of cases)

First reaccion as of the 1st injection: 12
First reaction as of the 2nd injection: 11
First reaction as of the 3rd injection: 10
First reaction as of the 4th injection: 7
First reaction as of the 5th injection: 5
First reaction as of the 6th or subsequent inj.: 6

Interval between vaccination & reaction	No. of cases	Case number
1 day	12	8, 10, 11, 13,16, 25, 26, 34, 40, 46, 50, 51
1-4 days	8	5, 9, 15, 17, 18, 20, 22, 27,
4-8 days	5	14, 29, 36,48, 49,
8-15 days	7	1, 3, 30, 33, 35, 38, 43
15 days-1 month	8	4, 6, 12, 23, 31,37, 42, 47,
1-6 months	9	2, 7,19, 21, 28, 32, 39, 41, 45,
Over 6 months	2	24, 44,

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6. Comments

- The pathologies observed varied with the age of the individual and many patients reported suffering from several diseases at once.
- The pathologies tended to increase in number with continued vaccination.
- The total number of vaccines exceeds the number of patients because pathologies which arose following booster injections were included in the count: practitioners who reported a reaction after a multiple vaccine, followed by another reaction after a booster injection, tried to separate the respective values to determine which vaccine was responsible for the particular pathology observed, especially in the event of death.

7. Pathologies by type of vaccine

Type of Vaccine	Cases total	Case number
Tetanus	7	18, 19, 32, 39, 40, 41, 45
DT	3	8, 22, 51
DPT	6	1, 13, 15, 21, 24, 44
DPT + oral Polio	6	2, 16, 20, 21, 26, 50
DPT + oral Polio + HiB	15	4, 5, 6, 11, 12, 14, 17, 23, 28, 33, 34,35, 36, 42, 48
DPT + Polio inject + HiB	4	30, 46, 48, 49
HiB	1	24
Oral Polio	5	21, 25, 39, 43, 45
MMR	6	17, 23, 24, 28, 46, 47
Hepatitis A and B	11	4, 7, 24, 27, 31, 33, 42, 43, 44, 45, 51
Meningitis C	2	29, 46
Flu	5	3, 9, 10, 37, 38
Pneumococcus	1	3
Typhoid	3	39, 44, 45
Yellow Fever	4	39, 45, 47, 51

8. Pathologies observed

Type of pathology	Number	Case number
Allergies	4	21, 24, 39, 41, 47
Eczema, eruptions	12	4, 5, 15, 20, 21,26, 28, 29, 30, 38, 46, 50
Respiratory problems	12	6, 11, 12, 15, 20, 24, 28, 33, 40, 42, 43, 47
Chronic fatigue	6	25, 26, 27,39, 45, 51
Fever	10	5, 17, 20, 32, 35, 43, 47, 49, 50, 51
ENT problems	14	10, 14,17, 21, 24, 30, 33, 34, 35, 36, 37, 42, 47, 48
Digestive problems	7	11, 12, 13, 14, 17, 27, 31
Gastro-intestinal, colitis Crohn's disease	11	7, 11, 12, 20, 24, 25, 34, 37, 42, 47, 50
Auto-immune disease	1	45
Oedema	1	10
Kidney disease	1	24
Leukaemia	2	9, 44
Cancer	4	19, 22, 23, 31
Musculo-skeletal problems	1	39
Urinary tract infections	1	39
Nervous system problems	14	20, 23, 25, 27, 29, 35, 36, 37, 40, 42, 46, 47, 49, 51
Glandular system issues	1	45
Reproductive system	1	17
Loss of consciousness	2	18, 28
Rheumatism, joints	1	20
Hodgkin's disease	1	32
Polyarthritis	1	38
Death	3	1, 2, 44
Total	**108**	

9. Conclusions

We observe that the most frequently occurring complications involved the nervous system, the respiratory and ENT systems and the digestive system. This was common to all European case analyses, across the board. It is clear therefore that vaccinations cause very severe and deep disturbance at the very heart of the body's vital functions.

Case Analysis: FRANCE

1. Cases analysed: 355

2. Age Distribution

Age	0-2 mths	2-4 mths	4-6 mths	6-12 mths	12-16 mths	16-24 mths	2-5 yrs	5-10 yrs	10-15 yrs	15-25 yrs	25-45 yrs	45-75 yrs	+75 yrs	Total
M	5	12	10	16	8	12	14	6	7	18	16	9	2	135
F	3	16	11	7	4	8	7	12	11	39	66	34	2	220
Total	8	26	21	23	13	21	21	17	18	60	81	42	4	**355**

3. Worsening of pathology after further vaccines or booster injections: 164

4. Onset of damage immediately after vaccination

Injection no.	1	2	3	4	5	6 +	Total
Cases	89	54	70	51	23	68	**355**

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5. Interval between vaccination and onset of first symptoms noticed by either the patient himself or the practitioner

Reaction interval	Cases
1 day	36
2-4 days	41
5-8 days	44
9-15 days	65
15 days to 1 month	79
2-6 months	67
7 months to 1 year	14
1 year and over	9
Total	**355**

6. Initial Observations

- **Serious pathologies** (leukaemia, cancer, chronic fatigue syndrome, severe allergies…) all manifest gradually and are therefore subtly progressive and difficult to diagnose. As a result, practitioners do not make any connection between these pathologies and the vaccination which is consequently never part of the equation when the aetiology of these devastating diseases is considered.
- **Multiple** and simultaneous **vaccinations** make it virtually impossible to link observed pathologies with a particular vaccine.
- In most of the **very serious** cases, there were either several simultaneous vaccinations given or the interval between vaccinations (e.g. DPT and Hepatitis B) was less than two months.
- In a large number of cases, in different parts of the country and for totally different individuals, the **attitude of the medical profession** was, as a general rule, first to **deny the reaction**: there was no acknowledgement of the pathologies as *serious* ("it's all in your mind", "your pains are psychosomatic", "perhaps it would help to see a psychiatrist", "you're making it up", etc.). This humiliating, condescending and disempowering attitude was only intensified when the patient dared to suggest that a vaccine might have been the cause—any attempt to blame vaccination was met with immediate defence of the vaccine on the part of the doctor, before he would even stop to consider the possibility of any cause and effect link. The doctor would often try to convince the patient that his case was "unique", that it was the very first time such a reaction had been observed. In fact, the patient was almost made to feel guilty for reacting badly to a vaccine which never triggered any adverse effects in or complaints from anyone else. **The concept of any failure on the part of the vaccination** was unthinkable for most doctors; in fact they were so uncomfortable with this notion that it created in them a desperate need to reinforce their basic convictions.
- Once the pathologies became established and did not improve over time, or when they worsened in spite of treatments, the attitude of the doctors was usually to **abandon** the patient: this attitude was particularly visible in the hospital environment where the staff receive a great many vaccines with consequences which are often very serious. Dealing with adverse effects is not part of the remit of the company doctor who originally forced these people to be vaccinated; he can arrange for them to be laid off or pronounced disabled but the poor people are then left to their own devices with their health problems, whether chronic disease, constant pains or a disability which prevents them from working or from living a normal life. These people receive no support from their employers, their doctors or even the social services.
- **Some examples**
  - Case 132: To convince her that she should be vaccinated, the doctor told this patient: "Hepatitis B is worse than AIDS; it will decimate our young." Once vaccinated, this teenager ended up with MS.
  - Case 165: Did not have any further vaccinations after the initial onset of her symptoms but was laid off from her teaching job.
  - Case 166: This accountant for an association of multiply-disabled individuals was forced to be vaccinated by the company doctor; she later refused a booster when her HB antibodies were measured to be 317 UI/ml.
  - Case 170: This school cleaner who only worked after the children had gone home, was forced by the school doctor to accept vaccination. She is now a cripple.
  - Case 176: When this victim refused the second injection, the company doctor threatened to have her laid off. The patient demanded that the doctor accept responsibility in the event of complications and the doctor changed his mind, letting her off without the injection.

6.1 Pathologies by type of vaccine

Type of vaccine	Cases
BCG and Heaf test	59
Tetanus	14
Tetanus + Polio	5
DT	9
Typhoid	11
DTPolio	43
DTP + Polio	20
DTPolio + HiB	1
Infanrix	6
Prevenar Pneumoccocus	5
Tetravax, Tetracoq	10
Pentacoq	52
HiB	3
Oral Polio	5
MMR Priorix	25
Hepatitis A and B	172
Meningitis	4
Measles	2
Flu	14
Yellow Fever	5
Total	**465**

Comment: the number of vaccinations exceeds the number of patients because a single individual might have received several vaccinations in the same day or several different vaccines on dates which were very close together.

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7. Pathologies observed

Type of pathology	Cases	Pathology (cont.)	Cases
Allergies	16	Musculoskeletal ailments	64
Eczema, eruptions	66	Autoimmune diseases	13
Respiratory ailments	63	Immune system problems	21
Chronic fatigue	54	Nervous system problems	179
Fever >39 , 40°C	43	Cardiovascular problems	8
ENT problems	47	Endocrine system problems	22
Eye problems	32	Reproductive system problems	1
Digestive problems	56	Urinary tract/kidney problems	14
Gastro-intestinal, colitis Crohn's disease	24	Loss of consciousness	11
Macrophagic myofasciitis	1	Articular rheumatism	0
Oedema	2	Hodgkin's disease	1
Raynaud's disease	2	Polyarthritis	5
Leukaemia	2	Impotence	1
Cancer	8	Death	6

8. Outcome of pathologies after treatment

Outcome	Stable	Recurring	Chronic	Disability	Death	Total
Cases	38	70	103	131	13	355

Stable: the condition did not worsen or the victim was able to return to a normal life.

Recurring: the pathology(ies) came back from time to time.

Chronic: the pathology(ies) were virtually permanent but did not prevent the victim from working or going to school.

Disability: The individual was either severely disabled or unable to work.

9. General Comments

Over 400 questionnaires were returned but only **355** were analysed for this study. Around fifty questionnaires were eliminated because they were incomplete. We also removed all cases in which the smallpox vaccine was implicated.

We observe that a large number of the pathologies which arose following vaccination were misleading because they were not an exact fit with official medical terminology and were therefore given different names, e.g. *polio-like*, *asthmatic whooping cough*, etc. Often, several different names were used for the same clinical condition, e.g. *chronic fatigue*, *ME*, *fibromyalgia*, resulting in the development of categories which then distort the figures. The incidence of poliomyelitis might for example have decreased while the number of fibromyalgias increased, obscuring the fact that these were in fact all cases of post-vaccinal poliomyelitis.

All in all, we observe that vaccinations have a disastrous impact on our health. A large number of people have been the victims of vaccine adverse effects which have left them disabled and ruined their lives. In an effort to protect children and adults from diseases which are always *hypothetical*, we destroy their health. Vaccinations are standardised products administered to people who are totally different, and whose reactions at the time of the vaccination or afterwards are **unpredictable**. Is what vaccines achieve really worth all the damage?

The true result of vaccinations is diametrically opposed to what we think it is. With improved hygiene and living conditions, the acute contagious diseases against which we vaccinate had already started to disappear long before mass vaccination became standard practice. This is corroborated by all the epidemiological data available. In truth, vaccinations are not responsible for the eradication of the infectious diseases against which we vaccinate but sadly, they **are** responsible for an **explosion of chronic, degenerative and incurable diseases** which burden our society**.**

Today, there is another threat to our health: germs have become all the more virulent with the turmoil man has caused in our ecosystem. Instead of freeing man from *miasms* we have caused germs to become stronger and more widespread. He who is vaccinated can be a carrier for viruses and bacteria whose purpose and future we do not know. What progress have we really made?

What makes this scandal all the worse is that the adverse effects of vaccination are **not acknowledged**. Instead of providing support for these patients, these victims of a system which offers neither freedom of choice nor informed consent, the medical, political and legal authorities simply abandon them without benefits, without moral or financial support. They end up alone with their disabilities, often in abject poverty because all family and social structures crumble around them and they do not have the strength to fight. Is this the victory modern medicine attributes to vaccines?

Case Analysis: GERMANY

1. Cases Analysed: 84

Age ► Sex ▼	0-2 mos	2-4 mos	4-6 mos	6-12 mos	12-16 mos	16-24 mos	2-5 yrs	5-10 yrs	10-15 yrs	15-25 yrs	25-45 yrs	45-75 yrs	75 +	Total
M	8	11	6	11	1	2	0	1	0	1	0	2	1	**44**
F	4	4	3	8	4	3	7	0	2	0	3	2	0	**40**
Total	12	15	9	19	5	5	7	1	2	1	3	4	1	**84**

Worsening of pathologies after further vaccinations or booster shots: 32

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2. Onset of Reactions (after injection no.)

Injection no.	1	2	3	4	5	6 +	Total
Cases	34	19	12	3	0	1	69*

* number smaller as some didn't provide this information

3. Interval between vaccination and first symptoms noticed by patient or therapist

Interval	Cases
Up to 24 hours	12
2-4 days	12
5-8 days	8
9-15 days	11
15 days to 1 month	13
1 to 6 months	12
6 months to 1 year	4
1 year and more	2
Gradual onset	10
Total	**84**

4. First observations

- The severe pathologies (chronic fatigue, fibromyalgia, heavy allergies, brain damage) can appear very progressively and a diagnosis is often made only after a long period of time. So it is not easy to see the relationship between cause and effect (the act of vaccinating and the pathology). When people are questioned the vaccinations are usually ignored or "forgotten".
- Polyvalent vaccinations (where several vaccines are given in one injection) or several vaccinations given on one day, offer no possibility to find out which fraction is responsible for the pathology.
- In most severe cases there have been or several vaccinations in one sitting or after a short time (less than two months).recognized as their consequence, even when they are faced with a very severe case.
- In most cases the opinion of the medical staff is quite similar: that vaccines cause illnesses is always negated, pathologies are not recognized as their consequence, even when they are in presence of a very severe case. The victims are told: "It's all in your head!" – "Your pain is of psychic origin!" – "You only imagine all this!" – "You are a case for psychiatry!"
- If the patient dares to suspect the vaccination this accentuates the depreciative attitude of the doctor. The very hypothesis – that a vaccination could cause an illness – arouses an immediate alarm and need to stand up for them, long before the slightest thinking has had a chance to take place. Often they try to make the patient believe that he is an exceptional case and that it is the first time the therapist learns about such a reaction. In other words: it's the patient's fault, he has reacted badly—as all other vaccinated people have reacted wonderfully! The notion that a vaccination could lead to a lifelong damage, is unconceivable for many of Pasteur's worshippers. They feel that they personally could suffer a crushing defeat and this perspective causes a deep feeling of being unwell.
- If the pathologies are lasting and if there is no chance of improving—or if the condition even worsens—official medicine often is taking this position: the patient is abandoned. You can see this especially in the domain of Health Care. Especially here the personnel receive a great number of vaccinations that are usually forced on them—so they also get sick more often. The doctors for the personnel—some being the same who pressurized them into taking the vaccines—do not care for the secondary effects. They simply send them their dismissal letter or attest their handicap, but they think it's not their department to help them with their problems (chronic illness, constant pains, handicaps, all making a normal life impossible) and leave them alone. They get no help, whether from official medicine nor from the employer nor from Society.

5. Types of Vaccines Implicated (with number of cases)

The **MMR** and the multiple vaccine containing Diptheria, Tetanus, Polio, Whooping cough and/or Hib were the most frequently blamed for neurological pathologies.

Type of Vaccine	Cases
BCG	15
Heaf Test	4
Tetanus	1
DT	6
DPT	7
DPT-Polio	14
Pentavalent (DTP + Polio + Hib)	16
Hexavalent (pentavalent + Hepatitis B)	15
HiB	4
Polio oral	13
Polio injectable	1
MMR	14
Rubella	2
Measles	1
Hepatitis B	3
Hepatitis A + B	1
FSME (tick meningo-encephalitis)	5
Influenza	5
Smallpox	5
Total	132

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6. Pathologies Observed

Pathology	Case number
Allergies	3, 8, 11, 14, 15, 18, 21
Eczema, skin disorders	7, 15, 18, 23, 26, 27, 30, 31, 35, 37, 42, 48
Respiratory system ailments, asthma	5, 6, 8, 9, 18, 28, 35, 36, 37, 39, 41, 44, 47, 48, 51
Fever over 39°C, abnormal crying	10, 15,16, 17, 24, 44, 103, 2103
ENT problems	3, 6, 9, 10, 11, 13, 25, 39, 43, 46, 51, 2103
Eye problems	1006
Digestive system problems	3
Crohn's and other inflammatory diseases	34, 44, 51
Musculo-skeletal system	1, 13, 14, 21, 33
Autoimmune diseases	1, 56, 59, 102
Neurological disorders	1, 6, 11, 12, 13, 14, 16, 21, 22, 40, 45, 51, 103
Loss of consciousness	14, 16
Articular rheumatism	14
Polyarthritis	1
BCG-induced ailments	2903, 2904*
Chronic fatigue/fibromyalgia/ME	14, 29
Macrophagic myofasciitis	13
Behaviour problems	19, 22
Cognitive problems	21
ADD/ADHD	38, 49, 51
Convulsions	7, 12
Epilepsy	49, 52, 53, 111, 151, 153, 155, 173
Enuresis	38
Encephalitis / encephalopathy	54, 58, 107, 110, 170, 171, 172, 1006. 2904
Autism	38
Hydrocephalus	12
Poliomyelitis after Polio vaccine	50, 60, 102, 152, 1124
Paralysis	503, 2302, 2904
Guillain-Barré syndrome	103, 501, 502
BNS (Blitz-Nick-Salaam Syndrome)	109, 156, 157, 174
Severe brain damage	7, 49, 52, 57, 58, 105, 111, 173, 1006, 2903
Aplastic anemia	2
Rett Syndrome	61
Death	55

*Longer case numbers originate from the register of the German association *Schutzverein für Impfgeschädigte*.

7. Outcome of These Pathologies

Outcome:	Stable	Recurring	Chronic	Disability	Death	Total
Cases:	7	5	22	49	1	84

Stable: no worsening observed. The individual is able to live an almost normal life.

An impressive number of these people were treated with homeopathy, other therapies and / or strict diets, especially organic and vital foods – several needed to avoid animal-based food, especially animal proteins.

Recurring: The pathology/pathologies come(s) back repeatedly.

Chronic: The pathologies are permanent individuals are still able to go to work or school.

Disability: The person is severely handicapped; work is impossible.

8. General Observations

We received a total of 89 questionnaires and were able to use 84. Five were incomplete.

We can see that the number of pathologies that can appear after a vaccination is puzzling. They often are not named after the official nomenclature but are given new names ("polio-like" – "asthma-like whooping cough") Very often there are a variety of names describing the same clinical realities (Chronic fatigue Syndrome, fibromyalgia, encephalomyelitic polymyalgia; SSPE = MIBE). This fact allows the creation of new categories in order to make up statistics (the number of polio cases diminishes while the number of fibromyalgias goes up), thus it becomes less apparent that in reality, this is post-vaccinal polio.

We also have to consider that the so called measures of prevention are just hypotheses. Certain illnesses are supposed to diminish, while they would not reappear anyway, as the levels of hygiene and nutrition are dramatically better than some decades ago. We should not forget that today we have a number of excellent treatments for these infectious diseases. The probability of an epidemic of these infections is near zero. The vaccines are standardized products and this is in flagrant contrast with the person who is to be injected—every individual is different. Everybody is unique, different in age, sex and especially their whole genetic code. So the reaction of each vaccinated person is individual. Everywhere in the world it is noted that vaccinations do have a disastrous influence on the health status of the populations. Almost 50% of individuals have to live with some handicap; their quality of life is taken away. So, in order to protect children and adults from hypothetical infections, quite often their health is destroyed. Is this risk worth it?

The result of vaccination is exactly the opposite of what is wished for, as infectious diseases were already vanishing long before (mass) vaccination started. (This is clearly proven by statistics). Vaccinations have nothing to do with the disappearance of those diseases. On the contrary, they are causative factors to the explosion of chronic, degenerative and therefore incurable illnesses. Here we have the urgent question: Why do we have more and more babies with neurological problems, allergies and autoimmune illnesses? Why do we have younger and younger patients? We have to look at the rising costs of the "health system". Due to the changes in the ecosystems of the human being, some microbes seem to have become more aggressive. Instead of freeing man from his miasmas (hereditary burdens), humans have become carriers of microbes – the vaccinated person is the one who carries the viruses and bacteria – this in contradiction to what Medicine is claiming. No, a vaccinated person cannot protect others. So, what have we gained…?

The greatest scandal in such a situation is that the secondary effects of vaccination are rarely recognized or acknowledged. Instead of helping the patient who has become a victim of vaccination, some because they had no say, no informed choice,

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the medical, legal and political authorities leave these victims without financial or moral support. They are left alone with their disability. Far too often this means a life in abject poverty, because faced with this burden, many families fall apart and they even lack the energy to fight! They need what is left of their strength to keep going and to save what is left of their health. Where is the victory which modern medicine attributes to vaccination?

Case Analysis: HOLLAND

Foreword

The questionnaires were compiled from spontaneous reports received during the first half of 2004. Over 200 reports were received. A number of questionnaires were not filled in properly. A total of 161 were usable for the analysis that follows.

1. Number of cases: 161, classified according to age

0-2 mths	3-4 mths	5-6 mths	7-12 mths	13-16 mths	16-24 mths	2-5 yrs	5-10 yrs	11-15 yrs	16-25 yrs	25-45 yrs	45-75 yrs	**Total**
36	51	13	23	14	2	3	5	1	2	1	1	**161**

2. Pathologies by type of vaccine

Type de Vaccine	Cases
DT + Polio	4
DPT + MMR	2
DT + Polio + accellular Pertussis + HIB	4
DPT + Polio +HIB	129
HIB	4
MMR	12
Hepatitis B	5
Hepatitis A	1
Meningitis C	4
Total	**161**

- At the time the questionnaires were being collected, the whooping cough exponent in the DKTP vaccine was still whole-cell. In 2005, the Netherlands switched to the a-cellular whooping cough vaccine. Other countries made this switch earlier. DTP+Polio+ Hib scores very high in the case of complaints.

3. Interval between vaccination and appearance of symptoms

Reaction Time	Cases
Within 24 hours	103
Within 48 horus	12
After one week	25
Over one week	14
Unknown	7
Total	**161**

- The side-effects are generally noticeable soon after vaccination.

4. Longterm outcomes

With Permanent Damage	Without Permanent Damage	Death
46	113	2

Note: permanent damage implies a serious disability.

5. Pathologies Observed

Pathology	Case Number	Cases
Eczema	138,152,185	3
Rash/Urticaria	56,67,122,185	4
Loss of hair	114	1
Encephalitis	146,157	2
Febrile convulsions	1,8,15,30,66,74,78,99,141,183	10
Epilepsy	21,29,33,65,95,145,173	7
Status epilepticus	6,90,139	3
Convulsions	2,10,11,22,36,46,49,58,62,70,73,82,112,115, 116,130,135,142,162,180,181	21
Persistant crying	27,41,44,51,53,55,77,123,175	9
Eating and sleeping disorders	19,28,32,68,158	5
ADHD	117	1
Behavioural problems	105,151	2
Developmental problems	69,172	2
Shock	154	1
Oedema	155	1
Bronchitis	103,144,156	3
Asthma	13,31,34	3
High fever	4,26,39,47,52,53,85,86,100,109,110,119,131, 136,159,160,163,166,169,175,176,179	23
Nausea	93	1
Allergy	5,12	2
Intestinal problems	59	1
Collapse	3,7,16,23,37,42,48,50,57,61,83,91,94,104, 107,118,121,127,128,149,161,174	22
Legg disease	24,43,108,111,168,177	6
Kysbourne syndrome	60	1
Perthes disease	83	1
Hypotonia	35	1
Fever <39°C	14,17,18,20,25,38,39,40,41,45,54,63,64,71,72, 75,87,88,89,102,106,113,126,140,143,171	27
Death	98,147	2
	Total	**165**

6. Conclusion

The conclusions we can draw from all of the 161 reports correspond with testimonies from the other countries involved in our study:

- The confirmed side-effects are very diverse, ranging from a commonplace fever to death.
- The visible effects often appear immediately or very soon after vaccination.
- The simultaneous or combined administering of several vaccines makes it impossible to link confirmed complaints to a particular vaccine.
- Most side-effects occur in very young children.
- The DKTP + Hib vaccination is responsible for the most side-effects.

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In addition to the above survey, the NVKP also sent its own (different) questionnaire to parents, asking them about the health of their children. That analysis consists of a comparison of a group of vaccinated children with a group of non-vaccinated children. The results are very interesting. The analysis is included in the appendix.

Case Analysis: SPAIN

Cases collected from 1989 – 2004.

1. Introduction

The vaccination schedule applied in the different regions of Spain has undergone an unjustified intensification since the Eighties. At the same time, the number of pathological disorders linked to the injected vaccine ingredients continues to rise. This is why, in 1989, at the request of people affected by vaccines, we decided to initiate a survey through PROESVA (*Programa Efectos Segundarios de las Vacunaciones* or Vaccine Adverse Effect Programme), and to include these people in a table reflecting the situation as it is in Spain.

Later, following the development of the EFVV, we decided to submit all these data to the European Parliament in 2005 for the benefit and use of the entire European community.

This programme will continue to operate as long as there are people affected by routine vaccination programes applied on a massive scale and without discrimination.

2. Methodology

This is a retrospective study of the adverse effects experienced by vaccinated individuals in Spain who had contacted the *Liga para la Libertad de Vacunación*.

It is not an epidemiological study of all the people who have received routine vaccinations in Spain.

In 2000, delegates from nine European countries drafted a questionnaire together; in Spain this sheet was called *VAO* (*Vacunas Asunto a Observar* – Vaccine-Watch). The sheet included a number of variables geared to the collection of data on vaccine adverse effects. The questionnaire was distributed throughout Spain, either by post or by hand at seminars. It was also included in some magazines and newsletters.

Between 1989 and 2004, a total of 250 questionnaires were returned and analysed. This data collection work continues to this day and is updated all the time.

3. Results

Cases Analysed: 250

3.1 Geographical distribution of observers

The 45 different observers who reported vaccine adverse effects during this time period were distributed as follows across Spain: 48.89% in Catalonia, 17.7% in the Basque Country, 8.9% in Madrid, 6.7% in the Balearic Isands, 4.4% in Valencia and 15% in various other Spanish regions.

3.2 Geographical distribution of victims

Of the 250 people affected, 72.8% lived in Catalonia, 7.6% lived in the Basque Country, 6.8% in Madrid, 5.6% in the Balearic Isands, 2.8% in Galicia and the remainder in the rest of Spain.

3.3 Age distribution of reactions

Of the 250 individuals affected, 22% experienced a reaction between the ages of two and four months, 15.6% between the ages of six and 12 months, 12% between the ages of 12 and 16 months, 10.8% between the ages of 16 and 24 months, 15.6% between the ages of two and five years, 5.6% between the ages of five and ten years and between 25 and 45 years, 2% between 45 and 75 years (Table 1).

3.4 Gender distribution of victims

54.4% of the 250 victims were men and 45.6% were women.

3.5 Types of vaccine

37.2% of the vaccines administered were the DPT + Polio, 16% the MMR, 6% Tetanus, 4.8% the DPT + Polio + Hib, 5.2% Hepatitis B and A, 7.2% Meningitis A and C, 4.4% the DPT alone, 4% the flu vaccine, 3.6% the DTPolio, 3.2% Polio, 1.2% Smallpox and 0.8% Cholera (Table 2).

3.6 Type of vaccine by gender

The DPT + Polio combination was administered to 15.2% of the women and 22% of the men.

The MMR was givn to 8% of the women and 8.4% of the men.

The Tetanus vaccine was given to 2.4% of the women and 3.6% of the men.

The Hepatitis B and Hepatitis B + A were given to 3.2% of the women and 2% of the men.

The flu vaccine was administered to 1.6% of the women and 2.4% of the men.

The Meningitis A and C vaccines were given to 4% of the women and 3.6% of the men.

3.7 Existance of contraindications at the time of vaccination

14.4% of the 250 people affected presented with contraindications compared with 85.6% who had no contraindications at the time of vaccination.

3.8 Post-vaccinal complications

15.6% of the 250 victims had an encephalopathy, 10.4% had epilepsy, 18.2% had other neuropathies (Multiple Sclerosis, Meningitis, convulsions, ataxia, dystonia), 13.6% had bronchiolitis, bronchitis or asthma, 6.8% had a fever, 5.25% had infections, 3.2% contracted thrombocytopenia or diarrhoea, 2.8% had skin problems, 2.4% ended up with diabetes, 2% had rheumatism and 2% died (Table 3).

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3.9 Post-vaccinal complications by type of vaccine

The DPT + Polio vaccine, administered in 37.2% of the cases reported, triggered neurological complications (encephalopathy, convulsions, epilepsy, paralysis), respiratory ailments (asthma, bronchiolitis, laryngitis), haematological disorders (purpura), renal diseases (nephritis), febrile conditions and sudden infant deaths.

The MMR, which was administered in 16% of the cases reported, resulted in neurological, respiratory, haematological, renal and febrile conditions as well as diabetes and parotites.

The Meningitis A and C vaccines, which were administered in 7.2% of the cases reported, generated neurological complications (Meningitis), respiratory, haematological and febrile conditions.

The Tetanus vaccine, which was administered in 6% of the cases reported, triggered neurological complications, infectious diseases (recurrent Tonsillitis and Pharyngitis), rheumatological complaints (Arthritis) and skin ailments (Psoriasis and Lupus Erythematosus.

The Hepatitis A and Hepatitis A + B vaccines, administered in 5.2% of the cases reported, caused neurological and dermatological ailments, infectious diseases (Hepatitis), renal complications and Hypothyroidism.

The flu vaccine, administered in 4% of the cases reported, led to respiratory complications, vascular diseases (Angina), infectious diseases (the flu) and renal conditions.

3.10 Post-vaccinal complications by gender

It was observed that 8.8% of the women suffered with encephalopathy while only 6.8% of the men acquired this condition. At the same time, more men (7.2%) than women (3.2%) became epileptic.

Many more men (5.6%) than women (0.8%) became asthmatic while more little girls (1.2%) than little boys (0.4%) suffered a sudden infant death.

3.11 Post-vaccinal complications and other vaccines received

60% of the vaccine victims had received further vaccinations while only 39.2% had not.

3.12 Post-vaccinal complications by age

The highest incidence of neurological complications and sudden infant death occurred between the ages of two and 16 months (Table 1).

A relatively high incidence of convulsions and behaviour changes occurred between the ages of two and 24 months.
A large number of bronchiolitises were observed between birth and 16 months while drops in platelet count occurred more between six and 24 months.

3.13 Post-vaccinal complications by geographical area

The largest number of vaccine adverse effect victims were in Catalonia (72.8%), with the distribution of the others as follows: Basque country (7.6%), Madrid (6.8%), the Balearic Isands (5.6%), Galicia and Valencia (2.8%), Castile, Andalusia and Aragon (1).

3.14 Personal history, state of health and vaccines

91.2% of the victims had no illnesses at all at the time of vaccination while only 8.8% had an immune-compromised condition.

3.15 Relationship between post-vaccinal complications and allergies

10% of the vaccinated respondants had had previous allergic reactions while 90% of them had no knowledge of any allergies. We suspect that the victims who ended up with Laryngitis, Asthma, Pneumonia or Henoch-Schonlein Purpura had had allergic reactions related to these diseases.

3.16 Family history of allergy and vaccines

22.2% of the victims reported cases of allergy in their families while 78.8% of them reported no allergies in the family.

3.17 Family history, immune diseases and vaccines

12.8% of the victims reported family members with immune system disorders compared with 87.2% who reported none.

3.18 Relationship between post-vaccinal complications and family allergies

A related family allergy was observed in 20% of the victims who became asthmatic following vaccination, in 20% of the victims who had bronchiolitis after vaccination, in 15% of the victims who got bronchitis or a fever and a cough after vaccination, and in 10% of the victims who had convulsions or diarrhoea following vaccination.

3.19 Chronological cause and effect links

163 (65.2%) of the 250 cases studied presented a well-defined chronological cause and effect link, 50 (20%) presented a conditional cause and effect link, 36 (14.4%) a probable lilnk and in 1 (0.4%) there was no link at all.

3.20 Chronological cause and effect link and post-vaccinal complications

Well-defined link: 38% of the neurological disorders, 11.2% of the respiratory ailments, 3.2% of the haematological and febrile complications, 1.6% of the dermatological and nephrological conditions, 1.2% of the digestive complaints.

Probable link: 2.4% of the asthma cases and 1.2% of the pneumonia cases.

Conditional link: 2% of the diarrhoea cases, 1.2% of the diabetes and recurrent tonsillitis cases.

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3.21 Chronological link and gender

Well-defined link: 34.8% of the women compared with 30.4% of the men.

Probable link: 7.6% of the men compared with 6.8% of the women.

Conditional link: 12% of the male victims compared with 8% of the female victims.

3.22 Reaction time and vaccination

The reaction was immediate in 93 (37.2%) of the cases. The interval between vaccination and reaction was relatively short-term in 77 (30.8%) of the cases, moderate in 66 (26.4%) of the cases and long-term in 14 (5.6%) of the cases.

3.23 Type of Reaction

The complication was specific in 128 (51.2%) of the cases compared with 122 (48.8%) in which it was non-specific.

3.24 Relationship between the type of vaccine and the type of reaction

DPT + polio: 26% were specific reactions and 11.2% were non-specific.

MMR: 7.6% were specific reactions and 8.8% were non-specific.

DPT + polio + Hib: 3.6% of the reactions were specific compared with 1.2% which were non-specific.

Meningitis A and C: 3.6% of the reactions were specific and 4% were non-specific.

Flu, Polio, Hepatitis B and Hepatitis B+A: 2% of the reactions were specific and 4% were non-specific.

3.25 Intensity of the reaction

In 56 (22.4%) of the cases, the reaction was mild compared with moderate in 73 (29.2%) and serious in 113 (45.2%); in 8 (3.2%) of the cases the victim died.

3.26 Relationship between the type of vaccine and the severity of the reaction

Our study revealed that the DPT + Polio, Tetanus, DTPolio and DPT alone caused 60% of the serious complications and 50% of the deaths.

The MMR vaccine caused 15% of the mild reactions, 10% of the moderate reactions, 20% of the serious reactions and none of the deaths.

The Meningitis A and C vaccines resulted in 15% of the mild reactions, 5% of the moderate reactions, 2% of the serious reactions and 35% of the deaths.

3.27 Relationship between the post-vaccinal complications and the severity of the reaction

The most serious adverse effects were neurological, respiratory, renal, haematological and endocrine (diabetes).

4. Conclusions

Most of the reactions observed were specific, i.e. they could be presented as direct consequences of a particular vaccination. The most frequent reactions were neurological (encephalopathy, epilepsy, meningitis, myelitis, neuritis).

- A number of vaccines, e.g. DPT + Polio, MMR, Tetanus, Hepatitis B, caused convulsions; behavioural changes were linked with several vaccines such as Meningitis A and C, Hepatitis B, DPT + Polio, MMR. Autism appeared after the DPT + Polio or DPT + Polio + Hib, and Myelitis appeared after DPT + Polio, Polio alone or Tetanus injections.
- Convulsions, epilepsy and Rett's Syndrome were observed after administration of the MMR.
- Among the non-specific reactions, it is important to mention the allergic-type respiratory ailments such as asthma, bronchiolitis and bronchitis; the skin conditions such as atopic eczema and urticaria; and the digestive disorders such as food allergies and intolerances. These also included autoimmune reactions such as thrombocytopenia, nephrotic syndrome, vascularity, diabetes, rheumatoid purpura (Henoch-Schonlein Purpura disease), optic neuritis, hypothyroidism, lupus erythematosus, retinitis pigmentosa, multiple sclerosis and psoriasis, as well as inflammations and infections such as adenitis, recurrent tonsillitis, diarrhoea, pharyngitis, urinary tract infections, mononucleosis (glandular fever), pneumonia, fever, parotitis and tuberculosis.
- The most frequent and incapacitating neurological complications were caused by the combined DPT + Polio vaccines, primarily between the ages of two and 24 months.
- It is of interest to compare the effects observed following the administration of DTPolio and DPT. A comparison reveals that the DPT caused two cases of bronchiolitis and two cases of convulsions while the DTPolio did not cause this type of reaction at all. The Pertussis component was therefore significant in the appearance of these complications.
- Considering the characteristics of the pathology and the point in time when it appeared, the sequelae were severe, irreversible or even led to death.
- The incidence of death following administration of the combined Meningitis A and C vaccines was high.
- The incidence of post-vaccinal complications from the Tetanus and flu vaccines was high, in spite of the fact that they are single vaccines.

5. Recommendations

- Based on the conclusions of this study, it would be advisable to propose that the health and other competent authorities delay application of vaccination schedules until 24 months at the very earliest, preferably later, and to adapt them to each individual case.
- Considering the complications they cause, the manufacture, distribution, and sale in pharmacies of combined and multiple vaccines should be discontinued.
- Considering the very serious reactions it triggers, the Pertussis vaccine should be reomoved from the market.
- Adjuvants such as mercury and aluminium must be banned from use in vaccines.

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Table 1. Age distribution of victims

Age	0-2 mths	2-4 mths	4-6 mths	6-12 mths	12-16 mths	16-24 mths	2-5 yrs	5-10 yrs	10-15 yrs	15-25 yrs	25-45 yrs	45-75 yrs	75 + yrs	Total
No.	9	55	21	39	30	27	24	14	6	5	14	5	1	
%	03.60	22.00	08.40	15.60	12.00	10.80	09.60	05.60	02.40	02.00	05.60	02.00	00.40	**250**

Table 2. Types of vaccine implicated

Type of Vaccine	Cases	%
Cholera	2	0.8
DT polio	9	03.6
DPT	11	4.4
DPT + polio	93	37.2
DPT + polio + Hib	12	4.8
DPT + polio + Hib + Men C	5	2.0
Acellular DPT + Polio	1	0.4
Acellular DPT +Polio + Hib	2	0.8
Acellular DPT + Polio + Hib +Men C	1	0.4
Flu	10	4.0
Hepatitis A + B	1	0.4
Hepatitis B	12	4.8
Men C	12	4.8
Men C + A	7	2.8
Pneumococcus	1	0.4
Polio	8	3.2
Heaf test	1	0.4
Rubella	1	0.4
Measles	1	0.4
Tetanus	15	6.0
MMR	41	16.4
Small pox	3	1.2
Miscellaneous other vaccines	1	0.4
Total	**250**	100.0

Table 3. Adverse effects observed

Pathologies	Cases	%
Angina	1	0.4
Aplasia (low platelet count)	2	1.6
Arthritis	3	1.2
Asthenia	1	0.4
Asthma	16	6.4
Atopic dermatitis	2	0.8
Autism	2	0.8
Behavioural changes	10	4.0
Bronchiolitis	13	5.2
Bronchitis	5	2.0
Cellulitis	1	0.4
Convulsions	11	4.4
Cough	4	1.6
Coxotuberculosis	1	0.4
Deafness	1	0.4
Death	1	0.4
Diabetes	6	2.4
Diarrhoea	7	2.8
Digestive intolerance	1	0.4
Dystonia	1	0.4
Eczema	4	1.6
Encephalopathy	39	15.6
Epilepsy	26	10.4
Febrile syndrome	17	6.8

Pathologies (cont.)	Cases	%
Flu	4	1.6
Food allergies	2	0.8
Henöch-Schonlein Purpura	4	1.6
Hepatitis	2	0.8
Hyperthyroidism	1	0.4
Laryngitis	5	2.0
Leukaemia	1	0.4
Lupus erythematosus	2	0.8
Lymphadenitis	2	0.8
Meningitis	3	1.2
Mononeucleosis (Glandular fever)	1	0.4
Multiple Sclerosis	2	0.8
Mumps	4	0.8
Myelitis	4	1.6
Nephrotic syndrome	5	2.0
Optic Neuritis	1	0.4
Otitis	3	1.2
Paralysis	5	2.0
Pneumonia	6	2.4
Psoriasis	1	0.4
Recurrent pharyngitis	1	0.4
Recurrent tonsillitis	4	1.6
Retinitis pigmentosa	1	0.4
Rett's Syndrome	2	0.8
Cerebellar ataxia	1	0.4
Sudden infant death	4	1.6
Tuberculosis	1	0.4
Urinary tract infection	2	0.8
Vascularity	1	0.4
TOTAL	**750**	100.0

Some Letters—British Testimonies

Alan R., father of M.R.

As many of you know, my younger son was severely damaged by vaccines. Our home videos show how a normal, happy, healthy, sociable child who could laugh and talk, was rendered autistic, unreachable and speechless—humming, screaming, flapping his hands and banging his head. It was horrific. Even worse—we were told the condition was incurable and that nothing could be done….

…I was able to get a series of tests done. These showed that M. had severe dysbiosis and suffered from leaky gut syndrome. He was riddled with fungus and parasites and their toxins were lodged in his body. The vaccines had damaged his gut wall, his digestive system was not working properly, proteins were being broken down into peptides instead of amino acids and these and other semi digested foods were leaking through his damaged gut and causing havoc…

…It is easy to destroy someone's life with a jab. It is the work of a moment…

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…It is plain from the medical and scientific literature that there is no evidence that vaccines confer immunity against anything. No double-blind placebo-controlled trials have ever been conducted. No long-term safety trials have ever been carried out. Even if such evidence did exist, scientific studies show that vaccines cause death, cancer, acute encephalopathy, anaphylaxis, febrile seizures, Guillan Barre syndrome, arthritis, M.S. polio, asthma and allergies, among other things. When Japan raised the the vaccination age to two years, cot death ceased to exist and infant mortality plummeted. Vaccines contain known carcinogens such as formaldehyde, aluminium phosphate, thiomersal (a mercury compound), foreign proteins and contaminating animal proteins and viruses from the tissues used to grow them…

…The last few years have been extremely difficult and I would not wish this misfortune on anyone. Let us bring the autism epidemic to an end so that nobody else has to suffer as we have. The strain has been appalling but your support and encouragement have made things a lot easier. Thank you once again.

J.S., born 1990

J. was 16 months when he was given his first MMR vaccine (pluserix – batch 142 A434 SKF). This was withdrawn in September 1992 as being a high-risk vaccine. Until now James had developed normally. He was very bright and outgoing and spoke exceptionally well for his age. He would call Mummy on waking in the mornings, and shake his cot. He enjoyed talking to his grandparents on the telephone and would greet them enthusiastically when they came to visit saying "Hello Granny June" or "Granny Mo". He had a bedtime conversational routine about who loved him: "Mummy loves James", "Daddy..." etc., going through the names of all his relatives. This was not a rigid autistic-like routine, but a real thought process about his family. He would dance in front of the TV to Top of The Pops, and sang nursery rhymes. He would look at pictures in books and say the names of animals and make their noises. He loved to laugh and make others laugh too. He was a very cuddly and gregarious boy, a real bundle of fun.

Within two weeks of receiving his first MMR injection we noticed his eyes were glazed. We expressed concern. We noticed he was not speaking so much and he would often rub his head as if in pain. He also developed diarrhoea and a tremendous thirst. The GP thought that none of these symptoms were significant and said his glazed eyes and loss of speech were due to catarrh. James was given a second dose of MMR on 19.5.93 (records at the surgery do not tie up with those kept by the health authority). After this he lost his speech almost completely, often struggling to find a word, being unable to find it, and eventually giving up trying. His behaviour became increasingly hyperactive. He would race round the room uncontrollably at playschool and we noticed he was speaking less and less. Eventually all three playschools we tried said they could not cope with him and asked him to leave. We also noticed he no longer seemed to feel pain. Once, his fingers were shut in a door and he didn't cry, and he touched a hot grill without whimpering. He lost his extrovert character and developed severe communication problems, to the point where he now rarely acknowledges anyone, cannot speak, cannot play games and has no concentration…

…His psychologist has described him as having atypical autism.

J. is now at the Forum school in Dorset. He still has no language at all. He is still very destructive, wrecking his bedroom and furniture when home, and, when frustrated, rips his clothes to shreds and runs around naked. He needs two carers to look after him. During holidays at home with his mother, Social Services send two people for occasional respite. His parents have now split up and are living in separate homes.

C.S.—Chronological events following Hepatitis B injection

1990	*Initial 3 Hep B injections throughout the year. Three large boils on R. leg resulting in eczema.*
09.01.95	*Engerix B given, age 50.*
12.01.95	*Severe cold and flu. Sick for one week. Aches and pains in joints. Acute tiredness.*
20.03.95	*Severe cold and flu. Sick for one week. Aches and pains in joints. Acute tiredness. Saw a doctor who realised his hands were swollen and prescribed a pain killer, Brufen®. Chronic fatigue, bad tempered, continual aches and pains.*
04.09.95	*Visited doctor who told him his aches and pains were due to him getting old.*
01.12.95	*Severe cold and flu. Very high temperature. Shaking and felt cold. I have never seen him like this before. Sick for ten days. Hands X-rayed and blood tests for rheumatism.*
12.01.96	*Returned to work but collapsed. Doctor didn't know what was wrong. X-rays showed nothing. Diagnosed with Rheumatoid Arthritis. Off work until 06.99. Gained weight because he had been told only to do light exercise. Prescribed Sulphasalazine. What damage are these drugs doing to his kidneys and liver? If he didn't take them he could not hold down a job. Our doctor is very sympathetic and completed a confidential questionnaire and sent it to SmithKline Beecham. They wrote a standard letter back saying they only have 10 reports of reactions in every 10,000 doses. We have started a Hepatitis B Vaccination Victim Support Group. We have 50 people on our list.*
07.96	*Returned to work as a medical and dental engineer, but no longer has the energy and strength to perform his job. Given a desk job.*
12.97	*"Tomorrow's World" TV program discussed the Hep B vaccine. They said that in older people the vaccine was causing people's immune system to attack itself.*
09.99	*My husband applied for medical retirement as he is unable to work more than two days a week.*

D.T., father of O.T.

Dear Lesley, I returned the enclosed form. There should be many thousands of people, in my view, filling out these forms. I am on good terms with my MEP, and please let me know if this can be of any help. I also gave evidence to the House of Commons Health Committee last June, and enclosed the contents and executive summary. The full document was published through HMSO, and is available on the House of Commons website, under Health Committee publications. If you want me to post you a copy let me know. With kind regards, D.T.

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Anonymous

I can't tell you my name and I can't give you my baby's details because I'm scared of anything coming back to me, but I wanted to get in touch when I heard about your project, because I'm so glad that someone is doing something. My baby died within 24 hrs. of having her first DPT, two months ago. I feel so dreadful, no one can begin to imagine what it's like. She was perfect. Then she had the injection and screamed for at least an hour, in a strange way. Then she got very sleepy, and basically just didn't wake up again. I got worried because she seemed to be sleeping longer than usual and when I went to check her I found she wasn't breathing and she'd vomited a small amount. They had to do a post mortem but couldn't find any reason for her death. I know it was the vaccine that killed her. She hadn't had a day's illness before it. I'm scared even writing this to you though because I know they think I killed her. "Munchausen's syndrome by proxy" it's called. The more I told them I think it was the vaccine, the more hostile they got. I'm scared because I don't want them to take my other child away, and I don't want them to charge me with murder. I shouldn't have to live like this, it's terrible. I'm almost too frightened to grieve properly for my baby. She was so sweet.

Please do your project and make sure that people see the truth. Please be my voice.

8. OVERALL CONCLUSIONS

Our research was based on approximately 1000 cases of individuals ranging from birth to 75 years of age and, for the Belgian, British, French and Dutch components, covered a six-year period (from 1999 to 2004). The Spanish research covered 12 years (1987-2004). Most of the pathologies testified by the respondents had not been recognised or acknowledged as post-vaccinal complications and had consequently not been reported to the pharmacovigilance services.

The patients all admitted that from the very beginning, they had suspected a vaccination to be the cause of their symptoms, but the medical profession did not monitor them and denied any cause and effect link. Most of the patients complained that their doctors had treated them with disregard and scorn, even to the point of ridicule, refusing to accept that a vaccine could have been responsible for the often poorly defined ailments they were experiencing (see attached letters pg 57).

The following points are worth noting, among others, as significant:

- Most of the time, especially in the case of heavy pathologies, the onset of symptoms was gradual—the degradation would start with a few minor changes which the patient would tend to dismiss. Things then got worse after a booster vaccine.
- The greater the dose of the vaccine, the worse the ailment.
- Multiple vaccines tend to complicate the situation making it difficult to blame any one particular component.
- The complexity of the ailments observed would tend to indicate the emergence of a whole new health catastrophe in our society—vaccine-triggered diseases.

8.1 Types of ailment

The post-vaccinal complications observed ranged from an abnormally high and persistant fever or an inexplicable hypothermia all the way to death, including a whole series of pathologies involving all bodily systems. The list below gives an idea of the pathologies observed in the data collected.

1. Neurological	Autism
	Changes in behaviour
	Convulsions
	Persistant, inconsolable crying
	Encephalitis
	Epilepsy
	Chronic fatigue
	Fibromyalgia
	Hyperactivity
	Meningitis
	Myelitis
	Paralysis
	Multiple Sclerosis
	Deafness
	Rett's Syndrome
	West Syndrome
2. Allergic	Asthma
	Bronchiolitis
	Cellulitis
	Anaphylactic Shock
	Dermatitis
	Eczema
	Digestive Intolerance
	Laryngitis
	Psoriasis
	Persistant cough
	Hives
3. Infectious	Lymphadenitis
	Tonsillitis
	Arthritis
	Bronchitis
	Flu
	Hepatitis
	Urinary Tract Infection
	Mononucleosis (Glandular Fever)
	Mumps
	Otitis
	Pharyngitis
	Pneumonia
	Measles
	Fever syndrome
	Tuberculosis
3. Autoimmune	Diabetes
	Thrombocytopenia
	Lupus
	Henoch-Schonlein Purpura
	Retinitis
	Nephrotic syndrome
	Thyroiditis
	Vascularitis
4. Cancer	Leukaemia
	Hodgkin's Disease
5. Death and Sudden Infant Death (SID)	

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8.2 Types of Vaccines Implicated and Related Pathologies

The multiple vaccine containing Diphtheria, Tetanus, Polio, Whooping Cough and/or Hib was the most frequently blamed for neurological pathologies.

The Hepatitis B vaccine was the most often blamed for auto-immune and joint diseases and various poorly defined pathologies falling under the generic term of "chronic fatigue".

The triple MMR (Measles, Mumps, Rubella) vaccine was considered to be responsible for the appearance of diabetes, ENT and kidney problems, and also arthritis.

The flu vaccine seemed to result in respiratory problems and various flu-type ailments.

All the other vaccines, whether combined or not, managed in one way or another to trigger ailments whose intensity and sequelae varied depending on the individual.

8.3 Length of Time before Symptoms Appeared

For three quarters of the victims, the length of time before the post-vaccinal reactions occurred ranged from hours after the injection up to around 60 days following the injection. Other reactions occurred beyond the first two months after the injection. For a few victims, the significant undesirable effects only became apparent several years after the injection. It is of course difficult in such cases to establish an absolute link between a deterioration in health and vaccinations received, especially since we have never set up a system for monitoring these phenomena carefully. There is however a consistent theme—right from the very first injection, vaccinated children seem to be somehow "off colour" (disturbed sleep, loss of appetite, changes of character, irritability, recurrent ENT infections, etc….). Such disturbances are considered to be "normal" but sadly, they are precursers to much heavier pathologies which may only manifest much later in life.

This study does not claim to be of rigorous statistical or epidemiological value. We must however acknowledge that the number of post-vaccinal adverse effects collected is significant. They are enough to deny the claims of the pro-vaccination camp, the propaganda which would tend to suggest that vaccinations are virtually harmless. The percentages presented by the medical profession are not often an accurate reflection of reality. The parents of a vaccine-damaged child have become nothing more than figures in a profit and loss statement (if they are considered at all) while for them the vaccine was more than 100% counterproductive. The victims all, without exception, felt abandoned and alone with their distress.

If detailed records of the adverse effects arising after vaccination had been kept for more than a century, the Vaccination track record would surely be far from impressive. There is a very good chance that the total number of vaccine damage victims would exceed the number of victims of the diseases concerned. Should we really continue a practice which is so destabilising for the health of our world populations and which represents such a financial burden for our societies? We sincerely hope that the results of the work we have done here in Europe will resound across the globe and trigger growing awareness of this controversial issue.

9. EFVV PROPOSALS

9.1 Introduction

The European Forum on Vaccine Vigilance has been working actively in around ten European countries for the last six years. This work, which has involved research into the undesirable effects caused by vaccination, has culminated in the conviction that **vaccination must never be enforced as mandatory and its adverse effects must be acknowledged on a much greater scale**.

9.2 Absence of Pre-vaccination Pharmacovigilance

Our work has revealed that in all European countries, the patient's background prior to vaccination is never taken into account. This lack of knowledge of the vaccinated individual's profile and sensitivities is only compounded by a similar insufficiency, across Europe, of pharmacovigilance. If vaccination is designed to be a disease prevention tool, in-depth awareness of each individual's medical history must be a prerequisite to its administration. Current knowledge in the field of immunology (and particularly information on the HLA system) necessitates investigation into susceptibilities, predispositions and the individual diathesis before any vaccination may be administered.

9.3 Absence of Post-vaccination Pharmacovigilance

No vaccine-focussed pharmacovigilance worthy of such a name exists in any country. It would therefore seem of utmost urgency today to institute a comprehensive and independent system whereby the impact of vaccinations on our populations would be monitored. At present, the effects of vaccinations are observed in the short term (three months at most) which is totally insufficient for detecting the adverse effects of antigenic stimulation. Vaccines cause long-term physical changes to the human body and it is therefore in the long term where we must consider the validity of any preventative techniques.

We have observed that routine vaccination causes a gradual destabilisation of the body resulting in the emergence of new diseases, chronic degenerative diseases whose development is progressive and diffuse, often inconspicuous and insignificant at first, diseases against which conventional therapies repeatedly remain ineffective. This realisation has become clear not only in all the European countries in which our group has worked but also across the globe, regardless of race, geography or culture.

9.4 Combined Vaccines Make Cause and Effect Links Difficult to Establish

At present, the use of multiple vaccines (up to seven antigenic stimulations at once) makes it difficult, if not impossible, using any kind of allopathic medical method, to establish a cause-and-effect link between a specific vaccine and subsequent ill health. Only non-conventional medicines offer a precise approach to these issues and can provide insight into this potential relationship. The large number of combined vaccines in use today has made cause-and-effect research hopelessly entangled.

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This does not however justify the acceptance of these risks, or the suggestion that problems arising after vaccination are nothing more than "coincidence". Such an opinion is ethically unsound. Now, after 100 years of mass vaccination, we have observed that the number of post-vaccinal pathologies far exceeds the number of diseases which were supposed to be eliminated by vaccination. Is this progress? What is the **real** impact of mass vaccination on our health?

There is no single definition of health, and illness is usually multi-faceted. This makes it difficult to draw a clear link between cause and effect. We must therefore stop demanding "absolute proof" (as in criminal law) and err on the side of caution, basing our decisions on clusters of scientific probability. We must, above all, listen to the victims and take their "dis-ease" into consideration. Human beings are more than simple numbers in statistical tables; to reduce them to a profit and loss statement is nothing less than tragic.

We therefore propose:

I. Assuming Constitutional Equality

1. That mandatory vaccination be abolished in all European countries

No law can justify the practice of vaccination because mandatory vaccination is an assault on our physical integrity and therefore a breach of all texts guaranteeing the fundamental liberties advocated across Europe (Declaration of Human Rights, the EU Charter of Fundamental Rights, the EU Code of Medical Ethics, the precautionary principle…).

Abolition of mandatory vaccination would eliminate the possibility of restrictions being imposed against children attending school or individuals at work. All direct or indirect, physical or moral obligations or coercions to immunise must therefore also be abolished.

2. Barring full abolition of mandatory vaccination, that a conscience clause be applicable

This implies that all citizens will be governed by a **conscience clause** whereby, following examination of their souls and consciences, and assuming full responsibility, they have the right to make the choice themselves as to whether or not they will be vaccinated and whether they will vaccinate their children. When it comes to vaccination, freedom of choice is a fundamental human right; consequently non-compliance may not ever constitute grounds for criminal proceedings.

3. That there be no discrimination in the eyes of the law

This implies equal rights for all in all matters of law, employment and health. No discrimination will therefore be tolerated between those who have been vaccinated and those who have not. The choice not to vaccinate a child must never be considered an offence which might incriminate a parent in a personal conflict (e.g., in divorce proceedings).

It goes therefore without saying that this freedom, which is clearly stipulated in law, must be enforced across Europe, in all countries without exception and in the same way.

4. That the physical integrity of every European citizen de serves total respect

Enforced vaccination is an assault on an individual's physical integrity, as defined in all the texts which guarantee fundamental liberties in the European Union. It is intolerable that vaccination might be an exception to this rule or fall outside the law. By claiming protection of the masses, vaccination somehow manages to evade our system of private law whereby all citizens are guaranteed control of their bodies. We insist that vaccination be a matter only of personal and individual choice, without any governmental, medical or economic pressure of any kind on anyone.

II. That Everyone be Fully Informed of the Adverse effects of Vaccinations

1. That both the health authorities and the public be informed

Doctors and the pharmaceutical industry are required by law to inform their patients and the general public of the risks associated with their treatments. As such, notification of the accidents which might occur as a result of a vaccination must be compulsory. Data on this subject must be accessible to all, in their entirety, without lies or omissions, and in complete transparency. They must not be concealed, censored or denied by the medical profession. In fact, they could be the basis of a pre-vaccination discussion between a patient and his general practitioner, enabling the patient to make an informed decision. The GP's duty must be to reduce any possible vaccination risk (e.g. through the use of a standard questionnaire). It is essential that all medical students receive in-depth training on both the risks and the benefits of vaccination and that a broad range of both medical and para-medical research be consulted for this purpose.

2. That the experts be informed

We insist that the full range of medical disciplines and options with respect to health and disease prevention be democratically represented in all European governmental bodies where decisions are taken.

3. That patients be informed

All the different ingredients contained in a vaccine must be specified on the leaflet supplied by the manufacturer for the consumer. Manufacturers failing to provide this information must be fined and brought to account. These ingredients must also be specified in all specialised medical dictionaries (Vidal, Martindale, Red Book, Medex, etc.)

III. That an Effective and Independent Vaccinovigilance Unit be Created.

1. That the precautionary principle be respected

Based on their ingredients alone, vaccines are highly toxic substances. In addition, the live or attenuated germs from which they are made present a direct risk, as there is always the potential for these germs to revert to their original state. What is more, far too much of the information disseminated on the effectiveness, the harmlessness and the duration of the protection vaccines impart remains uncertain, making vaccination extremely risky. Vaccinations are also given to

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individuals who are totally different one from another, which can result in unexpected and unpredictable reactions. It is vital, in such a case, that the precautionary principle, whereby no action is taken if there is the slightest shadow of a doubt, must be respected. Against this background, it would be absolutely iinconceivable for the doctors who prepare vaccine contraindication literature to be put under any kind of pressure.

At the same time, parents who choose to delay vaccination for their children, must be allowed to postpone the start date until the child is at least age two.

Considering the damage that heavy metals cause in the human body, it is crucial that all mercury, aluminium and other composites whose adverse effects are well known, be removed from vaccines.

2. That an exhaustive survey be conducted of the adverse effects of vaccines

It is imperative that there be a dedicated pharmacovigilance unit for vaccinations alone. The data collected by this unit must be accessible to the general public, to the medical profession, to all healthcare practitioners, to support and campaign groups, to patients, etc.

This unit, which would operate in all EU countries, would report to independent scientific bodies. It would be the responsibility of these pharmacovigilance authorities to receive and dispense (in the standard format of drugs side effects leaflets) all information on the effects of vaccinations, without restrictions of any kind. The medical profession would be required to notify this unit of any post-vaccination events and anyone would have the right to file a complaint for non-compliance with these rules.

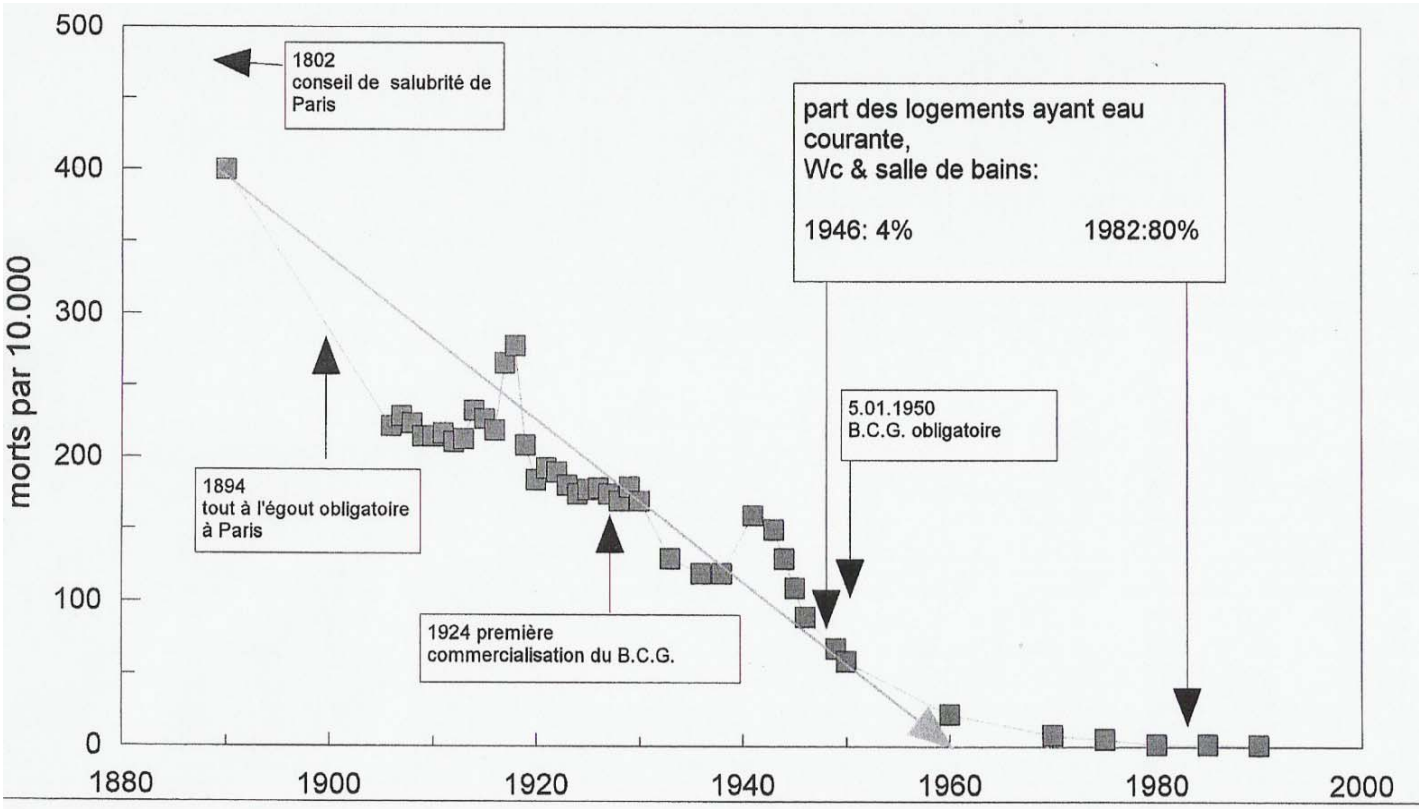
The idea of a **European Vaccinovigilance Centre** or a **European Observatory for the Adverse Effects of Vaccination** was already proposed long ago, during the intergroup meeting of the European Parliament held with Professor Lery on the 7th of July 1996 in Strasbourg. To be truly effective, such a vaccinovigilance unit would have to be dedicated to the service of consumers, not the vaccine manufacturers. As such, a broad range of independent opinions would be required before any research study could be considered to be valid.

IV. Compensation for all Vaccine Damage

It is also imperative that all European Union countries institute a system for systematic compensation of vaccine damage victims. The procedure which victims must follow to obtain recognition of the damage they have suffered, and for the medical profession to take their conditions seriously, needs to be simplified. Far too often, the complaints of these victims are minimised to the point of ridicule, as soon as vaccination is blamed. If adequate compensation for vaccine damage pathologies is to be considered without dispute, a dramatic change of attitude will be required on all levels. It is then, and only then, that it will become possible to assess the true cost of vaccination for our society and to reverse the risk/benefit balance.

Appendix 1. Tuberculosis in France with Salient Events over Time

(Sources: quid, insem, institut national d'Hygiène, Larousse Médical)



Deaths per 10,000;1802 Paris Public Health Council;1894 Mandatory mains drainage in Paris; 1924 BCG launched
Proportion of homes with running water, toilet & bathroom: 1946: 4% 1982: 80%; 5.01.1950: BCG mandatory

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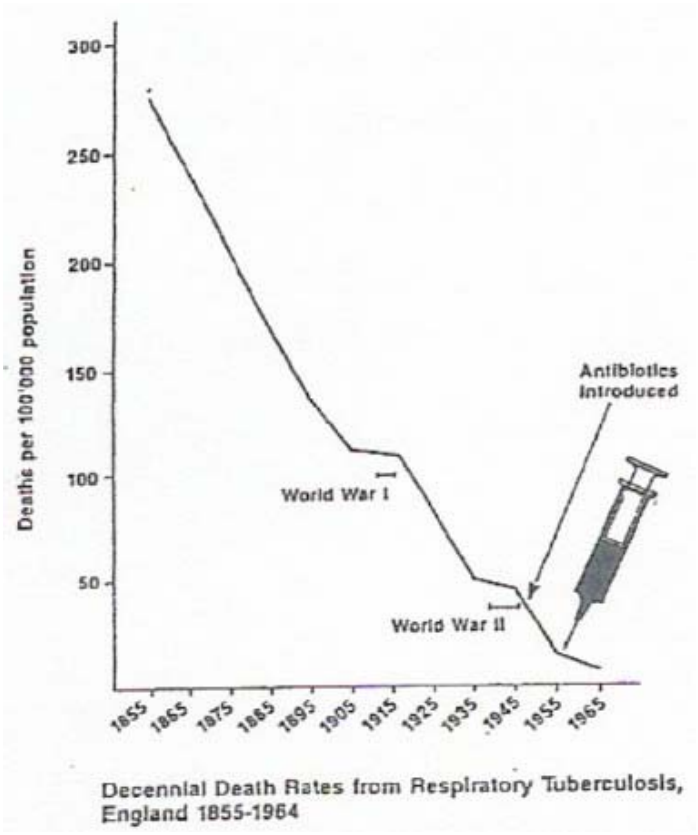
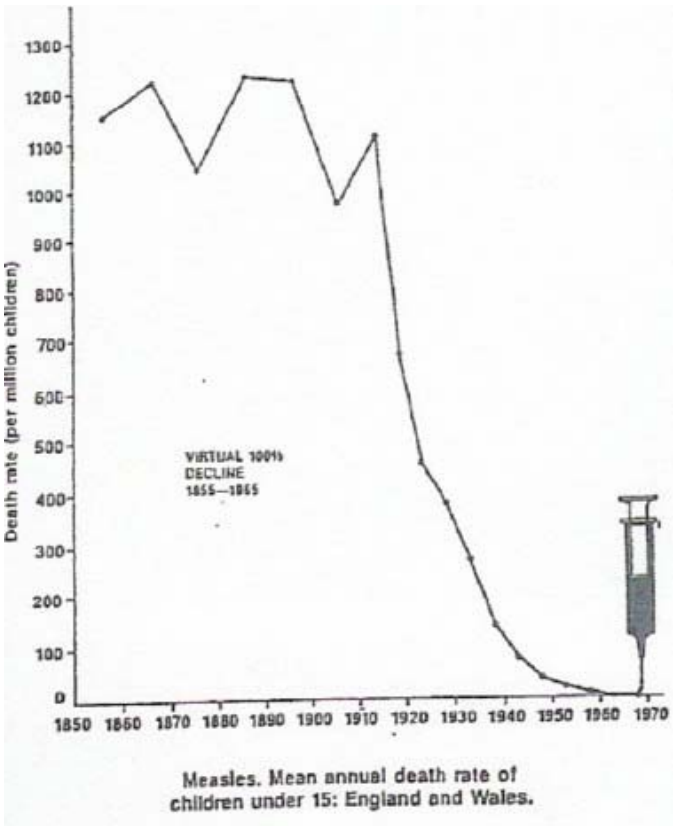
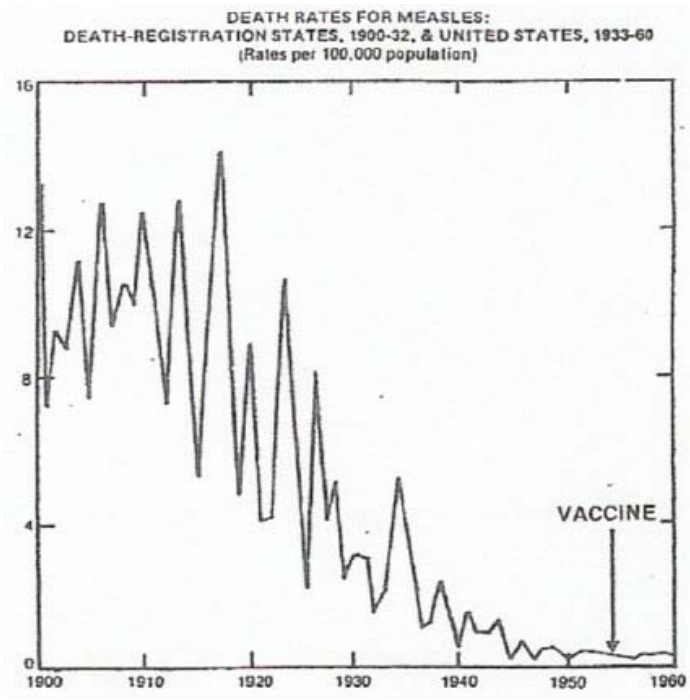
Some Infectious Disease Graphs

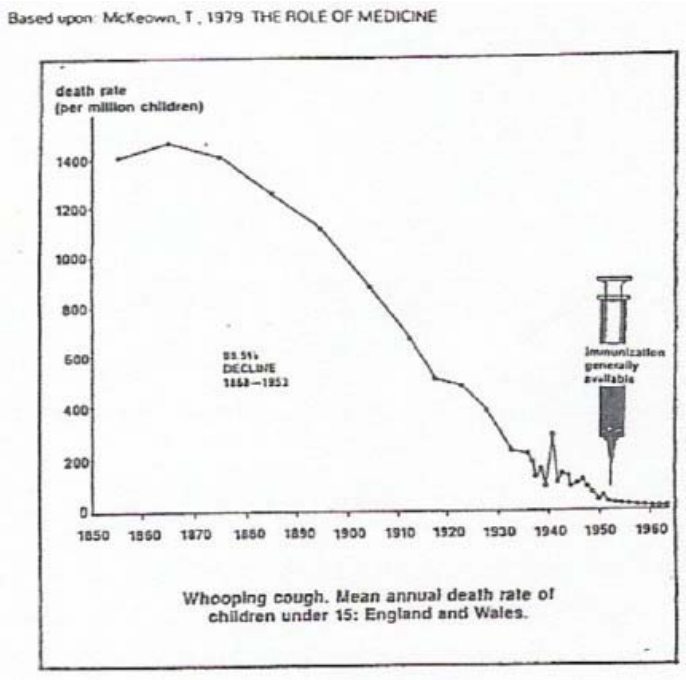


Decennial Death Rates from Respiratory Tuberculosis, England 1855-1964



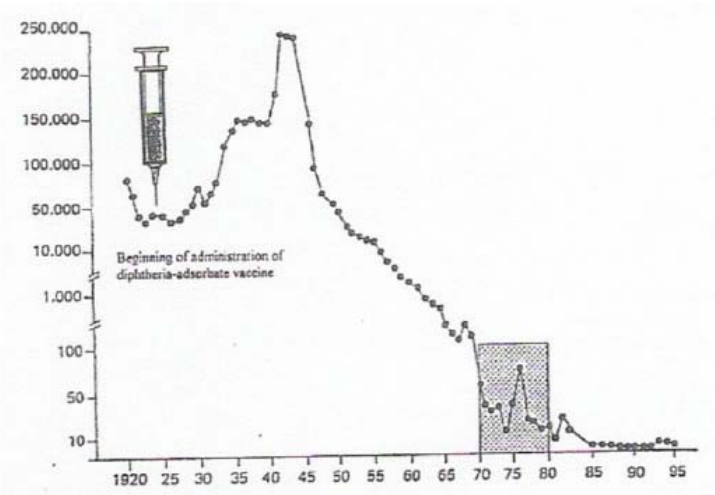
Measles. Mean annual death rate of children under 15: England and Wales.



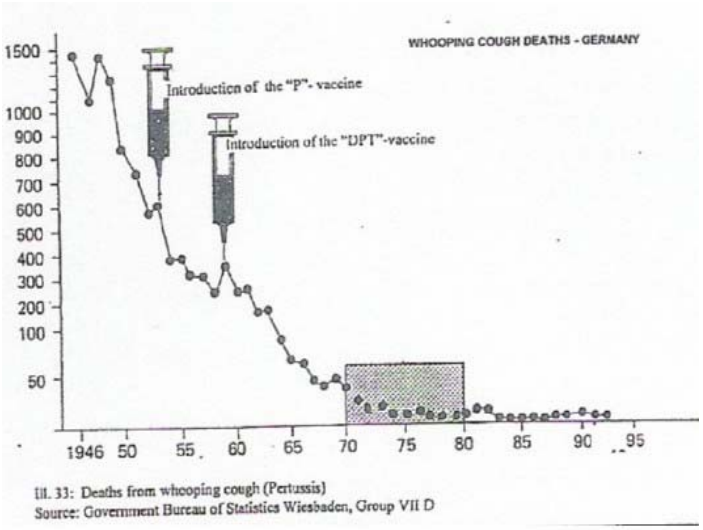


Whooping cough. Mean annual death rate of children under 15: England and Wales.

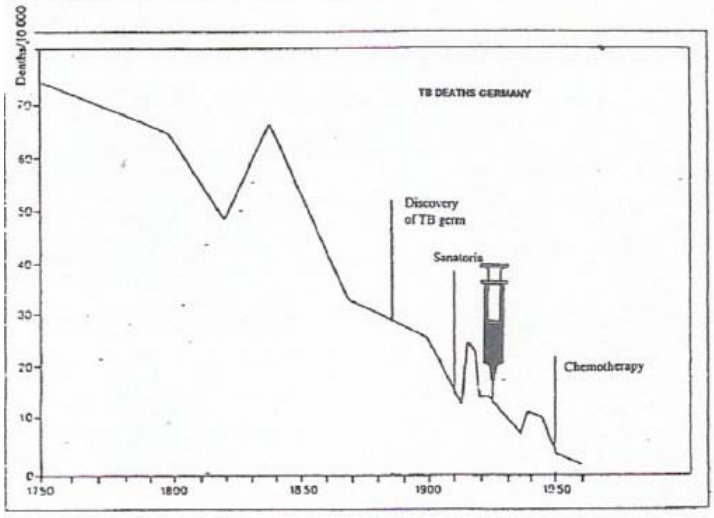
doi: 10.1588/medver.2005.02.00089



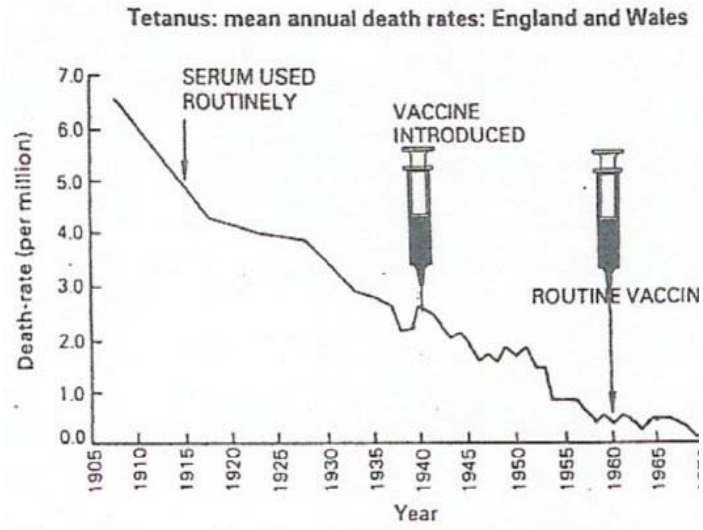
Diphtheria cases in Germany 1920-1995
Source: Government Office for Statistics, Wiesbaden



Ill. 33: Deaths from whooping cough (Pertussis)
Source: Government Bureau of Statistics Wiesbaden, Group VII D



Ill. 4: Mortality curve of Tuberculosis in Germany from 1750 to 1950.
Source: Wise. H.-J.: Epidemiology of infectious diseases in West Germany.
Yellow Journals 5 (1984)



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Appendix 2. Dutch study comparing a group of vaccinated children with a group of non-vaccinated children

The NVKP (Nederlandse Vereniging Kritisch Prikken) [in English: Dutch Association for Conscientious Vaccination] is an independent association made up of therapists, doctors, and parents, amongst others. The NVKP's aim is freedom of choice for parents when it comes to vaccinating their children, based on honest, comprehensive, and independent information. We view the current 'one size fits all' vaccination policy with great concern. The NVKP is therefore urging the adoption of more thorough independent research by representatives from different disciplines.

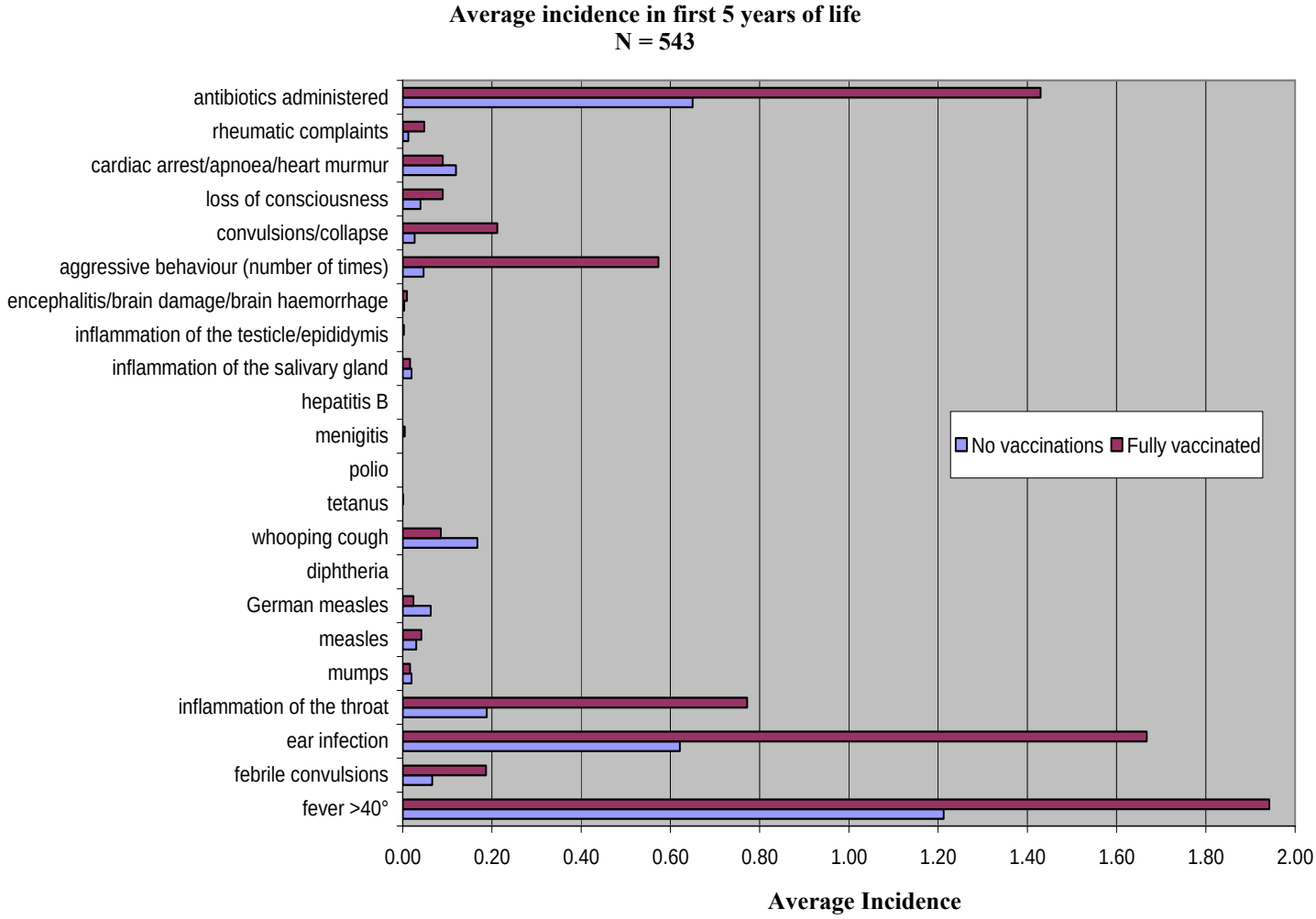
NVKP
PO Box 1106
4700 BC Roosendaal
The Netherlands

Information number: ***0900 - 2020171***
Email: info@nvkp.nl
Website: www.nvkp.nl

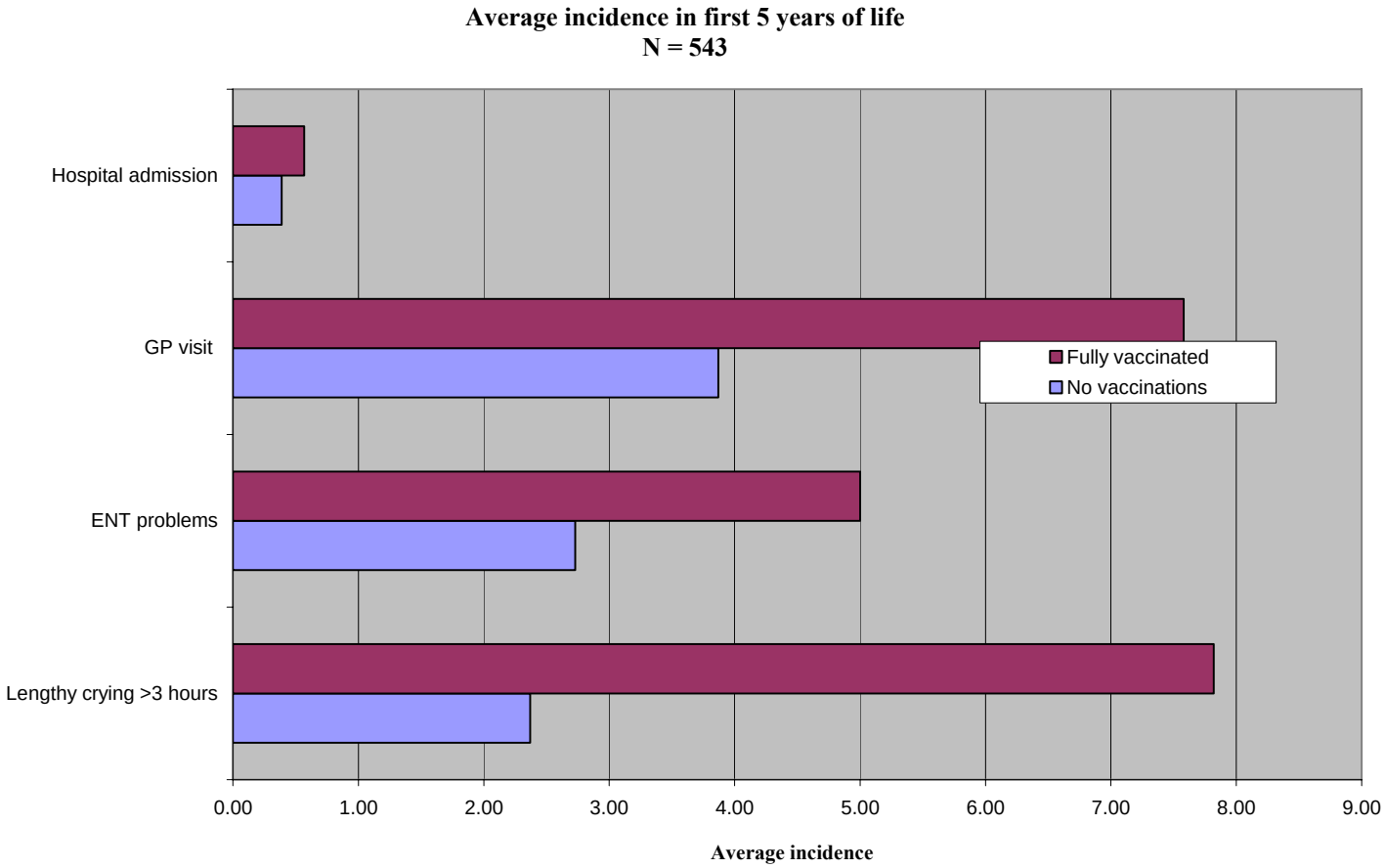
The survey

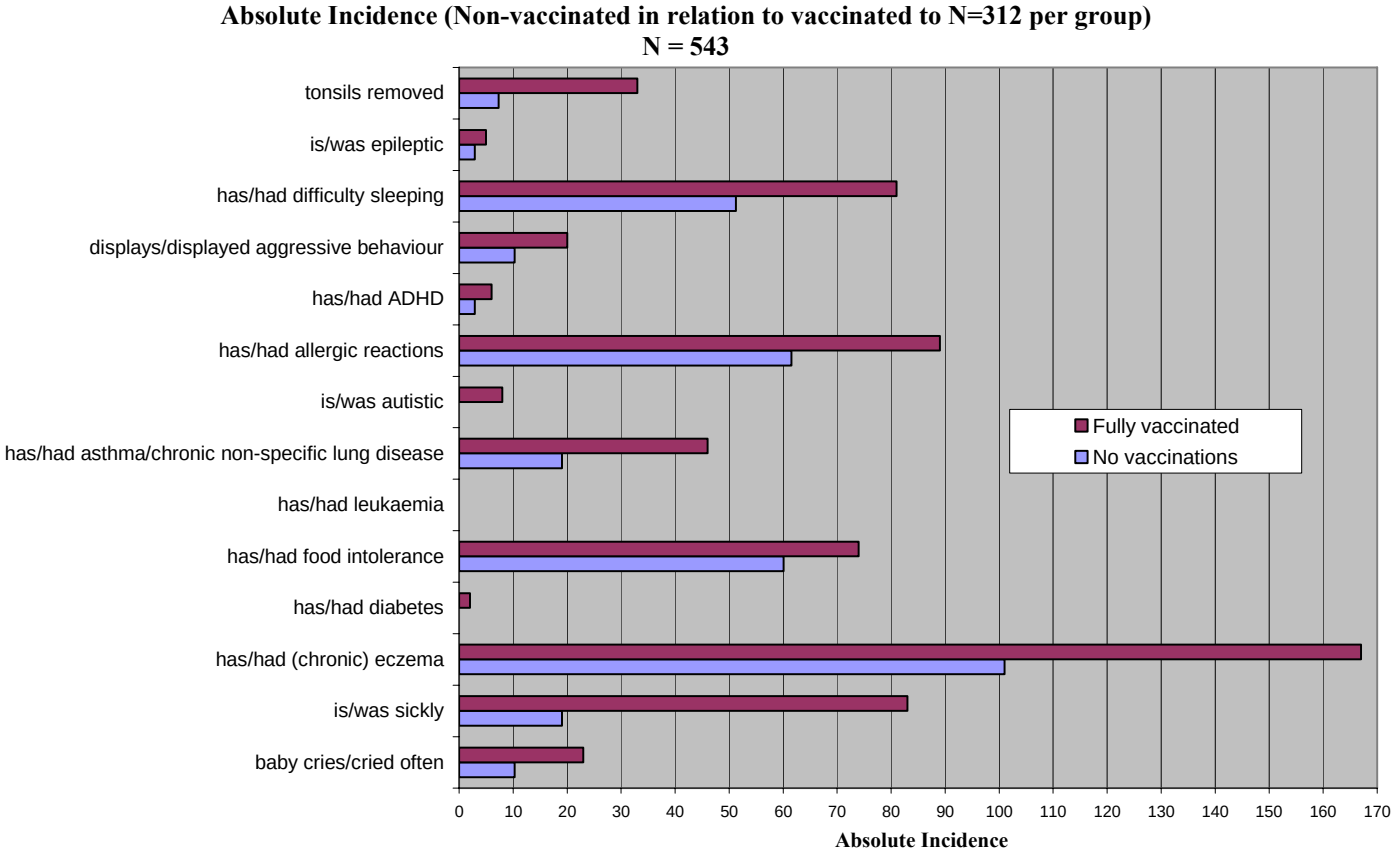
The NVKP survey was conducted in the Netherlands in the latter half of 2004 with the parents of 635 children, and involved both members and non-members of the NVKP. The survey was geographically distributed over the entire country, and the postal codes of the respondents are known. We asked the parents to fill in a questionnaire with questions about the health of their child or children. All parents were subsequently approached for supplementary information and were asked to answer control questions. The personal details of all the participating parents and children are known. Questionnaires that were not filled out properly or questionnaires from parents who did not react to our request for supplementary information and/or control questions were not included in the results.

Questionnaires from the parents of children that were not vaccinated in the normal way – that is, not entirely in accordance with Dutch Vaccination Programme (RVP) – and questionnaires from the parents of children that were not entirely unvaccinated were also excluded from this survey.



doi: 10.1588/medver.2005.02.00089





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Data list figures

Average incidence (First 5 years of life):	Fully vaccinated	No vaccinations
N =	312	231
Fever >40°C	1.94	1.21
Febrile convulsions	0.19	0.07
Ear infection	1.67	0.62
Throat inflammation	0.77	0.19
Mumps	0.02	0.02
Measles	0.04	0.03
German Measles	0.02	0.06
Diphtheria	0.00	0.00
Whooping cough	0.09	0.17
Tetanus	0.00	0.00
Polio	0.00	0.00
Meningitis B/C/Viral	0.00	0.00
Hepatitis B	0.00	0.00
Inflammation of salivary gland	0.02	0.02
Inflammation of testicle /epididymis	0.00	0.00
Brain damage	0.01	0.00
Aggressive behaviour (frequency)	0.57	0.05
Convulsions/collapse	0.21	0.03
Loss of consciousness	0.09	0.04
Heart rhythm disorder/heart murmur	0.09	0.12
Rheumatic complaints	0.05	0.01
Antibiotics administered	1.43	0.65
GP visit	7.58	3.87
Hospital admission	0.57	0.39
ENT problems	5	2.73

Absolute data

	Vaccinated	Non-Vaccinated
NUMBER:	312	231
Sickly	83	19
Has/had chronic eczema	167	101
Baby cries/cried often	23	10.3
Has/had diabetes	2	0
Has/had food intolerance	74	60.1
Has/had leukaemia	0	0
Has/had asthma/chronic non-specific lung disease	46	19
Is/was autistic	8	0
Has/had allergic reactions	89	61.5
Has/had ADHD	6	2.9
Displays aggressive behaviour	20	10.3
Has/had difficulty sleeping	81	51.3
Is/was epileptic	5	2.9
Tonsils removed	33	7.3
(non-vaccinated in relation to vaccinated N=312 per group)		

Conclusions

- Group A (the vaccinated) went twice as often to the GP than group B (the unvaccinated).
- Group A was admitted twice as often to hospital.
- In group A we observed many more sleeping problems, rheumatic complaints, ear/nose/throat-problems and convulsions than in group B.
- Group A received three times more often antibiotics.
- Tonsils were removed five times more often in group A compared to group B.
- Parents of children from group A said that in 27% of cases the children were sickly compared to 7% in group B.
- The children in group A were muh more aggressive than those in group B.
- In almost all categories the children in group A scored much worse than those from group B.

So, we can say that children from group B are much healthier than those from group A.

Appendix 3. British EFVV Questionnaire

EUROPEAN COLLECTIVE STRASBOURG 2004
SECONDARY EFFECTS OF VACCINATION

Dear Sir or Madam

We have formed a European collective, co-ordinated by two groups - ALIS (France) and La Liga Para la Libertad de Vacunacion (Spain), in order to promote awareness of post-vaccinal problems. To this effect we have compiled the adjoining questionaire.

Our aim is to gather a bank of detailed and objective information about the seconary effects of vaccination, our eventual intention being to present a report to the European Parliament.

In effect, the authorities promote vaccination without having truly ascertained the possible consequences. Post-vaccinal accidents, both short- and long-term, are officially trivialised or treated as coincidences. Our objective is to alert politicians, media and the public to this serious problem.

If you would like to help with this research we would be greateful if you would complete all sections of the questionnaire carefully. You may report on behalf of someone else (for example as their therapist, parent or carer, etc.) or you may report on your own behalf if you are old enough. If you are a therapist reporting a patient's case, you will need to allocate a Patient Number (see top of form). Please keep a record of it. The asterist (*) at the top of the form indicates items to be completed by the research team.

The second with your address will be detached in the presence of a solicitor. This procedure will guarantee both professional confidentiality and the authenticity of our observations, whilst ensuring your anonymity.

Please make a copy of your completed form and retain it for future reference.

We thank you in advance for your help, and send you our best wishes.

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Questionnaire

***Country Code no.___ *Case Reporter no___ Patient No. ___**

Case reporter:
Name and address_____

Relationshi8p to patient (Therapist / GP/ parent / carer / self etc)_____

(02)
*County Code no_____ *Case Reporter no. ____ Permit no._____
Patient:
Date of Birth_____ Sex: M □ F □ Blood Group_____
Today's date_____

Vaccine in question (03)
Name (eg: DPT, "Trivax-Ad")_____
Date of dose/s_____Lot no_____
Health of patient when vaccinated_____

Did there exist any contraindication/s to vaccination? □ Yes □ No

Other vaccinations received (04)

Date	Name

Symptoms (05)

Date	Description	Treatment	Better/worse?

Post-vaccine diagnosis; development of symptoms (07)

(eg: secondary conditions; recovery - partial / total; death)

Medical History (08)

Personal:
Mother's pregnancy, birth, breat/boottle fed etc._____

Childhood illnesses (dates)_____

Other illnesses (dates)_____

Family:
Does anyone else suffer with a related condition?
Other condition (eg: hormonal, cardiovascular, joints, neurological, digestive, autoimmune, diabtes, cancer, alergies, TB) Details_____

Other Information (09)

(eg: test results, other examinations, follow-up treatment, etc.)

We guarantee the confidentiality of all information given.

List of Associations and Individuals Campaigning for Freedom of Choice with Respect to Vaccinations

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www.vaccinationdebate.com

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Brain Damaged Children Rehabilitation Association
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Website: www.nvkp.nl

Stichting Vaccinatieschade
Website: www.vaccinatieschade.nl

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IAS (Immunisation Awareness Society)
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Fax: + 64 09 424 41 44
www.netlink;co.nz/~ias/ias.htm

Erwin Alber (German/English)
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Website : www.Aegis.ch

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Association STELIOR
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WDDTY (What Doctors Don't Tell You)
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Website: www.wddty.co.uk

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Editorial Note: The original EFVV Report containg 16 additional pages of British legal cases (not included in this Medical Veritas® reprint) can be ordered from www.EFVV.org

Another organization not included in the above list is:

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