Submission to the Senate Standing Committees on Community Affairs

Re: Senate Inquiry into the Social Services Legislation Amendment (No Jab, No Pay) Bill 2015

Australian Vaccination-skeptics Network Incorporated

14th October 2015

avn.org.au
building responsibility into vaccination

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Executive Summary

ES.1 The Statement of Compatibility with Human Rights accompanying the Bill does not accurately reflect the Bill's true purpose, which we demonstrate is chiefly budgetary. That the government projects savings in the forward estimates of over $500 million lends weight to our view that the Bill is merely a budgetary-savings measure and not a health measure as it is purported to be.

ES.2 Similarly, it does not accurately reflect the Bill's true effects. The Bill masquerades as conferring health benefits on three fronts: protection of the children of conscientious objectors; protection of other children attending child care; and protection of the public health generally. Our analysis demonstrates that the Bill's effect is to confer no such benefits. It demonstrates that the Bill's effect will be chiefly financial (increasing socioeconomic disparity) and social (exacerbating social divisions by promoting discrimination against women, children, the disabled, and anybody not practising a particular set of beliefs) and will not and cannot act to attain the stated health goals.

For its assertion that vaccination represents the best method of protecting the children of conscientious objectors from infectious diseases, no such evidence exists. In addition, we demonstrate the inability of the Bill's coercive power to force a significant number of conscientious objectors to submit their children to vaccination.

Insofar as the Bill will succeed in affecting child-care benefits, its claim to confer protection on other children or the public health more generally is spurious in the absence of a concomitant prohibition on enrolment in child-care services. The Bill has no power to prohibit enrolment in child-care services; merely the power to regulate entitlement to subsidies. Therefore, it will still permit parents on high incomes to enrol their unvaccinated children in child-care services, albeit without the benefit of subsidisation. For this reason, it is a financial, and not a health measure.

We present expert medical opinion that the vaunted hypothesis of "herd immunity" cannot even hypothetically support the use of inactivated polio (IPV), tetanus, diphtheria, whooping cough, Hib (due to a shift in strain dominance under pressure from the vaccine), or hepatitis B vaccines, and that systematic diagnostic bias has skewed notifications of vaccine-preventable disease in areas of relatively high conscientious objection.

To the extent the Bill targets Family Tax Benefit A supplement, the purported public health benefit is even more tenuous. The denial of entitlement to Family Tax Benefit is a strictly punitive, financial measure which could not possibly be construed as being capable of conferring a public health benefit even with the most liberal interpretation to that effect.

ES.3 The Bill's effect will be to introduce 'practical compulsion' of an invasive and experimental medical procedure in violation of international human rights treaties and accepted common law principles of the right to consent, free of coercion. It also requires medical doctors to accept consent which has not been given freely in direct violation of the Medical Board of Australia's Code of Conduct. We note that Australia does not have a statutory compensation scheme for those children consequently injured under the Bill's 'practical compulsion' for the 'greater good'.

ES.4 The Bill significantly limits the human rights of conscientious objectors and their children in many broad areas over and above those that the Statement of Compatibility admits to:

a) The right to equality and non-discrimination;

b) The right to freedom of religion, conscience, and belief;

c) The right to work, to a reasonable standard of living, and to social security;

d) The right to privacy and the right of the family and children to be protected from arbitrary interference;

e) The right of children to have access to child-care services; and

f) The right to consent freely to medical or scientific experimentation; and

g) The right to consent freely to invasive medical treatment.

ES.5 Such broad incursions on human rights are not reasonable; necessary; or proportionate to the Bill's true purpose and effects. First, there are less restrictive means by which the government may increase vaccination rates because the vast majority of unvaccinated children in Australia have parents who support vaccination in-principle. This group represents 6.15% of Australia's unvaccinated children (compared with 1.77% of children whose parents hold a conscientious objection), and a recent study found that most of this group are not up-to-date because they are either socioeconomically disadvantaged or suffering chronic medical conditions. The existence of this larger unvaccinated sub-group presents a less restrictive means by which to increase vaccination rates by assisting these families to attain vaccination for their children rather than coercing parents who are actually opposed to vaccination.

Second, less restrictive, far less controversial means of attaining the broader stated public-health goal of increasing physical and mental health—many of which are far more cost-effective than the complex problems of enforcing vaccination, creating social divisiveness, and financially providing for additional vaccine-injured children—are available to the Government.

ES.6 The Bill introduces a retrogressive measure in relation to the denial of economic benefits for conscientious-objector parents generally, women more specifically, and children, which benefits they have the right to under the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of all Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC). These rights include the right to social security, the right to a reasonable standard of living, and the right to work.

ES.7 The Bill's effect in denying children access to child-cares services will be in direct opposition to the goals of the National Partnership Agreement on Early Childhood Education, which promotes universal access to early childhood education.

ES.8 Our analysis demonstrates that the Bill directly conflicts with the Disability Discrimination Act 1992 (Cth) by discriminating against two classes of persons with disability: those already injured by vaccines, and those whose disability consists in an imputation of current or future presence, in the body, of organisms capable of causing disease or illness. The Australian Human Rights Commission Act provides that a representative complaint may be made for unlawful discrimination in the administration of Commonwealth programs on such a basis.

Rational, relevant exclusion of children on the basis that they may pose a risk to other children must instead focus on actual infectiousness. The Bill's effect to deny benefits in relation to the children of conscientious objectors, and not other unprotected or unvaccinated children is arbitrarily discriminatory and not based on consistent risk assessment principles. For example we present evidence that children recently vaccinated with live attenuated viruses are susceptible to vaccine-associated disease and can transmit these vaccine-strain viruses to close contacts in the post-vaccine period.

State-based health powers already enable child-care services to exclude children during outbreaks; and there is absolutely no empirical evidence that excluding healthy children at any other time enhances the safety of other children attending child care.

ES.9 The Commonwealth does not hold the necessary legislative power under a relevant constitutional head of power to regulate entitlement to child-care or family tax benefits with a vaccination requirement. This leaves open the strong possibility that the courts would invalidate the vaccination requirement if an action were brought before them.

ES.10 A concerted and repugnant media campaign in progress for most of 2015 has sought to cast conscientious objectors to vaccination as responsible for the deaths of babies too young to be vaccinated against whooping cough, and to suggest that they are responsible for a resurgence of the disease. This campaign appears to have been, at least in part, the impetus for this 'vaccination crackdown'.

We are sympathetic to politicians' time poverty, wide briefs, and potential susceptibility, along with that of the general public, to emotive but false media campaigns. For these reasons, we have provided a detailed refutation of these specific claims. The analysis, appearing at Appendix B, clearly demonstrates the media campaign's falsity as follows:

ES.10.1 The death rate from whooping cough in Australia is low and stable.

ES.10.2 Whooping cough is not a vaccine-preventable disease.

ES.10.3 Vaccine-induced herd immunity, including the cocooning strategy, has been shown to be ineffective to protect babies too young to be vaccinated against whooping cough.

ES.10.4 Pertussis vaccines have consistently failed to influence whooping-cough morbidity and mortality in the 60 years for which Australia has employed them.

ES.11 Contrary to popular claims that vaccination is responsible for transitioning us from a time when the child mortality rate was extremely high to the now low rate, we present evidence showing this claim to be false. Further, we suggest that vaccines have not reduced the overall burden of so-called infectious disease, and that as soon as one is allegedly reduced by vaccination, an equally severe disease apparently emerges with an identical clinical presentation but which is alleged to be caused by a different pathogen.

ES.12 There is also evidence that the overall burden of chronic disease and disability has not decreased since the introduction of mass vaccination programmes and that in some respects, vaccination may actually have contributed to an increase. We present evidence that vaccination provides a plausible explanation for the dramatic increase in auto-immune conditions now afflicting the Australian population.

ES.13 Published research shows that the US Vaccine Injury Compensation Program has been quietly compensating cases of Autism arising from vaccination under the alternative diagnostic labels of Encephalopathy and Residual Seizure Disorder since its inception.

Contents

The Australian Vaccination-skeptics Network Inc. (AVN) opposes the Commonwealth government's proposal to introduce a vaccination mandate for eligibility to child care and family tax benefits.

We believe that this Bill is ill-informed. It relies on hearsay rather than solid evidence for its justification. It results in 'practical compulsion' of a procedure which carries unquantifiable risk and bears unguaranteed benefit. In addition even our nation's experts concede that it will not lead to a meaningful increase in vaccine uptake. It will however have a severe impact on human rights.

The Bill will erode social cohesion by fostering discrimination against our members and others in the community who question vaccination. It will create divisiveness and bitterness. It will strip away means-tested welfare payments from low and average income parents, as well as access to affordable child care. It will force some out of the work force, and many away from their social networks.

While we acknowledge that there is widespread support for vaccination, there is more than sufficient evidence to suggest that retaining freedom of choice represents the best public policy. Pro-vaccination and pro-choice positions are not mutually exclusive; both positions can and should be accommodated.

We also take this opportunity to express disappointment at the lack of consultation with our organisation. We are a key stakeholder, representing those in the community who hold views, concerns, and a level of uncertainty which leads them to hesitate, research, question, and sometimes reject, vaccination for their children.

1.0 Purpose

Our submission provides evidence to suggest that the Bill should not be passed by identifying the most significant human rights limited by the Bill, exploring how these limitations arise and the reasons such limitations are not reasonable, necessary or proportionate having regard to the Bill's true purpose and effects.

2.0 Scope

Human rights limitations considered in this submission pertain to the seven instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011* as well as the Universal Declaration on Bioethics and Human Rights. Conventional acronyms have been adopted throughout the submission. For example, the acronym ICCPR is used to describe the International Covenant on Civil and Political Rights.

3.0 Recommendation

The committee should recommend to Parliament that the Bill not be passed.

4.0 About AVN

AVN is a not-for-profit, incorporated association, founded in 1994 in New South Wales by a group of parents and health professionals who were concerned about the quality of scientific evidence purporting to support the effectiveness and safety of vaccination as a means to achieving good health and/or preventing disease.

AVN believes good health is vital for a functioning society. A healthy society translates directly into a happier, more peaceful social group. Australia is made up of many diverse groups – groups who follow different religions, speak different languages and those who raise their family in more liberal environments – and we as Australians are accepting of these behaviours. This tolerance is based on respect for the individual. In Australia people call it giving people a fair go.

However, AVN believes it is not giving people a fair go if they are ordered by higher powers to change their beliefs in the way they raise their family. It is not giving people a fair go if they are being coerced into following, what amounts to, a mandatory vaccination program under the threat of financial penalty.

AVN is campaigning for social health programs to be more transparent. We want government, pharmaceutical companies and the medical industry to show honesty in informing people about all aspects of vaccination, good and bad, and to support all individuals in their choice.

Former Senator, Australian Greens leader, and GP, Bob Brown stated in the Senate in 1997, *"there is very much contradictory evidence and debate, even in scientific and medical circles, about vaccination."*

(1997, Hansard, p. 8725)

http://www.aph.gov.au/binaries/hansard/senate/dailys/ds111197.pdf

5.0 The stated purpose and effects of the Bill do not reflect their true purpose and effects

It is our view that the true purpose and effects of the Bill are not represented accurately in the Statement of Compatibility. This is important, because it would appear that the entire rationale for the human rights limitations is predicated on the false premise that the Bill's purpose and effect will be to protect the children of conscientious objectors, other children, or the public health more generally. The following analysis shows this to be false, and exposes the Bill as nothing more than a punitive budget savings measure.

6.0 The stated versus true purpose of the Bill

While the Statement of Compatibility states that the purpose of the Bill is to merely encourage parents to vaccinate their children by reinforcing the importance of vaccination in protecting them and the public health more broadly, it is our view that this statement does not accurately reflect the Bill's true purpose. That the stated purpose of the Bill has been cast in such neutral terms as 'encouragement' and 'reinforcement' serves to conceal the sinister and totalitarian nature of the Bill's true purpose, which we suggest would be more accurately described as follows:

> *The purpose of the Bill is to coerce parents with a conscientious objection to vaccination into vaccinating their children under threat of loss of entitlement to child care benefits and family tax benefits, and their place in the paid workforce, study or other self-development pursuits.*

The existing immunisation requirement in section 6 of A New Tax System (Family Assistance) Act 1999 already encourages parents to vaccinate their children. This Bill does not extend this principle of encouragement, it introduces the element of coercion, a fact not reflected in the stated purpose. That the Bill introduces coercion, and not mere encouragement, can be seen in light of the significant consequences of non-compliance with the vaccination requirement.

7.0 The stated versus true effects of the Bill in relation to Child Care Benefits

The effect of the Bill will be that parents with a conscientious objection to vaccination who do not acquiesce to the vaccination of their children will be denied entitlement to child care subsidies of up to $15,000 per annum per child, and Family Tax Benefit A supplement of $726 per annum per child, and in relation to the loss of child care subsidies, will necessarily result in some parents (many of them women) having to give up paid work or study due to a loss of access to affordable child care services.

The High Court has adopted a non-literal, broad interpretation of coercion or 'practical compulsion' when the whole or substantial part of one's livelihood is at risk.

> *"To require a person to do something which he may lawfully decline to do but only at the sacrifice of the whole or a substantial part of the means of his livelihood would, I think, be to subject him to practical compulsion. [...] If Parliament cannot lawfully do this directly by legal means it cannot lawfully do it indirectly by creating a situation, as distinct from merely taking advantage of one, in which the individual is left no real choice but compliance."*

(Justice Webb in British Medical Association v The Commonwealth [1949] HCA 44; (1949) 79 CLR 201)

http://www.austlii.edu.au/au/cases/cth/HCA/1949/44.html

That child care services are an essential, but usually unaffordable service but for subsidisation, and vital to the economic prosperity of Australia and workplace participation of women, is reflected in the long-standing and bipartisan taxpayer subsidisation of these services. The government's argument to the effect that parents who have a conscientious objection to vaccination are only being encouraged and not coerced into vaccinating their children should be considered spurious and dishonest in this context.

The true effect of the Bill as shown above stands in stark contrast to the purported effects of the Bill. The Statement of Compatibility states that the effect of Bill will be to confer protection on three fronts.

7.1 Protection of the children of conscientious objectors and their right to physical health

Firstly: that the children of conscientious objectors will receive the benefit of vaccination to which they are allegedly entitled because their parents – against their long-standing and deeply held beliefs – will suddenly feel compelled to submit them to vaccination in order to qualify for benefits. This is not consistent with our knowledge of the characteristics of conscientious objectors to vaccination who would only submit their children to vaccination "over my dead body" or by force under martial law.

That conscientious objectors hold particularly strong and unchangeable views against vaccination and will not acquiesce to coercion is uncontroversial and widely accepted by public health experts. For example, Professor Raina Macintyre argues that an immunisation requirement will be unlikely to change the views of 'hard-core' anti-vaccinators, and that there has been a lot of research into the beliefs of conscientious objectors, which has found it is extremely hard to change their views.

(Edwards, 2015, Vaccination: Expert says draconian threats to withhold welfare payments unlikely to get parents to vaccination kids, ABC News)

http://www.abc.net.au/news/2015-04-13/no-benefits-for-anti-vaccination-parents/6387914"

Two recent studies lend supports to Professor Macintyre's view.

(2015, Forbes et al, Vaccination uptake by vaccine-hesitant parents attending a specialist immunization clinic in Australia, Human vaccines & immunotherapeutics)

http://www.ncbi.nlm.nih.gov/pubmed/26366978

(Nyhan et al, 2014, Effective Messages in Vaccine Promotion: A Randomized Trial, Pediatrics)

http://pediatrics.aappublications.org/content/early/2014/02/25/peds.2013-2365

Associate Professor Leask has estimated that the effect of this Bill on immunisation rates may even be as little as 0.3% in total.

(Leask, 2015, Will stopping vaccine objectors from accessing payments have its desired impact?)

https://julieleask.wordpress.com/2015/04/11/will-stopping-vaccine-objectors-from-accessing-payments-have-its-desired-impact/

The Statement of Compatibility states that the Bill promotes the right of the children of conscientious objectors to mental and physical health and that vaccination assists in achieving this end. This claim needs to be considered in light of the health outcomes that have accrued from the widespread use of vaccines.

7.1.1 Vaccination is at best a zero-sum game and does not reduce the net burden of infectious disease

Vaccination has not been shown to have reduced the overall burden of infectious disease. If the practice were medicine's greatest health achievement, as claims would have us believe, we could expect to find clear and unequivocal evidence that it has independently reduced deaths and hospitalisations from infectious disease.

Child-mortality rates (Figure 1) show a steady decline over the past 100 years, a trend seemingly unaffected by the introduction of mass vaccination in 1953 or any other prominent vaccine milestone since.

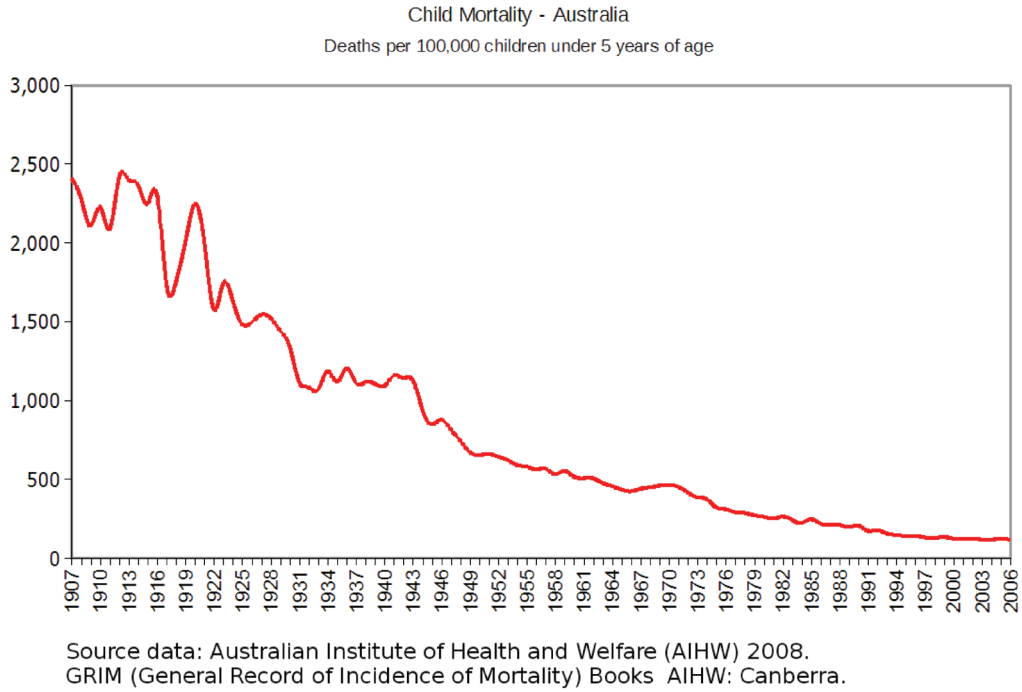


Figure 1. Child-mortality rate, Australia, 1907–2006. Source data: GRIM books, AIHW.

This stands in stark contrast to the oft-repeated claims crediting vaccination with our transition from the days of high child-mortality rates. The graphs in Appendix A, plotting directly data from J.H.L. Cumpston, the Commonwealth Year Books, and the A.B.S., show more specifically the Australian historical trends in mortality from vaccine-specific illnesses.

Before the mid 1980s, data on hospitalisations were not compiled nationally, so comparing rates before and after the start of mass vaccination is difficult. Certainly, the overall hospitalisation rate of children due to "all cause" infectious diseases is still high. Queensland Health reports that hospitalisation for infectious disease has increased over the period 2004–2014, a period that immediately followed a massive and sustained increase in vaccination rates.

(Infectious disease episodes in Queensland hospitals: Who are the patients?,

https://www.health.qld.gov.au/hsu/pdf/statbite/statbite66.pdf

Apart from deaths and hospitalisations, there are few reliable data from which we can gauge the incidence of infectious disease. A requirement to notify certain diseases has resulted in the passive collection of data on a subset of diseases, but this collection is notoriously unreliable, being passive and subject to frequent schedule changes over time.

Efforts to lower the death and hospitalisation rates due to a single disease, via a vaccine, consistently fail to achieve an overall fall in deaths and hospitalisations. As soon as one disease is allegedly reduced, there appears an equally dangerous disease to replace it, which inevitably requires yet another vaccine. We see this happening time and time again.

One example is Haemophilus influenzae type B (Hib), a microbe once claimed to be the major cause of meningitis. In the early 1990s, a vaccine was introduced upon the claim that it would reduce meningitis substantially. Soon after its introduction, the vaccine was heralded as a major success, using data showing that the number of infections with Hib had dramatically reduced. But no such reduction was seen in meningitis, nor in any of the other illnesses that the vaccine was supposed to reduce. Figure 2 shows death rates for meningitis before and after the introduction of the vaccine. Hospitalisations were similarly unaffected. This “anomaly” has been noted in the peer-reviewed literature, and researchers have suggested that the decline in Hib was accompanied by an increase in other microbes leading to similar outcomes.

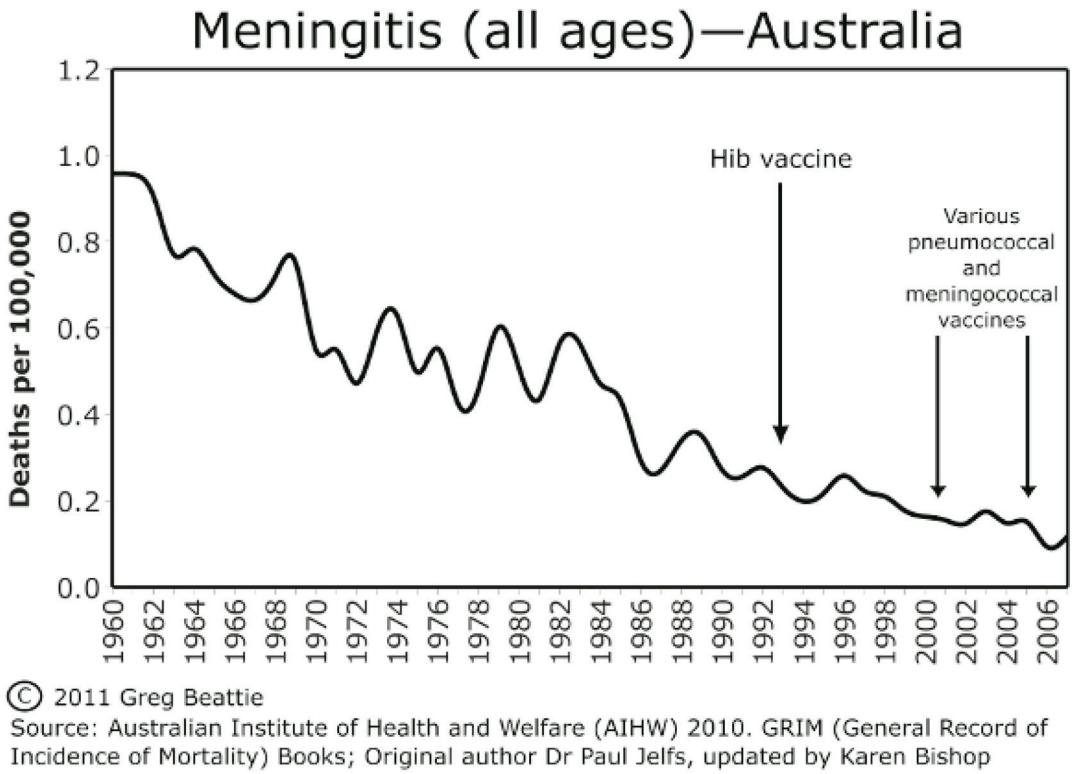


Figure 2. Death rate for Meningitis, Australia, 1960–2007.

Respiratory Syncytial Virus (RSV) is another case in point. It is thought to be the leading agent responsible for severe respiratory infections in children.

The virus was not discovered until 1956: a mere three years after the DTP vaccine was licenced in Australia, signalling the start of mass vaccination. The global burden of RSV is now estimated at 64 million cases and 160,000 deaths per year.

http://jvi.asm.org/content/84/15/7500.full

http://www.cdc.gov/rsv/research/history.html

Is there reason to celebrate a decline in hospitalisations from a so-called vaccine-preventable respiratory illness, when another illness of similar appearance simply takes it place? Although many public-health experts appear to find this acceptable, we do not. RSV is now one of the latest in a long line of projected vaccine targets.

(Drug Discovery and Development, 2015, Vaccine for Common Childhood Infection May Finally be Possible)

http://www.dddmag.com/news/2015/08/vaccine-common-childhood-infection-may-finally-be-possible

A third example is the now well-publicised increase in acute flaccid paralysis (AFP) that has occurred alongside declining morbiidity in polio itself. AFP is clinically indistinguishable from polio, and was included in polio notifications in Australia and in the Indian states until mass vaccination against polio had been established in those states. In India, the announcement in recent years of the elimination of polio stirred heated debate in the medical literature, with paediatric experts questioning the value of happily ignoring the non-polio AFP that has more than made up the shortfall.

http://www.ncbi.nlm.nih.gov/pubmed/22591873

The taxpayer should not continue to fund endless rounds of vaccines whose result is nothing more positive than a shift in the apparent causes of the infectious-disease burden to other pathogens and never an overall decrease in that burden and, correspondingly, in deaths or hospitalizations.

7.1.2 Vaccines have not reduced the overall burden of disability and chronic disease and have possibly contributed to its increase

Contrary to claims by proponents of vaccines – claims which have been ingrained in the public psyche over many decades – vaccines haven't lead to a decreased burden of disability in Australia. We acknowledge the existence of a public health emergency but that emergency doesn't reside in vaccination rates, but rather, in the disastrous levels of chronic disease and disability in the Australian population.

According to the ABS, as at 2012, approx 2.2 million people between the ages 15-64 have a disability with approx 25% of those having profound disability and 47% a moderate to mild disability. These figures don't even include a significant percentage of the population suffering from a chronic disease.

(ABS, 2012, Disability and Labour Force Participation)

http://www.abs.gov.au/ausstats/abs@.nsf/mf/4433.0.55.006

These statistics are alarming and cannot be explained by reference to the aging population or an increase in the rate of Type 2 Diabetes, both of which are popular excuses to dismiss our high rates of disability. Surely people under 65 could not be said to be aged.

According to the National Commission of Audit (NCA), the National Disability Insurance Scheme (NDIS) will cost $22 billion per annum when fully rolled out in 2019/20. Eligibility for the NDIS is restricted to the young (15-64) so is not a function of an aging population, and that $22 billion doesn't even include income support payments such as the Disability Support Pension.

http://www.ncoa.gov.au/report/phase-one/part-b/7-2-the-national-disability-insurance-scheme.html

A 2013 report on the wellbeing of children in Australia highlighted some key health indicators which suggest that Australia's high vaccination rate is not resulting in positive physical health outcomes. Australia ranked in the bottom third for infant mortality (22 of 31 OECD nations) and in the bottom quartile for incidence of diabetes and asthma (14 of 16 OECD nations).

(2013, Report Card: The Wellbeing of Young Australians, Australian Research Alliance for Children and Youth p5)

http://www.aracy.org.au/documents/item/126

The following conditions have also been reported to be increasing in children.

Allergy requiring hospitalisation.

http://www.abc.net.au/news/2015-07-15/number-of-children-hospitalised-with-food-allergies-on-the-rise/6619752

Eczema requiring hospitalisation

http://www.abc.net.au/news/2011-09-07/eczema-on-the-rise-in-australia/2874462

Multiple Sclerosis in Children

http://www.msra.org.au/understanding-early-brain-inflammation-children-who-develop-multiple-sclerosis

Type 1 Diabetes

http://www.adelaide.edu.au/news/news74624.html

Juvenile Arthritis

http://www.hica.com.au/health-insurance-news/hospitalisation-rates-for-juvenile-arthritis-are-increasing-aihw-report

Childhood Cancer

http://www.nature.com/bjc/journal/v102/n3/fig_tab/6605503f1.html

7.1.3 Vaccines provide a plausible explanation for Australia's high rates of immune system mediated diseases

A 2013 report outlined some damning truths about the high level of immune system dysfunction in the Australian population.

1) Allergy and immune diseases (immunodeficiency and autoimmune diseases) are among the fastest growing chronic conditions in Australia.
2) Almost 20% of the Australian population has an allergic disease and this prevalence is increasing.
3) Hospital admissions for anaphylaxis (severe life threatening allergic reaction) have increased 4 fold in the last 20 years.
4) Food-induced anaphylaxis has doubled in the last 10 years and 10% of infants now have an immediate food allergy.
5) Immunodeficiency diseases are serious, potentially life threatening conditions that are increasing in number and complexity.

6) Autoimmune diseases affect 5% of Australians and are more common than cancer or heart disease.

(Allergy and Immune Diseases in Australia (ADIA) Report 2013, Australasian Society of Clinical Immunology and Allergy Inc., p 2))

http://www.allergy.org.au/images/stories/reports/ASCIA_AIDA_Report_2013.pdf

We are of the informed view that the dramatically expanding immunisation schedule provides a scientifically plausible explanation for the widespread, and increasing incidence of immune system dysfunction in the population. Increases of this magnitude cannot be explained by genetics and immunisation stimulates the immune system in an abnormal way. There are clearly other environmental factors at play. Scientific studies have not been able to exclude any link between an increase in the number of vaccines with an increase in auto-immune disorders.

A recent published review echoes our concerns in relation to autoimmune conditions. It states *"vaccines are able to elicit the immune system towards an autoimmune reaction, and "there is evidence of vaccine-induced autoimmunity and adjuvant-induced autoimmunity in both experimental models as well as human patients".*

(Guimaraes et al., 2015, Vaccines, adjuvants and autoimmunity, Pharmacological Research)

http://www.sciencedirect.com/science/article/pii/S1043661815001711

An analysis of the connection between vaccination and autoimmune disease is provided at Appendix C. The government's argument that, by coercing conscientious objectors into vaccinating their children for the children's own good, it is promoting their right to physical health cannot be sustained in light of the above evidence.

7.2 Protection of other children and the public health

Secondly and thirdly: that the Bill confers a protection on other children attending child care, or the public health more generally under herd immunity theory. In the Minister's second reading speech he justified the Bill on similar public health grounds, but went one step further in appealing to the base instincts of pro-vaccination parents, by casting conscientious objectors as a direct threat to their vaccinated children.

> *"Parents who vaccinate their children should have confidence that they can take their children to child care in particular, without the fear that their children will be at risk of contracting a serious or potentially life-threatening illness because of the conscientious objections of others."*

In relation to the claim that the effect of the Bill will be to confer protection on other children as well as the public health more generally, the Bill isn't capable of achieving that effect even if vaccination of the children of conscientious objectors was capable of conferring such protection in the first place. This is because the Bill does not actually prohibit enrolment in child care services. Rather, it only denies entitlement to child care subsidies, which is obviously not the same thing. Parents on high incomes will still be able to enrol their unvaccinated children in child care; they just won't receive the benefit of subsidisation. In other words, while this draconian Bill is masquerading as a necessary public health measure for 'the greater good' it doesn't have any capability of conferring benefits on other children or the public health in the first place.

No doubt the government would make the argument that it doesn't hold the necessary legislative power to regulate child care entry because that is a responsibility of the states. However, that argument ignores the fact that the Commonwealth holds the quarantine power under section 51 (ix) of the Constitution. If it is the government's position that the unvaccinated children of conscientious objectors pose a clear and present danger to other children in the child care setting, then we are left to speculate why they have chosen not to invoke this power.

We would suggest the government hasn't invoked their quarantine power because they are well aware that the claimed risks unvaccinated children pose to other children and the public health more generally are not supported by evidence.

That the government has estimated this measure will produce budgetary savings of over $500 million over four years lends further weight to our argument that this Bill is nothing more than a cynical budget savings measure, one which the government believes will not carry any political consequences due to the bipartisan support of the Bill.

Even if the Bill was capable of conferring public health benefits we note that herd immunity theory is the subject of ongoing scientific debate.

7.2.1 Vaccine-induced herd immunity

We reject the view that unvaccinated children pose a risk to other children due to a breakdown in herd immunity. It is our view that the popularly claimed 95% vaccination threshold to achieve herd immunity is merely a spurious invention which has been the subject of frequent upward revisions over the years every time a vaccine failure has been identified.

Even if we were to accept there is a herd immunity effect arising from vaccination, it would be impossible to quantify in such discrete numerical terms, and would obviously vary by disease. It would also need to consider vaccination coverage rates in adults as well as children over six years of age. Reported vaccination coverage rates only pertain to children up to six years of age.

The theory of herd immunity evolved from observations of naturally occurring disease patterns in animals, diseases which were believed to confer lifelong immunity. Vaccines, while once believed to confer lifelong immunity, are now accepted as being capable of conferring only short-term protection, if at all. That estimates of herd immunity allegedly conferred by vaccination only consider vaccination coverage rates in children under six years of age and not older children or adults, who can serve as significant reservoirs of disease, provides the necessary context in which vaccine-induced herd immunity theory can be rightly dismissed as a pseudo-science.

In addition, many of the vaccines on the current vaccination schedule are not even theoretically capable of producing a herd immunity effect anyway; this much at least, is uncontroversial.

A US-based immunologist recently published an open letter to legislators, wherein she identifies vaccines that are not theoretically capable of producing a herd immunity effect and which are only capable of offering protection to individual vaccine recipients. These include inactivated polio vaccine (IPV), tetanus, diphtheria, whooping cough, HIB (via a shift in strain dominance under pressure from the vaccine), and hepatitis B.

(Obukhanych, 2015, An Open Letter to Legislators Currently Considering Vaccine Legislation)

http://thinkingmomsrevolution.com/an-open-letter-to-legislators-currently-considering-vaccine-legislation-from-tetyana-obukhanych-phd-in-immunology/

The Bill, as a blanket measure, does not give due consideration to the fact that some vaccines are not even capable of conferring a benefit under herd immunity theory even if such a theory was scientifically sound.

7.2.2 Healthy unvaccinated children do not pose a greater risk than other children merely by virtue of their vaccination status

It may surprise the committee that there is absolutely no empirical evidence that healthy, unvaccinated children are more likely to be vectors of disease, whether vaccine-preventable or not, or that excluding unvaccinated children from child care centres will serve to enhance the protection of other students or the public health in general. While this may be a popular belief, there's simply no evidence to support it. Indeed, there are numerous examples in the medical literature and media reports of disease outbreaks in highly vaccinated populations.

Given every human being carries billions of microbes – many of which are claimed to be potentially pathogenic – it's simply impossible to quantify the risk posed by an individual based on vaccination status alone.

> *"[...] It seems to me that any human can be described as a "potential infective hazard"; and one could not reasonably demand of Dr Whitby that he quantify precisely the increased risk, if any, posed by L; but the evidence is so imprecise that even if I disregarded Dr Vance's views (which I am not in the least inclined to do), I would not be able to reach a conclusion that suspension was reasonably necessary to protect public health. [...]."*

(L v Minister for Education [1996] QADT 2 (18 January 1996))

http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/qld/QADT/1996/2.html

There is no evidence that the overall quantum of pathogenic microbes is reduced in those vaccinated relative to those who remain unvaccinated.

A 2009 study supports our contention that vaccination does not reduce the overall quantum of disease in vaccinated children, and in this particular case, vaccination actually conferred an increased susceptibility to other viruses in recipients. The study found an increase in non-vaccine-preventable respiratory viral infections in children receiving Influenza vaccine.

> *"We randomized 115 children to trivalent inactivated influenza vaccine (TIV) or placebo. Over the following 9 months, TIV recipients had an increased risk of virologically-confirmed non-influenza infections (relative risk: 4.40; 95% confidence interval: 1.31-14.8). Being protected against influenza, TIV recipients may lack temporary non-specific immunity that protected against other respiratory viruses."*

(Cowling et al, 2012, Increased Risk of Noninfluenza Respiratory Virus Infections Associated With Receipt of Inactivated Influenza Vaccine, Clinical Infectious Diseases)

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3404712/

Whilst notifications of vaccine-preventable diseases are regularly recorded by health departments, the relative percentages of notifications attributable to vaccinated versus unvaccinated children is rarely provided to the general public. Just because vaccine-preventable diseases are notified does not necessarily mean the source of these arise exclusively or even mostly, from unvaccinated children, and it would be misleading to suggest otherwise.

> *"It is assumed that unvaccinated children are the primary reservoirs of disease. This assumption is challenged by the recent release of Australian data showing that, of all notified cases of whooping cough in 1-4-year-olds, roughly 75% had been previously fully vaccinated."*

http://vaccinationdilemma.com/whooping-cough-australian-children-how-many-were-vaccinated

(Beattie, 2013, Submission to the Health and Community Services Committee Queensland Parliament, p.3)

https://www.parliament.qld.gov.au/documents/committees/HCSC/2013/PHunvaccinatedchildren/submissions/061.pdf

We would suggest that most notifications of vaccine-preventable disease represent vaccine failure in fully vaccinated children and in the interests of transparency call on the government to release the percentages of notifications attributable to unvaccinated, partly, and fully vaccinated children if that information is available.

As detailed in the whooping cough analysis (Appendix B), there is sufficient empirical evidence that vaccinated children may serve as asymtomatic carriers of whooping cough. In a study published in 2000, it was found that 60% of the children at a child care centre who tested positive to the bacteria remained asymptomatic, and this was in relation to the earlier whole cell vaccine which has been claimed to be more effective than the one used currently. In other words, vaccinated children can act as a reservoir for infection.

(Srugo et al. 2000, Pertussis Infection in Fully Vaccinated Children in Day-Care Centers, Israel)
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2627963/pdf/10998384.pdf

In 1999, a fully immunised Sydney health care worker was noted to have transmitted Pertussis to four neonates.

(Peterson et al, 2010, Nosocomial pertussis infection of infants: still a risk in 2009)
http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi3404e.htm

In the case of Mumps, as recently as July, a large outbreak of Mumps was reported in Western Australia. Of 49 confirmed cases, all had been fully vaccinated with two doses of the vaccine.

(Broome North Primary School, 2015, Kimberley Mumps Outbreak)
http://broomenorthps.wa.edu.au/2015/07/kimberley-mumps-outbreak/

We are able to provide many other examples if required.

In addition, there is a significant body of evidence that children recently vaccinated with live attenuated viruses pose a risk of transmitting these viruses to close contacts in the post-vaccine period. This evidence is provided in Appendix D.

7.2.3 Diagnostic bias in relation to notifications in high exemption areas

Public health officials often make the argument that areas with higher rates of conscientious exemption will have higher rates of notifications of so-called vaccine preventable diseases. This may be true but it is meaningless as the notification data is subject to what is often called 'diagnostic bias'. Diagnostic bias is the increased tendency of doctors to consider vaccine-preventable disease in unvaccinated children, and conversely, a decreased tendency to consider such a disease in a vaccinated child. Diagnostic bias is also covered in the whooping cough analysis in Appendix B.

This bias is a well known phenomenon in epidemiology, and in fact, is the basis for the gold standard of testing known as the 'randomised double blind placebo controlled trial'. In these trials the doctor (as for the patient) is not permitted to know the true treatment status of the patient – hence the term double blind – because of the likelihood that such knowledge will prejudice their diagnosis giving an artificially positive result to the treatment efficacy.

> *"[...] it is possible that physicians are more likely to make a diagnosis of varicella in children who are unvaccinated than in children who are vaccinated. This type of diagnostic bias would lead to an overestimate of the risk associated with vaccine refusal."*

(Glanz et al,2010, Parental Refusal of Varicella Vaccination and the Associated Risk of Varicella Infection in Children, JAMA Pediatrics)

http://archpedi.jamanetwork.com/article.aspx?articleid=382631

Of course the data being used by those who support these more draconian vaccination policies is not double blind and is therefore simply ineligible to be used the way they want it to be. The fact that this data provides such people with data that confirms their prejudices does not magically make said data valid.

But it is even worse than this because not only are doctors likely to be naturally prejudiced to favour the vaccine, they are often encouraged (implicitly or explicitly) by the public health authorities not to diagnose a particular condition if the patient has been vaccinated. This is a quote from the American organisation, the Center for Disease Control.

> *"To minimize the problem of false positive laboratory results, it is important to restrict case investigation and laboratory tests to patients most likely to have measles (i.e., those who meet the clinical case definition, especially if they have risk factors for measles, such as being unvaccinated, [...]"*

www.cdc.gov/vaccines/pubs/surv-manual/chpt07-measles.html

As can be seen, doctors are actually explicitly instructed not to diagnose Measles if the patient is vaccinated. In Australia the instruction is slightly less explicit, but it is still there.

This is from the Victorian government health website under the headline "Susceptibility and Resistance".

> *"Natural infection provides lifelong immunity. A history of prior measles infection should be confirmed serologically before vaccination is deferred as reports of clinical measles infection are not always accurate. Vaccination at 12 months of age produces a protective antibody in approximately 95% of recipients. The second dose of vaccine, recommended at 4 years, increases protection to approximately 99% of recipients."*

http://ideas.health.vic.gov.au/bluebook/measles.asp

Clearly if doctors are being told that those who have received the vaccines are not susceptible to Measles then it logically follows that many of them will simply refuse to consider such a diagnosis in the vaccinated (they might call it Roseola or Fifth Disease instead). It may seem odd that doctors can simply call similar sets of symptoms different diseases in different people else but in fact, this is a fundamental aspect of medicine – the differential diagnosis. In some cases the symptoms are unambiguous and the diagnosis is simple but in many cases doctors have a hard time discerning what the condition might be because every patient presents slightly differently. This is why doctors don't just use symptoms alone but other factors and indeed have quite a bit of "wriggle room" in their diagnoses which will be dependent on various lifestyle factors relating to the patient (whether they smoke, how much exercise they do, where they work and, yes, whether they have been vaccinated). This makes perfect sense for the doctor because, from their perspective, it allows them to provide a more accurate diagnosis, however, it presents a fundamental problem for epidemiologists trying to analyse the meaning of the notification data in terms of evaluating a treatment because there is every chance that much of the data will be a self-fulfilling prophecy.

That is why in order to evaluate the efficacy of the vaccines there needs to be either a double blind evaluation or researchers have to analyse data that is not subject to this diagnostic bias. For example, if researchers wanted to evaluate the true success of the Polio vaccine they would need to look at the trend in total non-trauma paralysis (because paralysis is the main complication of Polio). In the case of Measles the complications are thought to be encephalitis, deafness and blindness so an attempt should be made to evaluate the trends in these conditions since the measles vaccine. Needless to say there is no point looking at rates of encephalitis blamed on Measles because this is subject to diagnostic bias; only total rates of encephalitis are useful for this evaluation.

All of this is particularly disturbing when it is considered in context with the soon to be introduced National Disability Insurance Scheme which would suggest that rates of severe disabilities caused by these diseases most likely have not fallen at all since their vaccines.

In other words, vaccines have never been evaluated in a manner that is statistically valid and it is very likely that were an attempt made to actually evaluate the data in a manner that was statistically valid we would find that few, if any, of the vaccines provide any benefit at all.

8.0 The effect of the Bill in relation to Family Tax Benefits

To the extent the Bill targets Family Tax Benefit A supplement, the purported public health benefit is even more tenuous. The denial of entitlement to Family Tax Benefit is a strictly punitive financial measure which could not possibly be construed as being capable of conferring a public health benefit even with the most dishonest of representations to that effect.

9.0 The Bill is neither necessary nor legitimate with regard to its purpose and effects

As the above analysis clearly shows, the Bill is entirely unnecessary; so the human-rights limitations it imposes are not justified. The purported rationale for the Bill is to provide protection on three fronts: protection of the children of conscientious objectors, protection of other children attending child care, and protection of the public health more generally. The Bill will achieve none of those goals, so is not a necessary or legitimate government measure.

10.0 No rational connection exists between the Bill's incursions upon human rights and its objective

The states parties to the human-rights instruments are under an obligation to demonstrate a rational connection between any limitations on human rights and the objective of the Bill. The above analysis clearly demonstrates that there is no such rational connection between the limitation on the human rights of conscientious objectors and the Bill's purported ability to protect the children of conscientious objectors, other children attending childcare, or the public health more generally. The purpose and effect of the Bill are financial, and will not confer protection on the children of conscientious objectors, other children, or the public health more generally.

11.0 The Bill's limitations of human rights are not proportionate to its objective

The states parties are also obliged to demonstrate that any limitation on human rights are proportionate to the objective being sought, having regard to the following matters.

11.1 Less restrictive ways to achieve the same objective

Whilst the purported purpose of the Bill is to encourage conscientious objectors to vaccinate their children, the greater proportion of unvaccinated children in Australia have, as we show in section 11.6, parents who generally support vaccination. For this reason, the government has at its disposal a means by which to increase vaccination rates in Australia without a need to infringe on the human rights of conscientious objectors who oppose vaccination. The government should be endeavouring to increase vaccination rates by assisting those parents who wish their children to be vaccinated, rather than infringing upon the rights of those who do not wish theirs to be.

Associate Professor Leask argues that vaccination rates can be increased by positive policies without the need to resort to coercive legislative measures as proposed by this Bill. Vaccination acceptance/ hesitancy and risk communication are her special areas of interest and expertise. She strongly favours tailored communication strategies; positive policies to remove structural barriers to vaccination uptake; and professional development and engagement of vaccination providers as the means to achieve such an end.

(Leask, 2011, Target the fence-sitters, Nature)

http://ses.library.usyd.edu.au/bitstream/2123/8960/2/Leask_Nature_accepted.pdf

11.2 The extent to which the Bill interferes with human rights

The Bill significantly limits the human rights of conscientious objectors in many broad areas over and above those the Explanatory Memorandum admits to. Detailed later in this submission, they include:

a) The right to equality and non-discrimination;

b) The right to freedom of religion, conscience, and belief;

c) The rights to work, to a reasonable standard of living, and to social security;

d) The right to privacy and the right of the family and children to be protected from arbitrary interference;

e) The right of children to have access to child care services; and

f) The right to consent freely to medical or scientific experimentation; and

g) The right to consent freely to invasive medical treatment.

Having regard to the marked limits of the Bill's possible effect on vaccination rates, such broad incursions upon human rights are disproportionate to the Bill's alleged benefits.

11.3 Vulnerability of sub-groups

There will be a disproportionate negative effect on low-income parents with a conscientious objection to vaccination, including especially single parents, many of whom are women. High-income parents will still have the financial capacity to enrol their children in child care, defeating the Bill's claimed intent.

11.4 Flexibility of the measure

The Bill essentially represents a blanket measure. While the medical contraindication exemption has been retained in the Bill, permitted contraindications to vaccination are largely limited to those adverse effects arising in the immediate post-vaccination period. Medical authorities would have us believe that vaccination rarely has long term negative consequences on health even though they claim vaccination confers long term beneficial effects (immunity to disease). In our view, this is extremely illogical all by itself, without having to refer to published evidence to contradict this claim. If vaccination is able to exert long-term beneficial effects on the immune system, then it's more than plausible that it would also be capable of conferring long-term negative effects; claims to the contrary necessitate evidentiary justification.

The Full Court of The Federal Court of Australia recently found there is no requirement to establish a "sudden or identifiable" physiological change to meet the definition of injury arising from vaccination (in relation to work-related injury), and that an injury may be established by a lay account of physiological changes, and need not be a matter for formal medical evidence and diagnosis.

(May v Military Rehabilitation and Compensation Commission [2015] FCAFC 93 (30 June 2015))

http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/FCAFC/2015/93.html

This judgement lends weight to our view that vaccine injuries occur outside the commonly accepted time-frames, and that parents' observations of physiological changes in their children which they have connected with the vaccines their children received, should be accepted as evidence of a contraindication to vaccination. Permitted medical contraindications under this Bill are too narrowly defined and also require endorsement from the medical profession.

There also exists an active denial by medical experts of evidence that vaccines can cause autism and other developmental arrest; no medical exemption is permitted on that basis either.

11.4.1 Vaccines can and have caused autism

Whilst some published epidemiological studies have purported to show that vaccines are not a cause of autism, all of them have employed critically flawed statistical methods, and most have compared a population of children who have received *x* vaccines with one of children who have received *y* vaccines. In studies of this type, the group that received just one fewer vaccine than the other is deceptively described as the "unvaccinated" control. No studies conducted to date have compared rates of autism or other disabilities or diseases in the completely unvaccinated with rates in the fully vaccinated.

As early as 1948, observers noted that developmental arrest as a result of encephalopathy had arisen from vaccination, and that the risk of encephalopathy might be higher in boys. This is interesting in the context that boys are over-represented in rates of developmental disorders, including autism.

> *"That constitutional factors may have been involved was suggested by both the preponderance of males as opposed to females, and by the high incidence of abnormalities of the nervous system in the family histories."*

(The Department of Pediatrics, Harvard Medical School and from the Infants' and Children's Hospitals, Boston, Mass., "Encephalopathies following prophylactic pertussisis vaccine", Pediatrics, 1948))

http://pediatrics.aappublications.org/content/1/4/437.abstract

The US Vaccine Injury Compensation Program (VICP) has been quietly compensating cases of autism since its inception in 1986. A preliminary study published in 2011 found 83 compensated cases of autism under the alternative diagnostic labels of encephalopathy or residual seizure disorder. In other words, compensation was awarded for a vaccine-related brain injury that led to autism.

(Holland et al., 2011, Unanswered Questions from the Vaccine Injury Compensation Program: A Review of Compensated Cases of Vaccine-Induced Brain Injury, Pace Environmental Law Review, p 3)

http://digitalcommons.pace.edu/cgi/viewcontent.cgi?article=1681&context=pelr

This study only represents the tip of the iceberg too. The question of whether vaccines are one of the causes of autism no longer arises: that question has been answered in the positive. Rather, the question is how many cases of autism vaccines have caused.

These articles report on other compensated autism cases; and there have been others.

(Kirby, 2013, Vaccine Court Awards Millions to Two Children With Autism, Huffington Post)

http://www.huffingtonpost.com/david-kirby/post2468343_b_2468343.html

(Attkisson, 2010, Family to Receive $1.5 m in First Ever Vaccine-Autism Court Award, CBS News)

http://www.cbsnews.com/news/family-to-receive-15m-plus-in-first-ever-vaccine-autism-court-award/

11.5 The unavailability of remedies

Upon those reliant on child-care services, the proposed legislation amounts to an effective mandate or practical compulsion. Any degree of coercion or compulsion that Parliament imposes with success will have a statistical certainty of causing injury, serious long-term adverse health effects, and death. Yet, unlike many industrialised countries, Australia does not have a statutory scheme for vaccine-injury compensation.

In 1997, former Australian Greens Senator Dee Margetts, during a Senate discussion about the Child Care Payments Bill, argued that there was a *"reciprocal obligation on any government which actually requires compulsion for a particular activity—in this particular case child immunisation—which is seen to be for the public good" so that "if the vaccination harms the child, there is an obligation on the Commonwealth government to make sure that adequate compensation is available"*.

(Hansard, p. 8687)

http://www.aph.gov.au/binaries/hansard/senate/dailys/ds111197.pdf

It is widely accepted among Australia's legal profession that victims of vaccine injury face extremely poor prospects of obtaining legal redress, without a statutory compensation scheme, due to the significant constraints of existing remedies under product liability or negligence law.

The family of Ben Hammond, a Western Australian father-of-five who was left quadriplegic by the whooping-cough vaccine he received as an adult under the auspices of the discredited 'cocooning strategy', has learnt at first hand the difficulties of obtaining compensation for his vaccine injury, and has been campaigning for such a compensation scheme ever since.

https://www.youtube.com/watch?v=xvcMo_-RM78

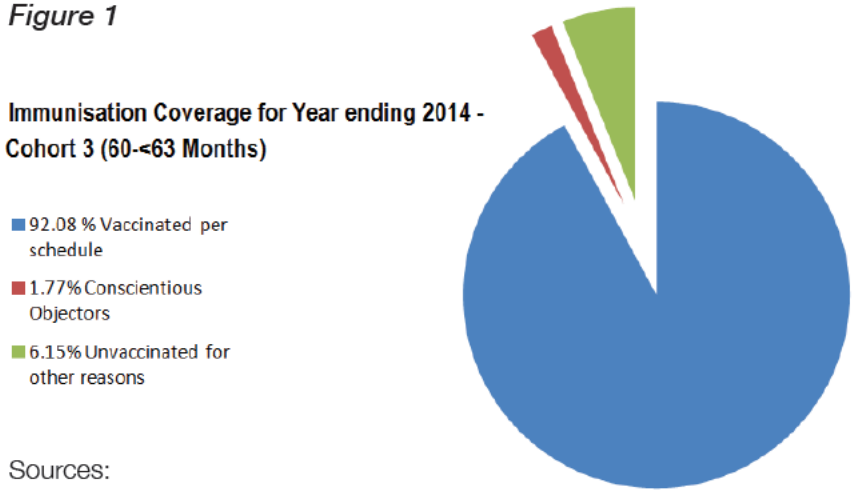
For some perspective, the U.S. Vaccine Injury Compensation Program (VICP) has paid out $3.2 billion in compensation since its inception.

11.6 Composition and characteristics of unvaccinated children in Australia in relation to the percentage of children who are fully vaccinated

The Bill's purported effect to confer protection on other children and the public health more generally also needs to be considered in the context of current overall vaccination coverage rates, and the relative percentages of children unvaccinated on conscientious-objection grounds and those children unvaccinated for other reasons.

The following chart provides a breakdown of these three categories in relation to the cohort of children aged 60 to 63 months Rates in the younger two cohorts are broadly similar.

Figure 1



Sources:

ACIR – National Vaccine Objection (Conscientious Objection) Data
http://www.immunise.health.gov.au/internet/immunise/publishing nsf/Content/acir-cons-object-hist.htm

ACIR – Annual Coverage Historical Data
http://www.immunise.health.gov.au/internet/immunise/publishing nsf/Content/acir-ann-cov-hist-data htm

** Data on rates of conscientious objection differentiating between specific age cohorts is not available, so the overall rate of recorded conscientious objections has been used.*

It s important to note that the real percentage of fully vaccinated children is likely to be much higher than that reported. For example a recently published study found that apparent lower vaccination uptake in inner-urban areas of Australia may be attributable to reporting error.

(Hull et al, 2015, Is low immunisation coverage in inner urban areas of Australia due to low uptake or poor notification?, Australian Family Physician)

http://www researchgate net/publication/8932280_Is_low_immunisation_coverage_in_inner_urban_areas_of_Aust alia_due_to_low_uptake_or_poor_notification

In other words, vaccination rates may be higher than those notified to and recorded by the Australian Childhood Immunisation Register.

One thing that should be immediately obvious when examining the chart is that the vast majority of unvaccinated children in Australia are not the children of conscientious objectors, but rather are unvaccinated for other reasons.

A recently published Australian study found that most children who were not up-to-date with vaccinations had parents who were generally in favour of vaccination and that socioeconomic disadvantage and chronic medical conditions were the key reasons for their not being up-to-date.

(2015, Children not immunised due to socioeconomic barriers, University of Adelaide)

https://www.adelaide.edu.au/news/news79888.html

12.0 Human Rights limited by the Bill

12.1 Right to consent freely to medical experimentation

Article 7 of the ICCPR provides that *"no one shall be subjected without his free consent to medical or scientific experimentation".*

The Bill introduces coercion of conscientious objectors to submit their children to vaccination in direct conflict with their deeply held beliefs in order to qualify for child care and family tax benefits. Consent to vaccination under such circumstances could not be said to have been given freely.

The Bill proposes that the immunisation requirement be in accordance with the Australian Immunisation Handbook, which also defines valid consent as requiring it to have been given voluntarily, in the absence of undue pressure, coercion or manipulation.

http://www.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home~handbook10part2~handbook10-2-1#2-1-3

The Bill also conflicts with the Medical Board of Australia Code of Conduct (the code) pertaining to informed consent.

Section 3.5 of the code defines informed consent as *"a person's voluntary decision about medical care that is made with knowledge and understanding of the benefits and risks involved."* Subsection 2 requires a doctor to obtain informed consent prior to providing a treatment.

(Medical Board of Australia, Good medical practice: a code of conduct for doctors in Australia, accessed 21 September 2015)

http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx

Australian law generally protects an individual's right to refuse medical treatments for themselves or on behalf of their children, except in the limited circumstances of a medical emergency or parental neglect, and that includes a right to refuse immunisation. Consent to vaccination is a matter between a medical professional and their patient without intrusion or coercion by the state.

Immunisation, like all medical procedures, carries with it the risk of death, disability and chronic disease. The tragic examples of Saba Button, Lachlan Neylan, Izzy Olesen and Ashley Epapara are cases in point. Both Saba Button and Lachlan Neylan suffered major brain injuries resulting in severe and permanent disability from the immunisations they received. Izzy Olesen suffered Stevens Johnson Syndrome resulting in blindness and major skin scarring, and regrettably, Ashley Epapara died. You can read their stories at the following links.

(Rule, 2011, Saba Button, the girl who is never alone, Perth Now)

http://www.perthnow.com.au/news/western-australia/saba-button-the-girl-who-is-never-alone/story-e6frg13u-1226035296706

(Hansen, 2013,Toddler who was given an adult flu shot is left severely brain-injured and unable to walk, Daily Telegraph)

http://www.themercury.com.au/news/national/toddler-who-was-given-an-adult-flu-shot-is-left-severely-brain-damaged-and-unable-to-walk-or-talk/story-fnj3ty2c-1226756398505

(Olesen, 2014, Izzy's Story, Vaccination Information Network)

http://www.vaccinationinformationnetwork.com/izzys-story/

(ABC News, 2010, Flu Vaccine can't be ruled out in toddler's death)

http://www.abc.net.au/news/2010-09-10/flu-vaccine-cant-be-ruled-out-in-toddlers-death/2256142

In addition, an often overlooked fact is that immunisation is a medical procedure carrying the risks of death, disability or chronic disease performed on otherwise healthy children for a purported future benefit. The procedure is not capable of conferring any immediate protective effect and is not being administered for an immediate therapeutic goal. For this reason alone, consent to the procedure should only be given freely and in the presence of the highest standards of evidence of its benefit. Conscientious objectors are not satisfied with the standard of evidence purporting to show protective effects for the individual or the general population under herd immunity theory, or the evidence purporting to demonstrate its safety.

That immunisation is an experimental procedure is shown by the following evidence.

1) The danger inherent in all vaccines is acknowledged by all vaccine manufacturers explicitly, in their product advice. Vaccines have been described as an unavoidably unsafe product.

   "Vaccines are a type of 'unavoidably unsafe' product; that is, a vaccine is a product that is incapable of being made safe for its intended and ordinary use. The Court in Bruesewitz notes that NCVIA expressly eliminates liability for a vaccine's unavoidable, adverse side effects:

   > *No vaccine manufacturer shall be liable in a civil action for damages arising from a vaccine-related injury or death associated with the administration of a vaccine after October 1, 1988, if the injury or death resulted from side effects that were unavoidable even though the vaccine was properly prepared and was accompanied by proper directions and warnings." 42 U.S.C.A. § 300aa-22(1)."*

   (La Greca, 2011, Supreme Court Gives Big Pharmaceuticals a Vaccination Against Lawsuits, Pace International Law Review Blog)

   https://pilr.blogs.law.pace.edu/2011/10/27/supreme-court-gives-big-pharmaceuticals-a-vaccination-against-lawsuits/

2) Many pre-market clinical trials of vaccines use a non-inert placebo such as aluminium adjuvant or another vaccine in the no-treatment control group. This has the effect of increasing the rate of side effects in the no-treatment group acting to minimise the difference in rates of side effect between the treatment and no-treatment group, which in effect is not a no-treatment group at all. The following is one of many examples.

"Women were randomized 1:1 to receive HPV-16/18 AS04-adjuvanted vaccine or aluminum hydroxide as a control."

(Zhu et al, 2014 Efficacy, immunogenicity and safety of the HPV-16/18 AS04-adjuvanted vaccine in healthy Chinese women aged 18–25 years: Results from a randomized controlled trial, International Journal of Cancer)

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4277330/

A 2010 study of randomized controlled trials found that the composition of placebos is rarely disclosed.

(Golomb et al, 2010, What's in placebos: who knows? Analysis of randomized, controlled trials, Annals of Internal Medicine)

http://www.ncbi.nlm.nih.gov/pubmed/20956710

The purpose of a placebo being to induce no symptoms beyond those inherent in involvement in the experiment, such secrecy is a matter of concern by reason of the strong possibility of the poor trial design exemplified immediately above.

3) Pre-market clinical trials only test an individual vaccine in isolation from the rest of the scheduled vaccines. The effect of administration of more than one vaccine at the same time requires trial itself; no such pre-market trial having been conducted, that experiment is taking place in the marketplace; administration of more than one vaccine at a time therefore amounts to medical experimentation upon the vaccines' recipients.

The tragic example of Saba Button referred to above is a case in point. Whilst her catastrophic injuries have been conveniently attributed to the experimental flu vaccine she received, she also received four other vaccines on that fateful day, namely the Meningococcal C and MMR vaccines, and the maker of the seasonal flu vaccine claimed that it was not required to conduct pre-market clinical trials of the vaccine, let alone trials about the effect of the vaccine when given in combination with the other scheduled vaccines.

(Trigger, 2013, Company denies fault over ill baby, The West Australian)

https://au.news.yahoo.com/thewest/wa/a/17845400/company-denies-fault-over-ill-baby/

The monitoring of adverse effects when vaccinations are administered in combination with other scheduled vaccines is conducted only in the form of post-market surveillance, which, in Australia, is a passive-surveillance system. This passive-surveillance system results in a significant under-reporting of adverse effects from vaccination.

"It is generally acknowledged that adverse events are under-reported around the world, with estimates that 90-95% of adverse events are not reported to regulators.[1]"

https://www.tga.gov.au/media-release/new-web-service-helps-consumer-reporting-side-effects

The world's most sophisticated reporting system for vaccines, that of the U.S., is acknowledged by the FDA as under-reporting serious adverse events from all medicines by 99%. Physicians are universally more reluctant to report serious adverse events from vaccines, as it invites questioning of their loyalty to vaccination.

4) Susceptibility factors underlying severe adverse reactions resulting in death, disability, and long-term chronic disease are largely unknown and can't be predicted. This matter is discussed further in Appendix C of this submission.

5) Available scientific methods do not have the ability to predict who will be allegedly protected from disease by vaccination, or for how long.

6) Nor do they have the ability to predict who will be adversely affected by the vaccination, or how seriously, or for how long. What they have eventually revealed, though, is that every childhood vaccination manufactured to date has adversely affected some children permanently, some of these very seriously, some fatally.

12.2 The requirement of legally valid consent to invasive medical treatment

In fact, every invasive medical treatment requires legally valid consent except when the patient is incapable of giving it; even in such an exceptional case, the treatment must be in the patient's best interests.

"(1). Subject to (3) below, in general it is a criminal and tortious assault to perform physically invasive medical treatment, however minimal the invasion might be, without the patient`s consent…

"(2). A mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death…

"(3). Medical treatment can be undertaken in an emergency even if, through a lack of capacity, no consent had been competently given, provided the treatment was a necessity and did no more than was reasonably required in the best interests of the patient…."

(Re MB [1997] EWCA Civ 3093 (26 March 1997), paragraph 17)

http://www.bailii.org/cgi-bin/markup.cgi?doc=ew/cases/EWCA/Civ/1997/3093.html

A decision expressed in form only, not in reality, under undue influence – as in applied financial pressure – is not legally valid consent.

(Re T [1992] EWCA Civ 18 (30 July 1992), paragraphs 31, 32, and 35

http://www.bailii.org/ew/cases/EWCA/Civ/1992/18.html

In addition to common law rights to consent freely to a medical procedure, Article 6.1 of the Universal Declaration on Bioethics and Human Rights also protects this right.

> *"Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information. The consent should, where appropriate, be express and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice."*

http://portal.unesco.org/en/ev.php-URL_ID=31058&URL_DO=DO_TOPIC&URL_SECTION=201.html

The Bill violates this right under 'practical compulsion'.

12.3 Right to equality and non-discrimination

The Bill limits rights to equality and non-discrimination conferred by articles 2, 3 and 26 of the ICCPR, articles 2.2 and 3 of the ICESCR, articles 2 and 3 of the CEDAW and CRPD, and article 2 of the CRC.

The Bill's purpose to apply punitive financial sanctions to conscientious objectors exclusively (except in relation to medically exempt children) and not other unprotected children, is arbitrarily discriminatory. If deliberately unvaccinated children are claimed to pose a risk to the other children and child care staff, then by necessity, similarly unprotected children and adults must also pose the same risk. These include:

(a) those who can't be vaccinated for medical reasons; and

(b) those who are too young to have been vaccinated; and

(c) those who have been vaccinated, but who are not protected due to not producing the required biological response claimed to confer immunity; and

(d) those who were not vaccinated in utero; and

(e) child care centre employees.

In addition there is also a significant body of scientific evidence that children recently vaccinated with live, attenuated viruses pose a genuine risk to close contacts in the post-vaccine period. Live attenuated vaccine viruses, such as Measles, Mumps, Rubella, Chickenpox and Rotavirus have been regularly associated with disease in the recently vaccinated, and transmission of the vaccine-strain viruses to others resulting in disease has been documented as well. A list of references evidencing vaccine-associated disease in recipients of live attenuated virus vaccines and transmission of vaccine-strain viruses to close contacts is provided in Appendix D of this submission.

If unvaccinated children are alleged to pose a risk to others then surely children receiving live virus vaccines would also pose a risk, possibly a greater one, but the Bill does not discriminate against the parents of these children on such a basis. The parents of children receiving live attenuated vaccines will still enjoy access to full benefits.

A particularly ironic effect of this Bill will be that conscientious objector parents will be denied benefits on the basis their unvaccinated children allegedly pose a risk to other children, while the parents of a Hepatitis B positive child will retain all benefits, and are not even under a legal obligation to advise a child care centre of their child's positive status.

(Hepatitis B, Do I have to tell the school/day care that my child has hepatitis B?, The Sydney Children's Hospital Network)

http://www.schn.health.nsw.gov.au/parents-and-carers/fact-sheets/hepatitis-b

Rights to non-discrimination have also been incorporated into some domestic laws including the Disability Discrimination Act 1992 (Cth) (DDA)

12.3.1 The Bill conflicts with the DDA

Sections 3 - 6 of the DDA prohibit discrimination against a person on the ground of disability and section 29 prohibits discrimination in the administration of Commonwealth programs. Disability is defined in section 4 to include:

(c) the presence in the body of organisms causing disease or illness; or

(d) the presence in the body of organisms capable of causing disease or illness; and includes a disability that:

(j) may exist in the future (including because of a genetic predisposition to that disability); and

(k) is imputed to a person.

(Disability Discrimination Act 1992 (Cth))

https://www.comlaw.gov.au/Details/C2013C00022/Html/Text#_Toc345412388

This definition was interpreted by Hon. William Carter QC to include children who are not vaccinated according to the recommended schedule:

> *"Therefore, a "disability" as defined... above remains a "disability" by definition even though it does not presently exist. If it "may exist in the future" it is nonetheless a "disability" for the purposes of the Act. In the case of the Beattie children it is therefore the case that since they may in the future have in their bodies the organisms which cause or are capable of causing certain diseases or illnesses they suffer a "disability" as defined in the Act. The complaint on their behalf is that they have been discriminated against contrary to s.5 (1) of the Act because on account of that disability they have been treated less favourably by the Council in that they were refused admission to the Council's child care centre. Prima facie such discrimination is unlawful."*

(Beattie (on behalf of Kiro and Lewis Beattie) v Maroochy Shire Council [1996] HREOCA 40 (20 December 1996))

http://www.austlii.edu.au/au/cases/cth/HREOCA/1996/40.html

The Bill seeks to amend the A New Tax System (Family Assistance) Act 1999 (FAA), and proposes to administer certain government allowances in the above discriminatory manner by removing entitlement for parents who have not vaccinated their children according to the recommended schedule. Hence the Bill proposes prima facie unlawful discrimination against parents of unvaccinated children, and is therefore incompatible with the DDA. We note that this incompatibility has not been explored in the Bill's Statement of Compatibility with Human Rights.

If the Bill is passed there will be an immediate challenge on this basis by numerous motivated parents who support freedom of choice on the issue of vaccination. A representative (group) complaint is permitted under section 46P section 2(b) having regard to conditions governing representative complaints in section 46PB of the Australian Human Rights Commission Act 1986 (Cth).

(Australian Human Rights Commission Act 1986, sections 46P & 46PB)

http://www.austlii.edu.au/au/legis/cth/consol_act/ahrca1986373/s46p.html

http://www.austlii.edu.au/au/legis/cth/consol_act/ahrca1986373/s46pb.html

Should the government wish to defend these challenges, it will need to rely on Sections 47, 48, or 51 of the DDA in order to demonstrate that the discrimination is not unlawful. Sections 47 and 51 do not offer the requisite support as FAA is neither directly listed (for the purposes of Section 51) nor a prescribed law (for the purposes of Section 47).

It would remain therefore for an argument to be mounted, via Section 48, that "the discrimination is reasonably necessary to protect public health". This would be an exceedingly difficult claim to substantiate given that the denial of benefits – especially in the absence of a concomitant prohibition on enrolment in child care - confers no capability to protect the public health.

12.4 The right to freedom of religion, conscience or belief

Article 18 of the ICCPR protects this right.

12.4.1 Historical legislative precedent for belief based exemptions in Australia in the context of low immunisation rates

There has been long-standing and bipartisan legislative support for exemptions based on religious or other beliefs since 1998, when an immunisation requirement was first enacted in Commonwealth legislation.

(Child Care Payments Act 1997 (Cth), section 8)

https://www.comlaw.gov.au/Details/C2004A05289/Html/Text#param10

It's important to consider that in 1997, immunisation rates were significantly lower than today, with less than 75% of children aged 12 months fully immunised in accordance with the schedule, yet the Commonwealth parliament still elected to provide for exemptions in that context.

(Figure: Trends in vaccination coverage, Australia, 1997 to 30 September 2012, by age cohort)

http://www.health.gov.au/internet/main/publishing.nsf/Content/cdi3701m

This compares with the approximately 91% of 12-15 month olds fully vaccinated at the end of 2014, an increase of more than 20% from baseline over that period.

(2015, ACIR – Annual Coverage Historical Data, Immunise Australia Program)

http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/acir-ann-cov-hist-data.htm

Far from contributing to a fall in immunisation rates, immunisation rates have actually increased significantly since the right to object to immunisation was first protected by legislation. In other words, the significant increase in immunisation rates has occurred within a legislative framework which accommodates freedom of choice based on beliefs without the need for coercion or punishment by the state.

In addition to support for broad belief exemptions, both the ALP and LNP – when in federal government – have given specific legislative force to religious belief exemptions under section 7 of A New Tax System (Family Assistance) Act 1999 (Cth) for the purpose of eligibility to Child Care Benefits and/or Family Tax Benefits.

Section 7 of the Act provides that the Minister may make determinations, by legislative instrument, to exempt a specified class of children from an immunisation requirement (sub-section 1), or that a specified class of children meets the immunisation requirement in the circumstances described in the determination (sub-section 2).

(A New Tax System (Family Assistance) Act 1999 (Cth), s7)

https://www.comlaw.gov.au/Details/C2014C00170/Html/Text#_Toc386550790

As recently as 2013, then federal ALP government determined, by legislative instrument, a religious exemption from the immunisation requirement for the purpose of eligibility to Child Care Benefits.

(Child Care Benefit (Immunisation Requirements) (DEEWR) Determination 2013)

https://www.comlaw.gov.au/Details/F2013L01056

The federal LNP government has made similar determinations in the past.

(Family Assistance (Exemption from Immunisation Requirements) Determination 2003)

https://www.comlaw.gov.au/Details/F2007B00271

While the only determinations that have been made historically under section 7 have been in relation to a religious organisation, there is no requirement in the wording of the provision for the determination to be in relation to a religion specifically. In other words, it's a broad discretionary power.

It is also important to consider that a more general religious exemption has been available under section 6, sub-sections 3 and 4, using the definition of conscientious objection in section 5 of the same Act since 1999 when it repealed the Child Care Payments Act.

"An individual has a conscientious objection to a child being immunised if the individual's objection is based on a personal, philosophical, religious or medical belief involving a conviction that vaccination under the latest edition of the standard vaccination schedule should not take place."

https://www.comlaw.gov.au/Details/C2014C00170/Html/Text#_Toc386550788

12.4.2 Recent bipartisan policy support for religious exemptions

It is also noteworthy that the ALP and LNP both expressed in-principle support for religious exemptions as recently as April of this year.

ALP Leader Bill Shorten stated his support for exempting the children of parents who have a deeply-held religious view against immunisation from such a requirement under Commonwealth legislation.

(Shorten, 2015, Labor will work with government to increase immunisation rates)

http://billshorten.com.au/labor-will-work-with-government-to-increase-immunisation-rates

Similarly, then Social Services Minister, Scott Morrison, in announcing the so-called No Jab No Pay Commonwealth laws, expressed his in-principle support for religious exemptions, by stating that existing exemptions on religious grounds will continue.

(Morrison, 2015, No jab – no play and no pay for child care)

http://www.liberal.org.au/latest-news/2015/04/12/no-jab-no-play-and-no-pay-child-care

While the Minister has since revised his position on religious exemptions to the effect he will not be approving any further exemptions and will be cancelling the one existing exemption because the church concerned no longer has an objection to immunisation, that position was informed on the basis there is currently no other religions in Australia with a registered objection to immunisation. His position also failed to give due consideration to a broader definition of religion, and as such, did not provide for the possibility of emerging religions which have an objection to immunisation.

(Morrison, 2015, Government ends religious 'No Jab No Pay'of benefits exemption)

http://parlinfo.aph.gov.au/parlInfo/download/media/pressrel/3783547/upload_binary/3783547.pdf;fileType=application%2Fpdf#search=%22media/pressrel/3783547%22

The High Court of Australia has adopted a broader definition of religion than is popularly accepted.

(High Court of Australia, Church of the New Faith v. Commissioner of Pay-Roll Tax (Vict.) [1983] HCA 40; 1983 154 CLR 120)

http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/HCA/1983/40.html

In his judgement that Scientology was a religion, Justice Murphy stated:

> *"The truth or falsity of religions is not the business of officials or the courts. If each purported religion had to show that its doctrines were true, then all might fail. Administrators and judges must resist the temptation to hold that groups or institutions are not religious because claimed religious beliefs or practices seem absurd, fraudulent, evil or novel; or because the group or institution is new, the number of adherents small, the leaders hypocrites, or because they seek to obtain the financial and other privileges which come with religious status. In the eyes of the law, religions are equal. There is no religious club with a monopoly of State privileges for its members."*

He subsequently suggested conditions which may be sufficient, but not necessary, to show the existence of a religion:

> *"On this approach, any body which claims to be religious, whose beliefs or practices are a revival of, or resemble earlier cults, is religious. Any body which claims to be religious and to believe in a supernatural Being or Beings, whether physical and visible, such as the sun or the stars, or a physical invisible God or spirit, or an abstract God or entity, is religious. For example, if a few followers of astrology were to found an institution based on the belief that their destinies were influenced or controlled by the stars, and that astrologers can, by reading the stars, divine these destinies, and if it claimed to be religious, it would be a religious institution. Any body which claims to be religious, and offers a way to find meaning and purpose in life, is religious. The Aboriginal religion of Australia and of other countries must be included. The list is not exhaustive; the categories of religion are not closed."*

It is our view, that under such a definition, a deep and abiding belief against vaccination, (or even just against certain vaccines), in addition to a belief that pharmaceutical based medicine only be used as a last resort or in the case of an emergency or trauma, instead of being central to therapeutic and preventative health goals, satisfies such a definition of religion.

Certainly, some of our more dogmatic critics have described us as a tin-foil hat wearing, science-denying religious cult on more than one occasion, and opposition to vaccination as a belief, has been around since Jenner's Smallpox vaccine was first unleashed on an unwitting public.

In any case, the Minister and ALP leader, in giving their in-principle support to religious belief exemptions, should also continue to support secular belief exemptions, because at law, there is no difference between beliefs informed by religious doctrine and beliefs arising for other reasons. In saying that, we would be surprised to discover that the Minister and ALP leader weren't already aware of this fact, so we are left to conclude that for some reason, the Minister and opposition leader have chosen to attach a higher weight to religious beliefs than other secular beliefs.

It's rather interesting that back in April of this year, then Minister for Social Services Scott Morrison saw fit to seek counsel from the Church of Christ Scientist on the question of that church's current section 7 immunisation exemption, yet chose not to undertake any consultation with conscientious objectors or their representative organisations who also hold deep beliefs against vaccination. This would suggest to us that there is a religious bias being applied in public policy.

The committee can be reassured that conscientious objectors have deeply held beliefs against vaccination and are no less devout in their beliefs than the followers of the Church of Christ Scientist.

12.5 The rights to work, a reasonable standard of living, and to social security

The Bill introduces a retrogressive measure in terms of economic rights conferred by the ICESCR (articles 6, 9 and 11) (and included in CEDAW (articles 10 and 13) and CRC (article 26)).

The states parties are obliged to implement the progressive realisation of these economic rights within the limits of their resources and refrain from implementing retrogressive measures. This Bill undoubtedly takes a backward step in the realisation of the economic rights of conscientious objectors and their children, who will be denied access to social security and paid work by being denied access to affordable child care. This will necessarily impact on their standard of living be denying them access to wages, and in some case will result in parents not being able to pay their mortgages due to the loss of one income for household expenses.

That the government is attempting to leverage compliance with a medical procedure using non-means-test based criteria is repugnant. Welfare or equity measures should never be subject to a requirement to submit to vaccination. The only test that should apply to means-tested welfare measures is a means test.

While this retrogressive measure will affect both male and female conscientious objector parents, the impact on women will be greater due to their over-representation in the care giving role. It will be women mainly who will be forced out of the workforce by the effect of this Bill

> *"Australian women continue to be under-represented in the workforce, with 78% of Australian men aged 20-74 years participating in or looking for work in 2013-14, compared with 65% of women.[28] This gap widens with the arrival of children, with 57.5% of mothers whose youngest child is aged 0-5 years participating in the labour force, compared with 94% of fathers.[29] When employed, women are also more likely to work in part-time or casual roles than men, with women comprising 35.8% of fulltime employees in Australia, 75.3% of part-time employees and 57.2% of casual employees.[30]"*

(Broderick, 2015, Submission to the Senate Inquiry into the Fairer Paid Parental Leave Amendment Bill 2015, Australian Human Rights Commission, p 4)

https://hrawards.humanrights.gov.au/sites/default/files/15.07.27%20AHRC%20submission%20-%20Fairer%20Paid%20Parental%20Leave%20Amendment%20Bill%202015.pdf

The Bill then can be seen to be a direct attack on previous gains in equal opportunity in increasing the workplace participation of women and consequent accrual of retirement savings.

In any case it is our view that the denial of these economic benefits, to which conscientious objectors contribute by way of income taxes, are not permitted under the constitutional heads of power.

12.5.1 The immunisation requirement is not authorised by the Constitution

Child Care Benefits and Family Tax Benefits are authorised by the welfare power under section 51 (xxiiiA) of the Constitution and by the appropriations power under section 81, however, the Commonwealth is not authorised to regulate entitlement to these benefits with an immunisation requirement.

While we accept that the Commonwealth's legislative powers generally carries with it a concomitant authority to regulate matters incidental to the subject matter of the power – the control of which is necessary to achieve its main purpose – immunisation could not be said to be incidental to the provision of child care of family tax benefits, nor is it necessary to achieve the purposes of the provision of these benefits.

The main purpose of child care benefits is to ameliorate the high cost of child care services by way of subsidisation, and the purpose of family tax benefits is welfare or wealth distribution. These benefits do not have a health purpose; they are primarily concerned with the distribution of economic or financial benefits. Consequently, an immunisation requirement could not be said to be incidental to the subject matter of the authorised power, or that an immunisation requirement is necessary to achieve the purpose of those benefits. For this reason the Commonwealth does not hold the necessary power to regulate entitlement to child care and family tax benefits with an immunisation requirement under its welfare power.

While the immunisation requirement to regulate entitlement to child care benefits may be authorised under a head of power – other than the welfare power – we are of the belief that the Commonwealth does not have an alternative head of power to authorise the immunisation requirement.

The Commonwealth does not hold the general health power. Health is a residual power of the States. The Commonwealth holds a health power only to the extent provided in section 51(xxiiiA), namely, medical and dental services, sickness and hospital benefits, and pharmaceutical benefits.

Funding of the National Immunisation Program is authorised under the Commonwealth's pharmaceutical benefits power, but this power represents a narrow funding power rather than a broad health power pertaining to immunisation. That the health power in relation to immunisation is held by the states can be seen in light of the following.

The Australian Government provides funding to:

> *State and territory governments to obtain vaccines listed on the NIP Schedule in accordance with the list of Designated Vaccines, as defined under the National Health (Immunisation Program – Designated Vaccines) Determination 2014 (No 1)*

http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/about-the-program

It is our view therefore, that the Commonwealth does not hold a broad enough health power to authorise an immunisation requirement in Commonwealth laws in relation to vaccines funded under the National Immunisation Program.

The Commonwealth also holds the quarantine power under section 51(ix), but regulation of eligibility to child care and family tax benefits by way of an immunisation requirement in relation to otherwise healthy, but unvaccinated children, could not be justified under this power, having regard to the scope of quarantine as provided in section 4 of the Quarantine Act 1908 (Cth).

http://www.austlii.edu.au/au/legis/cth/consol_act/qa1908131/s4.html

Having regard to the above, section 81 of the Constitution only permits the appropriation of funds *"in the manner and subject to the charges and liabilities imposed by this Constitution".*

http://www.austlii.edu.au/au/legis/cth/consol_act/coaca430/s81.html

In other words, the Commonwealth, while authorised to appropriate funds for the purpose of child care and family tax benefits, is not authorised to regulate entitlement to these benefits with an immunisation requirement because immunisation is not incidental to child care or family tax benefits, does not assist in achieving their purposes, and is also not authorised under the Commonwealth's pharmaceutical benefits or quarantine powers.

12.6 The right of children to have access to child care services

Article 18 of the CRC protects the right of children to have access to the benefits of child care services. The states parties are under an obligation to take all appropriate measures to ensure that children of working parents have the right to benefit from child-care services and facilities for which they are eligible.

The Bill's effect will be to deny the children of conscientious objectors access to these services. Somewhat ironically, some of these will be children with disabilities, disabilities which were caused by vaccines in the first place. The government's targeting of this most vulnerable section of our community is unconscionable by any measure.

Under this Bill, children will be denied early socialisation and developmental opportunities that may put them at a disadvantage in the future in terms of how they integrate into formal education. Child care services also offer children with disabilities access to specialised developmental programs delivered by qualified early childhood educators, programs which cannot be delivered by parents in many cases. In addition, for parents of children with disabilities, child care services often serve as a type of respite service for families already struggling with the immense challenges that come with raising children with significant special needs.

The Commonwealth is already committed to the provision of universal access to early child care education, but this Bill will act to strip away that right in relation to the children of conscientious objectors.

Under the first national Partnership Agreement on Early Child Care Education:

"all governments committed to work together to ensure that all children have access to a quality early childhood education programme, delivered by a qualified early childhood teacher for 600 hours of preschool education in the year before they attend full-time school."

The Commonwealth has already allocated more than $2 billion to states and territories to progress the right to universal access to child care, and in May of this year, announced a further two years of funding for that purpose.

Under the agreement, states and territories are under an obligation to develop implementation plans which set out strategies that will give effect to the goal of universal access including in relation to vulnerable and disadvantaged children.

https://education.gov.au/national-partnership-agreements

12.7 The right to privacy and the right of the family and children to be protected from arbitrary interference

Articles 17 and 23 of the ICCPR protect these rights. The right to privacy includes a right not to have one's private life arbitrarily interfered with. This extends to families, as the fundamental unit of society. The Bill seeks to arbitrarily interfere with the privacy of families who choose to raise their children free of medical and pharmaceutical interventions to the greatest extent possible, by coercing parents to submit their children to vaccination under a medical model of health of which they are largely opposed.

It is only in the last 30 years or so that the mainstream medical model has come to dominate child-rearing practices as they pertain to health. Childhood health has been medicalised to such an extent that many people have likely forgotten this, and contrary to what mainstream medical experts claim, there is no single best method by which to promote and manage children's health. The assertion in the Statement of Compatibility that vaccination represents the most effective method of preventing so-called infectious disease in an individual, or others under herd immunity theory, implies that different methods have been the subject of scientific inquiry, but this is not the case. In any case, we are confident, that in the not too distant future, it will be shown that susceptibility to so-called infectious disease is in no way tempered or mediated by receipt of a vaccine.

An emerging theory suggests that susceptibility to serious outcomes from so-called infectious can be attributed to susceptibility genes.

> *"Jean-Laurent Casanova, MD, PhD, is a Professor and Head of Laboratory at the Rockefeller University, Senior Attending Physician at the Rockefeller University Hospital, and Investigator of the Howard Hughes Medical Institute. He is a pediatrician and immunologist by training, and in practice, has become a human geneticist investigating infectious diseases. He discovered that life-threatening infectious diseases of childhood may be caused by single-gene inborn errors of immunity. He revealed single-gene mutations that create 'holes' in the immune system of children who are susceptible to specific infectious diseases, yet remain normally resistant to other infectious agents."*

(The Human Genetic Theory of Infectious Diseases: A Brief History)

http://www.nyam.org/events/2015/2015-09-09.html

In this context, vaccination can be seen as a blanket population measure, which will now include the practical compulsion of people opposed to the practice if the Bill is passed, a measure which more than likely has no ability to improve health outcomes in greater than 95% of the population.

In any case, as shown in an earlier section, the state of children's health in Australia under the dominant medical model which includes vaccination is far from good anyway.

In the end, the promotion and management of children's health is, first and foremost, the responsibility of parents, not the state. It is only when parents neglect their responsibilities to promote and protect their children's health is the state authorised to enter the private sphere of child rearing. Non-vaccination of perfectly healthy and well-cared for children is not one of those occasions.

It would be instructive for the government to undertake a study evaluating health outcomes in unvaccinated children compared with children vaccinated on schedule. Given the Australian Childhood Immunisation Register has been in operation for nearly 20 years it is incumbent on the government to utilise that information to undertake such a study before it enters the sphere of private life proposed by this Bill. The information available to the government in that register would be put to far better use for that purpose, rather than being used as a tool against otherwise intelligent and responsible parents who choose to raise their children outside the medical model.

Appendix A

Vaccination – the scientific controversy

A.1 Vaccines did not save us from high rates of death from infectious disease

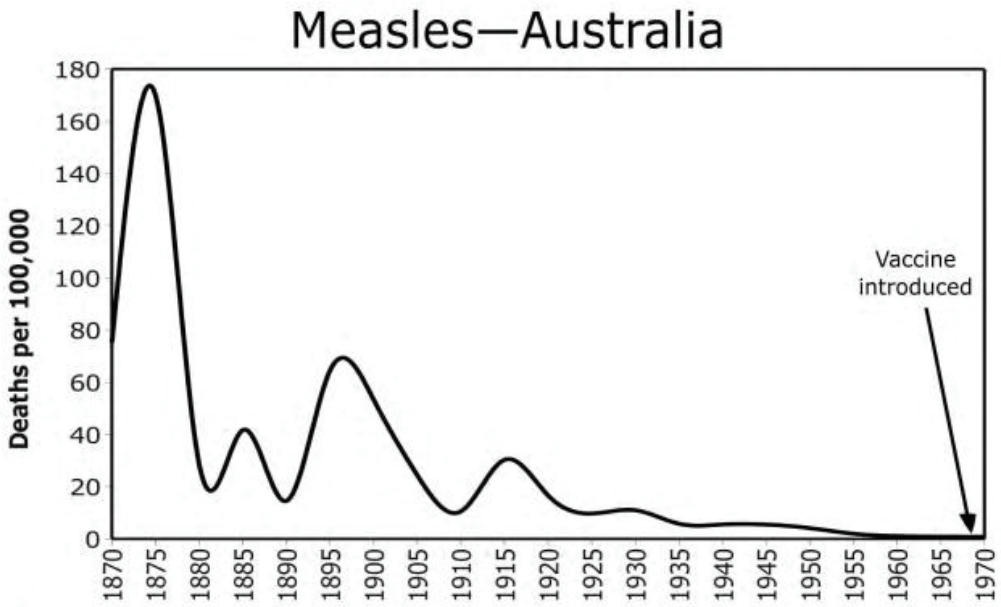
The claim that mass vaccination was responsible for the decline in deaths from infectious disease in the 20th century is disputed and runs contrary to the best available evidence.

> *"Vaccines are popularly thought to have saved more lives than any other intervention in human history other than clean water. They are frequently credited with conveying us from the days when children died in large numbers from infectious disease to the present day where such deaths are rare. Indeed it is this image that forms the fundamental marketing slogan for vaccination.*
>
> *An examination of the publicly available data, however, suggests these claims are lacking in evidence. The attached graphs (Appendices 1-4)* provide pictorial representations of the limited role vaccines played in the reduction of deaths from infectious disease in Australia. It should be immediately obvious that if a role was played in the transition, it was small in comparison to other factors.*
>
> *The vast majority of the decline in infectious disease, for which vaccination is typically given credit by its promoters, occurred before the vaccines were even available. The real heroes of our past were those who brought about improvements in nutrition, sanitation, housing, education and the many other areas which have long been considered the primary determinants of health. It was through these efforts that our communities were forged into the robust and safe living environments they are today.*
>
> *The scenario represented in the graphs was identical to that found throughout the developed countries of the world."*

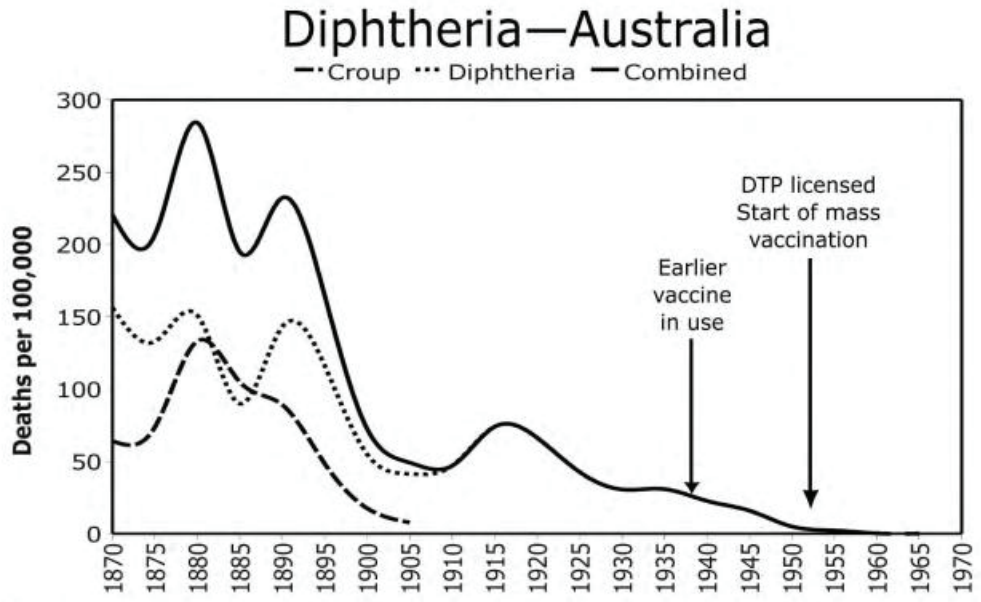
(Beattie, 2013, Submission to the Health and Community Services Committee Queensland Parliament, p. 2)

https://www.parliament.qld.gov.au/documents/committees/HCSC/2013/PHunvaccinatedchildren/submissions/061.pdf

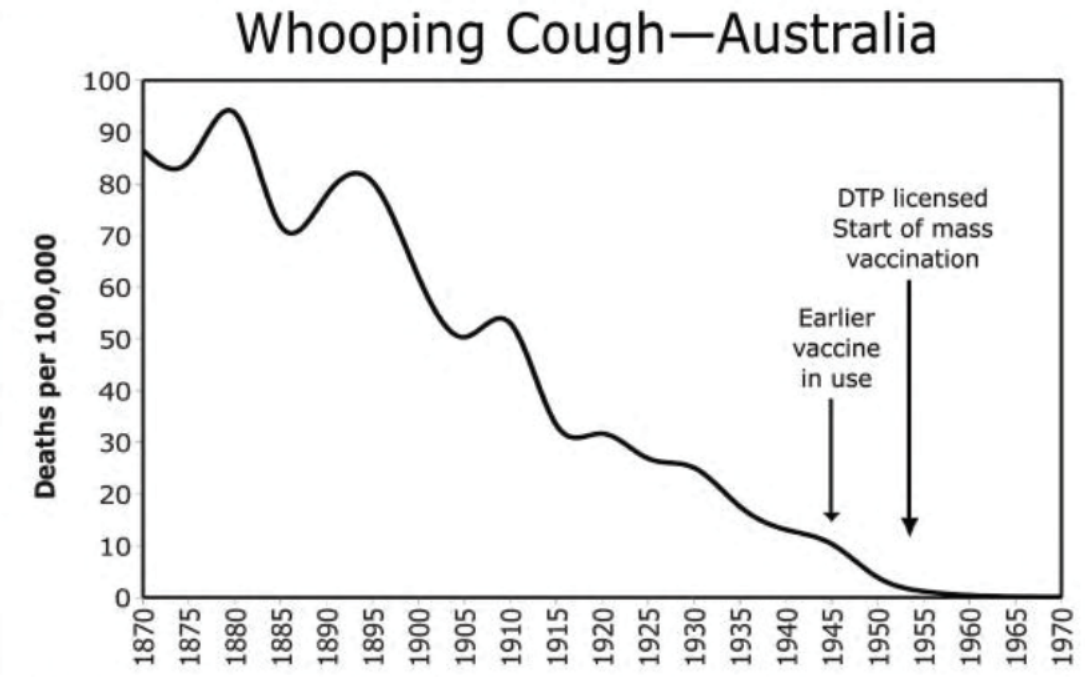
* For convenient reference, a copy of the graphs referred to follows.



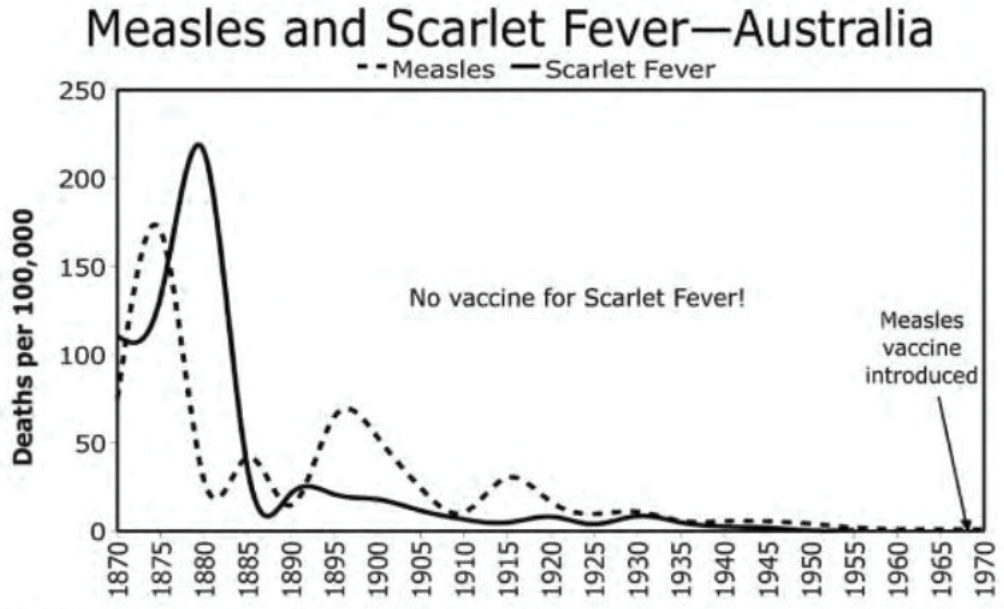
Plot points are 5-yearly totals.
Sources: Data published by Commonwealth of Australia in *The History of Diphtheria, Scarlet Fever, Measles, and Whooping Cough in Australia, 1788–1925* (Cumpston, 1927) and Commonwealth Year Books, plus Australian Bureau of Statistics population data.



Plot points are 5-yearly totals.
Sources: Data published by Commonwealth of Australia in *The History of Diphtheria, Scarlet Fever, Measles, and Whooping Cough in Australia, 1788–1925* (Cumpston, 1927) and Commonwealth Year Books, plus Australian Bureau of Statistics population data.



Plot points are 5-yearly totals.
Sources: Data published by Commonwealth of Australia in *The History of Diphtheria, Scarlet Fever, Measles, and Whooping Cough in Australia, 1788–1925* (Cumpston, 1927) and Commonwealth Year Books, plus Australian Bureau of Statistics population data.



Plot points are 5-yearly totals.
Sources: Data published by Commonwealth of Australia in *The History of Diphtheria, Scarlet Fever, Measles, and Whooping Cough in Australia, 1788–1925* (Cumpston, 1927) and Commonwealth Year Books, plus Australian Bureau of Statistics population data.

A.2 The alleged eradication of Smallpox and near-eradication of Poliomyelitis was achieved through improvements in living standards and diagnostic substitution

There is much evidence to suggest that the alleged eradication/near eradication of smallpox and poliomyelitis was achieved, not by vaccines, but rather, by changes to living standards, food standards such as pasteurisation, sanitation, and, just as importantly, diagnostic substitution via a shift from clinical to laboratory-based diagnosis.

A.2.1 Smallpox

"Smallpox vaccine was in use in England during the 19th and 20th centuries. During this time the illness declined in parallel with all other infectious illnesses, as can be seen from the attached graphs (Appendices 5-6). This was the period when industrialised communities were being built, as described above, and infectious illness deaths were declining across the board. The extent to which vaccination may have assisted this decline, if indeed it did, is impossible to ascertain."

(Beattie, 2013 ibid. p. 2-3)

It's not unreasonable to believe that smallpox still afflicts human beings today. Smallpox, as a clinical entity, is still very much with us, but bearing alternative diagnostic labels such as monkeypox and chickenpox.

Prior to the declaration by the World Health Assembly that smallpox had been eradicated, monkeypox, a disease clinically identical to smallpox, was first identified in humans.

"The differential diagnoses include usually smallpox, chickenpox, measles, bacterial skin infections, scabies, medicamentous allergies and syphilis. Monkeypox can only be diagnosed definitively in the laboratory where the infection can be diagnosed by a number of different tests"

(World Health Organization, 2011, Monkeypox)
http://www.who.int/mediacentre/factsheets/fs161/en/

The results of a monkeypox study were reported in the science media during 2010. It was claimed that monkeypox is not a rare disease, and in some parts of Africa, is commonplace. The study found that between 2006 and 2007, in regions of the Democratic Republic of Congo (DRC) where the virus is known to circulate, there were 760 active cases (approximately 14 per 10,000 people) of monkeypox.

(Scientific American, 2010, Pox Swap: 30 Years After the End of Smallpox, Monkeypox Cases Are on the Rise)
http://www.scientificamerican.com/article/pox-swap-30-years-after-small-pox-monkey-pox-on-the-rise/

It is the existence of such clinically identical disease forms as monkeypox which informs, in part, the scientific controversy surrounding the questionable eradication of smallpox. A more detailed account of the smallpox controversy is provided by medical researcher and specialist, Dr Suzanne Humphries. We encourage you to access the smallpox sub-section as an entry point to the controversy.

(Humphries, 2012, "Herd Immunity." The flawed science and failures of mass vaccination)

http://www.vaccinationcouncil.org/2012/07/05/herd-immunity-the-flawed-science-and-failures-of-mass-vaccination-suzanne-humphries-md-3/

A.2.2 Poliomyelitis

What has been described as poliomyelitis, is, in reality, a family of paralytic diseases of various names of similar or identical clinical presentation, many of which were classified as polio in the pre-vaccine era when diagnosis was usually made on clinical signs only, and which are still commonly diagnosed in Australians today.

(Marks et al, 2000, Differential Diagnosis of Acute Flaccid Paralysis and Its Role in Poliomyelitis Surveillance)

http://epirev.oxfordjournals.org/content/22/2/298.full.pdf

Following the rollout of mass polio vaccination in the 1950s, diagnostic criteria were immediately narrowed to more restrictive clinical indicators, and to require laboratory identification of one of the polio viruses.

"This change meant that one could have expected to see a massive decline in case numbers whether there was a vaccine or not. The major element of the change was that we now require detection of the polio virus at a special polio reference laboratory before a case may be recorded as polio."

(Beattie, 2013, ibid. P 3)

Acute Flaccid Paralysis (AFP) is an umbrella term given to many conditions which includes poliomyelitis. AFP is still a notifiable condition in Australia, and outbreaks of paralysis continue to be identified in Australia under various labels including Enterovirus 71 (EV71), Enterovirus 68 (EV68) Guillain Barre Syndrome, and even polio-like illness when a virus cannot be identified!

(The Age, 2013, Five children hit by polio-like paralysis)

http://www.theage.com.au/victoria/five-children-hit-by-poliolike-paralysis-20130601-2nipr.html

The following report details six cases of AFP in Western Australia, four of which were alleged to have been caused by EV71, the same virus alleged to be one of the causes of the now common, but historically rare Hand, Foot and Mouth Disease. These cases were identified in a short time frame in Western Australia during 1999 and in three of the cases required ventilation with the modern equivalent of an iron lung.

(Communicable Diseases Intelligence Volume 23, 1999, Enterovirus 71 outbreak in Western Australia associated with acute flaccid paralysis: Preliminary report)

http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-pubs-cdi-1999-cdi2307-cdi2307e.htm

While India was recently declared polio-free, it has become apparent that at the same time as polio was alleged to be disappearing through vaccination programmes, there was a dramatic, parallel increase in non-polio acute flaccid paralysis (NPAFP). This provides a more contemporary example of the type of diagnostic substitution which has been taking place since the advent of mass vaccination.

> *"Although the incidence of polio acute flaccid paralysis (AFP) has decreased in India, the nonpolio AFP (NPAFP) rate has increased. Nationwide, the NPAFP rate is 11.82 per 100 000 population, whereas the expected rate is 1 to 2 per 100 000 population. We examined the correlates of NPAFP to discern explanations for the increase. The incidence of polio AFP in India has decreased. However, the nonpolio AFP rate has increased since 2000. Follow-up of these cases of nonpolio AFP is not done routinely. However, one-fifth of these cases of nonpolio AFP in the state of Uttar Pradesh (UP) were followed up after 60 days in 2005; 35.2% of patients were found to have residual paralysis, and 8.5% had died. This suggests that the pathology in children being registered as having nonpolio AFP cannot be considered trivial. Therefore, there is a compelling reason to try to determine the underlying causes for the surge in nonpolio paralysis numbers."*

(Vashisht et al, 2015, Paediatrics, Trends in Nonpolio Acute Flaccid Paralysis Incidence in India 2000 to 2013)

http://pediatrics.aappublications.org/content/135/Supplement_1/S16.2.full

"In short, polio – the microbe – appears to be undergoing eradication.
Polio – the illness – on the other hand, appears to be unaffected."

(Beattie, 2013, ibid. p 3)

Similar questions about diagnostic substitution arise in relation to scientific claims about other "vaccine-preventable" diseases such as measles, but in the interests of brevity have not been included. Indeed, our submission would run to volumes if all matters relevant to the controversy were included.

A.3 Conflicts of interest are ubiquitous in medical science and don't always involve money

Financial conflicts of interest are common in medical science, so the general public should have every right to remain sceptical of recommendations of experts.

"Conflicts of interest in medical research are extremely common – one recent study† found that 52% of the experts involved in developing clinical practice guidelines for the management of diabetes in the United States and Canada had a financial conflict of interest."

Conflicts of interest don't always involve money. It has been suggested that intellectual conflicts of interest are almost ubiquitous and often overlooked as a source of bias.

"According to Gordon Guyatt, a Professor in the Faculty of Medicine at McMaster University, "intellectual conflicts of interest are completely ubiquitous" and have generally been ignored.

Intellectual conflicts occur when clinicians or researchers may be too deeply embedded in their own area of expertise to objectively look at a research question "with an open mind". Guyatt argues that "even when money is not involved … we [scientists] get very attached to our ideas." This is compounded by university culture, which rewards researchers if their work is highly referenced by others and is perceived to be influential. This environment creates an incentive for those participating in guideline development to highlight their own research in clinical practice guidelines."

(Laupacis & Born, 2012, Conflicts of interest don't always involve money, KevinMD)

http://www.kevinmd.com/blog/2012/02/conflicts-interest-involve-money.html

† Barbiturates and fractures. The BMJ (formerly the British Medical Journal)

http://www.bmj.com/content/2/6087/640.1

Appendix B

The Myth of whooping cough as a vaccine-preventable disease

B.1 Whooping cough (pertussis) – conscientious objectors are not to blame for outbreaks

Australia is in the grip of an unprecedented, fear-based media campaign to mislead and convince an unwitting general public of the dire risk conscientious objectors to immunisation pose to the public health, particularly in relation to whooping cough. As a result, we felt obliged to address the issue separately here. Some segments (not all) of the medical and scientific community have been complicit in this fear-mongering, by failing to correct blatant falsehoods perpetuated by tabloid journalists and shock-jocks, as well as actively propagating misinformation themselves.

For example, following the well-publicised of death of an infant from whooping cough earlier this year, Dr Bridie O'Donnell, who was described as a medical expert in an interview on 'The Project', claimed that if everyone had been vaccinated that the baby would still be alive. This is a blatant lie.

The infant, at eight weeks of age, was too young to be vaccinated, and it has been reported that his mother was vaccinated only three years prior and that close family contacts were also up-to-date with boosters. If the vaccine his mother received three years ago had been effective, then some level of passive immunity should have been conferred via trans-placental transfer. Clearly this did not occur.

B.2 Death rate for whooping cough is low and stable

While the death of any baby is regrettable, the number of deaths from whooping cough is stable and this is unlikely to change while the current vaccine is used. It is offensive in the extreme to promote a conclusion that conscientious objectors are to blame for whooping cough deaths.

Professor Peter McIntyre espoused this exact view back in 2012.

> *"What's certain is that whooping cough will not go away and, tragically, deaths in very young babies will still occur without better ways to protect them before they themselves can be protected by immunization."*

(McIntyre, 2012, Does whooping cough vaccine for parents protect newborns (and who should pay for it)?, The Conversation)

https://theconversation.com/does-whooping-cough-vaccine-for-parents-protect-newborns-and-who-should-pay-for-it-6980

The following graph details deaths from whooping cough in Australia between 1995 and 2010.

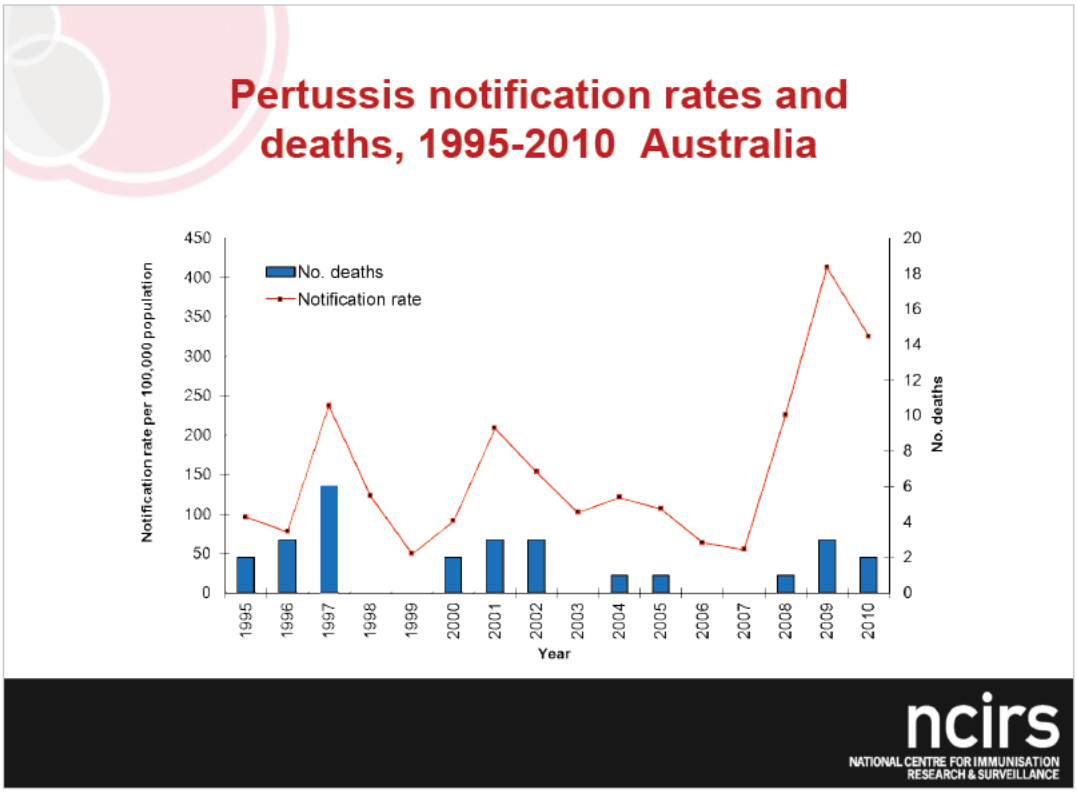


Figure 1

Source: McIntyre, 2011, Is Australia the World capital of Pertussis, National Centre for Immunisation Research and Surveillance (accessed online 15 August 2015)

http://www.ncirs.edu.au/news/past-news-events/Day%201/McIntyre-Is-Australia-world-capital-PertussisWS-25_26Aug11.pdf

Death rates were stable between 1995 and 2010, yet vaccination rates increased significantly in the same period, lending weight to the argument that increasing vaccination rates against whooping cough will not reduce the small number of deaths from the disease. Between 2006 and 2012 there were 11 deaths from whooping cough, 10 of whom were too young to be vaccinated, and between 2009 and 2015, 12 babies have died from whooping cough. This equates to 2 deaths per year, the same number as in 1995.

(2015, Pertussis Vaccines for Australian: Information for Immunisation Providers, National Centre for Immunisation Research and Surveillance, p. 2)

http://www.ncirs.edu.au/assets/provider_resources/fact-sheets/pertussis-fact-sheet.pdf

B.3 Whooping cough is not a vaccine-preventable disease

Whooping cough is a toxin mediated disease, endemic to Australia, with cyclical epidemics, and contrary to popular belief, this hasn't changed in the 60 years that the vaccine has been used in mass vaccination programmes. While the medical and scientific communities have claimed that the earlier whole-cell whooping cough was more effective than the one used today, there have always been outbreaks of whooping cough in highly vaccinated populations and speculation about a resurgence of the disease.

(Christie et al, The 1993 epidemic of pertussis in Cincinnati. Resurgence of disease in a highly immunized population of children, New England Journal of Medicine)

http://www.ncbi.nlm.nih.gov/pubmed/8202096

There have been many revisions to scheduled boosters over the years including when the allegedly more effective whole cell vaccine was used. For example, in 1985, when the earlier vaccine was used, a booster was added to the schedule for 18mth olds in response to increased outbreaks in fully vaccinated four- to five-year-olds, lending weight to the argument that whooping cough has never been well controlled by vaccination.

(2015, Significant events in diphtheria, tetanus and pertussis vaccination practice in Australia, National Centre for Immunisation Research and Surveillance p. 1)

http://www.ncirs.edu.au/assets/provider_resources/history/Diphtheria-tetanus-pertussis-history-July-2015.pdf

The current vaccine is an acellular, toxoid vaccine. As an acellular vaccine, it's not even theoretically possible for the vaccine to prevent the colonisation and transmission of the bacteria alleged to be responsible for whooping cough. The vaccine largely targets the toxins produced by the pertussisis bacteria, but does not prevent the colonisation or transmission of the bacteria to either vaccinated or unvaccinated people, including babies who are too young to be vaccinated. The vaccine is, at most, only theoretically capable of reducing the severity of the disease, not the incidence of the disease. Whooping cough would be more accurately described as a potentially vaccine-modifiable disease.

(Jason et al., 2013, Acellular pertussis vaccines protect against disease but fail to prevent infection and transmission in a nonhuman primate model, Proceedings of the National Academy of Sciences of the United States of America)

http://www.pnas.org/content/early/2013/11/20/1314688110

What this means is that even if every single person was vaccinated against pertussisis, the disease could not be eradicated, was not close to being eradicated, and a small number of babies will still die from the disease. A healthy unvaccinated child is no more likely to transmit the disease to a vulnerable baby than is a fully vaccinated one.

B.4 The whooping-cough cocooning strategy has been shown to be ineffective

The cocooning strategy was funded in most Australian states until 2012 even though it has never been funded through the National Immunisation Programme (NIP). It was abandoned by all states at that time following the negative findings of the Pharmaceutical Benefits Advisory Committee (PBAC) which had considered an application for funding of cocooning under the NIP in November 2011.

"The PBAC therefore rejected the submission on the basis of uncertain clinical effectiveness of the cocooning strategy and likely high and highly uncertain cost effectiveness."

PBAC, 2011, Pertussis vaccine-acellular combined with diphtheria and tetanus toxoids (Adsorbed), 0.5 mL, Adacel® – November 2011

http://www.pbs.gov.au/info/industry/listing/elements/pbac-meetings/psd/2011-11/pbac-psd-pertussis-nov11

An Australian study published just last month confirmed that the cocooning strategy did not protect infants from whooping cough. There was no difference in the incidence of whooping cough among infants whose parents were both vaccinated postpartum compared to those with unvaccinated parents. Similarly, when assessed independently, maternal postpartum vaccination was not protective.

(Carcione et al., 2015, The impact of parental postpartum pertussis vaccination on infection in infants: A population-based study of cocooning in Western Australia, Vaccine)

http://www.ncbi.nlm.nih.gov/pubmed/26320420

B.5 The significant increase in whooping-cough notifications has been misrepresented to mislead the public

One of the key ways the general public is being misled by the media and some (not all) public health experts is through the misuse and misrepresentation of whooping-cough notifications. They are using the dramatic increase in notifications in recent years to cultivate the belief there's been a dramatic resurgence of the disease, when there are any number of alternative explanations for the rise. While we acknowledge a real rise in notifications, this doesn't necessarily mean there's been an increase in incidence of the disease, although we acknowledge that possibility. It needs to be remembered that notifications and incidence are not the same thing. If the real incidence of whooping cough had increased as dramatically as notifications, then deaths should have dramatically increased as well, but this is not what has been observed. Secondly, even if there had been a real increase in incidence, that would be a poor indictment of the vaccine, given that vaccination rates have increased significantly since the 1980s. Vaccination rates increased from a low of 53% in 1989–90 to 92.08% in 2014.

(Australian Bureau of Statistics, 2001, Vaccination Coverage in Australian Children – ABS Statistics and the Australian Childhood Immunisation Register (ACIR))

http://www.abs.gov.au/ausstats/abs@.nsf/mf/4813.0.55.001#4.%20RESULTS%20-%20VACCINATION%20COVERAGE

(Department of Health, 2015 ACIR – Annual Coverage Historical Data)

http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/acir-ann-cov-hist-data.htm

Scientists have proposed various reasons for the increase in whooping-cough notifications. These include, changes to diagnostic criteria, more sensitive laboratory procedures such as PCR, a shift in strain dominance as well as increased awareness, vigilance, and a willingness of medical doctors to diagnose and seek laboratory confirmation of whooping cough, particularly in fully vaccinated children and adults.

When the vaccine was believed to be highly effective, doctors were unlikely to consider the possibility of whooping cough in the fully vaccinated, and as such were unlikely to seek laboratory diagnosis for the presence of the bacteria in these patients. This is known in scientific circles as a pro-treatment or diagnosis bias. As evidence about the ineffectiveness of the vaccine began to be accepted, doctors began to consider whooping cough in their differential diagnosis of fully vaccinated children presenting with persistent cough.

Between 2006 and 2012, an increasing proportion of notifications had PCR (a more sensitive laboratory test), recorded as the method of diagnosis, increasing from 6.9% in 2006 to 58.7% in 2012.

(2014, Australian vaccine preventable disease epidemiological review series: pertussis, 2006–2012, Department of Health)

http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi3803b.htm

Similarly, a study published in 2011 found that "an increase in pertussis testing following recognition of early epidemic cases may have led to identification of previously undetected infections, resulting in a further increase in notified disease and awareness among GPs" and that "the changing likelihood of being tested may also be due to expanding availability and use of PCR testing in Australia."

(Kaczmarek et al, 2013, Sevenfold rise in likelihood of pertussis test requests in a stable set of Australian general practice encounters, 2000–2011, Medical Journal of Australia)

https://www.mja.com.au/journal/2013/198/11/sevenfold-rise-likelihood-pertussis-test-requests-stable-set-australian-general

It was reported in 2012 that a vaccine-resistant strain had emerged and was increasingly being identified in diagnosed cases.

"The strain was responsible for 31% of cases in the 10 years before the epidemic, but has accounted for 84% since – a nearly three-fold increase, indicating it has gained a selective advantage under the current vaccination regime."

(Norrie, 2012, Vaccine-resistant whooping cough takes epidemic to new level, The Conversation)

https://theconversation.com/vaccine-resistant-whooping-cough-takes-epidemic-to-new-level-5959

A study published in 2012 found a temporal association between increased media coverage of outbreaks of influenza and an increase in notifications, by increasing demand for diagnostic tests.

(Olowokure et al, 2012, Volume of print media coverage and diagnostic testing for influenza A(H1N1)pdm09 virus during the early phase of the 2009 pandemic, Journal of Clinical Virology)

http://www.ncbi.nlm.nih.gov/pubmed/22710009

Further, a very recent published study, suggests that a resurgence in whooping cough can be explained by asymptomatic transmission of the bacteria by the fully vaccinated.

(Althouse et al, 2015, Asymptomatic transmission and the resurgence of Bordetella pertussis, BMC Medicine)

http://www.biomedcentral.com/1741-7015/13/146

B.6 Recently reported whooping cough outbreaks in fully vaccinated children

The following three articles report on outbreaks of whooping cough in fully vaccinated children in schools.

The first one reports that 19 children from the same school were diagnosed with the disease despite being fully vaccinated.

(Nunez, 2015, 19 kids in Summit Co. diagnosed with whooping cough despite being up to date on vaccinations, Fox13)

http://fox13now.com/2015/03/27/19-kids-in-summit-co-diagnosed-with-whooping-cough-despite-being-up-to-date-on-vaccinations/

The second reports on four diagnosed cases in the same school all of whom were fully vaccinated, with the school having a 99.5% vaccination rate.

Seaver, 2015, Pertussis outbreak at Salinas school, KSBW.com

http://www.ksbw.com/news/pertussis-outbreak-at-monterey-park-school/31881324

The third reports on an outbreak of whooping cough outbreak at Kilcoy State School in Queensland, during which 19 children were diagnosed, whose vaccination status, however, has not been reported. We have been unable to obtain this information from Queensland Health and will need to apply for it through the Right to Information process, and there is no guarantee that it will be provided even then.

(Curry, 2015, Whooping Cough Outbreak, Kilcoy, Caboolture Times)

http://www.caboolturenews.com.au/news/whooping-cough-outbreak-kilcoy/2595513/

Appendix C

The case for a plausible link between rising autoimmunity and vaccination

Autoimmune diseases affect 5% of Australians and are more common than cancer or heart disease.

(Allergy and Immune Diseases in Australia (ADIA) Report 2013, Australasian Society of Clinical Immunology and Allergy Inc., p 2))

http://www.allergy.org.au/images/stories/reports/ASCIA_AIDA_Report_2013.pdf

We are of the view that the dramatically expanding vaccination schedule provides a scientifically plausible explanation for the widespread, and increasing incidence of immune system dysfunction in the population. Increases of this magnitude cannot be explained by genetics; and vaccination stimulates the immune system in an abnormal way.

A recent published review echoes our concerns in relation to autoimmune conditions. It states "vaccines are able to elicit the immune system towards an autoimmune reaction, and "there is evidence of vaccine-induced autoimmunity and adjuvant-induced autoimmunity in both experimental models as well as human patients".

(Guimaraes et al., 2015, Vaccines, adjuvants and autoimmunity, Pharmacological Research)

http://www.sciencedirect.com/science/article/pii/S1043661815001711

Many autoimmune diseases have been identified following vaccination. The question isn't if vaccines cause autoimmune disease, but rather, how often they do.

C.1 The health effects of multiple vaccines given simultaneously as part of the schedule has not been tested rigorously

When mass vaccination was first implemented in the 1950s only diphtheria, tetanus, pertussisis, and polio vaccines were recommended for babies and children, while today vaccination against 13 diseases is recommended starting at birth, with many subsequent boosters. While it's claimed that individual vaccines are sufficiently tested for side effects prior to being added to the schedule, we would argue that the health effects of giving multiple vaccines simultaneously has never been sufficiently tested. Even if a vaccine has allegedly been shown to be safe when used individually does not mean it's safe when used in combination with other vaccines.

C.2 Repeated vaccination with an antigen has been shown to trigger autoimmunity in mice without a genetic susceptibility

While it is routinely claimed that autoimmunity is largely genetically determined, a 2009 study, showed that autoimmunity could be triggered in mice without a genetic susceptibility by repeated vaccination.

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

(Tsumiyama et al, 2009, Self-Organized Criticality Theory of Autoimmunity, Plos One)

http://www.ncbi.nlm.nih.gov/pubmed/20046868

C.3 Autoimmunity as an environmental disease

The rise in type 1 diabetes since the rollout of mass vaccination in 1950s has been attributed to a major environmental impact. A 2004 study noted that the proportion of high-risk susceptibility genotypes was increased in the earlier cohort diagnosed more than fifty years ago which supports an environmental hypothesis.

(Gillespie et al, 2004, The rising incidence of childhood type 1 diabetes and reduced contribution of high-risk HLA haplotypes, Lancet)

http://www.ncbi.nlm.nih.gov/pubmed/15530631

While infection with various microbes is often given as the cause of autoimmune disease, we consider that to be illogical given that rates of autoimmunity have risen significantly since the 1950s. It doesn't make sense that infection would result in more autoimmune disease than in the past. Why would a particular virus or bacteria be more likely to cause an autoimmune disease today than in the past? Clearly that hypothesis is flawed.

C.4 Testing causation between vaccination and autoimmunity is problematic using conventional epidemiological methods

Guimaeres et al have argued that epidemiological methods are ineffective to establish definitive causation between vaccination and development of autoimmunity due to differences in classifications of symptoms and the long latency period of the diseases. It's not hard to see why symptoms of autoimmunity which may only be detected months or years after a vaccination would be overlooked as being caused by vaccination.

(Guimaraes et al., 2015, ibid)

AVN has been arguing for years that health authorities need to undertake a true 'fully vaccinated / fully unvaccinated' study which would provide definitive information about how common autoimmune diseases are in vaccinated children relative to unvaccinated ones. Given that the Australian Childhood Immunisation Register has been in operation for nearly 20 years, we believe such a retrospective study would now be possible.

C.5 Sub-populations believed to be susceptible to autoimmune conditions following vaccination have been identified

Soriano et al argues that the risk of autoimmune disease from vaccination is not uniform across the population and that "by defining individuals at risk we may further limit the number of individuals developing post-vaccination" autoimmunity.

They have defined four groups which might be susceptible to vaccination-induced autoimmunity

These include *"patients with prior post-vaccination autoimmune phenomena, patients with a medical history of autoimmunity, patients with a history of allergic reactions, and individuals who are prone to develop autoimmunity (having a family history of autoimmune diseases; asymptomatic carriers of autoantibodies; carrying certain genetic profiles etc".*

(Soriano et al, 2015, Predicting post-vaccination autoimmunity: Who might be at risk?, Pharmacological Research)

http://www.sciencedirect.com/science/article/pii/S104366181400139X

The existence of sub-populations with heightened susceptibility to vaccination-induced autoimmune conditions is not reflected in pre-vaccination risk assessments in current practice. The narrative is that vaccines are generally safe for greater than 99% of the population, which we dispute.

C.6 Autoimmune Diseases associated with or following vaccination

Most autoimmune diseases have been shown to arise following vaccination at one time or another. We have provided a few examples below.

Macrophagic myofasciitis

Has been attributed to bio-persistence of aluminium adjuvant in muscle at injection site.

Aluminium is used as an adjuvant in a variety of vaccines on the Australian Immunisation Schedule.

(Shingde et al, 2005, Macrophagic myofasciitis associated with vaccine-derived aluminium, Medical Journal of Australia)

https://www.mja.com.au/journal/2005/183/3/macrophagic-myofasciitis-associated-vaccine-derived-aluminium

(Israeli et al, 2011, Macrophagic myofaciitis a vaccine (alum) autoimmune-related disease, Clinical Reviews in Allergy & Immunology)

http://www.ncbi.nlm.nih.gov/pubmed/20882368

Enthesitis-related arthritis
Rheumatoid arthritis (RA)
Systemic lupus erythematosus (SLE)

These cases were associated with the HPV vaccine.

"This was a case study in which 3 patients with autoimmune/auto-inflammatory syndrome induced by adjuvants (ASIA) after quadrivalent human papillomavirus vaccination (HPV) were evaluated and described. All the patients were women. Diagnosis consisted of HLA-B27 enthesitis related arthritis, rheumatoid arthritis and systemic lupus erythematous, respectively."

(Anaya et al, 2015, Autoimmune/auto-inflammatory syndrome induced by adjuvants (ASIA) after quadrivalent human papillomavirus vaccination in Colombians: a call for personalised medicine, Clinical and experimental rheumatology)

http://www.ncbi.nlm.nih.gov/pubmed/25962455

Postural orthostatic tachycardia with chronic fatigue (POTS)

Case study associated with HPV vaccination.

(Shoenfeld, 2014, Postural Orthostatic Tachycardia With Chronic Fatigue After HPV Vaccination as Part of the "Autoimmune/Auto-inflammatory Syndrome Induced by Adjuvants, Journal of Investigative Medicine)

http://hic.sagepub.com/content/2/1/2324709614527812.short

Six cases associated with HPV vaccination.

(Blitshteyn, 2013, Postural tachycardia syndrome following human papillomavirus vaccination, European Journal of Neurology)

http://onlinelibrary.wiley.com/doi/10.1111/ene.12272/full

21 cases associated with HPV vaccination.

(Brinth et al, 2015, Orthostatic intolerance and postural tachycardia syndrome as suspected adverse effects of vaccination against human papilloma virus, Vaccine)

http://www.ncbi.nlm.nih.gov/pubmed/25882168

Japan withdrew the HPV vaccine from its vaccination schedule in 2013 due to concerns this condition and other serious adverse effects were caused by that vaccine.

(Mulcahy, 2013, Japan Withdraws HPV Vaccine Recommendation for Girls, Medscape)

http://www.medscape.com/viewarticle/806645

It was recently reported that the European Medicines Agency has launched an investigation into HPV vaccines at the request of Danish health officials.

(Cha, 2015, Worries about HPV vaccine: European Union medicines agency investigating reports of rare but severe reactions, The Washington Post)

http://www.washingtonpost.com/news/to-your-health/wp/2015/07/13/worries-about-hpv-vaccine-european-unions-medicines-agency-investigating-reports-of-rare-but-severe-reactions/

Multiple sclerosis
Rheumatoid arthritis (RA)
Systemic lupus erythematosus (SLE)

A 2005 case control study found a significantly increased risk of these conditions in adults receiving Hepatitis B vaccine relative to tetanus vaccine (control).

(Geier & Geier, 2005, A case-control study of serious autoimmune adverse events following hepatitis B immunization, Autoimmunity)

http://www.tandfonline.com/doi/abs/10.1080/08916930500144484#.Vez9DBGqqko

Systemic lupus erythematosus (SLE)

Five cases following secondary vaccination.

(Older et al, 1999, Can immunization precipitate connective tissue disease? Report of five cases of systemic lupus erythematosus and review of the literature, Seminars in Arthritis and Rheumatism)

http://www.ncbi.nlm.nih.gov/pubmed/10622677

Ten cases of SLE following primary or secondary Hepatitis B vaccination.

(Agmon-Levin, 2009, Ten cases of systemic lupus erythematosus related to hepatitis B vaccine, Lupus)

http://www.ncbi.nlm.nih.gov/pubmed/19880567

Juvenile Idiopathic Arthritis (JIA)

Thirty-five percent of children with JIA experienced flare of the disease after influenza vaccination.

(Toplak, 2012, Safety and efficacy of influenza vaccination in a prospective longitudinal study of 31 children with juvenile idiopathic arthritis, Clinical and Experimental Rheumatology)

http://www.ncbi.nlm.nih.gov/pubmed/22513085

Multiple sclerosis

Five cases of Multiple Sclerosis associated with HPV vaccination.

(Sutton, 2009, CNS demyelination and quadrivalent HPV vaccination, Multiple Sclerosis)

http://www.ncbi.nlm.nih.gov/pubmed/18805844

A 2004 study found a significantly increased risk of developing Multiple Sclerosis within three years after Hepatitis B vaccination.

(Herman, 2004, Recombinant hepatitis B vaccine and the risk of multiple sclerosis: a prospective study, Neurology)

http://www.ncbi.nlm.nih.gov/pubmed/15365133 A case following HPV vaccination.

A case following HPV vaccination.

(DiMario et al, 2010, A 16-year-old girl with bilateral visual loss and left hemiparesis following an immunization against human papilloma virus, Journal of Child Neurology)

http://www.ncbi.nlm.nih.gov/pubmed/20189933

Vaccination of any type was associated with an increased risk of CNS ADS onset within the first 30 days after vaccination. The short-term increase in risk suggests that vaccines may accelerate the transition from subclinical to overt autoimmunity in patients with existing disease.

(Langer-Gould et al, 2014, Vaccines and the risk of multiple sclerosis and other central nervous system demyelinating diseases, JAMA Neurology)

http://www.ncbi.nlm.nih.gov/pubmed/25329096

Transverse myelitis

A systematic review found over 37 reported cases of transverse myelitis associated with different vaccines including those against hepatitis B virus, measles-mumps-rubella, diphtheria-tetanus-pertussis and others, given to infants, children and adults.

(Agmon-Levin et al, 2009, Transverse myelitis and vaccines: a multi-analysis, Lupus)

http://www.ncbi.nlm.nih.gov/pubmed/19880568

Guillain–Barre syndrome (GBS)

An elevated risk of GBS following H1N1 influenza vaccination was found.

(Polakowski et al, 2013, Chart-confirmed guillain-barre syndrome after 2009 H1N1 influenza vaccination among the Medicare population, 2009-2010, American Journal of Epidemiology)

http://www.ncbi.nlm.nih.gov/pubmed/23652165

774 cases within six weeks of vaccination with various vaccines.

(Souayah, 2009, Guillain-Barré syndrome after vaccination in United States: data from the Centers for Disease Control and Prevention/Food and Drug Administration Vaccine Adverse Event Reporting System (1990-2005), Journal of Clinical Neuromuscular Disease)

http://www.ncbi.nlm.nih.gov/pubmed/19730016

Immune thrombocytopenia (ITP)

Case of ITP following measles, mumps, rubella (MMR) vaccine.

(Owatanapanich et al, 2014, Measles-mumps-rubella vaccination induced thrombocytopenia: a case report and review of the literature, South East Asian Journal of Tropical Medicine and Public Health)

http://www.ncbi.nlm.nih.gov/pubmed/25417506

A recent large study identified an increased risk of ITP following Measles, Mumps, Rubella, Varicella (MMRV) vaccine.

(Klein et al, 2015, Safety of measles-containing vaccines in 1-year-old children, Paediatrics)

http://www.ncbi.nlm.nih.gov/pubmed/25560438

Case of recurrence of ITP following meningococcal vaccine.

(Amirifard et al, 2015, An unusual occurrence of Kleine-Levin syndrome in a man with refractory immune thrombocytopenic purpura: a case report, Journal of Medical Case Reports)

http://www.ncbi.nlm.nih.gov/pubmed/25885480

Over 1000 cases following live and inactivated vaccines.

(Woo et al, 2011, Thrombocytopenia after vaccination: case reports to the US Vaccine Adverse Event Reporting System, 1990-2008, Vaccine)

http://www.ncbi.nlm.nih.gov/pubmed/21126606

A 2014 literature review found 48 cases of ITP following Hepatitis B vaccination.

Table 3

Idiopathic thrombocytopenic purpura after hepatitis B vaccination

Author (years)	Number of cases	Article type	Article title
Poullin and Gabriel[17]	2	Case report	Thrombocytopenic purpura after recombinant hepatitis B vaccine
Meyboom *et al*.[56]	28	Case report	Thrombocytopenia reported in association with hepatitis B and A vaccines
Ronchi *et al*.[57]	3	Case series	Thrombocytopenic purpura as adverse reaction to recombinant hepatitis B vaccine
Neau *et al*.[60]	7	Retrospective cohort study	Immune thrombocytopenic purpura after recombinant hepatitis B vaccine: Retrospective study of seven cases
Llimiñana *et al*.[61]	1	Case report	Immune hemolytic anemia and thrombocytopenic purpura after recombinant hepatitis B vaccine administration
Maezono and Escobar[62]	1	Case report	Thrombocytopenic purpura after hepatitis B vaccine
Conesa *et al*.[63]	1	Case report	Thrombocytopenic purpura after recombinant hepatitis B vaccine. A rare association
Ferreira *et al*.[64]	1	Case report	Trombocitopenia autoimmune apos vacinac¸ ao contra hepatite B
Jadavji *et al*.[65]	3	Case series	Thrombocytopenia after immunization of Canadian children, 1992-2001
Polat *et al*.[58]	1	Case report	Severe thrombocytopenia after hepatitis B vaccine in an infant from Turkey

Source:

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4250977/table/T3/

(Tarakji et al, 2014 Hepatitis B Vaccination and Associated Oral Manifestations: A Non-Systematic Review of Literature and Case Reports, Annals of Medical &Health Sciences Research)

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4250977/

A case of ITP following Pneomococcal vaccination.

(Kojima et al, 2014, Acute thrombotic thrombocytopenic purpura after pneumococcal vaccination, Blood Coagulation Fibronolysis)

http://www.ncbi.nlm.nih.gov/pubmed/24469391

ITP is an on-table condition for the purpose of the US Vaccine Injury Compensation Program (VICP) but only in relation to the measles component of MMR.

http://www.hrsa.gov/vaccinecompensation/vaccinetable.html

Type 1 diabetes

A 2003 literature review found an increased risk of type 1 diabetes two to four years following vaccination with Hib, pertussis, and MMR vaccinations.

(Classen et al, 2003, Clustering of cases of type 1 diabetes mellitus occurring 2-4 years after vaccination is consistent with clustering after infections and progression to type 1 diabetes mellitus in autoantibody positive individuals, Journal of Paediatric Endocrinology and Metabolism)

http://www.ncbi.nlm.nih.gov/pubmed/12793601

Narcolepsy / cataplexy

A 2013 study found H1N1 vaccination was strongly associated with an increased risk of narcolepsy–cataplexy in both children and adults in France.

(Dauvilliers et al, 2013, Increased risk of narcolepsy in children and adults after pandemic H1N1 vaccination in France, Brain)

http://www.ncbi.nlm.nih.gov/pubmed/23884811

Similarly, another 2013 study found that during the 3 years following vaccination there was a significantly increased risk for narcolepsy with cataplexy.

(Heier, 2013, Incidence of narcolepsy in Norwegian children and adolescents after vaccination against H1N1 influenza A, Sleep Medicine)

http://www.ncbi.nlm.nih.gov/pubmed/23773727

It was reported in 2014 that the UK government would be paying $60 million pounds in compensation to Narcolepsy / Cataplexy victims arising from this vaccine.

(Porter, 2014, Brain-Damaged UK Victims of Swine Flu Vaccine to Get £60 Million Compensation, International Business Times)

http://www.ibtimes.co.uk/brain-damaged-uk-victims-swine-flu-vaccine-get-60-million-compensation-1438572

This strain is included in the yearly seasonal infuenza vaccine in Australia.

Autoimmune hepatitis 2

Case following HPV vaccine.

(Della Corte et al, 2011, Autoimmune hepatitis type 2 following anti-papillomavirus vaccination in a 11-year-old girl, Vaccine)

http://www.ncbi.nlm.nih.gov/pubmed/21596082

Autoimmune polyneuropathy

Two cases following Hepatitis B vaccination.

(Vital et al, 2002, Post-vaccinal inflammatory neuropathy: peripheral nerve biopsy in 3 cases, Journal of Peripheral Nervous System)

http://www.ncbi.nlm.nih.gov/pubmed/12365564

Appendix D

Cases of vaccine-associated disease in recipients of live attenuated virus, and of transmission of vaccine-strain viruses to close contacts

Chickenpox

(a) This case report notes transmission of the vaccine strain. A 12-month-old healthy boy had approximately 30 vesicular skin lesions 24 days after receiving varicella vaccine. Sixteen days later his pregnant mother had 100 lesions. Varicella-vaccine virus was identified by polymerase chain reaction in the vesicular lesions of the mother. After an elective abortion, no virus was detected in the fetal tissue. This case documents transmission of varicella-vaccine virus from a healthy 12-month-old infant to his pregnant mother.

(Salzman et al, 1997,Transmission of varicella-vaccine virus from a healthy 12-month-old child to his pregnant mother, Journal of Paediatrics)

http://www.ncbi.nlm.nih.gov/pubmed/9255208

(b) Twelve days after receiving an investigational Oka strain* live attenuated varicella vaccine, a 38-year-old healthy white woman developed a rash consisting of 30 scattered lesions. Sixteen days later, her 2 children also developed rash. Swabs obtained from the skin lesions of the vaccinee and her children demonstrated the presence of varicella-zoster virus determined to be vaccine type.

*This is the strain used in current vaccines.

(LaRussa et al, 1997, Transmission of vaccine strain varicella-zoster virus from a healthy adult with vaccine-associated rash to susceptible household contacts, Journal of Infectious Diseases)

http://www.ncbi.nlm.nih.gov/pubmed/9333170

(c) A vaccinated child transmitted vaccine-strain chickenpox to a vaccinated sibling.

(Brunell et al, 2000, Chickenpox attributable to a vaccine virus contracted from a vaccinee with zoster, Paediatrics)

http://www.ncbi.nlm.nih.gov/pubmed/10920184

(d) A vaccinated child transmitted vaccine-strain chickenpox to teacher 13 months after receiving vaccine.

(Gan et al, 2011, Transmission of varicella vaccine virus to a non-family member in China, Vaccine)

http://www.ncbi.nlm.nih.gov/pubmed/21134454

(e) A child developed severe vaccine-strain chickenpox and transmitted it to another child and a health care worker.

(Grossberg et al, 2006, Secondary transmission of varicella vaccine virus in a chronic care facility for children, Journal of Paediatrics)

http://www.ncbi.nlm.nih.gov/pubmed/16769402

(f) A three year old girl transmitted vaccine-strain chickenpox to an unvaccinated brother.

(Otsuka et al, 2009 Transmission of Varicella Vaccine Virus, Japan, Emerging Infectious Disease)

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2866412/

(g) A woman vaccinated post-partum transmitted vaccine-strain chickenpox to her 3 week old infant.

(Kluthe et al, 2012, Neonatal vaccine-strain varicella-zoster virus infection 22 days after maternal postpartum vaccination, Paediatric Infectious Disease Journal)

http://www.ncbi.nlm.nih.gov/pubmed/22572750

Measles

(a) Vaccine-associated measles in a child was confirmed to be vaccine-strain 8 days following vaccination.

(Kaic et al, 2010 Spotlight on measles 2010: excretion of vaccine strain measles virus in urine and pharyngeal secretions of a child with vaccine associated febrile rash illness, Croatia, March 2010, Euro Surveillance)

http://www.ncbi.nlm.nih.gov/pubmed/20822734

(b) A 17-month-old child developed measles after measles-mumps-rubella vaccination. Vaccine-strain measles virus was confirmed.

(Jenkin et al, 1999, What is the cause of a rash after measles-mumps-rubella vaccination?, Medical Journal of Australia)

http://www.ncbi.nlm.nih.gov/pubmed/10494235

(c) A case of vaccine-strain measles that was clinically indistinguishable from wild-type measles was reported.

(Berggren et al, 2005, Vaccine-associated "wild-type" measles, Paediatric Dermatology)

http://www.ncbi.nlm.nih.gov/pubmed/15804301

(d) Vaccine-strain measles virus was isolated in a throat swab taken 4 days after fever onset in vaccine recipient who had received MMR vaccine 8 days prior.

(Morfin et al, 2002, Detection of measles vaccine in the throat of a vaccinated child, Vaccine)

http://www.sciencedirect.com/science/article/pii/S0264410X01004959

(e) A case of vaccine-associated measles in a 15 month old was confirmed to be from a vaccine-strain. The child had been vaccinated 15 days earlier.

(Nestibo et al, 2012, Differentiating the wild from the attenuated during a measles outbreak, Paediatric Child Health)

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3381670/

(f) A case of vaccine-associated measles five weeks after vaccination was reported.

(Murti et al, 2013, Case of vaccine-associated measles five weeks post-immunisation, British Columbia, Canada, October 2013, European Surveillance)

http://www.ncbi.nlm.nih.gov/pubmed/24330942

Rotavirus

(a) Transmission of vaccine-strain rotavirus from a vaccinated infant to an older, unvaccinated sibling was reported, resulting in symptomatic rotavirus gastroenteritis that required emergency department care.

(Payne et al, 2010, Sibling Transmission of Vaccine-Derived Rotavirus (RotaTeq) Associated With Rotavirus Gastroenteritis, Paediatrics)

http://pediatrics.aappublications.org/content/125/2/e438.abstract

Further information about the risks of rotavirus vaccines has been covered extensively by the National Vaccine Information Centre.

"Vaccine Strain Rotavirus Shedding Poses Risks for Immunocompromised Children

The author of a 2008 article discussing rotavirus vaccine viral shedding and transmission by vaccinated children stated that "A review of rotavirus vaccine prelicensure studies shows that viral shedding and transmission were higher with the old tetravalent rhesus rotavirus vaccine [Rotashield withdrawn in 1999] than with the current human attenuated monovalent rotavirus vaccine [Rotarix] and the pentavalent bovine-human reassortment vaccine [RotaTeq]." [236]

He warned that "Immunocompromised contacts should be advised to avoid contact with stool from the immunised child if possible, particularly after the first vaccine dose for at least 14 days" but added that "the risk of vaccine transmission and subsequent vaccinederived disease with the current vaccines is much less than the risk of wild type rotavirus disease in immunocompromised contacts."

Healthy Children Can Be Infected with Vaccine Strain Rotavirus Too

In 2010, a case report was published in Pediatrics describing a 30-month old healthy boy who had never received rotavirus vaccine and was infected with vaccine strain rotavirus. [237] *He ended up in the emergency room with severe gastroenteritis 10 days after his healthy two- month old brother was given a dose of Merck's RotaTeq vaccine. A stool sample was taken in the emergency room and came back positive for RotaTeq vaccine derived strains after RT-PCR testing. The authors of the case report noted that "transmission of RotaTeq strains to unvaccinated contacts was not evaluated in the pivotal clinical trials." They added that both RotaTeq and Rotarix [GlaxoSmithKline Biologicals] vaccines have "the potential for vaccine-virus transmission to contacts.""*

(Fisher, 2014, The Emerging Risks of Live Virus & Virus Vectored Vaccines: Vaccine Strain Virus Infection, Shedding & Transmission, National Vaccine Information Center)

http://www.nvic.org/CMSTemplates/NVIC/pdf/Live-Virus-Vaccines-and-Vaccine-Shedding.pdf

End of submission

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