7 February 2010.

Submission on the Select Committee regarding Immunisation.

To the Health Committee.

Introduction. This is a submission from: Hilary Butler, 25 Harrisville Road, Tuakau 2121. www.beyondconformity.org.nz I wish to speak to the select committee in person, with my husband, Peter Butler, at a venue in the Auckland region. Phone 092368990. Email butler@watchdog.net.nz

Summary

While this submission will primarily address issues relating to number five in the terms of references, relating to “benefits and disadvantages”, other points will be referred to.

Inquiry into How to Improve Completion Rates of Childhood Immunisation

Before I address the terms of reference, I would like to comment on these two statements on the Parliament Website:

Many New Zealand children suffer measles, whooping cough, pneumococcal pneumonia and other common infectious diseases despite immunisation being available at no charge. The mortality and related co-morbidity is high and could be prevented.

There is clear scientific evidence that the benefits of high levels of immunisation to the individual and to society outweigh the disadvantages.

In the real world that I live in, these two dogmatic statements, aren’t as clear cut as the Committee is being led to believe. One of the terms of references, provides the opportunity to address these issues.

The Committee’s Terms of Reference are as follows:
1. To collate current statistics for New Zealand children on timeliness of delivery and completion of immunisation, and how we compare internationally.

The National Immunisation Register is the vehicle for collection of data on vaccines. How we compare internationally, is accessible through the World Health Organisation, which requires all countries to submit accurate data to them annually.

2. To assess how well the New Zealand Immunisation Register is working, and the effectiveness of utilisation.

Apart from families who opt off the National Immunisation Register, the current function of the New Zealand Immunisation Register is to record the details of those who are vaccinated, ...and those who are not.

The list of those being vaccinated, is solely to record the vaccines given and when.

The lists of those not vaccinated are to use in the event of an outbreak. If there is an infectious disease for which there is a vaccine, the NIR list is used to remove unvaccinated children from education establishments.

What other purpose for the NIR, beyond those functions, does the committee also envisage? It could be far more useful than it is right now.

3. To search relevant world literature for optimal methods of how to achieve timely and high immunisation completion rates.

IMAC, and all the pro-vaccine people who hound those who don’t vaccinate, are up-to-date on the most novel vaccine-pushing tactics being used worldwide. They expound on them annually in their conferences. This is what you pay them handsomely for. Why is this provision even in the terms of reference?
4. To seek up-to-date information on community concerns, informed consent and conscientious objection issues.

This is a strange term of reference.

a) **Community concerns.** Example: When you are told about many parents concerns about Gardasil, these concerns are merely document in a “Myths” column on a website. Listening to concerns, equates to blanket dismissal of concerns.

b) **Informed consent.** This is an oxymoron, because the New Zealand vaccination programme does not operate on informed consent. It operates on “conformed consent”. For evidence of this please ask the Ministry of Health to provide you with their most recent “informational” DVD for parents (Code HE1915). This DVD is a professional embarrassment. Ask the Ministry to provide for you, the brochures handed to parents, and then try to defend the reference term “informed consent”. In a medical article called “Parent comprehension of polio vaccine information pamphlets” (PMID 8657518 should you wish to check it in Pubmed) there is a comment which says, **“The number of concepts per pamphlet should be limited. Pamphlet authors should determine the key points that the patient (or parent) needs to know to achieve the behavioral objectives. Nonessential concepts can then be deleted. The key is to write for the desired health behavior, rather than for high-level knowledge.”**

“Nonessential concepts” are defined as anything which might result in the parent deciding refusing a vaccine. The MOH is expert at excluding these concepts, which are actually crucial to informed choice. They “write”, to make people vaccinate.

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Unfortunately for the Committee, ... to evaluate New Zealand brochures would presume that you know enough information about those vaccines and diseases, to know why the brochures are totally inadequate.

Most people in this country fall Term of reference Number 6: (“the first 60% of vaccinated ... are easy to get,”) because most people just do because their doctor told them to; their friends do it; and because they assume that every drug and vaccine given to them will make them healthier.

c) Conscientious objection issues are irrelevant in a country where vaccination is a matter of choice. Conscientious objection only applies to “compulsion” such as legal military conscription.

5. To seek an analysis of benefits and disadvantages.

To what do the words “benefits and disadvantages” apply to?

- Does this analysis apply to the benefits and disadvantages of new “optimal methods of how to achieve timely and high immunisation completion rates” whose purpose is to harass parents, unconvinced with the current “information”, to complete the schedule, in order to raise the vaccination rate as high as systematically possible?
- The benefits and disadvantages of vaccinating children?
- The benefits and disadvantages of non-vaccination?
- The benefits and disadvantages of being able to crow at WHO meeting, about having high rates of immunisation completion?

Let us assume that the Committee wishes to see an analysis of the benefits and disadvantages of vaccinations themselves. Let’s try a currently topical example, whooping cough, mentioned by Dr Paul Hutchison in his press release about this Committee.

Whooping cough Vaccine – Benefits and Disadvantages
I could give you a full analysis from New Zealand medical literature, ESR published data, Appendices to Parliamentary Journals etc... which would show you graphically, *why everything you may believe, about the whooping cough vaccine’s “wonderful” use in New Zealand ... is not true.* It’s all there in black and white, in both the medical and parliamentary literature.

I could also show you the medical literature from the last 10 years, which tell scientists *why the current pertussis vaccine not only doesn’t work, but is part of the current problem.* I could also give you all the full text copies of those articles, *but .... are you interested?*

The New Zealand medical literature as well as ESR graphs on whooping cough, the older CDC graphs, and even earlier graphs from the Appendices to Parliamentary Journals have constantly detailed over the *years that the whooping cough vaccine has done nothing to reduce the numbers of whooping cough deaths, hospitalisations, or indeed cases, since before the vaccine was introduced into the country.* I can supply this Committee with all the medical data, graphs and statements to this effect - if they wish to read them.

That is data which IMAC et al, will not present to this Committee, and if confronted with it, would explain away the miserable failure of the whooping cough vaccine, with a variety of clichés which have been their mind-numbing mantra for decades. However, I would refer the Chair of this Committee to a report from ESR which pointed out that the New Zealand whooping cough vaccine has an “effective vaccination rate” of 30%.

http://www.surv.esr.cri.nz/PDF_surveillance/NZPHSR/2004/NZPHSR2004December.pdf (I have that medical study: PMID 12927532. That this study has never been publicly discussed is a disgrace).
Pubmed is accessible at http://www.ncbi.nlm.nih.gov/sites/entrez and I would assume that parliamentarians have of right, access to full text articles).

It is notable that since this 2004 report, IMAC and others have stopped pushing their blanket-coverage whooping cough vaccine messages in the media, because they know they will be picked up on it, by those who know that their previous messages have been for marketing purposes, not factual education for parents.

And if Dr Cameron Grant et al, put in a submission to the Committee on his article (PMID 17316188), I would relish the opportunity to reply to some of the amazingly inaccurate, sweeping assumptions, published in that article – even though the graphs he uses proves me right. His explanations as to why his graphs to 2005 show no benefit from the vaccine, are pathetic.

If you ask me for the whooping cough analysis including full text articles, I will give it to you, as a supplementary submission.

The reason that pro vaccine organisations will not tell you those things, and won’t provide you with the full text articles to read yourself, is because it doesn’t suit their 30 years of “eliminating non-essential concepts” from the eyes of the public, politicians, and GPs on the coal-face of interaction with the public. All of us like to believe MoH would tell you the truth and everything they know. They know that, and do exactly what they want anyway.

If you realised the fact that the whooping cough vaccination has had a nil impact on hospitalisation rates or circulating cases, since the vaccines was introduced, what would you think?

The same as IMAC and Dr Cameron Grant do…? Which is that “all shots should be timely”, and when confronted with the evidence that even that
doesn’t work, their answer is “lots more vaccine jabs in each child, will make the situation go away”.

Currently they are also talking about whooping cough vaccinations for all medical staff, and any adult who looks after, or regularly sees young children. **Revaccination of mothers** is being pushed, and **grandmothers and aunties** are being asked to have DPTH “to protect their wee babies”. Isn’t it amazing how babies have survived this well, without vaccinating everyone in sight, all the time? I predict within 10 years, whooping cough vaccine will be a ten yearly booster, but no-one will stop and think, “Now hang on a minute. Isn’t there something wrong with this concept?” Why? Because since 1961, the MoH has deliberately left out of pamphlets and public information, the fact that the vaccine is an expensive failure.

Another problem I foresee, should you be asked to evaluate data on pertussis (and measles) is that **the current testing where possible, is in primarily unvaccinated children**. It’s very common for parents with **vaccinated children** to not only be misdiagnosed, but also to be refused PCR testing for Pertussis, or IgM and IgG testing for measles. Therefore, vaccine efficacy could be **even less** for pertussis, as a result of what Dr James Cherry called pertussis **“Observer Bias”**. “They’re vaccinated; their sickness can’t be pertussis/measles.” (PMID 9755264).

In terms of “concerns”, one of my biggest concerns is that the Chair of this Select Committee’s knowledge is such that he could, or would, state in public that infections from measles, whooping cough etc were “unnecessary”.

- Does the Chair of this Committee know how many of the measles cases were in appropriately vaccinated children?
Does the Chair of this Committee not realise that in each whooping cough epidemic in the last 10 or more years, more than 2,000 of the cases have been appropriately vaccinated?

How can we REALLY assess the benefits and disadvantages of vaccination and non-vaccination for New Zealanders, living in New Zealand, based on New Zealand data?

Benefits and Disadvantages of repeated specific vaccines in comparison with natural immunity.

One example: Only recently, have questions been asked about repeated influenza vaccines.

Bodewes Lancet 09 (PMID: 19879807) discusses research indicating that vaccination against seasonal influenza could prevent people developing more broad spectrum immunity effective against pandemic strains.

Disadvantages of specific vaccines pertinent to new vaccines.

Toplak Autoimmunity Reviews 08 (PMID: 18700173) discusses how up to 15% of apparently healthy adults develop the appearance of new autoantibodies after receiving an influenza vaccine. I can’t find any studies following people who get them every year, to see what happens after the fifth or sixth yearly flu shot. In the elderly, if they develop autoimmunity, are they told it’s just part of aging? Do totally unvaccinated people develop autoimmunity at the same rates as those who have a flu vaccine every year? What other vaccines, administered repeatedly, can cause autoimmunity?

Tsumiyama PLoS One (PMID: 20046868)
http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0008382 is lead author of an article which starts off by saying, “Repeated immunization with antigen causes systemic autoimmunity in mice otherwise not prone to spontaneous autoimmune diseases.” Given that many vaccines are tested for safety in mice on a one-off basis, why is it that looking at repeated vaccination in mice has never been done before?
Perhaps we should do it with monkeys too. Tsumiyama et al, talk about how repeated immunisation in mice causes autoimmunity as a natural consequence of normal immune response when stimulated maximally beyond the ability of the immune system to cope. Yet IMAC and others repeat Dr Paul Offit’s totally unscientific opinion that a baby could have 100,000 vaccines in one go and they would be just fine. Any volunteers amongst you to try out Dr Paul Offit’s bright idea in your children?

Shaw 09 Journal of Inorganic Biochemistry (PMID: 19740541) has a self-explanatory title of “Aluminium hydroxide injections lead to motor deficits and motor neuron degeneration” So it should come as no surprise to the committee if I tabled an article detailing Multiple Sclerosis in some girls after Gardasil, … which has Aluminium Hydroxide in it. It should also come as no surprise to know that injected aluminium hydroxide causes Chronic Fatigue Syndrome and macrophagic myofascitis. Why? Because injected aluminium hydroxide messes up mitochondrial superoxide dismutase in the body

Kumar 09 Toxicology (PMID: 19010380) and in rat’s brains Kumar 08 Brain Research (PMID: 18691561) (It’s unethical to chop open live humans to see whether very sick childrens’ brains are a total mess.) Sutton 09 Multiple Sclerosis (PMID: 18805844) Talks about “CNS demyelination and quadrivalent HPV vaccination”. For those of you who don’t know, … that’s …. GARDASIL. CNS demyelination is … autoimmunity.

Overseas, where the influenza vaccines contain aluminium, it was no surprise to me, when I read of an 8 month baby who died from polyneuromyopathy and demyelinating Myelitis after an influenza vaccine. Adamovic 09 J Child Neur (PMID: 19264734) If you look at all those journal names, is there one journal reputed to be the “go to” source for vaccines in that list? Adamovic’s article had a title, abstract and keywords which never mentioned the influenza vaccine. That was hidden in the text. Is this what it comes to, to be able to say something? Bury it so deep, so that few will find it? We’ve got to say it in secret?
Like Holy Grails, vaccine reaction problems are needles hidden in a mountainous haystack. Where would the average person start, if they wanted to look for facts? Most people wouldn’t look, because they would assume that doctors had told them the WHOLE truth. But family practitioners are in the dark, as much as parents are, and have no idea that the Ministry of Health is actually “lying by omission”.

Just do a full search using the words “neuropathology of aluminium toxicity” and you will find a heap of medical articles which put together, can explain the denied side effects after MeNZB, and the denied side effects coming to light now, following the Gardasil vaccine. No-one is looking at them. And they write them up as myths.

The above medical article list is a sample from the many medical papers which have been published, detailing some vaccine “disadvantages”. This committee could set up a more effective data base which might answer a whole lot of questions that some parents have right now, which relate to why they don’t want to vaccine, or why they refuse to complete the Gardasil series of three shots.

If this Committee was to expand the National Immunisation Register (NIR) database, to collect pre and post medical data, all the relevant end-point outcomes could be studied easily, at minimal expense.

**Community concerns.**

Every doctor and hospital has instant access to the *National Immunisation Register*, because it of a New Zealand policy called “*Opportunistic vaccination*”. On consultation at a hospital for any reason whatsoever, vaccination records are checked, and any or all vaccines were not given on time, they will all be given on the spot to “catch the person up”, *often without regard for the reason the child is there*. The same applies to GP visits.
“Opportunistic vaccination” is aggressively pursued at every possible “opportunity”. It also happens to children (who are often unable to “argue” with the medical profession), when the parents are not there to give or refuse their “informed consent”. Doctors assume “in loco parentis” decision-making. This is totally unacceptable.

Currently, the National Immunisation Register’s principle purpose is to police and TRACK children and make sure they have all their vaccinations, .... or round up and remove unvaccinated children from schools in the event of an outbreak.

Most hospitals also have “outreach” nurses, who are provided with NIR lists of “non-compliant” families. These nurses either ring up and deliver a lecture, or turn up, sometimes unannounced, at people’s homes to hound parents who have CHOSEN to stop their vaccination schedule.

Many people who chose not to vaccinate and who ask to be removed from the NIR, do so because of harassment or coercion from these nurses. The tactics used by them usually breach the codes relating to informed consent, provided by the Department of Health 1991 Principles & Guidelines for Informed Choice & Consent 1.5 which says that providers should not coerce users, and should be alert to actual coercion by others, and to inadvertent coercion that can occur because of the user’s circumstances or background. These nurses also breach section 1.6.1 which says:

“Implementing informed choice and valid consent means respecting the user’s right to refuse treatment or participate in teaching activities, and their right to have change of mind without fear of recrimination, penalty, or the withdrawal of physical and emotional support.”

These nurses also seriously, consistently, breach Right 1 of the Code of Health and Disability Services Consumers Rights 1996 (to be treated with respect and have their privacy respected), Right 2: “every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.” As well as Right 3 “Every consumer has the
right to have services provided in a manner that respects the dignity and independence of the individual”. Stories are legion about the aggressive, unacceptable tactics of these nurses, and this needs to stop.

Parents’ reasons for withdrawing consent for further vaccines, and refusing to complete a vaccination schedule, or even refusing to start vaccinating, are dismissed, and their choices are not respected at all.

Any meaningful analysis of the benefits and disadvantages should surely look at these parents’ experience of a system which treats them like criminals in hospital, if their children are not vaccinated, and slams the doors on their backsides as they leave, dissatisfied with unacceptable harassment on all fronts.

How could the NIR be improved?

I made the following suggestions at a meeting with Dr Karen Poutasi, Dr John Stevenson, and Dr Michael Soljak in the late 80’s after the Northland trial of their NIR and when their NIR was mooted for a nationwide expansion. Dr Soljak wanted to do it, as did Dr Stevenson. Dr Poutasi was silent on the issue. Nothing was done. I make the identical suggestions again today.

It is my submission that the NIR’s core functions should be expanded to include:

a) Description of every child’s health status at birth, and any known problems from either their GP or a hospital admission, prior to vaccination, with this record to continue from then on. When an adolescent or adult goes on to the NIR for the first time, pertinent points from their medical history should also be entered.

b) Perhaps Otago University might like to access the NIR data to assist it in their Longitudinal study on children’s health into adulthood.
http://dunedinstudy.otago.ac.nz/ *2* as well as the “Next Generation study” and “Lifecourse” studies. This committee should recommend a much larger inclusion of unvaccinated children and adults in any studies being completed in Dunedin. The lack of a proper control group in these studies is proof of serious scientific bias. These studies could add to the number of New Zealand data-bases which could be combined in order come up with definitive New Zealand data, from the past, to compare old vaccine schedules with new vaccine schedules. But to do that, would require another cohort added – people between the ages of 20 – 30 who have never been immunised. To do that would require nationwide advertising, and guarantees to unvaccinated people who join, that they will not be subjected to abuse and harassment for repeatedly refusing to be vaccinated at every “opportunistic vaccination events” they continue to turn down.

2 It interests me that in this study, of 1,265 children, only 23 did not receive DPT and Polio vaccines. Given that the rates of vaccination in New Zealand were far lower than they are now, it is extraordinary that so few unvaccinated children were involved in this study. Did the researchers put the pressure on parents to vaccinate their children? This serious non-representation means that this study does not represent a wide spectrum of families making different health choices. That is not a “healthy” study in my opinion. I wonder what this following study would have found, if half of the 1,265 children had been unvaccinated? . Kemp T, Pearce N, Fitzharris P, et al. Is infant immunization a risk factor for childhood asthma or allergy? Epidemiology. 1997;8 :678 –680 “The Christchurch Health and Development Study comprises 1,265 children born in 1977. The 23 children who received no diphtheria/pertussis/tetanus (DPT) and polio immunizations had no recorded asthma episodes or consultations for asthma or other allergic illness before age 10 years; in the immunized children, 23.1% had asthma episodes, 22.5% asthma consultations, and 30.0% consultations for other allergic illness. Similar differences were observed at ages 5 and 16 years. These findings do not appear to be due to differential use of health services (although this possibility cannot be excluded) or confounding by ethnicity, socioeconomic status, parental atopy, or parental smoking.” A realistic representation from of vaccinated and unvaccinated groups would have provided a basis from which to answer some of the questions asked of the Committee in this submission.
c) Vaccinations given to children, **with the manufacturer, batch number, date, and the name of the person who administered the vaccine**, and a body map for babies, showing the exact body SITES the vaccines we injected into.

d) Every subsequent visit to the doctor or hospital, should be entered into the NIR with date, diagnosis, any drugs prescribed, and the long term outcome.

e) Any event, whether classified as a vaccine reaction or “coincidental” (– since most vaccine reactions are not recognised as reactions –) should be entered into the NIR.

f) All deaths, from whatever cause, should be entered into the NIR.

g) CARM should have automatic access to NIR to evaluate potential trends in vaccine side effects. However, CARM will need to be “rebooted” as well. (more later on CARM)

The NIR database and framework to collect this data already exists.

**Why is it important to expand the NIR to accommodate the above points?**

On Tuesday, 2\textsuperscript{nd} February, 2010 on Close Up, Doctor Stuart Jessamine informed the country that every year, **20 adolescents under the age of 20 die**.

Why has there been no previous public discussion of this phenomenon? Dr Jessamine stated that after eliminating accidental deaths such as car crashes, the most common cause of death was inherited cardiac issues.

Four young women in the age group eligible for Gardasil, have mysteriously died in their sleep between June and December 2009. (As of 12\textsuperscript{th} February, another two suspected cases have been heard of) Many young women remain sick after Gardasil vaccinations last year. On Monday, 8 February, yet another mother contacted me with a child with identical side effects from Gardasil as elaborated on Close-up. The mother tells me that the doctor does not agree that her daughter’s serious deterioration is Gardasil related, but has said he will report it at the mother’s insistence. Will the
doctor get the story correct? I’ll be advising the mother to ask for a copy of the doctor’s reporting form, and to fill CARM in on any missing details. On Tuesday, 9th February, yet another mother contacted me with a similar story.

Right now, the uptake of Gardasil is less than 50% of the eligible girls, on the National Vaccination Register. If all the above suggested information had already part of the National Immunisation Register since I first asked over 20 years ago, and if, for instance, RED FLAG alerts came up for all deaths, or serious health issues following (any) vaccination (or non-vaccination), then this committee could have analysed a comprehensive 20 years of New Zealand data. You can’t.

Every year, the following data in the NIR could be analysed and compared:

- the list of health issues most commonly identified in children who have been fully vaccinated - with
- the list of health issues most commonly identified in partially vaccinated children (and the parents reasons for not completing the schedule) and
- the list of health issues most commonly identified in children who have not been vaccinated by parental choice.

So for instance, any increase in serious hard-to-treat empyema following Prevenar, as has been happened in other countries, could be noted very quickly.

The bulleted information above, should be made public. After all, what is there to fear from transparency? Only when honest information is placed in front of New Zealand parents will they be able to make a fully informed choice as to the benefits and disadvantages of vaccinations in New Zealand, for those who chose to vaccinate, and those who chose NOT to vaccinate.

Those who have opted off the vaccination register, or have never gone on the NIR, will still have an National Health Index number. Given that the two
systems run off the same computer software, it would not be hard to find out what ‘hospitalisations’ have taken place in people who chose not to vaccinate, but have opted off the register.

For the NIR to be useful, *anyone who is happy to have vaccines, should be automatically enrolled on the National Immunisation register, with all “before and after” health information, including any known pre-existing issues.* An analysis could also be done, to see if certain pre-existing health issues are associated with in higher reactions in those subgroups.

However, following our experiences in 2009 and 2010, assisting parents and young women who believe their lives have been seriously affected by Gardasil, I have no confidence that the Ministry of Health dogma is such that it would allow personnel to disclose to the public, even anonymised vaccine reaction trends identified within the NIR.

*I believe that these analyses should be carried out by an independent, non-governmental body, immune to “influence” from any “stakeholders” (vested interests). The data should be publicly accessible, as with the VAERS data in USA (vaccine adverse event reporting system), and should also be reported on an annual basis by the media. CARM does not fulfil these criteria either.*

If the NIR had been enabled to do all I’ve suggested years ago, what would the Ministry of Health say, if all the teenagers who “died mysteriously in sleep” in 2009, showed up in the NIR, as *only occurring in the 40 something percent of Gardasil-vaccinated girls?*

*Would the Ministry of Health have the honesty to admit that? I doubt it.*
Does the Ministry of Health even want to know that? I *doubt* it.

Would the Ministry of Health do everything in its power to have other excuses found, for those deaths? I definitely think so.

For exactly the same reason, I believe that the Ministry of Health will fight tooth and nail to prevent any of the suggestions I have made being taken seriously.

Their excuses will be “money”; vaccines are so safe, that this is a waste of time; and last but not least, they are too scared to learn whether or not what the non-vaccinators by choice see in their children in comparison to vaccinated children. That non-vaccinated children are much healthier; have far less allergy, asthma, diabetes, or other chronic health problems.

As a Committee, wouldn’t you like to know the answer to that question? Are unvaccinated (by choice) children healthier than vaccinated children?

**Why does CARM need to be “rebooted” (to use a computer term)?**

Most doctors refuse to report reactions to CARM. Parents need to be told before their child is vaccinated, that they have the right to do this themselves. All parents should be handed a pamphlet about CARM and what information CARM would find useful when filing a report, and how to do it themselves.

In terms of CARM itself, the way it has handled Jasmine Renata’s death is utterly atrocious. It’s form in some instances in the past has been as bad. I can expand on that verbally if needed.
**My submission is that**, this Committee owes it to both vaccinating and non-vaccinating parents to have a long term, comprehensive *useful* data collection system, which answers questions about the benefits and risks of vaccinating New Zealanders, using New Zealand events and facts. Comparison with overseas is inadequate, because the same limitations in attitudes and data, which apply in this country, are just as bad in most countries overseas.

However, I repeat - the most serious reservation about expanding the NIR into a meaningful data-collection base is: *The conduct of the New Zealand Ministry of Health, IMAC or any other pro vaccine group over the last 27 years has lead to serious doubts about the ability of any of them to analyse, or report vaccine reaction data to the public, with any degree of honesty.*

**Why is neutral analysis of NIR data vital?**

If this Committee were to advise that the National Immunisation Register be expanded to incorporate pre-vaccine health status, vaccine reactions and/or subsequent illness events, those analysing that data would need to be an acceptable organisation *to parents who chose not to vaccinate their children*, in order for them to be willing to participate. Parents who chose not to vaccinate, and who opt off the register, do so because of a total loss of trust in a system which has no respect for any choice the system disagrees with.

All parents who chose not to vaccinate would have to be legally guaranteed that the current culture of harassment; coercion, and of being “criminalised” by nurses, doctors, IMAC and the MOH will stop ... in order for them to be willing to stay on the NIR database, and be studied as a control group.

*For any analysis of the health of the vaccinated New Zealanders on NIR to be meaningful*, the participation of a cohort of *totally unvaccinated*
children/adults by choice, is vital. The short term and long term “health” outcomes of the unvaccinated-by-parental-choice children or adults, are the “normal” baseline against which partly or fully vaccinated children should be compared with.

6. To define, and make recommendations as to what methods could be applied at minimal cost to improve immunisation in New Zealand, (bearing in mind the first 60 percent are easier to get, the next 20-30 percent require more effort, the next 5 percent lots of effort, and around 5 percent are declines).

While this is the focus for you, it’s irrelevant to me. What parents deserve is accurate information upon which to decide the benefits and risks of vaccination or non-vaccination, in New Zealand, for themselves. The system as it functions now, is designed to prevent most of the relevant information on serious side effects from being collected, analysed and published. Therefore the rights of parents to know accurate information is being systematically prevented.

Expanding the NIR and having an outside independent group evaluating and publishing that data would give Parliament, and the people of New Zealand a more accurate picture of both short term and long term benefits and risks of vaccinating, compared to the benefits and risks of not vaccinating.

The public’s ability to see that information, is an inherent part of “informed consent”.

The inability of the Ministry of Health to provide that specific data, is one (of the many) reason why there is no “informed consent” in this country. One other reason is that contrary to the law as it stands now, many people in the medical profession and schools deliberately portray vaccinations as if they
are compulsory, and tell people that – which leaves those people wondering why they actually have to sign a consent form in the first place.

Sincerely,

Hilary Butler.