

Submission to
Scrutiny of Acts and Regulations Committee
Parliament of Victoria

Re: Public Health and Wellbeing Amendment
(No Jab, No Play) Bill 2015

Australian Vaccination-skeptics Network Incorporated

23rd September 2015

avn.org.au
building responsibility into vaccination

Australian Vaccination-skeptics Network Incorporated

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23rd September 2015

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Re: Public Health and Wellbeing Amendment (No Jab, No Play) Bill 2015

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22 September 2015
On behalf of the committee and the members of
Australian Vaccination-skeptics Network Incorporated

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The Australian Vaccination-skeptics Network Incorporated (AVN) notes the Victorian government's agenda to introduce an effective vaccination mandate for access to child care services in Victoria.

AVN takes this opportunity to express its extreme disappointment about the lack of consultation with stakeholders in relation to the Bill, and to submit its arguments against such a mandate.

AVN has concerns about the negative effects an immunisation requirement without exemptions will have on social cohesion, believing it will cultivate and legitimise intolerance, bigotry and lack of respect for individual choice.

While acknowledging there is bipartisan support for vaccination, AVN also believes there is sufficient evidence that retaining freedom of choice represents the best public policy. Pro-vaccination and pro-choice positions are not mutually exclusive goals; both positions can and should be accommodated.

1.0 Scope

Our submission pertains to the Public Health and Wellbeing Amendment (No Jab, No Play) Bill 2015 and the Statement of Compatibility accompanying the Bill introduced to the Victorian Legislative Assembly on 15 September 2015. For the purpose of this submission, the terms immunisation and vaccination have been used interchangeably, even though in strict scientific terms, vaccination does not necessarily result in immunisation, the state of being immune to a disease.

2.0 Summary

We are opposed to the Bill. An immunisation requirement for entry to child care services is unnecessary and unjustified to protect the public health and will not act to increase immunisation rates. Our key arguments against the Bill are described in sections 7-18 of this submission and summarised below.

- (1) There is historical legislative precedent for immunisation exemptions in Australia.
- (2) The Bill's immunisation requirement exceeds the power of the parliament to make such a law.
- (3) The Bill conflicts with two Commonwealth laws, namely the Disability Discrimination Act 1992 (Cth) and A New Tax System (Family Assistance) Act 1999 (Cth).
- (4) The Bill conflicts with the Medical Board of Australia Code of Conduct.
- (5) The Bill's immunisation requirement limits several protected human rights which cannot be justified as required by section 7 of the Charter of Human Rights and Responsibilities Act 2006.
- (6) The Bill's immunisation requirement will not achieve its purpose of increasing immunisation rates.
- (7) Immunisation rates can be increased by less restrictive means.
- (8) The absence of a vaccine injury compensation scheme will result in class action lawsuits against the State of Victoria for injuries or deaths attributable to coerced vaccination.
- (9) The immunisation requirement violates principles of equity and the right to work under the Universal Declaration of Human Rights.
- (10) The immunisation requirement violates both the Convention on the Rights of the Child and International Covenant on Economic, Social and Cultural Rights to which Australia is a party.
- (11) Immunisation exemptions – statutory declaration by parents should be sufficient.

Sections 5 and 6 of the submission discuss vaccination as a scientific controversy.

3.0 Recommendations

- 1) The Bill should be amended to provide for an exemption for conscientious objection to the immunisation requirement on philosophical or religious grounds, in accordance with the obligations imposed by Charter of Human Rights and Responsibilities Act 2006, other human rights instruments to which Australia is a party, and to eliminate conflict between this Bill and the Commonwealth Disability Discrimination Act 1992 (DDA) and A New Tax System (Family Assistance) Act.
- 2) We propose that a statutory declaration made by a child's parents or legal guardians to the effect they have a conscientious objection to immunisation on philosophical or religious grounds should be sufficient to satisfy the immunisation requirement due to the difficulties in obtaining a signed objection form from a doctor.

4.0 About the Australian Vaccination-skeptics Network Incorporated (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.

5.0 Vaccination – the scientific controversy

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>

5.1 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 convenience we have provided Appendices 1 – 4 as Appendix A to our submission.

5.2 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.

5.2.1 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 clinically identical disease 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 committee members 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/>

5.2.2 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-20130601-2n1pr.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 so-called vaccine-preventable diseases such as Measles, but in the interests of brevity have not been included. Indeed, the submission would run to volumes if all matters relevant to the controversy were included.

5.3 Vaccine-Autism Controversy – vaccines can and have caused Autism

While there have been some published epidemiological studies purporting to show that vaccines are not a cause of Autism, all of them employ critically flawed statistical methods, and in most cases compare a population of children who have received ‘x’ number of vaccines, with one that has received ‘y’ number of vaccines. In these types of studies, the group which received only one less vaccine than the other group is deceptively described as unvaccinated. There have been no studies conducted to date which compare the rates of Autism, other disabilities and diseases in the completely unvaccinated with rates in the fully vaccinated.

The US Vaccine Injury Compensation Program (VICP) has been 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 vaccine-related brain injury which lead 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=pehr>

This study only represents the tip of the iceberg too – it isn’t a question of if vaccines are one of the causes of Autism – that question has been answered in the positive. Rather, it’s a question of how many cases of Autism have been caused by vaccines.

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/>

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

Vaccination does not reduce the overall burden of infectious disease. Certainly, the overall hospitalisation rate of children arising from all-cause infectious diseases is still high. It would seem to us that those efforts to lower the death and hospitalisation rate from a single disease never results in an overall reduction in deaths or hospitalisation from all-cause infectious diseases. For example, is it any reason to celebrate a decline in hospitalisations from a so-called vaccine-preventable respiratory illness, if overall hospitalisations for all-cause respiratory illnesses are not reduced? We don't believe so, but this would seem to be the approach favoured by public health experts. As soon as one disease is allegedly reduced there is an equally dangerous "emerging" disease to replace it, which inevitably requires yet another vaccine. We see this time and time again.

Respiratory Syncytial Virus (RSV) is a case in point, the latest in a long line of projected vaccine targets, and which is reported to cause significant numbers of hospitalisations of children in Australia each year.

(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>

Do we really need to state the obvious that the taxpayer cannot continue to fund endless numbers of vaccines if the only result is that the infectious disease burden just shifts to another pathogen and never, ever results in overall savings from reduced hospitalisations due to an overall decrease in infectious diseases.

5.5 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 rates 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>

Of similar concern is the increasing rates of chronic disease and disability in children. The following conditions have recently 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

5.6 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/ASCI_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.

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>

The relative contribution vaccines make to immune system mediated chronic disease is potentially medical science's dirtiest and best-kept secret and should not be permitted to continue.

5.7 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>

6.0 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 death of Riley Hughes 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 he would still be alive. This is a blatant lie.

Riley Hughes 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 was not the case.

6.1 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 stated this exact view back in 2012.

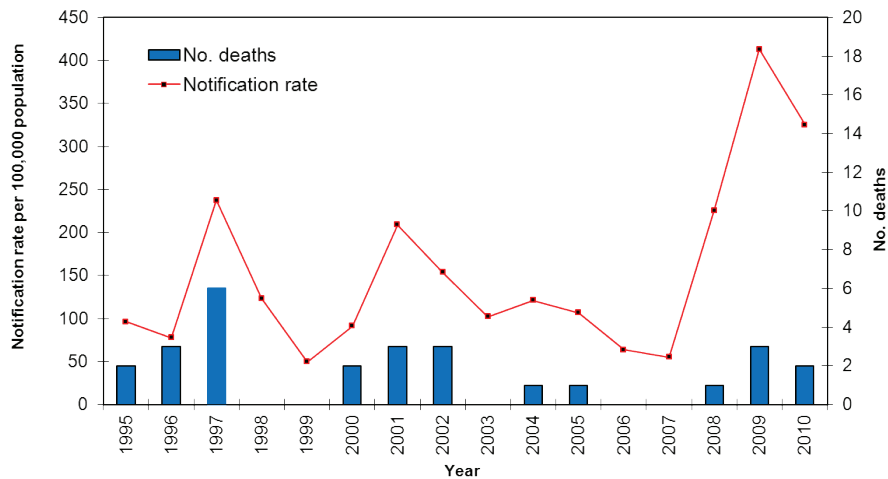
“What’s certain is that whooping cough will not go away and, tragically, deaths in very young babies will still occur without better ways to protect them before they themselves can be protected by immunization.”

(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 graph on the following page details deaths from Whooping Cough in Australia between 1995 and 2010.

Pertussis notification rates and deaths, 1995-2010 Australia



ncirs
NATIONAL CENTRE FOR IMMUNISATION
RESEARCH & SURVEILLANCE

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 immunisation rates increased significantly in the same period, lending weight to the argument that increasing immunisation 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 immunised, 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.

(*Pertussis Vaccines for Australian: Information for Immunisation Providers*, 2015, NCIRS)

<http://www.ncirs.edu.au/immunisation/fact-sheets/pertussis-fact-sheet.pdf>

6.2 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 immunisation 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 4-5 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 Pertussis bacteria, but does not prevent the colonisation or transmission of the bacteria to either immunised or unimmunised 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 immunised against Pertussis, 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 unimmunised child is no more likely to transmit the disease to a vulnerable baby than a fully immunised one.

6.3 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 vaccination rates have increased significantly since the 1980s. Immunisation 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 immunised.

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

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

6.4 Recently reported Whooping Cough outbreaks in fully vaccinated children

The following three articles report on outbreaks of Whooping Cough in fully immunised children in schools.

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

(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 immunised, with the school having a 99.5% immunisation 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, however the immunisation status of these children has not been reported. We have been unable to obtain this information from Queensland Health and will need to apply for this information through the Right to Information process, and there's no guarantee 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/>

7.0 We oppose the Bill unequivocally

We are stridently opposed to the Bill. The proposed immunisation requirement to attend child care services in Victoria represents an unnecessary, unjustified and insidious intrusion by the state into decisions about the health and welfare of children, decisions which rightly reside with parents.

Providing for exemptions to the immunisation requirement for conscientious objection on philosophical or religious grounds would go some way to alleviating our most potent concerns with the Bill.

8.0 Historical legislative precedent for immunisation exemptions in Australia in the context of low immunisation rates

We note the longstanding and bipartisan legislative support in Australia for exemptions to an immunisation requirement since at least 1997, when such a 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 and without a need for coercion or punishment by the state.

In addition to broad support for exemptions, both the ALP and LNP – when in federal government – have given specific legislative force to religious 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, the 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 is 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

9.0 Recent bipartisan policy support for religious exemptions

We acknowledge current ALP and LNP policy to pursue measures which aim to increase immunisation rates, but note, both parties have recently expressed in-principle support for religious exemptions in relation to an immunisation requirement in Commonwealth laws.

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, federal LNP 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://scottmorrison.dss.gov.au/media-releases/no-jab-no-play-and-no-pay-for-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://scottmorrison.dss.gov.au/media-releases/government-ends-religious-no-jab-no-pay-of-benefits-exemption>

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 should 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. It would also be fair to say, that some of our members would only submit to vaccination “over my dead body” or by force, statements which could be considered further evidence of the religious nature of a belief against vaccination.

10.0 The Bill's immunisation requirement exceeds the power of the parliament to make such a law

We acknowledge the parliament's power to make laws in relation to public health matters generally and disease outbreaks more specifically, but it is our strong view, that power doesn't extend to applying effective quarantine measures to otherwise healthy, but unvaccinated children in **non-outbreak conditions**, a power which is usually reserved for public health emergencies, and usually not even then.

The proposed exclusion of deliberately unvaccinated children is analogous to applying wartime powers during times of peace. We feel certain the general public would have been rightly outraged if the Australian government had continued to exercise its wartime powers of detention of citizens of German descent after the end of World War II, yet this is the type of power that is being proposed in this Bill. It's one thing to exclude unvaccinated children in the event of an outbreak of Measles, quite another to exclude them in non-outbreak conditions.

11.0 The Bill conflicts with the Disability Discrimination Act 1992 (Cth) and A New Tax System (Family Assistance) Act 1999 (Cth)

11.1 Disability Discrimination Act (DDA)

The Bill's immunisation requirement conflicts with sections 5 and 6 of the DDA and seeks to limit its operation by requiring persons in charge of a child care centre to not enrol unvaccinated children except in the circumstances provided for in the Bill.

(Discrimination Act 1992 (Cth), sections 5 & 6)

https://www.comlaw.gov.au/Details/C2013C00022/Html/Text#_Toc345412390

Refusal to enrol a child based on vaccination status will amount to unlawful discrimination under the DDA, and will expose child care centres to legal liability for acts of unlawful discrimination.

For the purposes of the DDA, an unvaccinated child has a disability so is protected from discrimination on that basis.

Disability is defined in the DDA as:

- (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).*

While section 48 provides that discrimination is not unlawful if it is reasonably necessary to protect the public health, we believe that it would be impossible for a child care centre to satisfy such a condition for the reasons outlined elsewhere in our submission.

In addition, while Section 47 subsection 2 of the Act provides that this part does not render unlawful anything done by a person in direct compliance with a prescribed law, the Public Health and Wellbeing Act 2008, which this Bill seeks to amend, is not a prescribed law in Schedule 1 of the DDA Regulations.

(Disability Discrimination Regulations 1996, Schedule 1)

https://www.comlaw.gov.au/Details/F2012C00527/Html/Text#_Toc331768859

The New South Wales parliament considered a similar Bill to this one back in 2013 and, following legal advice and debate in the parliament, took the decision to provide for exemptions for conscientious objection on philosophical and religious grounds due to concerns that an immunisation requirement without exemptions would be in breach of the DDA. This is an excerpt taken from NSW Hansard in relation to the issue.

“I am advised that on the issue of protection, section 48 of the Commonwealth Disability Discrimination Act dealing with discrimination against those with infectious disease will face problems as paragraph (b) states that “discrimination reasonably necessary to protect public health” will be determined by the level of risk. Clearly, a child with a vaccine-preventable disease poses a risk to other children. However, an unvaccinated child poses the risk in the future. The risk is that a court will not find a refusal to enrol an unvaccinated child is reasonably necessary to protect public health.”

The full transcript is available here:

<http://www.parliament.nsw.gov.au/prod/parlment/hansart.nsf/V3Key/LC20130620006?>

11.2 New Tax System (Family Assistance) Act (FAA)

The Bill’s immunisation requirement conflicts with the FAA by its effect to deny a benefit conferred by that Act, namely the right to access subsidised childcare services (child care benefits). While eligibility to child care benefits under the FAA is subject to an immunisation requirement, exemptions from this requirement is permitted on the grounds of conscientious objection.

(A New Tax System (Family Assistance) Act 1992 (Cth), section 6)

http://www.austlii.edu.au/au/legis/cth/consol_act/antsaa1999357/s6.html

12.0 The Bill's immunisation requirement 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>

For those with a philosophical or religious objection to vaccination, and who rely on access to child care services, the consent could not be said to be given voluntarily, due to the presence of coercion in the form of the threatened loss of the ability to participate in work or study. Doctors are prohibited from accepting consent unless it has been given voluntarily.

Professor Raina Macintyre recently expressed the concern that doctors were prevented from accepting consent under such circumstances in relation to a proposed immunisation requirement in Commonwealth laws.

“In addition, doctors must obtain valid consent to vaccinate children, and consent is not valid in the presence of any form of coercion.”

(The Australian, 2015, Questioning vaccination policy is not synonymous with anti-vaccination)

<http://www.theaustralian.com.au/opinion/letters/questioning-vaccination-policy-is-not-synonymous-with-anti-vaccination/story-fn558imw-1227312423699>

This obviously raises questions about the legal validity of the Bill particularly in the absence of provision for immunisation exemptions on conscientious grounds.

13.0 The Bill's immunisation requirement limits human rights protected by the Charter of Human Rights and Responsibilities Act 2006 (CHRR)

The Bill's immunisation requirement violates several provisions of the CHRR.

13.1 Protection from discrimination

Section 8, subsections 2 and 3 protects the right of every person to enjoy their human rights free of discrimination, and to equal and effective protection from discrimination by the law. The immunisation requirement violates these rights.

The Bill's requirement for child care services to not enrol unvaccinated children exclusively – except for prescribed groups - and not other unprotected children, is arbitrarily discriminatory. If deliberately unvaccinated children are claimed to pose a risk to the other children and staff, then by necessity, similarly unprotected children and people 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.

There is also a significant body of scientific evidence that children recently vaccinated with live, attenuated viruses pose a risk to close contacts in the post-vaccine period. Live attenuated vaccine viruses, such as Measles, Mumps, Rubella, Chickenpox and Rotavirus have been 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 consequent transmission of vaccine-strain viruses to close contacts is provided in Appendix B 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, but the Bill does not discriminate against these children on such a basis. Only deliberately unvaccinated children are singled out for exclusion.

13.2 Protection from coerced medical consent

Section 10, subsection c, protects the right to give free and full consent to a medical treatment. The immunisation requirement will limit this right.

Australian law, and the CHRR more specifically, 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>

Importantly, unlike a medical procedure performed on a sick or injured person for therapeutic goals, immunisation is a medical procedure performed on healthy people for a potential future benefit. For this reason, it is our view that the standard of informed consent to the procedure should be arguably higher than that for a therapeutic purpose, and most definitely should only be given freely, without coercion.

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>

Requiring vaccination for entry to child care services interferes with the ability to give valid consent at law for those with a deeply-held belief against immunisation, and who are reliant on child care services in order to work or study. Parents with a conscientious belief against vaccination will be unable to comply with the Bill's immunisation requirement because their consent cannot be given fully or freely.

13.3 Protection of freedom of thought, conscience, religion or belief

Section 14 protects freedom of thought, conscience, religion and belief. The Bill's immunisation requirement interferes with this right by preventing those with a conscientious belief against vaccination from observance to this belief, and seeking to coerce people with these beliefs into abandoning these beliefs. Such limitation is not justified as required by section 7 of the CHRR for the reasons presented elsewhere in our submission.

13.4 Protection of families and children

Section 17 protects the right of families and children, to be protected by the state, in their best interests. Far from protecting this right, the Bill's immunisation requirement will require parents to consent to vaccination on behalf of their children against their best interests. Many parents with an objection to vaccination have witnessed their children being injured by vaccines in the past, injuries which are not recognised as evidencing a medical contraindication to future vaccination. The immunisation requirement seeks to coerce parents into submitting their children to a medical procedure which they have previously witnessed to cause injury in their children. Limitation of this right is not justified as is required by section 7 of the CHRR.

14.0 The Bill's limitation of human rights is not justified

We acknowledge that individual rights may be subject to reasonable limitation by the state when it can be demonstrably justified, but reject the claims in the Statement of Compatibility (SOC) which accompanies this Bill purporting to justify a limitation of human rights in accordance with section 7 of the CHRR.

Section 7, subsection 2 of the CHRR provides that protected human rights may only be subject to *“such reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom”*.

It is commonly accepted among jurists - and we concur with that consensus - that the state needs to satisfy a very high burden of proof when pursuing any derogation of individual human rights. It is not sufficient for the government to merely claim it is necessary, it needs to show that it is necessary by the highest standards of evidence. We don't believe the government has, or could satisfy this burden of proof for the following reasons.

14.1 The immunisation requirement will not achieve the stated purpose of the Bill

Section 7 of the CHRR, requires that all relevant factors be taken into account in determining if limitations on protected rights are justified. Subsections b and d are relevant to the stated purpose of the Bill which is to increase immunisation rates.

Section 7

(b) the importance of the purpose of the limitation; and

(d) the relationship between the limitation and its purpose

While the SOC claims that the immunisation requirement will satisfy the stated purpose of increasing immunisation rates, we are of the considered view that the effect on immunisation rates will be negligible at best.

To determine if the immunisation requirement will act to increase immunisation rates, it is necessary to consider the characteristics of those children who are unvaccinated.

At the end of 2014, 1.59% of children in Victoria had a registered conscientious objection to vaccination, and between 90.83% and 92.46% of children under 63 months were fully vaccinated.

(2015, ACIR - State and Territory Vaccine Objection (Conscientious Objection) Data)

<http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/acir-s-t-cons-objection-data.htm>

(2015, Annual Coverage – Historical Data)

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

This means that between 5.95% and 7.58% of children are unvaccinated for reasons other than that their parents have a conscientious objection to vaccination, but these figures may over-estimate the extent of non-vaccination. A recently published study found that apparent lower immunisation 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_Australia_due_to_low_uptake_or_poor_notification

In other words, purported vaccination rates may be higher than notified to and recorded by the Australian Childhood Immunisation Register. A recently published Australian study found that most children who were not up-to-date with immunisations had parents who were in favour of vaccination, and that socioeconomic disadvantage and chronic medical conditions were the key reasons for them not being up-to-date.

(Bourne, 2015, Children not immunised due to socioeconomic barriers, Medical Xpress)

<http://medicalxpress.com/news/2015-08-children-immunised-due-socioeconomic-barriers.html>

In this context, it's important to note that these children are extremely unlikely to be attending child care anyway (unless their parents have extremely high incomes), because if they were, they would already be registered as conscientious objectors which is currently required to access Commonwealth Child Care Rebates.

14.1.1 An immunisation requirement enacted in New South Wales did not result in an increase in immunisation rates

New South Wales introduced an immunisation requirement for enrolment in child care services commencing in January 2014. In the 18 months following the introduction of this law to June 2015, immunisation rates have only increased marginally in the youngest and oldest cohorts, and have actually declined in the middle age cohort.

(2015, Annual Coverage – Historical Data)

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

(2015, ACIR – Current Data)

<http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/acir-curr-data.htm>

14.1.2 Coercive vaccination policies are polarising and may have unintended consequences

Public Health experts have also argued that coercive vaccination policies, may have the opposite effect to that intended by polarising immunisation-hesitant parents, or parents who selectively immunise, and convert them to immunisation objectors.

“Parents who feel they are being unduly coerced or punished to vaccinate their children are likely to become anti-vaccination. This coercion may push the hesitant parent in the exact opposite direction to what it is intended to achieve. Other members of the public may also feel sympathy for these parents.”

They claim access, education, awareness, and affordability are the key determinants of immunisation uptake with GP incentives also playing a role.

(Macintyre & Salmon, 2015, Want to boost vaccination? Don't punish parents, build their trust)

<https://newsroom.unsw.edu.au/news/health/want-boost-vaccination-don%E2%80%99t-punish-parents-build-their-trust>

For example, a child of a parent who is generally in favour of immunisation but who has an objection to only one particular immunisation will be punished to the same extent as one that is totally unimmunised. Similarly, many parents who generally support immunisation, also value civil liberties and the right to choose, free from coercion by the state. The immunisation requirement does not provide for such nuanced and diverse beliefs, and may act to achieve the opposite of increasing immunisation rates. by eroding public trust in immunisation.

14.1.3 The effect of the immunisation requirement in increasing immunisation rates in relation to those children with a registered conscientious objection will be negligible

To the extent that the immunisation requirement targets the 1.59% of children whose parents have a conscientious objection to vaccination, it will have zero to negligible effect in increasing immunisation rates.

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 vaccinate kids)

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

Professor Leask has estimated that the impact of the Commonwealth No Jab No Pay laws (which would have the effect of excluding unvaccinated children from child care services by making the cost prohibitive) on immunisation rates may 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/>

We concur with the view that parents with a conscientious objection to vaccination will continue to refuse to vaccinate their children under draconian laws such as this. Consequently, and having regard to section 7, subsections b and d of the CHRR, a limitation on human rights is not authorised by the Act in relation to this group of unvaccinated children.

For this reason, we recommend that if an immunisation is enacted that provision be made for exemptions for conscientious objection on philosophical or religious grounds.

14.2 The Bill's purpose to increase immunisation rates can be achieved by less restrictive means

Section 7 of the CHRR requires that less restrictive means to achieve the purpose of the limitation be considered.

Section 7

(e) any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.

Immunisation rates can be increased by positive policies without the need to resort to coercive policies. Immunisation acceptance/hesitancy and risk communication are A/Professor Leask's special areas of interest and expertise. She strongly favours positive policies to remove structural barriers to vaccination up-take, tailored communication strategies, and professional development and engagement of vaccination providers.

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

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

Public health experts, including Professor Raina Macintyre and A/Professor Kristine Macartney have made similar arguments.

(Macintyre & Salmon, 2015, ibid)

(Macartney, 2015, Forget 'no jab, no pay' schemes, there are better ways to boost vaccination)

<https://ama.com.au/ausmed/forget-%E2%80%98no-jab-no-pay%E2%80%99-schemes-there-are-better-ways-boost-vaccination>

Consequently, and having regard to section 7, subsection e of the CHRR, a limitation on human rights is not authorised by the Act.

14.3 The Bill's immunisation requirement without exemptions amounts to an effective mandate or 'practical compulsion'

We note the claim in the SOC to the effect that the Bill does not mandate vaccination and that therefore section 10 (c) of the CHRR relating to consent to medical procedures is not engaged. We reject this claim and would argue that the Bill does mandate vaccination in an effective or practical sense.

The Bill's immunisation requirement amounts to an effective mandate or 'practical compulsion' for those who rely on access to child care services in order to participate in the workforce or self-development activities such as study. The concept of 'practical compulsion' was defined by Justice Webb in *British Medical Association v The Commonwealth*.

"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."

([1949] HCA 44; (1949) 79 CLR 201)

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

The above definition skilfully exposes the element of compulsion when the whole or substantial part of one's livelihood is at risk. We feel it is misleading in the extreme to argue that parents will still have a choice about whether to immunise their children if the Bill is passed without provision for exemptions. A choice between immunising one's children and forfeiting one's place in the workforce is no choice at all for those parents with a deeply-held belief against immunisation; they will have to leave their jobs (or study) if they rely on access to child care services.

14.4 Australia and Victoria have high and stable rates of immunisation and low rates of conscientious objection

Australia already has high and stable rates of immunisation, the highest ever, and the small increase in the rate of recorded conscientious objections to immunisation does not represent a real increase, but rather reflects an increased awareness of the need to register in order to receive Commonwealth entitlements.

(Leask, 2013, With vaccination rates stable, 'no jab, no play' rules are beside the point, The Conversation)

<https://theconversation.com/with-vaccination-rates-stable-no-jab-no-play-rules-are-beside-the-point-14522>

For as long as vaccines have existed, there have been people opposed to the practice, but the numbers have always been small. There's no evidence to suggest the rate of conscientious objectors is rising from its historically very small base, even though registered rates may have.

Australia has gone from very low rates of immunisation in the 1980s to very high rates currently, and this has been achieved without the need to resort to draconian measures such as that proposed. Immunisation rates increased from a low of 53% in 1989-90 to 92.08% in 2014.

(ABS, 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>

Victoria's vaccination and conscientious objection rate was broadly consistent with the rest of Australia at the end of 2014.

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

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

"[...] 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>

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. 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/>

While 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.”

(Beattie, 2013, ibid. p 3)

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

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 Minister to release the percentages of notifications attributable to unvaccinated, partly, and fully vaccinated children if that information is available. The secrecy surrounding this type of information is a source of constant frustration - it is in the public interest that this information be readily accessible. If the information is collected it should be available as a matter of course.

As has been described in the Whooping Cough section in the controversy section of our submission, there is sufficient empirical evidence that vaccinated children may serve as asymptomatic 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/>

In addition, as noted in section 12.1 of our submission, children recently vaccinated with live attenuated viruses pose a risk of transmitting these viruses to close contacts in the post-vaccine period. (See Appendix A)

14.6 Vaccine-induced herd immunity is disputed

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 claimed 95% vaccination threshold to achieve herd immunity referred to in the SOC, is merely a spurious invention, and one 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 under six years of age.

The theory of herd immunity evolved from observations of 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 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 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/>

Measles

Vaccine-induced herd immunity has been questioned in relation to Measles. A 2014 paper reported on a case of Measles in a person previously vaccinated with two doses of the vaccine and which resulted in four secondary cases that were also confirmed to have received either two doses of measles-containing vaccine or a past positive measles IgG antibody.

(Rosen et al., 2014 Outbreak of Measles Among Persons With Prior Evidence of Immunity, New York City, 2011, Clinical Infectious Diseases)

<http://cid.oxfordjournals.org/content/early/2014/02/27/cid.ciu105>

A recent study found waning vaccine immunity to Measles even in cohorts receiving 2 doses of the vaccine.

(Goncalves et al, 2015, Persistence of measles antibodies, following changes in the recommended age for the second dose of MMR-vaccine in Portugal, Vaccine)

<http://www.sciencedirect.com/science/article/pii/S0264410X15011858>

Chickenpox

An outbreak of Chickenpox in a school with 97% vaccination coverage was reported in 2009. Attack rates among 2-dose recipients (10.4%) and 1-dose recipients (14.6%) were not significantly different.

(Gould et al, 2009, An outbreak of varicella in elementary school children with two-dose varicella vaccine recipients--Arkansas, 2006, Paediatric Infectious Disease Journal)

<http://www.ncbi.nlm.nih.gov/pubmed/19593254>

This paper reported low effectiveness of Chickenpox vaccine in South Korea in the results of 3 different studies.

- 1) Case-based study - Among 152 Chickenpox patients with a median age of 4 (child care based age), 139 children received varicella vaccine and all had breakthrough infections. Clinical courses were not ameliorated in vaccinated patients.
- 2) Case-control study – Overall adjusted vaccine effectiveness was only 54%.
- 3) Immunogenicity and safety study – Only 76% seroconversion and in any case there is no evidence that seroconversion (antibodies) necessarily indicates immunity.

(Oh et al, 2014, Varicella and varicella vaccination in South Korea, Clinical Vaccine Immunology)

<http://www.ncbi.nlm.nih.gov/pubmed/24671555>

Whooping Cough

The Whooping Cough cocooning strategy, a micro version of herd immunity, has recently been shown to be ineffective. As the committee may be aware, the cocooning strategy was funded in Victoria 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 the November 2011 meeting.

“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>

The cocooning strategy was based on the speculation that if parents are vaccinated against Whooping Cough then they will be less likely to transmit the bacteria responsible for the disease to their newborns who cannot be vaccinated until at least six weeks of age.

An Australian study published just last month confirmed that the cocooning strategy does 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.sciencedirect.com/science/article/pii/S0264410X15012049>

Whether or not the other vaccines have the capability to produce a herd immunity effect is the subject of an ongoing scientific dispute. The question has certainly not been answered to the standard necessary to introduce an effective vaccine mandate.

14.7 Existing outbreak measures are sufficient and do not need to be extended to the exclusion of healthy unvaccinated children

We note that the Public Health and Wellbeing Regulations 2009 already confers the power to exclude unvaccinated case contacts from child care in the event of a Measles or Whooping Cough outbreak. There is absolutely no evidenced need to extend these powers to the exclusion of healthy but unvaccinated children for all vaccine-preventable diseases on the basis of some poorly defined risk of a future, potential outbreak being caused by these children.

(Vic Health, 2013, Minimum period of exclusion from primary schools and children's services centres for infectious diseases cases and contacts)

https://www2.health.vic.gov.au/getfile/?sc_itemid=%7B4D311051-EEBB-4BD4-A149-C0B81931B3C5%7D

These existing powers are more than sufficient, and strike the right balance between the rights of the individual, and the rights of other children attending child care services.

15.0 The absence of a vaccine injury compensation scheme will result in class action lawsuits against the state for injuries or death attributable to coerced vaccination

Unlike many industrialised countries, Australia does not have a statutory vaccine injury compensation scheme, and while we are not lobbying for such a scheme, would argue that the parliament should not pursue legislation with any level of coercion or compulsion, and for those reliant on child care services, the proposed legislation, amounts to an effective mandate or practical compulsion.

In 1997, former Australian Greens Senator, Dee Margetts, during a Senate discussion about the Child Care Payments Bill, argued 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>

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

16.0 The immunisation requirement violates principles of equity and the right to work under international human rights instrument

There will be a disproportionate, negative impact on women, including single mothers, by reducing their workforce participation or opportunities for self-development, their ability to provide essentials and luxuries for their children, and the immunisation requirement violates Article 23 (1) of the Universal Declaration of Human Rights, which protects the right to work and the right to protection against unemployment. The Bill's immunisation limits this right for those parents with a conscientious belief against vaccination.

Article 23.

(1) Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.

<http://www.un.org/en/documents/udhr/index.shtml#a23>

17.0 The immunisation requirement violates both the Convention on the Rights of the Child and International Covenant on Economic, Social and Cultural Rights to which Australia is a party

That child care and early education services are an essential service, vital to the economic prosperity of Australia, is reflected in the bipartisan, taxpayer subsidisation of these services over a long period. The effect of the Bill will be to deny some children access to early education and socialisation opportunities which their parents subsidise through their taxes.

Article 9 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognises the right of everyone to social security.

Article 9

The States Parties to the present Covenant recognize the right of everyone to social security, including social insurance.

(International Covenant on Economic, Social and Cultural Rights)

<http://www.ohchr.org/EN/ProfessionalInterest/Pages/ICESCR.aspx>

Article 26 of the Convention on the Rights of the Child (CRC) recognises the right of every child to benefit from social security.

Article 26

1. States Parties shall recognize for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realization of this right in accordance with their national law.

18.0 Immunisation exemptions – statutory declaration by parents should be sufficient

In the event an immunisation requirement is enacted with provision for exemptions, we submit that a duly certified statutory declaration from the parents to the effect they have a conscientious objection to vaccination for philosophical or religious reasons be deemed sufficient to satisfy compliance. A form signed by a doctor to register an objection should only apply to objections on medical grounds.

This position is informed by the significant difficulties our members have faced over the years in finding doctors who are willing to sign off on exemptions, which is currently required for eligibility to Family Tax Benefit A supplement and Child Care Rebate.

Many doctors have demonstrated they are prepared to circumvent the intent of the legislature by refusing to sign the forms on the basis they have a conscientious objection to immunisation exemptions, even though the signing of the forms does not constitute an endorsement of conscientious objection to vaccination, but rather certifies that they have counselled a parent on the benefits and risks of vaccination. This has been particularly problematic for people living outside capital cities.

Whether or not doctors are legally required to sign the forms has been the subject of debate. We are of the view that doctors are legally obliged to sign the forms under the current Commonwealth Act, and this view accords with the view of a medico-legal expert who wrote about this issue a few years ago.

(2012, Dorey, Do doctors have to sign Conscientious Objector forms? Australian Vaccination-skeptics Network)

<http://avn.org.au/2012/04/do-doctors-have-to-sign-conscientious-objector-forms/>

However, a 2013 article argues that doctors are not required to sign the forms.

(Shepherd, 2013, How to handle non-vaccinators, Australian Doctor)

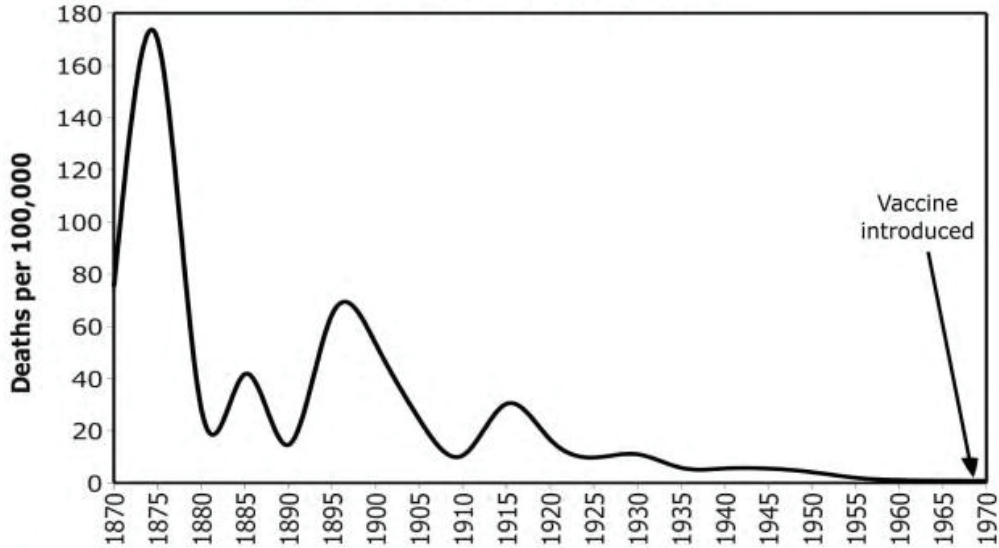
<http://www.australiandoctor.com.au/smart-practice/work-wise/how-to-handle-non-vaccinators>

Given a significant percentage of doctors do not want to sign these forms in the first place and have demonstrated their willingness to circumvent the intent of the Commonwealth legislature in the past, we would suggest not enacting a requirement for them to do so in relation to the Queensland Bill, and instead adopt our suggestion. This would eliminate any ambiguity and legal conflict about the issue.

Appendix A

Appendix 1

Measles—Australia



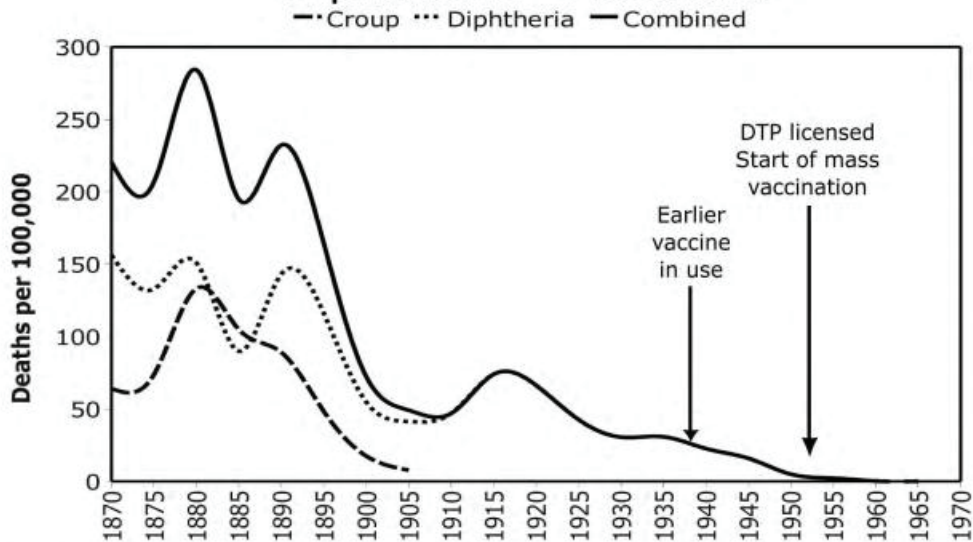
© 2011 Greg Beattie

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.

Appendix 2

Diphtheria—Australia



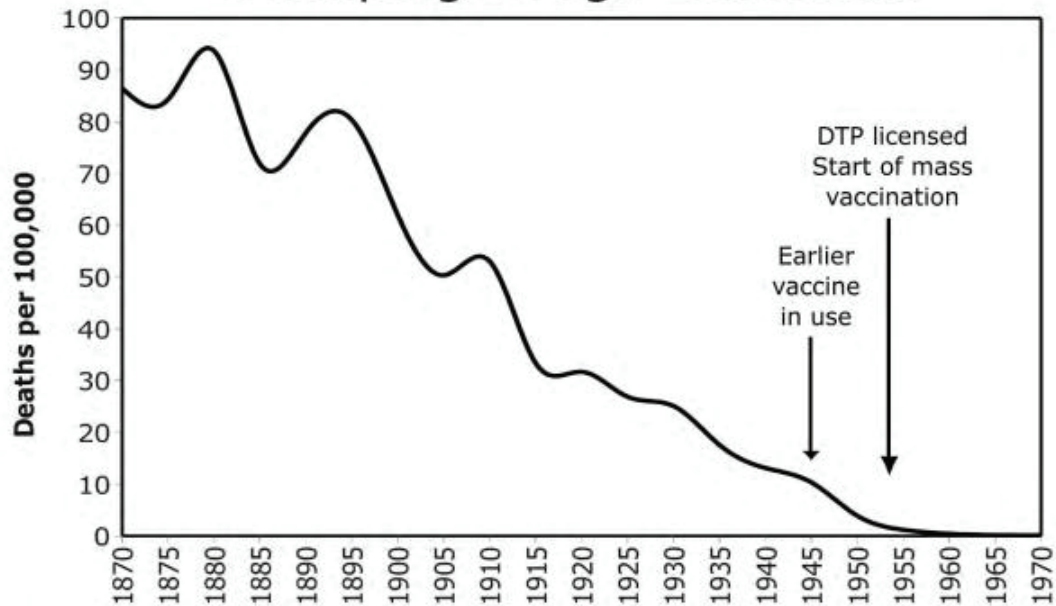
© 2011 Greg Beattie

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.

Appendix 3

Whooping Cough—Australia



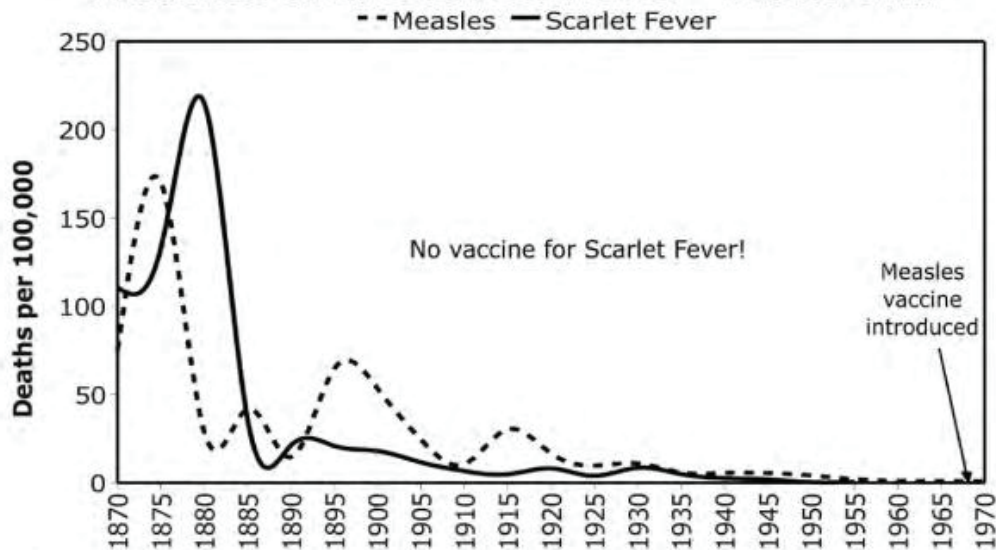
© 2011 Greg Beattie

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.

Appendix 4

Measles and Scarlet Fever—Australia



© 2011 Greg Beattie

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.

Appendix B

Cases of vaccine-associated disease in recipients of live attenuated virus vaccines and 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 which 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

(g) 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].’

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 vaccinatederived 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 Vected 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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