April 6, 2026

VIA ELECTRONIC MAIL

Jay Bhattacharya, MD, PhD
Acting Director
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329

Re: *Expansion of Clinical Shared Decision-Making: Considering Transmission*

Dear Dr. Bhattacharya:

We write on behalf of Informed Consent Action Network ("**ICAN**") regarding the CDC's vaccine schedule. As you are aware, recommended vaccines fall into three categories:

(1) vaccinations recommended for all children;
(2) vaccinations recommended for certain high-risk groups or populations; and
(3) vaccinations based on shared clinical decision-making ("**SCDM**").

The third category, SCDM, requires a clinician-patient/parent discussion about the benefits, risks, values, and circumstances of a particular individual/child before vaccination.[1]

While all vaccines should be administered based on SCDM, at the very least, CDC should forthwith move all vaccines that do not meaningfully prevent transmission into this category. As CDC's own guidance provides: "ACIP makes shared clinical decision-making recommendations when individuals may benefit from vaccination, but broad vaccination of people in that group is unlikely to have population-level impacts."[2] For the vaccines that meet this definition, there is indeed an urgency to assure they fall into the SCDM category so that there is, at least for those products, individualized counseling that weighs benefits, risks, and timing for the particular patient.

DTaP, Tdap, IPV, & MenACWY

With regard to DTaP, Tdap, IPV, and MenACWY, please find attached Chapter 9 from the book, *Vaccines, Amen*, which provides the supporting citations, with explanations, regarding the failure of these products to prevent transmission. The only additional evidence not included in Chapter 9 that we would like to bring to your attention regarding these vaccines is an FDA Briefing Document, dated September 20, 2024, titled *Use of Controlled Human Infection Models to Support Licensure of Pertussis Vaccines* which explains that "aP [acellular pertussis] containing vaccines

[1] *See* https://www.cdc.gov/acip/vaccine-recommendations/shared-clinical-decision-making.html.

[2] *Id.*

induce helper T cells (TH2) memory and neutralizing antibody responses that effectively prevent symptomatic disease but fail to prevent colonization and carriage."[3]

HPV

HPV vaccine should also be moved to SCDM. HPV is almost exclusively transmitted through sexual contact, and, in the vast majority of cases, an 11-year-old child is not sexually active and may not face any meaningful near-term exposure risk. The decision to vaccinate at age 11 versus later should therefore be based on individualized considerations—family circumstances, anticipated timing of exposure, medical history, and parental values—rather than a uniform community-wide transmission concern. Hence, even putting the significant risks of this product aside, HPV vaccines should be moved to the SCDM category so that clinicians and parents can evaluate risks, benefits, and timing for the individualized child, rather than applying a one-size-fits-all approach.

Influenza (Pregnancy)

Similarly, influenza vaccination during pregnancy should not be presented as a blanket, routine recommendation for every pregnant woman, but rather addressed through individualized counseling and SCDM. Pregnancy involves widely varying clinical circumstances and risk profiles, and patients differ in their medical history, prior vaccine reactions, trimester-specific considerations, and personal values. A meaningful recommendation therefore requires an individualized discussion of expected risks and benefits, available alternatives, and the patient's preferences—not a reflexive "routine" assumption. This approach is consistent with an evidence-based framework that prioritizes informed consent and individualized care—especially where community transmission benefits are not the driving rationale for giving this vaccine during pregnancy.

* * *

Under the shared clinical decision-making framework, vaccines with limited or uncertain community-level impact should forthwith be moved to the SCDM category so that they will be administered through counseling based on the individual's circumstances.

Very truly yours,

Aaron Siri, Esq.
Elizabeth A. Brehm, Esq.
Erin Bello, Esq.

Enc.

[3] https://www.fda.gov/media/181937/download.

Chapter 9

"Vaccines Prevent Transmission!"

After the "we would all be dead without them" mantra, the next most common mantra is "everyone must be injected to achieve herd immunity!"

"Herd immunity," also known as "community immunity," is the idea that if enough individuals in a community are infected with a pathogen, the natural immunity they develop will prevent further transmission of the pathogen in that community. Many believe that all vaccines can create herd immunity.

The main problem with this belief is that "herd immunity" requires the prevention of transmission and many vaccines do *not* prevent transmission of the pathogen they are targeting. Let me write that again: many vaccines do *not* prevent transmission. The measles vaccine can prevent transmission of measles in most people receiving this product for a certain duration of time. But that is *not* the case for many vaccines. I know, heresy.

Let's take a look at the vaccines commonly mandated for school attendance: IPV, DTaP/Tdap, MenACWY, HepB, MMR, and Varicella. After all, if any vaccine should prevent transmission, it should be those mandated to children under the illiberal, informed consent-crushing, draconian threat of expulsion from school.

Polio Vaccine

Let's start with polio. The polio vaccine used exclusively in the United States for over two decades, inactivated polio vaccine (**IPV**), does not prevent transmission of the polio virus. In the 1990s, IPV was phased in and oral polio vaccine (**OPV**), which had been used starting in the 1960s, was phased out due to safety issues.

Polio is transmitted from fecal to oral contamination. Meaning, to become infected with the polio virus, the virus must come out of someone's bottom and end up in another person's mouth. That lovely image

aside, OPV (the one long ago phased out in the U.S.) is a liquid that is administered by placing a few drops of live but weakened (Frankenstein version of the) polio virus in one's mouth. By placing it in the mouth, it introduces live polio virus (plus a bunch of other ingredients) into the intestinal tract, which is how one would normally be infected with polio.

The vaccine virus of polio then proliferates in the intestinal lining, intending to mimic what the real virus would do, and generates a form of immunity, including IgA antibodies, in the intestinal lining. Because of this, studies reflect that if one encounters polio again in the wild after getting OPV, the polio virus is less likely to multiply in the intestines and hence is less likely to be pooped out (lessening the chances of further transmission).

However, OPV, while having a certain degree of efficacy, has serious safety issues. One issue is that OPV can cause paralysis in some children, which is one reason why it was phased out in the United States starting in the 1990s and replaced with IPV

IPV, as noted, does *not* prevent transmission of polio. This is because it is injected into the arm and primarily creates antibodies to polio virus in the blood (IgG antibodies) but not in the intestinal tract (IgA antibodies) where the polio virus proliferates. The result is that not a single child in the United States vaccinated for polio since 2000 has immunity that prevents them from becoming infected with or transmitting the polio virus. If they encounter the polio virus, it can still multiply in their intestinal tract, and they will still poop out the virus. The only difference is that children getting IPV are theoretically more protected from having the polio virus travel from their intestinal tract into their bloodstream and then to their spinal column.

Sound untrue? Well feel free to argue with the CDC, which explains on its website that IPV "does not stop transmission of the virus" and that "IPV does not prevent intestinal infection and therefore does not prevent poliovirus transmission."[1] So, there you have it from the horse's mouth.

So, think about it. Children not vaccinated for polio and children vaccinated with IPV can both become infected with and transmit polio. The only difference is that the IPV-vaccinated children are supposed to have fewer symptoms if they become infected. So, if an IPV-vaccinated and an unvaccinated child both become infected with polio, the IPV-vaccinated child is supposed to have fewer symptoms and hence will be more likely to continue to socialize; whereas the unvaccinated child is supposed to be more likely to have symptoms and hence would be more likely to remain home in bed. Meaning, as compared to the unvaccinated child, the IPV-vaccinated child is more likely to come into contact

with others and—hold your breath—therefore, more likely to spread the polio virus. I know, sacrilege. But those are the facts.

I can already hear the hysterical reactions. "But polio vaccine saved everyone!" Putting aside the fact that this claim lacks footing as briefly discussed in Chapter 7, it doesn't change the reality that IPV does not prevent transmission—a fact begrudgingly accepted even by "health" authorities—which means IPV cannot have any impact on so-called herd immunity.

Pertussis Vaccine

Let's move on to pertussis vaccine. After polio and measles vaccine, this is probably the most celebrated and venerated of all the vaccine gods. The issue is that, like IPV, the pertussis vaccine potentially reduces symptoms but does not prevent transmission of pertussis, so those who receive this vaccine are *more* likely to spread pertussis. Sound familiar?

Before someone blows a gasket, here are the facts. Until the 1990s, the pertussis vaccine used in the United States was known as "whole cell pertussis vaccine." It is the "P" in DTP—the vaccine discussed in Chapter 7 that is increasing deaths among babies. The United States replaced this vaccine with "acellular pertussis vaccine" in the late 1990s.[2] This newer version is typically denoted as "aP" which is the "aP" in DTaP.

After introducing aP in the United States in the 1990s, and as time marched on, outbreaks of pertussis continued to occur despite increasing coverage of this vaccine. As with all problems, the vaccinologists' go-to solution was … yep, increase coverage and add more doses. They expanded efforts to vaccinate the entire globe with pertussis vaccines, and, in the United States, the number of recommended doses rose to six by age 12 with a recommendation to receive another dose every ten years thereafter through adulthood.[3]

Along the way, another curious phenomenon became apparent and, try as they may, they could not ignore nor explain it away. This phenomenon was that, even with increasing numbers of doses being administered, the time period between outbreaks of pertussis *remained the same or got shorter*.[4] This phenomenon meant that the amount of pertussis bacteria in circulation was the same or was increasing.

Had there been a reduction in pertussis bacteria in circulation because of increased vaccination, then the time period between epidemics should have gotten longer. But that did not happen. The only logical conclusion was that there was at least the same amount or more pertussis bacteria circulating than there was before the use of acellular pertussis vaccine. That thought drove vaccinologists wild—how could that be?!

After decades of pretending this problem did not exist, the FDA did something it rarely does. Or at least three brave scientists in the FDA did something almost no scientists at the FDA or CDC would typically dare to do. They conducted an actual experiment to determine whether pertussis vaccines prevent infection and transmission. And here is the really amazing part: when the findings showed the vaccine does not prevent infection or transmission, they published the findings.

Those findings came from a baboon study published in 2013.[5] To geek out just a bit on this study, let's quickly walk through how it was conducted and what its findings were. This study could not be conducted with humans since it would require purposefully exposing people to the pertussis bacteria which is considered unethical. So, the FDA scientists used baboons instead. The reason they chose baboons was that baboons have similar biological systems to humans relevant for conducting this experiment.

The FDA scientists split the baboons into separate groups. One group of baboons was exposed to pertussis bacteria so that they developed "natural" immunity. A second group of baboons received acellular pertussis vaccine. And a third group of baboons were left alone—meaning, no exposure to pertussis bacteria or to the pertussis vaccine.

The FDA scientists then exposed all three groups of baboons to pertussis bacteria. (This means the group previously exposed to pertussis was exposed a second time, the group vaccinated for pertussis was exposed, and the group that was neither exposed nor vaccinated originally was now exposed). After exposing these three groups to the bacteria, they then stuck a swab up the nose of all baboons every day and sought to culture (*i.e.*, grow in a petri dish) pertussis bacteria. The findings were striking.

The group of baboons with natural immunity (previously exposed) never shed any pertussis bacteria. None. But the group that had no prior immunity to pertussis (had not been exposed to vaccine or bacteria) *and the group that had been vaccinated* were both equally shedding pertussis bacteria. In fact, the baboons with no prior immunity shed pertussis bacteria for an average of 38 days while the vaccinated baboons shed the pertussis bacteria longer—for an average of 42 days. This finding was, no doubt, jaw dropping. The moral fortitude of those FDA scientists to conduct the study was incredible, but what it took to actually publish the study is hard to imagine.

This study brought into sharp focus the reality that vaccinologists had been trying desperately to ignore by covering their ears, keeping their eyes shut tight, and yelling loudly "more coverage!" and "more doses!" for decades. It forced a reckoning. It took years, but eventually, on June 22, 2018, there was a "Consensus Conference" held regarding

pertussis vaccine organized by the World Association for Infectious Disease and Immunological Disorders. In attendance were those considered the "world-leading" experts on pertussis and pertussis vaccines from numerous countries—each one of these mainstream experts more beholden to the mythology of vaccines than the next. From the United States, in attendance was Dr. Kathryn Edwards, the godmother of vaccinology, and Dr. Tina Tan, an author of *The Vaccine Handbook* for practitioners.

These Plotkin disciples were not only fervent vaccine zealots, they were also paid spokespersons for the pharmaceutical companies—Sanofi and GSK—that produce and sell pertussis vaccines. For example, Dr. Edwards has been paid by Sanofi and by GSK to give lectures, has consulted for these companies, has taken trips paid for by Sanofi to cities around the world, and has been on the advisory board within GSK.[6] Dr. Tan has similar conflicts and has also been a member of the speakers bureau for both of these companies.[7]

Despite the powerful dogma and the pharma conflicts, after the FDA study, its fallout, and most critically, the anticipated licensure of a new pertussis vaccine that could prevent transmission, *they were allowed to tell the truth*. In a consensus paper published after that conference authored by sixteen pertussis "experts," together with the World Association for Infectious Diseases, they said in no uncertain terms:

> Natural infection evokes both mucosal and systemic immune responses, while aPVs [acellular pertussis vaccines] induce only a systemic immune response. … Mucosal immunity is essential to prevent colonization and transmission of B. pertussis organisms. Consequently, preventive measures such as aPVs that do not induce a valid mucosal response can prevent disease **but cannot avoid infection and transmission**. …
>
> **aPV pertussis vaccines do not prevent colonization**. Consequently, **they do not reduce the circulation of *B. pertussis* and do not exert any herd immunity effect**.[8]

If the above is at all unclear, just read the bold portions again. Let me quote just one more time: "aPV pertussis vaccines do not prevent colonization" and "do not exert any herd immunity effect."[9] The authors even admit that the lack "of mucosal immune responses after aPV administration favor infection, persistent colonization, and transmission of the pathogen."[10] It took a few decades of the obvious staring them in the face but there it finally was: the truth.

I would like to think that it was the truth that drove them to make these admissions, but that was no doubt not the reason. Nor public health, nor morals, nor conscience. They apparently were finally ready to admit this truth (regarding the only pertussis vaccine used in the United States and almost all other developed countries) because there was a lot of excitement around 2018 regarding a potential new pertussis vaccine, inhaled through the nose, which was expected to prevent transmission. The clinical trial for this vaccine was ongoing at Dr. Edwards' university, Vanderbilt, at the time, but when this experimental vaccine later petered out, I am sure these scientists regretted their admission above.[11]

In any event, here is a final story that should really drive home the reality of pertussis vaccine. GSK sells a pertussis vaccine administered to adults. To increase sales of its pertussis vaccine, GSK created and launched an advertising campaign in which grandmothers who don't take this vaccine are depicted as wolves that will kill their own grandchildren. A truly heartwarming way to sell a product. Here are images from this campaign:

Screenshot of GSK advertisement © 2017 GSK

Screenshot of GSK advertisement © 2017 GSK

And here are images from the television commercial for this campaign:

Screenshots of GSK advertisement © 2017 GSK

A voice-over during this GSK commercial ominously warns: "There's something out there. It's a highly contagious disease. It can be especially serious, even fatal to infants. Unfortunately, many people

who spread it may not know they have it. It's called whooping cough." The voice-over then urges grandparents to: "Understand the danger your new grandchild faces. Talk to your doctor or pharmacist about you and your family getting a whooping cough vaccination today."[12]

But, given the reality that this product does not prevent infection and transmission, but does appear to reduce symptoms, being vaccinated makes you more likely to spread pertussis. Why? Because if you can still get infected and transmit pertussis when vaccinated, but you have fewer symptoms, you are more likely to spread pertussis to your grandchild unknowingly. If you had symptoms, you would know to stay away. It's common sense.

So, my firm brought a class action lawsuit against GSK alleging, among other things, claims for consumer fraud and false advertising. We served the lawsuit on GSK on July 14, 2020. By mid-September, these ads and the entire campaign were taken down.[13] Wiped, except, from what we could find, copies saved by others and reposted to criticize the campaign.

As an example, the GSK website for its Big Bad Cough campaign used to say, "you should receive a booster at least 2 weeks before having close contact with an infant."[14] After filing the lawsuit, this statement was scrubbed.

It is amazing what happens when faced with potential financial liability, a rare occurrence for a pharmaceutical company with regards to a vaccine. It's too bad this type of lawsuit cannot be brought for serious injuries and deaths caused by vaccines.

But for the Vaccines Amen crowd, I am sure even all the foregoing is not enough. They still hold onto the belief that somehow, the pertussis vaccine must do what they believe it does. That it still somehow prevents the spread of pertussis. How could it not? It is a vaccine, dang it! But, alas, the truth is that the vaccinated are more likely to spread the pertussis bacterium.

Yet the religion of vaccinology expels children from school who do not have this vaccine to prevent transmission of pertussis. There is something evil about kicking children out of school altogether, but especially when it is done in the name of a cult belief that has nothing to do with reality.

Tetanus Vaccine

Moving onto the tetanus vaccine. As explained by the CDC: "Tetanus is not contagious from person-to-person."[15] This means someone infected with tetanus cannot transmit it to another person. The vaccine therefore

cannot prevent transmission of tetanus because this bacterium does not spread from person to person.

It is also noteworthy that the tetanus vaccine is a toxoid vaccine—meaning it contains only antigens to a toxin sometimes released by the tetanus bacterium. It does not have any antigens in the vial for the tetanus bacterium itself. The tetanus vaccine therefore does not, after injection, result in any antibodies being created to the tetanus bacterium.

Hence, even if the tetanus bacterium could be transmitted from person-to-person, which it cannot, the tetanus vaccine does not, in any event, create any immunity to the tetanus bacterium that would prevent it from colonizing and multiplying. It only, potentially, generates immunity to a toxin sometimes released by this bacterium. Similarly, the diphtheria vaccine, like the tetanus vaccine, is also a toxoid vaccine and hence does not create any immunity to the diphtheria bacterium, just potentially a toxin it sometimes releases.[16]

Meningococcal Vaccine

Next is the meningococcal conjugate vaccine, (**MenACWY**), often required for school attendance. According to the CDC: "Rates of meningococcal disease have declined in the United States since the 1990s and remain low today. Much of the decline occurred before the routine use of MenACWY vaccines. … [D]ata suggest MenACWY vaccines have provided protection to those vaccinated, *but probably not to the larger, unvaccinated community (population or herd immunity).*"[17]

Also consider that, according to the CDC: "Protection from MenACWY vaccination wanes in most adolescents *within 5 years*," and the CDC does not recommend routine administration of this vaccine for adults.[18]

The Rest of the Vaccines Mandated for School

Aside from the vaccines covered above, the only remaining vaccines typically required for school are Hep B, MMR, and Varicella. Let's go through each.

Regarding the Hep B vaccine, mandating this vaccine for school (and hence expelling children from school for not having this vaccine) is not rational since Hep B is mainly passed through sexual intercourse or sharing needles, neither of which are school related activities.

To confirm and drive home this point, my firm, on behalf of ICAN, sent a FOIA request to CDC for "documentation sufficient to reflect any case(s) of transmission of Hepatitis B in an elementary, middle, or high school setting."[19] CDC's response? It could not identify any such case.

Not one. As CDC conceded: "A search of our records failed to reveal any documents pertaining to your request."[20] Meaning, CDC could not find documentation of a single case of Hep B being transmitted in a school setting.

That brings us to the final two vaccines typically required for school—MMR and Varicella. And for those in the Vaccines Amen crowd pulling their hair out from the above, we have finally arrived at vaccines that can prevent transmission (well, at least in some people for some period). But as addressed in Chapter 7, eliminating these infections, based on the best available science, has likely caused more deaths than it has prevented. As discussed therein, over millennia, humans developed an ecological relationship with measles, mumps, rubella, and chickenpox, and eliminating these typically benign infections appears to have been a disastrous idea. And in Chapters 10 and 11, we will go through the concerning safety issues with these products.

The Fanatics? Those Wanting Informed Consent or Those Seeking to Mandate

I know that those in the Vaccines Amen crowd reading the foregoing are yelling to themselves that it is crazy to claim that most vaccines do not prevent transmission! But, alas, it is simply a fact that even most vaccines mandated for school do not prevent transmission. And they don't just fail to prevent it sometimes or in some scenarios—they fail every time.

Here is the critical point: the claim that everyone must get fully vaccinated to prevent transmission is simply a belief, even for most school-mandated vaccines. Again, belief, not "science." In fact, for many of these products, the opposite is true: it is the vaccinated who are more likely to spread the pathogen in school. This flips the script that the unvaccinated are more likely to transmit and are relying on others for protection. Using Vaccines Amen logic, the exact opposite is true for many vaccines.

Given this reality, and applying the logic of the vaccine fanatics, it is those vaccinated for pertussis, for example, who should be excluded from school, employment, etc., to reduce the spread of pertussis. Should we do this? Of course not. Individual and civil rights, including the rights to informed consent and to refuse an injection into one's body, are far too important.

This also brings into sharp relief another misconception: that it is those who are not vaccinated who want to force their medical decisions on others. The precise opposite is true. It is the vaccine promoters who want to force their medical decisions on others through mandates and

coercion, while those who are not vaccinated typically just want to be left alone.

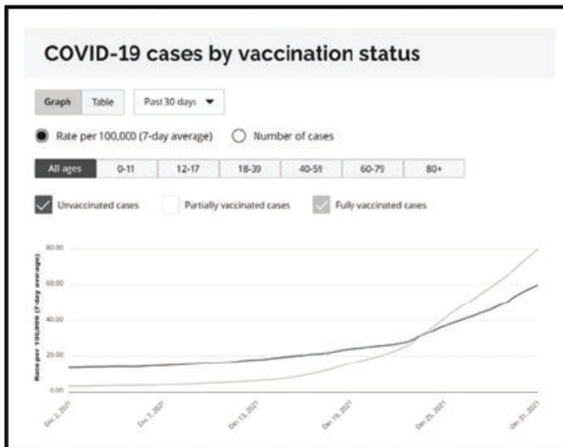
It is also cruel and illogical to expel a child from school for not getting a medical product—any medical product—but especially for not receiving a product that only provides personal protection. Even worse is expelling a child for not getting an injection that makes the child *more* likely to spread the pathogen at issue. What is the point of depriving a child of an in-school education for not getting a pertussis vaccine or tetanus vaccine? Not health. Rather, they are excluded for their refusal, or that of their parents, to slavishly believe a religious tenet of vaccinology. Punishing children for this refusal is the worst form of tyranny.

Covid-19 Vaccines

The belief that vaccines must prevent transmission is so strong it even causes otherwise intelligent individuals to suspend logic and reason and even hide the data and evidence that contradicts their belief. Covid-19 vaccines provide a good final example of this phenomenon. The data reflects that these vaccines make the vaccinated more likely to become infected with, and hence spread the virus that causes Covid-19 than the unvaccinated. When this became apparent, let's see what the "health" officials in the countries that actually reported infection rate data did with that data.

In Ontario, Canada, the health department reported infection rate data to the public, at least for a while. The data clearly showed that the vaccinated were far more likely to become infected than the unvaccinated. That was not always true, but starting in December 2021, the number of cases per 100,000 residents among the "fully vaccinated" surpassed the number of cases per 100,000 residents among the "unvaccinated." This can clearly be seen in a chart published by the province of Ontario, Canada on its website. The gap between the number of cases among the vaccinated versus the unvaccinated kept getting wider and wider, until it was unmistakable: the vaccinated were far more likely to become infected.

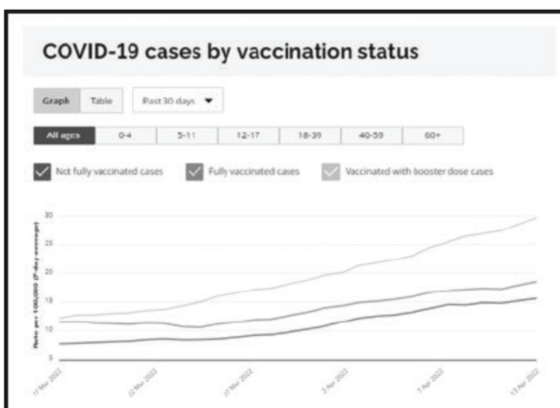
In fact, we used the following chart from the Ontario, Canada health department in our brief to the United States Supreme Court challenging the federal government's mandate that certain companies require their employees to receive a Covid-19 vaccine:[21]



As the line reflecting the rate of cases among the vaccinated kept climbing up and away from the line reflecting the rate of cases among the unvaccinated, it no doubt created unease among the believers. So, what was their solution? Admit the problem? Seek to correct the problem? Of course not. It was to change the chart.

Yep, they eliminated the "unvaccinated" category and replaced it with a "Not fully vaccinated" category, which included the unvaccinated *as well as* the partially vaccinated (including those who received a second dose of a 2-dose series and then developed symptoms within 14 days after that second dose). The only issue is that over time that also did not fix the problem. In fact, it made it crystal clear the vaccinated were the ones becoming infected with the virus.

Just look at the following chart from April 13, 2022, and you will see that the fully vaccinated plus booster had by far the highest rate of infections, the fully vaccinated had the second highest rate of infection, and the group with the *lowest* rate of infection were the "Not fully vaccinated"[22]:



So maybe Ontario, Canada was a fluke? Let's jump across the Atlantic and look at Scotland. The following is from a report from Scotland's health authorities from January 2022 which clearly shows that those fully vaccinated had more than twice the case rate as the unvaccinated[23]:

Table 14 – Cases

	Unvaccinated		
Week	No. tested positive by PCR	Population	Age-standardised case rate per 100,000 with 95% confidence intervals
18 December - 24 December 2021	5,594	1,006,025	**540.82** (518.55 - 563.08)
25 December - 31 December 2021	9,496	998,045	**958.52** (926.37 - 990.68)
01 January - 07 January 2022	9,105	988,033	**923.27** (893.85 - 952.70)
08 January - 14 January 2022	3,601	979,617	**412.77** (390.36 - 435.18)
	2 Doses		
Week	No. tested positive by PCR	Population	Age-standardised case rate per 100,000 with 95% confidence intervals
18 December - 24 December 2021	32,628	1,866,426	**1,328.29** (1,310.47 - 1,346.10)
25 December - 31 December 2021	50,622	1,522,561	**2,551.97** (2,522.57 - 2,581.37)
01 January - 07 January 2022	34,327	1,121,214	**2,418.35** (2,383.69 - 2,453.01)
08 January - 14 January 2022	9,363	995,855	**865.79** (839.92 - 891.67)

What did Scotland's health authorities do with this damning data? Address the underlying failing of the vaccine? Of course not. They simply stopped issuing these reports. Yep, they were apparently very happy to publish the data showing that the rate of infection in the unvaccinated was higher. But when it started to show the opposite, that the vaccinated were far more likely to be infected—meaning, the data dared to not fit the dogma—it had to go. And so, it did. They stopped publishing this data.

It is also worth noting that Ontario and Scotland have centralized government-run health care systems, unlike in the United States. This allowed them to capture more accurate health care information. And their data sure was startling.

The point is: when the data doesn't fit the dogma, the vaccinologists and public "health" agencies will stop collecting and/or reporting the data. They just pretend that the data does not exist. This is why what the three FDA scientists did in publishing the baboon data regarding the pertussis vaccine was a rare, almost incredible occurrence.

Transmission Wrap-Up

If one still cannot accept that many of the childhood vaccines do not prevent transmission, then Vaccines, Amen. If one still argues that measles vaccine prevents transmission to support mandating vaccines that do not prevent transmission, then Vaccines, Amen. If one still thinks every child who has an increased risk of transmitting an infection should be excluded from school, yet does not support excluding children vaccinated for pertussis, then Vaccines, Amen. If one still cannot accept that these products often do not possess what many of their worshippers say is their essential quality—preventing transmission (and for some products, increase transmission)—then Vaccines, Amen.

When those pushing a position cannot persuade on the merits, often the next step is force. And that is precisely what the Vaccines Amen crowd has resorted to—the use of force, by expelling children from school, removing them from the homes of parents who refuse to abide by their orthodoxy, and worse. Let's put it this way: if one thinks that a vaccine, like pertussis vaccine, which at best provides personal protection, should be mandated, then that person is supporting a belief through force. Depriving a child of an in-school education to force them to make a personal medical decision against their or their parents' will—maybe a pertussis vaccine, maybe an asthma inhaler—is simply cruel.

If the government can mandate a product that only provides personal protection, then it can mandate any medical procedure. Heart disease, for example, is the number one killer of Americans, so why can't the government mandate eating well, exercise, and heart medicine? The only reason some people think differently about vaccines, as opposed to heart medicine, is that they hold no religious beliefs about heart medicine—but they do about vaccines.

civilianintelligencenetwork.ca/wp-content/uploads/2021/11/ThePresentStatusOfPolioVaccines-1960-Chicago.pdf (https://perma.cc/BZ79-JHBA).
18 Id.
19 Id.
20 Id.
21 Id.
22 Id.
23 Id.
24 Id.
25 Id.
26 https://pubmed.ncbi.nlm.nih.gov/13857182/ (https://perma.cc/MLV8-54GF); https://www.civilianintelligencenetwork.ca/wp-content/uploads/2021/11/ThePresentStatusOfPolioVaccines-1960-Chicago.pdf (https://perma.cc/BZ79-JHBA); https://web.archive.org/web/20151112061302/http://archives.chicagotribune.com/1961/03/05/page/62/article/the-truth-about-the-polio-vaccines.

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1 https://www.cdc.gov/poliovirus-containment/diseaseandvirus/ (https://perma.cc/4C4R-T63K); https://www.cdc.gov/mmwr/volumes/71/wr/mm7133e2.htm (https://perma.cc/2XXP-RADT).
2 https://www.cdc.gov/vaccines/hcp/imz-schedules/resources.html (https://perma.cc/9NQH-BNDY).
3 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6616129/ (https://perma.cc/2YUK-R8M9); https://www.cdc.gov/vaccines/hcp/imz-schedules/index.html (https://perma.cc/5A49-WTFT).
4 https://pubmed.ncbi.nlm.nih.gov/29180031/ (https://perma.cc/ACW9-4MDK) ("That vaccination does not prevent B. pertussis infection in humans, nor the circulation of the organism in human populations in any important manner, comes from the observation that the inter-epidemic intervals have not changed in a major way since the implementation of mass vaccination.")
5 https://pmc.ncbi.nlm.nih.gov/articles/PMC3896208/ (https://perma.cc/56SF-7WQW).
6 https://thehighwire.com/ark-videos/the-deposition-of-the-godmother-of-vaccines-dr-kathryn-edwards/.
7 https://openpaymentsdata.cms.gov/physician/517174 (https://perma.cc/8WNS-RZHH); https://www.waidid.org/uploads/board/cv/CV-Tan.pdf (https://perma.cc/4829-KAQ9).
8 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6616129/ (https://perma.cc/8VE3-U53A); https://pmc.ncbi.nlm.nih.gov/articles/PMC6616129/pdf/fimmu-10-01344.pdf.
9 Id.
10 Id.
11 https://clinicaltrials.gov/study/NCT03541499 .
12 https://www.youtube.com/watch?v=OTAySm4iZSI (https://perma.cc/ED99-ZY3A).
13 Compare https://web.archive.org/web/20171009024842/https://www.aboutwhoopingcough.com/index.html?cc=dd5a1583fe6b (October 9, 2017) with https://web.archive.org/web/20200812114325/https://www.aboutwhoopingcough.com/index.html?cc=dd5a1583fe6b (August 12, 2020) with https://web.archive.org/web/20200915173048/https://www.aboutwhoopingcough.com/index.html?cc=dd5a1583fe6b (September 15, 2020).
14 Id.
15 https://web.archive.org/web/20240531201312/https://www.cdc.gov/vaccines/pubs/pinkbook/tetanus.html.
16 "Diphtheria toxoid helps prevent symptomatic disease but does not prevent the carrier state nor stop the spread of infection … [T]he known importance of carriers in the spread of diphtheria, and the demonstrated failure of toxoid to prevent the carrier state lead us to conclude that the concept of herd immunity is not applicable in the prevention of diphtheria." https://pubmed.ncbi.nlm.nih.gov/5026197/ (https://perma.cc/5GCV-XEX6). In any event, immunity from the diphtheria vaccine wanes rapidly even after six doses in childhood, which is why the CDC provides for revaccination every 10 years during adulthood, and over 40% of adults do not follow

this schedule. https://www.cdc.gov/vaccines/hcp/imz-schedules/downloads/child/0-18yrs-child-combined-schedule.pdf (https://perma.cc/BNY5-VGAV) ; https://www.cdc.gov/vaccines/hcp/imz-schedules/downloads/adult/adult-combined-schedule.pdf (https://perma.cc/3C3B-ZDQL); https://www.cdc.gov/adultvaxview/publications-resources/adult-vaccination-coverage-2022.html (https://perma.cc/TNF5-AKU9).

17 https://web.archive.org/web/20240509230842/https://www.cdc.gov/vaccines/vpd/mening/public/index.html.

18 https://web.archive.org/web/20240421022106/https://www.cdc.gov/vaccines/vpd/mening/hcp/adolescent-vaccine.html. Moreover, the clinical trial for this vaccine did not even prove it prevented a single case of meningococcal disease; it instead relied on antibody levels. https://www.fda.gov/media/75619/download.

19 https://www.icandecide.org/wp-content/uploads/2020/12/Final-Response-No-Records.pdf (https://perma.cc/6DSU-P4WR).

20 Id.

21 https://www.supremecourt.gov/DocketPDF/21/21A259/207136/20220103063642965_OSHA-Reply-ETS-FINAL_2022_01_03.pdf (https://perma.cc/Q7V4-NEWP).

22 This graph was, for a period of time, available from the Ontario government; the underlying data remains available at https://data.ontario.ca/en/dataset/covid-19-vaccine-data-in-ontario (https://perma.cc/LL7U-GZYQ).

23 https://x.com/AaronSiriSG/status/1486432700969807873 (https://perma.cc/9328-SX5E); https://web.archive.org/web/20220126153845/https://publichealthscotland.scot/MEDIA/11223/22-01-19-COVID19-WINTER_PUBLICATION_REPORT.PDF.

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1 https://www.fda.gov/media/74274/download.

2 Id.

3 Id.

4 https://www.icandecide.org/wp-content/uploads/2020/09/COMBINED-02.pdf (https://perma.cc/SZL9-JFSB). Note that only for adults, there was some safety follow up a few months after injection.

5 https://pubmed.ncbi.nlm.nih.gov/2943814/ (https://perma.cc/A85Y-77QK).

6 https://www.nature.com/articles/d42859-020-00016-5 (https://perma.cc/J44R-UAWG).

7 https://www.fda.gov/media/119403/download.

8 https://www.ncbi.nlm.nih.gov/pubmed/1330942 (https://perma.cc/T9NY-8NM2) ("a placebo is a pharmacologically inactive substance").

9 https://www.cdc.gov/vaccines/glossary/?CDC_AAref_Val=https://www.cdc.gov/vaccines/terms/glossary.html#heading-p (https://perma.cc/VR3G-NXNV).

10 https://www.fda.gov/media/130326/download. See also https://www.fda.gov/media/71349/download ("the placebo control design, by … including a group that receives an inert treatment…").

11 https://web.archive.org/web/20230309063403/https://www.nia.nih.gov/health/placebos-clinical-trials.

12 Note that as of this writing, the Covid-19 vaccine was no longer recommended for routine use by the CDC.

13 Supporting references for each vaccine in the table: **Engerix-B** (https://www.fda.gov/media/119403/download); **Recombivax HB** (https://www.fda.gov/media/74274/download); **Infanrix** (https://www.fda.gov/media/75157/download); **Daptacel** (https://www.fda.gov/media/74035/download, lists DT vaccine in one of its efficacy trials as a "placebo"); **ActHIB** (https://www.fda.gov/media/74395/download); **Hiberix** (https://www.fda.gov/media/77017/download); **PedvaxHIB** (https://www.fda.gov/media/80438/download, note that in Lyophilized PedvaxHIB's pre-licensure trials, the test group received Lyophilized PedvaxHIB, OPV, and DTP, and the control group received an injection of lactose, aluminum adjuvant, and thimerosal, along with OPV, and DTP); **Prevnar 13** (https://www.fda.gov/media/107657/download, claims placebo used in an adult trial, but never in a trial for children, and Prevnar was also licensed without a