

18 Meningitis, then . . .

In 1987 the media woke up to the fact that not all was well in vaccine-machine land. The Auckland Menomune A meningitis vaccination campaign had become a public relations disaster. Some children were in a bad way after the vaccine. The Health Department was forced to admit that it had lost the plot by claiming it was all “*hysteria*”, so for once, the media had half the other ear open as well.

Strange things happen when a person writes in the newspaper that nutrition, housing and other social factors have everything to do with increasing the risk of catching infectious diseases, especially meningitis. And that the face of vaccine campaigns shouldn't be posters, brochures and consent forms, covered with lotteries, prizes and draws, paid for and sponsored by Homestead Chicken.

The telephone rang and at the other end was a mother so angry that even though the onslaught hasn't started, you could feel the sparks before the illogic.

“It's the likes of you people who won't vaccinate your kids, that make all the rest sick. Your snotty-nosed little brats are the ones who carry these bugs and put all the rest at risk.”

Even worse, at one talk in Auckland a doctor stood up and berated me, saying that the unvaccinated kids were a hazard to the vaccinated kids.

I held up for all to see, the then current Health Department wall-

poster. It read: “*Immunization MEANS THEY WON’T CATCH IT*”. “It doesn’t always work . . .” he blustered. I asked him if he ever told his patients that. Silence. I also asked him if he could explain to our children how they got measles from vaccinated children who became sick, not unvaccinated children. More silence.

I explained to him that those of us who chose not to vaccinate our children are not telling those who want vaccines, NOT to vaccinate. All we want is to make our own choices based on all the information. Not a select few sound-bites. We want to know WHY certain people, or groups get sick and whether our child fits in that group. If they do, and we still don’t want to vaccinate, what can we do to make our children healthier and safer? If they don’t, then we will still want to make our children healthier and safer. We want to have enough facts to make our own decisions, about what all the risks are. It’s called INFORMED CONSENT.

Yet, here we were in 1987 (and again, in 2004–2005), at the mercy of medical spin meisters.

The advent of vaccines has so far paralysed most “pavement epidemiology”¹ and gagged research into the really important risk factors of meningitis, and most other infectious diseases as well. What is the point in knowing what the risk factors are if the only thing that will be pointed at the problem is a needle and the assumption is that that will fix everything? The reason meningitis is important in terms of shoe-leather epidemiology, is that various experts predicted long ago that in spite of vaccines, meningitis would become epidemic in the future.²

When the 1987 promotional campaign was launched, it focused on how terrible this disease was for children, with documentaries on how this killer disease causes death, brain damage, gangrenous legs and arms, deafness and a whole host of permanent nasties enough to scare any mother watching. In 2004–2005, the tactics were similar, maybe even worse, depending on whether the children were shown “that” video.

1 “Pavement epidemiology” is where epidemiologists would walk into communities and homes to look at everything and analyse what social factors were contributing to the seriousness of various diseases.

2 Lambert, H. *Radio Pacific New Zealand* broadcast, 7 January 1988, at 7 a.m. “The trouble with this germ is that it’s sort of like an iceberg. A lot of people carry the germ in their throat, and then every now and again it hits someone who’s susceptible and bingo: they get the disease.”

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Auckland city's one million people had it drummed into them that unless 250,000 children between the ages of 3 months and 12 years were vaccinated with Menomune A, they could all drop dead. It was monotonously repeated that in two years, 141 people had caught it, and 14 had died.

During those two years before the campaign was launched, one million relaxed people didn't worry their grey matter over it, then suddenly, three weeks before the vaccine campaign, everyone went hysterical. The fact that "*meningitis bacteria hardly ever cause disease*" was lost in the hype, as was the really important information from the statistics.

The tactic employed by the Health Department of using lots of prizes, was to catch the attention of people who aren't usually interested in jabs, but were interested in something for nothing. Homestead Chicken supplied \$25,000 worth of prizes: 2000 packs of chicken, hundreds of iceblocks, 50 Barbie dolls, 50 Masters of the Universe, 20 Postbank accounts of \$100.00 each for winning children; and for the parents, 2 video recorders, 3 stereo ghetto-blasters, and a microwave oven.

All these could be yours with three chances each, but only for children who were vaccinated. Most of the space on the consent form was taken up by competition pictures and details, which were, after all, the really important information. Not only were these forms handed out at schools, but there were letter-box drops as well.

Parents who didn't want to be part of this campaign faced considerable pressure, not just from children who felt they were missing out on a chance to win if they got a jab, but also because teachers and nurses were telling the non-vaccinated children they could now turn blotchy and die. Even school principals got into the act.

Initially I thought the kids were getting the wrong end of the stick, but then teachers started to ring me because they felt they were being required to socially engineer compliance. Then a few doctors rang to say that their children had come home with the same stories.

One teacher was so upset with the Education Department education units that she supplied me with copies. Then I understood the concerns.

The important information that parents needed in order to discuss the issues were: "*What is the risk to my child of catching this disease?*", "*What age are the children who are most likely to*

catch this disease?” and “Who are the groups most likely to catch this disease?” To figure that out, data was needed. After some reluctance, the following data was handed over by the Health Department, and it showed that for every 1 European meningitis case, there were 10 Maori cases and 14 Polynesian cases.

Ethnicity	No of cases	Proportion of population.	Strike rate per year
European	58	83%	20 per 100,000 per year
Maori	73	11%	200 per 100,000 per year
Polynesian	80	6%	300 per 100,000 per year

The distribution of Type A cases were:

Takapuna = 13
 Auckland = 47
 South Auckland = 79

Most of the North Shore cases were not Type A.

When I eventually published this data, the Health Department contacted me, and the media,³ to say that I was being a racist. I thought I was being a realist.

Amongst survivors, there were four profoundly deaf children and six partially deaf children. There were no gangrenous, amputated limbs and no brain-damaged children. However, I was interested to see that the antibiotic used to treat those children had “*deafness*” written as a common side effect. So was the deafness caused by the meningitis or by the treatment?

The youngest case was 3 weeks old, the oldest 85 years, and the mean average 13.7 years of age. The majority of the 1986 cases had been older than the proposed vaccine target group, and the 1987 cases had followed that pattern even more closely.

Some people did simple division and decided 1 million people divided by 72 cases each year meant that they or their children were less likely to get meningitis than they were to get smashed up in a car crash on the road. But regardless of logical thinking, parents were never told information from the medical literature on meningococcal disease which

³ 1988. “Anti-jab lobby effectively racist-doctor”. *The Evening Post*, May 18.

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said that only one in every 5000 carriers might get a clinical infection and only one in every 1000 clinical infections would get the actual disease.⁴

Parents were not told that meningococcal bacteria of many types are “*commensal*” bacteria that sit there doing nothing other than create immunity in at least 400,000 Auckland throats at any one time; that there are many meningitis varieties; that they circulate in the community all the time, and that during outbreaks, the bacteria can be found more commonly than the common cold.

It’s not rocket science. But even the media didn’t do simple maths and ask why it was that, if this bacterium is so common, it does nothing to most people, most of the time, and then suddenly descends like a relatively predictable axe on a few specific individuals?

Yet at the time the *Manukau Courier* screamed out, “*About half a million South Aucklanders live in poverty, a Mangere budget adviser estimates.*”⁵ South Auckland would have been the first place anyone would expect to find an increased rate of infection. Not just of meningococcal disease, but of most diseases.

The Health Department line was simple. A flyswat vaccine will fix it all up now.

I tried to point out, through the media, that overcrowding, poor housing, smoking, poor general health, acute respiratory diseases, anaemia, and immune deficiencies were very important risk factors.⁶ Much of the medical literature on risk factors in meningitis in 1987 was observational, whereas the very comprehensively detailed information now is more from the immunological perspective.

N. meningitidis is a bacteria carried in the nose and throat on 10 per cent of adults but⁷ “*the organism rarely colonized the proximal airways of healthy young children.*” Healthy children. How do you define healthy?

The New Zealand experts⁸ said in their own publications that “*Susceptibility is generally very low and a large proportion of*

4 Peltola, H. 1983. “Meningococcal Disease: Still with Us”. *Reviews of Infectious Diseases*, Jan–Feb; 5(1): 71–91; 82. PMID: 6338571.

5 Ashton, A. 1987. “Hundreds in real poverty”. *Manukau Courier*, June: 13(48).

6 De Voe, I.W. 1982. “The Meningococcus and Mechanisms of Pathogenicity” *Microbiological Reviews*; June: 46(2): 162–190. PMID: 6126800.

7 Pollard, A.J. et al. 2001. “Development of natural immunity to Neisseria meningitidis”. *Vaccine*. 19; 1327–46. PMID: 11163654.

8 Baker, M. et al. 1992. “Epidemiology and Control of Meningococcal Disease in New Zealand in 1992”. *Communicable Disease New Zealand*, July: 92(7): 57–61; p. 60. ISSN 01133-1974.

the population is colonized without ill effects.” But the Health Department’s 1987 response to my comments about housing, overcrowding, poverty and diet, was to say that fixing those things is too hard, and takes too long. Then they would dismiss all that by saying, “*anyway, it hits the rich too, you know*”.

As if the rich might not also have immune system problems? Yes, it can hit the rich. But the statistics from 1985 to now show that it hits the poor far more frequently than it hits the rich.

Dr Jane O’Hallahan still tells us in 2005, that “*meningococcal disease knows no social and economic boundaries*”.⁹ Another doctor¹⁰ tells us of “. . . *unequal incidence of meningococcal disease (with rates of 28.9, 20.5, 12.1, and 6.8 per 10⁵ population respectively in Pacific, Maori, European and ‘other’ ethnic groups)* . . .” Dr Nikki Turner¹¹ told the country that, had housing and other problems been solved earlier, maybe New Zealand wouldn’t have the epidemic we see today.

What can be said, is that meningococcal bacteria take advantage of IMMUNOLOGICAL WEAKNESSES, which have many causes; risk factors which are most often operative in lower socio-economic communities, but which can also occur anywhere people live under stress; or where people ignore basic aspects of health care, nutrition and environmental risk taking.

If meningococcal meningitis was an indiscriminate killer that knew no boundaries, we would all have been dead of it, long before vaccines were invented.

Even the worst type of meningitis, which is the C-type, has a reasonably low strike rate. In the UK which introduced a vaccine against the most serious C-type (one which has a hypervirulent strain ET-37) doctors said that when there isn’t an epidemic, 3–9% of meningococcal bacteria found in the throats of symptom-free people was the hypervirulent strain.¹² UK had 1500 cases every year, but they also stated that as many as 500,000 people in the UK could

⁹ 2005. *Sunday Star Times* 10 April: p. A3.

¹⁰ Thomas, M. 2004. “Prevention of group B meningococcal disease by vaccination: a difficult task”. *New Zealand Medical Journal*, August: 117(1200). Retrieved on 18 September, 2005 from <<http://www.nzma.org.nz/journal/117-1200/1016>> PMID: 15475986.

¹¹ Television Broadcast on *60 Minutes* on 11 April 2005.

¹² Maiden, M.C.J. 1999. “Meningococcal conjugate vaccine: new opportunities and new challenges”. *The Lancet*, August: 354: 615–616. PMID: 10466659.

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carry it at any time, all the time, which means that as the bacteria shift around, and another 500,000 people have it, and pass it on to the next 500,000 people, eventually the whole population of the UK will have been exposed. That is, after all, how the majority of us already have acquired natural immunity.

I have listened to parents say that their children are perfectly healthy, when their children's blood tests have just returned showing clinically significant anaemia. To some parents, so long as their child isn't in bed all the time, "*they are perfectly healthy*".

I've also heard parents who are chain smokers and who also smoke marijuana and drink alcohol, whose children are fed junk food, whose teeth would make most dentists cringe, whose children live in dirty houses, run around bare-foot, unkempt with running noses, say with a straight face that their children are perfectly healthy and well fed.

Like most of us, their children will have carried other meningococcal bacterial strains many times before, or maybe even that strain before, but that child or person may be at risk of contracting meningitis at that time, because of immune system issues, life-style factors, nutritional factors, or family dynamic stress, but to suggest the illness was just one of those things, would be ridiculous. During an epidemic, and particularly when a vaccine is being promoted, the medical profession and politicians deny that real social risk factors are relevant. Our culture prefers to blame some outside monster so that parents feel they can't control the problem and feel helpless and afraid.

Dr Mark MacDonald, the Medical Officer of Health from Hamilton, was the speaker at a May 1987 meeting in Onewhero, organized by a local doctor to promote the upcoming Menomune A vaccination campaign. He commented that on the basis of statistics that year, up until the meeting, there had been far fewer meningitis A cases than the previous two years, and that they believed that the epidemic was running out of steam. Then he said:

"But we can't really tell, because now is the time when we have increases in meningitis case numbers."

I asked him, "If you are right and the epidemic is running out of steam and we do this vaccine campaign, what will get the credit? The

vaccine or the natural epidemiological trend?” He didn’t know how to answer that question.

The Menomune A vaccine got the credit for wiping out the epidemic¹³ not just on radio, but in all subsequent articles.

After the Menomune A vaccination campaign started, there were rumblings of trouble, but nothing that gave me much concern. Reports filtered out from the media about a group of children in school vomiting, fainting, being unable to walk, feeling nauseous, looking pale and wobbly. The Health Department investigated and said it was adolescent hysteria because of an hour’s delay which got the children upset. But the children didn’t know there was a delay, because they weren’t told. They just stayed in class until lined up for their dose.

Some of these kids got a lot sicker, and the parents weren’t very happy with the “*hysteria*” tag. Worse was to come when they tried to talk to doctors in the Health Department. Some parents rang me to say that it had been inferred by the medical profession that they were being “*neurotic*”.

Then it was revealed that similar reactions had happened in other schools, too. I filled an exercise book with names and addresses of people whose children had been affected. Soon the issue was so large that hotlines had to be set up by the Health Department. The problem was, the hot line didn’t work half the time, and many parents whose children did have side effects, didn’t know about the hotline. Some who rang it, either couldn’t get through, or got the brush-off.

About this time, Television New Zealand contacted the American office of the vaccine manufacturers, who confirmed to TVNZ that this specific vaccine had only previously been trialled in Burkina Faso, for which there were no results, and in some US Army recruits.

The news presenter, Lindsey Perigo was brave enough to confront the Health Department representative, on TV. On the same programme, I also tried to drive home the point that this vaccine was actually an experimental vaccine being used on our children. This comment brought forth howls from the Health Department who quoted studies to prove that it wasn’t. When it was pointed out that the studies hadn’t used the vaccine we were using here, their retort was that it was “*so similar, it made no difference*”.

By the next morning, radio reported that the vaccine manufacturers

13 Dr Dell Hood, *National News Radio* broadcast on 26 June 1987.

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weren't talking to anyone. The Health Department's further "proof" that the vaccine had been trialled overseas showed that, in many studies, the vaccines used were multi-strain vaccines, not Menomune A. In the end, the Department resorted to saying that the vaccine had "passed all standard tests".

Parents started telling me about symptoms which I considered serious, and I was becoming very concerned. The medical profession brushed them all off. One of the worst cases was a young boy of 11, who was vaccinated on Friday, 5 June 1987. All Saturday he felt unwell; for three days he lay around lethargically, vomiting consistently. A ripper of a headache continued for days. Then, one morning, two weeks later, he woke up, and his arms were so sore he couldn't move them. He had stomach pains, and was as white as a sheet. By the following week his feet and legs were sore, his back was aching, and his mother, Anne, described his walk as being like that of a spastic. "He crawled into his room, sobbing . . . a total blithering mess . . . so we lifted him into his bed, but he complained that when we touched him, it hurt. He was so sore, we couldn't touch him at all. The doctors just scratched their heads." All the doctors would say was, "It can't be the vaccine." Well, what else was it then?

For months this child was lethargic, with constant headaches, sore legs and nausea, often in cycles of three weeks. The family eventually went to America in search of treatment for their son.

Out of all the cases parents related to me, only one was blood-tested correctly. This little 8-year-old girl was vaccinated on 21 June 1987. After a week of severe and painful symptoms, she was blood-tested. The liver tests were grossly abnormal, the rheumatoid test was very high, and some of the other results were also very abnormal, but in view of the fact that she was no longer in pain when the doctor finally rang to tell the parents the results a week after the tests were done, no diagnosis was offered. In fact, nothing more was said, and the doctor never reported any "*reaction*". The mother rang the hotline but said that no one there was interested in looking at any of the blood test results done on her daughter either.

Others reported that the examining neurologist set up to investigate reactions reported to the hotline, was pleasant enough, but wouldn't listen to parents' concerns.

At this point, Finlay Macdonald from the *Listener* wrote the first thoughtful article on poverty and overcrowding risk factors for

meningitis, the side-effects of the vaccine, and presented one of the children who reacted to the vaccine.¹⁴ He tried to pose the questions as to why so many of our children were at risk from these diseases and the socio-economic factors involved to Dr Salmond, who in my view, ducked the issue by saying that it had just crept up on them, so they had to do what they could now, and maybe later, “*We have to go back and look at the implications for other infectious diseases.*”

They didn’t. Then when the meningococcal B crept up on them, the medical profession did a study which confirmed their previously stated link between meningococcal disease, poor housing, overcrowded living conditions, and passive smoking. Annette King posted it on the Government website as a press release, saying that the Labour Party had said all that for years, but National had denied it and done nothing to fix it.¹⁵ “*The NZHS identified ‘the unacceptable reality that some New Zealanders live in unhealthy housing, have poor nutrition and, in rural areas, have limited access to clean water and sewerage systems’ . . .*”.

Finlay MacDonald’s 1987 article brought a swift response from the Health Department who then placed the blame for unwarranted media exposure on “*anti-vaccine propaganda*”.

Looking back, the Health Department’s strategy had been fascinating. First, it tried to prevent publication of unfavourable articles by delay tactics and constant denial. By July 5, the Department admitted in *Sunday Star Times* that it hadn’t published material on the reactions, in order not to “*threaten*” the campaign.¹⁶ Then, as more parents reported trouble a few Health Department people spoke out contradicting each other, so by the time the *Listener* article was published all responses to journalists were handled by one medical spokesperson and mainly consisted of comments about how well the vaccine campaign had gone.

Public disquiet was so persistent by the end of the first vaccination shots that the Health Department had to postpone the booster programme until the Adverse Effects Committee had considered the

14 Macdonald, F. 1987. “Meningitis a campaign goes astray”. *New Zealand Listener*, 29 August: 17.

15 King, A. 2000. 10 January. “Findings of Meningococcal Disease study”. Retrieved on 18 September, 2005 from <<http://www.beehive.govt.nz/ViewDocument.cfm?DocumentID=8176>>

16 Roberts, J. 1987. “Health Dept admits cover-up”. *Sunday Star*, July 5: pp 1 and 3.

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vaccine reactions. The committee decided on the basis of an Auckland neurologist's report that because there was "no pattern" to the side-effects, they were probably not caused by the vaccine, therefore it was most likely safe and effective. This was a situation that journalists found somewhat ironic, since their lists of cases showed the same distinct patterns as mine. But to be cautious, the Committee also advised that any child who had had any reaction didn't need a second dose.

Less than a third of those parents whose babies were supposed to have the second dose, allowed their babies to have it.

The Adverse Reactions Committee report studied 546 children whose parents requested full investigation. Of these, 217 were excluded for reasons of insufficient information, or were judged to be due to "other causes". Of the remainder, 92 had peripheral nerve involvement, 80 of which involved weakness and heaviness in limbs, 57 had sensory disturbance with paraesthesia, dyesthesia or pain in a limb separate to injection site. Some had both sensory and motor disturbances.¹⁷

Guillain Barre (which used to be called "ascending paralysis") was never considered to have been a side-effect, yet several children had the exact symptoms you would have expected, starting off with heavy legs, pins and needles in the extremities, and loss of balance which can then progress to breathing difficulty. Ninety-nine out of 100 cases of Guillain Barre don't result in loss of ability to breathe or swallow, but if the condition gets to the lungs, it can kill the patient if there is not appropriate medical support. It's a condition which can have long term sequelae. Anyone who experiences Guillain Barre after one vaccine should not have another one.

The Committee's conclusion was that "a final causality cannot be attributed according to the current data".¹⁸ All the fainting, nausea, dizziness and slurred speech etc., at the time was attributed to psychological reasons. Needless to say, there were many very unhappy parents out there, who felt they were being dismissed, and seen as a vocal minority.¹⁹ Although one consultant leapt to their defence in a medical journal,²⁰ no one leapt to their defence in public.

17 Hood, D. et al. 1989. "Meningococcal vaccine – do some children experience side-effects?" *New Zealand Medical Journal*, Feb 22; 102(862): 65–7. PMID: 2919016.

18 Conclusion in report (received from Minister of Health David Caygill on 13 July 1988, by Centre for Adverse Reactions Monitoring, Dr Ralph Edwards).

19 Ellis-Peglar, R.B. 1987. "Meningitis vaccination in Auckland". *New Zealand Medical Journal*, Aug 12; 100(82a): 501. PMID: 3455519.

20 Newman, J. 1987. "Meningitis vaccination in Auckland". *New Zealand Medical Journal*.

The other reason stated for considering this vaccine safe, was that such reactions had not occurred in Finland, and their vaccine was classified as safe.

I was told later, by the then Medical Assessor for Adverse Reactions, that he had been to an overseas meeting where the vaccination campaign was discussed. He said he tried to table the report, as a potential side-effects signal, but it was rejected on the basis that no other country had seen those side-effects.

Side-effects, obviously have to be seen somewhere for the first time. Why is it then, when it comes to vaccines, that no one wants to know, if your country happens to be the first?

So the reputation of the Menomune A vaccine will remain squeaky clean, by virtue of the fact that no other country, before ours, saw side-effects. The side-effects seen with Menomune A looked remarkably like the ongoing problems seen now with Menactra (A, C, Y, W135) vaccine in America.^{21,22} I wonder if they too will be finally listed as coincidental.

A Department of Health national working party for the implementation of Hepatitis B in New Zealand,²³ compared the rates of doctors who reported Menomune A reactions to the Centre for Adverse Reactions Monitoring (CARM) with the numbers of parents who had heard about reporting on the hotline, and reported their children's reaction. The working party stated that:

“. . . the 1987 meningitis campaign reporting rate was only 0.8%”.

What does that tell you about how seriously doctors viewed parental concerns? What might the real figure have been if all parents had been heard?

Oct 14; 100(833): 636. PMID: 3132658. “Unfortunately so long as we see dissatisfied customers as ‘a vocal minority’ we will continue to alienate groups of our clientele. Perhaps the message is starting to get through that a more literate population, a more discerning population and a more skeptical population does not look to the medical profession for magic but looks to us rather for advice, for technical expertise and above all for accountability for our actions.”

- 21 FDA News. 2005. “FDA and CDC issue alert on Menactra meningococcal vaccine and Guillain Barre syndrome”. 30 September. Available from <<http://www.fda.gov/bbs/topics/news/2005/new01238.html>>
- 22 Medscape Medical News. 2006. April 7. Available from <http://www.medscape.com/viewarticle/529405_print>
- 23 Minutes of 6th meeting, “Department of Health National Working Party for the Implementation of Hepatitis B in New Zealand” dated 20 January 1988, p. 3.

19 And Meningitis Now . . .

In 1990, not long after Meningitis A was pronounced “vanquished”, Meningitis B case numbers started to creep up. In 1992, we were told that there was a new, different meningitis crisis caused by Haemophilus B. In 1994, the Hib vaccine was inserted into the schedule. This is a vaccine which, wherever it has been used, has drastically reduced meningitis cases caused by capsular haemophilus B. It also appears to remove the capsular strain from circulating in the community. Other Hib strains continue to circulate.

One year after the introduction of Tetramune (1995), doctors were worried that the proportion of very young children admitted to hospital was getting higher,¹ and mentioned illnesses such as pneumonia, asthma, meningococcal disease, fevers and bronchiolitis. The reasons for this increase in hospital admissions weren’t clear, but it seemed lack of money to pay doctors’ bills was a factor. What else might keel over as a result of lack of money? Nutrition, by any chance?

I had read an American article which stated, “*We have great concern for the increasing prevalence of relatively or absolutely penicillin-resistant pneumococci coupled with the increased relative frequency of pneumococcal disease as a result of universal*

1 Barber, F. 1995. “Children sicker and lots more attending Starship hospital”. *New Zealand Herald*, 26 December: Section 1, p. 3.

Haemophilus vaccination.”² I fired off a letter to Bill Birch,³ then the Minister for Health asking him whether or not, in shooting off the grey wolves (Meningitis A) then the white wolves (Haemophilus B), we were simply clearing space so that other, different meningitis strains could walk in and take their places? He wrote back politely suggesting that was a ridiculous thing to say.

The trouble is, there is some reason to believe that this is exactly what happens. The concern is not so much that it can happen, because out of the 13 meningococcal serogroups, only 5 commonly cause disease⁴ . . . the concern is that:

“the vacancy created by the elimination of serogroup C organisms may be occupied by meningococci of other serogroups . . . of particular concern is the possibility that serogroup B, W-135, or Y variants of the ETE-37 complex might exploit this opportunity.”

In Finland⁵, Belgium⁶ and Sweden⁷ after the use of the Hib vaccine, haemophilus declined, and the rates of invasive pneumococcal infections increased. The increase in numbers of pneumococcus was real and serious, and it’s harder to treat than haemophilus.

But this wasn’t exactly what was happening in New Zealand. It seems to me that after the decline of first Meningitis A and then Haemophilus out of the bacterial mix in the community, as would also happen in any epidemic cycles or swings, the bacteria that developed and took over the vacuum was a unique-to-New Zealand home-grown type of Meningococcal B.

By 1996, Meningitis B had filled the hole well. 2001 was the peak year for Meningitis B cases and deaths. Since that year, we have seen substantial decreases in both the numbers of cases and deaths caused by Meningitis B. Looking at the graph which shows a decline of 50% in

2 Nelson, J.D. 1992. “The perilous pneumococcus”. *The Pediatric Infections Disease Journal Newsletter*, June; 18(6): 12.

3 Letter from H. Butler to B. Birch, dated 1 May 1993.

4 Maiden, M.C.J. 1999. “Meningococcal conjugate vaccine: new opportunities and new challenges”. *The Lancet*, August: 354: 615–616. PMID: 10466659.

5 Baer, M., Vuento, R., and Vesikari, T. 1995. “Increase in bacteraemic pneumococcal infections in children”. *The Lancet*, March: 345(8950): 661. PMID: 7898220.

6 Van Hoeck, K.J. et al. 1997. “A retrospective epidemiological study of bacterial meningitis in an urban area in Belgium”. *Eur J Pediatr*, 156: 288–291. PMID: 9128813.

7 Schonheyder, H.C. et al. 1997. “Increase in pneumococcal bacteraemia in Sweden”. *The Lancet*, 1997 March: 349(9053): 699–700. PMID: 9167485.

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cases since 2001 and 75% in deaths, it would also be logical to suggest, just as Dr Mark MacDonald did, back in 1987 in Onewhero, that the historical natural cycle of Meningitis B, like other meningitis types before it, was well on the downturn before the vaccine was even used.

Why do epidemic cycles happen? Most people will carry different bacterial meningitis types many times, and simply acquire immunity. However, immune people repeatedly carry and continue to spread most of the bacterial types circulating, but fewer cases will occur of that strain, because there are fewer people at risk of the disease, who haven't been exposed to it. Once there are no infections to keep the carriage rates higher, cases from other strains which exploit the same risk factors rise in numbers, just as happened with all the other meningitis epidemics in the past.

What will happen next? We are told that Meningitis C vaccine is the next vaccine the medical profession wants to give to children, along with a pneumococcus vaccine called Prevnar.

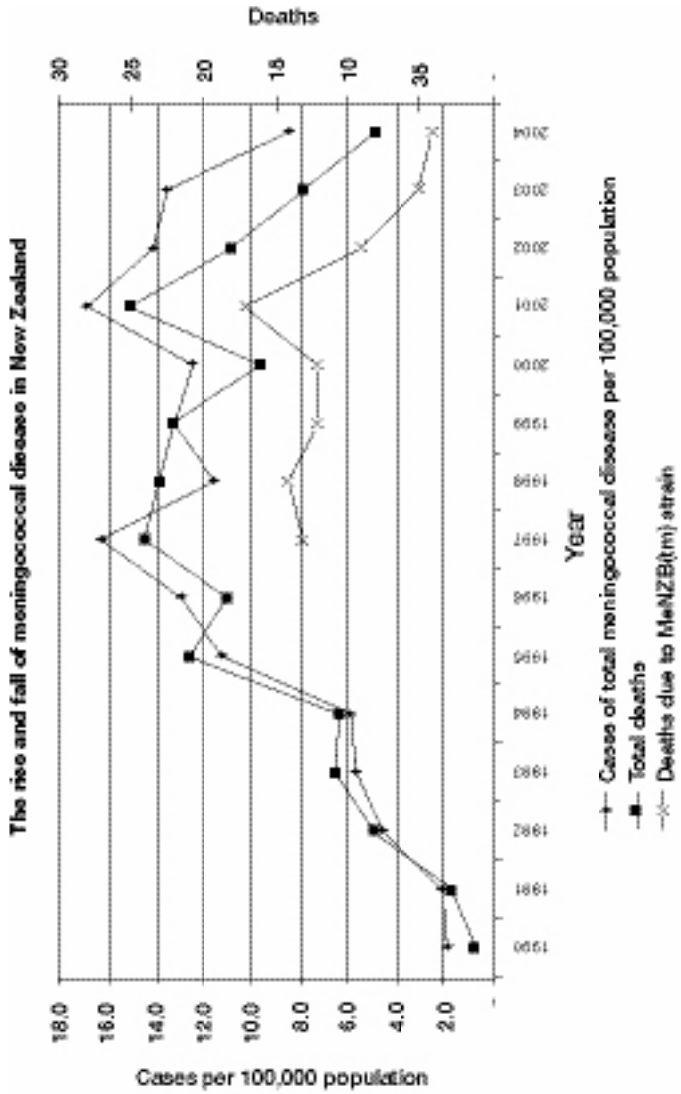
In the UK, research was done⁸ on carriage of the hypervirulent C strain after the Meningitis C vaccination campaign, testing 15,010 vaccinated individuals and finding 19 carriers. They tested 1170 unvaccinated people and found 4 carriers. Statistically, there were 63% fewer carriers in the vaccinated than the unvaccinated group. So the MenC UK vaccine may reduce carriage. I use the word may because bacteria tend to sit around in isolated corners and play musical chairs, which people who take throat swabs can't see. Those tests, repeated in other places over time, could have found higher or lower rates of carriage.

Studies are also being done to see if the ET-37 hypervirulent stain will be replaced by "*vaccine escape variants or virulent non-serogroup C strains*". Just as bacteria become resistant to antibiotics, they can do become resistant to vaccines.

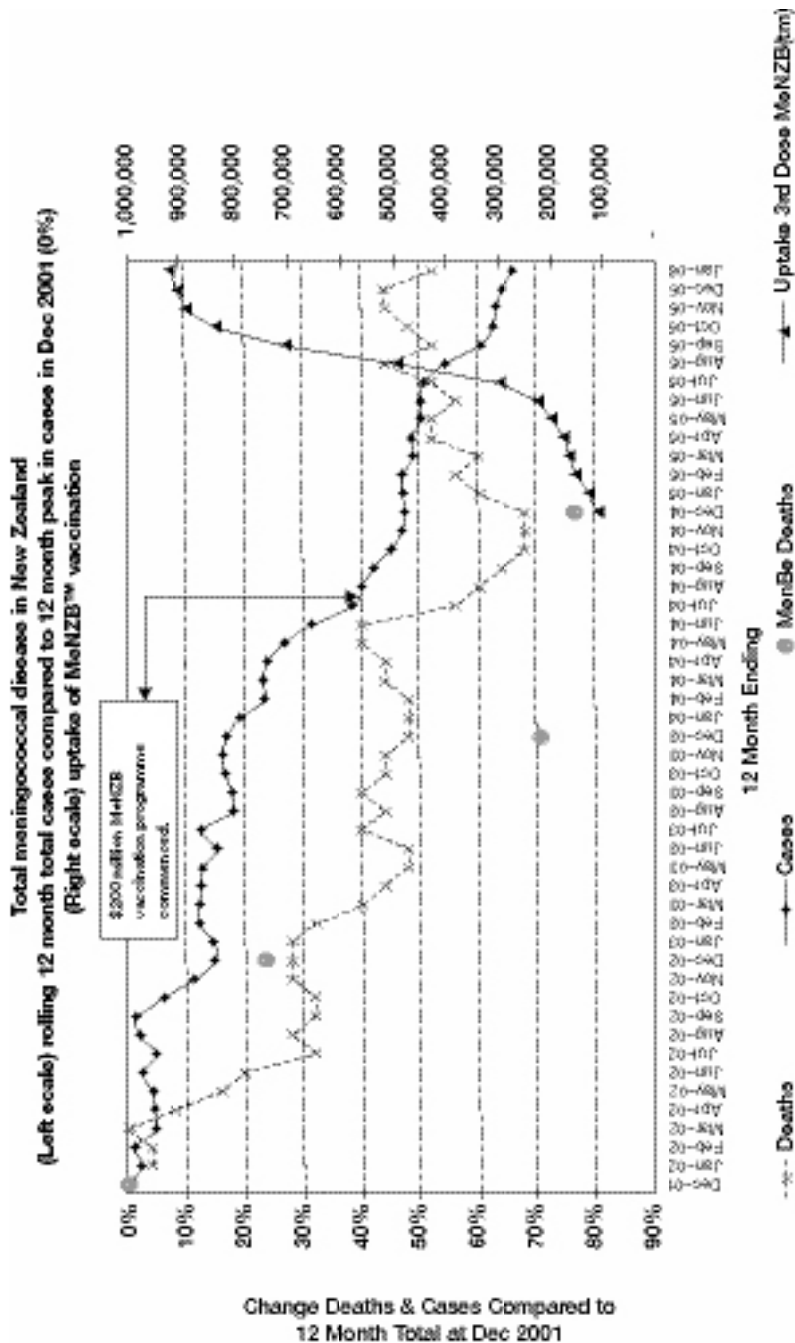
Prevnar knocks out carriage of the vaccine types, but other pneumococcus types step in.⁹ The overseas studies show that while Hib vaccine seems to knock out carriage to the type in the vaccine, and that in the USA between 1995 and 2003, there was a decline in

8 Maiden, M.C.J. 2002. "Carriage of serogroup C meningococci 1 year after meningococcal C conjugate polysaccharide vaccination". *The Lancet*, May: 359(9320): 1829-31. PMID: 12044380.

9 Lipsitch, M. 2000. "Bacterial Vaccines and Serotype Replacement: Lessons from Haemophilus Influenzae and Prospects for Streptococcus pneumoniae". *Emerging Infectious Diseases*, May-June: 5(3): 336-45. PMID: 10341170.



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 Source: Ministry of Health, ESR, NZ Stats



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Source: Ministry of Health/ESR

pneumococcus ear infections, there was an increase in haemophilus ear infections.¹⁰ Not all children were immunized with Prevnar though. The reasons for the changes are stated as unknown.

Pneumococcus has 90 known strains and since the introduction of the 7–strain Prevnar in the USA, there has been a slow and definite rise in infections not covered by the three doses of the vaccine. One article¹¹ said,

“Recent studies have found that strains of pneumococci not covered by Prevnar multiply in the noses and throats of children after they are given the vaccine. Although Prevnar reduces the amount of the seven strains it covers, other strains completely fill in the gap – so the total amount of pneumococcus found in children’s noses and throats is not reduced by vaccination.”

The article also stated that Wyeth and GlaxoSmithKline now have vaccines in development to tackle the next *pneumococcus* epidemic. So what will happen here?

In New Zealand we have come full circle with another vaccine campaign started in mid-2004 and having been completed in 2005. What will be given the credit for the decline in Meningitis B cases since 2001? The vaccine used in 2004 and 2005?

The history of medicine is very clear in terms of all infectious diseases. Nature abhors a vacuum. Epidemics come in cycles. The use of vaccines won’t prevent the next vacuum opportunist, or get rid of the individual risk factors.

Many families, including ours, have lived through decades when we have been told that we are at risk from Meningitis A, Haemophilus B, Meningitis B, and now Meningitis C, Pneumococcus and whatever else is floating around. We’ve been told that in order to survive, our children needed all the vaccines available. We, and they have not had any of those vaccines, and none of us have had meningitis.

Yes, you can say that some people have had meningitis, and that is a fact. If that’s all you are going to say, then you’ve missed the point.

10 Casey, J.R. et al. 2004. “Changes in Frequency and Pathogens Causing Acute Otitis Media in 1995–2003”. *Pediatric Infect Dis J*, 23(9): 824–828. PMID: 15361720.

11 Hochman, M.E. 2005. “Childhood vaccine saves lives, but may lead to other infections”. *The Boston Globe* 21 June. Retrieved on 9 March, 2006 from <http://www.boston.com/news/globe/health_science/articles/2005/06/21/childhood_vaccine_saves_lives_but_may_lead_to_other_infections/>

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The point is that if people want vaccines, they are welcome to have them. But if people don't want them, they should not be hounded to have them. And if parents get upset and talk about the fact that official information is unfactual and biased because it omits critical information, they shouldn't be pilloried for doing so. After all, if the pamphlets were accurate, there would be nothing for anyone to criticize. People should be given all the information instead of snippets in emotionally loaded pamphlets, and be allowed to make their choices based on all balancing facts.

As was stated in the *Boston Globe*, the medical profession has recognized that in order to attempt to eliminate all types of meningitis, there will have to be lots of new vaccines to inject into people.

And perhaps we should get rid of another myth. New Zealanders appear to really believe that state funded vaccines are free. But vaccine manufacturers don't donate vaccines out of the goodness of their hearts. The actual cost of the vaccines comes out of the back pocket of every tax payer, whether they want their tax to go towards vaccines or not. Given that the Health Department has just put a wide variety of meningitis vaccines on the "free" list for "at risk" people, let's get facts straight. These vaccines are taxpayer funded. How many billions might that be in the future?

There is another way of looking at the actual meningitis risk issue and it's this.

New Zealand's population is approximately 4,250,000.

NO meningitis VACCINES for 60 years and let us assume we used the epidemic figures for the last 15 years carried on for the next 45 years:

	<i>Cases</i>	<i>Deaths</i>
Department of Health statistics for last 15 years	5000	200
Estimates for next 45 years	15,000	600
Total over 60 years, 1990–2050 =		
With <i>no</i> meningitis vaccines:	20,000	800

Using these figures in 60 years without vaccines 4,230,000 out of 4,250,000 New Zealanders would never have had any type of meningitis illness at all.

In *60 years without vaccines*, 4,249,200 people out of 4,250,000 would never have died either.

So for all those four million people plus any alleged vaccine benefit from all types of meningitis vaccines is NIL and the huge costs will

be totally wasted, even more so if rapid decline in antibodies means repeat doses will be advised every year or two.¹²

That is the statistical history of meningitis.

However, the *reality history* for those 20,000 cases and 800 deaths over 60 years is that the reasons the people got meningitis in the first place will not have been remedied, while the huge cost to this country of lots of vaccines to people who would never have got the disease anyway, would have long since gone over the multi-billion dollar mark.

In 1925, a doctor had this to say:

*“It is fortunate for the world that pre-immunization against the typhoid group was not discovered in the days of laissez-faire; had it been, many more thousands would have died of typhoid than actually did. Eighty years ago it would have been hard to persuade the possessing classes to spend money on safeguarding water supplies if so cheap an alternative method of protection could have been provided.”*¹³

This is what upsets me most about this whole issue. Vaccines are a cheaper option than real preventive medicine. *“Jabs rushed in to save a gazillion children,”* would sound much more heroic than *“Manukau poor now have warm, dry housing and good food”*. Using vaccines does nothing to get rid of bad nutrition, anaemia, obesity, overcrowding, bad housing, stress, despair, dislocation, social discord, drug abuse, smoking, and alcoholism. Deal with these risk factors, and you will get rid of most serious cases of TB, and other infections of most types; viral and bacterial meningitis; you will drastically reduce diabetes, rheumatoid arthritis, and a whole range of other chronic complaints which will become an impossible financial burden in the future.

A fence at the top of the cliff is better than an ambulance at the bottom.

Nikki Turner was right about one of those factors on TV.¹⁴ If the

12 Thomas, M. 2004. “Prevention of group B meningococcal disease by vaccination: a difficult task.” *New Zealand Medical Journal*, August: 117(1200): PMID: 15475986. Available from: <<http://www.nzma.org.nz/journal/117-1200/1016/> Accessed 11 November 2005.

13 Greenwood (Major). 1925. *Epidemic and Crowd Diseases, An Introduction to the Study of Epidemiology*. London: Williams & Norgate. Page 75.

14 Television broadcast on *60 Minutes*, 11 April 2005.

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reality issues in South Auckland (and everywhere else), had been dealt with all those years ago, we might not have had to worry about any wolves: white, grey, black or green, in the future. Or any more meningo-vaccines, for that matter.

In 1987 in both print media and on radio, I said that I saw little hope that either politicians or the medical profession would ever commit to real educational, or social reforms, which could radically slash rates of both infectious and chronic disease in this country. Nearly twenty years on I see nothing on the horizon to change that view, either here or overseas.

All over the world vaccines are now used as a cheap substitute for basic necessities, which the WHO has admitted in the past, is the best immune caretaker of all: warm dry housing with sanitation, clean water, adequate nutrition and basic medical care. The *New York Times*¹⁵ recently inflicted upon readers misleading statements like this: *“Vaccinating children against measles is the greatest return on investment for child health that we have,” said Dr. Mark Grabowsky, who for five years was the adviser to the Red Cross for the Centers for Disease Control and Prevention. “It’s the low-hanging fruit.”*

Best of all in this world that looks for feel good media sound bites, the measles vaccine only costs 15 cents per child, and no-one notices the factors that cause severe measles or any other diseases in Nepalese children. Has one “fruit” been picked off, only for those children to fall to another for the same reasons? What might be the greatest future return on investment for overall health in Nepal or India, if the medical profession really cared? The Vitamin A programme studied by Professors Sommer and Keith West from John Hopkins University,^{16,17} and forcibly pushed by 49,000 Nepalese grannies.¹⁸ This programme, not any vaccine, has resulted in substantial reductions in disease and death in Nepalese mothers and children. Next on the list for Nepal should be overall diet, clean water and sanitation.

15 Dugger, C.W. 2006. “Mothers of Nepal Vanquish a Killer of Children.” *New York Times*, April 30 from <http://www.nytimes.com/2006/04/30/world/asia/30measles.html>

16 Sommer, A. 2006. “Global Health Champions” April from http://www.pbs.org/wgbh/rxforsurvival/series/champions/alfred_sommer.html

17 West, K.P. Prof. “Vitamin A for Health, Vision and Survival” (no date) from <http://www.healthnet.org.np/sachetana/ss.html>

18 PBS TV special 2006 “Rx for Survival – The Heroes” April from <http://www.pbs.org/wgbh/rxforsurvival/series/about/special.html>