Risk of death | Vaccination vs. Non-vaccination
- Summary of method of calculating the risk on each side

The data that was used for this comparison was all sourced from government web sites and from medical research results published in government-respected journals.

First of all, it needs to be noted that the analysis was only of risks related to vaccination status – the risk arising from vaccination compared to the risk arising from non-vaccination. It did not involve a totaling on either side of the risk of death from any cause, such as being a victim of a car or other accident, murder, etc.

Within the text is multiple references to (in addition to Footnotes, numbered 1 to 4) Endnotes, numbered i to xi, that describe assumptions or non-assumptions made in relation to that variable.

The categories of assumptions or non-assumptions are as follows:

A. those assumptions that most or many people make but I did not, and

B. those that I made that favored vaccination, and

C. those that could potentially favor either side, in view of multiple relevant factors that, if there was data available to quantify them, could potentially influence the result in either direction, and

D. any that some might argue favor non-vaccination, but I don't think that any can reasonably be claimed to do so, and I will explain why.

1. Calculation of Risks from Non-vaccination and from Vaccination

The following methods were used to calculate the risk for each age group over the relevant age range, starting from the first scheduled vaccination (or end of the first course thereof) up to the oldest age of mandatory vaccination for daycare or school in the US.

(1) The (disease-associated) Risk from Non-vaccination

I. This calculation started with establishing the following figures for each relevant age group over recent years,[1] in the case of most of the targeted diseases:

1) the **disease notifications** and the **population size**, enabling determination of the **disease notification rate.**[i,ii,iii]
2) the **vaccination coverage**, and
3) the average **effectiveness of the vaccination** for that age group[iv,v], and
4) the **case fatality rate** in that age group.[vi,vii]

II. In summary, after determining the above figures, a calculation was made using the following mathematical formula for each relevant age group:

SRIUD = SRPD x VE / (1 – (VC x VE)), where:

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[1]The period chosen to rely upon for this data tended to be shorter where the disease notifications were more numerous and/or there was a lack of availability of data.

SRIUD[2] was the resultant risk of death attributable to not being vaccinated (i.e. the expected increase in the rate of death from the disease in the unvaccinated, compared to that in the vaccinated)

SRPD[3] was the average rate across the population (including vaccinated and unvaccinated) of deaths attributed or attributable to the disease, which was determinable either:

- indirectly, by multiplying the rate of disease notifications attributed/attributable to the disease by the case fatality rate, or
- directly, where reports are available of death rates in the relevant population (applicable with pertussis),

VE was the government-claimed vaccination effectiveness (incorporating antibody waning rate), and

VC was the vaccination coverage.

III. The results for the respective age groups were then totaled over the age range to get what can reasonably be seen to be the **maximum** risk from non-vaccination, maximum being in consideration of the assumptions set out above.

(2) The Risk from Vaccination

Different alternative methods, depending on the vaccination, were used for calculating an estimate of this risk:

I. One method (used for diphtheria-tetanus-pertussis and polio vaccines) was, in summary, to:

i. determine the rate, across the vaccinated population, of deaths reported to VAERS (U.S. Vaccine Adverse Event Reporting System) per vaccination dose. Subsequently that rate was multiplied by the number of doses scheduled of that vaccination, then

ii. divide that reported death rate by 1% (i.e. multiple it by 100), that 1% being the rate concluded by the CDC-commissioned Lazarus report (published in 2011) to be the overall maximum rate of notification to VAERS of actual serious adverse events (so the adjustment multiplication factor of 100 is the **minimum** applicable), i.e. the very small percentage of such events that are actually reported, and

iii. multiply the above approximate actual death rate by the percentage of reported post-vaccination serious adverse events assessed in Australia to have been “certainly” or “probably” vaccination-caused (treating the category of “possible” causation the same as no causation). That percentage is approximately 20%, so in other words, the actual death rate was divided by approximately 5 to arrive finally at an estimate of the rate at which the vaccination caused death.

This percentage is also likely a **minimum** in view of the counting of only “certain” or “probable”, and not “possible”, causation assessments to arrive at it.[viii,ix]

OR

[2] “SRIUD” stands for “Serious adverse effect Risk Increase in the Unvaccinated, as applicable to Death”

[3] “SRPD” stands for “Serious adverse effect Risk Increase in the Unvaccinated, as applicable to Death”

II. The main other method was to:

i. extract the rates of serious adverse events published in medical research (vaccine clinical trials or other studies) as assessed to be caused by the vaccination.[x]

ii. proportionately derive an estimate of the death rate by applying to the above rate of serious adverse effects the same proportion of serious adverse events that were reported in VAERS for diphtheria-tetanus-pertussis and polio vaccines to be deaths.[xi]

2. Comparison of above calculated risks from non-vaccination versus from vaccination

After the results from (A) and (B) were determined, the resultant estimated minimum risk from vaccination (in (B) above) by the maximum risk from non-vaccination (in (A) above), for each age group separately and also across all age groups. The result from dividing the totals across all age groups (i.e. the quotient) is called the (minimum) relative risk. That result is presented for each vaccination in a graph here: https://www.kidsfirst4ever.com/risk-of-death-postcard.html.

There was no retrospect massaging of the results - they were the results of objective mathematical calculations. Indeed they were conservative, because when assumptions were made that favored either side, they favored vaccination.[4]

Despite that conservatism, the finding was that for every vaccination on the childhood schedule, a child is more likely to die from **vaccination** than from the disease **due to non-vaccination**.

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[i] This is based upon **not** making the assumption that is made by most or many people that an unvaccinated person will somehow automatically contract the disease.

That assumption is especially far from the truth in the case of very rare, indeed now virtually non-existent, diseases such as diphtheria, tetanus and polio.

With respect to those three diseases, the average annual notification rates in the age range of 6 months to 19 inclusive was found to be, respectively, about 1 in 700 million, 1 in 23 million, and 1 in 100 billion, and even if we assume that the vaccines are as effective as claimed, the absolute increase in the chance of their being contracted by an unvaccinated child compared to a vaccinated child is still less than 1 in 100 million, 1 in 2 million and 1 in 10 billion respectively.

(Assumption/Non-assumption category A)

[ii] An argument might be attempted to be made that there would be some under-reporting of disease cases and that the comparison does not take that into account. Notwithstanding that an adjustment has actually been made for that in the case of one or two of the diseases, such under-reporting is not actually relevant because the determination of case fatality rates and rates of other serious disease effects are based only on **notified** cases anyway.

(Assumption/Non-assumption category D)

[iii] See also the two assumptions described under “4) case fatality rate”.

[iv] Incorporation of vaccine effectiveness into the comparison means **not** making the assumption that is made by most or many people that vaccines are 100% effective (and who, especially in combining that with the incorrect assumption described in Footnote i above, consequently think that the decision before them is simply between the risk of vaccination and the risk from the targeted disease).

(Assumption/Non-assumption category A)

[v] The estimation of vaccine effectiveness incorporates an assumption that vaccine-induced antibodies at high enough concentrations in the blood (deemed “seroprotective” titres) do indeed provide the theorized protection (which is

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[4] What might be viewed as an exception to that is the movement of the causality category of “probable” into “certain”, but that could reasonably be expected to be outweighed by the total disregard of “possible” causation.

not claimed to be 100%). To make that assumption is significantly generous in favor of vaccination, in view of it having been acknowledged:

(1) that vaccine-induced antibodies have not been clinically demonstrated to be protective, and further,

(2) that vaccine recipients have died from the targeted disease despite having much higher than theoretically "seroprotective" antibody levels.

(Assumption/Non-assumption category B)

In accordance with that assumption, what is determined is:

(a) the average time that would have transpired since the age of the latest scheduled administration of the relevant vaccination dose(s), and

(b) the observed rate at which vaccine-induced antibodies decline after that vaccination, and hence extrapolated or interpolated, waning rate.

[vi] In order to perform a proper comparison between non-vaccination and vaccination, the figures on the non-vaccination side ought to be only in relation to children who are vaccine-eligible, because on the other side - vaccination, only children that are vaccine-eligible are vaccinated.

However the rates of death and other serious adverse effects on the targeted diseases are not known for the particular subset of all children who are vaccine-eligible.

Instead, the only case fatality rates available and hence used in the calculations are those that have been determined to apply overall, covering both the vaccine-ineligible as well as the vaccine-eligible in one combined group.

It is reasonable to expect that the factors that cause vaccine-ineligibility are also themselves likely to increase susceptibility to the disease, independently of vaccination status. Therefore the assumption made that the overall case fatality rates are just as high for the subset of children who are vaccine-eligible is one that favors vaccination.

(Assumption/Non-assumption category B)

[vii] The case fatality rates are rates that have been historically observed in the community in which it is evident that alternative measures have not been used nearly as much as they could have been. (This is attributable to such measures not being included in mainstream medical training, which is focused almost only on the administration of products manufactured by the pharmaceutical industry, upon which medical education and research is financially reliant).

In accord with the Hippocratic Oath "First, Do No Harm" (traditionally sworn by doctors), all available safe and potentially effective measures, of a preventative or treatment nature, ought to be applied before consideration of applying any measure that is acknowledged to carry risk, such as vaccination. So the risk that is calculated on the non-vaccination side ought to be only the amount of risk that remains after all such other measures have been applied.

Hence the calculations incorporate an assumption that there are no unapplied available safe, effective measures, that would reduce the risk of dying (or suffering an adverse effect) from the targeted disease.

That is an incorrect assumption that favors vaccination because there are indeed measures that are evidenced from published medical research to be effective for reducing the risk of death from the targeted disease by way of the support that they provide to the immune system. Such measures include, for example, megadoses of Vitamin C. (Evidence for the protective effect of Vitamin C was included in the risk comparison report but is not taken into account in the calculations.)

(Assumption/Non-assumption category B)

[viii] Disregarding the percentage of serious adverse events categorized as having only a "possible" causation by the administered vaccine(s) was an assumption that favors vaccination, though that could be argued to be offset to some extent by the inclusion of "probable" causation in with the "certain" causation category.

(Assumption/Non-assumption category B)

[ix] The application of this causality percentage to serious adverse events especially after making the adjustment for the under-reporting rate could potentially favor either vaccination or non-vaccination.

(Assumption/Non-assumption category C)

[x] The assumption incorporated into the calculations that these were the only serious adverse effects is one that favors vaccination because of such limitations as, inter alia, the limited surveillance periods. Therefore these can also be reasonably judged to be minimum rates.

(Assumption/Non-assumption category B)

[xi] To apply that same proportion could potentially favor either vaccination or non-vaccination in the case of the vaccinations in which that method was used to determine the risk of death.

(Assumption/Non-assumption category C)