Gardasil, Merck's troubled, liability free human papillomavirus vaccine, was originally approved in 2007 in Maryland to protect against cervical cancer. This terrible disease afflicts about 250 Marylanders per year, resulting in about 60 deaths (out of a total population of 5.63 million). Before the vaccine was introduced, cervical cancers had declined by over 75%, due to the Pap smear and other public health measures such as education about risk factors.

Maryland public health bureaucrats pushing the HPV vaccine program give every appearance of ignoring concerning data about the shot. There is credible evidence put out by Merck showing a high rate of serious negative reactions. Cancer registries from countries that have implemented broad coverage show a disturbing increase in cervical cancers that is only evident in the age groups that took the vaccine.

The HPV vaccine program in Maryland is financed largely through grants from out of state pharma related groups such as CDC Foundation, Vaccines for Children, Association of Immunization Managers, and Merck itself. The total dollar outlay just since 2012 exceeds $125 million.

The tactics endorsed by Maryland bureaucrats includes data mining our public school classrooms to pharma, as well as endorsing sales contests in your pediatrician's office to reward hitting HPV vaccine sales targets.

Our state has about 1.85 million young people between the ages of 5 and 29. The aim of our public health bureaucrats is to inject each one of them, at least twice, with Merck's Gardasil shot. Before that is allowed to happen, the following questions must be answered:

1) Is the Gardasil program an effective use of limited public health resources? Based on the number of HPV cancers, and the cost of the program, could more loves be potentially saved by directing the funds into other pressing areas?

I) Why is Dr. David Blythe, Maryland State Chief Epidemiologist, ignoring increases in cervical cancers in HPV vaccinated populations?

Dr. Blythe is turning a blind eye to concerning data from the national cancer registries in Australia, UK, Norway, France, and Sweden. Instead of looking at the data, Blythe is simply repeating industry talking points. It is worth noting that Blythe personally signed at least two grants totaling over $30 million for the program (see financial data below).

June 20, 2019

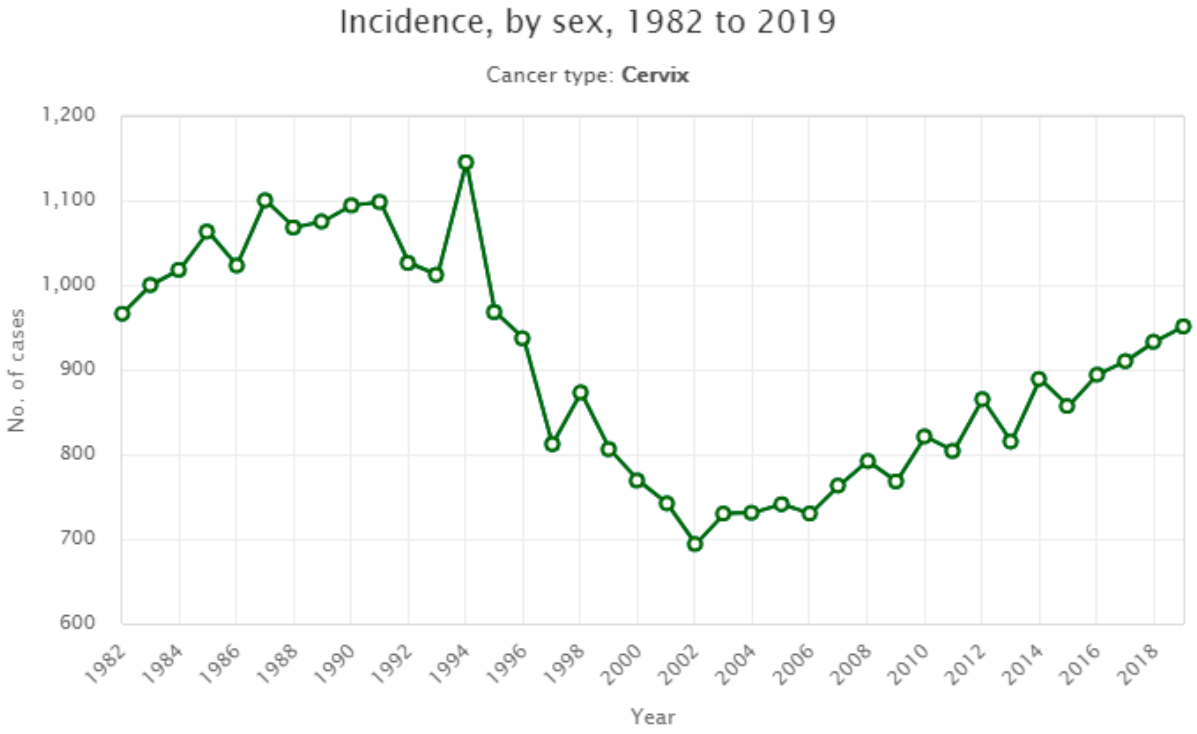
funding from Merck or any other vaccine manufacturers for research of vaccines. Numerous studies have shown that the HPV vaccine is highly effective at preventing HPV related cancers. Clinical trials have shown that HPV vaccines provide close to 100% protection against cervical pre-cancers and genital warts. Since its introduction in 2006, there has been a significant reduct in vaccine type HPV infections among teen girls in the United States. In other countries like Australia where vaccine rates are higher than in the US, larger decreases in HPV associated outcomes have been observed.

Sincerely,

David Blythe, MD, MPH
Bureau Director, Infectious Disease Epidemiology &
Outbreak Response

cc: Frances B. Phillips, RN, MHA
Donna Gugel, MHS
Courtney McFadden, MPH
Ruth Thompson
Kurt Seetoo, MPH

The data from Australia shows cervical cancer increasing since the vaccine was introduced in 2006:



Displayed graph groupings
Population groups can be toggled on or off by clicking on the respective names below.

Males Females Persons

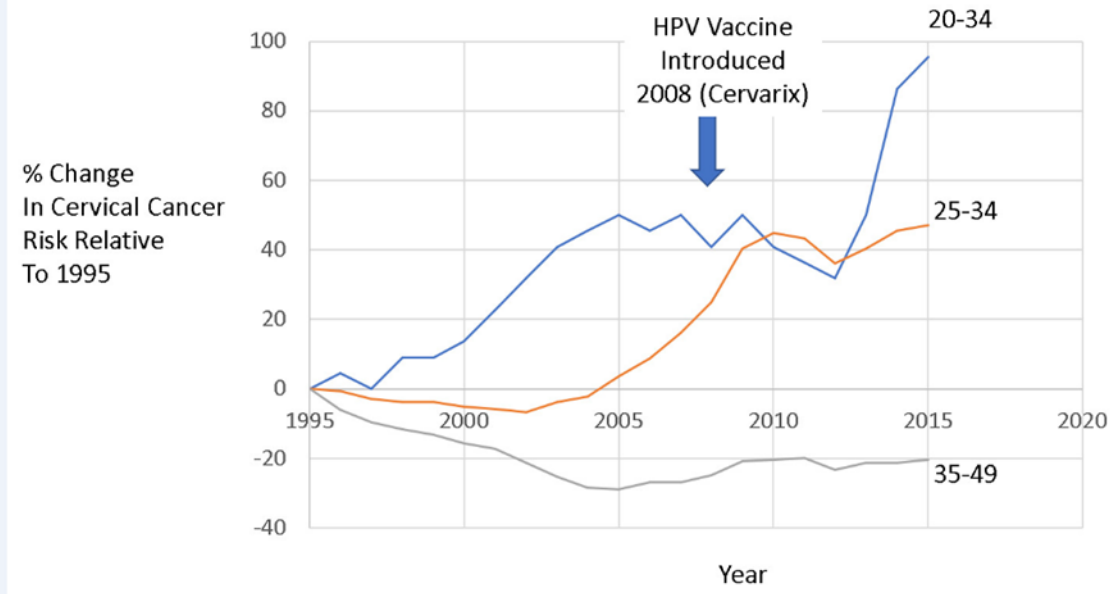
Filter graph by:
Select the type of variables in order to filter the graph shown above.

Cancer type
Cervix

Notes

• Data sourced from AIHW ACIM books (for 1982 to 2015) and Cancer in Australia 2019 - Supplementary data tables (for 2016 to 2019 estimates).

Data from the United Kingdom also shows increasing cervical cancers in only the vaccinated girls:



Data source: https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/cervical-cancer/incidence#heading-Two

In Maryland, cervical cancer is on the rise as well, with a 13.6% Increase in Cervical Cancer in Maryland Since 2013:

Cervical Cancer Incidence Rates, Diagnosis Years 1995-2015

Year	Rate (per 100,000 women)
1995	11.0
1996	10.7
1997	9.9
1998	9.0
1999	8.2
2000	7.9
2001	7.0
2002	8.5
2003	9.3
2004	7.5
2005	8.5
2006	6.7
2007	6.4
2008	6.5
2009	6.8
2010	7.3
2011	6.4
2012	6.3
2013	5.9
2014	6.3
2015	6.7

*Rates are age-adjusted to the 2000 U.S. Standard Population
Source: Maryland Cancer Registry

Independent evaluations have consitently revealed that vaccinated girls have a higher prevalence of HPVs than unvaccinated girls:

American Center for Cancer Research Guo et al 1015: Vaccinated Women Have Higher Prevalence of High Risk, Low Risk, and All Strains HPV:

Results After controlling for past sexual behaviors, vaccinated women had a lower risk of testing positive for the 4 types included in the HPV vaccine (6, 11, 16, or 18; Table 1). This association became stronger when the number of recent sexual partners was controlled for. However, vaccinated women had a higher prevalence of nonvaccine high-risk types than unvaccinated women (61.5% vs 39.7%, prevalence ratio 1.55, 95% CI 1.22-1.98). After adjusting for the number of recent sexual partners, the difference in prevalence of high-risk nonvaccine types was reduced, but remained significant.

Conclusion HPV vaccination was effective for the protection against all four vaccine types in young adult women. Vaccinated women had a higher prevalence of nonvaccine high-risk types, which suggests that they may benefit from vaccines that cover additional types of HPV.

Table 1. Type-specific HPV prevalence among US adult women by HPV vaccination status.

	Prevalence (95% CI) [a]		Adjusted Prevalence Ratio (95% CI) Vaccinated vs. Unvaccinated			
	Vaccinated (n=80)	Unvaccinated (n=512)		Model 1 [b]	Model 2 [c]	Model 3 [d]
Any HPV	70.7 (59.1-82.3)	56.1 (50.2-62.0)	1.26(1.05-1.52)	1.28(1.05-1.55)	1.24(1.02-1.52)	1.21(0.99-1.48)
Low-Risk Type	41.6 (30.4-52.8)	40.3 (34.0-46.5)	1.03(0.77-1.38)	1.06(0.76-1.47)	1.03(0.72-1.45)	0.96(0.68-1.37)
High-Risk Type	63.6 (51.4-75.7)	44.5 (39.1-49.9)	1.43(1.14-1.79)	1.34(1.07-1.69)	1.30(1.06-1.60)	1.26(1.03-1.53)
HPV 6, 11, 16 or 18	10.8 (2.2-19.4)	19.7 (15.8-23.7)	0.55(0.26-1.15)	0.48(0.23-1.01)	0.46(0.22-0.93)	0.42(0.21-0.87)
HPV 6 or 11	0	5.6 (3.5-7.7)	0			
HPV 16 or 18	10.8 (2.2-19.4)	15.9 (12.1-19.7)	0.68(0.32-1.45)	0.57(0.27-1.21)	0.54(0.26-1.12)	0.51(0.25-1.04)
Nonvaccine Type	68.6 (57.1-80.2)	53.9 (47.9-60.0)	1.27(1.05-1.54)	1.28(1.05-1.57)	1.25(1.02-1.54)	1.21(0.98-1.48)
Nonvaccine Low-Risk Type	41.6 (30.4-52.8)	38.1 (31.9-44.4)	1.09(0.81-1.46)	1.11(0.79-1.56)	1.08(0.76-1.55)	1.02(0.71-1.47)
Nonvaccine High-Risk Type	61.5 (49.4-73.7)	39.7 (34.7-44.7)	1.55(1.22-1.98)	1.47(1.15-1.88)	1.43(1.14-1.79)	1.38(1.11-1.71)

https://www.abstractsonline.com/plan/ViewAbstract.aspx?mID=3682&sKey=7f019f73-accb-484e-becc-5ecc405f8ec5&cKey=e2313b32-d6ac-4443-ab2d-49c368ea3b89&mKey=19573a54-ae8f-4e00-9c23-bd6d62268424

The Vaccine and Related Biological Products Advisory Committee noted as early as 2006 that the HPV vaccine can increase the risk of cervical lesions and cancer:

44.6% Greater Likelihood of Cervical Lesions in Vaccinated Cohorts: VARBPAC Report:

1. **Evaluation of the potential of Gardasil™ to enhance cervical disease in subjects who had evidence of persistent infection with vaccine-relevant HPV types prior to vaccination.**

The results of exploratory subgroup analyses for study 013 suggested a concern that subjects who were seropositive and PCR-positive for the vaccine-relevant HPV types had a greater number of CIN 2/3 or worse cases as demonstrated in the following table:

Table 17. Study 013: Applicant's analysis of efficacy against vaccine-relevant HPV types CIN 2/3 or worse among subjects who were PCR positive and seropositive for relevant HPV types at day 1. [From original BLA, study 013 CSR, Table 11-88, p. 636]

	Gardasil™ N=2717				Placebo N=2725					
Endpoint	N (subgroup)	Number of cases	PY at risk	Incidence Rate per 100 person years at risk	N (subgroup)	Number of cases	PY at risk	Incidence Rate per 100 person years at risk	Observed Efficacy	95% CI
HPV 6/11/16/18 CIN 2/3 or worse	156	**31**	278.9	11.1	137	**19**	247.1	7.7	-44.6%	<0.0, 8.5%

13

"there is compelling evidence that the vaccine lacks therapeutic efficacy among women who have had prior exposure to HPV and have not cleared previous infection (PCR positive and seropositive), which represented approximately 6% of the overall study populations."

Source: VRBPAC Gardasil TM HPV Quadrivalent Vaccine May 2016 VRBPAC Meeting

The reason for the increased risk of cervical lesions and cancers revealed in the VRBPAC and national cancer registries may be related to type replacement risk, which is an acknowledged phenomena In vaccinology:

Type Replacement Risk

JAMA. 2007 Apr 25;297(16):1784-92.

Invasive pneumococcal disease caused by nonvaccine serotypes among alaska native children with high levels of 7-valent pneumococcal conjugate vaccine coverage.

Singleton RJ[1], Hennessy TW, Bulkow LR, Hammitt LL, Zulz T, Hurlburt DA, Butler JC, Rudolph K, Parkinson A.

Author information

1 Arctic Investigations Program, National Center for Preparedness Detection and Control of Infectious Diseases, Centers for Disease Control and Prevention, Anchorage, Alaska, USA.

Abstract

CONTEXT: With routine childhood vaccination using heptavalent pneumococcal conjugate vaccine, one concern has been the potential for emergence and expansion of replacement disease caused by serotypes not contained in the heptavalent conjugate vaccine.

OBJECTIVE: To determine whether replacement disease is associated with the overall decline in invasive pneumococcal disease among Alaska Native children.

DESIGN, SETTING, AND PATIENTS: Alaska statewide longitudinal population-based laboratory surveillance of invasive Streptococcus pneumoniae infections from January 1, 1995, through December 31, 2006.

MAIN OUTCOME MEASURES: Incidence and types of pneumococcal disease in children younger than 2 years.

RESULTS: In the first 3 years after introduction of routine vaccination with heptavalent pneumococcal conjugate vaccine, overall invasive pneumococcal disease decreased 67% in Alaska Native children younger than 2 years (from 403.2 per 100,000 in 1995-2000 to 134.3 per 100,000 per year in 2001-2003, P<.001). However, between 2001-2003 and 2004-2006, there was an 82% increase in invasive disease in Alaska Native children younger than 2 years to 244.6/100,000 (P = .02). Since 2004, the invasive pneumococcal disease rate caused by nonvaccine serotypes has increased 140% compared with the prevaccine period (from 95.1 per 100,000 in 1995-2000 to 228.6 in 2004-2006, P = .001). During the same period, there was a 96% decrease in heptavalent vaccine serotype disease. Serotype 19A accounted for 28.3% of invasive pneumococcal disease among Alaska children younger than 2 years during 2004-2006. There was no significant increase in nonvaccine disease in non-Native Alaska children younger than 2 years.

CONCLUSIONS: Alaska Native children are experiencing replacement invasive pneumococcal disease with serotypes not covered by heptavalent pneumococcal conjugate vaccine. The demonstration of replacement invasive pneumococcal disease emphasizes the importance of ongoing surveillance and development of expanded valency vaccines.

https://www.ncbi.nlm.nih.gov/pubmed/17456820?dopt=AbstractPlus

Children's health on NBCNEWS.com

Search NBCNews.com

Shot may be inadvertently boosting superbugs

Strains tied to kids' ear infections flourish as vaccine fights common germs

Jump to discuss
comments below

Below: Discuss Related

Associated Press
updated 9/17/2007 6:02:34 PM ET

Print | Font: A A + –

CHICAGO — A vaccine that has dramatically curbed pneumonia and other serious illnesses in children is having an unfortunate effect: promoting new superbugs that cause ear infections.

2) Why are Maryland state health bureaucrats ignoring evidence that Gardasil causes serious injuries at 2.3% rate, documented by Merck?

Table 9: Summary of Girls and Women 9 Through 26 Years of Age Who Reported an Incident Condition Potentially Indicative of a Systemic Autoimmune Disorder After Enrollment in Clinical Trials of GARDASIL, Regardless of Causality

Conditions	GARDASIL (N = 10,706)	AAHS Control* or Saline Placebo (N = 9412)
	n (%)	n (%)
Arthralgia/Arthritis/Arthropathy[†]	120 (1.1)	98 (1.0)
Autoimmune Thyroiditis	4 (0.0)	1 (0.0)
Celiac Disease	10 (0.1)	6 (0.1)
Diabetes Mellitus Insulin-dependent	2 (0.0)	2 (0.0)
Erythema Nodosum	2 (0.0)	4 (0.0)
Hyperthyroidism[‡]	27 (0.3)	21 (0.2)
Hypothyroidism[§]	35 (0.3)	38 (0.4)
Inflammatory Bowel Disease[¶]	7 (0.1)	10 (0.1)
Multiple Sclerosis	2 (0.0)	4 (0.0)
Nephritis[#]	2 (0.0)	5 (0.1)
Optic Neuritis	2 (0.0)	0 (0.0)
Pigmentation Disorder[Þ]	4 (0.0)	3 (0.0)
Psoriasis[ß]	13 (0.1)	15 (0.2)
Raynaud's Phenomenon	3 (0.0)	4 (0.0)
Rheumatoid Arthritis[à]	6 (0.1)	2 (0.0)
Scleroderma/Morphea	2 (0.0)	1 (0.0)
Stevens-Johnson Syndrome	1 (0.0)	0 (0.0)
Systemic Lupus Erythematosus	1 (0.0)	3 (0.0)
Uveitis	3 (0.0)	1 (0.0)
All Conditions	245 (2.3)	218 (2.3)

*AAHS Control = Amorphous Aluminum Hydroxyphosphate Sulfate

https://www.merck.com/product/usa/pi_circulars/g/gardasil/gardasil_pi.pdf

3) Is the Maryland HPV vaccine program being driven by money?

Public information Act requests have revealed a disturbing trend of the Maryland Department of Health being financially conflicted with the HPV vaccine program.

State Senator Clarence Lam promised an industry insider conference legislation to mandate the HPV shot in Maryland. His office later denied Lam did so.

2:30 – 2:45 **Closing Remarks**
Clarence Lam, MD, MPH, State Delegate, Maryland General Assembly

- Another tool that we would like to utilize is mandating HPV vaccination as a school requirement.
- Maryland wants to be in the forefront, joining just a few other states by implementing an HPV vaccination requirement for school.
- We understand some systematic preparations are needed to ensure this will be successful.
- This will take some time but the MDH would like to move forward with this in next 1-2 years.
- Stay tuned as the MDH will look to you and your colleagues to help as we mov forward.

From: Lam, Clarence Delegate [mailto:Clarence.Lam@house.state.md.us]
Sent: Monday, October 22, 2018 11:03 AM
To: Mazer, Josh
Subject: RE: Association of Immunization Managers

Dear Mr. Mazer,
Thank you for reaching out to our office about this issue. At this time, Del. Lam does not have plans to introduce a bill mandating HPV vaccinations. For the next few weeks Lam does not have much availability for a meeting but should have more availability after November 6th.

I also shared with Del. Lam the information you left at the office regarding the HPV vaccine.

Thank you again for keeping us up to date on this issue.
-Scott

Scott Tiffin
Legislative Aide
Delegate Clarence Lam, MD, MPH
Maryland House of Delegates
District 12 | Baltimore & Howard Counties
Office: 410-841-3205

From: josh.mazer@wfafinet.com [mailto:josh.mazer@wfafinet.com]
Sent: Thursday, October 18, 2018 9:47 AM
To: Lam, Clarence Delegate <Clarence.Lam@house.state.md.us>
Subject: RE: Association of Immunization Managers

Dear Mr. Tiffin:

Is Delegate Lam planning on introducing a bill mandating HPV vaccination in Maryland?

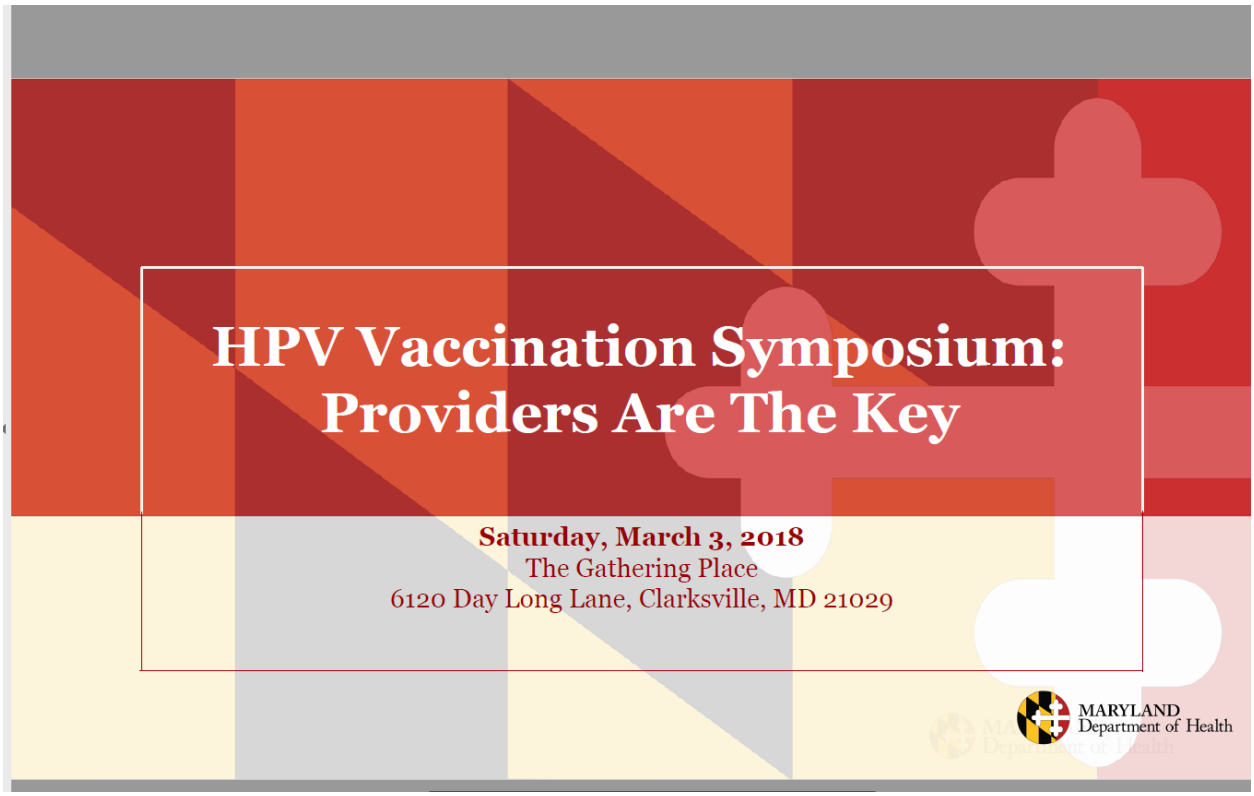
I would like to request a meeting with Dr. Lam to briefly review the HPV vaccine FDA package insert. What would be a good time to do so?

Thanks!

Josh Mazer
Annapolis, Md

Maryland state bureaucrats endorse sales contests in pediatric offices to rewrd hitting sales quotas for HPV vaccine:

Ten Oaks, Maryland HPV March 2018 Vaccine Symposium:



Physician Incentives

- Competition
- Wine
- Quality Bonus Structure

Dr. Diana Fertsch, Md President Maryland AAP Offering "Honorarium" for HPV Vaccine Study: No Evidence of IRB or Informed Consent from Study Participants:

NEW Opportunity for Maryland Practices

- UNC Gillings School of Global Public Health looking for primary care clinics that wish to participate in our study to help physicians and other providers effectively communicate recommendations for HPV vaccine
- Looking for 2 practices in Maryland who want to improve HPV rates through effective communication strategies
- Honorarium ($100 per provider order vaccine) and CME
- Staff and office team invited
- Training will be provided at a location convenient to you (your office or local venue)
- Contact Diana Fertsch at diana.fertsch@gmail.com or Loretta Hoepfner at Loretta@mdaap.org

Maryland state health bureacrats ignore the HPV vaccine caused death of Baltimore County resident Christina Tarsell. Beyond ignoring Chris's death, our bureaucrats covered it up because having a public announcement of the federal decision would have a negative financial impact on the program.

Tarsell Decision Sept 2017

In the United States Court of Federal Claims

OFFICE OF SPECIAL MASTERS

* *		
EMILY TARSELL, as the Executrix of the Estate of CHRISTINA TARSELL, Petitioner,	*	No. 10-251V Special Master Christian J. Moran
	*	Filed: September 25, 2017
v.	*	
SECRETARY OF HEALTH AND HUMAN SERVICES, Respondent.	*	Entitlement; human papillomavirus ("HPV") vaccine; sudden death; plausible medical theory; onset of arrhythmia; challenge-rechallenge
* *		

Mark T. Sadaka, Mark T. Sadaka, LLC, Englewood, NJ, for petitioner;
Ann D. Martin, United States Dep't of Justice, Washington, D.C., for respondent.

PUBLISHED RULING ON REMAND FINDING ENTITLEMENT[1]

Ultimately, because of the finding that Christina began to experience arrhythmia after her HPV vaccination, Ms. Tarsell has presented preponderant evidence of a logical sequence of cause and effect, connecting the HPV vaccination to the ensuing arrhythmia.

IV. Conclusion

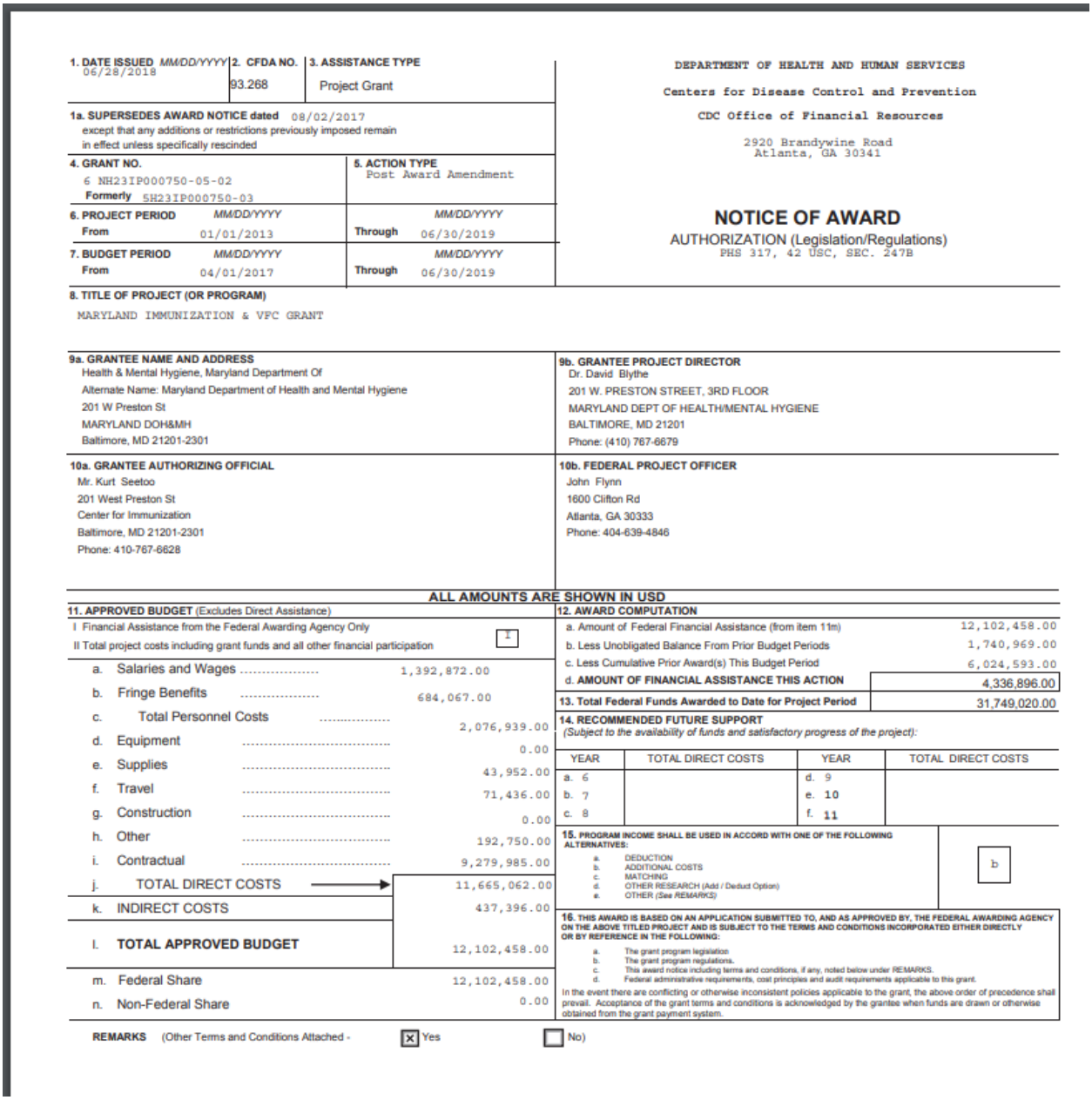
The Court's Opinion and Order required additional consideration consistent with the legal principles articulated by the Court for analyzing the evidence in this tragic case about a woman, Christina Tarsell, who died much too young. Under the approach dictated by the Court, Ms. Tarsell is entitled to compensation. The parties should anticipate that a separate order regarding damages will issue shortly.

Pursuant to Vaccine Rule 28.1(a), the Clerk's Office is instructed to notify the Court of this ruling.

https://drive.google.com/file/d/1N8unQE5Q2wAM-HtmgH1cxWKMbU2dWIAh/view

Financial documents:

$31.7 million:



1. DATE ISSUED MM/DD/YYYY: 06/28/2018
2. CFDA NO.: 93.268
3. ASSISTANCE TYPE: Project Grant

1a. SUPERSEDES AWARD NOTICE dated 08/02/2017
except that any additions or restrictions previously imposed remain in effect unless specifically rescinded

4. GRANT NO.: 6 NH23IP000750-05-02
Formerly 5H23IP000750-03

5. ACTION TYPE: Post Award Amendment

6. PROJECT PERIOD: From 01/01/2013 Through 06/30/2019

7. BUDGET PERIOD: From 04/01/2017 Through 06/30/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
CDC Office of Financial Resources
2920 Brandywine Road
Atlanta, GA 30341

NOTICE OF AWARD
AUTHORIZATION (Legislation/Regulations)
PHS 317, 42 USC, SEC. 247B

8. TITLE OF PROJECT (OR PROGRAM)
MARYLAND IMMUNIZATION & VFC GRANT

9a. GRANTEE NAME AND ADDRESS
Health & Mental Hygiene, Maryland Department Of
Alternate Name: Maryland Department of Health and Mental Hygiene
201 W Preston St
MARYLAND DOH&MH
Baltimore, MD 21201-2301

9b. GRANTEE PROJECT DIRECTOR
Dr. David Blythe
201 W. PRESTON STREET, 3RD FLOOR
MARYLAND DEPT OF HEALTH/MENTAL HYGIENE
BALTIMORE, MD 21201
Phone: (410) 767-6679

10a. GRANTEE AUTHORIZING OFFICIAL
Mr. Kurt Seetoo
201 West Preston St
Center for Immunization
Baltimore, MD 21201-2301
Phone: 410-767-6628

10b. FEDERAL PROJECT OFFICER
John Flynn
1600 Clifton Rd
Atlanta, GA 30333
Phone: 404-639-4846

ALL AMOUNTS ARE SHOWN IN USD

11. APPROVED BUDGET (Excludes Direct Assistance)
I Financial Assistance from the Federal Awarding Agency Only
II Total project costs including grant funds and all other financial participation: I

a. Salaries and Wages	1,392,872.00
b. Fringe Benefits	684,067.00
c. Total Personnel Costs	2,076,939.00
d. Equipment	0.00
e. Supplies	43,952.00
f. Travel	71,436.00
g. Construction	0.00
h. Other	192,750.00
i. Contractual	9,279,985.00
j. TOTAL DIRECT COSTS	11,665,062.00
k. INDIRECT COSTS	437,396.00
l. TOTAL APPROVED BUDGET	12,102,458.00
m. Federal Share	12,102,458.00
n. Non-Federal Share	0.00

12. AWARD COMPUTATION

a. Amount of Federal Financial Assistance (from item 11m)	12,102,458.00
b. Less Unobligated Balance From Prior Budget Periods	1,740,969.00
c. Less Cumulative Prior Award(s) This Budget Period	6,024,593.00
d. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	4,336,896.00
13. Total Federal Funds Awarded to Date for Project Period	31,749,020.00

14. RECOMMENDED FUTURE SUPPORT
(Subject to the availability of funds and satisfactory progress of the project):

YEAR	TOTAL DIRECT COSTS	YEAR	TOTAL DIRECT COSTS
a. 6		d. 9	
b. 7		e. 10	
c. 8		f. 11	

15. PROGRAM INCOME SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:
a. DEDUCTION
b. ADDITIONAL COSTS
c. MATCHING
d. OTHER RESEARCH (Add / Deduct Option)
e. OTHER (See REMARKS)
b

16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, THE FEDERAL AWARDING AGENCY ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:
a. The grant program legislation
b. The grant program regulations.
c. This award notice including terms and conditions, if any, noted below under REMARKS.
d. Federal administrative requirements, cost principles and audit requirements applicable to this grant.
In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS (Other Terms and Conditions Attached - [X] Yes [ ] No)

$447,000 Signed by Dr. David Blythe

1. DATE ISSUED MM/DD/YYYY	2. CFDA NO.	3. ASSISTANCE TYPE
04/27/2018	93.733	Cooperative Agreement

1a. SUPERSEDES AWARD NOTICE dated 03/21/2017
except that any additions or restrictions previously imposed remain in effect unless specifically rescinded

4. GRANT NO.	5. ACTION TYPE
6 NH23IP922568-01-02 Formerly	Post Award Amendment

6. PROJECT PERIOD	MM/DD/YYYY		MM/DD/YYYY
From	09/30/2016	Through	09/29/2018
7. BUDGET PERIOD	**MM/DD/YYYY**		**MM/DD/YYYY**
From	09/30/2016	Through	09/29/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
CDC Office of Financial Resources
2920 Brandywine Road
Atlanta, GA 30341

NOTICE OF AWARD

AUTHORIZATION (Legislation/Regulations)
Sec 317A, 317B, & 317(k) (2) PHS Act CFDA: 93.322

8. TITLE OF PROJECT (OR PROGRAM)
Increasing HPV Vaccine Coverage by Strengthening Adolescent AFIX Activities in Maryland

9a. GRANTEE NAME AND ADDRESS
HEALTH & MENTAL HYGIENE, MARYLAND DEPARTMENT OF
201 W Preston St
-DUP7
Baltimore, MD 21201-2301

9b. GRANTEE PROJECT DIRECTOR
Dr. David Blythe788009
201 W PRESTON ST
BALTIMORE, MD 21201-2301
Phone: 410-767-6685

10a. GRANTEE AUTHORIZING OFFICIAL
Ms. Sandra McLean
201 W Preston St
Maryland Department of Health and Mental Hygiene
Baltimore, MD 21201-2301
Phone: 410-767-7254

10b. FEDERAL PROJECT OFFICER
John Flynn
1600 Clifton Rd
Atlanta, GA 30333
Phone: 404-639-4846

ALL AMOUNTS ARE SHOWN IN USD

11. APPROVED BUDGET (Excludes Direct Assistance)

I Financial Assistance from the Federal Awarding Agency Only
II Total project costs including grant funds and all other financial participation — I

a.	Salaries and Wages	0.00
b.	Fringe Benefits	0.00
c.	Total Personnel Costs	0.00
d.	Equipment	0.00
e.	Supplies	13,937.00
f.	Travel	6,000.00
g.	Construction	0.00
h.	Other	25,000.00
i.	Contractual	402,718.00
j.	TOTAL DIRECT COSTS →	447,655.00
k.	INDIRECT COSTS	0.00
l.	**TOTAL APPROVED BUDGET**	447,655.00
m.	Federal Share	447,655.00
n.	Non-Federal Share	0.00

12. AWARD COMPUTATION

a. Amount of Federal Financial Assistance (from item 11m)	447,655.00
b. Less Unobligated Balance From Prior Budget Periods	0.00
c. Less Cumulative Prior Award(s) This Budget Period	447,655.00
d. **AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION**	0.00
13. Total Federal Funds Awarded to Date for Project Period	447,655.00

14. RECOMMENDED FUTURE SUPPORT
(Subject to the availability of funds and satisfactory progress of the project):

YEAR	TOTAL DIRECT COSTS	YEAR	TOTAL DIRECT COSTS
a. 2		d. 5	
b. 3		e. 6	
c. 4		f. 7	

15. PROGRAM INCOME SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:
a. DEDUCTION
b. ADDITIONAL COSTS
c. MATCHING
d. OTHER RESEARCH (Add / Deduct Option)
e. OTHER (See REMARKS)

b

16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, THE FEDERAL AWARDING AGENCY ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:
a. The grant program legislation
b. The grant program regulations.
c. This award notice including terms and conditions, if any, noted below under REMARKS.
d. Federal administrative requirements, cost principles and audit requirements applicable to this grant.

In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS (Other Terms and Conditions Attached - [X] Yes [ ] No)

AIM 2016 $70,000 to Maryland PHPA

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Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

Grants and Other Assistance to Organizations, Governments and Individuals in the United States

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.
▶ Attach to Form 990.
▶ Information about Schedule I (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
ASSOCIATION OF IMMUNIZATION MANAGERS

Employer identification number
52-2346043

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . ☐ Yes ☑ No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments. Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000. Part II can be duplicated if additional space is needed

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1) MD PARTNERSHIP FOR PREVENTION 360 MAIN ST REISTERSTOWN, MD 21136			70,000	0			SUBRECIPIENT CONTRACT

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . ▶ 0

3 Enter total number of other organizations listed in the line 1 table . . . ▶ 1

For Paperwork Reduction Act Notice, see the Instructions for Form 990. Cat No 50055P Schedule I (Form 990) 2016

The problems and issues with the HPV vaccine have been the subject of numerous news articles and scientific reviews. Below are two New York Times articles describing how the HPV vaccine is driven by financial considerations over public safety:

New York Times; Exposes HPV Vaccine as Marketing Driven, Not Medically:

Researchers Question Wide Use of HPV Vaccines

By ELISABETH ROSENTHAL AUG. 20, 2008

Two vaccines against cervical cancer are being widely used without sufficient evidence about whether they are worth their high cost or even whether they will effectively stop women from getting the disease, two articles in this week's New England Journal of Medicine conclude.

RELA

https://www.nytimes.com/2008/08/21/health/21vaccine.html?searchResultPosition=21

Drug Makers' Push Leads to Cancer Vaccines' Rise

By ELISABETH ROSENTHAL AUG. 19, 2008

In two years, cervical cancer has gone from obscure killer confined mostly to poor nations to the West's disease of the moment.

In the United States, hundreds of doctors have been recruited and trained to give talks about Gardasil — $4,500 for a lecture — and some have made hundreds of thousands of dollars. Politicians have been lobbied and invited to receptions urging them to legislate against a global killer. And former state officials have been recruited to lobby their former colleagues.

"There was incredible pressure from industry and politics," said Dr. Jon Abramson, a professor of pediatrics at Wake Forest University who was chairman of the committee of the Centers for Disease Control and Prevention that recommended the vaccine for all girls once they reached 11 or 12.

"This big push is making people crazy — thinking they're bad moms if they don't get their kids vaccinated," said Dr. Abby Lippman, a professor at McGill University in Montreal and policy director of the Canadian Women's Health Network. Canada will spend $300 million on a cervical cancer vaccine program.

https://www.nytimes.com/2008/08/20/health/policy/20vaccine.html?action=click&contentCollection=Health&module=RelatedCoverage&region=Marginalia&pgtype=article

Conclusion: The Maryland HPV vaccine program is rife with financial conflicts of interest. Public health bureaucrats such as Dr. David Blythe are lying about the safety and effectiveness of the shot. 10 years of cancer registry data gives an urgent and ominous warning that vaccinated kids are seeing increased prevalence of cancers. The licensing data for the show clearly shows that some kids are at 44.6% increased risk if they take the shot. The rate of serious systemic automimmune disease disclosed in the licensing documents is 2.3%. Maryland public health bureaucrats covered up the 2008 HPV vaccine caused death Christina Tarsell. The HPV vaccine program in Maryland is a public health rip off, aided and abetted by corrupt state officals.