Israel: Measles death in non-vaxxed

CHD March 2026

MARCH 18, 2026

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LIVE UPDATE → FROM THE LIVEBLOG OF TUESDAY, MARCH 17, 2026

Unvaccinated 17-year-old dies of measles, Health Ministry says

By DIANA BLETTER FOLLOW

17 March 2026, 1:36 pm

SHARE

The Health Ministry reports that an unvaccinated 17-year-old boy died of measles last night. The boy suffered from underlying conditions. When hospitalized two and a half weeks ago, he was diagnosed with measles.

This is Israel's 17th death from measles since the current outbreak began last May.

Of the other 16 deaths, most of the deceased were otherwise healthy infants and children with no underlying conditions who were not vaccinated.

Measles

Measles is an extremely contagious disease. It can be serious, even fatal. This page provides information about common symptoms of measles and the vaccine, and gives answers to frequently asked questions.

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asles | Measles Vaccine | Measles in Israel & Worldwide

Measles in Israel & Worldwide

Measles in Israel

In the 1950s, between thousands and tens of thousands of people contracted measles in Israel each year. Measles outbreaks were unavoidable, and nearly every child in the country was infected. The disease took a heavy toll because it carries a complication rate of about 30%, a risk of brain damage in 1 in 1,000 cases, and 1–3 deaths per 1,000 cases. Contrary to common belief, measles is t a “mild childhood s.”

gov.il

Israel

- 1700 lab confirmed cases over six months, 437 hospitalized, 39 ICU admissions
- Ultra Orthodox Jews with low MMR coverage.
- According to AI sources, Hebrew Ministry releases lump unvaccinated and unknown vaccination status together in many of their tables.
  - Unknown theoretically low due to digital tracking registry.
- Historically 10-20% of the numbers are “unknown”
- No strain/genotype reported
- Measles vax rate in ultra orthodox is 70-80% but has risen to 82-84% recently.

How serious a problem was measles before vaccine availability?

sitism. This self-limiting infection of short duration, moderate severity, and low fatality has maintained a remarkably stable biological balance over the centuries. Those epidemiologists, and

To those who ask me, "Why do you wish to eradicate measles?," I reply with the same answer that Hillary used when asked why he wished to climb Mt. Everest. He said, "Because it is there." To this may be added, ". . . and it can be done."

Langmuir 1962 PMID: 14462171

1959

Few complications.

No attempt to prevent Spread

Antibiotics drugs not Necessary

PMC: 1992477

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1992477/pdf/brmedj02957-0102.pdf

Vital Statistics:

Br Med J. 1959 Feb 7; 1(5118): 380–383.
PMCID: PMC1992477

M. J. Oldroyd, P. Papworth, Shirley A. Peacock, B. Philpott, B. A. Poley, C. J. F. Potter, S. Ramrakha, V. E. Rees, L. A. Reitsma, D. S. [illegible], A. Shamash, M. S. Shashpiri, M. M. R. Stead, J. H. Stevens, R. V. Steward, E. Sweetapple, W. S. Sykes, W. P. Thatte, Simpson, P. A. Tsoia-Sue, T. de L. Walker, Walton, Audrey J. Wheeler, Valmae J. M. Kathleen M. Whitfield, D. Williams, R. V.

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DIPLOMA IN PSYCHOLOGICAL MEDICINE.—J. P. Baker, G. J. Barry, I. Berman, Ann D. Black, S. Bourne, Joyce E. Brest, M. W. Browne, Elizabeth M. Bruce, M. W. P. Carney, M. D. Cashman, A. D. Charles, S. I. Cohen, Carice Ellison, M. D. Enoch, N. D. Farnan, A. R. Foster, H. C. Fowlie, H. L. Freeman, A. Galea, Mabel L. Haigh, J. V. Halpenny, M. A. Hargreaves, R. W. Johnston, W. Johnston, G. E. Langley, J. McDonald, J. Macintyre, Dorothy M. McWhirter, P. J. Mannion, D. H. Neale, J. W. G. Nixon, B. M. N. Pitt, G. Pollitt, V. R. Puzantian, W. H. Reid, R. Rodriguez-Arabaolaza, D. Rooney, L. F. W. Rowe, E. M. Russell, V. O. G. Smyth, D. I. Storey, P. Sykes, J. Warner, J. H. P. Willis, J. R. E. Wilson, Y. C. Wong.

DIPLOMA IN PATHOLOGY.—M. A. Ali, B. C. Bhattacharyya, H. N. Harrison, T. Manners, T. K. Narayanan, Don S. P. S. V. J. Wijesekera.

DIPLOMA IN PUBLIC HEALTH.—S. L. Adesuyi, Lily Arasoon, L. H. Brearley, P. Chanetrakul, E. Darabian, J. M. Deka, Lilian Kerr, Christine Kirby, W. G. Lewis, K. M. A. Malazie, Esther E. Simpson, M. F. X. Slattery, D. J. Stephen, G. C. Young.

DIPLOMA IN TROPICAL MEDICINE AND HYGIENE.—K. K. Appaji, G. Gaire, D. H. Melville-Swarries, Hnin Yee.

DIPLOMA IN CHILD HEALTH.—T. P. Linham, K. Tharmarajah.

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

At a meeting of the College held on September 29, 1958, Major-General G. T. L. Archer was admitted to the Fellowship of the College.

On November 7, 1958, T. E. Lear, S. Lourdenadin, J. S. McCormick, and G. B. Plunkett were admitted to the Membership.

At a meeting of the College held on December 5, 1958, with the President, Dr. P. T. O'Farrell, in the chair, Dr. J. J. Cockburn was admitted to the Licence and Membership of the College.

The following were admitted to the Licence in Medicine and Midwifery:

Y. M. Ali, R. G. R. Bobart, R. J. Christmas, Margaret M. Day, K. A. Docrat, Noreen M. Duffy, Meari A. Fenwick, M. N. Fitzgibbon, H. Holmes, S. N. Jewson, O. C. Parry-Jones, H. A. Marcelin, Louisa E. Moran, M. A. O. Muhairez, J. McAleer, J. F. McCusker, R. H. Narozny, J. C. Okoye, P. R. Panniker, Janina Pisko-Dubienski, D. L. Seawn, M. E. Seedat, Y. Z. Shah, A. L. Tawiah.

Vital Statistics

MEASLES

REPORTS FROM GENERAL PRACTITIONERS

We are much indebted to the general practitioners whose names appear below for the following notes on the present outbreak of measles.

Dr. G. F. WATSON (Peaslake, Surrey) writes: Measles was introduced just before Christmas by a child from Petworth. He went to school, coughing, on December 15–17, 1958, and to the school party that afternoon, after which he developed his rash. In school and at the party he was in contact with 52 children, 25 of whom were said to be susceptible. Of these, 21 (84%) developed measles, 2 on December 27, 2 on the 28th, 6 on the 29th, 9 on the 30th, 3 on the 31st, 3 on January 1, 1959, and 2 on the 2nd. The shortest incubation was thus 12 days and the longest 16 until the rash appeared. Out of 27 other children who were said to have had measles or were doubtful, 6 (22%) developed it. One child's mother said he was 3 months old when previously affected, which suggests confusion wtih roseola infantum.

Treatment of Attack.—No drugs are given for either the fever or the cough; if pressed, I dispense mist. salin. *B.N.F.* as a placebo. Glutethimide 125 mg. may be given in the afternoon if the child is restless when the rash develops; 250 mg. in single or divided doses at bedtime ensures a good night's sleep in spite of coughing. I encourage a warm humid atmosphere in the room by various methods: some electric fires and most electric toasters allow an open pan of water to rest on top; an electric kettle blows off too much steam to be kept on for more than short periods. Parents, conscious of the need to darken the room and to forbid reading, may carry this to an unnecessary extreme, starting even before the rash appears. To save a mother some demands, the wireless is a boon to children in darkened rooms. They are allowed up when the rash fades from the abdomen—usually the fourth or fifth day—and may go outside on the next fine day. Apart from fruit to eat, solid food is avoided on the day the rash is appearing; fruit drinks or soups are all they appear to want.

Complications.—So far few complications have arisen. Four cases of otitis media occurred in the first 25 children, but only one had pain. No case of pneumonia has occurred, but one child had grossly abnormal signs in the chest for a few days after the fever subsided, uninfluenced by oral penicillin. One girl had a tear-duct infection and another an undue blepharitis. Of three adult males with the disease, two have been more severely affected than any of the children.

Treatment of Complications.—For otitis media with or without pain oral penicillin in therapeutic doses is given four times a day. Dacryocystitis was treated with an oral mixture of penicillin and sulphonamide.

Interesting Features.—The invasion phase of measles this year seems to be more drawn out than previously. Several children have been febrile for a week, one for nine days before the rash appeared. In two boys measles was tentatively excluded: the first developed no catarrhal signs in spite of his fever, and then mumps appeared; the second, who was coughing, had an evening temperature of 102° F. (38.9° C.) for three nights running, before signs of primary atypical pneumonia appeared in the right lung. Two children have had transient rashes on the trunk before the typical rash appeared on the face. One girl, who was given gamma globulin as an infant when her elder brother had measles, was on this occasion a house contact of a younger brother with a typical attack; in due course she developed a low fever and transient catarrh but no rash, at the same time that her younger sister developed a typical attack of measles. In a neighbouring practice a baby of 9 months developed fever and catarrh, but no rash, at the same time as two older children in the house developed typical attacks of measles. A girl of 2 years who has not had measles in the past failed to develop it from house contact with her father, although her younger sister had a typical attack. A girl of 8 was not infected at the school party, though she nursed the ailing victim on her knee, but later took the disease from her sisters, who were infected at the party.

LATE START

Dr. F. H. STAINES (Callington, Cornwall) writes: This practice had a large epidemic of measles from July to October, 1957 (overlapping with the Asian influenza), and a small epidemic in April, 1958, occurring in a village that was bypassed by the 1957 infection. The current epidemic has not yet reached here, and in this practice only one of the last five epidemics has started early in the New Year, the others all starting in spring or summer.

BED REST

Dr. R. E. HOPE SIMPSON (Cirencester, Glos) writes: We make no attempt to prevent the spread of measles, and would only use gamma globulin to mitigate the severity of the disease in the case of the exposure of a susceptible adult or child who is already severely debilitated. Bed rest, for seven days for moderate and severe cases and of five to six days in mild cases, seems to cut down the incidence of such complications as secondary bacterial otitis media and bronchopneumonia. We have not been impressed by the prophylactic or therapeutic use of antibiotics and

1959

Normally mild

Rarely gamma globulin

Commonest disease in The world.

PMC: 1992477

MEASLES EPIDEMIC

In the first three weeks of this year about 41,000 cases of measles were recorded in England and Wales. This is well above the corresponding figures of the last two years—namely, about 9,000 in 1958 and 28,000 in 1957—though, as the graph on p. 382 shows, it is below the highest levels reached in the last nine years. To give some idea of the main features of the disease as it appears to-day and of how it is best treated, we invited some general practitioners to write short reports on the cases they have seen in their practices recently. These appear at p. 380. It is interesting to note, first, that the distribution of the disease is rather patchy at present. It has not yet reached the areas where two of these doctors practise (in South Scotland and Cornwall), and other areas are known to be free of the disease so far. On the other hand, in Kent it is reported to have arrived in time to put the children to bed over Christmas. These writers agree that measles is nowadays normally a mild infection, and they rarely have occasion to give prophylactic gamma globulin. As to the treatment of the disease and its complications, the emphasis naturally varies from one practice to another. Amount of bed-rest, when to administer a sulphonamide or antibiotic, the use of analgesics and linctuses—all these may still be debatable problems in the treatment of what is said to be the commonest disease in the world. But there is probably much in the opinion which one of the writers expresses: "It

1959

Infection over in a week.

Best encountered between 3 – 7 yrs of age.

Mothers say, “how much good the attack has done their children and how much better they are after it.”

PMC: 1992477

sulphonamides in the first week of the disease. As soon as the patient is out of bed we allow him out of doors almost regardless of the weather.

Otitis Media and Bronchopneumonia.—These conditions often appear so early, sometimes even before the rash, that in such cases one can only conclude that the responsible agent is the virus itself. Despite their initial alarming severity, they tend to resolve spontaneously, and treatment apart from first principles seems useless. When, on the other hand, otitis media or bronchopneumonia comes on after the subsidence of the initial symptoms of measles, it is probably due to a secondary bacterial invader, and we find antibiotics or sulphonamides useful if the severity of the complication demands them.

Staphylococcal Infections.—Styes and blepharitis commonly develop within six weeks of measles and can be dramatically severe. They often persist as a recurrent nuisance for months or even years. In the long view local applications are conspicuously unsuccessful, as are courses of antibiotics. Prolonged use of sulphonamides, on the other hand, often seems to stop the cycle of recurrences, and heartening results are achieved by the old-fashioned iron tonics or their vitamin-and-iron successors.

Experience bears out the expectation that children under 2 years old usually have mild attacks, and under 6 months often escape the disease altogether. These mild attacks in infancy do not appear to give a solid immunity, and such children are often subject to a second attack when they reach school age. One wonders if the same principle applies to attacks modified by gamma globulin.

Less Severe.—The present outbreak in this area is not distinguished by any peculiar characteristics except that it seems less severe than usual.

Mild Ailment

Dr. John Fry (Beckenham, Kent) writes: The expected biennial epidemic of measles appeared in this region in early December, 1958, just in time to put many youngsters to bed over Christmas. To date there have been close on 150 cases in the practice, and the numbers are now steadily decreasing. Like previous epidemics, the primary cases have been chiefly in the 5- and 6-year-olds, with secondary cases in their younger siblings. No special features have been noted in this relatively mild epidemic. It has been mild because complications have occurred in only four children. One little girl aged 2 suffered from a lobular pneumonia, and three others developed acute otitis media following their measles. In the majority of children the whole episode has been well and truly over in a week, from the prodromal phase to the disappearance of the rash, and many mothers have remarked “how much good the attack has done their children,” as they seem so much better after the measles.

A family doctor's approach to the management of measles is essentially a personal and individual matter, based on the personal experiences of the doctor and the individual character and background of the child and the family. In this practice measles is considered as a relatively mild and inevitable childhood ailment that is best encountered any time from 3 to 7 years of age. Over the past 10 years there have been few serious complications at any age, and all children have made complete recoveries. As a result of this reasoning no special attempts have been made at prevention even in young infants in whom the disease has not been found to be especially serious.

Treatment.—In the acute phase non-specific symptomatic measures such as aspirin and linctus have been the basis of treatment, and without the routine use of antibiotics or sulphonamides the rate of complications has not exceeded 3%. Even in the possibly susceptible “catarrhal children” with previous histories of recurrent ear and chest infections antibiotics have not been used in attempting to prevent complications; if and when these did occur they were treated on their merits. The few complications that did arise—namely, otitis media and chest infections—were either allowed to settle naturally on non-specific treatment, or, when severe enough, were treated with intramuscular injections of penicillin. In the present epidemic the one child with pneumonia and two of the children with acute otitis media were the only ones who required specific antibiotics. In all the others the disease followed a relatively uneventful course with complete and spontaneous resolution.

I would like to express my thanks to Dr. G. E. H. Callebaut, who has worked with me during this time.

No Permanent Disabilities

Dr. R. M. McGregor (Hawick, Roxburghshire) writes: In Scotland measles is not a notifiable disease except in the case of certain ports. Information concerning incidence, therefore, is known only to the family doctor and to a lesser extent the school authorities. In this area since 1948 serious outbreaks have occurred in the autumn of 1950, in March and April of 1953, and in June and July of 1955. In the intervening periods, and since the last serious outbreak, sporadic cases have occurred without causing an epidemic. At present we enjoy a complete freedom from this disease, and it is hoped that the act of writing on the subject will not incur the penalty of a visitation.

Scanning the notes of the previous epidemics, it is evident that the 1955 episode was one of low virulence. Indeed, many of the cases were sufficiently mild as to make diagnosis difficult. The follow-up of all the epidemics reveals that the patients have not suffered any permanent disabilities. This could be due to the treatment given being satisfactory or to the excellent recuperative powers of a sturdy population.

It is conspicuous that the 5–15-years age group contained the vast majority of the cases. No effort was made to prevent the spread of the disease, except the ordinary precaution of not permitting juvenile visitors. Gamma globulin to thwart the onset of the disease was never used, since the few cases seen affecting the adults have always been severe. It is felt advisable to get the infection over in childhood and thus avoid this hazard in later life.

In these epidemics no serious complications were encountered. A troublesome cough for a few weeks after the infection was fairly frequent. In the 1955 episode only two cases of concomitant otitis media were seen, and in both cases it was a recrudescence of a previous attack. Contrariwise three of the cases had otitis media a few months before, and did not have a flare-up during the measles infection. In one case, as the rash of measles was fading, typical spots of chicken-pox were seen to develop. This superimposed infection did not prolong the convalescence.

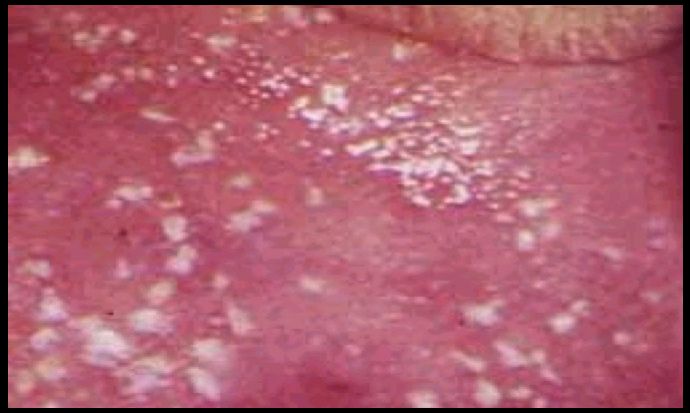
The treatment given in all cases was sulphadimidine. In the older children it was dispensed in the form of tablets. In the younger children and in those that complained of difficulty in swallowing, the suspension was used. When the sulphadimidine was stopped, a sedative mixture was given to those who complained of a troublesome cough.

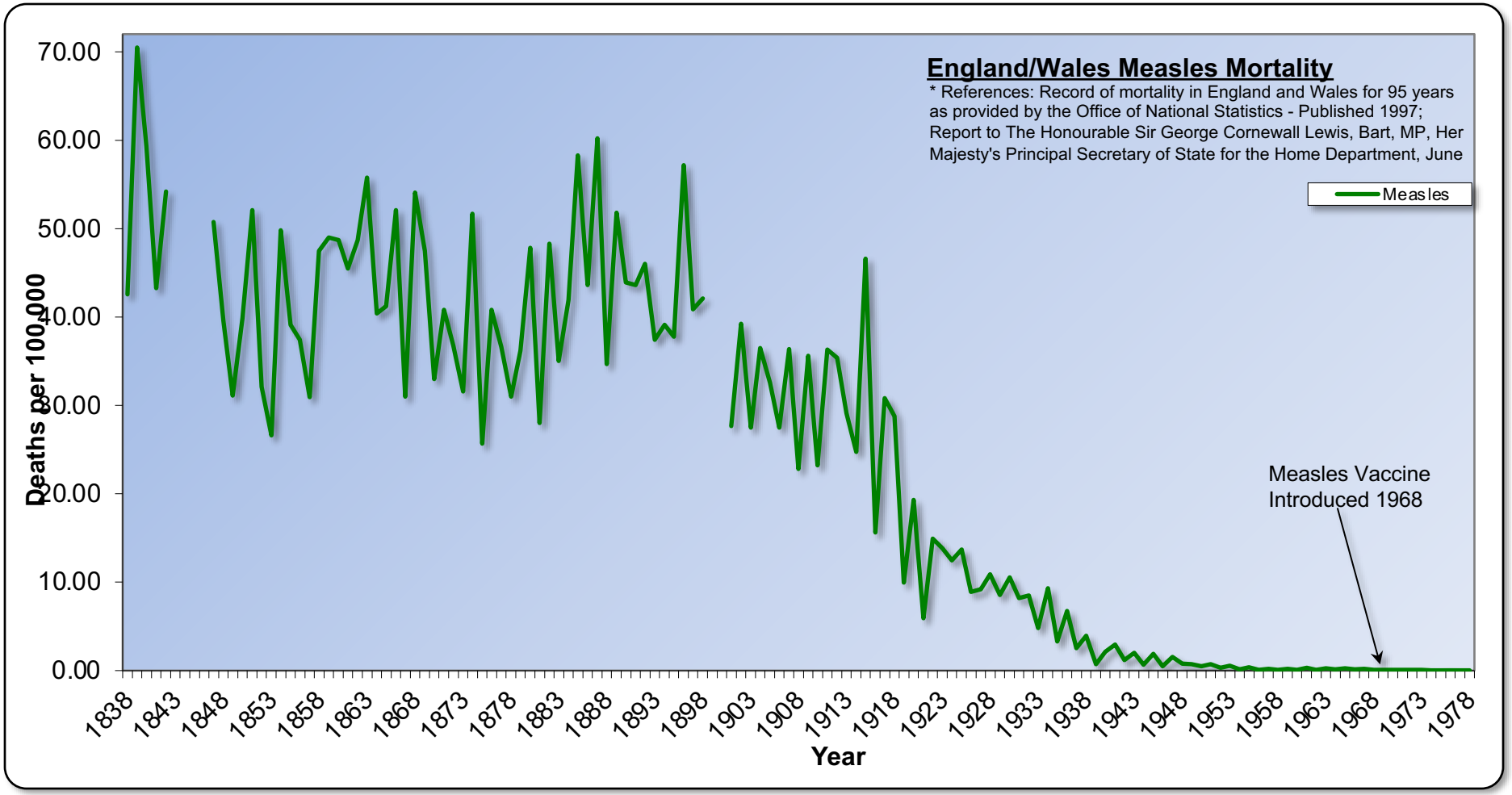
Importance of Visits

Dr. Keith Hodgkin (Redcar, Yorks) writes: If the present measles epidemic of nearly 100 cases is compared with the two previous epidemics (250 cases), no obvious differences are observed. Several clinical observations were made which influence early diagnosis and treatment: (1) In *all* cases the classic triad of cough, Koplik's spots, and rash was found. (2) The cough began 1–5 (usually 3) days before the rash in over 80% of cases. (3) Koplik's spots were never observed more than 2 days before the onset of rash. Extensive Koplik infiltration appearing as a diffuse red granularity over the inside of the cheeks indicated the likelihood of a severe illness. (4) A stage of pulmonary catarrh as judged by moist adventitious sounds was observed in 54% of cases. This stage always appeared 1–3 days after the appearance of rash—i.e., just as the clinical condition was improving. These catarrhal sounds had disappeared in most cases four days later.

Measles treatment

- Quarantine
- Vitamin A
- Vitamin C
- Skin care (oil and AA)
- Food
- Appropriate rest




England/Wales Measles Mortality
* References: Record of mortality in England and Wales for 95 years as provided by the Office of National Statistics - Published 1997; Report to The Honourable Sir George Cornewall Lewis, Bart, MP, Her Majesty's Principal Secretary of State for the Home Department, June
Measles
Measles Vaccine Introduced 1968
Deaths per 100,000
70.00
60.00
50.00
40.00
30.00
20.00
10.00
0.00
1838
1843
1848
1853
1858
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1928
1933
1938
1943
1948
1953
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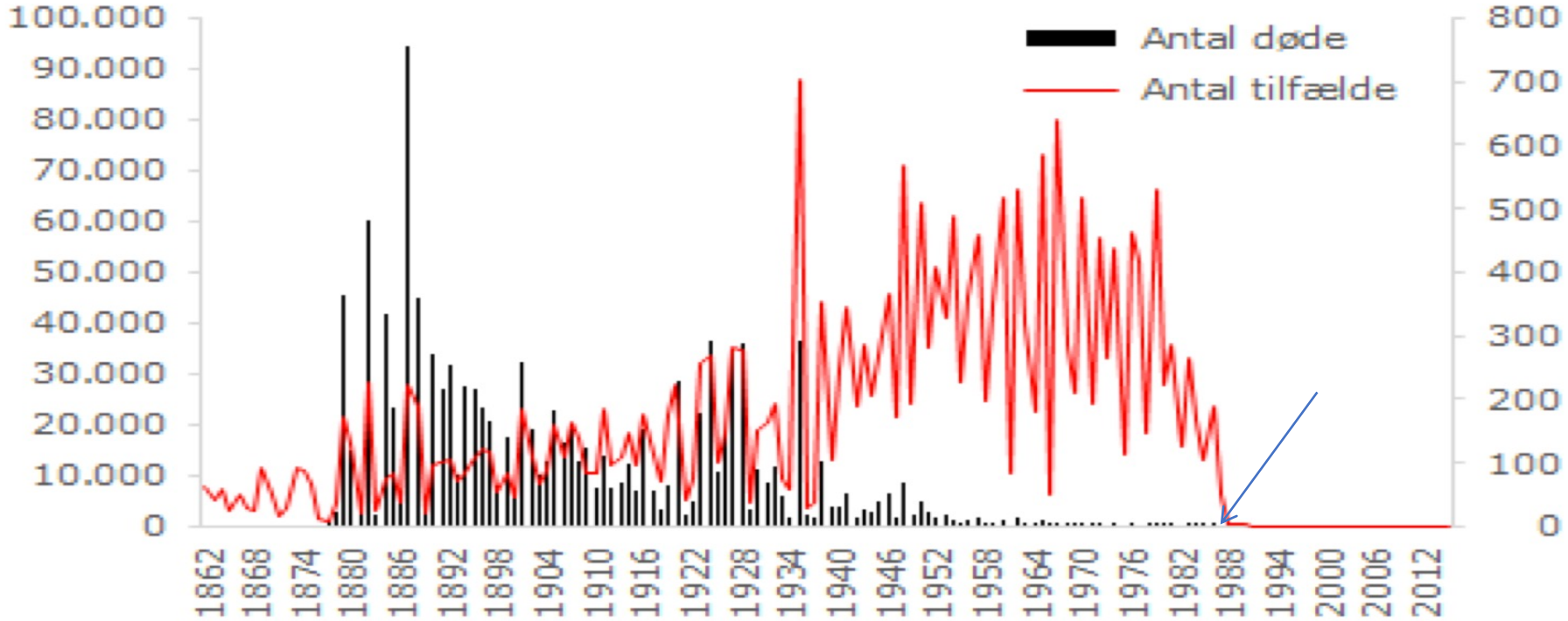
1968
1973
1978
Year

Figur 1. Mæslingetilfælde og antal dødsfald* som følge af mæslinger 1862-2014



Vaccinated v. convalesced

- Whose blood is stronger?

Klingele study: 12 year olds

Nigeria, natural immunity **Luxembourg, vaccinated**

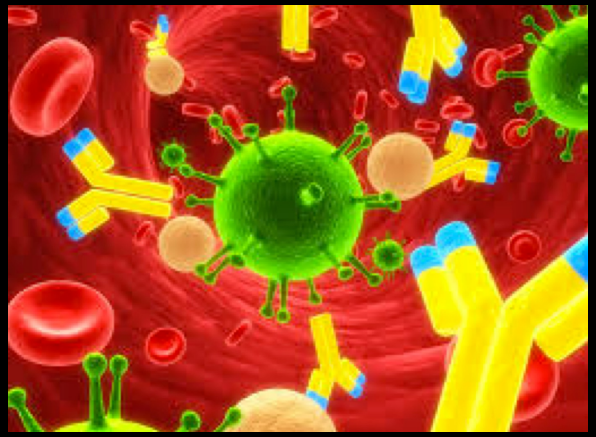
- Is there a difference in the ability to fight wild measles types?

Klingele 2000 PMID: 10935994

ability to neutralize all viruses?

Nigerian natural immune

- 12/22
- 54%



Luxembourg vaccinated

- 6/24
- 25%

The power of normal blood

Nigerian

- 2/20 (10%) virus types were NOT neutralized

Luxembourg

- 10 of 20 (50%)were NOT neutralized

"Children who survive the acute phase of measles infection may have a survival advantage compared with unimmunized, uninfected children. Hence, ***both disease and immunization*** *may be associated with non-specific beneficial effects, presumably due to some form of immunostimulation."*

Aaby 1995 PMID: 7502100

DR. WITSENBURG

Witsenburg B., J Anthrop Med., Volume 9, Nr. 3, Autumn 1992

THE USUAL TREATMENT

1 Sedatives and severe in the tropics.

2 Antipyretic drugs (salicylates, pyrazolone derivatives)

3 Antitussives, antihistamines or codeine, alone or combined with expectorants.

4 Treatment of manifest or subclinical malaria.

5 Antibiotics as required (for pneumonia, enteritis, etc.)

6 Blood transfusion in case of severe anemia.

7 General measures such as bed rest, fluids, diet.

50% OF CHILDREN

- Stopped all drugs
- Given bedrest, fluids and healthy food
- No vitamin C or A

RESULTS

Mortality remained 35% with the usual treatment.

Dropped to 7% in Witsenburg's non-interference group. 80% drop

Summary

- Measles should be a mild infection.
- Natural immunity is way better than injected simulated immunity.
- Medical system has always done harm (inadvertently?), and continues today. 2 Texas cases in 2025.
- The situation in Israel doesn’t make sense.
  - Narrative control
  - Legal protection of medical institutions
  - Something else

Year	Cases (approx.)	Deaths	Scale Notes / Key Details
2016	~10	0	Sporadic
2017	31	0	Small cluster
2018	~2,000	1	Outbreak start
2019	~2,300	1	Outbreak peak
2020	~15	0	COVID suppression
2021	~15	0	Low transmission
2022	~15	0	Low transmission
2023	~27	0	Sporadic/imported
2024	~27	0	Sporadic/imported
2025	~2,500–2,900	12–13	Major outbreak (mid-year start; cumulative ~2,659–2,898 by late 2025/early 2026)
2026 (YTD mid-March)	Additional ~100–300+ (ongoing; cumulative from 2025 start ~3,000+)	3–5 (YTD; cumulative from 2025 start 15–17)	Outbreak continuation; e.g., 14th death early Feb, 15th mid-Feb, 16th late Feb, 17th mid-March (unvaccinated 17-year-old with underlying conditions)

Why such a high case/fatality rate??

- Ultra orthodox avoiding medical doctors
- Lack of awareness of nutrition, sunlight, and Vitamins C, A, and D?
- Doctors harm: delay in diagnostics, antibiotics, appropriate antibiotics, sedation, acetaminophen and ibuprofen numerous doses?
- Discrimination? Religious-secular divide within Israel. Religious Zionists, secular Zionists, and religious ultra orthodox. Resentment towards ultra orthodox.
- Recent stress and fallout of war. (doesn’t account for 2025)

Major Direct Threats and Conflicts in 2025

- **June 2025: The 12-Day War (Israel–Iran Direct Conflict)**
  This was the most significant direct threat to Israel's homeland in 2025. On June 13, Israel launched a major preemptive strike on Iranian nuclear facilities, military sites, missile production, and leadership targets. Iran retaliated with hundreds of ballistic missiles and over 1,000 drones targeting Israel.
    - Iranian missiles penetrated defenses in some cases, striking areas including central Tel Aviv (e.g., near military headquarters in the Kirya), residential buildings, and other sites.
    - Dozens of civilians were killed in Israel (reports vary from ~28–29 total fatalities), with impacts on homes, hospitals, and infrastructure.
    - Israel's multi-layered defenses (Iron Dome, David's Sling, Arrow) intercepted most projectiles, often with U.S. assistance, but the barrage still caused significant disruption, civilian deaths, and damage.
    - A U.S.-brokered ceasefire ended the direct exchanges on June 24. This was a clear, existential-level threat involving long-range missiles hitting Israeli soil.

- **Ongoing Gaza Conflict and Ceasefires**
  Israel remained engaged in operations in Gaza throughout much of 2025, with intermittent ceasefires (e.g., phases in January–March and from October onward).
  - Rocket fire from Gaza continued sporadically, though diminished compared to prior years.
  - Threats included short-range rockets and potential incursions, posing risks to southern Israeli communities (e.g., Sderot, Ashkelon).
  - Ceasefires were fragile and repeatedly violated (reports of hundreds of alleged Israeli violations post-October), but direct large-scale homeland attacks from Gaza were lower than in 2023–2024.
- **Lebanon/Hezbollah Front**
  Following the 2024 ceasefire with Hezbollah, tensions persisted into 2025 with Israeli strikes in southern Lebanon targeting Hezbollah sites to enforce disarmament and prevent rearmament.
  - Hezbollah launched some rockets into northern Israel, though at reduced scale due to prior degradation of its arsenal.
  - Israeli operations included airstrikes and limited ground presence, with occasional cross-border fire threatening northern communities (e.g., Galilee region).
  - No full-scale war resumed in 2025 on this front, but the risk of escalation remained high.

implemented in relation to other diseases as well. This directive illustrates how profound the reversal that Dewey wrote about is. When a patient is

Modern day lepers

- Patients not treated the same if not vaccinated.
- The person carrying the disease as more problematic than the disease itself.
- *"guidance issued this week by the Ministry of Health regarding measles patients. According to the guidance, such a patient will not be transferred to a protected area during an alarm, for fear of infecting others. In other words, a hospitalized person may be left unprotected during a missile strike, not because there is no way to protect him, but because he has been defined first and foremost as a risk to others*".
  ~Israeli guidance issued re measles patients (unverified)

AI Overview

Based on standard hospital emergency protocols regarding infectious disease control, particularly during conflict, highly infectious patients may be isolated in place rather than moved to shared, protected areas. This action prioritizes the prevention of mass infection among other patients and staff over the risk posed to the individual patient by a missile strike. Facebook +3

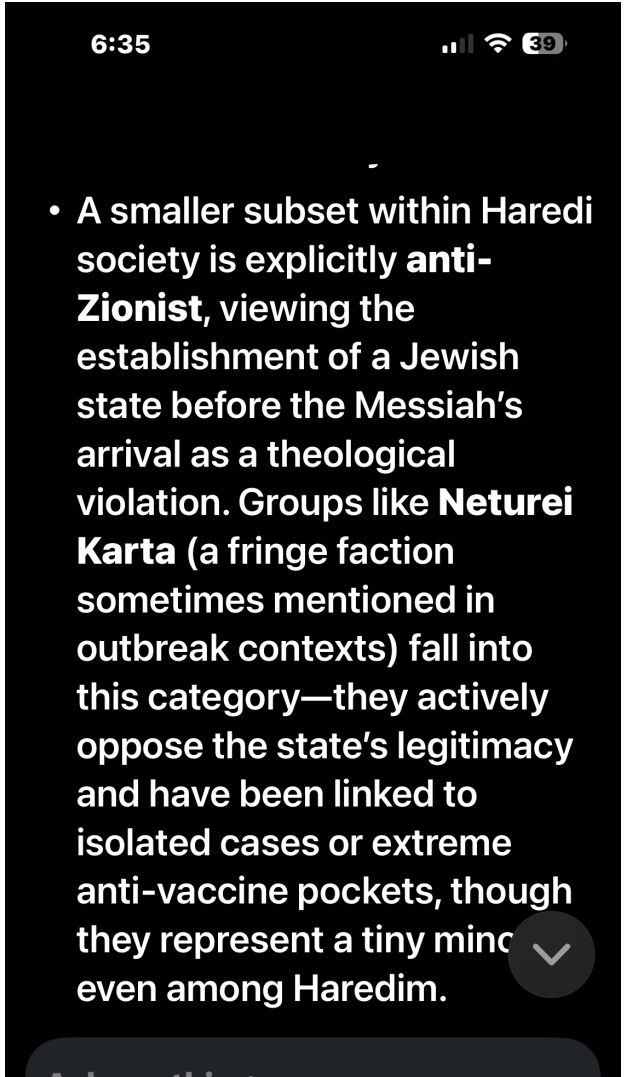
Key considerations include:

- **Protection vs. Infection Risk:** While protected spaces are designed for safety, infectious disease specialists often enforce protocols where severely contagious individuals are segregated to prevent outbreaks, making their transfer during a rapid alarm technically and medically risky to the general population.
- **Ethical and Legal Dilemma:** International Humanitarian Law (IHL) requires the protection of all patients, yet in scenarios where a patient represents a severe threat (such as a high-mortality contagious virus), hospital protocols may prioritize the safety of the many over the few.
- **Missile Strike Situations:** In situations like the conflict in Gaza and in Israel, hospitals, especially those with underground, fortified facilities, prioritize moving vulnerable patients first. However, isolating a highly contagious person in a secure room on-site is sometimes chosen, treating the infectious risk as the most imminent threat. Lieber Institute West Point +4

However, there are **significant social tensions**, mutual resentments, and some isolated incidents of harassment or discrimination directed at Haredim from parts of secular Israeli society. These stem primarily from deep cultural and political divides, especially over issues like mandatory military service, economic integration, and the role of religion in public life.

Key points from recent developments (up to 2025–2026):

- The **central flashpoint** is the long-standing exemption from mandatory IDF (Israel Defense Forces) conscription for full-time yeshiva students. This exemption, dating back to Israel's early years, has become increasingly contentious, especially after October 7, 2023, and ongoing security demands. In 2024–2025, court rulings declared blanket exemptions illegal, leading to draft orders, low response rates (e.g., only ~5% in some reports), arrests of draft dodgers, and massive Haredi protests (tens to hundreds of thousands in Jerusalem in 2025). Some protests turned violent with clashes against police.
- Secular Israelis often view the exemption as unfair burden-sharing — Haredim (about 14% of the population but growing rapidly) contribute less to taxes and the workforce while receiving high state support. Polls show this as one of Israel's most divisive issues, with many secular Jews expressing negative views toward Haredim (e.g., 44% negative sentiment in some 2024 surveys), and tensions ranked high alongside political left-right divides.
- Some Haredi voices describe this pressure as "persecution" or "discrimination," claiming incitement, social exclusion, or even rare physical attacks (e.g., isolated incidents during protests or in secular areas like Tel Aviv). They argue the state and media foster an atmosphere hostile to their lifestyle.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39
• A smaller subset within Haredi society is explicitly **anti-Zionist**, viewing the establishment of a Jewish state before the Messiah's arrival as a theological violation. Groups like **Neturei Karta** (a fringe faction sometimes mentioned in outbreak contexts) fall into this category—they actively oppose the state's legitimacy and have been linked to isolated cases or extreme anti-vaccine pockets, though they represent a tiny mino
even among Haredim.

resistance. **Satmar** Hasidim (especially in Williamsburg, Brooklyn, and parts of Israel) have been repeatedly linked to lower uptake and outbreaks due to insularity, distrust of secular/government authorities, and misinformation spread via community networks (WhatsApp, hotlines). Other Hasidic groups like Bobov show variability, but overall Hasidic communities (vs. Litvish) tend toward higher hesitancy in some surveys.

- **Neturei Karta** (a small, ra… anti-Zionist sect) is

more negative attitudes toward vaccine safety, benefits, and health authorities, often relying less on professionals and more on alternative sources. They include fringe elements that distribute anti-vaccine leaflets even amid infant deaths (e.g., “Guardians of Life” flyers in 2025 Haredi neighborhoods).

- **Certain Hasidic sects** (particularly the more insular ones) have pockets of strong resistance. **Satmar** Hasidim (especially in Williamsburg, Brooklyn, and parts of Isra
have been repeatedly linked to

Yes, many **ultra-Orthodox (Haredi)** Jews in Israel and elsewhere tend to **avoid or minimize contact with the broader medical establishment** when possible, though this is **not absolute** and varies significantly by subgroup, specific situation, and the nature of the health issue.

This pattern stems from a combination of cultural, religious, and practical factors:

- **Insularity and suspicion of secular/"establishment" institutions** — Haredi

rates overall.

These patterns stem from factors like:

- Insularity and large families delaying routine care.
- Distrust of secular/"Zionist" authorities.
- Misinformation (e.g., claims of non-kosher ingredients, fertility risks, or "natural immunity" preference).
- Occasional influence from fringe rabbis or groups promoting conspiracy views.

Importantly, **major Haredi rabbinic authorities** (including

Questions

- Were patients jabbed with measles vax on presentation?
- How many doses of antipyretics given?
- Nutritional status?
- Scurvy
- Isolation and attention paid to patients
- Strain/genotype?
- Were cases turned away from hospitals initially and having to return?

Tara Haelle
Contributor
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How Do You Change An Anti-Vaccine Parent's Mind? Scare The Crap Out Of Them

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A new study suggests a glimmer of hope in changing the minds of those who are uneasy about vaccines: scaring them – albeit with facts – works. At least with some of them.

SIDS rates in Israel. Steady.

- Specific examples from available data:
  - Around 2016–2017: Reports indicated **40–53** cases of SUID (Central Bureau of Statistics data referenced in studies).
  - Older reports (e.g., 2017 news) cited about **45** babies per year from SIDS-like causes.
  - A 2021 study referenced rates of 0.23–0.6 per 1,000 live births in the prior decade, equating to roughly **40–100** cases annually given Israel's ~170,000–180,000 annual births.
- No major shifts or large increases are documented in the past 10 years; the figure has remained relatively stable in the **50–80** range per year, with the **60–80** estimate most commonly referenced by official and advocacy sources.

> Proc Natl Acad Sci U S A. 2020 Dec 22;117(51):32657-32666. doi: 10.1073/pnas.2014468117. Epub 2020 Nov 30.

A highly immunogenic and effective measles virus-based Th1-biased COVID-19 vaccine

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Affiliations + expand

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Abstract

The COVID-19 pandemic is caused by severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) and has spread worldwide, with millions of cases and more than 1 million deaths to date. The gravity of the situation mandates accelerated efforts to identify safe and effective vaccines. Here, we generated measles virus (MeV)-based vaccine candidates expressing the SARS-CoV-2 spike glycoprotein (S). Insertion of the full-length S protein gene in two different MeV genomic positions resulted in modulated S protein expression. The variant with lower S protein expression levels was genetically stable and induced high levels of effective Th1-biased antibody and T cell responses in mice after two immunizations. In addition to neutralizing IgG antibody responses in a protective range, multifunctional $CD8^+$ and $CD4^+$ T cell responses with S protein-specific killing activity were detected. Upon challenge using a mouse-adapted SARS-CoV-2, virus loads in vaccinated mice were significantly lower, while vaccinated Syrian hamsters revealed protection in a harsh challenge setup using an early-passage human patient isolate. These results are highly encouraging and support further development of MeV-based COVID-19 vaccines.