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Vaccination Risk Awareness Network Inc.

Will the Poliovirus Eradication Program Rid the World of Childhood Paralysis?

With So Little Poliovirus Detected Around the World, What Is Causing Today's Outbreaks of Acute Flaccid Paralyis?

By Neenyah Ostrom

April 20/2001

Every child of the early '50s surely remembers the polio panics that swept the nation, invariably during the hottest days of summer, closing public pools and resulting in doctor visits at the first sign of a stiff neck or leg prone to falling asleep. My memory of the terror induced by the whispered word "polio" resides in a spot in the pit of my stomach just distal to the one recalling the Cold War era duck-and-cover drills we practiced in grammar school.

In retrospect, it seems darkly hilarious that we ever believed plywood desks and plump little arms would protect school children from a nuclear attack. Our not-quite-rational fear of the poliovirus, however, endures despite World Health Organization eradication programs [www.polioeradication.org] in the corners of the developing world where poliovirus is thought to lurk. One reason for this lingering concern is the continuing prevalence of acute flaccid paralysis, polio's most crippling symptom that can leave its victims unable to control entire muscle groups, even those that allow us to breathe.

Worldwide polio-related public health alarms sounded on the first day of 2001 when a new epidemic was reported to have broken out on the island of Hispaniola, on which Haiti and the Dominican Republic are located. David Brown reported in the *Washington Post* that a "mutant" poliovirus, derived from strains present in the oral polio vaccine, appeared to have run amok on this Caribbean island during the latter half of 2000.(3)

When the US Centers for Disease Control and Prevention (CDC) examined these cases, another mystery was revealed: Only about one-third of the paralysis cases were associated with poliovirus. The CDC identified 19 individuals in the Dominican Republic who developed acute flaccid paralysis (AFP, the hallmark symptom of poliovirus infection as well as a syndrome unto itself) between July 12 and November 18, 2000. However, poliovirus was detected in *only six of those individuals*. The cause of the other cases of paralysis remains unknown. (25)

The mystery deepens when we examine World Health Organization (WHO) statistics on AFP and poliovirus infection in the Dominican Republic for the last several years. [http://www.nt.who.int/vaccines/polio/case.asp] Although the number of cases

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Editorial

Edda West

POLIO PERSPECTIVES

Time and again, when parents call VRAN searching for vaccine risk information, the question of polio comes up. Anxious mothers ask – but what about polio – isn't that an important vaccine to get? What if my child gets polio? Although most young parents today didn't live through the polio era, there is an inherited fear that lingers on – a fear that is reinforced by health officials who use the threat of the resurgence of infectious diseases like polio to elicit compliance with mass vaccination programs. Statements like "these diseases are just a plane ride away" conjure images of predatory pathogens invading from more primitive corners of the world.

That the polio virus is the sole cause of polio is accepted by most people as gospel, and that the Salk and Sabin vaccines eradicated polio in the western world is etched into

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VRAN NEWSLETTER

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Statement of Purpose

•VRAN was formed in October of 1992 in response to growing parental concern regarding the safety of current vaccination programs in use in Canada.
•VRAN continues the work of the Committee Against Compulsory Vaccination, who in 1982, challenged Ontario's compulsory "Immunization of School Pupils Act", which resulted in amendment of the Act, and guarantees an exemption of conscience from any 'required' vaccine.
•VRAN forwards the belief that all people have the right to draw on a broad information base when deciding on drugs offered themselves and/or their children and in particular drugs associated with potentially serious health risks, injury and death. VACCINES ARE SUCH DRUGS.
•VRAN is committed to gathering and distributing information and resources that contribute to the creation of health and well being in our families and communities.

VRAN's Mandate is:

•To empower parents to make an informed decision when considering vaccines for their children.
•To educate and inform parents about the risks, adverse reactions, and contraindications of vaccinations.
•To respect parental choice in deciding whether or not to vaccinate their child.
•To provide support to parents whose children have suffered adverse reactions and health injuries as a result of childhood vaccinations.
•To promote a multi-disciplinary approach to child and family health utilizing the following modalities: herbalist, chiropractor, naturopath, homeopath, reflexologist, allopath (regular doctor), etc.
•To empower women to reclaim their position as primary healers in the family.
•To maintain links with consumer groups similar to ours around the world through an exchange of information, research and analysis, thereby enabling parents to reclaim health care choices for their families.
•To support people in their fight for health freedom and to maintain and further the individual's freedom from enforced medication.

VRAN publishes a newsletter 4 times a year as a means of distributing information to members and the community. Suggested annual membership fees, including quarterly newsletter and your on-going support to the Vaccination Risk Awareness Network:
$25.00—Individual $50.00—Professional
We would like to share the personal stories of our membership. If you would like to submit your story, please contact Edda West by fax or e-mail, as indicated above.
VRAN website: www.vran.org

VRAN NEWS

FALL FUNDRAISING APPEAL STARTS

It is with great pleasure that we launch our fall fundraising campaign with a new book bonus offer – Walene James' **Immunization – The Reality Behind The Myth**, second edition. Many years ago, when the first edition was published and Dorothea Nusbaum and I were running The Committee Against Compulsory Vaccination, we both agreed that this book said everything that we had ever wanted to say about the vaccine issue, and more. It is undoubtedly one of the most important books ever written on the subject because it thoroughly dissects the narrow minded germ theory of disease that keeps us captive to the vaccine paradigm, and liberates us from that tyranny. Walene James, historian, teacher and wisewoman, encourages us to embrace a much larger and wholisitc perspective that embraces natural health philosophies and empowers us to truly create health in our families. I think of the book as the vaccine dissenters Bible as it not only thoroughly educates us about the history of vaccines and their use, the path of disease and suffering spawned by vaccines, but most importantly, inspires us to evolve to a new consciousness – a new understanding of the true, and timeless determinants of health. In Canada, the retail value of Immunization: The Reality Behind the Myth is $42.95 We offer you this book bonus in appreciation of fundraising donations of $150 or more.

PROTECTING CHILDREN'S HEALTH

We thank VRAN member Christine Longford for requesting that the VRAN newsletter put more emphasis on ways that we can enhance children's health, and have responded to her excellent suggestion with a new **Protecting Children's Health** section in the newsletter. Says Christine, "I know parents who say, yes it is a big risk to get the vaccine, but what is the alternative? Perhaps there should be some valid research studies done on hygiene, quarantine, building immune response, and long term nursing (breastfeeding). Perhaps mother'' milk could be the next future version of antibodies and inoculations and could be given in areas of outbreaks…rather than vaccines genetically engineered into rice or lettuce. I myself am advocating for long term nursing well into the fourth and fifth years to be an accepted process and part of health & prevention that will save lives and millions in care."

KEEPING THE PUBLIC IN THE DARK

Many thanks to VRAN members Rita Hoffman and Lara Fitzgerald for sending us a new brochure by The Durham Region Health Department in Ontario, and distributed to thousands of families. It's a colourful eye catching pamphlet with a cheery cartoon drawing of children dangling from an umbrella, entitled "Immunization –The Best Protection. It's opening statement shoves scare tactics in your

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face…"Children need vaccinations (shots) to protect them from dangerous childhood diseases. When children are not vaccinated and come in contact with one of these diseases, they can get very sick or even die." It fraudulently misrepresents Ontario's Immunization of School Pupils Act, and fails to inform about available exemptions under the Act…"Failure to provide immunization information may result in suspension from school." We plan to address our concerns to Dr. Robert Kyle, Medical Officer of Health in the Durham Region, as well as Ontario's Minister of Health, Tony Clement. If you live in the Durham Region, please contact us to co-ordinate a direct action on this violation of personal choice on the vaccine issue in Ontario.

3rd ANNUAL COMMON CAUSE MEDICAL RESEARCH FOUNDATION CONFERENCE

Many thanks to VRAN member Rose Stevens for sending us a conference overview. The 3rd Annual Medical Research Foundation Conference on Aug 17-19th was well received in Winnipeg, with doctors, researchers and executive CCMRF members travelling from all corners of the continent to attend.

Professor Don Scott, author of the book The Brucellosis Triangle, presented startling information on how a military patented mycoplasma is the probable common cause of many neurodegenerative diseases, such as Alzheimer's, Creutzfeldt Jacob, Multiple Sclerosis, Chronic Fatigue Syndrome, Gulf War Syndrome. He presented a perspective of these diseases from a molecular, chemical, political and historical aspect, and the best hope for a cure was presented . Much of this information can be accessed via the Eagle Foundation Press Release(www.ealgefoundation.net) under "latest news" and on the Nexus Magazine website (www.nexus-magazine.com) (recent issue)

Dr. Rebecca Carley is one of those people who ":walks the talk". "Walk the Talk -What is Ailing America?", is the name of Dr. Rebecca Carley's radio show in Long Island New York. At the conference Dr. Carley spoke about the dangers associated with vaccines, and how she has successfully treated may people with vaccine induced illnesses.

Dr Harold Clark, Honorary, Chair and Director Emeritus, for the CCMRF was amazed to meet other so called "maverick doctors" at the conference. After 40 years of research into mycoplasma contaminated vaccines, he finally felt like he had met his fellow believers. Harold said that viral vaccines were found to be contaminated with mycoplasma as early as 1956 and probably the cause of vaccine adverse reactions in hypersensitive hosts.

To antidote this bad news on how we have all been contaminated with mycoplasma, Don Tunny presented his approach on how to lower the body's microbial load using the Rife Technology. Don Tunny, a world leading expert on the Rife Technology, showed us in his presentation, how these "frequency medicine" devices are probably our best hope of defending ourselves in this age of "patented plagues". Dr. Gerry Bohemier, president of the Eagle Foundation, spoke about the 'Dr. Beck Protocol' on purifying the blood using the silver and magnetic pulser.

Video tapes of the conference are available through the Eagle Foundation. Seven two hour tapes of the conference will be sold for a cost of $60 plus shipping. For more information on tapes or how to subscribe to the Journal of Degenerative Diseases, please contact Rose Stevens at novaccines4me@yahoo.ca or phone 204-254-3996.

DID YOU KNOW ?

There is no law that can force you to vaccinate your children. The only laws relating to vaccination govern school pupils, not infants, and these can be waived through available exemptions. If your child has exhibited any of the following adverse reactions or conditions, you may wish to defer from continuing the course of vaccinations.

- If your child is ill or running a fever.
- If the child collapses or goes into a shock-like state following a vaccine.
- If the child has high pitched screaming for several hours; and cannot be comforted
- If the child has a temperature of 38° C or higher after vaccination.
- If the child develops pain, redness, swelling, lump at the needle site
- If the child develops severe diarrhea and/or vomiting
- If the child has one or more convulsions or has a family history of convulsive disorders (eg. epilepsy); if the child has an evolving neurological condition.
- If there is a family history of severe allergies and/or history of vaccine reactions.
- If the child has signs of brain injury such as a bulge in the soft spots of the head or a severe change of consciousness.
- If the child is receiving treatments that suppress the immune system
- If the child has a widespread allergic reaction, rashes, hives, wheezing, trouble breathing.
- If the child develops swollen joints/arthritis like symptoms
- If the child has an irregular heartbeat within several hours after vaccination.
- If the child is excessively sleepy following vaccination.
- If the child has an episode of sleep apnoea (stops breathing during sleep)

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of AFP in the Dominican Republic from 1996 to 1999 range from 4 to 24, *not a single case of poliovirus was detected*.

If we further examine other WHO statistics on poliovirus-associated AFP and those in which the virus is not detected, a striking fact becomes clear: *Most acute flaccid paralysis diagnosed around the world today is NOT associated with poliovirus*.

This fact raises new, disturbing questions, including whether there ever was an epidemic of poliovirus infection in the United States and Canada. There was a greatly increased prevalence of AFP, to be sure, during which many children (and some adults) tragically were paralyzed or died. Since many of those cases showed all the hallmarks of a typical poliovirus infection — fever, stiff neck and back, severe headache, muscle pain, sore throat and, in severe cases, paralysis — and occurred in clusters, they were assumed to be caused by the easily-transmitted poliovirus.

But were they? If not,what *is* the cause of so much misery today in areas of the world least-equipped to be able to deal with it? Is it correct to assume that poliovirus causes most cases of paralysis?

What Is Poliomyelitis?

The word "poliomyelitis"comes from two Greek words: "polio," which means gray, and "myelitis," inflammation of the spinal cord. Poliomyelitis can cripple and kill vulnerable individuals, especially children, within days. It often affects the very young, which is why it is also called "infantile paralysis." Some individuals develop only flu-like symptoms without paralysis; "aseptic meningitis" (swelling of the membranes surrounding the brain) can result. This "minor illness" of poliomyelitis (as it is called) is characterized by slight fever, malaise, headache, sore throat, and vomiting; patients usually recover completely in 24-72 hours. Non-paralytic poliomyelitis cannot be differentiated clinically from aseptic meningitis caused by other transmissible agents. Surprisingly, fewer than one in 100 cases (and possibly as few as one in 1,000 cases) of infection with poliovirus produces any obvious disease, even during out-breaks. (23,24)

The "major illness " of poliomyelitis usually develops suddenly with fever, stiff neck and back, severe headache, and muscle pain. Major illness can progress to loss of tendon reflexes and asymmetrical weakness or paralysis. Poliomyelitis is generally diagnosed clinically by the concurrent presence of high fever and acute, asymmetrical flaccid paralysis, which develops in 2-4 days following the fever and muscle aches. Approximately 50% of people stricken with paralytic poliomyelitis remain disabled throughout their lives.(24)

The paralysis produced by poliomyelitis results from inflammation and destruction of motor neurons in the

The Search for the Transmissible Agent of Poliomyelitis

Poliomyelitis became an important public health concern when it first spread along the eastern seaboard of the United States, as well as in industrialized areas of Europe, in the early 1900s. Its inexplicable outbreaks were frightening to the public and medical personnel alike, as Simon Flexner and Paul A. Lewis (both of the Rockefeller Institute for Medical Research in New York) demonstrated when they wrote in the *Journal of the American Medical Association* in 1909, "The cause and mode of dissemination of the disease [poliomyelitis] are unknown; and hence there exists no intelligent means of prevention. While the severity and fatality of the disease fluctuate widely, its effects are always so disastrous as to make it of the highest medical and social importance." (14)

Just a year earlier, Austrian researchers Karl Landsteiner and Erwin Popper had made a historic breakthrough in the study of poliomyelitis. Landsteiner had a nine-year-old poliomyelitis patient who died on November 18, 1908, after just four days of illness. With his colleague Popper, Landsteiner created a suspension from the child's spinal cord and injected it into two monkeys, as well as a number of rabbits, guinea pigs, and mice. While the other animals were unaffected by the injections of spinal cord material, the two monkeys developed lesions in their spinal cords and brains that appeared indistinguishable from those found in humans suffering from poliomyelitis. One of the monkeys developed acute flaccid paralysis in both legs. Although Landsteiner and Popper attempted to transmit paralysis to other monkeys using the sick monkeys ' nervous system tissues — which is called "passaging" of the transmissible agent — they were unsuccessful. (10,20)

The following year, Flexner and Lewis succeeded where Landsteiner and Popper had not: Flexner and Lewis reported in the *Journal of the American Medical Association* that they had successfully passaged poliomyelitis through several monkeys (i.e., from monkey to monkey). They began, like Landsteiner and Popper, by injecting diseased human spinal cord tissue into the brains of monkeys. After a monkey fell ill, a suspension of its diseased spinal cord tissue was injected into other monkeys. Flexner and Lewis's 1909 work was considered a breakthrough because the second monkey (and the third, and fourth,

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gray matter of the spinal cord and brain. The type or degree of paralysis induced depends upon the location and extent of motor neuron destruc-tion, and can range from minor to severe limb paralysis, to paralysis of the muscles that allow us to breathe. The iron lung was used in the 1940s and '50s to assist children who could not breathe on their own. As frighten-ing as iron lungs look in the old photos, many children recovered completely. However, paralytic poliomyelitis is fatal in 2-10% of cases. (24)

With the exception of patients who go into respiratory failure, poliomy-elitis treatment is symptomatic: non-narcotic pain killers, application of hot packs, and physical therapy.

What Is Poliovirus?

Despite the damage it causes to nerve tissue, the poliovirus has been placed in the enterovirus family of viruses that live in the gastrointestinal system. It is formed of a single strand of RNA enclosed in a protein coat that protects it from environmental attack (inactivation). Poliovirus is quite small by viral standards (22-32 nano-meters). Humans are thought to be poliovirus's only host, which is why the WHO launched an eradication program. According to the CDC, the only confirmed cases of poliovirus-associated paralysis in the US since 1979 have been associated with the oral, live-virus vaccine. (24,31) In fact, the CDC now concludes that "Both laboratory surveillance for enteroviruses and surveillance for polio cases suggest that endemic circulation of indigenous wild polioviruses ceased in the United States in the 1960s." (24) Other investigators question the CDC 's conclusion that wild poliovirus circulation truly "ceased" in the United States four decades ago.

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through at least six by the time of publication) developed poliomyelitis. Flexner and Lewis had successfully passaged the disease's transmissible component from animal to animal. (14)

But what was the passaged agent? "We failed utterly to discover bacteria, either in film preparations or in cultures, that could account for the disease," Flexner and Lewis reported. Therefore, they concluded, "…the infecting agent of epidemic poliomyelitis belongs to the class of the minute and filterable viruses that have not thus far been demonstrated with certainty under the microscope." (14)

Did Flexner and Lewis succeed in isolating poliovirus in 1909? Hindsight being 20/20, it is possible to see that early experiments attempting to create purified poliovirus preparations might well have contained other agents.

The debate over the nature of the causative agent of poliomyelitis continued. One research team speculated in 1919 that a type of bacteria, cautiously named "poliococcus," was either the culprit or a co-factor. (7) In early experiments, all kinds of biological materials — spinal cord, brain, fecal matter, even flies — were ground up and injected into monkeys to induce paralysissis. (4,7,15,21,22,33) These early "virus preparations" were *known* to contain bacteria. The amount of bacteria was determined by seeding a tissue culture plate with some of the spinal cord (or fecal matter) emulsion to measure how long it took for bacterial colonies to appear. As F. B. Gordon and colleagues pointed out in a paper published in the *Journal of Infectious Diseases*, "If there was no [bacterial] growth after approximately 22 hours incubation at 37 C., the specimen was considered suitable for inoculation into monkeys. This was not an actual sterility test, since growth would usually occur on longer incubation; it was rather an indication of the amount of bacterial contamination in the specimen." (15)

Early poliovirus researchers, then, knew that the "virus" they were injecting into monkeys also contained an undetermined amount of bacteria. They had no way of determining what else might be present.

While Flexner and Lewis may have been incorrect in assuming they had transmitted a purified form of "filterable virus" into their monkeys, they certainly transferred a disease-causing agent or agents from animal to animal. Although they could not actually visualize this agent, they described it in the greatest detail that they could. In doing so, which they undoubtedly meant to be a service to other researchers, they may have voiced their conclusions in ways that would haunt poliomyelitis research for decades.

At the beginning of the 20th century, as scientists began trying to understand and characterize viruses and viral diseases, many of them — including poliomyelitis researchers like Flexner and Lewis — overstated their findings.

Early poliomyelitis researchers were true scientific pioneers: Flexner, Lewis, Dalldorf, Landsteiner, Popper, Dulbecco, Sabin, Salk, and many others worked with unknown agents. They didn't understand the properties of the contaminated tissues they handled, and they didn't know how to protect themselves from the diseases those tissues might contain. Their bravery in undertaking these risks should never be underestimated, especially in our era when latex gloves, biosafety cabinets, and many other methods of protecting scientists from dangerous transmissible agents are readily available.

Nevertheless, these early 20th century researchers should not get a free pass for their lack of precision in describing experiments and their results.

For example, in 1948, Gilbert Dalldorf and Grace M. Sickles from the New York State Department of

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Health published a research report that illustrates some problems in virology that persist even today. Dalldorf and Sickles described an "unidentified, filterable agent" that they had "isolated" from the feces of paralyzed children. (6)

The problems become clear when Dalldorf and Sickles described how they "isolated" this agent:

"Twenty per cent fecal suspensions, prepared by ether treatment and centrifugation, were inoculated intracerebrally into albino mice of the laboratory strain. Suckling mice, 3-7 days of age, became paralyzed, while mice 10-12 gm in weight did not. The isolations were repeated several times.…"(6)

Dalldorf and Sickles used the word "isolation" to describe their creation of a suspension of fecal matter — which was a vast overstatement, to put it mildly.

Dalldorf and Sickles then attempted to identify the agent. In 1948, antibodies, like viruses, could not be characterized as they now can. "Neutralizing serum" — the non-cellular portion of the blood, taken from a person or animal presumed to be infected with the agent — was used to differentiate between viral strains. This neutralizing serum probably contained antibodies against the agent.

According to Dalldorf and Sickles, neutralizing serum from paralyzed children inhibited paralysis in mice when they were injected simultaneously with it and the unidentified agent. This absence of evidence — that the mice did not develop paralysis — was interpreted to mean that the agent injected into the mouse had been successfully stopped by the neutralizing serum (i.e., the immune response generated by the sick child). There was no proof, as Dalldorf and Sickles asserted, that the neutralizing serum was reacting with and inhibiting *one specific agent*.

Dalldorf and Sickles believed they 'd "isolated" a novel agent that could infect people, although they did not argue that it was responsible for producing the paralysis seen in their patients. "The patients we studied may possibly have been coincidentally infected with the new agent and classical poliomyelitis virus, although isolations were not successful in [causing disease in] the rhesus monkey," they write. (6) *Again, they write of "isolation" when they are referring to taking a partially processed specimen (spinal tissue or feces) from a paralyzed person and injecting it into an animal to see if the diluted specimen produced paralysis*. True isolation did not take place.

Has Poliovirus Ever Really Been Isolated?

It is an article of faith in modern medicine that poliovirus has been isolated, characterized, is fully understood and on its way to extinction, thanks to aggressive vaccination/eradication programs. As the recent outbreak in the Dominican Republic illustrates, however, we may be further from eradicating poliomyelitis than we are generally led to believe.

Furthermore, while the agent identified as poliovirus was certainly cultured in the late 1940s, do we know for sure that it was truly isolated i.e., grown in a pure form containing no contaminants? We now know that adventitious ("passenger") viruses like SV40 are common in the monkey tissues that early poliovirus researchers used for cell cultures. While these agents apparently cause no harm to the monkeys, their long-term effects on humans remain to be determined. [http://www.chronicillnet.org/online/bensweet.html#anchor714274]

Some 90 years after Landsteiner and Popper's report of successful transfer of poliomyelitis to monkeys, Dr. Wolfgang K. Joklik reviewed the great leaps forward during the 20th century by its defining discipline, virology. (19) The occasion was the concurrent 100th anniversaries of the American Society for Microbiology and the field of virology itself. Having served as editor-in-chief of *Virology* and an editor of *Journal of Virology* over his long career as a professor of microbiology, Joklik was uniquely placed (as he noted) to evaluate what had been learned since early experiments in virology.

Before the founding of *Virology* and *Journal of Virology* in the 1950s and '60s, respectively, Joklik noted, a number of "epoch-making discoveries in virology" appeared in journals not devoted to the field. Among the seven discoveries he singled out, were two related to paralysis research. The first was "the discovery by Enders et al. in 1949 that poliomyelitis virus could be grown in human embryonic tissue cells cultured in vitro, which formed the basis of the technique of tissue culture (single cell culture)"; the second, "…the demonstration by Dulbecco, also in 1952, that an animal virus …was capable of forming plaques in monolayers of cloned cultured cells, which opened up the field of molecular animal virology." (19) While Dulbecco's 1952 study did not involve poliovirus, it led directly to his 1954 paper in which he extended the new methodology to the study of poliovirus. (8,9)

In 1949, as Joklik recounted, Harvard Medical School researcher John F. Enders, along with his colleagues Thomas H. Weller (a Fellow of the U.S.Public Health Service) and Frederick C. Robbins (a Senior Fellow in Virus Diseases of the National Research Council) showed not only that poliovirus could grow in cultured cells, but also that it could replicate in non-nervous system tissues, a stunning discovery at the time. (13) It was already suspected that poliovirus was often present in the intestines of affected individuals. However, no one had been able to propagate the virus in gut tissue, primarily because of the bacte-

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ria that naturally live there. Enders and colleagues were successful in part because they added antibiotic (penicillin and/or streptomycin) to their cell cultures to kill the bacteria — a technique that had not, of course, been available to researchers working in the pre-World War II era.

While Enders and colleagues' 1949 paper is widely acknowledged to be a turning point in poliomyelitis research — many, including World Health Organization poliovirus eradication researchers, credit this piece of science with paving the way for the development of both the Salk and Sabin polio vaccines — poliovirus was not actually isolated by these investigators, either. They successfully grew "filterable agents," which they assumed to be poliovirus, in human embryonic tissues. Like Landsteiner and Popper 40 years earlier — and like just about everyone else in the field during its first 60 years or so — Enders and coworkers called this disease-transmitting suspension of tissue "virus."

Despite this overstatement, Enders, Weller, and Robbins were the first to prove that a transmissible agent associated with poliomyelitis could be propagated in cells in the laboratory, and that cell cultures could be substituted for live animals in studying such transmissible agents. In 1954, their groundbreaking work was rewarded with a Nobel Prize.

Renato Dulbecco's 1952 paper lauded by Joklik is considered to have made a significant contribution to viral research in general and, by extrapolation, to poliovirus research. Working at the California Institute of Technology (in Pasadena), Dulbecco developed a method of growing plates of cells so that "virus plaques" could be visualized. He grew Western Equine Encephalomyelitis virus plaques on a substrate of chicken embryo cells and, when he published his paper, he pointed out that it was still unknown-whether all viruses could be cultured in this manner. These were truly the very earliest days of modern virological research, and Dulbecco expressed hope that investigators would some day be able to distinguish between various viruses grown in cell culture by using his methodology and examining the resulting plaques under the microscope. (8)

In 1954, Dulbecco and his colleague Margaret Vogt published a classic research paper [see sidebar, "The Dulbecco Isolation Experiment,"] that set the standard for purifying poliovirus cultures for decades. (9) Dulbecco and Vogt, like their colleagues, used monkey kidney cells to culture tissues thought to contain poliovirus. Dulbecco and Vogt explained where the "virus " they grew came from:

"The virus was supplied as a 20 percent suspension of spinal cord of rhesus monkey in distilled water. Type 1 virus obtained from passage through the monolayer kidney cultures was used. Type 2, Yale-SK strain, and Type 3, Leon strain, were kindly supplied by Dr .J. L. Melnick in form of tissue culture supernatants." (9)

In other words: Dulbecco and Vogt *did not isolate pure poliovirus* in any of the experiments described in this 1954 report . While they write of seeding their cultures with "virus," they actually used unpurified suspensions, not pure viral isolates.

It is clear from this historical review of early poliovirus research papers that none of these poliomyelitis researchers truly isolated poliovirus. Additionally, they were injecting monkeys with experimental fluids that were probably contaminated with other disease-associated agents.

Further confusing the picture (but not reviewed here) is the fact that enteroviruses other than poliovirus are associated with AFP. For example, as recently as February 2001, it was shown that Coxsackie A24 is associated with nonpolio AFP. (5)

How Much Flaccid Paralysis Is NOT Caused by the Poliovirus?

There is an astonishing number of cases of paralysis around the world not associated with poliovirus. If you visit the World Health Organization website that tracks acute flaccid paralysis (AFP), polio and non-polio [http://www-nt.who.int/vaccines/polio/case.asp], you will see that the world is not rid of the scourge of AFP. For example, India reported 9,580 cases of AFP in 1999; 2802 of them, fewer than one-third, were associated with poliovirus. China reported 5,064 cases of AFP to WHO in 1999; only one of those cases was associated with poliovirus. Poliovirus eradication and vaccination programs have not eliminated paralysis.

WHO recently declared Egypt on the threshold of eradicating poliovirus. "We are now at the end of a polio era," a UN Children 's Fund Project Officer told Reuter's news service in late February 2001. Egypt had "not a single case of the crippling virus reported so far this year" or in 2000, according to Reuters. (17)

According to the WHO AFP/polio surveillance web site, however, there were 54 cases of acute flaccid paralysis in Egypt in 2000 (the most recent year for which statistics are available). In 1999, although there were 9 AFP cases classified as due to poliovirus, 276 were classified as nonpolio. During 1998, Egypt had 295 cases of AFP, 35 of which were classified as poliovirus-related; in 1997, Egypt reported 217 cases of non-polio paralysis compared to 14 cases in which poliovirus infection was confirmed; and in 1996, the earliest year for which statistics are available, Egypt reported 309 cases of acute flaccid paralysis. One hundred of those were classified as poliovirus-related, leaving

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209 cases — two-thirds of the total — probably due to a cause other than poliovirus (with the caveat that epidemiological statistics are not perfectly accurate in every country of the world). [http://www-nt.who.int/vaccines/polio/case.asp]

Afghanistan is another country in which there is an increasing prevalence of AFP compared to a decreasing incidence of poliovirus. As the U.S.Centers for Disease Control and Prevention 's *Morbidity and Mortality Weekly Report* (MMWR) notes on March 2, 2001, "During 1999-2000, the number of AFP cases [in Afghanistan] increased from 230 to 253, and the number of wild polioviruses isolated from AFP cases decreased from 63 to 28." (28)

How does the CDC explain the increase in AFP cases in Afghanistan, in the face of a vigorous poliovirus eradication campaign? Well, it doesn't. In fact, the *MMWR* report almost makes the increase in nonpolio AFP sound like a triumph of public health: "During 1999-2000, the nonpolio AFP rate almost doubled and the number of districts reached by NIDs [National Immunization Days] increased steadily. Careful planning and supervision of house-to-house vaccination and support from an increasing number of local partners resulted in the largest number of children ever being reached. Monitoring by nongovernment organizations, United Nations' agencies, and local authorities has increased the quality of NIDs …." (28) In other words, the more National Immunization Days there were, the more cases of paralysis appeared. Does this mean immunizations were causing paralysis? No, but neither was increased immunization preventing children from becoming paralyzed.

The Western Hemisphere has also been impacted by an increased case load of AFP. As mentioned earlier, the island of Hispaniola (the Dominican Republic and Haiti) experienced what the CDC called an "outbreak of poliomyelitis" that began in July 2000. There were 54 cases in the Dominican Republic, 12 of which were "laboratory-confirmed poliomyelitis cases attributed to vaccine-derived poliovirus type 1," according to the CDC. Although the oral polio vaccine is known to cause polio in about 1 of every 750,000 infants who receive it or their mothers — unlike the inactivated Salk vaccine "shot," the Sabin oral vaccine contains live viruses — the 45 cases reported in January 2001 in the *Washington Post* are, if confirmed, clearly outside the realm of this statistic. (3)

As of the end of February 2001, the cause(s) of 33 AFP cases in the Dominican Republic and three in Haiti remained undetermined. (27) All of these cases might be due to the oral polio vaccine, in which case the mystery would be solved — leaving unanswered, however, the question of what factors contributed to such a large vaccine-associated outbreak of paralysis.

If these 36 AFP cases are not related to the polio vaccine, however, then what is causing them? What is causing other nonpolio outbreaks of AFP identified by WHO all over the world?

And in cases in which poliovirus is fingered as the culprit in an outbreak, how sensitive are the current methodologies that virologists use to isolate and identify it?

How Is Poliovirus Detected Today?

It is nearly unimaginable how sensitive and sophisticated laboratory technology has become over the last 30 years. As we examine the entire sequence of the human genome in early 2001, it's difficult to imagine that it was only in the 1970s that scientists first developed the technology that allowed the rapid sequencing of genes, including genetic sequences from transmissible agents like bacteria and viruses.

This new sequencing methodology was immediately applied to poliovirus research. During the 1970s, the CDC began routinely performing genotypic testing ("molecular sequencing" or "oligo-nucleotide fingerprinting") on stool samples collected in suspected poliovirus outbreaks to determine whether the virus was present. Using findings from the new technology to extrapolate to the prior decade, CDC documents now state that, "Both laboratory surveillance for enteroviruses and surveillance for polio cases suggest that endemic circulation of indigenous wild polioviruses ceased in the United States in the 1960s." (24)

To detect poliovirus today, according to CDC and WHO guidelines, two stool samples should be collected from each patient, 24-48 hours apart within 14 days of the onset of paralysis, and they must arrive at the laboratory in "good condition." While WHO 's target is to obtain two good samples in at least 80% of all AFP cases, some areas of the world fall short of this, approaching only 50%. (28)

The CDC provides the following guidelines on how to detect poliovirus:

"The following tests should be performed on appropriate specimens collected from persons who have suspected cases of polio: a) isolation of poliovirus in tissue culture; b) serotyping of a poliovirus isolate as serotype 1, 2, or 3; and c) intratypic differentiation using DNA/RNA probe hybridization or polymerase chain reaction to determine whether a poliovirus isolate is associated with a vaccine or wild virus.

"Acute-phase and convalescent-phase serum specimens should be tested for neutralizing antibody to each of the three poliovirus serotypes. A four-fold rise in antibody titer between appropriately timed acute-phase and convalescent-phase serum specimen is diagnostic for poliovirus infection. The recently revised standard protocol for

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poliovirus serology should be used. Commercial laboratories usually perform complement fixation and other tests. However, assays other than neutralization are difficult to interpret because of inadequate standardization and relative insensitivity." (24)

While this procedure is a time-honored method of detecting the poliovirus and the body's response to it, it does not "isolate"the poliovirus — it simply detects poliovirus. The samples tested by the CDC and WHO should be described as "poliovirus reactive material," not as samples that contain isolated, pure poliovirus.

Once again, we have no proof that poliovirus has been isolated.

If Not Poliovirus, Then What Is Causing Today's Cases of Flaccid Paralysis?

"The history of the etiology of poliomyelitis is a history of errors."
J. F. Eggers, *Medicine*, 1954

If the majority of the U.S.population has been immunized since the 1950s, why did it take until 1979 to "eradicate" poliovirus within the United States? (24,31)

And what is causing the nonpolio cases of paralysis that continue to occur all over the world?

It is becoming clear that one culprit capable of causing not only paralysis but also other neurological conditions is organophosphate pesticides. Recent research has tied chronic organophosphate pesticide exposure to development of Parkinson 's disease signs and symptoms in an animal model. (2) And researchers in Paraguay have good evidence that an outbreak of AFP among children in 1990-1991 was associated with organophosphate pesticide exposure.

The 50 Paraguayan children identified in this study — given that it was conducted in a rural, isolated area meant that quite a number of affected children might have been excluded from the study, as investigators noted — developed a type of AFP named Guillain-Barré Syndrome, or GBS. As is the case in other forms of AFP, the myelin sheath that surrounds and protects nerves is damaged in GBS. The disease's causes are unknown, but it's generally believed to be an autoimmune condition provoked by infections, toxins, or a combination of both. (16)

The children became ill during the Paraguayan summer (January to April), with weakness, upper respiratory tract infection, fever, and gastrointestinal symptoms. Three children developed difficulty breathing, and two of them required mechanical help to breathe (intubation). "Weakness progressed in an ascending pattern in 95% of the children, and simultaneously in all limbs in 5%; the average time to reach the nadir was 7 days (range, 2-12 days), "the investigators reported. Of the 35 children observed while they were in the acute stage of AFP, 18 were unable to walk, 10 walked with assistance, four walked independently, and three were too young to walk. The children exhibited full or partial paralysis of facial muscles and their bladders; they also experienced autonomic nervous system changes that created fluctuations in blood pressure, erratic heartbeat, flushing of skin, and intestinal motility. One child died. (16)

The study was conducted as part of the Pan American Health Organization's effort to eradicate poliomyelitis. David E. Hart of the U.S. National Institute of Neurological Disorders and Stroke at the National Institutes of Health was the lead investigator working alongside researchers from the Paraguayan Ministry of Health. (16) The majority of cases, they point out, were clustered in a rural, farming province named Concepcion.

"The clustering of patients in Concepcion could be related to the use of organophosphate pesticides in the cotton fields," Hart and colleagues suggest. "Farmers use great amounts of these pesticides, often in concentrated form, and empty containers serve as toys. Also, the maximum usage of organophosphates occurs during the summer (December-March)," when these children became ill. (16)

Although they note that retrospective measurement of organophosphate exposure is very difficult, Hart and coworkers cite a report that the cotton industry officially spent approximately US $6.7 million on organophosphate pesticides in 1991. However,more than half of the pesticides used in Paraguay are obtained "unofficially," according to this report.

"Four children were excluded from this study because of definite exposure to this product and presentation with concurrent acute cholinergic syndrome," the severe disease produced by organophosphate pesticide exposure. Hart and colleagues added, "Their clinical course, however, was similar to that of the children included" in the study. (16)

By examining the possibility that the AFP observed in these Paraguayan children might be associated with organophosphate pesticides, Hart and colleagues took that extra step that is so often omitted. Clusters of illnesses in communities can arise from any number of causes; they are not exclusively due to transmissible agents. Toxins in the environment are significant factors in many illnesses.

Since the time of Koch, bacteriologists have used the gold standard he described for the assignment of the disease process to single organisms. Bacteria and fungi can be truly isolated and grown independently on artificial media; they don 't require the presence of human or other cells. One problem that researchers have faced in describing non-bacteriologic related diseases has been the assumption that a single

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entity can cause them, without interaction from the cells in which they are grown, the human genome, or the environment.

We live in an important time: We are about to redefine much of what we know about medical science. In early 2001, two stunning reports on the Human Genome Project, published simultaneously in February issues of *Science* [http://www.sciencemag.org/feature/data/genomes/landmark.shl]and *Nature* [http://www.nature.com/genomics/] turned much of what we thought we knew about the human genome on its head. Instead of possessing 100,000 genes, for example, we learned that the human genome is made up of only about 30,000 genes — fewer than the number possessed by rice. (1)

Our new understanding of the human genome was produced, in part, by new technologies that we can now apply to revisiting many of the assumptions of modern medicine. One of the most important lessons learned from the challenge of decoding the human genome is that scientists need to describe laboratory experiments and results accurately. Technologically advanced tools can provide detailed and precise information,but the researchers using them must describe those results with equal precision. When a sample is laboratory reactive, it should not be assumed to be infectious. Likewise, suspensions of diseased brain tissue should not be called "virus" and dilutions of brain tissue material should not be called "isolations."

As the human genome comes more precisely into focus, our understanding of how our genes interact with one another, the environment, and other organisms will also become more precise.

Precision should also be applied to research objectives. Clearly, it is incorrect to state that poliomyelitis has been eradicated from many countries. The surprisingly large number of cases of nonpolio acute flaccid paralysis around the world warrants continued pursuit of the original objective of the March of Dimes: the elimination of infantile paralysis. On its website, the March of Dimes takes some well-deserved credit for helping to limit the amount of paralysis in the world today. "Historians have called the conquest of polio one of the great achievements of this century," a fact sheet on the website states. "Thanks to the March of Dimes, and the millions of people who supported it, we no longer have the devastating epidemics that terrorized generations." [http://www.modimes.org/HealthLibrary2/factsheets/Polio.htm]

Clearly, the original objective of the March of Dimes has not yet been met, or there would not be so much acute flaccid paralysis around the world today. Examining the last 50 years of poliomyelitis research shows that the objective of eliminating infantile paralysis has been replaced with the objective of eliminating poliovirus. As governments, international health organizations, and charitable foundations pour hundreds of millions of dollars into poliovirus eradication efforts, shouldn't we also invest in basic research that will prevent all cases of childhood paralysis?

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The Dulbecco "Isolation" Experiment

In 1954, Dulbecco and his colleague Margaret Vogt published a classic research paper that is credited with having set the standard for purifying poliovirus for decades. (9) In it, they introduced a technical innovation to the process of "purifying" viruses from tissue culture. This new technique was called "plaque purification"; a single plaque (a circular area of cells that stained differently from the surrounding culture) was considered to represent a pure virus population. Plaque purification utilized trypsinization,which involves treating the cells — in this case, monkey kidney cells — with the enzyme trypsin, breaking up any clumps of cells that might have formed and resulting in a single-cell suspension.

In the early days of poliovirus research, tissue culture was usually conducted using monkey kidneys (or, sometimes, monkey testes). Dulbecco and Vogt explained where the "virus" they grew came from:

"The virus was supplied as a 20 per cent suspension of spinal cord of rhesus monkey in distilled water. Type 1 virus obtained from passage through the monolayer kidney cultures was used. Type 2, Yale-SK strain, and Type 3, Leon strain, were kindly supplied by Dr. J. L. Melnick in form of tissue culture supernatants." (9)

That passage clearly demonstrates that Dulbecco and Vogt *did not isolate pure poliovirus* in any of the experiments described in this 1954 report . While they write of seeding their cultures with "virus," they actually used unpurified suspensions, not pure viral isolates.

Once the monkey kidneys were

ground up into "single cells, cell clusters, and cell debris," they were seeded with the monkey spinal cord emulsion. The appearance of the plaques was evidence that the virus was growing, according to the model Dulbecco had developed in 1952. (8)

The control for these experiments was to treat the cultures with monkey antiserum (derived from monkeys infected with Type 1, 2, or 3 poliovirus); if Type 1 antiserum inhibited plaque formation but Type 2 or 3 (or normal monkey) antiserum didn't, then Type 1 poliovirus was assumed to be *exclusively present in the culture*. In other words, it was assumed that no other organism or disease-associated agent was growing in the culture.

Once again, what Dulbecco and Vogt describe as "isolation" of the poliovirus is not isolation in the way we would understand it in modern microbiology. To perform their "plaque purifications," they simply pipetted some liquid ("plaque stock") from one culture plate and replated it onto other culture plates. When the second-generation cell cultures showed evidence of viral growth (i.e., plaques), monkeys were inoculated with the plaque stock. The inoculated monkeys developed paralysis and, subsequently, most died. Since the plaque purified viral stock both grew new plaques in second-generation cell culture and caused monkeys to develop flaccid paralysis, Dulbecco and Vogt concluded they had "isolated" poliovirus.

Like poliovirus researchers before them, it is clear that Dulbecco and Vogt were propagating disease-associated substances in their tissue cultures, and that they later transferred these substances to monkeys in whom acute flaccid paralysis developed. These were impressive accomplishments.

Dulbecco and Vogt 's claims, however, went further than they had evidence to support. They asserted not only that they had isolated poliovirus, but that,"Since each plaque stock originated from a single virus particle (as proved in the Discussion), these stocks constitute the purest lines of virus presently available."

How could they possibly know that a "single virus particle," something they had never seen or measured, was causing the growth of exactly one plaque in their cultures? The evidence Dulbecco and Vogt supplied to "prove" that a single virus particle produced each plaque is contained in a mathematical equation: They extrapolated the cell culture's assumed "virus concentration" from the number of times the original fluid (for example, monkey spinal cord suspension) was diluted. The fewer times the fluid was diluted, the more plaques grew in laboratory cultures; the more times it was diluted, the fewer plaques grew. Dulbecco and Vogt's mathematical model assumed this linear relationship between dilution of virus stocks and number of plaques formed and, when they reached the greatest possible dilution that still caused a single plaque to grow, they assumed that only one "virus particle" was present therein. And how did they prove that assumption, as promised? They provided their mathematical model. This is a perfectly tautological proof. Its most apparent flaw is that the mathematical model did not — could not —distinguish between a "single virus particle" and a biological complex that may have contained a single virus.

This is made clear in Dulbecco and Vogt's description of the plaque- forming "single virus particle" they claim to have isolated:

"Having arrived at this point, it is now possible to define properly the characteristics of the virus particle detected by a plaque. Owing to its all-or-none effect, it has the character of a particle. It corresponds to a unit of the virus which is not further subdivisible at high dilution. From the property by which it is recognized, we call it a plaque-forming particle. We do not know its morphological or genetic properties. It might be a single elementary body, or a clump of them, provided that the clump persists indefinitely at high dilution...." (9)

It is puzzling,in retrospect,that Dulbecco and Vogt raised the possibility that they were detecting a "clump" of material, but thereafter ignored it. What if another type of virus was also included in these particles? Or, what if host genetic material attached itself to the particle to form a "clump"?

Although electron microscopy — which would have allowed them to visualize a single viral particle — existed in 1954, Dulbecco and Vogt did not use it. Instead, they employed the time-honored technology in which viruses were assumed to be present in cultures if certain chemicals stained them, or if fluids thought to contain them produced characteristic patterns of growth, like the poliovirus-related plaques described here. Dulbecco and Vogt could not possibly determine that they were viewing single viruses in their cultures and, therefore, their assumption that they had isolated a "single virus particle" was a vast overstatement. Dulbecco and Vogt did not isolate poliovirus.

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our collective consciousness as **the** major medical miracle of our time. But the history of polio and its vaccines is shrouded in a murky mist of politico/scientific manipulation, altered statistics, redefinition and reclassification of the disease, increased cases of vaccine induced paralytic polio, and monkey viruses transmitted by contaminated vaccines to millions of people worldwide. Live virus oral polio vaccine continues to be the only source of paralytic polio in North America. And the fallout continues as researchers find the imprint of SV40 virus in a wide range of cancers and tumours, even in people who were not exposed to contaminated polio vaccine.

Neenyah Ostram's feature article invites us to broaden our concept of the disease called polio. Was the polio virus really to blame for all those cases of polio in the 40's & 50's - and what factors other than a virus are precipitating polio-like paralytic disease?

The last case of indigenous wild poliovirus transmission in Canada and the American region, was "certified" in September 1994 says Health Canada. Yet, despite polio having been officially conquered in the western world, crippling disease still strikes young and healthy people, the majority being children between the ages of 6-10. In Canada, health officials eagerly monitor all cases of Acute Flaccid Paralysis because it is the yardstick by which they monitor polio.

Health Canada's Dr. Paul Varughese emphasizes that when symptoms of paralysis present "the single most important laboratory investigation is a stool specimen collected within two weeks of onset of paralysis for screening for wild or vaccine strain poliovirus, and that negative results of polio-specific investigations are as important as positive results for the evaluation of AFP cases." (1)

With a measure of pride, Health Canada says that 59 confirmed AFP cases were reported in 1999 in children under the age of 15. "The number of cases in 1999 represents a 40% increase over the number of cases reported in an equivalent reporting period for 1998, indicating continued improvement in reporting and that the majority (83.1%) of cases were diagnosed Guillain-Barré syndrome, followed by transverse myelitis (10.2%)." (1)

No speculation is offered as to what may have triggered the paralytic illnesses. Within VRAN, we know of several families whose children have suffered acute long term paralytic illness following MMR vaccination which later was reclassified as transverse myelitis. Yet the attending medical experts vociferously deny a vaccine association. One can almost hear a collective sigh of relief every time a paralysis is diagnosed as AFP – never mind what caused it – **it's not polio!**

Within days of launching the Salk vaccine in the U.S. in April, 1955, 79 polio cases and 11 deaths were caused by the Cutter vaccine which was found to contain live virus. Assuming contagion patterns, the numbers were later increased to 204 cases.(4) A fascinating chapter in the Rodale Encyclopedia of Common Diseases (1962), gives a year by year report of the Salk polio vaccine drama. Fast tracked through government approval processes, rigorous safety testing thrown to the winds, and a massive propaganda campaign oiled to the nines, the vaccine was thrust onto a fear filled public.

As the Salk vaccine program expanded, cases of paralytic polio began to increase – "in 1959 more than 5,000 paralytic polio cases occurred – 50% more than in 1958, and 100% more than in 1957. This trend developed in spite of 300,000,000 doses of Salk vaccine administered in the nation (U.S.) by the end of 1959. Dr. Harold Fletcher predicted in the Journal of the American Medical Association (April 9, 1960) that of a probable 6,000 paralytic cases expected by the end of 1960, 1,000 were likely to have had 3 shots." (2)

Rodale offers some prophetic insight - **"Beneath all the hullabaloo over the Salk polio vaccine runs a consistent thread of hesitation and doubt expressed by responsible medical men throughout the world. There are doubts as to its safety; doubts as to whether this is the best way to make the vaccine; doubts as to whether, even if the vaccine does conquer the present-day forms of polio virus, we will perhaps then be confronted with a host of viruses just a little different, each of which will also have to have it's own vaccine."** (2)

One of the heroes that emerged during the Salk polio vaccine debacle was Dr. Herbert Ratner, MD. As public health director in Oak Park Illinois, assistant professor of Preventive Medicine and Public Health at Stritch School of Medicine in Chicago, and editor of the Bulletin of the American Association of Public Health Physicians, Dr. Ratner took on the corrupt polio vaccine establishment.

In an eloquent editorial in the Bulletin, he criticized the blatant manipulation of statistics, the "double standard" in reporting vaccine induced paralytic polio, and the secrecy that shrouded the 1954 polio vaccine field trials saying " One questions the propriety of imposing upon the medical profession at large, and local health officers in particular, an "enforced" inoculation program in the absence of making available to them the written report on the basis of which the program was presumably launched. **Such a failure has the effect of converting the medical profession into slave technicians."** (3) Dr. Ratner was referring to the Francis Report – a key evaluation of the field trials that tested the vaccine on humans. Fraudulently, it failed to disclose to the medical community "that those who contracted polio after

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their first inoculation and before their second inoculation were placed on the **"not inoculated list"!** (4)

Citing the prudent approach of other countries, Ratner hoped to infuse a measure of sanity into the chaos. "All European countries, with the exception of Denmark, have discontinued their programs – even Denmark is reported to have found live virus in the Salk vaccine… English authorities have cancelled the Salk vaccine program as too dangerous." And quoting Dr. G.S. Wilson, director of the British Public Health Laboratory Service, "I do not see how any vaccine prepared by Salk's method can be guaranteed safe"…and "Canada has postponed its vaccination program until the early part of 1956 in keeping with its earlier prudent approach." (3)

In May of 1960, Dr. Ratner chaired a panel discussion, at the 120th Annual Meeting of the Illinois Medical Society to review the increasing rise in paralytic polio in the U.S. The proceedings were reprinted in the August, 1960 Illinois Medical Journal which exposed the Salk vaccine as a frank and ineptly disguised fraud. One of the experts on the panel, statistician Dr. Bernard Greenberg, who went on to testify at Congressional hearings, revealed how data had been manipulated to hide the dangers and ineffectiveness of the vaccine from the pubic. Dr. Greenberg explained that the perceived overall reduction in polio cases was achieved by changing the criteria by which polio was diagnosed. (2)

Prior to 1954, all that was required was an examination on admittance and another 24 hours later; if the classic polio symptoms were discernible, the patient was considered to have polio. No lab test, and no residual paralysis were required to establish a paralytic polio case definitely. When the new criteria was established in 1954, for a case to be reportable as polio, residual paralysis had to linger for 60 days or longer. From this time onward, all cases in which paralysis lasted less than 60 days would no longer be classified as polio! Overnight, the majority of cases that would have been diagnosed as polio, were now shifted into a new disease category, cocksackie virus, or aseptic viral meningitis.

In Canada, the Dominion Bureau of Statistics issued an official bulletin in June 1959 titled Poliomyelitis Trends, 1958. "Data shown in this report are confined to paralytic poliomyelitis only. It may be noted that the Dominion Council of Health at its 74th meeting in October 1958 recommended that for the purposes of national reporting and statistics the term non-paralytic poliomyelitis be replaced by "meningitis, viral or aseptic", with the specific viruses shown where known." (13)

Dr. Ratner continued to stir up the dirt. Having already publicly stated that "in 1957 the largest producer of Salk vaccine in the U.S. had several million dollars worth of vaccine on hand which did not pass the minimum potency requirements of the U.S. Public Health Service ….and that subsequently, the Division of Biological Standards reinterpreted the minimum requirements to make possible the commercial utilization of the vaccine", he then dropped another bombshell in the February 16, 1961 issue of the Journal of the American Medical Association. Ratner denounced the Salk vaccine as "an unstandardized product of an unstandardized process" and that the 335 million polio shots given until now were a waste because they were too weak to be effective and that one's chances against polio , regardless of the previous number of shots, were no more dependable than those of someone who had not been inoculated at all! (2)

In her soon to be published book, **Vaccination and The Making of Mass Mind**, author, educator and historian Walene James, exposes the ruthless methods employed by the medical/pharmaceutical industry to forward their toxic agenda with the complicity of government and the media as willing co-conspirator. Having lived through the polio era, she bears witness to the hideous charade that masqueraded as a public health measure. With keen insight she dissects the statistical and epidemiologcal evidence that was suppressed to forward the **big lie**.

Walene James gives voice to the many medical people whose views disagreed with the official polio (viral caused) construct, many of whom questioned polio being a contagious disease. Some medical people had already begun to link paralytic polio-like illnesses as a response to the increasing use of serious neurotoxins like DDT, lead and arsenic compounds. Dr. Ralph R. Scobey presented "compelling evidence" that the real cause of polio is not viral, but a response to poisons in a series of articles published in The Archives of Pediatrics (1946-53). (4) Dr. Scobey's work can be viewed on line at the **Images of Poliomyelitis** website (10)

Revisiting the work of numerous doctors, naturopaths and chiropractors whose natural therapies helped heal polio victims, James cites the tremendous work done by Dr. Frederick Klenner, MD, whose unequivocal success with vitamin C in healing polio and many other diseases, including recovery from pesticide poisoning, is best described as a true gift to humanity. (5) Another important discovery was forwarded by North Carolina physician, Dr. Benjamin Sandler, MD, who found that polio could be prevented by a diet that eliminated refined carbohydrates, sugar, candy, cookies, pop and ice cream which were ingested in enormous quantities in the summer months when polio was rampant. His research showed that hypoglycemia

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(low blood sugar) was a common disorder in children and adolescents and was at the root of polio attacking this age group. Low blood sugar is readily induced by wrong diet, followed by overexertion. Many people followed Sandler's recommendations, and the incidence of polio in North Carolina dropped from 2,402 cases in 1948 to 214 cases in 1949 when the country as a whole showed an increase in the number of cases in that time frame. (4)

Around the turn of the 20th century, people began reporting paralytic illness after smallpox vaccination. (15) By the 1920's, infantile paralysis (later renamed polio) began to emerge as an important new disease that often afflicted the limb that had been vaccinated. And later, when typhoid vaccine, then diphtheria, tetanus vaccines and pertussis vaccines gained widespread use, illness and paralytic episodes following vaccination became common knowledge. Provocation polio is a well known phenomenon precipitated by "diverse factors that provoke or increase the severity of polio in its victims, or localize it to a certain section in the nervous system. Some of these factors included: vaccination, trauma, tonsillectomies, pertussis vaccines, and the injection of numerous substances such as cortisone, bismuth, guanine and penicillin.(9)

Strangely enough, polio is the only disease whose rise has been linked to improvement in sanitation and hygiene. Epidemiological theory speculates that early on in the 20th century, people in the upper classes who could afford a cleaner environment became more susceptible to polio than poorer class people who lived in more primitive conditions, where early exposure to the virus enhanced immunity readily acquired in infancy and early childhood. Undoubtedly, the decline of breastfeeding among the upper classes played an equally important role in the increase of paralytic diseases involving entero viruses. **The infant immune system evolves from the gut, and intestinal integrity determines whether the baby's immune function will be weak or strong. The most critical immune protection arises from the foundation laid down by breastfeeding – a foundation that cannot be derived from any source other than mother's milk.**

Dr. Derrick B. Jelliffe, MD, describes colostrum and breast milk as an **'antiseptic intestinal paint'**, protecting intestinal epithelial surfaces until the infant's own immune mechanisms mature. He explains that "the proven effect of sIgA (secretory Immuneglobulin A) appears to be enteral, including as a mucosal protection, particularly against the dominant pathological bacteria in the newborn, and especially pathogenic E. coli, and enteroviruses such as polio virus and probably such newly recognized pathogens as rotaviruses, …..as well as other microbacteria, including strptococci, staphylococci, and pneumococci." Dr. Jelliffe lays particular emphasis on the crucial role of human milk in infant health – **"This is extremely important as not only is infective diarrhoea a serious neonatal disease, but in addition many systemic generalized infections, such as some cases of septicaemia of the newborn and poliomyelitis, commonly enter via the intestinal tract."** (7)

Polio is in a class of enetero viruses – meaning they can colonize the gut. In a discussion paper on CFS (Chronigue Fatigue Syndrome), Dr. William Campbell Douglas, MD says that many researchers view CFS as another form of polio. "Modern genetics has confirmed the genetic similarity between polio viruses, coxsackie, and another group called the echo viruses. Before the advent of the Salk and Sabin vaccines, there were only three polio viruses. Now, with the drastic alteration of the human gut over the years as a result of these vaccines, there are at least 72 viral strains that can cause polio-like diseases." (6)

"When the coxsackie viruses were first isolated from CFS patients, it wasn't realized that we were simply dealing with a new form of polio. This new polio was caused by the replacement of the polio viruses with their brothers, the coxsackie viruses. As the researchers didn't get the connection at first, these new polio cases were labelled "post-polio syndrome," "chronic fatigue syndrome," and "myalgic encephalomyelitis." By altering the population's resistance to a particular organism, we alter the balance of infectious agents in the environment. The circulation of wild polio viruses 1-3 has declined through vaccination. However, this has left us open to the other 69 polio-related viruses, which have thrived." (6)

Shortly before his death in 1999, Dr. Herbert Ratner contacted SV40 virus researcher, Dr. Michele Carbone and gave him seven sealed vials of polio vaccine that had been stored in his basement fridge since 1955. He had saved those vials for 45 years waiting for the right person to inherit them – someone perhaps a little like himself, a man of integrity, a lover of truth, a whistleblower - you could call it a kind of divine cosmic joke.

I had the extraordinary privilege of meeting Herbert Ratner on a number of occasions at La Leche League International conferences. He served on their medical advisory board for many years, along with Dr. Robert Mendelsohn – two fearless mavericks who dared to expose the lies of the vaccine establishment.

Herbert Ratner was a philosopher, a theologian, a passionate advocate of family values and children's health, homebirth, and of course breastfeeding. He also published Child & Family, a journal on attachment parenting. He was a tremendous, loving human being. I loved his lectures – they changed my life in the most profound

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way. **"Love is the cement of society and the prime function of the family is to raise children who know how to receive love – who know how to give love, who develop the kind of self-respect and love for themselves they must have if they are going to love anybody else. We have to do everything possible to give the newborn infant a sense of worth. The function of the family is to turn the newborn individual into an adult who is emotionally secure and capable of loving because love is what keeps us together."** (from a 1979 lecture)

On analyzing Dr. Ratner's vaccine vials, Dr. Carbone made a startling discovery. "Not only was the vaccine contaminated, it contained a second form of the virus - an **"archetypal"** SV40 strain." Explains William Carlsen in his indepth review of SV40 viral research, "Although manufacturers switched from rhesus monkeys to SV40-free green African monkeys to grow the bulk vaccine in 1961, **they have continued to use potentially contaminated polio seed strains originally grown on the rhesus monkey (kidney)tissue to start the bulk vaccine process."** (8)

"Manufacturers check the purity of their vaccine with a series of 14-day tests to detect whether any SV40 slipped through. But when Carbone replicated the tests, he found that the second, slower growing **"archetypal"** strain took 19 days to emerge." Carbone noted in a published report, that it is possible that this second strain of SV40 had been evading manufacturers' screening procedures for years – and continued to infect vaccine recipients after 1962. (8)

"By the end of 1996, dozens of scientists reported finding SV40 in a variety of bone cancers and a wide range of brain cancers, which had risen 30 percent over the previous 20 years. Then, Italian researchers reported finding SV40 in 45 percent of the seminal fluid samples and 23 percent of the blood samples they had taken from healthy donors." This meant that SV40 was probably spreading through sexual activity, transmitted from mother to child, raising the possibility that the virus may now be incorporated into our genetic makeup. Another possibility is that, undetected by vaccine manufacturers, the virus continues to contaminate current stocks of polio vaccine. At a recent SV40 conference, it was revealed that funding has been granted to develop an anti-SV40 virus vaccine! (8) And so goes the disease merry-go-round - create more vaccines to target the diseases caused by vaccines in the first place. It is a very old game.

Back in 1962, Rodale reported that spraying programs of DDT were carried out "regularly in many parts of our country as a precaution against polio…..we have never heard of any polio epidemic being stopped by spraying with DDT **and we have heard of localities where the polio incidence rose after the DDT spraying."** (2)

Today 40 years after Rodale's observations, New York researcher Jim West has assembled an impressive body of evidence that traces the parallel rise of polio with the widespread indiscriminate use of highly neurotoxic chemicals used in increasing intensity in the 20th century. He has created an extraordinary website called **Images of Poliomyelitis – A Critique of Scientific Literature.**(10) Early in the century, lead and arsenic compounds were the favourites to control pests in agriculture. Later on in the 40's & 50's, powerful organochlorine nerve poisons like DDT & BHC (benzene hexachloride) were used as pesticides, for agricultural use, home and gardens and even sprayed over densely populated areas to control mosquitoes, exposing people to unprecedented poisonous chemical blasts. These neurotoxic chemicals were dumped into the environment by the billions of pounds. (10)

DDT was a popular chemical used in the dairy industry, so in the peak polio years, during the 40's and 50's, children were heavily exposed to high levels of contamination in milk and cow's milk based infant formulas, which had become a popular substitute for breastmilk. In retrospect, we can see the multiple disaster that unfolded through toxic contamination of milk, a primary food ingested by most children, as well as the wholesale deprivation of the basic immune protection afforded by breastfeeding - which in that era had become nearly extinct with only an estimated 5-10% of mothers initiating breastfeeding at birth. DDT was phased out in 1968 yet continues to be exported to the developing world where it is still widely used today as an agricultural chemical, and for mosquito control.

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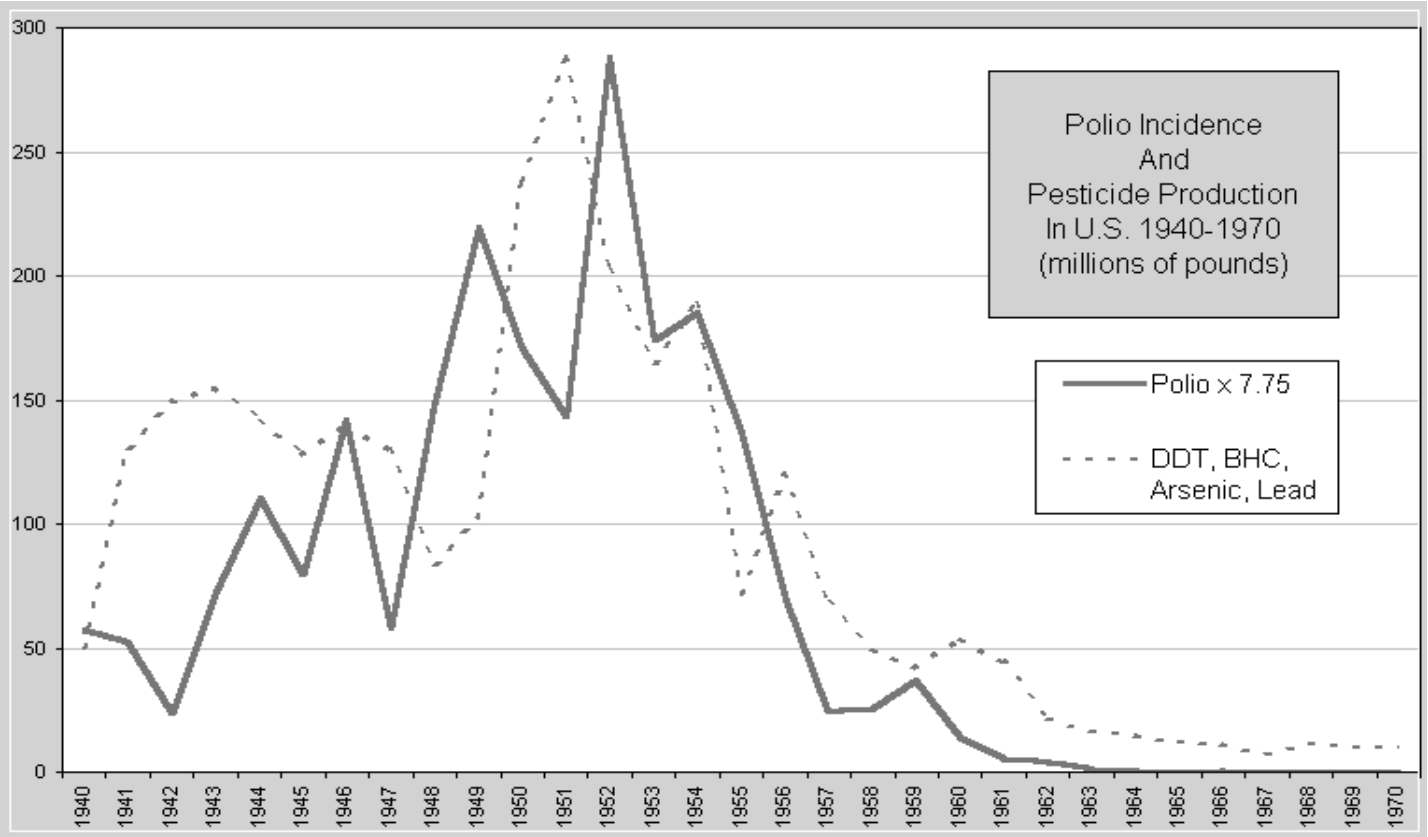
A composite graph of the most persistent pesticides, lead, arsenic, DDT and BHC (benzene hexachloride), a persistent, organochlorine pesticide, is several times more lethal than DDT, in terms of LD50 (lethal dosage required to kill 50% of a test population),(3.1 billion pounds of persistent pesticides are represented in the graph below) Source: Images of Poliomeyelitis



"These four chemicals were not selected arbitrarily. These are representative of the major pesticides in use during the last major polio epidemic. They persist in the environment as neurotoxins that cause polio-like symptoms, polio-like physiology, and were dumped onto/into human food at dosage levels far above that approved by the FDA. They directly correlate with the incidence of various neurological diseases called "polio" before 1965.They were utilized in the "most intensive campaign of mass poisoning in known human history." (quote from Biskind)" (10)

"In 1983, via new legislation, DDT was allowed back into the U.S. marketplace, but only in pesticide blends. Within only a few months of this re-entry, a new kind of polio epidemic suddenly occurred. It was labeled "post-polio", the re-emergence of polio symptoms in former victims. This has involved approximately 600,000 victims. Like most of the data on this website, this correlation is not even a whisper in the mainstream media." (11) Central nervous system diseases other than polio continue in the U.S. and throughout the world: acute flaccid paralysis, chronic fatigue syndrome, encephalitis, meningitis, muscular sclerosis. A paper entitled "The Environmental Aspects Of The Post Polio Syndrome" explores the correlation. (12)

I can remember walking to Wellesley Park in Toronto with my 3 year old daughter in 1979 and fleeing in outrage because the city weed control people were there spraying herbicides all around the swings and slides. I remember thinking, "they" (city officials & parks department) must be insane to spray toxic chemicals where children play. Phone calls and complaints to city officials fell on deaf ears. I heard years later, that herbicide spraying in children's play areas was discontinued.

Today's parents of autistic and neuroimmune injured children, understand the devastating effects of exposure to neurotoxic substances, in particular mercury and other toxic chemicals injected into children via vaccines. We're talking about toxic exposures off the scale of insanity – of injecting nerve and immune system destroying poisons directly into the internal fragile micro-environment of the young child. (14) Naively, we entrusted our precious children to the experts who have violated their sacred oath of "First Do No Harm". We are witness to the most shameful chapter in human history.

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Children are the most vulnerable members of the human family. How gently and tenderly we cradle them when they are tiny infants. How carefully and lovingly we nurture them and guard them from harm. How diligently we protect their well being in their early years. How deeply we commit all our love and resources to ensure that they have the best opportunities to grow in the healthiest way possible. We hold them as the most precious gift that life can bless us with. What quality of commitment will it take to heal and protect our children? It will be the power of Truth as the driving force that will propel us to move heaven and earth to make this world a healthier and safer place for all the children.

VACCINE NOTES & INGREDIENTS

Both inactivated (IPV) and live oral (OPV) poliovirus vaccines are licensed for use in Canada, but because of the risk of vaccine associated paralytic polio, only IPV is recommended for routine use. IPV is contained in Pentacel.

Starting at two months of age, Canadian infants are injected with a five in one vaccine called Pentacel that is a comarketing of 2 vaccines, Quadracel and Act-HIB.

Pentacel ingredients: Lyophilized Haemophilus b Conjugate Vaccine (bound to tetanus protein) – Act HIB, and is to be reconstituted with Component Pertussis Vaccine and Deiphteria and Tetanus Toxoids Adsorbed combined with Inactivated Poliomyelitis Vaccine – Quadracel.

-Each .05 ml. Of Act-HIB contains purified capsular polysaccharide covalently bound to tetanus protein .

-Each .05 ml. Does of Quadracel contains pertussis toxoid, filamentous hemagglutinin, fimbriae, pertactin(a membrane protein), diphtheria toxoid, tetanus toxoid(inactivated with formaldehyde), aluminum(.33mg), purified inactivated poliomyelitis vaccine: Type 1(Mahoney); Type 2(M.E.F.1); Type 3(Saukett); and 2-phenoxyethanol 0.6% + 0.1% added as preservative. The vaccine also contains 20 ppm Tween 80, less than 0.05% human albumin, and less than 1 ppm bovine serum. Trace amounts of polymyxin B and neomycin may be present from the cell growth medium. The three poliovirus types are inactivated by formalin (formaldehyde) and are grown on human diploid cells derived originally from aborted human fetuses. (Source: Compendium of Pharmaceuticals and Specialties 1999)

Toxicology notes on some vaccine ingredients:

2-phenoloxyethanol contains phenol which has the ability to inhibit phagocyte activity, meaning it is toxic to all cells. It can disable the immune system's primary response mechanism. It can cause systemic poisoning, headache, shock, weakness, convulsions, kidney damage, cardiac or kidney failure, death.

The ethylene oxide component is an irritant causing dermatitis, burns, blisters, eczema. Animal studies have demonstrated that it can cause cancer in female mice. In 1978, the EPA issued "a rebuttal presumption against registration of ethylene oxide for pesticide applications...on the basis of mutagenicity and testicular effects."

Editor's note: But they can inject it into infants and babies!

The quote is from: Marshall Sittig, Handbook of Toxic and Hazardous Chemicals and Carcinogens 2nd ed. (Park Ridge, NJ: Noyes Publications, 1985): 433f.

Tween 80 - Polyoxyethylene Sorbitan Monooleate:

"Previous studies by Gajdova et al. have shown that polysorbate 80 (also known as Tween 80) administered by intraperitoneal injection to neonatal female rats on days 4-7 after birth produced estrogenic effects including earlier vaginal opening, prolongation of the estrus cycle and persistent vaginal estrus. Some of these effects were evident many weeks after cessation of administration of polysorbate 80." Gajdova et al - "Delayed effects of neonatal exposure to Tween 80 on female reproductive organs in rats" Food Chem Toxicol 31(3):183-90 (1993) Institute of Preventive and Clinical Medicine, Limbova, Bratislava.

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MONTREAL AUTISM SOCIETY HOSTS CONFERENCE

Autism 2001: Place for New Medical Discoveries was the theme of a recent conference held in April in Quebec City and hosted by ATEDM, the Montreal based autism support society and featured key researchers in the field of Autism Spectrum Disorders. In a unified voice, the speakers called for a redefinition of autism as a systemic illness and an autoimmune disease. There was consensus among the speakers that the new "regressive autism" can no longer be considered solely a psychiatric illness – rather it is a systemic illness that has gastrointestinal, immunological, endocrinological, psychological and neurological complications. These researchers believe that autism is triggered by an environmental insult or toxic assault that damages the immature and fragile immune system of a fetus, infant or young child. Compound vaccines like MMR and DPT, some of which contain neurotoxic chemicals, and the enormous increase in vaccines injected into infants and young children in recent years, are seen by these researchers as probable factors in triggering regressive autism in genetically susceptible children.

In its May 8th issue, the Medical Post, the leading medical trade magazine supported by huge pharmaceutical advertising, and circulated to doctors across Canada, published a detailed report of the conference proceedings. Medical Post staff writer Susannah Benady was given two full pages in the magazine to present the findings of leading researchers like Dr. Andrew Wakefield, Dr. F. Edward Yazbak, Dr. Bernard Rimland, Dr. Karoly Horvath, Dr. Jeff Bradstreet and others.

In the same issue of the Medical Post, another headline reads - **Autism-MMR Vaccine Link Unproven,** quoting from the recent U.S. IOM (Institute of Medicine) report that concludes "The evidence favors rejection of a causal relationship at the population level between MMR vaccine and autistic spectrum disorders", the article debunks the vaccine connection to ASD, saying that, "Two new reports – one American, the other Canadian have said there is no evidence of a link between measles-mumps-rubella vaccine and autism." The IOM report however concedes that "the MMR vaccine could in rare cases contribute to autistic spectrum disorders resulting in a very small number of affected children".....and that they have "not closed the door on the issue". Meanwhile, the Canadian government, who has done no studies to determine the prevalence of autistic spectrum disorders in this country, had the unmitigated gall to release a report of a literature review intoning its all too familiar mantra of denial - "The evidence does not support a causal association between MMR vaccination and autism."

In contrast to officialdom's denial of the vaccine/autism connection, Ms. Benady reported that "Pediatricians at the conference agreed that one of the risk factors associated with the MMR was the concentration of live vaccines given all at one time." "Many of the children also have a long history of susceptibility to infections and experience hormonal imbalance, such as hyperthyroidism and early puberty.....research presented showed that tests on blood and tissue samples from autistic children have detected autoantibodies to proteins in the brain, gastrointestinal system and other organs." Said Dr. Bradstreet- "The child becomes the victim of his immune system."

"The speakers also agreed that autism happens more often in families suffering diseases of the immune system such as rheumatoid arthritis, lupus, inflammatory bowel disease and even asthma and eczema…and that the incidence of these diseases has markedly increased in recent decades, they noted."

Boston area pediatrician, Dr. Yazbak pointed out that "When the oral polio vaccine was taken off the market for fear that it had caused polio, there had been only 124 cases of polio – or one case per 24 million of population. We now have one case of autism in 250 of the population and a suspicion that it might be linked to the MMR vaccine.....but neither the manufacturer nor the public health bodies – the CDC in the U.S.A and the Department of Health in the U.K. – are willing to do the research."

Dr. Walter Spitzer, emeritus professor of epidemiology at McGill University in Montreal has voiced concern about the absence of adequate long term safety testing of the MMR vaccine, and is planning an independent study of 3,500 children with autism to determine if there is an association between the MMR vaccine and regressive autism.

Quebec Health Minister Agnes Maltais said that the ministry for health and social services would be pushing for more research into autism and its related disorders, and the Quebec government is setting up a task force to investigate the needs of autistic children and their families to insure that services will be available to them throughout the province. Dr. Victor Goldbloom, chairman of the conference called the announcement a breakthrough for sufferers of autism and their families. "We have been heard. We have been understood. It is what we have waited so long for," he said.

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Statistics from California and North London show a jump in autism cases starting in 1987. MMR was introduced in California in 1979. It was started in the U.K. in 1987, but a "catch-up" campaign resulted in children born in 1984 being vaccinated, hence the early hump in the curve, it is argued.

Editor's note: With many thanks to VRAN member Leah Raso for putting us in touch with ATEDM, and much appreciation to ATEDM staff person Joanne Lefebvre for sending us conference transcripts and the Medical Post articles. ATEDM can be contacted at: (514) 524-6114

FLAWED IMMUNISATION POLICIES IN INDIA LED TO POLIO PARALYSIS

Ganapati Mudur, New Delhi
BMJ 1998; 316:1261 (25 April)

Thousands of children across India may have been paralysed by poliomyelitis because of flawed immunisation policies, a leading paediatrician has said.

The government pursued a polio immunisation policy advocated by the World Health Organisation which was unsuitable for Indian conditions, said Dr Thekkekara Jacob John, the president elect of the Indian Academy of Pediatrics and former head of clinical virology at the Christian Medical College in Vellore. The flawed policies contributed to massive outbreaks of provocation poliomyelitis in children who received injections of the vaccine against diphtheria, tetanus, and pertussis (DTP vaccine) and slowed down India's efforts to eradicate poliomyelitis, Dr John said.

India's poor poliomyelitis surveillance mechanisms make it incapable of proving the absence of acute flaccid paralysis caused by wild polioviruses, he said in the April issue of Indian Pediatrics (1998;35:4). The incidence of recorded poliomyelitis in India dropped from 38000 cases in 1981 to around 8000 cases in 1995. A study earlier this year by India's National Institute of Communicable Diseases, however, suggested that even in the early 1990s only a third of poliomyelitis cases were being reported.

"With the right set of policies in place we could have eliminated poliomyelitis a decade ago. But now it is highly unlikely India will eradicate polio by the target year of 2000," said Dr John.

In the late 1970s the Indian health ministry introduced three doses of the oral poliomyelitis vaccine into its immunisation programme on advice from the World Health Organisation. Dr John said that this recommendation ignored research indicating that three doses were inadequate to protect children from wild polioviruses in the tropical environment of India. He said that during the 1980s hundreds of thousands of children developed poliomyelitis because three doses of the vaccine did not give adequate protection.

Moreover, the introduction of the DTP vaccine without adequately protecting infants from circulating wild polioviruses increased the risk of provocation poliomyelitis, he said. This is a phenomenon in which an injection given to a child harbouring a silent poliovirus infection can trigger paralysis in the injected limb. In the early years of the immunisation programme millions of injections of the DTP vaccine were given to infants who had not received even a single dose of the oral poliomyelitis vaccine.

"The large scale introduction of DTP vaccine in a country hyperendemic for polioviruses without appropriate steps to protect children from polioviruses was unscientific and cruel," said Dr John. Government officials say that the three dose strategy was adopted because of cost, high drop out rates, and poor infrastructure.

Dr John wrote earlier this year in the journal *Current Science*: "Indian health officials should not blindly follow World Health Organization prescriptions but do some independent thinking."

To view the article and accompanying graph:
http://bmj.com/cgi/content/full/316/7140/1261/f

THE MMR/AUTISM CONTROVERSY: Should We Believe the IOM?

Bernard Rimland Ph.D.

"...Then will come the billion-dollar awards, by enraged juries, to the children and their families. I can't wait!"

You have seen the headlines:

-Panel Finds No Link Between Childhood Vaccines, Autism (New York Times)

-No Links Found Between Childhood Vaccine, Autism (Los Angeles Times)

-US Expert Group Rejects Link Between MMR and Autism (The Lancet)

Is it true? Has the autism/MMR link been scientifically disproved? Absolutely not!

The above headlines refer to a report published by the heretofore-respected Institute of Medicine (IOM), a branch of the National Academy of Sciences. You may be thinking: If a prestigious independent group such as the IOM rejects the autism/MMR connection, there must be good reason for doing so. Why shouldn't I accept that verdict? You shouldn't accept the verdict for several reasons. One is that the headlines are wrong - the IOM did not reject the hypothesis that the MMR is a possible cause of autism. The headlines were based on a press release written by individuals with suspected links to the vaccine manufacturers, and did not accurately reflect the actual statement by the 1OM itself.

Representative Dan Burton, who has conducted intensive investigations of the evidence linking vaccines to autism, and had insisted on excluding from the 1OM panel those with a conflict of interest, was furious when he found that individuals with ties to the vaccine manufacturers had distorted the position of the 1OM report to make it appear to wholly reject the /MMR link.

He noted that two of those who issued the press release appeared to have ties with the vaccine manufacturers, and be has vowed to determine the extent of their conflict of interest. Burton's very normal grandson became autistic soon after receiving in one day multiple vaccines containing 40 times the acceptable level of mercury.

The IOM report actually said: "Although the committee has concluded that the evidence favors rejection of the causal relationship at the population level between MMR vaccine and ASD, the committee recommends that this issue receive continued attention.... its conclusion does not exclude the possibility that MMR vaccine could contribute to ASD (autistic spectrum disorders) in a small number of children."

This is an exceedingly weak statement, considering the evidence at hand, but it certainly does not reject a causal link. (And what does "at the population level" mean?) Autism currently occurs in about one child in 130, far above the 1-in-2500 figure reported in the 1970s and 1980s, before the MMR triple vaccine was introduced. And 1 in 130 is quite consistent with what both the IOM and the vaccine critics claim: "MMR may cause autism in a small number of children." The IOM statement thus supports, not refutes, what the MMR critics contend.

Despite the headlines, the safety of the MMR is certainly not assured. The media have been duped by the medical establishment's spinmeisters, with the intentional complicity of the IOM.

It is the medical establishment's burden to have proven that the vaccines are safe, not the critics' burden to prove them unsafe. Safety testing should have been done 20 years ago, when the MMR triple vaccine replaced the measles, mumps, and rubella vaccines which were given separately, over a period of time, and when the number of vaccines was 8 rather than 22.

As we pointed out in ARRI, the UK expert panel charged with evaluating the safety of the MMR said, "Being extremely generous, evidence on the safety of the MMRI was very thin. "The granting of a product license was definitely premature" and, 'In almost every case observation periods were too short to include the time of onset of late neurological or other adverse events, interaction between vaccines had not been considered adequately with multiple, vaccinations and potentially ill-equipped immune systems."

A spokesperson for the Journal of Adverse Drug Reactions, in which the above statements appeared, stated, "All the reviewers conclude that something needs to be done about the MMR, and that there is a case to answer against the vaccine."

The fact that the IOM report was misrepresented by the drug industry's spinmeisters does not exonerate the IOM from having shirked its responsibility to report that:

1. The MMR had not undergone adequate safety testing.

2. The practice of injecting increasingly large numbers of vaccines-many containing large amounts of mercury and other toxins-into the bloodstreams of immature infants was never evaluated for safety.

3. The Vaccine Adverse Event Reporting System (VAERS) is a travesty; fewer than 10 percent of side effects are ever reported.

4. Thousands of U.S. and U.K. families say-and can demonstrate with-videotapes and photos-that their children were normal prior to being vaccinated, reacted badly to the vaccines, and became autistic shortly after.

5. A number of clinical laboratory

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studies demonstrate that vaccines may-cause chronic damage to the gastrointestinal tract, immune system, brain, and otherorgans. Several such studies have been reported in past issues of the ARRI. Wakefield, Sabra, Singh, O'Leary and Kawashima are among the authors whose work documents lingering vaccine effect on children on the autistic spectrum, compared to normal controls.

The IOM report pays little heed to this evidence, instead focusing attention on several deeply flawed epidemiological studies. None of the laboratory studies were mentioned in the popular press reports. Why did the 1OM stoop to issue such a devious, misleading report, thereby incurring a permanent blot on its credibility? **The IOM is an instrument of mainstream medicine, and mainstream medicine has an enormous stake in the public belief that vaccines are safe.**

During the past decade, mainstream medicine has suffered a hemorrhage of patients who have been flocking to practitioners of alternative medicine. Too often have prescription drugs been found more dangerous than the illness. When the link between the use of unsafe, mercury-laden vaccines and autism, ADHD, asthma, allergies and diabetes becomes undeniable, mainstream medicine will be sporting a huge, self-inflicted and well-deserved black eye.

Then will come the billion-dollar awards, by enraged juries, to the children and their families. I can't wait. Be that as it may, the parents of today are confronted with the question: "What do we do about vaccinations?" Even as I write these words, the California legislature is conducting hearings to decide if two more vaccines, Hepatitis A and Prevnar, will be required before children can be admitted to day care or kindergarten.

Parents of vaccine-injured children are opposing these measures. When will it end? Profit, not public health, is the goal of many who advocate the use of all of these unnecessary vaccines. Alternative medicine provides a much more rational approach to preventing disease-including the diseases that are a direct result of vaccines-bolstering the immune system.

Even during the most horrific epidemics-the bubonic plague, smallpox, polio, and AIDS - most humans escape death, despite exposure to the pathogen. Why? Obviously, because their immune systems were competent to defend the body. That is the immune system's job. Can we enhance the immune system's capacity to defend us? Of course! Rely on nutrients, not drugs. As we have pointed out previously (ARRI 12/1), providing the immune system with the nutrients it needs by means of a high quality multiple vitamin/mineral supplement, with extra amounts of vitamins C, A and E, as well as extra selenium and zinc, can make a big difference in your and your child's vulnerability to pathogenic viruses, bacteria and yeasts. Such fortification of the immune system is especially important in the weeks proceeding and following vaccinations.

Bernard Rimland is the founder of the Autism Society of America and now leads the Autism Research Institute, which he also founded. We appreciate Dr. Rimland's kind permission in allowing us to reprint this editorial from the Autism Research Review 1nternational newsletter, Vol. 15, No. 2, 2001. Web link to the Autism Research Institute:
http://www.autism.com/ari/
Summary of IOM report:
"Immunization Safety Review: Measles-Mumps-Rubella Vaccine and Autism."
http://www.iom.edu/IOM/IOMHome.nsf/Pages/MMR+Autism+Summary/

BC SUPREME COURT UPHOLDS INFORMED CONSENT LAW

"The right of self-determination, which underlies the doctrine of informed consent, also obviously encompasses the right to refuse medical treatment. ... The doctrine of informed consent is plainly intended to ensure the freedom of individuals to make choices concerning their medical care. For this freedom to be meaningful, people must have the right to make choices that accord with their own values, regardless of how unwise or foolish those choices may appear to others." (Malette v. Shulman (1990), 2 C.C.L.T. (2d) 1 (Ont. C.A.) Robins J.A. for the court)

On November 12, 1997, the plaintiff Georgia Toews, then 11 years old and in Grade Six, was vaccinated in the school setting with Hepatitis B vaccine by a community health nurse who disregarded the child's protests that she was not to receive the vaccine. Her family brought a law suit against the nurse and her employer, the South Fraser Health Region, and sought exemplary damages and compensation for emotional injury claiming that the vaccine was injected without either the child's consent, or parental consent.

The case was heard in BC's Supreme Court and presided over by Madam Justice Lynn Smith on Dec 7-8, 2000. Nel Weisner, the public health nurse had obtained neither a signed consent form, nor verbal consent from Georgia's parents. When Georgia was called to the nurse's office and told she was getting a Hepatitis B shot, the child protested and said she didn't want the shot and that her mother said she wasn't to get the shot. The nurse told Georgia she had spoken to her mother, and her mother had agreed to it.

BC Supreme Court cont. on page 22

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Under oath, the nurse admitted that she had no recollection of a conversation with the child's mother, but despite this, had noted on the consent form that "verbal consent" for the Hepatitis B immunization was given on October 27, 1997 at 1:10 pm by a parent of Georgia Toews. She also had no recollection of completing that particular form.

The defense argued that "battery" against the child was not committed by Ms. Weisner because she had an actual and 'reasonable belief' when she administered the vaccination that consent had been obtained. The Judge rejected this argument saying that – "While I have no doubt that Ms. Weisner acted in complete good faith, and that she believed she had verbal consent from the parents, she should not have proceeded in the face of the child's statement to the contrary. Georgia Toews's statement should have put Ms. Weisner on notice that there might be a mistake in the documentation or that there might have been a revocation of consent."

Under Canadian Medical Law, derived from case law and from Supreme Court decisions, persons are granted the fundamental right to be free from unwanted physical interference. "Battery" is seen as "the intentional infliction of unlawful force on another person. Consent is a defense to battery and consent may be either express or implied. "The defendant carries the onus of proving that there was consent. In this case, because of the plaintiff's age, it was common ground that consent had to be obtained from a parent or legal guardian rather than from the child herself."

Following are several key parameters reviewed by the court that govern vaccination procedures for children as defined by the BC Supreme Court:

✦ In the case of immunizations, the person bringing the child for service will be questioned about any adverse reactions to previous immunizations and contraindications. The PHN [public health nurse] must be certain that he/she obtains current, accurate information regarding previous reactions and contraindications.

✦ If the PHN is in doubt regarding the reliability of the information received from the presenting person, the parent/guardian must be contacted to ensure the accuracy of the information prior to the treatment being given.

✦ When a child refuses service although the parent/guardian has given consent, the service should be deferred and alternate arrangements made with the parent/guardian.

The judge addressed the defendants' argument on "efficiency and expediency" and the need for public health officials to be able to conduct immunization programs on children who are sometimes eager to avoid the procedure. Said the Judge, "I accept that it is necessary to recognize the need for efficiency in carrying out these important public immunization programs, and I accept Ms. Weisner's evidence that some children do use evasive tactics when faced by a community health nurse carrying a needle**…….nevertheless, health care providers must always respect the fundamental principle that all individuals control access to their own bodies. Individuals may give but then withdraw consent. When the individual is a child, it is the parent who gives or withholds consent."** (empasis ours)

"The child's statement should not have been disregarded. Inconvenient though it may have been, Ms. Weisner should have checked with a parent before going ahead with the immunization."

In conclusion, Madam Justice Lynn Smith found "that the vaccination in these circumstances constituted a battery on the plaintiff Georgia Toews.

Counsel for the Toews family argued for general damages to compensate the plaintiff for the emotional upset she suffered. He also argued for aggravated damages, urging that this was an act by an agent of a quasi-governmental authority, it was an act committed on a child, and the guidelines of the South Fraser Health Region show community health nurses what to avoid, for example, that they should be careful and defer an inoculation if there is an indication that there is something wrong. He submitted that the court should send a message to this governmental agency that this kind of approach is not lawful.

Conclusion and Award of Damages:

"I have concluded that the defendants are liable to the plaintiff and that she will receive $1,000 in general damages. This is an amount which takes into account both the lack of evidence of any actual harm caused to the plaintiff by the vaccination, and the circumstances in which this battery took place."

"I have further concluded that this is not an appropriate case for exemplary or punitive damages. Although the defendant Nel Weisner did commit the intentional tort of battery, there was no conduct warranting the description "harsh, vindictive, reprehensible or extreme". Ms. Weisner wrongfully over-rode a child's communication of non-consent but on the strength of a good faith belief that a valid parental consent had been obtained. The award of general damages is sufficient and appropriate vindication of the plaintiff's rights in these circumstances."

With appreciation to Andreas Schuld for bringing our attention to this case. To view the full transcript of court proceedings:
http://www.courts.gov.bc.ca/jdb%2Dtxt/sc/01/00/2001bcsc0015.htm

FLU VACCINE SEASON IS REVVING UP AGAIN

By Catherine J. M. Diodati, M. A.

As summer wanes, and fall approaches, flu vaccine season is revving up again and the mandate still looms heavily over the heads of our valued health care workers (HCWs). The issue is one of coercion, selectively abrogating the legal and ethical rights of one sector of society, with the unsupported promise that their vulnerable patients will be protected from disease.

What do the studies reveal? After an extensive review of various trials, studies and articles, it has become very clear that the documentation used by officials to support the flu vaccine mandate are methodologically flawed.

Studies will suggest that HCW vaccination will prevent influenza transmission to patients but they invariably fail to establish any actual source for influenza outbreaks. It is just assumed that HCWs are responsible for transmitting influenza rather than visitors, other patients, delivery persons or anyone else who may come into contact with vulnerable patients. In one study, for example, vaccination was strongly recommended for HCWs following 3 confirmed cases of flu in a neonatal intensive care unit. (1) At the time, there were 4 unit nurses off duty due to an influenza-like illness. Although it was suspected that they introduced influenza into the unit, they were never tested for influenza and none of these nurses had attended the ill infants. Still, the authors stated that HCW vaccination is "the most effective strategy to diminish nosocomial [(hospital-derived)] infections." This is pure conjecture. There simply are no studies that unequivocally demonstrate that HCWs are responsible for nosocomial influenza infections. There is ***no evidence.***

In nearly every study read, the researchers have failed to actually determine whether upper respiratory infections, in either their unvaccinated control groups or their vaccine groups, were caused by influenza. There are many other pathogens that are known to circulate during flu-season. Adenovirus, RSV (respiratory syncytial virus), coronavirus, rhinovirus, etc., all can cause exactly the same symptoms and complications as the influenza virus and cannot be distinguished unless proper tests are performed.

This was precisely the case for one of the central documents used to support the vaccine mandate for health care workers. (2) In this case, only 5% of all unvaccinated patients, in 12 geriatric care facilities, demonstrated a rise in antibody titre, indicating exposure to the influenza virus, but when symptomatic patients were tested, nasopharyngeal swabs failed to produce a single influenza-positive result. All symptomatic patients were either positive for RSV or adenovirus. Attending HCWs, whether vaccinated or not, were never tested for influenza and no mention was made of any respiratory illness amongst the staff. Nonetheless, without any direct evidence whatsoever, the authors concluded that vaccinating health care workers reduced mortality and influenza-like illness in geriatric patients and Health Canada cites this article in support of HCW influenza vaccination. (3) The same holds true for almost every article Health Canada cites to support the vaccine mandate: no one is ever tested for influenza but HCW vaccination is said to prevent transmission of the disease. There is ***no evidence.***

Safety and efficacy assertions are similarly fraught with flaws. Of particular note, is the frequency with which systemic reactions are dismissed. In one study, for example, 86% of vaccinees experienced local reactions (soreness, redness, swelling) and 49% experienced systemic reactions such as fever, chills, aching/myalgia, tiredness/weakness, lightheadedness/dizziness, sore throat, runny nose, stomach upset/cramps, vomiting, painful neck glands and insomnia. (4) The authors stated that such symptoms are commonly associated with the vaccine but that "the vaccine could not have been responsible for such illnesses." How convincing is this argument when 49% of the vaccinees experienced systemic symptoms, which are the same as flu symptoms, and 24% experienced a cluster of symptoms? If these systemic symptoms are accompanied by viral shedding then we are exposing vulnerable patients to influenza ***because we are vaccinating our HCWs.*** Local reactions are of importance too, even if they are transitory, because they will affect HCWs abilities to perform their duties. Lifting patients, intubations, suturing, surgery, etc., all require precision and fitness.

Studies typically state that the influenza vaccine is effective in preventing the flu for at least 70% of the population under 65 and approximately 30%-40% effective in preventing the flu in those over 65. Rarely do these studies ever compare the match between the vaccine strains and the circulating strains for the given year. If the strains do not match-well, how useful is a rise in antibody titre? Even when the strains do match, influenza vaccination creates a cost-deficit. A US study found that during a year when the strains were well-matched, the cost of vaccination was $11.17 per person ***more*** than the costs associated with not vaccinating. (5) During another year, when the strains were not well-matched, the cost of vaccination was $65.59 US over and above the costs associated with not vaccinating. From a financial perspective, this does not

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comprise a good use of our health care dollars.

Italian Epidemiologist Dr. Vittorio Demicheli made some interesting observations regarding influenza vaccine efficacy. Demicheli et al. conducted a metanalysis of existing literature examining live and inactivated flu vaccines and anti-virals. (6) He found that the vaccine could only claim a 24% reduction in clinical influenza cases. Although the vaccine may elicit an antibody response in 70%-90% of individuals, this is not the same thing as preventing clinical influenza. Further, the metanalysis revealed that 69% of vaccinees experienced some type of local reaction and 26% experienced systemic reactions. Antivirals fared no better. Reactions included CNS depression/excitation and gastrointestinal effects. Some individuals (10%-27%) "secreted drug-resistant virus within 4-5 days of commencing treatment." The antivirals were 61%-72% effective in preventing influenza but only reduced the duration of existing illness by about 1 day. Demicheli et al. did state that the inactivated influenza vaccine was the most cost-effective intervention of those studied but this assertion was based upon a "lesser of all evils" philosophy. The other interventions were either extremely ineffective or associated with such horrendous adverse events that the inactivated vaccine won a place of honour by default. In the end, Demicheli concludes:

"If assessed from and effectiveness and efficiency point of view, vaccines are undoubtedly the best preventive means for influenza in healthy adults. But when safety and quality of life considerations are included, parenteral vaccines have such low effectiveness and high incidence of trivial local adverse effects that the trades-off are unfavourable. This is so even when the incidence of influenza is high and adverse effect quality of life preferences are lowly rated. We reached similar conclusions for antivirals and NIs even at high influenza incidence levels. **We conclude that the most cost-effective option is not to take any action."**

Studies do not provide any evidence that HCWs are responsible for transmitting influenza to patients. They do not provide evidence that the influenza vaccine reduces transmission or improves the quality of life for HCWs. They do not demonstrate that the benefits of vaccination are greater than the risks and they cannot legitimately claim that this is a wise use of our diminishing health care dollars. Although only a few studies are mentioned here, methodological problems abound in existing literature and there is absolutely no justification, ethically, legally or medically, for abrogating the rights of health care workers.

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5 Carolyn Baxton Bridges et al., "Effectiveness and Cost-Benefit of Influenza Vaccination of Healthy Working Adults," Journal of the American Medical Association 284 no.13 (4 October 2000): 1655-1663.

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KIRK'S STORY

COLLATERAL DAMAGE

By Scott Hunter

August, 2001

Our son Kirk might never be the same. He was by all measures a normal healthy 6 month old that was reaching all his milestones. He was sitting, rolling over, saying da, ma, up, focused on objects and people, in short everything a healthy 6 month old baby should be doing. Fast forward to more than a year later and he doesn't say anything, can barely roll over, doesn't sit unaided, doesn't focus on any objects or people, rock's back and forth, has distant vacant eyes and displays autistic tendencies. What could possibly have happened to the bright vibrant active child that was there 1 short year ago?

Well it's a long painful story. A story of a child that was sacrificed for the betterment of others we're told. A casualty in the war against childhood disease and the **risk** in the highly touted "benefits outweigh the risks" equation propagated by virtually every able body in the medical establishment today. In fact Kirk's damage didn't take a year to manifest it happened virtually overnight on December 13, 1999, exactly 12 days after his second diphtheria, tetanus, acellular pertussis, haemophilus influenza B, and inactivated polio vaccination at age 6 months.

As the events of the next year unfolded, what is left in retrospect, is the measure of untold pain of watching your helpless child struggle through near death multiple seizures, the beginning of which were mere hours post vaccination.

It was a routine visit to the Webb farm in Wynyard that the story begins. The Hunter family including myself and Sheri with our son Brandyn 2 years, our baby boy Kirklan and two

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Yorkshire terriers named Felix and Roz. The day was painfully uneventful until 2 mid afternoon, when Kirklan was observed lying on the floor staring and drooling and struggling to respond to our calls of concern. Immediately assuming the worst, that he had swallowed something, we quickly examined his mouth and throat and packed him up to head to Wynyard hospital. We arrived there and presented Kirklan to a doctor that frankly didn't know what to do. He examined Kirk and with the encouragement of a Pediatric EMT the decision was made to send him to the Royal University hospital in Saskatoon.

Words can't describe the anxious pain that enveloped me and my wife...would he make it to the city? - what was wrong? - did he swallow something? - did one of the children hurt him...? One hour of relentless worry, intense prayer and rocking back and forth with my face in my hands...

Midway through the trip, Kirk's condition improved. His oxygen levels began to rise and he was beginning to respond normally to Mom. When we arrived at the hospital Kirk was fine. Doctor's examined him and found all his vitals to be normal and sent us home. All seemed fine yet puzzling. The next day Kirk began what would be the beginning of the rest of his painful life.

Again that evening on the 13th of December, he had begun drooling and staring uncontrollably and yet trying to make eye contact with a look of fear and uncertainty in his eyes. We packed him up and went back to emergency where we spent the first two hours watching him have undiagnosed staring spells. They put him on machines to monitor his breathing and oxygen levels in his blood. As it became clear they were slowly worsening they admitted him to hospital. As the situation became grave the nurse ushered mom and dad into another room where we were told to call family. We called Sheri's parents during which time we were told to get family down to help us. It was now midnight and no family were in a position to hurry down, but Sheri's parents agreed to drive an hour and a half in as quick a time as possible.

It had now been a half hour to 45 minutes since we'd seen our son and no one had told us anything. Sheri and I rocked each other in our arms back and forth whispering prayers to God and anyone that would listen when the someone came into the room. "So tell me what happened" he said by way of an introduction Our response was swift and angry - asking whether our son was alive or not. It was at that moment the man realized that we had been lead to believe our son was dying. He explained our son was ok but that he had had a seizure...many of them to be exact! It wasn't until he had begun to crash and his oxygen levels dropping that one of the doctors, a neurologist, began to administer numerous IV drugs to stop what he considered now to be multiple seizures. Even though he appeared to be in little relative stress the past three hours, he had indeed been having seizure after seizure without time enough in between for the body to expel the poisonous carbon dioxide. He was out of immediate danger but no one could tell us whether he had gone without oxygen and for how long.

On the 17th prior to discharge from hospital, Kirk again lapsed into intractable multiple seizures. They administered a heavy dose of IV Ativan until the seizures seemed to stop. Hours later we came to realize he hadn't yet stopped seizing and it took Sheri and I an hour of badgering and belligerence to finally get a resident to contact the neurologist on call only to get the standard "call me when it gets worse" professional response. When it became clear to Sheri and I that our son was heading down the same road as before and the end result just hours away was slow suffocation due to increasing CO2...we demanded the doctor come down and see Kirk. I tried to reason with him and Sheri grabbed the phone away from me and abruptly told him to get his attending ass down to see Kirk! He complied.

When he arrived he quickly assessed him and tried to interrupt his seizures with Ativan and Dilantin, which didn't seem to work until just before they were advising admitting him to the Pediatric Intensive Care Unite and putting him on a ventilator. He began to respond and return, but they decided all would sleep better having him monitored closer and ventilated.

The following days and weeks were a blur. Numerous blood tests and EEG's, and Kirk more or less vegetative on the intense anticonvulsive drugs that were being pumped into his tiny body to keep it from seizing to death.

Now began the questions. What happened to our son? To the best of our knowledge nothing out of the ordinary precipitated the onset of the event. Racking our brains, Sheri remembered us feeling that something wasn't quite right a week previously when Kirk had stared vacantly prior to our leaving for our Christmas party and since then she noticed similar stares which she had simply dismissed. The first of these staring episodes appeared within 72 hours of his shot.

In mentioning this to all the attending staff it was quickly dismissed in favor of investigation. They began searching for anything that may have triggered these seizures. Meanwhile Kirk continued to be heavily medicated. He was reacting to the drugs with rashes around his mouth and lips, groin, bum. He had received the parting gift of a cold when leaving the PCIU and was barely coherent. He was placed in a room for quarantine pending standard tests for meningitis and

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other neurologically altering diseases. During the next weeks he went through several EEG's, a CAT scan, complete blood and body fluid workup. None proved fruitful. In the beginning their wasn't even any abnormal brain activity EEG. After a few weeks the continued seizures began to show up as unhealthy brain activity. With temporal spikes indicating random electrical patterns.

I had gone back to work and Sheri had notified her employers at the Royal University Hospital that she would have to take a leave of absence.

In the coming months we became as educated as we could, seeking out numerous experts in their fields, undertaking trips to the Mayo Clinic in Rochester, Homeopathic clinics in Calgary, Saskatoon and Winnipeg, investigating various on-line resources as well as consulting with Kirk's numerous doctors here.

Through the Nielsen Homeopathic clinic in Winnipeg/Yorkton we have seen children in similar situations. Many of whom have not yet come to make the connection to vaccines. When Kirk was in hospital in March 2000, a 3 month old boy from Regina was admitted to the bed next to us since Saskatoon has the only two pediatric neurologists in the province. This child had a very similar presentation and timing post vaccination.

When I performed a search of the VAERS database at the below address, I uncovered the culprit in reactions similar to my sons is almost always one brand of vaccine. http://fedbuzz.com/vaccine/vac.html (This is the American vaccine adverse events reporting system) Days after Kirk's reaction I searched the web under infantile multiple seizures. At the time one of many hits came up indicating vaccine as a possible cause. I say at the time, because now when you perform a similar search it seems most of the propaganda you get in the first few pages is government pro-vaccine sites.

What have we learned almost 2 years later? **Most important - Don't trust anyone, do your own research!!**

1. Get to a good homeopath.
2. Don't vaccinate your children.
3. If you are too scared to say no, at the minimum resist vaccinations until after your child's 2nd birthday.
4. Make sure they are healthy immunilogically.
5. Trust your instincts.
6. If seizures present consider using the ketogenic diet as soon as the first few drugs and homeopathy become ineffective.
7. Vaccines routinely injure and are based on arguable science.
8. Pharmaceuticals are evil.
9. Doctors are the pharmaceutical's salespeople.
10. Nobody but the parents of damaged children gives a fuck! (Sorry but I have to say this)

Prognosis:

Our Kirk will never enjoy the gifts he was born with. Unaided, Kirk will be diagnosed with a syndrome of our doctors' choice and will probably be declared autistic. Even with the divine help of Dr. Nielsen and the best of all possible scenarios he will struggle for the next few years trying to catch up. He will continue to endure seizures, physiotherapists, occupational health visits, speech and language pathologists, innumerous visits scheduled and otherwise to the hospitals emergency rooms, neurologists, pediatricians, dieticians and a host of healthcare professionals. We will continue to have to rely on the financial and emotional support of family to help ends meet and the list goes on.

Our lives have been leveled with one foul allopathic swoop.

LETTERS

Congratulations to Dawn Winkler, mother and vaccine activist, whose dedication succeeded in blocking Hepatitis A and penumococcal vaccines from being mandated for children in California. Dawn's baby daughter died of a vaccine reaction.

July 9, 2001
Hello Everyone:

I'd like to fill you in on the details of the hearings. It was truly an incredible chain of events. AB182-Hepatitis A, came up right away. The author (Vargas) presented the bill, support spoke (one doctor and one mother of a child who contracted hep A), and then Vargas announced "I don't believe there is any opposition". Consider that I mailed, emailed, and faxed my letter of opposition to his office and I am certain many of you faxed his office as well. California Vaccine Awareness was listed in the analysis under opposition along with another California health organization and 2 individuals. So for him to say there was no opposition was ridiculous. I jumped out of my seat, raised my hand and yelled (it's a BIG room), "Excuse Me!!! I'm opposition!" I was then called up to testify.

As I was sitting at the table, Rick Rollens came up and sat by me. I wasn't sure who he was at first until I saw what was in his hand - the July 31, 2000 issue of Newsweek with a picture of his son Russell on the cover. Newsweek did a cover story on autism and talked a little about the MMR vaccine in the article. I was ecstatic to have Rick there. He gave incredible testimony as he is a wonderful, calm, and diplomatic speaker.

Keep in mind that during our testimony, neither the Chair (Ortiz) nor several committee members were present. They did have a quorum present so they are allowed to proceed. Once

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Ortiz arrived, they took a vote for the bill. Ortiz voted no, everyone else voted yes to pass the bill. They were only in need of 2 more votes to pass it out of Health committee. Rick and I looked at each other and thought "we did the best we could, it's over." But it was far from over.

We stuck around and finally at around 4:30, AB1354- pneumococcal vaccine came up. The author (Pescetti) presented the bill, support spoke, and then Senator Edward Vincent piped up and motioned to move the bill before allowing Rick or I to speak. Ortiz recognized this and allowed me to proceed with my testimony. Then Rick once again gave tremendous testimony.

As we both spoke, something happened. Some of the Senators began to have a look of disgust on their faces. Ortiz began to ask questions and make comments. Then Senator Kuehl began to question just how many vaccines we are injecting into children. And then, the miraculous. Ortiz started to discuss the possibility of sending both bills to an interim hearing. I sat there on pins and needles hoping and praying that somehow, these bills would not pass out of committee but would be sent to interim hearing. The committee did just that, **they took a recount on Hep A and most everyone changed their vote to NO!**

They then voted yes to move to interim hearing and did the same for pneumococcal vaccine. And that is where we stand now.

Many of these Senators are on the right track. They are questioning the issue and I truly believe that after this hearing, there is no way they will pass either bill next year. The Chair also talked about setting a policy that would ensure every bill dealing with vaccine mandation automatically be sent to an interim hearing. In other words, no more rubber stamping every vaccine bill that comes through. This is great news everyone. This is a major change. And it could not have happened without you.

Thanks again to everyone who faxed, prayed, called, or helped in any way. We should all be proud of what we accomplished together.

Sincerely, Dawn Winkler
President - California Vaccine Awareness
(530)284-1819
noshots4me@yahoo.com
http://cavax.homestead.com/CVAhome.html

* *

Catherine Diodati has informed us that "the Ontario government has released the following on the flu vaccine program (to which they are investing $44 Million next year) due to the HUGE success of this years program - "success" is defined in terms of how many shots were given - how perverse is that!"
http://www.newswire.ca/government/ontario/english/releases/June2001/27/c7833.html

To The Honourable Tony Clement, MPP
Minister of Health and Long Term Care
29 June 2001

Dear Sir,

Regarding your Press Release entitled "Ontario Launches Campaign to Fight Influenza," dated 27 June 2001, I request your direct response to the following:

You are quoted as saying that "last year's incredible success, with over five million Ontarians vaccinated, illustrated the government's commitment to making Ontarians healthier. This year, we've expanded that pledge to focus on the workplace." It is stated that $44 million will be invested into next year's influenza vaccination campaign.

Is the "success" of last year's campaign evaluated only in terms of the number of vaccine doses administered? Certainly you are aware that this past flu season was extremely mild, with low incidence, throughout the country. Can you direct me to the published studies that demonstrate that Ontario's influenza campaign was a success in terms of efficacy, i.e. influenza prevention, and that we experienced a lower incidence of influenza than any other province in Canada due specifically to the vaccination campaign?

Are there published studies demonstrating that the influenza vaccination campaign in Ontario reduced workplace absenteeism and increased production as the new release suggests?

Can you also please direct me to published studies on the number and types of vaccine associated adverse event reports submitted for this past flu season and similar reports for prior flu seasons? As Ontario is the only province with mandatory VAAE reporting, I am assuming that this information is readily available.

I would also like to be directed to the Ontario Government's cost-benefit analysis for the campaign. Specifically, I would like information on the following:

- What was the actual savings per Ontarian when accounting for the cost of the vaccine; its administration; wastage; storage; handling; treating influenza-infected vaccinated persons; and, those who experienced VAAEs in comparison to the costs associated with treating influenza-infected unvaccinated persons?
- How much actual time was lost from work or school due to vaccination (at school, at work, or at the doctor's office), due to VAAEs, or due to infection (for the latter, differentiating between vaccinated and unvaccinated persons)? How does this compare with other years when incidence was similarly low throughout the province and the country?

I will look forward to receiving your prompt reply to my questions as I am very interested in reading the aforementioned reports.

Sincerely,
Catherine J. M. Diodati, M. A.

PROTECTING INFANT & CHILD HEALTH

Immunological Protection

By Kathry Orlinsky

The immunological properties of human milk may be as important as the nutritional aspects of human milk. How do we know that human milk really does make a difference in preventing disease? Many studies show that children who are fed human milk substitutes end up sick or hospitalized at a much greater rate than children who breastfeed. For example, diarrhea was significantly reduced in infants fed human milk compared with bottle-fed and weaned children.(9,19,20) Most bacterial infections are caused by organisms that are already colonizing the host, usually in the gastrointestinal or respiratory tracts. Human milk may prevent the growth of these bacteria.

There are several ways in which human milk protects children from infection. Human milk contains antibodies (immunoglobulins) which can help ward off disease in the infant. Human milk is particularly high in immunoglobulin A (IgA);(10) there is more IgA in human milk than in serum.(6) IgA binds to viruses and bacteria, particularly those that enter through the gut and other mucus membranes. This is especially protective of infants, who are always putting things in their mouths.

In addition to antibodies, human milk also contains lysozyme and lactoferrin, two antibacterial enzymes which protect against a host of infectious agents, including E. coli and Staphylococcus.(3)

Human milk also contains whole immune cells called white blood cells. Many of these cells are phagocytes, so called because they engulf bacteria and viruses, especially if these germs have IgA attached to them. Other immune cells in human milk include B cells, which make antibodies, and T cells, which attack diseased cells.(17)

How can these antibodies and other proteins help the infant if they are swallowed and digested along with the nutritional components of human milk? It turns out that these immune factors are resistant to proteolysis in the infant's gut.(7,8) Ninety percent of the IgA in human milk exists in a complex with secretory component (SIgA).(10) SIgA is resistant to trypsin digestion in the neonatal gut.(22)

Another way human milk protects children from disease is by favoring the growth of beneficial microorganisms. These benign colonizations prevent dangerous infections from taking hold. For example, bifidobacteria are more numerous in breastfed infants than in those fed with human milk substitutes.(1,3) This may be because of nucleotide salts present only in human milk, however, when these nucleotide salts were added to the human milk substitutes, the growth of bifidobacteria was still discouraged.(1) Breastfeeding may also favor the proliferation of bacteria with decreased virulence.(15,21) These strains may be more sensitive to bactericidal agents in serum, more prone to agglutinization, or less able to attach to epithelial surfaces.(14)

Human milk does not contain the same proportion of immune cells and antibodies that are found in the mother's blood, nor does it contain a stationary amount of these protective agents.4 Human milk contains much more IgA and less immunoglobulin M than serum does.(6) In addition, the type of T cells predominantly found in human milk is different from the predominant type of T cell found in serum.(17) This is because the mammary glands themselves contain lymphoid cells which produce the IgA antibodies needed by the breastfeeding child.(10,13,18) This mechanism is functional throughout lactation. In addition to providing protection from specific germs in the infant, the production and secretion of these immunological factors by the mother's mammary gland may be linked to the development of the child's own immune system.(4)

Skeptics have said, "yes, human milk benefits infants, but older children cannot continue to receive immunity by breastfeeding, can they?" The answer to this question is a resounding yes. Children enjoy health benefits for as long as they breastfeed. Studies have compared weaned children with breastfeeding children at 30 months (16) and at 36 months,(20,23) and found them to be sicker. In some parts of the world, weaned toddlers have a mortality rate three and a half times higher than toddlers who receive human milk.(20) Weaning foods and even water from some regions are highly contaminated with E. coli,(2) but even undernourished mothers from these regions produce ample milk antibodies.(5)

There are at least two reasons why breastfeeding continues to benefit older children. First, human milk contains immune factors regardless of the duration of lactation. Both lysozyme and SIgA levels have been found in human milk for the entire period of lactation studied, including the second year.(10,12,13) Many of these immune factors would be otherwise unavailable.(13) Second, human milk is more easily tolerated by a sick child than weaning foods. Thus, breastfeeding ensures that sick children remain hydrated and do not lose excessive weight. For a more detailed description of how breastfeeding can help an older child combat a severe illness, "**What if he hadn't been nursing**?" *(accessible at the website below)*.

There are special cases where human milk is particularly high in immune factors. Colostrum is exceptionally rich in immune factors, containing more

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white blood cells per unit volume than blood.(17) Preterm milk also contains more immune factors than term milk, both in colostrum and mature milk.(11) Newborns and premature infants need immunological protection more than toddlers, and they get that increased protection in the human milk they consume. This does not preclude older children from benefiting immunologically from continuing to breastfeed.

Reprinted with the author's permission from: **"Breastfeeding and Parenting Beyond The First Year"**
http://www.kjsl.com/~boynews/ImmunologicalProtection.html

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Editor's note: Studies from around the world emphasize the critical importance of extended breastfeeding in protecting children from serious infectious diseases.

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Class-specific antibodies to Bordetella pertussis, Haemophilus influenzae type b, Streptococcus pneumoniae and Neisseria meningitidis in human breast-milk and maternal-infant sera.

"Children under 2 years of age are most susceptible to acute respiratory infections caused by Bordetella pertussis, Haemophilus influenzae type b, Streptococcus pneumoniae and Neisseria meningitidis. We analysed milk samples and sera from mother-infant pairs for specific antibodies that may enhance protection against the bacterial pathogens. The results show that the breast-milk samples contained significant titres of specific IgG and IgA antibodies to the four organisms, although the mean IgG antibody levels were higher in maternal sera than in breast-milk. On the other hand, the mean IgA antibody levels to the four organisms were higher in breast-milk than in both maternal and infant sera. IgM antibodies to these organisms were relatively low or absent in many milk and serum samples. Nevertheless, the significant concentrations of specific IgG and IgA antibodies in milk samples may indicate a protective role for breast-milk against the four infections in early childhood."

Kassim, Raphael,D.H.et al
Ann-Trop-Paediatr. 1989 Dec; 9(4): 226-32

NATIONAL VACCINE INFORMATION CENTER CALLS FOR FULL PUBLIC DISCLOSURE OF CDC VACCINE STUDY DATA

August 30, 2001

Characterizing the CDC study on DPT and MMR vaccine-induced brain seizures published in today's New England Journal of Medicine as "methodologically flawed" and the conclusions "dangerous and irresponsible," the National Vaccine Information Center is calling for the CDC to immediately release the study data for independent scientific and public review.

The study found "significantly elevated risks of febrile seizures after receipt of DPT vaccine or MMR vaccine" within 24 hours to 14 days after vaccination. The conclusion of the authors, however, was that "these risks do not appear to be associated with any long term adverse consequences" even though at least 25 children who had seizures in the study were later diagnosed with learning or developmental disabilities, including ADHD, speech and language disorders.

NVIC president Barbara Loe Fisher said, "The bottom line is that children who get DPT and MMR vaccines are more likely to suffer brain seizures. And if these children are re-vaccinated, they can end up brain damaged or dead. For CDC officials to try to suggest that brain seizures after vaccination or for any other reason do not cause permanent brain damage contradicts the evidence in more than 100 years of medical literature; the landmark prospective, case-controlled National Childhood Encephalopathy Study conducted in Britain; the historic 1991 and 1994 reports by the Institute of Medicine on vaccine adverse events; the 1998 study by public health officials confirming that measles and MMR vaccine is associated with permanent neurological damage, including seizures; and the nearly 15 years of awards made to vaccine injured children under the National Childhood Vaccine Injury Act of 1986," said Barbara Loe Fisher, NVIC co-founder and president.

The National Vaccine Information Center points out that the study conclusions are misleading because they are based on comparing the neurodevelopmental health of children who had febrile seizures after vaccination with those who had febrile seizures for other reasons rather than looking at the neurodevelopmental health of children without a history of seizures or vaccination. NVIC is questioning the use of the closed CDC-operated Vaccine Safety Datalink database as a valid means of drawing scientific conclusions about vaccine risks.

"The Vaccine Safety Datalink project is a closed database operated by the CDC in collaboration with HMO's. CDC officials have steadfastly refused to make the raw data from the database available to independent researchers or the public for independent analysis. The test of good science is reproducibility and validation. The extraordinary claims of this study cannot be reproduced and, therefore, cannot be trusted," said Fisher.

The National Vaccine Information Center is a non-profit educational organization founded by parents of vaccine injured children in 1982. "Protecting the health and informed consent rights of children since 1982" http://www.909shot.com

NEWSCLIPS

Canada licenses new meningitis vaccine

A new group C meningococcal conjugate vaccine was approved for use in Canada in May 2001. According to the Meningitis Research Foundation of Canada, it is "very safe and stimulates production of high levels of protective antibodies in infants and young children."

The new vaccine has already been used in Abbotsford, BC and in London, Ontario where outbreaks of group C disease occurred in the spring of 2001. Health officials plan to vaccinate children under the age of 2 with the new vaccine. Alberta has announced that it will provide the vaccine for routine immunization of all infants starting in September, 2001. The Meningitis Research Foundation is urging "all provincial and territorial governments to fund this vaccine so that it can be provided to all Canadian infants and children."

Editor's note: The Foundation does not mention the deaths and high rates of adverse reactions experienced by British children injected with the new group C conjugate vaccine when it was introduced there in 1999.

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Gelatin in Vaccines Causing Anaphylaxis?

Andreas Schuld, founder of Parents of Fluoride Poisoned Children sent us the following analysis that describes the systemic effects of injecting gelatin into humans. www.bruha.com/fluoride

Why, if it was withdrawn from intravenous drugs, is it allowed to remain in vaccines?

In 1978 the FDA withdrew all intravenous drugs containing gelatin. Gelatin had been marketed as a plasma

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expander, but the FDA found gelatin "not suitable" because it caused increased blood viscosity, reduced blood clotting and prolonged bleeding time.

These events are directly related to the activity of two main receptors, the prostaglandin E2 receptor (PGE2) and the thromboxane A2 (TXA2) receptor - both of which are coupled to a G protein called G q/11.

What in gelatin could be responsible for this? The gelatin in vaccines - according to the FDA - comes from cow bones. Gelatin contains very high amounts of fluoride and aluminum. Aluminum fluoride complexes [AlF(x)] are formed in the human organism. Aluminum will potentiate (amplify) the effects of fluoride manyfold.

Fluorides are now known as the universal G protein activators, meaning they can activate all known G proteins - the On/Off switches involved in cell communication. They are well established to activate the two receptors named above.

The only known receptor so far which has shown to be able to activate all G proteins in the organism is the TSH receptor. Fluorides thus directly mimic TSH, the thyroid-stimulating-hormone. They have been used extensively as TSH substitutes in laboratory investigations, particularly relating to thyroid cancer.

According to the 1999 CPS, Merck Sharp's MMR vaccine contains hydrolised gelatin, added as a stabilizer.

And from Health Canada's division of vaccine adverse events:

"Reviewing the literature published between 1994 and the present day, reveals that there is considerable new data suggesting that ***modified gelatin* rather than egg proteins is responsible for most episodes of anaphylaxis following measles vaccination."**

Duclos P, Ward BJ - "Measles vaccines: a review of adverse events" Drug Saf 19(6):435-54 (1998) Division of Immunisation, Bureau of Infectious Diseases, Laboratory Centre for Disease Control, Health Canada, Ottawa, Ontario

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New Research Suggests Cause of Autism

NEW ORLEANS, May 10, 2001 /PRNewswire/ -- Autism, a poorly understood genetic disorder present in more than a half million Americans -- may be caused by a defect in metal metabolism that impairs the development of the brain and can result in hypersensitivity to toxic environmental substances. In a study of 503 autism patients, 99 percent exhibited evidence of this metabolic disorder, according to information presented here today at the annual meeting of the American Psychiatric Association. Blood and urine analyses yielded evidence of a metallothionein (MT) dysfunction in 499 of 503 patients (99 percent) diagnosed with autism spectrum disorders, according to William J. Walsh, Ph.D., biochemist and chief scientist of the Pfeiffer Center, Naperville, Ill., and Anjum Usman, M.D., a physician at the Center, who presented the findings in a presentation at the APA meeting."

MT is a family of proteins essential for many important processes in the body, and a dysfunction in this system can explain most of the classic symptoms observed in autism," said Dr. Walsh. "An MT disorder may affect the development of brain neurons and may cause impairments in the immune system and gastrointestinal tract, along with hypersensitivity to toxic metals,"

he said. The study included a search for distinctive chemical markers for the major components of autism spectrum conditions, including classic autism, Asperger's Disorder and pervasive development disorder with autistic features. No substantive differences were found among these populations. However all three populations exhibited a very high incidence of a severe metal-metabolism disorder."

A careful analysis indicated that all but 4 of the 503 autism-spectrum subjects exhibited evidence of a metal metabolism disorder associated with MT functioning," Dr. Walsh said. The study findings suggest that the primary cause of autism may be an inborn error in MT functioning, perhaps aggravated by an environmental insult, he said. The study findings also suggest that autism may be caused by either a genetic MT defect or a biochemical abnormality, which disables MT protein. If correct, the study finding could lead to an early infant screening test for autism predisposition, and advanced treatments to correct the metal-metabolism disorders.

Editor's note: This new evidence sounds like one more nail in the coffin of the vaccine/mercury induced autism catastrophe.

http://www.prnewswire.com/cgi-bin/stories.pl?ACCT=104&STORY=/www/story/05-10-2001/0001490675&EDATE=

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Drug Company Knew Vaccine Was Unsafe - July 8, 2001

British reporters Antony Barnett and Tracy McVeigh reported in The Observer that "the former UK company Wellcome allowed thousands of babies to be inoculated in the 1960s and 1970s with toxic whooping cough vaccines it knew had not passed crucial safety tests. It said its investigations showed that two batches of the firm's vaccine were more than 14 times more potent than the standard dose and 14 other batches containing thousands of vaccine doses were not put through a crucial toxicity test."

One of the toxic batches was the same batch that led the Irish Supreme Court in 1992 to award 2.7 million (US$3.8 million) in compensation to Kenneth Best, a Cork boy who suffered permanent brain damage. At the time the Irish judge accused Wellcome of negligence and attacked the compa-

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ny's poor quality control at its Kent laboratory." Now, 9 years after the award, the newspaper said the Irish Department of Health had received details from GlaxoSmithKline about the batch--numbered 3741--and was tracing 296 Irish children who were inoculated with it. Glaxo Wellcome merged with SmithKline Beecham to form GlaxoSmithKline in late 2000."

A second batch of vaccine, numbered 3732, produced by Wellcome around the same time, was even more potent than that used on Best in 1968. Dozens of British parents believe their children suffered brain damage or died from these vaccines.

Gordon Stewart, emeritus professor of public health at Glasgow University, is quoted as saying the revelations are "scandalous." Stewart, who had investigated the link between the vaccine and brain damage in 1984, had advised the government about these potential toxic batches in 1989, but his concerns were not heeded. His report, which was never published by the government is highly critical of the whooping cough vaccine used at this time, which he believes was toxic.

A British Commons committee is holding emergency meetings to determine what measures need to be taken. Says MP Ian Stewart "The families need to know the truth. If it can be shown that Glaxo Wellcome were negligent in allowing toxic vaccines to be used, then the company must face up to its responsibilities", and pay compensation over and above the $100,000 pounds vaccine injured children are currently eligible to receive in Britain. Both the pharmaceutical company and the British department of health deny any problem with the vaccine.

To view the full article:
http://www.observer.co.uk/uk_news/story/0,6903,518459,00.htmlhttp://www.observer.co.uk/uk_news/story/0,6903,518459,00.html

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Resistance to whooping cough vaccine grows

A recent article by E.J. Mundell published by Reuters Health (May 22/01) reports that the bacterium that causes whooping cough is mutating and has developed resistance to the vaccine used to immunize Dutch schoolchildren against the disease.

"It seems like the bacterium is changing part of its coat, thereby disguising itself'' from the immune system, according to Dr. Audrey King of the National Institute of Public Health and the Environment in Bilthoven, the Netherlands. She presented the findings here Tuesday at the annual meeting of the American Society for Microbiology.

In recent years whooping cough has been making a comeback in the Netherlands, the United States and elsewhere. When King and her colleagues compared old
and new strains of the Bordetella pertussis bacterium under the microscope, they found that, over time, "at least two proteins located on the outside of the bacterium have been changed.'' These changes could explain why the pertussis vaccine now provides Dutch children with weaker protection against whooping cough than it did in years past.

King's team infected mice with either an older or present-day version of the whooping cough bacterium. The results showed that more mice infected with current strains of pertussis showed signs of illness than those infected with strains dominant in years past.
King recommends that children receive booster shots of new and improved vaccines--that recognize the bacteria's altered "coat"--in those countries where they are available.

Commented Barbara Loe Fisher, President of NVIC – The National Vaccine Information in the U.S - "This is further evidence that vaccines, like antibiotics, can place pressure on microorganisms to mutate in order to survive. The larger question for public health officials embracing the eradication of microorganisms through forced mass vaccination with multiple vaccines as their number one mission is: are they going to take responsibility for the multiple, more virulent organisms that may plague humanity as a result of their narrow-minded view? Not likely. But certainly, the public has a right and responsibility to question the mandate they have assumed."

RESOURCE & INFORMATION LIST

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What About Immunizations? Exposing the Vaccine Philosophy
by Cynthia Cournoyer Nelson's Books, Box 2302 Santa Cruz, CA, 95063

Natural Alternatives to Vaccination
by Dr. Zoltan Rona, M.D.
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Vaccinations—The Rest of the Story
published by Mothering Magazine. P.O. Box 1690-Santa Fe, N.M. 87504.

The Immunization Decision—A Guide for Parents
by Dr. Randal Neustaedter.

The Case Against Immunizations
by Richard Moscovitch M.D.
available from American Institute of Homeopathy, 1500 Massachusetts Ave. N.W. Washington, D.C. 20005.

The Immunization Resource Guide
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