THE *informed* PARENT

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ITALIANS BAN HIB VACCINE IN BSE SCARE

Taken from: BMJ, Vol 314, p397. 8/2/97

The Italian ministry of health has suspended the use and marketing of a vaccine against Haemophilus influenzae type b (Hib) because of fears that it could transmit bovine spongiform encephalopathy (BSE) to humans.

The police were called in to seize batches of HibTITER from the Italian outlets of the US manufacturer Wyeth-Lederle on 17 January. The vaccine was used in the Italian national vaccination programme, but the use of bovine heart-brain infusion agar to promote bacterial growth early in the manufacturing process has worried the Commissione Unica per il Farmaco, which is part of the ministry of health.

Last year the ministry was given new powers to minimise the risk of transmission of BSE to humans after the possibility of a link between BSE and the new form of Creutzfeldt-Jakob disease was raised. It has subsequently closely monitored the manufacturing processes of all drugs and vaccines used in Italy.

Don Barret, a spokesman for Wyeth in the UK, said: "We are aghast, we do not know why the Italian government has taken this action. There is no scientific basis for it. We strongly disagree and remain thoroughly convinced of the safety of our product."

The European Agency for the Evaluation of Medicinal Products, the key advisory body overseeing safety of medicinal products for the European Union, discussed the issue on 22 January. Its Committee for Proprietary Medicinal Products (CPMP) concluded that it 'remains confident about the safety of HibTITER and is reassured that the manufacturing process complies with all relevant CPMP guidelines on prevention of the risk of transmission of animal spongiform encephalopathy."

The committee said that careful examination of materials used in the manufacture of vaccines was carried out, including a review of the sources of bovine material, before the vaccine was licensed. Bovine material was used only in the first step of the manufacturing process and was not an ingredient in the finished product. The bovine material came from herds in countries free of BSE, such as Australia and the US. There had been no breeding from outside the herds, and the material was obtained under veterinary supervision.

The Italian ministry of health said that there was little or no risk to the public and that people who had received the vaccine should not worry, but that under Italian law even the remotest risk of transmission of BSE was a reason to act. The ministry added that there was another Hib vaccine which was not made using bovine heart-brain infusion and that it would be used in the national vaccination programme.

FEWER JOBS FOR JABS

Taken from: A West Midlands publication Inner Western Suburbs, 'The Courier', 20/1/97.

While plans to pay parents to pay parents to have their children immunised are being considered by the Federal Health Minister, Dr Michael Wooldridge, local rates of immunisation are falling.

Statistics contained in Strathfield Council's annual report reveal that there has been a 33.5% drop in the number of immunisations administered at its childhood clinics.

In the 1995-6 financial year, 617 local children were vaccinated compared with 928 for the same period in the previous year.

"It is difficult to determine if this represented a lowering of immunisation levels in the community, or a change in whether residents obtain their immunisation from council or local medical practitioners," the council report states.

Council's general manager, Max Woodward, said the community should be aware of the dangers of not immunising children against deadly diseases.

"Immunisation is particularly important when you consider that children too young to be immunised could be at a greater risk if there are older children around them who haven't been properly treated against these diseases." he said.

WHEN VACCINATING DEFAULTERS MAY NOT PROVE TO BE WORTH IT

Taken from: Pulse, 8/2/97, Practice diary, p56.

It made a very pleasant change last week to go home feeling satisfied with my day. We had held our child health surveillance clinic that day.

Like many practices, we get well above the top target level for infant and pre-school immunisations but we still have a small core of families who prevent us reaching 100 per cent. Inevitably most of these families live in deprived areas where the children are more likely to be exposed to infections.

Our clinic clerk knows who these families are, so when one such family of three children aged 16 months, four years and five years turned up she pounced immediately.

The four-year-old was due for his pre-school check and booster, including the new MMR booster. His siblings were only there for the ride but were overdue for their MMR vaccinations.

I spent 10 minutes persuading their parents why the children should all have vaccinations and the reasons for the MMR booster campaign. Somewhat to my surprise they agreed so we rapidly ushered them in to the nurse before they could change their minds.

We congratulated ourselves on this minor coup but unfortunately our delight was short-lived. That night the four year old developed diarrhoea and vomiting and the deputising service had to visit.

The doctor who called told the parents that this was probably due to his immunisation. Of course this was extremely unlikely to be the case as the next day an upper respiratory infection had appeared.

The deputising visit cost us £48, but worse than this is the likelihood of the parents telling their friends and neighbours about the horrible new vaccine. It does not take long for frustration to set in again.

HEALTH PROFESSIONALS COMMENTS

The Informed Parent have been receiving an increasing number of enquires from members of the medical profession regarding their growing concerns surrounding vaccination. Reproduced below are three extracts from letters recently received.

"As a practice nurse in a GP surgery I have increasingly become concerned about the information I have at my disposal with which to advise parents about immunisation and whether parents are truly given the chance to make an informed choice regarding the immunisation of their children"

After a feature on vaccination on Radio 4's Woman's Hour in Sept. 1996 one letter we received said:

"I am a health visitor and just happened to catch Womans Hour when immunisation was discussed. I have to tell you that I probably support much of what was said about the lack of information to health professionals who are administering vaccines to children. Our DoH circulars informing us of a change in practice do not allow us to make an informed choice - we only hear one side. I wonder sometimes who has an interest in giving these vaccines.....Good luck with your work."

Another writes:

"No-one really knows what we are doing to the immune systems of our children with these foreign substances - I am a Registered Nurse and have been suspecting a link between immunisation and asthma/eczema/leukaemia for years, as they are auto-immune. The body is unable to recognise itself and therefore turns on itself as the enemy.

The medical profession's answer to asthma is to give regular inhaled steroids and sometimes systemic steroids as well. The effect of this is to damp down the body's response, effectively suppressing it. Now, supposing the vaccine has suppressed the 'whoop' in the whooping cough, what are we to make of the effects of suppressing the only cough with which the body is able to communicate its distress?

I have no answers but I am uncomfortable with the way disease and illness are being dealt with by current medical practise. I have a nightmare vision of millions of misdiagnosed vaccine-damaged children queing up for their inhalers like little lemmings. Are we creating a generation of chronic respiratory cripples?.....The government receives taxes from the drug companies. The drug companies receive huge profits by way of increased sales and the word 'epidemic' is like music to their ears. There will never be 'informed consent' or two equally weighted sides to the debate on immunisation. If there were honesty, our whole economy would collapse. To the bitter end, even the makers of Thalidomide would protest their innocence. "

GPS MISDIAGNOSE MEASLES IN 97% OF CASES

Taken from: PULSE, January 18, 1997

Measles is wrongly diagnosed in 97 per cent of cases, according to new data from the Public Health Laboratory Service.

An evaluation of 12,000 notifications and salivary samples from suspected cases showed the vast majority of people with a measles-like rash has some other condition instead, according to Dr Mark Reecher, consultant in public health medicine at the Public Health Laboratory Service, Colindale.

'We're not saying for one minute that GPs are poor at making a diagnosis - these findings simply show how inherently difficult it is to make a diagnosis based on clinical symptoms alone. Any doctor would find it difficult to differentiate between viruses.

'Previously we had a lot of measles infection in the community and these other viruses were submerged, but as the incidence of measles subsides we are able to see more clearly what other viruses are lurking in the background,' he said.

According to Dr Roger Buttery, consultant in communicable diseases at Cambridge and Huntingdon health authority, many patients probably had common viral infections such as cytomegalovirus or Epstein Barr virus.

He also said that measles was not the only condition being misdiagnosed.

'Hardly any cases of suspected mumps were confirmed from salivary tests, which is surprising as you would think it had a fairly clear clinical picture,' he added.

Rubella, however, which has more ambiguous symptoms, was correctly diagnosed in about 25 per cent of cases.

'We think we know what many of these illnesses look like, but diagnostic tests show there is great diversity and what we think is classic mumps may well be something else,' he said.

Editor - It would be interesting to know how long the misdiagnosis of measles has been occurring? - Perhaps the last thirty years or more? - In which case how can they be sure of the effectiveness of the measles vaccine?

LETTER FROM HOLLAND-1872

Taken from The Anti-Vaccinator, and Public Health Journal, Vol.2, 1/5/1872.

Gentlemen,- I rejoice very much in the publication of your *Anti-Vaccinator*, and I will tell you the reason. I am a physician. I took my degree, after many years of most serious study, at Leyden, in the year 1818. I was a strong vaccinator; but like so many others, I had not made a study of vaccination, and followed the custom without hesitation; but in the year 1822 a great change took place in my opinions. I became a Christian, I am a Jew by birth. This great change in my mind compelled me to examine all things with more seriousness, especially the history and nature of vaccine and vaccination. I can truly say, that after a *most earnest study of more than two years*, I became deeply convinced that the practice of vaccination was very pernicious to the life of man, especially in the case of children, by counteracting the normal development, and giving the opportunity for many diseases to become *inserted with the virus of vaccine*. I wrote and published a volume in 1826 against vaccination, as opposed to the true theory and practice of medicine, as well as subversive of morality and religion. Thirty physicians wrote volumes and brochures against me in the most vigorous manner: they persecuted me, threatened me by anonymous letters, induced many of my patients to leave me, and I was designated in the public and medical papers as a visionary, a fanatic, etc. No one writer against me remained without refutation, for I published many volumes to refute my opponents, and further expose the dangers of vaccination and re-vaccination. But now I am 76 years old, and by the weakness of my bodily constitution I was constrained many years ago to leave the practice of medicine. Now, you may consider how glad I was to see that an Anti-Vaccination periodical is coming to light! If you will send me some little books or pamphlets on this subject, I will try and translate them into Dutch, and spread over the land, because just now in our parliament compulsory vaccination is a subject of discussion. I remain, gentlemen, with the kindest regards, yours in sympathy,

Dr A Capadon.
The Hague, Holland. May 1st, 1872

'LITTLE FOUNDATION FOR CLAIMS OF SAFETY'

Taken from: PULSE
January 25, 1997

Evidence is emerging of possible long-term complications of measles vaccine. Some GPs have expressed concern over the safety of two-dose MMR schedules.

Measles vaccine is a live 'attenuated' derivative of wild strain measles virus. The nomenclature implies that the vaccine is a 'weakened' form of the virus: there is little evidence to support this.

The attenuation of clinical disease in children is likely to reflect in part the low dose and altered route of administration of the vaccine compared with natural infection.

Thus, when measles vaccine was first licensed in the 1960s it contained a live virus. Furthermore, when compared with natural infection, the route, strain and dose of infection are different and the age of exposure lower than normally encountered with wild virus.

In terms of safety, the effect of these changes was unknown. The effect of lowering the age of exposure bears particular mention since early exposure to measles incurs a greater risk of persistent infection and delayed disease. Viral dose is also a major determinant of whether either protective immunity or persistent infection develops.

Safety and efficacy trials of measles vaccine in the US were first reported in July 1960. Most were not controlled, nor observer-blinded. No pre- and post-vaccine neurological assessments were undertaken and adverse events were not monitored beyond three weeks post-vaccination.

The first UK trial of live measles vaccine took place in December 1960. Adverse events were recorded for a maximum of 21 days.

The majority of the 76 vaccinees - all mentally subnormal children - developed mild measles, some severe, and one child died. There was no attempt to evaluate long-term safety.

In 1964 a trial of the safety and efficacy of measles vaccine was set up by the MRC Vaccine Committee. It involved 36,000 children from 10 months to two years of age. Once again, monitoring of adverse events was limited to three weeks post-vaccination, with no attempt to monitor long-term safety.

Worldwide, there have been no prospective studies of measles vaccine safety beyond the initial three- to four-week follow-up period.

It was not until 1995 that long-term vaccine safety was investigated in the 1964 cohort. With the exception of subacute sclerosing panencephalitis (SSPE registries), there have been no other attempts to actively monitor medium- or long-term vaccine safety.

Further attempts to detect adverse events to measles vaccines have relied, almost exclusively, on 'passive surveillance' - the patient presenting to the GP, the doctor making the association between the symptoms and vaccine and reporting this.

In 1995 researchers from the Public Health Laboratory Service pointed out this system's 'failure to detect an unacceptably high risk of aseptic meningitis with MMR vaccine that contained the Urabe mumps strain'.

Professor Michael Rawlins, chairman of the CSM, acknowledged '...that a spontaneous reporting scheme might not detect possible adverse reactions which have a long delay in onset, such as inflammatory bowel disease linked to MR vaccine.'

In 1988, the combined MMR vaccine was introduced into the UK. This consisted of three live virus vaccines - a combination that was potentially hazardous.

Measles vaccine causes temporary suppression of cellular immunity. Potentially this could interfere with the immune system's ability to handle a simultaneously administered virus. The committee to which vaccine-related events are reported in the US expressed its anxiety over this issue: 'It may be asked, then, whether the use of combination viral vaccines might exacerbate the potential problem of immune suppression. The committee found no report of any systematic comparison of the effects of monovalent and polyvalent live attenuated vaccines on immunity.

In 1993, a conference in Europe of experts on the measles virus gave voice to concerns about the lack of knowledge about measles vaccine and its potential for adverse effects. An area highlighted as requiring epidemiological input was: 'evaluation of the safety and efficacy of two-dose schedules of standard titre vaccines'.

Despite this, a two-dose schedule was adopted in the UK one year later, without any attempt to monitor safety prospectively.

Restricting safety studies to three weeks for a live, potentially mutated RNA virus that can cause persistent infection and delayed disease, given by a different route, at a different dose and age and a different strain, was a grave error of judgment. To re-challenge the host by revaccination with the same agent, without any follow-up safety studies, only serves to compound this error.

The experts acknowledged these shortcomings before revaccination programmes were started in the UK and the US but no steps were taken to rectify them.

The dogma - measles vaccine is safe - has little foundation in hard scientific fact. Merely giving measles vaccine to 70 per cent of the world's population - not once, but twice in many cases - does not qualify its safety.

A response by Dr Elizabeth Miller entitled -'No justification to withhold vaccine' followed, which we've reproduced on page 5.

THE EAGLE FOUNDATION IN CANADA

The Eagle Foundation was formed as a non-profit vehicle whose mandate is to, where possible, assist individuals in their struggle for knowledge and justice, particularly in the area of scientific technologies and procedures. In early 1995, a Winnipeg child, Sara Dignazio was diagnosed with post-vaccinal encephalopathy with resultant 'pervasive developmental disorder' (a condition similar to autism). Her parents went through great length and expense to obtain this diagnosis. It was eventually confirmed by numerous renowned specialists. Having linked their daughter's condition to her 18 month DPT vaccination, they wanted to pursue this matter in the courts. They soon found out that the 'Justice System' was for the rich. Their lawyer informed them of the horrendous costs and the complexities of a case of this nature. Soon thereafter they discussed this matter with their family chiropractor and through him, we were asked for support. We then reviewed this matter with a prominent law firm and were told that this was a good case but that it would cost upwards of $500,000.00 without lawyers fees. Mr Robert Tapper of the firm of Wolch Pinx Tapper Scurfield agreed to take on this case on a contingency basis subject to our promise that we would raise the necessary money for costly disbursements. It was then that Dr Raymond E Shupena, Dr Gerald F J Bohemier and myself, Dr Gilbert E Bohemier, established The Eagle Foundation.

We accepted this challenge because as chiropractors, we are extremely concerned about any toxic assault on the nervous and immune systems which are known to cause serious short and/or long term adverse effects to the health of an individual. We are not however, against immunity. Who in their right mind could be against proven safe and effective methods of gaining immunity! Having said this, we have found through research and study that vaccination is, to the best of our understanding, one of many procedures routinely utilized by the medical community which has not passed the rigours of proper scientific scrutiny.

According to a growing number of scientists, there is sufficient worldwide evidence of harmful effects to the immune and nervous systems to warrant immediate restraint on the use of vaccination until proper studies are completed. Despite the lack of proper short term and virtually no prospective (long term) outcome studies, vaccination has become the hallmark of modern medicine gratuitously forced onto people.

Moreover, we took on this challenge because we are adamantly opposed to any procedure coerced onto people and especially without full and honest disclosure of its risk/benefit ratios and without the recipients informed consent.

Furthermore, we are of the opinion that it is high time the medico/government officials admit to and accept the consequences for the adverse effects their procedures are often rendering onto individuals.

For further information regarding The Eagle Foundation, please write to:

The Eagle Foundation, c/o 154 Provencher Boulevard, Winnipeg, Manitoba, R2H 0G3, Canada.

US CHANGES POLIO VACCINATION PROGRAMME

Taken from: BMJ, Vol 314, 15/2/97

The United States Centers for Disease Control and Prevention has issued new guidelines for administering the polio vaccine after determining that nearly all cases of paralytic polio contracted recently in the country were caused by the oral polio vaccine.

Two types of polio vaccine are available: the Sabin vaccine consists of live attenuated virus, which is administered orally, and the Salk vaccine consists of inactivated polio virus and therefore cannot cause polio.

The new recommendations call for a sequential vaccination schedule in which the inactivated vaccine is given at ages 2 months and 4 months, followed by the oral vaccine at age 12-18 months and again at age 4-6 years. The aim of the schedule is to reduce the incidence of vaccine associated polio while preserving the benefits of herd and mucosal immunity provided by the Sabin vaccine. Because the Sabin vaccine consists of live virus it more closely mimics wild polio.

Vaccine experts and epidemiologists believe that when a person is given the inactivated virus first, he or she will develop enough immunity to prevent the development of polio from the live version.

Between 1980 and 1994, 133 people contracted polio in the US, and 125 of these cases, or 94% were attributed to the oral vaccine. Although the risk of contracting vaccine associated polio is only one in 2.4 million doses, for children receiving their first dose of oral polio vaccine it rises to one in 750,000 doses. The new schedule is expected to cut vaccine associated polio cases to between two and five a year. The plan is to eventually use only inactivated vaccine once polio is eradicated globally.

The decision to revise the polio vaccination programme was controversial and debated for over 10 years. Although public health doctors clearly favour the sequential approach, they have left the final decision to individual families and doctors.

'NO JUSTIFICATION TO WITHHOLD VACCINE'

Dr Millers reponse to Dr Wakefields article, see page 3 of this issue.

'The UK joins a growing number of countries worldwide which have adopted a two-dose strategy to achieve measles elimination. Some, such as Finland where a two-dose programme has been in place since 1982, have already achieved this goal.

The article by Dr Wakefield questions the wisdom of giving a second dose of measles vaccine and claims that this will expose children to unknown safety risks. The implicit advice he gives to GPs is - withhold the second dose. The dangers of following this advice are ignored.

Measles is extremely infectious and populations in which immunity levels have fallen below a critical threshold are at risk of an explosive resurgence - as shown by the epidemic that ravaged the US in 1989-90 and resulted in 135 deaths.

With a single-dose strategy, the number of susceptible individuals in the population increases year by year, comprising unvaccinated children and those in whom vaccination fails. Even children with detectable measles antibodies may not be fully protected, hence the importance of giving a second dose irrespective of antibody status.

With a 92 per cent coverage for the first dose and a vaccine failure rate of around 10 per cent, the susceptibility threshold for an epidemic will be reached in the UK every five to six years. This outcome is a certainty - not a vague theoretical conjecture.

There are now many examples of countries where epidemics have occurred after prolonged periods of low incidence. Since these epidemics involve older children, the morbidity and mortality is high.

Many cases occur in older vaccinated children who have not achieved adequate immunity from a single dose. In the US epidemic, 10 per cent of the deaths were in older vaccinated children; overall some 80 per cent of the cases in school-aged children were vaccinated.

We should not become complacent about claims that measles vaccine is unsafe, but this is no excuse for lack of scientific rigour in presenting the evidence.

Dr Wakefield asserts that the vaccine strain is not attenuated and only produces an attenuated infection because a low dose is given by the parenteral route; this is contrary to all the virological and clinical evidence accumulated over four decades. This evidence is too numerous to summarise here but one simple observation refutes his hypothesis.

Aerosol administration of the vaccine virus at titres much higher than those necessary to establish a wild virus infection results in the same attenuated effects as administration of the vaccine by injection.

The evidence of possible long-term risks of measles vaccine referred to by Dr Wakefield derives from his own work on Crohn's disease, the validity of which has been heavily criticised. This evidence has been thoroughly scrutinised by the Joint Committee on Vaccination and Immunisation and by international agencies such as WHO. None of the national or international advisory committees have changed their recommendations as a result.

In Finland, no increase in the incidence of Crohn's disease has been observed following the introduction of their two-dose MMR programme. In the UK, no change in hospital admissions for Crohn's disease in children in England in the wake of the MR vaccination campaign has been seen.

The only confirmed late effects of the wild measles strain are sub-acute sclerosing panencephalitis and immunosuppression, both of which have been extensively studied in vaccine recipients. Long-term surveillance has shown no evidence that measles vaccine causes SSPE and the condition disappears from countries where measles has been brought under control though vaccination.

The attenuated measles strain does have a mild immunosuppressive effect but, by protecting against infection with the more virulent wild strain, the long-lasting immunosuppression and increased general mortality associated with natural infection is avoided.

The alleged association between autism and MMR derived from a television programme in Denmark in 1993 in which the mother of twins, one of whom developed autism, claimed MMR vaccine was responsible.

A thorough investigation conducted by the Danish National Department of Epidemiology concluded that there was no biological or epidemiological evidence to support a link.

With Crohn's disease, the evidence was extensively reviewed by the JCVI and epidemiological studies were set up to investigate the possibility of an association.

The UK immunisation programme has achieved much since the 1970s, when pertussis vaccine coverage plummeted following claims about the safety of whole cell vaccine. The evidence that disproved these claims took time to collect and hundreds of thousands of children suffered.

No vaccine should be withheld from a child without just cause.
Dr Wakefield's article does not provide the justification for such an action in relation to measles vaccine.

DEALING WITH COLDS

By Cassandra Marks homeopath and health journalist

Homeopathic remedies are very good for treating infections and catarrhal problems, clearing up fevers, colds, coughs, sore throats, runny noses and earaches quickly. They work by stimulating the defence mechanism, enabling it to deal with disease more effectively.

Almost 200 different viruses are known to cause the common cold, which causes inflammation of the throat and nose. Typical symptoms are watery eyes, runny nose, mild fever, a sore throat and mild cough, a headache and sometimes aching muscles and listlessness. There is a lot of sneezing and a runny nose. The mucous usually changes from clear to white, or thick and yellow green.

Acute infections are the body's way of building up the immune system, and a child who is basically healthy should be able to throw off a cold within a couple of days.

However, whenever colds turn into prolonged coughs, affect the ears or go down to the chest, your body needs help to deal with the infection. The way to good health is not to wage war on the symptoms associated with every minor illness, but to use natural methods to support the body in its efforts to heal itself.

The conventional way of dealing with an infection, giving antibiotics, is rarely justified. Antibiotics kill off friendly as well as harmful bacteria in the body. Not only are they frequently prescribed for colds, flus and earaches when they shouldn't be (since antibiotics only deal with bacteria, not viruses), they tend to make you more run down, leaving your child open to yet another infection. This can lead to a spiralling problem of frequent infections and eventually to deeper health problems.

Over-the-counter medicines may be less harmful, but they're also of limited help. The sale of largely ineffective pharmaceuticals containing non-specific analgesics and fever-reducing drugs may be a multi-million pound business but virtually all of them have been proven to be useless in affecting the course of a cold. The main ingredients are analgesics (pain-killers) like paracetomol and aspirin, antihistamines and sympathomimetics like ephedrine (which stimulate the sympathetic nervous system). According to Peter Parish, the author of Medicines: A Guide for Everybody, "to take a proprietary cold remedy which contains a decongestant, painkiller, stimulant (e.g., caffeine) and an antihistamine is like taking a sledgehammer to crack a nut - a nut that is any case virtually uncrackable.' (at least by conventional means!) Parish continues ' No drug has a single effect and to try to take several drugs with many diverse effects and adverse effects in order to dry up a few square centimetres of the lining membrane is quite irrational.'

Since all of these drugs can occasionally cause serious side effects why not try one of the following homeopathic remedies. Safe and gentle, they work with the immune system's efforts to deal with infection, rather than against.

ACONITE

Use: for the beginning of colds. Rapid onset, especially after being chilled. Sudden heat and fever, which can alternate with chills. The face is hot and flushed while the feet are cold.

Indications: Thirsty, prefers cold drinks. Slight cough, which sounds hard and dry; or 'barking'. Breathing in cold air tends to bring on the cough. Anxious and restless behaviour.

ALLIUM CEPA

Use: for streaming nose and eyes; especially when the discharge makes nose red raw.

Indications: Body is hot and the head aches. Thirsty.
Feel worse in a warm room, better with fresh air.
Coughs on entering a warm room.
Allergic symptoms like a runny nose cold - especially during the hayfever season.

EUPHRASIA

Use: especially where the eyes look very irritated; swollen or with conjunctivitis.
(NB. For conjunctivitis you can also bathe eyes with Euphrasia tincture - use one drop in an eye bath of water. Or use a flannel dipped in water containing a drop or two of Euphrasia.)

Indications: Eyes and nose streaming. Eyes seem oversensitive to light.
Eyes water with the cough. Only coughs during the daytime.
Feels better lying down. The nose can be streaming - but the discharge seems much less irritating than that from the eyes.

FERRUM PHOS

Use: for the first stage of an inflammation with generalised discomfort in the nose and throat. Temperature is usually over 102.

Indications: Pale and weak with bright red cheeks. Congestion in the nose may cause light nosebleeds on blowing.
Thirsty, with a dry throat.

DULCAMARA

Use: When nose stuffs up with catarrh in rainy or windy weather.

Indications: Thick catarrh filling up nose and inner ears; yellow mucous also in eyes.
Chilly; feels cold with stiff muscles and backache. Glands slightly swollen.
Feels a bit sick; no appetite.
Thirsty.
Seems a bit confused; head feels thick with mucous.

PULSATILLA

Use: for runny nose with thick yellow or green mucous,. Main remedy for coughing on lying down (when mucus accumulates), and in the morning on waking (to clear it out).

Indications: Very snotty. Thick yellow catarrh constantly hangs from nose.
They can lose their sense of smell.
Nose stuffed up in a warm room, and at night so it's difficult to sleep.
Nose runs in the open air.
Not very thirsty. Mild fever.
Weepy and clingy behaviour. Demands lots of fuss and attention - and cuddles, and doesn't like to be left alone.

SILICA

Often follows Pulsatilla. Use when a rattly cough doesn't clear up on Pulsatilla.

Indications: Pale and quiet. Glands in the neck are usually quite swollen and their head may feel sweaty. They feel chilly and might like a scarf around their neck. Nose blocked with yellowish mucous. Hearing is often dimished during a cold.

STICTA

Use for snuffles; when the nose is plugged with yellow mucous (even in babies.) The nose doesn't run; the nostrils are blocked with a plug of yellowish mucous. Nasal secretions may dry and form thick crusts inside the nose.
In older children the root of the nose can feel sore, and when they try to blow their nose nothing comes out.

QUICK REMEDY SPOTTER:
Cold and ...
Blocked nose; Sticta
Fever: Compare Acon and Ferr phos (see last issue)
Streaming nose: Compare All-cep, Ars, Nux vom, Nat mur, Euphrasia
Thick catarrh: Dulcamara, Ant tart, Pulsatilla, Kali bich.
Conjunctivitis: Pulsatilla
Cold sores: Natrum mur
nosebleeds: Ferrum phos, Phos.
(see subsequent issues for pictures of remedies not covered here.

Next issue: coughs.

DOSAGE
Take one tablet of the 6 potency three or four times daily for mild infections.
Take one tablet of the 30 potency every two or three hours only if your child seems very distressed by the symptoms. Reduce the frequency as soon as they start feeling better.
Be flexible regarding how often you give the remedy. Generally the worse the condition the more frequently it should be taken- sometimes every hour or two until you see a response. In less urgent problems, take a 6 potency three times a day until improvement sets in, and then quickly tail off the remedy.
Don't forget - the minimum dose that can achieve a cure is always the best.

CAN YOU HELP?

I am planning to start a newsletter/journal for fathers which focuses on parenting - and particularly fatherhood issues.

I am writing to ask if any of the readers of 'The Informed Parent' would be interested in contributing and/or subscribing.

I would be grateful if you would publish this letter with my address so that people may contact me.

Richard Harvey.
35 The Marles, Exmouth,
Devon, EX8 4NE.

BOOK REVIEW

Who Killed the Darling Buds of May?
by Catherine O'Driscoll

We are advised to vaccinate our dogs and cats every year and are assured that 'only a tiny minority' will suffer adverse vaccine reactions. Is this the truth, or is vaccine damage in our pets vastly under-reported?

Today, vets around the world are questioning the vaccine regime. Some are beginning to assert that we are doing more harm than good when we repetitively vaccinate our pets. There is solid scientific research to demonstrate that vaccines are harmful. Indeed, researchers have shown that:

-vaccines can cause encephalitis, an inflammation of the brain

-encephalitis has many diverse symptoms, usually involving a highly sensitised state.....allergies, skin problems, behavioural problems, convulsions, eating disorders, and more

-vaccines are mixed with deadly poisons

-vaccines can cause the disease they are designed to prevent

-vaccines shed into the environment, spreading disease

-vaccines disarm and unbalance the immune system

-there is no scientific evidence to support annual vaccination

If you wish to make a conscious, informed choice about your pet's annual booster, then you must read this book. For the first time, the scientific evidence - plus dog and cat owners' experiences of vaccination - have been assembled in one volume. Vaccination is a practice surrounded in secrecy, risks which are not spoken of, and unnecessary suffering. This book contains information you need to know.

For further details and orders please write to: Abbeywood Publishing, PO Box 1, Longnor, Derbyshire, SK17 0JD. Tel. 01298 84737

TAKING A GAMBLE OVER GP FLU VACCINE

From: Pulse, 19/10/96, page 58.

For me autumn means harassed nurses sticking flu syringes into anything that moves.

Not that I mind. Far from it - listening from the coffee room while the practice nurse, at £9 an hour, earns money at the rate of £200 an hour is surely one of the great pleasures that the changing of the seasons can bring a GP.

The flu vaccine manufacturers seem to have been getting themselves in a bit of a tiz just lately.

Even before we'd given our first injection we were being pushed to sign up for next year's supplies.

The first offer added up to 24%, which is much better than we are getting this year.

But we have resisted the temptation for a number of reasons. I didn't like the way the rep was insisting that 5% of the discount was conditional on us signing up before the end of October.

I also wasn't too impressed with the complicated pricing structure they wanted to impose on us for their other vaccines.

I've never thought of myself as particularly shrewd but if the drug company is so keen to sign me up this early it seems to me there must be a good reason not to.

I think I will wait and see what it is. We might not order any vaccines at all but wait and see what's going to develop next summer.

With extra players in the field there may still be an over-production and there could be some discounts as manufacturers try to unload their excess.

On the other hand we might lose a packet.

GENE SCIENTISTS TURN THE POTATO INTO A VACCINE

Taken from: The Sunday Times, 8th September 1996

Scientists are creating a new source of drugs from potatoes. They are genetically engineering the vegetable to turn it into an edible vaccine against killer diseases. Their next target is the banana.

The researchers have altered the genetic make-up of potato plants to produce a cholera vaccine that has already been shown to work on laboratory mice. Trials on humans will begin within six months to create the first oral vaccine in the world made from plants.

The technique to transform vegetables into natural pharmaceutical factories could lead to an array of cheaply produced vaccines against diseases such as malaria, hepatitis and measles. They could be simply grown as crops, enabling developing countries to produce their own remedies and save thousands of lives.

Vaccines in food could also make inoculations by needles a thing of the past, as well as enabling medical authorities to carry out immunisation programmes without the need for expensive medical training or equipment.

The genetically manipulated potato will be eaten raw by the volunteers, but scientists are developing a vaccine-producing banana which will be ready within two years as a more palatable alternative for children.
Scientists at the Boyce Thompson Institute for Plant Research at Cornell University in New York have applied for official approval for the clinical trials and it is understood permission will be given within the next few months.

Charles Arntzen, the institute's president and head of the research team, said sufficient amounts of cholera vaccine had been detected in the genetically altered potato to enable the research to proceed. Tests on mice indicate the potato vaccine is effective against cholera, which accounts for most of the 2.5m deaths from diarrhoea each year in children under five, will be safe.

Only part of the cholera bacteria is used, so there is no danger of the potato being able to infect the volunteers.

Each of 12 volunteers will eat one medium-sized potato and their blood will be analysed over the following three months to see if they produce antibodies against cholera. A second clinical trial on up to 60 volunteers will involve trying to infect them to see if they are immune to cholera.

Potatoes are being used because they are easy to manipulate, but the long-term aim is to make genetically engineered bananas that can contain vaccines against a range of diseases.

The scientists are also working on food vaccines against the hepatitis-B virus, which infects one-in-20 people, and malaria, which kills 3m people each year. Plants are also being developed to produce vaccines against the bacteria that cause tooth decay.

Recent developments in plant vaccines are being keenly followed by scientists in Britain engaged in similar research. Iain Cubitt, chief executive of Axis Genetics in Cambridge, said his scientists were about 18 months away from human tests on vaccines made from plants.

Steve Connor, Science Correspondent

SNIPPETS FROM THE PRESS

Nine years after the tragic death of their baby son, a couple are still refusing to bury his body until they are certain of what caused his death. Eight hours before he died, he was given DPT and polio vaccinations and his parents are fighting to discover whether the vaccines could have been responsible for their son's death.

Some experts believe the vaccinations may have carried the bacteria which killed him.

His father said "I won't bury Christopher until an inquest is held," and added " I am convinced Christopher did not die of a cot death and I want the truth."
The Advertiser, N. London Weekly, 1/1/97

A recent article discussing the use of animal organs for transplants to humans was featured in The Times, Higher, 31/1/97. Robert Weiss, a microbiologist expressed his concerns regarding zoonosis (the transfer of infectious microrganisms from animals to humans). In one part of the article he comments:"Aids was absent from humans 30 years ago, and HIV almost certainly originated as an extremely rare sporadic event from an animal to a human host.....Just because we have lived close to domesticated animals a long time does not mean that they could not pass on unknown viruses in unusual circumstances, such as inoculation or transplantation. A new epidemic form of a diseases in dogs is caused by a parvovirus that only recently jumped species from cats, possibly through the hypodermic needle of a distemper vaccine manufactured in cat cells.

He continues further on by adding, "cattle developed a form of leukaemia as a result of vets using the same needles to vaccinate against other diseases, so that the retrovirus causing leukaemia spread from cow to cow."

The Express,Health, 12/11/96 featured an article about an 18 month old boy who suffers from severe multiple allergies. The two-page article gave a vivid description of the difficulties faced in the day-to-day life of the toddler and his parents. Even his mother's good-night kiss brings up a small weal on his forehead, and in the last year alone he spent 75 days in hospital, often in a critical condition.

At one point in the article it states: 'The Dunnes first realised something was different about Isaac when he was just 10 weeks old after a rare reaction to his first vaccination.'

Unfortunatly the article did not expand any further on the reaction, almost as if it was a minor detail.

ROSEOLA

The following extract was taken from the Virtual Hospital Home Page. The author: Moses Grossman MD, Prof. of Paediatrics, University of California, School of Med., San Francisco, CA. May '95.

Roseola

('Baby Measles', Roseola Infantun, Exanthem Subitum, Sixth Disease)

General information

Roseola is a very common disease of infants characterised by high fever and a rash. About one third of all infants have the typical illness, almost always between 4 months and 2 years of age. Many others probably catch the infection without ever feeling or acting sick.

The disease is caused by a virus, herpesvirus 6, related to but different from the other better known herpesviruses. It is not clear how roseola is spread, how contagious it is or how long it takes to become sick after exposure to an infected child.

The Illness

Typical roseola is relatively easy to diagnose. The infant develops a rapidly rising temperature, usually up to 104 degrees F (40 degrees C) and sometimes even higher. Despite the fever, there are no other signs of infection such as diarrhoea or vomiting, cough or runny nose. The baby alternates between being very comfortable, even happy, and acting irritable or fussy. S/he usually eats and drinks reasonably well.

After 3 to 5 days the temperature drops to normal, and within a few to 24 hours a rash develops. The rash consists of small pink spots, mostly over the neck, chest and body. It is usually very faint but may be heavy, and it lasts about a day, a little less or a little more. The characteristic feature of roseola is that the rash comes out after the temperature drops to normal. In most other childhood diseases the fever is present along with the rash.

The most worrisome complication for parents is a convulsion (seizure, fit). The rapid onset of fever, young age of the child and probably the nature of the virus combine to cause this problem which looks terrifying but rarely causes any after-effects.

Editor: The information sheet then indicates 'when to call your doctor'. Under the heading treatment, it states:

There is no specific treatment for roseola, antibiotics do not help. Your doctor may prescribe an antibiotic, however, if s/he thinks the fever might be caused by a bacterial illness.

Almost nothing is known about the contagiousness of roseola. It is believed that children are contagious from a few days before the fever until onset of the rash.

Editor - I wonder how long it will be before a vaccine will be available for this one?

PERTUSSIS BOOSTERS LOOK LIKELY

Taken from: Pulse, March 8, 1997

Introduction of a pre-school acellular pertussis vaccine looks increasingly likely, now that new results have confirmed its safety.

Dr Elizabeth Miller, head of the immunisations division at the Public Health Laboratory Service, said trials using a combined DTP vaccine with acellular pertussis showed it was safe and had few side-effects in pre-school children.

The whole-cell pertussis vaccine is known to cause significant side-effects in older children, making it unsuitable as a booster.

Dr Miller said it was highly likely that boosters would be introduced, possibly at school-leaving age as well, as outbreaks of pertussis had occurred in the US which suggested increasing vulnerability in the adult population.

'As natural contact with pertussis falls, children no longer receive a natural booster. In Canada and the US there has been a resurgence of pertussis despite a stringent immunisation policy that includes a pre-school booster,' she added.

Researchers were now examining the effect on antibody levels when an acellular vaccine was added to the DT vaccine of given alongside the MMR vaccine, Dr Miller said.

Editor - If there has been a resurgence of whooping cough in the States and Canada despite a booster shot, then surely that would indicate that the booster shot has not been successful?

"AN INSULT TO DEDICATED HEALTH AND SCIENTIFIC PROFESSIONALS"

MICHAEL HENRY, FATHER OF FOUR AND A GRANDFATHER WRITES A PERSONAL VIEW BASED ON HIS OWN FINDINGS AND EXPERIENCES

These words, together with "our campaign is based on sound scientific fact," appeared in a letter to my local paper. The offended party was my local Health Authority who were responding to my letter which dared to questioned the 1994 MR campaign. I have often mused on these words and, as my understanding of vaccination has widened, they have intrigued me more prompting me to read further on the subject, inparticular the history, and the following is a brief resume of my findings.

Just as nowadays the inconsistencies associated with vaccination abounded. It all started, or so we are told, with Edward Jenner who in 1796 vaccinated a boy with cowpox in the hope of making him immune to smallpox. Yet the history books ignore several very important issues. According to Benjamin Jesty's gravestone in Worth Matravers, Dorset he inoculated his wife and two sons with cowpox in 1774 (the only difference being that infected pus was introduced in inoculation by cutting the 'victim' and in vaccination by injecting.) Prior to that the practice of inoculating existed using pus from smallpox blisters and in the early 1700's gained Royal approval when Lady Montague, on her return from Turkey, introduced the practise to society including King George III. Even Jenner himself was inoculated with smallpox in 1757 at the age of eight and was extremely ill.

So why did Jenner get the credit? Was it anything to do with the fact that he was a doctor, whilst all the others were lay people? Though in those days doctors never formally sat an examination they probably, like Jenner, studied under a surgeon for several years. And some may even have purchased their Doctorate, as did Jenner, whose own came from a Scottish University costing £15. He also obtained his membership to the Royal Society by simply writing and submitting an obscure article on his observations of a cuckoo.

On the 14th of May 1796 Jenner vaccinated 8 year old James Phipps with cowpox pus from a dairymaid. Eight weeks later he repeated the action with smallpox pus and the boy did not succumb to smallpox. He had no way of knowing whether the pus was infectious or not. Yet having infected (?) a male with a non-infectious complaint taken from a different species, in which only the females (cows) got cowpox, Jenner believed he could prevent a different disease, smallpox, in humans. On this sole deed he announced "the grand proof of the value of inoculation of cowpox as a preventive of smallpox" Jenner submitted a paper to the Royal Society of his findings and, on it's rejection, set about exploring other avenues to gain acceptance. He then discovered horse-grease from the heels of horses and announced that "this is the life preserving fluid" against cowpox."

He again submitted a paper to the Royal Society without waiting for test results using James Phipps as proof (despite the fact that he was only ever vaccinated with cowpox) and declared that his cowpox paper was useless and offered no protection against smallpox. As there was a great out-cry against taking filthy grease from horses heels the Royal Society threw out this theory in favour of Jenner's original paper. Did he argue his case? No. In the "fond hope of enjoying independence" he accepted the verdict. Thus, on a total lack of scientific understanding and double-blind or even adequate trials, and having twice about turned his views, vaccination was accepted.

So much so that in 1802 Admiral Berkeley, prompted by Jenner, petitioned Parliament for financial reward for the discovery and to cover any expenses incurred. Although the work of Jesty and others was brought to the attention of the investigating committee Parliament, guided by William Pitt, credited vaccination to Jenner. They also awarded him the considerable sum of £10,000 (for which, at the same time, one could have purchased one fifth of the land that Bournemouth now stands on.)

In the intervening six years between "discovery" and full approval were adequate trials and controlled experiments undertaken? In Jenners 1798 Inquiry article half of the patients (just six) who had had cowpox when young were vaccinated in adulthood with smallpox without ill effect. These were paraded as an example to prove his case despite the widely known fact that adults rarely got smallpox.

So why was vaccination so readily accepted? Without doubt the main reasons then, just like now, were fear and money. By extrapolating the awfulness of the disease from towns and cities to the rest of the country doctors were able to frighten people into having jabs whilst earning a good living. But, again, this ignores certain issues-in fact extremely important issues. The towns had appalling over crowded living conditions made worse by non-existent clean water supplies and narrow streets that were open drains full of raw sewage. These were the ideal conditions for disease to flourish. Whereas to live in the country, or a small town, with improved water supplies and drainage together with easier access to fresh food greatly improved health. Thus disease was much rarer accounting for dairymaids renowned fair complexions. Further credence was given in 1808 by all of London's doctors, signing a testimonial, declaring that once vaccinated a person was for ever protected against smallpox. Doctors in those days were not widely used and any means to improve their status would have been grasped, particularly as they were paid for by the people they attended. Mainly these were the upper classes and Royal patronage ensured the more wider adoption of this untested procedure. (Even the Duke of Clarence's illegitimate sons were vaccinated.)

Having Royal consent and £10,000's worth of Parliaments approval guaranteed the success of vaccination. Two such august bodies, committed at such an early date, could not be wrong. Just as they could not be seen to have hastily voted away public money without adequate reason. Then, as now, pride, position and status in society were far more important. Acceptance was ably supported by fellow doctors and by sweeping comments, on Jenners work, such as

"the proof was now complete" (A History of Medicine) and "by a very simple measure the world could be made immune for ever" (The Story of the Progress of Medicine). Jenner with the letters FRS and MD after his name furthered his own cause by announcing "that a person who is once inoculated with cow pox is for- ever secure against smallpox."

Amid the "scientific" evidence there was ample proof of failure:-

- Dr B. Moseley of Chelsea Hospital in 1804 published many cases of vaccinated people who subsequently had smallpox. Together with cases of severe illness, injury, and even death resulting from vaccination.
- Dr. W Rowley of St. Marylebone Infirmary in 1805 and 1806 published 504 cases ditto with 75 deaths. He even opened his doors so his brother medical men could " come and see. I have lately had some of the worst species of smallpox all known to have been vaccinated."
- Dr Squirrel ex. Apothecary to the Smallpox and Inoculation Hospital in 1805 published ditto.
- John Birch a London surgeon published many pamphlets ditto.
- Mr W. Goldson a Portsea surgeon in 1804 ditto. He sent accounts of cases to Jenner as early as 1802.
- Mr Brown a Musselburgh surgeon in 1809 published 48 cases ditto.
- Dr Maclean in 1810 published 535 cases ditto with 97 deaths.

Did the powers that be take heed of all the contradictory and damning evidence. No. Instead Parliament in 1807 voted Jenner a further £20,000 and in 1808 endowed an annual sum of £3,000 to vaccination. (This would have been of little comfort to James Phipps who having been re-vaccinated many times died in the same year at the age of 20 from TB).

Jenners gratitude to the upper classes was evident in 1811 when he sat with Lord Grosvenor, aged 10, who was very ill with smallpox. Having previously vaccinated the boy Jenner was quick to recover the situation saying, on signs of the boys recovery, "what a lucky job he was vaccinated. If he had not been, he would surely have died."

This justification is likewise used today and vaccination became a procedure that was merely adopted rather than one that was scientifically based

Next issue...more manipulated figures.

HEALTH HAZARDS OF NAPPY WASTE REVEALED

A new report by the Women's Environmental Network examines the issue of disposable nappy waste.

PREVENTING NAPPY WASTE by Ann Link was published in September 1996. It states that an alarming 4% of domestic waste (nationally) is throwaway nappies. Since most of this ends up in landfill, there are severe public health concerns; by weight, 3/4 of a nappy is urine and faeces which harbour an estimated 100 active viruses for 2 weeks. This untreated sewage (including the excreted polio vaccine) is a risk to refuse workers, but affects us all in a more sinister way. As a nappy rots, it releases acids, which mobilise metals into the leachate - a sort of chemical soup which filters down through the landfill lining - which can contaminate groundwater. There is concern that viruses could also seep into our water supply.

So hazardous are throwaway nappies that they are treated a clinical waste when collected in sufficient quantities (eg from hospitals). Nappies are found as litter at road sides, in car parks, public toilets and residential areas. They are the second most common clinical waste problem for local authorities after syringes.

There are also question marks about the direct health impact on babies themselves. Throwaway nappies are basically an industrial product, a complex cocktail of ingredients of unproven quality. One substance used as a wetting agent in the topsheet, nonylphenyl ethoxylate, is now known to be an oestrogen mimic, associated with sex changes in fish, and possible with the drop in the sperm count. It is being phased out in Germany.

So we have now reached a point where around 9 million nappies are being tipped into landfill every day in the UK. What can be done? These days reusable cotton nappies are attractive and easy to use; terries and pins are not the only option anymore. In fact, there is a greater choice of 'real' nappies than disposables.

For the latest information on products available, send an large SAE for a free information pack to: REAL NAPPY ASSOCIATION, PO Box 3704, London, SE26 4RX.

For those parents without time or inclination to homewash, an affordable alternative exists in nappy laundry services. Nationwide there are about 18 of these. A nappy service supplies a weekly stock of hygienically cleaned cotton nappies direct to your doorstep, at a price comparable to disposables. To find out if there is a service operating in your area, contact the NATIONAL ASSOCIATION OF NAPPY SERVICES, Edmonston House, 200 Foundry Lane, Regents Park, Southampton, SO15 3JX, Tel 01703 740 583, Fax 01703 223 783.

For anyone contemplating a change to real nappies, REUSABLE NAPPY WEEK is a good time to start. In its third year, it runs from 21-27 April. For a copy of WEN's report, a comprehensive overview of the current situation, ring 0171 247 3327. WEN can also put interested local members in touch with each other, and give them help in changing the situation in their area.

Eirlys Penn, Informed Parent reader, 54 Sherland Road, Twickenham, TW1 4HD. Tel 0181 744 0562

GPs IN IMMUNISATION EDUCATION DRIVE

Taken from: Medial Monitor, 5/2/97

GPs and primary healthcare workers are to be offered a series of immunisation seminars designed to help them answer increasingly complicated questions asked by anxious parents.

The Health Education Authority seminars follow research that found that many GPs were having to respond to increasingly complicated questions from parents, and felt ill-equipped to do so. GPs who attend will receive updates on vaccination research from local immunisation specialists and from the HEA immunisation team.

Pilot seminars are set for London, Essex, Manchester, Newcastle, Yorkshire and Hertfordshire.

Editor - Unfortunately I don't suppose the health professionals attending will be presented with the full information!

The 1st What Doctors Don't Tell You Conference

VACCINATIONS:

THE FACTS & THE PROPAGANDA

Are we getting the whole truth from the Government?
Is there a cover-up of the dangers?
Do vaccines really work?
What else can parents do to safeguard their children?

Wednesday May 14 1997
Conway Hall, Red Lion Square,
London WC1.
7.30pm
(scheduled finishing time: 9.45pm)

Main speaker: Lynn McTaggart, editor; WDDTY
Guest speakers: Dr Richard Nicholson and Prof. Gordon Stewart
(further guest speakers may be added)
Cost: £15 (£12 for WDDTY subscribers.

For further details and bookings, please contact WDDTY on:
Tel 0171 354 4592

CHILD HEALTH FORUM

Sunday 20th April 1997
9.30am - 4.30pm
Askham Bryan College,York

The aim of the Child Health Forum is to bring together many different areas of child care and development. There will be a wide variety of workshops on topics including breastfeeding, vaccination, homœopathy, birth preparation, education, acupuncture,baby massage. There will also be opportunities to browse through many informational stalls.

Cost (including lunch) -
Individual - £45 Couple - £70
Concessions - £30 Creche available
For further information contact -
The Healing Clinic,
33 Fulford Cross, York.
Tel: 01904 679868

VIERA SCHEIBNER'S UK LECTURE DATES

Vaccination - Is there a point?
A talk by Viera Scheibner
followed by an open forum.
Saturday 19th April 1997
10am - 4pm
At Mangreen Hall, Swardeston,
Nr Norwich.
Cost £5, to include tea/coffee & biscuits. Bring a packed lunch.
Booking is essential
as there are limited places
For further details and bookings please phone:
Michelle on 01379 676644
or Sue On 01379 608235

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Vaccination - A shot in the dark?
A public lecture by Viera Scheibner
Tuesday 22nd April 1997
7.30 - 10.00pm
University of Hertfordshire
Hertford Campus
Mangrove Road, Hertford
Tickets £3.00.
Bookings in advance only.
Please telephone
Carolyn 01992 553714
or Margaret 01992 583734

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Vaccination - The medical assault on the immune system
A lecture by Viera Scheibner
Thursday 24th April 1997
7.30pm
Friends Meeting Hse,
Queens Road, Leicester
Tickets £3.50 (waged)
£2.50 (concessions)
Bookings in advance, please phone
Sue King on: 01455 822289

IRELAND

Vaccination lecture
by Viera Scheibner
Sunday 20th April 1997
4.00 - 6.00pm
Venue: Don Marmion House,
Dundrum, Dublin 14

£5.00 fee, bookings required
Telephone Finola Moore
(Mon.-Wed. 10.00 - 12.00pm)
on 01 450 4438
or Gina Wheelan
(Mon. -Fri. 8.00pm - 10.00pm)
on 01 493 3171

All profits go to the Osteopathic Centre for Children, 44 Lower Leeson St.,Dublin 2. UK Reg. Charity 1003934

FAMILY OPEN DAY

The Natural Nurturing Network (NNN) is holding a national Family Open Day in the conference centre at Ryton Organic Gardens in Coventry on 5th May 1997.

A range of discussions and workshops will be available for adults and children, as well as information about NNN and other organisations involved in parenting. birth, breastfeeding etc.

For further details please phone Paula Rice on 01629 580508.

IF YOU REQUIRE A QUANTITY OF THE INFORMED PARENT LEAFLETS, PLEASE SEND A LARGE SAE TO THE ADDRESS BELOW.

The views expressed in this newsletter are not necessarily those of the members or founder members. We are simply bringing these various viewpoints to your attention. We neither recommend nor advise against vaccination. This organisation is non-profit making.

AIMS AND OBJECTIVES OF THE GROUP

1. To promote awareness and understanding about vaccination in order to preserve the freedom of an informed choice.

2. To offer support to parents regardless of the decisions they make.

3. To inform parents of the alternatives to vaccinations.

4. To accumulate historical and current information about vaccination and to make it available to members and interested parties.

5. To arrange and facilitate local talks, discussions and seminars on vaccination and preventative medicine for childhood illnesses.

6. To establish a nationwide support network and register (subject to members permission).

7. To publish a newsletter for members.

8. To obtain, collect and receive money and funds by way of contributions, donations, subscriptions, legacies, grants or any other lawful methods; to accept and receive any gift of property and to devote the income, assets or property of the group in or towards fulfilment of the objectives of the group.

The Informed Parent, P O Box 870, Harrow, Middlesex HA3 7UW. Tel./Fax: 0181 861 1022