THE informed PARENT

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NEWS FROM JAPAN

Earlier this year a two-day conference was held in Naples, Italy (31st May-1st June 1997) entitled "Should vaccinations be compulsory or free choice?" Doctors from various areas of the world were invited to present the situation in their country and also to highlight problems surrounding some of the vaccines.

I recently received a copy of the presentation made by Dr Yamamoto entitled 'Why Japanese Government had to cease compulsory vaccinations.' A viewpoint from a pediatrician. Reproduced here are some of the points he presented .(The English translation is reasonably clear.)

'In Japan, many children have been damaged from vaccinations and the government has made light of the safety of vaccinations. Moreover the victims increased under the situation of compulsory vaccination system.

EVALUATION OF VACCINATIONS

Effectiveness - Many factors such as medical progress, public health and an inadequate surveillance system influences the data.

Necessity - We must consider international disease prevalence, however in Japan I do not think diphtheria, Polio and Japanese encephalitis vaccinations are necessary because there are only a few cases. In data from 1993 all cases of polio were related to the vaccine.

Safety - Looking at the governments data from 1995, there were 54 cases of anaphylaxis reported. Recently it is supposed that almost all the cases of anaphylaxis are caused by gelatin, which is used as a stabiliser in vaccines.

Two cases of rubella vaccination induced convulsions were reported. Rubella is not a serious disease in childhood, so 2 cases of convulsion are important.

VIEWPOINT OF A PEDIATRICIAN

1. If there are no/few cases of a disease for several years resulting in few sequelae or deaths, all over the country annually, the vaccination may not be necessary.
2. If some vaccinated patients get the disease the vaccination may not be effective.
3. If you see clinical sequelae of death from clinical experience or from medical literature, the vaccination may not be safe.

According to this standard, as a pediatrician I recommend my patients only measles, tetanus and BCG vaccinations in Japan.

In Japan, since 1995, strictly speaking BCG for school children is compulsory, all other vaccinations have become free choice.

In the years 1971 to 1976, 27 children died from the smallpox vaccination, so in 1976 Japanese government decided to cease compulsory smallpox vaccination. USA and the UK had already ceased smallpox vaccination in 1971, therfore if the Japanese government had ceased this vaccination or if the vaccine had not been compulsory we could have saved these children from unnecessary vaccination.

MMR IN JAPAN

MMR vaccination started in April,1989. Immediately after, aseptic meningitis cases began to be reported. At the end of 1989, for example, a report said that the incidence ratio of aseptic meningits was 0.5% of vaccinated children. The government announcements at this time regarding its safety were as follows:

September 1989 - MMR safe
October 1989 - Caution
December 1989- To be vaccinated only if parents wanted it
May 1991 - Parents consent needed
April 1993 - MMR withdrawn

INFLUENZA IN JAPAN

Mass influenza vaccination programmes for school aged children had been started in 1960, and about 3 million children were vaccinated. In 1976, the compulsory vaccination system had been introduced and 17 million children from primary to high school had to be vaccinated twice annually. This was a unique vaccination programme in the world, which the government believed would avoid the social influenza epidemics. This was a wrong hypothesis which was not verified for a long time.

Since the '80s the vaccination uptake was constant at about 60% every year but the incidence rate per 100,000 changed from 5 to 60 without concern to the vaccination rate. Since 1989 the vaccination uptake decreased rapidly to 20%, but the incidence rate did not increase.

Influenza incidence rate between non-vaccinated city and neighbouring vaccinated cities - 1984

City A ceased compulsory Influenza vaccination in 1980.
City B to D continued compulsory vaccinations.
City A - The number of school children were about 25,000
City B - Number of school children were about 21,000. Statistically, they were almost the same groups.

The results

City A - Vaccination uptake below 1%. Influenza incidence 43%
City B - Vaccination uptake 90% Influenza incidence 40%
City C - Vaccination uptake 77% Influenza incidence 43%
City D - Vaccinaiton uptake 76% Influenza incidence 52%

A similar study was documented in 1985 with similar results.
It was an important epidemiologic study for compulsory influenza vaccination programme to be ceased.

(contd. page 2)

(contd. from page 1)

ADVERSE REACTIONS TO INFLUENZA VACCINATION

A mass study of adverse reactions against the influenza vaccine was conducted in 1987 involving about 400,000 children.

The total adverse reaction rate was 254.3 per million.
(10 per million children had complained of neurological symptoms.)

This study was revealing, since from 1971 the government had changed the flu vaccine from a whole body type to a split particle type announcing that adverse reactions were almost nothing with the new one. The previous type , used in the 1960s had resulted in between 5-9 deaths occurring every year.

In 1987 the government changed the vaccine from compulsory to free choice.

From 1972 to 1979 , a total number of 142 children and families sued the government for damages. The total number of deaths were 50, severe developmental retardation were 65, and intractable epilepsy were 35.

In 1992, the government lost the case in the court after about 20 years of legal proceedings.

Should vaccination be compulsory or free? The answer is clear.

1. Once a system of compulsory vaccination is established, immediate discontinuation of the system becomes difficult, even if a large number of victims are caused by the vaccinations.
2. We learned this lesson from Japanese history of compulsory vaccinations.
3. So compulsory vaccinations should be ceased as soon as possible.

There are two problems with free choice.

1. Compensation. Who will save the victims?

In Japan, Influenza vaccination induced adverse reactions have been removed from the objects for governmental compensation by vaccination law since 1995.

2. Does the vaccination uptake decrease?

Vaccination uptake was compared over the two-year period 1994-95 for three vaccines. In 1994 the vaccines were compulsory and in 1995 were free choice.

DT (diphtheria, tetanus) and Japanese encephalitis vaccination decreased from 85% to 70%, whereas measles vaccination uptake increased to 100%. This shows that if parents think the vaccination is necessary the rate may not decrease.

CONCLUSIONS

1. Safety is the most important factor to evaluate vaccinations for pediatricians.
2. Over 2,000 victims of vaccine damage were reported in Japan.
3. Compulsory vaccinations played a large part in increasing the number of victims.
4. Epidemiologic studies proved influenza vaccination as not safe nor effective in 1980s
5. Influenza vaccination rates began to decrease in 1987 and in 1992 had decreased to 20%.
6. In 1992, the government lost the case in the court. 142 plaintive won the case.
7. For these reasons, the government had to cease compulsory vaccination programmes in 1994.

HEAR SAY

Talking to many concerned parents on the telephone can be extremely enlightening as many of the callers have very interesting comments to make. I thought an example would be of interest to you:

A mother recently called very concerned about the baby jabs and wanted general information on all of them except the whooping cough vaccine. She was certain that her baby was not receiving this particular vaccine since a friend of the family who works in the vaccine area for a pharmaceutical company had said "Don't even consider the whooping cough vaccine!"

That's an interesting comment about a vaccine from someone who works in that field.. Why would they say that when the vaccine is suppose to be safe and effective? Editor

BOOK NEWS!

AN EDUCATED DECISION

BY CHRISTINA J HEAD MCH, RsHom

I have been a full time, working homœopath in South London for over 10 years. During this time I have observed a huge number of subtle and not so subtle ill effects from young children being vaccinated. I have spent 4 years researching the subject and trying to work out what happens to these children and how to get them right. I also specialise in supporting families who have made the decision not to vaccinate and currently have about 200 children on my books, of varying ages who are not vaccinated at all and extremely healthy. The questions and queries that parents have proved to be too much to answer in the average consultation time, so I decided to put it all in a book that parents can dip in and out of and hopefully gain a better understanding of this highly controversial subject and also about Homœopathy and the art of creative medicine.

Copies of "An Educated Decision" can be bought from:

C Head,
The Lavender Hill Homœopathic Centre,
33 Ilminster Gardens, London, SW11 1PJ.
Tel: 0171 978 4519
Price £15.00 + £1.00 p&p.

IRISH CONTACTS?

I have recently emigrated to the Republic of Ireland. I am expecting my second child in January 1998 and on investigating maternity hospitals I was dismayed to discover that they routinely give the BCG innoculation at birth!

There is no way we will allow this but I would be grateful to hear from any parents in Ireland who have refused this, and what the reaction has been.

Eleanor McCann, 11 Moatlands, Ratoath, Co Meath, Eire.

IS INFANT IMMUNISATION A RISK FACTOR FOR CHILDHOOD ASTHMA OR ALLERGY?

Kemp T et al Epidemiology 1997 Nov; 8(6): 678-680

The Christchurch Health and Development Study comprises 1,265 children born in 1977. The 23 children who received no diphtheria/pertussis/ tetanus(DPT) and polio immunisations had no recorded asthma episodes or consultations for asthma or other allergic illness before age 10 years; in the immunised children, 23.1% had asthma episodes, 22.5% asthma consultations, and 30.0% consultations for other allergic illness. Similar differences were observed at ages 5 and 16 years. These findings do not appear to be due to differential use of health services (although this possibility cannot be excluded) or con-founding by ethnicity, socio-economic status, parental atopy, or parental smoking.

VACCINE CLUE FOUND TO GULF WAR SYNDROME

By Hugh McManners, The Guardian

British scientists believe they have pinpointed a medical cause for Gulf war syndrome in a breakthrough which could force the Ministry of Defence into paying tens of millions of pounds in compensation.

Immunologists at University College London say they have for the first time established how vaccinations given to troops in the war against Iraq, combined with exposure to insecticides, could cause the symptoms afflicting many hundreds of British veterans.

The MoD, which has always denied that the syndrome has a single medical explanation, will test the hypothesis as part of the programme of epidemiological studies announced by the Conservative government earlier this year.

If the theory - to be published this week in the Lancet medical journal - proves correct, it will open the door to massive compensation claims from veterans. For six years, former soldiers have battled to prove that the drug cocktails they were given to protect them against disease and chemical weapons were to blame for their illnesses.

Professor Graham Rook and Dr Alimuddin Zumla, who made the breakthrough, also believe that their work could lead to an effective treatment for Gulf war syndrome using drugs already on the market.

Rook said this weekend that the effect of the vaccinations combined with insecticides had been devastating. The drug cocktails suppressed one part of the body's immune system, known as Th1, which combats viruses and cancers.

At the same time Th2, a part of the immune system which normally reacts mildly against pollen or house dust mites, was made hypersensitive to outside irritants.

This double effect meant that soldiers were more likely to succumb to common diseases, while also suffering extreme allergic reactions to harmless elements in the atmosphere.

"A systematic shift towards Th2 leads to patients developing more diseases, particularly chronic virus infections, as their Th1 protection is diminished," said Rook.

"There is also an increase in allergic symptoms prompted by increases in Th2 reactions, and mood changes which we can attribute to the corresponding changes in their hormone cytokine levels. This explains the extraordinary diversity of symptoms seen in Gulf war veterans."

Many of the vaccines given to British and American troops in the Gulf, including cholera, anthrax and bubonic plague, are believed to cause the precise immune system changes described by Rook.

French troops, who did not receive the same massive drug cocktails as their American and British counterparts, have not suffered the same incidence of Gulf war syndrome.

British soldiers often received several vaccinations at once, without proper records being kept; many erroneously received more than one dose of each.

The new medical study has been hailed by campaigners as a landmark in securing a fair deal for the 1,500 British veterans who are afflicted. Terry English, of the Royal British Legion, which has advised most of the sick British Gulf war veterans, said the soldiers who claimed they had been made ill serving their country appeared to be vindicated.

"This is the first time that anybody has come up with a sound scientific basis for the veterans' suspicions which also accounts for all their symptoms." he said.

THE FLU JAB

Exctract From:
Guardian Education 21/10/1997

.... It is debatable as to whether they get value for money, according to a study of 170 post office workers. The 85 who had been vaccinated fared no better than those who had not.

But the jabs are said to be 70 to 80 per cent effective; and the Department of Health recommends them for those most at risk: the elderly, people with chronic respiratory diseases, chronic heart diseases, kidney disease, diabetes and health service staff.

Dr John Van-Tam, of Nottingham University, emphasises that jabs not only prevent flu, but can also reduce hospital admissions for pneumonia, bronchitis and the lung disorder emphysema by about 60 per cent.

UK vaccination rates are low compared with those of other countries. Dr John Watkins, director of primary care in Gwent, who has made an extensive study of flu, says "We've got a national sickness service- not a national health service. You can see it in the way we treat heart disease - and high blood pressure - and you can see it in flu. Public perception of flu as a potentially deadly disease is very low."

Many of the 6.5 million vaccinations manufactured for use this winter in the UK will be injected into the so called "worried well". The Association for Influenza Monitoring and Surveillance, financed by vaccine manufacturers, says: "Many people not at high risk are vaccinated while many of those who are at high risk are not".

The jabs cost about £5 each.

Extract from an Informed Parent member's letter:

'Incidentally, my new son Ethan, contracted whooping cough at 8 weeks, naturally. It was terrible to get through but we used lots of steam and acupuncture as well as homeopathic remedy, Drossera. He is beautiful and healthy now. I shudder to think they were trying to vaccinate him just as he was coming down with it anyway! It could have been much worse! (And of course I would have blamed it on the vaccine!)'

BMJ SNIPPETS

UK action on the Gulf war syndrome: The British government has promised Gulf war veterans a £6.5m ($11m) package of research and treatment. This will include testing the side effects of giving simultaneous pertussis and anthrax vaccines.
BMJ Vol. 315, p144, 19/7/97

A small outbreak of rubella among British troops serving in Bosnia caused some alarm because of the 620 women among the personnel (Epidemiology and Infection 1997; 118:253-7). One woman soldier who was pregnant was flown out of Bosnia as a precaution. Policymakers are now trying to decide whether all recruits to the armed forces should be immunised with measles-mumps-rubella vaccine whatever their vaccination status.
BMJ Vol. 315, p68, 5/7/97

The recent epidemic of diphtheria in the newly independent states of the former Soviet Union had some curious features, says Eurosurveillance (1997;2:59-68).Around 70% of the cases were in adults, though the underlying cause of the outbreak was said to be failure of child immunisation. All the reported cases in other European countries were also in adults, but the disease did not spread to the West. Clearly a lot has still to be learnt about the epidemology of infections in the post-immunisation era.
BMJ Vol. 315, p438, 16/8/97

Childhood fevers such as chickenpox and measles are more likely to cause serious illness in adults that in children, as was shown recently in an outbreak of measles in Greece (Eurosurveillance 1997;2(7):57-8). Of the 431 reported cases, 126 were in adults, 79 of whom needed admission to hospital. Measles pneumonia and hepatitis were more common and more severe in the adult patients. Seventy six of the 92 adults whose vaccination status was known had been immunised with monovalent vaccine before the introduction of the measles, mumps and rubella vaccine.
BMJ VOL. 315 p262 26/7/97

Three deaths from chickenpox, two of them in healthy young women, are reported in the Morbidity and Mortality Weekly Report (1997;46:409-12). The Centers for Disease Control and Prevention argues that deaths of this kind (and the risk from chickenpox to people who are immuno-compromised) make a strong case for universal immunisation with the vaccine that has been available in the United States since 1995. The report also emphasises the value of early treatment with antiviral drugs for adults who develop chickenpox.
BMJ VOL. 314 p1774 14/6/97

Informed consent is not always obtained in the United States.

We also found evidence that the US government, which makes annual payments to survivors of the study in Tuskegee, has sponsored experiments on unsuspecting subjects well in to the 1990s. Among our case studies were tests by the Centers for Disease Control and Prevention, begun in 1990 in Los Angeles, of the immunogenicity and efficacy of the Edmonston-Zagreb measles vaccine, which the centers knew had earlier caused excess mortality in Africa; and a study in 1991 of hepatitis A vaccine, conducted on a Sioux reservation, in which the letterhead on the consent form implied an established prevention programme rather than the safety and efficacy trial that it was.
Extract from: BMJ Vol.315, p249, 26/7/97

Bovine spongiform encephalopathy threatens drugs in European Union.

If the revisions are accepted by the European Union's Council of Ministers it will mean that drugs for human consumption that have bovine, ovine or caprine ingredients, or ingredients derived from such, will (with one exception) not be allowed on any member state's market after 31 December. Over 200 drugs with gelatin capsules will be affected, as will specific products such as HibTITER (Haemophilus influenzae type b vaccine), Hyalase (hyaluronidase), and Hypurin (insulin).
Extract from: BMJ Vol. 315, p426, 16 /8/97

OUR LIVES IN HIS HANDS

Extract from:
The Guardian, 8/8/97

George Dick, who has died aged 82, was a leading research scientist with a worldwide reputation in the study of virus diseases and had wide interests in medicine and society.

In Japan, he was an expert witness in a whooping cough vaccine damage lawsuit. More recently, he had given advice about a case of Creutzfeld-Jacob disease in Australia.

His honest, forthright declaration of his views did not often endear him to the establishment but his recommendations based on scientific facts could not be ignored. During his time in Belfast, he had the care of a baby with a fatal reaction to smallpox vaccine. It was because of his work - demonstrating from records that smallpox vaccinations were more likely to cause illness than the disease itself in this country - that routine infant vaccination was stopped in 1971. He also persuaded the authorities not to use an early oral polio vaccine, a warning which was later vindicated when the vaccine caused problems elsewhere in the world.

IMMUNISATION TARGETS UNFAIR WHILE WE RELY ON PATIENT'S DECISIONS

Margaret Safranek from north London asks: Has the general medical services committee made any progress in persuading the Department to let us exclude from our target figures children whose parents refuse immunisation?

It seems extremely unfair that we should suffer because of our patients' decisions, especially as we have done our best to persuade them of the benefits of immunisation. I practice in an area where complimentary medicine is popular and about 10 per cent of parents refuse to have their children immunised.

This will get worse if measles, mumps and rubella are included in the pre-school booster. We are only just managing to reach our higher target levels but I cannot see this lasting much longer.
BMA NEWS REVIEW 25/6/97 p 22

THE EFFECTS OF VACCINATIONS ON LONG TERM DISEASE PATTERNS

Barbara Wren, Principal of The College of Natural Nutrition, regards the customary procedure of vaccination as having a considerable damaging effect on the health of the growing and adult individual. Throughout her twenty five years of practising, Barbara was able to observe the unequivocal results that vaccinations have on long-term disease patterns, affecting the physical, mental and emotional being. Barbara had first hand experience to add to her own observations, having developed Anorexia soon after the BCG inoculation. Her conclusions on the effects of vaccinations were integrated with her own naturopathic philosophy around dehydration and nutritional imbalances, to present a picture of the problem which, although alarming, can be tackled at the source with the aid of rehydration techniques, a healthy diet and specific supplementation. Below, Barbara has summarised the main points that need to be borne in mind when looking at vaccinations from a Natural Nutrition viewpoint.

Barbara believes that everything that causes stress to a person has an end manifestation as dehydration. Among some of the common causes of stress are a poor diet, excessive travelling, magnetic interference, living and working against the seasonal cycles and using modern drugs (e.g. antibiotics, steroids and the pill). However the most serious cause of stress are indeed vaccinations, which are like setting a top class athlete on the starting blocks and never firing the pistol; they will drop from adrenal exhaustion and dehydration.

To understand how deeply dehydration can affect the physical, mental and emotional well being, one must be aware of a very simple, yet fundamental process common to all animals on this planet. This process is called 'the sodium-potassium exchange' : during the day sodium is pushed inside the cells by the sun's action, whilst during the night this process is reversed as the sodium is pulled out of the cell by the moon's activity as we lie down. This process relies on the condition of the membrane surrounding each cell, and the cell's membrane is mainly composed of two vital substances, cholesterol and phospolipids. But more of this later.

Stress, as for example a challenging diet comprising diuretics (e.g. tea, coffee, fizzy drinks, alcohol), excess salt and sugar, convenience foods and damaged fats, would drive the body to go on what Barbara calls 'dehydration alert". This starts a process where the body defends the precious fluids inside the cell by producing natural cholesterol to coat the cell membrane. Whilst this is a very beneficial temporary measure, it disables the cell's vital ability to cleanse on a day to night basis and so a vicious circle is started. The more sodium is locked within the cell, the more water is needed to dilute it, hence more water is locked within the cell, leading to water retention and bloating. The irony is that all this water is actually inaccessible to the rest of the body, which thus goes on 'dehydration alert '.

All vaccinations cause extreme adrenal exhaustion and dehydration, which in turn have an immediate effect on the body's ability to cleanse. As our ability to cleanse is impaired, so our toxic load increases accordingly. Our body will do its best at any given time to preserve its most fundamental vital functions and so disease will naturally progress from a physical level to a mental level. As a result of the internal toxicity increasing consistently and dramatically ever since the Industrial Revolution, we are seeing a great deal of brain/head level toxicity in all of the central nervous system disorders: Schizophrenia, Autism, Eating Disorders, Dyslexia, Manic Depression, M.E, M.S, Parkinsons, Aids and H.I.V.

Furthermore, vaccinations are generally administered at a time when the child's or teenager's body is already negotiating considerable internal upheaval. In young children, fevers and childhood illnesses are in fact healthy natural measures the body uses to liberally 'burn out' internal toxicity. These episodes should be viewed as positive events, with long-term beneficial effects in terms of reduction of internal toxic load. Vaccinations at this stage in the child's growth are more likely to act as a suppressant, driving the body's cyclical cleanse, out of synch and the disease deeper, on a chronic level. In puberty, the child's body experiences dramatic hormonal changes, which if interfered with or suppressed, can lead to serious physical and mental/emotional imbalances. It is usually during this very vulnerable time in a child's growth that one of the most potent and damaging vaccines is administered: the BCG.

"In 90% of the cases I have seen of Anorexia, the disease had developed within 6 months of the BCG vaccination" says Barbara. This is because dehydration sets up a need for Essential Fatty Acids (EFAs) and Phospholipids in the central nervous system. These substances are vitally important for maintaining hydration at a cellular level and the EFAs are responsible for 30 different prostaglandins which work directly with the endocrine system, the hormonal regulation network so to speak. This is, according to Barbara, the reason why there is a direct effect of the BCG vaccination on the central nervous system causing Anorexia. It is believed, in fact, that in Anorexia cellular changes occur in the frontal brain due to EFAs and Phospholipid deficiency. "We can see that the stress of the vaccination has increased the dehydration problem and EFAs and Phospholipid destruction. The BCG vaccination is particularly damaging when given to someone who is already very 'tubercular', i.e. very dehydrated and struggling with body cleansing and showing deficiencies in EFAs and Phospholipids. A similar picture can be seen in Autism which is rapidly increasing among young children; they are given so many antibiotics, steroids and vaccinations, that their weakness picture goes from physical to mental very quickly".

This alarming picture throws the spotlight on the real culprits here, the real causes of long-term disease. We are not talking about the infectious diseases that vaccines are supposed to be targeting and which have been largely declining ever since the introduction of improved diets, sanitation and living conditions. The real offenders here are vaccinations themselves, along with antibiotics, steroids and similar prescription drugs. They all generate incredible stress to the body, draining it of vital energy and essential substances and creating a fertile ground for long-term disease to thrive upon. This, with the overwhelming evidence that has recently been made available to the general public, arguing the effectiveness of vaccines and confirming the spectrum of their side-effects, should provide ample doubts around the medical justifications for such a procedure.

Barbara Wren can be contacted at:
The College of Natural Nutrition,
1 Halthaies, Bradninch, Nr.
Exeter, Devon, EX5 4LQ.
Tel/Fax: (01392) 881091.
Email: cnn@globalnet.co.uk

CRANIAL OSTEOPATHY

It is a common belief that babies and children should have no structural stresses or strains in their bodies, because they are 'so young'. The reality is very different.

The birth of a baby is one of the most stressful events of our lives. The baby is subjected to enormous forces, as the uterus pushes to expel the baby, against the natural resistance of the birth canal. The baby has to turn and twist as it squeezes through the bony pelvis on its short but highly stimulating and potentially stressful journey.

The baby's head has the remarkable ability to absorb these stresses, in a normal delivery. In order to reduce the size of the head, the soft bones overlap, bend and warp as the baby descends. The baby's chin is normally well tucked down towards its chest to reduce the presenting diameter of the head.

Many babies are born with odd shaped heads as a result. In the first few days, the head can usually be seen to gradually lose the extreme moulded shape, as the baby suckles, cries and yawns. However, this unmoulding process is often incomplete, especially if the birth has been difficult. As a result, the baby may have to live with some very uncomfortable stresses within its head and body.

What effect does retained moulding have on the baby?

Some babies cope extremely well with even quite severe retained moulding and compression, and are contented and happy. For others it is a different story, and they can display a variety of problems.

Crying. irritable baby

Crying, fractious, irritable baby, needs to be rocked to sleep. Prefers being carried.
Reason: The baby may be uncomfortable, with a constant feeling of pressure in the head. This is made worse by the extra pressure on the head when lying down.

Feeding difficulties

Baby takes a long time to feed one feed merges into the next. He/she may be a 'windy' feeder.
Reason: Feeding is difficult and tiring due to mechanical stresses through the head, face and throat. The nerves to the tongue may be irritated as they exit from the skull, which makes sucking difficult.

Sickness, colic and wind

Regurgitation of milk between feeds, bouts of prolonged crying due to colic and wind. Often worse in the evening.
Reason: The nerve to the stomach is irritated as it exits from the base of the skull. which impairs digestion. The diaphragm may be stressed or distorted, which further compromises both digestion and the ability of the stomach to retain its contents.

Sleep disturbances

Baby sleeps for only short periods, and may sleep little in the day (or night!) Wake to the slightest noise.
Reason: The tension on the bony and membranous casing of the skull keeps the baby's nervous system in a persistently alert state.

As the child grows

As the child grows, the effects of retained moulding can lead to other problems. The following are the most common, but it is by no means an exhaustive list.

Infections

Retained moulding and birth stresses takes its toll on the body's reserves, and also depletes the immune system. This leaves children more vulnerable to all types of infection.

Ear infections

Recurrent ear infections. gradually becoming more frequent. Loss of hearing, leads to 'glue ear'.
Reason: Retained birth compression within and around the bones of the ear impedes fluid drainage from the ear, causes poor development of air sinuses in the ear, and partial or complete blocking of the Eustachian tube.

Infections never fully clear, leaving a vulnerability to the next infection and a depleted immune system.

Sinus and dental problems

Persistent mouth breathers. Constantly blocked or runny nose. Later, this increases the chance of dental overcrowding.
Reason: Impaired growth and drainage of the sinuses and bones of the face due to retained moulding compression.

Behavioural problems and learning difficulties

Poor concentration, constant fidgeting. difficulty sitting still, hyperactivity. 'Butterfly' type of child who flits from one thing to the next.
Reason: Continuation of the restlessness as a young baby. Retained moulding compression makes them uncomfortable in one position for too long - which becomes habit forming. Severe compression can modify normal patterns of learning in the brain.

Headaches, aches and pains

Headaches begin age 7-8. Growing pain. Vulnerability to sprains, or other aches and pains.
Reason: Retained moulding may focus areas of pressure in the skull, as the bony joints (sutures) of the skull form at around the age of 7-8 years. Postural tensions making other areas of the body more vulnerable to strain and fatigue.

Asthma

Vulnerability to chest infections. Aggravation of all degrees of asthma from mild to severe.
Reason: Retained moulding compression can aggravate a tendency to asthma. General lowered immunity leads to more chest infections. After infections, the chest remains tense and the ribs do not return to full function. aggravating an asthmatic tendency. Osteopathic treatment to release birth stresses and help to improve chest function, is often beneficial in reducing the frequency and severity of asthma attacks.

Osteopathic Treatment

Osteopathic treatment using the cranial approach is very gentle, safe and effective in the treatment of babies and children. Specific gentle pressure is applied where necessary to enable the inherent healing ability of the body to effect the release of stresses.

Reactions to treatment are variable, often the baby or child is very relaxed afterwards and sleeps well. Others have a burst of energy after treatment, usually followed by a good nights sleep.

Occasionally children are unsettled after treatment. This is a temporary situation, and is usually caused when

the release of the retained moulding has been incomplete. It is not always possible for all the retained moulding compression to release in one session, especially if it has been severe.

On average, 4 to 6 treatments are sufficient. This varies according to the severity of the problem.

When to treat

The younger the better, it is never too early to treat. For best results, treatment should be before the age of 5 years. After this, the stresses and asymmetries can often not be completely eliminated, but it is still possible to achieve beneficial release of the stresses throughout life.

For further information and appointments please contact:
Robin Watkins,
The Sutherland Society,
31 Ayrsome Road,
Stoke Newington.
London, N16 0RH.
Tel: 0171 254 6425

VACCINE ALERT

New Scientist 9/8/97

Britain's Ministry of Defence was warned of potential health dangers from a vaccine combination similar to the one given to soldiers during the Gulf War, defence minister John Reid revealed last week. However, the warning never reached ministers.

In a fax sent in 1990, the Department of Health noted that mice suffered "serious loss of condition and weight" when given vaccines against anthrax and pertussis (whooping cough). Pertussis vaccines were used during the Gulf War to accelerate the development of anthrax immunity.

The raw data from the study by the National Institute of Biological Standards and Control were destroyed after the vaccines' expiry date, says a health department spokesman.

DOCTORS TO BE GUINEA PIGS IN TESTS OF HIV VACCINE

The Guardian 23.9.97

An international group of doctors said yesterday it would try to accelerate the fight against Aids by volunteering to become human guinea pigs and experiment on itself with a vaccine containing the HIV virus.

The announcement immediately triggered extensive offers from members of the United States public to join the volunteer group.

Some 50 members from several countries of the Chicago-based International Association of Physicians in Aids Care said that they had signed a pledge offering themselves as volunteers in tests of the attenuated viral vaccine, a genetically weakened version of the vaccine.

Other Aids charities immediately urged caution. But the Chicago group insisted last night that its proposal was not a publicity stunt.

"We cannot sit around after 16 years and continue to debate how quickly we can do trials," said Gordon Nary, the association's executive director and one of the volunteers.

"There are 8,000 new cases of Aids a day, and 1,000 children a day are born with the disease," he said. "A vaccine is the only significant type of scientific intervention that is going to have any impact."

Dr Nary said the group had been swamped with offers to join the programme. Aids organisations were compiling lists. "It has touched a nerve among the public," he said.

Aids vaccine development is a slow process because of the safety measures and rigorous animal testing which are observed before humans are injected with a trial vaccine. Research in the past decade has tended to focus on vaccines which do not involve a live strain of the HIV virus, because of fears that even a weakened strain might cause Aids or other complications.

Advocates of the human guinea pig programme say Dr Ronald Desrosiers of the Harvard Medical School has developed a vaccine which seems to protect monkeys from the primate-equivalent of HIV. The group wants to use that vaccine in its experiment.

"We are not calling for a trial tomorrow, or even the next day," the Chicago group's deputy director, Joe Zuniga, said yesterday. "We want there to be enough safety protocols in place for this not to harm anybody." But Dr Zuniga said that "bold steps should be taken while observing good science."

Another volunteer told CNN last night: "Of course I'm scared. I think that any volunteer would be scared."

The researchers will have to obtain permission from the federal Food and Drug Administration (FDA) before going ahead with the plan on a nationwide basis. It might, however, be legal to proceed within the state of Illinois - whose laws govern Chicago - more quickly. Another option is to conduct the research outside the US.

The Chicago group want approval from the National Institutes of Health and the FDA and will meet officials in Maryland on Thursday to discuss the plan. However, the volunteers made clear that they intended to find a way of going ahead with the experiment irrespective of the outcome of the talks.

Dr Nary said his group was simply carrying out a long-standing tradition in medicine. "These are informed decisions by scientists who understand that there will be some risks. This is how the principal vaccines that we enjoy today have been developed." He added: "If we do not do everything that is humanly possible, we are in some part responsible."

TROUBLE WITH DRUGS; ANTIBIOTICS

THE DOWNWARD SPIRAL OF ILL HEALTH

A child was brought in to my homeopathic clinic recently, with a long history of infections treated by a succession of antibiotics. The first course was given at birth merely because the doctor thought the labour had been too long, so antibiotics were needed 'just in case' of an infection. When she came in, aged 4 and a half, her glands were chronically enlarged as a result of a succession of sore throats, ear infections and so on, and she frequently developed very high fevers for no apparent reason. She was being investigated for urinary tract infections because the presence of bacteria in her urine was picked up on yet another of her endless tests. In spite of showing no sign of infection, the doctor was pressing to give a further course of antibiotics. Of course, the mother was very concerned about the possibility of risking kidney damage, but she was also getting more and more concerned that her daughter was ill with one thing or another every two weeks, with the result that she was eating very poorly and was very small for her age. The kidney ultrasound results came back negative - confirming my suspicion that the clinical findings were more likely due to a bacterial imbalance caused by the frequent rounds of broad-spectrum antibiotics, rather than a new, nasty infection. Her health has improved dramatically by stopping all antibiotics and treating her constitutionally with homeopathy - she hasn't had any fevers or infections in several months.

By Cassandra Marks, homœopath and health journalist

This is an example of the all-too-familiar downward spiral of health, where a course of anti-biotics 'just in case' seems to lead to the necessity for yet more for other infections. Before you know it, your child is on endless rounds of antibiotics.

All too many young children receive numerous courses of antibiotics - as if they have no adverse affects on the immune system.

Antibiotics should be used as the last resort - not the first. They used to work magically for serious infections, but sadly it's due to the careless practice of repeatedly doling them out even for minor infections that some illnesses like meningitis, pneumonia and tuberculosis have become drug resistant.

Antibiotics are one of the most abused of modern medicines. Once considered a miracle drug, they're handed out routinely at the slightest hint of infection. Dr John McKenna describes the case of a 7 year old boy who'd had no less than 14 different courses of antibiotics in the previous 12 months, in spite of the obvious fact that the drugs weren't getting to the root of his problems of recurrent ear and chest infections. He also responded well to homeopathic treatment and dietary changes - without further need for antibiotics.

Because of the risk of drugs which may make them sicker in the long run, Robert Mendelsohn cautions you against visiting the doctor unless your child is really unwell. In his book How to raise a healthy child... in spite of your doctor, Dr. Mendelsohn points out that 95 percent of children's ailments resolve themselves naturally and most medical interventions are needless. Parents usually need reassurance, not unnecessary and often potentially dangerous treatments for passing problems of a minor nature. As he points out, most of the time infection doesn't need medication - your child's body will naturally fight it.

Childhood infections are usually viral - not bacterial, and since antibiotics only affect bacteria, they can't help. Upper respiratory tract infections such as colds, flu and snotty noses are viral, so antibiotics shouldn't be taken. Most of us assume that a yellow-green discharge means an 'infection', but as Dr McKenna explains, even in these cases 'swabs consistently show no bacterial growth'.

Unlike adults, childhood bronchitis is usually viral (caused by respiratory syncytial or rhino viruses etc.), and unless there are signs of respiratory distress (such as very rapid shallow breathing and a very fast pulse rate) can be safely treated by a skilled homeopath. Gastro-enteritis (tummy troubles) are also usually viral and usually respond quickly to homeopathic remedies like Podophyllum.

Robert Mendelsohn argues that because every course of antibiotics contributes to the possibility of sensitisation in later life they should be avoided unless treatment is appropriate and absolutely essential. That means for life-threatening infections like pneumonia or meningitis. If your doctor recommends antibiotics 'just in case', that's not a good enough reason! If they tell you your child's ear or throat is a bit red, that doesn't mean your child is seriously ill and must take the drugs. Many parents tell me about how their GP's have tried to scare them into giving their children antibiotics for a mild infection - "If you don't treat it will go down to their chest..."

WHAT TO DO FOR INFECTIONS

Specific homeopathic remedies will be described in this column for you to use to treat your child's earaches, sore throats and sinus infections. We have already covered fevers, colds and coughs.

Pointers when recommended antibiotics, adapted from 'How to survive medical treatment' by Dr Stephen Fulder.

- Check whether your homeopath can treat the condition easily.
- Ask your GP to confirm if the infection is self-limiting - in other words, it doesn't need antibiotics. You can then treat it yourself homeopathically.
- Make sure the antibiotic is justified - discuss the reason why with your doctor.
- If antibiotics are recommended. Ask your GP why s/he thinks it's a bacterial infection? Ask whether a lab report would be helpful to ensure that the appropriate antibiotic is the one that's given.
- If you do decide to use antibiotics, ask for the mildest antibiotic available.
- Don't take new antibiotics if older traditional ones are effective, and avoid broad spectrum antibiotics wherever possible.
- Take the shortest course of antibiotics you can - 3-4 day courses are often as efficient as 5-10 day courses. Discuss the number of days with your GP.
- Keep a list of ALL courses of antibiotics taken by your child, including the brand name and the duration of the course - as well as any bad effects noticed.
- If any infection comes back after a course of antibiotics you should seriously consider seeking homeopathic as an alternative.

HOW DO ANTIBIOTICS WORK?

Most of us think that antibiotics actually kill off bacteria. They don't. Their aim is to keep bacteria at bay long enough to allow your immune system to remove and destroy them. So it doesn't really make sense to take drugs which undermine the immune system.

If for any reason your immune system is weak and the infection is protracted, bacteria may adapt to the drugs and mutate, resulting in a much more difficult battle to clear them out. It's because of such mutations that meningitis has become penicillin resistant.

This can be the case where your child has been given repeated courses of antibiotics, but the infection stubbornly just keeps coming back. If the first course of antibiotics doesn't work, you're better off looking for an alternative approach to the problem.

Antibiotics have a variety of different ways in which they affect the mechanisms of bacteria reproduction. Some antibiotics, like penicillin, prevent bacteria reproducing by stopping them making cell walls. Some inhibit protein synthesis, and these are generally more toxic to the body (e.g. chloramphenicol and tetracycline). Tetracycline binds calcium, magnesium and other minerals in the body and is not recommended for children.

Antibiotics like erythromycin target an intra-cellular membrane, while others interfere with genetic material in the bacterial cells (e.g., streptomycin). Some drugs are made of combinations of antibiotics, (e.g. Septrin or Bactrim), but these broad spectrum drugs particularly sweep your system clean of all bacteria- both beneficial and harmful. According to pathologist Marc Lappe, "The wholesale assault of an antibiotic can be tremendously disruptive to the normal balance of microbes on our bodies and can overcome our natural resistance to being colonised with foreign bacteria".

Most antibiotics are taken by mouth, or injected, and expose the whole system to their effects - they don't just target the affected area. The strategy of killing bacteria is non-specific; after all, there are about a hundred trillion bacteria living on our skin, in our mouth and all throughout our digestive tract - for the most part existing in happy symbiosis with us. Not only are most of them harmless, but naturally occurring bacteria are protective, maintaining a positive balance between friend and foe. For instance the streptococcal bacteria responsible for a nasty 'strep throat' are normally prevented from proliferating by the presence a more benign strain of the same species.

Next issue: Dealing with earache.

Cassandra Marks RSHom
works at North End Practice
8a Burghley Road,
London NW5 1UE.
Tel: 0171 485 9362

COMMON 'SIDE' EFFECTS OF ANTIBIOTICS, ADAPTED FROM ALTERNATIVES TO ANTIBIOTICS BY DR JOHN MCKENNA.

- There is a risk of an allergic shock reaction to antibiotics of all kinds. Allergic reactions are quite common - not just the skin rash we know penicillin can produce, but a severe spasm of the airways and shock.
- In the respiratory tract; increased mucous production, chronic cough, nasal congestion, ear-ache and itchy ears. (Funnily enough these are the very symptoms antibiotics are likely to be prescribed for!)
- In the digestive tract; abdominal pain, a sickly feeling in the stomach, increased wind, alteration of bacterial flora, and damage to the pancreas (which secretes insulin, as well as digestive enzymes).
- Nutritionally, antibiotics decrease the level of certain vitamins (especially K, B2 and B3) and minerals (calcium, magnesium and zinc).
- Antibiotics can have a suppressive effect on the immune system, inhibiting the action of white blood cells or of antibody production and increasing the likelihood of subsequent infections. For instance, studies show that children with ear-ache who are treated with antibiotics are more likely to develop recurrent ear problems.
- All drugs tend to undermine the immune system, even where they provide symptom relief. Repeated courses of antibiotics devastate the balance of bacteria naturally colonising our bodies and actually undermine immune system function. For children this can mean getting locked into a spiral of ever more intrusive medical interventions. Like many of conventional medicine's favourite interventions, short term gains are often at the price of long term health.
- There is a risk of developing an anti-biotic resistant infection should a second course of penicillin be needed for a later illness.
- There is a dramatic reduction of intestinal bacteria within the first few doses of an antibiotic. The benign varieties of Streptococcus die off, increasing the risk of an overgrowth of streptoccocal varieties more likely to cause disease. Some regrow, but are now drug resistant, while other more beneficial types such as the lactobacillus strain are almost completely destroyed. As these bacteria die, more resistant bacteria take the opportunity to proliferate. These are the 'superbugs' so difficult to clear out. Opportunists such as the yeast, candida albicans, can get out of hand, and the likelihood of such overgrowth increases with every round of antibiotics. The What Doctors Don't Tell You Guide to Candida and ME traces suspected links between candida and hyperactivity, allergies, arthritis, psoriasis and a host of other problems. According to Dr McKenna, candida infections used to be found only in those whose immune systems were in a sorry state - such as those on long-term steroid treatment. The fact that Candida is now widespread through the population suggests that our immune systems are under threat. The long term effects of changes in the internal ecological balance have barely been discovered.

"AN INSULT TO DEDICATED HEALTH AND SCIENTIFIC PROFESSIONALS .....CONTINUED

In the last two issues I concentrated on smallpox as it highlighted the absence of science in the discovery and adoption of vaccination. Scientific studies were non-existent and comparisons between non and fully vaccinated groups, which graphically illustrated the failures, were deemed meaningless. Despite decades of vaccination with rates reaching very high levels (95% and above) children and adults were still dying of smallpox. As people wearied of the compulsion, in particular as they could see first hand that the procedure was far from satisfactory, they started to reject vaccination. This in turn, according to official figures, caused a decline in the death rate as shown in the following table:

Year	Vaccination rate	Deaths
1881	96.5%	3,708
1891	82.1%	933
1901	67.9%	437
1911	67.6%	395
1921	42.3%	12
1931	43.2%	25
1941	39.9%	1

Before I leave smallpox it's worth noting several incidences that further serve to illustrate the failure of vaccination to protect against disease.

In Italy, in the 1887-89 epidemic, although 98.5% were already vaccinated, army recruits were revaccinated when enlisted. Yet they had a far greater incidence of smallpox than young women who were less vaccinated. In the same outbreak in Vittoria, Sicily 2,100 died of smallpox. This was despite vaccination of the entire population of 2,600 having "been performed twice a year in the most satisfactory way for many years."

The disease was relatively unknown in the Philippines before the US invaded in 1903. They embarked on a thorough systematic smallpox vaccination campaign. This resulted in epidemics in 1905-6, 1907-8 and a far greater one in 1918-19 affecting an acknowledged 145,317 people with 63,434 deaths. When comparing cases to deaths, the rate rose from 10% before 1905 to 65% in 1918-19. So instead of protecting against smallpox, vaccination failed to stop/ created large epidemics and induced a far greater risk of dying if people caught smallpox. As more received the smallpox vaccine so the cases of typhoid, malaria and TB rose. The death rate in the last epidemic was nearly 6,000/million whereas here in the late 1700's, when we were told smallpox was rife, the maximum was less than 2,000/million.

So why has vaccination become one of the cornerstones of modern medicine? Perhaps the biggest clue lies in the adoption of the Italian animal lymph in the late 1880's. This replaced arm-to-arm vaccination as it was claimed it could not spread syphilis, leprosy, TB and other diseases. (Strange! Injurious result from vaccination had always been denied.) But it then could be manufactured and sold. This was an important step in the continuation of profit ruling health care!

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

The tradition of re-diagnosing disease started in the 1800's when smallpox became pustular eczema. This was extended in 1936 when the Dept. of Health decreed that a person's vaccination status dictated diagnosis of smallpox. That's why we get deaths from chickenpox despite doctors being taught that it is non-fatal. Same symptoms - same disease?

In the Commissioners Final Report on smallpox in the late 1800's Prof. Vogt of Berne University, Switzerland, who had access to data from the whole of Europe, showed that 63% of people could suffer a second attack. All the Commissioner commented was that "very few people have smallpox twice.: If that admittance is correct, then vaccination does not confer immunity and the germ theory is wrong. The germ theory is another cornerstone of modern medicine, whereby a person's immune system reacts to a disease by producing antibodies to that disease. Having produced the antibodies, that person then has lifelong immunity. So they believe being injected with a disease makes one immune for life.

Not so it would appear. The theory was again shown up nearly a century later, in 1950, when the Medicine Control Agency conducted a study during an outbreak of diphtheria. They concluded that sufferers had enough anti-bodies to be immune whilst doctors and nurses looking after them did not - but were free of the illness.

Having extensively covered smallpox in order to try and show why vaccination was adopted, despite its obvious failure, I would like to further my 'revelations' by covering several other diseases.

DIPHTHERIA:- Initial 'experiments' were claimed to be an advantage. In reality it was different. Between 1895 and 1907 there were 63,249 cases of diphtheria in the vaccinated group, of which 8,917 died. Whilst at the same time there were 11,716 unvaccinated cases of which 703 died. The death rate in the vaccinated group was 2.4x greater than the unvaccinated. Further the death rate from diphtheria after the introduction of vaccination was 20% greater than the 15 years prior. During the same period unvaccinated diseases like measles, scarlet fever and whooping cough declined dramatically.

An improved (?) vaccine was developed, but between the years 1919 and 1941 records show

vaccination injuries and death in countries as far apart as Australia, Canada, China, Columbia, Ireland, Russia and the USA.

Nearer to home, between 1941 and '44 the Dept of Health for Scotland admitted to 23,000 cases of diphtheria in fully vaccinated children, of which 180 died.

Diphtheria declined here through the 1940's attributed, of course, to vaccination. This is in stark contrast to Sweden where it virtually disappeared without vaccination. Again other diseases decline at the same time - without vaccination!

At the same time cases rose between 30-45% in France, 35% in Hungary, trebled in Geneva and in Germany annual cases shot up from 40,000 to 250,000 in five years. In all these countries vaccination was compulsory.

TYPHOID:- The old tactic of false claims was evident during the first world war when the French army was held up as an example of the vaccine success. Apparently it had a 'marvellous effect' after the army suffered heavily from typhoid at the start of the war. This admission is worth noting particularly as compulsory typhoid vaccination of the army began the year before the war started.

TETANUS:- Our army was held up as a success for vaccination. If so why did these tetanus sufferers reach hospitals in England?:-

1914 / 192 cases / 104 deaths
1915 / 134 " / 75 "
1916 / 501 " / 182 "
1917 / 353 " / 68 "
1918 / 266 " / 68 "

Again the question has to be asked - where's the immunity? Medical journals of the time carried studies of a new form of tetanus in those who received the vaccine.

POLIO:- This disease was rare earlier this century and I've yet to find reference to it in the 1800's. Yet vaccination against it came about due to its ravages in the 1940's and 50's. But several studies at that time record its incidence after diphtheria injections. This is confirmed by a study of the graph recording polio since 1940 Cases rose rapidly after diphtheria jabs, and fell after the introduction of the polio jabs. The polio cases dropped noticeably at this time, but what must be taken into account is that the diagnoses of polio was altered and many cases which would have been originally classed as polio were being reported as aseptic meningitis and Coxsackie virus. This happened here and in the USA and a fall in cases was achieved, however the rise in meningitis cases were ignored.

In order to further show the 'excellence' of science I would like to comment on the 1994 MR (measles/rubella) campaign.

- After 26 years of measles vaccination, with coverage rising to 92% plus, why was an epidemic, suddenly predicted? One has to question its efficacy - particularly as the death rate had plummeted from 1850 by over 95% prior to vaccination.
- The report recommending the MR campaign was not published (11th Nov 1994) until after the vaccinations had started.
- A paper presented at an international conference on vaccination in Italy (March '93) revealed that "a mass campaign to vaccinate all UK school age children is being considered."
- The opportunity arose when the 'use by date' of the MR part of a previously withdrawn MMR vaccine was due to expire. The DoH, without going out to tender as required by EU law, purchased the vaccine.
- The report instigated a change in the diagnosis of measles using the EILISA test. This revised the number of notified cases, reported by doctors, downward by 62%. Previous figures did not have the benefit of this test, and were not adjusted accordingly, thus guaranteeing a fall in cases and success of the MR campaign.
- We were told that only 1:1 million would be affected. With 7m doses only 7 should have experienced side effects. Judging by the amount of parents about to sue for injuries, due to the vaccine, that figure should have been a great deal higher! That is only the "tip of the iceberg" as parents experience reluctance on their GPs part to acknowledge side effects due to the GPs being told that few exist. This denial covers all vaccines and is, in part, due to GPs receiving payment for administering jabs.

As it marches on under the guise of saving lives and therefore health-care costs, vaccination must not be questioned. It is given the benefit of doubt whereas vaccine damaged children are not. That's of little comfort if they are one of the millions whose lives have been detrimentally affected by the practise or even prematurely terminated. Nor is it cheaper when the diseases it creates are costed. These include:- Allergies, asthma, autism, encephalitis, dyslexia, cancer, cot death, hyperactivity and, of course, death. These are only some of the illnesses that continue to be disputed/dismissed by doctors and drug companies. They have to - after nearly 200 years of maintaining the charade they, and politicians, can't possibly be seen to be wrong.

Vaccination has been adopted with little or no scientific basis. There were no double blind trials and no studies. Of the mass of scientific studies this century many raise questions regarding vaccination and independent trials are non-existent.

Society has been misled into accepting unsound procedures. These are so readily accepted by medical professionals that one is left seriously questioning their actions and motives.

So did I "insult' them? I don't think I need to as their failure to put the interests of our children first does it for me.

As for you I believe that the decision is yours to make.

Just like I believe it is yours, and yours alone, to decide if you vaccinate your child or not.

Michael Henry, Oct. 1997.

If you would like a full copy of the 3-part article by Michael Henry, please write, enclosing a SAE. to: The Informed Parent, P O Box 870, Harrow, Middx., HA3 7UW

RESPONSE TO W.H.O. EVIDENCE FOR VACCINE SAFETY AND EFFECTIVENESS

Trevor Gunn, BSc, RSHom,
corresponding on behalf of The Informed Parent has forwarded a series of questions to Dr. C.J. Clements, EPI, Global Programme for Vaccines and Immunisation, of the World Health Organisation (WHO). Replies have thus created an opportunity for dialogue on the issue off immunisation safety and effectiveness. A response to Dr Clements reply has been recently sent and the following, summaries the points raised ie: the inadequacies in vaccine testing and the inadequacies in the rationale behind mass immunisation. We shall of course be happy to print follow-up responses from the WHO when available.

Many measles vaccine efficacy studies relate to their ability to stimulate an antibody response, (sero-conversion or sero-response). An antibody response does not necessarily equate to immunity, the WHO was asked for evidence showing how sero-response relates to protection in a real disease situation. Dr Clements thought we were implying that "whatever seroconversion level is measured, there will be no protection".

However that was not the case, the point being made was that the level of antibody needed for effective immunity is different in each individual and as Dr. Clements agreed, immunity can be demonstrated in individuals with very low or no detectable levels of antibody.

Similarly in other individuals with higher levels of antibody there may be no immunity. We therefore need to stay clear on the issue: How do we know if the vaccine is effective for a particular individual when we do not know what level of antibody production equals immunity?

Dr. Clements agreed, "...there is not a precise relationship between seroresponse and protection...". This places a greater reliance on obtaining efficacy results of immunisation from population studies. In the UK the government Health Authority quotes figures of the measles vaccine as being 90% effective.

Inevitably this leads us to ask the question; 90% effective in doing what? Reducing incidence by 90%? Reducing severity by 90%? Reducing death rate by 90%? Creating antibodies in 90%?

It does in fact mean that, 90% of the recipients of the vaccine, produce a certain level of antibodies to the viral agents in the vaccine, 10% have produced no or undetectable levels of antibody. This information has NOT been derived from population studies and as we have already acknowledged, this does NOT indicate what percentage of those people are actually immune, (or, for that matter, how long that apparent immunity lasts).

So, to state that the vaccine is 90% effective is somewhat misleading and at any rate inaccurate with regard to a statement of immunity in a real disease situation.

Therefore the question of vaccine effectiveness can only be answered by population studies that, as stated by Dr. Clements, "do not concern themselves with the response of the individual, rather the protection afforded against the disease to the population immunised".

Dr Clements has therefore quoted references to such studies.
Unfortunately they are all studies in developing countries, and as noted in the same studies, the results cannot be directly extrapolated to developed countries. The fear of many individuals in the UK faced with the decision to immunise, is that the risks of vaccination may be greater than that of diseases such as measles, in countries of the developed world. We should like to know of such studies in the so-called developed world and why so few, if any, have been carried out.

We shall nevertheless look at five of the seven studies referenced, as it can sometimes be possible to make worthwhile comparisons with other countries. (One study omitted, P. Canrelle et al, Eds. Paris, as this has proved difficult to obtain in the UK, but again looks at survival rates in a developing country, Senegal, Africa. Also the reference Bolotovski et al, only looks at the difference in antibody responses comparing different types and concentrations of vaccine, and does not compare vaccinated with non-vaccinated).

Reference: P.Aaby et al, Pediat Infec Dis J 8:197-200,1989

This paper looks at the impact of measles vaccination on childhood death rate, (childhood mortality), in Bandim, Guinea-Bissau, Africa. The study acknowledges that if it can be demonstrated that the vaccine is safer than natural measles and is reasonably effective in reducing the incidence of measles, there are still two possible impacts that measles vaccine could have on childhood mortality. On the one hand the weakest children are likely to die from any number of infections, if measles vaccination could prevent measles and therefore measles related deaths, it may still create no overall reduction in mortality as children would be as likely to die from another infection. On the other hand if measles itself causes weakness and malnutrition, effective measles vaccination could lead to a reduction in deaths.

Studies exist that appear to support both theories. Supporters of vaccine programmes adhere to the view that measles vaccination does effectively reduce childhood mortality. However this paper does acknowledge the fact that the vaccinated and unvaccinated groups are NOT strictly comparable in any of the studies supporting this view.

By comparing groups of children with apparently different vaccination status, this study suggests that measles vaccination reduces mortality by 30%.

However, their comparisons in this study would lead one to have serious misgivings about their conclusions. The group used as a "non-vaccinated" group were in fact vaccinated between certain dates. They were found to have undetectable levels of antibody and therefore it was assumed that the vaccine did not work, hence this was used as a 'control' non-vaccinated group.

Most of a second group of 123 individuals, vaccinated at another time were found to have responded and were therefore used as the vaccinated group. However 15 of this vaccinated group did not seroconvert and they were excluded from the results! Three of these children died!

In trying to assess the effectiveness of a vaccine in populations exposed to real disease situations, it will obviously be very misleading to exclude those that do not apparently seroconvert. These may constitute the very percentage of those that suffer adversely in the real disease situation. Therefore results excluding these individuals may obviously favour the effectiveness of the vaccine.

Reference: Clemens et al, American J Epidem Vol 128, No. 6, 1330-39

This study looked at the impact of measles vaccination on childhood mortality in rural Bangladesh. Again the study acknowledges the fact that groups looked at were not strictly comparable for many reasons stated in the paper. In addition one factor overlooked was the effect of selecting individuals for vaccination on the basis of having apparently lacked a history of measles. This may select out those that have had measles at a young age and using the same rationale expressed in the study, these may well be the weaker section of the community most likely to die of measles or go on to die from underlying comorbid illnesses aggravated by contracting measles at an

early age.

The paper goes on to say that their results cannot necessarily be extrapolated to programs in other countries, where measles vaccine may be given according to different age criteria or where a different relation may exist between measles and the subsequent risk of death.

Reference:Koenig et al
Bulletin of WHO
68 (4): 441-447 (1990)

This was an extension of the above previously quoted study conducted at the same centre in rural Bangladesh. Again concentrates on survival, defining a period of three years as a long term study.

Reports from studying two periods were given, one found a reduction of mortality of 46%, the other 36%. One of the reasons given for this difference was that, an area from which non-vaccines were drawn experienced higher childhood mortality than the vaccinated area as a result of a localised outbreak of dysentery. Consequently the vaccine appeared to be more effective than might otherwise have been.

This highlights the difficulty in using separate areas with different localised disease conditions for comparing the effects of vaccination. Again the report states that caution must be exercised in extrapolating the results of the present study to settings other than Bangladesh.

Reference: E. Holt et al, Paediatrics Vol.85, No 2, p188-194, Feb 1990

This was a study of the effect of measles vaccination on childhood mortality in a peri-urban slum in Tahiti. This showed much higher rates of reduction in mortality. It was not so clear as to why this was the case. It was suggested that the earlier age of vaccination compared to other studies could have been responsible. This is , 9 months (studied over a period of 30 months), as compared to 10 months (studied over a period of 40 months). It does seem hard to imagine why this difference of one month should make such a large difference in survival.

There was no mention in the paper that this may also relate to the shorter period studied. It has been reported that "gains in survival of a vaccinated group tend to diminish over time to approach a survival rate of unvaccinated individuals". (The Lancet April 4, 1981 765). The weakest children most at risk go on to die from other infections, (as discussed in the first paper above, P.Aaby et al Ped Inf Dis).

This study does show however that socio-economic factors make a huge difference with regard to childhood survival. Improvements in living standards having almost as much an effect on reducing mortality as that predicted using vaccination.

Given the interest of the WHO in responding to questions, and their desire to show convincing evidence, one would assume that these studies were some of the better ones. Yet as we can see, they are sadly inadequate.

The last paper goes on to state, (as have others), that "the definitive test of the papers hypothesis would require a prospective randomised placebo-controlled trial that we believe would be unethical". We shall therefore look at the issue of a placebo-controlled trial and the question of ethics.

Double-blind placebo-controlled trial.

This involves a comparison of the results from a placebo group, (a group of individuals that do not take the active medication), with an equivalent group that have had the active medication. Double-blind refers to conditions where the individuals in the trial and those administering the drugs do not know what is active medication and what is placebo.

I would like to bring your attention to an article published in the Lancet, January 12 1980, the vaccine reviewed was the BCG, (immunisation against tuberculosis). It reported that though the protective efficacy of BCG, was not rigorously assessed, this BCG was increasingly used in Europe during the 1920's.

From 1935 to 1955 the first well controlled trials of BCG were organised only after a serious accident in the production of the BCG vaccine had left 72 children dead from tuberculosis within a few months of inoculation. Of these trials, the Lancet goes on to comment that, "their results varied strikingly and mysteriously", from 0% to 80% effectiveness. (Note the results of the above measles vaccine studies on childhood mortality varying from little more than 0% to 90%).
Consequently in the 1970's, the largest controlled field trial ever done on the BCG vaccine, was organised, with 260,000 participants, comparing equal sized vaccine and placebo control groups. Not only did the results show NO evidence of a protective effect but slightly more tuberculosis cases have appeared in vaccinated than in equal sized placebo control (non-vaccinated) groups.

As a consequence of this trial, the BCG vaccine was continued to be used. It appears as though evidence of its ineffectiveness had made no difference whatsoever.

Most of the previous BCG studies were unable to establish the ineffectiveness of the BCG vaccine. Assuming there was no intention to falsify results, this must have been due to the inadequacies of the trials. Trials that did not take into account other factors, for example:

- Comparing groups that were not strictly comparable.
- Inconsistencies in disease classification, between groups and also inconsistencies before and after vaccination.
- Inaccuracies in diagnosis.
- Studies may not have taken into account natural declines in disease rate that generally occur when other living conditions improve.

When deciding whether to vaccinate against measles we appear to have a similar situation. The above trials in developing countries, have specifically admitted to not having strictly comparable groups of vaccinated and non-vaccinated. They also warn of the dangers of allying those results to situations in the developed countries i.e. the UK. One study shows quite graphically the impact of improved living conditions on mortality.

Certainly there are no studies with double-blind placebo-controlled trials. What would be the results of such a trial on measles vaccination?

It has been mentioned that placebo-controlled trials would be unethical now. This does not explain why they were not carried out in the first place. Dr Clements states that the measles vaccines were introduced when there was no alternative to measles epidemics. In the UK over 95% reduction in mortality had occurred BEFORE the introduction of measles vaccine. This is undoubtedly due to aspects of increased standards of living, a point that is further demonstrated by the results of the Tahiti study referenced by Dr Clements.

There are in fact many primary health care measures and conditions of diet and life-style that have had a dramatic effect on measles mortality, unfortunately these factors are overlooked by drug companies which leads to statements where one feels the only measures available are drugs, i.e. vaccines, which is of course not true.

We therefore have a situation where it is difficult to assess the impact of measles vaccination especially in a developed country, such as the UK, where few, if any, adequate trials have been carried out.

(To be contd.. The second part of Trevor's response to the WHO will be published in the next issue - Issue 22.)

GP PRACTICE CONSIDERS HALTING MMR BOOSTERS PENDING NEW RESEARCH

PULSE p 8, 16/8/97
by Louise McKee

Concern about MMR vaccine and its alleged links with serious illness has prompted one GP surgery to consider suspending the booster dose for six months until all new evidence is reviewed.

Dr David Young, a GP in Spondon, Derby, said he and three other partners were considering suspending the pre-school booster but were awaiting the return of a fifth partner from holiday before a final decision was made.

'We are concerned enough to consider stopping giving boosters for six months until we see the research.

'It seems that further, harder evidence has emerged since we were given extra information about the booster last year. It therefore seems reasonable to compromise and look at the vaccine more critically.

'This may involve withholding around 60 doses until the following year. If the evidence is poor and critics suggest that current behaviour should not change, then we will go with the flow and carry on vaccinating. We have to make sure that scary scientific hypotheses are correct before we change our health prevention policy.'

But Dr Mary Ramsay, a consultant epidemiologist at the Public Health Laboratory Service responsible for vaccine coverage monitoring, said she hoped GPs would carry on vaccinating as normal.

She said recent negative publicity surrounding the MMR vaccine and alleged serious side-effects could have an impact on uptake figures. This could particularly affect the pre-school booster dose, which in some districts already falls below 90 per cent.'

'I hope GPs will continue to reassure the public until evidence being bandied about is properly reviewed,' she said.

'We are still convinced that MMR vaccination is the right thing to do. It has been used in several countries for many years. Why abandon the programme on the basis of unpublished research?

'At the moment there is no evidence of a link between the vaccine and serious side-effects. We would be unhappy if coverage fell dramatically.'

SAFETY FEAR MAY HIT MMR BOOSTER PAY

PULSE p 36 4/10/97
By Louise McKee

The GMSC is considering requesting a delay in incorporation of the MMR booster dose into the target payment scheme if uptake of the vaccine drops as a result of recent safety concerns.

GMSC chairman Dr John Chisholm told Pulse an investigation headed by the GMSC's hospital and special services sub-committee would start in the next few weeks.

'The sub-committee will look at the whole issue of MMR booster dose and report back to the GMSC with recommendations. They will consider the latest and most up-to-date scientific evidence on vaccine safety and look at whether vaccine uptake in general practice has dropped,' he said.

'If we see evidence that uptake levels are falling we will be banging on the Department of Health's door. We will want to defer incorporation of the second MMR dose into the target payment system, currently scheduled for January 1, 1999,' he added.

He said a big fall-off in the vaccine uptake would have major implications for GPs' capacity to earn target payments.

'It will prevent them from reaching targets they would have otherwise achieved. All the cherries have to be in a row before the money comes out.'
He said several GPs had written to the BMA expressing their anxiety about the combined vaccine.

'If the evidence shows there are serious side-effects associated with the MMR vaccine, it is encumbent on the department to urgently inform GPs. At the moment they say the vaccine is safe and is not associated with inflammatory bowel disease. They are concerned that the vaccine should proceed,' he added.

The department is due to meet researchers shortly to discuss safety of the MMR vaccine.

MINISTER MOVES ON MMR LEGAL CASES

PULSE p4, 9/8/97

Solicitors representing parents of children alleged to have suffered serious side-effects as a result of MMR vaccination have been invited to meet Public Health Minister Tessa Jowell to discuss the new scientific research on the link. They hope to start court proceedings against vaccine manufacturers at the end of the year.

Richard Barr, a solicitor with Dawbarns in King's Lynn, Norfolk, told Pulse: 'The number of parents who have contacted us claiming their child had suffered a range of side-effects including Crohn's disease, autism, and other forms of brain damage has increased dramatically over the last year.

'We have been approached by 850 parents, of whom around 75 per cent have a strong case. The number of inquiries we are currently receiving is phenomenal. We are dealing with around 20-30 new cases every week.

'People are putting two and two together by recognising there may be a link between vaccination of their previously healthy child and the onset of serious side-effects, which can take up to a year to appear.'

He added: "We are also getting very precise descriptions of children aged 12-18 months who were passing all milestones up to the point of being vaccinated when their condition suddenly deteriorated - sometimes in five to 10 days.

'Older children involved in the government's 1994 measles and rubella campaign have also suddenly developed conditions ranging from epilepsy, Crohn's disease and diabetes.'

FUTURE VACCINES COULD BE PAINTED ON TO THE SKIN

PULSE p30 6/9/97

Genetically engineered vaccines which can be painted directly on to the skin instead of being injected are expected to undergo clinical trials next year.

US researchers from the Gene Therapy Program at the University of Alabama are developing a range of vaccines against illnesses including influenza and HIV which are designed to mount effective immune responses when applied topically.

Dr De-chu Tang, assistant professor at the university whose paper was published in Nature (August 21), said the strategy was simple, painless and economical. The vaccine design also enabled administration by individuals without the need for specialised medical training.

He told Pulse the strategy which involved cloning a single gene taken from the infectious agent and putting it into a 'carrier' adenovirus solution could be used for virtually all protein-based vaccines including pertussis and diptheria.

'The potential risks of this strategy are minimal. The biggest advantage is that is needle-free', he said.

The new approach which could eventually lead to 'over-the-counter' vaccination involves removing the dead surface layers of skin and hair using depilatory cream so the solution can be absorbed by live cells.

Once taken up by the cells the gene, which is contained within the carrier virus, is converted into a protein. The body then mounts an immune response against that protein which in turn confers protection against whatever illness is being vaccinated against.

Another more costly approach involves making the protein from the gene and purifying it in the laboratory before giving it to the patient.

But the researchers believe that administering a gene inserted into a carrier virus and allowing the individual to make the protein themselves is technically less difficult, is less expensive and produces a more effective immune response.

ACTION ON MMR FEARS

Extract from: PULSE, 9/8/97
Vol 57 no.32, p1

..... Professor Roy Pounder, professor of medicine at the Royal Free Hospital, spoke on BBC TV's Newsnight programme last week in strong defence of the link. *(Crohn's disease and autism/vaccine link.)*

He said: 'I am very convinced. The story, the science behind it, is thoroughly coherent and rigorous.... biologically plausible - data, almost all of them demonstrate exactly the same finding, that the virus is there.'

Dr Wakefield is set to speak on the alleged link with autism at a scientific meeting in San Diego next month and the first of his five papers is scheduled for publication some time in October.

A SHORT NOTE FROM THE EDITOR

I would just like to thank you for your continued support, and your patience in waiting for the newsletters!!

I've been kept very busy over the last few months due to the increasing media coverage on this issue, resulting in a greater demand for information.

I hope you will enjoy this bumper issue, and please continue to send in any vaccination articles (publication and date required)

Seasons greetings and a happy new year to you all!!

Magda Taylor

NEW GROUPS

A new UK group has recently been set up to highlight the dangers of the National Vaccination Programme.

VACCINATION AWARENESS NETWORK UK.

178 Mansfield Road
Nottingham
NG1 3HW
Fax: (0115) 958 5666 or
Phone: 0115 948 0829
or 0115 922 6977
Email: info@vanuk.force9.net
Web:
http://www.vanuk.force9.co.uk

IRISH GROUP

A group of parents in Ireland are hoping to set up an information and support group regarding immunisations.

If you are interested in getting involved, please contact:

Mrs Anne Cassidy
Glomerstown, Castletown
Geoghegan Mullingar,
County Westmeath, Eire
Tel: 044 26247

PROBABILITY

Autism, emotional abuse and munchausen syndrome by proxy

If any mother of an autistic child feels she has been falsely accused or if emotional abuse or munchausen syndrome by proxy has been mentioned in association with having an autistic child we would be interested to hear about it.

Please ring Julie on:
01703 581864
or 01273 888535

FUTURE TALKS???

Salli Rose, is an experienced homœopath specialising in the treatment of mothers and children throughout the pregnancy period and formative years. Salli recently visited Australia and was involved in presenting a number of vaccination lectures with Ian Sinclair, naturapath and author of 'Vaccination - The Hidden Facts' and 'Health _ the only immunity.'

Ian is very interested in visiting the UK to lecture with Salli on vaccination in early spring 1998.

Viera Scheibner, also, intends to be in the UK (probably the second part of April '98) to present further lectures.

If any members are interested in the possibility of setting up talks please contact me (Magda) at The Informed Parent on: Tel 0181 861 1022

NEW HOMEOPATHIC MOTHER & BABY CLINIC

When: Every Wednesday between 10 am and 6 pm starting Wednesday 3rd September 1997.
Where: The all new Grove Health Centre in Kensington.

Tell me more:

This exciting new clinic is aimed primarily at those planning a pregnancy, expectant & new Mums, newborns & infants up to two years old, although older children will also be seen.

The clinic is run by two very experienced Registered Homeopaths, Salah Ben-Halim and Pali Bakhshi.

Pali is also a Registered Midwife with over 15 years experience.

Homeopathy is an extremely safe and effective form of holistic treatment. The remedies have no harmful side effects and as such are excellent for use with babies and expectant Mums. Indeed treating homeopathically during pregnancy is one of the best times to do so, helping to ensure the best possible health outcome for Mother & Baby.

Examples of areas where homeopathy is very successful:
MORNING SICKNESS
INSOMNIA
INFERTILITY
CONSTIPATION
DEPRESSION
FEVERS
VARICOSE VEINS
ECZEMA/ASTHMA
COLIC
EXHAUSTION
TEETHING
"GLUE EAR" *PLUS MUCH MORE!*

In addition to normal consultation, Salah and Pali will also be offering a Special Pregnancy Package, a Pre-Conception Advisory Consultation, homeopathic advice for labour & delivery, as well as general advice on diet & lifestyle and vaccination decisions. They would be more than happy to liaise with either your doctor or health practitioner should you wish so.

Call now for more information or to make an appointment.

Remember - the earlier the better.

THE GROVE HEALTH CENTRE
182-184 Kensington Church St, London W8
Telephone: 0171-221 2266

INSPIRED FATHERHOOD

I am writing to let you know that a magazine/journal for fathers, entitled *Inspired Fatherhood*, which focuses on parenting - and particularly fatherhood - issues is now available.

In the first issue, we have an exclusive piece from Michel Odent on the father's role in childbirth and an interview with Satish Kumar, the environmentalist and peace-activist who started the Small School in North Devon. The second issue features interviews with Zoe Readhead - A S Neill's daughter and now principal of Summerhill School - and John Burningham, the eminent children's author.

Inspired Fatherhood also aims to present fathers' own personal stories, provide networking contacts and stimulate dialogue on fathering issues through its letters pages. I am writing to ask if any of your readers would be interested in contributing and/or subscribing to this and future issues. I would be grateful if you would publish this letter with my address so that people may contact me, preferably with an SAE, for details.

***Inspired Fatherhood*,**
Richard Harvey, 35 The Marles, Exmouth, Devon, EX8 4NE.
Tel: 01430 860173

HOMŒOPATHIC LOW COST CHILDRENS'S CLINIC IN HERTFORDSHIRE

£10 per appointment. 9am - 12.30pm

Monday morning at Berkhamstead -	Joyce	01442 385973
Tuesday morning at Hemel Hempstead -	Joan	01442 61416
Wednesday morning at Abbots Langley -	Amanda	01923 443240

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