THE informed PARENT

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ATOPY IN CHILDREN OF FAMILIES WITH AN ANTHROPOSOPHIC LIFESTYLE

Extract from: The Lancet, Vol 353, 1/5/99, p1485

Summary

Background increased prevalence of atopic disorders in children may be associated with changes in types of childhood infections, vaccination programmes, and intestinal microflora. People who follow an anthroposophic way of life use antibiotics restrictively, have few vaccinations, and their diet usually contains live lactobacilli, which may affect the intestinal microflora. We aimed to study the prevalence of atopy in children from anthroposophic families and the influence of an anthroposophic lifestyle on atopy prevalence.

Findings

At the Steiner schools, 52% of the children had had antibiotics in the past, compared with 90% in the control schools. 18% and 93% of children, respectively, had had combined immunisation against measles, mumps and rubella, and 61% of the children at the Steiner schools had had measles. Fermented vegetables, containing live lactobacilli were consumed by 63% of the children at Steiner schools , compared with 4.5% at the control schools. Skin-prick tests and blood tests showed that the children from Steiner schools had lower prevalence of atopy than controls (odds ratio 0.62 [95% CI 0.43-0.91]). There was an inverse relation between the number of characteristic features of an anthroposophic lifestyle and risk of atopy (p for trend =0.01).

Interpretation

Prevalence of atopy is lower in children from anthroposophic families than in children from other families. Lifestyle factors associated with anthroposophy may lessen the risk of atopy in childhood.

IAN SINCLAIR'S LECTURE DATES

Australian natural health author, Ian Sinclair, will be lecturing in the UK during September and October.

This is due to a good response from Informed Parent subscribers, who were willing to organise a talk. I would urge you to support these events and the organisers by booking a place and/or telling friends about these lectures.

This is Ian's first visit to the UK, which he has funded himself, so it would be good to have full audiences!

Ian will be focusing on topics such as: vitality- the dynamics of health, basic causes of disease, nutrition, exercise, beneficial nature of acute illnesses, and treatment of disease and drug and vaccine side-effects.

Listed here are the dates and places of the talks, please ring the contacts for further details and bookings.

•9th Sept. - Worthing, Sussex
Ruth 01903 695385

•13th Sept. - Nottingham
Andy 0115 948 0829

•14th Sept. - Louth , Lincs.
Fabienne 01507 603629

•15th Sept. - Lancaster
Jane 0171 794 5177

•16th Sept. - York
June 01904 679868

•20th Sept. - Rotherham, S. Yorks.
Howard 01709 839830

•21st Sept. - Birmingham
Julie 0121 477 6613

•22nd Sept. - Shrewsbury
Sharon 01743 352740

•24th Sept. - Carmarthen, S. Wales
Caroline 01994 484354

•28th Sept. - North London
Alice 01672 520957

•29th Sept. - Newcastle
Robin 0191 296 2159

•30th Sept. - Blackheath, London
Christina 0181 852 6562

•1st October - Ealing, London
Annie 0181 566 2920

•5th-8th October - Ireland
Colin 00 353 149 46201

The College of Naturopathic & Complementary Medicine is running a number of Open Days in London and Manchester during Sept./Oct., also. There will be a number of speakers presenting various aspects of health and disease. For further details please contact Hermann Keppler on: Tel 01342 410 505

The Natural Health and Ecolgy Show, Watershed Media Centre, Bristol. Sept.11/12th For details phone Sally on: Tel 01934 813407

FEAR OVER MMR JABS SPREADS TO AMERICA

From: Evening Standard, 4/8/99

Fears about the vaccination of young children which have gripped Britain are spreading to America, where experts are trying to explain an enormous rise in cases of autism. Parents are lobbying politicians to investigate the link between the behavioural disorder and the measles, mumps and rubella (MMR) jab given to children of about 15 months.

Dr Bernard Rimland, who has studied the connection in the US and England, said: "There has been a huge upsurge in cases of autism in the US coinciding with the onset of the measles, mumps and rubella vaccine. Three vaccines at once may be too much for some children's immune systems."

In Britain, hundreds of parents refused to let their children receive the jab after research from the Royal Free Hospital suggested the jab might cause some bowel disorders *(contd. on page 2)*

MENINGITIS

From: Vaccination - L'Overdose (Sylvie Simon, Editions Déja, 1999). Translated by H. Clarke.

If, in the fight against cancer, we have not advanced as far as in other fields, it is possibly because we are too attached to Pasteurian theories. Are these viruses outside us? Could they not come from our traumatised bodies? (Prof.Jean Bernard)

The meningococcus, neisseria meningitidis, is responsible for septicemia and, particularly, meningitis. A third of meningitis cases are due to meningococcus A, B or C, the latter being the most dangerous in its effects. In total the cases amount to only 400 p.a. but nearly 10 per cent are fatal. Antibiotics are effective but the vaccine, prepared from the bacteria's polysaccharide capsule, does not protect against the B type, the most widespread in France. It is only of relevance to types A and C.

L'Impatient comments: " The hysteria created every time a meningitis case is suspected in a community, particularly among infants, seems out of proportion to the reality. It serves only to justify vaccination of that community even though the vaccine is not compulsory."

Given that as soon as a case is flagged a mass vaccination campaign is undertaken, it is interesting to look at the history of the disease in the countries where it is endemic. In Africa, the Niger and bordering countries are liable to epidemics in November and February. In 1995 Dr Bruno Martin, Adviser to UNICEF at Geneva, stated: "Epidemics come in cycles, every 11-12 years, and it is necessary to foresee their arrival. We need stocks of vaccine because protection is only for 3 years. We vaccinate outside the centre, then towards the centre, to stop propagation."

In fact, an epidemic of cerebro-spinal meningitis hit the Niger (8 million inhabitants) in 1995. Vaccination sessions were organised and in March humanitarian effort had provided 2 million doses. By the 29th of that month 4 million doses had been procured. Dr Marc Vercoutère has studied the official figures:

28 February	2000 cases notified with 233 deaths
3 March	5000 cases notified with 500 deaths
9 March	529 deaths
16 March	8800 cases notified with 874 deaths
22 March	10000 cases notified with 1000 deaths
23 March	12645 cases notified with 1300 deaths
29 March	15000 cases notified with 1500 deaths
7 April	22000 cases notified with 2192 deaths
23 May	40000 cases notified with 3200 deaths

and he observes: " You will note the appreciable and constant increase in the epidemic, particularly at the end of March, when the vaccination campaign has virtually ended and protection was supposed to be effective after 8 days. Despite massive vaccination which, in principle, should have given protection for about 3 years, we counted, in March 1996 after a new epidemic, 341 deaths in 2945 cases. On 8 October 1997, after yet another epidemic (within the supposed period of vaccine protection), they announced 504 deaths from 4925 cases." Dr Vercoutère noted a slight increase in the deaths-to-cases ratio, which would suggest increasing resistance to the antibiotics treatment, in addition to the inefficacy of the vaccinations. A review of the 1996 epidemic in Nigeria, which killed 8000, provided similar findings.

In September 1997, when Spain had just undertaken a meningitis vaccination programme, the President of the Spanish Society of Paediatricians, Manuel Moya, was opposed to it on the basis that "The vaccination is not effective" and, in any event, "we are nowhere near the 10 cases stipulated by the WHO for mass vaccination." (Le Quotidien du Médicin, 29 September 1997.) According to Ignacio Sanchez, president of the doctors' organisation, this measure was "above all a political decision without any foundation in epidemiology." (Dépêche AFP, International Espagne-Santé, 22 September 1997.) On meningitis vaccination in Spain Le Quotidien du Médicin added: "An expert pharmacist at Madrid's largest hospital did not hide his intention to leave his own infants unvaccinated." The individual was well placed to know what was in the vaccine and was disinclined to expose his children to the associated risks.

When we know that vaccine antigens are nearly all a neurocerebral tropism*, the question that arises when a child presents with meningitis is: "Has the child been vaccinated?" In nature dangerous meningococci do not wander about haphazardly. Vaccinations predispose to more aggressive bacterial strains which will soon have nothing to fear from all our antibiotics.

*Turning of (part of) particular organism in particular direction in response to external provocation.

(contd, from page 1) and also trigger autism. However, two other groups of scientists said there was no evidence to link autism and the jab.

Nevertheless, concerns about the immunisation are now spreading to the US, where in some towns there has been nearly a 300% increase in autism cases over the past 11 years.
Dan Burton, a Republican congress man from Indiana, told a congressional hearing this week that two of his grandchildren suffered reactions from a rotavirus vaccination and the child of his daughter's friend died after being vaccinated. He wants an investigation into vaccine reactions.

The Centre for Disease Control in Atlanta and the National Institutes of Health in Washington insist there is no link between vaccination and autism.

"We are desperately trying to find out not the cause but the causes of autism," said Dr Marie Bristol-Power. "We believe there are a variety of different causes for this behavioural syndrome."

Editor: So they're certain there is no link with vaccination, but are desperately trying to find causes for this condition. As mentioned in an earlier newsletter, the Institute of Medicine, admitted the 'many gaps and limitations in knowledge bearing directly and indirectly on the safety of vaccines.'

AUTISM MMR LINK

TheTimes, 11/6/99 reported on the findings that 'no link has been found between the rise in autism cases and the introduction of the triple vaccination for measles, mumps and rubella, according to government-backed research.'

The study, published in The Lancet, was carried out after a report last year suggested a link between the MMR vaccine and children who develop both inflammatory bowel disease and autism.'

The Allergy Induced Autism organisation immediately issued the following press release.

•FIRST PUBLIC ADMISSION BY GOVERNMENT OF MASSIVE INCREASE IN AUTISM
•CYNICAL ATTEMPT TO DISGUISE THE TRUTH
•SCANDALOUS PUBLIC DUPE OF BSE PROPORTIONS
•CALL FOR RESIGNATION OF STUDY AUTHORS

MMR Vaccine and Autism : No Epidemiological Evidence for A Causal Association. Taylor B. Miller E. Farringdon P.C. Petropolous M.C. Favot-Mayaud I.LiJ & Waight A.

The above paper, due for publication in the Lancet on Friday 11th June 1999, was funded by the Medicines Control Agency and authored by the Department of Community Child Health Royal Free and University College Medical School, London, together with The Public Health Laboratory Service.

Details appear to have been leaked by the authors prior to publication. AiA received anonymously a pre-publication copy of what is believed to be the original form of the paper as intended for publication.

SUMMARY OF STUDY

The study is a case series analysis, a weak form of epidemiological analysis which can only suggest or refute very large relationships. The authors begin by admitting the intrinsic flaws in the available data whilst clarifying the aim of the study as to look for evidence of a change in trend in incidence or age at diagnosis associated with the introduction of the MMR vaccine. The most significant finding of the study is that the number of children with autism has risen by 25 % year on year compounded since the introduction of MMR.

Additionally a significant temporal clustering for the onset of parental concern about their child's behaviour was found within six months of the MMR vaccine. Astonishingly, despite these clear finding, the interpretation of the study is that the analyses do not support a causal association between MMR vaccine and autism. Alarmingly the reader may easily be misled into believing that the rise in autism predates MMR introduction whereas the study demonstrates a potential association.

AiA's INTERPRETATION OF STUDY

AiA has access to a large number of parents trained in highly relevant disciplines which allows us to interpret accurately and analyse the integrity and validity of the study. The following highly pertinent points have arisen from our investigations.

•The data underlying the key graph are fundamentally incorrect. The Public Health Laboratory Service itself instituted a catch up policy meaning that all children who had not previously received the mumps or rubella vaccine, irrespective of their having received a monovalent vaccine, were targeted for MMR inoculation. Despite this, the group has been ignored completely for the purposes of this exercise. The study states that the group was of children eligible for MMR vaccination in the second year of life, indicating the authors' awareness of older eligible children. Had the children vaccinated in the 'catch up' campaign been properly accounted for, as well as having been diagnosed before 60 months of age (as per the study's criterion), the relevant starting year of birth should have been 1986. Figure 1 clearly shows a significant rise in cases between those born in 1986 over those born in 1985. This has either been a totally inept analysis of the data or a deliberate attempt to cover the truth. There is a 'step up' and the conclusions in relation to the first hypothesis are without doubt invalid.

•With regards to the age of diagnosis of autism in relation to the MMR. Most children have been vaccinated with MMR by 15 months and subsequent time of diagnosis of autism relative to parental concern is an unknown variable nor do the authors declare the relative numbers of vaccinated to unvaccinated children. Thus the second analysis is not only totally meaningless in any scientific sense but it also bears no relation whatsoever to the fundamental hypothesis and certainly does not exclude exposure to vaccine as having a causal relationship to autism.

•It is not surprising that the study finds no significant relationship between timing of diagnosis considering the wide variation of age at which final diagnosis is completed.

•The third analysis looked at the first expression of parental concern about their child's behaviour in relation to any potential temporal relationship to MMR vaccination. What was identified was a significant statistical cluster of first parental concerns within 6 months of MMR vaccination. This is then explained away by suggestion of lack of precision in definition of symptoms of the condition, however, if this significant finding were truly due to a parental recall bias it would have been seen in all vaccine groups i.e. those who received any measles containing vaccine. The significant clustering is only seen in recipients of the MMR indicating that this is likely to be a true effect.

•In statistical terms the data set is of limited size despite assurances that the findings are based on a large study.

•The absolute defence of the MMR vaccination in the discussion section of the paper is out of all proportion to the weak scientific evidence presented in the findings. Indeed the findings indicate the opposite of the defence given.

•There are no control groups in this study to compare against i.e.
Rates of occurrence of:
a) Autism in children who have not been vaccinated with either the MMR

or the monovalent vaccines and
b) Autistic children vaccinated with the monovalent vaccines.

It is impossible to say if a higher or lower proportion of children given MMR developed autism compared with those who didn't receive it.

It is clear that the study was commissioned to dismiss the hypothesis that there may exist a relationship between the MMR vaccine and autism. In reality the study is fatally flawed and statistically inadequate. Despite clear findings supporting the relationship hypothesis, the authors discard their own clearly unexpected, statistical findings and manipulating the results to 'prove' their own pre-existing hypothesis.

This approach, coming from the Medicines Control Agency, is an outrageous attempt to pervert public perception of the potential relationship between the MMR vaccination and autism.

In the continuing interests of the children and adults represented by our organisation, AiA calls for the resignation of all key members of the Study Group, on the grounds that they are prepared to place a skewed and feeble study into the public arena in an attempt to defend the MMR vaccination. In addition, AiA demands that the Medicine Control Agency or the Government commissions a totally objective and completely independent study to ascertain the truth.

On March 1, 1999 the State of California released a report, mandated by state law and enacted as a result of concerns raised to the Governor and Legislature by parents, educators, and health care professionals who had observed that within a very short period of time, autism in California had increased at an alarming rate. The report to the Legislature from the Dept. of Developmental Services (www.dds.ca.gov/autismreport.cfm) examined the increase in autism and pervasive developmental disorders compared to other defined developmental disorders. Analysis was of data provided by California's 21 regional centres covering the period from 1987-1998. Among the most striking findings in the report was that the number of young children diagnosed with autism entering the system over the past 11 years had increased 273% (page 8 of the Report), while the other developmental disorders showed only modest, population adjusted increases. Also contained on page 8 of the Report, is a graph which documents a sudden, unexpected and unexplained increase in autism starting exactly at the same time as California was requiring, for the first time, the use of MMR.

Plotting the North Thames findings against the California study illustrates a similar upwards trend, beginning at time of introduction of the MMR into the UK and including children in the 'catch up' campaign.

The recent Peltola study from Finland, which tested the wrong hypothesis, is now widely quoted in PHLS literature as proof of MMR safety. Few GP's, parents or other professionals have sought the paper out to verify the implied findings yet the paper so easily became incorporated into medical folklore.

If the nonsensical study now under discussion achieves the same giddy heights of acceptance by the medical profession as the Finnish study, then the only chance of treatment for the ever-increasing numbers of autistic children in this country will die. With it a lost generation of doomed and forgotten babies.

AiA is a membership based, medical research charity, which has not previously taken a public stance on the issue of autism and vaccination. However, the serious implications of the publication of this paper have forced the executive of AiA to take immediate action. AiA considers that any such attempt to justify health policy by using inadequate research as propaganda is reprehensible.

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Also Paul Shattock, MRPharmS, wrote a long letter that was published in the Pharmaceutical journal, 17/7/99. A few of the points made have been summarised by homœopath, Lesley King and reproduced here.

The letter comments on the reports that were commissioned and funded by the Medicines Control Agency and the Committee on Safety of Medicines. One of the reports was based on a selection of questionnaires sent to clients of the solicitors acting on behalf of the parents. The questionnaires had been answered by the physicians and consultants dealing with the cases, NOT by the parents. It had been agreed that there would not be publication without consultation. This agreement was broken. The review was based SOLELY on these questionnaires and contained no other evidence and according to the letter writer "hardly justified the powerful statements issued by the Dept. of Health. Neither does the report by Taylor et al also published in the Lancet, June 12th." This second report actually shows, for the first time in a published paper that there has been a dramatic increase in the reported incidence of autism. They did not publish the relevant numerical data but did report that there had been a 1,750% increase in the incidence of the annual birth rate of people with autism in the N.E. Thames region between 1979 - 1992. Mr Shattock states "Given the staggering increase in the reported incidence it is not surprising that the researchers were unable to detect a "kink" in the upward surge which would correspond with the introduction of the MMR vaccines in 1988." The authors of the report stress that the upward surge started before the MMR. They indicate that in fact there was notable increase of autism in children born 1984-85 onwards.

However, Mr Shattock points out that because the MMR was newly available it was also given to children of a slightly older age group, whose dates of birth were pre-1987. These children would have also, already had the measles jab at around 12 months old. Mr Shattock says that "the claims of the authors to have provided evidence of non-linkage are unsustainable," and "the claims of the press releases from the DoH accompanying the reports are grossly misleading." He finishes with "the results of independent studies which address these issues are eagerly awaited. For better or for worse, it will be the courts who decide these issues and I am not sure that they will be impressed by the facts supporting the statements presented last month."
Summarised and extracted by homœopath, Lesley King, RS Hom.

ECZEMA, PSORIASIS AND GENERAL SKIN PROBLEMS

It all began 13 years ago, when working as a burns and plastics specialist nurse, I began to see amazing results from trying my home-made cream on my burns patients.

Fate, however, decided that eczema, especially infantile eczema became my niche. Since then I have spoken to many mothers in need of help and at the end of their tether, due to the varying degrees of eczema their babies are suffering from. Unfortunately there is not much help or good advice given at the surgery and steroid preparations have a number of side-effects, as was mentioned in Cassandra Marks 's article in the previous issue of The Informed Parent.

Eczema does often run in the family, however in my view it is a disease of the 90s. It is said that every 5th baby is born with eczema or some sort of allergy and I do feel that environmental factors are related. Other research indicates that the cells in the skin called Langerhans cells are not functioning properly in atopic eczema, they seem to be over sensitive. *(Exchange, No. 93, June 1999; Atopic eczema in children by D J Atherton.)*

In my view a topical treatment of the skin is vital as the hot, itchy, red, dry skin can be quite unbearable and also it is important to heal the individual from within using, for example homœopathy. Many homœopaths advise the use of my hand-made range of creams and oils during their treatment and after. Also, many of my customers come by word of mouth.

I have developed a triangle - consisting of my day cream and night cream, which takes care of the moisturisation, itch and redness and an oil, which takes care of the lubrication. I do not use paraffin, Vaseline, lanolin or petroleum based by-products in my range as in my view these ingredients act as barrier products.

Over the last 10 years most of my customers have been 'over the moon' with my range of creams and after-care lotions and I also offer lots of tips, advice and help.

Three years ago, due to a great deal of support and encouragement from my customers I finally made time to research, produce, run a trial and present my Trinity all-in-one soap and shampoo. The idea was, firstly, to have an antiseptic cleanser to use daily on the affected areas, full of teatree oil, true blue oil of camomile, frankincense, geranium, and Danish seaweed and panthenol.

Secondly, Trinity was produced to use daily as an all-over cleanser leaving it on the body, especially the affected areas for 3-5 minutes for maximum effect in the shower.

Thirdly, it was produced to wash the hair and is especially good for cradle cap.

Finally one of my tips is to use a drop of Trinity on the nail brush, cleaning the baby's nails after each nappy change. I do advise filing the baby's nails daily; a good time to do this is at night time followed by cleansing and a drop of Trinity, to avoid micro-organisms. Night time is always the worst for eczema sufferers and this is when most scratching takes place. So try burning an oil lamp with essential oil of frankincense or geranium, out of reach of course. Air the duvet daily and the mattress weekly and keep that favourite Teddy in the freezer during the day, killing house-dust mites. Teddy will be a 'cool' friend at night on those hot and itchy areas. Giving your child a little massage along the spine, neck and back of head is also very calming and bonding.

At the end of the day we are all healers. Trust your instincts, follow your intuition, what works for one doesn't always work for another. People must learn, and are learning, to take responsibility for themselves. To liberate our human potential by taking personal initiative gives us the chance to enhance our creativity, use our imagination, dare, trust and have faith in what we need in a modern society. *Elena Schalburg, July 1999.*

For further information on Elena's Nature Collection and/or tips, advice, please phone: 01892 783753 or write to:

Elena Schalburg,
2 St George's Cottages,
Brinkers Lane, Wadhurst,
East Sussex, TN5 6LT.

GM VACCINES - A WELCOME PROSPECT?

An article in the Pulse, 27/2/99, p.28 reported on GPs concerns about GM foods. However it was followed by an article about how the same doctors were in favour of GM vaccines, entitled ***'... but they welcome prospect of GM vaccines'***

GPs' concerns about genetic modification do not extend beyond food to medical experimentation.

A number of GPs' have welcomed new initiatives in vaccine production.

Dr. George Lomonossoff, head of virology at the John Innes plant and micro-organism research centre in Norwich, has developed a system using plant viruses as 'inert carriers' of vaccines.

He said: 'Plant viruses are very stable and are known not to be dangerous and you get a tremendous amount of them.' The plant viruses are then coated with epitopes - the part of the virus which stimulates the immune system from the matching animal or human virus.

Experiments have already been carried out to see if the system can be used to develop a vaccine for HIV. Dr Lomonossoff said the method could theoretically be used to help combat a wide variety of human diseases.

Anti-GM lobbyist Dr David Birley, a GP in Swindon, said such a system was a 'perfectly reasonable application' of GM. He added: 'You don't have to grow these plants on a field system so you don't have to worry about cross-pollination.'

GP and Green Party activist Dr Richard Lawson said: 'We have GM insulin already. I'm in favour of the medical application of this. If the plants can be hermetically contained then I am content.'

NEW BOOK

VACCINATION ROULETTE: EXPERIENCES, RISKS AND ALTERNATIVES

Produced by The Australian Vaccination Network

Available in the UK from:
Nexus Magazine,
55 Queens Road,
East Grinstead,
West Sussex, RH19 1BG
Tel: 01342 322854

MD SPEAKS OUT ABOUT IMMUNISATION

VRAN newsletter (Canadian Vaccination Risk Awareness Network)
Issue May 1999

This is an excerpt from Dr. Mercola's weekly newsletter 'Healthy News You Can Use', Issue # 99, May 2, 1999.

Dr. Mercola can be reached at: Mercola@pol.net, Immunisation Comment.

The following was written by Dr. Thomas Stone last week in a response to another physician in a forum on Physicians On Line. This is a physicians only discussion group. He and I have been attempting to convince paediatricians of the problem with immunisation. It is a most frustrating task since most of them are so brainwashed they are incapable of implementing any type of logic to think through this issue.

It is immensely more difficult for you and others who have not lived WITHOUT these Vaccines to see the horrible, insidious damage that is being inflicted on the brains and health of our infants and children by this irrational and fraudulent vaccine mania. This has been politically programmed and financed by those who have deceived us into believing that we were being saved from the ravages of frequent and common serious complications and death from the usual childhood illnesses with outright lies, half truths, propaganda and deceptive and fraudulent statistics.

As a child all of my siblings, my relatives, my friends, my classmates experienced measles, mumps, chickenpox, etc. and recovered without serious complications or fatality and probably even benefited from these infections. Two of my classmates in grammar school were absent for an extended period with polio - both returned to class. Does this mean that there were no complications or deaths? Not at all. What I am saying is that in the usual middle class neighbourhood even during the depression when few had any money there was usually adequate food for us that we had sufficient immunologic functions, so that we were rarely overwhelmed by these infections.

This experience continued through high school, college and even medical school. My classmates and I in medical school read about complications such as encephalitis, orchidist, etc. but they were not something that any of us had any personal experience with in our earlier years. These complications and fatalities obviously did and do exist, but they were not the everyday common experience that the hysterical purveyors of these quietly brain damaging poisons that we are injecting into our infants and children claim over and over again.

It was not until I began working at Cook County Hospital in Chicago that I had anything but book experience with the dreaded complications of these infectious diseases. As I recall, at that time every serious contagious infection and all cases of meningitis, encephalitis, pneumonitis and other rare infections were required to be hospitalised at Cook Country Contagious Hospital. Yes, these were terrible to see, and I can understand that anyone who has seen and worked with these diseases would want to do anything to prevent them. Unfortunately, the chosen solution, while it may have saved a small number of malnourished, immune or congenitally compromised children, has become an increasing tragedy and nightmare for millions of other children AND parents.

The real solution has been and is continuing to be concealed from us by powerful political - economic interests. There is no better defence against these naturally occurring childhood infections that an intact functioning immune system - and this is most often impaired by inadequate nutrition. For example, when I was on the Tetanus Team at County, it was well known (and verified in my own experience) that the severely malnourished drug addicts all perished while the other tetanus cases survived with the same identical treatment. Once again we find that knowledge and training in nutrition has been ACTIVELY SUPPRESSED.

It has been said that the average physician knows as much about nutrition as their secretary - UNLESS she happens to be obese! There are many shocking examples in these discussions of how incredibly limited our education has been in both the significance of and application of nutrition in our daily practice. Dr. Mercola is correct. This alone would do more to prevent serious childhood illnesses than any vaccine!

There is much more that I will try to share about this topic as time permits. Let me summarise: We and our children have been and are the victims of a carefully orchestrated, programmed propaganda campaign in which MAXIMUM publicity is repeatedly given to the occasional, in fact rare, complications from one of the childhood diseases such as encephalitis, polio paralysis, or orchidist, while ACTIVELY SUPPRESSING the cases of morbidity and death caused by the vaccines. This ACTIVE SUPPRESSION is used to quietly terrorise any professional who does honest research and reports negative or adverse effects from vaccines.

It is well known that they will NEVER again be allowed on any vaccine committee and they will find it difficult or impossible to obtain EITHER a government OR private grant for any future research. I have given numerous well documented examples of this programmed punishment of any professional that dares to speak or publish the truth about vaccines for more than 50 years! And how have the paediatricians responded to this? 'I'm going to wait until there is 'scientific' verification that these vaccines are harmful', they almost always say. THERE IS NOT GOING TO BE ANY! IT HAS NOT BEEN and WILL NOT BE ALLOWED.

There will now be the postings of how many millions of children have been saved by these vaccines! And I am accused of anecdotal reports. We have seen the recently released data from California. A parent of one of my patients has just forwarded the newly released data from Illinois: 'Illinois State Board of Ed. Reports Huge Autism Increase', too.

Thursday, April 29, 1999.

The following is from the Illinois State Board Of Education regarding Figures on learning disabilities and autism:

Year	Learning Disability	Autism
1991	111,326	317
1992	113,465	575
1993	115,140	755
1994	116,202	800
1995	118,121	1363
1996	121,672	1754
1997	126,065	2305

Truth is like oil and water - it eventually comes to the surface. How long are we going to wait for scientific data? From whom? The CDC have been telling us for years there is no problem, 'The vaccines are as safe as water.' our

Public Health Departments and our schools are given a 'Bounty' to force each and every child to risk brain damage from the insidious encephalitis and auto-immune disorders in those that are vulnerable. Who is vulnerable? Sorry, no research funds available. But it could be your child, grandchild, OR YOUR PATIENT!

PARENT SPEAKS OUT

Margaret Cummings, a subscriber to The Informed Parent, recently sent in the following letter for publication.

My 15 year old daughter Kimberley and my 10 year old son Craig suffer all manner of ailments including: croup, allergies, viruses, infections, thrombocytopaenic purpura (Henoch Schonlein Purpura), alopecia aureata, left temporal lobe focal epilepsy (later re-diagnosed as focal epilepsy with secondary generalisation, nystagmus, bowel problems, sight and hearing problems, joint and limb pains, oedema, behaviour change, abnormal sweating and poor temperature control.

I started to ask questions - doctors said "idiopathic"- that means there's no known cause. Comments like 'psychological", "growing pains", "don't be neurotic about this" etc were typical responses. My instinct kept telling me 'something's wrong.'

In January '97 my whole world came crashing in when I read a leaflet 'encephalitis' which concluded - vaccines can cause focal brain damage- from that I realised vaccines had caused my son Craig's suffering. I could see it began within hours of the school campaign injections, MR (Two were used on Craig, the lady said the first one didn't work.) How devastation makes one blind and I was blinded by feelings of guilt and shame - I didn't suspect, I didn't know!

Why?

Denied by my GP, the encephalitis support group gave me JABS details who directed me to the MMR/MR factsheet prepared by solicitor Richard Barr. On reading the factsheet my husband and I realised we had the reason for our daughters suffering, too. Both our children's lives, our family's lives - ruined by vaccines. The incomprehension as to why this 'monster in our medicine' has been allowed to happen? The incomprehension could well drive anyone to the brink of madness, so many feelings, sheer devastation, sheer grief - grieving for the normal, healthy children we had.

My children had every vaccination recommended prior to '97, including DPT's, polio, measles, MMR, tetanus, MR, influenza and BCG. Why did no-one inform us?

Doctors go to extraordinary lengths to deny our experience, apparently lie, ignore, dismiss, stonewall, even threats become order of the day and insults - "who are you, a checkout operator" as if my family were lesser human beings! If this treatment is intended to 'beat us down' it has the desired effect. Our devastation has been made far worse by doctors we'd trusted with our family's lives. Perhaps they need reminding it's to their patients they swear 'to do no harm.' I turned into 'a quivering lump of jelly wondering who on earth can we trust anymore.....

To date we have no accurate diagnosis for either of our children. I strongly believe autism and crohn's disease (or similar) will be amongst the eventual diagnosis. I now firmly believe that the Dept. of Health use fear in order that we have our children immunised. I was part of that 'trance' conditioned into believing vaccines would protect my children from harm. I'd advise any parent to seek all the information they can - living with the consequences isn't easy. We don't know what the future holds for our family or if our family has any future, we simply take each day as it comes, one step at a time. We're only beginning to come to terms with this, at least now I feel I can face this 'monster' I see in our medicine. Surely our nations children are all our hopes, all our dreams - they are our future. There is outrage if our nations children are harmed by a madman, yet our nations children who are being harmed by vaccines and drugs are being ignored!

Meanwhile, I can only wonder how many more children, and how many more family's lives will be ruined? I know this will go on until the government recognises the real situation, and what is happening to our nations children.

My family need help, I would like to hear from anyone who'd kindly explain the mechanism by which vaccines cause harm, anyone who can help with the Vaccine Damage Payments Unit (Newcastle), and anyone, in particular in my area, whose lives have been ruined by vaccines. I'd be available to chat most evenings.

Finally for all those who have (maybe unknowingly) helped me through this time, for all those who have the courage to stand up and say 'vaccines do harm', I salute you all with these words:

"Those in the world who have the courage to try and solve in their own lifetimes new problems of life are the ones who will raise society to greatness! Those who merely live according to rule do not advance society they only carry it along," - *Gurudev Rabindrath Tagore.*

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MENINGITIS VACCINE FIRST FOR BRITAIN

The government announced the introduction of a vaccine against meningitis C into the immunisation programme on 20th July. The announcement has come a year earlier than expected reported The Times, 21/7/99, and the aim is to vaccinate 15 million children in the first year. The article comments on the availability of the new vaccine and that babies will be vaccinated first and children and teenagers during next year as stocks become available.

It goes on to say 'the programme will cost many millions of pounds but the Government has yet to start negotiations with the manufacturers so the cost is unknown. '.....' Frank Dobson, the Health Secretary, told the Commons:

"Meningitis fills parents with fear because it can arrive out of the blue and bring a healthy child to death's door in a few hours. This new vaccine will help to reduce the incidence of meningitis but it won't bring to an end."

Editor: A 'healthy' individual can carry the bacteria without any problems or symptoms, as mentioned in the previous issue of the newsletter, meningitis is a disease of a compromised immune system. The nest issue will look at the new jab and the disease in more depth.

DEALING WITH ALLERGIES; HAY FEVER & RHINITIS

By Liz Salter, homœopath

WHAT IS HAY FEVER?

Hay fever has become an umbrella term relating to both an allergic reaction to pollens and seasonal allergic rhinitis (inflammation in the nose) caused by mould spores, pollution and dust mites. An allergic response comes about when the body recognises the pollens, spores, and other pollutants as foreign bodies or antigens. The immune system responds by generating antibodies. Because of the action of these antibodies, the mucous membranes in the nose and surrounding areas release histamine and other substances which are normally produced in response to infection. The role of histamine is to dilate local blood vessels, making them more permeable, and thereby helping components of the immune system to get to work clearing up any irritation. As a result the classic symptoms of streaming eyes, blocked noses and headaches are produced.

HAY FEVER EPIDEMIC

In my practice this spring and summer I have been inundated with more hay fever sufferers than ever before. Pollen counts rose to 900 grains of grass per cubic metre this summer - anything over 50 is considered high. June was the worst month for the past 12 years. Many, who have not suffered from allergies in the past, have suffered from symptoms for the first time. Others, concerned about the unpleasant side effects of conventional treatment, are looking for a gentler and safer alternative.

Josie aged 12 is a typical case. She was brought to me last December for some preventative treatment - her mother didn't want a repetition of the intense hayfever symptoms of the previous year. Josie is an introverted child who was nervous and self - conscious in the consultation room. "She's happiest playing on her own these days" her mother reported. "and she's had difficulty making friends at her new school". The family had moved into the area the previous year and she was missing her old friends. I treated her constitutionally with Natrum Mur, a remedy suiting people with reserved natures who are predisposed to sadness; in this case triggered by the move. They are closed and undemonstrative. Natrum Mur is not one of the main hayfever remedies but in this case it alleviated the hay fever symptoms as it fitted Josie's case. June arrived but the hay fever didn't! She had a couple of colds instead over June and July which she recovered from quickly, and a few bouts of sneezing and itchy nose but nothing like in previous years. When she feels as if the hay fever symptoms are returning, she takes a dose of Natrum Mur again, and her allergic response subsides. I would expect her symptoms to become milder with every season.

WHY IS HAY FEVER ON THE INCREASE?

Hay fever, contrary to its name, is not just caused by hays and grasses prevalent in the countryside. People in cities have also fared particularly badly in recent years. Increasing levels of diesel fumes have been proven to boost IgE production - the isotope that causes allergy. A study carried out in Japan showed that people living next to a busy road lined with cedar trees were three times more likely to develop hay fever symptoms than people living near forests of the same tree but well away from traffic pollution. It seems that pollution aggravates the condition as it sensitises the linings of the upper respiratory tract.

One theory has been put forward linking intensive farming with hay fever symptoms. People living near to large fields dedicated to the growing of one type of flower only, such as oil-seed rape, sunflowers or fruits are being exposed to pollen in huge quantities. The most gentle breeze will be dense with pollen. Insects, weighed down with the abundant pollen, jettison their surplus into the air. When we breathe in high concentrations of an allergen it both irritates the respiratory tract and causes an allergenic response.

PERENIAL RHINITIS

If you appear to have hay fever but give no positive skin prick test to pollen there are other possibilities to consider: Mould spore allergy, can produce seasonal symptoms, usually in late summer and autumn. The main culprits are areas such as compost heaps and forest floors where there is plenty of rotting matter and the air is damp. Clouds of spores get dispersed into the atmosphere on contact and can produce hay fever like symptoms. In winter the indoor environment is a more mouldy one than outdoors as windows are opened less and clothes are dried inside and more hot meals are prepared.

Some people will have a recurrence of symptoms as late as Christmas when the mould spores on Christmas trees are rejuvenated by the warmth of the house

In the UK one mould, cladosporium herbarum, releases its spores from June to September. The person may feel they have grass-pollen hayfever, but their symptoms are entirely out of step with the pollen counts.

THE DOWN SIDES OF CONVENTIONAL TREATMENT

Anti-histamines, in the form of nasal sprays and decongestants are not recommended; it's well known that they cause 'rebound' symptoms, making sufferers feel worse after the initial relief. Some brands can cause drowsiness in adults and hyperactivity in children and even skin rashes. With anti-histamines, there is a danger in the very early stages of pregnancy, some anti-histamines should not even be taken at the time of conception as they can inhibit foetal development.

In severe cases steroid preparations are sometimes prescribed, but these can depress more important immune functions in the long term and may make the body prone to fungal infections in the short-term (Candida).

HAYFEVER AND CHILDREN

If your family is strongly atopic - has a history of eczema, asthma and/or hayfever - consider that the evidence shows that being born during or just before the pollen season increases the risk of hayfever. Babies are most vulnerable to sensitisation by pollen in the first three to six months of life so keep allergens and irritants down to a minimum. Don't undertake structural work in your house just

before the baby is born as this can stir up house dust and mould spores. Air filters can be the answer if you suspect that your house is dusty.

Breastfeeding is a clear preventor of allergies in babies; it particularly reduces allergies to cow's milk. Even topping up with a bottle whilst breastfeeding is not recommended as it can sensitise baby to cow's milk at an early age. Continue breast-feeding for 6 months if possible and avoid solids until 4 months and then introduce them gradually. The main problem foods are eggs, milk and milk products, fish, peanuts, wheat, rye, barley, nuts, soya, citrus fruits and chocolate. Delay the introduction of these for at least 9 months.

FOOD INTOLERANCES AND HAY FEVER

Nutritionist, Lara Berni-Klerck of the Individual Wellbeing Clinic (0171 730 7010) suggests that there can be a link between pollen and foods. She says "If you're suffering from food intolerances as well as pollen allergies then you are increasing the allergenic load making symptoms more exaggerated".

Look at your child's likes and dislikes, if they dislike the taste or smell of a food especially a fruit or a vegetable then don't insist on them eating it. It could mean that there is an impending reaction.

Dr Jonathan Brostoff and Linda Gamlin in their book entitled "Hayfever, The Complete Guide" (Bloomsbury, 1993) suggest an initial home test for food allergies. "Apply a small amount of the food to the face, making sure none of it goes near the mouth. If this produces a rash, then the food should not be eaten".

Lara Berni-Klerck also recommends the following:

- Avoid mucus-producing foods such as dairy produce, which put an extra load on the immune system. But don't switch to soya, which is even more mucous producing than dairy! Goat's milk is the best.
- Look at the cross-reactions to your allergy. For example if you suffer from hay fever brought on by grass, then melon, orange and tomato should also be avoided as they cross react and increase the allergenic response. Full lists of cross-reactions are available from nutritionists or in hay fever literature.
- Avoid dairy foods if you are allergic to grass, as grass pollens can be transferred from the dairy foods into the system.
- Have your child allergy tested if you are still unsure.
- Take plenty of vitamin C - a natural anti-histamine.

HOMOEPATHY AND HAYFEVER

Clinical trials have shown that homoeopathic remedies are very effective at alleviating the symptoms of hay fever. For best results treatment should begin 3 or 4 months prior to the sufferer's 'season' with remedies specifically chosen by the homoeopath which treat the whole person. When the season arrives the symptoms are often greatly reduced and any residual ones can be treated with specific remedies for hay fever such as allium cepa, euphrasia, sabadilla, nux vomica, arsenicum album, wyethia and arum tryphillum. I generally see a drastic lessening or complete disappearance of hay fever symptoms over 2 to 3 years of treatment.

QUICK REMEDY SPOTTER

When choosing a remedy from the list below the most troublesome symptom should determine the remedy that would suit you best:

- Sneezing

Allium cepa, sabadilla, nux vomica

- Nasal Discharge

Allium cepa, arum triphyllum, arsenicum album, kali iod

- Nose blocked up

pulsatilla, nux vomica, kali iod, dulcamara

- Itching/burning in the nose

Sabadilla

- Itching/burning in roof of mouth

Wyethia

- Itching in ears

Nux vomica

- Eyes burning and watery

Euphrasia, pulsatilla

- Sensitivity to bright light

Euphrasia, arsenicum album, dulcamara

- Symptoms worse outdoors

Sabadilla, arsenicum album, dulcamara

- Less stuffiness in open air

Allium cepa, euphrasia, pulsatilla

- Pollen asthma

Arsenicum album, dulc, kali iod, nux vom,

CHOOSE YOUR REMEDY

ALLIUM CEPA

For much sneezing and runny nose, where the mucus seems watery and burning. The upper lip may be swollen and irritated.

EUPHRASIA

Eyes more irritated than the nose. Conjunctivitis with burning tears. Lids swollen. Discharge from the eyes burns, while that from the nose is bland.

SABADILLA

Where sneezing is the main symptom Streaming nose with bouts of violent sneezing. Sensitive to newly mown grass, and the scent of flowers.

NUX VOMICA

The main remedy for sneezing and runny nose in the morning. The nose dries up after going outside, and starts to feel blocked.

ARSENICUM ALBUM

For when the nose feels blocked, even when streaming. Burning discharge, nostrils raw and inflamed inside. May even be small ulcers inside nostrils.

PULSATILLA

When discharge is bland, or eyes are affected by conjunctivitis. Nasal discharge can be thick or yellow-green in the evening.

ARUM TRYPHILLUM

Skin below the nose and on the upper lip looks inflamed/chapped. For children who constantly lick their upper lip, or pick off the skin, causing bleeding.

WYETHIA

Where irritation centres on the roof of the mouth. Very itchy; sensation that something is stuck down the back of the nose and can't be removed.

Take one tablet of 6c potency 3 or 4 times daily. Dissolve the tablet under your tongue without water. If possible don't eat or drink for 10 minutes before and after taking a remedy.

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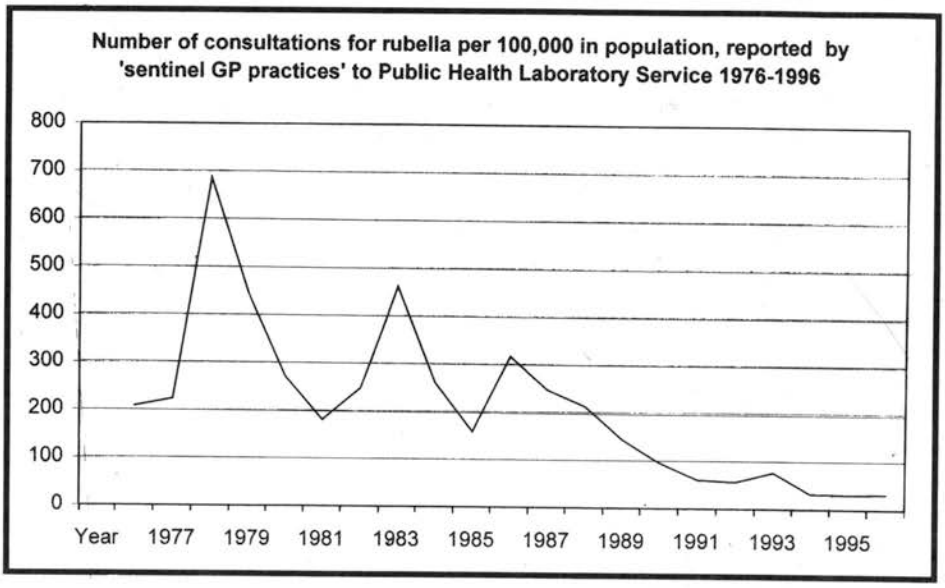
RUBELLA RESPONSE



In the previous newsletter a number of questions were published which had been forwarded to Pat Tookey, Institure of Child Health.
Reproduced here is Pat's response.

1. According to the DoH 'Immunisation against Infectious disease' rubella was made notifiable in 1988. Therefore would it be correct to presume that there are no reliable figures prior to 1988 regarding rubella cases?

Rubella became a notifiable disease in Britain in October 1988 when MMR was introduced for 1-year olds - this means that a doctor making a clinical diagnosis of rubella is expected to report the case to the public health authorities.

Information on rubella infections and susceptibility was collected in a number of different ways before 1988. Public health laboratories reported laboratory-confirmed rubella infections to the Communicable Disease Surveillance Centre (CDSC) of the Public Health Laboratory Service (PHLS), and a large number of 'sentinel GP practices' routinely reported the number of consultations for clinically diagnosed rubella cases to the Royal College of General Practitioners; these data are available from 1975 onwards for England & Wales[1,2] and show a reduction in infection rates which is particularly marked after the introduction of MMR (see graph). There would have been considerable underreporting of the real number of cases: people with no symptoms or only mild symptoms would not be diagnosed and many infected people would not consult a doctor. Despite underreporting, these surveillance systems were able to show trends in infection rates as long as reporting patterns remained reasonably constant. As well as monitoring cases of infection, the proportion of people in different sub-groups of the population (eg pregnant women, children) who are susceptible to rubella is also monitored over time using routinely collected blood samples.

For congenital rubella figures, see Q3 and Table 2.

2. Please could you supply annual figures for the number of rubella cases over the last ten years, stating what percentage were confirmed cases.

The PHLS collects and publishes this information. Table 1 shows the number of laboratory confirmed cases reported through public health laboratories, and also the number of notifications from doctors since 1989. Since 1995 notifying doctors have been encouraged to collect a salivary sample from individuals whom they diagnose with clinical rubella. About half of all notified cases have been tested in this way since then (the table shows what percentage of notified cases were tested, and what percentage of tested cases were confirmed). When there is very little rubella about, as was the case in 1997, the likelihood of clinically diagnosed cases being real cases becomes less - most rashes are not due to rubella. This is explained in the following illustration:

Imagine that while rubella is common, for every 40 true rubella cases reported, there are 12 cases of parvovirus infection*, four allergic rashes and four other infections also reported as rubella: the proportion that are laboratory confirmed (true cases) would be 40/60 (67%). If the number of cases of rubella declines to 1/40th of what it was, but other conditions continue to be misdiagnosed as rubella, then there will be only 1 true case of rubella for the other 20 misdiagnosed cases - 1/21 (5%).

*Parvovirus infection is another common and usually harmless infection of childhood that can look like rubella; it is also known as slapped cheek syndrome or fifth disease.

"Table 1. Laboratory reports, rubella notifications " and proportion with salivary test confirmation England & Wales 1989-1997

	laboratory reports	no. of cases notified	tested %	confirmed %
1989	760	24750		
1990	705	11491		
1991	249	7174	notavailable for these years	
1992	197	6212		
1993	1489	9724		
1994	309	6326		
1995	971	6196	45.9%	16.4%
1996	2776	9253	45.6%	30.7%
1997	99	3409	59.6%	1.8%
1998	131	3208	68.7%	1.2%

Data from PHLS <http://www.phls.co.uk> date accessed 30/6/1999

3a. Which year was the single rubella vaccine first introduced in the UK?

The single vaccine was introduced in 1970, and was offered to schoolgirls between the ages of 11 and 14, and susceptible adult women. Rubella was most common amongst 4-9 year olds, and the aim of this so-called 'selective vaccination programme' was not to stop rubella circulating in the community but to protect individual pregnant women who might come into contact with it. The young teenagers who were vaccinated were on average not going to have their first baby for another ten years or so, so any effect on the incidence of congenital rubella would be delayed. The women who were vaccinated were mothers who had been tested during pregnancy and found to be susceptible - if they had another baby this was likely to be at least 2 years later, and probably more.

3b. And how was its success monitored given that the disease was not notifiable until 1988?

Alongside the continuing surveillance of

Table 2: Congenital rubella births registered with NCRSP and rubella associated terminations notified to ONS (1971-97)

	CRI only	CRS	all CRI/CRS births	rubella-associated abortions*
1971	5	39	44	1018
1972	6	45	51	738
1973	12	55	67	816
1974	6	28	34	633
1975	11	34	45	504
1976	5	26	31	213
1977	2	11	13	184
1978	10	43	53	830
1979	10	68	78	575
1980	7	24	31	200
1981	5	10	15	134
1982	9	28	37	180
1983	23	49	72	238
1984	17	36	53	142
1985	7	17	24	65
1986	6	24	30	110
1987	8	29	37	75
1988	3	18	21	44
1989	5	8	13	25
1990	3	9	12	14
1991	0	3	3	19
1992	0	7	7	2
1993	2	1	3	13
1994	0	7	7	4
1995	0	1	1	5
1996	1	11	12	9
1997	0	0	0	2

Births are reported to NCRSP from England , Scotland and Wales;
CRI is congenital rubella infection only, without apparent damage
CRS is cngenital rubella, with associated damage, see Q7 for fuller definition
*Abortions for rubella disease or contact, data from ONS, for England & Wales only

rubella infection in the community described above (Q1) the success of the vaccination programme has been measured by
a) The number of congenital rubella births notified to the National Congenital Rubella Surveillance Programme (NCRSP)[3] (Table 2)
b) The number of rubella-associated terminations reported to the Office of National Statistics (ONS)[4] (see Q8) (Table 2)
c) Vaccine uptake figures published regularly by the PHLS[5]

The selective vaccination programme introduced in 1970 could not hope to have an immediate effect on the number of congenital rubella births or rubella-associated terminations as explained previously in Q3a. The NCRSP was set up in 1971 and audiologists, paediatricians, virologists and other health professionals were asked to report to it all suspected or confirmed congenital rubella cases. The first report from the NCRSP in 1973[6] stated:

"The aim of the surveillance programme is first to establish a base line for the annual incidence of congenital rubella defects in England, Scotland and Wales and then to monitor the annual incidence over a number of years so that, when vaccinated children reach the age of child-bearing, it should be possible, if vaccines are effective and vaccination policy has been correct, to detect a fall in the number of children born with rubella defects. Other factors, however, will have to be taken into consideration in the assessment, for example the number of pregnancies terminated on account of maternal rubella, and both the type and amount of vaccine used."

Since 1990 congenital rubella has been one of the rare conditions monitored through a national paediatric reporting system run by the Royal College of Paediatrics and Child Health. Every consultant paediatrician in the country receives a monthly reporting card and is asked to state whether or not s/he has seen any of the rare conditions listed on the card. When a case of congenital rubella is reported it is followed up by the NCRSP.

4. There appear to be differing figures regarding the risk of CRS. Could you clarify the percentage risk in a) the first trimester b) the second trimester.

The estimates of the risk of damage following rubella infection in pregnancy are based on
a) the likelihood of the infection being passed from mother to baby, and
b) the likelihood of damage if the baby is infected.

Infection just before conception (rash appearing less than 12 days after the first day of the last menstrual period (LMP)) is most unlikely to result in infection in the baby.[7] However, with infection from 12 days after LMP to about the tenth week of pregnancy, the risks are very high - about 90% of infected women pass the infection on to their baby, and virtually all infected infants have one or more rubella associated problems. The risk of passing the infection on drops to about two thirds in the next four weeks, and about a quarter of infected infants have rubella damage, usually hearing loss. In the second trimester about a third of infected women will pass the infection on, but damage is very rare.[8]

5. Since there are also many other viruses which have the potential to affect the unborn baby, do you have figures of the risk of congenital defects from these viruses?
6. Are there figures on the number of congenital defects occurring in relation to these other viruses?

There are many other infections in pregnancy which can be passed on to the baby, either before birth, around the time of delivery or in early life. These include chicken pox, cytomegalovirus (CMV), herpes simplex virus, hepatitis B and C, parvovirus, HIV, and non-viral infections like syphilis and toxoplasmosis. However, none have the high rates of congenital abnormality associated with rubella infection in the first three months of pregnancy. See Q9 for more information on CMV.

7. What is the difference between CRS and CRI? Are there separate figures?

See Table 2 for the figures. Congenital rubella infection (CRI) means that the mother's rubella infection in pregnancy was transmitted to the baby before birth (confirmed by laboratory tests). If the baby is infected but appears to have no health problems associated with rubella the NCRSP records this as 'CRI only'. Congenital rubella syndrome (CRS) is used when the child has health problems directly associated with the infection. The so-called 'classic triad' of CRS is sensorineural hearing loss, cataracts or other serious eye abnormalities, and congenital heart defects.[9] However, many affected children have only one or two of these conditions, and there are other associated problems which are less common, including speech, language

and behaviour problems, microcephaly (small head), and slow growth. Later onset conditions which appear to be more common in young people with congenital rubella than in other people include diabetes mellitus and thyroid disorders. About a third of the children reported to the NCRSP as 'CRI only' at notification have subsequently been reported to have a rubella-associated disability, usually sensorineural hearing loss. In Table 2 cases are categorised according to the most recent information available.

8. Do you have yearly figures of the number of terminations as a result of exposure to a) rubella b) other viruses.

Data on rubella-associated terminations have been published since 1971 by the Office of National Statistics (previously OPCS). See Table 2. There is no routinely available breakdown for terminations associated with other viruses.

9. I understand that CMV is a more common virus than rubella, and also has the potential to cause congenital defects. Could you comment as to why the public are unaware of CMV if there is a greater risk of being exposed to it than rubella.

It is true that CMV is a common virus; most people in Britain catch it at some time in their life - about 20% by the age of one year, about 50% by young adulthood. It is passed on by intimate contact, usually with a sexual partner or close family member. When infection occurs it is usually without symptoms; it may, however, be experienced as a mild and non-specific illness and occasionally people have a more serious flu-like illness. Like other viruses in the herpes family, for example herpes simplex and chicken pox, once you've caught it the virus it remains in the body throughout life. Usually it causes no problems, but occasionally it reactivates, again usually without symptoms. It can be a serious illness in people whose immune system is not working properly (for example people with HIV, or people having organ transplants or therapy for cancer).

A woman who catches CMV infection for the first time in pregnancy has about a 1 in 3 chance of passing it on to her baby. Occasionally a woman may experience a reactivation or reinfection in pregnancy - usually this is not transmitted to the baby, but if it is, the chance of damage is much lower than with a first infection, although it can occur.

About 3 or 4 babies per 1000 in the UK are born with congenital CMV infection. About 15% of them have related health problems, the rest are healthy and are rarely diagnosed. The most common disability caused by congenital CMV is sensorineural hearing loss; now that congenital rubella is rare, congenital CMV is probably the most important infectious cause of congenital hearing loss. A minority of children with congenital CMV have other severe physical and/or intellectual impairments. Before rubella immunisation had an impact on congenital rubella births it is estimated that in non-epidemic years in Britain about 1-2 per thousand babies were damaged by congenital rubella. Although 3-4 per thousand babies have congenital CMV, the majority are unharmed: about 1 in 2000 will have associated problems.

Some people have suggested that there should be a screening programme to identify women who are susceptible to CMV infection in pregnancy, or women with CMV infection in pregnancy or infected babies at birth. Routine testing for CMV is not carried out at the present time due to:

* problems with diagnosis of infection in pregnancy
* the lack of any suitable treatment or vaccine
* the fact that damage can follow infection at any stage of pregnancy
* the relatively low risk of damage if infection does occur
* the lack of a consensus about how best to avoid infection

Research is continuing on diagnosis of CMV infection in pregnancy, vaccine development and treatment, and it is possible that CMV may have a higher profile in the future. In the meantime, it is reasonable to suggest that pregnant women working with young children (for example nursery workers) should wash their hands after changing nappies or carrying out other intimate tasks, and should minimise the kind of contact that might involve the transfer of saliva (eg wet kisses), as it is known that a significant minority of perfectly healthy children excrete CMV in urine and saliva.

10. Is data kept regarding the immunisation status of the mothers of babies with CRS?

The NCRSP does ask about the immunisation status of mothers of registered babies: there is no information for 32% of mothers, 63% said they had not been immunised and 5% thought they had been. Of the 5% who reported immunisation, just under half had a documented history of immunisation, and there was no record available for the other half.

11. How thorough and accurate are the tests to establish which virus may have caused congenital defects?

There are laboratory tests specific to each virus, and those for congenital rubella are very reliable. Rubella antibodies are passed on to the baby by any mother who has rubella antibodies of her own - but only the protective IgG antibodies can cross the placenta. If the baby has IgM antibodies, which indicate current infection, then they were made by the baby itself and indicate congenital infection. Babies with congenital rubella usually also excrete rubella virus in urine and saliva, and are infectious for as long as they continue to do so (sometimes for as long as a year). It is very rare for infants to catch rubella infection in the first year of life because the maternal antibodies which are passed on to the newborn infant are protective, so a baby with rubella IgM was almost definitely infected before birth.

Congenital CMV is more difficult to diagnose than congenital rubella. Many infants pick up CMV infection from their mothers during the birth process, or through breast milk, at which stage it normally causes no problems at all. However, because it is so common for babies to acquire infection at birth or soon after, to confirm that a baby acquired its CMV infection in the womb, you have to test it in the first three weeks of life.

Doctors looking after a baby with signs of infection around the time of birth used to ask for a TORCH screen - Toxoplasmosis, Rubella, Cytomegalovirus, Herpes simplex. This is not helpful however, because the tests for each infection require different sorts of specimens, and it is more useful to consider which specific signs and symptoms the individual infant has, and whether the mother had any indication of a specific infection in pregnancy. In 1990 guidelines[10] were produced which recommended that doctors no longer request a TORCH screen, but instead request tests for specific infections relevant to the individual case.

12. I understand that rubella tends to appear every 6-9 years. Do you have figures showing the epidemic years in recent times, and when is the next cycle due?

In the pre-vaccine era rubella had an epidemic cycle of about 6-9 years in the United States. In Britain it was a shorter cycle of about 4-5 years which continued into the 1980s (see Figure). There was also a seasonal cycle in that infection was more common in the spring (and consequently there were

more congenital rubella births in the autumn). The vaccination programme has depressed both the epidemic and seasonal cycle. There were small outbreaks of rubella infection in Britain in 1993 and 1996, both mostly affecting young men who had not been eligible for vaccination. It is difficult to predict whether and when there will be another rubella epidemic. If vaccine uptake rates are maintained at about 90% or above, then there will be very little rubella infection about, and even those women who are susceptible in pregnancy will be unlikely to come into contact with it in Britain. However, lower vaccine uptake rates will result in a renewed circulation of rubella, and inevitably in the medium term in congenital rubella births.

13. When was CRS first diagnosed, and are there annual figures for the number of confirmed cases since it was first discovered? It would be useful to know the annual number of live births over this period too.

See Table 1 for the annual number of confirmed cases in Great Britain. The annual number of live births has ranged from 600,000 to 700,000 over the period. The link between rubella infection in pregnancy and congenital rubella damage was first recognised by an Australian ophthalmologist - Norman Gregg - in 1942.11 He had an unusually large number of infants with cataract - some of whom also had heart defects - in his clinic, and several of the mothers happened to mention that they had had rubella infection in early pregnancy (there had been a rubella epidemic several months previously). His theory was not well received initially. Isolation of the virus was not achieved until the 1960s, when there was another world-wide epidemic of rubella. It is thought that over 20,000 infants with congenital rubella were born in the United States in 1965-66 alone, and there was also a large number of cases recognised in the UK at that time, although no precise figures are available. In the late 1990s congenital rubella is extremely rare in most developed countries. However, in the developing world, tens of thousands of infants are born every year with congenital heart defects, deafness and blindness because their mothers caught this otherwise insignificant infection in early pregnancy.

OTHER IMPORTANT POINTS

1. Rubella vaccination protects 19 out of 20 vaccinated individuals with one shot, so even if everyone was vaccinated once, 5% of people would remain susceptible; however, rubella would disappear because that is too small a proportion of the population to sustain transmission of infection. The second dose of MMR is offered to all children aged 4 in order to give those who did not receive it earlier another opportunity to take it up, and to protect those who did not respond to one or other of the component vaccines the first time around.
2. Occasionally a woman is told in one pregnancy that she is immune to rubella, and later in another pregnancy that she is not protected. A screening test is not a diagnostic test, and in the case of antenatal testing for rubella antibody it is important that women who are susceptible to infection are not falsely reassured. Therefore the test threshold is set at a level where some women with low level antibody will be told they are susceptible and recommended to have the immunisation after their baby is born. In most cases they probably do have protective antibodies, although they have fallen below the cut-off set for the screening test.
3. Reinfection in pregnancy rarely causes congenital infection, though there are occasional case reports of this happening.
4. Women who came to Britain as teenagers or adults and missed out on rubella vaccination at school are more likely to be susceptible than women born and brought up in Britain. In the 1980s although only about 7% of all births were to Asian women in Britain, they accounted for about 20% of congenital rubella births. Ethnic minority women, migrants and refugees from many different parts of the world are more likely to be susceptible than women born and brought up in Britain, and will be at particular risk if rubella infection once again starts to circulate.
5. Rubella is common in many other parts of the world, although it is now rare in Britain. Susceptible pregnant women may come into contact with infection while travelling abroad on holiday or business. The best time to check your rubella status is before becoming pregnant. Pregnancy should be avoided for one month following vaccination, though the risks of damage following inadvertent vaccination around the time of conception are very low.
6. The surveillance of congenital rubella has always provided a minimum estimate for the annual number of congenital rubella births, because if a woman did not have the recognised symptoms in pregnancy, or the baby had no obvious signs at birth, then the diagnosis might not be made. However, long-term surveillance looks not only at actual cases, but also monitors trends. It is likely that some children with deafness as the only sign of congenital rubella might not be diagnosed, especially since the introduction of MMR, because most children have vaccine-induced rubella antibodies and it is therefore more difficult to diagnose congenital rubella in an older child. However, it is unlikely that there has been any major change in the diagnosis rates for children born following maternal rubella in very early pregnancy which usually results in serious multiple problems which are obvious at or soon after birth.

Questions: The Informed Parent
Answers: Pat Tookey, NCRSP, Institute of Child Health, London, June 1999.

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Editor: I would like to thank Pat Tookey for kindly supplying a very full response to the questions asked. Hopefully this response will be helpful for those of you enquiring about official figures and statistics.

Having recently sat through a number of sessions at the House of Commons, looking at the 'Procedures relating to adverse clinical incidents and outcomes in medical care', I personally do not feel reassured by the presentation of any 'official' figures or data. During these sessions it became crystal clear that there is a great lack of data at all levels, gross under-reporting, and poor communication between the various official bodies. I will be reporting fully in the next issue on these sessions.

NATURAL HYGIENE -HEALTH FOR ALL

Only you can live your own life
by Keki R. Sidhwa, N.D., D.O.
From: The British Natural Hygiene Society's publication - The Hygienist, summer 1999. Extract from the editorial.

Natural Hygiene , it's philosophy and laws are not man-made. It is part and process of life itself and bedded into the very fabric of all living beings. We all practise natural Hygiene - whether we like it or not - some of us to a greater degree than others. We are all bound by the same inexorable laws of nature and maintain a degree of health and well-being due to the inherent capacity of the body to heal and repair and rejuvenate. For example we all need sleep, fresh air, exercise, food, rest, mental and emotional poise for our well being. To a degree we meet these needs, otherwise none of us would be alive, but for a great many, (need I say 95% in majority) meet only the minimum of these needs - result; A mere survival just the body ticking over, no more, no less. The optimum not being met, there is no experiencing of real well-being, - something which a great many of us have left with our childhood. Natural Hygiene is that science which helps you to understand all the multifaceted needs of your living organism and through self-responsibility meet those needs.

Self-responsibility, - how much do we realise its meaning, understand the depths to which we have to go to learn that it is not just criticising other people. It is so easy to observe others, what they do, what they say, but can we do it for ourselves? Can we really appreciate our motives, our desires? The reason why we love and why we hate?. So I say to you, let the inner hidden harmony within you be allowed to be manifest. If you are guided by your inner insight, if you can listen to your heart, and not just your head, there will be no need for discipline. The more you have been taught, the more you have been intellectualised, the more confused you have become. There are two types of discipline. One discipline that which is forced from without: somebody says "Do this!", the other discipline that comes from within: you feel what will be Natural, you feel where your being is flowing, and you move with your feelings; Then an inner discipline comes in. All animals fast when they are unwell - no priests, no doctors, no preacher is preaching to them and yet it happens. Such a fast is an example of the inner discipline. Men have fasted in the past because of their religion, their scriptures, their dogmas and mistake this with the inner voice. If in your illness you simply listen inwards and don't eat, that's beautiful. Sometimes you don't feel hungry, then don't eat. But don't take a vow that, "I will fast for such a length of time", because who knows? - in the evening or the next morning you may feel hungry. Move with Nature. when Nature wants you to fast, fast. When Nature wants you to eat, eat.

To me there is only one religion and that religion is to find the inner voice; the inner guide, and Natural Hygiene can help you to find your inner guide. It helps you - not to give to yourself an outer discipline; it simply helps you to find the inner harmony which gives discipline. And that discipline has a grace, because its not forced. And that discipline has a beauty of its own because it is always fresh. And with that discipline you cannot go astray because you cannot revolt with that discipline. It is you, your very innermost core.

The following extract is from an article by Keki R. Sidhwa from Heath for All, "The Scare Diseases", May 1965.

.....' For years Dr. Matthew J. Rodermund, MD of Wisconsin, USA, offered $10,000 to anyone who could prove scientifically that smallpox is contagious. Nobody ever claimed the money.

Dr Charles A.A. Campbell, MD of San Antonio, USA, who was for years in charge of an isolation hospital made exhaustive experiments in order to demonstrate that smallpox is contagious, but found that this is not the case. He even succeeded in persuading the mayor of San Antonio and the city council to go to the hospital and mingle with the patients and have a meal with them. The Bexar County Medical Society, before whom he read a paper detailing his experiments and his conclusions, refused to publish his findings. He later published them in his book, 'Bats, Mosquitoes and Dollars'.

Dr. Rodermund was even more daring. He broke open the smallpox pustules, rubbed the pus on his face and hands and moved about freely for three or four days, deliberately neglecting to wash himself. No smallpox outbreak occurred.

The famous Dr. Sydenham, of England, called smallpox 'the most safe and slight of all diseases as long as no mischief be done by either physician or nurse', which is significant indeed. In olden days people died not of smallpox but of the treatment that was given to them.

Does vaccination prevent smallpox? Anyone who has made a thorough study of the subject will in all honesty have to admit that it does not. In India, even today, when over 90 per cent of the population are said to have been vaccinated, thousands are dying of what is diagnosed as smallpox in spite of - or because of - the compulsory injections. Major Reginald F. E. Austin (R.A.M.C.), who served in India in a medical capacity, was greatly in favour of hygienic living, cleanliness, and sanitation rather than vaccination, and he said so in so many words. He poo-pooed the whole vaccination programme as a diabolical disaster.

'MOST INNOCENT'

Dr. Henry Blumberg, the medical superintendent of Southport Children's Sanatorium, speaking before the Royal Commission on Vaccination, described smallpox as 'most innocent and least dangerous', and he spoke against vaccination.

When we turn to tetanus - and other of the scare diseases - we find Dr. J. A. Toomey, MD of Cleveland, Ohio, USA, saying in the Journal of the American Medical Association, May, 1942, that drainage, cleanliness and proper incision of wounds were of greater importance than the anti-toxins administered. In 1940, the Surgeon-General of the American Army sent a letter to Congress requesting a change in the manner of treating tetanus in soldiers. He rightly stressed the fatal effects due to anaphylaxis resulting from the administration of anti-toxin, and claimed that better results were achieved by ensuring cleanliness and the proper drainage of wounds.

What applies to smallpox and tetanus applies to all the other scare diseases. In

typhoid and cholera more people are killed by wrong treatment, i.e., feeding and drugging the patients, than by the disease itself. The writer knows many people who have suffered from quinine poisoning - the after effects of the deadly 'cinchona bark' remedy for malaria. The list could be multiplied.

What, then, is the nature cure approach to these so-called scare diseases? In brief the answer is the same as that which applies to all problems of ill-health. Health/high-level health alone will safeguard you against coronary thrombosis, typhoid, cholera, etc.

If circumstances are such that you cannot avoid being vaccinated or inoculated, there are ways and means by which the body can be helped to get rid of the poisons. A short fast before and after the inoculation will speed up the elimination of toxins from the body. It may be possible, when vaccination has just been carried out, to distract the physician's attention while wiping away the pus quickly with a wet handkerchief kept in readiness. A short fast may be undertaken afterwards as an additional safeguard.

PRECAUTIONS

The following precautions should always be taken when contemplating a journey overseas.

Ensure that you are in good physical condition by paying special attention to correct diet, exercise and rest beforehand. You lay yourself open to all sorts of trouble if you gourmandize. Pick and choose what you eat and avoid rich foods, especially heavy protein and carbohydrate meals. If you are travelling in a ship, see that you get enough exercise; lethargy and inactivity do not promote high-level health. Conversely, avoid excessive activity, because exhaustion, both physical and mental, is just as debilitating as too little exercise.

When you arrive at your destination pay particular attention to climate, sanitation and hygienic habits. Remember Noel Coward's 'mad dogs and English-men'! if you are not accustomed to heat, expose yourself to it gradually, and only during the cooler hours of the day. Too much heat and sun is enervating and vitality-sapping.

Do your best to live in clean surroundings and where sanitation and hygiene are adequate. Filth, squalor and overcrowding breed disease in India as well as in Britain. A clean water supply is a necessity, but there is no need to be finicky and chemicalize it.

Many people give up hope of following a natural dietary because they have been led to believe that eating fruits and vegetables in tropical countries is fraught with danger and that one is safe only on highly cooked or canned foods. Nothing could be further from the truth. After living in Britain for nearly 17 years the writer has revisited the tropics and picked fruits and vegetables off the bazaar stalls and eaten them raw, then and there, without ill effects. Provided that one takes the normal precautions of cleaning and washing fruits and vegetables, these countries are a paradise from a natural food point of view. A preponderance of fruits and vegetables, with only a minimum amount of proteins and carbohydrates, will afford the best kind of immunity from an all-round point of view.

Editor: In June, 1999, I had the opportunity to ask Keki Sidhwa a few questions regarding vaccination and travel.

1. What is your main concern about the effects of vaccination?

My main concern is very simply that vaccination has not proved to help people, there have been a lot of cases where vaccination has harmed people, and these are well-documented.

2. What advice would you offer regarding travel vaccines?

Live healthy as much as you can, and if you do get something then fast, take things easy and your body will heal itself.

3. People travelling to far away places, with very different climates etc. are concerned that they would be at risk from various diseases. Could you comment?

I have travelled to, for example, Africa, India and parts of the Caribbean and I've never had any shots. I still feel that even if you are going to a different climate as long as your food and health habits are good then one doesn't need to worry over it.
If there is any compulsory vaccination for specific countries then I simply would not visit that country.

4. What measures would you suggest to individuals whose general diet lacks in some areas ?

Even then, vaccination is not going to condone bad living habits. In other words as I said earlier I don't think that vaccination really does protect and if people feel that psychologically they need to take something rather than take vaccination, I would take homœopathic alternatives or something like that.

5. Would vitamin supplements be appropriate in some situations?

Yes in some situations it is appropriate but at the same time it gives some people a false sense of security once you start on taking supplements you try to neglect your way of life because you think oh well I'm taking this so I can eat any rubbish and once again taking supplements will not condone bad habits of living.

6. Do you consider that certain foods should be avoided, eg. in areas where the water quality is suspect would fruit with high water content be a problem?

Provided the fruits are well skinned then I would have no objection to eating fruits like oranges, pineapples, bananas, avocados, even water melon would be perfectly alright provided you don't eat a water melon which is cut in half and sold in a market, in other words get the whole thing and cut it yourself.

7. Can you offer any comments regarding swimming in the sea?

So much of the seas are being polluted that I would be concerned about swimming. The Mediterranean is particularly polluted now and although I used to swim in the Mediterranean 30-40 years ago, I wouldn't do it now. There may be areas of the world where it is quite alright still, eg I was in Bali recently and the sea was beautiful. So one has to be careful of where there is industry throwing its rubbish into the sea, obviously that sea has to be avoided.

For further information about the British Natural Hygiene Society and the quarterley publication produced by Keki Sidhwa, please contact Keki at:
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CONFERENCE OF THE STRASBOURG 2004• POST-VACCINATION INCIDENTS GROUP

In July a 2-day conference took place in France, organised by two groups, the French ALIS (Association Liberte Information Sante) and the Spanish 'Liga Para La Libertad de Vacunacion.' Representatives from France, Spain, UK, Belgium, Germany, Luxembourg and Switzerland were present, and a number of other interested parties, who were unable to attend, have pledged their support to the proposed project under discussion. Lesley King, from The Society of Homœopaths, attended and the following briefly outlines the main points of discussion.

The main objective of the conference was to design a European questionnaire for people to fill in if they believe that they or a member of their family have suffered symptoms following a vaccination. The plan is to make the forms available through parents' groups, therapists and clinics etc. so that they are readily available to be filled in and then returned to one central place in each country. The form has not yet been finalised, but should be available for distribution by the autumn. All information retained will be anonymous and the confidentiality of both patient and practitioner will be protected.

During the conference there tended to be a focus on the situation in France due to the high number of French delegates present and the fact that a number of vaccines in France are compulsory. Theirs is therefore an issue not simply about the effect of vaccines but also of human rights, freedom of choice etc.

It is to be made clear that the European group will not be a radical anti-vaccination group. The intention is not to "oppose" or advise against anything, but to simply raise awareness that there are many more vaccine after-effects than are officially acknowledged. If the Public Health Laboratory Service in the UK was prepared to admit a five-fold level of under-reporting (see previous issue of this bulletin, p9), then common sense tells us that in reality the figures for reactions are being grossly under-estimated.

Francoise Joet, (chair) from ALIS gave the statement: "Our objective is only to collect information about unrecognised vaccine reactions, not to analyse, not to judge and not to interpret. That information will not form a scientific, analytical study. We simply want to inform people that "this is happening." The results will be communicated to the European Parliament in 2004, and to the public through the media.

The meeting also addressed the issue of general mutual support. Dr Kris Gaublomme, has had great difficulty in producing The International Vaccination Newsletter as he has no other contributors and finds the research too much for one person. It was agreed that those present would endeavour to forward any news items from our countries to Kris with a résumé in English from non-English speaking countries.

Lesley King, July 1999.

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HOMŒOPATHIC & GENERAL MEDICAL TREATMENT OF CHILDHOOD ILLNESSES & EMERGENCIES

Dr Jayne L M Donegan, MBBS, DROCG, DCH, MRCGP, General medical practitioner
Annie Friedmann, homœopath, LCH, MCH, RS Hom

This course will run over five Sundays from 2.00 -5.30pm
The dates are as follows: 10th, 17th, 24th, 31st Oct, and 7th Nov 1999
At: 38 St Gabriels Road, London, NW2 4SA
To book a place call Annie Friedmann on 0181 452 2946
Places are limited to 10, plus one concessionary place
Cost of course: £130
(£120 if paid before August 31st)
(Price includes tea and biscuits)

You will learn how to use safe and effective homœopathic remedies to deal with such childhood ailments as earache, fevers, febrile convulsions, stomach bugs, coughs, colds, sore throats and many more. You will also learn how to resuscitate a child as well as how to recognise and deal with childhood accidents, such as concussion, burns, and broken bones. If you have a young child and would like to be better informed and equipped to cope with your child's first few years of life, then this could be the course for you.

This is a practical and supportive course to enable you as a parent to feel safe and encourage you to use your inherent knowledge in caring for your child.

Annie Friedmann is a practising homœopath of 11 years standing and has a busy practice in North and Central London, and is a tutor at the London College of Homœopathy. Dr Jayne Donegan qualified in 1983. She is a General Medical Practitioner and mother, with a wide experience of family medicine in hospital, general practice and at home.

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.

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