THE *informed* PARENT

ISSUE ONE - 2005 A QUARTERLY BULLETIN ON THE VACCINATION ISSUE & HEALTH

JAPAN STUDY REJECTS MMR AUTISM LINK

In early March it was announced through the media that a new study had been published dismissing any MMR/autism link. Here follows an article from The Scotsman, 3/3/05, and two articles commenting on this study by Hilary Butler and John Heptonstall, which were both published on bmj.com.

'STUDY SHOWS MMR JAB HAS 'NO LINK TO AUTISM'

Alison Hardie, health correspondent for The Scotsman, 3/3/05.

'A study of more than 30,000 children showed that when the triple vaccine was replaced by single shots, the number of children with autism continued to rise.

It is the second comprehensive study to dismiss the link between MMR and autism, outlined in the Lancet medical journal six years ago, which led thousands of parents to opt for single vaccines or avoid inoculating their children altogether.

In Scotland, the take-up of the triple vaccine slumped to 70 per cent - the World Health Organisation's recommended safe level is 95 per cent - leaving swathes of the population at risk of contracting the potentially deadly diseases.

Health officials are fighting the biggest incidence of mumps for decades, a grim scenario directly attributed to the number of youngsters denied the protection of the MMR jab.

The latest research was conducted in the Japanese city of Yokohama. Dr Hideo Honda, of the Yokohama Rehabilitation Centre, who led the investigation, told New Scientist magazine: "The findings ... are resoundingly negative."

The study was the first to examine autism rates after withdrawal of the MMR vaccine. Japan stopped using the jab in April 1993 following reports that the anti-mumps part of the vaccine was causing meningitis.

Fears about MMR surfaced in the UK in 1998 when Dr Andrew Wakefield, from the Royal Free Hospital in London, claimed that the vaccine might trigger autism.

His findings, published in the Lancet, were based on a study of just 12 children and later retracted by most of Dr Wakefield's co-authors, although he continues to stand by his claim.

However, the Lancet published a report - by far the biggest British study to date - in September last year in which the authors concluded that they could find no "convincing" evidence of a link between autism and MMR.

Dr Wakefield's suggestion of a link with autism and bowel disease led to MMR vaccination rates plummeting by up to 60 per cent in some parts of Britain. A subsequent increase in measles outbreaks has also been blamed directly on the MMR scare.

Not one epidemiological study has revealed a link between the vaccine and autism. But, until yesterday's report, every one focused on what happened after the triple jab was introduced. In contrast, the Japanese researchers looked at autism rates after the vaccine was replaced with single jabs, New Scientist reported.

Working with Professor Michael Rutter of the Institute of Psychiatry in London, Dr Honda's team checked the records of 31,426 children born in Yokohama between 1988 and 1996.

The researchers found the number of children diagnosed as autistic by the age of seven continued to multiply after the withdrawal of MMR.

Writing in the Journal of Child Psychology and Psychiatry, the researchers concluded that the MMR vaccine "cannot have caused autism in the many children with autism-spectrum disorders in Japan who were born and grew up in the era when MMR was not available".

However, the latest studies failed to impress the Scottish charity Action Against Autism.

A spokesman said: "What parents want to know is what causes autism, not what does not cause it."

Isabella Thomas, a spokeswoman for Justice Awareness and Basic Support, a group that provides support to parents of "vaccine-damaged" children, said that the report covered little new ground.

"It's not telling us very much," she said. "They are looking at a selective cut-off point of 1996, and many of the children who suffered from MMR-related autism were not diagnosed until after this period."

A spokeswoman for the Scottish Executive said: "The expert scientific groups that look at this issue say that the current evidence does not support the suggested link between MMR and autism."

Now follows two of the many responses made on: www.bmj.com regarding the study from Japan.

Hilary Butler, freelance journalist, New Zealand. Rapid Response, 5/3/05

Hilary wrote:

1) Last year, when I wrote and asked the Japanese Department of Health for the figures on Autism in Japan for the last thirty years, I was told they did not keep them.

2) Many, many years ago, when Japan stopped using the pertussis whole cell vaccine, they did so on the basis that it was causing unacceptably serious side effects.

Two things happened. Firstly, UK and America denied it could happen anywhere else, inferring that it must be something "peculiar" about Japanese babies.

Secondly, when Japan brought out a successful acellular vaccine, in order to prevent these side effects that America and UK said, didn't exist, that vaccine wasn't accepted by the rest of the world. Apparently it wasn't good enough and didn't "work" for the rest of the world's children. It wasn't until AMERICAN companies made a "good"

acellular vaccine that suddenly a vaccine came available that was "suitable" for the rest of the world's children.

3) Years ago, when Japan abandonned the MMR because it was causing unacceptable side effects, the rest of the world medical profession, again considered this to be an anomaly. There must be something "different" in Japan. Nothing that came out of Japan about the inadvisability of using MMR was either supported by the rest of the world, or even, to my knowledge, reported in the media.

This brings up another glaring error in this paper. Hideo Honda says that MMR was discontinued after the Urabe strain caused aseptic meningitis. This is not true. Japan then trialled all the other MMRs and got the same result with that, as they did with Pluserix.

Which is why, to this day, they do not use "any" MMR vaccines. I wonder why he did not say that? Perhaps because he is a psychiatrist and not an immunologist?

When two Japanese psychiatrists, and Michael Rutter, one London 'psychiatrist' suddenly jump on a bandwaggon acceptable to the aims and agendas of the rest of the pro-vaccine world, the John Rumbold's of this world come out of their closet?

Why is it that we aren't hearing the old hoaries about how Japan is "different"? That their vaccination schedule bears no resemblance to the rest of the world? When, for instance, was the Japanese Encephalitis vaccine introduced into the baby schedule? Why is there not, as part of this article a chart showing the years that key vaccines were put in or removed to their national schedule, and also the mercury components of the vaccines used in Japan?

Why is it, these psychiatrist don't even provide the "actual" data from these children's immunisation records? They should since all Japanese parents carry that data in a special book, which they must take to all health visits. Might that data argue against their epidemiology?

Seven years based solely on observational ASD data only, in Yokohama analysed by psychiatrists only, does not a summer make.

Take into account also, that enquiries in Japan, today, show that though M, M and R, are indeed administered in separate syringes, and that while it is stipulated that they "should" be given four weeks apart, in practice they are often given at the same time, for the very same reason as is "stated" in our countries.

It saves time and visits, and most importantly... money. Going to a doctor in Japan is very expensive, and for those who have lived there, traffic is a total nightmare.
(http://idsc.nih.go.jp/vaccine/dschedule/ImmEN_05.gif)

There are too many assumptions made in this article; assumptions which should not be left unchallenged.

They should ALSO have checked whether or not other vaccines, such as Japanese encephalitis, were ALSO administered at the same time. The Japanese encephalitis vaccine is not without its problems.

Here is another glaring omission in this study. The Japanese Health Ministry does not aggressively promote vaccine in Japan. They would be stupid to do so, given its history in that country. There is quite a strong movement in Japan particularly amongst the breastfeeders, and homebirthers not to vaccinate There is, therefore a reasonable cohort of totally unvaccinated children in Japan. I cannot help but wonder then, why this study didn't actively seek out a totally unvaccinated control group with which to compare the "subjects". These doctors mention two studies where supposedly, vaccinated children were compared to unvaccinated children.(Marsden 2002, Smeeth 2004) In fact, neither of those studies had TOTALLY unvaccinated children as controls. To use, as controls, otherwise up-to-date, vaccinated children, who hadn't got the MMR isn't a valid comparison to totally unvaccinated children. You might say that its all about MMR only, but is it?

Are there other cumulative factors imposed by the use of all the other vaccines that walk some babies towards the edge of a cliff, but some only fall over after MMR? How can you tell, without a truly valid "control" group?

I notice the remark about studies using supposedly unvaccinated children:

-"The strategy is constrained by uncertainties over the factors that led parents not to have their children vaccinated." -

That in itself begs explanation. Interesting too, that in the Japanese study the upward blip in 1992 in figure 1, is a downward blip in Table one. Or is that yet another unexplained "anomaly"?

There are a lot of unanswered questions that come out of this paper. Such as "Why there were no immunological tests performed on these children to see exactly what was going on in their systems?" Or is that outside the brief of psychiatrists? I have yet to see one child who with regressive autism following ANY vaccination, to present with a properly working immune system.

I do not find that this study presents resoundingly negative data arguing against a hypothesis that MMR causes autism. I find that this study raises far more questions than it attempts to answer. It also raises questions about what constitutes good accurate scientific analysis, when the actual records of the vaccinations of these children were never presented or discussed. Just "assumed".

Finally, it would indeed be interested to know not only the competing interests of developmental psychiatrists, Michael Rutter, Hideo Honda and Yasuo Shimizu, but also their "expertise" in the area of vaccines, and the immune system, for it seems to me, this is, yet again, another pro-vaccine study lacking critique and solid data in critical areas.

Sincerely, Hilary Butler.

And the second response....

Evidence suggests MMR and Monovalent Vaccines cause ASDs
16/3/05
John P. Heptonstall,
Director of The Morley Acupuncture Clinic and Complementary Therapy Centre. Practitioner of TCM -acu
LS27 8EG
John wrote:

How can Andrew Cole refer to the Japanese research study Honda et al 2005 as "the strongest proof yet that the MMR vaccination does not cause autism" when it is based on the naive hypothesis that the continuing rise in ASD after withdrawal of the MMR vaccine is incompatible with the causal hypothesis – to the exclusion of many other factors that might have contributed heavily to the continual rise in incidence of ASDs despite withdrawal of MMR in 1993.

Takahashi et al 2003 (1), although a small study that requires larger follow-up, makes two very important

observations. The team found a "statistically significant association of ASD with monovalent measles immunisation, non-mumps and non-rubella immunisation" and that "results suggest a decreased risk of developing ASD with MMR compared to monovalent antigens".

Taking Honda et al together with Takahashi et al, one might suspect that
1. Replacing MMR vaccine with monovalent measles vaccine may be expected to cause a rise in the incidence of ASD and
2. If monovalent measles vaccine poses a significant risk of ASD then MMR, which contains the equivalent of a monovalent measles component, might also be expected to pose a risk of ASD.

The rate of increase in ASD throughout the period of Honda et al, 1988-96, might not result solely from any increase attributable to monovalent vaccines but also to other as yet unspecified agents and any alterations to the criteria for diagnosis under review through that period and beyond.

Thimerosal, and therefore ethyl mercury, is suspected of causing ASD. If this is the case, the study period being for children born between 1988 and 1996 includes children born between 1988 and 1992 who may have received MMR vaccine, and up to 150ug mercury in scheduled DTP (3 doses of 25ug in first year of life) and Japanese Encephalitis (JE) vaccines (3 doses of 25ug between 3 and 4 years of age), whereas those born between 1993 and 1996 would be likely to have received monovalent vaccines and no MMR (banned in April 1993) vaccine plus a potential for up to 75 ug mercury as they would not have attained the age for JE vaccination (3 to 4 years of age) before study end 1996.

Also statistics show there was considerable parental concern over MMR vaccines prior to withdrawal as uptake dropped from almost 70% in 1988 to 1.8% in 1992 – and some parents may have become suspicious of other vaccines during the study period confusing the study outcome.

In addition to ethyl mercury there are other potential agents of cause of ASDs and other adverse effects within the MMR and M, M and R vaccines. They range from the attenuated viruses themselves (measles virus was found in autists and not controls by Singh et al and Wakefield et al; MMR vaccine virus was found in the brains of autists and not controls by Singh et al; rubella virus has long been associated as congenital rubella with autism) and adjuvants such as neomycin (2) which is a highly toxic antibiotic and gelatine (3) which has caused anaphylaxis after MMR vaccination. If MMR and monovalent vaccines cause ASDs the constituents must be investigated and adjuvants might feature more highly if, as Takahashi et al suggests, monovalent vaccines carry greater risk of causing ASD; each child may have received several monovalent jabs instead of a single MMR jab.

To complicate analysis further, the Japanese MMR vaccines used at the time of these studies were of different types and might present separate risks for causing ASDs. Kimura et al 1996 (4) shows that Standard MMR was associated with 16.6 cases of aseptic meningitis/10,000 recipients compared to Biken MMR which had 0 cases/10,000, Takeda MMR with 11.6/10,000 and Kitasato MMR with 3.2 cases/10,000 recipients of the vaccine. One might reasonably expect any risk of ASD to vary with vaccine type.

Rather than an uninterrupted increase in incidence of ASD from 1988 to 1996 as the conclusion suggests, the incidence varied considerably during the 8 years covered. The 47.6 (per 10,000) 1992-3 incidence almost returned when it dropped from 85.9/10,000 in 1990 back to 55.8 and 63.3 respectively in 1991 and 1992. In 1993 it jumps to 96.7, then to 161.3 in 1994, then falls back to settle at 115.3 and 117.2 in 1995 and 1996. I see no scientific merit in ignoring those considerations and concluding that a rise in incidence from 47.6 to 117.2 over 8 years when MMR was withdrawn in 1993 proves that MMR had no part to play in that increase. Important statistical variations may have been ignored. Children born between 1988 and 1992 might have lesser risk of ASD from MMR compared with monovalent vaccines but a greater risk from a potential 150ug mercury intake which contrasts with the 1993-96 cohort who may have realised a greater risk of ASD from the monovalent vaccines but a lesser risk of mercury-induced ASD from a lesser potential intake of 75ug mercury. Other vaccines carrying additional toxic burdens might add to the risk such as the 6 or more doses of neomycin injected via varicella, rubella, OPV, mumps and measles vaccines and 4 doses of gelatine injected with mumps, measles, rubella and varicella vaccines. These variables might eventually explain why Honda et al's incidence rate is not of constant increase.

Contrary to Cole's and Evan Harris's rather overenthusiastic acceptance of Honda et al 2005, when one considers both the Honda and Takahashi studies one must surely suspect that both MMR and monovalent/single antigen vaccines are probable causes of ASDs. If that is the case all haste is required from Members of Parliament and the Health Protection Agency to direct that identification of the risk posed by MMR and monovalent vaccines to our children is a national priority.
Regards, John H.

REFERENCES

1. "An epidemiological Study on Japanese Autism concerning Routine Childhood Immunisation History" by Takahashi H et al, Jpn. J. Infect. Dis 2003; 56: 114-117
2. Kwittken PL et al "MMR vaccine and neomycin allergy", American Journal of diseases of children 1993; 147(2): 128-9
3. Kelso JM et al "Anaphylaxis to measles mumps and rubella vaccine mediated by IgE to gelatine", Journal of Allergy & Clinical Immunology 1993; 91(4): 867-72
4. Kimura M et al "Adverse events associated with measles mumps and rubella (MMR) vaccines in Japan", Acta Paediatrica Japonica 1996; 38(3): 205-11

Competing interests: None declared

SCIENTIFIC ARGUMENTS

If you are particularly interested in some of the up-to-date scientific debates on vaccination I would highly recommend a visit to the British Medical Journal website:www.bmj.com Go to 'Rapid Responses'. If there are no vaccination articles listed, then do a 'Search'. In the last few months there have been some lengthy debates with some excellent responses, including those by Dr Viera Scheibner, John Heptonstall, Hilary Butler, Dr Jayne Donegan, and many others. And of course you may wish to participate yourself!!

INNATE & ADAPTIVE IMMUNITY

Nature Immunology 6, 17 - 21 (2005) Published online: 20 December 2004; | doi:10.1038/ni1153

'Innate and adaptive immunity: specificities and signaling hierarchies revisited.'

Eric Vivier & Bernard Malissen

Eric Vivier and Bernard Malissen are with the Centre d'Immunologie de Marseille-Luminy, INSERM-CNRS-Univ. Méditerranée, Campus de Luminy, case 906, 13288 Marseille Cedex 09, France.

vivier@ciml.univ-mrs.fr and bernardm@ciml.univ-mrs.fr

The conventional classification of known immune responses by specificity may need re-evaluation. The immune system can be classified into two subsystems: the innate and adaptive immune systems. In general, innate immunity is considered a nonspecific response, whereas the adaptive immune system is thought of as being very specific. In addition, the antigen receptors of the adaptive immune response are commonly viewed as 'master sensors' whose engagement dictates lymphocyte function. Here we propose that these ideas do not genuinely reflect the organization of immune responses and that they bias our view of immunity as well as our teaching of immunology. Indeed, the level of specificity and mode of signaling integration used by the main cellular participants in the adaptive and innate immune systems are more similar than previously appreciated. www.medscape.com/

PASTEUR'S NOTES

Brief extract taken from: *The Decline of Tuberculosis despite "Protective" Vaccination.* By Dr Gerhard Buchwald, English edition 2004.

'On 16 May 1995 the New York Times reported sensational discoveries in the diaries of Pasteur. After reviewing over 10,000 pages of Pasteur's diaries, Professor Dr Gerald L Geison of the Historical Institute at the University of Princeton, USA, reported that if the results of his experiments did not live up to his expectations, he modified his experiments until they provided the outcome desired to prove his ideas. This meant that Pasteur had deliberately falsified scientific experiments to suit his own purposes. Geison published his findings in his book "The Private Science of Louis Pasteur" (1995). In the New York Times article, Pasteur was referred to as "a liar and a crook." In the light of these discoveries it may yet turn out that the accepted theories about "immunity", "immune protection", "immune defence" and "antibodies", which are based on Pasteur's experiments, are based on false premises.'

CONJUGATE VACCINES GIVE RISE TO PENICILLIN-RESISTANT PNEUMOCOCCAL CLONES

NEW YORK (Reuters Health) 8/12/04 - In southern Israel, where antipneumococcal conjugate vaccines have not been introduced, researchers have documented the presence of penicillin-nonsusceptible non-vaccine type Streptococcus pneumoniae strains in children with acute otitis media.

Dr. Nurith Porat of Soroka University Medical Center in Beersheva, and colleagues, explain in the December 15th issue of The Journal of Infectious Diseases that after the introduction in 2000 of a pneumococcal conjugate vaccine, there was a shift toward carriage of pneumococcal strains that had not been included in the vaccine.

Dr. Porat's group used pulsed-field gel electrophoresis to analyze nasopharyngeal and middle ear isolates obtained from children in Israel between 1998 and 2003, and from children in Costa Rica between 1998 and 2001.

In the Israeli samples, all from children under the age of 5 years, the researchers studied 46 nasopharyngeal and middle ear fluid isolates expressing serotype 11A and 45 middle ear fluid isolates expressing serotype 15B/C. In addition, using middle ear fluid samples obtained from young children in Costa Rica, the researchers analyzed 57 isolates expressing serotype 19F.

Genotypic analyses of the Israeli samples revealed "two clusters expressing non-vaccine type serotypes with a genetic background closely related to that of two vaccine type clones," according to the article.

One was documented in a cluster of isolates expressing serotype 11A, and the other in a cluster of isolates expressing serotype 15B/C. Both clones were more common among Bedouin children than among Jewish children.

According to the article, the electrophoresis patterns of the first clone"were almost indistinguishable from those of the penicillin-resistant serotype 9V/14 international clone, which was first identified in Spain and France," and has become widely disseminated around the world. The pattern of the second clone was closely related to that of the serotype 19F clone recovered from the Costa Rican children.

"Penicillin-nonsusceptible pneumococcal clones of serotypes not related to those included in the 11-valent conjugate vaccines may derive from capsular transformation of vaccine-related serotypes," the authors speculate.

"This phenomenon, although seemingly rare at present, can have implications for the long-term effectiveness of the conjugate vaccines," they conclude.

J Infect Dis 2004;190:2154-2161.

BRIEF RESPONSE

I wrote to Aventis Pasteur MSD recently and asked them whether the new 5-in-one vaccine contained 2-phenoxyethanol, and what safety trials, short and long term, have demonstrated its safety in humans. Their reply, dated 27 Jan 2005, simply stated:

'Pediacel does contain 2-phenoxy-ethanol. This product has been widely used in pharmaceuticals, including vaccines, and cosmetics since the 1970s. Regulatory agencies do not license a particular preservative; rather, the vaccine containing that preservative is licensed, with safety and efficacy data generally being collected in the context of a license application for a particular vaccine.'

NURSES STILL 'SUSPICIOUS' OF MMR

http://www.nursingtimes.net
Nursing Times, 11 03 2005

The vast majority of nurses lack confidence in the measles, mumps and rubella (MMR) vaccine despite overwhelming evidence that it does not cause autism. In a poll of over 300 nurses conducted on nursingtimes.net, 94% said they were 'still suspicious' of MMR.

The results come as a leading academic today said the UK has 'all but lost the battle for MMR'.

Professor Paul Bellaby, writing in the British Medical Journal <http://bmj.bmjjournals.com/> blamed the lack of support for MMR on a failure of leadership by health professionals, lack of support from politicians, including the prime minister, and journalists who 'have more interest in amplifying risk than allaying public anxiety.'

Last week week a major Japanese study showed no link between the vaccine and childhood autism.

The research is the latest in a long line of studies which have failed to replicate or validate a paper published in The Lancet in 1998 suggesting the vaccine caused bowel disease and autism.

Up to that point, MMR vaccinations in the United Kingdom reached 92% of its targets. But by 2002, the United Kingdom lost considerable ground and coverage of MMR in London is around 75%.

FUTURE TALKS

Patrick Quanten, MD, *(see 'Virus' article overleaf)* will be available for presentations on his research as regards to health, germ theory, and the myths surrounding vaccination. I am looking to organise a talk in London and Brighton initially, so I would iike some feedback from you, as to the interest this will generate.

Talks could be arranged for June or early autumn, so please contact me soon if you are interested. Also, if you are interested in setting up a talk in your locality, please phone to discuss options. Thanks!

Contact Magda at T.I.P.:
01903 212969

INTRAMUSCULAR, NOT INTRAVENOUS

Some medical professionals will argue that vaccines are not injected intravenously so therefore do not enter the bloodstream. This issue was raised in one of the discussions featured on the www.bmj.com Rapid Responses. Here follows a response by Dr Viera Scheibner, 5th March, 2005.

'I have been following the polemic about whether vaccines are injected into the blood stream or not with great interest.

To take everybody out of their misery, according to Taber's Cyclopedic Medical Dictionary (14th Edition, 1981):

- Blood vessels = The veins, arteries and capillaries.
- Blood stream = The blood which flows through the circulatory system of an organism.
- Circulatory system = The cardio-vascular system consisting of the heart and the blood vessels (arteries, arterioles, capillaries, venules, veins, and sinuses) and the lymphatic system.
- Lymphatic system = That system including all structures involved in the conveyance of lymph from the tissues to the blood stream. It includes the lymph capillaries, lacteals, lymph nodes, lymph vessels, and main lymph duets (thoracic and right lymphatic duct)
- Lymphatic vessels = Thin-walled vessels conveying lymph from the tissues. They resemble veins in structure, possessing three layers: the intima, media, and adventitia. They possess paired valves.

The vaccines contents, whether injected into the muscles or subcutaneously, are picked up by the capillaries which carry the material into the larger blood vessels of the circulatory system and even into the lymphatic system. So, the contents of vaccines are introduced into the blood stream and the lymphatic system.

If in doubt, look it up in a dictionary.
Competing interests: None declared

ALUMINIUM?

Extract from. The Truth Behind The Vaccine Cover-up
By Russell Blaylock, MD. 2004
www.russellblaylockmd.com

Here are some of the neurological problems seen with the use of aluminium hydroxide and aluminium phosphate in vaccines. In two children aged three and five, doctors at the All Children's Hospital in St Petersburg, Florida, described chronic intestinal pseudo-obstruction, urinary retention and other findings indicative of a generalised loss of autonomic nervous system function (diffuse dysautonomia). The 3-year old had developmental delay and hypotonia (loss of muscle tone). A biopsy of the children's vaccine injection site disclosed elevated aluminium levels.

In a study of some 92 patients suffering from this emerging syndrome, 8 developed a full-blown demyelinating CNS disorder (multiple sclerosis) (Authier FJ, Cherin P et al, 'Central nervous system disease in patients with macrophagic myofasciitis,' Brain 2001; 124;974-983.) This included sensory and motor symptoms, visual loss, bladder dysfunction, cerebellar signs (loss of balance and co-ordination) and cognitive (thinking) and behavioural disorders.

Dr Gherardi, the French physician who first described the condition in 1998, has collected over 200 proven cases; in one third of these, the patients developed an autoimmune disease such as MS. Of critical importance is his finding that, even in the absence of obvious autoimmune disease, there is evidence of chronic immune stimulation caused by the injected aluminium - known to be a very powerful immune adjuvant.

The reason this is so important is that there is overwhelming evidence that chronic immune activation in the brain (activation of microglial cells in the brain) is a major cause of damage in numerous degenerative brain disorders, from multiple sclerosis to the classic neurodegenerative diseases (Alzheimer's disease, Parkinson's and ALS). In fact, I have presented evidence that chronic immune activation of CNS microglia is a major cause of autism, attention deficit disorder (ADD) and Gulf War syndrome.

Dr Gherardi emphasises that once the aluminium is injected into the muscle, the immune activation persists for years. In addition, we must consider the effect of the aluminium that travels to the brain itself. Numerous studies have shown harmful effects when aluminium accumulates in the brain. A growing amount of evidence points to high aluminium levels in the brain as a major contributor to Alzheimer's disease and possibly Parkinson's disease and ALS (Lou Gehrig's disease). This may also explain the 10x increase in Alzheimer's disease in those receiving the flu vaccine five years in a row (Dr Hugh Fudenberg, in press, Journal of Clinical Investigation). It is also interesting to note that a recent study found that aluminium phosphate produced 3x the blood level of aluminium, as did aluminium hydroxide (Flarend R E, Hem S L et al, 'In vivo absorption of aluminium-containing vaccine adjuvants using 26 Al,' Vaccine 1997;15:1314-1318).

VIRUSES

By Patrick Quanten, MD. Nov.2004

Let's start with a medically well-known fact: viruses aren't themselves alive. They are smaller and simpler than bacteria and by themselves they are inert and harmless. So, the immediate question then has to be: How can you "catch" a virus if it isn't a living thing? The answer is: You can't.

Experimenters have incubated viruses for the common cold, placed them directly on the mucous lining of the nose, and found that their subjects came down with colds only 12% of the time. These odds could not be increased by exposing the subjects to cold drafts, putting their feet in ice water to give them chills, or anything else that was purely physical.

Swine flu (viral infection) arose as a normal, non-lethal flu in the spring of 1918, but somehow, over the following months, it mutated into something more severe. In an attempt to devise a vaccine, medical authorities conducted experiments on volunteers at a military prison on Deer Island in Boston Harbour. The prisoners were promised pardon if they survived a battery of tests. These tests were rigorous to say the least. First, the subjects were injected with infected lung tissue taken from the dead and then sprayed in the eyes, nose and mouth with infectious aerosols. If they still failed to succumb, they had their throats swabbed with discharges taken from the sick and dying. If all else failed, they were required to sit open-mouthed while a gravely ill victim was sat up slightly and made to cough into their faces. The doctors chose sixty-two of the volunteers for the tests. None contracted the flu, not one. The only person who did grow ill was the ward doctor, who swiftly died.

One of the mysteries of viral epidemics is how it can erupt suddenly all over, in places separated by oceans, mountain ranges and other earthly impediments. Although a virus is not alive in itself, it also loses its potential of hijacking the genetic material of a living host cell within a few hours of being outside the host body. The commonly heard answer that it travels in "carriers" (people who have no symptoms but carry and distribute the virus) cannot be proven and after decades of using it as "the" explanation remains nothing more than a shaky and desperate theory. It is made even more unlikely in the light of the fact that you cannot catch a viral infection, as proven above, so even if it did travel that way, how would it "jump" from the carrier to the victim? Furthermore, how does a virus manage to lie low for several months, in the case of HIV or variant CJD we are to believe it can be up to 20 years, before erupting so explosively at more or less the same time all over? What's the trigger and why instantaneously in all those different places?

Some of these viral epidemics have been known to be more devastating to people in their prime rather than infants and the elderly, who are more likely to have a more vulnerable immune system. Strange, to say the least.

From time to time certain strains of virus return. A disagreeable Russian virus known as H1N1 caused severe outbreaks over wide areas in 1933, then
again in the 1950s and again in the 1970s. Where it went in the meantime each time is uncertain. Could it have survived, lying "dormant", in humans or animals for all that time? This raises the same old two questions: Why did it not cause any symptoms wherever it was hiding? and if it was hiding somewhere, how did it spread so quickly when it did, as you can't catch it - not from a human, not from an animal?

What do we know about Viruses?

We have already mentioned that they are very small, and they weren't detected until 1943 with the invention of the electron microscope. Many, including HIV, have ten or fewer genes, whereas the simplest bacteria require several thousand. To create a living thing you need properly organised DNA of a substantial quantity, which the virus hasn't got.

We define "a living organism" as something that performs three tasks in succession: taking in stuff (eating, breathing), metabolising stuff (digesting, absorbing), and excreting waste. A fourth necessary task is reproduction. A virus doesn't do any of these. No virus does. Within the viral capsule there are no other structures that are required for a metabolic process. There is no activity at all inside the viral capsule. Not only doesn't it look structurally as if its alive, it also isn't alive in physiological terms.

So what is it then? As we all know, viruses can have devastating effects on the health of plants, animals - great and small, including bacteria - and humans. How does it produce these effects, if it is not alive, can't be caught and doesn't reproduce? Known scientific facts about viruses and the way they function are obtained from chemical analysis and looking at still pictures from electron microscopes. The story is pieced together, not actually observed! This means that what you are told happens, is actually a theory at best, and a fantasy story at worst.

What has actually, in simple terms, been discovered?

- Viruses contain either RNA or DNA, a small amount and mostly one or the other, but there are exceptions. Bits of genetic material of whatever kind, really; but only bits.
- Viruses are marked species and organ specific, and on the whole, viruses infecting plants, insects, rickettsiae, bacteria and other animals are distinct from their human counterparts, but this is now thought not to be entirely the case. They are specific, but then again they are not.
- Viruses may be naked with the genome only protected by a protein capsid, or they may have a lipid envelope surrounding the capsid. Bits of genetic material in a thin simple bag, and sometimes put in a fatty bubble.
- Viruses are seen to be "encapsulated" by the body cells that have specific receptors for the virus. Once inside the cell, it seems that the virus capsule is removed and the exposed bit of DNA or RNA is "read" and the host cell seems to duplicate it. These bits of genetic materials are encapsulated once again, and with the host cell bursting with complete viruses it will explode and the viruses are spilled into the cellular surroundings. So, we see a lot of genetic bits within the cell; these bits are then encapsulated and

eventually the cell burst open to release the now bagged up genetic material into the cellular environment.

• Viruses in the intercellular environment are engulfed by cells from the immune system (macrophages and lymphocytes), which collect them and destroy them. These bags that contain bits of genetic material are collected into cells from the immune system.

• Viruses are very difficult to demonstrate (they are extremely small) and the diagnosis of viral infection is mostly made on clinical symptoms alone and the assumption that it fits into a known disease pattern for which there is no causative factor known. Virtually every time a diagnosis of viral infection is pronounced no proof is offered for this diagnosis.

• Materials for virus isolation must be obtained as early as possible during illness. It is at the very early stages of the illness that the highest titres are found and the most likely it is one can produce a positive test result. There are more viruses present right at the beginning of the illness than at any other stage of the disease process. If the viruses were multiplying you would expect the number to rise as the disease developed.

•Identification of viruses is done in laboratories by measuring the level of antibodies against specific viruses, not by measuring or demonstrating the virus itself. Measuring a higher protection level is diagnosed as the illness itself!

Summarising this scientific knowledge, we can say that viral infections are not diagnosed by finding the specific virus, but by guessing a virus is the cause of the symptoms. In practical terms, this happens when the doctor doesn't really know what the cause is.

As regards the story of the viral infection is concerned, we now know that as soon as the symptoms start the number of viruses will very quickly be dramatically reduced. There is no evidence of rapid number proliferation once the disease manifests itself.

Before we move on to explain the real virus story, it is worthwhile to remind ourselves of what we now know:

•A virus is not alive.

•You cannot catch a virus.

• A virus disintegrates very quickly outside the host.

•A virus consists of small bits of genetic material, variable from virus to virus, surrounded by a thin coating, either protein (water-soluble) or fat.

•Viral materials are seen in large numbers inside the host cell.

•A full host cell breaks open and the viruses are spilled into the environment.

•In the environment the viruses are bagged up by the cells of the immune system (See "The Inflammation Process", available on: www.activehealthcare.co.uk).

THE VIRUS STORY

If viruses are not living things they cannot multiplicate and they don't need a specific environment to "survive". They cannot appear from nowhere and they can't spread and infect other cells. When a cell becomes diseased and the function of the cell begins to falter, it may start to come apart at the seams. Bits of its essential structure, the DNA and RNA, may become detached as it is falling apart. The cell will try and clean up these bits by preparing them for the rubbish bin. The small pieces of genetic material, which are now floating around in the intracellular fluid, will be isolated by means of encapsulating them. As the cellular disintegration continues more and more of these bits are seen inside the cell and more and more small "bags" of useless genetic material will appear. Once the cell is totally dysfunctional and filled with rubbish the cellular wall itself bursts and the contents will be spilled into the cellular environment. Here, the clean-up continues by packaging these small bags up even further into what has been called the lymphocytes and macrophages of the immune system. These large vesicles now drift away into the lymphatic fluid and the blood stream, from where they will be filtered out at appropriate draining stations, like the spleen and the lymph nodes.

This process continues until the whole lot has been cleared. This explains why the numbers of "viruses" is the highest at the very beginning of the disease and continues to decline steadily throughout the disease process, even without treatment. This also accounts for the thousands and thousands of different "viruses" that have been identified and for the "mutation" of viruses. Viral behaviour is essentially totally unpredictable because the cells and the way they disintegrate is never the same, not because this is an animal that changes its behaviour so quickly and intelligently that nothing can keep up with it. It also does away with the idea that the "virus" can lay dormant for an indefinite period of time and become activated without any triggers or reasons having been identified.

How do we then explain "viral epidemics"? Why is it then that we get a cold the day after someone in the office starts to cough and sneeze a lot?

The medical profession knows that viruses have incubation periods. These are said to vary from virus to virus from a few days to several years. A cold virus has an average incubation period of about a week. Now, first of all, you can't catch a virus; and secondly, if you could catch the cold virus, it would take a week before it had established itself within your body and starts to show symptoms. Consequently, your cold cannot have been caused by the other person's cold in the office the day before!

What is seen and has been named "a virus" starts after the cellular structure begins to disintegrate. Why does a cell start to fall apart?

Because it is diseased. The disease is already there, long before any viral particles show up in any pictures. So, then we have to ask the question why the cell has become diseased? The answer to this lies in the build-up of toxic material within the cellular structure. As the cell gets loaded up with inappropriate material it will eventually be unable to cope and it will start to fall to pieces. It is exactly those pieces that are photographed by the electron microscope and have been named "viruses". The influences that can lead to an increased pressure on the system are many and are varied. They range from the weather, to living and working environment, to life style and diet, to the balance of activity and rest, to mental balance, stress and worries. Because a lot of these influences, such as working conditions and the weather,

are general circumstances which affect all of us, it is very likely that a great number of us, in the same environment, will fall ill at or around the same time, succumbing to the environmental influences. Add to this that people who are working in the same environment are very likely to have similar life styles and another factor has been identified explaining why similar disease pattern occur within certain groups of people at certain times. On top of that, we now know that worry reduces our immunity capacity and increases the likelihood of illness. The belief that, if one person close to you has a cold you are going to get it, increases the likelihood of this actually happening dramatically, as you become more vulnerable through the immune reducing effect of the worry itself.

Epidemics occur because people in similar circumstances, living environments and conditions, have similar imbalances within their systems, leading directly to similar disease patterns. This causes fear and apprehension all around them, making others more vulnerable to start showing a breakdown of health themselves. The disease is spreading. More accurately, the fear of the disease is spreading first, resulting in a lowered resistance, which allows each individual's imbalances to show up through the inability to cope with the problems the system has already been faced with for a long time. More and more people are becoming ill and showing signs of the fact that their bodies have been under extreme pressure for quite a while to maintain health. The showing of an illness is the end result of a long process, even an "acute" illness, of a slow deterioration of the system's normal functioning. Disease is a process, not a state of being.

It is time to learn the facts of life. It is time to do away with ignorance and the resulting fear. It is time to focus on individual health and the factors that influence it.

Viruses are dead, but diseases are very much alive. Let's concentrate on the living, not the dead, if we want to be healthy.

ahcare.qua@virgin.net
www.activehealthcare.co.uk

PERTUSSIS VACCINE FOR ADOLESCENTS?

From: http://www.idinchildren.com/
Pertussis vaccine for adolescents?
The benefits an adolescent booster program would provide are debatable.
by Philip A. Brunell, MD,
Chief Medical Editor. February 2005

There has been increased interest here in the United States in immunization of adolescents against pertussis. The impetus for this has been the increase in the number of cases of pertussis reported in the past decade in this age group. In addition to the morbidity pertussis produces in adolescents and is projected to cause even in older individuals (Clin Infect Dis. 2004;39:20), it also is a source of infection for younger children and infants (JAMA. 2003;290:2968). There also has been an increase in cases in the first year of life, when the risk of death or hospitalization is greatest (JAMA. 2003;290:2968). It is postulated that increasing immunity of potential mothers may confer protection on their newborns, which might prevent pertussis in those too young to be immunized. During the 1990s, the rates of pertussis in those younger than 2 months of age increased from 72 to 107 per 100,000, and for those younger than 4 months, from 63 to 89 per 100,000 as compared with the rates in the '80s.
The number of deaths during the two decades increased from 61 to 93 per 100,000 (JAMA. 2003;290:2968).

THE HAWTHORNE EFFECT

However, there are some that question what would be gained by an adolescent immunization program (Clin Infect Dis. 2004;39:29). Even if it were found to have merit, there would be major hurdles to surmount in implementing it given the difficulty in accessing this group. Although the increase in pertussis in the newborn is credible, there is some concern about the reported rise in cases in the older groups.

Both figures may have increased by the 'Hawthorne effect,' ie, when you measure something you influence the results. As we are told the problem is getting worse, we start looking for cases. The number of cultures for pertussis obtained within 10 days of onset rose from 40% to 78% between 1994 and 1996 in the state of Massachusetts (J Infect Dis. 1999; 28: 1230).

To what extent of these increases represent a Hawthorne effect is difficult to discern. One might simply compare the rates of infection by testing sera collected from adults at the present time and a similar group collected 10 or 20 years ago. That is, if one knows what to measure. Many would choose antibody against pertussis toxin, which apparently is less likely to result from cross-reacting antibody from related bacteria and has a shorter half-life than some of the other pertussis antibodies (Vaccine. 2003,21:3442)(J Infect Dis. 2004; 190:535).

Neither the CDC nor the World Health Organization accepts any serologic test as acceptable criterion for confirming the diagnosis of pertussis. It is likely that some of the apparent increase in cases, particularly in older individuals, may be due to the increased popularity of serologic tests.

It is likely that some of the apparent increase in cases, particularly in older individuals, from whom isolation of the organism is more difficult, may be due to the increased popularity of serologic tests. These have become more popular coincident with the rise in incidence during the past decade. The increase in reported cases in older individuals has been weighted by the reporting from a few states, at least one of which has relied heavily on serologic diagnosis (J Infect Dis. 1999;28:1230).

Despite the caveat about relying on antibody measurements, some have used these to promote particular pertussis vaccines over others. The FDA, in a letter to all vaccine manufacturers in 1998, has warned that there are 'no clinical data on file that would support any claim or suggestion of clinical superiority or benefit regarding the numbers of combinations of pertussis antigens contained in the DTaP vaccines.' Serologic data have been used to support the use of booster doses in adolescents (J Inf Dis.2004;190:535) although the licensure of the acellular pertussis vaccines had been based on clinical trials because of the lack of serologic correlates of protection. Several other countries have adolescent pertussis immunization programs, and perhaps, it would be prudent to just wait and see what is accomplished in these countries.

HOW MUCH PROTECTION?

It is unclear if protection would be conferred on adolescent vaccinees or the duration of such protection and how much would be conferred on their babies. Based on serologic studies, it is estimated that immunoglobulin G (IgG) antibody will remain 'above threshold'

for four to 13 years. It appears, however, that this 'threshold' is defined as 'the lower limit of the precision of the assay' rather than the protective titer (J Infect Dis. 2004;190:535). IgG antibody is transmitted to infants, but how much protection this would confer in actual terms, given the uncertainty about the protective effects of various antibodies, the persistence of passively acquired antibody and the levels of maternal antibody at the time of gestation, are all unknown. *(Our emphasis)*

It is important that we address the problem of adolescent health care. There are vaccines that may be useful in this group, including those against meningococci, human papillomaviruses and pertussis. Immunization of babies has been credited by some as bringing them into the medical care system, and perhaps, this can be accomplished for adolescents. We certainly can do a better job of addressing the health problems of this group than we are doing at the present time. Finally, it may be a propitious time for vaccine producers to develop a better pertussis vaccine than we now have rather than trying to repackage the existing vaccine. Of the components of diphtheria-tetanus-pertussis vaccine, the latter has done the least to eliminate disease. Alternative approaches using existing vaccines, eg immunization of adolescents, pregnant woman or newborns, have their proponents, but all have significant drawbacks.

For more information:

Purdy KW, Hay JW, Botteman MF, Ward JI. Evaluation of strategies for use of acellular pertussis vaccine in adolescents and adults: a cost-benefit analysis. Clin Infect Dis. 2004;39:20-28.

Tanaka M, Vitek CR, Pascual FB. Trends in pertussis among infants in the United States, 1980-1999. JAMA. 2003;290:2968-2975.

Balcewicz-Sablinska MK, Gan H, Remold HG. Interleukin 10 produced by macrophages inoculated with Mycobacterium avium attenuates mycobacteria-induced apoptosis by reduction of TNF-alpha activity. J Infect Dis. 1999;180:1230-1237.

Vandelaer J, Birmingham M, Gasse F, et al. Tetanus in developing countries: an update on the Maternal and Neonatal Tetanus Elimination Initiative. Vaccine. 2003;21:3442-3445.

Le T, Cherry JD, Chang SJ, et al. Immune responses and antibody decay after immunization of adolescents and adults with an acellular pertussis vaccine: the APERT Study. J Infect Dis. 2004;190:535-544.

RISE IN WHOOPING COUGH CASES OPENS NEW MARKET FOR VACCINES

From: investors.com 28/03/2005

By Amy Reeves. Investor's Business Daily *(Underlining our emphasis.)*

You probably don't remember getting your whooping-cough shot, since most are given to folks when they're still babies. That might soon change.

On March 18 a Food and Drug Administration advisory panel recommended approval of two whooping-cough booster shots for adults. The shots, designed to support the initial infant one, are GlaxoSmith-Kline's (GSK) Boostrix and Sanofi-Aventis' (SNY) Adacel. Both are weakened and slightly altered forms of the basic infant formula. The FDA usually follows its panels' advice, so the drugs likely will get cleared in early May.

RISING CASELOAD

Whooping cough, or pertussis, has long been considered a relic of a lost age of child mortality. That's no longer the case. Last year the number of U.S. cases rose 40% from 2003 to 19,000, according to the Centers for Disease Control. That's almost double the 2002 number and a 40-year high.

Scientists have found that the infant vaccine wears off after about 10 years. The disease rarely kills teenagers and adults, who often just think they have a bad flu.

As the name implies, the main symptom is coughing, with a characteristic "whoop" sound as the patient struggles to inhale.

The main concern is young adults can transmit the disease to unvaccinated infants and elderly folks. That could be fatal. Those with weaker constitutions can suffer vomiting, hernias and even broken ribs from the coughing. They might also develop seizures and pneumonia as the disease drags on.

ADOLESCENT FOCUS

39 percent of new cases last year appeared in teenagers. That's why Boostrix combines the pertussis vaccine with the usual booster for tetanus and diphtheria that kids receive in their early teens.

"We focused on adolescents because that's where we saw the biggest increase in the disease," said Glaxo spokeswoman Amanda Foley. "It makes sense to add that (pertussis) component to that standard vaccine so it works without additional shots." Because of this focus, Glaxo tested Boostrix only on kids ages 10 to 18, and the FDA recommended approval only for that age group.

Sanofi, which got into the vaccine business when it bought Aventis last year, is more ambitious. Adacel, which also combines a tetanus, diphtheria and pertussis booster, has been tested on ages 11 to 64 and would be approved for that entire range.

"Eventually we'll see that vaccine, in the U.S., will replace the traditional TD booster shot," said Phil Hosbach, vice president of immunization policy at Sanofi Pasteur, Sanofi's vaccine division. Glaxo's Foley won't say whether her employer will seek wider age approval for Boostrix. She does say that immunizing teenagers alone could prevent as many as 1.8 million cases over the next 10 years. Glaxo has the head start abroad. Boostrix is being used in 42 countries; Adacel has been launched only in Canada and Germany.

VOLUME, VOLUME, VOLUME

Vaccines don't get the sort of attention on Wall Street that the next big cholesterol buster or sexual-performance drug gets. The basic vaccines have been around for decades and have changed little, so no one expects explosive growth. Still, vaccines have certain advantages over their flashier rivals. One is volume. Almost everybody in the Western world gets vaccines, and a growing number in the developing world receives them as well. Vaccines face little generic competition because of the complexity of making them. Sanofi and Glaxo, along with Merck (MRK) and Wyeth, (WYE) pretty much control the field.

The global market runs at $9 billion annually, with $3 billion of that in the U.S.

Since vaccines are designed to ensure that nothing happens to the patient, they can't be marketed quite the same way as drugs whose benefits people can actually feel.

Hosbach and Foley say they're keeping an eye on the CDC's Advisory Committee on Immunization Practices (ACIP), which has convened a working group on the pertussis problem.

"Recommendations from advisory bodies like ACIP help in the education process and help instruct physicians on where the vaccines are to be utilized," Hosbach said. ACIP has said in public statements that it will wait and see if the FDA approves the boosters before recommending who should receive them, and how often.

ANNUAL BOOSTERS UNJUSTIFIED

From: Dogworld, 29/10/04

Annual booster vaccinations can no longer be justified, according to a senior vet.

Dr Hal Thompson of Glasgow Veterinary School, who presented the 'case for change' at the British Veterinary Association's (BVA) recent congress, said the profession could not wait for 'experimental evidence' before changing vaccination intervals.

When the necessary evidence was to hand, he said, he believed it would support lengthening the intervals at which dogs and cats were vaccinated.

As fully reported in The Veterinary Record. Dr Thompson said it was difficult to obtain evidence on how long an animal's protection would last after vaccination takes place, not least because of the animal welfare implications of long-term studies. He said there was evidence to suggest that antibodies persisted in vaccinated dogs for several years.

He suggested it was essential to vaccinate puppies at eight and 12 weeks and for them to receive a booster at 12 months. After that it 'is going to be a three year interval.'

'That's what's going to happen, whether we like it or not," he said at the London congress. "We may fight and we may scream but, mark my words, that's the way it's going to go."

Pressure on the profession to address the growing storm of debate around vaccination has increased since a group of vets called for a cessation of the annual vaccination policy back in March this year (2004), as highlighted in Dog World. The group suggested boosters should be given every three years and that promoting annual vaccination allegedly constituted fraud and theft.

Introducing the congress debate, 'Vaccination: who are we protecting?', past-president Peter Jinman said public concern about the subject was evident and that clients at veterinary surgeries were asking questions. Vets had a duty to get the right message across the rights way, he said.

Professor Quintin McKellar said that vaccines had been very successful in controlling disease but there had been occasional safety concerns about them; recent fears had focused on whether animals were being vaccinated too frequently. However, a Veterinary Products Committee (VPC) working group had found very low incidence of adverse reactions in dogs and cats.

The group had concluded that although there was evidence of a longer duration of immunity than the year cited on product literature, there was insufficient information to suggest any other interval.

Dr Bonnie Beaver, president of the American Veterinary Medical Association, told those present that changes had already been made to vaccinate protocols in her country. After the booster at 12 months, animals were inoculated again three years later.

VPC chairman David Skilton said it was important that vets reported any problems with vaccines. Speakers agreed that more evidence regarding the prevalence of disease and the persistence of immunity was needed.

Professor McKellar drew attention to the VPC working group's recommendation that product literature should state the need for vets- in conjunction with owners-to carry out a risk assessment on each animal with regard to the necessity and frequency of boosters.

U.S. STUDY CONFIRMS BOWEL DISEASE FINDINGS IN CHILDREN WITH AUTISM

From: Neuropsychobiology. 2005 Feb 28;51(2):77-85
Dysregulated Innate Immune Responses in Young Children with Autism Spectrum Disorders: Their Relationship to Gastrointestinal Symptoms and Dietary Intervention.
Jyonouchi H, Geng L, Ruby A, Zimmerman-Bier B. Department of Pediatrics, New Jersey Medical School, UMDNJ, Newark, N.J., USA.

Autism researchers at the University of New Jersey Medical School in the US have confirmed the original findings of researchers from the UK, by finding evidence of marked inflammatory and immune abnormalities in children with autism associated with gastrointestinal symptoms.

The study compared the production of inflammatory and anti-inflammatory molecules by immune cells in autistic children on unrestricted (n = 100) or elimination (n = 77) diets with developmentally normal children with non-allergic food hypersensitivity on unrestricted (n = 14) or elimination (n = 16) diets, and healthy typically developing children.

In response to challenge with bacterial toxins or dietary proteins from cow's milk, immune cells from autistic children with bowel symptoms showed a strong pro-inflammatory response and a reduced ability to switch off immune system activity compared with the other children.

The authors conclude that the findings indicate intrinsic defects of these immune responses in autistic children with intestinal problems, suggesting a possible link between gastrointestinal and behavioral symptoms mediated by immune abnormalities.

Dr Wakefield who led the team that first described intestinal disease in UK children with autism and demonstrated very similar immune abnormalities to those described by the New Jersey researchers in this group of patients, now heads up 'Thoughtful House Center for Children' in Austin, Texas. Dr Wakefield confirmed the importance of these new findings and stressed their potential for increasing our understanding the role of gastrointestinal inflammation in the behavioural symptoms in children with developmental disorders such as autism.

Thoughtful House in a not-for-profit organization dedicated to recovering children with developmental disorders through a unique combination of state of the art medical care, education and research.

PASTEUR'S RABIES VACCINE

Short extract taken from: The Decline of Tuberculosis despite "Protective" Vaccination. *By Dr Gerhard Buchwald,* English edition 2004. Page 49.

'Then he (Pasteur) produced a vaccine against rabies. He had used weakened germs he had removed from the spinal cords of infected animals. By means of several laboratory experiments he had successfully tested the vaccine on dogs.

On 6 July 1885 he used the vaccine on the nine-year-old Joseph Meister who 48 hours earlier had received 14 bites from a rabid dog. Pasteur began his treatment with a suspension prepared from spinal marrow which had been dried for 14 days, followed by a suspension prepared from spinal marrow of lesser virulence. The vaccine was injected under the abdominal skin. The last injection was carried out with spinal marrow which had been dried for three days. The boy remained healthy. Pasteur's resulting fame was greater than the combined fame of all previous occasions.

When another boy who had been severely bitten did not become ill and of 19 Russian peasants who had been attacked by rabid dogs, and 16 were returned to health after receiving Pasteur's vaccine, France was ecstatic. The Academy of Science unanimously decided to found an institute in honour of Pasteur. The "Institute Pasteur" was opened on 14 November, 1888.

The following quote may help to create a more realistic portrayal of Pasteur than the glorified image usually provided by medical historians:

On page 193 of his book "The Naked Empress" Hans Ruesch has this to say concerning the 16 Russian peasants saved by Pasteur's vaccine:

"Sixteen of these Russian peasants were 'saved' by Pasteur's vaccine and 'only three' died. Pasteur became an international celebrity after his heroic deed and contributed considerably to the glorification of 'modern' laboratory science. Three deaths of nineteen - this means about a 14% mortality rate. Because today we know that of a hundred people bitten by a rabid animal less than one person becomes infected on average, it has to be assumed that at least two, but probably all three of the Russian peasants died as a result of Pasteur's vaccination just as countless people died from the vaccine after them. Also, in Russia it was not possible at that time to find out whether a wolf was rabid. It often happened that hungry wolves attacked villagers in winter and even today many people, e.g. in Italy, believe that every dog which bites a human must be rabid as otherwise it would not have been brave enough to bite."

PNEUMOCOCCAL VACCINE SET TO CUT RESISTANCE

Pulse: 12 March 2005

Introducing the pneumococcal vaccine to the UK childhood schedule is likely to cut the rates of antibiotic resistance dramatically, new research suggests.

US researchers recorded a sharp decline in infections with resistant bacteria after the vaccine was introduced in 2000. They concluded vaccination could be a powerful strategy for combating resistance.

In the UK Government advisers have welcomed the findings, which come as the NHS prepares to introduce the vaccine to the childhood schedule in the next two years. Researchers from Emory University Hospital in Florida traced cases of macrolide resistance in Streptococcus pneumoniae before and after introduction of the pneumococcal conjugate vaccine in children.

Cases of resistance rose prior to the vaccine's introduction but dropped sharply afterwards, from 9.3 per 100,000 population in 1999 to 2.9 per 100,000 in 2002. Study leader Professor David Stephens said the fall in resistance had occurred because the decline in pneumoccal disease had reduced the potential for transmission.

Dr David Livermore, a member of the Government's standing advisory committee on antimicrobial resistance, said giving pneumococcal vaccine to children in the UK could have a 'positive effect'.

Editor: There's always yet another bacteria to wipe out, and a vaccine to 'protect' our children with. I can only repeat the obvious.....why are children so much more susceptible to all these things now? Bacteria that is harmless in healthy individuals does not just randomly strike, the right conditions within the body have to be in place, ie unhealthy internal chemistry.

"FLU VACCINE SAFE FOR INFANTS, BUT MONITORING NEEDED"

Reuters Health Information Services (www.reutershealth.com 9/2/05

Data collected between 1990 and 2003 from the Vaccine Adverse Event Reporting System suggest that the trivalent influenza vaccine is safe for infants and toddlers under two years of age, but officials from the U.S. Food and Drug Administration (FDA) say children should continue to be monitored for some of the more severe adverse reactions, such as seizure.

In a report published in the journal Pediatrics, Dr. Ann W. McMahon and colleagues from the FDA's Center for Biologics Evaluation and Research evaluated data on adverse reactions to the influenza vaccine reported both before and after the Advisory Committee on Immunization Practices began encouraging vaccination for healthy infants; the committee now recommends universal vaccination for healthy infants six to 23 months of age. A total of 166 adverse events associated with vaccination were reported among this age group between 1990 and 2003, with the most common side effects being fever, rash, seizure, and injection site reaction. Though the majority of the seizures were combined with fever, and fever-related seizures are not always linked to vaccination, McMahon and colleagues recommend that infants who receive the trivalent influenza vaccine be monitored for this serious adverse reaction.

Editor: Universal flu jab for healthy infants? Healthy infants should not develop flu in the first place. Vaccinating groups that are not likely to develop the flu in the first place, and then claiming that the flu vaccine protected them is a very convenient way to mislead the masses.

If it is becoming common then then we must ask 'why are infants becoming more susceptible to flu?' Could it be anything to do with all the other vaccines they receive in their early lives, resulting in a skewed immune system? I guess that once the latest 5-in-one vaccine is accepted, alongside creating a sufficient amount of fear about other infections, then vaccines, such as the one for flu, will be introduced.

VACCINATION AND THE STATE

The above is the title of a paper by Arnold Lupton, MP, which was presented on December 10, 1906 held at the National Liberal Club Political and Economic Circle.

On reading the text it struck me how many of the comments and observations are greatly similar to the present situation, just the disease in question has altered. There is an enormous wealth of information coming from publications from the 1800s and early 1900s, and so I intend to publish extracts regularly from the archives, as it is not always easy to come by these texts.

Here follows just a few extracts from Lupton's 84-page booklet, which you may find of particular interest:

STRANGE INSISTENCE ON VACCINATION (page5)

What is the reason for this extraordinary insistence on vaccination or small-pox for every child, and for every soldier, sailor, civil servant, or school teacher? The supposition underlying this requirement are 1) that a person who has once had either vaccinia or smallpox cannot afterwards be attacked by smallpox; 2) that universal vaccination is a smaller evil than periodical outbreaks of natural smallpox; and 3) that it is right, necessary and proper for the State to impose the supposed smaller evil on the community in order to protect it from the greater scourge. Not one of these positions can be maintained.

ONCE VACCINATED ALWAYS SAFE?

The fact that the law, when framed, only insisted upon one vaccination, and that it exempted people who had already had smallpox, is sufficient proof in itself of the original assumption on which it was passed. This was that once you had got smallpox over, you were done with it; that one attack of smallpox protected against another. One vaccination or one attack of smallpox was, and up till this day it is, all that the law asks. During the last epidemic in London, however, all the machinery of Government was in use to put pressure on people through their employers to be re-vaccinated..... I repeat that the law rests on the false assumption that one vaccination or one attack of smallpox protected against another, and so was likely to free the country from smallpox altogether. We do not need to be told that this assumption was wrong. The very demand for re-vaccination, the endeavour of the Imperial Vaccination League to get a Re-vaccination Law passed, will save us the trouble of further considering that point. Both vaccinators and anti-vaccinators are agreed that there may be second attacks of smallpox, and that one vaccination is, in any case, of no use.

PRIMARY VACCINATION ADMITTED TO BE A FARCE. (page 6.)

The Right Hon. Walter Long, MP on January 14, 1903, received a deputation in favour of compulsory re-vaccination on the ground of the inefficiency of the prevailing system of primary vaccination. Mr Long, in replying, said: "As to re-vaccination, he agreed with the remark made by Dr McVail, and emphasised by him in a very interesting article, which he had had the advantage of reading within the last day or two, that primary vaccination, of itself, was really almost a farce. To vaccinate children, and then to believe that everything had been done that was necessary in order to secure the proper effects of vaccination, was almost a farce, and was really almost a deception. It would be a great advantage if a well-considered system of re-vaccination at certain ages could be devised..... Vaccination in infancy, unless it were repeated at proper intervals was not a certain safeguard....."

.....Let us see how this confession of the inefficacy of one vaccination affects the second assumption of the law - the assumption that universal vaccination would be a smaller evil than periodical outbreaks of natural smallpox. It must now be observed that it is not one universal vaccination that is in question. It is universal vaccination frequently repeated, and nobody can be got to say definitely how frequently. The majority of the last Royal Commission on Vaccination thought parents ought to be warned to have their children re-vaccinated not later than at the age of 12 years. That recommendation is already quite out of date. The Imperial Vaccination League and Jenner Society found that interval dangerously long, and sought to reduce it to 7 years, by having the first vaccination at the age of 5 or 6 on condition of having another at 12, that is to say, an interval of only six or seven years. Others prefer a quinquennial vaccination; and I think all the pro-vaccinators recommend re-vaccination again, unless it has been done within six months, when you are face to face with an epidemic. So the protection against smallpox is no longer promised at the cost of one universal vaccination. The price to be paid is a frequently, almost perpetually recurring re-vaccination. Is it possible that anyone can seriously maintain that this would be a smaller evil than an occasional outbreak of natural smallpox? After all, vaccination is a disease, and those who promote it have recently warned practitioners against regarding it as a trivial operation. Even applied to infants only, it means, in a country where the births are about 900,000 a year, a vast amount of continually and deliberately inflicted temporary illness in the infantile population followed much oftener than is supposed by permanent injury and death. Re-vaccination every 5 years would cause at least 40 times the amount of illness that was due to smallpox before the compulsory vaccination law. By way of reconciling the public to this, it is usual to draw lurid pictures of the smallpox scourge in pre-vaccination days, and to suggest that the difference between smallpox then and smallpox now is due to vaccination. It is a false suggestion and a false contrast. It is no more fair to take the heavy death-rate in London from smallpox for 20 years preceding vaccination as a criterion of what it would be now without vaccination, than it would be fair to take the eighteenth century deaths from plague as likely to recur when vaccination is abolished. It is not only the different sanitary conditions that have to be taken into account. It is the treatment of smallpox itself, the measures, apart altogether from vaccination, for dealing with it

and controlling it when it appears, and above all the avoidance of the wilful spread of smallpox, in the hope of combating its terrors.....

VACCINATION USELESS. (page 13.)

"That vaccination is capable of extirpating the disease or of controlling epidemic waves is," says Crookshank, "absolutely negatived by the epidemic in 1825, and the epidemics which followed in quick succession in 1838, 1840, 1841, 1844-5, 1848, 1851-2. Vaccination was made compulsory in 1853, but epidemics followed in 1854, 1855, and 1856, culminating in the terrible epidemic in 1871-2 with more than 42,000 deaths. Epidemics followed in 1877 and 1881. "

HORSE-GREASE COWPOX.

Another and more modern stumbling block is the notion that Jenner's method was founded on a beautiful tradition which science has in these modern days of serum treatment confirmed. This supposition does not bear the scrutiny of students of the whole question. There is certainly not much poetry in Jenner's own account of the dairymaid's prophylactic, and it was repudiated by his own professional brethren, even those who profited by his idea of substituting cowpox for smallpox inoculation. The cowpox which Jenner recommended, he said, was produced in the following manner (I quote his words): "There is a disease to which the horse is frequently subject. The farriers have termed it 'the grease'. It is an inflammation and swelling in the heel, accompanied in its commencement with small cracks of fissures, from which issues a limpid fluid possessing properties of a peculiar kind. In this dairy county a great number of cows are kept, and the office of milking is performed indiscrimin- ately by men and maidservants. One of the former having been appointed to apply dressings to the heels of a horse affected with the malady I have mentioned, and not paying due attention to cleanliness, incautiously bears his part in milking the cows with some particles of the infectious matter adhering to his fingers. When this is the case, it frequently happens that a disease is communicated to the cows, and from the cows to the dairy maids, which spreads through the farm until most of the cattle and domestics feel its unpleasant consequences. This disease has obtained the name of 'the cowpox.' Thus the disease makes its progress from the horse (as I conceive) to the nipples of the cow, and from the cow to the human subject."

Jenner contended that every person who had had horse-grease cowpox was protected against smallpox, but person who had had the other kind of cowpox were not protected, so that when he was confronted with cases where cowpox had failed to protect, he said it was a spurious kind of cowpox.....

It is amazing today to recall the original grounds on which the State began its patronage of vaccination. The petition of Jenner for a grant from Parliament (and he ultimately had two grants amounting together to £30,000) claimed that vaccination had "the singular effect of rendering through life the persons so inoculated perfectly secure from the infection of smallpox."

ABSURDITY OF THE CLAIMS OF THE VACCINATORS

To people accustomed to modern methods of scientific inquiry, it is unnecessary to point out the absurdity of claiming from an experience of not more than 3 years that some inoculation of the blood would protect for life. No person with any understanding of scientific methods would venture to draw so general a conclusion from such a particular premise.....

JENNER ABANDONS HIS ORIGINAL CLAIM

Before Jenner died he had really abandoned his original claim for vaccination. He no longer said it would protect for ever, or that its protection would be certain. He said it would be as efficacious as inoculation or a previous attack of smallpox. At the same time he set about collecting cases of smallpox after smallpox, and collected one thousand cases to prove that his failures were not more numerous than the failures of smallpox to protect against smallpox. He thus gave away the very foundation of his claim for vaccination. But the State has gone on legislating on the original assumption. It will be found that whenever a vaccination law is introduced the members of the Administration responsible excuse themselves from discussing the merits of vaccination. These they insist on taking for granted.

From the earliest experiments down to the present time the history of vaccination is a record of failure. Jenner's time was fully occupied in explaining his failures, and he displayed great ingenuity and resource in this work. Smallpox, like other diseases of its kind, sometimes increases and sometimes declines. Whenever, since vaccination was started, smallpox has declined, people have said: "See what vaccination has done for us; it has stamped out the disease." Whenever there has occurred an epidemic, people have said: "See what those wicked anti-vaccinators have done; by not being vaccinated themselves, they have exposed those who are vaccinated to an attack of smallpox."....It is curious that the most obvious facts are those which some people find most difficult to see. For instance, it is obvious that if vaccination is a protection against the smallpox, the vaccinated person has nothing to fear in an epidemic of that disease, and that if vaccination will not protect a person when he is exposed to the infection of smallpox, it is an entirely useless precaution when there is no smallpox about from which to be protected. Yet the advocates of compulsory vaccination are, as a general rule, incapable of seeing this obvious fact.....

The next argument is the statistical one: that since the introduction of vaccination smallpox has been very greatly reduced, and from being a considerable scourge has become an ailment hardly known. The statement is true as regards the decline in smallpox since vaccination was discovered, but the decline had begun before vaccination was discovered, and it has continued notwithstanding vaccination. The reasons for the decline of smallpox are as follows:

A) The cessation of the inoculation of smallpox, which was itself the chief cause of the persistency and wide spreading of the disease.

B) The great improvement in highways,

canals, and railways, by means of which fresh vegetables and fresh meat can be easily conveyed to all parts of the country.

C) The enormous improvement in drainage, in the sanitary arrangements of houses, in the closing of graveyards in towns, in the closing of polluted wells, and the bountiful supply of pure water by means of waterworks.

D) The increase of wages, the cheapening of food, and the improvement in the dwellings of the working classes.

E) Increased care to prevent the spread of infectious diseases by the separation of infected persons from healthy persons, and the provision of better hospital accommodation, better nursing, and better medical attendance.....

ALL THE PATIENTS REALLY VACCINATED

There is a third comment to be made on these classifications of the Metropolitan Asylums Board. It would appear from the Reports that as a matter of fact the whole of the smallpox patients in their hospitals had been vaccinated. This is shown in the elaborate tables given, but in the Summary every patient is put in the unvaccinated list who was not known to have been efficiently vaccinated at least fourteen days before symptoms of smallpox were observed. But, considering that all these patients were, as it would appear from these tables, actually vaccinated, either what is called successfully or unsuccessfully, it would have been better not to classify 2,278 as unvaccinated. if the medical men were of the opinion that vaccination was no good, why did they vaccinate these poor people, and so give them two diseases to fight -cowpox as well as smallpox? And if they thought that vaccination did the patient good, why do they classify them as unvaccinated? This is another instance of the absurd predicaments in which the pro-vaccinator finds himself when he has to deal with the actual facts.....

"AUTHORITY"

Perhaps the chief argument used in favour of vaccination is that of "authority." It is said that the medical profession are in favour of vaccination, that they know all about it, and it is folly for anyone who has not been medically trained to have an opinion on the question. I would suggest that the real authority is a man who has devoted some years of his life to the study of the vaccination question and who is unbiased by any pecuniary advantage or professional sympathy in the conclusions at which he arrives.

If such is the standard of authority then "authority" is on the side of the anti-vaccinators. We have the opinion of the late Dr Collins, who was a public vaccinator, but who resigned that appointment because he considered vaccination did great harm and no good, and he wrote a book to prove his case. We have the opinion of Dr Creighton, who was employed by the publishers of the "Encyclopaedia Britannica" to write an article on the subject of Vaccination; he thereupon made a careful study of the question, and came to the conclusion that vaccination was not only useless, but dangerous. There is Professor Edgar Crookshank, who has published two ponderous volumes on "The History and Pathology of Vaccination," a work which he undertook in order to demonstrate the scientific basis of vaccination; but the result of his inquiry was to show that there was no scientific basis for the practice, and he expressed the opinion in his book that the practice would fall into desuetude.....

It is a remarkable fact that whilst the pro-vaccinists of England, France, Germany and America insist on the danger to the health of the community of the existence of unvaccinated people, yet the most enlightened ladies and gentlemen of these four great countries crowd into Switzerland, and into its unvaccinated cantons every year as the great health resort of Europe.....It is curious how long it takes to extirpate a well-paid fallacy, but it is evident that if there were any truth at all in the alarmist statements of the pro-vaccinators, Switzerland, instead of being the health resort, as it is acknowledged to be, would be the plague spot of Europe.....

As previously mentioned, all those people who pride themselves on being authorities on the question of vaccination assert that no person is safe from smallpox who has not been vaccinated during the last ten years. Now, according to the census of 1901 there were in England and Wales rather more than 7 million children under 10 years of age, leaving 25 million persons in England and Wales who were practically unprotected by vaccination, except for the comparatively small number who had been re-vaccinated. It is safe to say that in England and Wales there are at the present moment not less than 20 million persons who have not been vaccinated within the last 10 years, and who are therefore admittedly unprotected by vaccination. The fact is that the cry for re-vaccination, as clearly foreseen by Jenner 100 years ago, has entirely knocked the bottom out of the pro-vaccination case. Their case was, "See how much smallpox there was before vaccination was introduced; see how little smallpox there is now that vaccination is general." Jenner's case was, "Once vaccinated, always protected." Then came the dissatisfied re-vaccinators, like Dr MacVail, Right Hon. Walter Long, and others, who said, "Primary vaccination is 'a farce,' 'a deception, ' a source of danger.'" But at the present time we have, practically speaking, only got this farce and this deception to defend us all from extermination by smallpox, unless we adopt the more rational conclusion that after all we do not require this prophylactic; that we can be healthy without putting matter from a diseased calf into our blood; that not only primary vaccination, but re-vaccination also, is "a farce," " a deception," and "a source of danger."

In conclusion, I have thus shown, I hope, beyond the possibility of dispute, that all the claims made in favour of vaccination are unfounded in fact; that it is a dangerous practice, and that it is a useless practice; and the sooner the Government of the country dissociates itself absolutely from such a piece of eighteenth century quackery, the better it will be, not only for the health of the nation, but for the progress of true science, and for the honour and dignity of Parliament and the executive authority.

ASTHMA AND THE CULT OF CLEANLINESS

A country doctor visiting a farmhouse in Norfolk 45 years ago with rats in the yard, cats in the kitchen and dogs all over the house might expect to find many diseases among the children, but asthma would not have been one of them.

Today, if he visits a house in the same village, with floors so clean that someone could eat off them, there is a very good chance that the call will be to see a child who is wheezing. One in seven children between the ages of 2 and 15 in Britain and one in 25 adults suffers from asthma.

As well as concerns regarding vaccination causing allergies and asthma in some children, there has also been an obsession for cleanliness in recent years, leading to heavy use of all kinds of chemical-based cleaning products. Recent research carried out by doctors from the University of Bristol have indicated a clear connection between breathing problems in children and the use of household cleaners.

When a friend told me that his daughter (an asthma sufferer) no longer wheezed at night and hadn't had an asthma attack for months I was delighted. I was even happier to learn that it wasn't just a coincidence but had occurred since his wife had begun using a range of non-toxic, eco-friendly cleaning products. I immediately started using the products and found that they were both beneficial as regards to my asthma, and also my son's eczema. I love the products so much now that I will never go back to buying all those old toxic nasties that I used to buy in the supermarket. These products are so convenient to purchase - I simply select what I want from a catalogue, make a free-phone call and they get delivered direct to my door a few days later.

As a result of my experiences I now work part-time as an agent for the catalogue company who produce these products, and recommend them whenever I get the chance to my friends and family, and those looking for an environmentally-friendly option.

So if you would like to try some of these products please give me, Erini, a call on: 020 8951 1211 and I will be happy to give you further information.

WAR INJECTIONS LINKED TO ILLNESSES

http://www.smh.com.au/
By Julie Robotham, Medical Editor
December 7, 2004

The more immunisations that Australian Gulf War veterans received before the 1991 conflict, the more likely they are to suffer physical symptoms afterwards, researchers have found.

The study of more than 80 per cent of Australia's Gulf War deployment also suggests those who took tablets to protect against nerve gas and biological agents are more likely to suffer joint, skin, vision, sinus and psychological problems, compared with defence personnel who did not serve in the Gulf.

The Monash University research, sponsored by the Australian Defence Force, is the first attempt in Australia to cross-reference the symptoms experienced by individual Gulf veterans against the specific medicines and chemicals they were exposed to.

The study's leader, Helen Kelsall, said the 1456 veterans completed questionnaires from 2000 to 2002 about their physical and mental health. A doctor then interviewed them to evaluate accuracy. After the more unlikely claims were weeded out, the Gulf War veterans still suffered extra symptoms and diagnosed illnesses compared with others of the same age and background. The doctor dismissed as unlikely just 10 per cent of the conditions that either group reported, Dr Kelsall said.

The Gulf veterans, "certainly had more symptoms, and more of them had severe symptoms," Dr Kelsall said. She said the Australian findings were consistent with those for Gulf veterans from other countries - including the US, Britain, Denmark and Canada. But the Australian results were more reliable because other countries had not undertaken independent medical assessments.

The findings were published last month in the journal Occupational and Environmental Medicine - the first time the research has been subject to rigorous scientific scrutiny.

Of all the conditions, psychological problems stood out as occurring at a much higher rate among the Gulf veterans - three times that of other military personnel. They were followed by skin, sinus and eye complaints, which occurred between 40 and 70 per cent more frequently.

Although all these conditions can be caused by an inflammatory response, Dr Kelsall said there was no evidence to connect them. But more research should be conducted on whether illnesses were linked to the veterans' psychological distress. "There certainly is a relationship between physical health and mental health," she said.

Those who had 10 or more jabs reported almost double the rate of health symptoms compared with those who had four immunisations or fewer. The health complaints rose in direct proportion to the number of injections. There was a 4 per cent increase in the number of symptoms reported for each extra immunisation, Dr Kelsall said.

But the veterans' poorer health did not amount to a Gulf War syndrome, Dr Kelsall said. There was no unusual pattern of symptoms, and the complaints were common in the forces. "I don't think we can say this increase in medical symptoms is caused by the Gulf War exposures," she said. The most common problems reported - back, neck and joint pain - "in a young, physically active group of people are very common", she said.

JUNO MAGAZINE - A NATURAL APPROACH TO FAMILY LIFE

Juno is a magazine with a strong ethos based on natural parenting, environmental sustainability, social justice, spirituality and a child-centred approach. The content is a mix of specially commissioned articles and personal stories covering a broad range of topics; from natural health and alternative medicine to current affairs, and from gardening to travel.

4 issues (1 year) - £11 (UK)
8 issues (2 years) -£20 (UK)

To subscribe please send your contact details and payment (cheques made payable to Juno Magazine) to:
Juno Magazine, P O Box 592, East Grinstead, West Sussex, RH19 3AQ
Or visit our website on:
www.junomagazine.com
subscriptions@junomagazine.com

VACCINATION - MAKING AN EDUCATED CHOICE

With Acupuncturist, David Cox BSSc. Homeopath, Trevor Gunn BSc. and Magda Taylor, Editor of The Informed Parent.

3rd May 2005, 7-9pm

Seasons Vegetarian Cafe

199 The High Street, Lewes,

East Sussex, BN7 2NS

Tickets £7.00 each/ £10 for couples
For further details, contact David on: 01342 824305

WEBSITE DETAILS

http://www.mmrthequestions.com/

MMR: The Questions is a new and developing website. It will be used to present contributions from scientists, other professionals and parents who believe that there is sufficient evidence to warrant further research into the issue of whether exposure to measles-containing vaccine increases subsequent risk of a range of developmental disorders and/or gastro-intestinal problems

The purpose of the site will be to provide access to pertinent scientific materials, links to other sites of interest and a forum for discussion of relevant topics.

MMR: The Questions will also provide a means for scientists to respond in the public domain to any perceived misrepresentations of their work, their motivations and their professional integrity.

Please email questions, suggestions and contributions to:
info@mmrthequestions.com

NEW HOMEOPATHIC RESEARCH

Homeopaths in South Wales are launching a pilot study to assess the benefits of homeopathy for children whose health, their parents feel, has changed since vaccination. After some exciting results with individual children they felt it was appropriate to launch a study that would demonstrate the effectiveness of homeopathic treatment for children affected.They hope to widen the geographic area covered as soon as the initial research study has finished.

If you know of anyone anywhere in the UK who would be interested in taking part in the initial or subsequent phases of this research, please contact **Charlotte Haynes 01600 713179 or Jane Lindsay 0n 01291 690112**

Magda Taylor, editor, and director of The Informed Parent will be presenting an evening talk entitled:
CHILDHOOD VACCINATIONS: AN EDUCATED DECISION
Tuesday April 26th 2005
7.30 - 10.00 pm
Venue: Methodist Church, Marlborough Road, St. Albans
7 min walk from St Albans Station
Cost: £7/£10 couples.
Limited tickets on door. Books, pamphlets, information, homeopathic remedies and First Aid kits on sale.
Enquiries and bookings:
Ms Stone, 2a St Helier Road, Sandridge, St Albans, AL4 9LG
Tel: 01727 869 045
Email: helens@hertshomeopaths.com
For more information please visit our website www.hertshomeopaths.com

COMPARING NATURAL IMMUNITY WITH VACCINES

with **TREVOR GUNN**, *BSc. LCH RSHom, graduate in biochemistry and author of 'Mass immunisation - A Point in Question'*

Would you like to know whether vaccines work? Would you like to know how to avoid serious illness? Would you like to live feeling safe, knowing what treatments work?

Topics covered:
Short and long term effects of childhood and travel vaccines - evidence from orthodox & complementary sources - information that the authorities don't tell you - making sense of statistics - childhood illnesses - dealing with fear- avoiding future problems- increasing health now

BRIGHTON

8 Jun 2005

Further dates to be confirmed.

Contact Karel on: 01273 277309

A new guide for parents: 'The No Nonsense Vaccine Handbook' by Liz Bevan-Jones, is now available. Includes info on latest 5 in 1 jab. For details phone Liz on: 020 8540 0486

PLEASE HELP PROMOTE THE INFORMED PARENT

You can send off for leaflets to pass on to friends, relatives or patients.
Just send a large sae and state quantity needed.
THANK YOU
FOR YOUR SUPPORT!

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

AIMS AND OBJECTIVES OF THE GROUP

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

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

3. To inform parents of the alternatives to vaccinations.

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

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

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

7. To publish a newsletter for members.

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

The Informed Parent, P O Box 4481, Worthing, West Sussex, BN11 2WH. Tel/Fax: 01903 212969
www.informedparent.co.uk

The Informed Parent Company Limited. Reg.No. 3845731 (England)