Refusing Vaccination:

An Introductory Guide to an Informed Choice

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Coalition for Informed Choice, www.cfic.us

Note to reader: This article is a polemic against the practice of vaccination. I wrote it for the benefit of parents and students who are not familiar with the health risks from vaccines, or its lack of efficacy. However, even people familiar with the issue may learn new things from some of the sections.

This document touches on several issues related to vaccination very broadly. Periodically, I've updated and revised portions of this document. Perhaps the section, "Medical History and Epidemics", and the sections that follow it, might be novel to most readers. This document provides a good overview of the topic of vaccination. I refer the reader to other more recent articles that I and others have written that explores the specifics of vaccination and human health.

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The Vaccine Injury Compensation System

By the late 1970's, there had been so many successful lawsuits for vaccine injuries from childhood vaccinations that not a single insurance company was willing to underwrite vaccines marketed in the U.S. In 1986, Congress undertook to insure vaccine products by passing the National Childhood Vaccine Injury Act (NCVIA). However, following the law's passage, the government under-funded the program and made it highly adversarial. Hearings for claims are now complicated, drawn-out, and hostile to petitioners. Funds that have been awarded have been meager, usually falling far below the total costs incurred by families over the long term. Compensation is also awarded too late—long after medical and related expenses bankrupt the family. Despite this, as of 2002, over a billion dollars has been awarded to only about 1,000 families affected by vaccine injuries. With thousands of cases still pending, on average 3 out of 4 applicants are refused compensation.

The basic fault in the system stems from the authorization of HHS to perform the conflicting roles of adjudicating claims, and establishing the criterias for causality. The Secretary of HHS has artifactually narrowed or eliminated contraindications based on mere budgetary considerations—often in contravention of IOM recommendations—in order to exclude many kinds of injuries eligible for federal compensation, thereby minimizing monetary awards the government must pay to families. (Authority for HHS to do this was upheld by the Federal Court of Appeals.) HHS has also been accused of this

manipulation in order to maintain public confidence in the efficacy of immunization programs. How could they possibly compromise their integrity this way? Just consider that they invested in a career in which they first were indoctrinated with an exaggerated hubris and confidence in the conventional theory of infectious disease and the notion that vaccination is modern medicine's greatest achievement, and then embarked on a career path in which they either promoted or administered vaccinations. Of those that enter the public health services, can we really expect them to impartially interpret and report on vaccine safety and effectiveness, or to extend compensation for delayed reactions in children, and thereby undermine the efficacy of vaccination programs that they operate? How else can HHS deny there are causal relationships involving dozens of diseases, while at the same time year after year reject grant applications from accredited researchers and institutions that want to investigate the associations, or the basic science that may unravel the causes, if it's not to sustain the disease paradigm that's become the cornerstone of their profession, and defend it when it's under attack?

The overtly strict rules for establishing causality by HHS are apparent when viewing the stark differences in the adverse effects listed in the HHS Vaccine Injury Table, as opposed to the Physician's desk reference, or the more cautious (and honest) manufacturer's product inserts that protects companies from liability—a condition of NVCIA under Public Health Service Act, Section 2122, Direct Warnings (Else why would they even consider listing adverse effects?)

On February (2002), Dan Burton (R-IN) and Congressman Henry Waxman (D-CA) introduced HR 3741 (still pending), which corrects at least some of the system's failings. It extends the statute of limitations for filing a petition in the Vaccine Injury Compensation Program to six years, and establishes a two-year window for families to file a petition if they were previously excluded from the program by the existing statute of limitations. It also increases the compensation for vaccine-related deaths to $300,000; make compensation for lost earnings more generous; allow compensation for the costs of family counseling and creating a guardianship; and allow for the payment of interim attorneys fees and costs while a case is under review.

However, what their bill cannot rectify is the inherent folly in having taxpayers assume the liability costs of a product that poses acknowledged adverse reactions, and is universally administered to children through state health mandates (the so-called "No Shots, No School" laws, where in many states the legal exemption provisions are difficult to qualify). As an analogy, it would be as if the federal government assumed the product liability costs of Ford automobiles, and every state thereafter mandated that only Fords be driven. No doubt the subsequent percentage of Ford's revenue spent on safety testing would be close to 0.00%. Hence, parent and consumer organizations argue that it's naive to assume that vaccine safety can improve under the compensatory mechanism for vaccines in place today.

Despite FDA estimates that 9 out of 10 reactions go unreported, the federal Vaccine Adverse Event Reporting System (VAERS) receives annually between 12,000 and 14,000 reports of adverse reactions, including hospitalizations, injuries and deaths following vaccination. About 17 percent range from life-threatening illness to death. Over 30 thousand reports of adverse reactions are associated with the recently mandated hepatitis B vaccine alone, with perhaps over 500 deaths. Follow-up surveys indicate many deaths and injuries that parents reported were not recorded by the system at all. Even injuries recorded under this passive reporting system don't include critical followup data, such as whether or not the person recovered from the injury. All told, each year there may be well over a million new health problems in children that appear soon after vaccination, with no mechanism in place to determine which ones have a causal relationship to the vaccine.

In the early 1900s, only small pox vaccine was given to children. By 1944, a dose each of diphtheria and pertussis was recommended, with the combined DPT vaccine introduced after 1947. By mid-

century, there were a few hundred cases of autism. A dramatic upsurge of autism cases by mid-1964 followed increased vaccine doses in that decade (which by then was added the live measles and polio vaccines) at 2, 4, 6 and 18 months of age. In 1979, rubella vaccine was available, and the MMR vaccine was routinely given to children at 12 to 15 months of age. Federal grants to states permitted free DPT, polio and MMR vaccines to children in public health clinics; and the CDC was encouraging states to actively enforce mandatory vaccination laws to raise national vaccination rates. The age of onset of autism began to shift by the mid-1980's, until today, the onset-at-18 months children outnumber the onset-at-birth children by 2 to 1.

Today, a child receives about 39 doses of vaccines by the time he's 6 years-old. By the time he's finished primary school, he would have received roughly four times that many doses. National vaccination rates for children under age three have climbed from between 60 to 80 percent in 1967 for DPT, polio and measles vaccine to 90 percent in 1999 for DPT, polio, MMR, and Hib vaccines. Vaccine coverage rates with core vaccines for five-year-old children entering kindergarten have reached over 98 percent in many states.

According to the April, 1996 FDA Pink Sheet, members of the Vaccines & Related Biologicals Advisory Committee cited flaws in the VAERS program including: "1) passivity of the surveillance system; 2) under reporting; 3) lack of a control population; 4) inability to determine causal relationships; 5) imprecise definition of 'serious' events; and 6) lack of a mechanism to detect delayed adverse events". Further flaws in the program were also noted by Dr. Robert Chen, MD, Chief of the Centers for Disease Control Office of Vaccine Safety & Development. FDA Pink Sheet dated June, 1996, reports his comment: "Of all the positive things that were done by the Vaccine Compensation Act…one thing that (was) more or less neglected is research. They (legislators) found a mechanism to fund an injury compensation program after the injury has already happened, but there's really no way at this point to fund research to try to prevent such injuries."

Because of problems like these, the 4,000 members of the Association of American Physicians and Surgeons (AAPS)—a professional association of physicians founded 1943—to vote on November 2000, at their 57th Annual Meeting in St. Louis to pass a resolution calling for an end to all state mandatory childhood vaccinations. The resolution passed without a single "no" vote. (www.aapsonline.org).

The simplistic counter-argument is that taxpayer indemnification of the drug companies will prevent trial lawyers from feeding at the trough with frivolous lawsuits. But accountability is an essential cornerstone of modern commerce. It's either that, or socialism, in which the government manufactures the vaccines. But NVCIA is a grotesque hybrid of both systems. It eliminates time-tested checks and balances by permitting the private sector to gladly accept profits, without assuming proportional risks, thereby ensuring that product safety takes a back seat.

Why Is Compensation Denied?

Contrary to the claims of vaccine promoters and proponents, vaccine injuries appear to be the norm: Many children exhibit seemingly "mild" reactions, followed later perhaps by slowed physical or cognitive development, or changes in consciousness or emotional behavior. So-called "minor" complications like these are never linked to the vaccine, nor do such cases ever receive compensation. The government denies that many common symptoms and disabilities are the result of vaccination, by citing biased and fraudulent "safety" studies and field trials sponsored or performed by the drug companies who developed the vaccine and wish to profit by its sale. For example, compensation is not awarded for delayed reactions, or for chronic diseases that vaccines are suspected of causing, like lupus, cancer, arthritis or multiple sclerosis.

Details of compensation claims are difficult to obtain. The government cites the privacy rights of the individual claimants. However, parent support groups have received many complaints from parents regarding seemingly clear-cut reactions just a few days following vaccination, but which failed to qualify for compensation.

Harold E. Buttram, M.D., author or Vaccinations and Immune Malfunction (1982, Humanitarian Publishing Co., Quakertown, PA) said in 1997, "If an individual patient goes into anaphyllactic shock following an injection of penicillin, no one questions that the penicillin caused the reaction. Yet when a severe reaction follows a vaccine, experience has shown that the vaccine is disallowed as a cause in a majority of instances."

The Problem With The Doctors

The safety reform portion of NCVIA requires doctors to provide parents with information about the benefits and risks of childhood vaccines prior to vaccination, and to report vaccine reactions to federal health officials. Doctors are required by law to report suspected cases of vaccine damage. To simplify and centralize this legal requisite, federal health officials established the Vaccine Adverse Event Reporting System (VAERS)—operated by the Centers for Disease Control and Prevention (CDC), and the Food and Drug Administration (FDA). But although there is a statutory requirement for doctors to report adverse effects, there are no sanctions in the law to deal with doctors who do not comply with this law. To the contrary, Congressional testimony chaired by Dan Burton (R-Il.) revealed that medical personnel are discouraged from reporting reactions.

Therefore, it is no surprise that most doctors won't report symptoms and complaints, nor will they associate them with the vaccination, thereby withholding the corroboration that is needed to substantiate a claim. This often happens even after a death or permanent injury just a few days following the administration of a vaccine. That's why about 95 per cent of all claims are filed exclusively by parents. Even parents who are generally aware that there are risks associated with vaccination do not realize that symptoms that become apparent days or weeks later, may have been the result of the vaccines. A special investigation in the December 1996 issue of Money magazine —The Lethal Dangers of the Billion-Dollar Vaccine Business—found that doctors and federal health officials tend to downplay vaccine reactions hoping the public will remain confident about vaccination and to keep vaccination compliance rates high.

According to Money: "from 1991 through 8/96, 48,743 adverse reactions were reported. Unfortunately, those figures represent only a small portion of the dangers. For example, a 1995 CDC study found that reporting rates were less than 1 per cent for serious reactions such as loss of consciousness after a DPT Shot. A 1994 survey of doctors' offices in seven states conducted by the NVIC, found that only 28 of 159 offices said they file a report after a patient has an adverse reaction to a vaccine."

What Do Doctors Really Believe?

If consensus among doctors is the gold standard for both the courts and policymakers, then perhaps looking at what doctors *do* for themselves and their families may reveal more of what they believe than what they *say* they believe.

Studies show that vaccination rates for doctors and nurses are not at the optimum levels one would expect to see. OB/GYN physicians, for example, are supposedly vulnerable to certain diseases. Yet the February 20th, 1981 issue of JAMA reported a study showing that less than 10 per cent of them were

vaccinated against their at-risk diseases. The next lowest rate of participation occurred among pediatricians. "Fear of unforeseen vaccine reaction" (quote from article) was the prevailing concern among the physicians.

More recently, there's a rebellion in the U.K., where uptake of the MMR injection is at its lowest level in over a decade, with one in five two-year-olds have not been given the shot. The concern among the public is the effects from the combined vaccine. Many parents have rejected MMR since it was linked to the development of bowel disease and autism in controversial research findings by Dr. Andrew Wakefield.

Yet it appears that doctors and nurses are more worried about the possible health risks of the triple vaccination than they are prepared to admit in public: Two out of five children being given single vaccines instead of the MMR jab have parents who are medically trained, a survey 2 years ago found. Data for 58,000 children who have completed courses of single vaccines since 1999. Of these, almost 23,000 had at least one parent who is medically trained, including GPs, hospital and practice nurses, health visitors and even consultants.

Another survey published the British Medical Journal two years ago found that one in three nurses working in GP surgeries believed the triple jab might be linked to serious side- effects, such as Crohn's disease and autism. It found that nearly half of family doctors and nurses were worried about giving children their second dose of MMR.

Last November 2005, Pediatrics published a study which surveyed 2,070 Swiss physicians, which found that 10% of nonpediatricians, and 5% of pediatricians do not agree with, nor follow official immunization recommendations for their own children. The authors of the study noted that this rate—and the rationales the dissenters provided—is roughly equivalent to those of other educated health care consumers.

For example, 5 percent of nonpediatricians would not use the Hib vaccine for their own child. Their reasons included a lack of concern about the disease, and the desire to reduce vaccines to a minimum. Similarly, almost 5 percent of physicians did not use the MMR vaccine in their own children. The reasons included a *"the wish to avoid the trivalent combined vaccines because of safety concerns, and the preference for infection-driven rather than vaccine-induced immunity."* The rates for *delaying* vaccinations were higher: Almost 10 percent of nonpediatricians would delay the initiation of DTaP vaccination beyond 6 months and 15 percent would not give the first dose of measles or MMR before 2 years of age.

In keeping with the theme of arrogance and paternalism, the authors were puzzled over the dissenting decisions of physicians who should apparently know better: *"Despite their scientific training and education, they express the same concerns as those that prevail in the public."*

Perhaps most of you recall that by the end of 2002, the news media reported that thousands of medical first responders and emergency room doctors refused to take the free smallpox vaccinations, even following later assurances from the Department of Homeland Security that those vaccinated would receive free and full insurance to cover possible adverse reactions. There were so many doctors and hospitals that refused the vaccine that the Department of HHS changed the directive to a voluntary recommendation, in order to calm a controversy liable to raise public awareness to the fact that vaccines pose risks.

In September 2004, Virginia Mason Medical Center wanted to be the first hospital in the nation to make flu shots mandatory for its staff and volunteers in an effort to protect patients. In response to a reported 55 percent immunization rate among the 5,000 staff members (vaccinations are free for staff members), all staff members—which included nurses but not doctors—were informed that they would be fired if they don't receive the flu vaccine for that year.

The Washington State Nurses Association (WSNA), representing 12,000 nurses in Washington state, released a statement opposing this requirement, stating in part:

> "Registered nurses understand better than anyone both the benefits as well as the side effects of the flu vaccine and must have the personal choice to decide whether or not to receive the vaccination. Educating nurses and other staff about the importance of the vaccination and allowing each individual to make a decision with regards to the vaccination is what we would support," said Lauralee Mayorkinos, RN, WSNA local unit chair at VMMC.

Barbara Frye, Director of Labor Relations for WSNA, said nurses are most concerned that what *"should be a matter of individual choice"* is being taken from them under threat of job loss. *"Getting stuck with a needle with a drug in itself is invasive,"* Frye said. *"Nurses are well-educated on this issue, and they know that there is no drug or vaccine that doesn't have a potential health risk."*

Indeed, that year some flu vaccine was found to be contaminated. Another case of bacterial contamination shut down a British plant that made half the U.S. supply of vaccines. In the prior year, it was estimated that half the adults who came down with flu had first received the shot. In the court filing to stop the vaccine requirement, WSNA wrote that requiring flu shots violates the hospital's duty *"to maintain a safe and healthy workplace."* It contended the shots pose risks, and that the hospital's alternative for religious or health reasons—an antiviral medicine—is even worse because those medicines have *"significant side effects."*

On January 7th, 2006, The United States District Court ruled in favor of WSNA. The nurses union wrote that it *"oppose[s] any health care facility threatening to fire people if they do not submit to the mandatory vaccination, especially in the absence of a declared public health emergency…"*

Finally, on January 26, 2006, the union filed an unfair labor practice charge with the National Labor Relations Board, alleging that Virginia Mason Medical Center *"retaliated and discriminated against the registered nurses for exercising their contractual right to refuse flu vaccination by forcing them to wear masks."* Their press release continued: *"According the Center for Disease Control and Prevention (CDC), 'no studies have definitively shown that mask use by either infectious patients or health-care personnel prevents influenza transmission.'"*

The comparisons here are striking. Children in schools have no comparable protections with regard to personal rights or advocates making such arguments. Yet one would think ill patients in hospitals are more susceptible to communicable diseases than healthy teachers and students.

Nevertheless, advocates for mandates for nursing staffs are persisting. According to Dr. Trish Perl, Johns Hopkins' senior hospital epidemiologist and flu expert, research shows that despite free and ready access to the vaccine, only 38 percent of all health care workers actually get a flu shot. In calling for mandatory vaccination of all health care workers in November 2005, she stated, "we have gone as far as possible with vaccination programs emphasizing education and health promotion. It's now time to go the extra step …" Although she acknowledged that current federal workers' rights prevent employers from making vaccinations a requirement.

[Note: The article about Dr. Perl by David March ended on a somewhat self-contradictory note, hinting that there exists free choice by alluding to an open discussion, but which is about a foregone outcome: *"Perl says her proposal is open to discussion at Hopkins. 'Ultimately, we want to make vaccination as mandatory for workers as the law allows…', she says."*]

The Problem With The Regulators

Not only is there gross underreporting by doctors in the federal Vaccine Adverse Event Reporting System (VAERS), but the FDA itself has been unwilling to investigate clusters of injury reports to identify particularly unsafe vaccine lots. The Money article reported that, "even with timely reporting, the FDA is reluctant to act". Money learned that not only did the FDA "feel that no action was needed" concerning a vaccine lot that produced 70 adverse reactions—including nine deaths, the FDA also felt that no action was needed for several other lots that had even higher numbers of reports of adverse reactions. The FDA also admitted that no lot has ever been recalled because of adverse effects since the centralized reporting system was established in 1990. Even prior to that, the government has neither publicized nor recalled such "hot lots", in over 15 years. NBC News ("Now" series, 3/2/94) reported that the FDA has never even established a criteria for a recall.

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Procedures for recognizing and reporting adverse reactions were allegedly set up to target unsafe batches of vaccines to prevent them from being further distributed to more children. Another reason for the data is that benefit/risk assessment cannot be determined solely by animal testing and human field trials: Scientists require data from large random samplings of children. Yet government officials insist that VAERS was designed to merely "document" suspected cases of vaccine damage. No attempt is made to confirm or deny the VAERS reports. Parents are not being interviewed, and the vaccines that are linked to the severe reactions are not being recalled. Instead, new waves of unsuspecting parents and innocent children are being subjected to the damaging shots.

In 1978, a study in Tennessee showed a significant increase in deaths and injuries occurring within 24 hours after vaccination against pertussis. Shamefully, this finding merely led to a change in the way pharmaceutical companies distributed the pertussis vaccine: the lot numbers were broken up so that a particularly bad batch of the vaccine could not kill or injure a large number of children within a small geographic region, thereby making it harder for parents to trace the cause of the injuries and take preventative measures to protect their other children. In effect, by allowing drug companies to disburse lots all over the country—thereby avoiding clusterings and public notice—federal health officials demonstate that their sole concern is to "protect" the efficacy of vaccination, by avoiding public outcry.

The Money magazine report said, "federal regulatory agencies reveals severe violations of public trust" and that, "health officials publicly downplay the lethal risks" of vaccination. They also discovered that "medical experts with financial ties to vaccine manufacturers heavily influence government decisions that have endangered the health of immunized kids while enhancing the bottom line of drug companies". For example, the minutes of one "CDC advisory committee meeting in 1995, at which members voted to delay recommending use of a safer polio vaccine, show that five of the nine members who participated in the discussion had financial ties to the manufacturers" of the vaccine.

On the federal level, The FDA approves vaccines for children based primarily on effectiveness. The CDC's Advisory Committee on Immunization Practices (ACIP)—a non-legally binding government committee, and the American Academy of Pediatrics Committee on Infectious Diseases (AAP)—a private special interest medical organization, each issue their general vaccine use guidelines for children, which are mostly dosage and scheduling recommendations.

Public health services are charged to ensure the well-being of the public at large. To fulfill this traditional role, its jurisdiction in state vaccination mandates has been to promote the benefits of immunizations and maximize compliance levels. These mandates have always included opt-out mechanisms for acknowledged high-risk situations and otherwise susceptible individuals. Since these individual conditions are best assessed through clinical examinations, legislatures have logically assigned this responsibility to clinical health practitioners.

But the trend in the U.S. among local health officials has been to apply these government and commercial vaccine policy recommendations to medical exemption provisions, even though the purpose for these recommendations was not to supplant assessments made by physicians. A recent JAMA editorial acknowledged that the vaccine approval and licensing process operated by the FDA and ACIP, actually functions primarily to release federal funds to buy vaccines from the manufacturers. The vaccine approval process is not strictly based upon safety considerations. (1)

To obtain FDA approval, a vaccine must demonstrate efficacy based solely on antibody response—a limited and sometimes misleading index. Field trials on a limited number of healthy children before and after licensure are designed to detect short-term reactions only (a few days at most). (2) Post-marketing surveillance through VAERS—the government's passive reporting system—grossly under-reports vaccine reactions. (3) ACIP and AAP vaccine use recommendations are consequently faulty, and some conflict with each other. (4) And both exclude the more cautious manufacturer's usage recommendations that are written into the product's package inserts, prudently listed to protect manufacturers from liability. Large discrepancies also exist between ACIP recommendations and those found in the Physician's Desk Reference.

Other safety data that affects these guidelines comes from the Vaccine Injury Table—a list of presumptive vaccine injuries—maintained by the Secretary of Health and Human Resources. But the Secretary of HHS has continually narrowed contraindications by reclassifying symptoms and discontinuing 'at risk' categories, which excludes many kinds of injuries formerly eligible for federal compensation. This has been done merely for budgetary considerations—often in contravention of IOM recommendations—in order to minimize monetary awards the government must pay to families. (The National Childhood Vaccine Injury Act of 1986 authorized HHS to perform the conflicting roles of litigating vaccine injury claims, and establishing the criteria for causality.)

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1. Journal of the American Medical Association (JAMA), December 27, 2000, Editorial. The journal opined that vaccine mandates go into effect in America in a procedure that evades accountability, because the purpose of ACIP and FDA recommendations is essentially to release federal funds to buy the vaccines from the manufacturers. JAMA issues a stern caveat to the states: "All vaccines that are licensed and recommended for use in children should not necessarily be legally mandated for day care or school entry. Each state needs to assess each vaccine individually."
2. Congressional Quarterly, August 25, 2000, pg. 647
3. Multiple Sources:

- JAMA (June 2) 1993;269(21):2765-68. Former FDA Commissioner David Kessler said, "Only about 1% of serious events are reported to the FDA…"
- Andrea Rock, The Lethal Dangers of the Billion-Dollar Vaccine Business, Money Magazine, December 1996. Quote: "A 1995 CDC study found that reporting rates were less than 1% for serious reactions, such as loss of consciousness."
- Barry Forbes, Feds Vaccine Policy Under Fierce Fire, The Tribune (Phoenix, Arizona), July 25, 1999
- Barbara Loe Fisher, Co-Founder & President, National Vaccine Information Center, Vaccines: Finding a Balance Between Public Safety and Personal Choice, Testimony before U.S. House Government Reform Committee, August 3, 1999
- John Hanchette; Sunny Kaplan, Federal Claims Court Seems to Connect Vaccine & SIDS, Gannett News Service (Washington, D.C.), September 5, 1998: Part of Gannett's four-month study of federal immunization policy, examining computer records from the National Vaccine Injury Compensation Program, obtained via Freedom of Information Act. Quote: "Dr. Marcel Salive, chief of the FDA's epidemiology staff, says, 'Any number you get, take with a grain of salt'." (referring to reports of reactions)

4. Harris L. Coulter and Barbara Loe Fisher, DPT: A Shot In The Dark, ©1986 by Barbara Loe Fisher. Warner Books, New York, chapter 13: 'Contraindications', p190

How Safe Are Vaccines?

Satisfactory safety studies are absent for all vaccines. The administration of multiple vaccines in one shot have not been tested for safety, let alone effectiveness. The new use of genetically engineered vaccines may have irreversible and unpredictable effects on the human genome. There haven't been generational studies on the teratological effects of attenuated virus vaccines, such as birth defects, cancer, and mutations. There haven't been adequate long-term studies to rule out the suspected link between vaccination and degenerative diseases later in life, such as arthritis, cancer and multiple sclerosis. Studies typically do not employ placebo controled, cohort groups of unvaccinated children. The safety studies that are done—usually pre-licensure tests done by the manufacturer—follow up for only 3 weeks or less, instead of several years.

The 1991 Institute of Medicine (a branch of the prestigious National Academy of Sciences) summary report titled, "Adverse Events Following Pertussis And Rubella Vaccine" (JAMA 1/15/92) stated, ". . . the committee found many gaps and limitations in knowledge bearing directly and indirectly on the safety of vaccines." ". . . Many of the reports of case series suffer from inadequate or inconsistent case definitions". ". . . Many of the population based epidemiological studies are too small or have inadequate lengths of follow-up to have a reasonable chance of detecting true adverse effects, unless these effects are large or occur promptly and consistently after vaccination. If research is not improved, future reviews of vaccine safety will be similarly handicapped."

In 1994, the Institute of Medicine followed up with another scathing report highly critical of the methods by which vaccines are tested for safety. According to Money, "Out of 59 health problems suspected of being associated with a variety of vaccines, the [IOM] committee found that no scientific studies had been conducted on 40 of them".

A 1994 study by the Institute of Medicine suggested these are among the medical conditions that may be causally or temporally associated with vaccination. Coma followed by death is also a common sequelae:

- severe pain, swelling, redness, and/or lumps at the needle site
- allergic reactions (hives, wheezing, puffiness, rashes, edema)
- demyelinating diseases of the central nervous system
- high-pitched screaming lasting for hours
- Sudden Infant Death Syndrome (SIDS)
- subacute sclerosing panencephalitis
- anaphylaxis/anaphylactic shock
- encephalitis/encephalopathy
- multiple learning disabilities
- autistic spectrum disorders
- Guillain-Barre Syndrome
- convulsions/seizures
- excessive sleepiness
- Parkinson's disease
- unconsolable crying
- rheumatoid arthritis
- transverse myelitis
- mental retardation
- Delayed Reactions
- arthritis/arthralgia
- multiple sclerosis
- juvenile diabetes
- severe vomiting
- optical neuritis
- ear infections
- paralytic polio
- hyperactivity
- meningitis
- adenopathy
- paralysis
- high fever
- anorexia
- diarrhea
- apnea
- lupus
- allergies
- epilepsy
- asthma
- blindness
- cancer
- deafness
- sterility

- anorexia

There has been mounting evidence that delayed reactions are caused or provoked by vaccinations. For example, several recent medical studies have demonstrated a significant causal link between vaccines given to infants and subsequent development of autoimmune diseases, such as asthma and diabetes [Science News, Vol.152, #21, 11/22/97] [ABC World News Tonight 12/8-9/97].

Science News reported that a growing number of scientists are concerned whether childhood vaccines initiate immune system problems, or builds resistance to them. "Immunization skews the activity of the immune system", says Howard L. Weiner, an immunologist at Harvard Medical School in Boston. "If a person has a tendency toward a disease at a certain age, a vaccine might…make [him or her] more susceptible later, when other challenges come along."

Although the delayed and long-term effects of persistent circulating antigens from vaccines in the body are unknown, they may be the cause of continual immune suppression, disabling our ability to react normally to disease: A latent virus from a vaccine injection can be incorporated into our body cells, yet still be viewed by our immune system as a foreign entity. This is one possible mechanism to explain how vaccines have provoked auto-immune diseases and recurrent infections.

For example, live virus vaccines require incubation in animal tissues. Not only are the foreign proteins toxic, but the incubation of live viruses in animal tissue introduces the risk that viruses may incorporate genetic material from the animal tissues in which they are incubated (through the process of "jumping genes") and subsequently introduce this animal genetic material into the child receiving the vaccine. This may be what sets the stage later for immune disorders.

Autoimmune Malfunctions

Our immune systems most effectively attack invading organisms that are inhaled, ingested or touched. The first line of defense against viruses and bacteria is immunoglobulin A (IgA), which is found in the mucosal linings of our noses and intestines and in our saliva. A deficiency of IgA causes allergies and frequent colds.

Injecting a disease bypasses this first line of defense. When bypassed the IgA transmutes to immunoglobulin E (IgE), the harbinger for recurrent infections. As the B cells, that make antibodies to antigens, increase, activated by the antigens in the vaccine, the T cells, which are responsible for cell-based immunity and cell memory, decrease. Cell memory makes those of us who have actually experienced the disease completely immune thereafter, whereas those who get vaccines sometimes get what they were vaccinated for: whooping cough, measles or chickenpox. Since 1979, with the rare exception of someone coming into this country with polio, the live oral polio vaccine has caused all other cases of polio in the U.S.

The virus in any vaccine is cultured on tissue from monkeys, chicks or aborted fetuses, which have produced antigens that cannot be filtered out. These antigens can affect the human body. For example, the antibody to the myelin (the protective sheath around nerves) protein from chick cell culture can cross react with human tissue, causing myelin destruction of the vaccine receiver, which can cause ADHD (attention deficit hyperactivity disorder), mental retardation, Lou Gehrig's disease, multiple sclerosis, seizures and other autoimmune disorders.

Another cause of these autoimmune conditions is molecular mimicry. The measles virus has proteins very similar to those in myelin, so the antibodies setting out to destroy the virus end up destroying the myelin of those vaccinated, causing postvaccinal encephalomyelitis, which has been renamed autism.

The hyperactivity of the B cells make autoantibodies that attack different tissues, causing allergies, Crohn's disease, colitis, juvenile diabetes and other autoimmune problems, depending on the targeted tissue. Most of these problems appear in children who undergo heavy vaccination programs. Many of our veterans, also heavily vaccinated, have neurological problems.

The ingredients of vaccines do not include eye of newt, which would at least contain vitamin A, but they do contain an impressive array of toxic substances in addition to the actual viruses. There are antibiotics that can cause reactions in those who are allergic; aluminum that has been implicated in the promotion of Alzheimer's disease; MSG and egg proteins, both of which are allergens for some people; thimerosal, a neurotoxin; formaldehyde, a carcinogen and aborted fetal tissue, which compromises the beliefs of those against abortion.

Example: Asthma

Despite steady improvements in air quality in U.S. cities since the 1970s (the Clean Air Act, etc.), and increased restrictions on indoor smoking, the incidence of asthma has more than doubled since 1979 to become the leading chronic illness among children (affecting 4.8 million) under 18 years of age. CDC statistics show that immunization levels among American children are at the highest levels ever, with more that 90 percent of American toddlers having received the critical doses of the most important vaccines.

In the last 30 years, the increase in vaccine dosages per child has coincided with childhood cancers rising to become the #1 disease from which children under the age of 14 are dying. Learning disabilities and emotional/behavioral problems have also reached epidemic proportions in children. Seven per cent of American schoolchildren have Attention Deficit Disorder (ADD) and are prescribed Ritalin. Millions of children are affected by the broad spectrum of neurocognitive difficulties. Before DPT shots were given in 1943, there were 11 cases of autism. Today there are 200,000 cases. The shot is given before an infant's cortical nerves have myelinated (developed). Sudden Infant Death Syndrome (SIDS) occurs between 1 and 4 months, with the peek incidence at 2 to 3 months. This coincides with the schedule for babies to receive their first vaccines, particularly DPT. The association between measles vaccine (MMR) and Crohn's disease (and autism) is now being made (Lancet 1998;351:611-12, 637-41). There had been no pediatric cases of this disease before the vaccine was introduced in 1970.

Why Do Vaccinations Fail To Protect?

Critics claim that there are too few properly designed, placebo controlled cohort studies to demonstrate vaccine effectiveness. For every article that purports to show a vaccine to be effective, another can be found that shows that it failed. Yet the failures don't receive much publicity. For example:

—The acknowledged failure of the DPT vaccine during the 1993 epidemic of whooping cough among primarily vaccinated children in Cincinnati (Christie CDC et. al., New Engl. J. Med. 1994; 331:16-21).

—Another study found a fivefold increased risk of hemophilus influenza-b meningitis in children vaccinated against this disease compared to unvaccinated controls (JAMA 1988; 260:1423-1428).

—Rubella cases had hit a 13-year high in Scotland since their 1994 push to vaccinate every child in school (Lancet, 4/6/96).

—JAMA (11/21/90) had confirmed that, "the vast majority of measles outbreaks were in those previously vaccinated against the disease."

—A controlled study of elderly Medicare patients showed "no demonstrated effect of influenza vaccine in preventing death or limiting the length of hospital stay" ("Options for the Control of Influenza II". Amsterdam: Excerpta Medica. 1993; 153-60).

—Incredibly, there aren't any controlled studies that prove that influenza vaccine will even reduce the incidence of influenza among "at risk" groups, like the elderly (Arch Intern Med 1994;154:2545-57).

—In 1989, 40 percent of measles cases were blamed on vaccine failure (Marwick C., Secretary of Health & Human Services to hear recommendations for improving immunization. Journal of the American Medical Association, 1990; 264(15): 1925-6).

Dr. Viera Scheibner, a distinguished Principal Research Scientist in Australia, reviewed about 30,000 articles showing the poor safety and effectiveness of vaccination for her book, Vaccination: 100 Years of Orthodox Research (New Atlantean Press, 1993).

Many studies have also demonstrated that at best, vaccines may only partially and temporarily confer immunity, and that repeated booster doses have little or no effect. Some researchers think that one reason for the high vaccine failure rates is that the immunological reserve for a wide range of antigens becomes substantially reduced in vaccinated people. Studies show that vaccination renders a substantial portion of immune bodies (T-lymphocytes) solely committed to the specific antigens involved with the vaccine. Having become committed, these lymphocytes become immunologically inert, incapable of reacting or responding to other antigens. By focussing exclusively on antibody production, which actually plays a minor role in the overall immune process, immunizations isolate this function and allow it to substitute for the entire immune response. Because vaccines "trick" the body so that it will no longer initiate a generalized inflammatory response (a good thing), they actually weaken our immune system.

This was probably why the Edmonston-Zagreb measles vaccine failed in 1992. It also explains why children with agamma globulin anemia who are incapable of producing antibodies, develop and recover from measles and other zymotic (so-called infectious or contagious) diseases almost as spontaneously as normal children. Another example is illustrated in a review of several British studies published in the Autumn 1989 issue of the Sunday Express: groups receiving the flu vaccine were at least twice as likely to get the flu or respiratory illnesses than the unvaccinated groups. Dr. Alexander MacNair, medical consultant to the vaccine industry-sponsored "Flu Monitoring & Information Bureau", admitted that claims for the vaccine's efficacy were based solely on its ability to stimulate antibody production against the virus.

The recent Edmonston-Zagreb vaccination campaign was a classic example of vaccination rendering substantial portions of immune bodies (T-lymphocytes) solely committed to the vaccine's specific antigens, making them immunologically inert and incapable of reacting or responding to other antigens. It also demonstrated that there are no relevant animal models for human inflammatory diseases. Hence all trials with respect to attenuation, immunogencity, and efficacy are necessarily carried out on human beings—usually Third World children, where health officials can callously allow the experiments to continue:

Dubbed the most effective measles vaccine ever developed, the journal, Science (10/23/92) reported that the high-titer Edmonston-Zagreb vaccine was withdrawn in 1992 because the children who received it, while allegedly protected from measles, were dying

at twice the rate from other infectious diseases compared to unvaccinated children. The vaccine was given to Third World children. In 1990, researchers in Guinea-Bissau reported higher-than-expected deaths. In 1991 the World Health Organization (WHO) also received a similar report from Senegal. "WHO allowed the trials to continue while gathering more data." By June, 1992 similar data were coming in from Haiti. It wasn't until October, 1992 that the vaccine was discontinued in younger infants. Commenting on the carnage, Dr. Steven Rosenthal—the vaccine "safety" expert at the CDC—stated in Newsday (8/2/94), "People now agree that we need more post-marketing studies . . ." ". . . Hell, most vaccines that are on the market now were never tested that vigorously [enough]".

Even a vaccine supporter, Sir Graham Wilson, M.D., stated in his 1967 book, The Hazards Of Immunization (Othone Press, Univ. of London), that he knew of many adverse effects that doctors never reported—many that were among large-scale "accidents" that doctors attempted to hide from the public. This had been done out of fear of lawsuits (high-risk children may have been poorly screened) or to deny the anti-vaccinationists more ammunition.

Finally, this alternative theory is also in accord with many studies showing the natural protection afforded to breast-fed infants. For example, exclusively bottle-fed infants were hospitalized with infectious diseases ten times more often and spent ten times more days in the hospital during the first year of life than breast-fed infants (Cdn Med Assn Jrnl, Vol 120, p295-298).

Even though immunizations for diphtheria, pertussis, tetanus and polio began at two months of age, a young infant is usually protected by measles, polio and tetanus antibodies from its mother for the first six months of life (Kaye R, Oski FA, Barness LA. Core Textbook of Pediatrics (second edition). Philadelphia: JB Lippincott Co., 1982). Breastfed children are protected by immunity factors contained in breast milk (Lawton JWM, Shortridge KF. Protective factors in human breast milk and colostrum (letter). The Lancet 1977; 1: 253.).

The many thousands of healthy unvaccinated children in the U.S., Europe, Australia, New Zealand, and elsewhere provides additional evidence that vaccination is not a requisite to be free of disease. Government health officials, through the news media, have warned the public of the prevalence of greater pathogenic, more resistant strains of germs. And despite greater surveillance of these groups by public health doctors, unvaccinated children appear no more likely to develop inflammatory diseases than vaccinated children.

Medical History and Epidemics

Most people would be surprised to learn that there are more than one thousand outbreaks worldwide each year, including colds, seasonal flus, hepatitus, and numerous noninfectious syndromes, all running their course and disappearing, often despite remaining unexplained by scientists. Even the dreaded Ebola epidemic failed to materialize. The CDC claimed that 108 people may have been killed by the Ebola in Zaire in 1995. However, there had been no further deaths and not a single case has ever been reported in the U.S. or Europe. As historian Elizabeth Etheridge wrote, "the epidemic was virtually over before their work [CDC & WHO] began" (Sentinel for Health, 1992).

Considering the speed from exposure to death, the mortalities were more likely the result of a chemical toxicological agent. A couple of other indications point in that direction: Symptoms were never seen outside the localized area where it began. And 20 per cent of the 55 million Zairens are Ebola virus

antibody-positive, having survived the virus without apparent disease (Dietrich J.,1995). One guess is that those who became sick had been exposed to the deadly cleaning solvents and oils that are often left at military base camps—possibly from groundwater contamination. Indeed, civil wars extending across 8 nations in central Africa killed about 2.5 million African civilians between 1998 and 2001 alone.

If it were not for the gullible media and fanatical virus hunters seeking fame and fortune, this virus would have joined the ranks of the thousands of known harmless passenger viruses. According to renowned molecular biologist Peter Duesberg, "these many outbreaks provide the CDC with its inexhaustible source of epidemics" (Inventing The AIDS Virus, 1996). To make their job even easier, public health agencies have assumed wide discretion in announcing "public health alerts". The CDC loosely defines an "epidemic" as 5 or more confirmed cases clustered in a concentrated area. An "area" may be a few city blocks, or an entire country. An "outbreak" is defined as at least one case in one area. Often, if one person living in a household has a confirmed case of a "communicable" disease, then there's no need to draw blood to test anyone else with similar symptoms living in that same household.

A History of Epidemics

The incidence and severity of measles, polio, diphtheria, and whooping cough began sliding dramatically well before widespread vaccination programs or antibiotics were introduced. The consensus among leading medical historians that have studied the issue have concluded that the eradication of the zymotic, or "filth" diseases—cholera, dysentary, typhus, plague, and smallpox—in the past that are popularly attributed to mass vaccination campaigns, had actually been due to improvements in diet, hygiene, sanitary measures, non-medical public health laws, and to a host of new non-medical technologies, like refrigeration, faster transportation, and the like (McKinlay, 1977; McKeown, 1979; Moberg & Cohen, 1991; Oppenheimer, 1992; Dubos, 1959).

One of the conclusions in Thomas McKeown's seminal work, "The Modern Rise Of Populations" (1976, also endorsed by a Lancet editorial, 2/1/75), was that the decline in mortality in the 18th and 19th centuries was essentially due to the reduction in deaths from infectious diseases, and that it was not the result of immunizations. Similar studies by scholars John & Sonia McKinlay (1977) shows that almost all the increase in human lifespan since the year 1900 is due to reductions in infectious disease, with medical intervention (of all kinds) accounting for only about 3 per cent of that reduction. According to World Health Statistics Annual, 1973-76, vol.2, "there has been a steady decline of infectious diseases in most developing countries regardless of the percentage of immunizations administered in these countries." Not surprisingly, smallpox epidemics had disappeared decades before the WHO decided to conduct their final "eradication" campaign.

According to the records of the Metropolitan Life Insurance Company, from 1911 to 1935 the four leading causes of childhood deaths from infectious diseases in the U.S.A. were diphtheria, pertussis (whooping cough), scarlet fever, and measles. However, by 1945 the combined death rates from these causes had declined by 95 percent, *before* the implementation of mass vaccine programs. (Dublin L, Health Progress, 1935-1945, Metropolitan Life Insurance Company, 1948, page 12) Other statistical information provided much the same pattern. (Alderson M, International Mortality Statistics, (Washington D.C., Facts on File, 1981, pages 161-162, 164-165, 177-178, and 216) According to a report in Morbidity and Mortality Weekly Report, July 30, 1999, improvements in sanitation, water quality, hygiene, and the introduction of antibiotics have been the most important factors in control of infectious diseases in the past century. Although vaccines were mentioned, they were not included among the major factors. (Morbidity and Mortality Weekly Report, July 30, 1999, 48:621-628)

Turn-of-the-century death rates for measles, pertussis, and diphtheria were horrific—with Pittsburgh, incidentally, often leading large American cities in mortality. But death rates for these diseases were dropping quickly before vaccinations were widely used—thanks probably to improved treatments and sanitation. According to U.S. Census Bureau figures, measles deaths nationwide declined from 12.6 per 100,000 in 1900 to .2 per 100,000 in 1960, three years before the vaccine was introduced. The pertussis death rate in the late '30s was about one-sixth the 1900 rate, yet pertussis vaccine wasn't available until 1944. One disease we routinely vaccinate for, the mumps, never posed much risk of death or permanent injury; others, such as scarlet fever and strep throat, have gone from major killer to medical nuisance without the help of any vaccine.

Measles started to decline rapidly at the turn of the century, and the death rate had reached very low levels by the time measles vaccination was introduced in 1968 (McKeown, The Role Of Medicine, 1979). Tuberculosis mortalities in Europe and North America had continuously fallen at almost a steady rate since the mid-nineteenth century—500 per 100,000 in 1845, down to about 50 in 1945—without any vaccine or drug therapy. It was accomplished with sanitation reforms, improved nutrition, and drug-free sanitariums to treat the afflicted. Even "a striking fall in the incidence of poliomyelitis had begun prior to the introduction of the Salk vaccine" (USPHS: NMR 1935-64.CDC). Polio disappeared in Europe during the 40's and 50's without mass vaccinations. It didn't occur in the third-world where only 10 per cent of the population had been vaccinated.

In fact, entire civilizations that had maintained their raw native diets and had not been vaccinated had somehow managed to avoid infectious disease epidemics. Historian Arnold De Vries', "Primitive Man And His food" [Chandler Book Co., Chicago, 1952] contains a wealth of myth-exploding information on this subject. He details all of the European and American explorations and encounters with primitive cultures during the 18th and 19th centuries. He demonstrates in case after case how the foods and diets introduced by these explorers to the natives had caused their diseases, and how those cultures that rejected them escaped so called infectious disease epidemics. For example, every investigator (carrying with them the Western germs) that had visited and lived with the Hunzas of the Himalayas had found no recorded cases of childhood infectious diseases, autism, SIDS, cerebral palsy, muscular dystrophy or cystic fibrosis.

Noted historians and explorers, like Washington Irving, Dr. Weston Price, Dr. Benjamin Rush, Captain James Cook, Nieuroff, Viedma, D.A. De Cordova, H. Melville, and others described the robust health and extraordinary strength and physical condition of native populations that were first encountered during the 18th and 19th centuries. The Ingalik indians of the Yukon, the Pantagonians and Yuracares of South America, the Aborigines of Australia, the Polynesians, Melanesians, Tahitians, Hawaiians, Eskimos, etc. were not decimated by infectious diseases immediately upon first contact with Europeans. Instead, their decline in health developed only after years of "exposure" to refined white flour (milled wheat), sugar (cane & refined), alcohol, cow meat and milk, salted-cooked-and-canned goods, chocolate, coffee, tea, tobacco, opium, cocaine, patent medicines, and snuff. The first patent for a food additive was filed in 1691.

Europeans were better able to tolerate these substances because their enzyme systems and enteric bacteria were able to adapt and tolerate them as they were gradually untroduced over generations. And we know from the work of Hygienic clinicians that all known infectious disease symptoms derive over the long term from a degraded diet; and are reversed through fasting, and adopting a healthy diet. So, primitive populations that were suddenly provided with these refined products and toxic substances all at once, and strayed from their raw food diets, initially experienced the natural catarrhal reactions identified as influenza and consumption (TB), which were not treated Hygienically, accounting for the resultant mortalities there, as well as everywhere else when these diseases are maltreated. As expected,

the rise in the deficiency diseases of beri-beri and rickets followed these catarrhal reactions. Chronic diseases of asthma, rheumatism, bone and coronary diseases appeared later.

According to the classical Germ Theory, if the infectious diseases were caused by transmissible microbes, then it should have spread quickly, and the time between infection and disease should have been just a matter of weeks. But instead, their chronic, deficiency, and infectious (inflammatory) diseases—born from the devitalized foods that they had adopted—all took years to develop. And when primitive populations adopted some of the poor sanitary and hygienic habits of Europeans, they also "caught" the same "filth" diseases, like cholera, dysentary, typhus, plague, and smallpox.

For example, Mr. De Vries describes various foods and health habits that Captain Cook introduced to the Maori natives of New Zealand in 1772. They gradually developed the same poor state of health as Europeans had, including decayed teeth. Inland areas had also been explored, presumably exposing the natives there with their foreign germs. However, those natives remained healthy because they were farthest from the ports where refined foods were less prevalent. And instead of developing infectious diseases soon after first contact with the Europeans, the first epidemic of dysentery among the Maori natives started in 1790—almost 3 decades after Cook's first visit! Also, it wasn't until 1844 to 1854 that other diseases like measles, mumps, scarlet fever had begun there. That's over 70 years after the epidemic should have risen and fallen, and immunity built up among the survivors.

Stories of the decimation of native populations by European germs are essentially medical urban legends. There are many alternative explanations for mass illnesses that are simply not considered. Forced migration and being displaced by European settlers was the obvious and main cause. I discuss several other causes beginning a few paragraphs down, as relayed from the journals written by European explorers.

But the most commonly cited myth was the deliberate infection by Europeans by passing along "small-pox blankets" to indians. These stories are based exclusively on two letters from British soldiers in 1763, at the end of the bitter and bloody French and Indian War. Essentially, it was based on an anectdotal interpretation of a couple of 18th century soldiers (not scientists). The claims by modern medicine that infectious diseases decimated native populations during that era are unsupportable, and are intended to justify mass vaccination and to prop the theory that diseases are transmissible from person to person. (Note: the microbes are, but not the diseases.)

For additional information on the myths of infectious (re: "contagious") disease epidemics among previously unexposed native populations, one may read the assembled writings on John Scudamore's website. The following example are excerpted quotes from William Tebb's "The Recrudescence Of Leprosy And Its Causation", London, Swan sonnenschein & Co., 1893, from John's webpage, http[colon]//www.whale.to/v/tebb/tebb.html:

"We also hear of the noble work of Father Damien among the lepers of Hawaii, but we are not told that there was not one leper in the whole of the Hawaiian Islands before the noble work of Jenner reached them. By the nineties, 10 per cent of the natives were lepers."—Lionel Dole

"The chief of the Public Health Department was clearly not aware that until a comparatively recent period arm-to-arm vaccination was practically the *only method in vogue;* and at the time Mr. Ritchie's declaration was made, to the effect that none of the lymph in use had passed through the human body, at least three-fourths of the lymph in use in the United Kingdom was the variety known as arm-to-arm vaccination virus."

"I should be sorry to see a leper cook, and I go further than that. In vaccinating, I think hardly a medical man would take vaccine lymph from the arm of a leper infant. I know it has been our practice for the last twenty years not to do so." —Dr. Henry Ebden, 1883, President of the (South African) Medical Board NB

It takes at least 3 years for leprosy symptoms to appear. "Moreover, leprosy is an insidious disease, and in its early stages cannot be diagnosed and detected save by experienced medical practitioners accustomed to treat this particular malady. Of the enumerators, not one in a hundred could detect a case of leprosy if he saw it, except when presented in its most aggravated and repulsive form."

"According to all the evidence which I have been able to obtain, leprosy was unknown in the Sandwich Islands until many years after the advent of Europeans and Americans, who introduced vaccination ; and there is no aboriginal word in the Hawaiian language for this disease. Mr. Dayton, President of the Board of Health, says that the natives, having no words of their own, used the Chinese words *maipake*: "what is this disease?"

In Captain Cook's time (1779) these islands were supposed to contain a population of 400,000 at the present time (1893) they do not number more than 40,000, and are rapidly diminishing. In all quarters, both native and European, lay and medical, among members of both Houses of the Legislature, I found the belief all but universal that leprosy was considered to be communicable, and that the propagation of the disease during the last twenty-three years was largely due to vaccination.

One medical authority told me that he had no doubt that the disease was inoculable and spread by vaccination, but he did not think it would be prudent to disclose the fact amongst the' natives, as he would not be responsible for what they would do."

"Vaccination, he says, is carried out in the Colonies in a most careless and perfunctory manner. He has seen the operator pass his lancet from one arm to another without the smallest attempt to disinfect the instrument or discriminate between the diseased and the healthy, in districts where both leprosy and syphilis are endemic. From other reliable sources I am satisfied that this is the rule rather than the exception. Canon Baker believes that leprosy is chiefly communicated by means of inoculation, and that arm-to-arm vaccination is a prolific cause of the spread of this fearful plague in South Africa."

"He remarks that in Antioquia (Colombia) not a single case of leprosy was known thirty years ago. Since then, the disease has spread in all directions, and the number in this town is now said to be over 800. I may add that, during the interval, vaccination has been introduced in all the Republics of South America with the usual sinister results."

The Smallpox "Epidemics"

The Smallpox epidemics a century ago—and it's eradication—has been touted as the greatest vindication for the practice of vaccination. While the retrospective studies of the aforementioned scientists has rendered this a myth of modern medicine, there were scientists at the time who demonstrated that vaccination played no role in the erradication of smallpox. In many instances, it was the cause of smallpox.

Not only had poor sanitation and nutrition lay the foundation for disease, it was also compulsory smallpox vaccination campaigns in the late 19th and early 20th centuries that played a major role in decimating the populations of Japan (48,000 deaths), England & Wales (44,840 deaths, after 97 per cent

of the population had been vaccinated), Scotland, Ireland, Sweden, Switzerland, Holland, Italy, India (3 million—all vaccinated), Australia, Germany (124,000 deaths), Prussia (69,000 deaths—all revaccinated), and the Philippines. The epidemics ended in cities where smallpox vaccinations were either discontinued or never begun, and also after sanitary reforms were instituted (Most notably in Munich-1880, Leicester-1878, Barcelona-1804, Alicante-1827, India-1906, etc.).

Before health agencies and schools of public health were completely taken over by allopathic medicine, the great legacy of the sanitary reformers—Max von Penttenkofer, James T. Briggs, Dr. John Snow, Edwin Chadwick, Florence Nightingale, Dr. Southwood Smith—was that they were able to eradicate cholera, yellow fever, tuberculosis, typhus, typhoid, scarlet fever, diptheria, whooping cough, measles and the bubonic plague long before vaccinations were developed or routinely used. In many nations, mortalities from smallpox hadn't begun to decline until the citizenry revolted against compulsory smallpox vaccination laws. For example, the town of Leicester from 1878 to 1898 stood in stark contrast to the rest of England where thousands were dying from the aggressive half century-old government mandatory immunization campaigns.

By 1907 the Vaccination Acts of England were repealed, with the help of some of the world's preeminent scientists who had turned staunchly against vaccination: Alfred Russel Wallace (one of the founders of modern evolutionary biology and zoogeography, and co-discoverer with Charles Darwin of the Theory of Natural selection), Charles Creighton (Britain's most learned epidemiologist and medical historian), William Farr (epidemiologist and medical statistician, first to describe how seasonal epidemics rise and fall—known today as Farr's Law"), and the renowned Dr. Edgar M. Crookshank, Professor of Bacteriology and Comparative Pathology in King's College, London, and author of the scathing scientific critique of vaccination, *The History and Pathology of Vaccination* (1889).

But before the law was amended in 1898 to include a conscientious exemption clause, an average of 2,000 parents per year were jailed and prosecuted—some repeatedly—for resisting vaccination. Large numbers went to prison in default of paying fines. Hundreds had their homes and possessions seized.

By 1919, England and Wales had become one of the least vaccinated countries, and had only 28 deaths from smallpox, out of a population of 37.8 million people. By contrast, during that same year, out of a population of 10 million—all triply vaccinated over the prior 6 years—the Philippine Islands registered 47,368 deaths from smallpox. The epidemic came after the culmination of a ruthless 15-year compulsory vaccination campaign by the U.S., in which the native population—young and old— were forcibly vaccinated (several times), literally against their will.

In a speech condemning the smallpox vaccine reprinted in the Congressional Record of 12/21/37, William Howard Hay, M.D. said, " . . . the Philippines suffered the worst attack of smallpox, the worst epidemic three times over, that had ever occurred in the history of the islands, and it was almost three times as fatal. The death rate ran as high as 60 per cent in certain areas, where formerly it had been 10 and 15 per cent." In the province of Rizal, for example, smallpox mortalities increased from an average 3 per cent (before vaccination) to 67 per cent during 1918 and 1919.

All told, after 10 years (1911-1920) of a compulsory U.S. program which administered 25 million vaccinations to the Philippine population of 10 million, there had been 170,000 cases, and more than 75,000 deaths from smallpox.

Those who reject the notion that small pox epidemics were really caused by polluted food, water and air, may at least want to consider the safety and efficacy of the smallpox vaccine. "Professor George Dick, speaking at an environmental conference in Brussels in 1973, admitted that in recent decades, 75% of

British people who contracted smallpox had been vaccinated. This, combined with the fact that only 40% of children (and a maximum of 10% of adults) had been vaccinated, showed that people vaccinated against smallpox had a much higher tendency to contract the disease." (http://www.healingwell.com/library/health/thompson2.htm) He continued, "There continues to be incidents like the one in West Germany in 1967, where smallpox vaccination damaged the hearing of 3,296 children, and of these 71 were rendered completely deaf."

In many additional examples, cases of sickness, injuries and deaths commonly attributed to the microbe were actually due, wholly or in part, to the poisoning effects of vaccination campaigns: from the worldwide Spanish Flu epidemic of 1918-19 that killed 20 million following the administration of anti-typhoid inoculations (see Postscript #1), to the 1976 Swine flu "epidemic" (among hogs!) that permanently crippled a "meager" few thousand Americans with Guillain-Barré syndrome following an ill-advised national vaccination program.

Paralytic disease has been recorded hundreds of years ago. But epidemic numbers hadn't appeared until the latter part of the 19th century when compulsory smallpox vaccination was first instituted. A major outbreak of infantile paralysis followed a diphtheria toxin-antitoxin vaccination campaign in the United States in 1916. Worst hit was New York City, where 9023 cases were reported with 2448 deaths ("Breakthrough: The Saga of Jonas Salk", by P. Carter). Pertussis and typhoid vaccination campaigns had also been implicated in outbreaks: Polio cases began to soar in 1948-9 when pertussis vaccine began. In 1976, of the 46 million Americans that were vaccinated with Swine Flu vaccine, two thirds were either killed, paralyzed, or injured neurologically with Guillain-Barre Syndrome. (Uncle Sam payed out damage claims totalling almost $4 billion from this debacle.)

How Does Natural Hygiene View Infectious Disease?

The symptoms during such illnesses are referred to as an "eliminative crisis". It may be very discomforting, but it is a necessary self-limiting process in which an accumulation of retained metabolic waste (dead cells that become toxic), and the residues of undigested or unassimilated food are being purged from the body through vicarious (abnormal, inappropriate) channels. These bodily eliminations are manifested in the familiar "runny nose", cough, stiffness, fever, and numerous rashes, swellings, lesions, and eruptions through the skin.

For the liver, the natural avenue of elimination is through the bowel; for the kidneys, through the bladder or urethra. However, when the liver is congested, or the kidneys inflamed, waste matter (toxins) is thrown into the blood. Nature then uses vicarious avenues of elimination, or substitutes. The lungs will eliminate some of the wastes that should have gone through the kidneys, or the skin will do the same for the liver. Obviously the lungs do not make very good kidneys. From the irritation caused by the elimination through this inappropriate channel, we may get bronchitis, pneumonia, or tuberculosis. The disease is determined by the chemistry of the poison being eliminated and not by the invasion of any microbe. Similarly, if bile poisons (from the liver) in the blood come out through the skin, we get various irritations of the skin, resulting in skin conditions manifested by rashes, boils, acne, etc. Thus, the skin is "substituting" for the liver, or a vicarious elimination is occurring through the skin. (Therefore, it is rank stupidity for dermatologists to treat the skin, or burden the liver, with antibiotics, steroids and other poisons.) During more acute and involved forms of toxemia, such as measles, chicken pox, fever, or flu (etc.), the liver is much too busy neutralizing toxic wastes to be bothered with digestion of food. Fasting is more essential in such cases, especially considering the lack of digestive juices produced, and the loss of appetite that accompanies these illnesses.

According to Henry Bieler, M.D. (Food Is Your Best Medicine, 1965), "the childhood years should be the healthiest of all. It is during those early years that the endocrine glands and the liver are in their best functional capacity, giving the healthy child his natural state of exuberance, inexhaustible energy, and faultless elimination." This is precisely why eliminative and inflammatory illnesses usually occur during childhood (garbage in, garbage out, the fastest way possible—usually through the skin.) Having these symptoms often leads to a medical diagnosis of one of the so-called "childhood infectious diseases", if the pattern of symptoms fits their standard case definition, and especially if there is increased public health surveillance of the particular disease (thereby artificially sustaining the myth that these conditions are communicable).

Conversely, a physician will not diagnose a child with any disease that he or she had been vaccinated for, or for a disease that he or she had contracted previously—falsely presuming that prior infection builds immunity (it works out statistically to be extremely rare for a person to get the same illness twice during a lifetime, let alone during the narrow time-span of childhood). Another disease having similar symptoms will be substituted—and there are many to choose from. Another reason that these medical diagnoses are biased is because almost all cases of infectious diseases are determined solely by clinical diagnosis (without confirmation via a culture). This is in spite of the fact that many different diseases are defined by the same, or very similar symptoms.

Actually, the illness is often the result of a poor diet usually consisting of animal products, cooked and refined foods, or factors contributing to faulty elimination. Symptoms are often triggered by a physiochemical or psychological "trauma", such as exposure to cold or toxic chemicals, stress, lack of sleep, ingestion of spoiled meat, a sting or bite from an insect, etc.

There Are No "Bad" Germs

The idea that germs and viruses cause disease gets to the real nuts and bolts of the theory. Historically, dissidents from the (now) conventional theory of infectious disease have admitted that microbial agents are transmissible through various vectors from one host to the next. The point of contention has always been about the diseases and the role, if any, that these microbes play in causing them.

The public sees news headlines like, "Staff infections kills 8 million people a year", or "Super germs are the result of resistance to routine antibiotic use." Yet they lack the basic information to understand these issues. Thus, this section will delve into some interesting details concerning these small, unique substances.

Bacteria

Germs (bacteria) are the oldest and simplest life forms on our planet. The form endogenically from dead and dying cells. That's why we see this form of life proliferate on decaying matter, and never on healthy living tissue and cells. They appear as nature's scavengers, helping the cycle of organic and inorganic matter.

They have a similar function within our bodies. After your cells have been damaged by toxicity or trauma, it is easy for bacteria to attack and devour these weakened, injured, and dead cells. The species & function of the bacteria is determined by what they eat. In part, you control what they eat by what you eat. So-called virulent or pathogenic bacteria are only generated in the presence of decaying matter. They consume this matter, as well as dead cells, to reduce (decompose) it to it's constituent elements. The body is then able to drain (eliminate) both the germ and the broken down waste products from the body. After they're done, the bacteria return to smaller, more basic constituents or "filterable" phases.

Since bacteria rapidly transfer different bits of genetic material (in the form of viruses, viroids, episomes, plasmids, phages, prophages—or collectively referred to as "small replicons") to other cells and to other hosts, then in effect, you're the one who's "programming" the bacterial culture within your body. If the small replicons in and on your body are transferred to another unhealthy host, then the same bacteria will likely develop & thrive in the same "favorable" conditions. Pathogenic, or putrefactive bacteria will not "grow" in healthy "soil".

If unclean or putrefying matter is injected into a healthy host, then morbid chromosomes can alter the genetic material of normal cells. Your body will mount an immune response to the foreign matter and symptoms of disease (elimination) may follow. You should allow this to proceed, unmedicated. Cleanliness, or the avoidance of morbid matter (asepsis), should not be equated with killing germs (antisepsis). The former leads to a state of health. The latter suppresses symptoms and creates more acute diseases. (Even an aseptic projectile is capable of starting the abnormal evolution of the living intracellular elements to produce pathogenic bacteria solely by way of the mechanical action that alters the normal state of the environment.)

Asepsis vs. antisepsis is easy to distinguish: If faced with a roach-infested sink full of dirty dishes, for example, we appropriately clean the dishes. That's asepsis. It denies the scavenger organism it's food. We shouldn't spray insecticide on the dirty dishes. That would be anti-sepsis. Likewise, with microbial parasites, one has only to remove their food—decaying matter. Going on a fast performs that function. It facilitates elimination of bodily waste, by allowing your organs to concentrate on processing the food by-products that's already in your system, and by denying any additional waste matter to build up.

Bacteria are involved in the end stages of digestion. It converts the residues of what was eaten to fecal material for elimination from the body. Yet allopathic medicine instructs us to use germicides (antipyretic drugs) when inflammation is manifested (swelling, rash, fever, cough, mucous, etc.). Ironically, these symptoms of inflammation means that the body has reacted appropriately. Antibodies and other specialized cells gather at the site of injury, and the dead cells are eliminated through the skin or lungs (socalled "vicarious" elimination), or else through normal channels. Tonsils and the appendix may be temporary storehouses.

Trying to reduce a swelling with ice, for example, would be akin to preventing firefighters and EMS workers and police from getting to the location where a building caught fire and collapsed. Sure, there will be less congestion around that block by doing that. But who would help injured survivors escape? Who would put out the fire and carry out the dead?

Thus, the use of germicides (drugs) make no sense. They're toxic to all bacterial cells, and adversely affect normal metabolic function. When has it made sense to use an atom bomb when a fly swatter was sufficient? And when has it made sense to use a fly swatter when cleaning the kitchen had sufficed. The use of germ-killing agents is a level of micro-manipulation of a complex system that yields unintended consequences. The most common are diseases from antibiotic-resistant strains of bacteria. And where do most such cases occur? In the place where there's the highest use of antibiotics (i.e. germicides). Hospital-acquired infections have reached alarming levels.

The principles that distinguish asepsis from antisepsis may be applied to the internal environment of our bodies when we've accumulated high amounts of abnormal bacterial cultures (i.e. to many bad bacterial cells). Fasting can facilitate the drainage and elimination of excess mucous and metabolic waste. A change to a health enhancing, vegetable-based diet will benefit you thereafter. Studies confirm that those who live on vegan or low-meat (zero cow's milk) diets generally live longer, healthier lives than

meat-eaters. In fact, historically there have been entire populations and civilizations who, by and large, managed to escape the spectrum of degenerative and (so-called) infectious diseases as long as they lived in accord with nature.

Does exposure and infection equal disease? There are always vastly more people who are exposed to, or infected with, pathogenic bacteria or viruses associated with disease, who do not exhibit any signs of disease—even during socalled "raging epidemics". This can be attributed mostly to their healthy internal "culture". In almost every instance though, whether in sickness or in health, your germs are "home-grown"—products of human tissue cell degeneration, with your internal environment determining their species and pathogenicity.

The same strain of pathogenic (abnormal) bacteria excrete the same toxic waste, inducing similar symptoms in different hosts. This may explain why people exposed to the same tainted food or toxic environment exhibit the same symptoms. Doctors claim that you "must have caught" another person's disease. In fact, you've simply "cultured & harvested" your own disease, either by exposure to the same environment, or the one you created for yourself, through diet or drugs (medically prescribed or recreational).

At that point you have two choices. You can re-normalize your internal environment safely without drugs by following the principles of Natural Hygiene. Or, you can become one of the estimated one million Americans each year who suffer from prescription, drug-induced death or adverse reactions (a sub-catagory of "Iatrogenic", or medically-induced disease).

Bacteria's Role In Nature

To understand one of the reasons for these drug reactions requires an understanding of the vital role that bacteria (both "good" and "bad") play in all life on earth.

Bacteria, also known as prokaryotes, appeared 3.5 billion years ago. Bacteria were the only forms of life for the first 2 billion years of earth's existence, living here twice as long as the life forms that evolved afterward. Therefore, their original function could not have been to attack healthy forms of life to render it diseased. The eminent American pathologist Theobold Smith—who probably contributed the most hard facts to microbiological knowledge—suggested in his classic essay, "Parisitism and Disease", that it is the biological advantage for the parasites not to kill their hosts, since disappearance of the host jeopardizes the parasite's survival. An unstable equilibrium exists between parasite and host. Disease occurs when that equilibrium is disturbed. But death is not inevitable if hygienic healing is adhered to (see articles on Natural Hygiene).

Bacteria are the ancestors of eukaryotes, or cells containing a nucleus, like our own tissue cells. Fully 10% of our own body weight consists of bacteria. Your bacterial cells outnumber your body cells by ten to one. In effect then, each of us are a living mass of bacteria. And only about 1% of all known bacterial strains are pathogenic to humans.

Without bacteria, all life on earth would cease to exist. Indeed, if it were not for the bacteria of the Proterozoic aeon, earth would have stabilized to a mostly carbon dioxide atmosphere like Mars or Venus. There is no such thing as a germ-free sustainable environment. Where there is life, there are necessarily bacteria.

Having a relatively limited number of genes that are not encased in a nuclear membrane, bacteria are necessarily "team" players. Their life cycles closely interlock with each other and the environment. The

waste products of one kind becoming the food sources of the next. Bacteria prevent all living matter from becoming dust. They keep the organic and inorganic elements of the biosphere cycling. They never function as a single individual in nature. Instead, in any given ecological niche, teams of several kinds of bacteria live together, responding to and reforming their environment, and aiding each other with complementary enzymes. They are even more interdependent inside our bodies. Some produce vital enzymes and vitamins. Others covert toxic into non-toxic matter. Bacterial cells are more sensitive than body cells to foreign substances introduced into the body. So this delicate balance is disturbed when a drug or vaccine is applied.

Bacteria's Role In Disease

Strains of bacteria that are associated with disease are those that proliferate on morbid, decaying matter. Inside your body, these germs, which are converting waste products for safe avenues of elimination, are killed by antibiotics. The so-called "beneficial", or "friendly" bacterial strains are also killed. This contributes to an increased buildup of waste, as well as an abnormal balance in the bacterial population. Your body soon becomes weakened, and it's efforts to expel waste vicariously—in the form of swelling, redness, pus, rash, stiffness, fever, coughing, etc.—eventually subsides. This is when the doctor may tell you that the drug is "taking effect". In reality, uneliminated waste is being stored in your tissues and vital organs. Over time, you will consequently develop acute, chronic, then degenerative diseases.

Unless waste products from our cells, as well as the waste products of certain bacteria, find avenues of escape, our bodies can be overcome by them, which can lead to death. Doctors attribute the cause of death to whichever viral or bacterial strain grows in a dish from a tissue sample taken from the organ that "failed". But obviously that's not the real cause. It's just a derivative substance found after the disease had begun.

To promote the growth of specific kinds of pathogenic bacteria, medical technicians provide a selective nutritive medium (food). However, bacteria in the real world are generally pleomorphic—their species change rapidly depending on the kind of "food" that exists around them. Pleomorphism is the transformation of more than one distinct species of bacteria in a single life cycle. For more than a century, bacteriologists have observed this trait. Ultraviolet light can induce the rod-shaped anthrax bacillus to transform into the spherical coccus. The virulent Tubercle Bacillus (tuberculosis) could be made to degenerate into harmless non "acid-fast" cocci, and then into "diphtheroid" coccobacilli. Since all strains of bacteria can potentially share all bacterial genes, then strictly speaking, there are no fixed species in the bacterial world. According to Canadian bacteriologists, Sorin Sonea and Maurice Panisset (The New Bacteriology. Boston:Jones & Bartlett, 1983), all bacteria are one organism, one entity capable of genetic engineering on a planetary scale.

It is the state of the host environment—malnourished vs. healthy—that precedes, and determines the strain of the bacteria. By altering the medium—whether in a petri dish or in your body—you then alter the germ. This means that the present biomedical model of specific etiology of disease (classifying a specific germ as the single causative agent of a specific disease) is seriously flawed. Therefore, the drugs and vaccines that medicine employs are based on a faulty construct. It means, for example, that the $700 that NYC spends each day on each hospitalized TB patient, as well as the employment of 600 personnel in the TB section at the NYC Dept. of Health, is a scandalous waste. It means that government and private sources nationwide did not have to spend over $700 million in 1991 alone on antibiotic treatment for TB patients. It also means that the NYC Dept. of Health policy of forcibly detaining and forcibly medicating noncompliant TB patients is criminally negligent and medically irresponsible. Even if drugging were the correct approach, antibiotic use over time merely creates resistant strains that have super-immunity to drugs.

The irony is that Robert Koch, the discoverer of the Tubercle Bacillus and considered the father of the Germ Theory of Disease, later recanted his original claim that the bacillus was the cause of Tuberculosis. However, by then the pasteurization industry was already in full force. The temperature at which milk is heated during pasteurization isn't even high enough to kill the Tubercle Bacillus. It is high enough, however, to kill the lacto bacillus that prevents the putrefactive bacteria (the germ that causes milk to sour as it decays) from taking over. Consequently, pasteurized milk does not keep longer. Instead, it rots well before the consumer is able to detect it through smell or taste.

The use of drugs (and vaccines) for infectious (inflammatory) diseases are inappropriate, and quite harmful. Since the 1960's, deaths that can be attributable to the use of steroidal medications have quietly replaced the asthma mortality rates. (The treatment has displaced the disease). Surprisingly, there are more deaths today from septicemia (blood poisoning caused by toxic waste from putrifactive bacteria) than there were before the use of antibiotics. Reactions from antibiotics include anaphylactic shock, aplastic anemia, and induced virulent infections. Death from penicillin still occurs. These antibiotics irritate an already over-worked liver, as well as whip the endocrine glands to a higher tempo, eventually exhausting and weakening the adrenals.

Usually the most apparent effects of antibiotics occurs in the colon. An antibiotic may kill enough of the intestine's normal microorganisms to allow more resistant competing strains to flourish and take over. If the surviving bacterium is Clostridium difficile, for example, the diarrhea from the toxins it produces could lead to severe dehydration, and possibly ulceration and perforation of the intestine. All drugs and antibiotics leave your body in an ecological mess. In fact, it is drugging that is the real reason there is such a high rate of infections among hospital patients: when you kill off one strain, you then allow others to over-proliferate).

The belief that germs cause disease allows health officials to forcibly medicate and vaccinate people. But actually, a diseased state in the host precedes the formation and growth of pathogenic bacteria. A range of "pathogenic" bacterial strains, or their genetic "blueprints" (e.g., the various cellular and sub cellular—or "filterable"—stages that bacteria cycle through), inhabit our bodies all the time. Some strains flourish in the bodily waste that accumulates well before any outward symptoms (elimination) begin to appear. Their strain (hence function) is determined by the type of waste that they feed upon. The appropriate bacteria always emerge, and are formed from, the genetic material contained in a cell's nucleus after the cell's death and decomposition—whether they were your body cells or other organic matter. It is the state of health of the host (that's you) that determines the strain of bacteria that will develop.

And 99% of the germs that live inside you are endogenic (born from within), not exogenic. Such comparatively low titers of bacteria originating from outside our bodies explains why they have virtually no effect on our health. We are constantly exposed to "infectious"agents and there are innumerable opportunities for us to "catch" a disease. Yet we don't. Even during so-called epidemics or outbrakes, it is only a handful of people who exhibit illness. Statistically, it is therefore extremely rare for a person to get the same illness twice during his or her lifetime. In fact, "infectious" diseases usually occur, if at all, within a narrow time-span of a person's life—during childhood. Yet doctors insist that you escaped illness because you built up your immunity by getting the disease the first time!

Their various explanations for vaccines that fail to protect against disease are even less plausible. In fact, many of their own studies, if one accepts their precepts and interpretations of the results indicate that vaccines only partially or temporarily confer immunity, and that repeated booster doses have little or no effect. Vaccination focuses on antibody production—just a single aspect of the immune process—and by-passes other important mechanisms and stages of the entire immune response. This explains the

numerous medical studies that have found that there is absolutely no relationship between antibody count and the disease: People who prove to be highly resistant may have a low antibody count, and people who develop disease show high antibody counts. Indeed, it has been shown that children with agamma globulin anemia (e.g., they are incapable of producing antibodies), develop and recover from measles and other zymotic (so-called infectious or contagious) diseases almost as spontaneously as other children.

Other studies show that vaccination renders a substantial portion of immune bodies (T-lymphocytes) solely committed to the specific antigens involved with the vaccine. Having become committed, these lymphocytes become immunologically inert, incapable of reacting or responding to other antigens. These findings tends to support other studies that indicate that the immunological reserve for a wide range of antigens is substantially reduced in vaccinated children.

Although the long-term effects of persistent circulating antigens (from vaccines) in the body are unknown, they may be the cause of continual immune suppression, disabling our ability to react normally to disease: A latent virus from a vaccine injection can be incorporated into our body cells, yet still be viewed by our immune system as a foreign entity. This is one possible mechanism to explain how vaccines provoke auto-immune diseases and recurrent infections. Ironically, vaccines seem to impair children's immune systems. Clinicians have observed ear infections, allergies, and asthma more frequently in vaccinated children. These and other ailments related to an impaired immune system effects hundreds of thousands of children each year. Perhaps the greatest tragedy are the thousands of children each year who are needlessly killed or rendered physically or mentally impaired as a result of vaccine injections in the guise of protecting their health.

> Note on the issue of antibiotic resistance as it relates to autoimmune malfunction: The excessive use of germ killers (antisepsis), as opposed to traditional germ removal (asepsis) may be a factor here as well. The large molecules in antibiotics, for example, readily form antigens with proteins. When this happens, antibodies are formed in the body. If that person is exposed to other germicides in the environment, it may come in contact with the antibodies within the cells. Allergic reactions as mild as skin rashes, or as serious as anaphylactic shock, may follow.

Viruses: How They Differ From Bacteria

Bacteria are much simpler and primitive, structurally and functionally, than other cells. They have fewer organelles, and fewer, more accessible genes that are not protected by a nuclear membrane. Viruses are the genetic material—fragments of DNA and RNA—from dead cells. Viroids are even much smaller fragments. They are not "living entities", or single-minded agents of disease. Rather, they move about from one life form to the next, transplanting grafts of DNA, and thereby keeping new mutant kinds of DNA in the widest possible circulation, thereby aiding life to evolve. A bacterium that consumes it can easily incorporate that "message" into it's own genetic structure and make use of it.

These "accessory genes", visiting from sometimes very different strains, can contain instructions that its own DNA may not have, and incorporate them into its own genetic makeup through various genetic repair mechanisms. Bacteria are nature's original genetic engineers, by being able to splice genetic fragments to and from each other. Though more difficult, some of these genetic bits can move into the genetic apparatus of nucleated (or eukaryotic) cells, such as the tissue cells of our bodies. These viruses, viroids, and other small replicons that our cells absorb, are themselves duplicated as our cells replicate.

Eventually, billions of cells may poses this new genetic message. But it is the environment inside your body that determines how cells use their genetic information. The result may be appropriate for the cell, but not necessarily for you: A toxic state, over time, can effect an increasing number of body cells causing them to mutate. Perhaps this triggers a survival reaction by causing them to over-proliferate, as in cancer. Or perhaps the poorly oxygenated environment induces certain cell organelles, which were at one time invaders of the cell who eventually stayed to take refuge from oxygen (which was toxic to them), to fall out of line and to assert their independent tendencies. Over a period of years, with increasing toxicity, an increasing number of healthy cells find applicability in the new viral instructions that they've acquired, leading to mutations.

Whichever mechanism ultimately becomes the explanation for cancer, and other mutagenic diseases, we at least know that the process doesn't commence until the internal environment of the host becomes toxic to normal, healthy cells. During the 1970's, many virologists were hoping to attribute the cause of cancer solely to the presence of oncogenic retroviruses—independent of the cellular environment of the host. However, these viruses are most often subsequently found in healthy people who never get cancer. Despite billions of taxpayer dollars spent over a 15-year period known as Nixon's War on Cancer, molecular biologists at the NCI utterly failed to prove that a virus can cause cancer in humans. (In simpler species, it can.)

Many of these same "scientists" went on to invent another "viral" disease in the early 1980's—AIDS (referred to elsewhere). Geneticists in that decade were promising, by implication, that once they are able to identify and manipulate (through gene therapy) the correct tumor suppressor genes, we could then continue to pollute our bodies and still avoid cancer. This was wishful thinking at best. Because over two decades later, and many unnecessary deaths from gene therapy experiments, there's nothing to show for it. Genes have turned out to be far more complex, and interactive with environment, than they thought. The expression of any gene is, in fact, dependent upon the environment it's in. Everything, from the food you eat to the cosmetics you apply to your skin, alters this environment, and hence the genes and germs therein.

We already possess many genetic "blueprints", both inherited and acquired, for your cells to use in response to varying environmental conditions. By nourishing your cells with the correct building materials, you create the proper environment and a healthy state may be achieved. Whichever ways the allopathic mindset attempts to circumvent Nature's laws, there is usually a price to pay for doing so. Those who seek easy solutions in the form of pills and promises, pay this price. When single-payer national health insurance comes, we will all be supporting this grotesque medical industry through mandatory payroll taxes.

What Is Natural Hygiene?

NH compares favorably to the German allopathic school of drugging. For the treatment of infectious diseases, hygienic clinical practitioners were equally successful as their counterparts in public health. For example, at the turn of the century while thousands died or suffered dementia from Dr. Paul Erlich's toxic mercury and arsenic syphilis treatments, Dr. Herman of the Hospital Weiden in Vienna, Austria managed to heal 60,000 cases over the 30 year period that he was superintendent there. He never experienced a case of tertiary syphilis, or "neurosyphilis", because he never used a drop of mercury—which causes neurological damage.

In the U.S., the modern history of Natural Hygiene (NH) began in 1830. Some of the early leaders of the movement were medical doctors Sylvester Graham, Dr. William Alcott, Dr. Mary Gove, Dr. Isaac Jennings, Dr. Russell Trall and Dr. John Tilden. The underlying philosophy of NH is that the body is

self-cleansing, self-healing and self-maintaining. Food only provides nourishment. There are no substances that possess mystical properties that heal cells, tissues, or organs. The process of cellular repair (healing) is performed by the body, and it performs this function best in the absence of foreign or extraneous matter, such as food, drugs, or even herbs and vitamin supplements.

NH is not a religion or cult. It does not teach dogma, nor impose a morality. It is not a means unto itself. It provides a means of achieving and maintaining basic health by understanding Nature's laws. Our understanding of these laws, as well as the various modalities used to augment the natural healing process, have evolved over time. But Nature's laws have not. Practitioners of Natural Hygiene have had phenomenal clinical successes. From 1880 to 1940, people from all over the U.S. came to John Tilden's Denver sanitarium. The same was true for Herbert Shelton's clinic in San Antonio, Texas from 1923 to 1981. Today, there are several good clinics and fasting retreats where people may regain their health (to the extent that they are physically able—and willing) from a wide variety of illnesses.

Allopathic medicine takes the opposite approach. It seeks to micro-manage (usually through drugs) the after-effects (symptoms) of metabolic dysfunction, which can only result, at best, in short-term palliation. The next disease to develop in a person so treated is often caused by the medical intervention itself. (Medical statisticians themselves estimate iatrogenisis—medically induced illness or death—to inflict hundreds of thousands annually in the U.S.) Yet they're careful, while claiming to have "conquered" one disease, not to admit to the ones that they've increased or created as a consequence of their intervention. The relationship between the second disease and the treatment for the first is not made clear to the public. Secondary drug illnesses are given harmless sounding terms like, "side-effects" or "negative outcomes." A drug, for example, doesn't "kill" a patient—the patient simply didn't "respond favorably" to the treatments, or died from "complications" of the disease (translation: the drug killed him).

Perhaps this deception is to be expected, considering how routinely "prestigious" medical journals have accepted for publication studies using biometric data of similar dubiousness. For example, many of the effects of medical intervention in efficacy, or pre-licensure treatment trials, such as surgical mortality or drug-induced illness, are often not considered in treatment response. This is one reason the FDA must often recall unsafe drugs that are marketed after having been "tested" for safety. Some of the most criticized (and deliberate) methodologies are among the following:

- The most common reason that studies in which the control group (i.e. the group that went untreated) does better than the test group is that such studies are not written up and published. The drug company has a legitimate and vested interest in promoting it's product. The failing in not with the drug company. The failing is with everyone—particularly the news media and press—who accepts the peer-reviewed published studies as scientific. It is not. (1) Drug companies financially support medical journals; (2) It's based on a *scratch my back and I'll scatch yours* system of reviewers, all belonging to the same incestuous click, who compete for the same limited pool of research grants. In other words, it's a consensus seeking system, and consensus is not science.

- Response rates are not related to survival rates (e.g.- the drug worked as intended, but had created another different disease in place of the first one. The second disease was not mentioned).

- If subjects in the tested group die or get sicker from the drug that's being tested, then they're classified as "non-responders", and these outcomes are excluded from the study results.

- Survival rates are not related to pain-free or functional years of life. For example, as long as the subject is still breathing, it doesn't matter whether he is hooked to a machine or rendered physically dysfunctional from the effects of the treatment.

- Subjects in the non-treated (e.g.- undrugged) control groups who get well and recover from the disease (instead of getting sicker or dying as expected) are excluded from the study results on the pretext that the subject must have been initially misdiagnosed (as false positive, for example), or else a "spontaneous remmission" had occurred. A spontaneous remmission (their terminology) is in fact, a cure that is discounted in medicine simply because it is an unanticipated positive outcome that cannot be attributable to the doctor's actions or participation! In other words, if medical treatment wasn't involved, then the reasons for such a recovery is not worth exploring (very scientific, huh?). Apparently, medicine feels there is little that an ill person on his own, may do or stop doing, to effect what doctors termed a "cure". This is contrary to the tremendous successes made through hygienic measures in public health and clinical practice (read the textbox elsewhere in this brochure).

It should be emphasized that medicine doesn't consider the above practices to be fraudulent. Though criticized by some, these are accepted methodologies in medical research. The public should be aware of them, because it is for the public that these deceptions are performed: For medicine to continue as a profit-making enterprise, they must convince the public that they are making progress against disease. Congress appropriates billions of dollars each year to biomedical research. Billions more are spent by medical consumers. Medicine must be able to show, or promise to show, something in return. As these few examples show, they achieve this goal by way of flim-flam.

Allopathy vs Natural Hygiene

Medicine also places a strong distinction between prevention and cure. "Prevention" equates to annual check-ups and medical tests before symptoms appear. The implication is that disease is inevitable and should be detected early. "Cures" are attempted only after symptoms are detected. (However, the disease process really begins before detectable symptoms.) In both stages, the role of the patient is passive. For Natural Hygiene, the role of the "patient" is active. "Prevention" is lifestyle: you do what is good for you and stop what is bad. Disease is not inevitable if the proper lifestyle is followed. "Prevention" and "cure" are one in the same, because the former determines the latter.

Diet is an important component in the Hygienic lifestyle. Unlike conventional medicine, NH doesn't subscribe to the "everything in moderation" philosophy. Some things are poisonous, and they have some effect—even in moderation. We may not discern any effects, but there is a biological effect—however small—to everything we do. Physiologically, humans most resemble other herbivores in the animal kingdom. A vegetable-based diet, free of refined and fractionated "foods", is recommended for many sound health reasons. For example, those nations that lead the world in meat and dairy consumption, also lead in the incidence of degenerative diseases. In fact, almost all degenerative diseases (cancer, osteoporosis, cardiovascular, gastrointestinal, atherosclerosis, hypertension, diabetes, urinary disease, etc.) may be prevented, reversed or ameliorated by adopting a vegetarian diet.

The wholesale slaughter of billions of farm animals (cows, pigs, fowl) annually supports one of the largest sectors of our economy—meat, poultry, milk, eggs, as well as secondary industries like leather and soap. Even though there is a preponderance of literature that documents the benefits of vegetarianism, it is rare that we hear or read about it through the major media. Such a major change would threaten large institutions which are linked or supported by these industries. Also, like drug addicts, most people are addicted to their barbecued steaks. It is extremely difficult for most people to modify their diet, especially when the food industry extols the so-called benefits of meat and dairy. The weight of the evidence linking diet to disease has been shielded from the public almost as effectively as the evidence linking vaccinations to disease.

One clinical modality that is used by Natural Hygienists, and adopted by other "alternatives" to allopathic medicine, is to fast only on distilled water during an illness. That's why a loss of appetite accompanies most illnesses. That's why no digestive juices can be produced during a fever (etc.). This physiological rest period facilitates bodily elimination of excessive waste and the bacteria that feed upon it. Fasting can be safely performed by most people if the principles of Natural Hygiene are followed. Even degenerative diseases have been reversed through properly conducted fasts.

Intake of food would divert energy and resources towards digestion and assimilation, and away from detoxification (mostly by the liver) and elimination. But pharmaceutical drugs, as stated, have even more harmful effects. If the use of medication leads to death, you may hear the doctor say that the patient "did not respond to treatment", or "died of toxic shock". If the patient survives, adverse effects can be manifested later—as chronic and degenerative diseases, including neurological effects. Thus we never associate diseases later in our life with medications that are taken today.

We usually heal and survive the immediate effects to our health in spite of what doctors do to us. But this wasn't the case during the half century prior to 1920, when allopathic physicians still employed mercury for syphilis, digitalis for heart disorders, Quinine for malaria, and as well as the use of strychnine, arsenic, opium, calomel and also bleeding the patient. (Note—digitalis is still prescribed today for heart problems while mercury and formaldehyde is used in vaccines!). One of the more famous drugs that contained both mercury and arsenic was used to "cure" syphilis: Salversan made a quick fortune for it's German manufacturer after Paul Erlich had been awarded the Nobel Prize in 1908 for developing it. This was before others realized that it could only "kill" syphilis only if it killed the patient along with it. Salversan vanished unnoticed from the world's pharmacopeia. Paul Ehrlich kept his Nobel Prize, and Hollywood later made a popular movie glorifying Ehrlich and his "discovery".

Patients did very poorly on all of these early allopathic treatments. This is why allopathic treatments were the least favored by the public at that time. The joke then (and should still be today) was, "is there any cure for the doctor's treatment?" Therefore, real "progress" in medicine has actually been due to the shift towards less toxic sub-lethal doses of poisons in their attempts to check necessary bodily eliminations. Allopathic medicine does not distinguish between symptoms and cause. Hence, they "treat" only symptoms. By successfully suppressing elimination, conventional doctors believe that they are curing disease. Instead, they are driving it deeper into our bodies. The symptoms associated with disease are actually indicators of a cure in progress, if it is left to run its course unmedicated, and if the person still has the capacity to recover.

You can kill a germ with a drug. But then they become an even greater toxic load than when they were alive. The feeding cells of the immune system (macrophages, granulocytes, and monocytes) then have to work harder. The germ will also return in a more resistant form if you fail to alter the nutritive medium that they prefer. Meanwhile, you're still left with the waste matter that they were feeding upon—as well as an imbalance in the population of microorganisms as a result of the drug. Add to this the toxic, debilitating effects of the drug itself, and the result is a body that cannot efficiently process and eliminate waste. For a cell with this problem, death is the result. For complex animals, death usually approaches gradually, in the form of chronic and degenerative diseases—which is the real epidemic in "advanced" societies.

Remember, a pathogenic germ's only destructive effect on you is caused by the byproducts of it's metabolism, or how it may compete with the host for some factor essential to vital processes. The more of them, the more of an effect they have. Germs are formed from the cells of the food that you provide your body by way of diet, as well as from the nuclear material derived from your own body cells after they expire. If you consume normal food for a human (predominantly vegetables, fruits, nuts, seeds,

sprouts, whole course grains, legumes), then normal bacteria will develop. Your body only becomes ‘“infected” by what you supply it, and not by someone coughing in your direction.

Options For Parents

There are other theories of “infectious” (inflammatory) disease and immunity advocated by scientists and physicians in medicine and by practitioners in other disciplines. Their modalities of prevention & treatment have been practically applied by parents and health practitioners for generations with clinical success. Succeeding generations of Hygienic practitioners have added to our understanding of the natural healing process, which is comparably superior to vaccines and drugs.

The prevention of inflammatory diseases, and the ensuing complications from drugging or even feeding during the illness, would be better achieved through non-toxic, holistic approaches. Childhood “infectious” diseases are not “killer” diseases, despite what some doctors may tell you. Mortalities from “infectious” diseases are rare, but when they do occur, they are the result of pre-existing malnutrition, or treatment with antibiotics and other drugs. Even feeding a child during these severe eliminative crises may be fatal. Children treated in accord with the principles of Natural Hygiene, without drugs, do not die from “infectious” diseases.

The Responsibilities of Parents

Even if there were some benefit from vaccination, would any sum of money be adequate compensation for the care of a physically or mentally impaired child for the remainder of his/her life? Before you subject your child to these risks, make every effort to become informed. You are ultimately responsible for your child’s health—not your doctor, and not the Health Dept.

As the parent, the decision is yours alone to make. At this point you should have many questions. But considering what you may have learned thus far, you cannot defer this decision to your doctor. Most doctors will urge you to vaccinate. That’s what they were taught. Doctors were taught to do many things that were later discovered to be wrong, despite warnings from Natural Hygienists and outspoken critics within medicine.

Tonsillectomies (which are not as much in fashion as they were 2-3 decades ago), hysterectomies, swine-flu and pertussis vaccines, silicon breast implants, Prozac, Halcion, and Orafix are just a few widely known examples. So there’s little chance of getting your doctor’s support in your decision not to vaccinate your child. Don’t even try. Doctors who have dissented on this and other mainstream policies have had their careers hurt by their colleagues and state medical boards. Doctors are aware of this. Your doctor has his business—and you have yours.

As parents, you are ultimately responsible for your child’s health—not your doctor nor any state medical bureaucracy. You now have some facts. To get more, contact CFIC or obtain some of the books we recommend in the list that follows. Remember, you can always decide to vaccinate later. But if you vaccinate now, you won’t be able to remove the poison later. Nor to undo the damages.

Some of the parents in CFIC (your neighbors) can describe for you the life-long nightmare of raising a brain-damaged or physically impaired child. On the other hand, mortalities from infectious diseases are rare and are the direct result of inappropriate treatment, such as with drugs and antibiotics. Children treated in accord with the principles of Natural Hygiene, without the use of drugs, do not die from infectious diseases.

Coalition For Informed Choice

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"For a successful technology, reality must take precedence over public relations, for Nature cannot be fooled" ...Richard P. Feynman