THE informed PARENT
ISSUE ONE 2013 A NEWSLETTER ON VACCINATION ISSUES AND HEALTH

MEASLES HITS THE HEADLINES AGAIN

MAGDA TAYLOR, EDITOR
April 2013

We are now experiencing yet another outbreak of measles and MMR propaganda via the media, resulting in a lot of parents becoming fearful and worried as to whether they should allow their children to receive the MMR.

In all the years I have been looking into the subject I have observed so many of these measles scares – they seem to be more regular than the measles outbreaks themselves.

It is extremely difficult to get any balanced information out in the public arena and the radio and TV coverages are almost all very biased. For example, on Tuesday 9th April I was invited to participate in a morning programme for BBC Radio Scotland as one of the guests. This turned out to be a most frustrating experience as apart from a short intro earlier in the programme I had to sit through around half an hour's worth of discussion without being able to contribute. The doctor and bacteriologist that had also been invited on were given the opportunity to respond to the various callers on the programme whilst I was left on the line not being able to give an alternative comment. Finally, right at the end of the slot I was suddenly invited to speak again. Knowing that I was going to be cut off at any time I attempted to try and make as many points as I could, which is not ideal as there was not enough time to give proper explanation. This is typical of how most of these programmes are broadcast these days, in fact, it's more common now not to invite any guests that will be challenging the present established views. Back in the 1990s The Informed Parent, JABS and other vaccination researchers were given much more opportunity to get involved with some healthy discussion on the subject. This is certainly not the case these days.

Measles is being described in such a scary way at the moment it is no wonder parents are running scared.

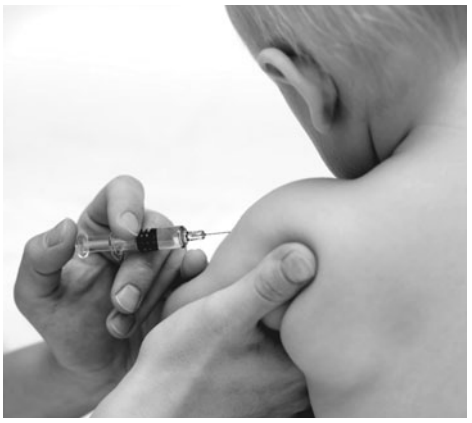
Here is an example of how measles was described back in 1959, nine years before a measles vaccine was introduced in the UK. I have also taken extracts from a few doctors describing their experiences of measles at that time. This paints a very, very different picture of the disease compared to the ones we are being given at the moment. I have highlighted some of the more significant comments in bold type.

Back in the 1990s The Informed Parent, JABS & other vaccination researchers were given much more opportunity to get involved with some healthy discussion on the subject. This is certainly not the case these days.

MEASLES EPIDEMIC TAKEN FROM: BMJ, FEB 7 1959, PAGE 354

In the first three weeks of this year about 41,000 cases of measles were recorded in England and Wales. This is well above the corresponding figures of the last two years-namely, about 9,000 in 1958 and 28,000 in 1957 - though, as the graph on p. 382 shows, it is below the highest levels reached in the last nine years. To give some idea of the main features of the disease as it appears today and of how it is best treated, we invited some general practitioners to write short reports on the cases they have seen in their practices recently.

These appear at p.380 (extracts from this page follow this article). It is interesting to note, first, that the distribution of the disease is rather patchy at present. It has not yet reached the areas where two of these doctors practise (in South Scotland and Cornwall), and other areas are known to be free of the disease so



far. On the other hand, in Kent it is reported to have arrived in time to put the children to bed over Christmas. **These writers agree that measles is nowadays normally a mild infection, and they rarely have occasion to give prophylactic gamma globulin.**

As to the treatment of the disease and its complications, the emphasis naturally varies from one practice to another. Amount of bed-rest, when to administer a sulphonamide or antibiotic, the use of analgesics and linctuses-all these may still be debatable problems in the treatment of what is said to be the commonest disease in the world. But there is probably much in the opinion which one of the writers expresses: "It is the frequent visiting by the interested clinician and not the therapy which produces the good results."

MEASLES REPORTS FROM GENERAL PRACTITIONERS BMJ FEBRUARY 7 1959, PAGE 380. EXTRACTS:

We are much indebted to the general practitioners whose names appear below for the following notes on the present outbreak of measles.

Dr G. R. WATSON (Peaslake, Surrey) writes: Measles was introduced just before Christmas by a child from Petworth.

Treatment of Attack.-No drugs are given for either the fever or the cough; if pressed, I dispense mist. salin. B.N.F. as a placebo. Glutethimide 125 mg. may be given in the afternoon if the child is restless when the rash develops; 250 mg.

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Editor's note

Magda Taylor

WELCOME TO THE FIRST EDITION FOR 2013.
I would like to start by thanking those who have been giving The Informed Parent a plug and their continued support – this is much appreciated and will help me carry on spreading awareness on this subject.
Very recently I was interviewed by Anuradhwa Kowtha, who runs a number of organisations, including Preparing For Pregnancy and Beyond. www.preparingforpregnancy.co.uk
One of Anuradhwa's main aims is to provide resources and tools to empower people, especially ancient and modern tools that bring consciousness and truth. My interview, along with other interviews on a variety of related subjects will be posted on Anuradhwa's website in the very near future, should you wish to learn more.
Christian Bates, Osteopath and Naturopath, based in West Sussex, has put together a publication entitled: Calming Colic – How To Help The 10 Causes of Colic. Having treated babies over a number of years, Christian started to see patterns in the causes behind colic in babies which led him into developing his own treatment protocols. Combining his clinical experiences and scientific data he has put together an ebook to give parents and interested parties more tools and information to work with, should they find themselves trying to deal with their infant's colic. You can find out more details by visiting: www.calmingcolic.com *or contacting Christian by email at* christian@theperrymount.com *or phoning 01444 410944.*

Another relatively recent book entitled Vaccine Epidemic – 'How Corporate Greed, Biased Science, and Coercive Government Threaten Our Human Rights, Our Health and Our Children' may be of interest to you. Many doctors, including Dr Andrew Wakefield, and research scientists have contributed to this publication. Mostly focusing on the position in the United States, it is an informative read especially for those who like to delve deeper into the human rights aspect, the legalities behind the established scientific fraternity, institutional scientific misconduct, and the influential power of the pharmaceutical industry. (Published by Skyhorse Publishing, ISBN: 978-1-62087-212-3. Available from Amazon).

Stay healthy and hope you enjoy this latest edition!
MAGDA TAYLOR, APRIL 2013.

› *from p01*

in single or divided doses at bedtime ensures a good night's sleep in spite of coughing. I encourage a warm humid atmosphere in the room by various methods: some electric fires and most electric toasters allow an open pan of water to rest on top; an electric kettle blows off too much steam to be kept on for more than short periods.

Parents, conscious of the need to darken the room and to forbid reading, may carry this to an unnecessary extreme, starting even before the rash appears. To save a mother some demands, the wireless is a boon to children in darkened rooms. They are allowed up when the rash fades from the abdomen-usually the fourth or fifth day-and may go outside on the next fine day. Apart from fruit to eat. Solid food is avoided on the day the rash is appearing; fruit drinks or soups are all they appear to want.

COMPLICATIONS.

So far few complications have arisen. Four cases of otitis media occurred in the first 25 children, but only one had pain. No case of pneumonia has occurred, but one child had grossly abnormal signs in the chest for a few days after the fever subsided, uninfluenced by oral penicillin. One girl had a tear-duct infection and another an undue blepharitis. Of three adult males with the disease, two have been more severely affected than any of the children.

Dr. R. E. HOPE-SIMPSON (Cirencester, Glos) writes: We make no attempt to prevent the spread of measles, and would only use gamma globulin to mitigate the severity of the disease in the case of the exposure of a susceptible adult or child who is already severely debilitated. **Bed rest, for seven days for moderate and severe cases and of five to six days in mild cases, seems to cut down the incidence of such complications as secondary bacterial otitis media and bronchopneumonia.** We have not been impressed by the prophylactic or therapeutic use of antibiotics and sulphonamides in the first week of the disease. As soon as the patient is out of bed we allow him out of doors almost regardless of the weather.

Otitis Media and Bronchopneumonia. - These conditions often appear so early, sometimes even before the rash, that in such cases one can only conclude that the responsible agent is the virus itself. Despite their initial alarming severity, they tend to resolve spontaneously, and treatment apart from first principles seems useless. When, on the other hand, otitis media or bronchopneumonia comes on after the subsidence of the initial symptoms of measles, it is probably due to a secondary bacterial invader, and we find antibiotics or sulphonamides useful…

MILD AILMENT

Dr. JOHN FRY (Beckenham, Kent) writes: The expected biennial epidemic of measles appeared in this region in early December, 1958, just in time to put many youngsters to bed over

Christmas. To date there have been close on 150 cases in the practice, and the numbers are now steadily decreasing. Like previous epidemics, the primary cases have been chiefly in the 5- and 6-year-olds, with secondary cases in their younger siblings. **No special features have been noted in this relatively mild epidemic.** It has been mild because complications have occurred in only four children. One little girl aged 2 suffered from a lobular pneumonia, and three others developed acute otitis media following their measles. In the majority of children the whole episode has been well and truly over in a week, from the prodromal phase to the disappearance of the rash, and **many mothers have remarked " how much good the attack has done their children," as they seem so much better after the measles.**

A family doctor's approach to the management of measles is essentially a personal and individual matter, based on the personal experiences of the doctor and the individual character and background of the child and the family. **In this practice measles is considered as a relatively mild and inevitable childhood ailment that is best encountered any time from 3 to 7 years of age. Over the past 10 years there have been few serious complications at any age, and all children have made complete recoveries.**

As a result of this reasoning no special attempts have been made at prevention even in young infants in whom the disease has not been found to be especially serious.

American parents awarded £600,000 in compensation after their son developed autism as a result of MMR vaccine

BY DAVID GARDNER

www.dailymail.co.uk

15 January 2013

AMERICAN PARENTS awarded £600,000 in compensation after their son developed autism as a result of MMR vaccine

- Saeid and Parivash Mojabi claimed their son suffered a 'severe brain injury'
- The Californian couple said that son Ryan was diagnosed with Autism Spectrum Disorder.

Parents who claim their 10-year-old boy developed autism as a result of being injected with an MMR vaccine when he was a baby have been awarded more than £600,000 in a landmark court decision in America.

Saeid and Parivash Mojabi claimed that son Ryan suffered a 'severe and debilitating injury to his brain' after being administered with two measles-mumps-rubella vaccinations in December, 2003 and in May the following year. They said in court papers that Ryan was diagnosed with Autism Spectrum Disorder.

The ruling comes months after a judge in Italy awarded £140,000 to an Italian couple who said their son had autism after his routine childhood MMR inoculation.

The American decision - although it doesn't lay fault for the child's disability with the drug - fuels anti-MMR campaigners challenging the view of the majority of the medical profession that holds the vaccinations are safe.

The claim was against the US government which set up a Vaccine Programme. Although a judgement rules whether or not each case is eligible for compensation and the amount - in this case against the US Health Department - it does not apportion blame. The San Jose, California-based family took their case to the US Court of Federal Claims in 2006.

Under the National Vaccine Injury Compensation Programme, parents can petition the US government for compensation for injuries or deaths allegedly caused by compulsory childhood vaccines.

- A judgement in Ryan's case, which was first filed in 2006, was made on December 13 last year by the Office of Special Masters set up by US Congress to decide on compensation claims. The defendant in the case was the US Secretary of Health and Human Services.

The damages payment takes into account the boy's future loss of earnings because it's unlikely he will be able to work.

In statements to the court, Ryan's grandmother Paravaneh Shah-Mohammadi and his aunt Pooran Vahabi told how the boy appeared 'lethargic', 'hardly responsive to noises and people around him,'and 'unable to hold himself upright' after having the first MMR vaccination.

Under the National Vaccine Injury Compensation Programme, parents can petition the US government for compensation for injuries or deaths allegedly caused by compulsory childhood vaccines.

The number of autism cases in the UK has soared over the past four decades. At the last count researchers found one in 64 British children have some kind of autistic condition.

In the Eighties, only four in every 10,000 children showed any signs of autism.

The Department of Health and NHS doctors insist that better diagnosis of autism and environmental factors are responsible for the dramatic rise in the number of cases and dismissed MMR vaccinations as a cause.

No link between the jabs and autism has been found in the British courts.

In America, nearly 5,000 families blame the MMR injection for causing their children's autism.

In 2008, a girl called Hannah Poling was awarded £1 million damages by the US government when a court ruled that receiving nine vaccines in one day, including the MMR, had caused her autistic condition.

But the court said that Hannah had an underlying cell disorder, mitochondria, which had been aggravated by the vaccinations and manifested itself as autism.

In Ryan's case, Chief Special Master Patricia Campbell-Smith decided his family was eligible for damages under the US government's Vaccine Programme.

FDA APPROVES FIRST GMO FLU VACCINE CONTAINING REPROGRAMMED INSECT VIRUS

BY: JONATHAN BENSON,
STAFF WRITER
http://www.naturalnews.com/
Friday, February 08, 2013

NATURALNEWS, A new vaccine for influenza has hit the market, and it is the first ever to contain genetically-modified (GM) proteins derived from insect cells. According to reports, the U.S. Food and Drug Administration (FDA) recently approved the vaccine, known as Flublok, which contains recombinant DNA technology and an insect virus known as baculovirus that is purported to help facilitate the more rapid production of vaccines.

According to Flublok's package insert, the vaccine is trivalent, which means it contains GM proteins from three different flu strains. The vaccine's manufacturer, Protein Sciences Corporation (PSC), explains that Flublok is produced by extracting cells from the fall armyworm, a type of caterpillar, and genetically altering them to produce large amounts of hemagglutinin, a flu virus protein that enables the flu virus itself to enter the body quickly.

So rather than have to produce vaccines the "traditional" way using egg cultures, vaccine manufacturers will now have the ability to rapidly produce large batches of flu virus protein using GMOs, which is sure to increase profits for the vaccine industry. But it is also sure to lead to all sorts of serious side effects, including the deadly nerve disease Guillain-Barre Syndrome (GSB), which is listed on the shot as a potential side effect.

"If Guillain-Barre Syndrome (GBS) has occurred within six weeks of receipt of a prior influenza vaccine, the decision to give Flublock should be based on careful consideration of the potential benefits and risks," explains a section of the vaccine's literature entitled "Warnings and Precautions." Other potential side effects include allergic reactions, respiratory infections, headaches, fatigue, altered immunocompetence, rhinorrhea, and myalgia.

According to clinical data provided by PSC in Flublok's package insert, two study participants actually died during trials of the vaccine. But the company still insists Flublok is safe and effective, and that it is about 45 percent effective against all strains of influenza in circulation, rather than just one or two strains.

FDA also approves flu vaccine containing dog kidney cells

Also from the same publication as above:

BACK IN NOVEMBER, the FDA also approved a new flu vaccine known as Flucelvax that is actually made using dog kidney cells. A product of pharmaceutical giant Novartis, Flucelvax also does away with the egg cultures, and can similarly be produced much more rapidly than traditional flu vaccines, which means vaccine companies can have it ready and waiting should the federal government declare a pandemic.

Like Flublok, Flucelvax was made possible because of a $1 billion, taxpayer-funded grant given by the U.S. Department of Health and Human Services (HHS) to the vaccine industry back in 2006 to develop new manufacturing methods for vaccines. The ultimate goal is to be able to quickly manufacture hundreds of millions of vaccines for rapid distribution.

Meanwhile, there are reportedly two other GMO flu vaccines currently under development. One of them, which is being produced by Novavax, will utilize "bits of genetic material grown in caterpillar cells called 'virus-like particles' that mimic a flu virus," according to Reuters.

Sources for this article include:
http://healthimpactnews.com
http://www.reuters.com

Tetanus vaccine causes new disease: new vaccines worse?

BY HEIDI STEVENSON
http://gaia-health.com
January 29, 2013

THE TETANUS vaccine causes a new disease known both as Hughes syndrome and antiphospholipid syndrome APS. It's an autoimmune condition that can attack any part of the body, though is best noted for heart attacks and killing fetuses. It's likely that APS will become more common with the new generation of vaccine adjuvants now being produced.

The sufferers of (APS) are mostly women, and its diagnosis is often made as a result of multiple pregnancy losses. As is typical of new diseases, research is focused on finding a genetic cause, in spite of the fact that the connection with vaccines is well known and documented.

As the name implies, APS is a condition in which phospholipids, natural and necessary substances required by every part of the body, is seen as an infectious agent by the immune system. So, this substance that exists in every cell becomes subject to attack. Symptoms include:

- Blindness
- Cardiovascular:
  - Deep vein thrombosis (clots in veins)
  - Phlebitis
  - Thrombocytopenia (deficiency of blood platelets, causing bleeding & bruising)
  - Atherosclerosis
  - Pulmonary embolus (clots in the lungs)
  - Heart valve abnormalities
  - Stroke
- Headaches & migraines
- Miscarriages
- Neurological disorders:
  - Epilepsy
  - Chorea (sudden uncontrollable jittery movements)
  - Transverse myelitis (inflammation of the spinal cord)
  - Multiple sclerosis
  - Cognitive dysfunction
- Skin disorders, including mottling, ulcers, and necrosis

APS can also be diagnosed - more accurately, misdiagnosed - as lupus erythematosus, which is another vaccine-induced condition.

APS AND VACCINES

One study calls Hughes syndrome the "classical antiphospholipid syndrome"[1]. That study refers to similarities between plasma protein beta-2-glycoprotein-I (2GPI), which is attacked in APS, and the tetanus vaccine. That is, the tetanus antigen has parts that are virtually identical to 2GPI, which is found virtually everywhere in the body.

"...antiphospholipid syndrome (APS). It's an autoimmune condition that can attack any part of the body, though is best noted for heart attacks and killing fetuses.."

Another study documents how APS can be induced in laboratory animals with tetanus vaccination[2]. Many large number of other studies document and investigate the connection between vaccines and antiphospholipid syndrome[3,4,5,6,7,8].

These studies leave little doubt that APS is caused by vaccines. That should come as little surprise, since it was first identified as a disease during the 1980s. If this disease existed prior to vaccines, it was so rare that it was unknown. Now, it can take its place among a growing list of vaccine-induced conditions, including rheumatoid arthritis, macrophagic myofasciitis, multiple sclerosis, autism, and siliconosis. The list keeps growing and many believe that all these conditions should be included under a single name, autoimmune/inflammatory syndrome induced by adjuvants, or ASIA.

WHY NEW GENERATION VACCINES ARE ESPECIALLY WORRISOME

Phospholipids are a primary part of your body, forming part of the membrane of every cell, among other functions. They're under attack in APS. As can be seen with regard to tetanus vaccine, APS can be induced by the antigen when the epitope - the part of the antigen forming the pattern that antibodies are designed to attack - is similar to a particular part of the body.

What's frightening is that phospholipids are becoming a primary ingredient of vaccines in the form of a new generation of adjuvants made via recombinant DNA by diddling with a part of pathogenic bacteria called outer membrane vesicles (OMVs). You can read more about them in New Generation of Vaccine Adjuvants: Worst Ever?

OMVs allow for designer vaccine antigens and adjuvants. OMV adjuvants are, of course, being promoted as the safest ever developed. That safety claim is based on the fact that they're so much like the body already. This is the same claim that's been used to promote squalene, which, as we've recently seen with the tragic cases of narcolepsy in children after the squalene-laced flu vaccine, Pandemrix, was unleashed in Europe, can devastate lives. Gaia Health explained the issue in How the Flu Vaccine Causes Narcolepsy.

Squalene is a lipid. That's what makes it so dangerous. OMVs are even more precisely analogous to human tissue, because they are not only lipids, they are phospholipids - which are precisely what the body attacks in APS. Therefore, we can anticipate that there will be ever-more cases of APS as we see the approval of ever-more OMV-based vaccines, which are in the pipeline now.

Have no doubt: these vaccines will be approved. The first one, Cervarix, is already out there - and it's been deemed safe, in spite of evidence to the contrary.

People with APS are suffering from phospholipid antibodies that are erroneously destroying parts of the eye, cardiovascular system, brain, nerves, skin, reproductive system - in short, any part of the body. This self-destruction is induced by vaccine technologies. These technologies are presumed safe without adequate, if any, testing. Just how many

people must suffer before this travesty is ended? When will the clearly mad purveyors of these technologies step back and question what they're doing?

The fact is that there are not just one, but several generations of people who don't even know what good health is. Worse, each successive generation is growing sicker than the previous one. And worst of all, the vaccine junta is not only unconcerned, it's massively gearing up this vaccine arms race against the human race.

"This self-destruction is induced by vaccine technologies. These technologies are presumed safe without adequate, if any, testing. Just how many people must suffer before this travesty is ended?"

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9. The Antiphospholipid Story, from the APS Foundation of America website
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12. Learning About Antiphospholipid Syndrome (APS)
13. The antiphospholipid syndrome (Hughes' syndrome)

Influenza vaccine fails completely

SOURCE: ARTSENKRANT, PAGE 2

www.healthimpactnews.com

February 12, 2013

AFTER some Cochrane publications proved influenza vaccination is not evidence based, except perhaps in COPD patients, a recent experience proved the complete failure of the vaccine in the field.

In a residential care centre in Vilvoorde, Belgium, between mid January and mid February 2013, 48 people fell ill with influenza. All of them had been vaccinated. Subsequently, the cafeteria was closed, and residents were served in their rooms. Yet, the number of ill people kept growing until 48 were affected, and 6 of them needed to be hospitalised.

Because of concern about this situation, the national influenza Commissioner Van Ranst was contacted. First they checked whether the patients had been vaccinated. This was the case with no exception. Then the virus responsible for the epidemic was identified because it was expected that it was not present in the vaccine used. But the influenza A H3N2 virus which was isolated was indeed present in the vaccine used.

Conclusion: full coverage with a perfectly matching vaccine did not offer any protection!

Being asked about the reasons for this failure, the commissioner blamed the personnel and the nurses for not being fully vaccinated, and also the visitors were held responsible for the epidemic. Complete nonsense, of course, because a) vaccinated persons are supposed to be protected against the disease anyway, and b) even vaccinated individuals can spread the infection, since vaccination does not offer mucosal protection and, hence, does not prevent droplet infection.

Kris Gaublomme, MD

"TO ENJOY GOOD HEALTH, TO BRING TRUE HAPPINESS TO ONE'S FAMILY, TO BRING PEACE TO ALL, ONE MUST FIRST DISCIPLINE AND CONTROL ONE'S OWN MIND. IF A MAN CAN CONTROL HIS MIND HE CAN FIND THE WAY TO ENLIGHTENMENT, AND ALL WISDOM AND VIRTUE WILL NATURALLY COME TO HIM. ~ BUDDHA"

VACCINATION FOR ALL MENINGITIS STRAINS?

www.sciencedaily.com
Feb. 27, 2013

SCIENTISTS at the University of Southampton have taken a significant and important step in keeping people safe from the most common form of meningitis in the UK.

Editor: Just a reminder that I reproduce articles the way ' they tell them' – it is for you to decide whether there is any validity in what is said.

Meningitis B (also known as Meningococcal group B or MenB) is one of the deadliest strains of meningitis. Each year, an average of 1,870 people in the UK are affected by the disease with one in 10 people dying from it.

Recently the first potentially universal MenB vaccine - Bexsero - was awarded a license for use throughout Europe, but it has been estimated that in this country, this new vaccine should protect against 73 per cent of the bacterial strains that cause the disease.

Now Dr Myron Christodoulides, Reader in Molecular Bacteriology/ Microbiology at the University, and his team have discovered a potential way of protecting people against the other 27 per cent of strains of the disease.

In a study, published in mBio February 26, 2013, the University of Southampton team discovered that a MenB protein called the Adhesin Complex Protein (ACP) is a new molecule that the MenB bacterium uses to stick to human cells.

Importantly, ACP also stimulates the production of antibodies that kill the bacteria. The team demonstrated that antibodies induced to an experimental ACP vaccine had the ability to stimulate protection against many more MenB strains.

Dr Christodoulides, who is also scientific Chairman for the Meningitis UK Scientific and Medical Panel, comments: "We are now starting to see the first generation of vaccines for Meningitis B, which is a fantastic development but we know that they may not be 100 per cent effective at this stage.

"There are already a number of successful vaccines that can prevent many cases of bacterial meningitis, including the Meningitis C, HIB and pneumococcal vaccines. These vaccines are made from the 'jelly-like' coats that surround these bacteria.

"But the issue with Meningitis B is that the coating of this bacterium has similar characteristics to a human protein found in the brain, and therefore if we used the same method, we would potentially create antibodies against the body's own protein."

ACP was identified from a previous study done by the team in Southampton, in which they analysed the types of protein that were present in the membrane that is found underneath the 'jelly-like' coat of the bacterium. The team believed that because these proteins might be exposed on the surface of the membrane, they could conceivably be targeted by the human immune system. The team confirmed that ACP was indeed exposed on the bacterium's surface and also that it was present in all the strains of meningococci that they were able to examine.

Dr Christodoulides adds: "We believe that ACP is potentially something that will bridge the gap that Bexerso does not appear to cover and break through into the second generation of vaccines for Meningitis B."

Dr Christodoulides and his team will continue preclinical work with the potential vaccine with an aim of taking it to Phase 1 trials.

TUBERCULOSIS: IS THE BCG VACCINE ANY GOOD?

BY DR JAYNE DONEGAN

ARTICLE FROM ISSUE 1 - 2000 of The lnformed Parent newsletter, by Dr Jayne Donegan

THE DISEASE

Tuberculosis is a disease caused by infection of a susceptible person with the tubercle bacillus. This bacillus is from the family, 'Mycobacteria'. Mycobacteria are very common and live all around us in tapwater, grass, mud, hay, rubber tubing and so on. Most do not cause infection in humans. Those that do need certain conditions: overcrowding, poor ventilation, dusty atmosphere, poor and low protein diet, migration, grief.

People anywhere that are uprooted, torn away from families, packed into shoddy accomodation with low pay, and bad working conditions will be susceptible to tuberculosis. Tuberculosis was described among city builders in Greek and Roman times and devastated Europe during the eighteenth and nineteenth centuries with the advent of the Industrial

Revolution, mass production, slum cities and subsistence wages.

In the 1800's seven out of every ten people became infected with the tubercle bacillus in the course of their lifetime but only one in seven died from the disease. The people who died were immigrants, industrial workers and the homeless [(1)].

Rich, well-nourished people became infected too but were less likely to die. except that by virtue of their wealth they could afford the ministrations of the physicians of the day. 'Treatments' such as purging and repeated blood letting often sapped their vital strength and saw them off despite their advantages.

Many famous artists, musicians and poets, succumbed to tuberculosis, contributing to or instigating the pathos of this 'romantic' period. Overwork, poor diet and damp, airless accomodation assisted the process [(2)].

Mycobacterium tuberculosis is spread from person to person by coughing, sneezing and talking. It does not take many bacilli to infect a susceptible person but it may take months living in the same house before this happens. When the disease is spreading across part of the lungs and forming cavities, people may produce large amounts of bacilli and are more infectious. Tuberculosis is not spread by clothes or bedding.

Dr Jayne L.M. Donegan

"Tuberculosis began to disappear from England in the 1850's. The shambolic growth of cities was taken in hand. Public health acts provided a basis for improved sanitation, new building standards and slum clearance."

Tuberculosis began to disappear from England in the 1850's. The shambolic growth of cities was taken in hand. Public health acts provided a basis for improved sanitation, new building standards and slum clearance [(3)]. Streets were widened, sewers were walled in, the dead were buried outside of towns. Railways were built bringing fruit and vegetables to urban centres. Ventilation of jails and hospitals was improved. The increased use of glass in windows sounded another death knell for tuberculosis. Mycobacteria are highly susceptible to ultra violet radiation and transmission rarely occurs out-of-doors in daylight [(1)(4)].

Mortality from tuberculosis fell as immigrants from the countryside became accustomed to their new situation. Factory acts improved the lots of workers and children. It still remained high among newer immigrants such as the Irish and those from the Indian subcontinent today, by the very fact of their migration.

The tubercule bacillus was discovered in 1882 by Robert Koch, a German scientist. This virtually single handedly put an end to measures aimed at the improvement of public welfare as a way of reducing disease. Doctors went rushing in the direction of drugs, antisera and vaccines. It is a shame that we all remember Louis Pasteur as the inventor of the 'germ theory of disease' but his deathbed recantation: "The soil is everything; the germ is nothing" is less-widely publicised.

Deaths from tuberculosis in this country fell from 270 to less than one per 100,000 population between the 1850s and the 1980s, apart from a couple of blips during world wars I and II, for obvious reasons. The introduction of anti-tuberculous drugs in the 1940s made no difference to the rate of fall and neither did the introduction of the BCG vaccination in the 1950s [(5)]. Countries like the U.S.A. who have never used BCG in their vaccination program show the same rate of decline in death rates from tuberculosis.

At the end of the twentieth century there were 17 million cases of active tuberculosis in the world, 60% in Asia [(6)]. It is a growing problem, with eight million pulmonary (lung) cases a year and three million deaths. As many as one third of the world's population is infected with M. tuberculosis [(7)]. Annual deaths from tuberculosis are still ten times greater than all the deaths from HIV put rogether [(8)]. Tuberculosis is decimating the Philippine slums. It is now that country's fourth biggest cause of death, killing 20,000 people a year and disabling hundreds of thousands more [(9)].

WHY IS THIS?

In the United Kingdom the incidence of disease in inner cities began to rise in the 1980s. During the same period

NewYork experienced an epidemic [10]. In 1995 numbers started to rise in Amsterdam [11]. Why? - For the same reasons that tuberculosis has always flourished - poverty, overcrowding, poor housing, poor diet, unemployment, misery and migration. Having HIV doesn't help either [12 – 15].

THE VACCINE

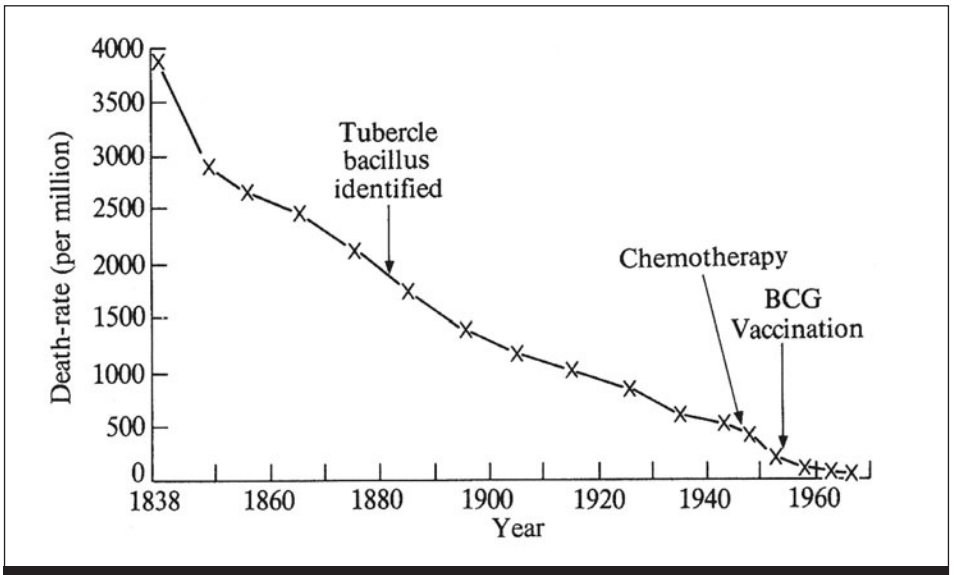
You may be wondering at this point what good a vaccine against tuberculosis would do, when the cause of human tubercular disease is so obviously seated in a person's environmental and social context. It is a good question.

Exposure to other common mycobacteria has been observed to confer a degree of protection against becoming infected with the tuberculosis bacillus. This was seen when children who drank unpasteurised milk developed mild forms of bovine tuberculosis but did nor contract the human type. However, some people do worse, for example, those with the mycobacterial disease of leprosy [1].

The BCG vaccine (Bacillus Calmette Guerin) is an attenuated (less lethal) form of the bacillus. Innoculation with BCG is supposed to substitute the natural and potentially harmful primary infection with tubercle bacillus for an artificial and innocuous (harmless) primary infection with attenuated bacilli that have maintained the immunogenic (ability to cause an immune response) properties but not the pathogenicity (ability to cause disease) of the tubercule bacillus [16].

There are problems. Over the years the original live vaccine has evolved into an array of different strains with unknown properties and immungenicity [17]. Very little is known about the correlation between dose of BCG and protection against tuberculosis in humans. A lot more is known about the dose of BCG required to give a certain size of response to tuberculin testing but this is not the same thing.

BCG certainly induces tuberculin sensitivity. Sensitivity to a tuberculin skin test (Mantoux or Heaf test) is the commonest and cheapest way of diagnosing and contact tracing cases of tuberculosis. This is how tuberculosis has been managed in the United States. After being vaccinated with BCG it is less clear whether the sensitivity - reaction is due to vacciriation or the disease. In this country it causes a lot of confusion as to who should be investigated further.[18] [19].



Respiritory TB: mean annual death rates E&W

"BCG vaccination may even be altering the body's response to the tuberculosis bacillus in such a way that it is contributing to the resistance of tuberculosis to all of the drugs currently used to treat it. This is a global problem of massive proportions."

The vaccine also interferes with the resistance created by exposure to local, non-pathogenic (friendly) mycobacteria.

BCG vaccination may even be altering the body's response to the tuberculosis bacillus in such a way that it is contributing to the resistance of tuberculosis to all of the drugs currently used to treat it. This is a global problem of massive proportions [1].

The history of immunisation against tuberculosis is a story of setback, controversy and surprise' [20] said a leader in the Lancet in 1980.

Trials of BCG vaccination have shown protection against tuberculosis to vary between zero and 78%. The best result was from a trial in UK school children from the 1950s. In the 1960s, the Indian Research Council and the World Health Organisation carried out a very large, well designed, double-blind controlled trial of 260 000 people in Madras, South India. The results showed that more of those vaccinated with BCG got tuberculosis than those who had not been vaccinated [16].

These discrepancies are not just due to the differences between the developed and the developing world. A recent study of children returning to the UK from the tropics showed that 75% of those vaccinated against Tb did not respond to tuberculin testing (a protective effect of 25% maybe?) [21]. All of 62 cases of French hospital employees who had contracted tuberculosis at work had been vaccinated with BCG [22]. Trials in the United States varied in protection from zero to 75% [16].

Many reasons have been put forward for the differences in the performance of the BCG in different trials and most of them, equally, have been refuted. What is clear is that where it is really needed it doesn't seem to work. Even at best its efficacy appears to be much less than that claimed for other widely used vaccines.

It is when reading about research into new vaccines against tuberculosis that the full ineffectiveness of the BCG becomes most apparent. One also becomes increasingly aware of how little scientists and doctors know about tuberculosis at all. "Immunity to

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tuberculosis vaccine presents a daunting task in the face of our limited understanding - of the organism's virulence (ability to cause disease) and the host's (human's) immune response."[23] "Understanding how the bacterium invades cells may be an important first step towards developing a vaccine to prevent tuberculosis." [24] - I thought we already had one… This is certainly not what it says on the information sheets that children take home so that their parents will sign the consent form for the schools' vaccination program. It is also not the information given when vaccinating newly arriving immigrants to this country nor to new parents in areas where all babies are vaccinated.

So where does this leave us wilh regard to BCG vaccination and protection against tuberculosis? Maybe we should take a tip out of Pasteur's book and concentrate on nurturing our "soil". What is the 'soil'? The soil is our body and our immune sysrem. A healthy diet with lots of clean water, fresh air and exercise will make us strong so that we will not be susceptible to tuberculosis (the 'seed') nor to any of the other micro-organisms by which we are surrounded. Tuberculosis is not the only disease whose death rate has plummeted since the nineteenth century. Scarlet fever, rheumatic fever, measles, diphtheria and whooping cough are some of the others and their death rates fell for the same reasons.

While we concentrate on food and nutrition let us also not forget the other ancient adage: "mens sana in corpore sano - a healthy mind in a healthy body." 'We do well not to forget the important part that emotions play in our health.

Allowing ourselves the time and the space to balance our emotions and nurture our relationships with others is more important than the right vitamin supplement or exercise program.

By Dr Jayne L M Donegan, MBBS, DRCOG, DCH, MRCGP Feb.2000

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EDITOR: Just adding on further comment to Dr Donegan's BCG article…. In the hefty orthodox book entitled 'Vaccines' by Plotkin and Mortimer there are some interesting comments on the BCG vaccine and its possible achievements.

Under the heading the 'Efficacy of Bacille Calmette-Guerin' (page 454) it states:

'The true effectiveness of BCG vaccine has been debated for decades. Large clinical trials conducted from the 1930s through to the 1970s yielded wide-range and conflicting results, demonstrating efficacy from 0 to 80%. The most recent trial in Chingleput, India, designed with hopes of settling the question of BCG's efficacy once and for all, had discouraging results and methodological difficulties that only served to continue the argument. Experts have offered a number of explanations for the variation in results among trials, but no one theory has been proved. In recent years, researchers have studied BCG efficacy using case-control and cohort study designs, but conclusions still diverge. Even with years of study and debate, the question "Does BCG work?" cannot be answered definitively.'

As usual when a study indicates that a vaccine's efficacy is questionable, it is described as a 'discouraging' result rather than just simply the 'result'. It seems that the researchers are very reluctant to conclude that this vaccine simply does not work in the way they are expecting it to.

In the same publication, reading through some of the previous paragraphs regarding immune responses to BCG vaccine it was interesting to note the general wording, which would not leave one feeling very confident about the vaccines at all. Here are a few examples, with my added emphasis:

'The exact immune response elicited by BCG vaccination and its mechanism of action within the host are not well understood.'

'Studies of the immunological events that occur within the human host after BCG vaccination are almost totally lacking….Both animal date and human clinical studies have provided information about the immune response to BCG, yet for no vaccine so widely used is so little known about its mechanisms of action……A major difficulty when studying tuberculosis and BCG immunisation is the lack of an accurate immunoassay (various techniques for determining the levels of antigen and antibody in a tissue) that correlates with resistance to infection….The immunology is complicated and development of an assay has been hampered by the lack of understanding of the protective response and the inability to identify specific antigens that stimulate immunity… Given our incomplete understanding of tuberculosis immunology, we are left with imperfect indicators of immunity. Neither the presence nor the size of post vaccination tuberculin skin test reactions reliably predicts the degree of protection afforded by BCG…Although a positive skin test result does indicate a response of the immune system to mycobacterial infection or BCG vaccination, how this reaction is related to protective immunity remains unsettled. Most experts conclude that immunity and the presence of tuberculin sensitivity are related but not identical.'

In my editorial back in Issue three, 2008 I also highlighted some of the points relating to the possible reasons for inaccurate test results regarding the skin test – the Mantoux test – which were also published in the Plotkin & Mortimer's publication. Here are some examples:

- ***Frequent inaccurate report results by inexperienced health professionals***
- ***The fact that a negative tuberculin skin test never rules out TB***
- ***That a variety of host-related factors such as young or old age, poor nutrition, immunosuppression by disease or drugs, viral infections and so on***
- ***False positive reactions also occur***
- ***Recent exposure to environmental mycobacteria can result in cross-sensitization leading to false positive reactions***
- ***The appropriate cut off size indicating a positive reaction varies with the person being tested and with related epidemiological factors.***

With so many confounding factors, how on earth are they able to deduce any useful information from this test?

Forthcoming Lectures by Dr Jayne Donegan

'NURSING CHILDREN SUPPORTIVELY THROUGH ACUTE ILLNESS'

22th April 2013, Monday morning and afternoon, Skegness, Lincolnshire PE25
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'VACCINATION: THE QUESTION'

28 April 2012, Sunday afternoon, London NW4
02 May 2012, Thursday evening, London SW7

'VACCINATION AND TRAVEL MEDICINE

19 May 2013, Sunday afternoon, London NW4
For further details see http://www.jayne-donegan.co.uk/lecturesworkshops

DUMBED-DOWN POPULATIONS ACCEPT OUTRAGEOUS VACCINE LOGIC

BY: JON RAPPOPORT
http://www.naturalnews.com
Monday, February 11, 2013

NATURALNEWS, I've written articles attacking the theory and practice of vaccination from a variety of angles. But the whole issue also needs to be approached from the perspective of logic.

Unfortunately, generations of people have been shut out of learning logic in school. They don't know what it is. Therefore, vaccine advocates have been able to peddle their basic theory without much challenge.

IT'S TIME TO PUT AN END TO THAT FREE RIDE.

First of all, I need to point out a massive contradiction. When a person receives a vaccine, it's said that his body produces antibodies against a particular germ and this is a good thing. Vaccination thus prepares the body for the day when that germ will really make its attack, at which point the immune system (including antibodies) will mount a successful defense.

However, let's look at another venue: for many diseases, when a person is given a blood test to see if he is infected, quite often the standard for infection is "presence of antibodies."

This makes no sense at all. If vaccination produces those antibodies, it is heralded as protection. But if a diagnostic blood test reveals those same antibodies, it's a signal of infection and disease.

Vaccine-produced antibodies=health. Antibodies naturally produced by the body=illness.

Logically speaking, you resolve a contradiction by dropping one of the two sides and admitting it is false. Or you go deeper and reject some prior premise that led to the contradiction in the first place.

So let's go deeper. What does vaccination supposedly do to "prepare" the body against the future invasion of a particular germ? It stimulates the production of antibodies against that germ.

Antibodies are immune-system scouts that move through the body, identify germs, and paint them for destruction by other immune-system troops.

However, since the entire immune system is involved in wreaking that destruction, why is bulking up one department of the immune system - antibodies - sufficient to guarantee future protection?

On what basis can we infer that bulking up antibodies, through vaccination, is enough?

There is no basis. It's a naked assumption. It's not a fact. Logic makes a clear distinction between assumptions and facts. Confusing the two leads to all sorts of problems, and it certainly does in the case of vaccination.

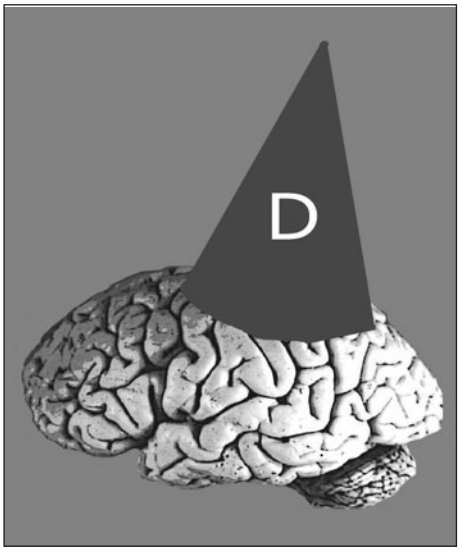
Furthermore, why does the body need a vaccine in order to be prepared for the later invasion of germs? The whole structure/function of the immune system is naturally geared to launch its multifaceted counter-attack against germs whenever trouble arises. The antibodies swing into action when a potentially harmful germ makes its appearance, at age five, eight, 10, 15.

IT'S SAID THAT VACCINATION IS A REHEARSAL FOR THE REAL THING. BUT NO NEED FOR REHEARSAL HAS BEEN ESTABLISHED.

And why are we supposed to believe that such a rehearsal works? The usual answer is: the body remembers the original vaccination and how it produced antibodies, and so it's better prepared to do it again when the need is real. But there is no basis for this extraordinary notion of "remembering."

IT'S ANOTHER ASSUMPTION SOLD AS FACT.

The terms "prepared for the real thing," "rehearsal," and "remember" aren't defined. They're vague. One of the first lessons of logic is: define your terms.



"Unfortunately, generations of people have been shut out of learning logic in school. They don't know what it is. Therefore, vaccine advocates have been able to peddle their basic theory without much challenge."

A baby, only a few days old, receives a Hepatitis B vaccine. This means the actual Hep-B germ, or some fraction of it, is in the vaccine.

The objective? To stimulate the production of antibodies against Hep-B. Assuming the baby can accomplish this feat, the antibodies circulate and paint those Hep-B germs for destruction now.

From that moment on, the body is ready to execute the same mission, if and when Hep-B germs float in the door.

But when they float in the door, why wouldn't the body produce antibodies on its own, exactly as it did after the vaccination was given? Why did it need the vaccination to teach it how to do what it naturally does?

And why should we infer the baby body is undergoing an effective rehearsal when vaccinated, and will somehow remember that lesson years later?

THE LOGIC OF THIS IS TATTERED AND WITHOUT MERIT.

To these arguments of mine, some vaccine advocates would say, "Well, it doesn't matter because vaccines work.

They do prevent disease."

Ah, but that is a different argument, and it should be assessed separately. There are two major ways of doing that. One, by evaluating claims that in all places and times, mass vaccination has drastically lowered or eliminated those diseases it was designed to prevent. And two, by a controlled study of two groups of volunteers, in which one group is vaccinated and the other isn't, to gauge the outcome.

Let's look at the first method of assessment. Those who claim that vaccines have been magnificently effective in wiping out disease have several major hurdles to overcome. They have to prove, for each disease in question, that when a vaccine for that disease was first introduced, the prevalence of the disease was on the rise or was at a high steady rate in the population.

Why? Because, as many critics have stated, some or all of these diseases were already in sharp decline when the vaccines were introduced for the first time.

For example: "The combined death rate from scarlet fever, diphtheria, whooping cough and measles among children up to fifteen shows that nearly 90 percent of the total decline in mortality between 1860 and 1965 had occurred before the introduction of antibiotics and widespread immunization. In part, this recession may be attributed to improved housing and to a decrease in the virulence of micro-organisms, but by far the most important factor was a higher host-resistance due to better nutrition." Ivan Illich, Medical Nemesis, Bantam Books, 1977

In other words, for reasons having nothing to do with vaccination, the diseases were on the way out. Nutrition had improved, sanitation was better, etc.

So let's see the proof, for every disease which vaccines are supposed to prevent, that those diseases were significantly raging in the population when the vaccines were first introduced.

Then let's also see proof that, after the introduction of vaccines, the diseases in question weren't merely given new labels (or redefined) to hide the fact that they weren't really going away. There is testimony, for example, that in America, the definition of paralytic polio was changed after the introduction of the Salk vaccine, and by the new more restricted definition, far fewer cases of polio could be diagnosed - thus making it seem the vaccine was effective.

There are also questions about the success of the famous smallpox vaccine campaign in Africa and Latin America. When all was said and done, were new cases of smallpox then diagnosed as meningitis? Was destruction wreaked by the vaccine then called AIDS?

Researchers, including Robert Gallo, have warned that the smallpox vaccine, when given to people whose immune systems are already grossly weakened, can destroy what's left of the immune system---and immune-defense destruction is the hallmark of the definition of AIDS.

THE SECOND MAJOR WAY OF ASSESSING THE SUCCESS OF MASS VACCINATION IS THROUGH A PROPER CONTROLLED STUDY.

For any vaccine, this is how it would be done. Assemble two large groups of people. Total, at least eight thousand. Make sure these two groups are very well matched. That means: similar in age; very similar in medical history and medical drug history; similar exposure levels to environmental chemicals; very close nutritional levels, status, and dietary habits.

The first group gets the vaccine. The second group doesn't. They are tracked, with very few dropouts, for a period of at least eight years. The INDEPENDENT researchers note how many from each group get the disease the vaccine is supposed to prevent. They note what other diseases or health challenges the volunteers encounter.

SUCH A STUDY, USING THESE PROPER STANDARDS, HAS NEVER BEEN DONE FOR ANY VACCINE.

If that fact seems rather illogical, you're right. It is.

Finally, vaccine advocates need to prove that substances in vaccines like mercury, formaldehyde, and aluminum, although classified as toxic when studied alone, are somehow exonerated when shot directly into the body through a needle. The (absurd) logic of this needs to be explained fully.

This is not a matter of claiming that "a particular disease," like autism, isn't caused by a particular chemical, like mercury. That's a logical ruse all on its own. We are talking about harm caused by toxins under any name or no name. When a person ingests cyanide, do we say he has a disease? Of course not.

Children in school, their parents, and teachers have never been exposed to logic, so it's easy to sell them vaccines as valid. But selling is not the same thing as science.

And "being a scientist" is not the same thing as knowing what science and logic actually are. The same fact can be applied to news anchors, public health officials, and politicians. They can say "the evidence for vaccinating is overwhelming," but so can a parrot in a cage, with enough training.

Of course, these so-called experts won't come out and engage in a serious debate about the theory and practice of vaccination. They refuse to.

Millions of people around the world would eagerly watch a true extended debate on the subject. Such debate used to be a standard practice when logic was studied, when it was understood to be vital for deciding the truth or falsity of a position.

Now, it's all about PR and propaganda, the modern version of logic for the dumbed-down crowd.

JON RAPPOPORT: The author of an explosive collection, THE MATRIX REVEALED, Jon was a candidate for a US Congressional seat in the 29th District of California. Nominated for a Pulitzer Prize, he has worked as an investigative reporter for 30 years, writing articles on politics, medicine, and health for CBS Healthwatch, LA Weekly, Spin Magazine, Stern, and other newspapers and magazines in the US and Europe. Jon has delivered lectures and seminars on global politics, health, logic, and creative power to audiences around the world. You can sign up for his free emails at www.nomorefakenews.com

FIRST CASES OF VACCINE-RESISTANT WHOOPING COUGH FOUND IN UNITED STATES

EDITOR: I reproduce articles such as the one below to remind you of how the established orthodox view of disease, antibodies, vaccines, and so on, are viewed.

Despite problems and failures that arise from vaccination programs the mentality is to still conclude that the way forward is to develop 'more effective vaccines' rather than daring to even think that an alternative to vaccination might be the answer.

BY LAUREN EDMUNDSON

www.healthmap.org

8 Feb 2013

IN A LETTER to the editor published in the New England Journal of Medicine, doctors have identified twelve cases of pertussis that do not respond to the pertussis vaccine. The samples were collected from children hospitalized in Philadelphia in 2011 and 2012. These are the first cases of vaccine-resistant pertussis identified in the United States.

Pertussis, also known as whooping cough, is caused by the bacterium Bordetella pertussis. The respiratory infection is spread when someone breathes in bacteria-contaminated air droplets from an infected person's cough or sneeze. Transmission often occurs from older family members to infants or children.

The disease causes cold-like symptoms and severe coughing, often accompanied by a "whoop" sound. Patients can usually be treated successfully with antibiotics.

A huge spike in pertussis cases occurred in the United States this year with twice as many cases reported in 2012 compared with 2011. Twenty-one states experienced outbreaks above the national incidence levels, and an epidemic was declared in Washington in April, bringing the nationwide 2012 total to over 40,000.

To prevent pertussis, the CDC recommends that children receive five doses of the DTaP vaccine, which also includes protection against tetanus and diphtheria. Protection gained from pertussis vaccines does decrease over the years; this is known as "waning immunity." For this reason, the CDC advises teens and adults to renew their protection with a TDaP vaccine.

"What the New England Journal of Medicine letter states is that doctors have found strains of B. pertussis that do not contain pertactin, therefore, our vaccines are not effective against them."

These vaccines contain an antigen, called pertactin. Antigens are proteins found on the surface of pathogens. Each pathogen has antigens that are specific; the antigens on B. pertussis are different than the antigens on V. cholerae (cholera).

Antigens are what trigger the immune system to produce antibodies, which fight the pathogen. Antigens and antibodies are shaped in such a way that only certain antibodies can fight certain antigens. Pertactin is an antigen typically found in B. pertussis. By adding the antigen to the vaccine, scientists were able to ignite an immune response in the human body and initiate protection against whooping cough.

THAT IS, UNTIL NOW.

The vaccine will effectively protect people against B. pertussis infection if the body recognizes pertactin in B. pertussis. Therefore, if someone is infected with bacteria that do not express pertactin, the body cannot recognize the bacteria and kill it.

What the New England Journal of Medicine letter states is that doctors have found strains of B. pertussis that do not contain pertactin, therefore, our vaccines are not effective against them.

Pertactin-negative pertussis bacteria have already been identified in Japan, France and Finland. Researchers in France have begun more regular testing for these strains of bacteria in order to monitor bacterial mutations.

In an upcoming article in Emerging Infectious Diseases, these same researchers report that the proportion of pertactin negative B. pertussis samples compared to the total number of samples collected each year has increased from two percent in 2005 to fourteen percent in 2012.

This new resistance to the pertussis vaccine may be why whooping cough cases have been increasing. Experts also believe that increased awareness about whooping cough has led to reporting of more cases.

While this news is significant, it is not entirely surprising. Several other pathogens have developed resistance to antibiotics. Both tuberculosis and gonorrhea, for example, have developed resistance to many of the drugs we use to treat them, which make these diseases far more difficult and expensive to treat.

Until recently, most doctors in the United States have not been checking pertussis samples for vaccine resistance.

The authors of these findings recommend that more testing should be done across the United States "to determine whether our finding is a local event or represents a more widespread shift in B. pertussis strains." They argue that this research will be key in the development of more effective vaccines.

PRIMITIVE REFLEX THERAPY: Part 2

Who's in the driving seat?

BY JANET NETHERCOTT-CABLE
IIHHT.DIP (MICHT)

Janet Nethercott-Cable

IN MY previous article 'PRIMITIVE REFLEX THERAPY: Part 1 - Essential developmental building blocks of life' I covered some of the basics behind the emergence, function and integration of the Primitive Reflexes. I also covered what happens when the reflexes fail to emerge and also the consequences of non-integration.

To recap, Primitive Reflexes (PR's), are involuntary responses to external or internal stimuli such as touch, movement, sound, light and heat. Each Primitive Reflex produces stereotypical muscular movements and complex responses, involving body movements, breathing, perception and hormonal changes, which are automatically directed by the brain. They allow no leeway for variation or choice of action.

In this article I'd like to highlight and investigate the ongoing struggle between the conscious and subconscious functions of our brain. I continue to be amazed and fascinated by the way the reflexes shape peoples lives and influence their relationship with the world.

Young children are interesting to work with as they are generally less inhibited and so the retained reflexes tend to reveal themselves more readily. For example a child is more likely to sit fidgeting without inhibition, whereas adults will employ all kinds of coping mechanisms in order to compensate and disguise the effects of the retained reflexes. These mechanisms then become second nature.

I aim to highlight one of the fascinating cases I came across including outcome of treatment.

With each reflex we have the emotional components which are the building blocks of our basic emotions.

FEAR PARALYSIS REFLEX (FPR)

Fear Paralysis, as it is so aptly named is the type of reflex where someone experiences the following highly alert state involving many physical changes;

- Immobility - 'rabbit in headlights'.
- Inability to respond to external events.
- Respiratory arrest.
- Flaccid floppy muscle tone.
- Deceleration of heart rate resulting in cardiac arrythmia.
- Pallor.
- Rise in blood pressure.
- Temporary paralysis of the muscles of the pharynx and larynx necessary for speech and swallowing.

This reflex can be activated by events such as restraint of movement, separation, sudden noise, distant movements/shadows, pain, perceived threat and the list goes on.

All these reactions have a survival function. In extreme cases such as drowning, it is possible to withstand longer periods under water without causing damage to the brain, also favourable in cases of wounding where bradycardia lessens the need for blood stream oxygen and vasoconstriction of blood vessels removes blood supply from the extremeties, preserving central arterial perfusion pressure.

Below is an interesting abstract [1] Regarding the Vasomotor Reactivity in Premature Neonates at Term:

ABSTRACT

"In order to assess the specific sympathetic reactivity in premature infants at term, we designed a study to evaluate the peripheral vasomotor response of such infants when exposed to auditory challenges. Testing was performed in 29 premature neonates at term in both quiet and active sleep during a morning session. Two types of noises were used (click and continuous tones) at three frequencies (250, 1,000 and 6,000 Hz) and at three intensities (60, 85 and 110 dBA). Vasomotor response was studied by analyzing with Mathlab® software the variability of the plethysmographic wave of the oxymetric pulse. No behavioral awakening was observed in response to any stimulation. When a tachycardia or a bradycardia reaction to the stimuli was observed, all neonates responded with a vasoconstriction. The global mean of the vasoconstrictive response was 18.45%. The overall ANOVA on the vasomotor response revealed significant effects for sleep stages ($t: 1.98$; $p < 0.05$), for frequency ($t: 3.3$; $p < 0.001$) and for intensity of noise ($t: 3.01$; $p < 0.03$) but no significant response with heart rate variability. From these results, we could conclude that the assessment of the vasomotor response is a very sensitive procedure to determine the reactivity of the autonomic nervous system in neonates, and could be used to study such vegetative responses in other stressful situations with good accuracy."

We can see that although none of the neonates consciously awoke, there was however significant physical response connected with the autonomic nervous system. This is regularly experienced by most with a retained FPR.

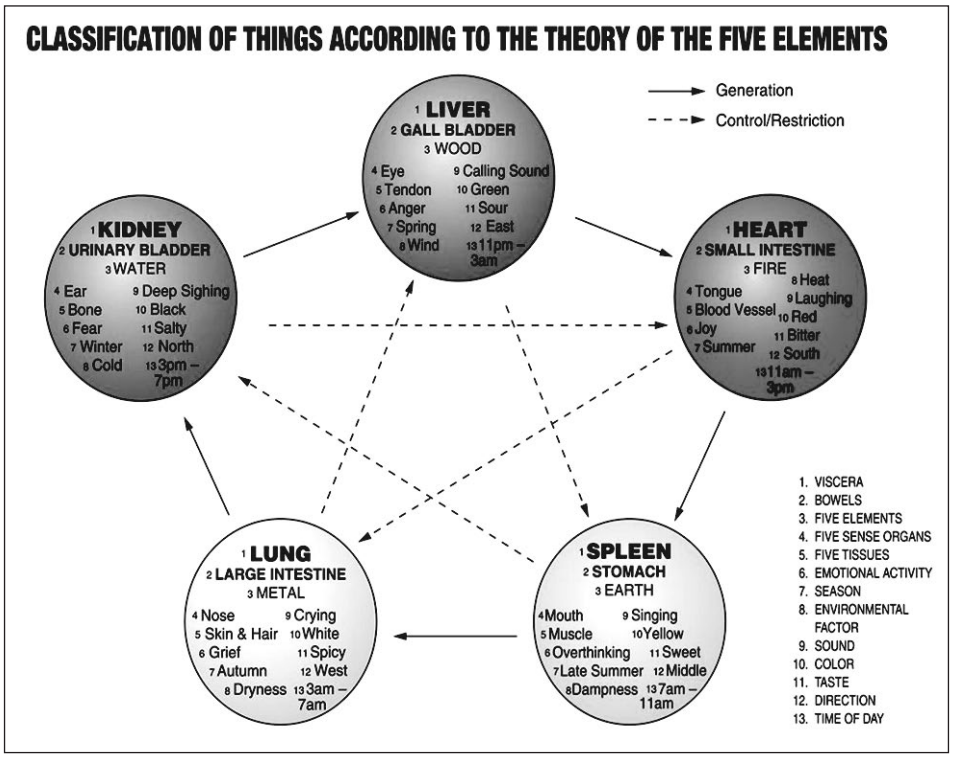
WHAT IF THE REFLEX RESPONSE IS DISPROPORTIONAL TO THE PERCEIVED THREAT?

We can see this acted out regularly in the classroom situation. A child is asked to read outloud in front of the class, finds this scary - fear of new situations. FPR manifests. The child loses the power of speech, appears frozen, mouth dries up. Body language withdrawn, appears vulnerable, inability to perform.

Children and adults with this reflex dislike change or suprise and can be fearful of social embarrassment. Poor self esteem and excessive shyness are some of the many emotions that manifest with this reflex along with many other emotional and social attributes. We can see that these aspects are building blocks of our emotions and experience and when this continues as a negative feedback loop ›

we can in some extreme cases see this developing into the following:

- Low tolerance to stress - Panic disorders.
- Victim mentality - negativity, easily bullied, unable to stand up for themselves
- Aggressive, controlling behaviour - due to frustration, fear or confusion.
- Depression - don't fit in (social withdrawal)
- Poor self esteem/Self harming - Anorexia/Bulimia/Compulsive/Obsessive disorder.
- Weeping.
- Breath holding/Asthma.
- Hypersensitivity - to sound, touch, specific fequencies, changes in visual field, smell, taste.
- Continuous fear and anxiety - Phobias.
- Controlling and rebellious behaviour.
- Won't eat or drink away from home.



These are just some of the general character traits which also can cross over with other reflexes too.

Emotions can also be clearly seen in connection to the Chinese 5 elements model, which also relates to the 14 meridians (energy pathways). These meridians have connections to muscles, organs, bodily systems and functions.

For example the Metal element contains the Lung and Large Intestine meridian. When an imbalance shows up in this element, I would check for an active FPR. The Lung meridian would be relevant for its obvious physical connection to the function of the lungs and ability to breathe. Also relevance to breath withholding and asthma. It also has relevant associative emotions and metaphors such as[3]:

1. Do you need a 'hard shell', barrier or boundaries to protect you from the demands or aggressions of people in your life, or do you need to open up more, let down your shield and communicate with people?
2. Can you breathe/speak easily?
3. Do you have a free flow of fresh air and/or inspiration to nourish the various functions of your life or are you feeling constricted, inhibited in speaking, literally or figuratively?
4. What do you need to uplift in your life?
5. Are you giving too much or too little praise?
6. Do you need to shout, cheer or even cough something up?
7. Do you hold it all in or cry when it's not appropriate?
8. Personal power - what aspects of your life are out of balance?

The Metal element also relates to: Grief, Guilt, Regret, Crying, Deep sighing. When there is 'over energy' in this meridian it can manifest as breathing problems. By sedating the over-energy in the lungs using acupressure holding points it is sometimes possible to reduce wheezing within a couple of minutes.

I would also look at the Kidney, Heart and Lung meridian's relationship when FPR is active, checking for any over-energy in each of the meridians. You can see these relationships in the meridian chart. In order to sedate the lung meridian we would look to move energy along to the Kidney meridian and then fix it by using the control acupressure points Heart 8 and Lung 10.

The kidney meridian is where we hold our fear.

CASE STUDY

I had an initial consultation with a 39 year old Lady who presented as very timid and nervous. She had very stiff and controlled body language with poor posture, rounded shoulders, caved in chest. It was as if she was trying to be invisible.

When she wasn't talking her facial expression took on a frozen and dumbfounded expression and her mouth hung open as if in shock. She was pale and her speech was very slow. I was mindful that I needed to give her extra time to process and respond to questions.

She mentioned reading about primitive reflexes and was wondering whether this could help. She had just started to take driving lessons for the first time and was struggling to cope.

The difficulties she highlighted and which were backed up by her instructor were:

- Applying too much pressure to the accelerator and brake and so would accelerate and brake too hard.
- She would see some cars but not visually register others.
- Problems with over-steering.
- She was overreactive to all situations.
- Poor coordination.

Using my usual primitve reflex and muscle testing techniques, I found there to be no obvious reflexes indicated, which I was very surprised by given the difficulties mentioned.

It was a warm sunny day and I had left my therapy window open, which I usually have closed to cut down sounds of cars on the road outside. It was a quiet time of day, but suddenly a very loud car raced by. Immediately, her muscles

overfacilitated! I then knew that we had to test the primitive reflexes on a 'contextual' basis, meaning that the reflexes would only become active when in a particular situation or context.

I shut the window, which cut down all the sound from the road, and her muscles began to test strong again! I asked her to imagine stepping into a car and used 'pause lock' which is a technique used by Kinesiologists to let the brain know what stimulus or circumstance we are investigating.

With this information in the system, her muscle status changed once again to overfacilitation and the following retained reflexes then became very apparent: FPR, MORO, ATNR, Root and Suck, Landau and Rage.

We then knew that the moment she steps into a car, the reflexes mentioned become active causing a whole myriad of reactions which would make learning to drive a real challenge!

Often contextual reflexes are triggered by trauma or a specific event.

Further testing revealed that, as a small child, she was involved with her mother and father in a life changing car accident. In order to preserve the identity of this client I am unable to go into specific details of the events.

This traumatic event may have triggered the reflexes above. The Moro with its characteristic features of arousal and reaction acts as an intermediary between the primitve withdrawal response and the more mature adult startle reflex. So these reactive patterns remained overreactive, meaning the whole time in the driving seat she would be reacting defensively. This produced the effect of being overreactive to all situations as each situation or stimulus would be perceived as a potential threat.

The fear paralysis is described by Kaada[2] as 'an innate atavistic fear paralysis reflex' which is the response to situations which evoke extreme fear. It can react with fight or flight or when reactions are not possible with a sudden prolonged state of immobility.

This state of immobility can be observed in certain animals such as rabbits if they are unexpectedly caught in the headlights of a car at night. Instead of running away they will freeze and remain rooted to the spot. This way of feighning death may have been fine before the invention of the motor car!

It is the same reflex used by magicians, who flamboyantly with slight of hand, produce doves from their cloak. The magician will keep the doves hanging upside down on hooks inside the cloak. This inversion will trigger the immobility of the dove until he decides to turn the dove the right way up. Only then will the dove become active.

The ATNR (Asymmetrical Tonic Neck Reflex) would have caused problems with steering while gear changing at the same time. This reflexes characteristics are due to 'rotation'. Meaning that when the head rotates to one side extention of arm and leg of the same side follows with retraction of the opposite arm and leg. Retained ATNR could also be problematical when moving from peripheral to focal vision, which could be behind her inability to see some cars when focusing on oncoming vehicles.

"The fear paralysis is described by Kaada[2] as 'an innate atavistic fear paralysis reflex' which is the response to situations which evoke extreme fear. It can react with fight or flight or when reactions are not possible with a sudden prolonged state of immobility."

Poor proprioception was also highlighted. When asked to adopt certain postural positions for muscle testing, often she would look at her arm before she was able to move it into position. In terms of driving this would manifest as being unable to change gear without looking down at her hand first!

Root and Suck reflex also needed balancing.

After her childhood accident she lost the power of speech and had to attend many speech therapy sessions too.

I began to realise that the fixed, tense, facial expression which I observed, was as if the FPR had remained fixed within muscles of her face thereafter, with her facial muscles frozen in time.

I gave my client a series of exercises to help with reflex integration in between balancing sessions. This included exercises to strengthen her jaw muscles and tongue movements. Along with puckering and over smiling exercises to activate and stimulate the lips and strengthening the muscles around the mouth to help integrate the root and suck reflex.

We also did a lot of trauma recall work to release her stuck emotions using flower essences and Phytobiophysics to support this process.

By balancing the reflexes she reported feeling much more 'in control' and less anxious. She became much more aware of other cars and her overractive tendencies reduced to a much more appropriate reaction time, much to the relief of her driving instructor! Her proprioception improved, no more looking down at her hand to move the gear stick.

I noticed her mental processing time was much quicker, meaning she was able to respond to answer questions and speak more promptly. Her facial muscles also became more relaxed to the point where her mouth no longer hung open in a look of shock and she was more relaxed and able to smile again!

It was fascinating to learn how the simple act of stepping into a car could ellicit so many reflexes. These had been triggered by trauma of the car accident during her childhood. No matter how much she attempted to compensate for these automatic reactions, she was still being controlled by them. It took the re-integration of these reflexes to get her truly back into the driving seat!

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JW SEEKS ANSWERS TO PAYOUTS MADE TO VICTIMS OF HPV VACCINES

HPV VACCINE GARDASIL LINKED TO SERIOUS SIDE EFFECTS, INCLUDING SEIZURES, PARALYSIS, BLINDNESS, SPEECH PROBLEMS, SHORT TERM MEMORY LOSS, GUILLAIN-BARRÉ SYNDROME AND DEATH.

www.judicialwatch.org
February 28, 2013

WASHINGTON, DC - Judicial Watch announced today that it filed a Freedom of Information Act (FOIA) lawsuit against the Obama Administration's Department of Health and Human Services (HHS) to obtain records related to the Vaccine Injury Compensation Program (VICP), a program that compensates patients who have been adversely affected by certain vaccines, including Gardasil, the vaccine for the sexually transmitted disease human papillomavirus (Judicial Watch v. U.S. Department of Health and Human Services (No. 1:13-cv-00197)).

Judicial Watch initiated an investigation of HPV vaccine Gardasil after the Food and Drug Administration (FDA) fast-tracked the vaccine through the approval process in 2006. Since 2007, Judicial Watch has uncovered government records documenting thousands of adverse reactions associated with the vaccine, including seizures, paralysis, blindness, pancreatitis, speech problems, short term memory loss, Guillain-Barré Syndrome and death.

Judicial Watch seeks the following records pursuant to its November 1, 2012 FOIA request filed with the Health Resources and Services Administration, a component of HHS:
1. Any and all records regarding, concerning, or related to the inclusion of human papillomavirus (HPV) vaccines as covered vaccines under the Vaccine Injury Compensation Program (VICP).
2. Any and all records depicting the number of claims filed under the Vaccine Injury Compensation Program (VICP) for injuries or deaths allegedly associated with human papillomavirus (HPV) vaccines.
3. Any and all records depicting the amount of compensation paid to claimants under the Vaccine Injury Compensation Program (VICP) pursuant to claims related to injuries or deaths allegedly associated with human papillomavirus (HPV) vaccines.

HHS acknowledged receipt of Judicial Watch's FOIA request on November 2, 2012. By law, HHS was required to respond no later than December 4, 2012. However, as of the date of Judicial Watch's lawsuit, the agency has failed to provide responsive documents, indicate when a response is forthcoming, or notify Judicial Watch why the records should be exempted from disclosure.

VICP is a Health and Human Services program that compensates patients who have been adversely affected by certain vaccines. The HHS web site describes the program as a "no-fault alternative to the traditional tort system," and it covers 16 specific classes of vaccines, including HPV vaccines which were added in 2007. The number of successful claims made under the VICP to victims of HPV will provide further information about any dangers of the vaccine, including the number of well-substantiated cases of adverse reactions.

According to the Annals of Medicine: "At present there are no significant data showing that either Gardasil or Cervarix (GlaxoSmithKline) can prevent any type of cervical cancer since the testing period employed was too short to evaluate long-term benefits of HPV vaccination."
"From the very beginning the federal government has attempted to shield the public from the truth about Gardasil. Despite safety concerns, the vaccine continues to be pushed for both girls and boys. For the supposed most transparent administration in history to stonewall on an urgent matter of public health is particularly galling," stated Judicial Watch President Tom Fitton.

In addition to obtaining records from the FDA through the agency's Vaccine Adverse Event Reporting System (VAERS) which has documented thousands of adverse reactions to Gardasil, Judicial Watch also published a special report in 2008 detailing Gardasil's approval process, side effects, safety concerns and marketing practices.

EUROPEAN MEDICINES AGENCY RECOMMENDS APPROVAL OF HEXYON 6-IN-1 PAEDIATRIC VACCINE

http://www.fiercevaccines.com/
February 26, 2013

EXTRACT: Lyon, 22 February 2013 - Sanofi Pasteur MSD, the joint venture between MSD and Sanofi Pasteur in Europe, announced today that their innovative 6-in-1 paediatric vaccine Hexyon has been recommended for marketing authorisation by the European Medicines Agency's Committee for Medicinal Products for Human Use (CHMP).

The new hexavalent vaccine, developed by Sanofi Pasteur, will be commercialised in Europe under two brands names – in Western Europe* by Sanofi Pasteur MSD under the brand name Hexyon and in Eastern Europe by Sanofi Pasteur under the brand name Hexacima.

Hexyon is the only fully liquid, ready-to-use 6-in-1 vaccine to protect infants against diphtheria, tetanus, pertussis (whooping cough), Hepatitis B, poliomyelitis and invasive infections caused by Haemophilus influenzae type b.

MELANIE'S MARVELOUS MEASLES:
Is the provaccine backlash rational or hysterical?

BY SUZANNE HUMPHRIES, MD

www.vaccinationcouncil.org

13/01/2013

THERE IS A NEW children's book available that teaches children that they don't have to fear childhood illnesses. It is entitled "Melanie's Marvelous Measles"

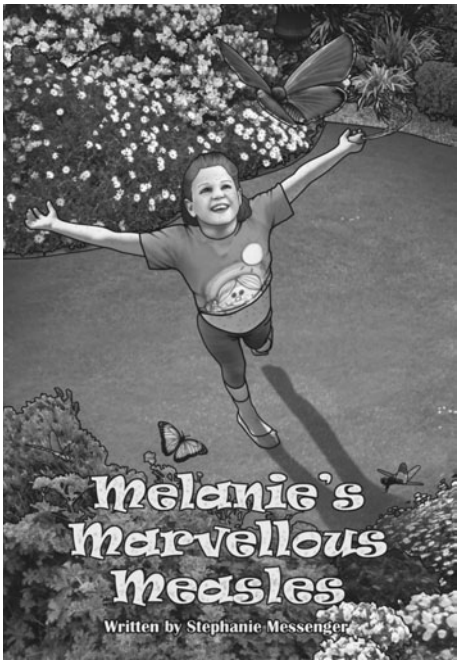
Mass hysteria has broken out among the provaccine with ideations of banning the book due to its perceived danger.

So what are the arguments in favor of shedding the mass fear that has been ingrained since the 1960s when the vaccines became available, prior to which measles was an acceptable childhood illness? In the developed world, mortality was reduced over 98% before the vaccine came along and before antibiotics were available. In England and in the United States, the chance of dying from measles had dropped to 1-2% by the 1930s.[1]

Immunology textbooks[2] point out that children who can't make antibodies, usually get through measles as well as children who can, because it's the innate or cellular immune system that is the key for measles (or any first time disease for that matter) not the humoral or the antibody system.

One of the most disconcerting discoveries in clinical medicine was the finding that children with congenital agammaglobulinaemia, who could make no antibody and had only insignificant traces of immunoglobulin in circulation, contracted measles in normal fashion, showed the usual sequence of symptoms and signs, and were subsequently immune. No measles anti-body was detectable in their serum (the water part of blood minus clotting factors and cells).[3]

The cellular immune system is dependent on good nutrition for optimal functioning. Bad nutrition comes in two forms: Plenty of food but all empty calories or not enough food of any calories at all. In the United States, studies have found that vitamin A deficiency is not just a thing of the past, but that even children with normal diets were vitamin-deficient upon measles infection. This 1992 study in California children showed that 50% of hospitalized measles cases had vitamin A



deficiency. But there was also vitamin A deficiency in 30% of the sick controls who did not have measles. None of the uninfected controls showed significant deficiency.

We studied 20 children with measles in Long Beach, Calif., and found that 50% were vitamin A deficient. This frequency among presumably well nourished American children supports evaluation of vitamin A status as a part of acute management of measles in the United States.[4]

So we could say that any child that lands up in a hospital in USA, or any developed country is suffering because their parents need educating about proper nutrition, or because their doctor is totally clueless about the nearly 80 years of proven benefit of vitamin A supplementation in acute measles. Take note that measles vaccines also deplete vitamin A. Previous studies have shown excess mortality and immune abnormalities among girls immunized with high titer measles vaccine 2 to 4 years after immunization... our results showed that serum vitamin A concentrations were depressed after measles vaccination, irrespective of whether it was the monvalent or combined measles vaccine. [5]

In parts of Africa, measles rampages precisely because there is no nutrition worth talking about. Are vaccines the answer? And, measles infections can be beneficial. Dr. Peter Aaby et al. and his team found that children who survived natural measles had a much higher survival rate from all other infectious causes than other children. Children who had had the measles vaccine, had a lower rate of survival and the worst group in terms of overall survival from infections, was the group which had neither measles vaccines nor measles disease. That's published research.[6] Their compromise conclusion was that it would be necessary to use the measles vaccine forever, because of the value of the vaccine in protecting against all cause mortality in the absence of actual infection.

Obviously, no research has been done in the developed world to see if there is a parallel here. Indeed, the ONLY reason that discovery was made in developing countries was because the high titer Edmonston measles vaccines (subsequently abandoned) resulted in excess all cause mortality, and they wanted to find out why. Had not that disaster occurred, they might never have discovered that measles infection actually reduced all cause mortality in the real world and that it's something worth having.

Therefore it could be said that measles does something worthwhile. Now, back to the book under attack.

"Here's how to turn a children's book into a hysterical controversy. Just declare any positive discussion of the benefits of childhood illness to be so evil that censorship is the only possible response. As a librarian, I'm shocked to find so-called "skeptics" advocating book banning. Why do they think this book has to be banned? Because the book in question tells the story of a little girl experiencing a mild case of measles.

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PREVENT. PROTECT. IMMUNIZE.

EUROPEAN VACCINE GROUPS COUNTER EUROPEAN IMMUNIZATION WEEK (EIW) 20–27 APRIL 2013 BY ANNA WATSON, ARNICA UK PARENT'S SUPPORT NETWORK.

http://arnica.org.uk/

EACH YEAR the WHO Europe coordinates events and resources to increase vaccination rates. It is an understandable focus for the WHO but one that should not pass unchallenged!

The group who will attempt to counter these actions are the EFVV. The European Forum for Vaccine Vigilance (EFVV) is a pan-European group campaigning for long-term natural health and immunity in both children and adults, as well as researching and highlighting the potential problems caused by certain vaccinations. EFVV members come from ten different European countries – Please take a look at their new website (http://www.efvv.eu) and pass on to your friends and colleagues in Europe. Each country will focus on different aspects of vaccination, for example mandatory vaccination in some member states, and in the UK we will focus on HPV vaccine awareness.

WHY IS BETTER AWARENESS OF THE HPV VACCINE NEEDED?

As of September 2012, 19 EU/EE countries had implemented a routine HPV vaccination. The UK has one of the highest uptakes of this vaccine (formally Cervarix) and with the US is experiencing high levels of reported adverse reactions. Gardasil still carries a Black Triangle meaning that reporting should be proactive and all new health problems should be collated.

Sometimes a report is sent to the MHRA, under the Yellow Card system, but only 6% of patients are aware that they can report side effects themselves so reporting is vastly inadequate. It is estimated that less than 10% of ADRs are ever reported and even when they are, the families are rarely contacted by the MHRA.

Anna Watson

"For example, existing figures may indeed already include cases of vaccine damage and lack of comparative studies over time means that there may not be a standard for normal prevalence e.g. Chronic fatigue in teenagers."

This example would concur with the report entitled The Influence of the Pharmaceutical Industry Fourth Report of Session 2004–05 which concluded the inefficiency of the MHRA in many ways. In fact 48 recommendations were made to address the serious issues including;

" We recommend that there be an independent review of the MHRA…"

"…. MHRA to become pro-active rather than re-active.."

"The MHRA should investigate options for the development of more effective post-marketing surveillance systems."

So if only the initial data is considered from Yellow Card reports of vaccine injury and compared to current prevalence rates in the community, this poses two serious problems for safety evaluation:

A) The longevity of new health problems and the increasing severity of the symptoms are not noted

B) The 'normal' prevalence in the community is virtually impossible to conclude for the purposes of investigating possible vaccine damage. For example, existing figures may indeed already include cases of vaccine damage and lack of comparative studies over time means that there may not be a standard for normal prevalence e.g. Chronic fatigue in teenagers.

UK HPV AWARENESS CAMPAIGN – HOW YOU CAN HELP?

The UK branch of the EFVV, under the Arnica network, www.arnica.org.uk will focus its efforts on highlighting awareness of the HPV vaccine. Arnica has produced a leaflet entitled 'Your body, your choice' outlining some of the issues with the HPV vaccine – please email info@arnica.org.uk for a copy. We have also supported a new website http://www.hpvfacts.co.uk/ to help you make an informed decision. Please share these with your friends and families, and the governors of your secondary schools.

Just one share of
http://www.hpvfacts.co.uk
or ***one leaflet given out could make a difference..***
Thank You

"THREE THINGS CANNOT BE LONG HIDDEN: THE SUN, THE MOON, AND THE TRUTH. ~ BUDDHA"

OVER VACCINATION OF YOUR PETS COULD BE HARMFUL TO THEIR HEALTH

www.over-vaccination.net

IN THE PAST 10 years the vaccine market has soared from $5.7 billion to $27 billion, a nearly five-fold increase. It's about time this over-vaccination racket was investigated.

Elizabeth Hart's interest in vaccination was initiated after she discovered companion animals were being unnecessarily revaccinated every year, and needlessly being subjected to the risk of an adverse reaction to vaccination. Along with her colleague Bea Mies, Elizabeth has undertaken extensive investigation and correspondence on unnecessary vaccination of pets.

As a result of Bea's and Elizabeth's work in this area, over-vaccination of pets has come under the spotlight in Australia, see for example the review by consumer watchdog CHOICE: "Pet vaccination: Over-vaccinating your pet could be harmful to their health as well as your own hip pocket". The ABC has also investigated this issue i.e. "Questions raised over pet vaccination". Despite this media exposure, over-vaccination of pets remains prevalent practice in Australia due to failures in the regulation of veterinarians and vaccine products. Vaccine product label recommendations are slowly being amended, but the government regulator, the Australian Pesticides and Veterinary Medicines Authority (APVMA), continues to drag its heels in this area, despite the publication of its Position Statement on Vaccination Protocols for Dogs and Cats, (January 2010). State Veterinary Boards in Australia blatantly disregarded the APVMA's request for the APVMA's Position Statement to be circulated to veterinarians in Australia. It is likely that many pet owners continue to be misled about appropriate vaccination of pets.

Bea and Elizabeth are continuing to pursue this matter, demanding effective and reduced vaccination protocols for companion animals.

Elizabeth's experience in investigating over-vaccination of pets is informing her investigation into lucrative over-vaccination of people, as there are interesting comparisons to be made. Elizabeth is not 'anti-vaccination'. Rather, she is challenging the increasing number of questionable vaccines and repeat vaccinations being foisted upon children, adults and animals by the

burgeoning and unfettered vaccine industry. There's a 'big picture' on lucrative over-vaccination which needs to be examined.

Elizabeth is a Research Officer, with experience in scientific literature searching. She has a degree majoring in politics and philosophy. This background has assisted her in researching and lobbying on over-vaccination. The ethical aspects of over-vaccination, particularly mandated vaccination, are of particular interest to her.
Elizabeth can be contacted via email:
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Risk of narcolepsy in children & young people receiving AS03 adjuvanted pandemic A/H1N1 2009 influenza vaccine: retrospective analysis

BMJ 2013;
CITE THIS AS: BMJ 2013;346:F794
Published 26 February 2013
www.bmj.com

ABSTRACT

OBJECTIVE To evaluate the risk of narcolepsy in children and adolescents in England targeted for vaccination with ASO3 adjuvanted pandemic A/H1N1 2009 vaccine (Pandemrix) from October 2009.

Design Retrospective analysis. Clinical information and results of sleep tests were extracted from hospital notes between August 2011 and February 2012 and reviewed by an expert panel to confirm the diagnosis. Vaccination and clinical histories were obtained from general practitioners.

Setting Sleep centres and paediatric neurology centres in England.

Participants Children and young people aged 4-18 with onset of narcolepsy from January 2008. Main outcome measures The odds of vaccination in those with narcolepsy compared with the age matched English population after adjustment for clinical conditions that were indications for vaccination. The incidence of narcolepsy within six months of vaccination compared with the incidence outside this period measured with the self controlled cases series method.

Results Case notes for 245 children and young people were reviewed; 75 had narcolepsy (56 with cataplexy) and onset after 1 January 2008. Eleven had been vaccinated before onset; seven within six months. In those with a diagnosis by July 2011 the odds ratio was 14.4 (95% confidence interval 4.3 to 48.5) for vaccination at any time before onset and 16.2 (3.1 to 84.5) for vaccination within six months before onset. The relative incidence from the self controlled cases series analysis in those with a diagnosis by July 2011 with onset from October 2008 to December 2010 was 9.9 (2.1 to 47.9). The attributable risk was estimated as between 1 in 57 500 and 1 in 52 000 doses.

Conclusion The increased risk of narcolepsy after vaccination with ASO3 adjuvanted pandemic A/H1N1 2009 vaccine indicates a causal association, consistent with findings from Finland. Because of variable delay in diagnosis, however, the risk might be overestimated by more rapid referral of vaccinated children.

The Quanten Theory

END STATION - The Journey of Infections (Part 2) by Patrick Quanten MD

Patrick Quanten MD

"There is no such thing as a test for AIDS. The diagnostic tests popularly referred to as "AIDS tests" do not identify AIDS."

MORE HISTORY

THE BIG INFECTION paradigms such as germs cause diseases, germs attack the system from outside, and microorganisms do not evolve from one form into another, are being removed by science that was already available at the time the authorities decided upon these paradigms. In spite of science re-proven what it basically already knew, authorities have clutched to the same paradigms, and often with vigour.

But of course, this is the story so far regarding infections. It started with the assumption that within the infectious process some unseen animals played a major part. It continued with actually "finding" these animals and learning more and more about them. The next step was one whereby the authorities put forward, as an explanation for all that couldn't be explained, another unseen animal, the virus. This allowed them to continue the same line of thinking and to stick to their own paradigms. But what does history tell us about the "discovery" of viruses?

1. POLIO

During the first half of the twentieth century infantile paralysis surged like a bush fire, afflicting large numbers of children, but not only in the industrialised West. Prior to these outbreaks it affected very few and was often called “palsy”. In the nineteenth century scientists gave it the name poliomyelitis, referring to the inflammation of the grey nerves of the spinal column in cases of paralysis. Poisonous metals were suspected of causing this disease, particular lead, arsenic and mercury. In 1878 the link between palsy and toxins was strengthened when Alfred Vulpian found that dogs dosed with lead suffered the same damage in their motor neurone cells. The Russian Popow discovered in 1883 that the same damage could be done with arsenic. Lead arsenate rapidly became the principle pesticide used on fruit and berries throughout the industrial world. Massachusets had a first epidemic of infantile paralysis in 1894 and again in 1908.

The first epidemic of poliomyelitis in a tropical nation was contemporaneous with the introduction of the pesticide DDT in that country. In 1944 the US federal research centre, the National Institute of Health, reported that DDT damaged the same part of the spinal cord that is damaged in infantile paralysis. Endocrinologist Dr Morton Biskind further described in 1949 how DDT caused lesions in the spinal cord resembling those in human polio. By 1952 the number of cases of infantile paralysis was three times higher than the figure for 1940, a rise paralleled by the increasing frequent use of pesticides in agriculture, in cattle farming and in medical cleaning procedures.

Most affected were the cleanest children of middle class parents. This does not correspond to the normal outbreaks of infectious diseases, where hygiene and decent food are known to be the most important factors. The use of lead arsenate to spray orchards was widespread in 1930’s America. Spraying occurred in summer, the season when children went down with infantile paralysis. Many researchers associated outbreaks of the condition with fruit supplies. The UK threatened to stop imports of US apples unless the pesticide was cut. Tobacco and other crops were also sprayed.

CONCLUSION:

- Polio is caused by high levels of toxins.

2. MAD COW'S DISEASE

Mad Cow Disease is the common term for Bovine Spongiform Encepholopathy (BSE), a progressive neurological disorder of cattle which can be transmitted to other species, including humans. In humans, it is called Creutzfeldt-Jakob Disease, after the two doctors who first described the symptoms of the disease. The disease in cattle is called Bovine Spongiform Encepholopathy because this form of the disease occurs in cows (therefore, the term bovine), it causes a sponge-like destruction of the brain (therefore, the term spongiform encepholopathy - enceph means brain and pathy means pathology - meaning an abnormality).

Currently the most accepted theory about the causes of BSE is that the causative agent is a modified form of a normal cell surface protein called a prion protein. A prion is neither a virus nor a bacteria. Prions are proteins that contain no DNA or RNA, two substances previously felt to be essential for reproduction of a living tissue. Prions are normal constituents of the body when in their normal form or conformation, but they can become twisted in a conformational change (a change in shape - in the way the molecule is folded), and then they are thought to cause disease.

In 1997, Stanley Prusiner M.D, a professor of neurology at the University

of California, San Francisco School of Medicine, won the Nobel Prize for his discovery of prions, "tiny protein molecules that seem to cause a variety of slow acting - and inevitably fatal - diseases in animals and humans; the name is an acronym for "proteinaceous infectious particles." But the diseases found in association with these tiny protein molecules have been known for over 50 years. In fact, the prion, as it has been named by Dr. Prusiner, may well have been discovered over 150 years ago, and rediscovered, every 25-50 years since then, by different scientists who gave the molecule different names.

Prions exist, but it is extremely doubtful that the prion is the cause of any disease. Prions are much more likely to be the result of a sick and dying body. Prions are most probably a response to the illness that was actually caused by a grossly improper diet and other unhealthy lifestyle factors. "Factory farming" of animals, with the massive use of hormones, pesticides and other harmful substances destroy the animal's immune system. When the animal's immune system is suppressed because of a violation of the immutable natural health laws that govern the health of both animals and man, then the body produces the agent necessary to clean up the mess of dead and dying tissue resulting from the violation of these health laws.

CONCLUSION:

- BSE is a toxic condition, sold to the public as a viral infection.
- Even the prion, taught to be "responsible" for the damage to the tissues is now seen as a result of the condition, not the cause.

3. AIDS

The person who announced that HIV caused AIDS was an American, Doctor Robert Gallo. He has since been accused of professional misconduct; his test has been exposed as fraudulent, and two of his laboratory executives have been convicted of criminal offences. Tens of millions of people are tested for HIV antibodies every year and Dr Gallo, who patented his "test", gets a royalty for every one. Luc Montagnier, Gallo's partner in the HIV-causes-AIDS theory, has since admitted in 1989: "HIV is not capable of causing the destruction of the immune system which is seen in people with AIDS". Nearly 500 scientists across the world agree with him. So does Dr Robert E Wilner, author of the book 'The Deadly Deception. The Proof That Sex And HIV Absolutely Do Not Cause AIDS'.

Dr Wilner even injected himself with the HIV virus on a television chat show in Spain to support his claims. Other doctors and authors come to the same conclusions, among them Peter Duesberg PhD and John Yiamouyiannis PhD, in their book, 'AIDS: The Good News Is That HIV Doesn't Cause It. The Bad News Is "Recreational Drugs" And Medical Treatments Like AZT Do'. That's a long title, but it sums up the situation.

"Dr Wilner even injected himself with the HIV virus on a television chat show in Spain to support his claims.".

There is no such thing as a test for AIDS. The diagnostic tests popularly referred to as "AIDS tests" do not identify AIDS. Both the ELISA and the Western Blot tests are used to detect only antibodies to HIV, but both of these tests are non-specific for HIV antibodies and are highly inaccurate. Non-specific means that these tests respond to a great number of non-HIV antibodies, microbes, bacteria and other conditions that are often found in the blood of normal, healthy people. A reaction to any of these other antibodies and conditions will result in an HIV positive diagnosis. A simple illness like a cold or the flu can cause a positive reading on an HIV test. A flu shot or any other vaccine can also create positive results. Having or having had herpes or hepatitis may produce a positive test, as can a vaccination for hepatitis B. Exposure to diseases such as tuberculosis and malaria commonly cause false positive results, as do the presence of tape worms and other parasites. Conditions such as alcoholism, liver disease and blood that is highly oxygenated through drug use may be interpreted as the presence of HIV antibodies. Pregnancy can also cause a positive response. The potential for cross-reactivity on HIV tests has been noted in such mainstream publications as USA Today and The Wall Street Journal which recently reported FDA (Food and Drug Administration) recalls of HIV tests for problems with high rates of "false positives."

These cross-reactions occur because the antigens used in HIV test kits react to the antibodies of many microbes, bacteria, viruses and other conditions and report them all as HIV antibodies. Since no antibody is ever specific to any one disease, it is not possible to have a specific antibody test for any one disease. An accurate antibody test can only be constructed and validated by viral isolation. Many doctors and scientists contend that the lack of viral isolation for HIV tests completely invalidates HIV tests. The HI-virus has never been isolated!

Another fundamental problem with the use of HIV antibody tests is that antibodies do not indicate the presence of active infection or disease. Antibodies, in fact, are a normal, healthy response to infection and actually indicate immunity to disease. Before Gallo's HIV hypothesis, antibodies had never been used as an indicator or a predictor of illness. There is no credible scientific evidence to suggest that this rule should now be disregarded to accommodate the HIV hypothesis. The most outstanding problem with any HIV test is that HIV has never been proved to be the cause of AIDS.

AZT, the main "cure" for AIDS, began its life as a "cancer drug" but was withdrawn for being too toxic. Its effects include cancer, hepatitis, dementia, seizures, anxiety, impotence, leucopenia, severe nausea, ataxia, etc. and the termination of DNA synthesis. In other words: AIDS/death by prescription. AZT eventually kills all those who continue to take it. It destroys the immune system, thereby causing AIDS. People are dying from the treatment, not the HIV. AIDS is simply the breakdown of the immune

system, for which there are endless causes, none of them passed on through sex. Anyone who now dies from a diminished immune system is said to have died of AIDS. It is even built into the diagnosis. If you are HIV positive and you die of tuberculosis, pneumonia, or 25 other unrelated diseases that the authorities have connected to "AIDS", your death certificate will state you died of AIDS. If you are not HIV positive and you die of one of those diseases, you are said to have died of that particular disease, not AIDS.

CONCLUSION:

- there is no link between HIV and AIDS.
- AIDS is a toxic condition that can manifest itself in different disease forms.
- HIV has never been found.

VIRUS FACTS

One of the great mysteries surrounding the viral story is always the sneaky way these exceptionally tiny creatures are managing to create such havoc. However, knowing that infections are not caused by outside enemies and knowing that proof of viral life has not been provided as yet, we may want to take a wider view at the science.

Firstly, what do you need to do in order to catch a virus? Here are a couple of extreme suggestions with their results.

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

Swine flu is a known viral infection, which was considered non-dangerous and normal, but for an unknown reason during an outbreak in the spring of 1918 in the US it mutated into a severe form that killed a large number of people. The medical authorities were pressurised into developing a vaccine in order to stop the spread of this now lethal disease. They conducted experiments on volunteers, which they recruited from a military prison on Deer Island in Boston harbour. The prisoners were promised complete pardon if they survived a series of rigorous tests. In order to infect the volunteers with the deadly virus they were injected with infected lung tissue taken from the dead. If this failed they had their eyes, nose and mouth sprayed with infectious aerosols. After that, they had their throats swabbed with discharges taken from the sick and dying. If all else failed, they were required to sit open-mouthed while a gravely ill person was sat up slightly and made to cough into their faces. There were sixty-two chosen volunteers. Not a single one caught the flu. The only person who did was the doctor who died soon afterwards.

"How then can a microorganism that supposedly only survives inside a cell remain undetected and alive when its own host cell has already died several times over?"

On the one hand the authorities tell us that you can be infected by a virus when you breathe in water droplets coming from an infected throat of someone else and on the other hand it says in the medical textbooks that viruses can only survive inside a host cell. Water droplets do not contain living cells! So, you can't catch a virus through "air" contact. And neither can you through ingesting it. As we will see, a virus has a very fragile structure, including a very weak membrane. If your stomach acid burns a hole in your own skin, which is rough and thick, it would easily blow apart the protection a virus has.

Furthermore, how does a virus manage to lie low for several months, in the case of HIV or variant CJD we are to believe it can be up to 20 years, before erupting so explosively at more or less the same time all over? What's the trigger and why instantaneously in all those different places? Other scientists show us that every single cell in the body is being replaced within one year. How then can a microorganism that supposedly only survives inside a cell remain undetected and alive when its own host cell has already died several times over?

It also is a fact that some of these viral epidemics are more devastating to people in their prime than they are to infants and elderly people, who are generally considered to be more vulnerable for infections. For some unknown reason people with a reduced resistance, a 'weaker' immune system, are seemingly more protected against certain viral infections. This has never been explained.

Sometimes viral infections that we consider eradicated will return. There are plenty of examples of this, even in our modern times, but a well-documented story is the Russian virus known as H1N1 which caused outbreaks over wide areas in 1933. It seemed to disappear and then return with devastating effects in the 1950's and again in the 1970's. Nobody knows where it went in the mean time. In the in-between periods it was never found anywhere. These phenomena are explained by using the tale of 'dormant viruses', but nobody has ever come close to proving that this could be a possibility. This raises the same old two questions: Why did it not cause any symptoms wherever it was hiding? and If it was hiding somewhere, how did it spread so quickly when it did, as you can't catch it - not from a human, not from an animal?

Let's list the basic things we know about viruses so we can get an overall view of what these elusive animals are like.

First of all, they are very small and they weren't detected until 1943 with the invention of the electron microscope. Interestingly enough, Rife never mentioned seeing them amongst the living matter he looked at. Many viruses, including HIV, have been said to contain ten or fewer genes, whereas the simplest bacteria requires several thousand genes. To create a living thing you need properly organised DNA of a substantial quantity, which the virus hasn't got.

We define "a living organism" as something that performs three tasks in succession: taking in stuff (eating,

breathing), metabolising stuff (digesting, absorbing), and excreting waste. A fourth necessary task is reproduction. A virus doesn't do any of these. No virus does. Within the viral capsule there are no other structures identifiable that are required for a metabolic process. There is no activity at all inside the viral capsule.

Not only doesn't it look structurally as if its alive, it also isn't alive in physiological terms.

So what is it then? As we all know, viruses can have devastating effects on the health of plants, animals - great and small, including bacteria - and humans. How does it produce these effects, if it is not alive, can't be caught and doesn't reproduce?

Known scientific facts about viruses and the way they function are obtained from chemical analysis and looking at still pictures from electron microscopes. The story is pieced together, not actually observed! This means that what you are told happens, is actually a theory at best, and a fantasy story at worst. What has actually, in simple terms, been discovered?

- Viruses contain either RNA or DNA (single strand which makes multiplying impossible!), a small amount and mostly one or the other, but there are exceptions. Bits of genetic material of whatever kind, really; but only bits, nothing organised or structured.
- Viruses are marked species and organ specific, and on the whole, viruses infecting plants, insects, rickettsiae, bacteria and other animals are distinct from their human counterparts, but this is now thought not to be entirely the case. They are specific, but then again they are not.
- Viruses may be naked with the genome only protected by a protein capsid, or they may have a lipid envelop surrounding the capsid. Bits of genetic material in a thin simple bag, or sometimes put in a fatty bubble.
- Viruses are seen to be "encapsulated" by the body cells that have specific receptors for the virus. Once inside the cell, it seems that the virus capsule is removed and the exposed bit of DNA or RNA is "read" and the host cell seems to duplicate it. These bits of genetic materials are encapsulated once again, and with the host cell bursting. Filled with complete viruses it will explode and the viruses are spilled into the cellular surroundings. So, we see a lot of genetic bits within the cell; these bits are then encapsulated and eventually the cell bursts open to release the now bagged up genetic material into the extra-cellular environment. We suppose that the viral genetic material (could be as few as ten genes) disrupts the function of the host cell completely. In the case of a human being that means that ten "faulty" genes dictates 25,000 human genes to produce viruses.

"The story is pieced together, not actually observed! This means that what you are told happens, is actually a theory at best, and a fantasy story at worst. What has actually, in simple terms, been discovered?"

- Viruses in the intercellular environment are engulfed by cells from the immune system (macrophages and lymphocytes), which collect them and destroy them. These bags that contain bits of genetic material are collected into cells from the immune system.
- Viruses are very difficult to demonstrate (they are extremely small) and the diagnosis of viral infection is mostly made on clinical symptoms alone and the assumption that it fits into a known disease pattern for which there is no causative factor known. Virtually every time a diagnosis of viral infection is pronounced no proof is offered for this diagnosis.
- Materials for virus isolation must be obtained as early as possible during illness. It is at the very early stages of the illness that the highest titres are found and the most likely it is one can produce a positive test result. There are more viruses present right at the beginning of the illness than at any other stage of the disease process. If the viruses were multiplying within the cells you would expect the number to rise as the disease developed and infected more and more cells.
- Identification of viruses is done in laboratories by measuring the level of antibodies against specific viruses, not by measuring or demonstrating the virus itself. Measuring a higher protection level is diagnosed as the illness itself!

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

Regarding the evolution of the viral infection we now know that as soon as the symptoms start the number of viruses will very quickly be reduced. There is no evidence of rapid number proliferation once the disease manifests itself.

All in all there are lots of things that don't seem to fit. Taken separately one could get away with "Maybe it is like this or like that - maybe", but all those maybe's put together casts a large shadow over the theory of viral infections and viruses as their cause. Let's see if we can put forward a different theory that includes all these anomalies.

If viruses are not living things, they cannot multiply and they don't need a specific environment to "survive". They cannot appear from nowhere and they can't spread and infect other cells.

From our knowledge about infectious diseases we know that when a cell becomes diseased and the function of that cell begins to falter, it starts to come apart at the seams. Bits of its essential structure, the DNA and RNA, may become detached as the cell itself is falling apart. The cell will try and clean up these bits by preparing them for the rubbish bin. The small pieces of genetic material, which are now floating around in the intracellular fluid, will be isolated by means of encapsulating them. That way they cannot accidently become stuck in the system, as single strands are normally used as messengers from the nucleus to the organelles inside the cellular plasma. As the cellular disintegration continues, more and more of these bits

are seen inside the cell and more and more small "bags" of useless genetic material will appear. Once the cell is totally dysfunctional and filled with rubbish the cellular wall itself bursts and the contents will be spilled into the cellular environment. Here, the clean-up continues by packaging these small bags up even further into what has been called the neutrophiles and macrophages of the immune system. These large vesicles now drift away into the lymphatic fluid and the blood stream, from where they will be filtered out at appropriate draining stations, like the lymph nodes and the spleen. This process continues until the whole lot has been cleared.

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

How do we then explain "viral epidemics"? Why is it then that we get a cold the day after someone in the office starts to cough and sneeze a lot? Bear in mind that we have identified the fact that it is impossible to catch a disease.

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

What is seen and has been named "a virus" starts after the cellular structure begins to disintegrate. Why does a cell start to fall apart? Because it is diseased. The disease is already there, long before any viral particles show up in any pictures. So, then we have to ask the question, why has the cell become diseased? The answer to this lies in the build-up of toxic material within the cellular structure. As the cell gets loaded up with inappropriate material it will eventually be unable to cope and it will start to fall to pieces. It is exactly those pieces that are photographed by the electron microscope and have been named "viruses".

"Children that have reached a certain development stage will get a "viral" infection. No, their system needs to make serious changes in order to accommodate future growth and development, which means that the tissues as they are need to be broken down and rebuilt."

The influences that can lead to an increased pressure on the system are many and are varied. They range from the weather, to living and working environment, to life style and diet, to the balance of activity and rest, to mental balance, stress and worries. Because a lot of these influences, such as working conditions and the weather, are general circumstances which affect all of us, it is very likely that a great number of us, in the same environment, will fall ill at or around the same time, succumbing to the environmental influences. Add to this that people who are working in the same environment are very likely to have similar life styles and interests, and another factor has been identified explaining why similar disease pattern occur within certain groups of people at certain times.

On top of that, we now know that worry reduces our immunity capacity and increases the likelihood of illness. The belief that, if one person close to you has a cold, you are going to get it too, increases the likelihood of this actually happening dramatically, as you become more vulnerable through the immune reducing effect of the worry itself.

This fits in exactly with the facts of science. Since Einstein and his contemporaries we know that all matter and all functioning of matter is in fact determined by its energetic field. All matter is energy, and all changes in matter are a representation of the changes within the energetic field. Matter is the most condensed part of the energetic field, sitting right at the centre of its own energetic field. Any malfunctioning of the tissues, any disease, comes after changes that have happened within the field. So, all physical ailments have an energetic cause.

Children that have reached a certain development stage will get a "viral" infection. No, their system needs to make serious changes in order to accommodate future growth and development, which means that the tissues as they are need to be broken down and rebuilt. It is the breaking down that results in the overload of toxins, of waste, and the excretion of that we identify as childhood diseases. The impulse for this change comes from their energetic field; they are "ready" to change. Then coming across someone who has started the process is an energetic incentive for that particular system to also start. And that is why German Measles and all the others seem to spread. Putting the children together in closed environments like schools encourages this exchange.

Epidemics occur because people in similar circumstances, living environments and conditions, have similar imbalances within their systems, leading directly to similar disease patterns. This causes fear and apprehension all around them, making others more vulnerable to start showing a breakdown of health themselves. The disease is spreading. More accurately, the fear of the disease is spreading first, resulting in a lowered resistance, which allows each individual's imbalances to show up through the inability to cope with the problems the system has already been faced with for a long time. More and more people are becoming ill

and showing signs of the fact that their bodies have been under extreme pressure for quite a while to maintain health. The showing of an illness, even an "acute" illness, is the end result of a long process, of a slow deterioration of the system's normal functioning. Disease is a process, not a state of being.

One more thing to clear up! Are doctors really stupid? In the media we are clearly told time and time again that antibiotics do not work against viral infections. There is no point in taking antibiotics to clear up a viral infection; it won't work. We all know that. When your doctor tells you that what you have is a viral infection, he is likely to prescribe you antibiotics. Dumb, isn't it? Well, he has been told that very often a viral infection will be followed by a secondary bacterial infection. And it is to prevent that one that he recommends taking antibiotics. In the story of infection, as we have illuminated it here, there is first an internal breakdown of the cellular structure, resulting in the cell filling up with small rubbish bags ("viral" phase), followed by the bursting of the cell and total destruction of the cellular structure, resulting in a variety of different waste that will stimulate the origin and development of microorganisms specific for the food the cellular debris is providing (bacterial phase).

TO REMEMBER

An infection is a further development stage from an inflammation.

The microorganisms found within an infection are generated by the kind of tissue debris the disease and the subsequent disintegration of the cellular structure has produced. They will remain as long as there is food for them.

Before the complete cellular structure starts to disintegrate, the internal cellular structure comes apart. this creates internal small waste products. Specific DNA and RNA pieces that have separated from the genetic code and that have been bagged up in very simple membranes have been called viruses. These are not microorganisms; these are remnants of the destruction of the inner structure of the nucleus of the cell.

The disease causes the disintegration of the physical structure. And disease originates in the energetic field that creates and operates the matter at its centre.

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Gunmen kill polio immunization workers in northern Nigeria

BY EMILY ALPERT

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NINE WOMEN working to immunize children against polio were killed Friday when gunmen opened fire on them in northern Nigeria, Kano state police said.

Women involved in the vaccination drive were targeted in two areas of the northern city of Kano, news reports said. Witnesses told the Associated Press that the death toll appeared to be higher than what police had reported, saying eight were killed in one attack and four were dead in another.

One injured woman told Agence France-Presse that two men stormed into a clinic and started shooting, then set a curtain on fire and fled, shutting the door. “We summoned courage and broke the door because we realized they wanted to burn us alive," the woman told AFP from her hospital bed. She declined to give her name.

Islamic extremists were suspected of being behind the shootings, which echo a string of attacks in December on vaccination workers in Pakistan.

The northern stretches of Nigeria have been menaced by Boko Haram, a radical militant group that has attacked schools, churches and mosques and assassinated politicians and religious leaders.

Conservative Muslim clerics in Nigeria's north have long been leery of immunizations. Polio exploded there a decade ago after imams called for a halt to immunizing of children, claiming the vaccinations were a Western plot to sterilize Muslim girls. Though the boycott was later dropped after Nigerian officials agreed to test vaccines in a Muslim country, the resistance lingers.

Suspicion has been fueled in part by deaths and disabilities after an earlier Pfizer drug trial. Pfizer said the deaths were caused by the meningitis the drugs were treating, but it agreed to pay up to $35 million to Nigerian families in a settlement.

Most people in northern Nigeria, including most Muslims, support immunizations, "but there is a strong element of cultural resistance to polio vaccines that predated Boko Haram,” said Paul Lubeck, associate director of African studies at the Johns Hopkins School of Advanced International Studies. “What Boko Haram has now done is to take that fear and use their assassination methods against health workers -- that’s a new threshold of violence.”

Boko Haram turning its guns on vaccination workers “is not particularly surprising,” said Bronwyn Bruton, deputy director of the Africa Center at the Atlantic Council. “The only thing they seem to stand for is the rejection of any kind of Western value.”

Health officials did not answer calls or immediately respond to an email seeking comment on how Friday's attacks might affect the effort to stamp out polio. A top health official told Nigerian media last week that “not a single case of polio” had been recorded in two months.

Nigeria reported 121 cases of polio last year, more than any other country, according to the Global Polio Eradication Initiative. It is one of only three nations in the world where polio remains endemic; the other two are Pakistan and Afghanistan. The persistence of polio in Nigeria has allowed the crippling disease to spread to other countries in the past, reinfecting areas where polio had been wiped out.

AIMS & OBJECTIVES OF THE *informed* PARENT GROUP

1. To promote awareness & understanding about vaccination in order to preserve the freedom of an informed choice
2. To offer support to parents regardless of their decisions
3. To inform parents of the alternatives to vaccinations.
4. To accumulate historical & current information about vaccination & to make it available to members & interested parties.
5. To arrange & facilitate local talks, discussions and seminars on vaccination, childhood illnesses & the promotion of health.
6. To establish a nationwide support network and register (subject to members permission).
7. To publish a newsletter for members.
8. To obtain, collect and receive money and funds by way of contributions, donations, subscriptions, legacies, grants or any other lawful methods; to accept and receive any gift of property and to devote the income, assets or property of the group in or towards fulfilment of the objectives of the group.

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