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There Is No Gold-Standard Polio Vaccine

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Theme: Science and Medicine

Efforts to eradicate polio, once considered a public health triumph, are now threatened by a complex interplay of scientific, logistical, and geopolitical challenges. The emergence of vaccine-derived polioviruses (VDPVs) and a rise in vaccine-related complications have introduced unforeseen obstacles. Despite the decades that our federal health officials believed mass vaccination campaigns were making progress, polio cases remain a persistent threat driven by socio-political factors, vaccine-associated risks, and new strains that may have very likely developed from over-vaccination. Research from leading institutions such as Stanford University, the CDC, and global health organizations like the World Health Organization (WHO) has increasingly confirmed independent researchers' long-held concerns that the polio vaccines' success story has been overblown.

The WHO in earnest launched its global polio eradication initiative in 1988. In 2002, Europe declared itself to be polio-free. In 2015, the WHO declared wild poliovirus type 2 was eradicated globally. However, recent detections of vaccine-derived poliovirus in Europe and the US, outbreaks in the Philippines, and resurgent cases across Africa and Asia have proven that vaccine-derived herd immunity has been nothing more than a myth.

For example, earlier this year researchers from the universities of Essex and Cranfield in the UK discovered poliovirus in wastewater samples from Germany, Spain, and Poland. Although no clinical cases were reported, the detection is worrisome. It signals the ongoing circulation of the virus. These findings highlight how the live attenuated virus in the oral polio vaccine (OPV) may have mutated and regained virulence. The British researchers noted that the strains identified were linked to vaccine-derived poliovirus. These detections parallel earlier outbreaks in Tajikistan and Ukraine in 2021 and Israel in 2022, where vaccine-derived strains caused paralytic disease. In the backdrop of the genocide against Palestinians, polio cases are reaching epidemic proportions in Gaza. In the UK, poliovirus was similarly detected in wastewater in 2022.

Vaccine-derived polioviruses arise from the oral polio vaccine, which contains a weakened live viral strain. Under certain conditions, it can mutate and regain its virulence. It is particularly dangerous in regions with poor sanitation where it spreads through fecal contamination. These mutated strains then behave like wild poliovirus and cause paralytic disease. This problem with the oral polio vaccine was first documented in 2000 and has gained prominence with the increase in polio vaccination campaigns. For instance, during the first nine months of 2014, Nigeria recorded more polio cases caused by vaccine-derived polioviruses than wild poliovirus. In 2019, the Philippines declared a polio outbreak nearly two decades after being certified polio-free by the WHO. A case was confirmed in a three-year-old girl in Lanao del Sur province followed by poliovirus being detected in sewage samples from Manila and waterways in Davao. Genetic sequencing has also linked these outbreaks to cross-border transmission fueled by population movements. In 2020, Sudanese children were being paralyzed by vaccine-derived poliovirus type 2 that was traced to an

outbreak originating in Chad. Although the live polio vaccine has been discontinued in developed nations, due to its risks in causing polio-like paralysis, it is still administered in poorer undeveloped countries. As long as the drug companies continue to make and distribute oral polio vaccines, solely for its cost saving benefits and ease to manufacture, vaccine-induced paralysis will rise. These outbreaks attributed to VDP type 2 highlight the risks associated with oral polio vaccine in areas with inadequate sanitation and water utility systems. Dr. Walter Orenstein, a professor of medicine at Emory University and former director of the US National Immunization Program has described vaccine-derived polioviruses as “the biggest surprise” in global vaccination efforts.

Today, US health authorities proudly claim the nation is polio-free. Medical authorities and advocates of mass vaccination raise the polio vaccine as an example of a vaccine that eradicated a virus and therefore proof of the “herd immune theory.” The simplistic belief that regional eradications of polio are an exemplary model of vaccine-induced herd immunity applicable for all other vaccines is both naïve and dangerous. It is a propagandist narrative that won’t disappear. It was parroted during the Covid-19 pandemic. For example, a University of Otago study claimed that mass Covid-19 vaccinations would achieve even better results than the polio vaccine. The entire one-size-fits-all study was fundamentally flawed. The New Zealand scientists’ claim that COVID-19 eradication might be feasible, and even more achievable than polio eradication, is fundamentally flawed. By drawing comparisons between COVID-19 and diseases like polio, the study overlooked critical distinctions in viral behavior, vaccine efficacy, and risk-benefit ratios due to adverse effects. It also failed to account for the fact that neither the Pfizer nor Moderna mRNA vaccines are capable of preventing infection, transmission and viral shedding.

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In light of the growing life-threatening risks associated with Covid-19 vaccines, it has become abundantly clear that fast tracking unsafe and poorly researched vaccines is a disastrous public health policy. This was also the case for one of the first polio vaccines in 1955. In fact, the polio vaccine received FDA approval and licensure only after two hours of regulatory review – the fastest approved drug in the FDA’s history. Known as the Cutter Incident, named after the vaccine’s manufacturer Cutter Laboratories, within days after its first mass administration, 40,000 children were left with polio, 200 with severe paralysis and ten deaths. Shortly thereafter the vaccine was quickly withdrawn from circulation and abandoned.[1]

Modern medical wisdom believes that the enterovirus associated with poliomyelitis is a highly infectious disease. The virus enters the body's system through the gastrointestinal tract, often because of fecal contamination in water resources. According to the CDC, the majority of people who contract this enterovirus will not experience any symptoms. Approximately 25% will show temporary flu-like symptoms that disappear after several days. It is only after the virus enters the bloodstream and infects alpha-motor neurons located in the spinal cord's anterior gray matter that there is the risk of paralytic poliomyelitis.

A question that has plagued historians of medicine is whether or not the scourge of paralysis starting in 1916, well before the introduction of the first polio vaccine, was actually caused by the virus. Before 1916, when there was an enormous leap in paralysis cases in a single year—from zero to 3 cases per 10,000—why were there no recorded cases in the medical literature before that time? Moreover, after a couple years, the cases declined back to near zero. For the next 35 years, there would continue to be spikes and declines until 1948 when polio cases started to skyrocket.

The enterovirus theory has never provided a satisfactory answer to account for poliomyelitis' sporadic trends. In a recent article about the Rockefeller Institute's role in fraudulent research to identify the pathogen behind the rise in poliomyelitis, William Engdahl presents a 1909 paper published by Rockefeller employees Simon Flexner and Paul Lewis whereby they assert the poliomyelitis virus had been identified after injecting diseased human tissue into monkeys, who then developed symptoms. However, Flexner and Lewis admitted they found no bacteria or conclusive evidence of a virus. They acknowledged, "We failed utterly to discover bacteria… and we had failed to obtain any such bacteria from the human material studied by us;" yet, they concluded the cause "must" be a virus, despite lacking any scientific proof. Their experiment involved using impure, contaminated materials, including spinal cord, brain, and even fecal matter, injected into monkeys. This speculative leap was accepted by the medical world without scientific proof, and the existence of an enterovirus as a paralytic agent remained unverified until 1955.

In his *Vaccines, Autoimmunity and the Changing Nature of Childhood Illness*, Dr. Thomas Cowan identifies some odd coincidences during the periods when paralysis cases spiked. For example, the first cases of paralytic polio clustered around Coney Island in New York, and later started to appear in the larger cities of the Northeastern states, such as Boston, Philadelphia and Baltimore. Curiously, the two major spikes in poliomyelitis cases — 1916 to 1918, and 1948-1955 — correlate with the widespread use of two dangerously neurotoxic chemicals: arsenite of soda and dichloro-diphenyl-trichloroethane, commonly known as DDT.

At the end of the 19th century, the majority of sugar came from Hawaii's sugarcane plantations. The industry was in a crisis due to weed proliferation. A plantation owner, Charles Eckhart, came up with the idea of spraying fields with a very potent form of arsenic known as arsenite of soda. Arsenic is also highly toxic to anterior horn cells, motor neurons that protect gray matter in the spinal cord. Over the years, sugar entering the US mainland was heavily contaminated with this neuro-toxin. The first recorded case of so-called polio was noted in Sweden where an arsenic-based insecticide was employed, and the famous Vermont polio outbreak several years later happened in a region where a lead arsenite spray was used to eradicate gypsy moths. Around this same period, the Swiss scientist Paul Hermann Muller first synthesized DDT in 1874 and started to be used as an insecticide in Europe to combat gypsy moths.

However, the largest rise in polio cases occurred when DDT was indiscriminately sprayed across large regions of the US. Older generations will remember television scenes of children literally being sprayed down with the chemical. Not all scientists were convinced that the epidemic of paralytic cases was being caused by a virus. Dr. John Polyani, who would later receive the Nobel Prize in chemistry, opposed the hypothesis because it failed to meet Koch's postulates: 1) a pathogenic organism must be present in every case of disease, 2) that the pathogen must be isolated from a disease host, and 3) the disease must be reproduced when introduced into a healthy host. These postulates have never been completely validated for an enterovirus as being the causal agent of poliomyelitis.

In the 1940s, a Connecticut physician Dr. Morton Biskind identified a relationship between poliomyelitis paralysis and the widespread use of DDT. Other researchers followed suit, including Dr. Ralph Scoby who testified before Congress in 1952 — after the radical decline in paralysis cases following a reduction in DDT usage. Scoby called polio "classic poisoning." The following year Biskind published a paper concluding that "central nervous system diseases such as polio are actually the physiological and symptomatic manifestations of the ongoing government and industry sponsored inundation of the world's populace with central nervous system poisons." His testimony before Congress stated that DDT's poisoning of the spinal cord may also "increase the susceptibility to the virus." The pharmaceutical industry, fully committed to a vaccine against an enterovirus, never heeded this other body of evidence challenging the viral-only theory.

Despite the medical establishment still promulgating the untruth that the Salk vaccine was a modern medical success, the National Institutes of Health was once convinced that the vaccine contributed to a rise in polio and paralysis cases in the 1950s. In her 1957 book *The Poisoned Needle,* Eleanor McBean documented that government officials called the vaccine "worthless as a preventive and dangerous to take." Some states such as Idaho where several people died after receiving the Salk vaccine, wanted to hold the vaccine makers legally liable. Dr. Salk himself testified in 1976 that his killed virus vaccine, which continued to be distributed in the US until 2000, was the "principal if not sole cause" of all polio cases in the US since 1961. However, after much lobbying and political leveraging, the drug industry seduced the US Public Health Service to proclaim the vaccine safe.[2]

The 1950s marked a decade of remarkable medical achievement; it also marked a period of scientific naiveté and enthusiastic idealism. After paralytic conditions were given a variety of names in an attempt to distinguish them (e.g., polio, aseptic meningitis, Coxsackie, etc.), another problem arose.

One of the more misleading names given to paralysis that may or may not be associated with the vaccine is Acute Flaccid Paralysis (AFP) and Non-Polio Acute Flaccid Paralysis (NPAFP). This is a class of paralysis indistinguishable from the paralysis occurring in thousands within the vaccinated population. It was incumbent upon health authorities to transfer polio vaccine-related injuries to non-poliovirus causation in order to salvage vaccination campaigns and relieve public fears. With the World Health Organization (WHO) leading efforts to eradicate polio through the Global Polio Eradication Initiative (GPEI), the terminology became a tool to focus public health narratives on eliminating wild poliovirus. However, increasing evidence suggested that many cases of paralysis—clinically indistinguishable from polio—were occurring in individuals vaccinated with the oral polio vaccine. These cases often tested negative for wild poliovirus, leading to their classification as Non-Polio Acute Flaccid Paralysis. Critics argue that this reclassification served to protect

the public image of vaccination campaigns, particularly as cases of vaccine-derived poliovirus emerged. Dr. Suzanne Humphries and her colleagues noted a direct relationship between the increase in Acute Flaccid Paralysis through 2011 and government claims of declining polio infectious rates parallel with increased vaccination.[3]

Cases classified as Non-Polio Acute Flaccid Paralysis lack laboratory confirmation of wild poliovirus. However, studies demonstrate that vaccine-derived strains can cause paralysis. Furthermore, studies from India and other regions have shown a strong correlation between high oral polio vaccine use and increased Non-Polio Acute Flaccid Paralysis rates that raise concerns that the live vaccine contributes to paralysis. In one study, Indian scientists estimated that 491,000 cases of paralysis were due to vaccine-related complications.[4] A follow up study in the *Indian Journal of Medical Ethics* concluded that the WHO's surveillance methods to distinguish between polio and Non-Polio Acute Flaccid Paralysis is artificial and has been driven by vaccine policy and not science.[5] Similar cases have been observed following the administration of other vaccines, including the HPV vaccine Gardasil, meningitis vaccines, and flu shots. Another study by Nathanson and Kew described the biomechanisms by which live oral polio vaccine strains mutate in the human gut, increases their neurovirulence and lead to NPAFP.[6]

It is important to note the dismal failures in Bill Gates' polio eradication campaigns in India. Touted as one of the "most expensive public health campaigns in history" according to *Bloomberg Business*, as many as 15 doses of oral polio vaccine failed to immunize the poorest of Indian children. Severe gastrointestinal damage due to contaminated water and wretched sanitation conditions have made the vaccine ineffective. According to epidemiologist Nicholas Grassly at Imperial College London, " There is increasing evidence that oral polio failure is the result of exposure to other gut infections."[7]

Another more frightening incident of Gates' polio vaccine boondoggles was launched upon rural India in 2011. This particular polio vaccine contained an increased dosage of the polio virus. In the April-June 2012 issue of *the Indian Journal of Medical Ethics*, a paper reported the incidence of 47,500 new cases of Non-Polio Acute Flaccid Paralysis, following Gates polio campaign.[8] The following year, there were over 53,500 reported cases. Non-Polio Acute Flaccid Paralysis is clinically indistinguishable from wild polio paralysis as well as polio vaccine-induced paralysis. The primary difference is that NPAFP is far more fatal.[9]

Physicians at New Delhi's St. Stephens Hospital analyzed national polio surveillance data and found direct links between the increased viral dosages and the high number of Non-Polio Acute Flaccid Paralysiscases. Coincidentally, the two states with the highest number of cases, Uttar Pradesh and Bihar, are also the two states with the worst water contamination, poverty and the highest rates of gastrointestinal diseases reported by Bloomberg. As early as 1948, during a particularly terrible polio outbreak in the US, Dr Benjamin Sandler at Oteen Veterans' Hospital observed the relationship between polio infection, malnutrition and poor diets relying heavily on starches.[10] Despite this crisis, in January 2014, Bill Gates, the WHO and the Indian government announced India is today a polio-free nation.[11] Another sleight of hand performance of the polio vaccine's magical act.

One of the largest and most devious medical scandals in the history of American medicine also concerns the polio vaccine. In his excellent history about polio, Neil Miller recounts the story of Dr. Bernice Eddy, a scientist at the NIH who in 1959 "discovered that the polio

vaccines being administered throughout the world contained an infectious agent capable of causing cancer." As the story is told, Eddy's attempts to warn federal officials resulted in being removed from her laboratory and demoted at the agency.[12] It was only later that one of the nation's most famous vaccine developers, Maurice Hilleman at Merck identified the agent as a cancer causing monkey virus, SV40, very commonly found in African rhesus monkeys and used to culture the polio virus in vaccine development. When tested, this contaminant virus was found in all samples of Sabin's oral polio vaccine. It was also found in Salk's killed polio injectable vaccine. No one knows for certain how many Americans received SV40 contaminated vaccines, but some estimates put the figure as high as 100 million people. In 1963, that was greater than half the American population when the vaccine was removed from the market.

Many Americans today—even more internationally—continue to be physically compromised from the legacy of this vaccine. Among some of the more alarming discoveries since the discovery of the SV40 in Salk's and Sabin's polio vaccines and its carcinogenic footprint in millions of Americans are:

- Loyola University Medical Center identified SV40 in 38% of bone cancer cases; 58% of mesothelioma cases, a life threatening lung cancer, had SV40 present.[13]
- A large national cancer database found mesotheliomas were 178% higher among those who received the polio vaccines
- A study published in *Cancer Research* found SV40 in 23 percent of blood samples and 45% of semen samples analyzed, thereby confirming that the monkey virus can be sexually transmitted.[14]
- Osteosarcomas are 10 times higher in states where the SV40-contaminated polio vaccine was most administered, particularly throughout the Northeastern states [15]
- Two 1988 studies published in the *New England Journal of Medicine* reported that SV40 can be passed on to infants whose mothers had received SV40 tainted vaccines. Those children later had a 13 times greater rate of brain tumors compared to children whose mothers did not receive the polio vaccines.[16]

There is a large body of scientific literature detailing the catastrophic consequences of SV40 virus infection. As of 2001, Neil Miller counted 62 peer-reviewed studies confirming the presence of SV40 in a variety of human tissues and different carcinomas. Although the killed polio vaccines administered in developed countries no longer contain the SV40 virus, the oral vaccine continues to be the vaccine of choice in poorer developing countries. After almost sixty years of silence and a federally sanctioned cover up, the CDC finally admitted in 2013 that the Salk and Sabin vaccines were indeed contaminated with the carcinogenic SV40 monkey virus.[17]

The polio vaccines on the market have not improved very much during the past 70 years. They continue to rely upon primitive manufacturing technology and animal tissue culturing. The present IPV vaccine issued in the US uses Vero cells, a continuous line of monkey kidney cells, during the cultivation process. The vaccine contains phenoxyethanol (a preservative used in cosmetics and personal care products); in 2008 the FDA issued a warning concerning phenoxyethanol as a nervous system depressant in Mommy's Bliss Nipple Cream due to its risks to infants.[18] Nevertheless, there is no such warning regarding the toxic preservative in injectable vaccines, which the FDA considers "safe." Other ingredients

include the carcinogen formaldehyde, and several antibiotics (i.e., neomycin, streptomycin and polymyxin B).

The Indian examples mentioned above, and subsequent cases in other developing nations, scientifically support a claim that has been stated for many decades; that is, improving sanitation, providing clean water, healthy food, and the means for better hygiene practices are the safest and most efficacious measures for fighting infectious disease. According to statistics compiled by Neil Miller, Director of ThinkTwice Global Vaccine Institute, the polio death rate had declined by 47% from 1923 to when the vaccine was introduced in 1953. In the UK, the rate declined 55% and similar rates were observed in other European countries.[19] Many historians of science, such as Robert Johnson at the University of Illinois, agree that the decrease in polio and other infectious diseases during the first half of the twentieth century were largely the result of concerted national public health efforts to improve sanitation and public water systems, crowded factory conditions, better hygienic food processing, and new advances in medicine and health care. Relying upon the unfounded myth that vaccines are a modern miracle to protect a population suffering from extreme conditions of poverty, while failing to improve these populations' living standards, is a no-win scenario. Vaccines will continue to fail and further endanger the millions of children's health with severely impaired immune systems with high levels of vaccines' infectious agents and other toxic ingredients.

Now with the reappearance of polio cases worldwide, we should ask whether or not a new more virulent poliovirus has begun to merge as a result of over-vaccination. In 2014, researchers at the University of Bonn isolated a new strain of poliovirus that was responsible for a severe polio outbreak in the Republic of Congo. This strain exhibited mutations that allowed it to evade vaccine-induced immunity, leading to an unusually high case-fatality rate of 47 percent; most affected individuals had previously been vaccinated against poliovirus.[20] One of the first discoveries of the vaccine contributing to the rise of new polio strains was reported by the Institut Pasteur in 1993. Dr. Crainic at the Institut proved that if you vaccinate a person with three poliovirus strains, a fourth strain will emerge; therefore, the vaccine itself is contributing to recombinant activity between strains. A later study isolated poliovirus strains with recombinant genomes from cases of vaccine-induced paralytic poliomyelitis. These recombinant genomes were naturally occurring, and included a genetic exchange between the attenuated vaccine polio strain and wild polioviruses and other enteroviruses.[21] This research gave proof that genetic changes can occur in vaccine viral strains that lead to more pathogenic variants.

Moreover, since the poliovirus is excreted through a person's GI system, it is no surprise it would be present in sewage and then some water resources. Recent studies have identified the presence of vaccine-derived polioviruses in environmental water samples that further indicate the failure of polio eradication campaigns based upon mass-vaccination. As we've seen, developed countries are not immune from this crisis. In 2022, the CDC detected VDPV Type 2 circulating in wastewater samples in Rockland County, New York. Genetic sequencing linked the environmental isolates to a clinical case of paralytic polio in a Rockland resident thereby confirming community transmission.[22] This year in Gaza, the Global Polio Eradication Initiative (GPEI) found circulating VDPV Type 2 at several different sites.[23] Other more recent incidents have occurred in Egypt, Haiti and the Dominican Republic.[24]

Although the emergence of new polio strains cannot be directly attributed to over-vaccination, more recent research now indicates that shortly after being vaccinated

with OPV, the live virus can mutate quickly and shed to the larger community. In a study published in a 2023 issue of *Vaccine*, scientists at the University of Utah further observed the genetic instability of the vaccine's poliovirus that can lead to more virulent strains and pose serious public health risks. The study tracked the shedding and transmission of polioviruses after a vaccination campaign in semi-rural communities in Mexico by analyzing over 15,000 stool samples. They found that the vaccine virus undergoes genetic mutations shortly after administration, with some mutations leading to a reversion to virulence. Notably, these revertant strains were transmitted not only among vaccinated individuals but also within unvaccinated community members, which would increase the potential for outbreaks. Even in populations with high vaccination coverage, the genetic evolution the live vaccine can lead to the emergence of transmissible, virulent strains.[25]

It is now the habit of our federal health agencies to review the studies provided by vaccine manufacturers and then reinterpret the evidence as it sees fit. They are never held accountable for misinformation and even blatant negligence that threatens the health of countless children at the cost of tens of billions of dollars. Vaccine policies are driven by biased committees, with deep conflicts of interest, that govern vaccine scheduling. Even if a wild assumption could be made that the polio vaccines are responsible for disease's eradication in the US, what has been the trade off? According to the American Cancer Society, by 2030 approximately 1.9 million new cancer cases will be diagnosed annually. In 2023, there were about 1,958,310 new cancer cases in the U.S., equating to roughly 5,370 cases per day. About 8 percent of Americans—26 million people—have an autoimmune disease with some sources suggesting it may be as high as 50 affected individuals. How many of these may be directly or indirectly associated to the polio and other vaccines? It can no longer be disputed that the polio vaccine's devastating aftermath raises serious questions.

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Notes

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Featured image: A child receiving an oral polio vaccine (From the Public Domain)

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