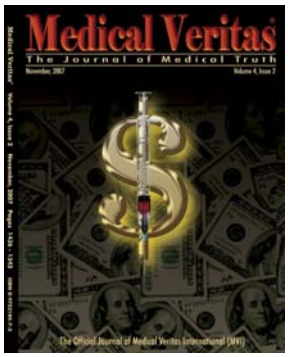
Subsequently, the CDC recommendations have removed the trimester restriction for pregnant women and have widened the age targeted for vaccination: children 6-months to 107-months, and vaccination up to age 18 is suggested [Fiore AE, Shay DK *et al.* Prevention and Control of Influenza—Recommendations of the ACIP, 2007. MMWR 2007 July 13;56(RR05):1-54]. Since both pregnant women and children as young as 6-months old receive the influenza vaccine, there is potential for a higher specific dose of mercury today compared to year 2000.

The CDC has made these recommendations despite vaccine effectiveness studies which found the influenza vaccine is no more effective than a placebo for children 2 years of age and under [Jefferson T, Smith S *et al.* Assessment of the efficacy and effectiveness of influenza vaccines in healthy children: systematic review. Lancet 2005;365:773-780]. The influenza vaccines are "Pregnancy C" drugs that lack the required toxicity studies which prove these vaccines are safe for the child developing in the womb.

Another problematic vaccine is the rotavirus vaccine given in a series of three injections between the ages of 2 to 6 months to prevent severe diarrhea, from which 20 to 60 infants die each year in the U.S. In February 2007, the FDA issued a public health notice on the rotavirus vaccine, RotaTeq®, after receiving 28 case reports of intussusception in vaccinated infants during Feb. 2006 to Jan. 2007. Intussusception is a serious life threatening condition where part of the bowel telescopes into itself causing a blockage that requires hospitalization and surgery.

Note: As of July 31, 2007, since approving RotaTeq® in Feb. 2006, the FDA has received more than 160 reports of intussu-sception in RotaTeq-vaccinated children as well as at least 14 case reports of Kawasaki's disease, a rare vascular disorder.



Additional Information

Scholarly articles for you and your physician are available in the official journal of Medical Veritas International Inc., a non-profit public charity. See www.MedicalVeritas.com

Disclaimer: The information in this brochure is not intended to replace a one-on-one relationship with a qualified healthcare professional and is not intended as medical advice. It is intended as a sharing of knowledge and information from the research and experience of Gary S. Goldman, Ph.D. (Computer Science) and Donna Young, Canadian Birth Researcher (Dawson Creek, BC). They encourage you to make your own healthcare decisions based upon your research and in partnership with a qualified healthcare professional.

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Birth a Healthy Child:
Understand the Dangers of Early Umbilical Cord Clamping, Standard Birthing Positions, and Vaccines

I. Immediate Cord Clamping (ICC) deprives your infant of up to 60% blood volume

Upon birth, usually within 30 seconds or so, the umbilical cord is usually clamped and subsequently cut as part of what is called Active Management of the third stage of labor. However, this procedure prevents from 30 to 60% of the newborn's blood volume from traveling from the placenta to the newborn. (The Lippincott Manual of Nursing Practice, 7th edition, Chapter 38. J.B. Lippincott Company, Philadelphia-Toronto) This "standard" protocol deprives the newborn of the volume of blood to optimally (a) expand the lungs and (b) maintain proper blood pressure in the heart and organs. The infant may also be deprived of important enzymes, hormones, proteins, nutrients, stem cells, and iron reserves that would have otherwise transferred from the placenta to the newborn [Reproduction, The Cycle of Life. K. Jensen. U.S. News Books. ISBN 0-89193-606-8, 1983, page 98]. While the infant appears alive and healthy, the newborn may have suffered brain damage as a result of immediate or early cord clamping which only becomes evident years later when the child manifests behavioral problems and/or learning difficulties. A typical 9-pound newborn only has around 10 to 12 ounces of blood of which 3 to 4 ounces, on average, is lost. It can take several months for the infant to recover from a weakened condition and the newborn may require resuscitation and/or blood transfusions. Several recent studies confirm that delayed clamping is not only beneficial for the newborn, but the benefits extend into infancy and include higher iron stores and less risk of anemia. [Hutton EK, Hassan ES. Late vs. early clamping of the umbilical cord in full-term neonates: systematic review and meta-analysis of controlled trials. JAMA 2007 Mar 21; 297(11):1241-1252].

The hazards of early clamping have been recognized for over 200 years: "Another thing very injurious to the child is the tying and cutting of the navel string too soon; which should always be left till the child has not only repeatedly breathed but till all pulsation in the cord ceases. As otherwise the child is much weaker than it ought to be, a portion of the blood being left in the placenta, which ought to have been in the child." [Erasmus Darwin, Zoonomia, 1801 3rd edition, Volume III. page 302]

Immediate cord clamping is one of many obstetric interventions in labor and birth whose long-term effects are poorly researched. Associations between birth interventions and increasingly common problems such as autism and behavioral abnormalities have been proposed. [Wahl RU. Could oxytocin administration during labor contribute to autism and related behavioral disorders?—a look at the literature. Med Hypotheses 2004; 63(3):456-460].

Summary: "Delayed cord clamping in term infants is safe and, compared with immediate clamping, is associated with higher hemoglobin concentrations and lower incidence of anemia in the first 4 months of life, and higher iron stores up to at least 6 months." [van Rheenen PF, Brabin BJ. A practical approach to timing cord clamping in resource poor settings. BMJ 2006 Nov 4;333(7575):954-958] Delayed clamping does not contribute to greater risk or severity of jaundice and has been shown to significantly reduce the (a) severity of infant respiratory distress syndrome (IRDS), (b) need for transfusion, and (c) risk of neonatal morbidity in premature babies. Storing cord blood (commercial blood banking) for future transplantation, which usually requires immediate cord clamping, is in conflict with the child's best interests.

Suggested Approach: Present your physician with a signed birth contract specifying that the infant's umbilical cord is ***not*** to be cut or clamped to allow full placental transfusion which occurs within 3 to 20 minutes of birth. Within a few days the placenta and cord will naturally separate. This approach minimizes infection and optimizes the health and well-being of your baby and is your legal right.

If the cord is clamped and cut, this ideally occurs only after delivery of the placenta when you observe that all pulsation of blood along the cord has ceased (i.e., the cord is limp and gray/silver). The cut umbilical cord stub will fall off in 1 to 3 weeks. See www.MedicalVeritas.com/FAQ.pdf for more info.

II. Common birthing positions can close your birth canal by 30%

Unfortunately, the flat-on-the-back or semi-sitting birthing positions recommended in hospitals, restrict the birth canal opening by as much as 30% [Russell JGB. Moulding of the pelvic outlet. J Obstet Gynaecol Br Commonw 1969 Sep.;76(9):817-820], necessitating risky episiotomies that can result in severe perineal lacerations [Shiono P, Klebanoff MA *et al.* Midline episiotomies: more harm than good? Obstet Gynecol 1990 May;75(5):765-770] or C-section deliveries. Complications can often be avoided by a forward leaning, sitting or side position, or a natural squatting position that fully opens the birth canal and also takes advantage of gravity to aid delivery [De Jonge A, Teunissen TA *et al.* Supine position compared to other positions during the second stage of labor: a meta-analysis review. J. Psychosom. Obstet. Gynaelcol. 2004 Mar;25(1):35-45; Keen R, Difranco J *et al.* Non-supine (e.g., upright or side-lying) positions for birth. J Perinat Educ. 2004 Spring:13(2):30-34; Nasir A, Korejo R *et al.* Child birth in squatting position. J Pak Med Assoc. 2007 Jan.;57(1):19-22; Terry RR, Westcott J *et al.* Postpartum outcomes in supine delivery by physicians vs non-supine delivery by midwives. J Am Osteopath Assoc. 2006 Apr.;106(4):199-202].

III. Hepatitis B vaccine is risky to your child

The hepatitis B vaccine is routinely administered on the day the baby is born or prior to being discharged from the hospital. The pediatrician will then follow up with a booster hepatitis B vaccines when the infant is 1 to 2 months old and then a final booster at age 6 to 18 months. Addressing the hepatitis B issue, Dr. Jane Orient, director of *The Association of American Physicians & Surgeons*, wrote:

> "In 1996, only 54 cases of the disease were reported to the CDC in the 0 to 1 age group. There were 3.9 million births that year, so the observed incidence of hepatitis B in the 0 to 1 age group was just 0.001%. In the Vaccine Adverse Event Reporting System (VAERS) there were 1,080 total reports of adverse reactions from hepatitis B vaccine in 1996 alone in the 0 to 1 age group, with 47 deaths reported.
>
> For most children, the risk of a serious vaccine reaction may be 100 times greater than the risk of hepatitis B. Overall, the incidence of hepatitis B in the U.S. is currently about 4 per 100,000. The risk for most young children is far less; hepatitis B is heavily concentrated in groups at high risk due to occupation, sexual promiscuity, or drug abuse."

IV. Adverse effects of vaccines

The Thimerosal-containing influenza (flu) vaccine is preserved with mercury which can reach toxic levels in a developing fetus when administered to a pregnant woman. Miscarriages have been reported following administration of this vaccine. Further, Thimerosal (49.55% mercury by weight) causes dysregulation of the immune system, and is a known human teratogen, carcinogen, and mutagen (capable of causing genetic abnormalities). Thimerosal in childhood vaccines has been implicated in a range of neurological developmental disorders ranging from ADD/ADHD to autism, which has increased over 800% from 1990 to 2000.

The linkage between Thimerosal and neurodevelopmental disorders has been documented in published case studies establishing that children with a diagnosed autistic spectrum disorder are mercury poisoned [Nataf R, Skorupka C *et al.* Porphyrinuria in childhood autistic disorder: Implications for environmental toxicity. Toxicology and Applied Pharmacology 2006;214:99-108. Geier DA, Geier MR. A prospective assessment of porphyrins in autistic disorders: a potential marker for heavy metal exposure. Neurotoxicity Research 2006;10(1):57-64; Geier DA, Geier MR. A case series of children with apparent mercury toxic encephalopathies manifesting with clinical symptoms of regressive autistic disorders. J Toxicol Environ Health A 2007; 70(10):837-851].

When many vaccine manufacturers voluntarily began to remove Thimerosal from most early childhood vaccines during 1999 to 2001, autism rates subsequently started to decline.

Coincidentally, in 2002, the CDC began suggesting the Thimerosal-containing flu vaccine be given to both pregnant women in their second and third trimesters and infants 6 to 23 months of age, restoring up to 60% of the Thimerosal dose that had been voluntarily removed [Bridges CB, Fukada K *et al.* Prevention and Control of Influenza—Recommendations of the ACIP, 2002. MMWR 2002 April 12; 51(RR03):1-31].