APR 20 1989

TELECOPY COVERSHEET

KENAI PENINSULA LEGISLATIVE INFORMATION OFFICE

312 TYEE STREET

SOLDOTNA, AK 99669

OFFICE NUMBER: (907) 262-9364

TELECOPY NUMBER: (907) 262-1881

DATE: 4-19-89 TIME: 4:16pm

TO: Juneau Rio - Delivers to Senate H&SS Committee (Please)

TITLE: _____ PHONE: _____

COMMENTS:

Written testimony for tele 89-04-0604 SB 148

FROM: Soldotna L.A.O for Shannon Kohler

TITLE: _____ PHONE: 262-9364

COMMENTS: _____

NUMBER OF PAGES FOLLOWING THIS COVERSHEET: 1

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SENT BY: - Klyson

Alaska State Legislature

Please enter into the record my testimony to the Senate H.E.S.S.
committee name

committee on SB. 148 / HB immunization of minors
bill/subject
, dated Apr. 19, 1989.

My name is Shannon Kohlee. I'm president of Alaska-DPT, a parent group concerned with vaccine safety and awareness. For the past several years since I've been president of AK-DPT, I've been in contact with many Alaskan parents whose children have suffered adverse reactions ranging from vomiting, fever ~~etc~~ one-time convulsive episodes, etc. to permanent neurological damage resulting in epilepsy, deafness cerebral palsy, paralysis, etc. Very few of these reactions have been effectively reported resulting in inadequate statistics which then filters down as inadequate ~~statistics~~ benefit/risk ~~to~~ information being given to parents. Alaskan parents are not being allowed a choice in this matter - much less an informed choice. I'm here to urge you all to become educated as to all aspects of this issue and to support Senate Bill 148 which would ultimately restore a basic right to all Alaskans: the right to choose which drugs their children ingest or don't ingest.

Signed: Shannon Kohlee
Testifier

Alaska DPT
Representing (Optional)

Box 1946 Soldotna, AK 99669
Address

262-3825
Phone No.

APR 20 1989

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312 TYEE STREET

SOLDOTNA, AK 99669

OFFICE NUMBER: (907) 262-9364

TELECOPY NUMBER: (907) 262-1881

Senate HESS

DATE: 4-19-89 TIME: 4:40

TO: Juneau LIO

TITLE: PHONE:

COMMENTS: please deliver to ... HESS Comm. to be treated as testimony.

FROM: Soldotna LIO

TITLE: [illegible] PHONE:

COMMENTS: Thanks!

NUMBER OF PAGES FOLLOWING THIS COVERSHEET: 1

IF YOU DO NOT RECEIVE THE TOTAL NUMBER OF PAGES FOLLOWING THIS COVER LETTER, PLEASE TELEPHONE OUR OFFICE. OTHERWISE WE WILL ASSUME YOU HAVE RECEIVED THIS TRANSMITTAL SATISFACTORILY.

SENT BY: Vesta

Alaska State Legislature

Please enter into the record my testimony to the HESS
committee name

committee on SB 148 Exemption immunization . dated 4-19-89 .
bill/subject

I'm Sanne Seggerman and I have 2 healthy children. I support SB 148 because I want the freedom to choose what I think is right for my children, based on philosophical objection. Just as I have the choice to feed them nutritiously, dress them properly, and provide them with a healthy atmosphere and environment, I want to choose what goes into my kids' bodies, without losing their right to go to public schools which I pay for. I'm an informed adult and believe it is my right to have my childs health protected how I see fit. Thank You

Signed: Ms. Sanne Seggerman
Testifier

Self
Representing (Optional)

HC #1 Box 157 E Sold
Address

262-3189
Phone No.

1

9/88 Legislative Information Office

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box ... State Capitol
Juneau, Alaska 99811-...
Main Office ...
(907) 465-...

January 13, 1987

MEMORANDUM

TO: Representative Mike Navarre

ATTN: Pat Malone

FROM: Mary Jennings
Legislative Analyst

RE: Laws Concerning Mandatory Immunization
Research Request 87-065

File with bill

You requested information on laws in Alaska and other states concerning mandatory immunization, specifically, allowable exemptions from immunizations, reporting of adverse events, and penalties enforced against children who have not been immunized. You also requested us to gather: 1) statistics on adverse events; and 2) any data showing a correlation between states that allow philosophical exemptions and higher rates of disease.

Exemptions

All 50 states and the District of Columbia allow children to be exempt from immunization regulations for medical reasons. Generally, the parent must acquire an affidavit signed by a physician affirming the opinion that the immunization would be injurious to the child's health. Forty-eight states and the District of Columbia allow children to be exempt from immunization requirements for religious reasons. In many states, the parents must present an affidavit signed by the parent affirming that immunization conflicts with the practices of the religious denomination of the child. Twenty-two states allow children to be exempt from immunization requirements for philosophical reasons. Typically, the parent must present an affidavit affirming that immunization conflicts with the family's philosophical beliefs. Attachment A, prepared by the Center for Disease Control (CDC) presents the exemptions from immunization requirements in the 50 states and the District of Columbia.

According to the CDC, children who are exempt from immunization for philosophical reasons comprise less than 1 percent of all school age children. No studies have been done to draw correlations between use of

ATTACHMENT #1

this exemption and greater rates of disease. The CDC stated that due to the small numbers that invoke this exemption, it would be difficult to make meaningful comparisons.

Enforcement of Immunization Requirements

Twenty-seven states have a penalty clause for noncompliance with immunization laws for children in grades kindergarten through 12. Thirty states and the District of Columbia impose a penalty for children in day care and two states have a penalty for college students. Depending upon state law, the parents or the school official may be found to have violated the immunization requirements. Generally, noncompliance is a misdemeanor.

Forty-four states and the District of Columbia have an exclusion clause in their immunization requirements which prevent children who are not in compliance with state immunization laws from entering school (kindergarten though grade 12). Thirty-one states and the District of Columbia have exclusion clauses pertaining to children in day care and five states and the District of Columbia have an exclusion clause pertaining to college students. Attachment B, prepared by the CDC, shows which states have penalty and exclusion clauses.

In some states, children are allowed a grace period, ranging from 30 to 60 days, in which they may attend school while coming into compliance with immunization regulations. An official in California stated that the grace period in California was recently repealed because it became difficult to remove children from school for noncompliance once they had entered the system. The official added that when a disease outbreak occurs in a school, all children who are exempt from immunizations are sent home and not allowed back into school until 14 days after the last occurrence of a case.

Reporting of Adverse Events

In forty-seven states, reporting in the private sector of adverse events from immunization is passive (the private sector is not required to report adverse events). In all states, publicly funded immunization programs must report adverse events to the CDC. Under federal law, vaccine manufacturers and pharmicists are required to report adverse events to the U.S. Food and Drug Administration.

During 1986, Maryland, West Virginia and New Jersey implemented laws which require all health care providers to report adverse events due to immunization.[1] In Maryland, the first state to implement a universal reporting law, health care providers are required to report adverse events to the local or state health department. The health department then reports to the CDC and the vaccine manufacturer. Bob Longenecker, the CDC reporting agent for the Maryland Department of Health, felt that the universal reporting law has not been effective; he said that the law increased costs, time and effort to provide data that are not useful. Mr. Longenecker stated that the data collected by the CDC from the public sector are a sufficient indicator of the rate of adverse events and that additional data from the private sector are not useful because there is no accompanying information on the number of vaccinations administered.

Monitoring System For Adverse Events Following Immunization. For immunization programs supported with public funds, the CDC has developed the Monitoring System for Adverse Events Following Immunization (MSAEFI).[2] Each parent of a child who receives publicly funded vaccines is requested to report any illness that is severe enough to require a visit to a doctor, clinic or hospital, that occurs within 30 days of receiving a vaccine. Local reactions involving only soreness, redness, or swelling in the immediate vicinity of the injection site are not considered to be adverse events. When notified that an illness has occurred following immunization, the Health Department summarizes the information on a reporting form and forwards it (through the State Health Department) to the CDC. The data are coded and then entered into a computer file for analysis. The CDC notes that the quality of the data collected by the system may be affected by underreporting, inclusion of events which may not be related the immunization, missing data, and other related conditions. Voluntary reporting by private physicians account for approximately 11 percent of MSAEFI data.

Tables 1 through 4B (attached) present adverse event data compiled by MSAEFI for 1979-82.[3] As of February 15, 1983, a total of 4,503 adverse events occurring within 30 days after vaccination had been reported to MSAEFI for the period 1979-82 (Table 1). Table 2 presents the number of reported vaccine doses administered, by age group, in the public sector during the period. These data are the denominators for subsequent rate

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[1]The U.S. Congress passed the National Childhood Vaccine Injury Act of 1986, which established the National Vaccine program and also contained language requiring all health care providers to report adverse events. The program did not receive funding so was not implemented.

[2]According to the CDC, approximately half of all childhood vaccines administered are provided with public funds.

[3]According to the CDC, these are the most current complied data available. The lag is due to the time that is needed to collect, verify and publish the data.

estimates. The proportions of net vaccine doses distributed by the manufacturer to both public and private providers that were actually administered in the public sector are also shown in Table 2. Table 3 shows the number and rates of reports submitted by each reporting area. Rates of reporting among the 52 reporting areas varied from 0 to 146 reports per million administered doses. Table 4A shows the number of reports of adverse events by vaccine type for 1979-82. If more than one vaccine is given simultaneously, an event is counted under each vaccine received. The largest number of reports was for events temporally related to receipt of DTP, followed by OPV and MMR (See glossary for terms).

Injury Compensation

During 1986, North Carolina passed legislation which created a program offering no fault compensation to children who are injuried as a result of vaccination. Under the program, state services are made available and the child may receive up to $300,000 in compensation. If negligence is suspected on the part of the vaccine manufacturer, the state may then sue for recovery. Similar legislation creating a program for injury compensation was also passed at the federal level, although the program has not been funded.

I hope you find this information useful. I have attached a table detailing immunization requirement in all fifty states for school children and Alaska regulations concerning immunization. I have also attached the National Childhood Vaccine Injury Act of 1986 as published in the Congressional Record. If you have any questions, please feel to contact me.

MJ

Attachments

Alaska State Legislature

SENATE

Official Business

P.O. Box V
Stute Capitol
Juneau, Alaska 99811

April 17, 1989

TO: Senate HESS Committee Members

FROM: Senator Jay Kerttula

SUBJECT: SENATE BILL 148, relating to immunization of minors.

Senate Bill 148 would amend Alaska Statutes 14.30.125 to allow school age children to be exempt from mandatory immunization for medical or personal reasons. Under present regulation, school age children must be immunized for diphtheria, tetanus, polio, measles, rubella and whooping cough(the later only if the child is under 7 years old). Exemptions are permitted for medical or religious reasons.

Attached is a position paper prepared by Sandy Mintz which explains the background and rationale for this legislation.

MAJOR POINTS FROM POSITION PAPER ON SB148
by Sandy Mintz

I. The vaccines are risky, and probably much riskier han is currently known, or even acknowledged to be possible.

A. Reported and theorized adverse effects are vast and varied, ranging from known effects, like brain damage and death, to speculated effects, like autoimmune diseases and cancer.

B. Current vaccination policy is a shotgun approach to the problem of infectious disease.

C. Unreliable methods for collecting and analyzing data are being used to assess risk from vaccinations.

II. There is no proof to the claim that unvaccinated people threaten the general public health.

III. Much of the credit for the decline in dangerous infectious diseases should go to factors other than the vaccines.

IV. Much is unknown about how vaccines work.

V. Policy which makes vaccinations compulsory is unjust and unwise.

VI. In a free society, it is parents, and not the government, who should decide among reasonable risks for their children.

VII. Most of the free world honors these parental rights and allows parents to choose whether or not to vaccinate their children.

VIII. What is accepted medical practice has changed over and over again. This history must not be ignored. Let parents make the final decision about whether or not to vaccinate.

POSITION PAPER ON SB148 by Sandy Mintz

In order to attend both public and private school in Alaska, the State of Alaska currently requires the following vaccinations of its children: DPT, polio, measles and rubella.* Exemptions or waivers from these vaccinations are only allowed on medical or religious grounds at this time. In spite of appearances, however, there is no consensus about the degree of efficacy of all vaccines for all children. The arguments which follow support the contention that reasonable people can can disagree about vaccines and that loving, conscientious, informed parents might choose to refuse one or more vaccinations for their children. I am hoping to engage your support to change the law to allow an additional waiver for personal or philosophical convictions. Similar laws are currently in effect in 22 states.**

The proposed law, presently before the State Senate, is a copy of current California law. In addition, an effort will be be made to include in the bill an as yet formally unidentified action or actions to be required of those seeking a philosophical exemption. The inclusion of such an action will be for the purpose of discouraging an otherwise uninformed or negligent parent from choosing the exemption as the path of least resistence. (One idea is to require an essay of undetermined length stating the parent's position on the issue, another that well-child visits, to the health practitioner of the parent's choice, be required and timed for the same intervals

* Interestingly enough, although mumps is not required, neither the schools nor pediatricians are forthcoming with information to that effect: school health forms which must be submitted to the state and which indicate student vaccination histories list measles-mumps-rubella (MMR) only and pediatricians do not inform parents that the mumps vaccine is optional.

**The following states allow the exemption:Washington,California,Idaho, Montana,Utah,Arizona,Colorado,North Dakota,Nebraska,Minnesota,Wisconsin, Missouri,Oklahoma,Michigan,Indiana,Ohio,Louisiana,Pennsylvania,Vermont, Maine,Rhode Island, and Delaware.

were the child to be immunized.)

I. THE VACCINES ARE RISKY, AND PROBABLY MUCH RISKIER THAN IS CURRENTLY KNOWN OR EVEN ACKNOWLEDGED

A. Reported and Theorized Adverse Effects Are Vast and Varied

There have been numerous reports about adverse effects. Reported adverse reactions are varied and include moderate to severe brain damage and death(20,42,44,49,170,53,60,63,64,65,66,67,69,70,71,73,74,75,76,77,79,80,85,90,91,97,105,43,84,109,136,143b,146,149,156,163a,163b,165). These reactions appear to be the result of toxins in the vaccines themselves (65,106,109,110,152), as well as poor quality control of the product (106,135,166). Also included in the many adverse reactions reported is contracting the very disease the vaccine was supposed to offer protection against (29,30,54,57,81,68,150), sometimes in a more virulent form than occurs naturally(45).

It is easy to dismiss fears about long-term unknown effects as paranoia. But legitimate concern is being raised about long-term autoimmune diseases, abnormalities of the immune system, and even cancer resulting from the use of vaccines(166,171,97,109). The difficulties in proving long-term effects are well-known. Clinical evidence is slowly mounting, however, as was the case with smoking and lung-cancer initially. There is concern, for instance according to the The London Times, 1987(177), that AIDS may have been triggered by smallpox vaccine. To quote "The Times": "Dr. Robert Gallo(SIC), who first identifed the Aids virus in the US, tcld "The Times": 'The link between the WHO programme and the epidemic in Africa is an important and interesting hypothesis. I cannot say that it actually happened, but I have been saying for some years that the use of live vaccines such as that used for smallpox can activate a dormant infection such as HIV. No blame can be attached to WHO, but if the hypothesis is correct it is a tragic situation and a warning that we cannot ignore.'" It has been long known that a small percentage of polio

cases were "provoked" by the pertussis vaccine(106). We can all hope that the fears about AIDS are groundless, that "provocation polio" is an aberration, and that there are not other equally worrisome ramifications of vaccination lurking around the corner. But the need to keep an open mind and maintain vigilance remains paramount.

B. Current Vaccination Policy Is A Shotgun Approach To The Problem of Infectious Diseases

Protecting children against relatively mild childhood diseases only to leave them vulnerable to these diseases as adults, when the diseases are frequently more serious(124,125), is an example of how short-sighted these policies may be. No one knows for sure how long protection is afforded(32,109,92,131). If vaccines mimicked real diseases, immunity would be life-long for most(109,121,124), and boosters would be unnecessary. Thus the price our children may have to pay as adults for the privilege of avoiding these diseases may be high.

One example of an innocuous childhood disease for which there is mass vaccination is german measles or rubella(124,122).

[illegible] who have not had german measles prior to pregnancy are at risk for fetal abnorma[illegible]ities and miscarriage. But the german measles vaccine is not administered to women of child-bearing age, nor do we know that it confers lifelong immunity(32). The rubella vaccine also has a reasonably high failure rate(109). Unless there is 100% eradication of the disease, a pregnant woman who was vaccinated as a child and did not contract measles is more, not less, vulnerable than one who was allowed an opportunity to get the disease as a child(92). As Dr. Hugh Paul stated in "The Control of Diseases"(124), before formulation of the rubella vaccine, "The disease (rubella) cannot be prevented, and in view of its very mild character, and the possibility that it may have catastrophic effects if contracted

by an expectant mother, it is questionable if it should be prevented in childhood and adolescence even if this were possible. It has been suggested that female children should be deliberatedly exposed to infection in order to achieve a life-long immunity from the disease and possibly from malformation in the offspring in later life. This idea is not an unreasonable one....Rubella does not kill, and even complications are uncommon." Perhaps it would be more prudent to vaccinate only pubescent schoolgirls, allowing those who wish to avoid vaccination to take a blood test to ascertain whether or not they have acquired natural immunity(35,109) than to require vaccinations of all children, as is presently done.

Although it is now known that naturally acquired immunity to rubella is not always lifelong, according to Dr. Vincent Fulginiti, life-long immunity occurs far more often among the naturally immune than the vaccine-immune (90-97.5% lifelong immunity for naturally acquired vs. 20-97% for the vaccine-induced)(109).

The hard or red measles (rubeola) is an example of a disease which generally is unpleasant but not serious in healthy children (102,121,68,125,124), yet which can be deadly serious for adults. When this measles first hits a population, the adults contracting it are hit very hard, with whole populations sometimes being wiped out(122,124). It then settles into the population, thereby effecting mostly children, since the adults have already been exposed. Statistics which cite disturbing incidence rates for encephalopathy and other adverse effects of measles do not take into consideration the general health status of the individual, and socio-economic factors which have reduced disease severity, nor do they give much weight to the vast incidence of problem-free disease.

Compounding the problem is the fact that the population most

vulnerable to measles, infants, is least protected. Vaccinating too early can cause vaccine failure more often(36,101) and/or later booster shots to be ineffective(36,96). The Catch-22 is that in the past, most mothers passed on naturally acquired measles antibodies transplacentally to their offspring who were protected until 6-9 months(124,99,48a). With the advent of vaccines, a higher percentage of mothers will be seronegative (have no antibodies) and will not pass those antibodies on to their children, at precisely the time that the vaccines are not effective, and yet the infant is most vulnerable(99,48a). On the other hand, those who would ordinarily be better off receiving maternal antibodies might find themselves in the untenable position of having those very antibodies interfere with vaccine efficacy(36,100), with the end-result that neither the vaccine nor the antibodies were protective.

The MMR (measles, mumps, rubella) vaccine probably does not confer lifelong immunity(109). What will happen to our children when they become adults? The medical community cannot possibly be confident that 100% eradication will occur with routine childhood immunization and that our children are not going to get seriously ill as adults(100). At a minimum, questions like these require better answers before anyone is forced to be vaccinated. These issues are barely being addressed in the medical literature.

C. Unreliable Methods For Collecting and Analyzing Data Are Being Used To Assess Vaccine Risk

At the current time only minimal information is available about short-term, known, acute reactions, while no hard data on long-term health and behavioral effects exists. To most accurately assess all risk, controlled, human experiments would have to be conducted. Of course, such experiments would not be considered ethical. The next best approach would be to conduct 20-30+ year studies of

matched groups (vaccinated vs. unvaccinated) in which all problems, including even minor behavioral and learning problems, would be recorded and compared. These have not been done, nor are they in progress.

Current reporting methods, unlike the aforementioned are fraught with bias and inaccuracies. First, they depend upon accurate reporting. Second, they depend upon the doctor or parent connecting a symptom with the vaccine. Third, they usually compare vaccinated groups to each other rather than a vaccinated group to an unvaccinated group. In the "Report of the Task Force...(177)" for instance, a study is cited in which immunization status is supposedly considered. But upon closer examination, it becomes clear that immunization status was not used; instead timing of immunization was the factor. What if a large percentage of vaccine-associated events occur after it is presumed they do not? The result will dramatically effect conclusions.

In fact, no one knows the relevance of time. Dr. Fulginiti, a well-known vaccine-use proponent, who has edited the book "Immunization in Clinical Practice", says: "A second confusing factor is the time relationship between vaccine administration and adverse event. How long an interval is possible in a vaccine-induced central nervous system infection or other untoward effect? Strom recorded data on some patients who first fell ill with neurologic symptoms 1 week after receipt of vaccine. Is that disease relatable to the vaccine? Most experts accept an interval of 24 hours between vaccine and onset of encephalopathy; a few suggest 2-3 days as an acceptable delay in onset. But there is no proof for any interval."(109) Most studies don't even make a pretense of controlling for immunization, instead opting to use time or some other equally questionable variable.

It is not possible to predict the potential intelligence, future

health, etc., of a given child. Claims, for instance, that a child has suffered no residual effects from a vaccine and is normal based on observation are totally unfounded. The only way to determine potential, be it intelligence or whatever,is to study groups. When attempting to determine vaccine effects, those groups must be unvaccinated vs. vaccinated, with the distribution of effects compared.

The utter inadequacy of the reporting system for even the most obvious and serious effects is accepted (42,74,80,106), even by vaccine proponents(105,43,109). In the U.S. there was no requirement to report adverse effects until recently, but even making it mandatory cannot change the basic problem with a reporting system of any kind. Furthermore, much of the analysis of adverse effect rates uses the number of doses administered(32,43,68,77,105,106,109,115,121,124,139, 140,146,152,160), rather than the number of children affected. Who cares how many doses it takes to damage a child? What should be sought is data on how many CHILDREN are harmed by a given vaccine, no matter how many doses have been received. Using doses skews results in favor of lower adverse effect rates for all multi-dose vaccines, and in the case of pertussis, dramatically so, since 4- 5 doses are usually required. These dose-related conclusions are made all the more insidious when they are then compared to disease-related problems among children. Even worse, in some known cases, reporting, as well as follow-up, appears to have even been discouraged(170). To quote P. Isacson (Progr. Med. Virol. 13,263, 1971, cited in a 1972 "Science" article (166), "There has been a tendency on the part of certain higher goverment circles to play down any open discussion of problems associated with vaccines...Perhaps this has been overdone. Scientists how find themselves in the position of balancing the benefits of a vaccine against the risks, yet are in no position to judge what the long-term risks are." Thus current analytical and data collection methods should be seriously questioned.

Where more effort is made to follow adverse effects, the riskiness of one or more of the vaccines appears to increase, although the totality of adverse effects is still unknown (70,74,78,80,85,90).

II. THERE IS NO PROOF TO THE CLAIM THAT UNVACCINATED PEOPLE THREATEN THE GENERAL PUBLIC HEALTH

A major argument in favor of compulsory vaccination is that the unvaccinated threaten the general public health. However, if the vaccines work, they protect anyone choosing to be vaccinated. Some people additionally claim, nevertheless, that since there are vaccine failures, the unvaccinated threaten those who try but fail to get protection. Even here, however, there are mitigating effects: first, in at least one of the more serious diseases, whooping cough, a vaccinated person who contracts the disease will usually get a less serious form of the disease. (105, 62,32,43,46,51,68,78,106,121,134,135); second, vaccine failure rates can be so high (32,43,46,87,100,105,109,116,131,134,135,152) that one could question the extent of any additional risk created by the unvaccinated. Even proponents of achievement of so-called "herd immunity" admit that nowhere near 100% compliance is necessary to result in protection to the entire population, although at least 80% is usually advocated(51,22,47).

There is virtually no threat posed by states allowing philosophical exemptions. Five states provided their rate of philosophical exemptions: exemptions: California, Vermont, Ohio, Arizona, and Wisconsin. Less than 1% took the exemption. Other states provided overall compliance rates: Missouri, Minnesota, Pennsylvania, and Delaware were all 98% or better, meaning philosophical exemptions have to be less than 2%. Two other states, Indiana and Oklahoma, were 97% or better, while none of the reporting states were less than 91%(172,173,179). We know that vaccine failure rates have been equal to

or greater by far than the philosophical exemption rates which are occurring. There is no reason to assume the unvaccinated are totally responsible for disease outbreaks unless vaccine proponents are unreasonably arguing that vaccine failures do not contribute to them in any way. Surely no one is arguing that, while a "vaccine failure" can catch a disease and spread a disease, it cannot be the first one to get the disease in an area.

Besides, a disease doesn't START anywhere. When public health officials cite the unvaccinated as the source of an outbreak, they are being arbitrary. Where did the alleged source catch the disease? Everyone gets these diseases from someone. Outbreaks are not isolated events with some sort of spontaneous (measles/pertussis/whatever) eruption at their source; they are part of chains of events. Where one looks for the source will determine what one finds. Where one stops will determine who is held responsible.

There are a number of diseases which can be mild enough that they would go unrecognized, particularly among the vaccinated. Pertussis is a well-accepted example, as discussed earlier. Measles has been noted to be milder among the vaccinated as well(46). A very credible scenario would be to have, for instance in the case of pertussis, a number of sub-clinical cases among the vaccinated causing a full-blown recognized case in an unvaccinated person. The blame could then easily be placed on the unvaccinated with no concern about where THEY got the disease.

Let's examine the role of vaccine failure more closely. It is commonly assumed that vaccine failure rates are low - after all, there are few outbreaks of the diseases in question, and what outbreaks have occurred are often attributed to the unvaccinated few. When actual outbreaks have occurred, however, as high as 80% of those contracting the disease have been reported to have been vaccinated(174). Upon close inspection, the success rate of the vaccines themselves must

be questioned. Estimates of failure vary widely (109,46,87,100,152,134,26,32,43,105), but it would appear that to some extent, success rates are statistical illusions - as long as no outbreaks occur, the vaccines appear to be working. By the same token, however, being unvaccinated appears to be working as well. Given these high failure rates among the vaccinated during disease outbreaks, it is hardly reasonable to conclude that the unvaccinated add any appreciable risk, especially in the small numbers seen in the "philosophical exemption states".

Another concern raised by vaccine proponents is fear that formerly vaccinated adults, whose immunity has waned, will then be threatened by disease outbreaks. Those same adults, can, however, choose to be revaccinated in most cases. One exception to that case is pertussis, which is not a safe vaccine for adults(105,108,175). Pertussis is also not usually serious for adults, however. (106) In fact, the practical effect of waning vaccines is to make formerly vaccinated adults contributors to disease outbreaks(108,68,135). Had they acquired natural immunity, this would be unlikely.

But what about pertussis and infants? Isn't it true that pertussis is mostly a problem for them? Shouldn't everyone be vaccinated to protect them? It is true that most fatalities occur among infants under 1 year of age(178,106). The vaccines are not recommended for use before 2 months of age, with protection sometimes not being conferred before the third administration at 6 months. But a number of factors make this a more complicated issue than would appear on the surface.

First, improvements in medical management, especially the use of antibiotics, have enhanced our arsenal against this disease. Antibiotics can, as stated in the "Task Force Report"(178) and elsewhere, prevent further contagion, prevent serious disease, particularly if timed right, and combat secondary infections like pneumonia, which are the

major cause of death in infants contracting whooping cough.

Second, even if everyone under 6 were vaccinated, infants would still be at risk. It is widely acknowledged(108,175,105) that booster shots given to anyone 6-7 years of age or older are not recommended because of the risks involved. Because of the known seriousness pertussis can pose to infants under 1 year of age, vaccinations are then given, but only to children up to 6-7 years old. It is also widely accepted that pertussis vaccine significantly loses its effectiveness over time(135,109, 108,131). With widespread waning immunity from pertussis vaccine a fact of life, however, large reservoirs of susceptibles exist in the older groups capable of infecting infants(108). Yet we do not vaccinate these older groups because of the risks associated with doing so. I have shown that the medical community has no hard, reliable data to back up claims of low risk from the vaccine to younger children. The most that can legitimately be said is that although some short-term risks have been established, both short-term and long-term risks are virtually unknown. It should not be acceptable to force young children to face risks which are unacceptable for older children and adults. The practical effect of not revaccinating either group is to put infants at risk. But because of unsubstantiated claims that the risks are low for children 6 and under, children 6 and under are being asked to shoulder the burden of protecting infants even though they cannot do it alone. I am not suggesting that older children and adults now be compromised. I submit, on the other hand, that the addition of small numbers of unvaccinated young children to the already significant pool of vaccine failures and larger pool of immunity-waned older children and adults adds marginal increased risk.

III. MUCH OF THE CREDIT FOR THE DECLINE IN DANGEROUS CONTAGIOUS DISEASES SHOULD GO TO FACTORS OTHER THAN THE VACCINES

The benefits of vaccination are over-rated since much of the decline in morbidity and mortality of the diseases targeted by the vaccines occurred before the vaccines were introduced(26,27,30, 34,91a,91b,105,124,126,90,106,108). Pro-vaccine reports will often begin around 1950 or later(34,68,98,178), after declines were already in effect, thereby giving unsubstantiated weight to the role of vaccines. As implied by the declining death rate, severity of the illnesses also has diminished for the unvaccinated(89,90,124).

Socioeconomic factors, including improved health care and living conditions, have contributed dramatically to both disease incidence and severity decreases(26,55,58,90,121,126,85,51,98,108,113b,119,121, 124,135). Even our previous inability to treat whooping cough has been aided in particular by antibiotic therapy aimed at secondary infections like pneumonia (105,118,78,91a,121,134,135) which is a primary factor in pertussis mortality if left untreated (107,106,152,124), and improvements in hospital care for the seriously ill (105,106,25).

Perhaps even more important, it would appear that a well-organized effort to control the spread of whooping cough could be effective since certain antibiotics like erythromycin given to an identified whooping cough victim will prevent the spread of disease to others, (107,108,120,121,117,134) and erythromycin given to an exposed person before the paroxysmal stage can actually prevent the disease in the treated individual(120,117,118). The "Task Force"(178) reports that erythromycin even given during the paroxysmal stage has been shown to reduce symptoms, contrary to popular belief. Hence widespread, uncontrolled spread of whooping cough could be a thing of the past without the risks associated with the vaccine and moral dilemmas posed by making it compulsory.

Two prominent examples of diseases which have decreased dramatically without the aid of vaccines are scarlet fever and TB.
Scarlet fever is no longer the scourge it once was. (103,122,126) There is no vaccine for it, but if there were, the vaccine probably would be given credit for a decline it had nothing to do with. In most places, where the general health of the population is good, TB is no longer a problem either(122,123,124,126,59,129). What would have happened had there been a TB vaccine? Sometimes the conditions the world used to face are forgotten - no toilets, unclean water, lack of refrigeration, crowding, lack of heat, poor nutrition, etc. Where those conditions and/or others still exist, for instance in parts of rural Alaska vis a vis TB,
disease morbidity and mortality increase. But those conditions in Alaska, for instance, have existed for a long time, and yet do not pose a threat to the general population, because the general population does not face those conditions.

IV. MUCH IS UNKNOWN ABOUT THE MECHANISMS UNDERLYING VACCINE PROTECTION

How vaccines work is not truly understood(109). When a human being contracts most of the diseases for which there are vaccines, lifelong immunity occurs. With the vaccines, boosters are needed and adults may go unprotected.

How well vaccines work is also not clear since, as discussed in section II, varying percentages of the vaccinated can contract the disease, and varying percentages of the ill have been vaccinated (3,46,85,86,87,98,101,169,95,108,147). Nowhere near 100% of the vaccinated are protected. For example, Dr. Stephen A. Hoffman, an expert on infectious diseases at Harvard University, and a proponent of vaccines writes(130), "In the majority of recent (measles) cases , the administered vaccine apparently never took hold in the first place.

This suggests that our ability to wipe out measles may, after all, be limited by a built-in failure rate of the vaccine itself." In the first 26 weeks of 1985, according to the Centers for Disease Control(174), 80% of those between the ages of 16 months and 28 years who contracted measles were vaccinated; in 1986(147), 57% from 16 months on up had been vaccinated.

V. POLICY WHICH MAKES VACCINATIONS COMPULSORY IS UNJUST AND UNWISE

Since anyone who wishes to be vaccinated has the right to do so, and built-in vaccine failures insure that the diseases remain in the population, no one can unequivocably argue that the unvaccinated appreciably affect the vaccinated. I would like to include some of the testimony made to Congress in 1962 by Clinton R. Miller of the National Health Federation because he so eloquently framed this issue in the context of history.

"The only time (NHF) would feel justified in violating an American's exercise of choice in matters of health would be when such exercise of freedom violated the equal right of another. Clearly at the present time no one is denied vaccination for themselves or their children if they desire it. Therefore, citizens who exercise their freedom of choice by choosing not to be vaccinated are not denying an equal right to another by the exercise of this freedom.

This principle of freedom is a superior and more fundamental consideration than that of vaccination. There are those people who so stoutly believe in the principle of vaccination that their enthusiasm leads them to an intolerance of anyone who just as stoutly does not believe in it.....

Those who believe in freedom of choice in matters of politics, religion, and health, emphasize that minority views of one generation become majority views of another. History has a wonderful lesson to teach us here if we will learn it. History will record a man of one age as a wise man, even though subsequent research might prove his theories to be in error, if he refrained from force of any kind in sharing of his beliefs with his disciples and contemporaries. But it will record the same man with the same theories as a fool or a tyrant, who uses, or allows to be used, force of any kind- not the least of which is governmental force - to gain acceptance for his beliefs.

Humility about the extent of one's knowledge, or of the collective knowledge of any age is always the mark of greatness, progress, and understanding....

Dr. Benjamin Rush, a signer of the Declaration of Independence, and Congressman is quoted as saying 'The Constitution of the Republic should make provision for medical freedom as well as for religious freedom.... All such laws'(which restrict health choices)'are un-American and despotic. They are fragments of monarchy

and have no place in a Republic'.

....We maintain that this right was implied, if not written.... But the fact is that it was not written, and we are left to argue that it was certainly implied. At the time Benjamin Rush made this plea, it was argued that this 'right' was assumed by the guaranteed freedom of religion and didn't need to be codified. ...Incidentally, Dr. Rush was a strong believer in vaccination theories of Jenner, but emphasized the greater need for freedom in all health matters."(104)

VI. MOST OF THE FREE WORLD HONORS THESE PARENTAL RIGHTS

22 U.S. states currently allow for personal or philosophical exemptions. Indeed, but for the communist countries, most of the world does not deny this basic right. The following countries have compulsary vaccination laws: the Eastern block nations(Albania, Bulgaria, Hungary, East Germany, Czechoslovakia, Poland, Romania, U.S.S.R., and Yugoslavia) as well as the Bahamas, Bolivia, Brazil, Costa Rica, Ecuador, Granada, Mexico, Peru(93), and 28 states in the United States. Obviously, allowing for this exemption is not a radical notion. I would like Alaska to join the 22 states and non-communist world which currently allows for a choice.

VII. IN A FREE SOCIETY IT IS PARENTS, AND NOT THE GOVERNMENT, WHO SHOULD DECIDE AMONG REASONABLE RISKS FOR THEIR CHILDREN

The state should not have the right to force a child to have a potentially harmful vaccine, no matter how statistically remote the possibility. Reasonable people can argue which is riskier for an individual child, the vaccines, or the diseases they are designed to prevent. In places where the standard of living is high and adverse effects conscientiously reported, arguments have been made to support the contention that the risks from the vaccines approach that of the disease(80,90). But even if the vaccines in general are safer, for a particular child they may not be. No one, not even public health proponents of compulsary vaccination, is arguing that individual children are not harmed by vaccines, only that the general public good is served by vaccination. The argument regarding general public good has

been addressed and I think shown to be weak. There is incontrovertible evidence that individual children are harmed by vaccines. It is the parent, not the state, who should be allowed to choose risk for an individual child.

VIII. HISTORY MUST NOT BE IGNORED

If government is going to force people to put known toxins into their bodies, they have a tremendous responsibility to be absolutely right. Of course that is not possible. History is replete with examples of medical procedures which were touted at one time, with nary a dissenting voice, which were later totally discredited. Examples are routine tonsillectomies, appendectomies, hysterectomies, X-rays and Cesarean-sections. X-ray pelvimetry during pregnancy, DES, coronary bypass surgery, the original Salk vaccine, the killed-cell virus measles vaccine and swine-flu shots are additional examples of now defunct or largely discredited medical approaches. Actual dangers of procedures have often been utterly denied, radiation being a most glaring example, only much later to be admitted, leaving many damaged health-care consumers. Where is our sense of humility and history? While there is nothing wrong with a medical professional informing a person about all sides of an issue, giving his or her opinion based on personal evaluation of current knowledge, and getting consent to proceed according to a certain plan, there is something terribly wrong about forcing individuals to comply.

If physicians and government saw themselves as providers of information and respectfully deferred the decision-making to willing patients, I submit that fewer malpractice suits would be brought. One cannot insist upon taking responsibility for a decision and reasonably deny responsibility for the outcome.

Obviously, the point of all this is not that anything has been proved here or elsewhere on the scientific level, but that

reasonable people can disagree on this issue. In a free society, reasonable disagreement on matters of conscience and health should be honored.

(There are approximately 115 references in all.)

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POSITION PAPER/Department of Health & Social Services

Position Paper

SB 148

[illegible] "An Act relating to immunization of minors."

SB 148 would amend AS 14.30.125 by allowing a child who is not immunized to attend Alaska schools if the child's parent or guardian files a letter with the school administrator that immunization is contrary to the beliefs of the parent or guardian or if a physician's affidavit is filed which states that immunization is contraindicated because of the child's medical circumstances. The bill further allows a school's chief administrative officer to exclude an unimmunized child if the administrator has reason to believe the child has been exposed to a disease for which immunization is required. Exclusion remains in effect until the parent or guardian submits a physician's affidavit stating the child is no longer at risk of developing the disease.

Under current regulation (4 AAC 06.055), immunizations are required against diphtheria, tetanus, polio, measles, rubella, and if the child is under seven years of age, pertussis (whooping cough). Exemptions to the immunization requirement are available only with a physician's affidavit of medical contraindications to immunization or a parent's or guardian's affidavit affirming that immunization conflicts with the tenets and practices of a religious denomination of which the family is a member. By vigorous enforcement of school immunization requirements, no adequately immunized Alaskan school children have contracted measles, rubella, polio, diphtheria, tetanus or pertussis since 1977.

However, these disease still occur in Alaska although at a relatively low level among individuals who are not adequately immunized and among young children who are too young to have completed recommended immunization schedules. Since 1980, there have been one case of diphtheria, 10 cases of measles, 101 cases of mumps, 56 cases of whooping cough, and 18 cases of German measles. Thus, the potential is present in Alaska for spread of these diseases.

There is controversy about mandatory immunization. Unfortunately, vaccines are not perfect. Vaccines are not 100 percent effective, and therefore some people who are immunized may not be protected. Also, vaccines are not perfectly safe and some people who receive them may be damaged by them.

The major debate about immunizations centers on the pertussis

fraction of the diphtheria-pertussis-tetanus (DPT) vaccine which is known to cause side effects which range from minor [illegible]. About 10 percent of vaccinated children develop minor redness, swelling, and pain at the site of injection. Convulsions or collapse with complete recovery occur at a rate of about one episode per 1,750 vaccine doses given. Encephalitis (inflammation of the brain) occurs at a rate of one case per 110,000 doses given and encephalitis with residual effects at a rate of one case per 310,000 doses administered. Sudden infant death syndrome is not related to pertussis vaccine use.

Given the relatively low number of cases of whooping cough which occur, the adverse effects associated with the vaccine seem to pose an unacceptable risk. However, the potential for harm from the vaccine needs to be balanced against the dangers of the disease itself. The death rate from pertussis for previously unvaccinated patients who develop the disease is one in 1,000; among affected children less than one year of age, the death rate is one percent. Permanent brain damage from whooping cough afflicts one child in 10,000 cases. Consensus among health authorities is that benefit from immunization outweighs the risk. This view has been expressed by the American Medical Association, the U.S. Public Health Service, the American Academy of Pediatrics, and the American Public Health Association.

It should also be stressed that a decision not to immunize has effects that extend beyond the individual who does not receive the vaccine. Pertussis is a highly contagious disease with an attack rate in the pre-vaccine era among exposed siblings in the 70 to 80 percent range. Thus, once the disease occurs, there is ample opportunity to spread, particularly among other unimmunized or inadequately immunized persons (particularly young children not old enough to have completed all their "baby shots") and there will also be an increased risk to the 10 to 20 percent of completely immunized children who are not protected because the vaccine is not 100 percent effective.

The provision in SB 148 allowing the school's chief administrative officer to exclude temporarily unimmunized children who have been exposed to the disease does not offer protection because the disease is highly communicable before clinical diagnosis is made and because of history of exposure is unlikely to be reliably available to school authorities.

Position

The Department of Health and Social Services is opposed to enactment of SB 148 since it would result in a significant

increase in the incidence of communicable and, in some instances, life threatening diseases among children.

Recommended: Elizabeth Ward
Elizabeth Ward, Director
Division of Public Health

Date: 2/3/89

Approved: Myra M Munson
Myra M. Munson, Commissioner
Department of Health and
Social Services

Date: 2/13/89

POSITION PAPER/Department of Health & Social Services

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: SB 148
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act relating to immunization of minors
Sponsor: Kerttula
Requestor: Senate HESS

Agency Affected: Dept. of Health & Soc. Svcs.
BRU: State Health Services
Components: Epidemiology

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Elizabeth Ward, Director E. Ward
Division: Public Health
Phone: 465-3090
Date: 2/13/89

Approved by Commissioner: Myra M. Munson Myra M Munson
Agency: Department of Health and Social Services
Date: 2/13/89

Distribution (by preparer):
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Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

IMMUNIZATION COMPLIANCE RATES OF SCHOOL AGE CHILDREN (K-1ST GRADE) AND INCIDENCE OF VACCINE PREVENTABLE DISEASES (1986)

ALL STATES INCLUDED IN SURVEY HAVE PHILOSOPHICAL OBJECTION TO STATE MANDATED IMMUNIZATIONS IN STATUTES

	compliance rate:	reported cases of: measles	rubella	mumps	pertussis	tetanus	diptheria	polio
Michigan	91%	185	24	467	36	1	INA	INA
1971 (approx.) - mandatory law implemented 1971 (approx.) - philosophical objection allowed								
Utah	93%	13 [38.5%] {61.5%}	15	16	44 [65.9%] {34.1%}	0	0	0
1975 - mandatory law implemented **1982 (approx.) - philosophical exemption allowed**								
Washington	95.7%	176 [65%] {35%}	15	30	163 [56%] {44%}	0	0	0
Missouri	98.3%	32	1	23*	32*	2(2)*	0	0
California	93.4%	497 [50%] {50%}	242	336	310 [40%] {60%}	3	0	1
1961-mandatory law implemented 1961-philosophical exemption allowed								
Pennsylvania	99.2%	28	1	63	52	1	0	0
Oklahoma	97.6%	39	0	INA	134	1	0	0
1976-mandatory law implemented 1976-philosophical exemption allowed								
Nebraska	96.5%	1	0	2	10	INA	INA	INA
1973-mandatory law implemented 1973-philosophical exemption allowed								
Indiana	97%	39	0	339	39	2	0	0
1976-mandatory law implemented 1976-philosophical exemption allowed								
Delaware	98%	35	INA	INA	INA	INA	INA	INA
1982-mandatory law implemented 1982-philosophical exemption allowed								

COMPLIANCE RATES CONT'D.

	compliance rate:	reported cases of: measles	rubella	mumps	pertussis	tetanus	diptheria	polio
Ohio	95%	10 [80%] {20%}	0	150	170	0	0	2
1959-mandatory law implemented **1970 (approx.)-philosophical exemption allowed**								
Arizona	95.1%	252	2	209	78	1	0	0
1976-mandatory law implemented **1981-philosophical exemption allowed**								
Minnesota	99%	50 [89%] {21%}	1	86 [88.8%] {11.2%}	50	0	0	0
1967-mandatory law implemented **1978-philosophical exemption allowed**								
Colorado	96.3%	11	1	17	84(2)	0	0	0
1974-mandatory law implemented **1979-philosophical exemption allowed**								
Maine	INFORMATION NOT AVAILABLE							
1977-mandatory law implemented 1977-philosophical exemption allowed								
Wisconsin	96.5%	287	1	325	111	0	0	0
1975-mandatory law implemented **1980-philosophical exemption allowed**								
Vermont	98%	0	1	6	5	0	0	0
1979-mandatory law implemented 1979-philosophical exemption allowed								

INA: information not available
*: immunization not mandatory in state
(n): fatalities
[n]: percent of ill fully immunized
{n}: percent of ill unimmunized

Data received from State Health Departments of states listed
22 states contacted - 17 states responded to date - January 20, 1988

All states implement exclusion of unimmunized children from school during vaccine preventable disease occurances.

13 of 17 states have mandatory disease reporting laws; 7 of those have penalties for non-reporting of contagious diseases

Data compiled by the Alaska Chapter of Dissatisfied Parents Together

Report of the Committee on Infectious Diseases

1988

American Academy of Pediatrics

Table 2
Recommended Schedule for Active Immunization of Normal Infants and Children*

Recommended Age	Immunization(s)†	Comments
2 mo.	DTP, OPV	Can be initiated as early as age 2 wk in areas of high endemicity or during epidemics
4 mo.	DTP, OPV	2-mo. interval desired for OPV to avoid interference from previous dose
6 mo.	DTP	A third dose of OPV is not indicated in the U.S. but is desirable in geographic areas where polio is endemic
15 mo.	Measles, mumps, rubella (MMR)	MMR preferred to individual vaccines; tuberculin testing may be done at the same visit (see Tuberculosis, page 431)
18 mo.	DTP,‡§ OPV,‖ PRP-D	See footnotes
4-6 yr	DTP,¶ OPV	At or before school entry
14-16 yr	Td	Repeat every 10 yr throughout life

*For all products used, consult manufacturer's package insert for instructions for storage, handling, dosage, and administration. Biologics prepared by different manufacturers may vary, and package inserts of the same manufacturer may change from time to time. Therefore, the physician should be aware of the contents of the current package insert.

†DTP = diphtheria and tetanus toxoids with pertussis vaccine; OPV = oral poliovirus vaccine containing attenuated poliovirus types 1, 2, and 3; MMR = live measles, mumps, and rubella viruses in a combined vaccine (see text for discussion of single vaccines versus combination); PRP-D = *Haemophilus* b diphtheria toxoid conjugate vaccine; Td = adult tetanus toxoid (full dose) and diphtheria toxoid (reduced dose) for adult use.

‡Should be given 6 to 12 months after the third dose.

§May be given simultaneously with MMR at age 15 months.

‖May be given simultaneously with MMR at 15 months of age or at any time between 12 and 24 months of age.

¶Up to the seventh birthday.

Table 3
Recommended Immunization Schedules for Children Not Immunized in First Year of Life

Recommended Time	Immunization(s)	Comments
	Less than 7 years old	
First visit	DTP, OPV, MMR	MMR if child ≥15 mo. old; tuberculin testing may be done at same visit (see Tuberculosis, page 431)
Interval after first visit: 1 mo.	PRP-D	For children aged 18-60 mo.; can be given concurrently with DTP (at separate sites) and other vaccines*
2 mo.	DTP, OPV	
4 mo.	DTP	A third dose of OPV is not indicated in the U.S. but is desirable in geographic areas where polio is endemic
10-16 mo.	DTP, OPV	OPV is not given if third dose was given earlier
4-6 yr. (at or before school entry)	DTP, OPV	DTP is not necessary if the fourth dose was given after the fourth birthday; OPV is not necessary if recommended OPV dose at 10-16 mo. following first visit was given after the fourth birthday
10 yr later	Td	Repeat every 10 yr throughout life
	7 Years Old and Older	
First visit	Td, OPV, MMR	
Interval after first visit: 2 mo.	Td, OPV	
8-14 mo.	Td, OPV	
10 yr later	Td	Repeat every 10 yr throughout life

*The initial three doses of DTP can be given at 1- to 2-month intervals; so, for the child in whom immunization is initiated at age 24 months or older, one visit could be eliminated by giving DTP, OPV, and MMR at the first visit; DTP and PRP-D at the second visit (1 month later); and DTP and OPV at the third visit (2 months after the first visit). Subsequent DTP and OPV 10 to 16 months after the first visit are still indicated. PRP-D, MMR, DTP, and OPV can be given simultaneously at separate sites if return of vaccine recipient for future immunizations is doubtful.