

The same criminal “profits before lives” response by capitalism to COVID-19 and monkeypox is allowing the resurgence of polio

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Following the initial discovery in July of an infected individual in Rockland County, evidence that polio is continuing to spread in New York state has now come to light. In addition to previous detection of the virus via wastewater testing in New York City and two suburban counties—Orange and Rockland—it has now been found farther away in Sullivan County, in samples taken in July and August.

A pattern of geographic spread is indicated. Rockland County lies immediately northwest of New York City, across the Hudson River. Orange County is adjacent to Rockland to the northwest and Sullivan to the northwest of Orange. Given the highly interconnected economy of the New York metropolitan region, which encompasses portions of the adjacent states of Connecticut and New Jersey, there is no reason to believe that the virus would not already be in those areas as well. However, wastewater testing so far has been extremely limited, making it impossible to comprehensively trace the spread of the polio virus.

Dr. Mary T. Bassett, New York State Health Commissioner, exemplified the official response to these developments in a guest essay published in the *New York Times*. She exclaimed that, “The case of a young adult paralyzed by polio in New York is not simply unexpected. It’s shocking.” No public health expert could be genuinely shocked.

It has long been recognized by those who have seriously considered the matter that, although it came close to achieving its goal, the underfunded and incompletely executed world campaign to eradicate polio, led by the Global Polio Eradication Initiative, would not only fail in its stated mission but would open the door to the resurgence of this dread disease. This failure provides an object lesson regarding the necessary approach to combating all infectious diseases. A brief review will make this evident.

There are two basic types of polio vaccine—the inactivated (“killed”) virus vaccine, the Salk vaccine, first deployed in 1955, and the attenuated virus vaccine, the Sabin vaccine, released in 1961, which contains live virus that has been weakened so that, although still infectious, it does not normally cause disease. Both are highly effective in preventing disease in

vaccinated individuals. However, each has advantages and disadvantages, which affected how and where they were employed.

The killed-virus vaccine requires three to four injections, depending on the age of the recipient, to reach full effectiveness. The doses require special handling and must be administered by a medical professional. Therefore, it is expensive and logistically difficult to deploy. By contrast, the Sabin vaccine, which also requires multiple doses, is administered orally as a liquid, which can be done by minimally trained individuals, making it easier and cheaper to use. Consequently, while the advanced capitalist countries in North America and Europe have for many years employed only the Salk vaccine, less wealthy countries with underdeveloped medical infrastructure rely primarily on the Sabin vaccine.

Unfortunately, there is a significant difference between the two vaccines. While the Salk vaccine prompts an immune response using “killed” virus, which cannot propagate or cause disease, the virus particles in the Sabin version, although they have been altered to inhibit their ability to cause disease, can still reproduce in a vaccinated individual and be spread via that person’s feces or by other means. This has been viewed as a benefit in that, when the non-virulent form is transmitted to other, unvaccinated community members it will result in the development of immunity without disease, thus further lowering the cost of the vaccination campaign.

However, in rare, but nonetheless significant cases, the “attenuated” live virus can mutate into a disease-causing form. When spread to unvaccinated individuals, new outbreaks of polio are triggered. This has resulted in the sporadic recurrence of polio in a number of countries, mostly in Africa, where vaccination rates are low. The disease also is endemic in Afghanistan and Pakistan, where vaccination efforts have been hampered due to political unrest and chronic warfare. This situation creates a pool of virus which, in a highly integrated global economy, provides new sources of infection anywhere in the world, in populations where vaccination rates are low.

The community spread of vaccine-derived virus has been identified in the recent episodes in Israel, the UK, and the US,

as has been confirmed by genetic assay. Since systematic wastewater testing, which could provide early warning of a new outbreak, has largely been eliminated in many countries to reduce cost, and vaccination programs have been inconsistent, leaving pockets with low rates of vaccination, especially since the spread of COVID-19, the terrain is ripe for the “vaccine-derived” disease to spread.

The failure to adequately fund the vaccination campaign, prompting the use of the attenuated version of the vaccine in many countries, has resulted in a failure to eradicate the disease. In 2021, a total of 688 cases of paralysis due to vaccine-derived virus polio infections were reported in 20 countries. By contrast, only six cases of naturally occurring wild-type polio were identified in three countries.

An additional ill-conceived decision has increased the likelihood of polio outbreaks in areas where the Salk vaccine is used. There are three wild types of polio virus, designated 1, 2, and 3. The “trivalent” oral vaccine provided immunity to all three types. Due to a substantial reduction in the type 2 virus, in 2016, based on a recommendation by the Global Polio Eradication Initiative, type 2 was dropped from the oral vaccine. This premature move has resulted in a resurgence of type 2, against which a substantial number of vaccinated individuals do not have immunity. Most of the vaccine-derived virus that is now circulating is of the mutated type 2. A specific vaccine targeting type 2 is under development but is inadequately funded.

Experts had already described the initial detections in Rockland and Orange counties as just the “tip of the iceberg,” since polio has the capacity to propagate asymptomatically from an infected individual for days or weeks. On average, only one in 200 infections leads to paralysis, and sometimes death, meaning that the virus can spread widely before detection. The latest discovery, coupled with the totally inadequate level of testing, strongly indicates that the polio virus has already spread widely in the region and possibly in other parts of the US as well.

The initial discovery of the symptomatic individual in Rockland County took place in July. Wastewater testing, which was initiated only following that discovery, then confirmed presence of the virus in New York City and Orange County as well. Retroactive testing of samples from Orange and Rockland subsequently determined that the virus was already circulating at least as early as April. It has now also been detected in Sullivan County.

The initial symptomatic case was a young man in Rockland County who was unvaccinated. The federal Centers for Disease Control and Prevention (CDC) has reported that he is infected with the vaccine-derived type 2 polio virus, indicating he had been infected by someone who had received the oral vaccine. He had not traveled out of the country, further confirming local community spread. Genetic testing of samples from the stricken individual identified similarities with the viruses recently

detected in Israel and the UK.

The New York State Department of Health (NYSDOH) has issued an urgent warning to individuals who are either unvaccinated or incompletely vaccinated to do so as soon as possible. The inactivated-virus vaccine, which is used exclusively in the US, requires a series of three or four injections at spaced intervals, depending on the person’s age, to reach full effectiveness. Therefore, the disease will continue to spread among previously un- and incompletely vaccinated individuals, even if a comprehensive program is now initiated.

In a statement issued by the CDC, “As of August 1, 2022, Rockland County has a polio vaccination rate of 60.34 percent, Orange County has a polio vaccination rate of 58.68 percent, and Sullivan County has a polio vaccination rate of 62.33 percent, compared to the statewide average of 78.96 percent, among children who have received 3 polio immunizations before their second birthday. A rate of well over 90 percent is NYSDOH’s goal.”

While the specifics of each disease differ, the necessity to deploy a comprehensive, systematic, and adequately financed global campaign tailored to the particular characteristics of each is evident. The example of the global eradication of the smallpox virus, officially declared in December 1979, demonstrates that such a goal is possible.

Equally evident is the criminal failure of the capitalist system, now in severe crisis, to marshal the necessary resources and strategies to meet the challenges posed by the growing number of epidemic disease outbreaks. COVID-19, monkeypox, and now polio are only the beginning. The combination of economic crisis, the decades-long attack on the public health system and other social services, and accelerating climate change leading to the growing danger of new zoonotic diseases, demonstrate that humanity is faced with devastating consequences due to wave after wave of pandemics.

The ruling class can marshal trillions of dollars to bail out the financial and corporate elites or to prosecute imperialist wars which could very well lead to nuclear holocaust. But when it comes to the health and welfare of the working class, “there is no money.” Only a socialist reorganization of society, in which human wellbeing rather than the maniacal pursuit of profit, can avert this dire future.



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