

NO LIBERTY WITHOUT LAW. PART ELEVEN.

GOD'S LAWS A SAFEGUARD AGAINST ILL-HEALTH.

In reconsidering the subject of the 'diseases of Egypt' it will be found that the Bible uses the phrase in a context other than that of food and diet. It will be noted that in Deuteronomy 7:15 where it occurs, the context (verses 1-8) is the prohibition against making covenants with the numerically superior seven nations in Canaan as well as the stringent warnings against intermarriage with them. In Deuteronomy 28:60 where it is again used, the context is the whole body of related Law with particular reference to relationships between Israel and other people. In an age wherein universalism or equalitarianism is the order of the day, this subject will naturally be most unpopular with 'do-gooders' not only resenting it, but rejecting it outright as 'unchristian' and 'inhuman'. The point of issue here, however, is not whether it is unchristian or inhuman, but whether or not it is what the Lord God has to say. How many times are the prophets of the Lord exhorted to say to God's people; 'Hear the word of the Lord'? Is this not an indication that His people had and have the peculiar predisposition toward superimposing their own concepts, their own interpretation of subjects over what God has to say about them? It is small wonder that Anglo-Saxondom today, as the modern development of true Israel is so willing to lend an ear to the doctrine of antinomianism i.e., the non-validity of God's Law. In the keeping of God's Law, Deuteronomy 28:13 states:

- ***“And the Lord shall make thee the head, and not the tail; and thou shalt be above only, and thou shalt not be beneath; if that thou harken unto the commandments of the Lord thy God, which I (Moses) command thee this day, to observe and to do them”.***

Failure to implement the Law which governs the whole spectrum of national life including the international relationships, would, according to the Lord, reverse the order of things with the 'stranger' dominating the scene.

- ***‘The stranger that is within thee shall get up above thee very high; and thou shalt come down very low. He shall lend to thee, and thou shalt not lend to him: he shall be the head, and thou shalt be the tail’ (Deut. 28:43-44).***

This is precisely what has happened within the Anglo-Saxon company of nations today, for their whole economy is directed towards accommodating the 'stranger' who calls the national tune by invoking the mythical world opinion in support of his claims to 'human rights'. This is the context in which Deuteronomy 28 uses the phrase, the '**disease of Egypt**' a situation which suggest that these were and are the by-product of indiscriminate immigration into Israel lands.

Racial Pathology

It behoves all of us who are truly seeking to know the truth as revealed in God's Word to investigate all avenues and not to be 'switched off' when research comes up with facts which are not in accord with popular opinion. Take for instance, the above quoted Scripture which suggests that the subject of the diseases of Egypt have a positive association with the breakdown in Law-observance in the context of national relationships. Many would tend towards the opinion that the prohibition against the free integration of people was motivated by religious considerations and yet, no one could honestly contend that the disease of Egypt

were anything else but a physiological subject. There must, of necessity, be something more to it than that. There are several genetic works available to the general public all of which intimate wide physiological disparity between the races of men. For instance, *'Biology of the Negro'* by Lewis, indicates racial differences in response to drugs with the Negro appearing to be less susceptible to the central action of atropine than does the White. On the other hand, the Negro is more susceptible to the actions of anodynes, sedatives and hypnotics. In *'Racial Differences in Mydriatic Action of Cocaine'*, Chen and Poth have discovered that the pupil-dilating action or mydriatic action of cocaine, euphthalmine and ephedrine upon the eyes of Whites is very much greater than upon the eyes of Chinese and Negroes. The pupils of the Whites were dilated by these drugs more than three times as much as those of the Chinese and the dilation in the case of Chinese was more than twice as much as in Negroes. If all men are equal, why are there these differences? In terms of racial pathology and depending upon ideological persuasion, many geneticists cloud the issues by explaining the results of their investigations in terms of environmental factors. It is contended that the difficulty in interpreting the established differences in the incidence of disease, the gravity of their effects and the death rates resulting from these lies in the environments of the races compared. It is suggested that in the United States for example, the condition of sanitation, housing, nutrition and almost every other environmental factor that might influence the infection by disease and recovery from them, are greatly inferior for the Negroes to those employed by the whites. However, such a suggestion appears to be without too much credence for in *'Biology of the Negro'* quoted above, it has been established that whether in the United States or in Africa, tuberculosis is a much more serious disease among Negroes than among Whites. In the United States, the mortality from this disease is five times as high in Negroes and begins actively at a much earlier age than in Whites. Among the causes of death, tuberculosis is second in the Negroes, while statistics reveal that it is seventh among the Whites. In the case of American Indians, the proportion of deaths from tuberculosis of the respiratory system is more than four times the White rate and about twice the Negro rate. In *'Up from the Ape'*, Professor E.A. Hooton indicates that research has established a predisposition of the Negro to venereal disease - a contact-contagious disease which is easily discernible in the males but less so in the females. Journalists of all sorts in Anglo-Saxondom are now indicating that the incidence of venereal disease is on the increase and unlike many of the depressing tales that are alone thought newsworthy, this one is true. However, few appear to link this increase with the new morality which takes no cognisance of racial barriers. Probably the clearest example of almost complete racial segregation in disease is sickle cell anaemia to which Negroes are especially liable and to which Whites are immune. In his work, Lewis states that it is doubtful if there is a single genuine instance of sickle cell anaemia among Whites - the only exception being those with either a remote or recent infusion of Negro blood. In sickle cell anaemia, a defect in the intricate chemical structure of haemoglobin reduces the oxygen supply to the red blood cells which then assume a crescent shape from which the term 'sickle cell' derives its name. These cells are destroyed by the body resulting in chronic anaemia. If one parent has the sickle cell trait, a child born would stand a reasonable chance of survival with intensive medical care but, if on the other hand both parents are carriers, the child will have nothing but sickle cells and will not survive beyond adolescence, This is definitely an inherited condition and is limited only to Negroes or those of part Negro parentage. The point to note here is that sickle cell anaemia is exclusive to the Negro whether he be born in the United States, Britain or Africa. Leaving racial pathology as it concerns and is contrasted between the Negro and

the White race, attention is now focused on the Mediterranean people whose genetic inheritance appears to be a disease known as thalassaemia which is also known as Cooley's anaemia and appears exclusively among Italians and Greeks. Much like the sickle cell anaemia among Negroes, this disease is a genetic defect in the formation of haemoglobin. Research has established that this disease is found in both Italians and Greeks regardless of where they live and occurs in two degrees of severity categorised as major and minor. In the case of the former - presumably where both parents have inherited the disease - the end is fatal anaemia which does not allow its victim into adult life while the minor degree is only helped by the removal of the spleen and blood transfusions. It makes absolutely no difference where a person lives, his occupation or station in life. A genetic inheritance remains with him and is passed on to his children irrespective of his environment or the platitudinous preaching of 'social scientists'. **The Ashkenazim Jew for instance, whether living in Eastern Europe, the state of Israel or the United States, is the exclusive carrier of Tay Sachs disease.** This disease is so named after the British ophthalmologist Waren Tay who first described the visual problems associated with it in 1881 and the New York neurologist Bernard Sachs who published the clinical description some six years later. Because of its exclusiveness, this disease has become known as the '**Jewish Disease**' and is one of six others usually associated with the Jews. The National Foundation for Jewish Genetic Disease listed the six Jewish genetic disorders as (1) Tay Sachs; (2) Gaucher's disease, an inherited bone cartilage and liver defect; (3) Dysautonomia, a severe nervous system disorder; (4) Niemann-Pick disease, which kills during childhood in most cases; (5) Bloom's syndrome, which causes dwarfism; (6) a form of dystonia or severe distortion of limbs, neck and trunk. The seventh disease is a combination of mental retardation and eye disease called mucopolysaccharidosis IV and, like the other six is peculiar to the Ashkenazim Jews alone. While all seven are prevalent, Tay Sachs is the most common and usually strikes at roughly the age of six months. The child begins to lose weight and energy very rapidly, lying in bed for hours on end without changing position. This is followed by deformation of the chest, loss of vision with the circumference of the head increasing accompanied by brain deterioration. The child usually dies within months, although some linger on until they are four or five. Medical researchers have known for some time that the apparent cause of this disease is an accumulation of fatty substances that obstruct the central nervous system causing blindness, paralysis, convulsions and mental retardation which generally precedes death. Geneticists at the University of California at San Diego discovered that the cause for this condition was the absence of an enzyme called hexosaminidase - a discovery which initiated a screening programme in which prospective marriage partners could determine whether or not either had this disease. Dr. Michael Kaback, an associate professor in the School of Medicine at the University of California at Los Angeles, contends that a child with Tay Sachs disease would cost between a hundred thousand and a hundred and fifty thousand dollars during the four or five years he lives. With so much research taking place and establishing racial criteria in terms of disease, one feature emerges which is overlooked by most people and that is that within the Anglo-Saxon company of nations, no racially inherited disease characterises these people as it does others. This is not to say that they do not die from disease, but in the long lists currently available detailing the statistics and causes of death, no pattern of inherited disease is discernible. Heart diseases, Cancer, Strokes, Pneumonia, Diabetes, Mellitus, Cirrhosis of the liver, Arteriosclerosis and a host of other causes are there, but none can be established as being peculiar to Anglo-Saxondom. What has become a problem are the

imported diseases which are transmitted by the carriers from other parts of the world who are permitted, through the immigration policies extant in Britain for instance, to flood the country. The United States policy of opening its doors to twenty five thousand Indo-Chinese per year could be an additive to the already grave problem. **The Spread of Disease** The 'Encyclopaedia Britannic' has a highly informative account of the spread of disease throughout the world in which it states: **"Transmission of disease by infected persons over longer or shorter distances, and from one country and people to another, is an established fact"**. The account continues by debunking the theory of climatic and environmental causes for the origin and spread of disease and although reticent in suggesting genetic origins for this, infers that this is the case. If one were to consider leprosy which many believe to be under control, but which according to the 1977 edition of 'Pears Medical Encyclopaedia' is now becoming evident in Iceland, one would find that the spread of this disease appears to be compatible with the migration of people from leprosy-dominated areas. Professor Gayre in '*Ethnological Elements of Africa*', may provide a clue to this situation for he writes: **"Leprosy is a scourge in Ghana as elsewhere in Africa and Asia. I have more than once referred to a probable genetic basis to be the incidence of this disease. If it is genetic it is likely to have a racial relationship"**. The 'Encyclopaedia Britannica' appears to corroborate this in that it contends that intermarriage between carriers is the major problem in the extension of this disease for, contrary to popular belief, leprosy is not as infectious as most people conceive. There is very little danger of contracting this disease even in a leper colony, provided that intimate personal contact is avoided. How then, one asks, is this disease making its appearance in a climatically unfavourable country such as Iceland? As with leprosy, so with other former exclusively tropical diseases such as bilharzia mentioned previously. This disease - one of the diseases of ancient Egypt - requires a host carrier in order to spread from its tropical homes in Africa, South America and the East. Its appearance in the colder regions of Anglo-Saxon lands - as with the appearance of leprosy in Iceland - would relate to the degree of immigration of people from Africa, South America and the East into those countries. Malaria, another spreading disease which flourishes in tropical and sub-tropical countries, is adding to the health burden of Anglo-Saxondom. "Kill the mosquito and you will kill malaria" has been the dominant cry of most people involved in combating this disease and yet, according to a Report of the Malaria Commission of the Health Organisation of the late League of Nations, the belief in the causation of malaria by the Anopheles mosquito has been a big obstacle in the control of the disease. In point of fact, if one examines the life cycle of the malarial parasite, the human host is found to be indispensable to its continuity. The mosquito bites an individual and introduces into his blood sporozoites, small fusiform cells with one nucleus. They have to find their way into the liver within one hour or they die - those who do manage to find the liver, grow there and reproduce. After a week, the parasites leave the liver as merozoites which pass into the blood and invade the red corpuscles where they start cycles of growth and reproduction. When the merozoite enters the red blood corpuscle, it takes the form of a ring and within a few hours, fills the cell completely. Fission of the parasite takes place and each one gives origin to 16 daughter cells which, in turn are liberated into the blood out of the red cells in which they developed and the asexual reproduction cycle starts again as they penetrate new blood corpuscles. The periodic attacks of fever characteristic of malaria coincide with the liberation of the daughter merozoites into the blood stream. While the asexual merozoites start the reproductive cycle in the blood stream, sexual forms of the parasite begin to appear in the blood which can only

survive and reproduce in a mosquito and if one comes along and bites the infected person, the merozoites pass into the stomach of the mosquito where both sexes join to produce a zygote which pushes its way out of the stomach. An oocyst is formed on the outside of the stomach within which many sporozoites develop and which, when fully grown, travel through the mosquito into its salivary glands from whence they hope to pass into another person when the mosquito bites him. From this it is apparent that humans are carriers and that the malaria disease can be transported from one part of the world to the other affecting people whose resistance to it is absolutely nil. It is small wonder therefore that the Lord God was so emphatic in His Law concerning the structure of international relationships. If one considers His command to Israel in respect of the seven nations of Canaan (Deut. 7:1) in which he demanded total destruction, many are inclined to feel that there was no justification for the order. On the surface this would appear to be the case, but when one studies the 'abominations of the Canaanites' so often referred to by the prophets and exposed through the science of archaeology, one is able to appreciate some of the reason behind such a demand by the Lord. It is only since scientific investigation into the Canaanite way of life that so much has come to light, that men are able to appreciate something of the enormity of the immorality and ill-health which dominated the then Palestinian scene. Philo of Byblos, a Phoenician scholar who lived a hundred years before the Birth of the Lord Jesus Christ, wrote a history of the whole Mediterranean coast land as this was populated by the Canaanites. His authority for earlier descriptions was the priest Sanchuniathon whose writings exposed the total depravity - both temporal and spiritual - of the people. Bishop Eusebius of Caesarea in Palestine discovered the writings of Philo and in A.D. 314 gave an account of them. The details were so shocking that people refused to believe him much in the same way that people today will refuse to believe the reason behind the Lord's restrictive structure concerning international relationships. The Canaanites were a disease ridden, depraved people whose history has been preserved on cylinder-seals which provide modern knowledge of perhaps the most perverted people in recorded human history. R. Labat in his '*Traite akkadien de diagnostics et prognostics medicaux*', has provided an excellent insight into the diseases of Canaan which number, among others, Tuberculosis, Jaundice, Volvulus, Haemorrhoids, Strokes, Gonorrhoea, Kidney and Bladder maladies, Poliomyelitis, Cancer and Smallpox. The contention expressed concerning these disease has been derived from medical cuneiform texts which have survived the ravages of time to the present day. Medical historians in attempting to discover what diseases afflicted the people of Canaan and indeed the whole of Mesopotamia were at a distinct disadvantage to their colleagues in Egypt. The graves, unlike those in Egypt, contained no mummies and being less dry than Egypt, did not favour either the natural mummification of corpses or the preservation of skeletons. Archaeologists who spent considerable time excavating the region had no doubt that it was a hotbed of epidemics and infectious diseases of all kinds. Even today, after the lapse of so many centuries, plague, leprosy, malaria, smallpox, cholera, dysentery, infectious hepatitis, ophthalmia and a host of other diseases still obtain. Is it any wonder that the Lord demanded the eradication of these people and is it any wonder that He prescribed a diet for His people which would ensure that their resistance was more than equal to the erosion of the diseases current in the land? Make no mistake here. Diet is imperative if the natural resistance within the body is to withstand the onslaught of disease, whether carried by humans or derived from other sources.