POST-POLIO
HEALTH

Winter 2026
Volume 42
Number 1

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The Weight of Caring when the Carer Can't

Frances Henke, Hastings, Australia

Writing about the physical impact of caring for, then loss of, a spouse as a polio survivor may seem self-serving, but in this case, having talked to others, I realized there were valuable shared experiences worth passing on.

When daily routines that match our abilities are suddenly added to, life can become debilitating. The person we may have relied on to do the heavy shopping, walk the dogs, cook evening meals, load the dishwasher, etc., can't do it anymore. They may be in pain, need daily nursing, or require frequent hospitalisation and rehab.

"My excuse for this blitz was not callous, but motivated by my desire to return the home to a state of wellness."

On top of those chores comes attending to their every need—drinks, meals, dressings, falls, and bad accidents in the bathroom or elsewhere involving heavy cleaning. Daily visits to the hospital can mean long corridor walks and parking lot battles.

Then comes the new equipment—shower chairs, toilet seats, walkers, cushions, protective sheets, and new electric recliners. All of that freaked me out. At first, I didn't know why. Dr. Steve de Graaff suggested a touch of PTSD from blocked memories of childhood equipment. Accepting this helped me face and then eradicate it.

Thus, the first thing I did once I knew my husband Ian wasn't coming home ever again was to get rid of the lot. Our honorary granddaughter arrived on Christmas Day asking if there was anything she could do. "Yes," I said rashly, "Take all that stuff back to Frankston Hospital." I had telephoned the Hospital in the Home people twice asking for it to be removed. They promised to collect, but before Christmas … nah. Anyhow, it was eventually all loaded into a 4WD and deposited at the hospital. Best gift ever.

My next clearance was to pass on Ian's two specially-built electric recliners to friends. One, with Parkinson's, was so pleased, as it allowed him to rest without going to bed during the day. The chair was also a link to the man who had been so supportive of him.

My excuse for this blitz was not callous, but motivated by my desire to return the home to a state of wellness. I didn't want electrified chairs or powered anything. To replace the recliners, I searched online. I made myself promise I wouldn't buy anything, even with free delivery, without first checking the Salvos.

So, the next morning I hit the Op shop store. In their Hastings window was a beautiful Moran lounge chair. Okay, the upholstery is ivory, not ideal for a gardening, art, and dog home, but the cleaning lady recommended I "just throw a shawl over it." Done … very comfy, too.

Also, promptly and remarkably, after cancelling his cleaning day (grrrr) the week after his death, windows and carpets were professionally cleaned and everything dusted. I had given Mercy Health a stern lecture on organizations like Telstra and Centrelink[1] with the help of trained bereavement officers. I was incredibly upset, needing the

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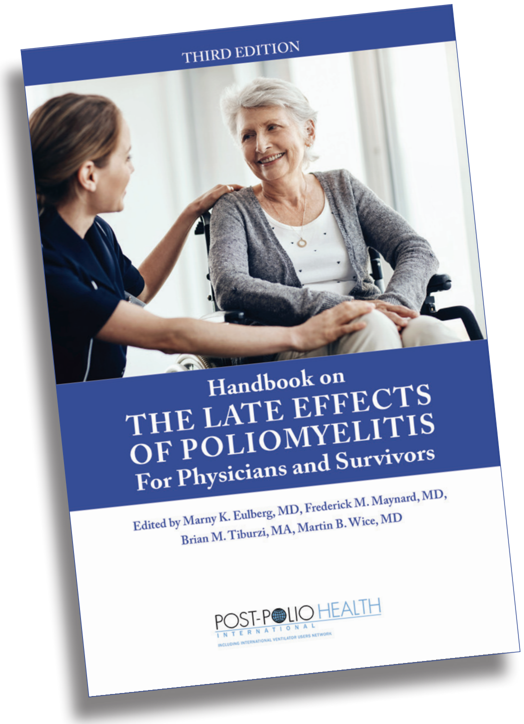

THIRD EDITION

Handbook on
THE LATE EFFECTS
OF POLIOMYELITIS
For Physicians and Survivors

Edited by Marny K. Eulberg, MD, Frederick M. Maynard, MD,
Brian M. Tiburzi, MA, Martin B. Wice, MD

POST-POLIO HEALTH
INTERNATIONAL

Newly Updated Print Edition Available

Handbook on the Late Effects of Poliomyelitis for Physicians and Survivors

Post-Polio Health International is pleased to announce the release of a new print edition of the *Handbook on the Late Effects of Poliomyelitis for Physicians and Survivors*—a trusted resource designed to help both polio survivors and healthcare professionals better understand and manage the long-term effects of poliomyelitis.

Written in an accessible style and grounded in current knowledge about post-polio care, the *Handbook* helps bridge the gap between survivors and the healthcare professionals who care for them. The *Handbook* provides clear, practical information about the late effects of polio and offers guidance for effective clinical care and self-management on over 85 topics.

Whether you are a polio survivor, caregiver, or healthcare professional, the *Handbook* serves as a valuable reference for navigating the long-term effects of polio.

Print copies are now available for $20.

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POST-POLIO HEALTH
Winter 2026
Vol. 42, No. 1
ISSN 1066-5331

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Post-Polio Health International's mission is to collect, preserve, and make available research and knowledge to promote the well-being, and independence of polio survivors, home ventilator users, their caregivers and families, and to support the health professionals who treat them.

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The Weight of Caring when the Carer Can't

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support of the cleaner who had been with us for years (once saving Ian's life by calling an ambulance). A subdued Mercy Health manager agreed they, too, needed bereavement training and grace on accounts for cleaning up after the deceased.

Naturally, fatigue was a huge issue in looking after Ian. I am still not sleeping well. The dogs are still out of sorts, too, missing him. They had gotten used to him going to the hospital, then coming home. Not this time.

The emotional weight of well-wishers had to be managed, too. I was exhausted from the influx of kind friends and family bringing flowers and food. We didn't have a formal funeral. I couldn't manage that emotionally. His death coincided with the funeral of one of our Mornington Peninsula Post-Polio Support Group (MPPPSG) members, a big church affair. I knew Tricia would understand me not going.

For Ian, we had a small, informal lunch instead at Tooradin Sports Club, where we would meet friends every year at Christmas. He had said recently that he was looking forward to that lunch. Well, he was there, his ashes released into the nearby inlet.

We polio survivors are notorious for "doing it mineself," powering through pain. There are times we have to call "barley," ask for, and accept help. Caring for family is one of those situations where it is essential to find out what support is available and make the most of it.

When the provider would not accept Centrelink's verbal acknowledgement that I could be grandfathered under the new scheme in order "not to be worse off" as legislated, I became unusually anxious about my security, needing GP and medications to settle.

Frances Henke

A face-to-face meeting at Services Australia was recommended. I had spent hours online last year in discussions over the new legislation. I did not expect to be told that I had to pay 25% for each service from November 1, 2025. That would mean cancelling services or reducing hours with the very people who keep me mobile (chiropractor, podiatrist, massage therapist, orthotics, etc.), and it would potentially be a bad outcome for those workers, as well. Already they are suffering. Our gardener had not been paid since before Christmas, and the local mobility store hadn't been paid for goods provided.

Back at Services Australia, aka Centrelink, it turned out that the Hastings office does not have an aged-care-trained officer. They had to communicate online with the Mornington office to resolve my issue. The separate interview over financial affairs was pretty odd, too. Claims of six figure sums we once had—pure fiction or error.

Losing a spouse of fifty years does not come easily. We only half celebrated that anniversary coming in the midst of his illness. But we made it. Ian Henke's influence is alive and endures. His legal research won a case against the state government the day he went into the hospital. The phone has rung off the hook with people telling me what he'd done for them—saved their farm, business, family, sanity. A senior barrister said Ian had "a colossal and vibrant intellect." Yes, a colossal intellect, but he never talked down to anyone, especially me.

I am okay. I am having to learn to manage the accounts and do some cooking. But, as a friend said, "Someone has to take over." ■

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1. Centrelink, a service operated by Services Australia, provides social security payments and services to eligible Australians, including retirees, job seekers, families, carers, and people with disabilities.

The Possibility of Polio's Return to the United States and Other Developed Nations

Michael Kossove

For much of the developed world, polio has faded into history. In the United States, Canada, Great Britain, and much of Europe, generations have grown up without witnessing the iron lungs, leg braces, hospital wards, and lifelong disabilities that once defined summer polio epidemics. The disease was declared eliminated in these countries decades ago, largely due to widespread vaccination programs that represented one of public health's greatest successes.

Yet elimination does not mean eradication. And increasingly, public health officials, epidemiologists, and polio survivors themselves are asking a troubling question: Could polio return to the United States, the United Kingdom, Canada, and other developed nations? The uncomfortable answer is yes—under certain conditions, it could.

Polio: Eliminated but Not Eradicated

Polio is caused by the poliovirus, an enterovirus that spreads primarily through the fecal-oral route, often via contaminated water or poor hygiene. While most infections are asymptomatic or cause mild flu-like illness, about one in 200 infections leads to irreversible paralysis. In severe cases, paralysis affects the muscles used for breathing, resulting in death.

Through aggressive vaccination campaigns, wild poliovirus transmission was eliminated from the Americas by 1994 and from most of Europe shortly thereafter. However, global eradication has not yet been achieved. Wild poliovirus continues to circulate endemically in Afghanistan and Pakistan, and sporadic outbreaks occur elsewhere due to imported cases or vaccine-derived strains.

As long as poliovirus exists anywhere in the world, no country is completely safe. Modern travel allows viruses to cross continents in hours, and even countries with advanced healthcare systems remain vulnerable if population immunity declines.

One of the most misunderstood aspects of polio risk today involves circulating vaccine-derived poliovirus (cVDPV). In many parts of the world, the oral polio vaccine (OPV) is still used because it is inexpensive, easy to administer, and highly effective at stopping transmission. OPV contains a weakened live virus that replicates in the gut and can be shed in stool.

In communities with high vaccination coverage, this is not a problem. But in under-immunized populations, the weakened virus can circulate, mutate, and eventually regain neurovirulence—becoming capable of causing paralysis. This is not a failure of vaccination itself, but rather a failure of insufficient vaccination coverage.

Developed countries no longer use OPV and instead rely on the inactivated polio vaccine (IPV), which cannot cause infection. However, vaccine-derived poliovirus can still be imported through international travel and detected through environmental surveillance.

Recent years have provided sobering reminders that polio remains a threat.

In 2022, the United States reported its first paralytic polio case in nearly a decade—an unvaccinated adult in New York State. Genetic analysis showed the virus was vaccine-derived and linked to strains circulating internationally. Subsequent wastewater testing revealed poliovirus in multiple counties, indicating community transmission, even though only one paralytic case was identified.

Around the same time, the United Kingdom detected poliovirus repeatedly in sewage samples in London, suggesting sustained transmission within certain communities. Canada and several European countries have also reported sporadic environmental detections of poliovirus without clinical cases.

These findings are not evidence of widespread outbreaks, but they are early warning signals. Polio surveillance works precisely by detecting silent transmission before paralysis becomes widespread. By the time multiple paralytic cases appear, extensive transmission has already occurred.

The most significant factor increasing the risk of polio's return in developed nations is declining vaccination coverage. In many countries, routine childhood immunization rates have fallen below the levels needed to maintain herd immunity.

Several forces are driving this decline:

- Vaccine hesitancy and misinformation
- Distrust of public health institutions
- Disruptions to healthcare access during the COVID-19 pandemic
- Complacency due to the absence of visible disease

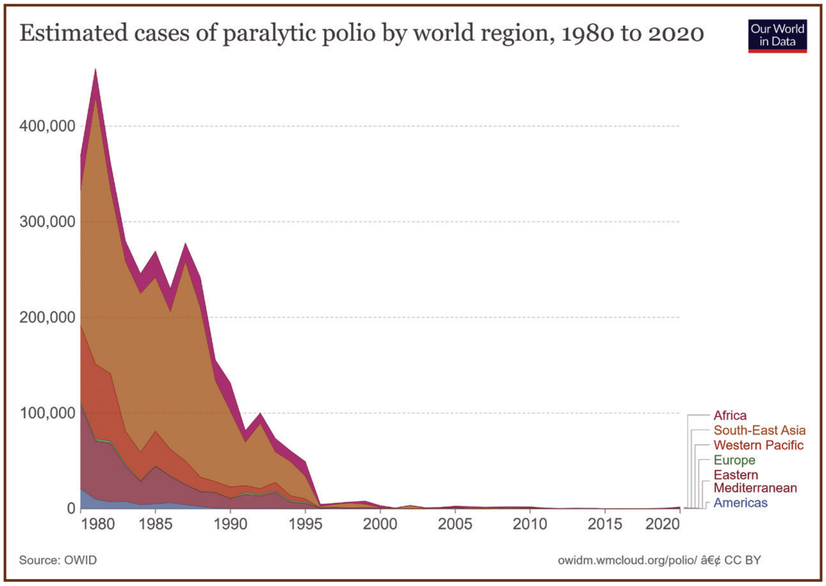
Polio requires very high vaccination coverage—typically around 95 percent—to prevent sustained transmission. When coverage drops below that threshold, pockets of susceptibility form, allowing the virus to spread silently if introduced.

These gaps are often geographically and socially concentrated, which increases risk. Polio does not spread evenly; it exploits weaknesses. Once introduced into an under-vaccinated community, it can circulate undetected for months.

It is tempting to assume that modern hospitals, advanced medical technology, and high standards of living provide protection against polio. Unfortunately, polio does not respect wealth or infrastructure.

Before vaccines, polio epidemics were most severe in affluent countries with good sanitation, precisely because delayed exposure led to more severe disease. Today, sanitation alone cannot stop poliovirus transmission, especially in dense urban environments.

Moreover, there is no cure for polio. Treatment is supportive. Once paralysis occurs, damage to motor neurons is permanent. Decades later, survivors may develop post-polio syndrome, a condition characterized by new weakness, fatigue, pain, and loss of function—a reality many survivors continue to face today.


Estimated cases of paralytic polio by world region, 1980 to 2020

Source: OWID

owidm.wmcloud.org/polio/ â€¢ CC BY

For polio survivors, the discussion of polio's possible return is not abstract. It is personal.

Survivors remember hospitals, isolation wards, surgeries, braces, and rehabilitation that lasted years. Many went on to live full, productive lives, only to face new challenges later due to post-polio syndrome. They understand that polio is not just a childhood illness—it is a lifelong condition with consequences that extend across decades.

The return of polio would not simply mean a few isolated cases. It would mean new generations facing permanent disability from a disease that is entirely preventable.

Ultimately, the only way to eliminate the risk of polio returning to developed nations is global eradication. Partial success is not enough. As long as poliovirus circulates anywhere, it threatens everyone.

The Global Polio Eradication Initiative (GPEI) has made extraordinary progress, reducing cases by more than 99 percent since 1988. Yet the final steps are the hardest. Political instability, conflict, vaccine misinformation, and logistical

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challenges have slowed progress in the remaining endemic regions.

Polio's return to the United States, the United Kingdom, Canada, or other developed nations is not inevitable. It would be the result of choices: choices to neglect vaccination, to dismiss public health warnings, or to forget the lessons of history.

The tools to prevent polio already exist. Vaccines are safe, effective, and widely available. Surveillance systems can detect the virus early. What remains necessary is the collective will to maintain high immunization rates and to support global eradication efforts.

Polio once paralyzed fear itself. That it no longer does so is one of humanity's greatest achievements. Allowing it to return would not be a failure of science; it would be a failure of memory.

A Survivor's Warning

For those of us who lived through polio, the word is not abstract. It is not historical. It is personal.

We remember the hospitals, the isolation, the braces and crutches, the months or years of learning how to live in bodies forever changed. We remember children who did not come home. We remember lives that were redirected before they had even begun.

Many of us went on to build full, productive lives. Now, decades later, some of us face post-polio syndrome—a reminder that polio never truly disappears. It leaves a lifelong imprint.

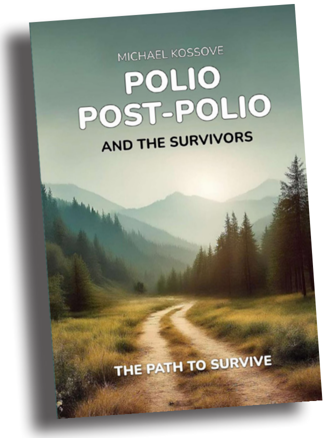
When we hear people say polio is "gone," we know better. It is controlled, not eradicated. Control depends on vaccination. When vaccination rates fall, polio finds opportunity.

The return of polio would not be a failure of medicine. It would be a failure of memory.

Polio is preventable. No child today should have to relearn what we already know. ■

Michael Kossove, a polio survivor, is Professor Emeritus and Adjunct Professor of Microbiology at Touro University, School of Health Sciences, New York.

He is certified as a Specialist in Public Health and Medical Laboratory Microbiology by the National Registry of Microbiology and the American Society for Clinical Pathology.



BOOK REVIEW

Polio: Then, Post-Polio, And The Survivors by Michael Kossove offers a comprehensive look at the story of polio—past and present—through both a scientific and deeply personal lens. A microbiologist and polio survivor himself, Kossove provides a solid overview of the history of the disease and the fear and uncertainty it created.

The book moves beyond the acute illness to examine the long-term realities faced by polio survivors, including the late effects of polio and post-polio syndrome. Drawing on research as well as lived experience, Kossove explores the physical, emotional, and social challenges that can re-emerge decades after apparent recovery.

Accessible to survivors, family members, and the general public alike, the book bridges medical knowledge and personal narrative, honoring the resilience of those who lived through the epidemics while shedding light on the ongoing needs of a generation still living with polio's legacy.

QUESTION: *I'm in my early 70s and starting to notice that some of the habits that helped me get through life aren't serving me so well anymore. I tend to push through fatigue, downplay pain, and tell people that I am 'fine.' I could get away with that when I was younger, but now it just leaves me feeling wiped out.*

I guess I should just do less or pace myself. I get it. But the problem is I don't even realize I'm doing it until after the fact. I don't want to upend my daily routine, but I do acknowledge that I should make some changes. Do you have any advice on how I can start to break these habits?

Response from Rhoda Olkin, PhD:

I really like this question as it pertains to so many of us polio survivors. At age 72 (Oh my, how did that happen?) I find I struggle with similar issues of knowing where the line is between doing and overdoing, when to push and when to let go. These are questions I've talked about with many polio survivors, so I do have a few tips.

Step one is to take stock of all you do. Write out a weekly schedule, and first include the 'musts,' like any jobs, appointments, eating (anything else?). Now put in everything else, and I do mean everything: laundry, grocery shopping, showering, driving, socializing, gardening, repairs, phone calls, bill paying, hobbies, etc.

Take a look at your week and see if you can find those times and days where you tend to feel wiped out. Is it towards the end of the week, and you use the weekends to recoup? If so, you will need to find time around Wednesday to do less (more on that later). Is it after a day where there is more on the schedule? Can you spread those tasks out or cut one out altogether?

Look at your week again and cut 10% out. What did you cut? I'm guessing you kept everything except hobbies, TV, and socializing as the only things that were expendable. That will not do! Those are the things that replenish you, even if they take energy.

So now you have to re-examine your schedule and look for those things you thought were necessary and cut something there. This is harder. Can you work from home one day a week; order groceries online; hire a high school student to do laundry, clean the kitchen, and shovel the snow; have a gardener put in a low-maintenance garden; change the sheets every other week instead of every week; subscribe to a home-delivery meal plan (I use Tovala every other week)?

Break up hobbies into steps (e.g., buy paints one day, take out paints and set up painting area on day two, do the actual painting on day three).

After you cut 10%, it's time to reassess your energy throughout the week. You may have to cut more. I know this is getting more difficult. Here is where you have to adopt a new mindset: "I can't do what I used to do, and that's OK; everyone changes as they get older. How do I want to live my best life for the next umpteen years?" Certainly not wiped out.

Small changes can make a difference, and you don't have to make all the changes at once. Follow the steps above each time you think you are still overdoing it. Do it for you, so you age with grace. ■

Please send questions for Drs. Olkin and Machell to info@post-polio.org.

Dr. Rhoda Olkin is a Distinguished Professor of Clinical Psychology at the California School of Professional Psychology in San Francisco, as well as the Executive Director of the Institute on Disability and Health Psychology. She is a polio survivor and single mother of two grown children.

NETWORKING

Ask the Doctors

QUESTION: *There are no physicians who specialize in PPS near my home. I believe I had non-paralytic polio in 1952. I started having symptoms of PPS in 1993. I have full body pain and suffer from extreme fatigue. Testing by a neurologist in 2024 showed mild evidence of having had polio. I have worked with my primary doctor since 1994 to treat the pain with various medications, which have almost eliminated the body pain. Other symptoms are increasing, such as throat irritation and GERD. Exercise seems to make my fatigue worse. Weakness has also been increasing.*

The orthopedist diagnosed me with osteoarthritis. He has thus far given me two steroid injections which have provided me with some relief. I've treated myself with Asian knee patches. I don't like the steroids in my body, so two weeks ago I had a prolotherapy injection. If the knee pain is caused by PPS, how should it be treated? Is there an indication as to how much longer I could live this way?


Marny Eulberg, MD

Answer from Marny Eulberg, MD: You are not alone in being in parts of the country with very few healthcare professionals who have expertise in helping people deal with possible polio-related symptoms or trying to figure out which symptoms may be polio-related and which could be from other conditions such as osteoarthritis or related to. If the neurologist did an EMG (electromyogram) that showed evidence of nerve damage from polio, then you did not have "non-paralytic polio," even though the paralysis may have been so slight that is did not show up on routine inspection/exam. Your GERD could be causing the throat irritation, or it could be due to allergies and several other non-polio-related conditions. GERD is quite common in people as they mature, including the majority with GERD who never had polio.

As for your question about how much longer you could live this way—if you are asking about life expectancy, unless polio survivors have severe breathing problems or severe swallowing problems, they can expect to live as long as their peers who never had polio. Post-polio syndrome is a slowly progressive condition and since the neurologist in 2024 felt you had "only mild evidence of polio," I would expect that any polio-related symptoms will either not get much worse or if they progress, it will be slowly. It seems that your knee pain is due to the wear-and-tear arthritis. It could be indirectly related to polio if you had long-term muscle imbalance in your legs or some deformity that was caused by your childhood polio.

Additional remarks from Daniel Ryan, MD: I would agree with Dr. Eulberg's assessment. Regarding your knee, I would like to add that treatment options you have already tried—cortisone injections and prolotherapy—are reasonable approaches. Other possibilities include physical therapy, knee bracing for added support, and if appropriate, viscosupplementation (hyaluronic acid) injections. If the osteoarthritis is very advanced, symptoms are significantly limiting your function, and you are medically cleared, a total knee replacement could be considered in the future.

QUESTION: *For the past 12 months, I have been taking Mounjaro for type 2 diabetes and weight loss. I am 69 years old, have post-polio syndrome, and weigh 215 lbs., down from a maximum of about 250 lbs. My objective is to reduce my weight to around 180. I have felt better in general from taking the weight loss drug, and my rate of falls has decreased significantly.*

At my last appointment with my weight-loss doctor, testing indicated that I had lost about 15 pounds of muscle mass. The doctor's suggestion was to increase my protein intake and exercise. They suggested swimming and resistance training. I have seen a physical therapist regarding exercise and am careful about how much I exercise to avoid overdoing it. My A1C has recently been reduced to the high end of normal. However, the loss of muscle mass has me concerned.


Daniel Ryan, MD

Answer from Daniel Ryan, MD: Congratulations on your impressive weight loss, the improvement in your A1C, and the significant reduction in falls. These are meaningful achievements that reflect your dedication and likely contribute to you feeling better overall.

Regarding your question about the use of GLP-1 receptor agonists like Mounjaro (tirzepatide) in post-polio patients, I am not aware of any specific studies examining these weight loss medications in individuals with a history of polio or post-polio syndrome. The available research on these drugs has generally focused on broader populations with obesity and/or type 2 diabetes, without targeted analysis in neuromuscular conditions like post-polio syndrome.

As you noted, rapid weight loss—regardless of the method—commonly leads to an initial loss of lean muscle mass before fat loss predominates. This can be minimized in any patient by ensuring adequate protein intake (typically 1.2–1.6 g/kg body weight daily, adjusted for kidney function) and incorporating resistance/strength training. There are several phone apps that are very helpful in tracking protein, carbohydrates, and fats. In post-polio patients, we must be particularly cautious to avoid overuse weakness, where excessive exercise can temporarily worsen neuromuscular fatigue. Your approach of working closely with a physical therapist is excellent—gentle, progressive resistance training and swimming/aquatic exercise (which reduces joint loading while providing resistance) are often ideal choices.

At age 69 with obesity, it's also reasonable to consider whether low testosterone could be contributing to muscle loss or difficulty maintaining strength. If not already evaluated, you might discuss this with your primary physician, who could refer you to a urologist experienced in men's health or an endocrinologist for appropriate testing and management if indicated.

Some patients and clinicians have explored creatine monohydrate supplementation (typically 3–5 g daily) to support muscle strength and function, with a generally favorable safety profile. However, this should only be considered after discussion with your primary care physician to ensure it aligns with your overall health and medications.

Your progress is encouraging, and continuing to balance weight loss benefits with muscle preservation through nutrition, carefully tailored exercise, and medical oversight appears to be the best path forward. ■

Have a medical question about the late effects of polio?

PHI's Medical Advisory Committee is here to assist. Just fill out the form at https://post-polio.org/ask-the-doctor/, and one of our volunteer physicians will be in touch. Please allow up to five business days for a response.

DISCLAIMER: PHI offers this program as an educational service but it in no way is a substitute for medical care by a personal healthcare provider. Our physicians/other healthcare providers can only make suggestions that you, in turn, will need to discuss with your healthcare provider. They cannot treat you or write prescriptions for you. Interactions in writing, verbally, or even by video, cannot replace the value of an in-person evaluation.

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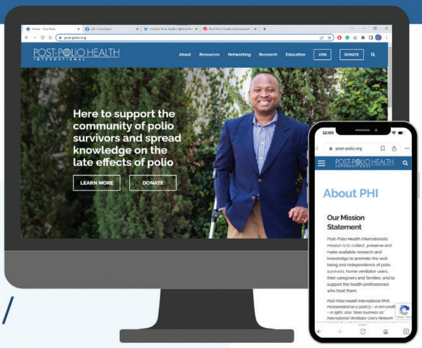

Here to support the community of polio survivors and spread knowledge on the late effects of polio

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Need help purchasing a brace or custom-made shoes? *We can help!*

The Joyce and Arthur Siegfried Memorial Fund offers up to $800 to polio survivors who need assistance purchasing these items.

Joyce and Arthur Siegfried were pioneer advocates for polio survivors. Mrs. Siegfried attended the 1987 PHI (GINI) conference and took “pages and pages of notes” back to the Raritan Valley Post-Polio Support Group, which she founded that year. She helped organize the first New Jersey Conference on the Late Effects of Polio in 1990, which led to the creation of the Polio Network of New Jersey in 1991. She died in 2004, after many years as the organization’s treasurer and leader of the Raritan Valley Support Group. Mr. Siegfried was a long time PNNJ board attorney and also served as president, retiring in 2010 a year before his death.

In 2012, the Polio Network of New Jersey (www.njpolio.org) established The Joyce and Arthur Siegfried Memorial Fund at Post-Polio Health International with an initial gift of $7,500.

Before completing the application, please make note of the following.

- Polio survivors from any country may apply.
- The maximum amount of funding available per individual within a two-year period is $800.
- Payments are made to brace or shoe companies and not to individuals.
- Funds are not available for buying two pairs of different sized shoes.

To apply, download an application at https://post-polio.org/siegfried-fund/ or call 314-534-0475.

Leaving a Legacy with PHI

The work of Post-Polio Health International has always been fueled by the generosity of our community. Membership dues and annual donations are essential, but it is often planned gifts—bequests made through wills or estate plans—that ensure PHI can continue serving survivors for years to come.

Over the years, PHI has been honored to receive sizable bequests from dedicated supporters, including Patricia Morrison, Olive Nesbitt Brewster, Lawrence Becker, and others. Their generosity has strengthened our programs, expanded our outreach, and sustained the vital resources we provide to polio survivors and ventilator users.

Planned giving is one of the most meaningful ways to leave a legacy. By including PHI in your estate plans, you help guarantee that the voices of survivors continue to be heard, that accurate information about post-polio and long-term ventilation remains available, and that our community stays connected and supported.

Making a planned gift does not require great wealth—only the desire to make a lasting impact. Even a modest bequest can help secure PHI's future and honor the values that matter most to you.

If you would like more information about how to include PHI in your will or estate planning, please contact us at info@post-polio.org. Together, we can ensure that the strength and resilience of the polio community live on for decades to come. ■

Lawrence Becker, PhD

In Appreciation

Thank you for recognizing your friends and loved ones with contributions to the activities of PHI and IVUN and for your generous Membership contributions.

Please contact us if we made an error.

Contributions to PHI's education, advocacy, and networking activities

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