IMMUNIZATION THEORY ISSUES

Theory:

Vaccination is the injection of antigenic material, such as pathogen derived foreign proteins and toxic adjuvants into the body, to initiate a “learned” immune system response in order to prevent particular diseases. Memory T cells (cell-mediated immunity) and Memory B cells (humoral-mediated immunity) learn to respond more quickly and strongly to specific infectious agents. B lymphocyte cell response to infectious agents are dependent on intelligence from memory T cells which serve as “helpers” aiding in the recognition of intrusive pathogens by signaling to B cells to produce “high affinity antibodies”.


Facts:

University of Chicago researchers found that Memory T cells are “distressingly slow learners”, requiring “several generations” of intensive stimulation to make a lasting impression on T cells “No vaccine trial to date has been able to produce significant numbers of memory T lymphocytes...”

University of Chicago Medical Center; T-cell memory finding may provide key to cancer, AIDS vaccines; March 11, 1999; http://www.uchospitals.edu/news/1999/19990311-tcell-memory.html

The Pasteur Institute found that “98% of the immune responses triggered at the early stages of infection are non specific. These non specific responses had been observed following different infections by viruses, bacteria, parasites and fungi.” This means that natural immune system affords 98% of the early response to an infectious disease agent, while the adaptive or memory-based protective response that vaccination seeks to stimulate represents only 2% of early response.

Pasteur Institute Press Release—Towards new vaccination strategies based on ‘non specific immunity’; August 1, 2000.

The Center for Vaccine Research in Pittsburgh, Pennsylvania confirms that “Vaccine induced enhancement of infection and disease has been reported for a number of viral pathogens.” The production of antiviral antibodies can fail to inactivate infectivity and actually “enhance” the entry of certain viruses (including Coxsackie virus; Respiratory Syncytial virus; Rabies virus; Influenza A virus; Epstein -Barr virus and Herpes Simplex virus) into target cells and increase infectivity and worsen disease symptoms. Whether antibodies neutralize or worsen viral infection depends on a number of factors, including virus strain and dose, host cell–antibody combination, and the concentration and class of the antibody.

Takada A. and Kawaoka Y.; Antibody-dependent enhancement of viral infection: molecular mechanisms and in vivo implications; Reviews in Medical Virology; No. 13; 2003; pp. 387-398.

Children with agammaglobulinaemia have no capacity to produce antibodies after contracting zymotic diseases, but still recover from measles with long-lasting immunity.


A mid 20th century study on the relationship of diphtheria incidence to the presence of antibodies found no observable correlation between antibody count and onset of the disease. “The researchers found people who were highly resistant with extremely low antibody count, and people who developed the disease who had high antibody counts.”


A group of military recruits were immunized for Rubella, and uniformly demonstrated antibodies, however 80 percent of the recruits contracted the disease when later exposed to it. Similar results were demonstrated in a subsequent study conducted at an institution for the mentally disabled.

Allan B.; Australian Journal of Medical Technology; Vol. 4, Nov. 1973, pp. 26 and 27

Disease is obviously a broad bio-ecological question which goes beyond whether one is vaccinated, or whether one’s body is producing desired antibodies. Scientists have concluded that: “It is important to stress that immunity (or its absence) cannot be determined reliable on the basis of history of the disease, history of immunization, or even history of prior serologic determination.”


These basic findings and observations suggest that there are serious frailties in vaccination theory and practice.

HISTORICAL INFECTIOUS DISEASE DECLINES

The textbook Aboriginal Health in Canada attributes
the decline in diseases such as “measles, rubella, mumps, poliomyelitis, tetanus and diphtheria in Aboriginal communities” to the “success of immunization programs.”

J.B. Waldram, D.A. Herring, and T.K. Young, Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives, University of Toronto Press, 1995, p. 75.

A large body of historical epidemiological data shows that major declines in most major infectious diseases took place in the western world before the use of specific vaccines. In the mid 20th century it was observed that “The decline in diphtheria, whooping cough and typhoid fever began fully fifty years prior to the inception of artificial immunization and followed an almost even grade before and after the adoption of these control measures. In the case of scarlet fever, mumps, measles and rheumatic fever there has been no specific innovation in control measures, yet these also have followed the same general pattern in incidence decline.” Claims about the historical life-saving impact of immunization programs appear to be presumptive and not factual.

McCormick W.J., Vitamin C in the Prophylaxis and Therapy of Infectious Diseases; Archives of Pediatrics, Vol. 68, No. 1, January 1951

Cause-specific mortality reports show that although life expectancy had increased by 23 years during the first half of the 20th century, actually no more than a year or two were actually attributable to advances in medical interventions.


INTER-SECTORAL DETERMINANTS OF HEALTH

The success of any genuine effort to alleviate infectious disease among socio-economically marginalized populations must prioritize the inter-sectoral determinants of health. “Involvement of specialists other than the traditional healing professions; water, food, housing, sanitation and education are all important prerequisites for health.”


“To assess priorities in health policies... the chief requirement is therefore to come to a conclusion about the reasons for the decline of the infections... All the countries that advanced rapidly achieved a substantial improvement in nutrition, which led to increased resistance. Indeed in some countries this was the only important direct influence. It is perhaps surprising that immunization appears to have contributed relatively little to the advances...”


“The most likely factors leading to health improve-

There has never been any community-based research in First Nations on the nature and extent of vaccine adverse events which are occurring. This represents a major research gap. “Significant adverse effects have been reported with every type of vaccine. These reactions may occur soon after vaccination or several months to years later. Delayed reactions are more insidious and less obviously linked to vaccination and thus necessitate large-scale epidemiological studies to be proven.”


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Because in the immunization procedure foreign pathogenic proteins and toxic adjuvants are placed directly into the body tissues and circulatory system, without censoring by the liver, this gives them accessibility to the body’s vital organs and systems as well as the brain. “Studies have linked neurodegeneration and a worsening of neurodegenerative diseases to systemic immune activation.” Science now understands the inks between systemic immune activation with vaccines, brain microglial activation, and major depressive disorder and a worsening of neurodegenerative diseases. “A number of studies have shown that live viruses used in vaccines can enter the brain and reside there for a lifetime... These viruses can trigger brain inflammation and degeneration - that is, there exist a chronic degeneration of the brain over years or decades. Because the resulting condition is so far separated from the time of administration of the original vaccine, physicians attribute the degeneration to old age or heredity.”

Blaylock, R.L., Vaccines, depression, and neurodegeneration after age 50 years: another reason to avoid the recommended vaccines, Medical Veritas No. 5, 2008, pp. 1727-1731.

VACCINES & NEUROLOGICAL DISORDERS

Dozens of published peer-reviewed studies demonstrate clinical and scientific links between vaccination/vaccine ingredients and autism spectrum disorders (ASDs) showing the mechanism by which the damage is done, including on a molecular level. These include cell culture studies, mixed cell cultures, organotypic tissue studies, in vivo animal studies, and human studies.


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Mice injected with the vaccine adjuvants aluminum hydroxide and squalene (adjusted for human body weight) by 20-24 weeks, exhibited significant loss in physical strength (50 percent) increases in anxiety (38 percent); memory deficits (41 times the errors as in the control group). One third of the neuron cells controlling bodily motor functions had destroyed themselves.


Thimerosal (ethylmercury) found in vaccines, leaves double the amount of inorganic mercury in the brain as does exposure to methyl mercury, the kind of mercury found in fish.


The set of psychiatric, speech, cognitive, sensory, motor, and behavioral symptoms used to diagnose autism are consistently comparable to the symptoms that are observed in persons with sub-acute mercury poisoning.


Analyses of the (U.S.) Vaccine Adverse Events Reporting System (VAERS), researchers reported 2- to 8-fold increase in risk of autism, speech disorders, mental retardation and thinking abnormalities following vaccination with thimerosal-containing vaccines compared to children who received vaccines with no thimerosal, or significantly less thimerosal.

It was found that the likelihood of children requiring special education services was 900% greater for male children vaccinated with hepatitis B (containing thimerosal) as for unvaccinated males after adjustment for confounders. The learning disability diagnosis rate of 18 percent for First Nations boys (off reserve) is 5 ½ times greater than for non-First Nation boys in Canada.


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Hepatitis B (with thimerosal) vaccination given to males in the first month exhibited a 294% greater rate of Autism Spectrum Disorder (ASD) among those aged 3-17, compared with those getting the vaccine later or the unvaccinated. It was also found that the white population (i.e. Caucasians, excluding Hispanics) were 61 percent less likely to have ASD.


A SurveyUSA 2007 study covering vaccinated and unvaccinated male subjects (over 9,000 males studied, age 4-17) in Oregon and California, showed in the 11-17 age bracket that the vaccinated experienced 158% more neurological disorders, 317% more ADHD, and 112% more autism. The Vaccinated, 4-17 age bracket, were 120% more likely to have asthma. Study confidence intervals were at or above 95 percent.


The cerebellum (senses, coordination and motor control) is much more sensitive to mercury in thimerosal than the cerebrum, thus supporting the biological plausibility that thimerosal-containing vaccines contribute to childhood autism.


Eight of nine patients examined were exposed to significant mercury from Thimerosal-containing vaccines during their fetal/infant developmental periods, and subsequently, between 12 and 24 months of age, these previously normally developing children suffered mercury toxic encephalopathies symptomatically consistent with regressive Autism Spectrum Disorders.


The very large rise in autism cannot be explained by better diagnosis and expanded diagnostic criteria, or genetics but rather is a real event, possibly propelled by environmental exposures to substances such as mercury; viral exposures; autoimmune disorders; and childhood vaccinations.


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