

SYNOPTIC OVERVIEW: ISSUES IN IMMUNIZATION THEORY AND PRACTICE

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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*”.

http://www.microrao.com/micronotes/pg/humoral_immunity.pdf

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.

Burnet M.; Auto Immunity and Auto Immune Disease, M.T.P., London, England, 1973, Chapter 3.

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.*”

Report No. 272, British Medical Council, London, England, May, 1950.

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.*”

Polk B.F., et al.; An Outbreak of Rubella (German Measles) among Hospital Personnel, The New England Journal of Medicine, Vol. 303, No. 10, September 4, 1980, pp. 541-545.

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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 assumptive 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.

Bunker J.P., *Symposium: The Role of Medical Care in Contributing to Health Improvements Within Societies*, *International Journal of Epidemiology*, 2001, No. 30, pp. 1260-1263.

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.*”

Helberg H., *An Evolving Process*, in *World Health*, Published by the World Health Organization, Geneva, Switzerland, Jan. - Feb. issue, 1988.

“*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...*”

McKeown T., *The Road to Health*, *World Health Forum*, Published by the World Health Organization, Geneva, Switzerland, Vol. 10, 1989, pp. 410 and 411

“*The most likely factors leading to health improve-*

ments...are a rise in the levels of nutrition and the slow spread of modern ideas of personal hygiene... the principal factor behind the improvement in health... in developing countries is probably not any form of health measure, but economic development itself... Mere exposure to a disease agent need not produce clinical disease and very frequently does not do so.” Malnutrition is of the highest importance because it hampers the body's natural resistance and acts “synergistically” with disease agents to increase the incidence and severity of clinical diseases.

Sharpston M.J., *Health and the Human Environment*, in (Ghosh P.K. editor) *Health, Food and Nutrition in Third World Development*, *International Development Resource Book No. 6*, Greenword Press,, Westport, Conn., U.S.A., 1984, pp. 85 and 80.

Vaccines or no vaccines, without improving the standard of living, and particularly nutrition status, children will frequently succumb to infections, and have repeated relapses.

Vaccines or no vaccines, without improving the standard of living, and particularly nutrition status, children will frequently succumb to infections, and have repeated relapses. For primary prevention, public health education, enhanced nutrition status and environmental sanitation deserve the highest attention. “*For obvious reasons, the highest priority must be given to preventive measures... The final and permanent answer to the problem will rest in... social and economic development... taking into account the need for nutritional improvement of the present generation. If good nutritional status is maintained in the first years of life, successive attacks of most infectious diseases of moderate virulence will probably produce no more than mild effects.*”

Standard K.L., *Infections and Malnutrition in Child Mortality*, in *Epidemiology and Community Health in Warm Climate Countries*, Cruickshank R., et. al. editors, Churchill Livingstone, Edinburgh, UK, 1976, pp. 45-48.

ADVERSE EVENTS MONITORING & LONG TERM ADVERSE EFFECTS

Although Canada has in place passive and active surveillance provisions, the chronic under-reporting of vaccine-induced morbidity, disability, and mortality appears to be the norm, with many vaccine reactions being unreported and undocumented. “*Precise data on the risk and incidence of adverse reactions are relatively difficult to obtain, ... [and] what is known with certainty about the causality and pathogenesis of vaccine-associated adverse events (VAAEs) is quite limited.*” Although the occurrence of “late” or long-term vaccine adverse events in some vaccines is incontestable, “*a major limitation of all the current approaches to monitoring VAAEs is the insensitivity or outright inability to detect events caused or initiated by vaccination which manifest more than 3-4 weeks after vaccination.*”

Ward, B.J., Vaccine adverse events in the new millennium: is there reason for concern?, *Bulletin of the World Health Organization*, Vol. 78, No. 2, 2000, pp. 205-207.

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.”*

Null, G., and Feldman, M., Vaccination: An updated Analysis of the Health Risks, 3 part series *Townsend Letter*, online Oct., Nov. & Dec. issues, 2007, http://www.townsendletter.com/Oct2007/vaccinate_null1007.htm

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.

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Blaylock, R.L., Vaccines, depression, and neurodegeneration after age 50 years: another reason to avoid the recommended vaccines, *Medical Veritas* No. 5, 2008, pp. 1742-1747.

At the following URL will be found access to copies of dozens of peer reviewed medical journal citations and articles on adverse effects associated with the following vaccines: Chicken Pox/varicella, BCG (TB), Cholera, Diabetes, DPT, DT & Polio, DTaP, Encephalitis, Hepatitis B, Hib, Gardasil, Influenza, MMR, Measles/rubella, Measles, EZ measles, Meningococcal, Mumps, Polio, Pneumococcal, Rabies, Rotavirus, Rubella, Smallpox, Tetanus, Typhoid, and Yellow Fever.

<http://www.whale.to/vaccine/citations.html>

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.

Blaylock, R.L., The danger of excessive vaccination during brain development: the case for a link to Autism Spectrum Disorders (ASD), *Medical Veritas*, Vol. 5, 2008, pp. 1727-1731.

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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.

Petrik, M.S., Shaw, C.S. et. al., Aluminum Adjuvant Linked to Gulf War Illness Induces Motor Neuron Death in Mice, *NeuroMolecular Medicine*, Vol. 9., 2007, pp. 83-99.

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.

Burbacher, T.M., et. al., *Environmental Health Perspectives, Comparison of Blood and Brain Mercury Levels in Infant Monkeys Exposed to Methylmercury or Vaccines Containing Thimerosal*, Vol. 113, No. 8, August 2005, p. 1020. <http://www.ehponline.org/members/2005/7712/7712.pdf>

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.

Bernard, S. et. al., Autism: a novel form of mercury poisoning, *Medical Hypotheses*, Vol. 56, No. 4, 2001, p. 463.

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.

Geier, D. and Geier, M., Early Downward Trends in Neurodevelopmental Disorders Following Removal of Thimerosal-Containing Vaccines, *Journal of American Physicians and Surgeons*, Vol. 11, No. 1 2006, pp. 8-9.

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.

Gallagher C., and Goodman, M., Hepatitis B triple series vaccine and developmental disability in US children aged 1-9 years, *Toxicological and Environmental Chemistry*, Vol. 90, No. 5, September-October 2008, pp. 997-1008. Bougie, E., Statistics Canada, Aboriginal Peoples Survey 2006 - School Experiences of Off-Reserve First Nations Children Aged 6-14, January 2009, p. 9

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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.

Gallagher, C. et. al, Hepatitis B Vaccination of Male Neonates and Autism, *Annals of Epidemiology*, Vol. 19, No. 9, September 2009, pp. 651-680.

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.

Generation Rescue, California-Oregon: Vaccinated vs. Unvaccinated Survey, <http://www.generationrescue.org/survey.html>

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.

Minami, T., et. al., Induction of metallothionein in mouse cerebellum and cerebrum with low-dose thimerosal injection, *Cell Biology and Toxicology*, April, 2009 Apr 9. [Epub ahead of print] http://www.ncbi.nlm.nih.gov/pubmed/19357975?ordinalpos=10&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DefaultReportPanel.Pubmed_RVDocSum

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.

Geier, D. and Geier, M., A Case Series of Children with Apparent Mercury Toxic Encephalopathies Manifesting with Clinical Symptoms of Regressive Autistic Disorders, *Journal of Toxicology and Environmental Health, Part A*, No. 70: 2007, pp. 837-851.

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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M.I.N.D. Institute, University of California, Davis, Report to the Legislature on the Principal Findings from The Epidemiology of Autism in California: A Comprehensive Pilot Study, October 17, 2002, pp. 3-5, and 14. http://www.dds.ca.gov/AUTISM/docs/study_final.pdf

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