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## "Herd Immunity." The flawed science and failures of mass vaccination, Suzanne Humphries, MD

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The oft-parroted sound bite – “we need herd immunity”- implies that if ninety five percent of the population can become “immune” to a disease via vaccination, target immunity levels will be met and diseases will either be eradicated or controlled. This sound bite is the most commonly pulled weapon used by the vaccinators, only second to “smallpox and polio were eradicated by vaccination.” “Herd immunity” is the trump card for the defense of vaccination on TV, Internet, medical journals and newspapers as to why we should be vaccinated over and over throughout our lives, with an ever-increasing number of vaccines.

Paul Offit smiled and **PLAYED THE CARD** while peddling his book on the comedy central channel as Steven Colbert jokingly said, “if the vaccines work so good for you, why do I need one?” Dr. Mark Segal **PULLED IT** on fox news as Mary Holland, JD eloquently described the issue of vaccine injury and loss of legal recourse in an era of forced and mandated vaccines. In addition to flaunting several false allegations and sound bites, Dr. Segal's well-rehearsed rant brushed right over the issue at hand, the fact that victims of vaccine injury have no legal right to sue – and instead launched into his agenda of scaring the listeners by parroting the “herd immunity” dogma.

The hype about herd immunity unfortunately creates a wall of hostility between those who vaccinate and those who delay some vaccines, avoid certain vaccines, or quit vaccinating altogether.

Since the beginning of vaccination, there is little proof that vaccines are responsible for eradicating disease even when herd immunity vaccination levels have been reached. Yet celebrity doctors rattle on about your unvaccinated neighbor being the biggest threat to your child – as if vaccination was the only way to avoid an illness or stay healthy.

To make matters worse, this intimidation to vaccinate is played out in an environment where WHO and vaccine manufacturers have been accused of scandalous misrepresentations of disease risk or vaccine safety and effectiveness. If the allegations against these entities are true, which I believe they are, we are being systematically altered, sickened and manipulated by powerful governing bodies that either don't understand the risks of vaccination, or don't care. We are told that the health of the herd is more important than any single life, and you now have no conventional legal recourse when your little sheep is wounded by any type of vaccine, no matter how it happened.

### The money factor

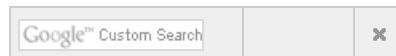
The population of the world is expanding over the past 200 years where vaccines have been used, and this makes obtaining herd immunity even more expensive and impossible today than ever. How many billions of people would need to be vaccinated how many times to eradicate just one illness based on the theory of vaccine herd immunity? How much would that cost? Consider the cost of vaccines, refrigeration, vaccinators, and hazardous waste removal. Just look at chicken pox vaccine at \$7.25 per dose for the CDC discounted price. Each child gets 2 doses. The US census shows 25.7 million children between 0-5 years. Just the cost of the vaccines to vaccinate each of those children, not including the lifetime of boosters, refrigeration, administration and waste, costs the government over 372 million dollars. Chicken pox vaccines are now being exposed for the failure they are, but vaccine profits are still climbing. After the members of the herd stopped transmitting natural immunity to each other because of the vaccine effect, shingles increased. The response- more doses of vaccine for children and a shingles vaccine to adults. **HERE** is a recent journal abstract describing the failure of herd protection by varicella vaccines. In a **SEPARATE DOCUMENT**, Dr. Goldman says:

*“Prior to the universal varicella vaccination program, 95% of adults experienced natural chickenpox (usually*

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### Translator



as school aged children)—these cases were usually benign and resulted in long term immunity. This high percentage of individuals having long term immunity has been compromised by mass vaccination of children which provides at best 70 to 90% immunity that is **temporary and of unknown duration—shifting chickenpox to a more vulnerable adult population where chickenpox carries 20 times more risk of death and 15 times more risk of hospitalization** compared to children. Add to this the adverse effects of both the chickenpox and shingles vaccines as well as the potential for increased risk of shingles for an estimated 30 to 50 years among adults. The Universal Varicella (Chickenpox) Vaccination Program now requires booster vaccines; however, these are less effective than the natural immunity that existed in communities prior to licensure of the varicella vaccine.”

In India, doctors are concerned about profit margins being protected before human lives, with recommendations to vaccinate every child with more expensive, newer vaccines. **Dr Jacob Puliyl describes the problems he sees..**

*“An analysis in the Lancet showed how the Pneumococcal vaccine reduces only 4 cases of pneumonia per 1000 children. The cost for vaccinating 1000 children comes to \$ 12,750. Treating the 4 cases of pneumonia in India using WHO protocol, would cost \$ 1. The pneumococcus strains prevalent in India are nearly all sensitive to inexpensive antibiotics like penicillin. In the US which has been using the pneumococcal vaccine for some years now, there has been a strain shift – strains covered in the vaccine are being replaced by other strains. Ominously the new strains are more antibiotic resistant. Vaccine has simply made the problem of pneumococcal disease worse. Yet this vaccine is being pushed in Africa and Asia....It is not about lives lost in poor countries – it is all about the cash register. These organizations and their sponsors have profit margins to protect. Ethics is not a major issue with them.”*

The profits to vaccine manufacturers and the government must be enormous.

The CDC is in the vaccine business. Members of the CDC's Vaccine Advisory Committee accept payment from vaccine manufacturers. Sanofi-Pasteur, Merck and others specifically seek to employ CDC staff once their contracts have run out. Relationships have included sharing a vaccine patent, owning stock in a vaccine company, payments for research, payment to monitor manufacturer vaccine tests, and funding academic departments. Thanks to a 1980 law, the CDC currently holds dozens of licensing agreements. It also has numerous ongoing projects to collaborate on new vaccines.

**The science?**

What science is there behind the belief that the herd can be protected by vaccinating enough of the sheep? Or that any disease has been eradicated from the planet thanks to a vaccine?

Recently, I was told by a vaccinator that “herd immunity is just a definition and so it can't actually be wrong. “ But the assumption of a 95% vaccination rate giving the herd a chance at eradication or higher levels of health – can be wrong. Let us go back in time and see just where the idea behind this definition probably comes from. Dr A.W. Hedrich in 1929, studied the natural occurrence of measles.

*“On the basis of field surveys of various workers, it is inferred that approximately 95% of the children in cities suffer measles attacks by the fifteenth birthday. “[1]*

Before vaccines, outbreaks of measles were observed in 2 to 3 year cycles, and 95% of the population developed immunity by the age of fifteen.

The original idea that vaccination could strengthen the herd's immunity, assumed that there was only one clinical event, and that one natural exposure equated life -long immunity. But this was not the case back when the diseases circulated freely. Vaccinators miss the point that the body defends most efficiently as a result of ongoing re-exposure. They try to mimic this with boosters. But the vaccination plan leaves the elderly(due to vaccine-induced immunity being short-lived and antigens taken out of circulation) and the very young(due to lack of transferrable maternal immunity) more vulnerable to several diseases that were not a threat to them before vaccination. In the case of chicken pox, vaccination renders the elderly more apt to shingles infections, because the herd has now lost the continued and benign re-exposures to children with chicken pox.

Instead of figuring out why a very small number develop dangerous invasive conditions, vaccine enthusiasts recommend vaccinating as often as possible in order to protect against something that would never be a danger to the vast majority of those vaccinated. If you constantly swab throats of healthy people most would be carrying and circulating supposed pathogens, as commensals.[2] At any one time in any society, *neisseriae*(the bacteria isolated in some cases of meningitis) are being circulated, yet most of the time, nothing happens, other than the body notes it, defends against it, and the host has no idea that they even carried it.[3] But now that vaccines for as many types as possible have been developed, the vaccine is the answer to the problem. This is typical for diseases today.

**Measles**

It is well documented that prior to vaccination, cycles of natural infection added to the herd's immunity.

*“The formal demonstration that both maternal antibodies and early exposure to infection are required for long-term protection illustrated that constant re-infection cycles have an essential role in building a stable herd*

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*In a population that is not constantly exposed to the infection during early infancy under the immunologic umbrella of maternal antibodies or vaccinated thoroughly a serious risk of re-emerging infections may arise. "*

[4]

Vaccination creates a "quasi-sterile" environment that opens up the possibility of disease outbreaks.

*"Attempts to eradicate measles virus or poliovirus eliminates antigen exposure of infants to these pathogens. Such quasi-sterile epidemiological situations may actually increase the risk of outbreaks."* [5]

We know this is possible because there have been eruptions of measles in the USA in populations that were 100 percent vaccinated.

*"The affected high school had 276 students and was in the same building as a junior high school with 135 students. A review of health records in the high school showed that all 411 students had documentation of measles vaccination on or after the first birthday, in accordance with Illinois law."* [6]

Within the scope of vaccination, when a quasi-sterile situation is created, and measles breaks out in the midst, the only solution within that paradigm is to vaccinate more people, more often. This is a backwards solution to the problem when considering who remains susceptible even in the face of full compliance: infants and non-immune adults. Susceptible age groups have essentially traded places since vaccinating. What used to happen with measles is that infants were protected by maternal antibodies, adults were protected by continued exposure, and infected children handled the disease normally and became immune for long periods of time. So, while measles vaccines have decreased the expression of measles infections, it has not necessarily improved the bigger picture. And certainly there are numerous troubles with the side effects of the vaccine.

Prior to vaccination, mothers were naturally immune to measles and passed that immunity to their infants via placenta and breast milk. Vaccinated mothers may have vaccine immunity, which is not the same immunologically, as natural immunity. One of the major differences in the vaccine-induced immunity is that it cannot be passed from mother to infant.

Since most vaccines are delivered by injection, the mucous membranes are bypassed and thus blood antibodies are produced but not mucosal antibodies. Mucosal exposure is what contributes to the production of antibodies in the mammary gland. A child's exposure to the virus while being breastfed by a naturally immune mother would lead to an asymptomatic infection that results in long-term immunity to that virus. Vaccinated mothers have lower levels of virus-specific antibodies in the serum and milk compared to naturally immune mothers and thus their infants are unprotected.

*"Infants whose mothers were born after 1963 had a measles attack rate of 33%, compared to 12% for infants of older mothers." Infants whose mothers were born after 1963 are more susceptible to measles than are infants of older mothers. An increasing proportion of infants born in the United States may be susceptible to measles."* [7]

For the disease of measles, we see that while the clinical case rate may have declined with vaccination, the most sensitive members of the herd are at an increased risk- *as a result of vaccination.*

Dr Peter Aaby has produced volumes of research on measles in Africa. Initially there was a belief that measles infection was associated with immune suppression and higher long-term mortality, but that belief came from vaccine research, not natural measles research.

*"The belief in persistent immune suppression was stimulated by increased mortality after high-titre measles vaccination."* [8]

Once natural measles was monitored long-term the knowledge changed. According to Aaby,

*"When measles infection is mild, clinical measles has no long-term excess mortality and may be associated with better overall survival than no clinical measles infection. Sub-clinical measles is common among immunised children and is not associated with excess mortality."* [9]

Measles is mildest when the infected person is replete with vitamins C and A. The devastation and mortality you hear about with measles comes from starving populations.

Do you know that 30% of cases of measles in unvaccinated are missed because they are so mild?[10] Subclinical measles is an entity that most doctors today are unaware of. If they are missed in unvaccinated, and there are known outbreaks of measles in 100 percent vaccinated populations, are cases missed in vaccinated populations too? Is measles still alive and well but going unnoticed in vaccinated countries, until a well-publicized outbreak occurs, as vaccine necessity is being trumpeted? What doctor would know or is even looking for atypical measles?

Talk to your grandmother about measles. Ask her if she saw death and destruction from the disease. It was not a disease that needed eradication. The high death rates were in countries where children were undernourished and lacked vitamins necessary to process the virus. Alexander Langmuir, MD is known today as "the father of infectious disease epidemiology." In 1949 he created the epidemiology section of what is now known as the CDC. He also headed the Polio Surveillance Unit that was started in 1955 after the polio vaccine misadventures. Dr Langmuir knew that measles was not a disease that needed eradication when he said:

*"To those who ask me, 'Why do you wish to eradicate measles?,' I reply with the same answer that Hillary used when asked why he wished to climb Mt. Everest. He said, 'Because it is there.' To this may be added, ". and it can be done."* [11]

Langmuir also knew that by the time vaccination was developed, measles mortality in the USA had already declined to minimal levels when he described measles as a

*"... self-limiting infection of short duration, moderate severity, and low fatality..."* [12]

The vaccine was created because it could be done, not because we needed it. Measles is not eradicated. Outbreaks happen all over the world, and will continue. And now infants will be unprotected because of the absence of maternal antibodies in their vaccinated mother's milk. So much for protecting the most vulnerable in the herd.

### Smallpox

*"We were fortunate enough to address their own medical (and) health officials where we reminded them of the incidence of smallpox in formerly "immunized" Filipinos. We invited them to consult their own medical records and asked them to correct us if our own facts and figures disagreed. No such correction has been forthcoming, and we can only conclude that between 1918-1919 there were 112,549 cases of smallpox notified, with 60,855 deaths. Systematic (mass) vaccination started in 1905, and since its introduction case mortality increased alarmingly. Their own records comment that "The mortality is hardly explainable."*—Dr.

Archie Kalokerinos from

Second Thoughts on Disease

Orthopox is a member of the family of Poxviridae. The ancestor of the poxviruses is not known but structural studies suggest it may have been an adenovirus or a species related to both the poxviruses and the adenoviruses. Orthopox viruses include cowpox(vaccinia), smallpox(variola), and monkeypox. Mutations do occur in these viruses, but at a very slow rate.

Between October 1970 and May 1971 a poxvirus was isolated from some symptomatic patients in West Africa. That virus is now known as "human monkeypox." Monkeypox got its name because monkeys were the first animals known to have harbored the monkeypox virus. Scientists now say that the primary reservoirs for monkeypox virus are not monkeys but probably squirrels. WHO officials in 1976 had no idea what the true reservoir of infection was.[13] Today, according to CDC, it remains uncertain.

Smallpox was declared eradicated worldwide by the World Health Assembly on May 8,th 1980. Vaccination was stopped in the USA in 1972. However, poxviruses that were indistinguishable from smallpox continued to cause human disease.

Monkeys in surrounding areas where monkeypox outbreaks occur usually test negative for monkeypox. But prairie dogs, exotic rodents, Gambian rats, dormice, rope squirrels and other animals have tested positive. Nobody really knows when or where monkeypox viruses originated, but they seem to be close relatives of cowpox and smallpox. All three viruses have rodent reservoirs, which is important when considering the history and current transmission of smallpox and monkeypox. Today, monkeypox outbreaks are blamed on rodents or exotic pet imports, not person-to - person transmission even though human transmission does occur. Historically, smallpox reservoirs were also rodents – during a time when rodents were eaten as food and when infestations were commonplace. Yet in the discussion of smallpox outbreaks this is rarely mentioned. What we hear is how the vaccine eradicated the disease.

**THIS ARTICLE** states that monkeypox was first recorded in 1970 after the eradication of smallpox in the Democratic Republic of Congo. University of California, School of Public Health epidemiologist Dr Anne Rimoin states that monkeypox first arrived in humans after smallpox eradication, even though it has been on the earth for millennia.

*"Monkeypox has probably occurred for millennia in central Africa, but it's only since the eradication of smallpox that it's been a disease that actually happens in humans," Rimoin says. "*

There is absolutely zero certainty as to when monkeypox first colonized humans. It is more accurate to say that monkeypox was first detected in humans around the time that smallpox was being declared eradicated, not that it arrived in humans at that time. Differentiation tests were not carried out on most cases of pox in the past 200 years.

Laboratory diagnostic assays for monkeypox include virus isolation and electron microscopy, ELISA, immunofluorescent antibody assay, histopathologic analysis, and Polymerase Chain Reaction (PCR). Unfortunately, most of these methods are relatively nonspecific and are unable to differentiate monkeypox viral infection from

infection with other poxviruses.[14] All but PCR are fraught with false positives, false negatives, and cross reactivity.

In the 1970s and 1980s, biochemical tests were unreliable in differentiating between monkeypox and smallpox. Animal challenge tests were historically used to determine the difference between monkeypox and smallpox. The technique involved inoculating rabbits and watching the characteristics of the pox. Initially the two kinds of pox appear similar in the rabbit, but after a few days, monkeypox distinguishes itself as it becomes hemorrhagic. [LINK TO DOC HERE](#).

The problem with such means for distinction is that there has always been a hemorrhagic form of smallpox.

*"There are four types of variola major smallpox: ordinary; modified; flat; and hemorrhagic.... Hemorrhagic smallpox has a much shorter incubation period and is likely not to be initially recognized as smallpox when presenting to medical care. Smallpox vaccination also does not provide much protection, if any, against hemorrhagic smallpox."*[15]

ELISA is not much of a gold standard test as it casts a very wide net, and is fraught with *false positive and false negative results*.[\[16\]](#) [ELISA TUTORIAL HERE](#).

The genomes of these three orthopox viruses are extremely conserved and require a technology that can detect the minute differences. Polymerase Chain Reaction (PCR) is a newer test that came on the scene in the 1980s. This test is different in that it can potentially find pieces of DNA from a virus. The genetic sequence of a virus has to first be mapped prior to designing a PCR test. So before smallpox, cowpox, or monkeypox viruses were characterized genetically, PCR could not be applied to distinguish between them. The first PCR test for monkeypox was used in 1997, but highly sensitive real-time PCR was not in use until 2006.[\[17\]](#) Different biotech companies have developed different tests that use different primers. PCR, while highly sensitive and specific at about 98%, still has drawbacks, contamination being the biggest one. No test is foolproof. Nonetheless it is probably the best assay available for detection and distinction today.

It should now be obvious that during the two centuries of smallpox vaccination and up until the 1990s there was no certain way of testing for distinct orthopox viruses. During the two centuries of vaccination, the viruses were likely to mutate, and certain strains could have been selected out as a result of vaccination.

Therefore, does anyone know how much 'smallpox' disease was actually monkeypox or vaccinia? Given that monkeypox is thought to be an ancient virus, where was it during the smallpox epidemics? Was it called hemorrhagic smallpox?

In 1972, scientists were asking similar questions when they said:

*"Is it possible that there is an animal reservoir for smallpox infection? Could monkeypox be a source of new outbreaks of true variola? Or, can the monkeypox virus undergo certain mutations and become identical in its pathogenicity and infectiveness to the variola virus?"*[\[18\]](#)

ACCORDING TO **SCIENTIFIC AMERICAN**., monkeypox is not that rare. Seven hundred and sixty cases of monkeypox were counted in the Congo between 2006 and 2007.

Before and during the time of eradication declaration, PCR was unavailable, and the different poxviruses couldn't be distinguished by their DNA, but by a skin test on rabbits, chick embryo membranes, and blood tests that were fraught with uncertainty. It seems to me that what was once called smallpox was likely a very non-uniform disease that could have been anything from cowpox to two forms of smallpox to chickenpox to monkeypox.

*"Monkeypox virus is closely related to some other orthopoxviruses such as variola (smallpox) virus, and it cannot be distinguished from these viruses in some laboratory tests....In 1996-1997, an outbreak [of monkeypox] in the DRC continued for more than a year, with a person-to-person transmission rate estimated at 78%. However, epidemiological evidence suggests that many of the cases in this outbreak may have been chickenpox (varicella); the number of monkeypox cases and the transmission rate might have been overestimated due to self-reporting and the unavailability of laboratory testing."*[\[19\]](#)

When vaccination stopped, monkeypox was suddenly diagnosed in humans. Diagnostic methods were absent during the great vaccine campaigns and everything pox-like was considered smallpox and counted as smallpox. Differentiating was not a priority.

Variola, the smallpox virus, is not in the smallpox vaccine. Instead, a cultured form of cowpox, called vaccinia, is the virus used to prevent smallpox. That same vaccine also covers monkeypox, according to the CDC:

*"Because the monkeypox virus is related to the virus that causes smallpox, the smallpox vaccine can protect people from getting monkeypox as well as smallpox."*

*Smallpox vaccine is effective at protecting people against monkeypox when it is given before they are exposed to monkeypox. (Exposure includes very close contact with a person or animal that has monkeypox.) Experts believe that vaccination after exposure to monkeypox may help prevent the disease or make it less severe."*



[20]

Even though PCR can distinguish between the three viruses, clinically and immunologically the viruses are so similar, that one virus in the vaccine is thought to immunize against the two other viruses. During outbreaks they all look the same.

After the world trade center collapses in New York there were concerns over potential bioterrorism. Forty thousand health care workers and first responders and 450 thousand military were vaccinated in 2003. They were all contagious for the nineteen-day post-vaccine shedding period. Some doctors were asked to receive the vaccine in order to care for those who took the vaccine and developed vaccinia, or to care for those who became infected upon contact with a recently vaccinated person.

Multi-state outbreaks of monkeypox were reported in the same year.[21] Most cases are presumed to have come from contact with prairie dogs exposed to rodents per CDC. However all cases were not exposed to animals.

**ACCORDING TO A 2005 REPORT**, of 72 cases only 37 cases were laboratory confirmed. Eleven original cases were thrown out of the database when they met exclusion criteria. **EXCLUSION CRITERIA.** There is mention of human to human infection, though in some reports this is denied.

This is a very strange coincidence; vaccination and concomitant pox outbreaks in the same year. Supposedly, monkeypox is not easily transmissible between humans, but there is a report in the literature of a 5 chain human-to - human transmission, and human-to-human monkeypox transmission is well documented.[22] **A NEW ENGLAND JOURNAL OF MEDICINE REPORT** vaguely stated that *“There was ‘limited or no’ spread of monkeypox virus through human contact during this outbreak.”*

In 2003, the year that half a million people were vaccinated in the USA – AND the only year of monkeypox outbreaks in the USA, a multistate (Illinois, Indiana, Kansas, Missouri, Ohio, and Wisconsin) outbreak, was the source of the outbreak definitely prairie dogs? CDC doesn't state how many pox cases were exposed to prairie dogs, just “the majority of them had direct or close contact.” The vagueness of CDC's reports gives rise to doubts. Only 37 of 72 cases were confirmed with PCR tests, and eleven of the original total were excluded from analysis. Excluding numerous cases on frivolous grounds is one way to dampen a negative outcome after a vaccine accident.

Considering the link with vaccination is not far-fetched especially given that CDC reports say that only roughly half of cases were PCR confirmed. Vaccination has long been a relatively common means of transmitting pox outbreaks. According to Arita and Gromyko's WHO bulletin in 1982, vaccination was a major fly in the eradication ointment...

*“During the last 24 months, for example, surveillance reports from Canada and the United Kingdom have included 6 and 9 cases, respectively, of vaccine complications. At least 8 cases, however, were in persons who, while not vaccinated themselves, had been infected with vaccinia virus after being in contact with persons recently vaccinated. In some countries vaccination of recruits to the armed services has continued; these recruits will occasionally transmit vaccinia infection to unvaccinated persons, and inevitably some of the complications will be fatal. In the United Kingdom and Finland, smallpox vaccination of army recruits was discontinued in 1981.” [23]*

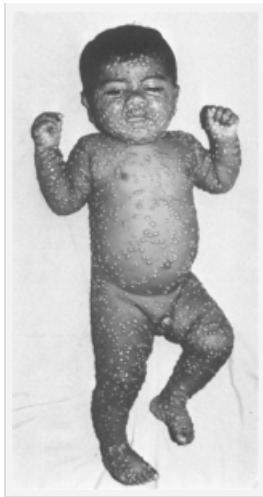
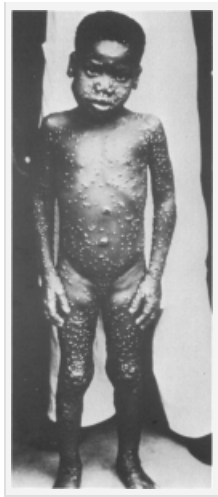
Without discontinuing vaccination, it would have been impossible to stop the flow of smallpox. Doesn't that lead you to wonder how much smallpox was the result of the vaccine rather than natural smallpox? We know that in places like Leicester UK, when vaccination ceased, so did smallpox. And there are numerous accounts of smallpox disease not only being much more severe and deadly among vaccinated populations, but also more prevalent.

Isn't it interesting that smallpox vaccine defies everything we know about specificity in immunity and that one vaccine covers all sorts of pox, except chicken pox? Can you imagine, nowadays, if a vaccine researcher suggested that an illness could be prevented by using a slightly related virus? Today's vaccines contain numerous strains and types of the same organism. Polio vaccine has 3 types of poliovirus, influenza 2 strains of type A and one strain of type B. But smallpox vaccine today contains one of many possible strains of a related virus, not even the smallpox(variola) virus at all. In Jenner's time, it is anyone's guess which viruses ended up in the vaccines since the technique was so primitive and typing methods were not available. Still, these vaccinia vaccines are thought to have eradicated smallpox, and serve as the foundation for vaccine faith.

Scientists back in the 1800s and early to mid 1900s had no way to differentiate smallpox, cowpox, monkeypox or most other pox diseases in humans. Nor was there any effort to differentiate, until the disease was declared eradicated – just like when polio was eradicated. Anything that looked like polio, but not caused by a polio virus, was called acute flaccid paralysis.

Monkeypox and smallpox look identical on physical examination. Have a look at these two photos:

You probably can't tell the difference between the two diseases, and neither can most doctors. Edward Jenner and the doctors of the 1800s and 1900s were also unable to distinguish smallpox – major and minor,



monkeypox, or cowpox, or even chickenpox.

*“When [monkeypox]infection in human beings does occur, it can be clinically indistinguishable from smallpox, chickenpox, and other causes of a vesiculopustular rash.”*

[23A]

It is now known that many cases of smallpox were mild. These are termed variola minor as the mortality is only about one percent. Variola major and variola minor are indistinguishable using the sensitive PCR test. In order to distinguish the variants, because they are nearly identical, an ultra-sensitive, highly technical real time

PCR test using MGB-Eclipse probe chemistry had to be designed. Note that these tests were designed using laboratory stored smallpox virus, not natural virus. Scientists have to go to great lengths in order to make a genetic distinction between these two variants because they are so very similar. So the question that begs an answer is, are these viruses really that different? Distinction is ridiculously laborious and such splitting hairs is fraught with potential errors. Loveless[24] et al. describe the tedious process of distinction and the pitfalls of the assay in their paper. **Other researchers** note that about one-third of the variola minor viral proteins are 100% identical to correlates in the variola major strains and the remainder were  $\geq 95\%$  identical.

Do you think your doctor would know a case of variola minor if he/she saw it? Or would it just be called chicken pox? Do you think your doctor would even think that it could be smallpox, given that smallpox is thought to be eradicated? There are clinical means to distinguish the difference, but few doctors think of it, and in the minor forms of smallpox it wouldn't matter anyway.

Many believe that smallpox was eradicated from the planet because of vaccination. I once believed this idea that was taught to me in medical school, and that all conventional doctors parrot as if they understood the history. With just a little research it becomes evident that even though smallpox seems to have disappeared, this was not the result of mass vaccination.

It is obvious that the vaccines of 1796-1900s were not purified or uniform, yet they serve as the foundation for successful vaccination. They were made on farms from scrapings of infected cow bellies, coarsely filtered, and mixed in glycerine. While today's vaccine product may be more meticulously manufactured, the CDC admits that the science behind even modern smallpox recommendations has been little more than a guess.

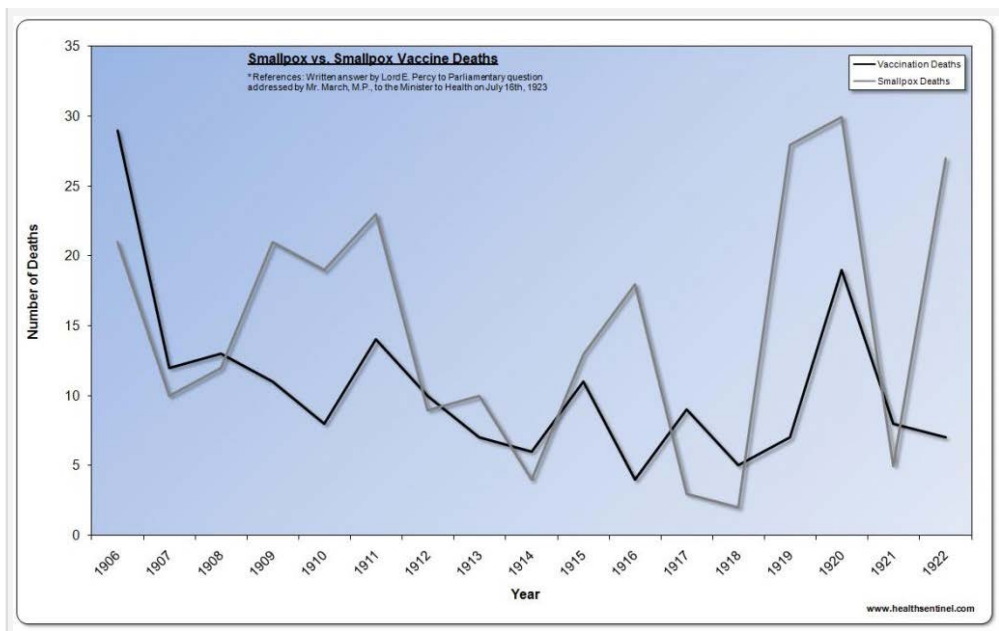
*“...data on duration of protection and recommendations on periodicity of vaccinations are limited and based to a large extent on historic precedent and expert opinion used to develop previous ACIP recommendations for smallpox vaccination for laboratory workers using orthopoxviruses.” [25]*

And CDC has no idea what antibody titer is protective.

*“The levels of antibody reported by these tests indicate only exposure, and the protective antibody titer against smallpox infection is unknown.” [26]*

They surmise that the vaccine provides high-level immunity for 3-5 years.

Here is a graph of smallpox vaccination deaths and smallpox disease deaths, from England spanning the years of 1906-1922.



The vaccine-associated deaths are conspicuously high, at about half the rate of smallpox deaths.

Dr. Charles T. Pearce in his 1868 essay on vaccination wrote:

*"It is a remarkable fact that Jenner's [the inventor of smallpox vaccine] first child, his eldest son, on whom he experimented, died subsequently of consumption [tuberculosis]. Another of his subjects, the man Phipps, whom Jenner vaccinated, also died of consumption."*

Those who were vaccinated for smallpox were noted to be more severely affected by smallpox and tuberculosis. Many were exposed to tuberculosis from tuberculous animals that were used to make vaccines. [CLICK HERE TO LINK TO "SMALLPOX AND THE FIRST VACCINE" CHAPTER FROM OUR UPCOMING BOOK.](#)

Smallpox manifested in several different forms (ordinary, modified, malignant, hemorrhagic). Genetically the minor and major forms of variola are related and indistinguishable by PCR. Individual susceptibility, rather than the virus probably made the biggest difference. Susceptibility would have certainly increased after injection of filthy vaccines that contained myriad bacteria and viruses.

What is most likely is that the appearance and disappearance of epidemics had much to do with the constitution and care of the population of the times. Scurvy was common in areas with hemorrhagic smallpox. This is no surprise to anyone who understands the full spectrum of ascorbic acid's function in the body, especially on blood vessels.

Pox epidemics declined as a result of sanitation and improved nutrition. During the era of smallpox most people were living in squalor, eating no fresh food, but rotten milk and rotten meat, drinking sewer water, living among filthy rodents, and working long hours for little pay. Pox viruses are ancient, but smallpox evolved as a deadly killer as humanity devolved to overcrowded city dwellers living with filth, squalor, and desperation.

Historical evidence points to the fact that the vaccinated were amongst the sickest in times of smallpox vaccines. Protests against the vaccinators and smallpox vaccination were massive.[27] Parents commonly chose jail rather than permit their newborn babies to be vaccinated. Entire towns and districts revolted before the disease was finally declared eradicated, and the vaccine madness ended.

Smallpox vaccination ended in the 1980s because smallpox had declined and because there was so much trouble with the old unsafe vaccine. That same trouble with the newer supposedly more safe smallpox vaccines is why smallpox vaccination ended after the 2003 first responder effort. Which makes you wonder just how much more trouble there was with the old smallpox vaccine which had a very long list of known bacterial and other "contaminants" because of its method of production. After the 2003 vaccines, reports of generalized vaccinia, autoinoculation, erythema multiforme, myopericarditis, ocular vaccinia, and postvaccinal encephalitis were reported.

Smallpox was declared eradicated before clear distinctions between different poxviruses were made using DNA analysis. Symptoms alone are what were counted for smallpox during smallpox epidemics. Vaccination was a major source of smallpox outbreaks, and only a small portion of the earth's entire herd was ever even vaccinated. Considering all of this, how can anyone believe that smallpox was eradicated with a vaccine?

With every vaccine suppressible disease, the general hysteria level usually depends on the availability of a vaccine. Once a vaccine was available, the disease was suddenly made out to be more problematic. Look how dangerous chicken pox became after the vaccine was developed.



Pertussis is now hot news and the unvaccinated interrupting herd immunity is raised over and over, despite the science that shows the vaccinated are by far and away the most affected by whooping cough.

*"Our unvaccinated and under-vaccinated population did not appear to contribute significantly to the increased rate of clinical pertussis. Surprisingly, the highest incidence of disease was among previously vaccinated children in the eight to twelve year age group."* [28]

This is the most recent, but not the first study to demonstrate 86% of cases of proven whooping cough are in the vaccinated. How can getting even 100% vaccination uptake create an immune herd with such vaccines?

Mumps vaccine was known to be ineffective after two major outbreaks in vaccinated populations in the USA. Yet the solution was to double the boosters in children with a vaccine that is now ALLEGED by two former Merck scientists, to have been known to be ineffective by Merck's executives.

Jenner's initial promise was "We have a vaccine that will protect you for life with one injection." But even he was revaccinating his patients yearly, within 5 years of making that statement. And when that doesn't pan out with whooping cough, measles, mumps and whatever, the authorities say,, "We have a highly effective vaccine if it is given on time with boosters," then "This is an excellent vaccine when 3 or 4 boosters are given, and adults are revaccinated." Or in the case of whooping cough, introducing an all-together new vaccine. There is a new nasal vaccine in the pipeline for newborns, which will be given alongside the already ineffective whooping cough vaccine series in childhood. This will no doubt be touted as a wonderful combination.

Eradication target dates are constantly moved forward, and the unvaccinated or the vaccine refusers are blamed for all outbreaks. Or in the case of Pakistan, they are branded **TERRORISTS** or **RELIGIOUS FANATICS** for not wanting their children to have 30 oral polio vaccines by age 5. I have outlined in a **PREVIOUS BLOG**, just what is really going on in India and how her people are being terrorized by WHO and CDC as the rate of paralysis continues to skyrocket.

I believe that when diseases disappear from sight, the disappearance is never solely by virtue of the vaccine. Yet the vaccine always gets the credit, because the blind faith in vaccines is prioritized over the scientific evidence. Evidence to the contrary of the value of vaccination is consistently snuffed out and kept away from the mainstream media, so that the herd never hears a peep of the truth. Instead, they get the "herd immunity" sound bite, which gives undeserved credit to the risk-benefit ratio of vaccination. Inside the web of half-truths and misinformation, the vaccine religion somehow justifies the public display of resentment and fear of the unvaccinated.



To read more of Dr Humphries' writing on vaccines, see her new book *"Dissolving Illusions: Disease, Vaccines and the Forgotten History"* available through amazon. Website is **HERE**.

~END

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