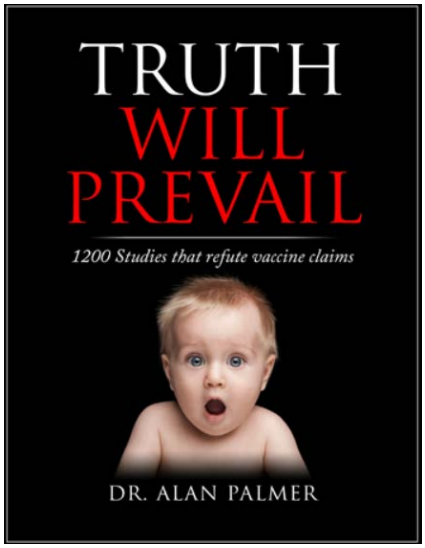
1200 Studies Update Newsletter December 1st, 2020



Welcome to *Issue 7* of the 1200 Studies Update Newsletter where the truth often flows against the mainstream narrative.

This month's issue contains updates on the stats, the data and the science of the many facets of the COVID-19 pandemic, including the direct and indirect consequences of the disease and the decisions that have been made along the way.

Links to major topics in this edition (titles are interactive links):

- Worse than lockdowns not saving lives, evidence is streaming in that they are killing millions worldwide
- Children in developed countries face many pandemic related hardships, but in third-world countries it is a matter of life and death
- Johns Hopkins Newsletter article if true, blows the lid off of the COVID-19 death number narrative and circles back to the change in death certification
- New study shows that up to 25% of people may be immune to SARS-CoV-2 without ever being infected by it
- What level of population immunity will it require with SARS-CoV-2?
- Another study puts effectiveness of wearing face masks into question
- As L.A. County imposes the toughest restrictions to date, let's look at how well these types of restrictions have worked previously
- Age as a risk factor for COVID-19- What is your true risk?
- One of the world's top epidemiologists from Stanford releases a new study showing that COVID-19 mortality reporting is greatly over-exaggerated
- Chronic metabolic disease increases risk of severity significantly from COVID-19
- COVID-19 vaccine update
- Legal updates- and more on the COVID-19 vaccines
- My featured article of the month- **Critical Information for those considering the flu vaccine- Part 2**
- Nutrient of the month- **My daily Immune/Detox Tonic**
- New PubMed articles of the month

COVID-19 trends in the U.S. as of November 30th, 2020

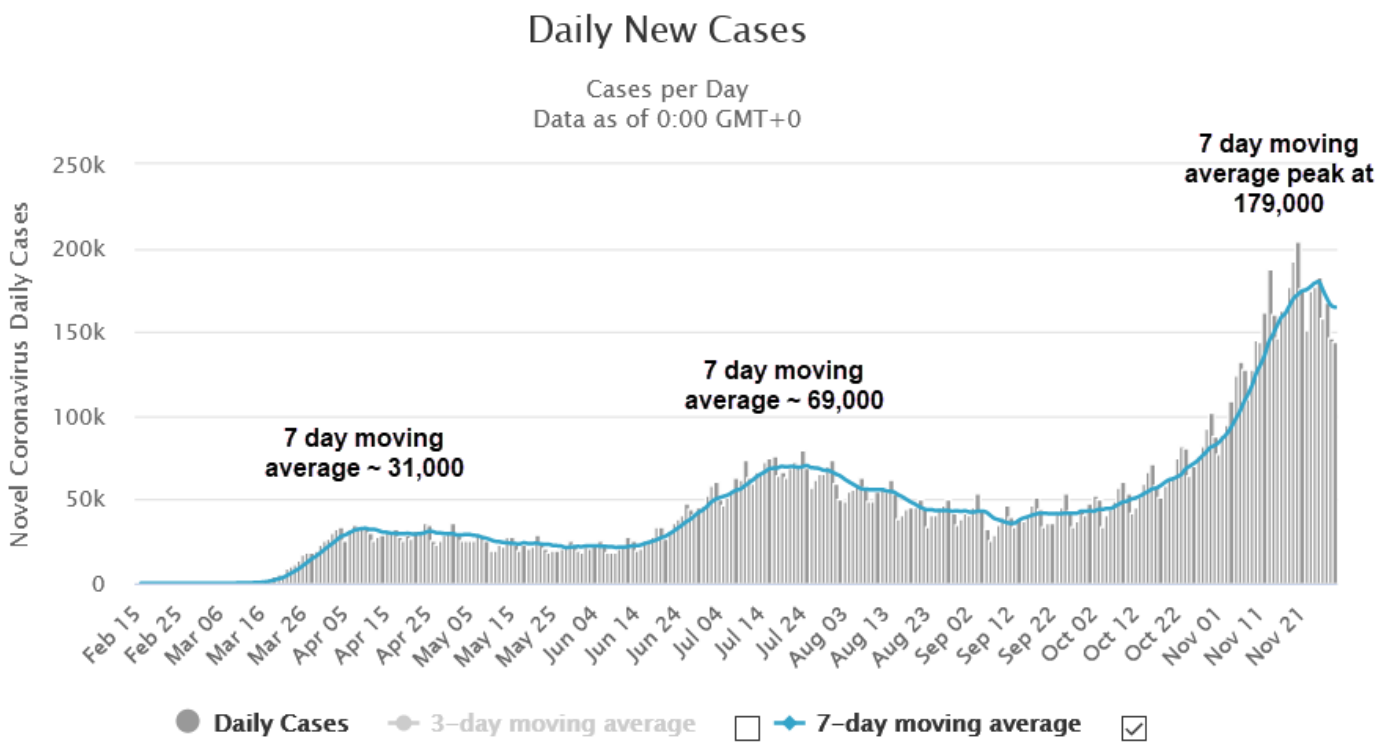
Testing and cases-

Reminder on the nuances of testing:

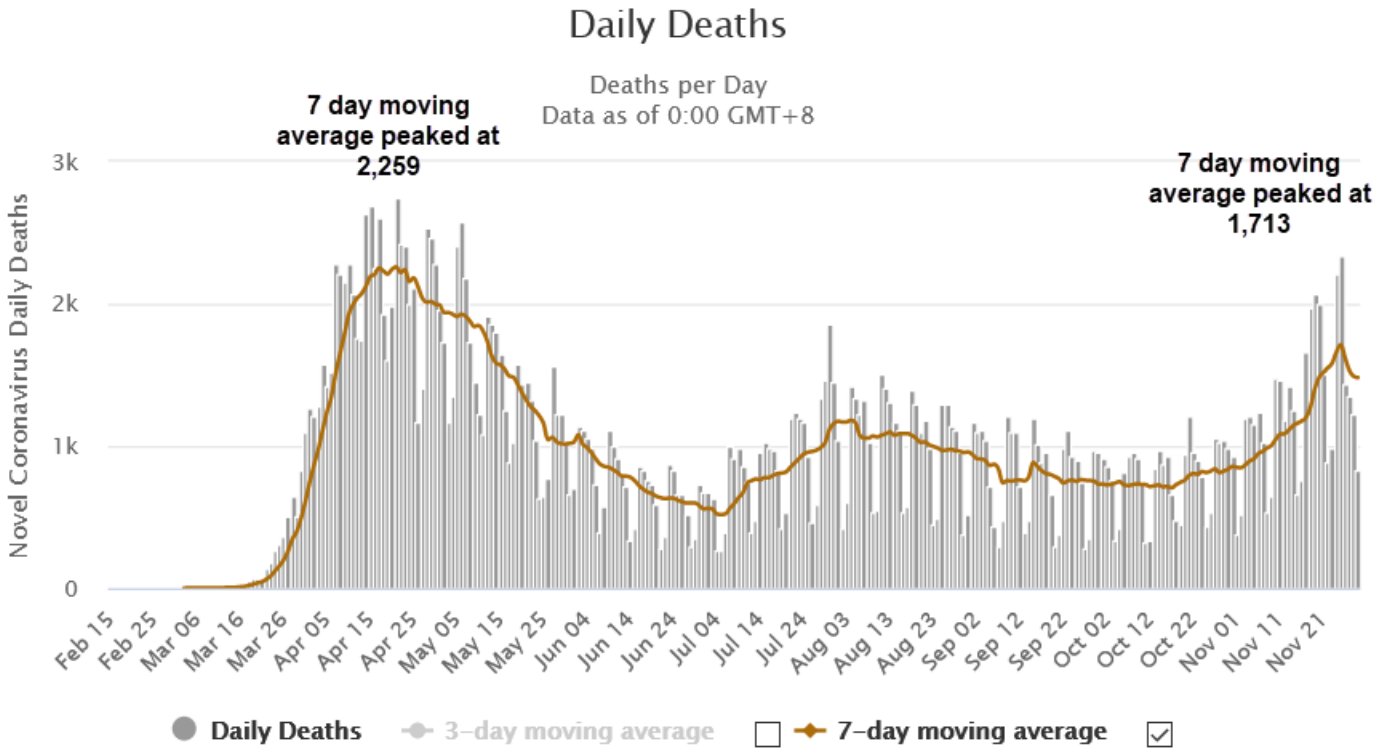
As you consider the case totals, bear in mind that new cases are only discovered through testing. More testing = more "known" cases or infections as I will explain in a minute. If we stopped testing tomorrow and as a result "new cases" went to zero, would that mean that there are no more new people infected? Of course not. So, while it a metric that is driving public fear and policy decisions affecting all Americans, it is in no way the most important metric. When compared to the percentage of tests that are positive, it becomes more meaningful. This is not to mention that the reporting is fraught with inaccuracies as discovered recently, including some people being tested multiple times and each test being counted as a new test or new positive, as well as significant rates of false positives and false negatives. We are even hearing of people that were never tested being called and informed that they tested positive! And, despite the numbers that are discovered, the numbers of people that have been infected, been asymptomatic or had mild symptoms and never tested, are many multiples of the known positive case numbers.

See graphs on the next page… I positioned them together for easier comparison.

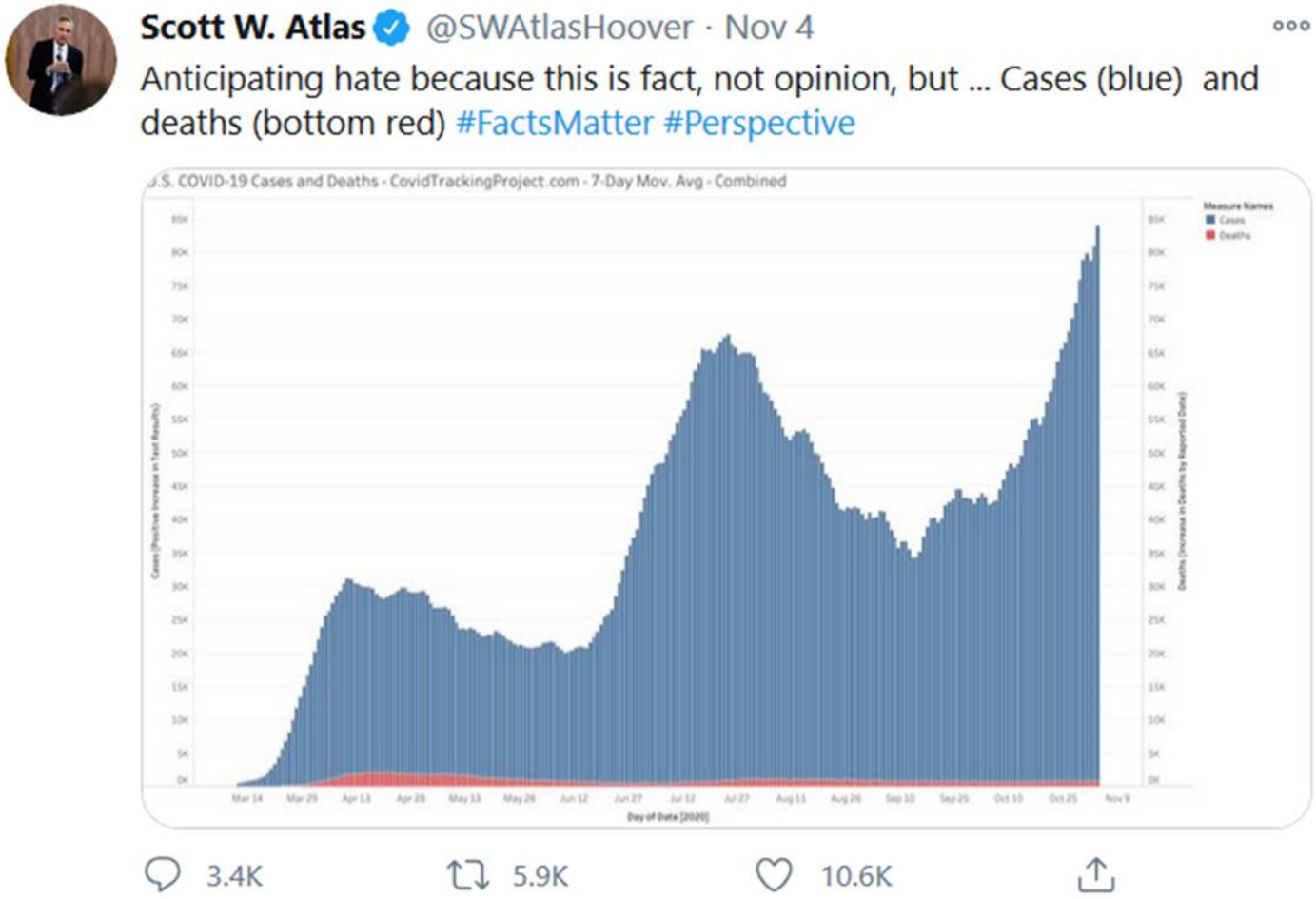
Daily New Cases- as of November 30th



AS CAN BE SEEN, THE AVERAGE DAILY CASES ARE 6X HIGHER THAN APRIL, BUT THE DEATHS ARE AT 75%



Despite record high cases, death rates are a small fraction of levels in April

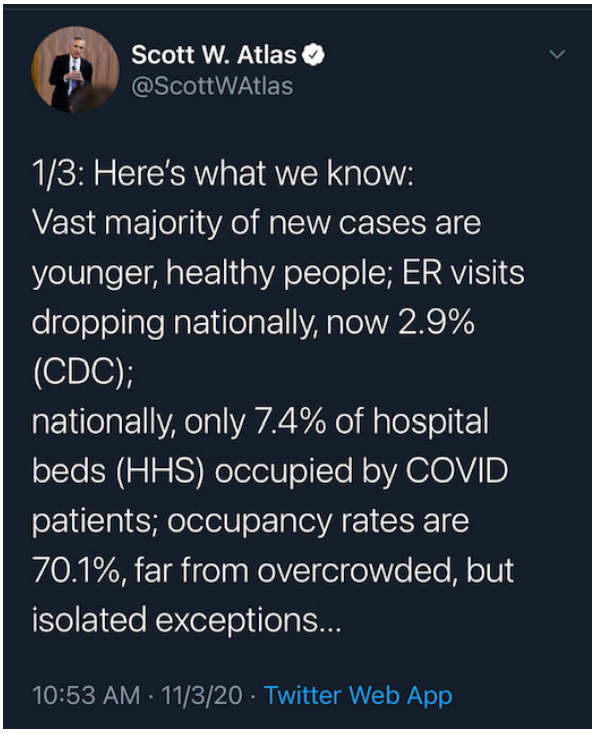


As can be seen clearly in this graphic, despite cases peaking (blue) at the highest rates since the pandemic deaths (red) are remaining relatively flat, especially in comparison to the northern states in late March to early May and the southern states mid-summer.

Think about the mainstream media and public health messaging as cases spike. Their message is, “cases are spiking, sound the alarm, hunker down, wear your masks and stay indoors”. Is it possible that as we march toward population/community/herd immunity, we are seeing the mortality rates flatten? This is very good news indeed!

Cases and hospital capacity

A November 3rd Tweet seen below by Dr. Scott Atlas, one of the President’s Coronavirus Task Force members gave additional encouragement when he said the following: (next page)



He went on to say that they hospitals are now well supplied with PPE, better infection control, better protection of seniors, mortality rate down 85% since April… These are all great developments that should also alleviate excess fear.

An article posted October 26th confirms the great news about falling death rates

An NPR article titled **Studies Point To Big Drop In COVID-19 Death Rates**, cites several reasons for the falling mortality rates.

Highlights from the article:

Two new peer-reviewed studies are showing a sharp drop in mortality among hospitalized COVID-19 patients. The drop is seen in all groups, including older patients and those with underlying conditions, suggesting that physicians are getting better at helping patients survive their illness.

"We find that the death rate has gone down substantially," says Leora Horwitz, a doctor who studies population health at New York University's Grossman School of Medicine and an author on one of the studies, which looked at thousands of patients from March to August.

The study, which was of a single health system, finds that mortality has dropped among **hospitalized** patients by 18 percentage points since the pandemic began. Patients in the study had a 25.6% chance of dying at the start of the pandemic; they now have a 7.6% chance.

"The people who are getting hospitalized now tend to be much younger, tend to have fewer other diseases and tend to be less frail than people who were hospitalized in the early days of the epidemic," Horwitz says.

So have death rates dropped because of improvements in treatments? Or is it because of the change in who's getting sick?

To find out, Horwitz and her colleagues looked at more than 5,000 hospitalizations in the NYU Langone Health system between March and August. They adjusted for factors including age and other diseases, such as diabetes, to rule out the possibility that the numbers had dropped only because younger, healthier people were getting diagnosed. They found that death rates dropped for all groups, even older patients by 18 percentage points on average. The research, an earlier version of which was shared online as a preprint in August, appears in the *Journal of Hospital Medicine*.

"I would classify this as a silver lining to what has been quite a hard time for many people," says Bilal Mateen, a data science fellow at the Alan Turing Institute in the United Kingdom. He has conducted his own research of 21,000 hospitalized cases in England, which also found a similarly sharp drop in the death rate. The work, which will soon appear in the journal *Critical Care Medicine* and was released earlier in preprint, shows an unadjusted drop in death rates among hospitalized patients of around 20 percentage points since the worst days of the pandemic.

Mateen says drops are clear across ages, underlying conditions and racial groups. Although the paper does not provide adjusted mortality statistics, his rough estimates are comparable to those Horwitz and her team found in New York. "Clearly, there's been something [that's] gone on that's improved the risk of individuals who go into these settings with COVID-19," he says.

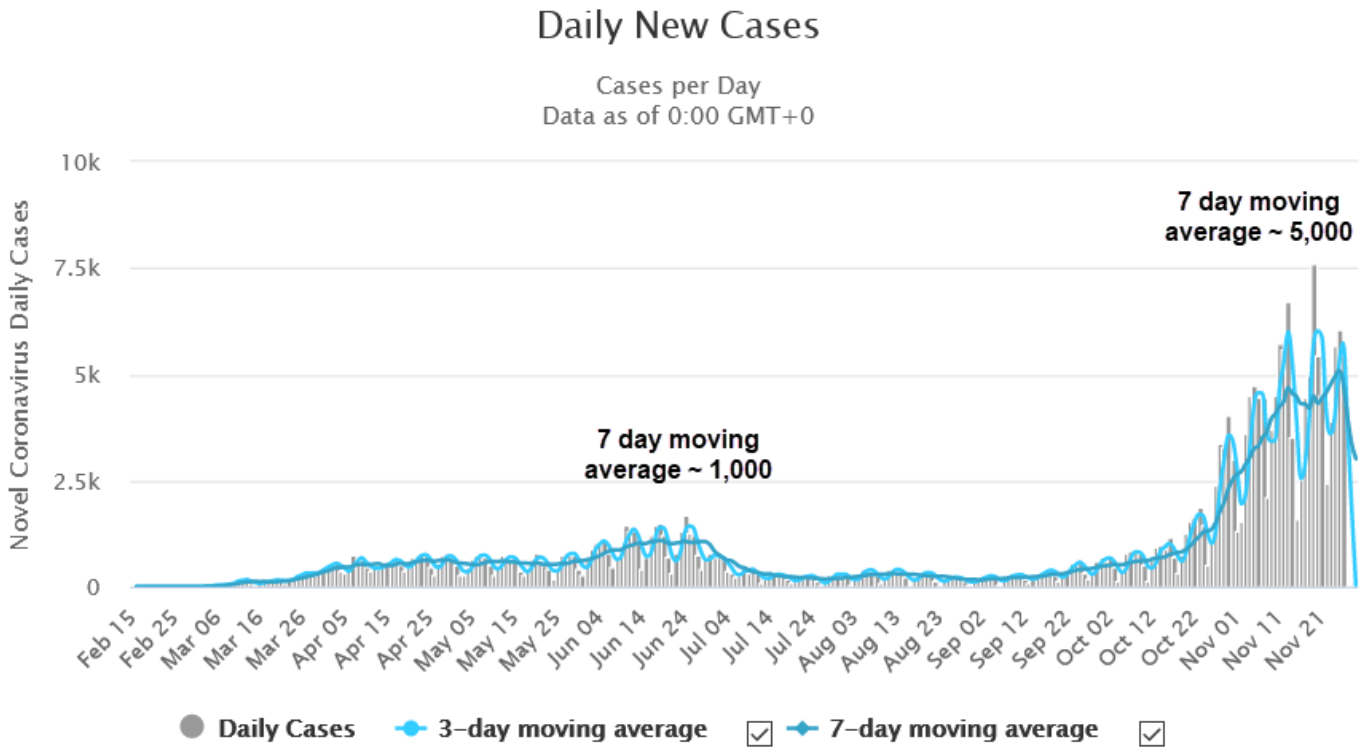
Doctors around the country say that they're doing a lot of things differently in the fight against COVID-19 and that treatment is improving. "In March and April, you got put on a breathing machine, and we asked your family if they wanted to enroll you into some different trials we were participating in, and we hoped for the best," says Khalilah Gates, a critical care pulmonologist at Northwestern Memorial Hospital in Chicago. "Six plus months into this, we kind of have a rhythm, and so it has become an everyday standard patient for us at this point in time."

Doctors have gotten better at quickly recognizing when COVID-19 patients are at risk of experiencing blood clots or debilitating "cytokine storms," where the body's immune system turns on itself, says Amesh Adalja, an infectious disease, critical care and emergency medicine physician who works at the Johns Hopkins Center for Health Security. He says that doctors have developed standardized treatments that have been promulgated by groups such as the Infectious Diseases Society of America.

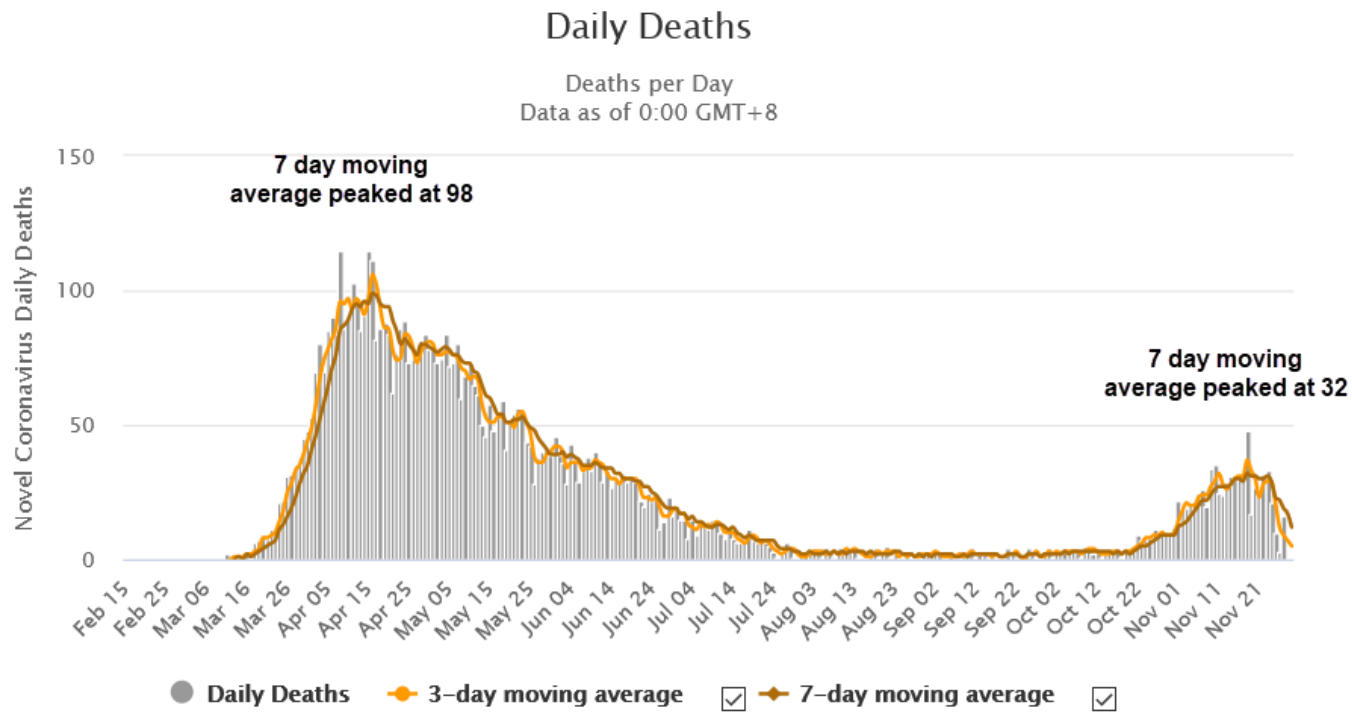
And Mateen says that his data strongly suggest that keeping hospitals below their maximum capacity also helps to increase survival rates. When cases surge and hospitals fill up, "staff are stretched, mistakes are made, it's no one's fault — it's that the system isn't built to operate near 100%," he says.

End of excerpts

Sweden update as of November 30th



AS CAN BE SEEN, THE AVERAGE DAILY CASES ARE 5X HIGHER THAN APRIL, BUT THE DEATHS ARE ONLY 1/3



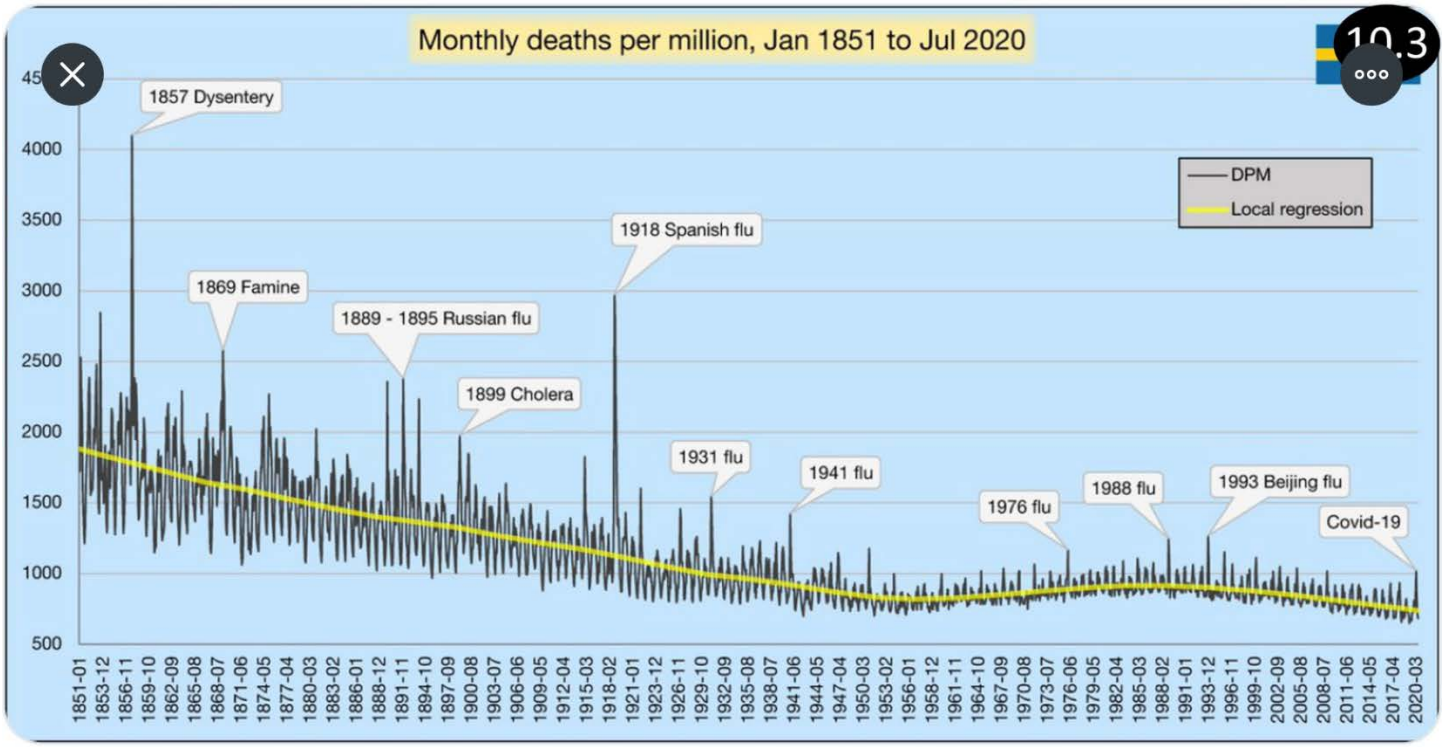
On November 30th, there were 5,464 new cases & only 10 deaths.

For those new to my newsletter and haven't been following it, Sweden is the one country in the world that did things differently. They never locked down. They never required or even suggested their citizens wear face masks. They never closed restaurants, bars, gyms, schools or other businesses. Their economy has flourished. Their people are not suffering from higher than usual percentages of mental health issues, alcohol and drug use, suicide, domestic violence and other collateral damage. They have avoided deaths of despair that countries using lockdowns and business closures are experiencing. They have essentially asked their citizens to social distance whenever possible and follow good hygiene practices.

They made the same mistakes as virtually every other country by not doing enough to protect their elderly in nursing homes and long-term care facilities. That is where a large percentage of their deaths came from early on and you can see that represented by the peak in deaths on the graph on the previous page. But other than that, it is pretty much been the textbook playbook that the authors of The Great Barrington Declaration are pushing for (more about that next). Obviously, they have and are continuing to do something right. This is exactly why I wish we would get the myopic focus off cases and look at hospitalizations, ICU capacity and deaths. Why should we really care how many cases there are if they aren't causing hospitalizations or deaths?

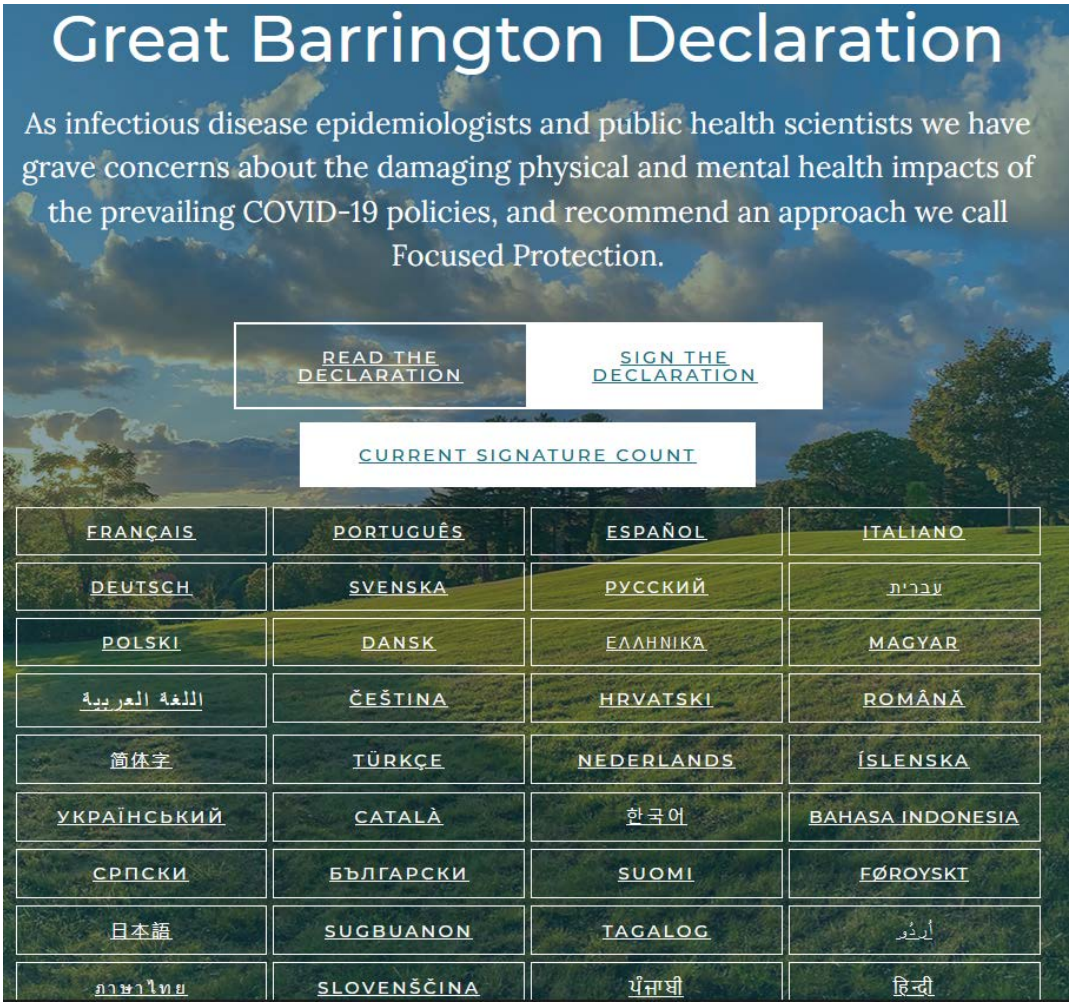
So, how do COVID-19 deaths per million compare to past epidemics in Sweden?

This graph really puts things into perspective when comparing the lethality of COVID-19 with other previous infectious diseases. Look at the COVID-19 deaths per million spike on the far right compared to other infectious disease outbreaks over the last 150 years.



Sign the Great Barrington Declaration

Scientists, researchers, infectious disease experts, virologists, immunologists, epidemiologists, economists, public health experts and statisticians, medical, chiropractic, naturopathic and homeopathic doctors and hundreds of thousands of concerned citizens, have all signed onto the ***Great Barrington Declaration***, declaring their support to end the lockdowns and provide an exit strategy from our current state of affairs in a safe and calculated way.



I am calling on all citizens (664,395), medical and public health scientists (12,422), medical practitioners (36,711) to sign on to ***The Great Barrington Declaration***. * Current number of signatures in parentheses. Let's send a signal loud and clear that this is the way to move forward and open up societies. Not only that, but this is THE BEST and in my opinion the only model for future infectious disease outbreaks.

Learn more and sign here: https://gbdeclaration.org/

To learn about their strategy for opening society and managing the virus see the FAQ's page here: https://gbdeclaration.org/frequently-asked-questions/

The many problems with PCR testing

Labs performing PCR testing are running too many cycles resulting in false positives and a better way to do things

For context in this discussion, it is important to remember that there is a distinct difference between infection and disease.

Infection is the replication of the SARS-CoV-2 virus in the body. Infection may or may not cause symptoms (disease) in the body. A large percentage of people contracting SARS-CoV-2, never develop symptoms (COVID-19).

COVID-19 (the disease) is when the infection causes symptoms. The symptoms can range from barely noticeable, to life threatening ones.

In an interview with Michael Mina MD, PhD from the ***Centers for Communicable Diseases at Harvard University*** and a proponent of at-home rapid testing that will tell if a person is infectious with COVID-19, he presented these graphs showing the exponential increase in viral titers, quickly followed by a rapid decline as the immune system does its job. Many people remain sick (with symptoms) after the virus is disabled because of the immune system and inflammatory chain of events the virus has set in motion in the body.

Dr. Mina is a very credible expert and has a very impressive bio. He is an Assistant Professor of **Epidemiology** at ***Harvard T. H. Chan School of Public Health*** and a core member of the ***Center for Communicable Disease Dynamics (CCDD)***. He is additionally an Assistant Professor in **Immunology** and **Infectious Diseases** at HSPH and Associate Medical Director in Clinical **Microbiology** (molecular diagnostics) in the ***Department of Pathology at Brigham and Women's Hospital, Harvard Medical School***.

Dr. Mina stated that 70% of the COVID-19 PCR positive tests are in people that are no longer infectious. As you can see from the graph below, the Ct (Cycle Threshold) scale reflects the highest viral load associated with the lowest Ct numbers. Let me explain. When the lab runs the test, it runs these "cycles" to see if genetic material from the SARS-CoV-2 virus is present. With each cycle run there is amplification applied to see if the next cycle can catch any of the specific genetic code. If large amounts of virus are present, it requires fewer cycles to identify it. The more cycles run before finding evidence of the virus, the lower the viral load in the sample and less likely the person can infect others. The problem arises when cycles above 30 are run. It may pick up fragments of genetic material from SARS-CoV-2, but none of those pieces would be able to infect another person. Yet, the test comes up positive! And labs are instructed to run up to 40 cycles with these sample which gives an erroneous FALSE positive. Hence Dr. Mina's assertion that up to 70% of "positives" are people unable to transmit to others. And they are told to quarantine unnecessarily. Fortunately, Dr. Mina has a great solution that I'll discuss below.

Dr. Mina has explained in other interviews, that the people who are transmitting the disease have Ct Values that are less than 30, with the vast majority of transmitters are less than 25 on the scale. Remember, the lower the number, the higher and the more contagious the infection.

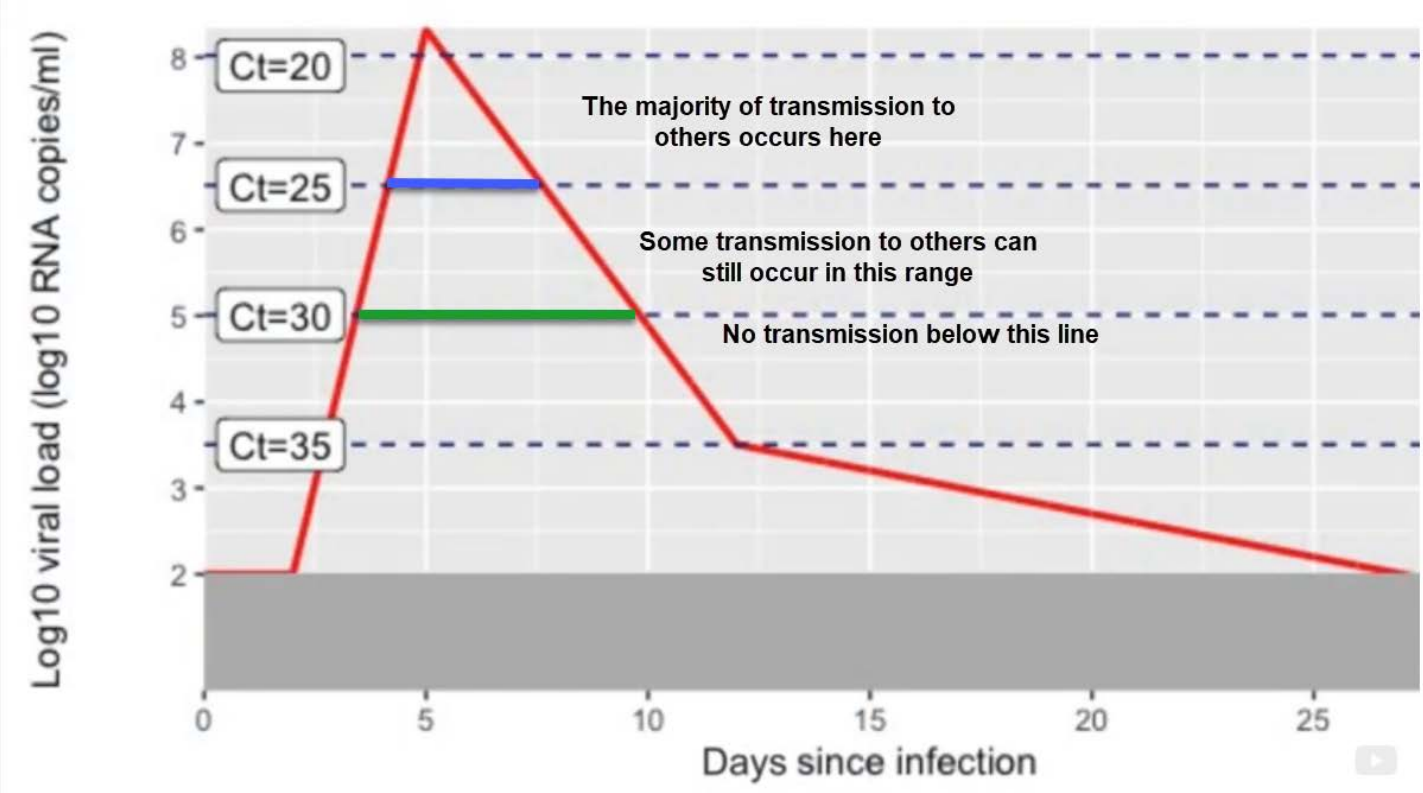
A visual representation of the viral explosion and decline

According to Dr. Mina, the vast majority of people capable of transmitting the virus to others are above the purple line.

There are a small percentage of people that are between the green and purple lines that can be transmitting, but this is the exception and not the rule.

People with levels below the green line cannot transmit the virus to others.

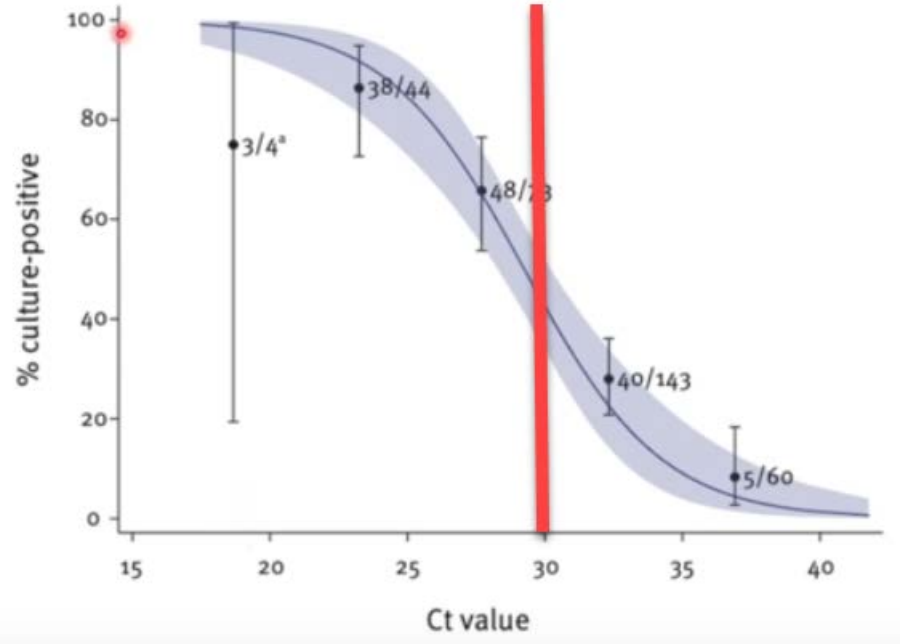
A visual look at the timeline of viral increase and decrease in the body



As you can see, the viral levels increase rapidly from about day 3 until day 5. The immune system (if working properly), gains the upper hand and the viral levels then drop precipitously.

As you will see in a few pages, people that are infected and never develop symptoms are not infecting others. Looking at the graph above, these are most likely people that if tested have viral loads below the green line. They have such strong innate immune response (natural killer cells, etc.), that their immune system prevents the exponential growth of the virus. Children are great examples. They have very robust innate immune response capabilities. That innate immune response can be optimized with a preventative strategy. That's not to say that everyone that does this will avoid symptoms. But, in doing so they stand a much better chance of experiencing a milder case. Check out the strategy I have posted on my web site for an example of such an approach **HERE**.

Another view of the concept of viral load looking at blood cultures of cases



The percentage of the culture that is positive is represented on the vertical "Y" axis. The Ct values are on the horizontal "X" axis. I've added the red bar to show where the cutoff point Dr. Mina would propose to be. Anything to the right of that line would most likely represent a non-contagious case.

Many people are being quarantined for no reason-

If someone gets a PCR test on day 6, has to wait 3-4 days to get the results and is at day 10 post infection, they are no longer able to infect others. But what is the protocol being used? They are told to quarantine for 14 days when there is NO reason for them to do that, since the only reason to quarantine an infected person is to prevent the spread to others. The same thing is true for the majority of people that test positive (and not a false positive, but that's a whole other issue that happens quite often). Again, according to Dr Mina 70% of people that test positive are not able to transmit the infection to others.

The test that Dr. Mina has been working tirelessly to promote could be revolutionary in the whole COVID narrative.

"Paper tests", is the term used for simplicity for this new type of test. This is paper coated with monoclonal antibodies that can detect antigens. They are not detecting RNA like the PCR Test, but just antigens.

This test has several benefits:

- It is a home test
- It only costs about $1 per test
- The results return in about a minute
- It identifies if you are contagious

So, the whole point is that people will be positive on the RT-PCR Test, because it is so sensitive, that it can detect fragments of virus which can turn the test positive, even when the person is no longer at risk for transmitting the disease. Therefore, with our current approach, we have no idea when a person tests positive for COVID-19 with the RT-PCR Test, if they are capable of infecting others. Whereas this paper test for antigens will. This could be revolutionary, because we could now know whether a person can go back to work of school after testing positive for COVID-19. This approach is how we can safely get society fully open!

A family could purchase a box of the test strips and test each family member twice a week. If negative, go about your business. If positive, stay home and treat accordingly. Then continue to test twice weekly until you return a negative test. That may only take 4-8 days. At that point you could return to work, school, the gym and social activities, knowing full well that you are not going to put anyone else at risk.

Unfortunately, these paper tests have been hung up in bureaucratic red tape. An incredible amount of investment and effort has gone into the PCR development and distribution.

Here is a video that explains PCR testing, Cycle Thresholds (Ct) and explains the deficiencies of this testing paradigm.

https://www.youtube.com/watch?v=S_1Z8cSXI-Q

PCR testing has had flaws from the start

A November 6th report from NPR.org titled, **CDC Report: Officials Knew Coronavirus Test Was Flawed But Released It Anyway**, reveals that the test was released when it was shown that it would fail a third of the time.

Highlights from the article:

The FDA had required a particular protocol be followed when designing the test, and the lab didn't seem to be using the correct one, it said. "The first round of [quality control] for final kit release used an 'incorrect' testing procedure," it said. "Later in the timeline, detection of a 33 percent kit failure" using the correct quality control protocols "did not result in a kit recall or a performance alert."

The FDA had required a particular protocol be followed when designing the test, and the lab didn't seem to be using the correct one, it said. "The first round of [quality control] for final kit release used an 'incorrect' testing procedure," it said. "Later in the timeline, detection of a 33 percent kit failure" using the correct quality control protocols "did not result in a kit recall or a performance alert."

HHS officials said there was nothing intrinsically wrong with the test Lindstrom's lab built but had Lindstrom been at the infectious disease lab longer, he might have pulled a MERS test out of the freezer and used that as the template for a coronavirus test instead because it had more in common with a respiratory virus than influenza did.

Because the respiratory disease lab had fewer entrenched systems than Lindstrom's previous lab, the review also found that basic mistakes were made. "The absence or failure of document control to ensure the use of a

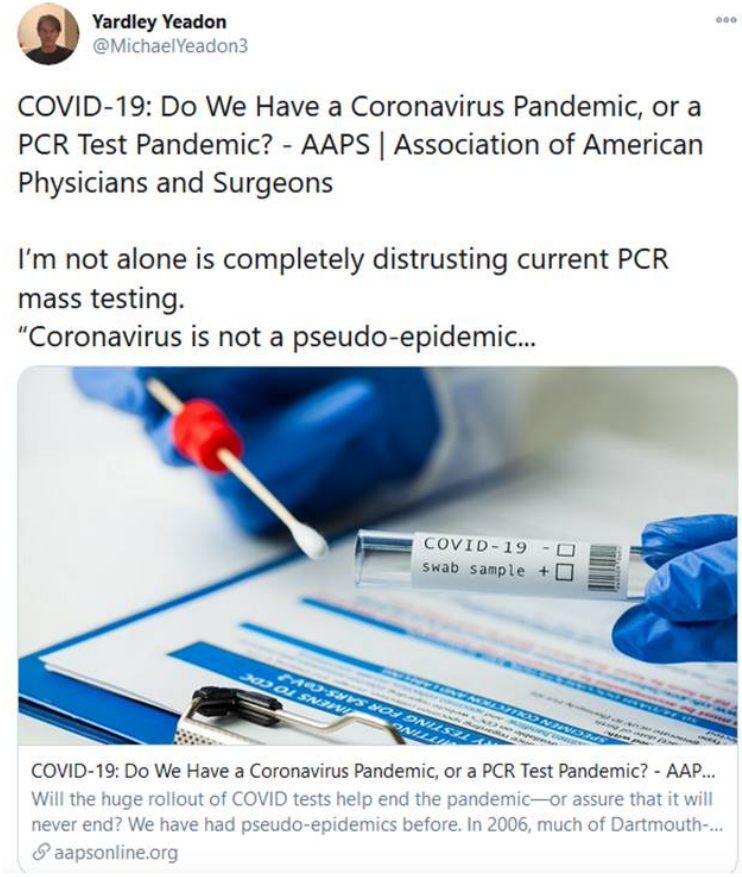
single verified correct test quality control procedure matching [Emergency Use Authorization] procedure," the review said, "resulted in deficiencies."

Wroblewski agreed. "The thing that hangs me up most is probably the 33% and not recalling or not immediately going to remanufacture or something at that point," she said, "because 33% is clearly a lot."

Compounding the problem, officials said, was the fact that the CDC had not established specific benchmarks for the test. There was not, for example, an agency directive that said the test needed to be correct some specific percentage of the time before it could be released.

Because there was no benchmark set for acceptance, it became Lindstrom's call. He appears to have decided either that the last quality control test was wrong or that the 33% failure rate was acceptable, officials said.

Posts by former Pfizer science executive criticize PCR test false positive rate inaccuracies



Dr. Yeadon has a very impressive bio.

Dr. Yeadon is an Allergy & Respiratory Therapeutic Area expert, developed out of deep knowledge of biology & therapeutics and is an innovative drug discoverer with 23y in the pharmaceutical industry. He trained as a biochemist and pharmacologist, obtaining his PhD from the University of Surrey (UK) in 1988 on the CNS and peripheral pharmacology of opioids on respiration. Dr Yeadon then worked at the Wellcome

Research Labs with Salvador Moncada with a research focus on airway hyper-responsiveness and effects of pollutants including ozone and working in drug discovery of 5-LO, COX, PAF, NO and lung inflammation. With colleagues, he was the first to detect exhaled NO in animals and later to induce NOS in lung via allergic triggers. **Joining Pfizer in 1995, he was responsible for the growth and portfolio delivery of the Allergy & Respiratory pipeline within the company. During his tenure at Pfizer, Dr Yeadon was responsible for target selection and the progress into humans of new molecules, leading teams of up to 200 staff across all disciplines and won an Achievement Award for productivity in 2008**. Under his leadership the research unit invented oral and inhaled NCEs which delivered multiple positive clinical proofs of concept in asthma, allergic rhinitis and COPD. He led productive collaborations such as with Rigel Pharmaceuticals (SYK inhibitors) and was involved in the licensing of Spiriva® and acquisition of the Meridica (inhaler device) company. **Dr Yeadon has published over 40 original research articles and now consults and partners with a number of biotechnology companies. Before working with Apellis, Dr Yeadon was VP and Chief Scientific Officer (Allergy & Respiratory Research) with Pfizer.**

Dr. Yeadon is on record saying that the current “epidemic” of positive cases is much overblown and inaccurate. He believes that under controlled laboratory conditions, the PCR accuracy is much better. But in the commercialization and supply chain of mass testing, such as the world has never seen, the false positive rates are amplifying the numbers significantly.

He is also an outspoken critic of the rushed experimental vaccine being promoted to the public as safe and anything but experimental. This is a scathing series of Tweets, Dr. Yeadon directed at Matt Hancock, the ***U.K. Secretary of State for Health and Social Care.***

Dear Mr. Hancock,

I have a degree in biochemistry and toxicology and a research based PhD in pharmacology. I had spent 32 years working in pharmaceutical R&D, mostly in new medicines for disorders of lung and skin. I was a VP at Pfizer and CEO of a biotech I founded Ziarco – acquired by Novartis). I'm knowledgeable about new medicine R&D.

I have read the consultation document. I've rarely been as shocked and upset.

All vaccines against the SARS-CoV-2 virus are by definition novel. No candidate vaccine has been in development for more than a few months.

If any such vaccine is approved for use under any circumstances that are not EXPLICITLY experimental, I believe that recipients are being misled to a criminal extent.

This is because there are precisely zero human volunteers for whom there could possibly be more than a few months past-dose safety information.

My concern does not arise because I have negative views about vaccines (I don't).

Instead, it's the very principle that politicians seem ready to waive that new medical interventions at this, incomplete state of development- should not be made available to subjects on anything other than an explicitly experimental basis. That is my concern.

And the reason for that concern is that it is not known what the safety profile will be, six months or a year or longer after dosing.

You have literally no data on this & neither does anyone else.

It isn't that I'm saying that unacceptable adverse effects will emerge after longer intervals after dosing. No: it is that you have no idea what will happen yet, despite this, you'll be creating the impression that you do.

Several of the vaccine candidates utilized novel technology which has not previously been used to create vaccines. There is therefore no long-term safety data which can be pointed to in support of the notion that it's reasonable to expedite development and to waive absent safety information on this occasion.

I am suspicious of the motives of those proposing expedited use in the wider human population. We now understand who is at particularly elevated risk of morbidity and mortality from acquiring this virus. Volunteers from these groups only should be provided detailed information about risk / benefit, including the sole point I make here. Only if informed consent is given should any EXPERIMENTAL vaccine be used.

I don't trust you. You have not been straightforward and have behaved appallingly throughout this crisis. You're still doing it now, misleading about infection risk from young children. Why should I believe you in relation to experimental vaccines?

Dr. Michael Yeadon

WOW! This section should be copied and pasted into emails and social media posts and sent to everyone you know. Here is a long-time pharma scientist, former Chief Scientific Officer with Pfizer ripping a top U.K. health official and laying out the risks of the coming vaccines, plain and simple.

An article titled, **COVID-19: Do We Have a Coronavirus Pandemic, or a PCR Test Pandemic?** echoes Dr. Yeadon's concerns.

From the article:

Will the huge rollout of COVID tests help end the pandemic—or assure that it will never end?

We have had pseudo-epidemics before. In 2006, much of Dartmouth-Hitchcock Medical Center was shut down, and 1,000 employees were furloughed or quarantined, because whooping cough was thought to be spreading like wildfire based on 142 positive PCR tests.

The employees also had cultures taken, and a couple weeks later not a single one had a positive culture for the slow-growing bacteria, *Bordetella pertussis*. There had simply been an outbreak of some other ordinary

respiratory disease, not the dreaded whooping cough. Gina Kolata wrote in *The New York Times*: "Faith in Quick Test Leads to Epidemic That Wasn't."

It is not so easy to culture a virus, and cultures of SARS-CoV-2 are not routinely done. Unlike in previous epidemics (SARS-CoV-1, H1N1 influenza, Ebola, or Zika), World Health Organization (WHO) guidance has no requirement or recommendation for a confirmatory test in COVID-19. *(isn't that strange?)*

Having great-sounding numbers, say a specificity of 99 percent, is not enough. For all tests, the predictive value of a positive test depends on the prevalence of disease. If most of the persons tested are free of disease, a positive test may be more likely to be a false than a true positive. This could at least partially explain the reports of large numbers of asymptomatic carriers of SARS-CoV-2.

Failure to recognize the problem of false positives has consequences—such as possible quarantining of uninfected with infected individuals.

The CDC limits the primers and probes that may be used for PCR testing. For the viral sequences that may be used for viral surveillance and research, the CDC posts this disclaimer on its website, cdc.gov: "Every effort has been made to assure the accuracy of the sequences, but CDC cannot provide any warranty regarding their accuracy."

End of excerpts

https://aapsonline.org/covid-19-do-we-have-a-coronavirus-pandemic-or-a-pcr-test-pandemic/

Many of these issues have been known by the FDA for months. Yet the media and those pushing the agenda of raging out-of-control disease are once again M.I.A. from doing their job.

Here are a couple examples of the fraught with problems PCR testing.

From the FDA: **Risk of Inaccurate Results with Thermo Fisher Scientific TaqPath COVID-19 Combo Kit - Letter to Clinical Laboratory Staff and Health Care Providers.**

https://www.fda.gov/medical-devices/letters-health-care-providers/risk-inaccurate-results-thermo-fisher-scientific-taqpath-covid-19-combo-kit-letter-clinical?

And this: **False Positive Results with BD SARS-CoV-2 Reagents for the BD Max System - Letter to Clinical Laboratory Staff and Health Care Providers**

https://www.fda.gov/medical-devices/letters-health-care-providers/false-positive-results-bd-sars-cov-2-reagents-bd-max-system-letter-clinical-laboratory-staff-and

And a solution to the problem with PCR accuracy… a paper by Dr. Sin Hang Lee M.D.

CDC Coronavirus Test Kits Generate *30% False Positive and 20% False Negative Results* - Connecticut Pathologist's Newly Published Findings Confirm
https://www.businesswire.com/news/home/20200717005397/en/CDC-Coronavirus-Test-Kits-Generate-30-False

It looks to me that the title of that article would indicate that the PCR test results are wrong 50% of the time! Yet we are making crushing policy decisions based on highly inaccurate data.

You can access his paper here: http://www.int-soc-clin-geriat.com/info/wp-content/uploads/2020/03/Dr.-Lees-paper-on-testing-for-SARS-CoV-2.pdf

Some takeaways from the abstract:

Currently, molecular tests for SARS-CoV-2 infection are primarily based on reverse transcription-quantitative polymerase chain reaction (RT-qPCR) on cell-free fluid samples of respiratory tract specimens. These tests measure the rate of fluorescent signal accumulation as a surrogate for direct DNA sequence determination and are known to generate false-negative and false-positive results. The author has developed a routine protocol to test the cellular components of respiratory tract specimens instead of cell-free fluids only and to use conventional nested RT-PCR to amplify the target nucleic acid for high detection sensitivity. A 398-bp heminested PCR amplicon is used as the template for direct DNA sequencing to ensure no false-positive test results.

Using this protocol to re-test 20 reference samples prepared by the Connecticut State Department of Public Health, the author found 2 positives among 10 samples classified as negative by RT-qPCR assays. One of these two positive samples contained a mutant with a novel single nucleotide insertion in the N gene and a wild-type parental SARS-CoV-2. Of the 10 samples classified as positive by RT-qPCR assays, only 7 (7/10) were confirmed to contain SARS-CoV-2 by heminested PCR and DNA sequencing of a 398-bp amplicon of the N gene.

Routine sequencing of a 398-bp PCR amplicon can categorize any isolate into one of 6 clades of SARS-CoV-2 strains known to circulate in the United States. The author proposes that extremely accurate routine laboratory tests for SARS-CoV-2 be implemented as businesses attempt to return to normal operation in order to avoid raising false alarms of a re-emerging outbreak. False-positive laboratory test reports can easily create unnecessary panic resulting in negative impacts on local economies.
End of excerpts

At the end of the day, I believe that the paper home tests promoted by Dr. Michael Mina are the real answer. They are fast, inexpensive, can be administered at home and give real time results about whether a person is contagious or not.

The narrative about asymptomatic spread that has driven many of the imposed Draconian measures may be a false after all

Since the beginning of the outbreak, there has been lots of noise about asymptomatic spread saying that it is the real danger that will drive the spread of COVID-19 and the lockdowns. In July, What do we know now? And, how should that inform our decisions moving forward?

A study published in ***Nature Communications*** November 20th, 2020 involving nearly 10 million people and titled **Asymptomatic people do not spread the virus- Post-lockdown SARS-CoV-2 nucleic acid screening in nearly ten million residents of Wuhan, China**, finds zero cases of assymtomatic spread in households and those close contacts od asymptomatic individuals.

The abstract-

Stringent COVID-19 control measures were imposed in Wuhan between January 23 and April 8, 2020. Estimates of the prevalence of infection following the release of restrictions could inform post-lockdown pandemic management. Here, we describe a city-wide SARS-CoV-2 nucleic acid screening programme between May 14 and June 1, 2020 in Wuhan. All city residents aged six years or older were eligible and **9,899,828 (92.9%) participated**.

No new symptomatic cases and **300 asymptomatic cases** (detection rate 0.303/10,000, 95% CI 0.270-0.339/10,000) **were identified**. There were **no positive tests amongst 1,174 close contacts of asymptomatic cases.** 107 of 34,424 previously recovered COVID-19 patients tested positive again (re-positive rate 0.31%, 95% CI 0.423-0.574%). *(My comment: As seen in the video under the PCR section, it is believed that the extremely rare cases of reinfection are most likely PCR testing picking up viral fragments long after infection).* The prevalence of SARS-CoV-2 infection in Wuhan was therefore very low five to eight weeks after the end of lockdown. https://pubmed.ncbi.nlm.nih.gov/33219229/

There have been numerous international studies showing that children don't spread COVID-19

The main reason that children are less likely to transmit the virus to others is that their immune systems are highly efficient and robust. Remember the discussion earlier about viral load and when a person is able to transmit the virus to others? If children's immune systems are efficient in preventing the exponential growth of the virus, they are not only less likely to transmit to others, but they typically have few if any symptoms.

Based on the studies and data that I have been looking at, there appear to be at least 4 main reasons why most cases are either asymptomatic or very mild upper respiratory symptoms:

1. **Young children have been "primed" by other coronaviruses** and their immune systems have been trained to recognize the commonality with SARS-CoV-2. I have covered this phenomenon of cross recognition and reactivity by the immune system to various coronaviruses based on the large percentage of common DNA/RNA structure in previous issues. There are at least 4 versions of coronavirus family members that are part of the wider spectrum of viruses that cause the common cold. Exposure to and infection from these viruses afford a degree of protection to SARS-CoV-2. That occurs largely from T-cell immunity.
2. **Children have a greater number of Natural Killer (NK) Cells** patrolling their body. NK cells are cytotoxic lymphocytes representing powerful immune forces that act like the rapid response team, working to destroy infected cells even without an antibody response. They play important roles in both the Innate and the Adaptive arms of the immune system.
3. **Children have a better trained immune system in general.** Their exposure to many different microbes (bacteria, viruses, fungi, yeast, etc.), have prepared their immune systems for a robust immune

response. That's why you want your kids playing outside in the dirt and mud. It's all immune system training.

4. **Children have less ACE-2 receptors-** This is the binding site on our cells for the SARS-CoV-2 virus. These are the gates to the castle so to speak, that when opened allow the virus to penetrate the cell where once inside they can replicate.

ACE-2 stands for Angiotensin-Converting Enzyme 2. Angiotensin-converting enzyme 2 is a zinc containing metalloenzyme located on the surface of endothelial and other cells. They are abundant in the epithelial cells of the mucous membranes of the nose, mouth, eyes, nasopharynx and lungs. It is also present in cells of many other organs and tissues. That is why those tissues are the target tissues for SARS-CoV-2.

A study published in the **August 2020** issue of the journal ***Pediatrics*** titled, **COVID-19 Transmission and Children: The Child is Not to Blame**, makes a pretty strong case that while children can be infected with COVID-19, they typically are either non-symptomatic or mildly symptomatic and are not great spreaders. There seems to be a sliding scale with regard to that potential for transmission. It seems that when looking at this potential for children in the teen years, there seems to be a greater the tendency to transmit the infection to others.

From the article:

"Coronavirus disease (COVID-19) presents arguably the greatest public health crisis in living memory. One surprising aspect of this pandemic is that children appear to be infected by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes COVID-19, far less frequently than adults and, when infected, typically have mild symptoms."

https://pediatrics.aappublications.org/content/146/2/e2020004879.long

New CDC data shows that deaths of despair from lockdowns on people aged 20-49 years far eclipses deaths from COVID-19

A report published in ***The Daily Wire*** on Oct 22nd titled, **New CDC Numbers Show Lockdown's Deadly Toll On Young People**, revealed some disturbing data that is being ignored by the mainstream media, data showing that the fear mongering, lockdowns, unemployment and business closures are having deadly consequences for young and middle-aged people. (link to original article with its references at end of this segment)

The new CDC numbers on increased deaths in young people from the lockdowns is devastating news. According the CDC, 20-49-year-olds have a 99.98% chance of surviving the virus, YET they now estimate that the number of excess deaths in that age group alone has eclipsed the deaths in this age group due to the virus by multiples. The former head of the FDA, a vocal proponent up to this point believes that a good percentage of the deaths were deaths of despair. To date, well over 100,000 small business have been forced to close permanently and many people in this age demographic have lost everything they have worked so hard for. As a result, suicides, drug overdoses, alcohol addiction and excess deaths from other reasons have skyrocketed. All this carnage in an age group that has an extremely low risk from CV19. We cannot afford any MORE LOCKDOWNS!

From the article:

The Center for Disease Control and Prevention (CDC) revealed Wednesday that young adults aged 25-44 years saw the largest increase in "excess" deaths from previous years, a stunning 26.5% jump.
The notable increase even surpassed the jump in excess deaths of older Americans, who are at much higher risk of COVID-19 fatality. https://www.cdc.gov/mmwr/volumes/69/wr/mm6942e2.htm?s_cid=mm6942e2_w

Moreover, according to the CDC, 100,947 excess deaths were not linked to COVID-19 at all.
Since such young people are at very low risk for COVID-19 fatality — 20-49-year-olds have a 99.98% chance of surviving the virus, per CDC data — it has been suggested that the shocking increase in deaths is largely attributable to deaths of "despair," or deaths linked to our "cure" for the disease: lockdown measures.
Former Food and Drug Administration (FDA) Commissioner Scott Gottlieb, one of the most vocal and earliest proponents of lockdown measures, admitted this much during a Wednesday news appearance.

"I would suspect that a good portion of the deaths in that younger cohort were deaths due to despair, due to other reasons," admitted Gottlieb (see video below). "We've seen a spike in overdoses, and I would suspect that a good portion of those excess deaths in that younger cohort were from drug overdoses and other deaths that were triggered by some of the implications of we've gone through to try to deal with COVID-19."
Critics roundly mocked President Donald Trump early in the pandemic for warning about excess deaths of despair under lockdown. Public health experts and others are now increasingly calling for an end to heavy-handed measures, citing a growing body of evidence that such policies are having drastic negative impacts on Americans' physical and mental health.

Possibly the starkest impact has been the worsening of another U.S. health crisis: the opioid epidemic. Deaths from opioids were already rising as initial estimates from the CDC show 2019 to be the worst year on record with roughly 71,000 deaths. The crisis has worsened across more than 40 states during the pandemic, according to an analysis of local news reports by the American Medical Association.
From the start of the year to the end of August, preliminary counts of overdose deaths have jumped 28% in Colorado, 30% in Kentucky, and 9% in Washington state over the same time frame last year, according to The Associated Press.

Calls to suicide hotlines spiked amid the pandemic as people, isolated at the direction of public health officials and scared of contracting COVID-19, suffered anxiety attacks and mental breakdowns. Calls to the Disaster Distress Helpline, which offers emotional support to people amid a natural disaster, jumped 890% in April compared to April 2019. Local law enforcement and health agencies in places such as Fresno, California, and Los Alamos, New Mexico, are reporting significant increases in death by suicide, sometimes as high as 70% in a month.

Many distressed callers reached out after losing a job or even their house after government-mandated closures plunged the U.S. to its highest unemployment rate since the Great Depression. Stay-at-home orders devastated small businesses and pushed an estimated 8 million Americans into poverty, according to a recent study from Columbia University.

By the end of August, for example, Yelp found that 97,966 small businesses were forced to close their doors permanently because of lockdown restrictions.

"I would suspect that a good portion of the deaths in that younger cohort were due to despair, due to other reasons. We've seen a spike in overdoses," says @ScottGottliebMD on a CDC report finding 25-44 year olds are being hit hard trying to deal with the #COVID19 pandemic. pic.twitter.com/lW9L4YwaTq
— Squawk Box (@SquawkCNBC) October 21, 2020.
Scott Gottlieb is a former FDA Commissioner.

End of excerpts

https://www.dailywire.com/news/new-cdc-numbers-show-lockdowns-deadly-toll-on-young-people?

New study looking at data from 160 countries shows lockdowns don't save lives

Lifestyle and co-morbidities as risk factors for death from COVID-19

A large study looking at 160 countries through August 31, 2020 and published November 19, 2020 in the journal ***Frontiers in Public Health*** titled, **Covid-19 Mortality: A Matter of Vulnerability Among Nations Facing Limited Margins of Adaptation**, tested major indices from five domains (demography, public health, economy, politics, environment) and their potential associations with Covid-19 mortality during the first 8 months of 2020. Some very interesting and insightful conclusions were made, including the first bullet point on lockdowns. Lockdowns have destroyed businesses, lives, families and economies, increased mental health problems, suicides, domestic and child abuse and deaths from despair, but it appears have not saved lives.

From the article:

- Stringency of the measures settled to fight pandemia, **including lockdown, did not appear to be linked with death rate.**

- Countries that already experienced a stagnation or regression of life expectancy, with high income and NCD rates, had the highest price to pay. This burden was not alleviated by more stringent public decisions. Inherent factors have predetermined the Covid-19 mortality: understanding them may improve prevention strategies by increasing population resilience through better physical fitness and immunity. **NCD stands for metabolic and non-communicable diseases, which are represented by chronic diseases such as cardiovascular, respiratory and kidney disease, diabetes, obesity, cancer, autoimmune disease, etc. This makes the United States, which has some of the highest percentage of these diseases in the world vulnerable to higher rates of mortality than some of the Asian countries and those with healthier and more active lifestyles.*
  https://www.frontiersin.org/articles/10.3389/fpubh.2020.604339/full

Worse than lockdowns not saving lives, evidence is streaming in that they are killing millions worldwide

Numerous publications have been running stories that are showing the devastating effects of the lockdowns we are seeing across the globe. And the devastation is not limited to lost jobs, destroyed businesses, ruined

marriages, domestic abuse, depression, anxiety and loss of hope. It also includes NON-COVID premature deaths, untimely excess deaths that are unprecedented in their cause and scope.

A November 2nd article published by the ***American Institute for Economic Research*** by Jeffrey Tucker titled **Death by Lockdown**, is very revealing. And, it asks some very important questions.

Highlights from the article:

On March 28 – very early in the pandemic – AIER published an article that I felt at the time received far too little attention. "Drugs, Suicide, and Crime: Empirical Estimates of the Human Toll of the Shutdown" by economists Audrey and Thomas Duncan cited empirical literature on the human toll of economic devastation. This article forecasted more than 100,000 excess deaths due to drug overdoses, suicide, alcoholism, homicide, and untreated depression – all a result not of the virus but of policies of mandatory human separation, economic downturn, business and school closures, closed medical services, and general depression that comes with a loss of freedom and choice.

These two economists demonstrated that as bad as a virus is, policies that wreck normal social functioning will cause massive and completely unnecessary suffering and death. Because the article was so well-cited, with references to all the available literature, I thought it would make a difference. But after it appeared, it was crickets. I was amazed. Here you have a beautiful piece of research that perfectly forecasted the nightmare being created by politicians and their advisers and it made no dent in the national narrative.

Here we are seven months later and the worst has come true. These two economists should be considered prophets. Sure enough, the Centers for Disease Control has documented a shocking number of excess deaths not from Covid.

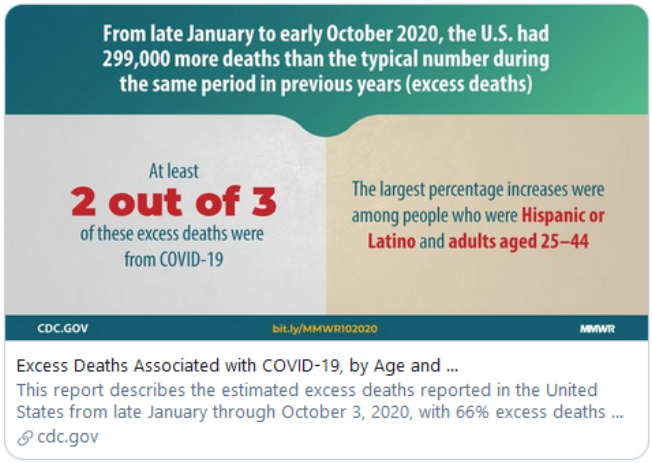
Dr. Scott Atlas Tweet that they summarize below:

Scott W. Atlas
@ScottWAtlas

Excess mortality, CDC
Hispanic: 40% excess deaths NOT Covid related
Black: 46% NOT Covid related
White: 38% NOT Covid related

25-44: 77% excess deaths NOT Covid related
65+: 39% NOT Covid related

What are they? Lockdown deaths likely #LockdownsKill #Vote

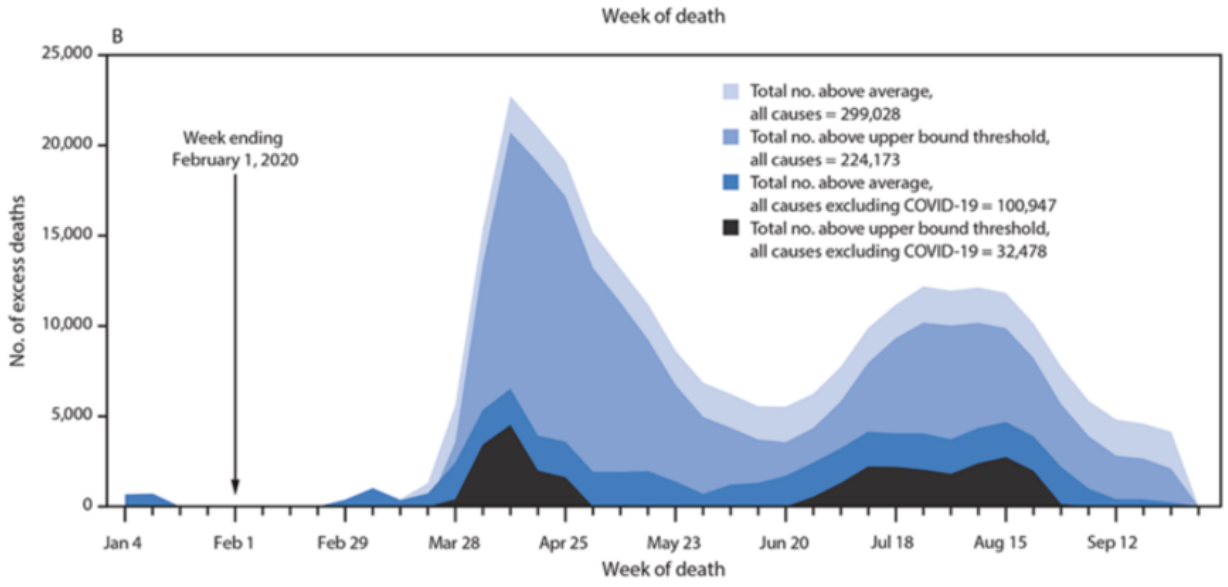


Excess Deaths Associated with COVID-19, by Age and ...
This report describes the estimated excess deaths reported in the United States from late January through October 3, 2020, with 66% excess deaths ...
cdc.gov

7:09 AM · Nov 2, 2020 · Twitter for Android

The most startling data concerns the age group 25-44. This is a group with a Covid-related infection fatality rate of 0.0092%, which is to say barely a disease at all for nearly everyone in this group. And yet they are dying at a rate far above what is expected, and mostly from issues not related to Covid. There should not be any excess deaths. Instead we find people dropping dead in ways that are shocking.

The relevant part of this CDC graph, which marks above expected deaths this year, are the dark blue and black portions of the graph, which indicated non-Covid deaths.



That's the CDC's way of saying: these policies are killing people. As for minimizing disruptions to health care, a major factor here is that people have been completely avoiding getting health care this year, for fear of Covid, for fear of contract tracing, and also because many medical services have been forcibly reserved for people with Covid, and to hell with everyone else. Cancer screenings, routine checkups, normal procedures, to say nothing of dentistry have certainly been disrupted. Now we can see the carnage in plain daylight.

People are dying across all demographics due to the radical transformation of life itself. In addition, new research is showing that there has been a huge increase in excess deaths in elder-care homes probably due to despair and loneliness from the prevention of family visits.

The whole pattern is extraordinary and deeply tragic. It was also entirely predictable. Instead of dealing rationally with a textbook virus, as we had done during the whole of the 20th century, we embarked on a new social/political experiment in lockdowns. We attempted to intimidate a virus with PhDs and political power, hoping that it would shrivel and die, and in so doing dramatically disabled human freedom and social functioning. What do we have to show for it? Massive carnage, and a virus that is still with us.

https://www.aier.org/article/death-by-lockdown/

My comment: As horrific as these statistics are, the article did not even touch on the devastation being caused in third-world countries due to starvation and loss of social services, which I cover in the next section.

***Note- See the article after this next section relating to the miscalculation of COVID-19 deaths from the Johns Hopkins News-Letter, which if true turns the whole COVID-19 narrative on its head.**

Children in developed countries face many pandemic related hardships, but in third-world countries it is a matter of life and death

In a press release by UNICEF on November 19th titled **UNICEF calls for averting a lost generation as COVID-19 threatens to cause irreversible harm to children's education, nutrition and well-being**, some shocking claims and predictions are made.

From the report:

UNICEF warned in a new report today of significant and growing consequences for children as the COVID-19 pandemic lurches toward a second year.

Released ahead of World Children's Day, *Averting a Lost COVID Generation* is the first UNICEF report to comprehensively outline the dire and growing consequences for children as the pandemic drags on. It shows that while symptoms among infected children remain mild, infections are rising and the longer-term impact on the education, nutrition and well-being of an entire generation of children and young people can be life-altering.

While children can transmit the virus to each other and to older age groups, there is strong evidence that, with basic safety measures in place, the net benefits of keeping schools open outweigh the costs of closing them, the report notes. Schools are not a main driver of community transmission, and children are more likely to get the virus outside of school settings.

COVID-related disruptions to critical health and social services for children pose the most serious threat to children, the report says. Using new data from UNICEF surveys across 140 countries, it notes that:

- Around one-third of the countries analyzed witnessed a drop of at least 10 per cent in coverage for health services such as routine vaccinations, outpatient care for childhood infectious diseases, and maternal health services. Fear of infection is a prominent reason.
- There is a 40 per cent decline in the coverage of nutrition services for women and children across 135 countries. As of October 2020, 265 million children were still missing out on school meals globally. More than 250 million children under 5 could miss the life-protecting benefits of vitamin A supplementation programmes.
- 65 countries reported a decrease in home visits by social workers in September 2020, compared to the same time last year.

More alarming data from the report include:

- As of November 2020, 572 million students are affected across 30 country-wide school closures – 33 per cent of the enrolled students worldwide.
- An estimated 2 million additional child deaths and 200,000 additional stillbirths could occur over a 12-month period with severe interruptions to services and rising malnutrition.
- An additional 6 to 7 million children under the age of 5 will suffer from wasting or acute malnutrition in 2020, a 14 per cent rise that will translate into more than 10,000 additional child deaths per month – mostly in sub-Saharan Africa and South Asia.
- Globally, the number of children living in multidimensional poverty – without access to education, health, housing, nutrition, sanitation or water – is estimated to have soared by 15 per cent, or an additional 150 million children by mid-2020.

Johns Hopkins Newsletter article if true, blows the lid off of the COVID-19 death number narrative and circles back to the change in death certification

The article published November 22nd in the student News-Letter titled, **A closer look at U.S. deaths due to COVID-19**, completely demolishes the narrative that COVID-19 has increased total death numbers for any age group, including the elderly. This is mind blowing if true! It has already been archived on the Way Back Machine web.archive.org, because you know that this won't last long before it is taken down.

Some highlights from the article:

According to new data, the U.S. currently ranks first in total COVID-19 cases, new cases per day and deaths. Genevieve Briand, assistant program director of the Applied Economics master's degree program at Hopkins,

critically analyzed the effect of COVID-19 on U.S. deaths using data from the Centers for Disease Control and Prevention (CDC) in her webinar titled “COVID-19 Deaths: A Look at U.S. Data.”

Briand also noted that 50,000 to 70,000 deaths are seen both before and after COVID-19, indicating that this number of deaths was normal long before COVID-19 emerged. Therefore, according to Briand, not only has COVID-19 had no effect on the percentage of deaths of older people, but it has also not increased the total number of deaths.

These data analyses suggest that in contrast to most people’s assumptions, the number of deaths by COVID-19 is not alarming. In fact, it has relatively no effect on deaths in the United States.

This comes as a shock to many people. How is it that the data lie so far from our perception?
To answer that question, Briand shifted her focus to the deaths per causes ranging from 2014 to 2020. There is a sudden increase in deaths in 2020 due to COVID-19. This is no surprise because COVID-19 emerged in the U.S. in early 2020, and thus COVID-19-related deaths increased drastically afterward.

Analysis of deaths per cause in 2018 revealed that the pattern of seasonal increase in the total number of deaths is a result of the rise in deaths by all causes, with the top three being heart disease, respiratory diseases, influenza and pneumonia.

“This is true every year. Every year in the U.S. when we observe the seasonal ups and downs, we have an increase of deaths due to all causes,” Briand pointed out.

When Briand looked at the 2020 data during that seasonal period, COVID-19-related deaths exceeded deaths from heart diseases. This was highly unusual since heart disease has always prevailed as the leading cause of deaths. However, when taking a closer look at the death numbers, she noted something strange. As Briand compared the number of deaths per cause during that period in 2020 to 2018, she noticed that instead of the expected drastic increase across all causes, there was a significant decrease in deaths due to heart disease. Even more surprising, as seen in the graph below, this sudden decline in deaths is observed for all other causes.
This trend is completely contrary to the pattern observed in all previous years. Interestingly, as depicted in the table below, the total decrease in deaths by other causes almost exactly equals the increase in deaths by COVID-19. This suggests, according to Briand, that the COVID-19 death toll is misleading. Briand believes that deaths due to heart diseases, respiratory diseases, influenza and pneumonia may instead be recategorized as being due to COVID-19.

“If [the COVID-19 death toll] was not misleading at all, what we should have observed is an increased number of heart attacks and increased COVID-19 numbers. But a decreased number of heart attacks and all the other death causes doesn’t give us a choice but to point to some misclassification,” Briand replied.

In other words, the effect of COVID-19 on deaths in the U.S. is considered problematic only when it increases the total number of deaths or the true death burden by a significant amount in addition to the expected deaths by other causes. Since the crude number of total deaths by all causes before and after COVID-19 has stayed the same, one can hardly say, in Briand’s view, that COVID-19 deaths are concerning.

According to Briand, the over-exaggeration of the COVID-19 death number may be due to the constant emphasis on COVID-19-related deaths and the habitual overlooking of deaths by other natural causes in society.

End of excerpts: **The graphs in the article are definitely worth viewing.**

https://web.archive.org/web/20201126163323/https:/www.jhunewsletter.com/article/2020/11/a-closer-look-at-u-s-deaths-due-to-covid-19

New study shows that up to 25% of people may be immune to SARS-CoV-2 without ever being infected by it

I have covered many studies over the last 6 months that reveal encouraging signs that T-Cell cross-reactivity from other coronavirus infections provides a significant amount of immunity against SARS-CoV-2 for many people. Here is another recent release with similar findings.

The study pre-print released November 04, 2020 and titled, **SARS-CoV-2 responsive T cell numbers are associated with protection from COVID-19: A prospective cohort study in keyworkers**, gives major insights and perspective on the real mortality rates from COVID-19.

According to an article published in The Sun Tmes (U.K.):

Dr Peter Wrighton-Smith, the CEO of Oxford Immunotec, the company that developed the T-cell test for trial, said that the results show that relying on antibody testing alone to see who is immune to the virus could underestimate the number of people who have immunity.

Data from the study found that none of the participants with high T-cell responses became infected with the virus in the following four months.

Commenting on the results Dr Wrighton-Smith said the people used in the study had all been frontline workers and were therefore more likely to have been exposed to the virus.

He said: “The implication is that there is a population of people who are protected from Covid who are not being picked up by the antibody studies.”

The experts stressed that the findings could mean that T-cells are longer lasting than antibodies or that people are left with immunity after suffering from similar coronaviruses such as the common cold.

Dr Wrighton-Smith added: “We are not picking up all cases with the antibody surveys - so more people may be protected than we thought.”

The lead author of the study, Dr David Wyllie, a consultant microbiologist at PHE said that just four months into the study, 20 of the participants had lower T-cell responses and had developed Covid, in comparison none of the individuals with high T-cell responses contracted the virus.

He said: “This suggests individuals with higher numbers of T-cells recognising SARS-CoV-2 may have some level of protection from Covid-19, although more research is required to confirm this.”

Reacting to the publication of the study, Professor Karol Sikora, a cancer expert at the University of Buckingham said the finding was “really good news”.

From the study:
Methods: We conducted a prospective cohort study in 2,826 participants working in hospitals and Fire and Police services in England, UK during the pandemic(ISRCTN5660922). Of these, 2,672 were unselected volunteers recruited irrespective of previous SARS-CoV-2 RT-PCR test results, and 154 others were recruited separately specifically because they previously tested positive.

Results: T cells responsive to the spike (S), nuclear (N) and membrane proteins (M) dominated the responses measured. Using the sum of the spots (responsive cells within each well of 250,000 peripheral blood mononuclear cells) for S, N and M antigens minus the control, the 2,672 unselected participants were divided into those with higher responses (n=669, 25.4%; median 30 spots (IQR 18,54)) and those with low responses (n=2016, 76.7%, median 3 (IQR 1,6)), the cutoff we derived being 12 spots. Of the participants with higher T cell responses, 367 (53%) had detectable antibodies against the N or S proteins. During a median of 118 days follow-up, 20 participants with lower T cell responses developed COVID-19, compared with none in the population with high T cell responses (log-rank test, p=6x10-3). Conclusions: Peripheral blood SARS-CoV-2 responsive T cell numbers are associated with risk of developing COVID-19.

Discussion: Overall, this study suggests that serology may underestimate the working age population at lower risk of clinical SARS-CoV-2 infection, something which might impact outbreak kinetics (29) and which has been suspected on epidemiological grounds (30). We would speculate that the declining number of individuals with high levels of SARS-CoV-2 responsive T cells with increasing age may explain higher illness incidence and severity in older age (1-4). Intriguingly, our data indicate individual level risk stratification may be possible using T-cell assays, including the standardised assay kits used in this study which, being in the same format as the widely used T-SPOT®.TBtests for latent TB infection, would be readily deployable at scale

https://www.medrxiv.org/content/medrxiv/early/2020/11/04/2020.11.02.20222778.full.pdf

Considering all of that…

What level of population immunity will it require with SARS-CoV-2?

The R-Naught (R_0 or Basic Reproduction Number) for an infectious disease event is the estimated number of people that an infected person will in turn infect. It is generally reported as a single numeric value or low–high range. An outbreak is expected to continue if R_0 has a value >1 and to end if R_0 is <1. It also is used to estimate the percentage of the population that would need to be “immune” from a disease to control its spread through the concept of herd or population immunity. The more infective the disease, the higher the percentage of the population would need to be immune. Measles for example is estimated to have an R_0 somewhere between 12-18. Therefore, it is thought that the percentage of the population that would need to be immune to protect the rest would be around 90-95%. A virus with an R_0 of 2-3 may only require 60% of the population to be immune to control the outbreak.

The R_0 for the SARS-CoV-2 virus is estimated to be 2.5, as of the last published data from the CDC in August. As an infection works its way through the population that number will be expected to drop. The R_0 for the seasonal flu ranges from 0.9-2.1. The common cold is estimated to be 2-3. Even with an infectibility rating near that of SARS-CoV-2, not everyone contracts the seasonal flu or the common cold each year. And, as larger numbers of the population become infected and recover, the number of susceptible hosts drop and the likelihood of getting infected drops. Eventually the virus "burns itself out". That is what happened to SARS-CoV-1. A vaccine was never successfully developed and in fact the effort was abandoned because the trials never went beyond animal studies. The vaccine candidates caused severe adverse effects in the animal subjects and the efforts were dropped.

Another study puts effectiveness of wearing face masks into question

A study published in the ***Annals of Internal Medicine*** November 18, 2020 titled, **Effectiveness of Adding a Mask Recommendation to Other Public Health Measures to Prevent SARS-CoV-2 Infection in Danish Mask Wearers**, found the rates of COVID-19 infections between the masked and non-masked groups was not statistically significant. The masked group was given a supply of 50 surgical masks for the study period. This study was a randomized controlled study, the highest standard for study design accuracy in research.

From the study

"A total of 3030 participants were randomly assigned to the recommendation to wear masks, and 2994 were assigned to control; 4862 completed the study. Infection with SARS-CoV-2 occurred in 42 participants recommended masks (1.8%) and 53 control participants (2.1%). The between-group difference was −0.3 percentage point (95% CI, −1.2 to 0.4 percentage point; *P* = 0.38)". The differences between the two groups is NOT statistically significant.

"The face masks provided to participants were high-quality surgical masks with a filtration rate of 98%".

"A published meta-analysis found no statistically significant difference in preventing influenza in health care workers between respirators (N95 [American standard] or FFP2 [European standard]) and surgical face masks".

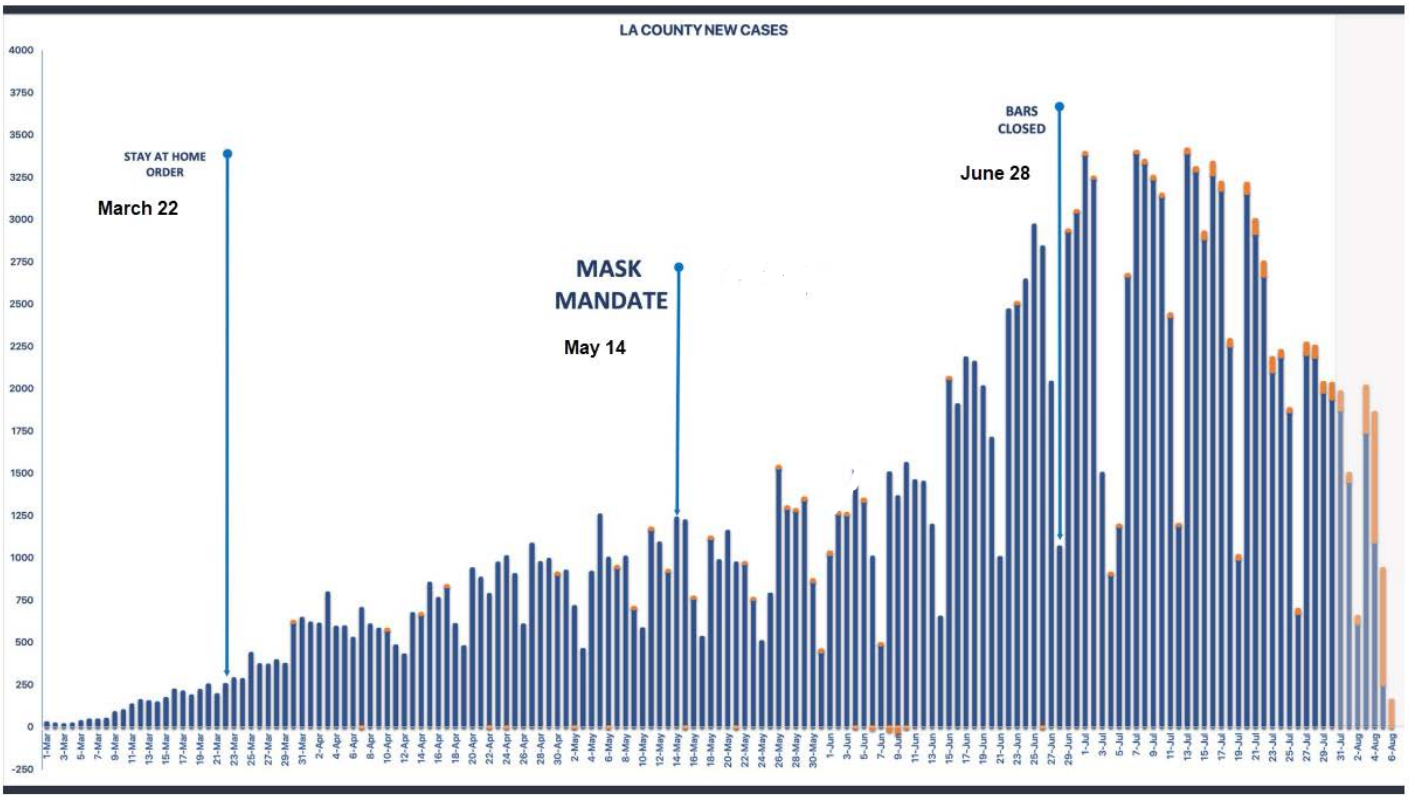
"The present findings are compatible with the findings of a review of randomized controlled trials of the efficacy of face masks for prevention (as personal protective equipment) against influenza virus".
https://www.acpjournals.org/doi/10.7326/M20-6817

Sweden's Chief Epidemiologist downplays the benefits of face masks for public use

Sweden has never suggested that their citizens wear face masks. In an October 28th YouTube interview on **GermanMarshallFund**, ***Sweden's Chief Epidemiologist*** Anders Tegnell, the architect of Sweden's successful approach to the pandemic said the following: "When you look at the evidence behind using face masks in society, they are not that great. Very few studies have been done. I saw one from CDC lately that shows that face masks may not make much of a difference…. It's definitely our feeling or our belief that keeping distance is much more important….. You also have to realize that the experiences in Europe are not that great. Many of

the countries are looking at huge increases in cases have had legal obligations to wear face masks for quite some time. Which does not say that it could not have been worse without the face masks, of course we don't know that, but it's also quite clear that face masks is not going to be the silver bullet. It's not going to make that huge difference. And I think it's a bit dangerous to believe that you can change so much by using face masks…. I get mailings from many Swedes coming back from other countries saying how happy they are to be back where we are without face masks. Face masks is problematic I would say. I've worked in infectious diseases for a long time. It's something you use, but it's not something that you would like to use if you didn't have to."

As L.A. County imposes the toughest restrictions to date, let's look at how well these types of restrictions have worked previously



Age as a risk factor for COVID-19- What is your true risk?

What is the risk of dying from COVID-19 in a given number of people of an age range, WITHOUT taking into consideration any comorbidities? The CDC data below dated August 08, 2020, is the latest reported on the Infection Fatality Rate (IFR) for COVID-19.

For the older crowd there is increased risk. But how much more risk? And, how does that relate to the risk from the seasonal flu? The annual flu was a concern every year, but we never locked the nations of the world

down over it. I am also going to show your risk based on the level and number of comorbidities shown to make COVID-19 more serious and potentially fatal.

Let's first take a look from 30,000 feet at the relative risk for people under a certain age according to CDC statistics reported June 7th, 2020:

- People under 45 years of age **account for only 2.5% of ALL COVID-19 deaths!**
- People under 55 **only account for 7.3%** of all COVID-19 deaths.
- People under 65 account for 19.27% of all COVID-19 deaths.
- **People 65 and over account for 80.73% of all COVID-19 deaths.** (65-74 = 20.77%, 75-84 = 26.64%, 85+ = 33.32%)

Next let's look at death rates by age groups and the numbers I prefer to look at, the **survivability** numbers. That means, what is my chance of surviving if a given number of people in my age group are infected with COVID-19? I am hoping that this will help to put it in another context for you and allow you to compare survival rates with fatality rates for your age category.

Age	SURVIVAL rates	Death rates	What does that mean in practical terms?
0-19:	99.997%	0.003%	If 34,000 people were infected, 1 would die
20-49:	99.98%	0.02%	If 5,000 people were infected, 1 would die
50-69:	99.5%	0.5%	If 200 people were infected, 1 would die
70+:	94.6%	5.4%	If 20 people were infected, 1 would die

https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html

Let this sink in a minute

A CDC page titled, **COVID-19 Hospitalization and Death by Age**, compares risk of different age groups. The rate of death from COVID-19 **in those 85 and older** is **630 times (63,000 percent)** greater than 18-29-year-olds. And, it is approximately **5,670 times (567,000 percent)** higher than children aged 0-4 and **10,080 times (1,008,000 percent)** higher than youth aged 5-17!
https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-age.html

If you are over the age of 70 and certainly if older than 85, there is cause for genuine concern. But there is also cause for genuine concern in those age groups with the seasonal flu or pneumonia. And, consider that nationwide 40% of deaths have occurred in nursing and long-term care facilities. In some states those deaths are higher, ranging as high as 82% of deaths as is the case in New Hampshire. https://www.kff.org/coronavirus-covid-19/issue-brief/state-data-and-policy-actions-to-address-coronavirus/#long-term-care-cases-deaths

One thing to consider when speaking of the very elderly dying from COVID-19, is that the average life expectancy in the U.S. is 79 years and people are much more likely to die of something else rather than COVID-19. The following graphic displays that fact and also shows the proportion of the COVID-19 deaths in the U.S. based on age ranges.

Considering these statistics, can anyone tell me who in their right mind would recommend locking down schools and businesses for a virus to which 99.5% of all Americans under the age of 70 survive?

One of the world's top epidemiologists from Stanford releases a new study showing that COVID-19 mortality reporting is greatly over-exaggerated

The author of a new peer-reviewed study is **Dr. John P.A. Ioannidis,** ***Professor of Medicine (Stanford Prevention Research), of Epidemiology and Population Health*** and by courtesy, of ***Statistics and of Biomedical Data Science***. ***Department of Medicine - Stanford Prevention Research Center.***

If you are interested in reviewing Dr. Ioannidis's Bio, which is incredibly impressive, you can see it here: https://profiles.stanford.edu/john-ioannidis

The study is titled, **The infection fatality rate of COVID-19 inferred from seroprevalence data.** It has recently been released in a bulletin from the ***World Health Organization*** and demonstrates that while the death rate from COVID-19 varies significantly in different countries, the death rate in people under 70 is much less than the seasonal flu and much lower than estimates earlier in the pandemic.

Results:
I included 61 studies (74 estimates) and eight preliminary national estimates. Seroprevalence estimates ranged from 0.02% to 53.40%. Infection fatality rates ranged from 0.00% to 1.63%, corrected values from 0.00% to 1.54%.

When looking at these stats, bear in mind that these are from a cross section of many countries.

- Across 51 locations, the median COVID-19 infection fatality rate was 0.27% (corrected 0.23%):
- the rate was 0.09% in locations with COVID-19 population mortality rates less than the global average (< 118 deaths/million),
- 0.20% in locations with 118–500 COVID-19 deaths/million people
- and 0.57% in locations with > 500 COVID-19 deaths/million people.
- In people < 70 years, infection fatality rates ranged from 0.00% to 0.31% **with crude and corrected medians of 0.05%.**

Conclusion:
The infection fatality rate of COVID-19 can vary substantially across different locations and this may reflect differences in population age structure and case mix of infected and deceased patients and other factors. **The inferred infection fatality rates tended to be much lower than estimates made earlier in the pandemic.**

https://www.marktaliano.net/publication-bulletin-of-the-world-health-organization-infection-fatality-rate-of-covid-19-john-p-a-ioannidis/

This is a shot across the bow of the pharma-controlled media and public health agencies that have been propagating fear and hysteria 24/7 around deaths due to COVID-19, a disease that now appears to be less deadly for people under 70 than the seasonal flu. This is not to discount the fact that many people have died due to complications from COVID-19. It is simply to point out the stark reality that with the survivability rates being so high for the vast majority of the population, it certainly doesn't warrant the extreme measures that we have taken, measures that have caused so much collateral damage and death all around the world.

Chronic metabolic disease increases risk of severity significantly from COVID-19

Sixty percent of adults suffer from at least one chronic disease. Forty percent have two or more.

This is undoubtably one of the key reasons why COVID-19 has hit countries like the U.S., that have high rates of chronic disease harder.

These are the 4 most significant risk factors for severe outcome from COVID-19 and the percentage of American adults in that age group that have them: (**Circle each one that you have been diagnosed with.)**

1. **Hypertension-** (45% of adults have it) https://www.cdc.gov/bloodpressure/facts.htm
   (47.91 of fatal cases) https://pubmed.ncbi.nlm.nih.gov/32573311/
2. **Diabetes-** (16% of adults have diabetes and 42% have pre-diabetes)
   https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf
   (24.9% of fatal COVID-19 cases) https://pubmed.ncbi.nlm.nih.gov/32573311/
3. **Obesity-** (42% of adults are obese) https://www.cdc.gov/nchs/data/databriefs/db360-h.pdf
   (3X risk of hospitalization and increased risk of death) https://www.cdc.gov/obesity/data/obesity-and-covid-19.html (11.3% of fatal COVID-19 cases)
4. **Respiratory diseases-**
   (10.9% of fatal cases) https://pubmed.ncbi.nlm.nih.gov/32573311/

Numbers 5- 8 are also significant risk factors. Circle the ones that pertain to you.

5. **Kidney disease**
6. **Smoking**
7. Being **immunocompromised**
8. **Non-Caucasian ethnicity**- One established reason is that those with darker pigmented skin have lower levels of Vitamin D, which is a risk factor for severe COVID-19.

   The following groups have increased risk of death from COVID-19 as compared to Caucasian and Asian Americans: African American (2.1X), Hispanic Americans (1.1X), Native Americans (1.4X). These

ethnic groups also have higher rates of obesity, diabetes, cardiovascular disease than Caucasian and Asian Americans.

The risk of being **hospitalized** from COVID-19 is much higher for Black (4.7X), Hispanic (4.6X), Asian (1.3X) and Native Americans (5.3X) as compared to Caucasian Americans. https://www.cdc.gov/coronavirus/2019-ncov/downloads/covid-data/hospitalization-death-by-race-ethnicity.pdf

COVID-19 vaccine update

As more is becoming known about the COVID-19 vaccine candidates, the sketchier the vaccines become.

Vaccine trials shortcut the typical 4-6 year process for vaccine development, leaving the public as the long-term risk group

I have several serious concerns about the experimental COVID-19 vaccines. There are multiple issues with skipping important steps and taking shortcuts in the way they are doing the safety studies, not to mention that the recipients of the vaccine are younger, very healthy people in the early stages of the clinical trials. There is inadequate time to ascertain the potential delayed adverse reactions that may occur, especially in all the high-risk groups. Yet, they plan on rolling it out to the most vulnerable groups first. They and the rest of the public become the experimental group for which long-term effects will be determined going forward. Without full disclosure to each person of the fact that they are part of a biologic (drug) experiment, in fact the largest human experiment in history, it clearly violates the ***Nuremberg Code***. **The first principle of the *Nuremberg Code* clearly states, "The voluntary consent of the human subject is absolutely essential".** This is followed by an explicit clarification of all the associated requirements, making it extremely difficult for research principle investigators to twist it's meaning. http://www.ushmm.org/research/doctors/Nuremberg_Code.htm"

Immune Enhancement has plagued past attempt to make a coronavirus vaccine

Also, the reason that they have never been able to produce a coronavirus vaccine in the past despite numerous efforts, is that the vaccine caused a phenomenon called Immune Enhancement or sometimes called Pathogenic Priming. That is where the animals in the study developed a severe immune reaction similar to cytokine storm when later challenged with the wild virus. They suffered various pathological responses including severe lung damage. Those studies never proceeded to human trials as a result. This time Moderna skipped animal trials altogether. The AstraZeneca (Oxford) trial tested their vaccine on macaque monkeys and all of them got sick when later challenged with the wild virus. The Daily Mail reported: *"In the latest animal trials of the vaccine carried out on rhesus macaques, all six of the participating monkeys went on to catch the coronavirus. "Dr William Haseltine, a former Harvard Medical School professor, revealed the monkeys who received the vaccine had the same amount of virus in their noses as the three non-vaccinated monkeys in the trial. This suggests the treatment, which has already received in the region of £90 million in government investment, may not halt the spread of the deadly disease."*

The mRNA vaccines are an experimental project and have never been used in humans before

According to Mary Holland, vice chair and general counsel for ***Children's Health Defense*** said the following: "New vaccine technology will likely mean new kinds of vaccine injuries. Because there's never been a licensed mRNA vaccine before, we really don't know what injuries are going to look like."

What exactly is mRNA technology? Fast Company describes it this way:

"Like other vaccines, mRNA vaccines work by training the immune system to recognize a threat like a virus and begin producing antibodies to protect itself. But while traditional vaccines often use inactivated doses of the organisms that cause disease, mRNA vaccines are designed to make the body produce those proteins itself. Messenger RNA — a molecule that contains instructions for cells to make DNA — is injected into cells. In the case of COVID-19, mRNA vaccines provide instructions for cells to start producing the 'spike' protein of the new coronavirus, the protein that helps the virus get into cells. On its own, the spike protein isn't harmful. But it triggers the immune system to begin a defensive response. As Bill Gates, who has supported companies like Moderna and BioNTech through the Gates Foundation, has described it, 'you essentially turn your body into its own manufacturing unit.'" https://www.fastcompany.com/90573488/how-pfizers-covid-19-vaccine-works-mrna

Watch the ***Chief Medical Officer*** of the ***Moderna*** mRNA vaccine explain how their vaccine is "hacking the software of life" in such a cavalier and nonchalant attitude.
https://www.instagram.com/p/CIJWGzunJgo/?igshid=bq8150epb69b

I don't know about you, but it seems that whenever pharma starts bio-hacking the natural processes of the body something bad happens. Again, new technology never been used in a vaccine before, rushed to market, shortcutting trials and already producing millions of doses, applying for emergency use authorization (because it is still in experimental stages)….WHAT CAN POSSIBLY GO WRONG!

When are the clinical trials set to be completed?

October 27, 2022. WHAT? Nearly 2 years from now? Yes, see the screen capture below from the clinicaltrials.gov website. That just confirms that the public is part of the clinical trials! With tens of millions of doses rolling off production lines now, are they going to inform each recipient of their participation in this experiment? **Moderna's vaccine:**

https://clinicaltrials.gov/ct2/show/NCT04470427?term=Moderna&cond=covid-19&draw=2&rank=1

Detailed Description:
Please access www.modernatx.com/cove-study for additional information, such as Study Overview, Participation, Site Locations along with contact numbers for each location for the study.

Study Design Go to

Study Type :	Interventional (Clinical Trial)
Estimated Enrollment :	30000 participants
Allocation:	Randomized
Intervention Model:	Parallel Assignment
Masking:	Quadruple (Participant, Care Provider, Investigator, Outcomes Assessor)
Primary Purpose:	Prevention
Official Title:	A Phase 3, Randomized, Stratified, Observer-Blind, Placebo-Controlled Study to Evaluate the Efficacy, Safety, and Immunogenicity of mRNA-1273 SARS-CoV-2 Vaccine in Adults Aged 18 Years and Older
Actual Study Start Date :	July 27, 2020
Estimated Primary Completion Date :	October 27, 2022
Estimated Study Completion Date :	October 27, 2022

https://clinicaltrials.gov/ct2/show/NCT04470427?term=Moderna&cond=covid-19&draw=2&rank=1

Pharma insiders are the foxes watching the henhouse in the vaccine clinical trials

Despite numerous statements by Anthony Fauci and Alex Azar among others that the oversight committee for the vaccine clinical trials consist of scientists independent of pharma influence. Well it appears that is not the case. This bias and conflict of interest puts all Americans at risk. ***The Informed Consent Action Network (ICAN)***, through its attorneys, headed by Aaron Siri, has therefore sent a demand letter to the Director of ***HHS***, Director of ***NIAID***, Director of the ***FDA's*** CBER, the White House Coronavirus Task Force, and POTUS. You can see that letter here: https://www.icandecide.org/wp-content/uploads/2020/10/Conflicted-Members-on-DSMBs-for-COVID-19-Vaccines-Final.pdf

Follow-up periods for clinical trials are not nearly long enough

How long would it be reasonable to follow subjects of a vaccine trial after they are injected to see if they suffered any adverse effects? Is 2 weeks long enough? Is 1 month long enough? Is 6 months? 12 months?

When it comes to **the Moderna vaccine**, Dr. Fauci's favored horse in the race, this is what ***ICAN's*** **legal update** dated August 25th, 2020 had to say.

"The NIH and Moderna have rigged the clinical trial of their COVID-19 vaccine, mRNA-1273, to avoid capturing adverse reactions that occur more than 28 days after injecting this experimental vaccine. ICAN's legal team has filed an emergency petition to stop this unethical conduct."

"**Their trick is to only capture adverse reactions that occur more than 28 days after injection *if* the participant withdraws from the clinical trial.** This is nonsensical, since there is little for a participant to withdraw from after getting two doses during the first 28 days of the clinical trial. Once a participant has received both doses, if anything, a participant would have an incentive to remain part of the follow-up check-ups to address any adverse effects." Link to the Clinical Trials.gov where the trial details are outlined https://www.clinicaltrials.gov/ct2/show/NCT04470427?term=mrna-1273&draw=2&rank=1

"There could be many autoimmune, neurological and chronic health disorders which have a major impact on the quality of life that this experimental vaccine could cause. All of which may only arise more than 28 days after the injection. But yet, as long as the participant does not withdraw from the clinical trial, these will nonsensically be ignored as if they did not occur. This is unethical and renders vacuous any claim of safety for this product based on this trial."

To date they have not received a satisfactory response to their petition.

With regard to another vaccine candidate, Pfizer and BioNTech have also rigged the clinical trial of their COVID-19 vaccine, BNT162b, to avoid capturing many potential life-altering adverse reactions that may occur from this experimental vaccine. ICAN's legal team again filed an emergency petition to stop this unethical conduct as announced in their Legal Update dated August 25, 2020. The following is from that update.

The **study design** for the clinical trial for **BNT162b** provides that -- **despite reviewing efficacy for at least 2 years -- it will only capture "adverse events" for 1 month and "serious adverse events" for only 6 months after each dose.**

The adverse events captured beyond a month after injection should not be limited to "serious adverse events," since there are many autoimmune, neurological, and chronic health disorders which have a major impact on the quality of life, yet are **categorized by the FDA** as "adverse reactions" and *not* categorized as "serious adverse reactions." To wit, there are a myriad of post-licensure adverse reactions reported by consumers and physicians and are also listed in the **package inserts** for one or more vaccines that any individual living with would categorize as "serious"; yet the FDA, under its current guidelines, may not. These include, but are not limited to: alopecia, autoimmune disease, lupus erythematosus, vasculitis, Bell's Palsy, hypotonia, migraine, myelitis, neuropathy, seizures, mental disorders, rhinitis, and vertigo.

These artificial limitations are unethical and make any claim of safety for this product based on this trial specious at best.

ICAN's legal team filed a **citizen petition** and an **emergency stay petition** demanding that the clinical trial design for this vaccine be updated to require that all adverse reactions for the entire period of the clinical trial be tracked. These petitions also demand that the number of participants in this trial be increased and that they be tested before and after injection for any T-cells to SARS-CoV-2. ICAN intends to take further legal action if its rational and sensible requests are not met.

Once again, the trial is not scheduled to be completed **until January 29th 2023.**

https://www.clinicaltrials.gov/ct2/show/NCT04368728

Condition or disease	Intervention/treatment	Phase
SARS-CoV-2 Infection	Biological: BNT162b1	Phase 2
COVID-19	Biological: BNT162b2	Phase 3
	Other: Placebo	

Study Design Go to

Study Type:	Interventional (Clinical Trial)
Estimated Enrollment:	43998 participants
Allocation:	Randomized
Intervention Model:	Parallel Assignment
Masking:	Triple (Participant, Care Provider, Investigator)
Primary Purpose:	Prevention
Official Title:	A PHASE 1/2/3, PLACEBO-CONTROLLED, RANDOMIZED, OBSERVER-BLIND, DOSE-FINDING STUDY TO EVALUATE THE SAFETY, TOLERABILITY, IMMUNOGENICITY, AND EFFICACY OF SARS-COV-2 RNA VACCINE CANDIDATES AGAINST COVID-19 IN HEALTHY INDIVIDUALS
Actual Study Start Date:	April 29, 2020
Estimated Primary Completion Date:	August 1, 2021
Estimated Study Completion Date:	January 29, 2023

https://www.clinicaltrials.gov/ct2/show/NCT04368728

Shipping and storage of the Pfizer/BionTech vaccine presents a huge challenge.

The vaccine must be stored at -70 degrees Celsius, which is -94 degrees Fahrenheit. There will undoubtably be problems and times when those temperatures will not be maintained. What happens then? If it goes unnoticed will it render the vaccine simply ineffective, or will it become harmful to the person receiving it? These are real challenges that will be playing out in real time to real people.

A major flaw in the study design

The Phase 3 trial of the vaccine only required a person to have 1 symptom of COVID-19. No positive PCR test even. Not multiple symptoms…one. The problem with that is there are many symptoms that COVID-19 has in common with the common cold, other respiratory viruses and influenza. Without conformation that the people they say contracted COVID-19 in the study actually did, it invalidates the results. Nothing in the media about this though. Crickets…

Another leading vaccine candidate overseas draws scrutiny

In the same Legal Update August 25, 2020, ICAN's legal team reported the following:

AstraZeneca and the University of Oxford have also rigged the clinical trial of their COVID-19 vaccine, **ChAdox1 nCoV-19**, to avoid capturing many potential life-altering adverse reactions that may occur from this experimental vaccine. ICAN's legal team once again filed an emergency petition to stop this unethical conduct.

Unlike the clinical trials for Moderna and Pfizer's vaccines for COVID-19, which are occurring in the United States, the current clinical trial for AstraZeneca's COVID-19 vaccine is not under the direct authority of the FDA, since this clinical trial is not occurring in the United States.

News **reports** have indicated that AstraZeneca will be starting a new clinical trial in the United States for its COVID-19 vaccine that presumably will include a placebo control group. In the meantime, its current clinical trial occurring outside the United States persists in **using a MenACWY vaccine as a control**. As if that were not enough to rig this trial's safety results, the **study design** for their vaccine, ChAdox1 nCoV-19, like the design of Pfizer's vaccine, provides that, despite reviewing efficacy for at least 2 years, **it will only capture "adverse events" for 1 month and "serious adverse events" for only 6 months after each dose.**

Therefore, ICAN's legal team has also filed a **citizen petition** and an **emergency stay petition** demanding that the clinical trial design for this vaccine be updated to require that all adverse reactions for the entire period of the clinical trial be tracked against a placebo control group. These petitions also demand that the number of participants in this trial be increased and that they be tested before and after injection for any T-cells to SARS-CoV-2. ICAN intends to take further legal action if its rational and sensible requests are not met.

Just as the pharmaceutical companies will never rest when it comes to promoting and selling their vaccine products, we will never rest in exposing the truth regarding these products.

AstraZeneca's vaccine has multiple issues with their clinical trials

There are 3 arms to the Phase 3 trial. One in the USA, one in the UK and one in Brazil.

IMPORTANT: In the trial, some people got the vaccine and some got the "placebo" in the form of a meningococcal vaccine, NOT an inert substance like saline.

The USA arm of the trial was paused after subjects has serious side effects and one subject in the Brazil trial died. In the UK arm (3,000 people), they accidentally gave ½ dose as the first dose and a full dose as the second dose, 28 days apart. In the Brazil arm (9,000) people, they got a full dose both times. As it turned out, the participants that got the ½ dose followed by the full dose got better results that the people that got two full doses. That has left scientists scratching their heads trying to figure out why.

Now here is where things get even more convoluted. In reporting the results, they mixed all three arms of the trial and "averaged" the results. This is highly unusual and has drawn scrutiny from experts around the world.

Many more questions than answers

An article from ***Forbes*** online titled, **Covid-19 Vaccine Protocols Reveal That Trials Are Designed To Succeed** reveals some very troubling issues and deficiencies in the vaccine candidate trials.

Key highlights from the article:

What would a normal vaccine trial look like?

Prevention of infection must be a critical endpoint. Any vaccine trial should include regular antigen testing every three days to test contagiousness to pick up early signs of infection and PCR testing once a week to confirm infection by SARS-CoV-2 test the ability of the vaccines to stave off infection. Prevention of infection is *not* a criterion for success for any of these vaccines. In fact, their endpoints all require confirmed infections and all those they will include in the analysis for success, the only difference being the severity of symptoms between the vaccinated and unvaccinated.

We all expect an effective vaccine to prevent serious illness if infected. Three of the vaccine protocols—Moderna, Pfizer, and AstraZeneca—do *not* require that their vaccine prevent serious disease only that they prevent moderate symptoms which may be as mild as cough, or headache.

The second surprise from these protocols is how mild the requirements for contracted Covid-19 symptoms are. A careful reading reveals that the minimum qualification for a case of Covid-19 is a positive PCR test and one or two mild symptoms. These include headache, fever, cough, or mild nausea. This is far from adequate. These vaccine trials are testing to prevent common cold symptoms.
These trials certainly do not give assurance that the vaccine will protect from the serious consequences of Covid-19. Johnson & Johnson is the only trial that requires the inclusion of severe Covid-19 cases, at least 5 for the 75 participant interim analysis.

One of the more immediate questions a trial needs to answer is whether a vaccine prevents infection. If someone takes this vaccine, are they far less likely to become infected with the virus? These trials all clearly focus on eliminating symptoms of Covid-19, and not infections themselves. Asymptomatic infection is listed as a secondary objective in these trials when they should be of critical importance.

It appears that all the pharmaceutical companies assume that the vaccine will never prevent infection. Their criteria for approval is the difference in symptoms between an infected control group and an infected vaccine group. They do not measure the difference between infection and noninfection as a primary motivation.
A greater concern for the millions of older people and those with preexisting conditions is whether these trials test the vaccine's ability to prevent severe illness and death. Again we find that severe illness and death are only secondary objectives in these trials. None list the prevention of death and hospitalization as a critically important barrier.

If total infections, hospitalizations, and death are going to be ignored in the preliminary trials of the vaccines, then there must be phase four testing to monitor their safety and efficacy. This would be long term massive scale monitoring of the vaccine. There must be an indication that the authorized vaccines are reducing infection, hospitalization, and death, or else they will not be able to stop this pandemic.

These protocols do not emphasize the most important ramifications of Covid-19 that people are most interested in preventing; overall infection, hospitalization, and death. It boggles the mind and defies common sense that the National Institute of Health, the Center for Disease Control, the National Institute of Allergy and Infectious Disease, and the rest would consider the approval of a vaccine that would be distributed to hundreds of millions on such slender threads of success.

End of excerpts

Fauci says early COVID vaccines will prevent symptoms, not block disease — and may be only 50% to 60% effective

In an article on The Blaze, Dr. Anthony Fauci explains how low the bar is set for the COVID-19 vaccines…

How soon will a vaccine be ready?

Dr. Anthony Fauci says that early COVID-19 vaccines will likely only prevent symptoms — not stop transmission.

He also pointed out that such vaccines may only be 50% or 60% effective.

What are the details?

According to a report from Yahoo! Finance, Fauci, director of the National Institute of Allergy and Infectious Diseases, cautioned that early vaccines are simply aimed at preventing or reducing symptoms of coronavirus infection.

Fauci made the remarks during Monday's Yahoo! Finance's All Markets Summit.

"If the vaccine allows you to prevent initial infection, that would be great," he said in remarks. "[But] the primary endpoint [is] to prevent clinically recognizable disease."

https://www.theblaze.com/news/fauci-covid-vaccines-symptoms-disease

These companies are now applying and getting emergency use authorization (EUA) from the Food and Drug Administration (FDA) **with just their limited preliminary results.** That means that the general public becomes an extension of the study and in essence are part of the largest human experiment ever. conducted, BUT without informed consent for each individual that they acknowledge and accept the risk of being a participant in an experimental product.

And a highly credible expert, the Associate Editor of the *British Medical Journal* criticizes the lack of significant outcome results in the vaccine trials designs.

The October 22nd article titled, **Coronavirus Vaccine Trials Underway May Not Tell if the Shots Save Lives of COVID-19 Patients: British Medical Journal Expert**

From the article:

Vaccines are being hailed as the solution to the COVID-19 pandemic, but the trials currently underway are not designed to tell us if they will save lives, according to a drug development expert from the prestigious *British Medical Journal* (BMJ).

Writing in The BMJ medical journal, Associate Editor Peter Doshi, said that several COVID-19 vaccine trials are now in their most advanced (phase 3) stage, but what will it mean exactly when a vaccine is declared "effective"?

Many may assume that successful phase 3 studies will mean we have a proven way of keeping people from getting very sick and dying from COVID-19. And a robust way to interrupt viral transmission.

Yet the current phase 3 trials are not actually set up to prove either, Doshi said. "None of the trials currently underway are designed to detect a reduction in any serious outcome such as hospitalisations, intensive care use, or deaths. Nor are the vaccines being studied to determine whether they can interrupt transmission of the virus," he wrote.

He explained that all ongoing phase 3 trials for which details have been released are evaluating mild, not severe, disease—and they will be able to report final results once around 150 participants develop symptoms.

Yet Doshi argued that vaccine manufacturers have done little to dispel the notion that the severe COVID-19 was what was being assessed. Moderna, for example, called hospitalisations a "key secondary endpoint" in statements to the media. But Tal Zaks, Chief Medical Officer at Moderna, told The BMJ that their trial lacks adequate statistical power to assess that endpoint.

Zaks confirmed that Moderna's trial will not demonstrate prevention of hospitalisation because the size and duration of the trial would need to be vastly increased to collect the necessary data.

But Doshi raised another important issue—that few or perhaps none of the current vaccine trials appear to be designed to find out whether there is a benefit in the elderly, despite their obvious vulnerability to COVID-19. If the frail elderly is not enrolled into vaccine trials in sufficient numbers to determine whether there is a reduction in cases in this population, "there can be little basis for assuming any benefit against hospitalisation or mortality," he warned.

End of excerpts

https://weather.com/en-IN/india/coronavirus/news/2020-10-22-vaccine-trials-may-not-tell-they-save-lives-of-covid-19-patients

Legal updates- and more on the COVID-19 vaccines

N.I.H. / Moderna Phase 1 clinical trial data

In a November 2nd ***Informed Consent Action Network (ICAN)*** Legal update, the successful results from their F.O.I.A. requests for Moderna's safety data from their Phase 1 trials are discussed.

After months of objections, the National Institutes of Health (NIH) and Moderna have capitulated and provided ICAN a copy of their internal 322-page Safety Summary Report for the Phase I trial of their COVID-19 vaccine (mRNA-1273). A full copy of this report is available below and this is the first time it is being made available to the public.

On May 18, 2020, Moderna issued a press release claiming the data from its Phase I trial "substantiate our belief that mRNA-1273 has the potential to prevent COVID-19 disease." Since this trial was actually conducted by the NIH, ICAN submitted a FOIA request on May 22, 2020 to NIH for: "All safety and efficacy data and information regarding mRNA-1273, including from the Phase I clinical trial of this experimental vaccine conducted by the National Institute of Allergy and Infectious Diseases." ICAN requested that NIH grant expedited processing for this request.

On June 8, 2020, NIH recognized the "compelling need" to expeditiously release to the public the information ICAN sought by granting its request for expedited processing. But then NIH failed to produce anything. Therefore, ICAN sued the NIH on August 13, 2020 in federal court to force NIH to release this data. NIH then finally sent a "final response" to ICAN stating: "The safety data for this study comprises 1,093 pages. I have determined to withhold those records in their entirety pursuant to [exemptions that] protect information that constitutes trade secret information and information that is confidential and commercial or financial in nature."

ICAN did not accept this objection and its attorneys, led by Aaron Siri, informed the court that we would argue for the documents via briefs to the court. NIH's opening brief – explaining why it should not produce this data – was set to be due to the Court on October 30, 2020. Eight days before that due date, on October 22, 2020, NIH and Moderna abruptly reversed their position and advised that they would produce all of the data.

On October 29, 2020, ICAN received the first 332 of 1,093 pages -- the remainder of which will be produced shortly. It can be downloaded here. ICAN and its subscribers are the first people in the world, outside of NIH and Moderna, to actually see this data. We will be carefully studying all of the disclosed data but ICAN wanted to widely disseminate it immediately so that others have the opportunity to do the same.

Despite only receiving a portion of the data, what ICAN has already received provides important information for the public to know in evaluating Moderna's vaccine. For example, the documents ICAN received reveal that approximately 70% of participants reported unsolicited adverse events, many of which are extremely concerning.

Just as the pharmaceutical companies will never rest when it comes to promoting and selling their vaccine products, we will never rest in exposing the truth regarding these products or in demanding full transparency and full informed consent for any and all vaccines.

Valid endpoints of vaccine trials

A November 16th legal update from ***ICAN*** demands valid endpoints for determining if the COVID-19 vaccine candidates are effective stated the following:

On November 6, 2020, ICAN filed a Citizen Petition and a Petition for a Stay of Action demanding that the FDA require valid endpoints for determining efficacy in the COVID-19 vaccine trials currently being run by Pfizer, Moderna, AstraZeneca, and Johnson & Johnson. ICAN's demands include that the vaccine be shown to prevent serious cases of COVID-19 (not just mild cases) and that it can stop transmission of COVID-19. As explained in our previous legal updates, ICAN's legal team has been hammering away at the safety requirements for the clinical trials of COVID-19 vaccines, including demanding they be placebo-controlled, long-term, and have other safeguards. Many of those demands were subsequently met and we are not done fighting on that front. But there is now another battle we are fighting.

ICAN's legal team, led by Aaron Siri, has now also focused its efforts on the basis the FDA will rely upon to determine whether any of the COVID-19 vaccine frontrunners are effective. Many Americans have been led to believe that the vaccines currently in trials are the answer to all pandemic-related problems. Many believe this is because a vaccine, when available, will prevent individuals from having a serious case of COVID-19 and will stop people from spreading it to others. However, the clinical trials for Pfizer, Moderna, AstraZeneca, and Johnson & Johnson's products are **not designed** to determine either of these!

Instead, each of the four trials' primary goals for determining whether the vaccine is effective merely requires determination of whether it can reduce symptoms of mild cases of COVID-19. The trials will also not demonstrate whether or not a vaccine recipient can still transmit COVID-19 to others. This means that, under the current rules, a COVID-19 vaccine can be licensed without demonstrating it can prevent severe COVID-19, hospitalization, or deaths, nor stop the spread of COVID-19.

Also concerning is that "cases" of COVID-19 for trial purposes are being demonstrated by positive PCR tests. The scientific literature has shown that such PCR tests can be highly unreliable, frequently giving false positives. Consistent with this literature, we demanded that only positive PCR results meeting certain criteria be relied upon. ICAN also demanded that all participants be tested before and after vaccination for T-cell immunity to SARS-CoV-2, which is not currently part of the protocols. If a person has pre-existing immunity to SARS-CoV-2 (either from being exposed to COVID-19 or otherwise) their presence in the study could affect the result by showing fewer people getting sick than would actually occur in the "wild."

These alarming deficiencies in the studies were what led ICAN to direct its attorneys to file a petition demanding that all four Phase III COVID-19 vaccine trials amend their efficacy endpoints. ICAN demanded, among other things, that the trials test and determine (1) whether these vaccines will prevent severe cases of COVID-19; and (2) whether they will stop the spread of the virus. ICAN further demanded improvements in the PCR testing protocol and T-cell testing pre-and-post vaccination.

Recognizing the critical importance that these changes be made in a timely manner, on November 11, 2020, ICAN's attorneys filed a Petition for a Stay of Action with the FDA which asks that the agency stay, or pause, any action related to the trials until the requested actions in the efficacy petition are implemented.

ICAN's attorneys separately sent a letter to Dr. Peter Marks, the Director of the Center for Biologics Evaluation and Research at the FDA, bringing these very concerns to his attention. You can read that letter here. Dr. Marks has referred to himself as "the FDA point person on COVID-19 vaccines" and has assured Americans that the FDA "will make sure they're safe and effective." ICAN will closely review any response from Dr. Marks given his promise that he and the FDA "uphold globally respected standards for product quality, safety, and efficacy" and his statement that he would resign if "something that was unsafe or ineffective [] was being put through."

In light of all that….

The massive P-R push to get the COVID-19 vaccine has begun

The public relations campaigns are already in full gear but prepare for the most hyped vaccination hard-sell in history. In order to make an informed decision, you need to know the potential risks involved. Stay tuned in future issues as the stories develop. They are already rolling out catch phrase talking points like, "do it for the good of all", or "do your civic duty", "think of others rather than yourself", "don't be selfish" and one I heard today, "everyone needs to do their part." I have heard nothing like, "if you have already had COVID-19, you can opt out." I even heard a doctor on today that said we will never reach herd immunity because that would take 80-90% of people getting infected. What a bunch of unscientific hogwash! And on the same segment, they said that they expect the vaccine to impart immunity for 0-15 years. Where in the world do they come up with such utter nonsense? Talk about vaccine misinformation! Vaccine immunity never, ever comes close to natural immunity as far as the length of protection. And, they are already trying to throw cold water on the idea that people who have had COVID-19 won't have lasting protection. That is far from the truth as evidenced by many studies looking at people that had SARS-CoV-1 back in 2002-2003 and just understanding basic immunology. And, if what they are saying were true where does that leave vaccine protection then? Certainly not at 10-15 years! It's sad because an uneducated and unsuspecting public has no idea that they are being conned. Which brings me to the next and disturbing topic…

Even if it means squashing all First Amendment rights

As if the Big Tech censorship of vaccine risk awareness wasn't enough, according to Mercola.com, British and American intelligence agencies are collaborating to eliminate "anti-vaccine propaganda" from public discussion using sophisticated cyberwarfare tools. This is a dangerous escalation of silencing real science, data and intellectual discussion in the public square on an important topic impacting the overall health of all citizens.

My featured article of the month-

Critical Information for those considering the flu vaccine

This is Part-2 of a 3-Part article I have written covering these 3 aspects of consideration:

Part-1: The Accuracy of Reported Seasonal Flu Deaths

Part-2: Flu Vaccine Effectiveness

Part-3: Risks of the Flu Vaccine

Access the complete 3-Part article HERE.

Since the flu marketing campaign is in full gear and people are feeling the pressure to get their annual flu shot, I would like to provide you with a link to the full article containing all three aspects for consideration. That way you can share it with your friends and loved ones allowing them to make an informed decision.

***This series was written with the intent of providing accurate information to share with friends, family and patients about this important and timely subject, so that you and they can make an educated decision about whether or not to take the flu vaccine.**

The annual flu shot campaign is in full gear. The public is being inundated with a blitzkrieg of marketing that is designed to frighten and coerce them into getting the flu shot for themselves and their children. But there are some important, in fact VITAL aspects that need to be considered regarding its effectiveness before anyone should consider the flu shot. After all, if the claims about the effectiveness of the flu shot are greatly exaggerated and the actual numbers of effectiveness were used for their marketing, how would that impact compliance and therefore revenue? Those numbers and their profits would tank. Therein lies their dilemma. Be transparent and lose market share or figure out a way to twist the truth. I'm going to share with you which strategy they have chosen and what the actual data says.

The ***Cochrane Collaboration*** is a highly respected and acclaimed organization. They are world-renowned in the scientific community. Their researchers do meta-analyses which look at all the studies that have been published on a particular topic. They then scrutinize the results for accuracy and bias before selecting studies that meet the criteria they are looking for and reject the ones that they can identify bias in. Then they analyze the studies, make their determinations and report them in a published review.

In 2018, the Cochrane Review released 3 reviews of published research on the flu shot's effectiveness over the last 30-40 years in children, adults and the elderly- The results show poor performance

Review #1-

2018 Cochrane Review of 41 studies on the effectiveness of the flu vaccine IN HEALTHY CHILDREN, reveals very limited efficacy

The ***Cochrane Database of Systematic Reviews*** published a review in 2018 titled, **Vaccines for preventing influenza in healthy children**, looked at **41 studies**, **encompassing over 200,000 children** aged 3-16 years, from 1984-2013. It is an update of a previous review that was published in 2011. The reviewed studies were from 4 different regions of the world including the United States and **looked at the live attenuated virus and the inactive virus vaccines compared to a placebo or no vaccine.** The results on effectiveness **were not very impressive** at all. https://www.ncbi.nlm.nih.gov/pubmed/29388195

From the Abstract: *(I.L.I. stands for Influenza Like Illness)*

"We included 41 clinical trials (> 200,000 children). Most of the studies were conducted in children over the age of two and compared live attenuated or inactivated vaccines with placebo or no vaccine. Studies were conducted over single influenza seasons in the USA, Western Europe, Russia, and Bangladesh between 1984 and 2013."

"Compared with placebo or do nothing, **live attenuated influenza vaccines** probably reduce the risk of influenza infection in children aged 3 to 16 years from 18% to 4%.... and they may reduce ILI by a smaller degree, from 17% to 12%.... **Seven children would need to be vaccinated to prevent one case of influenza, and 20 children would need to be vaccinated to prevent one child experiencing an ILI."**

(This represents a 14% effectiveness rate for influenza and a 5% effectiveness rate in preventing influenza like illness)

"Inactivated vaccines Compared with placebo or no vaccination, inactivated vaccines reduce the risk of influenza in children aged 2 to 16 years from 30% to 11% … and they probably reduce ILI from 28% to 20%.... **Five children would need to be vaccinated to prevent one case of influenza, and 12 children would need to be vaccinated to avoid one case of ILI."**

(This represents a 20% effectiveness rate for influenza and an 8% effectiveness rate in preventing influenza like illness)

"One brand of monovalent pandemic vaccine was associated with a sudden loss of muscle tone triggered by the experience of an intense emotion (cataplexy) and a sleep disorder (narcolepsy) in children."

The rationale that getting children vaccinated saved millions of dollars in lost wages due to parents having to take off work, or children missing school is often thrown out there. So, what did the review find on those concerns?

"There was insufficient information available to determine the effect of vaccines on school absenteeism due to very low-certainty evidence from one study. We identified no data on parental working time lost, hospitalisation, fever, or nausea." When 41 of the best and most reliable studies out there do not even address those issues, one has to wonder where those person's citing those concerns are getting their information from.

Review #2-

A 2018 Cochrane Review of 52 studies on the effectiveness of the flu vaccine IN HEALTHY ADULTS, shows that being vaccinated is only 1% better than not being vaccinated

The ***Cochrane Database of Systematic Reviews*** published a review in 2018 titled, **Vaccines for preventing influenza in healthy adults.** The results of looking at 52 clinical trials and over 80,000 people show a very low effectiveness of the flu vaccine. https://www.ncbi.nlm.nih.gov/pubmed/29388196

From the Abstract: *(I.L.I. stands for influenza Like Illness)*

"The consequences of influenza in adults are mainly time off work. Vaccination of pregnant women is recommended internationally. This is an update of a review published in 2014.

Randomised controlled trials (RCTs) or quasi-RCTs comparing influenza vaccines with placebo or no intervention in naturally occurring influenza in healthy individuals **aged 16 to 65 years**."

"We included **52 clinical trials of over 80,000 people** assessing the safety and effectiveness of influenza vaccines. **[15 included Randomized Clinical Trials were industry funded (29%)]."**

We have presented findings from 25 studies comparing inactivated parenteral influenza vaccine against placebo or do-nothing control groups as the most relevant to decision-making. The studies were conducted over single influenza seasons in North America, South America, and Europe between 1969 and 2009. We did not consider studies at high risk of bias to influence the results of our outcomes except for hospitalisation. Inactivated influenza vaccines probably reduce influenza in healthy adults from 2.3% without vaccination to 0.9%... and they probably reduce ILI from 21.5% to 18.1%..."

"71 healthy adults need to be vaccinated to prevent one of them experiencing influenza, and 29 healthy adults need to be vaccinated to prevent one of them experiencing an ILI."

(This represents a 1.4% effectiveness rate for influenza and a 3.4% effectiveness rate in preventing influenza like illness). Those are MISERABLE statistics on effectiveness.

"Healthy adults who receive inactivated parenteral influenza vaccine rather than no vaccine probably experience less influenza, from just over 2% to just under 1% (moderate-certainty evidence)."

- "Vaccination may lead to a small reduction in the risk of hospitalisation in healthy adults, **from 14.7% to 14.1%.**" ***(approximately one half of one percent)***
- **"Vaccines may lead to little or no small reduction in days off work (-0.04…)."**
- "Inactivated vaccines cause an **increase** in fever from 1.5% to 2.3%."
- "**Protection against influenza and ILI in mothers and newborns was smaller** than the effects seen in other populations considered in this review. Vaccines **increase the risk of a number of adverse events**, including a small increase in fever, but rates of nausea and vomiting are uncertain."

According to the article, "**Fifteen included trials were industry funded (29%)**". This makes the findings of minimal overall benefit all the more interesting! What I mean by that is, **if nearly a third of the studies they looked at were funded by the drug industry (and you can bet they put their best numbers forward), and that didn't even skew the results in their favor, most likely the non-drug industry studies found even less or no benefit at all.**

So, one has to ask oneself, is it worth playing Russian Roulette with all the toxic ingredients from the flu vaccine in order to have any questionable benefit at all? Why not just optimize your vitamin A, C & D levels, eat healthy, get quality sleep, practice good hygiene and you could lower your risk much more than risking the flu shot.

Review #3-

A 2018 Cochrane Review of 8 studies on the effectiveness of the flu vaccine ON THE ELDERLY, shows absolutely terrible results for efficacy

The ***Cochrane Database of Systematic Reviews*** published a review in 2018 titled, **Vaccines for preventing influenza in the elderly.** https://www.ncbi.nlm.nih.gov/pubmed/29388197 Once again, the success of the flu vaccines in elderly adults is very low.

From the Abstract: *(I.L.I. stands for Influenza Like Illness)*

"The consequences of influenza in the elderly (those age 65 years or older) are complications, hospitalisations, and death. The primary goal of influenza vaccination in the elderly is to reduce the risk of death among people who are most vulnerable. This is an update of a review published in 2010."

"We identified **eight RCTs (over 5000 participants)**, of which four assessed harms. The studies were conducted in community and residential care settings in Europe and the USA **between 1965 and 2000**."

"Older adults receiving the influenza vaccine may experience less influenza over a single season compared with placebo, **from 6% to 2.4%**... We rated the evidence as low certainty due to uncertainty over how influenza was diagnosed. Older adults probably experience less ILI compared with those who do not receive a vaccination over the course of a single influenza season **(3.5% versus 6%...)"**

"These results indicate that 30 people would need to be vaccinated to prevent one person experiencing influenza, and 42 would need to be vaccinated to prevent one person having an ILI." ***(This represents a 3% effectiveness rate for influenza and a 2% effectiveness rate in preventing influenza like illness). Those are MISERABLE statistics on effectiveness!***

"We are uncertain how big a difference these vaccines will make across different seasons. **Very few deaths occurred, and no data on hospitalisation were reported**. No cases of pneumonia occurred in one study that reported this outcome."

In the Cochrane Review above of the flu shot with healthy adults, even the decrease in hospitalizations was minimal at best… "Vaccination may lead to a small reduction in the risk of hospitalisation in healthy adults, **from 14.7% to 14.1%." *(approximately one half of one percent)***

It's not just the ***Cochrane Reviews*** that give the flu vaccines poor marks. There are dozens of other articles that agree. One such article was published in the ***Archives of Internal Medicine*** titled, **Impact of Influenza Vaccination on Seasonal Mortality in the US Elderly Population.** You can clearly see from the graphs below, that as the green line representing the percentage of persons aged 65 and older receiving the flu vaccine increases tremendously over the 33 year period, the black dashed line representing the average deaths in that age group from pneumonia and influenza (graph on the left) and all cause mortality (graph on the right) continues to rise. It's not going down as you would expect if the flu shot was saving lives. It's not even staying level. It is rising steadily despite exponential growth in the number of seniors receiving the flu vaccine.

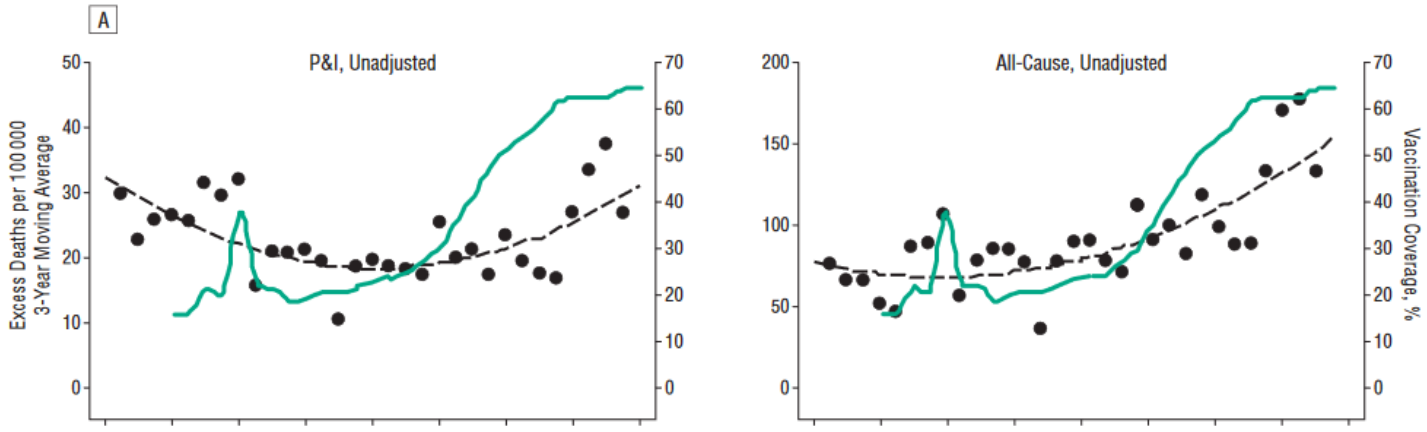


Figure 3. Seasonal excess pneumonia and influenza (P&I) and all-cause mortality rates in persons 65 years or older from 1968 through 2001. A, In the unadjusted findings, the black circles show the 3-year moving averages of the excess mortality rates, and the green line shows influenza vaccination coverage.

green line- the percentage of persons aged 65 and older receiving the flu vaccine (with the % of coverage on the right vertical)

black dashed line on the left- represents the average deaths from pneumonia and influenza in that age group
black dashed line on the right- represents all-cause mortality in that age group

https://pubmed.ncbi.nlm.nih.gov/15710788/

How about in young children?

In a 2008 study published in ***Archives of Pediatrics and Adolescent Medicine*** titled, **Influenza vaccine effectiveness among children 6 to 59 months of age during 2 influenza seasons: a case-cohort study**, researchers found that the flu vaccine did NOT demonstrate vaccine effectiveness (over two different flu seasons), in preventing the flu.

From the study:

"In 2 seasons with suboptimal antigenic match between vaccines and circulating strains, we could not demonstrate vaccine effectiveness in preventing influenza-related inpatient/emergency department or outpatient visits in children younger than 5 years. Further study is needed during years with good vaccine match." https://www.ncbi.nlm.nih.gov/pubmed/?term=18838647

This study says that the 2 seasons they studied were seasons where there was "suboptimal antigenic match", meaning the strains used in the flu shot didn't match well with the circulating strains. Let's face the truth. Every year that is the same reason given to the public for the abysmal results of protection from the flu shot. So, the 2 years selected for the study were certainly nothing out of the ordinary.

Here is another perfect example of that recycled excuse

A 2017 study in the **Journal of *Clinical Infectious Diseases*** titled, **The Household Influenza Vaccine Effectiveness Study: Lack of Antibody Response and Protection Following Receipt of 2014-2015 Influenza Vaccine**, found that the protection from the 2014-2015 flu vaccine was extremely poor. They followed 1,341 people older than age 13 from 340 households. **The background for the article even cited a study that found that persons that were vaccinated against the flu for 3 years in a row had a greater chance of contracting the flu. "At least one study paradoxically observed increased A(H3N2) infection among those vaccinated 3 consecutive years."** https://www.ncbi.nlm.nih.gov/pubmed/?term=29020179

From the Abstract: (VE stands for Vaccine Effectiveness)

"Influenza A(H3N2) was identified in 166 (12%) individuals and B(Yamagata) in 34 (2%). VE against A(H3N2) **was -3%... and similarly ineffective between age groups**; ….**Antibody against A/Hong Kong/4801/14, similar to circulating 2014-2015 A(H3N2) viruses and included in the 2016-2017 vaccine, did not significantly predict protection."**

From the Conclusion:

"Absence of VE against A(H3N2) was consistent with circulation of antigenically drifted viruses; however, generally limited antibody response following vaccination is concerning even in the context of antigenic mismatch."

This basically describes the reason the flu vaccine is such a crap shoot. They guess at the strains that will be circulating the following year. They ramp up production of the vaccines that will cover those 3 to 4 strains and then 2 things happen. First, they often guess wrong. Secondly, the strains that they have put into the vaccine have mutated. That is what antigenic drift means as referred to in the article above.

The bottom line is that the flu vaccine offers very little if any protection from the season influenza. In fact, as shown in this article, it may even make a person more susceptible to contracting other forms of respiratory infections and possible even COVID-19. In addition, there is always a risk of adverse reactions to the vaccine. After all, the influenza vaccine has been responsible for the greatest number of damage claims for vaccine injury as you will see in Part-3 of this series.

Conclusion:

The continued exaggeration of the effectiveness of the flu shot and all vaccines, is a prime example and a sober reminder that the pharmaceutical industry, our government health agencies and the media they control, are pushing an agenda that is based on inaccurate information at best and outright lies at worst. It remains up to all free people to take the time to do their own due diligence, think for themselves rather than being told what to think and come to their own conclusions about some of the most important decisions they will ever make regarding their health and the health of their children.

To help you with that investigative process, you can download my eBook called ***1200 Studies- The Truth Will Prevail*** at https://1200studies.com . This is the most exhaustive exposé on the problems with vaccines to date. It contains excerpts from over 1,400 studies that refute the claims made about the safety and effectiveness of vaccines, all presented in a format that allows for key word and phrase searching, an interactive table of contents and links directly to all of the study sources.

I have also authored two soon to be released books, one on the risks of vaccines during pregnancy and one on the risks and effectiveness of vaccines in infancy and childhood. I believe that they are the most thorough and evidence-based presentation of those topics ever done. Follow this link be notified as soon as they are released. https://lp.constantcontactpages.com/su/WSIEICc/safepregnancyandchildhood

Nutrient of the month-

This month I thought I would highlight an immune/detox drink that I have been making for myself and my family over the last few months. It combines several nutrients that I have covered in my ***Nutrient of the Month*** columns over the past few months.

First my immune tonic. I like orange flavored Emergen-C. With the vanilla whey, it makes it taste like an orange dreamsicle. 😉

In a glass of water, add:

- 1 Pack Super Orange Emergen-C (or similar powdered Vitamin C, mineral ascorbate formula)
- 1 Zinc capsule (30 mg)
- 1 Quercetin capsule (500 mg)
- 1 NAC- capsule (500 mg)
- 1 Selenium capsule (200 mg)
- 3 grams powdered glutamine
- 1 scoop vanilla whey protein (I use cold filtered, non-hydrolyzed)

Mix with a wire whip or blender

In addition to all of the other immune modulating effects of these nutrient listed in my previous issues, they can act directly in the efforts against viral pathogens in the following ways.

- The Quercetin (a Zinc ionophore) and Zinc act together to deliver Zinc into your cells and inhibit viral replication (not just COVID-19, but all viruses).

- The NAC, Selenium, Glutamine and undenatured Whey Protein help your body make Glutathione, the "Master Antioxidant" and detoxifier.
- The Vitamin C increases activity and effectiveness of the Innate Arm of the immune system, including Natural Killer Cells, Neutrophils and Macrophages.

I also make sure that myself and my family maintain Vitamin D levels between 60 and 80 ng/mL. If you haven't had your Vitamin D levels tested, you can order an at home test kit for just $70, postage included from and back to the lab. Order that here: https://lp.constantcontactpages.com/sh/qHdiKdW/vitaminD

If you don't have access to high quality nutritional supplements and would like help with finding the above products, you can visit my store at Wellnessdoc.com **HERE**.

New PubMed articles of the month

Retrospective study on HPV vaccination shows and increase in need for medical care post-vaccination

A study published in ***Clinical Epidemiology*** September 08, 2020 titled, **General Practitioner Attendance in Proximity to HPV Vaccination: A Nationwide, Register-Based, Matched Case-Control Study**, found a correlation with increased general practitioner visits in girls and young women after HPV vaccination. Interestingly, it appears at the end of the article they try some "gymnastics" to try to explain away the findings. Looking at the graphs really tells the whole story. The study says that in all groups the increase in GP visits began in the first year after vaccination. And, when you see the graphs, you can see that those increases in visits continued at an even higher rate after the first year.

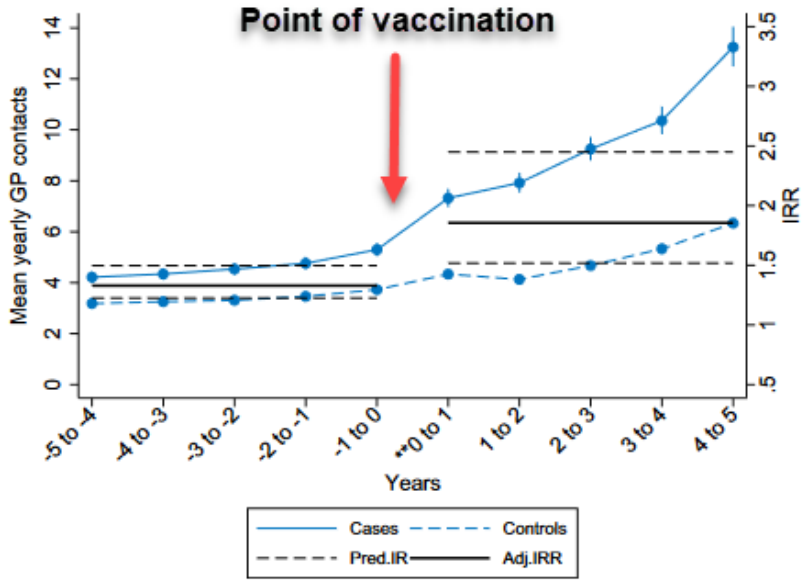


Figure 1 Mean yearly GP contacts and the ratio of the adjusted IRR from prior to vaccination compared to after vaccination between cases and matched controls (entire study population). Cases: 1,458; Controls: 7,212. ** Date of vaccination included.

https://pubmed.ncbi.nlm.nih.gov/32982458/

Another study by James Lyons-Weiler and Paul Thomas MD titled, **Relative Incidence of Office Visits and Cumulative Rates of Billed Diagnoses Along the Axis of Vaccination**, categorizes the illnesses that vaccinated and unvaccinated children saw doctors for at office visits during their first nine and a half years of life.

https://www.ar25.org/sites/default/files/ijerph-17-08674-v3.pdf

The graph on the next page shows visually in a dramatic way, the differences in rates of doctor visits for various health problems. The vertical axis on the left is the number of office visits. The horizontal axis is the number of days of life.

The far right of the horizontal (X) axis represents 3,500 days (9.6 years) of age.

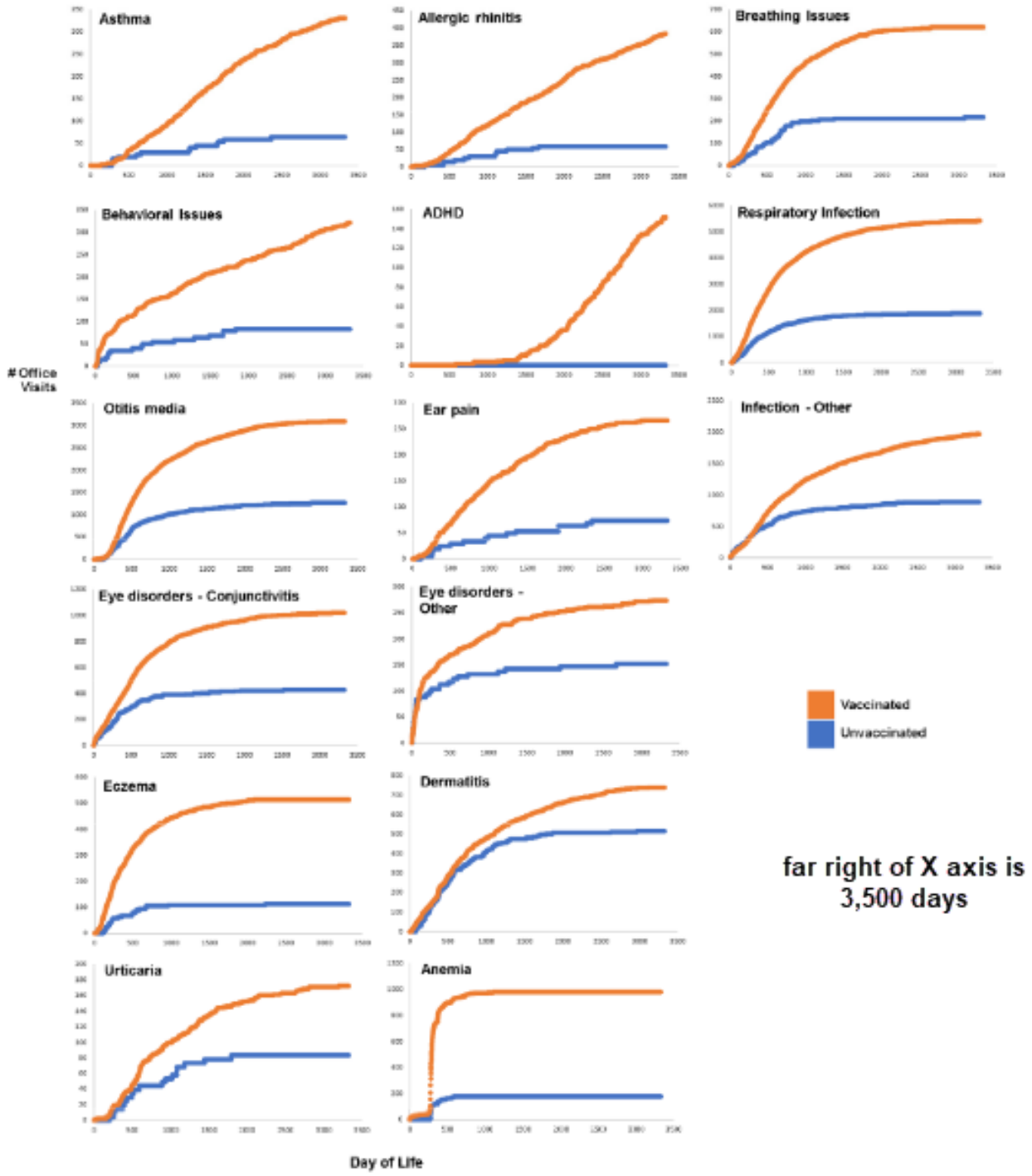


Figure 5. Analysis 5. Cumulative office visits in the vaccinated (orange) vs. unvaccinated (blue) patients born into the practice: the clarity of the age-specific differences in the health fates of individuals who are vaccinated (2763) compared to the 561 unvaccinated in patients born into the practice over ten years is most strikingly clear in this comparison of the cumulative numbers of diagnoses in the two patient groups. The number of office visits for the unvaccinated is adjusted by a sample size multiplier factor (4.9) to the expected value as if the number of unvaccinated in the study was the same as the number of vaccinated.

Thimerosal causes severe reproductive issues in male rats and is linked to multiple systemic health problems

A study published in the ***Saudi Journal of Biological Sciences*** titled **A study on the potential reprotoxic effects of thimerosal in male albino rats**, had many damning things to say about Thimerosal and it's use in vaccines.

Abstract:

"Thimerosal is ethyl mercury based compound which is being used as a preservative in vaccines since decades. Pharmaceutical products and vaccines that contain thimerosal are among the potential source of mercury exposure. Current research was intended to ascertain the reprotoxic effects of thimerosal on rat testes. Twenty-four adult male albino rats were sorted into four groups (n = 6). The first group was a control group. Rats of experimental Group 2, 3 and 4 were treated with various dosages of thimerosal (0.5, 10, 50 mg/kg) respectively. Rats were decapitated after thirty days of trial and different parameters were analyzed. Thimerosal exposure resulted in a significant decrease in antioxidant enzyme activities including catalase (CAT), peroxidase (POD), superoxide dismutase (SOD), glutathione reductase (GSR)and increased levels of thiobarbituric acid reactive substances (TBARS). Different doses of thimerosal significantly decreased ($p < 0.05$) the concentration of plasma testosterone, luteinizing hormone (LH) and follicle stimulating hormone (FSH). Additionally, Daily sperm production (DSP) and efficiency of daily sperm production were significantly reduced followed by thimerosal exposure. Moreover, thimerosal significantly ($p < 0.05$) decreased the primary spermatocytes, secondary spermatocytes, number of spermatogonia along with spermatids. Thimerosal induced adverse histopathological and morphological changes in testicular tissues such as decreased Leydig cells, diameter of seminiferous tubules, tunica albuginea height and epithelial height. On the other hand, the increase in tubular lumen and interstitial spaces was observed due to thimerosal. These outcomes indicated that thimerosal has potential repro-toxic effects in male albino rats."

From the study:

"Mercury is one of the most damaging sources of the reproductive system in animals and humans (Boujbiha et al., 2009). By disturbing the thyroid, pituitary, pancreas and adrenal glands, mercury can affect the endocrine systems of humans and animals even at very low concentration (Rice et al., 2014)."

"Thimerosal is used in vaccines, which breaks down into ethylmercury (Et-Hg) and thiosalycilic acid and readily accumulates in the tissues (Magos, 2003). Et-Hg, which is released from thimerosal is more lethal as compared to the parent compound (Clarksonet al., 2003). Due to lack of knowledge, the risk assessments forEt-Hg was made on the basis of toxicity caused by Me-Hg. Nonetheless, recent data have displayed that Me-Hg is not a proper reference for risk assessment for mercury released from thimerosal as there is a large difference between the kinetics of metabolism of both methyl and ethyl mercury (Magos, 2003; Burbacher et al.,2005)."

"The harmful impacts of thimerosal are abnormal pain sensitivity (Olczak et al., 2009), neuro-degradation of hippocampus(Olczak et al., 2010) and modification in dopaminergic pathways with successive behavioral disorganization (Olczak et al., 2011).Likewise, it is reported that neonatal administration of thimerosal may cause poor regulation of neurodevelopment, endocrine sys-tem and synaptic activity, which could be incidentally linked with mice autistic behavior (Li et al., 2014). Despite the harmful effects, thimerosal is still being used in antiseptics and vaccines (Sykeset al., 2014)."

Conclusion:

"In conclusion, our findings show that exposure to thimerosal results in increased oxidative stress and decreased activities of antioxidant enzymes, which ultimately lead to impairment in reproductive hormones and eventually decreased daily sperm pro-duction in testicular tissues of treated rats. Our findings provided information about the safe use of low concentrations of thimerosal in vaccines. Thus, the use of thimerosal as animal and human vac-cine preservative should be of great concern, specifically till the efficient risk evaluation." https://pubmed.ncbi.nlm.nih.gov/32994739/

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